

AHRQ Patient Safety Tools and Resources

The Agency for Healthcare Research and Quality (AHRQ) offers practical, research-based tools and resources to help a variety of healthcare organizations, providers, and others make care safer in all healthcare settings. These tools and resources help staff in hospitals, emergency departments, long-term care facilities, and ambulatory settings to prevent avoidable complications of care. They also address priority areas that have been identified as part of the U.S. Department of Health and Human Services Partnership for Patients and value-based purchasing programs. The tools and resources in this flier are organized alphabetically for clinicians by healthcare site, for use with patients, and as general patient safety research and data resources.

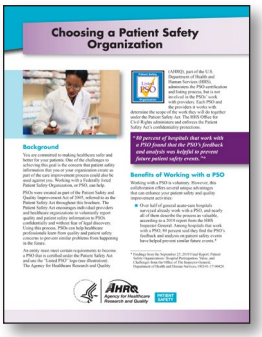
All tools can be found on the AHRQ website at ahrq.gov/tools/index.html

Tools and Resources for Healthcare Organizations

Multiple Settings

Calibrate Dx is a self-evaluation tool for clinicians to improve their diagnostic decision making. This resource provides structured exercises and tools to help clinicians learn from reviewing their clinical practice. Anyone whose scope of practice includes medical diagnosis can use Calibrate Dx.

Web: ahrq.gov/patient-safety/settings/multiple/calibrate-dx.html



Choosing a Patient Safety Organization (PSO) describes the benefits of working with a PSO. PSOs can help providers develop successful approaches to improving quality and reducing adverse outcomes, and make it possible to have Federal confidentiality and privilege protections apply to certain information (defined as "patient safety work product") developed when a provider works with a PSO. The brochure also discusses questions providers may want to consider when choosing a PSO.

Web: ahrq.gov/sites/default/files/wysiwyg/patient-safety/pso-brochure.pdf

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a suite of surveys originally developed by AHRQ and designed to measure patients' experiences of their care, including communication with doctors and nurses, responsiveness of staff, and other indicators of safe, high-quality care. The surveys are developed from the patient's perspective on what is important to measure. They are used by Federal agencies and other organizations for value-based purchasing programs, public reporting, accreditation, quality improvement, and health services research. The surveys are available for different settings and health plans. CAHPS surveys can be customized with supplemental item sets, including, for example, patient-

cahps® Surveys and Tools to Advance Patient-Centered Care

YouTube Check out AHRQ's New Patient Safety YouTube Channel
youtube.com/ahrqpatientsafety

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA
AHRQ Agency for Healthcare Research and Quality
PATIENT SAFETY


centered medical homes; health literacy; interpreter services; health information technology; and children with chronic conditions.

Web: ahrq.gov/cahps/index.html

Surveys include:
Settings:

- Clinician and group practices
  Web: ahrq.gov/cahps/surveys-guidance/cg
- Emergency departments
  Web: ahrq.gov/cahps/surveys-guidance/ed-cahps
- Home health care
  Web: ahrq.gov/cahps/surveys-guidance/home
- Hospices (hospice facility, hospital, home)
  Web: ahrq.gov/cahps/surveys-guidance/hospice
- Hospitals
  Web: ahrq.gov/cahps/surveys-guidance/hospital
- Hospital outpatient and ambulatory surgery centers
  Web: ahrq.gov/cahps/surveys-guidance/oas
- In-center hemodialysis facilities
  Web: ahrq.gov/cahps/surveys-guidance/ich
- Nursing homes (long stay, short stay, family member surveys)
  Web: ahrq.gov/cahps/surveys-guidance/nh
- Health Plans: Commercial, Medicaid, Medicare
  Web: ahrq.gov/cahps/surveys-guidance/hp
- Experience of Care and Health Outcomes
  Web: ahrq.gov/cahps/surveys-guidance/echo

Specialized Surveys:

- Cancer care—inpatient and outpatient treatment for drug therapy, radiation therapy, and surgical therapy
  Web: ahrq.gov/cahps/surveys-guidance/cancer
- Home and community-based services programs
  Web: ahrq.gov/cahps/surveys-guidance/hcbs

Comprehensive Unit-Based Safety Program (CUSP) Toolkit includes customizable training tools that build the capacity to address safety issues by combining clinical best practices, the science of safety, and attention to safety culture. Created for clinicians by clinicians, the toolkit includes training tools to make care safer by improving the foundation of how clinical team members work together. Each module includes teaching tools and resources to support change at the unit level and includes facilitator notes that take you step-by-step through the module, presentation slides, tools, and videos.

Web: ahrq.gov/cusptoolkit/

Settings and problems addressed include:

- Ambulatory surgery centers
  Web: ahrq.gov/haiambsurgery
- Central line-associated bloodstream infections (CLABSI)
  Web: ahrq.gov/CLABSItools
- Catheter-associated urinary tract infections (CAUTI)—hospitals
  Web: ahrq.gov/CAUTItools
- CAUTI—long-term care facilities
  Web: ahrq.gov/cautiltctools
- CAUTI and CLABSI—intensive care units
  Web: ahrq.gov/hai/tools/clabsi-cauti-icu/index.html
- Improving antibiotic use
  Web: ahrq.gov/antibiotic-use
- Mechanically ventilated patients
  Web: ahrq.gov/haimvp
- Perinatal safety
  Web: ahrq.gov/perinatalsafety
- Safe surgery
  Web: ahrq.gov/haisurgery

Healthcare Facility Design Safety Risk Assessment Toolkit helps healthcare design teams proactively identify and mitigate built environment conditions that may impact patient and work safety in the hospital and other healthcare environments. The toolkit addresses approaches to design that target six areas of safety: infections, falls, medication errors, security, injuries of behavioral health, and patient handling.

Web: ahrq.gov/hospsafetyassess-toolkit

Measure Dx: A Resource To Identify, Analyze, and Learn From Diagnostic Safety Events is a resource to help healthcare organizations detect, analyze, and learn from diagnostic safety events. Measure Dx can be used by any healthcare organization interested in promoting diagnostic excellence and reducing harm from diagnostic safety events. Potential users include clinicians, quality

and safety professionals, risk management professionals, health system leaders, and clinical managers.

Web: ahrq.gov/patient-safety/settings/multiple/measure-dx.html

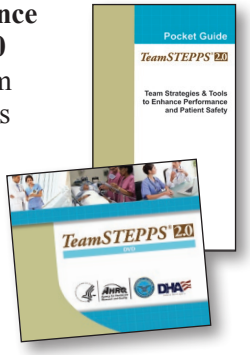
Surveys on Patient Safety Culture™ (SOPS®) ask healthcare providers and other staff in hospitals, medical offices, nursing homes, community pharmacies, and ambulatory surgery centers about their organizational culture's support for patient safety. The purpose of the SOPS® program is to advance our scientific understanding of patient safety culture in healthcare.

Web: ahrq.gov/sops/index.html

The SOPS program enables healthcare organizations to assess how their providers and staff perceive various aspects of patient safety culture in the following settings:

- Hospitals
  Web: ahrq.gov/hospsurvey
- Medical Offices
  Web: ahrq.gov/medicalofficesurvey
- Nursing Homes
  Web: ahrq.gov/nursinghsurvey
- Community Pharmacies
  Web: ahrq.gov/sops-compharmacy
- Ambulatory Surgery Centers
  Web: ahrq.gov/sops-asc

Users of SOPS surveys have the option of incorporating additional questions, known as supplemental items, to customize their questionnaires. The SOPS Hospital Survey supplemental items include health information technology, workplace safety, and value and efficiency. The SOPS Medical Office Survey supplemental items include diagnostic safety and value and efficiency.



Team Strategies and Tools to Enhance Performance and Patient Safety 2.0 (TeamSTEPPS®) is a core curriculum initially developed for use in hospitals and adapted to other settings. It is a customizable "train the trainer" program plus specialized tools to reduce risks to patient safety by training clinicians in teamwork and communication skills. Materials include a leader's guide for trainers, a pocket guide of important concepts for trainees (also available as an app through the Apple App Store and Google Play Store), and a multimedia guide featuring training videos to illustrate various concepts. Online modules also are available. Additional modules address:

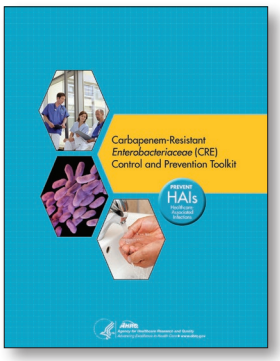
Web: ahrq.gov/teamstepps

- Long-term care
  Web: ahrq.gov/teamstepps/longtermcare
- Office-based care
  Web: ahrq.gov/teamstepps/officebasedcare
- Patients with limited English proficiency
  Web: ahrq.gov/teamsteppslep
- Rapid response systems guide
  Web: ahrq.gov/teamstepps/rrs

TeamSTEPPS for Diagnosis Improvement Course aims to raise diagnostic safety awareness, introduce the concept of a broad multidisciplinary diagnostic team that includes nonclinicians and patients and their families, and provide assessment and training tools to support local efforts to reduce diagnostic harm. The course consists of seven PowerPoint® training modules customizable to the needs of the local team and course facilitator.

Web: ahrq.gov/teamstepps/diagnosis-improvement/index.html

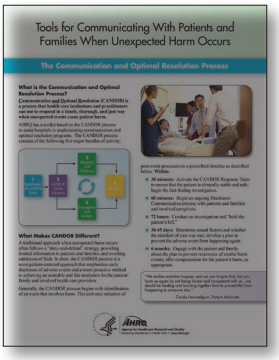
Hospitals



Carbapenem-Resistant Enterobacteriaceae (CRE) Control and Prevention Toolkit provides a framework for outlining steps needed to design and implement CRE control and prevention of infection transmission, including what staff is responsible for each task and timeframe for completing the tasks.

Web: ahrq.gov/cretoolkit

Communication and Optimal Resolution (CANDOR) Toolkit enables healthcare organizations to implement an AHRQ-developed process. Like similar programs in place in other organizations, CANDOR gives hospitals and health systems the tools to respond immediately when a patient is harmed and to promote candid, empathetic communication and timely resolution for patients and caregivers. Based on expert input and lessons learned from the Agency's $23 million Patient Safety and Medical Liability grant initiative launched in 2009, the CANDOR toolkit was tested and applied in 14 hospitals across three U.S. health systems.



Each of the toolkit's eight modules contains PowerPoint slides with facilitator notes. Some modules also contain tools, resources, or videos.

Web: ahrq.gov/candor

Fall TIPS: A Patient-Centered Fall Prevention Toolkit consists of a formal risk assessment and tailored plan of care for each patient. The toolkit has reduced falls by 25 percent in acute care hospitals and is used in more than 100 hospitals in the United States and internationally.

Web: ahrq.gov/patient-safety/settings/hospital/fall-tips

Family-Centered Rounds (FCR) Toolkit was designed to increase family engagement in rounds for hospitalized children. It is intended for use by healthcare providers initiating FCR and/or operationalizing optimal practices in the setting of existing FCR, including: physicians, nurses, hospital administrators, and quality improvement personnel.

Web: ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/fcrtoolkit.html

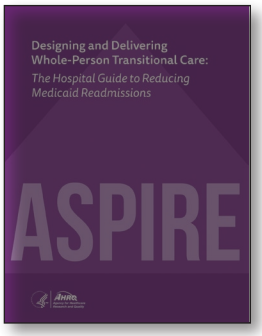
Guide for Developing a Community-Based Patient Safety Advisory Council provides approaches for hospitals and other healthcare organizations to use to develop a community-based advisory council that can drive change for patient safety through education, collaboration, and consumer engagement.

Web: ahrq.gov/qual/advisorycouncil

Guide to Patient and Family Engagement in Hospital Quality and Safety helps hospitals work as partners with patients and families to improve quality and safety. Includes an implementation handbook and tools for patients, families, and clinicians.

Web: ahrq.gov/hospital/engagingfamilies

Hospital Guide to Reducing Medicaid Readmissions provides evidence-based strategies to reduce readmissions among the adult Medicaid population.



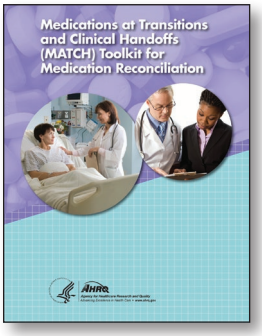
Web: ahrq.gov/reducemedicaidreadmis

I-PASS Mentored Implementation Handoff Curriculum is a comprehensive handoff curriculum that has been proven to improve the safety, efficiency, and efficacy of shift-to-shift handoffs during patient handoffs.

Web: www.mededportal.org/publication/10736

Making Informed Consent an Informed Choice: Training Modules for Health Care Leaders and Professionals provides tools to hospital leaders and health professionals to improve informed consent policy and practice.

Web: ahrq.gov/informedchoice



Medications at Transitions and Clinical Handoffs (MATCH) Toolkit features strategies from the field that can help hospitals improve medication reconciliation processes for patients as they move through the healthcare system.

Web: ahrq.gov/qual/match

Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS) Toolkit includes a set of medication reconciliation tools to reduce medication errors that frequently occur during care transitions when patients enter and leave the hospital.

Web: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/shm_medication_reconciliation_guide.pdf

The Network of Patient Safety Databases Chartbook provides an overview of data captured by Patient Safety Organizations on the nature of patient safety events in hospital settings.

Web: ahrq.gov/npsd/data/chartbook/index.html

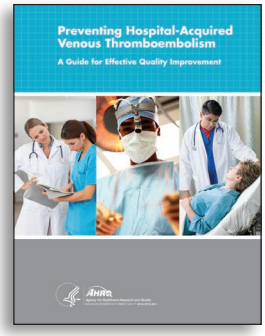
Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care focuses on overcoming the challenges associated with developing, implementing, and sustaining a fall prevention program. Includes an implementation guide to help put prevention strategies into practice.

Web: ahrq.gov/preventingfalls

- **Fall Prevention in Hospitals Training Program** supports the training of hospital staff on how to implement AHRQ's Preventing Falls in Hospitals Toolkit. It consists of a five-module, in-person training curriculum and a series of companion webinars on specific topics related to fall prevention. An Implementation Guide provides additional suggestions for how to use the training program and the toolkit.

  Web: ahrq.gov/fallprevtraining

Preventing Hospital-Associated Venous Thromboembolism: A Guide for Effective Quality Improvement outlines the latest evidence on how to lead a quality improvement effort to prevent hospital-acquired venous thromboembolism.



Web: ahrq.gov/vtguide

Preventing Pressure Ulcers: A Toolkit for Improving Quality of Care in Hospitals assists hospital staff in implementing effective pressure ulcer prevention practices through an interdisciplinary approach to care.

Web: ahrq.gov/pressureulcertoolkit

- **Pressure Injury Prevention in Hospitals Training Progam** supports the training of hospital staff on how to implement AHRQ's Preventing Pressure Ulcers in Hospitals Toolkit. It consists of a five-module, in-person training curriculum and a series of companion webinars on specific topics related to pressure injury prevention. An Implementation Guide provides additional suggestions for how to use the training program and the toolkit.

  Web: ahrq.gov/pressureinjuryprevtraining

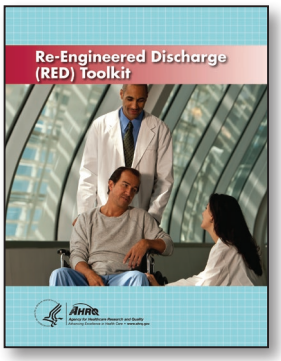
Project BOOST (Better Outcomes by Optimizing Safe Transitions) provides hospitals a comprehensive set of interventions to improve the care transition process after discharge in order to reduce readmissions.

Web: https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf

REDUCE MRSA (Methicillin-Resistant *Staphylococcus aureus*) Enhanced Protocol explains that universal decolonization is the most effective intervention to reduce MRSA infections. This tool provides instructions for implementing decolonization in adult intensive care units.

Web: ahrq.gov/universal_icu_decolonization

Re-Engineered Discharge (RED) Toolkit is a research-based tool to assist hospitals, including those that serve diverse populations, in improving their hospital discharge process and reducing avoidable readmissions. An English/Spanish guide to help staff ensure that patients understand their discharge instructions is also available.



Web: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html

Safe Operating Room (OR) Design is an interactive web-based tool that uses a 3D model to support clinicians, designers, and researchers in better understanding how to design a safer, more ergonomic OR. The tool engages multidisciplinary team members in a more collaborative design process when designing OR environments and provides a comprehensive understanding of how different design elements and strategies affect safety in the OR, using a systems approach.

Web: http://ordesign.clemson.edu/or_design_toolkit

Toolkit for Decolonization of Non-ICU Patients With Devices—Based on the ABATE Infection Trial Protocol provides hospital infection prevention programs with instructions for implementing targeted decolonization in adult patients with specific indwelling medical devices. It consists of decision-making tools, nursing protocols, assessment materials, and demonstration videos.

Web: ahrq.gov/hai/tools/abate/index.html

Toolkit for Using the AHRQ Quality Indicators: How To Improve Hospital Quality and Safety helps hospitals understand AHRQ's Quality Indicators and how to use them to identify areas of concern in need of further investigation, and monitor progress over time. See Quality Indicators entry under the section, Additional Patient Safety Resources: Research, Data, and Measurement.

Web: ahrq.gov/hospitalqitoolkit/

Toolkit To Improve Antibiotic Use in Acute Care Hospitals provides presentations and tools for clinicians to use to improve antibiotic prescribing in the hospital setting. The toolkit explains how to apply the Four Moments of Antibiotic Decision Making, an innovative approach to antibiotic stewardship that empowers clinicians to be stewards of their own antibiotic prescribing. The toolkit also provides guidance on developing and improving an antibiotic stewardship program, creating a culture of safety around antibiotic prescribing in your hospital, and learning and disseminating best practices for the diagnosis and treatment of common infectious disease syndromes.

Web: ahrq.gov/antibiotic-use/acute-care/index.html

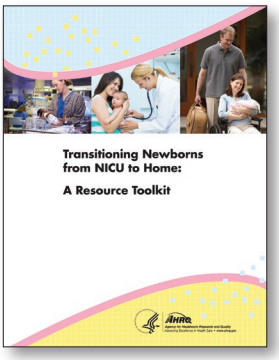
Toolkit for Preventing Central Line-Associated Bloodstream Infections (CLABSI) and Catheter-Associated Urinary Tract Infections (CAUTI) in ICUs provides ICU staff with customizable tools to decrease these infections using the Comprehensive Unit-Based Safety Program (CUSP) framework. It consists of 10 technical webinars, 5 CUSP onboarding modules, tip sheets, assessment tools, audio interviews, and short videos.

Web: ahrq.gov/hai/tools/clabsi-cauti-icu/index.html

Toolkit for Reduction of *Clostridum difficile* Infections Through Antimicrobial Stewardship assists hospital staff and leadership in developing an effective antimicrobial stewardship program that targets inappropriate use of antibiotics, which has the potential to reduce *C. difficile*.

Web: ahrq.gov/cdifftoolkit

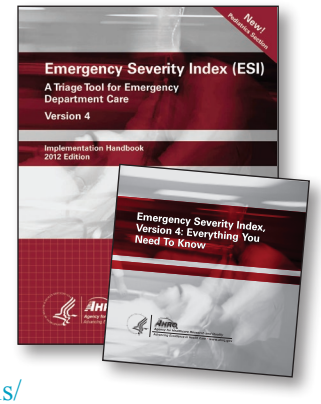
Transitioning Newborns From NICU to Home: A Resource Toolkit provides customizable resources to help hospitals and families safely transition newborns out of the neonatal intensive care unit to home using a Health Coach Program.



Web: ahrq.gov/nicutools

Hospital Emergency Departments

Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4 is a five-level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs.



Web: ahrq.gov/professionals/systems/hospital/esi/index.html

Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals presents step-by-step instructions for planning and implementing patient flow improvement strategies to alleviate crowded emergency departments.

Web: ahrq.gov/ptflow/

Sepsis Telehealth Project & Toolkit is a guide to train rural emergency department (ED) clinicians on how to integrate remote intensive care unit (ICU) staff into the workflow for the purpose of treating patients with severe sepsis and septic shock. The toolkit could be used to

integrate remote staff into any healthcare setting and applied to other medical conditions.

Web: www.jumpsimulation.org/research-innovation/research/sepsis-telehealth-study-toolkit

The Uncertainty Communication Toolkit gives healthcare providers a standardized approach to establishing competency in communication of diagnostic uncertainty with patients being discharged from the emergency department.

Web: https://research.jefferson.edu/connected-care-center/uncertainty-communication-toolkit.html

Long-Term Care Facilities

CAHPS® Nursing Home Survey (see description under Multiple Settings section)

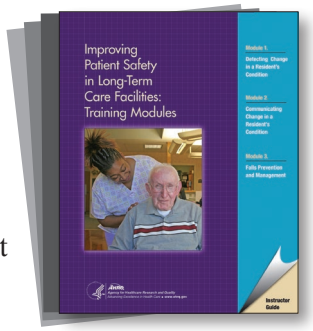
- Web: ahrq.gov/cahps/surveys-guidance/nh

CUSP Toolkit To Reduce CAUTI and Other HAIs in Long-Term Care Facilities (see description under Multiple Settings section)

- Web: ahrq.gov/cautiltctools

Falls Management Program: A Quality Improvement Initiative for Nursing Facilities is an interdisciplinary quality improvement initiative to assist nursing facilities in providing individualized, person-centered care and improving their fall care processes and outcomes through educational and quality improvement tools.

Web: ahrq.gov/fallsmgmtltc



Improving Patient Safety in Long-Term Care Facilities is a training curriculum for front-line personnel in nursing home and other long-term care facilities to help them detect and communicate changes in a resident's condition and prevent and manage falls. Includes an Instructor Guide and separate student workbooks.

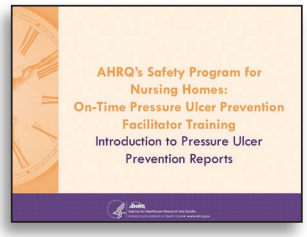
Web: ahrq.gov/psafetyltcmodules

Nursing Home Antimicrobial Stewardship Guide provides field-tested, evidence-based modules that can help nursing homes develop antibiotic stewardship programs to help them use and prescribe antibiotics appropriately. Appropriate antibiotic use can reduce antimicrobial resistance and help retain the effectiveness of treatments for infection, which are a common threat to resident safety.

Web: ahrq.gov/nh-aspguide

Nursing Home Survey on Patient Safety Culture (see description under Multiple Settings section)

Web: ahrq.gov/sops/surveys/nursing-home/



Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention is a team training curriculum to help nursing homes with electronic medical records reduce the occurrence of pressure ulcers.

Web: ahrq.gov/ontimeltc

TeamSTEPPS® Long-Term Care Version (see listing under Multiple Settings)

Toolkit To Educate and Engage Residents and Family Members helps nursing homes encourage an open and respectful dialogue between nurses and prescribing clinicians and residents and family members and helps residents and family members participate in their care.

Web: ahrq.gov/nh/residentengagementtoolkit

Toolkit to Improve Antibiotic Use in Long-Term Care provides presentations and tools for clinicians and staff to use to improve antibiotic prescribing in long-term care. The toolkit explains how to apply the Four Moments of Antibiotic Decision Making, an innovative approach to antibiotic stewardship that empowers clinicians to be stewards of their own antibiotic prescribing. The toolkit also provides guidance on developing and improving an antibiotic stewardship program, creating a culture of safety around antibiotic prescribing in long-term care facilities, communicating with residents and families about infection concerns, and using best practices for the diagnosis and treatment of common infectious disease syndromes.

Web: ahrq.gov/antibiotic-use/long-term-care/index.html

Understanding Omissions of Care in Nursing Homes helps nursing home staff understand how omissions of care are defined in a way that is meaningful to stakeholders, including residents and caregivers, and actionable for research or improving quality of care.

Web: ahrq.gov/patient-safety/settings/long-term-care/resource/omissions.html

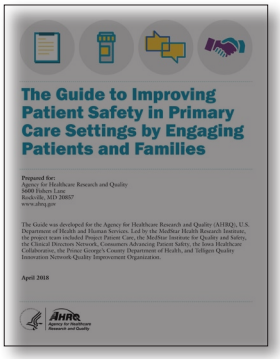
Ambulatory Care Settings

Ambulatory Surgery Center (ASC) Survey on Patient Safety Culture (see descripton under Multiple Settings section)

CAHPS® Clinician & Group Survey (see description under Multiple Settings section)

The **Community-Acquired Pneumonia (CAP) Patient Safety Clinical Decision Support Implementation Toolkit** is a resource to help clinicians and clinical informaticians in primary care and other ambulatory settings implement and adopt the CAP clinical decision support (CDS) alert for the management of community-acquired pneumonia.

Web: ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-care/cap-toolkit.html



Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families offers four interventions and four case studies designed to improve patient safety by meaningfully engaging patients and families in their care.

Web: ahrq.gov/pfeprimarycare

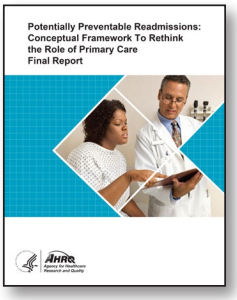
Health Literacy Universal Precautions Toolkit, 2nd Edition, can help primary care practices reduce the complexity of healthcare, increase patient understanding of health information, and enhance support for patients of all literacy levels. It includes tools to improve spoken and written communication, tools to improve self-management and empowerment, and others.

Web: ahrq.gov/health-literacy-toolkit

Improving Your Laboratory Testing Process: A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement. The tools in this step-by-step guide can increase the reliability of the testing process in your office by helping you examine how tests are managed.

Web: ahrq.gov/labtesting-toolkit

Medical Office Survey on Patient Safety Culture (see description under Multiple Settings section)



Primary Care-Based Efforts To Reduce Potentially Preventable Readmissions addresses the role of primary care in improving the quality and safety of care as patients transition from the hospital setting.

- Web: ahrq.gov/patient-safety/settings/ambulatory/reduce-readmissions.html

Reducing Diagnostic Errors in Primary Care Pediatrics Toolkit aims to assist primary care practice teams with a systematic approach to reduce diagnostic errors among children in three important areas:

- Elevated blood pressure, which is misdiagnosed in 74 to 87 percent of children
- Adolescent depression, which affects nearly 10 percent of teenagers and is misdiagnosed in almost 75 percent of adolescents
- Actionable pediatric diagnostic tests, which are potentially delayed up to 26 percent of the time

Web: ahrq.gov/professionals/quality-patient-safety/diagnostic-safety/toolkit.html

Safety Program for End-Stage Renal Disease Facilities Toolkit helps end-stage renal disease clinics prevent healthcare-associated infections in dialysis patients by following clinical practices, creating a culture of safety, using checklists and other audit tools, and engaging with patients and their families. The toolkit includes four instructional modules that a facilitator can use to teach dialysis center team members specific ways to create a culture of safety.

Web: ahrq.gov/esrdinfections

Six Building Blocks and Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care How-To-Implement Toolkit help support primary care clinics as they independently implement effective, guideline-driven care for their patients with chronic pain who are using opioid therapy.

Web: ahrq.gov/patient-safety/settings/ambulatory/improve/six-building-blocks-guide.html

TeamSTEPPS® for Office-Based Care (see description under Multiple Settings section)

The **Toolkit To Engage High-Risk Patients in Safe Transitions Across Ambulatory Settings** is designed to help staff actively engage patients and their care partners to prevent errors during transitions of care.

Web: ahrq.gov/hai/tools/ambulatory-care/safe-transitions.html

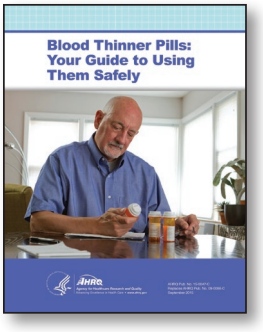
Toolkit for Engaging Patients To Improve Diagnostic Safety is designed to help patients, families, and health professionals work together as partners to improve diagnostic safety.

Web: ahrq.gov/patient-safety/resources/diagnostic-safety/toolkit.html

Tools To Engage Patients

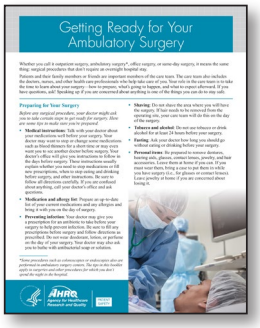
Be More Engaged in Your Healthcare: Tips for Patients, a brochure that gives patients tips to use before, during, and after a medical appointment to get the best possible care.

Web: ahrq.gov/tipsforpatients



Blood Thinner Pills: Your Guide to Using Them Safely explains, in both English and Spanish, what patients can expect while taking blood thinner medication.

Web: ahrq.gov/btpills/

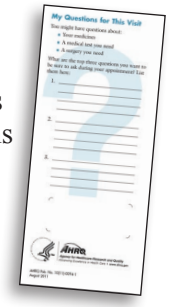


Getting Ready for Your Ambulatory Surgery. This 2-page patient brochure helps patients and their families prepare for ambulatory surgeries and other procedures performed in outpatient settings.

Web ahrq.gov/getting-ready-ambsurgery

InfoSAGE, short for "Information Sharing Across Generations," is a free web resource to facilitate care coordination among patient and family members and their medical team. It includes a medication manager to help older adults and their families keep an accurate medication list, coordinate the list with prescribing clinicians, track the impact of medications on symptoms, view medication precautions and drug-drug interactions, and become more engaged as partners in their care.

Web: www.infosagehealth.org/app/#/



My Questions for This Visit are 50-sheet notepads designed for use in physician offices to help patients identify the top three questions they want to remember to ask during medical visits.

Web: ahrq.gov/questioncard

Questions Are the Answer materials are designed to improve communication between patients and clinicians to help make healthcare safer.

Research from a wide variety of AHRQ patient safety projects was synthesized into materials featuring AHRQ's trusted evidence about diagnostic testing and results, medication safety, safe transitions between care settings, and the importance of patient and family engagement in healthcare.

In 2019, AHRQ developed its QuestionBuilder app by fusing the latest mobile technology with longstanding research to put questions to ask at patients' fingertips.

Notepads, an online Question Builder, and a DVD with a 7-minute videos (designed to be played in waiting rooms) of patients and clinicians discussing the importance of asking questions are also available.

Web: ahrq.gov/questions

- **QuestionBuilder en Español** (Know the Questions), a Spanish-language companion site to Questions Are the Answer, encourages Hispanics to go to the doctor and ask questions to achieve better health outcomes. The website features tips on how to talk with doctors and questions to ask when receiving medical care.

  Web: ahrq.gov/es/questions/question-builder/index.html

Staying Active and Healthy With Blood Thinners is a 10-minute video that features easy-to-understand explanations, in English and Spanish, of how blood thinners work and why it is important to take them correctly. It also introduces BEST, an easy way to remember how to fit blood thinner medication into daily life.

Web: ahrq.gov/bloodthinners

Taking Care of Myself: A Guide for When I Leave the Hospital is an easy-to-read guide to help nurses or discharge advocates work with patients to track medication schedules, upcoming medical appointments, and important phone numbers after they leave the hospital.

Web: ahrq.gov/goinghomeguide/

Your Guide to Preventing and Treating Blood Clots discusses ways to prevent, treat, and recognize symptoms of blood clots. It also describes medications used to prevent blood clots and their side effects.

Web: ahrq.gov/bloodclots

Your Medicine: Be Smart. Be Safe answers common questions about getting and taking medicines; includes a handy form to help patients keep track of their medicines.

Web: ahrq.gov/yourmedicine

Additional Patient Safety Resources: Research, Data, Measurement

Advances in Patient Safety and Medical Liability highlights results from a number of AHRQ-funded planning and demonstration grants aimed at improving patient safety and malpractice outcomes, as well as the environment in which those outcomes occur. Some of the topics include the role of patients and families in supporting improved care and patient safety; the impact of institutional silence when patient harm occurs; and the implementation of disclosure, apology, and offer programs.

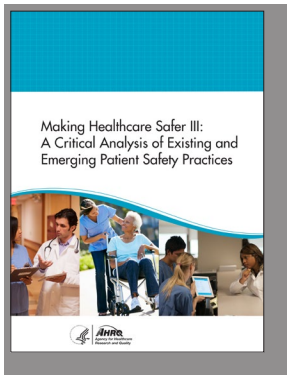
Web: ahrq.gov/medicalliabilityadvances

Common Formats are specifications used to collect patient safety event information in a standard way, using common language, definitions, technical requirements for electronic implementation, and reporting. The Common Formats can be used to collect data on all types of adverse events, near misses, and unsafe conditions in hospitals, nursing homes, and more. Common Formats are currently available for hospitals, nursing homes, and community pharmacies.

Web: https://pso.ahrq.gov/common-formats

Making Healthcare Safer III Report: A Critical Analysis of Existing and Emerging Patient Safety Practices reviews 47 practices that target patient safety improvement in hospitals, primary care practices, long-term care facilities, and other healthcare settings.

Web: ahrq.gov/mhs3



Comparative Databases for Safety and Quality

- **CAHPS Health Plan Database** gathers survey results from Health Plan Survey users across the country and then reports aggregated data in an Online Reporting System that all survey users can use to identify strengths and weaknesses in their own performance.

  Web: ahrq.gov/cahps/cahps-database/

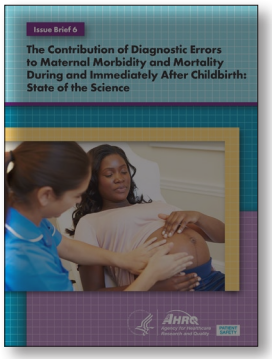
- **CAHPS Clinician & Group Survey (CG-CAHPS) Database** has been accepting survey data since 2010. It was developed in response to the growing demand for comparative results for the various versions of the Clinician & Group Survey. Submissions to the database will be suspended starting in 2021. However, the historic data will remain available.

  Web: ahrq.gov/cahps/surveys-guidance/cg

- **Hospital Survey on Patient Safety Culture (HSOPS) Comparative Database** is a central repository for survey data from hospitals that have administered the AHRQ Patient Safety Culture Survey instrument and can be used by hospitals to compare their results to those of other hospitals.

  Web: ahrq.gov/HSOPSdatabase

Diagnostic Safety Series of Issue Briefs



- **The Contribution of Diagnostic Errors to Maternal Morbidity and Mortality During and Immediately After Childbirth: State of the Science** discusses what is known about the contribution of diagnostic error to maternal morbidity and mortality, explains the rationale for improvement methods, and outlines the research agenda needed to make progress in this emerging area of diagnostic safety.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/maternal-mortality.html

- **Distributed Cognition and the Role of Nurses in Diagnostic Safety in the Emergency Department** discusses the nurse's role in diagnostic safety, using the conceptual lens of distributed cognition.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/distributed-cognition-er-nurses.html

- **Evidence on Use of Clinical Reasoning Checklists for Diagnostic Error Reduction** summarizes current evidence on use of checklists to improve diagnostic reasoning.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/dxchecklists.html

- **Health Information Technology for Engaging Patients in Diagnostic Decision Making in Emergency Departments** reviews the current state of health IT-based methods for engaging patients in the diagnostic process in the emergency department and outlines opportunities for further development.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/healthit-ed.html

- **Improved Diagnostic Accuracy Through Probability-Based Diagnosis** presents a framework that outlines the diagnostic process and highlights the role of probabilistic understanding at each step.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/probabilistic-thinking1.html

- **Improving Education—A Key to Better Diagnostic Outcomes** highlights the current state of diagnosis education, including gaps; describes innovations with high potential for wider impact; identifies key competencies needed to improve diagnostic performance; and describes next steps to ensure progress.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/education-dx-outcomes.html

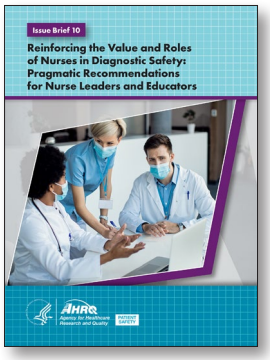
- **Leadership To Improve Diagnosis: A Call to Action** provides an overview of how healthcare leaders can start to carry out the responsibility of improving diagnosis.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/leadership.html

- **Operational Measurement of Diagnostic Safety: State of the Science** discusses the state of the science of operational measurement of diagnostic safety for the purpose of providing knowledge and suggestions to encourage healthcare organizations to begin to identify and learn from diagnostic errors.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/state-of-science.html

- **Reinforcing the Value and Roles of Nurses in Diagnostic Safety: Pragmatic Recommendations for Nurse Leaders and Educators** describes pragmatic approaches for nurse educators and leaders to convey the urgent need to improve diagnosis among their nurses and care teams and to guide nurses to embrace their leadership roles in the diagnostic process.



  Web: ahrq.gov/patient-safety/reports/issue-briefs/nurse-role-dxsafety1.html

- **Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis** highlights what we do and don't know about using telemedicine for diagnosis and the implications for research and practice.

  Web: ahrq.gov/patient-safety/reports/issue-briefs/teledx.html

Diagnostic Safety Journal Articles

- **Advancing Diagnostic Equity Through Clinician Engagement, Community Partnerships, and Connected Care** proposes a three-pronged strategy focused on advocacy and partnerships to begin to address diagnostic inequity: clinician engagement, community partnerships, and connected care.

  Web: ahrq.gov/sites/default/files/wysiwyg/topics/advancing-diagnostic-equity.pdf

- **Bridging the Feedback Gap: A Sociotechnical Approach to Informing Clinicians of Patients' Subsequent Clinical Course and Outcomes** discusses challenges to the development of systems for effective patient outcome feedback and proposes the application of a sociotechnical approach using health information technology (IT) to support the implementation of such systems.

  Web: ahrq.gov/sites/default/files/wysiwyg/topics/bridging-feedback-gap.pdf

- **Defining Diagnostic Error: A Scoping Review To Assess the Impact of the National Academies' Report Improving Diagnosis in Health Care** explores how researchers have operationalized the National Academies of Science, Engineering, and Medicine committee's definition of diagnostic error in peer-reviewed published literature and established its impact on this growing field.

  Web: ahrq.gov/sites/default/files/wysiwyg/topics/defining-diagnostic-error-a-scoping-review.pdf

- **Development and Usability Testing of the Agency for Healthcare Research and Quality Common Formats to Capture Diagnostic Safety Events** assesses whether users found the CFER-DS items valid, appropriate in scope, and adequate to the task of encoding details of diagnostic safety events.

  Web: ahrq.gov/sites/default/files/wysiwyg/topics/development-and-usability-testing-common-formats.pdf

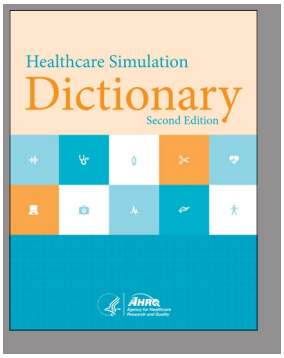
- **Managing Interruptions To Improve Diagnostic Decision-Making: Strategies and Recommended Research Agenda** presents a modified model of interruptions to visualize the interruption process and illustrate where potential interventions can be implemented. It also highlights strategies to minimize the negative impact of interruptions as well as strategies to prevent interruptions altogether.

  Web: ahrq.gov/sites/default/files/wysiwyg/topics/managing-interruptions-improve-diagnostic-decisionmaking.pdf

Healthcare Comes Home: The Human Factors is an AHRQ-funded report from the National Research Council that offers recommendations for system improvements to address the most prevalent and serious threats to safety and quality of care provided in the home environment.

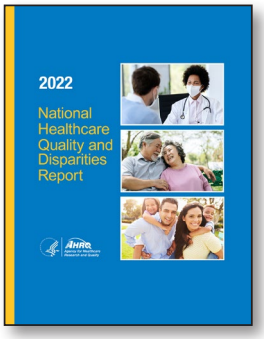
Web: ahrq.gov/homecarehumanfactors

Healthcare Simulation Dictionary – Second Edition has added 40 new terms to the more than 100 healthcare simulation terms and definitions in the first edition. The dictionary standardizes simulation terminology for healthcare simulation professionals to use in areas such as education, assessment, research, and systems integration.



Web: ahrq.gov/patient-safety/resources/simulation/terms.html

National Healthcare Quality and Disparities Report, a Congressionally mandated annual report that presents trends and disparities in the effectiveness, safety, timeliness, patient-centeredness, and efficiency of care based on more than 250 measures of care.



Web: ahrq.gov/research/findings/nhqrdr/index.html

- **Patient Safety Chartbook**, a companion report, presents data in easy-to-understand graphic format.

  Web: ahrq.gov/ptsafetychartbook

Network of Patient Safety Databases (NPSD) contains nonidentifiable, aggregated patient safety information voluntarily reported by AHRQ-listed Patient Safety Organizations from across the Nation. The NPSD data are made available to the public through various informational products, including interactive NPSD Dashboards, NPSD Chartbooks, and NPSD Data Spotlights.

Web: ahrq.gov/npsd/index.html

NPSD Dashboards page: ahrq.gov/ npsd/data/dashboard/index.html

NPSD Chartbooks page: ahrq.gov/npsd/ data/chartbook/index.html

NPSD Data Spotlights page: ahrq.gov/npsd/data/spotlights.html

Patient Safety in Ambulatory Settings Technical Brief explores fundamental questions about patient safety practices in ambulatory care and identifies promising safety initiatives that have not been broadly implemented or studied. The brief finds that significant gaps exist in ambulatory safety research, notably a lack of studies in patient engagement and timely and accurate diagnosis.

Web: ahrq.gov/ambulatorysafetybrief

Patient Safety Network (AHRQ PSNET) is a national Web-based resource that features the latest news and essential resources on patient safety, including weekly literature updates, news, tools, and meetings; patient safety primers; and annotated links to important research and other information on patient safety. It also includes case reports and safety perspectives from Web M&M (Morbidity and Mortality Rounds on the Web), a peer-reviewed online journal and forum on patient safety and healthcare quality.

Web: psnet.ahrq.gov

Quality Indicators

Web: qualityindicators.ahrq.gov

Settings and problems addressed by the Quality Indicators™ include:

- **Inpatient Quality Indicators** reflect quality of care inside hospitals, including inpatient mortality for medical conditions and surgical procedures.

  Web: qualityindicators.ahrq.gov/Modules/iqi_resources.aspx

- **Patient Safety Indicators** reflect quality of care inside hospitals to focus on potentially avoidable complications and healthcare-associated events.

  Web: qualityindicators.ahrq.gov/Modules/psi_resources.aspx

- **Prevention Quality Indicators** identify hospital admissions that evidence suggests may have been avoided through access to high-quality outpatient care.

  Web: qualityindicators.ahrq.gov/Modules/pqi_resources.aspx

- **Pediatric Quality Indicators** use indicators from the other three modules with adaptations for use among children and neonates to reflect quality of care inside hospitals and identify potentially avoidable hospitalizations.

  Web: qualityindicators.ahrq.gov/Modules/pdi_resources.aspx

Resident Duty Hours: Enhancing Sleep, Supervision, and Safety, an AHRQ-funded report from the Institute of Medicine, recommends changes to resident work hours and training programs to enhance patient safety.

Web: ahrq.gov/residentdutyhours

Resident Safety Practices in Nursing Home Settings is a technical brief that describes the state of the science around nursing home safety in order to establish a research agenda for moving the field forward.

Web: ahrq.gov/ressafetypracticesltc

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