IMPROVING PATIENT SAFETY CULTURE IN PRIMARY CARE:

A Resource List to Accompany Survey on Patient Safety Culture Results

HQCA
Health Quality Council of Alberta

About the Health Quality Council of Alberta

The Health Quality Council of Alberta is a provincial agency that brings together patients, families, and our partners from across healthcare and academia to inspire improvement in patient safety, person-centred care, and health service quality. We assess and study the healthcare system, identify effective practices, and engage with Albertans to gather information about their experiences. Our responsibilities are outlined in the Health Quality Council of Alberta Act.

Purpose of this Document

This document provides a list of references to websites and other publicly available, practical resources primary care clinics can use to improve patient safety culture and patient safety. While this resource list is not exhaustive, it is designed to give initial guidance to primary care clinics seeking information about patient safety initiatives.

How To Use This Resource List

Resources are organized by the Surveys on Patient Safety Culture™(SOPS™) composite measures assessed in the Agency for Healthcare Research and Quality (AHRQ) Medical Office Survey on Patient Safety Culture, followed by general resources. For easy access to the resources, keep the file open rather than printing it in hard copy because many of the website URLs are hyperlinked and cross-referenced to other resources within the document.

Resources by Composite

The following resources are organized according to the relevant Medical Office Survey on Patient Safety Culture composite measures they are designed to help improve. Some resources are duplicated and cross-referenced because they may apply to more than one composite.

Note: This Resource List has been adapted from the AHRQ resource list.

Updated May 24th, 2023

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Composite #1

Communication About Error

1. Amy Edmundson – Psychological Safety

https://amycedmondson.com/psychological-safety/

A webpage with various courses, books, articles, and educational videos pertaining to psychological safety. Theoretically, facilitating greater psychological safety in the workplace will encourage staff members to feel more comfortable communicating about errors.

2. HEC Creating a Safe Space Toolkit

https://www.healthcareexcellence.ca/media/zamhlhcq/5_creating-a-safe-space-toolkit_en-final-ua.pdf

Healthcare Excellence Canada (HEC) developed this toolkit to support healthcare leaders and policymakers to develop, implement or improve healthcare worker support programs, and introduce psychological safety. "The toolkit is divided into three tables:

- Table 1.1 includes resources for developing and improving peer support programs, and general psychological well-being resources.
- Table 1.2 includes resources that address psychological self-care in healthcare workers, such as fact sheets about psychological self-care and worksheets for developing a psychological self-care plan.
- Table 1.3 includes resources that address moral distress in the healthcare sector, such as links to moral distress projects currently being developed, fact sheets, toolkits, ethical decision-making frameworks, and PowerPoint presentations."

3. Living a Culture of Patient Safety Policy and Brochure

http://www.ihi.org/resources/Pages/Tools/LivingaCultureofPatientSafety.aspx

(requires free account setup and login)

"St. John's Mercy Medical Center created an institution-wide policy regarding nonpunitive reporting, as well as a brochure, Living a Culture of Patient Safety, that was developed by its Culture of Safety Subcommittee, signed by the president, and mailed to all co-worker homes. The brochure reinforces the nonpunitive reporting policy and encourages all coworkers to report errors".

4. TeamSTEPPS® ('Communication' and 'Mutual Support' modules)

- Canadian Essentials Course
  https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/
- Office-Based Care Course
  https://www.ahrq.gov/teamstepps/officebasedcare/index.html
- Pocket Guide
  https://www.ahrq.gov/sites/default/files/publications/files/pocketguide.pdf

TeamSTEPPS is a teamwork system designed for healthcare professionals that is:

- Evidence-based to improve communication and teamwork skills among healthcare professionals.
- A source for ready-to-use materials and a training curriculum to successfully integrate teamwork principles into all areas of your healthcare system.

5. HQCA Just Culture Webpage

https://justculture.hqca.ca/

This Health Quality Council of Alberta (HQCA) website provides information and resources on creating "a just culture for patient safety – an atmosphere of trust in which healthcare workers are supported and treated fairly when something goes wrong with patient care. In a just culture, people feel safe to discuss errors and safety concerns without fear of blame". The website provides resources that can help organizations establish a framework and actions to support a just culture, as well as tools for the fair assessment of staff involved in a patient safety incident.

6. Systematic Systems Analysis

https://hqca.ca/wp-content/uploads/2022/11/HQCA-2022-SSA-Patient-Review-F2-web.pdf

This guidebook was authored by Dr. J.M. Davies and Carmella Duchscherer to help healthcare providers, administrators, and regulators conduct retrospective reviews of healthcare. The guidebook provides a practical approach for the investigation of adverse events or close calls in healthcare, with the intent of considering the entire system within the analysis and when recommending and making improvements.

7. HQCA Just Individual Assessment (JIA)

https://rise.articulate.com/share/6LsC8i2h4_HHqNLvk5OHSis9O6YNCx8Q#/

This online resource "walks you through defining the JIA and the steps and decisions involved in performing a full and fair JIA". A JIA defines a fair and consistent process for leaders to assess errors made by individual staff members involved in adverse events. Primarily, JIA encourages managers and leaders to consider the entire picture and address the systemic factors that may have led to that event.

8. HQCA Patient Safety Framework

https://hqca.ca/wp-content/uploads/2021/11/HQCA_Patient_Safety_Framework_081010.pdf

The HQCA developed this framework "to guide, direct, and support the continuous and measurable improvement of patient safety in Alberta". The framework identifies the building blocks of patient safety and outlines strategic initiatives organizations can take to improve patient safety.

9. HQCA Disclosure Framework

https://hqca.ca/resources-for-improvement/frameworks/disclosure-framework/

"This framework guides healthcare providers through a process of open disclosure when a patient experiences unanticipated harm. Supporting materials include posters, a patient brochure, wallet cards, and a checklist for healthcare providers".

10. HEC Patient Safety and Incident Management Toolkit

https://www.healthcareexcellence.ca/en/resources/patient-safety-and-incident-management-toolkit/

Healthcare Excellence Canada (HEC) provides a Patient Safety and Incident Management Toolkit with practical strategies and resources for staff to use to manage incidents effectively and keep patients safe. The toolkit includes three sections:

1. Patient Safety Management – Provides resources to help staff proactively anticipate patient safety incidents and prevent them from occurring.
2. Incident Management – Guides the actions taken after patient safety incidents occur.
3. System Factors – Describes factors that shape and are shaped by patient safety and incident management (e.g., legislation, policies, culture, people).

11. AMA Employee Handbook Template (Clinic Incident Report Form)

https://actt.albertadoctors.org/media/hwhmkion/employee-handbook.pdf

The Alberta Medical Association (AMA) provides a template of an employee handbook intended for use in primary care clinics. Clinics can use the guide to develop their own handbook, which can then be made readily available to staff members.

- Includes a clinic report form (pg. 28) to be completed by a staff member within 12 hours following a patient incident or an error.

12. Developing a Reporting Culture: Learning from Close Calls and Hazardous Conditions

https://psnet.ahrq.gov/issue/developing-reporting-culture-learning-close-calls-and-hazardous-conditions

“This new sentinel event alert from The Joint Commission explores how organizations can change their culture to promote reporting. It highlights bright spots: organizations that use a Just Culture approach to investigating errors; celebrate employees who report safety hazards; and have leaders who prioritize reporting. The Joint Commission proposes actions for all organizations, including developing incident reporting systems, promoting leadership buy-in, engaging in systemwide communication, and implementing transparent accountability structures. An Annual Perspective reviewed the context of the no-blame movement and the recent shift toward a framework of a Just Culture”.

13. HQCA Patient Concerns Management Framework

https://hqca.ca/wp-content/uploads/2021/11/HQCA_Patient_Concerns_Framework_062217.pdf

This HQCA framework provides guiding principles, a Patient Concerns Management Model, and suggest practical steps to help Alberta healthcare organizations develop consistent patient concerns management processes. It can also be used as an assessment tool for those with current practices and policies in place.

Composite #2

Communication Openness

1. TeamSTEPPS® ('Communication' and 'Mutual Support' modules)

- Canadian Essentials Course
  https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/
- Office-Based Care Course
  https://www.ahrq.gov/teamstepps/officebasedcare/index.html
- Pocket Guide
  https://www.ahrq.gov/sites/default/files/publications/files/pocketguide.pdf

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2. Safety Briefings and Safety Huddles

Two resources are available for conducting safety briefings and safety huddles with the goal of increasing safety awareness among frontline staff and helping develop a culture of safety.

a. AMA Team Huddles Guide

https://actt.albertadoctors.org/file/Team-Huddles-Guide%20(2).pdf

This guide provides an outline for performing morning, afternoon, and evening team huddles. It focuses on "finding strategies for quickly planning and re-planning the day's activities to maximize communication and coordination". "Huddles help teams to be more efficient and patient-centered, and they can be done daily, weekly, or as needed".

b. Safety Huddle Results Collection Tool

https://www.ihi.org/resources/Pages/Tools/SafetyHuddleResultsCollectionTool.aspx
(requires free account setup and login)
"This tool can be used to aggregate data collected during tests of Safety Briefings (also called "safety huddles"). When first testing Safety Briefings, it is important to gather information about staff perceptions of value. However, this information need not be collected at every briefing, but only at the beginning and end of the test. If an organization then decides to permanently implement safety briefings, other data collection tools may be used to track important information, such as issues raised by staff and opportunities to improve safety".

4. Shining a Light: Safer Health Care Through Transparency

https://www.ihi.org/resources/Pages/Publications/Shining-a-Light-Safer-Health-Care-Through-Transparency.aspx
(requires free account setup and login)
"Defining transparency as "the free flow of information that is open to the scrutiny of others," this report recommends ways to bring greater transparency in four domains: between clinicians and patients; among clinicians within an organization; between organizations; and between organizations and the public. It makes the case that true transparency will result in improved outcomes, fewer medical errors, more satisfied patients, and lower costs of care. Case studies are included to document how transparency is practiced in each of the domains".

Composite #3

Clinic Processes and Standardization

1. AMA Process Mapping

https://actt.albertadoctors.org/file/2017-dec-pact-box-1-process-map.pdf

The AMA has developed a guide with specific steps for creating a process map. A process map is a visual display of steps that should be taken within any process. "It illustrates who owns each step in a process and clearly identifies when hand-offs or communication flows between [staff members and/or patients]. By visualizing the current state of processes, it becomes easy to identify inefficiencies, duplication, variation, unnecessary steps, and missing steps. Process mapping generates awareness, discussion, engagement, and a broader perspective across the team."

2. AMA Employee Handbook Template

https://actt.albertadoctors.org/media/hwhmkion/employee-handbook.pdf

The AMA provides a template of an employee handbook intended for use in primary care clinics. Clinics can use the guide to develop their own handbook, which can then be made readily available to staff members.

- Sections 1-8 act as template sections where standard policies and processes can be developed and listed for staff to follow.
- Appendix 3 details standard competencies crucial for staff members to be successful at work.

3. Create Contingency Plans

http://www.ihi.org/resources/Pages/Changes/CreateContingencyPlans.aspx

(requires free account setup and login)

This Institute for Healthcare Improvement (IHI) website provides information about how to create contingency plans, which can be used to address both expected and unexpected problems or events within a practice. Contingency plans define standard protocols to follow for each event, and individual responsibilities for staff members, helping clinics to function smoothly by planning ahead.

4. Workflow Assessment for Health Information Technology Toolkit

http://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit

"A key to successful implementation of health information technology (IT) is to recognize its impact on both clinical and administrative workflow. Once implemented, health IT can provide information to help you reorganize and improve your workflow. This toolkit is designed for people and organizations interested or involved in the planning, design, implementation, and use of health IT in ambulatory care".

Composite #4

Organizational Learning

1. HQCA Healthcare Quality & Safety Management Framework

https://hqca.ca/resources-for-improvement/frameworks/healthcare-quality-safety-management/

"This framework outlines what healthcare providers, managers, and executives need to do to effectively manage quality and safety in the healthcare system". It describes three components of quality and safety management:

- two models that highlight the important conceptual elements required to effectively manage healthcare quality and safety; and
- a foundational set of enablers to facilitate success.

2. AMA Website

https://actt.albertadoctors.org/PMH/capacity-for-improvement/Pages/QI-Tools.aspx#tools

The AMA website provides several tools and resources that can be used for implementing change in a primary care clinic, including quality improvement tools, change packages, and facilitator tools. They are organized according to the competency domains for practice facilitators and physician champions: Patient's Medical Home in the Health Neighbourhood, Quality Improvement, and Modes of Influence.

3. IHI Quality Improvement Essentials Toolkit

https://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx
(requires free account setup and login)

This IHI website includes many of "the tools and templates you need to launch a successful quality improvement project and manage performance improvement" (e.g., Cause-Effect diagram, Plan-Do-Study-Act worksheet).

4. Plan-Do-Study-Act (PDSA) Steps and Worksheet

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx
(both pages require free account setup and login)

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the results (Study), and determining needed modifications (Act). The first website listed provides the steps in the PDSA cycle and the second website listed provides a PDSA Worksheet, a useful tool for documenting a test of change.

5. Will It Work Here? A Decisionmaker's Guide to Adopting Innovations

https://www.ahrq.gov/innovations/will-work/index.html

The goal of this guide is to promote evidence-based decision making and help decision makers determine whether an innovation would be a good fit or an appropriate stretch for their healthcare organization.

6. Systematic Systems Analysis

https://hqca.ca/wp-content/uploads/2022/11/HQCA-2022-SSA-Patient-Review-F2-web.pdf

This guidebook was authored by Dr. J.M. Davies and Carmella Duchscherer to help healthcare providers, administrators, and regulators conduct retrospective reviews of healthcare. The guidebook provides a practical approach for the investigation of adverse events or close calls in healthcare, with the intent of considering the entire system within the analysis and when recommending and making improvements.

7. Health Quality Council of Alberta (HQCA) Human Factors Course

https://hqca.ca/resources-for-improvement/human-factors/human-factors-in-healthcare-course/

Human factors studies the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work. After this course, staff will be able to:

- understand aand describe the applicability of human factors in healthcare across a variety of areas, including medication safety, procurement, and process evaluation.
- recognize when human factors considerations or involvement is applicable in the work they do.
- apply human factors practices to enhance quality improvement and patient safety.

8. HQCA Patient Concerns Management Framework

https://hqca.ca/wp-content/uploads/2021/11/HQCA_Patient_Concerns_Framework_062217.pdf

This HQCA framework provides guiding principles, a Patient Concerns Management Model, and suggests practical steps to help Alberta healthcare organizations develop consistent patient concerns management processes. It can also be used as an assessment tool for those with current practices and policies in place.

Composite #5

Owner/Managing Partner/Leadership Support for Patient Safety

1. HEC Patient Safety Culture "Bundle" for CEOs/Senior Leaders

https://www.healthcareexcellence.ca/en/resources/patient-safety-culture-bundle/

Healthcare Excellence Canada (HEC) has released a Patient Safety Culture "Bundle". "The National Patient Safety Consortium Education Working Group has verified the critical role senior leadership plays in ensuring patient safety is an organizational priority". This training bundle provides a framework with various tools for establishing a patient safety culture, and it is directed at senior leadership. It "encompasses key concepts of safety science, implementation science, just culture, psychological safety, staff safety/health, patient and family engagement, disruptive behaviour, high reliability/resilience, patient safety measurement, frontline leadership, physician leadership, staff engagement, teamwork/communication, and industry-wide standardization/alignment".

2. TeamSTEPPS® ('Leadership' module)

- Canadian Essentials Course
  https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/
- Office-Based Care Course
  https://www.ahrq.gov/teamstepps/officebasedcare/index.html
- Pocket Guide
  https://www.ahrq.gov/sites/default/files/publications/files/pocketguide.pdf

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3. Patient Safety Leadership WalkRounds™

https://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx

https://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx

(both pages require free account setup and login)

"Senior leaders wishing to demonstrate their commitment to safety and learn about the safety issues in their own organization can do so by making regular rounds for the sole purpose of discussing safety with the staff". These IHI website links discuss the benefits of management making regular rounds, give tips for doing the rounds, and provide links to resources. These rounds are especially effective in conjunction with safety briefings.

4. Leading a Culture of Safety: A Blueprint for Success

https://www.ihi.org/resources/Pages/Publications/Leading-a-Culture-of-Safety-A-Blueprint-for-Success.aspx

(requires free account setup and login)

"Leading a Culture of Safety: A Blueprint for Success was developed to bridge a gap in knowledge and resources by providing chief executive officers and other healthcare leaders with a useful tool for assessing and advancing their organization's culture of safety. This guide can be used to help determine the current state of an organization's journey, inform dialogue with the board and leadership team, and help leaders set priorities".

5. HQCA Healthcare Quality & Safety Management Framework

https://hqca.ca/resources-for-improvement/frameworks/healthcare-quality-safety-management/

This HQCA "framework outlines what healthcare providers, managers, and executives need to do to effectively manage quality and safety in the healthcare system". It describes three components of quality and safety management:

- two models that highlight the important conceptual elements required to effectively manage healthcare quality and safety; and
- a foundational set of enablers to facilitate success.

6. HQCA Disruptive Behaviour Framework

https://hqca.ca/wp-content/uploads/2021/10/HQCA_Disruptive_Behaviour_Framework_041113.pdf

This framework helps organizations that deliver healthcare services address disrespectful behaviour and contribute to the creation of a healthy workplace. The framework highlights steps managers and leaders can take to address disruptive behaviour.

7. Provide Feedback to Frontline Staff

http://www.ihi.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx

(requires free account setup and login)

"Feedback to frontline staff is a critical component of demonstrating a commitment to safety and ensuring that staff members continue to report safety issues". This IHI website identifies tips and tools for providing feedback.

8. HQCA Patient Safety Framework

https://hqca.ca/wp-content/uploads/2021/11/HQCA_Patient_Safety_Framework_081010.pdf

The HQCA developed this framework "to guide, direct, and support the continuous and measurable improvement of patient safety in Alberta". The framework identifies the building blocks of patient safety and outlines strategic initiatives organizations can take to improve patient safety.

9. A Framework for Safe, Reliable, and Effective Care

http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx

(requires free account setup and login)

The IHI's Framework for Safe, Reliable, and Effective Care "describes the key strategic, clinical, and operational components involved in achieving safe and reliable operational excellence. The goal is to create a 'system of safety,' not just a collection of standalone safety improvement projects".

Composite #6

Patient Care Tracking/Followup

1. Patient Notification Toolkit

http://www.cdc.gov/injectionsafety/pntoolkit/index.html

This toolkit provides guidance and resources to help organizations with "a patient notification following identification of an infection control lapse or disease transmission".

2. Improving Your Laboratory Testing Process: A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement

https://www.ahrq.gov/hai/tools/ambulatory-care/lab-testing-toolkit.html

"The tools in this step-by-step guide can increase the reliability of the testing process in your clinic by helping you examine how tests are managed". This guide tells you how to assess your clinic testing process, assess patient experience and documentation, plan for improvement, implement change, and reassess to determine if you improved.

3. AMA Screening Maneuvers Menu for Adults 2022 - Alberta Screening and Prevention (ASaP)

https://actt.albertadoctors.org/file/asap-maneuvers-menu.pdf

This menu guides primary care clinics in identifying the most important screening maneuvers for their patient panel, with the aim of improving screening and prevention rates through outreach methods and by offering appropriate testing for each maneuver. The menu identifies the age range and interval for each maneuver, as well as evidence-based practice points.

4. HQCA Primary Healthcare Panel Reports

https://hqca.ca/resources-for-improvement/primary-healthcare-panel-reports/

The HQCA's panel reports uses administrative health data to provide information about a physician's patient panel. The reports provide information on their patients' continuity, and valuable data on their screening and vaccination statuses, chronic conditions, pharmaceutical use, and emergency and hospital visits. The reports can be used as a source of information to identify areas for improvement by:

- Informing panel management activities.
- Identifying gaps in screening and key preventive interventions.
- Better understanding characteristics of a patient panel, such as burden of illness.
- Understanding how patients utilize services outside of the clinic.

5. AMA After Hours Support for Continuity of Care

https://www.albertadoctors.org/Leaders%20--%20Clinical%20resources/Tips_for_Meeting_Continuity_of_Care_Standard.pdf

The AMA provides information for physicians about how to comply with the standard of practice with respect to continuity of care after hours. For example, it provides guidance on areas such as how to maintain continuity of care, what to do if your patient calls you after hours, and when test results are received after hours.

6. Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families

https://www.ahrq.gov/patient-safety/reports/engage.html

The Agency for Healthcare Research and Quality (AHRQ) developed this guide as "a resource to help primary care practices partner with patients and their families to improve patient safety. The guide is composed of materials and resources to help primary care practices implement patient and family engagement to improve patient safety".

Composite #7

Staff Training

1. TeamSTEPPS®

- Canadian Essentials Course
  https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/
- Office-Based Care Course
  https://www.ahrq.gov/teamstepps/officebasedcare/index.html
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2. AHRQ Patient Safety Education and Training Catalog

https://psnet.ahrq.gov/training-catalog

The AHRQ's Patient Safety Education and Training Catalog consists of patient safety programs currently available in the United States. The catalog, featured on AHRQ's Patient Safety Network site, offers a database of patient safety education and training programs, each tagged for easy searching and browsing. The database identifies a number of characteristics of the programs, including clinical area, program and learning objectives, evaluation measures, and cost.

3. HEC Patient Safety Culture "Bundle" for CEOs/Senior Leaders

https://www.healthcareexcellence.ca/en/resources/patient-safety-culture-bundle/

Healthcare Excellence Canada (HEC) has released a Patient Safety Culture 'Bundle'. "The National Patient Safety Consortium Education Working Group has verified the critical role senior leadership plays in ensuring patient safety is an organizational priority". This training bundle provides a framework with various tools for establishing a patient safety culture, and it is directed at senior leadership. It "encompasses key concepts of safety science, implementation science, just culture, psychological safety, staff safety/health, patient and family engagement, disruptive behaviour, high reliability/resilience, patient safety measurement, frontline leadership, physician leadership, staff engagement, teamwork/communication, and industry-wide standardization/alignment".

4. AMA Employee Handbook Template

https://actt.albertadoctors.org/media/hwhmkion/employee-handbook.pdf

The Alberta Medical Association (AMA) provides a template of an employee handbook intended for use in primary care clinics. Clinics can use the guide to develop their own handbook, which can then be made readily available to staff members.

- New Staff Orientation section (pg. 8) – Intended to inform employees if new staff orientation exists, what it looks like, who is responsible for delivering the orientation, and how long it lasts.
- Training and Education section (pg. 15) – Intended to inform employees if they have compensation for training and education programs. This includes information on what programs they can claim, how much they will be compensated, and who approves the compensation for these programs.

Composite #8

Teamwork

1. TeamSTEPPS®

- Canadian Essentials Course
  https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/
- Office-Based Care Course
  https://www.ahrq.gov/teamstepps/officebasedcare/index.html
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2. Patient Safety Primer: Teamwork Training

https://psnet.ahrq.gov/primers/primer/8

"Providing safe healthcare depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient". The AHRQ's Patient Safety Primer explains this topic further and provides links to more information on teamwork training.

3. Team Mapping

https://isu.familymed.ubc.ca/our-work/mapping-tools-resources/team-mapping/

The University of British Columbia's "The Innovation and Support Unit (ISU) has developed the Team Mapping Method to help developing team-based care initiatives (e.g., Primary Care Networks, and Patient Medical Homes) explore and describe how teams could be structured, …help groups describe how roles work together in team-based care projects, [and]…help build a sense of cohesion and consensus across a group". The ISU provides a facilitator toolkit for implementation.

4. AMA Interpersonal Style Colours Snapshot

https://actt.albertadoctors.org/file/coloursexercise-debriefguide.pdf

The AMA has developed a tool to help team members understand each other's interpersonal style. Once each team member has completed the interpersonal style 'colours exercise', the results are shared between team members each other. The tool can help teams work together more effectively.

5. AMA Team Roles and Responsibilities (Task Analysis)

https://actt.albertadoctors.org/media/pzodteto/asap-roles-responsibilities-guide.docx

"This AMA template may be used to guide team discussions about assigning roles and responsibilities related to quality improvement and clinical tasks. Sample tasks are included but it is best to modify and adapt it to suit the tasks to each team's specific needs".

6. Establishing an Effective Team and Leading Productive Team Meetings

https://grandeprairiepcn.com/wp-content/uploads/2021/06/Establishing-an-Effective-Team-and-Leading-Productive-Team-Meetings1.pdf

This resource developed by the Grande Prairie Primary Care Network, outlines specific steps for establishing an effective team and team meetings (e.g., by identifying the team, setting a consistent meeting time, roles and participation, ground rules).

7. AMA Introducing Team Members with Intention – the "Warm Handoff"

https://actt.albertadoctors.org/file/Introducing%20Team%20Members%20with%20Intention.pdf

"For some clinics, the concept of the patient seeing someone other than the primary provider for clinical care may be new. Patients may be concerned about this change of process, and feel that they're not getting the 'best' care. This guide provides tips to be strategic when introducing patients to team members for shared care".

8. AMA Team Behaviours Assessment Tool

https://actt.albertadoctors.org/file/team-assessment--behaviours-old-to-new.pdf

A team assessment tool from the Alberta Medical Association (AMA) that is used to analyze team behaviours and changes in team following an intervention effort. It is suggested to use this assessment at the start of improvement efforts and again at six months to assess the team's progress over time.

Composite #9

Work Pressure and Pace

1. AMA Balanced Panel Calculator

https://actt.albertadoctors.org/file/balancedpanelcalculator.xls
A calculator tool (in excel) that can be used to help determine an appropriate panel size based on appointments per day, workdays per week, weeks per year, statutory holidays, and revisit rate.

2. IHI Recalibrate the System by Working Down the Backlog

https://www.ihi.org/resources/Pages/Changes/RecalibratetheSystembyWorkingDowntheBacklog.aspx
(requires free account setup and login)
This IHI resource provides information for primary care clinics on how to reduce and eliminate backlog appointments. The resource includes a link to a Backlog Reduction Worksheet that helps users understand the extent of their backlog.

3. IHI Manage Panel Size and Scope of the Practice

https://www.ihi.org/resources/Pages/Changes/ManagePanelSizeandScopeofthePractice.aspx
(requires free account setup and login)
"Managing panel size and the scope of the practice allows a team to balance supply and demand and ensures that they can complete tasks on time". This IHI website also includes links that contain more specific information and strategies for managing panel size and the scope of the practice.

4. IHI Predict and Anticipate Patient Needs

https://www.ihi.org/resources/Pages/Changes/PredictandAnticipatePatientNeeds.aspx
(requires free account setup and login)
This IHI website includes links to specific information and strategies on advance planning, including predicting and anticipating patient needs in the context of clinic workflow (e.g., to arrange for equipment or tests for their visit).

5. Virtual Patient Messaging Systems

Theoretically, virtual patient messaging systems can help reduce overall work pressure and pace by reducing the number of patients coming to the clinic to receive communications. A sample of the available tools include:

- Brightsquid Secure Mail - https://brightsquid.com/pages/secure-mail-for-virtual-care
- Microquest Patient Messaging - https://welcome.dr2dr.ca/
- TELUS Health - https://www.telus.com/en/health

6. TeamSTEPPS® ('Situation Monitoring' module)

- Canadian Essentials Course
  https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/
- Office-Based Care Course
  https://www.ahrq.gov/teamstepps/officebasedcare/index.html
- Pocket Guide
  https://www.ahrq.gov/sites/default/files/publications/files/pocketguide.pdf

TeamSTEPPS is a teamwork system designed for healthcare professionals that is:

- Evidence-based to improve communication and teamwork skills among healthcare professionals.
- A source for ready-to-use materials and a training curriculum to successfully integrate teamwork principles into all areas of your healthcare system.

7. HEC Creating a Safe Space Toolkit

https://www.healthcareexcellence.ca/media/zamhlhcq/5_creating-a-safe-space-toolkit_en-final-ua.pdf

This Healthcare Excellence Canada (HEC) toolkit supports healthcare leaders and policymakers to develop, implement, or improve healthcare worker support programs and introduce psychological safety. "The toolkit is divided into three tables:

- Table 1.1 includes resources for developing and improving peer support programs, and general psychological well-being resources.
- Table 1.2 includes resources that address psychological self-care in healthcare workers, such as fact sheets about psychological self-care and worksheets for developing a psychological self-care plan.
- Table 1.3 includes resources that address moral distress in the healthcare sector, such as links to moral distress projects currently being developed, fact sheets, toolkits, ethical decision-making frameworks, and PowerPoint presentations".

8. HQCA Primary Healthcare Panel Reports

https://hqca.ca/resources-for-improvement/primary-healthcare-panel-reports/

The HQCA's panel reports use administrative health data to provide information about a physician's patient panel. The reports provide information on their patients' continuity and valuable data on their screening and vaccination statuses, chronic conditions, pharmaceutical use, and emergency and hospital visits. The reports can be used as a source of information to identify areas for improvement by:

- Informing panel management activities.
- Identifying gaps in screening and key preventive interventions.
- Better understanding characteristics of a patient panel, such as burden of illness..
- Understanding how patients utilize services outside of the clinic.

Patient Safety & Quality Issues

Access to Care

1. Choosing Wisely Canada

https://choosingwiselycanada.org/primary-care/#recommendations
The Choosing Wisely Canada webpage provides information and resources with the goal of reducing wasteful or unnecessary medical tests, treatments, and procedures. The website provides specific guidelines and resources for implementing recommendations to make change in areas such as primary care using antibiotics wisely, navigating serious illness conversations with patients and families, and further quality improvement resources.

2. IHI Balance Supply and Demand on a Daily, Weekly, and Long-Term Basis

http://www.ihi.org/resources/Pages/Changes/BalanceSupplyandDemandonaDailyWeeklyandLongTermBasis.aspx
(requires free account setup and login)
"The foundation of improved access scheduling is matching supply and demand on a daily, weekly, and monthly basis". This IHI website contains information on communication methods to "manage the daily and weekly supply and demand variation and to anticipate and plan for recurring seasonal events".

3. IHI Decrease Demand for Appointments

https://www.ihi.org/resources/Pages/Changes/DecreaseDemandforAppointments.aspx
(requires free account setup and login)
"One key way for a healthcare system to improve access is to reduce unnecessary demand for various services so that patients needing a particular service can receive it in a timely way". This IHI website contains information on decreasing demand for appointments, such as using alternatives to in-person visits (e.g., telephone, e-mail).

4. IHI Measure and Understand Supply and Demand

https://www.ihi.org/resources/Pages/Changes/MeasureandUnderstandSupplyandDemand.aspx
(requires free account setup and login)
"Improving access is all about getting supply and demand in equilibrium, meaning there is no backlog of appointments and no delay between when the demand is initiated and when the service is delivered". This IHI website contains information on how to measure and understand supply and demand.

5. IHI Optimize the Care Team

http://www.ihi.org/resources/Pages/Changes/OptimizetheCareTeam.aspx
(requires free account setup and login)
"Optimizing the care team is critical to maximizing the supply of the clinic and improving the daily workflow". This IHI website contains information on decreasing demand for appointments.

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6. IHI Reduce Scheduling Complexity

http://www.ihi.org/resources/Pages/Changes/ReduceSchedulingComplexity.aspx
(requires free account setup and login)
"Complex schedules, with many appointment types, times, and restrictions, can actually increase total delay in the system because each appointment type and time creates its own differential delay and queue". This IHI website contains information on how to reduce scheduling complexity.

Patient Identification

1. 2019 National Patient Safety Goals: Ambulatory Health Care

https://www.jointcommission.org/assets/1/6/2019_AHC_NPSGs_final.pdf
The purpose of the Joint Commission Ambulatory Care National Safety Goals is to improve patient safety in an ambulatory setting by focusing on problems in health care safety and how to solve them.

Charts and Medical Records

1. Health Information Technology Toolkit for Physician Offices

https://www.healthit.gov/resource/health-information-technology-toolkit-physician-offices
"The Health Information Technology Toolkit for Physician Offices helps these healthcare organizations assess their readiness, plan, select, implement, make effective use of, and exchange important information about their clients. The toolkit contains numerous resources, including tools for telehealth, health information exchange, and personal health records".

Medical Equipment

1. Medical Device Evaluation Forms

https://tdict.wpengine.com/tools/medical-device-evaluation-forms/
These forms were developed under the Training for Development of Innovative Control Technologies (TDICT) project with the aim of improving the overall evaluation and design of medical equipment and devices, and ultimately reducing occupational hazards for healthcare workers. This website includes forms for various medical equipment used in healthcare facilities and hospitals (e.g., Scalpels & Blades, Blood Collection Systems, Vascular Access Devices).

2. HQCA Human Factors Course

https://hqca.ca/resources-for-improvement/human-factors/human-factors-in-healthcare-course/

Human factors studies the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work. After this course, staff will be able to:

- understand and describe the applicability of human factors in healthcare across a variety of areas, including medication safety, procurement, and process evaluation.
- recognize when human factors considerations or involvement is applicable in the work you do.
- apply human factors practices to enhance quality improvement and patient safety.

Medication

1. ISMP List of High-Alert Medications in Community/Ambulatory Healthcare

https://www.ismp.org/sites/default/files/attachments/2017-11/highAlert-community.pdf

This fact sheet provides a list of high-alert medications commonly used in ambulatory care and recommends strategies to reduce risk of errors.

2. Patient Safety Primer: Medication Reconciliation

https://psnet.ahrq.gov/primers/primer/1/medication-reconciliation

"Medication reconciliation refers to the process of avoiding inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care". AHRQ's Patient Safety Network explains this topic further and provides links for more information on what is new in medication reconciliation.

3. A Toolset for E-Prescribing Implementation in Physician Offices

https://digital.ahrq.gov/health-it-tools-and-resources/implementation-toolsets-e-prescribing/physician-offices

"The purpose of this toolset is to provide practices with the knowledge and resources to implement e-prescribing successfully. The toolset is designed for use by a diverse range of provider organizations, from small, independent clinics to large medical groups. The toolset also includes specific tools to support planning and decision making, such as surveys to determine whether an organization is ready for e-prescribing, worksheets for planning the implementation and monitoring progress, and templates for communicating the launch to patients".

Diagnostics and Tests

1. Society to Improve Diagnosis in Medicine: Educational Resources

https://www.improvediagnosis.org/resources-for/

The Society to Improve Diagnosis in Medicine (SIDM) features educational resources for trainees, practitioners, and educators on clinical reasoning, critical thinking, and system factors that underlie diagnostic error, and strategies to improve diagnostic performance.

Information Exchange with Other Settings

1. AMA Community Information Integration Initiative & Central Patient Attachment Registry (CII/CPAR)

https://actt.albertadoctors.org/media/hbxd53gq/cii-cpar-information-sheet.pdf

The CII/CPAR "enables physicians and their teams to share patient information to Alberta Netcare directly from their electronic medical record (EMR)…, enhances communication amongst providers by enabling the sharing of important healthcare information across the province…, and sends eNotifications to providers when their patients are seen in the emergency department, or have a hospital admission or day surgery".

2. AMA Home to Hospital to Home (H2H2H) Transitions Guide

https://www.albertahealthservices.ca/assets/info/hp/phc/if-hp-phc-phcin-hthth-guideline.pdf

A guideline for healthcare providers to help support patients as they access multiple providers and services on their journey from community to hospital and then back home. The guide aims to "help healthcare providers and teams in acute, primary, and community care operate as a singular entity with patients and their loved ones as equal partners".

- Provides steps to support patients with confirmation of the primary care provider, admit notification, transition planning, referral and access to community supports, and follow up to primary care.

3. TeamSTEPPS® ('Communication' Module)

- Canadian Essentials Course
  https://www.healthcareexcellence.ca/en/what-we-do/all-programs/teamstepps-canada-essentials-course/
- Office-Based Care Course
  https://www.ahrq.gov/teamstepps/officebasedcare/index.html
- Pocket Guide
  https://www.ahrq.gov/sites/default/files/publications/files/pocketguide.pdf

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- Evidence-based to improve communication and teamwork skills among healthcare professionals.
- A source for ready-to-use materials and a training curriculum to successfully integrate teamwork principles into all areas of your healthcare system.

4. QuRe Referral Checklist

https://www.albertahealthservices.ca/assets/info/hp/arp/if-hp-arp-qure-digital-checklist.pdf

The Quality Referral Evolution (QuRE) working group created this checklist with the aim of improving referral communication between healthcare providers and their patients, ultimately to improve overall standards of care and healthcare access in Alberta. The checklist also comes with a readily available user guideline. It identifies crucial points of discussion between the provider and the patient (e.g., summary of patient's current status, purpose of consultation, follow up arrangements).

5. Health Information Exchange Projects

https://digital.ahrq.gov/health-information-exchange-hie-evaluation-toolkit

The AHRQ National Resource Center for Health IT has a toolkit for health information exchange projects. The toolkit offers suggestions and examples for evaluating the exchange of health information between various community stakeholders (e.g., providers, health departments, pharmacies, laboratories). Evaluation of data exchange is crucial to determining the impact of this new type of health IT project on healthcare quality and safety.

6. Transitions of Care Checklist

https://www.tnpharm.org/wp-content/uploads/Transitions_of_Care_Checklist.pdf

The National Transitions of Care Coalition Advisory Task Force has released a transitions of care list that provides a detailed description of effective patient transfer between practice settings. This process can help enhance communication to ensure that patients and their critical medical information are transferred safely, quickly, and efficiently.

Overall Ratings on Quality and Patient Safety

Patient Centered

1. HQCA Patient Concerns Management Framework

https://hqca.ca/wp-content/uploads/2021/11/HQCA_Patient_Concerns_Framework_062217.pdf

This HQCA framework provides guiding principles, a Patient Concerns Management Model, and suggests practical steps to help Alberta healthcare organizations develop consistent patient concerns management processes. It can also be used as an assessment tool for those with current practices and policies in place.

2. HEC Engaging Patients in Patient Safety

https://www.healthcareexcellence.ca/media/z2rgrtoj/engagingpatientsinpatientsafety_en_2020-final-ua.pdf

The purpose of the guide from HEC is "to help patients and families, providers and leaders work more effectively together to improve patient safety". The guide highlights strategies to achieve patient partnerships at the point of care, at organizational and systems levels, and to evaluate patient engagement.

3. AHRQ Patient Centered Medical Home (PCMH) Resource Center

https://pcmh.ahrq.gov/

"AHRQ recognizes that revitalizing the primary care system is foundational to achieving high-quality, accessible, efficient healthcare…. The primary care medical home, also referred to as the patient-centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care". The Resource Center website provides links to tools and resources on the five domains of PCMH, three foundational supports, and implementation of PCMH.

4. CAHPS® Surveys

https://www.cahps.ahrq.gov/surveys-guidance/index.html

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys aim to directly assess patient and family experiences with healthcare, more specifically patient experiences with providers, condition-specific care, health plans and programs, and facility-based care. This website provides information on the CAHPS® surveys, including the questionnaire and administration guidelines, as well as reporting and benchmarking data.

- CAHPS® Clinician & Group (CG-CAHPS®) Survey with Patient-Centered Medical Home (PCMH) Items
- CAHPS® Health Information Technology Item Set
- CAHPS® Health Literacy Item Set

5. Institute for Patient- and Family-Centered Care

http://www.ipfcc.org/resources/downloads-tools.html

"The Institute for Patient- and Family-Centered Care offers a wide variety of free downloadable PDFs to use in your organization". This website features many free resources, including a toolkit to enhance safety and quality, and a work plan for starting a patient and family advisory council.

6. Patient Care Experience Observation Exercise

http://www.ihi.org/resources/Pages/Tools/PatientCareExperienceObservationExercise.aspx
(requires free account setup and login)
This tool was developed by the Institute for Healthcare Improvement to allow care team members to "learn about and understand the experience of care in [their] organization from the patient and family perspective, and not from assumptions that may be made by those who are providing care. Care team members select a patient care process to observe and then document their observations about the care experience from the patient and family perspective in a non-judgmental way, using the observations to inform improvements to the care experience".

7. Patient-Centered Primary Care Collaborative

https://www.pcpcc.org/webinars
The Patient-Centered Primary Care Collaborative (PCPCC) website offers a variety of webinars related to Accountable Care Organizations (ACOs), care coordination, education and training, eHealth, employers, and transformation, with the aim of developing and advancing more patient-centered medical homes.

8. The Patient Education Materials Assessment Tool (PEMAT) and User's Guide

http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/index.html
"The Patient Education Materials Assessment Tool (PEMAT) is a systematic method to evaluate and compare the understandability and actionability of patient education materials. It is designed as a guide to help determine whether patients will be able to understand and act on information. Separate tools are available for use with print and audiovisual materials".

Effective

1. HQCA Quality Matrix

https://hqca.ca/about-us/our-mandate/the-alberta-quality-matrix-for-health/
The HQCA "Quality Matrix enables the public, patients, providers, and organizations to see how levels of quality and areas of need might intersect" to identify areas for improvement. It has two components:

1. Columns with dimensions of quality; and
2. Rows highlighting areas of need.

2. HQCA Patient Safety Framework

https://hqca.ca/wp-content/uploads/2021/11/HQCA_Patient_Safety_Framework_081010.pdf
Developed by HQCA, this framework "guides, directs and supports the continuous and measurable improvement of patient safety in Alberta". The framework identifies the building blocks of patient safety and outlines strategic initiatives organizations can take to improve patient safety.

Timely

Cross-reference to resources already described:

- See: Patient Safety and Quality Issues, Access to Care.

Efficient

1. Choosing Wisely Canada

https://choosingwiselycanada.org/primary-care/#recommendations

The Choosing Wisely Canada webpage provides information and resources with the goal of reducing wasteful or unnecessary medical tests, treatments, and procedures. The website provides specific guidelines and resources for implementing recommendations to make change in areas such as primary care using antibiotics wisely, navigating serious illness conversations with patients and families, and further quality improvement resources.

2. Going Lean in Healthcare

https://www.entnet.org/sites/default/files/GoingLeaninHealthCareWhitePaper-3.pdf

Examples in this IHI paper on lean thinking in healthcare show that, "when applied rigorously and throughout an entire organization, lean principles can have a dramatic effect on productivity, cost, quality", and timely delivery of services.

3. Improve Workflow and Remove Waste

https://www.ihi.org/resources/Pages/Changes/ImproveWorkFlowandRemoveWaste.aspx

(requires free account setup and login)

"Improving the flow of work and eliminating waste ensures that the primary care clinic runs as efficiently and effectively as possible". This IHI website provides information about how to improve workflow.

Equitable

1. Health Research & Educational Trust (HRET) Disparities Toolkit

http://www.hretdisparities.org/

The Health Research & Educational Trust (HRET) Disparities Toolkit provides resources and information to help primary care clinics collect demographic information from patients, such as race, ethnicity, and primary language data. This toolkit helps clinics plan to improve quality of care for all populations.

Overall Perceptions of Patient Safety and General Resources

1. Actionable Patient Safety Solutions (APSS): Culture of Safety

https://s3-ap-southeast-2.amazonaws.com/wh1.thewebconsole.com/wh/4798/images/Patient-safety-Movement-PSMF-Volume_updated_2019.pdf

A guide that provides practical and tangible actions for creating and sustaining a culture of safety throughout a healthcare organization. The guide highlights a leadership plan, action plan, and strategies to measure outcomes after implementation efforts.

2. Patient Safety Primer: Culture of Safety

https://psnet.ahrq.gov/primers/primer/5

"The concept of safety culture originated outside healthcare in studies of high-reliability organizations". These organizations "consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. High-reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives. This commitment establishes a 'culture of safety...'". The AHRQ's Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

3. HQCA Human Factors Course

https://hqca.ca/resources-for-improvement/human-factors/human-factors-in-healthcare-course/

Human factors studies the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work. After this course, staff will be able to:

- understand and describe the applicability of human factors in healthcare across a variety of areas, including medication safety, procurement, and process evaluation.
- recognize when human factors considerations or involvement is applicable in the work you do.
- apply human factors practices to enhance quality improvement and patient safety.

4. HEC General Patient Safety Quality Improvement and Measurement Resources

https://www.healthcareexcellence.ca/en/what-we-do/all-programs/hospital-harm-is-everyones-concern/hospital-harm-improvement-resource/general-patient-safety-quality-improvement-and-measurement-resources/

Healthcare Excellence Canada (HEC) provides "a list of patient safety, quality improvement and measurement resources that can be used by quality improvement teams, as well as resources for leaders".

5. CPSI 'Quick Start' Guide to Patient Safety Improvement

https://www.patientsafetyinstitute.ca/en/education/Canadas-Patient-Safety-Online-Learning-Centre/Pages/Quick-Start-Guide-to-Patient-Safety-Improvement.aspx

A "microlearning course [that] has been designed to support teams across all healthcare sectors in using a Knowledge Translation and Quality Improvement integrated approach to change that will impact patient safety outcomes. It is intended to be a 'Quick Start' version of the Guide to Patient Safety Improvement publication" (a more in-depth guide by the CPSI).

6. AAAHC Institute Research and Toolkits

http://www.aaahc.org/en/institute/Patient-Safety-Toolkits1/

Each patient safety toolkit from the Accreditation Association for Ambulatory Health Care, Inc., includes a concise overview of evidence-based information on a specific topic, references, and one or more patient assessment tools to aid in clinical decision-making and patient management.

7. AHRQ Impact Case Studies

http://www.ahrq.gov/policymakers/case-studies/index.html?search_api_views_fulltext=patient+safety

"AHRQ's evidence-based tools and resources are used by organizations nationwide to improve the quality, safety, effectiveness, and efficiency of healthcare". This subset of the Agency's Impact Case Studies specific to patient safety "highlights these successes, describing the use and impact of AHRQ-funded tools by State and Federal policy makers, health systems, clinicians, academicians, and other professionals".

8. IHI Appoint a Safety Champion for Every Unit

https://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx

(requires free account setup and login)

"Having a designated safety champion in every department and patient care unit demonstrates the organization's commitment to safety and may make other staff members feel more comfortable about sharing information and asking questions". This IHI website identifies tips for appointing a safety champion.

9. CAHPS® Improvement Guide

https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html

The extensive and growing use of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys has led to a greater understanding of patient and family experiences with healthcare and, consequently, areas requiring improvement have been identified. The CAHPS Improvement Guide aims to help leaders and staff take action after receiving survey results, address patient experiences, and advance the overall quality of healthcare services through new improvement interventions and resources.

10. Department of Defense Patient Safety Program Toolkits

https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits

The Department of Defense Patient Safety Program Toolkits provide various resources and guides to help foster increased patient safety culture within the Military Health System. These toolkits are "intended to be small, self-contained resource modules for training and application". Available toolkits and guides include:

- Briefs and Huddles
- Debriefs
- Eliminating Wrong Site Surgery and Procedure Events
- MHS Leadership Engagement
- Patient Falls Reduction
- Professional Conduct
- Situation, Background, Assessment, Recommendation (SBAR)

11. IHI Framework for Improving Joy in Work

http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

(requires free account setup and login)

This IHI white paper serves "as a guide for healthcare organizations to engage in a participative process where leaders ask colleagues at all levels of the organization, "What matters to you?" – enabling them to better understand the barriers to joy in work and co-create meaningful, high-leverage strategies to address these issues".

12. CDC Hand Hygiene in Healthcare Settings

http://www.cdc.gov/handhygiene/training.html

The Centers for Disease Control and Prevention's Hand Hygiene in Healthcare Settings provides healthcare workers and patients with a variety of resources, including guidelines for providers and patient empowerment materials. Other resources include the latest technological advances in measuring hand hygiene adherence, frequently asked questions, and links to promotional and educational tools published by the World Health Organization, universities, and health departments.

13. HealthPartners Ambulatory Safety Toolkit

https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/vgn_pdf_56420.pdf

This HealthPartners toolkit provides practical tools and suggestions that can be incorporated into clinical operations to eliminate harm due to error in the delivery of care.

14. National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition

http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

NCQA Patient-Centered Medical Home (PCMH) Recognition is the most widely used way to transform primary care practices into medical homes. The PCMH is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs and can improve patients' and providers' experience of care.

15. National Action Plan To Advance Patient Safety

https://www.ihi.org/Engage/Initiatives/National-Steering-Committee-Patient-Safety/Pages/National-Action-Plan-to-Advance-Patient-Safety.aspx

(requires free account setup and login)

The IHI's National Action Plan provides actionable and effective recommendations to advance patient safety by harnessing knowledge and insights from the National Steering Committee for Patient Safety (NSC). The site also includes a supplemental Self-Assessment Tool and Implementation Resource Guide and a Declaration to Advance Patient Safety issued by the NSC.

16. Patient Safety Primer: Medication Errors

https://psnet.ahrq.gov/primers/primer/23

A growing evidence base supports specific strategies to prevent adverse drug events (ADEs). AHRQ's Patient Safety Network outlines strategies providers can use at each stage of the medication use pathway – prescribing, transcribing, dispensing, and administration – to prevent ADEs. These strategies range from computerized provider order entry and clinical decision support to minimizing nurse disruption and providing better patient education and medication labeling. The primer also identifies known risk factors for ADEs, including health literacy, patient characteristics, high-alert medications, and transitions in care.

17. Patient Safety Primer: Patient Safety in Ambulatory Care

https://psnet.ahrq.gov/primers/primer/16

Although the "vast majority of healthcare takes place in the outpatient, or ambulatory care setting, efforts to improve safety have mostly focused on the inpatient setting. However, a body of research dedicated to patient safety in ambulatory care has emerged over the past few years. These efforts have identified and characterized factors that influence safety in clinic practice, the types of errors commonly encountered in ambulatory care, and potential strategies for improving ambulatory safety".

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18. Toolkit to Engage High-Risk Patients In Safe Transitions Across Ambulatory Settings

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

This toolkit developed by the AHRQ is designed to help staff actively engage patients and their care partners to prevent errors during transitions of care.

19. WHO Patient Safety Curriculum Guide: Multi-Professional Edition

http://apps.who.int/iris/bitstream/handle/10665/44641/9789241501958_eng.pdf;jsessionid=A826E89C4BF966F0FF417818B7685CBF?sequence=1

The World Health Organization developed this guide to assist in the teaching of patient safety in universities and schools in the fields of dentistry, medicine, midwifery, nursing, and pharmacy. It also supports the ongoing training of all healthcare professionals. The first part of the guide contains contextual elements to help familiarize educators with patient safety, while the second part provides curriculum guide topics and ready-to-use patient safety teaching materials.