

Patient Safety Culture

Improvement Cards



Patient Safety Culture Improvement Cards

This document offers a list of resource cards for users of the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture Version 2.0 that contains a brief introduction, definition, why it is essential, how to improve it, references, and a list of valuable resources that hospital quality and patient safety leaders can use as a guide to improve patient safety culture and patient safety. While this resource list is not exhaustive, it is designed to guide hospitals seeking information about patient safety initiatives.

Table of Contents

Domain cards 1 and 2

Supervisor, Manager, or Clinical Leader Support for Patient Safety and Hospital Management Support for Patient Safety

Domain card 3

Teamwork

Domain card 4

Communication Openness

Domain card 5

Reporting Patient Safety Events

Domain card 6

Organizational Learning-Continuous Improvement

Domain card 7

Communication About Error

Domain card 8

Response to Error

Domain card 9

Handoffs and Information Exchange

Domain card 10

Staffing and Work Pace

Supervisor, manager, or clinical leader support for patient safety, and Hospital management support for patient safety

Brief introduction

A comprehensive review on safety culture suggests that a "culture of safety" must start with leadership.¹ The authors contend that leaders are critical in creating, promoting, and developing a culture prioritizing safety.

Leaders are crucial in establishing a safe culture within hospitals.^{2,3} To address this issue, the AHRQ survey includes two domains that focus on safety culture at both the unit level or hospital-wide management.

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines Supervisor, Manager, or Clinical Leader Support for Patient Safety as "the extent to which Supervisors, managers, or clinical leaders consider staff suggestions for improving patient safety, do not encourage taking shortcuts, and take action to address patient safety concerns."⁴

The Agency for Healthcare Research and Quality (AHRQ) defines Hospital Management Support for Patient Safety as "the extent to which Hospital management shows that patient safety is a top priority and provides adequate resources for patient safety."⁴

Why is it important?

The Joint Commission's 2009 alert highlighted the importance of leadership engagement in enhancing patient safety. This alert emphasized the importance of leadership engagement in enhancing patient safety, urging organizations to foster a safety culture and implement a just culture⁵. A Study revealed that transformational leadership significantly influences patient safety culture and outcomes through employee education and system redesign initiatives.⁶

How to improve it?

Ensuring leadership competencies on patient safety:

Leadership competencies are essential for healthcare organizations to develop and support effective leadership, enhancing patient safety and quality of care.

Setting patient safety as a strategic priority

Establish and address strategic priorities and Specific System-Level Aims to prompt patient safety. Leadership should be collaborative and integrative, with leaders working together across boundaries to prioritize overall patient care.

Conducting Patient Safety Leadership Walk Rounds™:

Leadership Walk rounds™ are informal engagements between executives and patient care staff, breaking down hierarchical structures and promoting open communication. They involve non-threatening visits to areas, asking questions, listening to concerns, and providing feedback that would build connections between executives and staff and create a culture of openness and collaboration.

Conducting Safety Briefings:

Safety briefings are tools designed to increase awareness and promote a safety culture in patient care units.

References

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Useful resources

- **Leadership guide for patient safety:**

<https://www.ihl.org/resources/Pages/IHIWhitePapers/LeadershipGuideToPatientSafetyWhitePaper.aspx>

- **Seven Leadership Leverage Points for Organization-Level Improvement in Health Care**

<https://www.ihl.org/resources/Pages/IHIWhitePapers/SevenLeadershipLeveragePointsWhitePaper.aspx>

- **LEADERSHIP WALKAROUNDS™:**

<https://www.ihl.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx>

https://www.lhsc.on.ca/doc/orientation/falls/presentation_content/external_files/Patient%20Safety%20WalkRounds%20Toolkit.pdf

https://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0011/409817/Leadership-Walk-Arounds-Guidance-Document.pdf

Teamwork

Brief introduction

Teamwork includes the perceptions of the health professionals collaborating within a health team to provide safe patient care, and “safety climate” refers to the professional commitment to patient safety. It also refers to the behaviors (e.g., communicating and sharing information, checking for mutual understanding), attitudes (e.g., belief in the collective ability of the team and need for teamwork), and cognitions (e.g., shared mental models) teams use to communicate, coordinate, and collaborate their efforts to achieve shared, collective goals.^{1,2}

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines Teamwork as “staff work together as an effective team, help each other during busy times, and are respectful.”³

Why is it important?

Teamwork significantly impacts patient safety culture and is supported by evidence-based rationale. Effective teamwork is essential for creating a safety culture in healthcare, emphasizing the importance of reporting adverse events and near-misses, open communication, and continuous improvement. Research has shown that teamwork and collaboration among healthcare professionals are associated with improved patient safety outcomes, including reduced medical errors, improved patient satisfaction, and decreased mortality rates. Effective teamwork requires effective communication, mutual respect, and shared decision-making among healthcare professionals, which are key factors in promoting patient safety.⁴

How to improve it?

TeamSTEPPS®⁵

Implementing TeamSTEPPS® training to improve communication, collaboration, and patient safety outcomes among healthcare professionals.

ISBAR⁶

ISBAR is a communication tool in healthcare settings to improve the effectiveness and safety of patient handoffs between healthcare providers.

Briefing and Debriefing⁷

The use of briefing and debriefing in healthcare settings to improve communication, teamwork, and patient safety outcomes.

Safety Huddles (Daily Huddles)⁸

In healthcare delivery, a safety huddle is a short meeting involving interdisciplinary healthcare team members— no more than 10-15 minutes— that proactively enables teams to focus on patient safety, facilitating team communication.

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7. Briefing and Debriefing Tool | Agency for Healthcare Research and Quality. Accessed August 8, 2023. <https://www.ahrq.gov/hai/tools/surgery/tools/applying-cusp/briefing-debriefing.html>
8. Improving Patient Safety and Team Communication through Daily Huddles | PSNet. Accessed August 8, 2023. <https://psnet.ahrq.gov/primer/improving-patient-safety-and-team-communication-through-daily-huddles>

Useful resources

- TeamSTEPPS®

<https://www.ahrq.gov/teamstepps-program/index.html>

- ISBAR

<https://www.sahealth.sa.gov.au/>

- Briefing and Debriefing

<https://www.ahrq.gov/hai/tools/surgery/tools/applying-cusp/briefing-debriefing.html>

Communication Openness

Brief introduction

Communication openness is now recognized as a critical component of patient safety culture in healthcare. A culture of communication openness prioritizes transparency, collaboration, and continuous learning and improvement. It encourages healthcare providers to speak up and share information openly, even when uncomfortable or difficult. By fostering a culture of communication openness, healthcare organizations can enhance patient safety and improve the quality of care.

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines the Communication Openness domain as “to which extent staff speak up if they see something unsafe and feel comfortable asking questions.”¹

Why is it important?

Communication openness has a significant impact on patient safety culture in healthcare. Studies have consistently shown that a culture of communication openness is associated with improved patient safety outcomes, reduced medical errors, and increased reporting of safety incidents and near misses.²

Since then, there has been a growing recognition of the importance of communication and openness in creating a safety culture in healthcare. Healthcare organizations have developed various strategies and tools to improve communication and promote openness among healthcare providers. These include tools such as Situation, Background, Assessment and Recommendation (SBAR), Concerned, Uncomfortable, Safety Issue (CUS), and Daily Huddles, as well as programs such as TeamSTEPPS, which provide comprehensive strategies and tools for improving communication and teamwork among healthcare providers.

How to improve it?

Two-Challenge Rule³

The two-challenge rule, adopted from aviation, empowers the team members to STOP an activity if there is a safety concern. The idea behind the two-challenge rule is that the team member should restate his/her concern if the first one is ignored/dismissed.

CUS (Concerned, Uncomfortable, Safety Issue)^{4,5}

Implementing the CUS communication tool in healthcare settings will improve communication effectiveness and promote patient safety.

DESC (Describe, Express, Specify, Consequences)⁶

Constructively implement the DESC communication tool in healthcare settings to address and resolve conflicts or disagreements.

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4. CUS | AHA TeamSTEPPS Video Toolkit | AHA. Accessed August 8, 2023. <https://www.aha.org/center/project-firstline/teamstepps-video-toolkit/cus#>
5. CUS Tool - Improving Communication and Teamwork in the Surgical Environment Module | Agency for Healthcare Research and Quality. Accessed August 8, 2023. <https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/implementation/training-tools/cus-tool.html>
6. DESC | AHA TeamSTEPPS Video Toolkit | AHA. Accessed August 8, 2023. <https://www.aha.org/center/project-firstline/teamstepps-video-toolkit/desc>

Useful resources

- **Two-Challenge Rule**

<https://www.ahrq.gov/teamstepps-program/curriculum/mutual/tools/rule.html>

- **CUS**

<https://www.aha.org/center/project-firstline/teamstepps-video-toolkit/cus#>

<https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/implementation/training-tools/cus-tool.html>

- **DESC**

<https://www.aha.org/center/project-firstline/teamstepps-video-toolkit/desc>

Reporting Patient Safety Events

Brief introduction

The relationship between patient safety culture and safety events in hospitals has been a subject of significant interest and research. This study confirms that a positive patient safety culture is closely linked to a reduced incidence of sentinel events. ¹ To effectively enhance overall patient safety and alleviate concerns surrounding reporting safety events, it is imperative to initiate a culture change. This change should foster a blame-free environment, enhance teamwork, improve handoffs, and promote open communication. ¹ By implementing these measures, hospitals can cultivate a culture that prioritizes patient safety and strives for continuous improvement in healthcare delivery.

A positive correlation was revealed in another study on the relationship between safety culture and voluntary event reporting in a large regional ambulatory care group. ² The findings demonstrate that a strong safety culture leads to increased reporting of events and near misses.

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines reporting patient safety events as "the extent to which mistakes of the following types are reported: (A) mistakes caught and corrected before reaching the patient and (B) mistakes that could have harmed the patient but did not." ³

Why is it important?

Promoting an effective patient safety culture is vital to addressing the challenges of adverse event reporting. ⁴ This can be achieved by developing policies to regulate incident reporting. Additionally, dedicating sufficient support and resources to foster teamwork, effective communication, and a blame-free culture among healthcare managers can further enhance healthcare quality and patient safety. ⁵

Leaders play a vital role in building trust and promoting reporting within an organization. Leaders encourage constant vigilance for hazards by empowering their people, even in challenging conditions. One effective way for chief executives to demonstrate their commitment to fair reporting and learning cultures is through video presentations or showcases. ⁶

How to improve it?

According to the Joint Commission, the four key elements for improving reporting culture are the "4 Es":

1. Establish trust:

To build trust in an organization, leaders should communicate openly, listen actively, be accountable, create a supportive and transparent environment, and collaborate with governance structures. This trust-building culture enhances reporting and contributes to a safer healthcare environment, with governance playing a crucial role in policy alignment and resource allocation.

2. Encourage reporting:

Encouraging reporting within an organization includes measures like accessible incident reporting systems, timely data analysis, recognizing close calls and hazards, feedback-based recognition programs, and clear guidelines. Defining reportable incidents fosters a culture of comprehensive reporting, improving patient safety and promoting continuous learning.

3. Eliminate fear of punishment:

Organizations should adopt a non-punitive approach to eliminate the fear of punishment, where reporting errors and at-risk behaviors does not result in punishment. Instead, coaching and guidance are provided for at-risk behaviors, while reckless acts receive fair and equitable discipline. Consistent standards ensure accountability, fostering a culture of fairness, learning, and continuous improvement in patient safety

4. Examine errors, close calls, and hazardous conditions:

Examining errors, close calls, and hazardous conditions through data analysis helps identify risk factors and vulnerabilities while highlighting successful practices. These insights inform process improvements, educate staff about contributing factors, and improve risk awareness. Leveraging data for proactive action and continuous learning contributes to a safer healthcare environment.

An effective event reporting system should incorporate four essential elements. Creating a supportive reporting environment that prioritizes staff privacy, welcoming reports from diverse personnel, ensuring timely dissemination of event summaries, and implementing a structured review process with action plans is crucial for fostering a comprehensive and effective reporting culture within the institution.⁸

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- 8- Reporting patient safety events. Patient Safety Network. Accessed July 9, 2023. Available from: <https://psnet.ahrq.gov/primer/reporting-patient-safety-events>.

Useful resources

- **Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions** <https://psnet.ahrq.gov/resources/resource/32494>
- **Good Catch/Near Miss Campaign Toolkit** <https://info.americandatanetwork.com/good-catch-campaign-toolkit> <https://info.americandatanetwork.com/good-catch-near-miss-campaign-case-study>
- **Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions** <https://psnet.ahrq.gov/resources/resource/32494>

Organizational Learning - Continuous Improvement

Brief introduction

Organizational learning is a process that involves applying knowledge for a purpose and learning from the process and the outcome. The goal is for the organization to improve and learn continually. The process of organizational learning also links individual and organizational performance. It creates a culture of inquiry and dialogue in which people feel safe to share openly and to take risks.¹

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines Organizational Learning - Continuous Improvement as “the extent to which work processes are regularly reviewed, changes are made to keep mistakes from happening again, and changes are evaluated.”²

Why is it important?

Organizational learning is related to a range of positive organizational outcomes like³:

- **Clinical:** Different clinical outcomes can be improved through organizational learning and continuous improvement; examples include Surgical Site Infection (SSI), medication adverse events, and others.
- **Patient Experience:** Patient pain scores, thoughts and feelings, and overall patient satisfaction were shown to be improved with improved organizational learning.
- **Team:** Positive personal (enhanced satisfaction and increased awareness of the reason behind one's actions) and interpersonal (more effective teamwork and decreased nurse turnover rates) team outcomes were associated with organizational learning.
- **Financial:** Significant financial consequences can be experienced by organizations that miss learning opportunities, whereas organizational learning has been shown to increase profitability.
- **Adoption:** Successful adoption of a new technology, new best practices, or even a new culture was linked with organizational learning.

How to improve it?

Common Cause Analysis: Focus on Institutional Change

Common cause analysis (CCA) aggregates acts and causes from multiple events to identify the common causes of those events.

Building a robust reporting system to enhance organizational learning⁴

A robust reporting system enhanced voluntary reporting, overall reporting culture, and better engagement in the event review process and follow-up.

Toolkit for Using the AHRQ Quality Indicators™⁵

This toolkit supports hospitals that want to improve performance on QIs and patient safety indicators by guiding them through the process, from the first stage of self-assessment to the final stage of ongoing monitoring.

Healthcare Failure Mode and Effect Analysis (HFMEA)⁶

HFMEA is a hybrid prospective risk analysis system to identify hazards and vulnerabilities before an adverse event occurs.

Safety meetings^{7, 8, 9, 10}

Safety meetings, such as morbidity and mortality, briefings/debriefings, and huddles, can be used as tools for organizational learning and enhance the overall safety culture.

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

The model for improvement provides a framework for developing, testing and implementing changes leading to improvement. It is based on scientific methods and moderates the impulse to take immediate action with the wisdom of careful study.

Will It Work Here? A Decision Maker's Guide to Adopting Innovations This Guide aims 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.

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Useful resources

- **Common Cause Analysis:**

https://www.ahrq.gov/downloads/pub/advances2/vol1/advances-browne_5.pdf

- **Toolkit for Using the AHRQ Quality Indicators:**

<http://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html>

- **Healthcare Failure Mode and Effect Analysis:**

<https://www.patientsafety.va.gov/professionals/onthejob/HFMEA.asp>

- **Patient Safety Primer: Debriefing for Clinical Learning:**

<https://psnet.ahrq.gov/primers/primer/36/learning-through-debriefing>

- **Daily Huddle Component Kit:**

<https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/hais/tools/ambulatory-surgery/sections/sustainability/management/huddles/huddles-component-kit.docx>

- **Conducting a morning briefing:**

<https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/cusptoolkit/toolkit/morningbriefing.doc>

- **Improvement Capability Self-Assessment Tool:**

<http://www.ihl.org/resources/Pages/Tools/IHImprovementCapabilitySelfAssessmentTool.asp>

- **Plan, Do, Study, Act (PDSA) and the model for improvement**

<https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-pdsa-cycles-model-for-improvement.pdf>

- **Will It Work Here? A Decision Maker's Guide to Adopting Innovations**

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

Communication About Error

Brief introduction

Communication about medical errors involves two additional contexts: reporting information to health-care organizations for patient safety improvement and discussing errors with peers for professional learning and emotional support. Healthcare professionals contribute to a culture of learning, continuous improvement, and emotional well-being by engaging in both reporting and discussions.¹

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines Communication About Error as “the extent to which staff is informed when errors occur, discuss ways to prevent errors, and are informed when changes are made”.²

Why is it important?

Communication and feedback to front-line staff are crucial to demonstrate a commitment to safety and encourage ongoing reporting of safety issues. Acting upon staff suggestions and recognizing their contributions reinforces that their voices are valued, mainly when leadership's response may not be apparent. Consistently sharing information from senior leadership affirms the significance of every safety initiative and prevents them from being perceived as temporary or insignificant.³

How to improve it?

Healthcare organizations should emphasize a systems approach to patient safety, promoting transparency, learning, and supporting healthcare professionals in addressing errors. Effective error communication should be integrated across various healthcare settings and can be taught through methods like didactic sessions, role-playing, or simulation-based training for medical students and residents.¹

Enhancing healthcare transparency significantly improves patient safety through accountability, improvement, trust-building, and informed decision-making. Clear information holds clinicians and organizations accountable, detailed data supports learning from mistakes, and transparent communication builds trust between doctors and patients. Transparency empowers patients, enhances care, and promotes a safer healthcare environment.⁴

The Communication and Optimal Resolution (CANDOR®) process is a valuable tool for healthcare institutions and practitioners to respond to adverse events that harm patients.⁵ The CANDOR® toolkit includes eight modules, each providing PowerPoint slides with facilitator notes and additional resources, such as tools and videos. It improves communication by offering structured guidelines and tools for healthcare professionals to communicate openly and honestly with patients and their families when errors or adverse events occur. This improved communication helps in building trust and maintaining a more transparent environment.

Key lessons for hospitals implementing the CANDOR® process include:

- Involve patients and families in open and transparent communication following adverse events.
- Establish a Care for the Caregiver program to support healthcare providers involved in adverse events.
- Conduct thorough investigations and analysis of adverse events to extract valuable lessons and prevent future occurrences.
- Review and revise the organization's existing processes to align with the principles of the CANDOR® process.
- Implement a resolution process designed for the organization to address and resolve adverse events.

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Useful resources

- **Communication and Optimal Resolution (CANDOR®) Toolkit**

<https://www.ahrq.gov/professionals/quality-patient-safety-patient-safety-resources/resources/candor/introduction.html>

- **Provide Feedback to Front-Line Staff**

<http://www.ihl.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx>

- **Shining a Light: Safer Health Care Through Transparency**

<https://www.aha.org/center/project-firstline/teamstepps-video-toolkit/desc>

Response to Error

Brief introduction

A systematic review was carried out in Arab countries to examine the culture of patient safety among the 18 studies that met the inclusion criteria. In their analysis, the authors found that a non-punitive response to the error is a serious issue that requires improvement. Healthcare workers in Arab countries frequently believe that a "culture of blame" still prevails and stops them from reporting problems. In addition, the analysis discovered that healthcare workers in Arab nations appear to have concerns about communication openness.¹

Definition

The Agency for Healthcare Research and Quality (AHRQ) defined the Response to Error domain as "the extent to which staff are treated fairly when they make mistakes, and there is a focus on learning from mistakes and supporting staff involved in errors."²

Why is it important?

Fear of blame, inappropriate responses, and the potential for guilt were among the themes that Korean doctors and nurses in tertiary hospitals described as barriers to reporting safety events.³ Other studies have noted that an open and just culture increases nurses' patient safety activity and positively influences error-reporting experiences.^{4,5} Others concluded that authentic leadership positively impacts staff trust in their managers, providing them with a supportive practice environment, encouraging them to speak up, and accurately predicting patient safety and quality of care.⁶ The main issue with PSC in Arab nations was the lack of open communication.^{7,8} Leaders, managers, and supervisors should emphasize patient safety as a shared responsibility, remain available, and work closely with their teams using open communication.

How to improve it?

Establish and promote a Just Culture environment

Assuring transparency and accountability, using the proper tool, establishing a policy and procedure, adequate training, and Identifying metrics to track performance on just culture implementation

Create and enhance reporting and learning culture

Having a reporting mechanism in place, anonymous reporting methodology, providing enhanced feedback on errors and hazards, celebrating and recognizing individuals, and enhancing organizational learning and transparency

Foster Psychological safety

Leadership support to open channels and empower staff to voice their concerns, ideas, and fears

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Useful resources

▪ Saudi Patient Safety Center- Just Culture project:

<https://www.spssc.gov.sa/Arabic/JustCulture/Pages/default.aspx>Saudi

▪ Root cause analysis:

RCA2: <https://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx>

RCA: <https://www.patientsafety.va.gov/professionals/onthejob/rca.asp>

▪ Psychological safety:

https://onlinelibrary.wiley.com/doi/abs/10.1002/job.413?casa_token=t0D286alE08AAAAA:_HrKX4jEdWWCJ_wQTpim9X6_VOZxpZfl6dctI2KVgiT-qoea06moG5Brocq6RfNwhPLm0iRGm9T79TQ

<https://www.youtube.com/watch?v=jBLjdFqrUNs>
<https://www.youtube.com/watch?v=x9UwwY3xiiQ>

<https://www.youtube.com/watch?v=jBLjdFqrUNs>

<https://www.youtube.com/watch?v=x9UwwY3xiiQ>

▪ Living a Culture of Patient Safety Policy and Brochure

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

Handoffs and Information Exchange

Brief introduction

They are also known as handovers, sign-outs, endorsements, and shift reports. It is the transfer of professional responsibility and accountability for some or all aspects of care for a patient or groups of patients to another person or professional group on a temporary or permanent basis.¹

Definition

The Agency for Healthcare Research and Quality (AHRQ) defines Handoffs and information exchange as “the extent to which important patient care information is transferred across hospital units and during shift changes.”²

Why is it important?

Communication failures have been cited as the leading cause of a range of medical errors and adverse events (nearly 70%) in healthcare.³ Almost half of these communication errors occurred during handoffs between care providers.⁴ Several healthcare researchers and practitioners have highlighted that poor “handoffs often end in patient harm.”⁵

How to improve it?

Handoff Communications Targeted Solutions Tool (TST®)^{6,7}

A project that helps examine the current process provides a measurement system that supports the need for improving existing processes, identifies focus areas, helps with data collection, and provides guidelines for appropriate processes.

Actionable Patient Safety Solutions™ (APSS™): Hand-Off Communication

This document provides a blueprint that outlines the actionable steps organizations should take to reduce HOC-related errors successfully and summarizes the available evidence-based practice protocols.

The adoption of systematic and standardized hand-off communication tools

“I-PASS,” “SBAR,” “I PUT PATIENTS FIRST,” “I PASS THE BATON,” and other communication tools are evidence-based tools that have been shown to improve the hand-off communication process.

Training on and adopting, TeamSTEPPS®

TeamSTEPPS® is an evidence-based program designed to optimize the performance of healthcare teams.

Engaging Patients and families in transitions of care

Patient/family participation in the process is essential at each transition stage. This provides an opportunity to introduce the point-of-contact at the receiving unit and the transferring patient and family to ease the stress of the transition.

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Useful resources

- **Handoff Communications Targeted Solutions Tool (TST®)**
<https://www.jointcommission.org/-/media/cth/documents/what-we-offer/hand-off-communication-tst-fact-sheet-8-15.pdf>
- **Actionable Patient Safety Solutions™ (APSS™): Hand-Off Communication**
<https://www.spssc.gov.sa/English/PublishingImages/Pages/Resources/Hand-Off%20Communication.pdf>
- **Training on, and adopting, TeamSTEPPS®.**
<https://www.ahrq.gov/teamstepps/index.html>
- **ISHAPED Patient-Centered Approach to Nurse Shift Change Bedside Report**
<http://www.ihl.org/resources/Pages/Tools/ISHAPEDPatientCenteredNurseShiftChangeBedsideReport.aspx>
- **A “Ticket to Ride” Protects Patients Off the Unit**
https://www.nursingcenter.com/journalarticle?Article_ID=858666&Journal_ID=54016&Issue_ID=858618

Staffing and Workspace Resource

Brief introduction

The health workforce is crucial to increase the resilience of communities and health systems. Only healthcare professionals can run health systems, and their availability, accessibility, acceptability, and quality are critical factors in expanding access to healthcare services and attaining the right to the most significant attainable standard of health. By 2030, the World Health Organization (WHO) predicts a 10 million healthcare professionals shortage, primarily in low- and lower-middle-income nations.¹

Definition

The Agency for Healthcare Research and Quality (AHRQ) defined the staffing and work pace as “the extent to which there is enough staff to handle the workload, staff work appropriate hours and do not feel rushed, and there is appropriate reliance on temporary, float, or PRN staff.”²

Why is it important?

WHO recently published a report on workplace safety, stating that 18 million more healthcare professionals are required if countries with low or middle incomes are to attain Universal Health Coverage (UHC) by 2030. To achieve Sustainable Development Goal number three on health by 2030, nine million more nurses and midwives would be required.¹

In their recent publication in 2018, the Royal College of Physicians ensured that a fair and well-formulated work schedule would enable healthcare workers to be well, healthy, effective in work, and sustain contributions to high-quality patient care.³

Additionally, a 10% rise in the percentage of nurses holding bachelor's degrees is linked to a 7% decrease in mortality rates.^{4,5} Conversely, a high workload makes healthcare workers more susceptible to depression, anxiety, and occupational stress.⁶ The number of unfavorable events and near misses also rises due to rising work stress, anxiety, and depression.⁷

How to improve it?

1. To utilize the previously released SPSC national recommendations regarding Safe Staffing: Nurse/Midwife to Patient Ratio

2. Ensure safe and healthy working conditions and respect staff rights.

- Implementing initiatives that ensure the physical and mental health of healthcare workers
- Implement positive work environment strategies.

3. Designing a Rapid Response Program for Second Victims

A comprehensive support network for clinicians, Institutional awareness of the second victim phenomenon, and institutional understanding of the second victim phenomenon.

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Useful resources

▪ SPSC workforce safety:

<https://www.spsc.gov.sa/English/Pages/Safe-Staff-Saves-Lives.aspx>

<https://www.spsc.gov.sa/English/Pages/nurse-midwife-to-patient-ratios.aspx>

▪ Mental health and psychosocial support

http://www.emro.who.int/mhps/dealing_with_stress.html

▪ Second victim program

https://journals.lww.com/nursingmanagement/Fulltext/2020/06000/Second_victim_support_programs_for_healthcare.8.aspx

<https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-39-supporting-second-victims/>

For further information please contact:

Saudi Patient Safety Center

Telephone No: 920033937

Address: Al Muruj, Riyadh 12264, Saudi Arabia

Email: culturesurvey@spsc.gov.sa

Website: www.spsc.gov.sa

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