

# **Improving Patient Safety in Community Pharmacies: A Resource List for Users of the AHRQ Community Pharmacy Survey on Patient Safety Culture**

## ***Purpose***

This document contains references to Web sites that provide practical resources community pharmacies can use to implement changes to improve patient safety culture and patient safety. This resource list is not exhaustive, but is provided to give initial guidance to pharmacies looking for information about patient safety initiatives. This document will be updated periodically.

## ***How To Use This Resource List***

Resources are listed in alphabetical order, organized by the composites assessed in the Agency for Healthcare Research and Quality (AHRQ) [Community Pharmacy 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 the Web site URLs are hyperlinked and cross-referenced resources are bookmarked within the document.

**NOTE:** The resources included in this document do not constitute an endorsement by the U.S. Department of Health and Human Services (HHS), AHRQ, or any of their employees. HHS does not attest to the accuracy of information provided by linked sites.

Suggestions for tools you would like added to the list, questions about the survey, or requests for assistance can be addressed to: [SafetyCultureSurveys@westat.com](mailto:SafetyCultureSurveys@westat.com).

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Cardiovascular Risk](#)

## **Resources by Composite**

The following resources are organized according to the relevant Community Pharmacy Survey on Patient Safety Culture composites they can help improve. Some resources are duplicated and cross-referenced because they may apply to more than one composite.

### **Composite 1. Physical Space and Environment**

#### **1. Improve Pharmacy Workflow in 6 Steps**

<https://www.pbahealth.com/improve-pharmacy-workflow-in-6-steps/>

This Web page outlines six steps to improve workflow in the pharmacy setting.

#### **2. Institute for Safe Medication Practices (ISMP) Medication Safety Self Assessment® for Community/Ambulatory Pharmacy**

<http://www.ismp.org/Survey/NewMssacap/Index.asp>

This self-assessment is a comprehensive tool designed to help health care providers and their staff assess the safety of medication practices in their pharmacy, identify opportunities for improvement, and compare their experience with the aggregate experiences of demographically similar community pharmacies around the Nation. It is divided into the following 10 elements:

- Patient information
- Drug information
- Communication of drug orders and other drug information
- Drug labeling, packaging, and nomenclature
- Drug standardization, storage, and distribution
- Use of devices
- Environmental factors
- Staff competency and education
- Patient education
- Quality process and risk management

#### **3. Using Change Concepts for Improvement**

<http://www.ihi.org/resources/Pages/Changes/UsingChangeConceptsforImprovement.aspx>

(requires free account setup and login)

A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement. This Institute for Healthcare Improvement Web page outlines change concepts such as error proofing, optimizing inventory, and improving workflow.

## **Composite 2. Teamwork**

### **1. Patient Safety Primer: Teamwork Training**

<https://psnet.ahrq.gov/primers/primer/8/teamwork-training>

Providing safe health care depends on highly trained individuals with disparate roles and responsibilities acting together in the best interests of the patient. The AHRQ Patient Safety Primer explains this topic further and provides links for more information on what is new in teamwork training.

### **2. Professional Conduct Toolkit**

<http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Toolkits/Professional-Conduct-Toolkit>

The Military Health System (MHS) is led by office of the Assistant Secretary of Defense for Health Affairs under the Office of the Undersecretary of Defense for Personnel and Readiness. MHS focuses on changing how health care is delivered throughout the United States and the world. The Professional Conduct Toolkit is designed to help health care teams eliminate behaviors that undermine safe patient care and adopt the professional conduct that is a hallmark of high-performing teams.

### **3. TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module**

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/lep/index.html>

Developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality, TeamSTEPPS® is a resource for training health care providers in better teamwork practices. TeamSTEPPS® is designed to help you develop and deploy a customized plan to train your staff in teamwork skills and lead a medical teamwork improvement initiative in your organization from initial concept development through to sustainment of positive changes. The evidence-based limited English proficiency module will provide insight into the core concepts of teamwork as they are applied to your work with patients who have difficulty communicating in English.

### **4. TeamSTEPPS® Readiness Assessment Tool**

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/readiness/index.html>

Answering these questions can help an institution understand its level of readiness to initiate the TeamSTEPPS program. Staff may find it helpful to have a colleague review responses or to answer the questions with a larger group (e.g., senior leaders).

## **Composite 3. Staff Training and Skills**

### **1. AHRQ Patient Safety Education and Training Catalog**

<https://psnet.ahrq.gov/pset>

The AHRQ Patient Safety Education and Training Catalog consists of patient safety programs currently available in the United States. The catalog offers an easily navigable database of patient safety education and training programs consisting of a robust collection of information each tagged for easy searching and browsing. The new database identifies a number of characteristics of the programs, including clinical area, program and learning objectives, evaluation measures, and cost. The clinical areas in the database align with the PSNet Collections.

### **2. Strategies To Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff**

<http://www.ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/pharmlit/pharmtrain.html>

This training program is designed to introduce pharmacists to the problem of low health literacy in patient populations and to identify the implications of this problem for the delivery of health care services. The program also explains techniques that pharmacy staff members can use to improve communication with patients who may have limited health literacy skills.

### **3. Tobacco Cessation Counseling: A Protocol for Practicing Pharmacists**

<http://media.ashp.org/tobacco/> (multimedia file; may not be accessible to users with disabilities)

This slide show is a cessation intervention course that pharmacists and clinicians can take and earn free continuing education credit. The objectives of this course are:

- Describe a new, redefined role for the pharmacist in the tobacco cessation process, positioning them as the initiator of the quit, not solely as the provider of services.
- Summarize how the pharmacist can serve as a motivator and educator for cessation.
- Explain the importance of pharmacists referring all patients to appropriate intensive interventions after initiating the cessation process.

## **Composite 4. Communication Openness**

### **1. SBAR Technique for Communication: A Situational Briefing Model**

<http://www.ihl.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx> (requires free account setup and login)

The SBAR technique provides a framework for communication between members of the health care team about a patient's condition. This downloadable tool from Institute for Healthcare Improvement has two documents.

- “Guidelines for Communicating With Physicians Using the SBAR Process,” explains how to carry out the SBAR technique.
- “SBAR Report to Physician About a Critical Situation,” is a worksheet/script a provider can use to prepare to communicate with a physician about a critically ill patient.

## ***Composite 5. Patient Counseling***

### **1. AHRQ Pharmacy Health Literacy Center**

<http://www.ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/index.html>

AHRQ Pharmacy Health Literacy Center provides pharmacists with recently released health literacy tools, curricular modules for pharmacy faculty, and resources for pharmacists interested in understanding more about health literacy.

### **2. Implementing MTM in your Practice**

<http://www.pharmacist.com/implementing-mtm-your-practice>

The American Pharmacists Association outlines resources to support medication therapy management (MTM) services, including getting your MTM business started and inspiration and ideas from colleagues.

### **3. Patient Outreach Tools**

<http://www.pharmacist.com/tools-patient-outreach>

The American Pharmacists Association features a number of patient outreach tools that include information on national campaigns and initiatives to help pharmacies educate patients on important topics such as disposal of medications, poison control, diabetes, and physical activity.

### **4. Pharmacists Support Employees and Physicians in Managing Chronic Conditions, Leading to Better Care and Disease Control, Lower Costs, and Higher Productivity**

<https://innovations.ahrq.gov/profiles/pharmacists-support-employees-and-physicians-managing-chronic-conditions-leading-better>

Using a model known as medication therapy management, which is often sponsored by employers, a program manager assigns participants to care managers (typically pharmacists) to provide ongoing chronic care management support to employees/covered dependents and their physicians. The goal is to improve care processes and patient self-management skills related to diabetes, asthma, cardiovascular risk factors, and depression. Sponsoring employers create financial incentives for participation, typically through lower or waived copayments for drugs and supplies or reductions in the employee share of the premium. Care managers meet regularly with individual enrollees to support their self-management and contact their physician as needed to suggest treatment changes. Originally pioneered in Asheville, North Carolina, for city employees (and hence known as the Asheville Project) and now implemented by employers throughout the Nation, the program has improved adherence to recommended care and self-management behaviors, leading to better disease control, lower costs, higher productivity, and a significant return on investment.

## **5. The PROTECT Initiative: Advancing Children’s Medication Safety**

[http://www.cdc.gov/medicationsafety/protect/protect\\_initiative.html](http://www.cdc.gov/medicationsafety/protect/protect_initiative.html)

The PROTECT Initiative is an innovative collaboration bringing together public health agencies, private sector companies, professional organizations, consumer/patient advocates, and academic experts to develop strategies to keep children safe from unintentional medication overdoses. Medication overdoses can lead to harm, sometimes requiring emergency treatment or hospitalization and are a significant public health problem. Over-the-counter and prescription medications are commonly used for people of all ages. This frequency of use increases the potential for unintentional overdoses. Children are especially vulnerable to unintentional overdoses, most of which can be prevented.

## **6. Team Up. Pressure Down.**

[http://millionhearts.hhs.gov/Docs/TUPD/TUPD\\_Materials\\_Overview.pdf](http://millionhearts.hhs.gov/Docs/TUPD/TUPD_Materials_Overview.pdf)

Team Up. Pressure Down is a nationwide program to lower blood pressure and prevent hypertension through patient-pharmacist engagement. The videos and resources can help patients, pharmacists, and health care providers better understand high blood pressure and the steps they can take to prevent or treat it. Team Up. Pressure Down was developed through the Million Hearts® Initiative sponsored by the U.S. Department of Health and Human Services.

## **7. With Support From Web-Based Tools, Pharmacists Help Individuals Adopt Healthier Behaviors, Reduce Cardiovascular Risk**

<https://innovations.ahrq.gov/profiles/support-web-based-tools-pharmacists-help-individuals-adopt-healthier-behaviors-reduce>

This featured profile is available on AHRQ’s Health Care Innovations Exchange Web site. Under a program known as HealthyHeartClub.com, pharmacists work with individuals with or at risk for heart disease, educating them on ways to reduce cardiovascular risk and helping them set and reach goals related to health outcomes and health-related behaviors, including diet, physical activity, and medication adherence. Designed to support primary care providers’ work with patients, the program consists of pharmacists conducting an initial in person consultation, weekly check-ins via e-mail, and monthly group classes, supported by a patient-friendly Web site that provides easy-to-understand information and tools to track progress toward established goals.

## **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.

**Cross-reference to resources already described:**

- Composite 3. Staff Training and Skills, #2 [Strategies To Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff](#)
- Composite 3. Staff Training and Skills, #3 [Tobacco Cessation Counseling: A Protocol for Practicing Pharmacists](#)

**Composite 6. Staffing, Work Pressure, and Pace**

**1. Beating Behind-the-Counter Job Stress**

<http://www.pharmacytimes.com/publications/issue/2010/October2010/BeatingJobStress-1010>

Heavy workloads and long hours make stress management a critical skill for pharmacists. With a basic knowledge of coping strategies, pharmacists can overcome stress to achieve their personal best. This feature in *Pharmacy Times* defines stress in the pharmacy and identifies possible solutions for handling the stress.

**2. Deflect Distractions and Intercept Interruptions**

<http://www.pharmacist.com/node/206033>

This [Institute for Safe Medication Practices](#) error alert focuses on interruptions and distractions. The American Pharmacists Association discusses the effects of interruptions and distractions, their sources, and strategies to help decrease distractions.

**Composite 7. Communication About Prescriptions Across Shifts**

**Cross-reference to resource already described:**

- Composite 4. Communication Openness, #1 [SBAR Technique for Communication: A Situational Briefing Model](#)

**Composite 8. Communication About Mistakes**

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

<http://www.ihl.org/resources/Pages/Changes/ProvideFeedbacktoFrontLineStaff.aspx> (requires free account setup and login)

Feedback to frontline staff is critical in demonstrating a commitment to safety and ensuring that staff members continue to report safety issues. This Institute for Healthcare Improvement Web page identifies tips and tools for communicating feedback.

## **Composite 9. Response to Mistakes**

### **1. Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems**

[http://www.nahq.org/uploads/NAHQ\\_call\\_to\\_action\\_FINAL.pdf](http://www.nahq.org/uploads/NAHQ_call_to_action_FINAL.pdf)

The National Association for Healthcare Quality *Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems* provides best practices to enhance quality, improve ongoing safety reporting, and protect staff. It addresses accountability, protection of those who report quality and safety concerns, and accurate reporting and response.

### **2. Decision Tree for Unsafe Acts Culpability**

<http://www.ihi.org/resources/Pages/Tools/DecisionTreeforUnsafeActsCulpability.aspx> (requires free account setup and login)

The decision tree for unsafe acts culpability is a tool available for download from the Institute of Healthcare Improvement Web site. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and system issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach in an organization.

### **3. Patient Safety and the “Just Culture”**

[http://www.health.ny.gov/professionals/patients/patient\\_safety/conference/2007/docs/patient\\_safety\\_and\\_the\\_just\\_culture.pdf](http://www.health.ny.gov/professionals/patients/patient_safety/conference/2007/docs/patient_safety_and_the_just_culture.pdf)

This presentation by David Marx defines just culture, the safety task, the just culture model, and statewide initiatives in New York.

## **Composite 10. Organizational Learning—Continuous Improvement**

### **1. Department of Veterans Affairs National Center for Patient Safety—Root Cause Analysis**

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

The National Center for Patient Safety uses a multidisciplinary team approach, known as Root Cause Analysis (RCA) to study health care-related adverse events and close calls. The goal of the RCA process is to find out what happened, why it happened, and how to prevent it from happening again. Because the Center’s Culture of Safety is based on prevention, not punishment, RCA teams investigate how well patient care systems function. The focus is on the “how” and the “why,” not on the “who.” Through the application of human factors engineering approaches, the National Center for Patient Safety aims to support human performance.

### **2. High-Alert Medication Modeling and Error-Reduction Scorecards (HAMMERS) for Community Pharmacies**

<http://www.ismp.org/tools/HAMMERS/default.asp> (requires email address for access)

This free toolkit was developed to help community pharmacies identify risk factors within the dispensing process, provide estimates of the impact of each risk factor, estimate how often an

error or adverse drug event reaches a patient, assess how these risks may affect patients, and implement strategies to prevent errors. By using this tool, pharmacists can estimate how often prescribing and dispensing errors reach patients and how the frequency will change if certain interventions are implemented.

### **3. Improving Medication Safety in Community Pharmacy: Assessing Risk and Opportunities for Change**

<http://www.ismp.org/communityRx/aroc/> (requires email address for access)

This manual is designed to help community pharmacy personnel identify potential medication safety risks and prevent errors. Pharmacists can use the materials and tools in this manual to pinpoint specific areas of weakness in their medication delivery systems and to provide a starting point for successful organizational improvements.

The goals of this manual are to:

- Raise awareness of error-prone processes in the medication delivery system.
- Build awareness of risk-identification opportunities in the community pharmacy setting.
- Maximize the appropriate application of system strategies to reduce organizational risk.

### **4. Plan-Do-Study-Act (PDSA) Worksheet**

<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx> (requires free account setup and login)

The Plan-Do-Study-Act (PDSA) Worksheet from the Institute for Healthcare Improvement is a useful tool for documenting a test of change. The 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).

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

<http://www.innovations.ahrq.gov/guide/guideTOC.aspx>

The goal of this guide is to promote evidence-based decisionmaking and help decisionmakers determine whether an innovation would be a good fit or an appropriate stretch for their health care organization.

#### **Cross-reference to resources already described:**

- Composite 9. Response to Mistakes, #2 [Decision Tree for Unsafe Acts Culpability](#).
- Composite 1. Physical Space and Environment, #3 [Using Change Concepts for Improvement](#)

## **Composite 11. Overall Perceptions of Patient Safety**

### **1. Assessing Barcode Verification System Readiness in Community Pharmacies**

<http://selfassessmentsurvey.ismp.org/BarcodeDocIndex.pdf>

Developed by the Institute for Safe Medication Practices and funded by the Agency for Healthcare Research and Quality, this assessment tool can be used to help community pharmacies prepare for future implementation of a barcode product verification system. This tool can help pharmacy leaders and staff evaluate their current workflow, standard operating procedures, and technology to identify what needs to be accomplished before implementing a barcode product verification system.

### **2. Facts about the Official “Do Not Use” List**

[http://www.jointcommission.org/facts\\_about\\_do\\_not\\_use\\_list/](http://www.jointcommission.org/facts_about_do_not_use_list/)

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its “do not use” list of abbreviations as part of the requirements for meeting that goal.

### **3. Patient Safety Primer: Safety Culture**

<http://psnet.ahrq.gov/primer.aspx?primerID=5>

The concept of safety culture originated outside health care, 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 Patient Safety Network explains this topic further and provides links for more information on what is new in safety culture.

### **4. Verbal Orders**

[http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/verbal\\_orders/Pages/home.aspx](http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/verbal_orders/Pages/home.aspx)

The Pennsylvania Patient Safety Authority is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in various health care settings. The verbal orders tools promote safe practices to help reduce the risk of misinterpretation.

#### **Cross-reference to resources already described:**

- Composite 1. Physical Space and Environment, #2 [Institute for Safe Medication Practices \(ISMP\) Medication Safety Self Assessment® for Community/Ambulatory Pharmacy](#)

## **General Resources**

### **1. AHRQ Impact Case Studies**

<http://www.ahrq.gov/policymakers/case-studies/index.html>

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

### **2. CAHPS® Improvement Guide**

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

The extensive and growing use of CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys to assess the quality of health plans, medical groups, and other organizations has created a demand for practical strategies that organizations can use to improve patients' experiences with care. This guide is designed to help meet this need. It is aimed at executives, managers, physicians, and other staff responsible for measuring performance and improving the quality of services provided by health plans, medical groups, and individual physicians. This guide includes new improvement interventions and offers additional resources.

### **3. Department of Defense Patient Safety Program Toolkits**

<http://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 are intended to be small, self-contained resource modules for training and application. The available toolkits include: Briefs and Huddles, Debriefs, Patient Falls Reduction, Patient Activation Reference Guide, Professional Conduct, and Situation, Background, Assessment, Recommendation (SBAR).

### **4. Medically Induced Trauma Support Services (MITSS)**

<http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html>

Medically Induced Trauma Support Services (MITSS), Inc., a non-profit organization whose mission is “to support healing and restore hope” to patients, families, and clinicians who have been affected by an adverse medical event, developed a toolkit for clinician support. MITSS also provides an organizational assessment tool and a comprehensive work plan.

### **5. Patient Safety Primer: Medication Errors**

<http://psnet.ahrq.gov/primer.aspx?primerID=23>

A growing evidence base supports specific strategies to prevent adverse drug events (ADEs). The AHRQ Patient Safety Network outlines strategies providers can use at each stage of the medication use pathway—prescribing, transcribing, dispensing, 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.

## **6. SAFER Guides**

<http://www.healthit.gov/policy-researchers-implementers/safer>

SAFER guides, released by the Office of the National Coordinator for Health Information Technology (ONC) at the Department of Health and Human Services, are a suite of tools designed to help health care providers and the organizations that support them assess and optimize the safety and safe use of electronic health information technology products, such as electronic health records (EHRs). Each SAFER Guide addresses a critical area associated with the safe use of EHRs through a series of self-assessment checklists, practice worksheets, and recommended practices. Each SAFER Guide has extensive references and is available as a downloadable PDF and as an interactive web-based tool.

Areas addressed include:

- High Priority Practices
- Organizational Responsibilities
- Patient Identification
- Computerized Physician Order Entry (CPOE) with Decision Support
- Test Results Review and Follow-up
- Clinician Communication
- Contingency Planning
- System Interfaces
- System Configuration

## **7. A Toolset for E-Prescribing Implementation in Independent Pharmacies**

<http://healthit.ahrq.gov/health-it-tools-and-resources/implementation-toolsets-e-prescribing/toolset-e-prescribing-0>

This toolset is designed to assist pharmacies in adopting e-prescribing. It consists of seven chapters that provide guidance on various implementation topics and tools that can facilitate the implementation process.