Improving Patient Safety in Ambulatory Surgery Centers: A Resource List for Users of the AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture

I.   Purpose

This document provides a list of references to websites and other publicly available resources that ambulatory surgery centers (ASCs) 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 ASCs seeking information about patient safety initiatives.

II.   How To Use This Resource List

Resources are listed in alphabetical order, organized by the Surveys on Patient Safety Culture™ (SOPS®) composite measures assessed in the Agency for Healthcare Research and Quality (AHRQ) Ambulatory Surgery Center 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.

Feedback. Suggestions for resources you would like added to the list, questions about the survey, or requests for assistance can be addressed to: SafetyCultureSurveys@westat.com.

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

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III. Contents

IV. Resources by Composite Measure

The following resources are organized according to the relevant AHRQ Ambulatory Surgery Center 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 measure.

Composite Measure 1. Communication About Patient Information

1. **Ambulatory Safe Surgery Checklist Template**
   https://www.ariadnelabs.org/resources/downloads/ambulatory-safe-surgery-checklist-template/ (requires free account setup and login)

   This checklist is designed for use in ambulatory surgery centers (ASCs) or for other low-risk procedures. It includes items for this type of surgery and omits items that are not applicable to the ASC environment.

2. **Ambulatory Surgery Surgical Checklist**
   http://www.scoap.org/downloads/SCOAP-Surgical-Checklist_v3_4.pdf

   The Surgical Care and Outcomes Assessment Program (SCOAP), a program of the Foundation for Health Care Quality, provides a free, downloadable surgical checklist for ambulatory surgery. The one-page checklist was adapted from the World Health Organization (WHO) "Safe Surgery Saves Lives" campaign. It outlines staff-specific roles and activities for each stage of the surgery: operative preparation, briefing prior to incision, process control prior to incision, and debriefing at completion of case.

3. **Gastroenterology Safe Surgery Checklist**
   https://webfiles.gi.org/docs/TriSocietyASCChecklist.pdf

   The American Gastroenterological Association, in partnership with the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy, developed a safe surgery checklist specifically for ambulatory surgery centers that provide gastroenterology services. The safe surgery checklist helps ensure that certain measures are taken before administration of anesthesia/sedation, introduction of the endoscope, and patient departure from the procedure room.

4. **Guide To Integrate Patient-Generated Digital Health Data Into Electronic Health Records in Ambulatory Care Settings**
   https://digital.ahrq.gov/health-it-tools-and-resources/patient-generated-health-data-i-patient-reported-outcomes/practical-guide

   This guide promotes the collection, integration, and use of patient-generated health data in clinical care and includes evidence-based steps for implementation.

5. **Ophthalmic Surgical Checklist - Ambulatory Surgery Center Association**
   http://www.ascassociation.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=e456523c-a3f7-4ca8-b532-d5be7885c41b&forceDialog=0

   The American Academy of Ophthalmology and OMIC asked key ophthalmic societies to join them in developing a task force to devise an ophthalmic-specific surgical checklist. The task force produced a sample ophthalmic surgical checklist to meet the needs of patients undergoing many kinds of procedures. This checklist covers tasks before anesthesia, before incision, and before leaving the operating room.

6. **Patient Flow Worksheet for Surgery Centers**
   http://www.beckersasc.com/asc-accreditation-and-patient-safety/patient-safety-tool-patient-flow-worksheet-for-surgery-centers.html

   Sandy Berreth, administrator of Brainerd Lakes Surgery Center, in Baxter, Minnesota, and an Accreditation Association for Ambulatory Health Care surveyor, provided *Becker's Operating Room Clinical Quality & Infection Control* with a patient flow worksheet template for use in ambulatory surgery centers. A template in Excel® is available for download from this site.

7. **Safe Surgery Checklist Implementation Guide**
   https://www.ariadnelabs.org/resources/downloads/safe-surgery-checklist-implementation-guide/ (requires free account setup and login)

   Ariadne Labs has developed a framework for WHO Safe Surgery Checklist implementation based on lessons learned in more than 4,000 facilities worldwide. They created this implementation guide to describe the framework, identify best practices, highlight considerations for how individual facilities might apply the framework, and share practical examples from other facilities.

8. **SBAR Technique for Communication: A Situational Briefing Model**
   http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx (requires free account setup and login)

   The Situation-Background-Assessment-Recommendation (SBAR) technique provides a framework for communication between members of the healthcare team about a patient's condition. This downloadable tool from the Institute for Healthcare Improvement (IHI) contains 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 that a provider can use to organize information in preparing to communicate with a physician about a critically ill patient.

9. **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 helps staff actively engage patients and their care partners to prevent errors during transitions of care.

10. **WHO Safe Surgery Initiatives**
    https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery

    WHO has undertaken a number of global and regional initiatives to address surgical safety. Much of this work has stemmed from the WHO Second Global Patient Safety Challenge "Safe Surgery Saves Lives." One output of this initiative is the WHO Surgical Safety Checklist available for download from this website.

Composite Measure 2. Communication Openness

1. **Raising and Responding to Concerns**
   https://psnet.ahrq.gov/resources/resource/28738/Raising-and-Responding-to-Concerns

   Staff willingness to speak up when they are concerned about unsafe behaviors and conditions is a hallmark of safety culture. This website links to videos that use vignettes to demonstrate challenges to speaking up in healthcare, ways open communication can prevent errors, strategies to raise concerns on the frontline, and benefits of using checklists to support conversation.

Cross-references to resources already described:

- Composite Measure 1. Communication About Patient Information, #1, Ambulatory Safe Surgery Checklist Template
- Composite Measure 1. Communication About Patient Information, #2, Ambulatory Surgery Surgical Checklist
- Composite Measure 1. Communication About Patient Information, #3, Gastroenterology Safe Surgery Checklist
- Composite Measure 1. Communication About Patient Information, #5, Ophthalmic Surgical Checklist - Ambulatory Surgery Center Association
- Composite Measure 1. Communication About Patient Information, #8, SBAR Technique for Communication: A Situational Briefing Model

Composite Measure 3. Staffing, Work Pressure, and Pace

1. **13 Essential ASC Benchmarks & How To Stay Ahead of the Curve**
    https://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/13-essential-asc-benchmarks-a-how-to-stay-ahead-of-the-curve.html

    Three surgery center administrators discuss the benchmarks they rely on daily, monthly, and annually to run a profitable ASC. The daily benchmarks include staffing needs, case volume, patient satisfaction, and spending reports.

2. **How To Use the 4 Pillars of ASC Lean Staffing Without Sacrificing Your A-Team Employees**
    https://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/how-to-use-the-4-pillars-of-asc-lean-staffing-without-sacrificing-your-a-team-employees.html

    Any ambulatory surgery center (ASC) can apply a Lean staffing strategy. The best place to start is by looking at your caseload. How does it fluctuate? Hire and schedule based on those fluctuations. Use a high number of part-time and per diem staff members. This website provides the four pillars of Lean staffing that will engage and retain high-quality staff members.

3. **Patient Safety Primer: Missed Nursing Care**
    https://psnet.ahrq.gov/primers/primer/29

    This Agency for Healthcare Research and Quality (AHRQ) Primer highlights the importance of nurses to safety culture. Missed nursing care is a subset of the category known as error of omission. It refers to needed nursing care that is delayed, partially completed, or not completed at all. Missed nursing care is problematic because nurses coordinate, provide, and evaluate many interventions prescribed by others to treat illness in hospitalized patients. Nurses also plan, deliver, and evaluate nurse-initiated care to manage patients' symptoms and responses to care. Thus, missed nursing care not only constitutes a form of medical error that may affect safety, but has been deemed to be a unique type of medical underuse.

    Missed nursing care is linked to patient harm, including falls and infections. Organizations can prevent missed nursing care by ensuring appropriate nurse staffing, promoting a positive safety culture, and making sure needed supplies and equipment are readily available.

4. **Predict and Anticipate Patient Needs**
    http://www.ihi.org/resources/Pages/Changes/PredictandAnticipatePatientNeeds.aspx (requires free account setup and login)

    This Institute for Healthcare Improvement (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).

Composite Measure 4. Teamwork

1. **Patient Safety Primer: Disruptive and Unprofessional Behavior**
   https://psnet.ahrq.gov/primers/primer/15/disruptive-and-unprofessional-behavior

   Disruptive behavior and unprofessional actions increase the potential for medical errors and preventable deaths as well as lead to staff dissatisfaction and higher turnover. AHRQ's Patient Safety Network explains this topic further and provides links to more information on disruptive and unprofessional behavior.

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 Agency for Healthcare Research and Quality's (AHRQ) Patient Safety Network explains this topic further and provides links for more information on teamwork training.

Composite Measure 5. Staff Training

1. **Clinical Emergency: Are You Ready in Any Setting?**
   http://patientsafety.pa.gov/ADVISORIES/documents/201006_52.pdf

   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 healthcare settings. This article discusses the issues associated with the location of clinical emergencies and strategies for facilities to achieve rapid response preparedness.

2. **Infection Prevention Training for Ambulatory Surgical Centers**
   https://www.cdnetwork.org/hai

   The Clinical Directors Network, Inc. (CDN) is a not-for-profit network of primary care clinicians, researchers, and healthcare workers, provides several training resources pertaining to healthcare-associated infection (HAI) prevention in ambulatory care settings. Training topics include creating and implementing infection control programs in ambulatory surgery centers (ASCs), preventing surgical site infections, using safe injection practices, and cleaning, sterilization, and high-level disinfection.

Composite Measure 6. Organizational Learning – Continuous Improvement

1. **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 for Healthcare Improvement (IHI) website. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and systems issues contributed to the event. This decision tree is particularly helpful when working toward a nonpunitive approach in an organization.

2. **Root Cause Analysis**
   a. **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 multi-disciplinary team approach, known as Root Cause Analysis (RCA) to study healthcare-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."

   b. **RCA2: Improving Root Cause Analyses and Actions To Prevent Harm**
      http://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx (requires free account setup and login)

      With a grant from The Doctors Company Foundation, the National Patient Safety Foundation convened a panel of subject matter experts and stakeholders to examine best practices around RCAs. The panel developed guidelines to help health professionals standardize the process and improve the way they investigate medical errors, adverse events, and near-misses. To focus on the objective of preventing future harm, this updated process focuses on actions to be taken: Root Cause Analyses and Actions, or RCA2 (RCA "squared").

3. **Patient Safety Tools for Physician Practices**
   http://www.hret.org/quality/projects/pppsa.shtml

   Supported by the Commonwealth Fund, the Health Research & Educational Trust (HRET) and its partners at the Institute for Safe Medication Practices and the Medical Group Management Association Center for Research developed patient safety tools for physician practices. Pathways for Patient Safety™ is a three-part toolkit to help outpatient care settings improve safety in three areas: working as a team, assessing where you stand, and creating medication safety.

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 decisionmakers determine whether an innovation would be a good fit or an appropriate stretch for their healthcare organization.

Composite Measure 7. Response to Mistakes

1. **Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions**
   https://psnet.ahrq.gov/resources/resource/32494

   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 whose leaders prioritize reporting. The Joint Commission proposes actions for all organizations to take, 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.

2. **Incident Decision Tree**
   https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety/vol4/Meadows.pdf

   The National Patient Safety Agency has developed the Incident Decision Tree to help National Health Service (NHS) managers in the United Kingdom determine a fair and consistent course of action toward staff involved in patient safety incidents. Staff can use this decision tree when analyzing an error or adverse event in an organization to help identify how human factors and systems issues contributed to the event. The Incident Decision Tree supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences.

3. **Just Culture**
   a. **Just Culture**
      https://www.unmc.edu/patient-safety/patientsafetyculture/just-culture.html

      This website provides links to ways to engage and educate a Just Culture, execute a Just Culture, and evaluate a Just Culture.

   b. **Nursing 2015 Just Culture Toolkit**
      https://nursing2015.wordpress.com/blue-team/blue-team-documents/just-culture-tool-kit-building/

      This website provides a definition of Just Culture, presentations on Just Culture, a case study, and videos.

   c. **Understand Just Culture**
      http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/07a_just_culture/index.html

      The Agency for Healthcare Research and Quality (AHRQ) offers free resources on developing a "just culture" and applying strategies of the Comprehensive Unit-based Safety Program (CUSP). The Apply CUSP module of the CUSP toolkit presents the principles of a just culture, a nonpunitive environment that encourages reporting of adverse events. Included in the module is this video on understanding just culture.

4. **Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management**
   http://www.ihi.org/resources/Pages/Tools/LeadershipResponseSentinelEventEffectiveCrisisMgmt.aspx

   This page of resources was developed by the Institute for Healthcare Improvement (IHI). IHI periodically receives urgent requests from organizations seeking help in the aftermath of a serious organizational event, most often a significant medical error. In responding to such requests, IHI has drawn on learning and examples assembled from many organizations over the last 15 years who have respectfully and effectively managed these crises.

5. **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 coworker homes. The brochure reinforces the nonpunitive reporting policy and encourages all coworkers to report errors.

Cross-references to resources already described:

- Composite Measure 1. Communication About Patient Information, #8, SBAR Technique for Communication: A Situational Briefing Model
- Composite Measure 6. Organizational Learning – Continuous Improvement, #1, Decision Tree for Unsafe Acts Culpability

Composite Measure 8. Management Support for Patient Safety

1. **Conduct Patient Safety Leadership WalkRounds™**
   http://www.ihi.org/resources/Pages/Changes/ConductPatientSafetyLeadershipWalkRounds.aspx (requires free account setup and login)

   Senior leaders can demonstrate their commitment to safety and learn about the safety issues in their own organization by making regular rounds in units to discuss safety issues with the frontline staff. This Institute for Healthcare Improvement (IHI) website discusses the benefits of management making regular rounds and provides links to tools available for download.

2. **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 Framework for Safe, Reliable, and Effective Care describes the key strategic, clinical, and operational components involved in achieving safe and reliable operational excellence—a "system of safety," not just a collection of standalone safety improvement projects.

3. **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 this 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.

4. **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. **Guide to Safety Huddles**
http://www.wsha.org/wp-content/uploads/Worker-Safety_SafetyHuddleToolkit_3_27_15.pdf

This guide to conducting safety huddles defines a safety huddle and suggests who should attend, when they should occur, and how to get a huddle program started. Appendixes include safety huddle process maps, templates, and tools.

b. **Safety Huddle Results Collection Tool**
http://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 organizations first test 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.

V. Resources by Additional Measure

Communication in the Surgery/Procedure Room

Cross-references to resources already described:

- Composite Measure 1. Communication About Patient Information, #1, Ambulatory Safe Surgery Checklist Template
- Composite Measure 1. Communication About Patient Information, #2, Ambulatory Surgery Surgical Checklist
- Composite Measure 1. Communication About Patient Information, #3, Gastroenterology Safe Surgery Checklist
- Composite Measure 1. Communication About Patient Information, #5, Ophthalmic Surgical Checklist - Ambulatory Surgery Center Association
- Composite Measure 1. Communication About Patient Information, #8, SBAR Technique for Communication: A Situational Briefing Model

VI. General Resources

1. **AHRQ Impact Case Studies**
   https://www.ahrq.gov/news/newsroom/case-studies/index.html?search_api_views_fulltext=patient+safety

   The Agency for Healthcare Research and Quality's (AHRQ) 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 policymakers, health systems, clinicians, academicians, and other professionals.

2. **AHRQ Patient Safety Education and Training Catalog**
   https://psnet.ahrq.gov/training-catalog

   AHRQ's Patient Safety Education and Training Catalog consists of patient safety programs currently available in the United States. The catalog, which is featured on AHRQ's Patient Safety Network site, offers a database of patient safety education and training programs consisting of a robust collection of information 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. **Ambulatory Health Care: 2023 National Patient Safety Goals**
   https://www.jointcommission.org/standards/national-patient-safety-goals/ambulatory-health-care-national-patient-safety-goals/

   The Joint Commission released National Patient Safety Goals for the Ambulatory Health Care Program.

4. **The CAHPS® Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience**
   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 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 improvement interventions and offers additional resources.

5. **Department of Defense Patient Safety Program**
   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 is a comprehensive program with the goal of establishing a culture of patient safety and quality within the Military Health System (MHS). Patient Safety Program Toolkits are available and 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.
   - RCA Resource Guide.
   - SBAR.

6. **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 white paper from the Institute for Healthcare Improvement 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?" This approach enables them to better understand the barriers to joy in work and to create meaningful, high-leverage strategies to address these issues.

7. **Hand Hygiene in Healthcare Settings**
   http://www.cdc.gov/handhygiene/training.html

   The Centers for Disease Control and Prevention's (CDC) 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 (WHO), universities, and health departments.

8. **Improving Your Laboratory Testing Process: A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement**
   https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-care/labtesting-toolkit.html

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

9. **Infection Control Surveyor Worksheet**
   http://www.ascassociation.org/viewdocument/?DocumentKey=ae5c22ac-c283-4a36-b548-06ce81f200a0

   The Centers for Medicare & Medicaid Services (CMS), in conjunction with CDC, have developed a comprehensive infection control worksheet to evaluate compliance with infection control requirements. This worksheet serves as a guide for ambulatory surgery centers (ASCs) that want to fine-tune their infection control practices.

10. **Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care**
    http://www.ascassociation.org/viewdocument/?DocumentKey=d8c47834-ad16-4683-a193-5190829672cc

    Checklist for use in ensuring that the facility has appropriate infection prevention policies and procedures in place and supplies to allow healthcare personnel to provide safe care. Also used to systematically assess personnel adherence to correct infection prevention practices. Assessment of adherence should be conducted by direct observation of healthcare personnel during the performance of their duties.

11. **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 Institute for Healthcare Improvement'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 has a supplemental Self-Assessment Tool and Implementation Resource Guide and a Declaration to Advance Patient Safety issued by NSC.

12. **Oregon Ambulatory Surgery Center Infection Prevention and Control Toolkit**
    https://oregonpatientsafety.org/tools-and-best-practices/oregon-asc-infection-prevention-and-control-toolkit

    The *Oregon Ambulatory Surgery Center Infection Prevention & Control Toolkit* is specifically designed to provide guidance on the development and implementation of infection prevention programs that meet infection control standards outlined in Medicare's Conditions of Coverage and State of Oregon administrative rules. The toolkit was developed by the Oregon Patient Safety Commission to help Oregon's ASCs implement infection prevention quality improvement projects, reduce infection risks, and better protect patients.

13. **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.

14. **Shining a Light: Safer Health Care Through Transparency**
    http://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.

15. **Toolkit To Improve Antibiotic Use in Ambulatory Care**
    https://www.ahrq.gov/antibiotic-use/ambulatory-care/index.html

    The Toolkit To Improve Antibiotic Use in Ambulatory Care explains antibiotic decision making and has tools to improve prescribing in three areas: developing and improving antibiotic stewardship activities in a practice, learning strategies for communicating about antibiotic prescribing, and disseminating best practices for common infectious diseases.

16. **Toolkit To Improve Safety in Ambulatory Surgery Centers**
    https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/ambulatory-surgery/index.html

    The Toolkit To Improve Safety in Ambulatory Surgery Centers helps ASCs make care safer for their patients. ASCs can use the toolkit to apply the proven principles and methods of AHRQ's Comprehensive Unit-based Safety Program (CUSP) to prevent surgical site infections (SSIs) and other complications and improve safety culture in their facilities. The toolkit includes resources used by ASCs that participated in the AHRQ Safety Program for Ambulatory Surgery project.

17. WHO Patient Safety Curriculum Guide: Multi-Professional Edition
   https://www.who.int/publications/i/item/9789241501958

The World Health Organization developed the Multi-professional Patient Safety Curriculum 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 Curriculum Guide has two parts. Part A is a teachers' guide designed to introduce patient safety concepts to educators. It relates to building capacity for patient safety education, planning programs, and designing the courses. Part B provides all-inclusive, ready-to-teach, topic-based patient safety courses that can be used as a whole or on a per topic basis. The curriculum covers 11 patient safety topics, each designed to feature a variety of ideas and methods for patient safety learning.

VII. Alphabetical Index of Resources

13 Essential ASC Benchmarks & How To Stay Ahead of the Curve

AHRQ Impact Case Studies

AHRQ Patient Safety Education and Training Catalog

Ambulatory Health Care: 2023 National Patient Safety Goals

Ambulatory Safe Surgery Checklist Template

Ambulatory Surgery Surgical Checklist

The CAHPS® Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience

Clinical Emergency: Are You Ready in Any Setting?

Conduct Patient Safety Leadership WalkRounds™

Decision Tree for Unsafe Acts Culpability

Department of Defense Patient Safety Program

Department of Veterans Affairs National Center for Patient Safety –Root Cause Analysis

Developing a Reporting Culture: Learning From Close Calls and Hazardous Conditions

Framework for Improving Joy in Work

A Framework for Safe, Reliable, and Effective Care

Gastroenterology Safe Surgery Checklist

Guide To Integrate Patient-Generated Digital Health Data Into Electronic Health Records in Ambulatory Care Settings

Guide to Safety Huddles

Hand Hygiene in Healthcare Settings

How To Use the 4 Pillars of ASC Lean Staffing Without Sacrificing Your A-Team Employees

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

Incident Decision Tree

Infection Control Surveyor Worksheet

Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care

Infection Prevention Training for Ambulatory Surgical Centers

Just Culture

Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management

Leading a Culture of Safety: A Blueprint for Success

Living a Culture of Patient Safety Policy and Brochure

National Action Plan To Advance Patient Safety

Nursing 2015 Just Culture Toolkit

Ophthalmic Surgical Checklist - Ambulatory Surgery Center Association

Oregon Ambulatory Surgery Center Infection Prevention & Control Toolkit

Patient Flow Worksheet for Surgery Centers

Patient Safety Primer: Disruptive and Unprofessional Behavior

Patient Safety Primer: Medication Errors

Patient Safety Primer: Missed Nursing Care

Patient Safety Primer: Teamwork Training

Patient Safety Tools for Physician Practices

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

Predict and Anticipate Patient Needs

Raising and Responding to Concerns

RCA2: Improving Root Cause Analyses and Actions To Prevent Harm

Safe Surgery Checklist Implementation Guide

Safety Huddle Results Collection Tool

SBAR Technique for Communication: A Situational Briefing Model

Shining a Light: Safer Health Care Through Transparency

Toolkit To Engage High-Risk Patients In Safe Transitions Across Ambulatory Settings

Toolkit To Improve Antibiotic Use in Ambulatory Care

Toolkit To Improve Safety in Ambulatory Surgery Centers

Understand Just Culture

WHO Patient Safety Curriculum Guide: Multi-Professional Edition

WHO Safe Surgery Initiatives

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