Inventory of patient safety improvement spread strategies

COMMUNICATION, APOLOGY AND RESOLUTION (CARe)

An important part of CARe is the ability to prevent the harm of future patients after an unanticipated outcome occurs. Spreading patient safety improvements made in response to CARe cases both internally and externally is of great benefit to patients, health care providers, and health care institutions alike. CARe facilities work to improve patient safety and spread of such improvements in a number of ways. An inventory of these strategies is listed below.

1. **Practice alerts** such as emails or text messages are sent directly to staff and managers on relevant units to alert them to the safety issue and inform them of the recommended fix/warning if applicable.
2. **Huddles** are used to gather together chiefs and managers of different services to talk daily and efficiently communicate important safety information.
3. **Intranet portals** are used to broadcast adverse events and improvements made.
4. **Newsletters** are used to detail adverse events and improvement plans, and celebrate those who are putting the improvements into practice.
5. **Collaborative case reviews** are used to gather members of a variety of involved departments to review the event and to learn from the experience promptly.
6. **Nurse Practice Councils** assist in the development and dissemination of nursing strategies to prevent adverse events.
7. **PFACs** (Patient and Family Advisory Councils) work with the facilities to help make improvements with the patient in mind, and also help facilities communicate those improvements to patients and families.
8. **Submission of cases to external improvement databases**, such as those maintained by malpractice insurers, the Betsy Lehman Center, The Joint Commission, the Board of Registration in Medicine, and/or the Schwartz Center, contribute to better data and understanding of adverse events.
9. **Participation in a Patient Safety Organization**, to which safety events can be submitted and aggregation and analysis can occur, aid in the development of safety improvements and best practice recommendations.
10. **Participation in a system-based safety group** helps identify safety issues that could have similar contributing factors and system-level vulnerabilities.

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