**Title:** Compendium of Tools & Resources on Patient Safety- Strategic Objective 2
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**Source:** Global Knowledge Sharing Platform for Patient Safety (GKPS)
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| 2. High-reliability systems | Name | Link | Type of resource | Source | Description | Language | Cost | Interlinking areas |
|---|---|---|---|---|---|---|---|---|
| 2.1 Transparency, openness and No blame culture | Safety Culture: A Global Approach Supported by the Hierarchy | https://osha.europa.eu/data/d | Case study | Avery Dennison | The American multinational Avery Dennison is active in publishing in the graphic sector as well as printing. They require an efficient safety policy w in order to be able to initiate the process of improving the safety culture in general and to change possible unsafe behaviour during work. The only way to achieve this change in mentality was to implement a new health and safety culture. | English | Free | |
| 2.1 Transparency, openness and No blame culture | Safety Culture Discussion Cards (NHS: Education for Scotland) | https://drive.google.com/file/d | Discussion cards | NHS Scotland | The safety cards should be used to inspire conversation about safety culture. They are split into various safety culture elements and can be used for reflection and discussion by the Care Team. | English | Free | 5.1 |
| 2.1 Transparency, openness and No blame culture | Manchester Patient Safety Framework (MaPSaF) | https://improve.bmj.com/imp | Framework | National Patient Safety Agenda | The Manchester Patient Safety Framework (MaPSaF) from the NPSA is a tool to help NHS organisations and healthcare teams assess their progress in developing a safety culture. | English | Free | 1.1, 6.3 |
| 2.1 Transparency, openness and No blame culture | Hospital Survey on Patient Safety Culture | https://www.ahrq.gov/sites/d | Guidance | Agency for Healthcare Research and Quality | The Agency for Healthcare Research and Quality (AHRQ) and Medical Errors Workgroup of the Quality Interagency Coordination Task Force (QuIC) sponsored the development of the Hospital Survey on Patient Safety Culture. The hospital survey is designed specifically for hospital staff and asks for their opinions about the culture of patient safety at their hospitals. | English | Free | 6.1 |
| 2.1 Transparency, openness and No blame culture | Patient Safety Culture | https://www.patientsafetyinst | Guidance | Canadian Patient Safety Institue | Understanding the components and influencers of culture and assessing the safety culture is essential to developing strategies that creates a culture committed to providing the safest possible care for patients. This provides recommended strategies for how to do this. | English | Free | |
| 2.1 Transparency, openness and No blame culture | Safety Attitudes and Safety Climate Questionnaire | https://med.uth.edu/chqs/sur | Questionnaire | University of Texas and Texas Medical Center | The SAQ is a single page (double sided) questionnaire with 60 items and demographics information (age, sex, experience, and nationality). The questionnaire takes approximately 10 to 15 minutes to complete. Healthcare organizations can use the survey to measure caregiver attitudes about six patient safety- related domains, to compare themselves with other organizations, to prompt interventions to improve safety attitudes and to measure the effectiveness of these interventions. | English | Free | 6.1 |
| 2.1 Transparency, openness and No blame culture | Patient Safety Organizations and Transparency: Working Together to Improve Patient Safety | https://www.centerforpatient | Report | Center For Patient Safety | This paper provides a brief overview of the legal protections available to health care providers that participate in a PSO, discusses the PSO framework as it relates to transparency efforts, and describes how the PSO protections can work synergistically with other reporting mechanisms, including transparency efforts, to achieve safety and quality improvements. | English | Free | |
| 2.1 Transparency, openness and No blame culture | Shining a light: Safer Health Care Through Transparency | http://www.ihi.org/resources/ | Report | IHI | Defining transparency as "the free flow of information that is open to the scrutiny of others," this report offers sweeping recommendations to bring greater transparency in four domains: between clinicians and patients; among clinicians within an organization; between organizations; and between organizations and the public. | English | Free | |
| 2.1 Transparency, openness and No blame culture | From a blame culture to a learning culture | https://www.gov.uk/governm | Speech | UK Government | A speech given by health secretary Jeremy Hunt in 2016. It describes the move towards patient safety and the changes and commitments that the UK is making through the NHS. He talks about shifting from a blame culture to a learning culture, intelligent transparency and resources for learning. | English | Free | |
| 2.1 Transparency, openness and No blame culture | SCORE Survey - Safety, Communication, Operational Reliability, and Engagement | http://www.swscn.org.uk/wp- | Survey | Safe & Reliable Healthcare | The SCORE survey has been validated in a number of high-income settings and includes questions from the Safety Attitudes Questionnaire (SAQ) and the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety, with additional items on burnout, depression and work–life balance. | English | Free | 5.5, 6.3 |
| 2.2 Good governance for the health care system | An Introduction to Clinical Governance and Patient Safety | https://oxford.universitypress | Book | Oxford Universiy Press | his book presents a simple overview of clinical governance in context, highlighting important principles required to function effectively in a pressurized healthcare environment. It is presented in short sections based on the original seven pillars of clinical governance. These have been expanded to include the fundamental principles of systems, team working, leadership, accountability, and ownership in healthcare, with examples from everyday practice. | English | approx. 50 dollars | 1.1, 1.2, 1.4, 2.3, 4.1, 4.2, 4.5, 5.1, 5.5, 6.1, 6.2 |
| 2.2 Good governance for the health care system | Eighth futures forum on governance of patient safety | https://www.euro.who.int/ | Forum summary report | WHO | Launched in 2001, the Futures Fora are a series of meetings for policy-makers. They aim to generate insights into real-life decision-making issues that are often not available from academic sources. The baseline theme for the Futures Fora in 2003–2005 is tools for decision-making in public health. Several Futures Fora have already been organized under this theme. These include a forum on evidence-based recommendations as tools for decision-making (Brussels, June 2003); one on rapid response decision-making tools (Madrid, December 2003); | English | Free | |
| 2.2 Good governance for the health care system | National Model Clinical Governance Framework | https://www.safetyandquality | Framework | Australian Commission on Safety and Quality in Healthcare | The purpose of the Clinical Governance Framework is to ensure that patients and consumers receive safe and high-quality health care by describing the elements that are essential for acute health service organisations to achieve integrated corporate and clinical governance systems. Through these systems, organisations and individuals are accountable to patients and the community for continuously improving the safety and quality of their services. | English | Free | 2.3, 2.5, 4.1, 5.5 |
| 2.2 Good governance for the health care system | Royal College of Physicians - Patient Safety Committee | https://www.rcplondon.ac.uk/ | Framework | Royal College of Physicians | The purpose of the Royal College of Physician's Patient Safety Committee is to improve the safety of patients receiving care from our fellows, members and the multidisciplinary teams within which they work in all four countries of the UK and internationally. | English | Free | 4.3 |
| 2.2 Good governance for the health care system | Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems | http://www.ihi.org/resources/ | Guidance | IHI | This paper proposes a more holistic approach to quality management — whole system quality — that enables organizations to close the gap between the quality that customers are currently receiving and the quality that they could be receiving by integrating quality planning, quality control, and quality improvement activities across multiple levels of the system. The paper details how these leadership principles and management practices can enable health systems to pursue quality — with ambition, alignment, and agility — through a commitment to learning. | English | Free | 7,1 |
| 2.2 Good governance for the health care system | Essential public health functions, health systems and health security: developing conceptual clarity and a WHO roadmap for action | https://www.who.int/publicat | Guidance | WHO | The objective of the work underlying this report was to develop a reference document on WHO policy and operational perspectives of regional approaches on EPHFs and the links with the International Health Regulations (2005) and health systems strengthening, and to provide a glossary for use in framing discussions on resilient health systems and universal health coverage. | English | Free | |
| 2.2 Good governance for the health care system | Governance, patient safety and quality | https://www.england.nhs.uk/ | Handbook | NHS | The Matrons Handbook for the maternity transformation programme. It outlines how clinical governance can be achieved by monitoring systems and processes to provide assurance of patient safety and quality of care across the organisation | English | Free | 6.1 |
| 2.2 Good governance for the health care system | Taking safety on board: the board's role in patient safety | https://www.health.org.uk/sit | Paper | The Health Foundation | The authors of this thought paper identify the most important messages and the actions they believe board members should take to ensure patients are safe in their organisation. The paper looks at three main areas: the board's core roles in relation to patient safety; how boards might deliver these roles; and the optimal relationship between board leadership, clinical leadership and regulatory oversight. | English | Free | 2.3 |
| 2.2 Good governance for the health care system | WIHI: Patient Safety Officer: One Person's Title, Everyone's Responsibility (Podcast) | http://www.ihi.org/resources/ | Podcast | IHI | This podcast discusses the role of the Patient Safety Officer, as organised by the Joint Commission. | | | |
| 2.2 Good governance for the health care system | Strategies for Leadership: Hospital Executives and Their Role in Patient Safety | http://www.ihi.org/resources/ | Strategy | IHI | Hospital Executives and Their Role in Patient Safety is produced by the Dana-Faber Cancer Institute to pull together leadership strategies that grew from their experiences.These leadership strategies have been combined into a self-assessment tool that can be used by all executives within your organization. | English | Free | 4.3 |
| 2.2 Good governance for the health care system | Nova Scotia Quality & Patient Safety Advisory Committee: Advice and Recommendations prepared for Submission to the Minister of Health | https://novascotia.ca/dhw/hsc | Strategy | Quality and Safety Patient Advisory Committee (Nova Scotia) | The strategic plan of the nova Soita Quality & Patient Safety Advisory Committee. The purpose of QPSAC is to provide advice and make recommendations to the Minister of Health and Wellness on matters related to quality and patient safety across the continuum of services within Nova Scotia's health system, and to bring health system stakeholders together in a collaborative partnership to promote quality and patient safety improvement in Nova Scotia. | English | Free | 4.3 |
| 2.2 Good governance for the health care system | West Hertfrodshire Hospitals - Patient Safety, Qulity & Risk Committee Terms of Reference | https://www.westhertshospit | Terms of Reference | NHS | The purpose of the Committee is to provide the Board with assurance that high standards of care are provided by the Trust and in particular, that d appropriate governance structures are in place throughout the Trust to; promote safety and excellence in patient care; identify and manage risk; ensure the effective and evidence-based use of resources; protect health and safeyty of Trust employees. | English | Free | |
| 2.2 Good governance for the health care system | Effective Governance for Quality and Patient Safety: A Toolkit for Healthcare Board Members and Senior Leaders | https://www.patientsafetyinst | Toolkit | Canadian Patient Safety Institue | This toolkit teaches healthcare board members, senior executives, and physician leaders across Canada about the tools available to support organizational efforts in improving quality and patient safety. | English | Free | |
| 2.2 Good governance for the health care system | System Governance towards improved Patient Safety - Key functions, approaches and pathways to implementation | https://www.oecd-ilibrary.org | Working paper | Organisano for Economic Co-Operation and Development & Swiss confederation | A working paper that recognises that safety failures are largely the result of system failures and tehrefore strategeiges oimprofe and strengthen patient safety mus t take a systemic approach and align with policy measures. This report explores different patient safety governance models and strategies/recommendations for the future. | English | Free | |
| 2.3 Leadership capacity for clinical and managerial functions | NHS Leadership Academy: Leadership Framework | https://www.leadershipacade | Framework | NHS | The Leadership Framework sets out the standard for leadership to which all staff in health and care should aspire.The Leadership Framework has been developed by the National Leadership Council after extensive research and consultation with a wide cross section of staff, patients, professional bodies and academics. | English | Free | |
| 2.3 Leadership capacity for clinical and managerial functions | Leadership Guide to Patient Safety (IHI) | http://www.ihi.org/resources/ | Guidance | IHI | This paper shares the experience of senior leaders who have decided to address patient safety and quality as a strategic imperative within their organizations. It presents what can be done to make the dramatic changes that are necessary to ensure that patients are not harmed by the very care systems they trust will heal them. | English | Free | 6.1 |
| 2.3 Leadership capacity for clinical and managerial functions | Patient Safety Leadership WalkRounds™ | http://www.ihi.org/resources/ | Guidance | IHI | This tool provides key elements for successful implementation of WalkRounds™ and sample formats and questions to ask staff. Senior leaders are encouraged to use weekly Patient Safety Leadership WalkRounds™ to demonstrate their organization's commitment to building a culture of safety. WalkRounds™ are conducted in patient care departments (such as the emergency department, operating rooms, radiology), the pharmacy, and laboratories. They provide an informal method for leaders to talk with front-line staff about safety issues in the organization and show their support for staff-reported errors. | English | Free | 2.2 |
| 2.3 Leadership capacity for clinical and managerial functions | The PeaceHealth Governance Journey in Support of Quality and Safety | https://psnet.ahrq.gov/perspe | Report | Agency for Healthcare Research and Quality | PeaceHealth is a health care delivery organization that operates six hospitals, as well as a large multi-specialty medical group and regional lab, serving communities in Oregon, Washington, and Alaska. PeaceHealth system and regional governing boards have become increasingly focused on quality and safety, making it clear that improving clinical outcomes is their top priority. THey discuss how they exerted their leadership in order to improve patient safety | English | Free | 2.1 |
| 2.3 Leadership capacity for clinical and managerial functions | Developing leadership and management competencies in low and middle-income country health systems | https://resyst.lshtm.ac.uk/site | Report | Resilient & Responsive Health Systems | This brief provides an overview of the evidence on health systems leadership and management in LMIC. It describes who health leaders and managers (L&M) are, the scope of their work and the ideal competencies required for effective leadership and management. It then outlines approaches to developing leadership and management skills and the strengths and limitations of these approaches | English | Free | |
| 2.3 Leadership capacity for clinical and managerial functions | The Essential Role of Leadership in Developing a Safety Culture | https://www.jointcommission | Report | The Joint Commission | This article outlines what healthy leadership in an organization with a strong safety culture should look like and recommends 11 actions to establish and continuously improve a safety culture. | English | Free | 5.1 |
| 2.3 Leadership capacity for clinical and managerial functions | How can leaders influence a safety culture? | https://www.health.org.uk/pu | Thought paper | The Health Foundation | In this thought paper,Dr Michael Leonard and Dr Allan Frankel explore how effective leadership and organisational fairness are essential for patient safety within healthcare services. They discuss how leaders can influence their organisations to help create a robust safety culture. | English | Free | |
| 2.3 Leadership capacity for clinical and managerial functions | Canadian Patient Safety Institute: Patient Safety Culture "Bundle" for CEOs/Senior Leaders | https://www.patientsafetyinst | Tool | Canadian Patient Safety Institue | The Patient Safety Culture "Bundle" for CEOs and Senior Leaders encompasses key concepts of safety science, implementation science, just culture, psychological safety, staff safety/health, patient and family engagement, disruptive behavior, high reliability/resilience, patient safety measurement, frontline leadership, physician leadership, staff engagement, teamwork/communication, and industry-wide standardization/alignment. | English | Free | |
| 2.3 Leadership capacity for clinical and managerial functions | How-to Guide: Governance Leadership (Get Boards on Board) | http://www.ihi.org/resources/ | Tool | IHI | This How-to Guide recommends that boards of trustees in all hospitals undertake six key governance leadership activities to improve quality and reduce harm in their hospitals. | English | Free | |

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| 2.4 Human factors/ ergonomics for health systems resilience | Human Factors in Healthcare: A Concordat from the National Quality Board | https://www.england.nhs.uk/ | Action Plan | National Quality Board | This document outlines the NHS approach in addressing and incoroporting human factors in healthcare. It describes their specific actions and their approach moving forward, as well as some real case studies. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Managing the unexpected: resilient performance in an age of uncertainty. | https://www.researchgate.net | Book | John Wiley & Sons | Why are some organizations better able than others to maintain function and structure in the face of unanticipated change? Authors Karl Weick and Kathleen Sutcliffe answer this question by pointing to high reliability organizations (HROs), such as emergency rooms in hospitals, flight operations of aircraft carriers, and firefighting units, as models to follow. These organizations have developed ways of acting and styles of learning that enable them to manage the unexpected better than other organizations. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | The How to Guide: Implementing Human Factors in Healthcare (Volume 2) | https://improvementacademy | Guidance | Clinical Human Factors Group | Many healthcare organisations have carried out work on implementing human factors since this time and the first 'How to' guide created a demand for more information from the service. With these factors in mind, the Clinical Human Factors Group commissioned this second volume, with support from The Health Foundation | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Selecting safe & easy to use products for healthcare: using human specification & checklists | https://drive.google.com/file/ | Guidance | Clinical Human Factors Group | This Guide is to help staff working in procurement or with medical devices and equipment, to use Human Factors to specify and select the best and safest products to use in healthcare. This is important because conformity with Regulations and Standards does not always guarantee safe outcomes when products are used in practice. | English | Free | 5.1 |
| 2.4 Human factors/ ergonomics for health systems resilience | The How to Guide: Implementing Human Factors in Healthcare (Volume 1) | https://drive.google.com/file/ | Guidance | Patient Safety First | The purpose of this guide is to provide an introduction to the concept of human factors in healthcare and provide suggestions of how its elements can be applied by individuals and teams working to improve patient safety. It aims to build awareness of the importance of human factors in making changes to improve patient safety. It is divided into 2 parts: "organisational management and human factors" and "making your care and work safer". | English | Free | 5.5 |
| 2.4 Human factors/ ergonomics for health systems resilience | Human Factors and Healthcare (HEE) | https://www.hee.nhs.uk/sites | Guidance/Report | Health Education England | This report aims to:<br>- Identify the impact of Human Factors training undertaken within several sectors in England.<br>- Identify and recognise good practice in Human Factors training by means of a set of case studies<br>- Inform stakeholders about potential strategies for the implementation of Human Factors training across an organisation like the NHS | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Never? | https://www.england.nhs.uk/ | Report | Clinical Human Factors Group | This report was drown up by the Clinical Human Factors Group and looks at 9 wrong site surgery cases. It examines what went wrong and what can be learnt from the cases that can be implemented into everyday practice. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Department of Health Human Factors Reference Group - Interim Report 1 March 2012 | https://www.england.nhs.uk/ | Report | NHS | This report recognises the need for human factors to be embedded in the NHS in order to improve safety and efficiency. This report outlinesa set of recommendations for various elements of human factors in healthcare. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Summary of TeamSTEPPS pilot (Human factors training) | https://drive.google.com/file/ | Report | NHS | The patient safety lead at Barnsley Hospital decided to pilot TeamSTEPPS training for human factors in 2 wards. This report talks about the methods undergone to do this, the outcomes resulting from this and recommendations for further use. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Canadian Patient Safety Institute: Creating a Safe Space Strategies to Address the Psychological Safety of Healthcare Workers | https://www.patientsafetyinst | Strategy | Canadian Patient Safety Institue | Assist healthcare organizations support healthcare workers by creating peer-to-peer support programs (PSPs) or other models of supports to improve the emotional well-being of healthcare workers and allow them to provide the best and safest care to their patients. manuscript provides a comprehensive overview of what healthcare worker support models are available in Canada and internationally | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | What is human factors and why is it important to patient safety? | https://www.who.int/patients | Syllabus module | WHO | Topic 2 in the WHO Safety Curriculum. Guidelines on what should be taught about human factors in patient safety and how best to teach this. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Technical Series on Safer Primary Care: Human Factors | *available as pdf only* | Technical guide | WHO | This monograph describes what "human factors" are and what relevance this approach has for improving safety in primary care. This section defines human factors.The next sections outline some of the key human factors' issues in primary care and the final sections explore potential practical solutions for safer primary care. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | Human Factors across NHS England | https://www.youtube.com/wa | Video | Chartered Institute of Ergonomics & Human Factors | Paul Bowie. Programme Director - Patient Safety & Quality Improvement at NHS Education for Scotland shares his insights into progress and plans for human factors integration in Scotland's healthcare system. This was at the launch event for the Chartered Institute of Ergonomics & Human Factors White Paper. | English | Free | |
| 2.4 Human factors/ ergonomics for health systems resilience | White Paper on Human Factors for Health & Social Care | https://www.ergonomics.org.u | White Paper | Chartered Institute of Ergonomics & Human Factors | The purpose of this White Paper is to provide the authoritative guide to aid understanding of how Human Factors can and should be used, and the competence and experience needed to manage effort, solve problems and make decisions. It describes how Human Factors can bring a depth and clarity of understanding to Health and Social Care Issues. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | The Code of Conduct for the International Red Cross and Red Crescent Movement and Non- Governmental Organisations (NGOs) in Disaster Relief | https://www.icrc.org/en/doc/ | Code of Conduct | International Red Cross | This Code of Conduct seeks to guard our standards of behaviour.It seeks to maintain the high standards of independence, effectiveness and impact to which disaster response NGOs and the International Red Cross and Red Crescent Movement aspires. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Sendai Framework for Disaster Risk Reduction 2015 - 2030 | https://www.preventionweb.n | Framework | United Nations | The Sendai Framework for Disaster Risk Reduction 2015–2030 was adopted at the Third United Nations World Conference on Disaster Risk Reduction. The present Framework will apply to the risk of small-scale and large-scale, frequent and infrequent, sudden and slow-onset disasters caused by natural or man-made hazards. It aims to guide the multi- hazard management of disaster risk in development at all levels as well as within and across all sectors. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disasters | https://cdn.who.int/media/do | Guidance | WHO | The Foreign Medical Teams (FMT) Working Group commissioned this document. It introduces a simple classification, minimums standards and a registration form for FMTs that may provide surgical and trauma care arriving within the aftermath of a sudden onset disaster (SOD). These can serve as tools to improve the coordination of the foreign medical team response, and be the reference for registration on arrival as well as a possible global registration mechanism similar to what exists for urban search and rescue teams. | hinese, French | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Hospital Safety Index Guide for Evaluators | https://apps.who.int/iris/bitst | Guidance | WHO | The purpose of this Guide for evaluators is to provide guidance to evaluators on applying the checklist, rating a hospital's safety and calculating the hospital's safety index. The evaluation will facilitate the determination of the hospital's capacity to continue providing services fol- lowing an adverse event, and will guide the actions necessary to increase the hospital's safety and pre- paredness for response and recovery in case of emergencies and disasters. Throughout this document, the terms "safe" or "safety" cover structural and nonstructural safety and the emergency and disaster management capacity of the hospital. | English | Free | 6.1 |
| 2.5 Patient safety in emergencies and settings of extreme adversity | The Sphere Handbook | https://handbook.spherestand | Handbook | Sphere | The Sphere Project, now known as Sphere, was created in 1997 by a group of humanitarian non-governmental organisations and the Red Cross and Red Crescent Movement. Its aim was to improve the quality of their humanitarian responses and to be accountable for their actions. The principal users of The Sphere Handbook are practitioners involved in planning, managing or implementing a humanitarian response. This includes staff and volunteers of local, national and international humanitarian organisations responding to a crisis, as well as affected people themselves. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Occupational safety and health in public health emergencies: a manual for protecting health workers and responders | https://www.who.int/publicat | Manual | WHO | This manual provides an overview of the main OSH risks faced by emergency responders during disease outbreaks and other emergencies. The manual, which is particularly focused on needs in low-resource settings, provides technical guidance on good practices in establishing systems that can: 1) reduce occupational exposures, injury, illness and death among response workers; 2) decrease stress and reduce fears; and 3) promote the health and well-being of health-care and other response workers. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Patient Safety Incident Policy | https://bibop.ocg.msf.org/doc | Policy | Medecins Sans Frontieres | The Patient Safety Incident policy aims to minimize events happening during healthcare by supporting teams on the management and learning processes needed for the incidents encountered.<br>Through a contextual and detailed analysis of a PSI, measurable and appropriate interventions can be set-up in a systematic way and supported by specialists when needed. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Patient Safety Recommendations for COVID-19 Epidemic Outbreak | https://isqua.org/images/COVI | Recommendations | International Society for Quality in Healthcare and Italian Network for Safety in Healthcare | On the basis of reports and questions forwarded to the Clinical Risk Managers of the Italian Network for Health Safety (INSH) from physicians working on the front line, a series of recommendations have been developed referring to documents and papers published by national institutions (ISS) and Italian and international scientific societies and journals. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Healthcare quality in extreme adversity and FCV settings - UNC: Gillings School of Public Health | https://sph.unc.edu/wp-conte | Report | Gillings School of Public Health | As part of the NQPS Initiative, research and evidence scanning has been conducted by UNC since 2018 to focus specifically on quality in extreme adversity and fragile, conflict-affected and vulnerable (FCV)settings. This publication provides an overview of the NQPS initiative, with a focus on quality in extreme adversity and FCV settings. It describes the background and conceptual framework for the quality interventions and the supporting evidence scans. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Quality of care in fragile, conflict- affected and vulnerable settings: taking action. | https://www.who.int/publicat | Report | WHO | Quality of care in fragile, conflict-affected and vulnerable settings: taking action has been developed to provide a starting point for multi-actor efforts and actions to address quality of care in the most challenging settings. This includes practical approaches to action planning and implementation of a contextualised set of quality interventions. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Quality in Emergency Care: A safer emergency department - a strategic overview | https://www.rcem.ac.uk///do | Strategy | Royal College of Emergency Medicine | The guidance was commissioned by RCEM Council, and written by the Quality in Emergency Care committee, in recognition of the need for a strategic overview of the approach to safety, experience and quality of care in ED. This document is designed as an overview of QECC work on improving quality of care in ED. It is strategic in approach, underpinned by several processes within RCEM. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Recovery toolkit: supporting countries to achieve health service resilience: a library of tools and resources available during the recovery period of a public health emergency | https://apps.who.int/iris/bitst | Toolkit | WHO | The overall goal of this Toolkit is to support countries in the reactivation of essential health services in the aftermath of a public health emergency. The Toolkit has been constructed to support the implementation of national health plans. The initial target audience are WHO Country Offices, for onward sharing and dissemination to ministries of health and implementation partners in-country. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Quality of care in fragile, conflict- affected and vulnerable settings: tools and resources compendium | https://www.who.int/publicat | Tools | WHO | The Quality of care in fragile, conflict-affected and vulnerable settings: tools and resources compendium represents a curated, pragmatic and non-prescriptive collection of tools and resources to support the implementation of interventions to improve quality of care in such contexts. Relevant tools and resources are listed under five areas. | English | Free | |
| 2.5 Patient safety in emergencies and settings of extreme adversity | Respectful Management of Serious Clinical Adverse Events | http://www.ihi.org/resources/ | White Paper | IHI | This white paper introduces an overall approach and tools designed to support two processes: the proactive preparation of a plan for managing serious clinical adverse events, and the reactive emergency response of an organization that has no such plan. | English | Free | |