Title: Tools & Resources Mapped to Str. File Name: GKPSLINKA06-20232406	ategic Objective 6 or the Who	alobal Patient Salety Action Plan .	2021-2030					
6. Information, research and risk management	Name	Link	Type of resource	Source	Description  In this book the author angles reptemporary green theory in the pearly of investigators and of anyong attempting to understand	Language	Cost	Interlinking
6.1 Patient safety incident reporting and learning systems	Investigating Human Error	https://ewww.rostliedge.com/investigating-Huma	Book	Barry Strauch  Canadian Patient Safety	in this book the author applies contemporary error throny to the needs of investigators and of anyone attempting to understand why someone made a critical error, how that error led to an incident or accident, and how to prevent such error is the future.	English	35-80 pounds	
6.1 Patient safety incident reporting and learning systems	Concise Incident Analysis Tool	https://www.patientsafetyinstitute.ca/en/tpoist	Guidance	Institute, John Hopkins Medicine, WHO	Root cause analysis (RCA) investigations of patient safety incidents (an event or circumstance that could have resulted, or did result, in unnecessary have to a patient)? have played an important cells in improving care. This rignorus methodology is designed to understand all relevant appects of an incident and to stake effective actions that reduce the risk of a recurrence.	English	Free	
					This goldence lets on one operation to the aid oldoors will, whatever their role, take appropriate action to rake and act on concerns about printer care, depth yand safety. It is reparted into two parts.  Part 1 Railing occurry pers safety on raining concerns than patients might be at rain of serious harm, and on the help and support vanishes to you.  Part 2 Railing occurry pers safety on raining a concern than patients might be at rain of serious harm, and on the help and support vanishes to you.  Part 2 Railing occurry services or conserns that patients might be at rain of serious harm, and on the help and support vanishes to you.  Part 2 Railing occurry services developed the services of the part of the parts of the part			
6.1 Patient safety incident reporting and learning systems	Raising and acting on concerns about patient safety	https://www.emc-uk.org/-/media/documents/ra	Guidance	General Medical Council	Part 1: Raising a concern gives advice on raising a concern that patients might be at risk of serious harm, and on the help and support available to you.  Part 2: Acting on a concern explains your responsibilities when colleagues or others raise concerns with you and how those concerns.	English	Free	
6.1 Patient safety incident reporting and learning systems	A guide for health professionals on how to		Guidance	General Medical Council				
6.1 Patient safety incident reporting and learning systems	A guide for health professionals on how to report a doctor to the GMC	and the same and t	Guidance	General Medical Council	This booklet given doctors, medical directors, clinical governance managers and other health professionals advice on what action they should take if they have concerns about a doctor.	English	Free	
6.1 Patient safety incident reporting and learning systems	When Things Go Wrong: Responding to Adverse Events	http://www.macoalition.org/documents/respon	Guidance	Harvard Hospitals	This consensus abstracts exercises the potential benefits and risks of an institutional response quite different from what ment haspstals choses they. If Scores on regard and open disclosure and recrotional superior to patients and entires who expenses serious incidents. It also addresses ways to support and educate directions involved in such incidents and outlines the administrative components of a comprehensive institutional policy. The purpose of the document is to codify aprement on principles that	English	free	42, 44, 45
	Provide the Country				components of a comprehensive institutional policy. The purpose of the document is to codify agreement on principles that individual hospitals will use to develop specific institutional policies to implement them.			
					The purpose of this document is to ensure that efforts undertaken in performing RCA2 will result in the identification and implementation of sustainable systems-based improvements that make patient care safer in settings across the continuum of care.			
6.1 Patient safety incident reporting and learning systems	RCA2: Improving Root Cause Analyses and Actions to Prevent Harm	http://www.ihi.org/resources/Pages/Tools/RCA	Guidance	IMI	The approach is two-prospect identify methodologies and techniques that will lead to more effective and efficient RCA2 Provide tools to evaluate includiast RCA2 reviews so that significant flaws can be identified and remediated to achieve the ultimate	English	Free	
					objective of improving patient safety  The purpose of the MIM PS is to provide a list of information categories that should be collected as a minimum, when reporting an			
6.1 Patient safety incident reporting and learning systems	Minimal Information Model for Patient Safety Incident Reporting and Learning Systems	https://spps.who.int/iris/handle/10665/255642	Guidance	WHO	adverse event. The reason for this is that adverse event reporting is roundays increasingly seen, in the patient safety community, as a tool not only for assessing the patient safety situation at any one point in time, but also to contribute to sharing anonymous safety incident information with others, in a mutually understandable format, as part of a continuous learning process, in order to	English, Portuguese	free	
	systems				encourage to policy change.			
6.1 Patient safety incident reporting and learning systems	WHO Draft Guidelines for Adverse Event Reporting and Learning Systems	https://egps.who.int/iris/bitstream/handle/106	Guidelines	WHO	The objective of these deaft guidelines is to facilitate the improvement or develop-ment of reporting systems that receive information that can be used to improve patient safety. The target audience is contribed, which may select, adapt or otherwise modely the recommendations to enhance reporting in their specific environments and for their specific purposes.	English	Free	
6.1 Patient safety incident reporting and learning systems	WHO Inter-regional Consultation on Patient Safety Incident Reporting and Learning Systems in Africa and the Asia Pacific Regions	http://apps.who.int/iris/bitstream/handle/1056	Meeting Report	WHO	The bitter-opional Consultation on Patient Safety incident Reporting and Learning Systems in Artice and the Jobis Papilin Regions, was halde on 2924 Metro 2006 in Colombo, by Leinka The learnost derived from this secretic wave formulated into situating it recommendations to develop, implement, support and strengthen patient safety MESs, as quality and safety surveillance tools and a source of shared involvingly for botter care, which is foundational to patient safety strategies.	English	Free	7.4
	Pacific Regions							
6.1 Patient safety incident reporting and learning systems	Patient Safety: Rapid Assessment Methods	https://www.who.int/patientsafety/activities/su	Meeting Summary	WHO	The purpose of the meeting was to provide guidance and input towards the development of rapid assessment methodologies for estimating harm caused by the health care system. Facilitation was to be given to be development of tools for use in data- poor environments. A balance was to be sought between robustness of scientific nethods and the need for urgent assessment and	English	Free	6.5
	for Estimating Mazards				action on vital patient safety issues. This report and the recommendations of the Working Group meeting were to be targeted at policy and decision-makers, at national and international level, who are not necessarily experts in the field of patient safety.			-
	Improving the Value of Patient Safety			Agency for Health Research and	We developed and implemented a Web-based PSRS and discuss in this paper the benefits, limitations, and challenges we			
6.1 Patient safety incident reporting and learning systems	Reporting Systems	https://www.ahrq.gov/downloads/pub/advance	Paper	Quality	We developed and implemented a Wish-based PSSS and discuss in this paper the benefits, Institutions, and challenges we accountered. This, we discuss the benefits of PSSS as part of a partiest safety learning community. The remainder of the paper focuses on the challenges we faced that still need to be resolved to improve the value of reporting systems.	English	Free	
6.1 Patient safety incident reporting and learning systems	Sentinel Event Policy and Procedures	https://www.jointcommission.org/resources/pa	Policy	The Joint Commission	The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help health care organizations that experience serious adverse events improve safety and learn from those sentinel events.	English	free	
					Reporting systems (frequently referred to as reporting and learning systems) capture patient safety concerns, hazards and/or			
G.1 Patient safety incident reporting and learning systems	Reporting and Learning Systems	https://www.patientsafetyinstitute.ca/en/toolst	Recommendation	Canadian Patient Safety Institute	incidents and are meant to trigger action, facilitate communication, response, learning and improvement. Establishing a reporting system and processes to support it, including identifying and spreading learning, is foundational to patient safety and incident	English	Free	
					management and essential to advancing a patient safety culture.  This report represents the collective work of the National Patient Safety Consortium to identify, for the first time, a list of 25 never constraints.			
6.1 Patient safety incident reporting and learning systems	Never Events for Hospital Care in Canada	https://www.patientsafetyinstitute.ca/en/toolst	Report	Canadian Patient Safety Institute	This report operants the collective work of the National Patient Safety Connection to identify, for the first time, a list of 3.5 sever exents for hospital care is Carelad. Now events are patient to help reddent that result is serious patient hum or death and are preventable using organizational checks and bulances. Here events are not intended to reflect judgment, blame or provide a guarantee; rather, they represent a coll-to-action to provent their occurrence.	English	Free	
6.1 Patient safety incident reporting and learning systems	GP mythbuster 24: Reporting patient safety incidents to the National Reporting and Learning System (NRLS) for GP practices	https://www.coc.org.uk/guidance.gravidars/eas	Report	coc	This mythbutter is about reporting patient safety incidents to the National Reporting and Learning System (NRLS). NRLS has introduced a referral eform. This allows the learning to be used in the practice's significant event analysis programme.	English	Free	3.5
	Learning System (NRLS) for GP practices				introduced a referral efform. This allows the learning to be used in the practice's significant event analysis programme.  This report presents the findings of the NRLS Research and Development Programme conducted by the Patient Safety Translational	-		
6.1 Patient safety incident reporting and learning systems	NRLS Research and Development	https://www.imperial.ac.uk/media/imperial-coll	Report	NIHR Patient Safety Translational Research Centre at Imperial College London and Imperial College Healthcare NHS Trust	This report presents the finding of the NRS Research and Development Programme conducted by the Poisent Safety Translational Research Center (PTRC) and the Center for Yealsh Pacity (CPI) at Impress Codings Indions. It sets one the current state of all resistance regarding systems with producted regarding register safety reduced regarding safety safety reduced regarding safety safety indices regarding safety safety indices regarding safety safety or colorisms are, including through discriptions of the wireless indices for registering safety safety safety for the registering safety safety safety safety safety safety representations the south indices of producting safety safety in the systems take the NRS can opplish not evelopment to the south safety	English	Free	
				College Healthcare NHS Trust	and the second s			
G.1 Patient safety incident reporting and learning systems	The measurement and monitoring of safety	https://www.health.org.uk/sites/default/files/Ti	Report	The Health Foundation	The aim of this report is to provide a framework and approach to measuring and monitoring safety in all relevant dimensions and facets. The report is based on review of safety literature, exquiries into safety practice in other industries, case studies of organisations, and discussions and interviews with a wide variety of people.	English	Free	6.3
6.1 Patient safety incident reporting and learning systems	Developing a reporting culture: Learning from close calls and hazardous conditions	https://erww.jointcommission.org/-/media/tic/d	Report	The Joint Commission	The Joint Commission recommends that organizational leaders take the following actions to increase trust, reporting and responsibility/ accountability of all staff in support of a safety culture with the ultimate goal to protect patients from harm.	English	Free	2.1
6.1 Patient safety incident reporting and learning systems	Reporting and learning systems for patient safety incidents across Europe	http://buonepratiche.agenas.it/documents/Mor	Report	European Commission	responsibility accountability of all said fin support of a safety culture with the ultimate gad to protect patients from harm. This report presents the findings and recommendations of the reporting and learning systems (review) for incidents in the Member States of the European totion. The west of the subgroup on reporting and learning systems for incidents in the Member States of the European totion. 1 The west of the subgroup was to provide as set of law strategy and give recommendation 300(C 13)(D17 regarding experimentation of Council Recommendation 200(C 13)(D17 regarding experiments.)	English	Free	
					and learning systems.  This document is to urge the readers to understand the purpose, strengths and limitations of patient safety incident reporting. Data			
6.1 Patient safety incident reporting and learning systems	Patient safety incident reporting and learning systems: technical report and guidance	https://www.who.int/publications/i/item/97892	Report / Guidance	WHO	This document is to urge the readers to understand the purpose, strengths and limitations of patient safety incident reporting. Data derived from incident reports can be very valuable in understanding the usels and safetive of home anxiety from health care, provided that the properties of the data are reviewed carefully and condisions are drawn with caustion. This throcking juddone will ship the jummey to a position where we can have patient and the provided part of the patient patients. The patients were provided to the patients and their families how we used this latering to give them care that is use and dependable, very time they need it.	English, Portuguese	Free	
					dependable, every time they need it.			
	Patients' Safety: 2nd Round table on				The Execution of their in regarding systems in both low, which we had not in Statistics. Strains, or to the 2 and 22 becomes being a see appropriate propermentative of the complexity. Social and collection is transitive to present parts and the season and in the news of patients study rouns the first council table a passe admit. Counted tissue and distinctioned in social patients and patients with a second control of the council of the c			
6.1 Patient safety incident reporting and learning systems	Reporting systems in health care	https://www.euro.who.int/_data/assets/pdf fi	Round table Summary	WHO	regards to adverse events reporting systems and research in health related harm. The importance of patient engagement and education of healthcare workers on patient safety has been stressed again. The opportunities to tackle patient safety through these shad arranghes were explored while the importance of networking of all stakeholders an attionally and internationally was	English	Free	
					recognized. A set of further recommendations was developed, including continuing to meet at patient safety round tables.			
6.1 Patient safety incident reporting and learning systems	The Salzburg Statement on moving measurement into action: global principles for measuring patient safety.	https://www.salsburgelobal.org/fileadmin/user	Statement	Salzburg Global	The convensations in Salaburg have helped establish eight global principles for the measurement of patient safety. They feature in a new Salaburg Statement on Moving Measurement into Action: Global Principles for Measuring Patient Safety, which Safeburg Global is standing alongwidth this first of succious league institution.	English	Free	
			Strategy	Canadian Patient Safety Institute	Strategies for reporting systems that capture patient safety concerns, hazards and/or incidents and are meant to trigger action,			
<ol> <li>6.1 Patient safety incident reporting and learning systems</li> </ol>	Reporting and Learning System	https://www.patiencluseryinschuse.ca/en/scoss	Strategy	Canadian Patient Safety Institute	facilitate communication, response, learning and improvement. Stabilishing a reporting system and processes to support it, toucking identifying and spreading learning, is foundational to patient safety and incident management and essential to advancing a patient safety outsure.	English	Free	
6.1 Patient safety incident reporting and learning systems	Before the Incident	https://www.gatientsafetyinstitute.ca/en/toolsl	Strategy	Canadian Patient Safety Institute	Strategies for patient safety and incident management plans and processes proactively developed and in place, together with active monitoring, analyzing, prioritizing and implementing actions to mitigate risks and improve quality and safety, contribute to effective response to both expected and on spected safety issues.	English	Free	
				,				
	The Incident Decision Tree: Guidelines for			Agency for Health Research and	The National Patient Safety Agency has developed the incident Decision Tires to help National Health Service (INIG) managers in the United Dirigion determine a list and consistent course of existin lowest deal' incoloned in patient safety incidents. The Incident Decision Tires upport, that aim of creating a pose colorse, where expressers feel also report pastest safety redest without under fair of the consequences. The tool comprise an algorithm with accompaning galatities and power as series of structured quantities to be fair angreen decided whether unpersion in a session of whether alternations and might be feetable.			
6.1 Patient safety incident reporting and learning systems	Action Following Patient Safety Incidents	https://ewww.ahro.gov/downloads/pub/advance	Tool	Agency for Health Research and Quality	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. The tool comprises an algorithm with accompanying guidelines and pases a series of structured quantions to help managers decide whether suspension is essential or whether alternatives might be feasible.	English	Free	2.1
6.1 Patient safety incident reporting and learning systems	Self-Assessment Tool: A National Action	https://ii.hubspotusercontent30.net/hubfs/2416	Tool	IMI	This of an extractive is implementary to be commendation and talking presented is Seef. Tagging 2. National Annie William (Seef Frei in India of Seef Frei	English	Free	
	Plan to Advance Patient Safety				approach to advance patient safety. Culture, Leadership, and Governance; Patient and Tamily Engagement; Workforce Safety, and Learning System. The self-assessment questions represent a selection and synthesis of elements detailed in the complete National Action Plan and may, therefore, provide a partial representation of the current state of an organization's patient safety efforts.			
6.1 Patient safety incident reporting and learning systems	Patient Reported Outcome Measures (PROMs)	https://digital.nhs.uk/data-and-information/dat	Webpage	NHS	Patient Reported Cutome Measures (PICMA) measure health gain in patients undergring by replacement, bone replacement and put to September 2017, versious win end agrees here in England, based on responses to generate she before and after largers. This provides an indication of the outcomes or quality of care delivered to NICS patients and has been collected by all providen or NICS patients and has been collected by all providen or NICS patients.	English	Free	4.1, 4.2, 6.5
6.1 Patient safety incident reporting and learning systems	Patient Safety Authority	http://patientsafety.pa.gov/pst/Pages/Good_Ca	Webpage Guidance	Persosylvania Patient Safety Authority	following aggregate event analysis and facility interviews, the Pernsylvania Patient Selety Authority concluded that good catch programs can help hopstals more effectively analyse reported data and implements in interactions strategies. Additionally, using a Good Catch Comparison regord available through the Authority's Estient Selety Liseons can identify facility-specific event types or care areas that are reporting above to those aggregate per erac, potentially helpfating successful graction or targets for care areas that are reporting above to those aggregate per erac, potentially helpfating successful graction or targets for	English	free	5.3
					care areas that are reporting above or below aggregate peer rates, potentially highlighting successful practices or targets for improvement efforts.  The Pennsylvania Patient Safety Authority developed the Pennsylvania Patient Safety Reporting System, a secure, web-based system			
6.1 Patient safety incident reporting and learning systems	Pennsylvania Patient Safety Reporting System (PA-PSRS)	http://patientsafety.pa.gov/PA-PSRS/Pages/PAP	Webpage Report	Pennsylvania Patient Safety Authority	The Permission Parisms are to produce the Permission of the Permission Parisms and Permission and Permission of the Permission of	English	Free	
		<u></u>			Most people think of safety as the absence of accidents and incidents (or as an acceptable level of thik). In this perspective, which we term Safety-1, safety in defined as a state where as few things as exceeding the surrow. Safety management shared more form	_		
6.1 Patient safety incident reporting and learning systems	From Safety-I to Safety-II: A White Paper	https://www.england.nhs.uk/signuptosafety/wp	White paper	NHS	heap people in their of sellings, it has been of excellents and includes for a new assignable level of shift, in this purposettion, which are terrelatively, shift is desired as a size where it not their gas possible a more good feet processing the contraction through a possible gas execute the contract great and selling as a possible gas record to ensuring that is many things as possible gas right. We call this prespective faithing is contracted under varying continues, a Adult in Japanese and the terrelative performance variability provides the adaptations that are needed to respond to warring conditions, and hence is the reason why things go right. These variant risks on the reason why things go right. These variant risks can be desired to respond to warring conditions, and hence is the reason why things go right. These variant risks can be desired as displayed and suffered.	English	Free	
		<u>                                     </u>		<u></u>		L		
6.2 Patient safety information systems	Conceptual framework for the				The purpose of the International Classification for Patient Safety is to enable categorization of patient safety information using standardized sets of concepts with agreed definitions, preferred terms and the relationships between them being based on an			
	international classification for patient safety	https://www.who.int/patientsafety/taxonomy/	Framework	WHO	The purpose of the International Classification for Patient Safety is to enable categorization of patient safety information using standardized sint of concepts with agreed definitions, preferred terms and the instinctionship between them being based on an expected domain category (e.g., patients safety). Rev. 15 is designed to be a grained concepts profit the transmission proproption of the main issues related to patients safety and to facilitate the desoption, companion, measurement, monitoring, analysis and alterpretation of information to happower patient execut.	English	Free	
6.2 Patient safety information systems				Australian Commissi	Our purpose is to contribute to better health outcomes and experiences for all patients and consumers, and improved value and			
	Annual Report 2019-20	https://www.safetyandquality.gov.au/sites/defa	Report	Australian Commission on Safety and Quality in Healthcare	our purpose is to contribute to better health outcome and experiences for all patients and consumers, and improved value and statisticability in the health system by leading and coordinating, actional improvements in the safety and quittiery finantial results. Within this overarching purpose, the Commission aims to ensure that people are kept safe when they receive health care and that they receive the case they should.	English	Free	
6.2 Patient safety information systems					We are niessed to report on the progress we have made to inspire and advance a militare committed to sustained improvement for			
	Canadian Patient Safety Institute 2019- 2020 Annual Report	https://annualreport.patientsafetyinstitute.ca/e	Report	Canadian Patient Safety Institute	user hashborn. In this Armai Ropert, you will issue more about our public regardent strategy that builds urgency and calls to action to improve userige in bashborns, which providing the public with book and resources to keep them aids. We regord not be progress of our four Safety improvement Projects, and we provide a wapphot of the many algorithms activities undertaken over the past year that have impacted polypic and trengthered allows and ontablessive and instances.	English	Free	
6.2 Patient safety iformation systems	Annual Patient Safety Report 2018 -	https://www.spcele.com/url/ha+t&rct+i&g+&es	Report	Leicster Hospital	past year that have impacted policy and strengthened alliances and networks.  Annual report of patient safety incidents in Leicater hospitals	English	Free	
6.2 Patient safety information systems	Leicester's Hospitals  National Patient Safety Agency - Annual Report and Accounts 2008/09	https://assets.publishing.service.gov.uk/eoverne	Report	National Patient Safety Agency	The National Patient Safety Agency (NPSA) has worked with the wider NHS to understand and support its ever-changing needs and become a more exposure and agle organisation. This is the annual report of is work, covering the national reportings not learning	English	Free	
6.2 Patient safety information systems 6.2 Patient safety information systems	Report and Accounts 2008/09  Annual progress report for the NHS Patient	https://www.endand.phs.uk/www.endant-fha	Report	National Patient Safety Agency NHS	become a more responsive and aglie organisation. This is the annual report of its work, covering the national reportings and learnings service, national clinical assessment service and national research ethics service.  An annual report of 2015/20 on patient safety, categorised as safety system and safety culture, ingishigt, involvement and	English	Free	
and some systems	Safety Strateay: year one		-		incorporate.  The CCCC established a set of international gastern safety indicators and has regularly collected data from member states over the past decade. Over this period the CCCD has undertaken ongoing research and methodological development of these indicators to improve the rebotishment of the indicator for international comparison. This Action is taken within the content of the CCCD has undertaken ongoing research and member to the comparison. The Action is taken within the content of the CCCD has undertaken on the comparison. This Action is taken within the content of the CCCD has undertaken on the comparison. The Action is taken within the content of the CCCD has undertaken on the comparison of	udin	1.00	
6.2 Patient safety information systems	Data and Analysis of Data on Patient Safety within the OECD Health Care Quality Indicators Project (OECD-PS)	https://ec.europa.eu/chafea/health/documents	Report	OECD	past decade. Over this period the OCCD has undertaken ongoing research and methodological development of these indications for improve the robustness of the indication for international comparisors. This Action is taken within the context of the OCCD's orgains, R&D orgazier of work on patient safety. The general objective of the Action is to improve the "actionability" of the international patient safety indication of the OCCD across EU and OCCD member states, including a focus on expanding the soupe, uptake and use	English	Free	
	, (mann - o)				of these indicators.			
6.2 Patient safety information systems	Patient Safety Reporting Program 2018 Annual Report	https://oregonpatientsefety.org/docs/psrg/9588	Report	Oregon Patient Safety Commission	in 2015, Dregon healthcare organizations—ambulatory surgery centers (ASCs), hospitals, nursing facilities, and community pharmacies—voluntarily contributed 33% adverse event reports to PREP for learning. Through the information that healthcare organizations substituted to PSEA in through their evaluation of research in the field of pattern safety, they have identified key	English	Free	
					lessons in a abverse event reporting.			
6.2 Patient safety information systems	Patient Safety Annual Report 2017	http://www.oxfordahsn.org/wp-content/upload	Report	Oxford Academic Health Science Network	The Colord ARDN has highlighted and embedded withy across many of in region-wide project, more than 3D programma address safety issues across multiple divisal contents. Selely needs to be addressed differently in different clinical contents, and our approach needs to evolve as our healthcare systems address new challengs. In the following pages, we describe a range of physical and mental health pattern safety improvement programmes againing hospitals, the community and can be the home.	English	Free	
					The Toolkit for Using the AHRQ Quality Indicators (Q) Toolkit) is a set of tools available free of charge. The Qi Toolkit is designed to			
6.2 Patient safety information systems	Introduction to the Toolkit for Using the AHRQ Quality Indicators: How To Improve Hospital Quality and Safety	https://www.ahro.gov/sites/default/files/ensise	Toolkit	Agency for Health Research and Quality	support hospitals in assessing and improving the quality and safety of care they provide. Because hospitals vary in the extent to which they have existing quality improvement processes in place, the QI Toolkit is designed as a flexible, modifiable set of tools that	English	Free	
					can be selected according to your hospital's needs  The Framework seeks to support the NISC to ensure that robust systems are in place for reporting, investigating and responding to serious incidents to but lessors are selected enamed and appropriate action taken to prevent future harm. The Framework describes the			
6.3 Patient safety surveillance systems	Serious Incident Framework	https://www.england.nhs.uk/wp-content/uploa	Framework	NHS	recruitments are the support or in more detailed use, includes a special set of provincing, inheritography and important government are learned and appropriate action taken to prevent future harm. The Praemework describes the process for undertaking systems-based investigations that explore the problem (what?), the contributing factors to such problems (how)? and the root cause)(s)? Indemental issues (why?).	English	Free	2.4, 4.1
				Agency for Health Research and				
6.3 Patient safety surveillance systems	Module 7. Measuring and Benchmarking Clinical Performance	https://www.ahro.gov/nosocr/tools/of-handboo	Module	Agency for Health Research and Quality	Information reasonment involves collecting and reporting date on practices' climical processes and outcomes. Measuring climical performance can create buy-in for improvement work in the practice and enablesh the practice to track their improvements vortices. This information should also be used to identify and prioritize improvement goals and to track progress toward those goals. In addition, these detailed build be used to notice maintenance of changes sindery and and to track progress toward those goals. In addition, these detailed abouted to use of monitor maintenance of changes indired principles.	English	Free	
E 1 Detect of the co	A Process-centered Tool for Evaluating Patient Safety Performance and Guiding Strategic Improvement	https://granus.absrr	Banort	Association for Health Research	This page presents a patient safety applicator tool for implementing and assessing patient safety systems in health care immittution. The applicator tool consists of critical occesses and performance resources identified in the contest of the 2003		Free	
6.3 Patient safety surveillance systems	Patient Safety Performance and Guiding Strategic Improvement	and the second s		and Quality	This paper presents a patient safety applicator tool for implementing, and assessing patient safety systems in health care statisticates. The applicator tool consistent of critical processes and performance resources identified in the context of the 2003 Malcolm Baldrige National Quality Award (MERICA) Health Care Citizenia for Performance Excellence.	English	rree	

6.3 Patient safety surveillance systems.	International review of patient safety surveillance systems January20355afer Better Care	https://www.gov.ie/odi/Mis-https://essets.gov.	Report	Health Information and Quality Authority	In summary, this international review highlights the considerable variation in place across countries in relation to patient safety reporting. It is clear however, that the coordination and bringslation of patient safety intelligence for risk profiling is substrately interpreted to the control of the countries	English	Free	
6.3 Patient safety surveillance systems	Root Cause Analysis: Responding to a Sentinel Event	https://www.numingcenter.com/ce_articleprint)	Report	Lipincott Nursing Center	Adverse events, including sentinel events, require comprehensive review to improve patient safety and reduce healthcare errors. Root cause analysis (TR.4) provides an evidence-based structure for methodical investigation and comprehensive review of an event enabling appropriate identification of opportunities for improvement. Use of IATA is described in the home care stuffing propriate and the provides of the comprehensive study of the comprehens	English	Free	
6.3 Patient safety surveillance systems	Understanding benchmarking: RCN guidance for nursing staff working with children and young people	https://www.rcn.org.uk/professional-developme	Report	Royal College of Nursing	This Royal College of Nursing (RCX) document explains how benchmarking can support the development of best practice, and how you can develop benchmarks for your area of clinical practice. This guidance is aimed at nursing staff working with children and young people.	English	Free	
6.3 Patient safety surveillance systems	Safety Culture Assessment: Improving the Survey Process	https://www.jointcommission.org/-/media/tjc/d	Tool	The Joint Commission	The izeric Commission urges organizations to establish a safety culture that fosters trust in reporting unsafe conditions to ensure high-quality patient care. A project recently completed by The Joint Commission addressed how to improve the assessment of safety culture during survey.	English	Free	6.1
6.4 Patient safety research programmes	Patient safety research: a guide for developing training programmes	https://apps.who.int/iris/bitstream/handle/206/	Guidance	WHO	This golde is a comprehensive document that provides goldance to education for the development of training programmes in this important, but less well known, field of research. This golde addresses research for charge or research for improvement – a form of tomalistical and exploited research that seeks to improve position takely based on sound methodology.	English	Free	
G.A Patient safety research programmes	Global Priorities for Patient Safety Research: Better Knowledge for Safer Care	https://apps.who.int/iris/bitstream/handle/2000	Guidance	WHO	Or Deters Lakely brought tegriter a working group of inseason to group to the work of to locus on identifying research portation. As the developing transitional and developed counties. This work, published in May 2000, provides a routel focus and deterring point for global arreason this patient study. The identification of these provides continues the substitution of the study of the determinant of the study of th	English	Free	
6.4 Patient safety research programmes	Patient safety assessment manual, second edition	https://sops.who.int/iris/handin/10505/240500	Manual	WHO	The Pictient safety assessment manual is a component of the WNO Picient Safety Pricedly Nospital Initiative. The nanual integrates different standards that are develop visited to the recommended WNO patient safety interestions and challenge. These standards come for patient safety interestions and challenge. These standards come for patient safety contents: Insections, and management, patients and public incolonemes, lade evidence shade clinical practices, safe encomment and filling learning. The manual is intended to provide health care professionals with practical guidance on the set banding justice safety parts. It was pass in the heapful learn.	English	Free	
G.4 Patient safety research programmes	Summary of the Evidence on Patient Safety: Implications for Research	https://apps.who.int/ints/bitstream/handle/1068	Report	WHO	The sim of the report was to summarize existing research on patient safety and to set priorities on that bean. The group identified specific closed outcomes (such as health one-executed infections), underlying structural problems both as led at based sectionary and produced mechanisms (such a group communication between circulars) but combinate and communication of the section of the produced per dispensation of the produced between circulars (such combinate and combinate the combinate of the section of the	English	Free	
6.4 Patient safety research programmes	Centre for Quality Improvement & Patient Safety	https://cquips.ca	Webpage	Centre for Quality Improvement & Patient Safety	The webpage of the centre for quality improvement and patient safety	English	Free	
6.4 Patient safety research programmes	Center for Patient Safety Research (Columbia)	https://www.genmed.columbia.edu/research/re	Webpage	Columbia University	Webpage of the Center for Patient Safety Research at Columbia University	English	Free	
6.4 Patient safety research programmes	(Columbia)  High Quality and Safe Care - Wolfson Centre for Applied Health Research	https://wolfsoncahr.uk/research/safety/	Webpage	High Quality and Safe Care - Wolfson Centre for Applied Health Research	The webpagef the high quality and safe care research group within the Wolfson Centre for Applied Health Research	English	Free	
6.4 Patient safety research programmes	Armstrong Institute for Patient Safety and	https://www.hookinsmedicine.org/prmstrone_in	Webpage	Hookins Medicine	Webpage of the Armstrong Institute at Johns Mopkins	English	Free	
6.4 Patient safety research programmes	Quality NBIR Patient Safety Translational Research	https://www.imperial.ac.uk/patient-safety-trans	Webpage	Imperial College London	weepage or the Armstong misture at Johns mopions.  The webpge of the NIMR Patient Safety Translational Research Centre at Imperial College	English	Free	
6.4 Patient safety research programmes	Centre NBR King's Patient Safety and Service	https://www.kcl.ac.uk/lsm/research/divisions/wi	Webpage	King's College Landon	The webpage of the NIHR King's Patient Safety and Service Quality Research Centre at King's College London	English	Free	
	Quality Research Centre NBR Greater Manchester Patient Safety Translational Research Centre (Greater							l
6.4 Patient safety research programmes	Translational Research Centre (Greater Manchester PSTRC)	http://www.patientsafety.manchester.ac.uk	Webpage	The University of Manchester	The webpage of the NIHR Patient Safety Translational Research Centre at the university of Manchester.	English	Free	5.1
6.5 Digital technology for patient safety	Plan of Action for Strengthening Information Systems for Health 2019-2023	https://iris.paho.org/hardie/10665.2/51617	Action plan	WHO	This document presents the Plan of Action for Strengthering Information Systems for Health 2019-2013, which contains strategic lines of action and stook to support implementation of the 2000 Agends for Zoulandskib Greekipsmert. It is purpose, moreover, in the Markho Zistan to advance toward memoring the Length of the Sectional New York Agends for the American 2019-200, especially targets 6.1 and 6.2, in Algerment with other government initiatives such as open government and e-government.	English, Portuguese, Spanish, French	Free	
6.5 Digital technology for patient safety	Health IT and Patient Safety: Building Safer Systems for Better Care	https://www.nap.edu/catalog/13209/health-it-a	Book	Institute of Medicine	CBF) 1299 Jandmark study To Err is Numan estimated that between 44,000 and 95,000 lives are lost every year due to medical errors. That call to action has led to a number of effects to reduce renors and goods asks and effective health care, information schooling (IP) The best insoftends or as way to eshabitor the safety and effectiveness of care, in a relief to calcalays in implementation, the U.S. government has invested billions of dollars toward the development and massingful use of effective health IT.	English	38.99 - 48 dollars	
6.5 Digital technology for patient safety	A Framework for Selecting Digital Health Technology	http://www.ibi.org/resources/Pages/Publication	Framework	Institute of Healthcare Improvement	reason in.  The initiate of this 32 day 98 timeoustion Project, conducted in the summer of 2013, was to use for health technology innovations that will provide the greatest value to health yetlems working to achieve the 81th Tole Arin. The Triple Arin is a famework desireded by the instruction for Initiative Commercial Conference or Initiative Commercial Conference or Initiative Commercial Conference or Initiative Commercial Conference or Initiative Conference or Initiative Commercial Conference or Initiative Confer	English	Free	
G.5 Digital technology for patient safety	Improvement Leaders' Guide Technology to Improve service	https://www.england.nhs.uk/improvement-hub.	Guidance	NHS	This guide is a practical approach to enabling technology to be used to benefit your patients, your colleagues and you. This guide is for anyone in the NRS or social care who would like cimprove services and care for users and patients.	English	Free	
6.5 Digital technology for patient safety	Safely implementing health information and converging technologies	https://www.jointcommission.org//media/tio/d	Guidance	The Joint Commission	The overall safety and effectiveness of technology in health care ultimately depend on its human users, ideally working in close concert with properly designed and installed electronic systems. Any form of technology may adversely affect the quality and safety of care if it is designed or implemented improperly or it ministerpress. All not only must be thereothogic or device de designed to be safe, it must also be operated safely within a safe workflow process. This provides galdance on how to address this.	English	Free	
6.5 Digital technology for patient safety	Safe use of health information technology	https://www.jointcommission.org/-/media/tic/d	Guidance	The Joint Commission	This alert builds upon Sentinel Event Alart RAZ on safely implementing health information and converging technologies (published in 2008) to take a broader took at health IT, particularly the socio-technical factors having an impact on its safe use. This alert's imagented actions oner on safely culture, process improvement and featurings.	English	Free	
6.5 Digital technology for patient safety	Ethics and governance of artificial intelligence for health	https://www.who.int/publications/ultern/93892	Guidance	WHO	The report identifies the other idealineses and risks with the use of artificial intelligence of health, six consensus principles to ensure Al useful to the public benefit of all countries. It also contains a set of recommendation that can ensure the government of an intelligence of an observation of a section of an observation of a section	English	Free	
6.5 Digital technology for patient safety	SAFER Guides	https://www.healthit.gov/topic/safety/safer-guis	Guide	The Office of the National Coordinator for Health Information Technology	The SATER Guides comist of nine guides organized into three broad groups. These guides enable healthcare organizations to address ITR safety in a variety of areas. The guides identify recommended practices to optimize the safety and safe use of PIRE. The content of the guides can be explored where, the billab below, in telescents POF varieties on the guides can be downloaded and completed locally for self-assessment of an organization's degree of conformance to the Recommended Practices. T	English	Free	
6.5 Digital technology for patient safety	Electronic Health Records: Manual for Developing Countries	http://apps.who.int/his/bitstream/handle/1066	Manual	WHO	This manual has been designed as a basic reference for use when exploring the development and implementation of Electronic reliable Neurol (DRII systems. It provides a general overview, some basic definitions and exemples of DRII practices. Also covered are provided for contractive when moning baseds has introduction of mint, State issues and definition and diseases which may need to be addressed and some possible strategies, along with halps and exteriors to implementation. There is a particular focus on setting gails, revining politics developing an exist load and collating implementation procedures.	English	Free	
6.5 Digital technology for patient safety	Electronic Health Record Systems: Definitions, Evidence, and Practical Recommendations for Latin America and the Caribbean	https://publications.ladb.ong/en/electronic-heal	Recommendations	Inter-American Development Bank	This document uses the available evidence to growtde policy makers and other stakeholders with general insights about DTR systems. The first section summarizes the potential and promise of DTR systems for LTC, the extend section reviews definitions of DTR systems and the large formicularities, the first extender provides in service of the required first systems for and on the progress practical recommendations to support successful implementations of DTR systems sale side is LTC.	English, Spanish	Free	
G.5 Digital technology for patient safety	Technology in the NHS: Transforming the patient's experience of care	https://www.idngsfund.org.uk/sites/defauk/files	Report	The King's Fund	This review builds on current work in this area and aims to improve the uptake of warful consumer-facing technology in braich care by earlying the main barriers in adoption and suggesting measures to constant flown. We slight by describing an ideal consent of the control of t	English	Free	41
G.5 Digital technology for patient safety	Management of Patient Information: Trends and Challenges in Member States	https://spes.who.int/iris/bitstream/handle/2000	Report	WHO	This, the final report in the Global Chservatory for elteralth Series, assesses the results of the survey module that dealt with the plattert information. It examines the adoptions and used plattert information reptams in Marcher States and review data standards and legal protection for spater data. This survey much purposed by Why Proposity, Wild Series Income group, and globally observed that discharges information syntams are taking increasingly adopted within health settings. The report concludes with an exercise of ships (benefit States can take to delicable the implementation of platters information syntams are taking increasing and proposed within health settings. The report concludes with an exercise of ships (benefit States can take to delicable the implementation) or platters information syntams.	English	Free	
G.5 Digital technology for patient safety	Global strategy on digital health 2020-2025	https://www.vaho.int/docs/default-acures/docus	Strategy	WHO	The global intelligence of gital health builds on resolutions adopted by the United Nations General Assembly; and the World Neish Assembly; I raised WITO global and regional reports, regional strangers, the two-part report of the DOT Inchesic Committee on Months Information can be with VID and Information and WITO and Informational classifications and strandingers, the times expart National related investigate tools. Whether States Current Global Institutes and status, action, strangers, policies and instruments, and recommendations of evintro States Current Global Institutes and status, action, strangers, policies and instruments, and recommendations of evintro States Current Global Institutes and States	English	Free	
6.5 Digital technology for patient safety	Future of digital health systems: report on the WHO symposium on the future of digital health systems in the European Region (Copenhagen, Denmark, 6–8 ************************************	https://www.marp.voho.int/en/health-topics/Yea	Symposium Report	WHO	The ain of this Symposium was to develop priorities for public health action to accelerate the adoption of digital health in countries and to help to develop a Luropean roadmap for the digitalization of astional health systems by sharing country experiences and exploring how digital health and emergelia provisions are used to strengthen notational health systems by sharing country experiences and exploring how digital health and emergelia provisions are used to strengthen notational health systems.	English, Polish	Free	
6.5 Digital technology for patient safety	National e-health Strategy Toolkit	http://acos.who.i=#liris/hitteresm/ha-edie/1005	Toolkit	WHO	The Tooliki provides a framework and method for the development of a national effeatibly vision, action plan and monitoring finamework. It is a resource that can be applied by all government. It is a resource that can be applied by all governments of the resource of the	English, Arabic	Free	
6.5 Digital technology for patient safety	Video: Safe use of Health Information Technology	https://www.jointcommission.org/resources/pat	Webinar	The Joint Commission	This is a webinar, held by the Joint Commission, which builds upon Sentinel Event Alert 54: Safe Use of Health Information	English	Free	
6.5 Digital technology for patient safety	Technology  Marnessing technology and innovation	https://www.england.nhs.uk/five-year-forward-y	Webpage	NHS	Technology in the region work programmes reapped out in this Ties are underprinted by an agreed, costed and phased NPG technology plan, building on the recommendations of the Washter roles in well supporting position access to care, in the most appropriate location, while supporting position in ranging their costs better.	English	Free	
		No. (Across to the control of the co	Walaita	The Office of the National				
6.5 Digital technology for patient safety	Health IT Feedback and Inquiry Portal	nttps://inquiry.healthit.gov/support/plugim/sen	website	Coordinator for Health Information Technology	This website compiles evidence, tools, and case examples to help prepare organizations for problems associated with implementation and use of electronic health records.	English	Free	