Inventory of Patient Safety Improvement Spread Strategies at CARe Sites

An important part of Communication, Apology, and Resolution (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, healthcare providers, and healthcare institutions alike. MACRMI members work to improve patient safety and spread of such improvements in a number of ways. An inventory of these strategies is listed below.

Inventory of Patient Safety Improvement spread practices:

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 them make improvements with the patient in mind, and also work to 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, Joint Commission, the Board of Registration in Medicine, and/or the Schwartz Center.

9. **Participation in a Patient Safety Organization** to which safety events can be submitted and aggregation and analysis can occur to aid in the development of safety improvements and best practice recommendations.

10. **Participation in a system-based safety group** to discuss safety issues that could have similar contributing factors and system-level vulnerabilities.