Optional Risk Assessment/Management Tools

Risk assessment and management are central components of all Patient Safety programs. There are many patient safety risk assessment/management tools available for use. Below is a list of optional tools available to Patient Safety programs. This list is not exhaustive.

a. Trigger Tool. The Trigger Tool methodology is a retrospective review of a random sample of inpatient hospital records using "triggers" (or clues) to identify possible adverse events. The Trigger Tool focuses on and includes only those adverse events related to the active delivery of care (commission) and excludes, as much as possible, issues related to substandard care (omission).

b. Direct Observation. Direct observation of the health care environment and the care provided can be an effective tool in risk identification. Leadership rounds where leaders and Patient Safety staff walk around all areas of the health care facility on a regular basis is a powerful tool. Leaders who conduct regular rounds will be able to directly observe potential risks in the health care environment and direct resources to eliminate or mitigate those risks. Leaders who combine regular rounds with conversations with staff and patients about safety and potential risks are able to not only identify potential patient and workforce safety issues, but also strengthen the culture of safety and build trust.

c. Surveys on Patient Safety Culture. The Agency for Healthcare Research and Quality Surveys on Patient Safety Culture™ (SOPS®) are surveys of providers and staff that assess the extent to which their organizational culture supports patient safety and safe practices. The SOPS provide facility leadership with valuable data related to patient safety culture, including specific strengths and areas of improvement as identified by respondents. The SOPS® survey results, and any improvement projects initiated due to those results, should be shared with all facility staff as part of closed loop communication.

d. Escalating Huddles. Brief and routine meetings for sharing information about potential or existing safety problems facing patients or workers. They increase safety awareness among front-line staff, allow for teams to develop action plans to address identified safety issues, and foster a culture of safety. Risks identified are mitigated at the lowest level, and elevated to the next level, as needed, until the risk is elevated to the level where it can be addressed appropriately. Communication related to risk mitigation is provided back down the chain to the level of origination in order to close the communication loop.