PSNet
PATIENT SAFETY NETWORK

Quality improvement lessons learned from National Implementation of the "Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook".

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Sullivan JL, Shin MH, Chan J, et al. Quality improvement lessons learned from National Implementation of the “Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook”. Health Serv Res. 2024;59(suppl 2):e14317. doi:10.1111/1475-6773.14317.
https://psnet.ahrq.gov/issue/quality-improvement-lessons-learned-national-implementation-patient-safety-events-community

Effective implementation of patient safety practices remains an organizational challenge. This qualitative study explored lessons learned and opportunities for improvement based on nationwide implementation of the *VA Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook* aimed at standardizing patient safety practices in the Veterans’ Affairs (VA) Community Care Network. Researchers conducted semi-structured interviews with patient safety officers, quality managers, and community care staff, and identified barriers and facilitators to Guidebook implementation (e.g., resource availability, organizational culture). Qualitative findings underscored the importance of leadership engagement, role clarity, and effective communication.