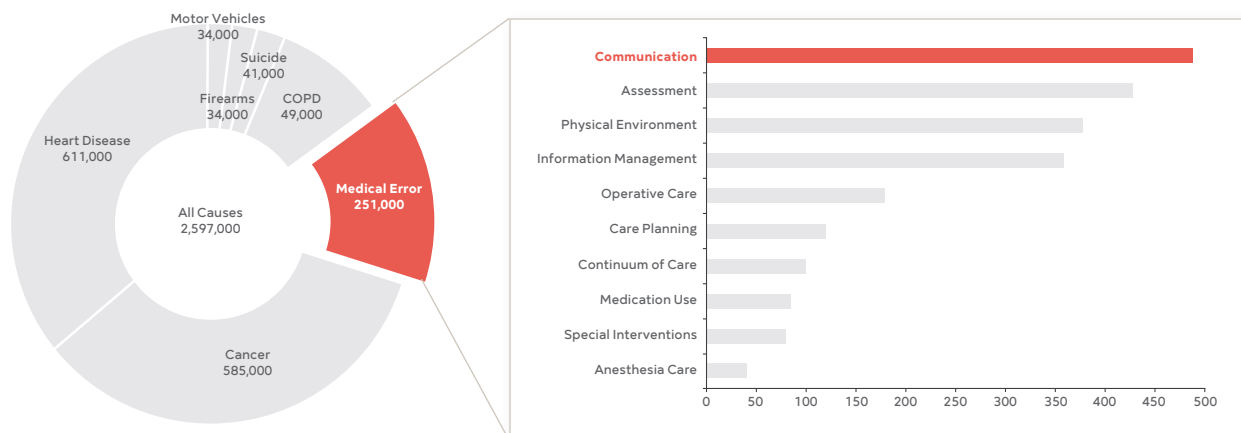


The I-PASS Patient Safety Institute

An evidence-based solution proven to reduce patient harm and help institutions of any size transform patient safety communication

The Problem

Each year, more than 251,000 deaths result from medical errors in the United States— with communication failures being the most common root cause of sentinel events.



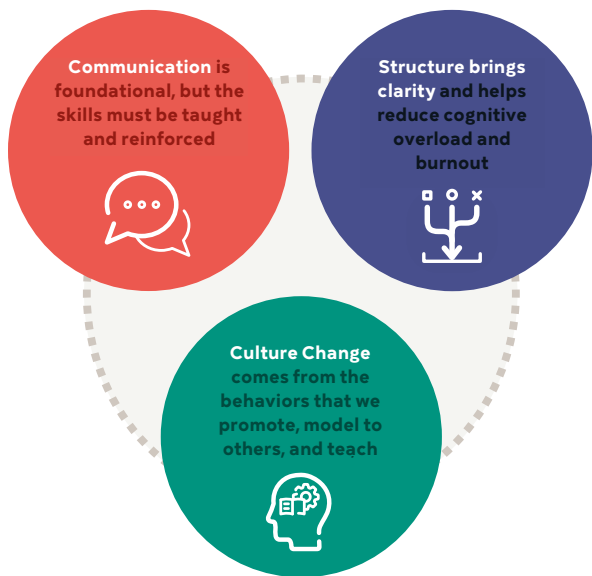
Causes of Death, U.S. 2013
BMJ 2016;353:i2139 (Published 03 May 2016)
© 2016 BMJ Publishing group, Ltd.

Communication Failure is the Most Common Root Cause of Sentinel Events

The I-PASS Solution

A proven blueprint for reducing patient harm by up to 70%, I-PASS methodologies, solutions, and services help institutions save money and enable clinicians to focus on what matters most—providing safe, high-quality patient care.

Born out of research findings from the I-PASS Study Group demonstrating **significant reductions in medical errors and patient harms** (Starmer et al., New Engl J Med, 2014), the I-PASS Patient Safety Institute has adapted the utility of our proven transitions of care model to improve patient safety in a broad range of clinical and educational settings.



Zeroing in on **Zero Patient Harm**

Key Benefits of I-PASS Patient Safety Institute Solutions and Services

- Reduces Miscommunication Errors and Patient Harm Events
- Improves Culture of Safety Performance
- Reinforces High-Reliability Principles and Communication
- Foundational Patient Safety and Patient Care Training
- Joint Commission Compliance
- Robust Intervention Bundle to Support Change Management and Sustainability

I-PASS understands change management—we have the tools, roadmap, and expertise to overcome organizational barriers and drive behavior change.

Our Tools

The I-PASS Bundle is a fully scalable, measurable, and actionable patient safety solution. I-PASS Coaches and clinical leaders are with you every step of the way—from planning, implementation, training, and ultimately, sustained behavior and a positive culture change.

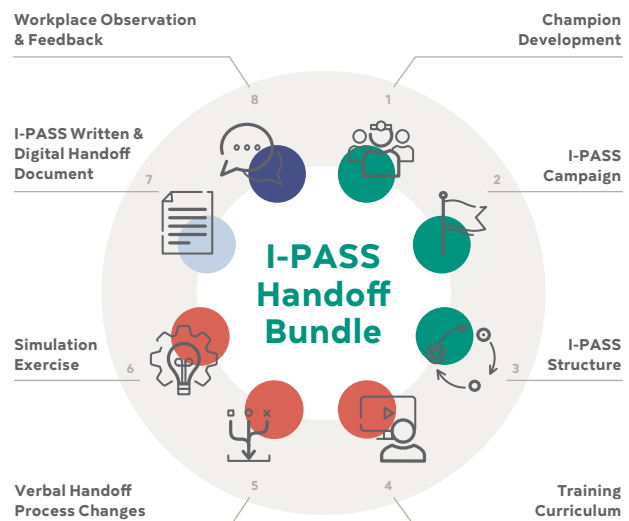
I **Illness Severity**
Stable, "Watcher," Unstable

P **Patient Summary**
Summary statement; events leading up to admission; hospital course; ongoing assessment; plan

A **Action List**
To do list; timeline and ownership

S **Situation Awareness & Contingency Planning**
Know what's going on; plan for what might happen

S **Synthesis by Receiver**
Receiver summarizes what was heard; ask questions; restates key action/to do items



Hands-On Services and Support

We partner with leaders at hospitals, universities, and care teams to ensure our program can be delivered, implemented, and sustained at scale.



Program Management

Program Managers and Coaches participate in all site visits, support the scheduling of meetings or workshops, facilitate program participation, and shares progress updates site-wide.



I-PASS Certified Coaches

Our experts have years of firsthand clinical and I-PASS implementation experience to help you launch the program and navigate any change management challenges that may arise.



Implementation Guide

This guide offers key milestones for effective I-PASS implementation built for your institution.



I-PASS Training

Our virtual platform is built to scale, keep learners engaged, and provide custom content developed for your institution.



I-PASS Written Tool Development

Embedded EHR (Epic-Certified) Support leveraging best practices for building and modifying written handoff templates to meet workflow needs.



I-PASS Assessment & Improvement

Capture, analyze, and report on key implementation data that is critical for sustaining a culture of high reliability.

Tested, Proven and Effective

Since 2016, the I-PASS methodology has been implemented at hundreds of hospitals and residency programs in the U.S. and Canada. Visit ipassinstitute.com/resources to view research and case studies.



Implemented in 100+ institutions



100M handoffs completed



3M minor and major harm events prevented

Valued Partners



Validated by Research



Learn more at ipassinstitute.com



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