

NQF

THE NATIONAL QUALITY FORUM

**Safe Practices  
for Better  
Healthcare**

A  
CONSENSUS  
REPORT

# THE NATIONAL QUALITY FORUM

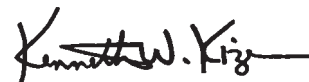
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## Foreword

**M**odern healthcare is a highly complex, high-risk, and error-prone activity. Not surprisingly, adverse healthcare events are a leading cause of death and injury, even though well-documented methods to prevent the occurrence of many such events are available. The recent heightened attention that has been focused on medical errors has sparked growing interest in the use of healthcare practices that reduce the risk of harm resulting from the processes, systems, or environments of care—i.e., “safe practices.” Although this growing interest in safe practices is to be applauded, the lack of standardization of these practices and the lack of a priority set of such practices have the potential to diffuse and dilute efforts to improve patient safety.

This report details 30 healthcare safe practices that should be universally utilized in applicable clinical care settings to reduce the risk of harm to patients. The 30 priority safe practices have been culled from an original pool of more than 220 candidate practices, based on each practice’s specificity, effectiveness, potential benefit, generalizability, and readiness for implementation. This set of safe practices has been carefully reviewed and endorsed by a diverse group of stakeholders pursuant to the National Quality Forum’s (NQF’s) formal Consensus Development Process and have the special status of “voluntary consensus standards.” By achieving consensus on this set of evidence-based, high-priority safe practices, NQF seeks to stimulate their universal implementation in applicable healthcare settings and, in turn, achieve substantial improvements in patient safety.

We thank NQF Members and the Safe Practices Project Steering Committee and its Advisory Panel on Dissemination and Implementation for their stewardship of this work. Their collective dedication to improving the quality of healthcare by making it safer should be an inspiration to all.



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President and Chief Executive Officer

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## Safe Practices for Better Healthcare

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# Safe Practices for Better Healthcare

## Executive Summary

**A**dverse healthcare events are a leading cause of death and injury in the United States—even though in many cases evidence-based methods are available that can prevent these deaths and injuries from occurring. Increasingly, practices that reduce the risk of harm from the processes, systems, or environments of healthcare—i.e., “safe practices”—are being deployed. The lack of standardization of these practices, however, may mitigate some of their benefits.

This National Quality Forum (NQF) report details 30 healthcare practices that should be universally utilized in applicable clinical care settings to reduce the risk of harm to patients. Although this set of safe practices is not intended to capture all activities that might reduce adverse healthcare events, it has been carefully reviewed and endorsed by a diverse group of stakeholders. Specifically, the set focuses on high-priority practices that:

- have strong evidence that they are effective in reducing the likelihood of harming a patient;
- are generalizable (i.e., they may be applied in multiple clinical care settings and/or multiple types of patients);
- are likely to have a significant benefit to patient safety if fully implemented; and
- have knowledge about them that is usable by consumers, purchasers, providers, and researchers.

Practices were derived from a report by the Agency for Healthcare Research and Quality’s University of California San Francisco-Stanford University Evidence-Based Practice Center; the Leapfrog Group’s three safety “leaps”; the NQF project Steering Committee;

NQF Members; and health professional specialty societies and other organizations responding to NQF's open call for suggested safe practices. All practices were evaluated based on the criteria of specificity (threshold criterion), benefit, evidence of effectiveness, generalizability, and readiness.

The practices are organized in five broad categories for improving patient safety:

- creating a culture of safety;
- matching healthcare needs with service delivery capability;
- facilitating information transfer and clear communication;
- adopting safe practices in specific clinical care settings or for specific processes of care; and
- increasing safe medication use.

By intent, the safe practices are not prioritized within or across categories because all are viewed as important in improving patient safety. Additionally, no objective, evidence-based method of prioritizing the practices could be identified that would equitably apply across the current heterogeneous universe of healthcare facilities. For any given healthcare provider, the choice of practices that will have top priority will depend on the individual provider's circumstances, including what practices already have been implemented, availability of resources, environmental constraints, and patient mix.

Also identified in the report are 27 practices that should receive high priority for additional research. Finally, the report recommends specific actions in the following three areas: dissemination and implementation of the practices; measuring their implementation; and updating and improving the set of practices.

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## NQF-Endorsed Set of Safe Practices\*

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1. Create a healthcare culture of safety.
2. For designated high-risk, elective surgical procedures or other specified care, patients should be clearly informed of the likely reduced risk of an adverse outcome at treatment facilities that have demonstrated superior outcomes and should be referred to such facilities in accordance with the patient's stated preference.
3. Specify an explicit protocol to be used to ensure an adequate level of nursing based on the institution's usual patient mix and the experience and training of its nursing staff.
4. All patients in general intensive care units (both adult and pediatric) should be managed by physicians having specific training and certification in critical care medicine ("critical care certified").
5. Pharmacists should actively participate in the medication-use process, including, at a minimum, being available for consultation with prescribers on medication ordering, interpretation and review of medication orders, preparation of medications, dispensing of medications, and administration and monitoring of medications.
6. Verbal orders should be recorded whenever possible and immediately read back to the prescriber—i.e., a healthcare provider receiving a verbal order should read or repeat back the information that the prescriber conveys in order to verify the accuracy of what was heard.
7. Use only standardized abbreviations and dose designations.
8. Patient care summaries or other similar records should not be prepared from memory.
9. Ensure that care information, especially changes in orders and new diagnostic information, is transmitted in a timely and clearly understandable form to all of the patient's current healthcare providers who need that information to provide care.
10. Ask each patient or legal surrogate to recount what he or she has been told during the informed consent discussion.
11. Ensure that written documentation of the patient's preference for life-sustaining treatments is prominently displayed in his or her chart.
12. Implement a computerized prescriber order entry system.
13. Implement a standardized protocol to prevent the mislabeling of radiographs.
14. Implement standardized protocols to prevent the occurrence of wrong-site procedures or wrong-patient procedures.
15. Evaluate each patient undergoing elective surgery for risk of an acute ischemic cardiac event during surgery, and provide prophylactic treatment of high-risk patients with beta blockers.
16. Evaluate each patient upon admission, and regularly thereafter, for the risk of developing pressure ulcers. This evaluation should be repeated at regular intervals during care. Clinically appropriate preventive methods should be implemented consequent to the evaluation.
17. Evaluate each patient upon admission, and regularly thereafter, for the risk of developing deep vein thrombosis (DVT)/venous thromboembolism (VTE). Utilize clinically appropriate methods to prevent DVT/VTE.
18. Utilize dedicated anti-thrombotic (anti-coagulation) services that facilitate coordinated care management.
19. Upon admission, and regularly thereafter, evaluate each patient for the risk of aspiration.
20. Adhere to effective methods of preventing central venous catheter-associated blood stream infections.
21. Evaluate each pre-operative patient in light of his or her planned surgical procedure for the risk of surgical site infection, and implement appropriate antibiotic prophylaxis and other preventive measures based on that evaluation.
22. Utilize validated protocols to evaluate patients who are at risk for contrast media-induced renal failure, and utilize a clinically appropriate method for reducing risk of renal injury based on the patient's kidney function evaluation.
23. Evaluate each patient upon admission, and regularly thereafter, for risk of malnutrition. Employ clinically appropriate strategies to prevent malnutrition.
24. Whenever a pneumatic tourniquet is used, evaluate the patient for the risk of an ischemic and/or thrombotic complication, and utilize appropriate prophylactic measures.
25. Decontaminate hands with either a hygienic hand rub or by washing with a disinfectant soap prior to and after direct contact with the patient or objects immediately around the patient.
26. Vaccinate healthcare workers against influenza to protect both them and patients from influenza.
27. Keep workspaces where medications are prepared clean, orderly, well lit, and free of clutter, distraction, and noise.
28. Standardize the methods for labeling, packaging, and storing medications.
29. Identify all "high alert" drugs (e.g., intravenous adrenergic agonists and antagonists, chemotherapy agents, anticoagulants and anti-thrombotics, concentrated parenteral electrolytes, general anesthetics, neuromuscular blockers, insulin and oral hypoglycemics, narcotics and opiates).
30. Dispense medications in unit-dose or, when appropriate, unit-of-use form, whenever possible.

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\* See full report for applicable care settings for each practice, detailed specifications, and additional background and reference material.

## NATIONAL QUALITY FORUM PUBLICATION INFORMATION

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