

TO: NQF Members

FR: Helen Burstin, MD, MPH, Senior Vice President, Performance Measures

RE: Voting draft for *Safe Practices for Better Healthcare – 2009 Update*

DA: November 7, 2008

Background

In 2003, NQF published *Safe Practices for Better Healthcare: A Consensus Report*, which endorsed 30 practices that should be universally used in applicable clinical care settings to reduce the risk of harm to patients. In 2006, NQF updated the *Safe Practices for Better Healthcare* with current evidence; harmonized the practices with other national standards, guidelines, and initiatives; and provided additional information for each practice. Over the last year, NQF conducted another update to review the evidence base for existing practices, harmonize practices, strengthen implementation guidance, update research recommendations, and evaluate new practices to ensure that the set remains current and appropriate.

The NQF Update Maintenance Committee for the *Safe Practices* recommended a total of 34 safe practices for the 2009 update. While references have been updated for all safe practices, only 21 practices - 8 new practices and 13 practices with material changes - were presented for comment and review. NQF defines material change as any modification that reasonably could be foreseen to affect the result or end product from use of the standard. Comments were solicited on the 8 new practices and 13 practices with material changes.

The Revised Document and NQF Staff Recommendations

NQF received 114 comments from 22 responders addressing a wide variety of issues. The Steering Committee reviewed the comments and made recommendations for changes to the practices and the specifications. Based on the extensive comments, the document has been modified.

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The revised report reflecting the 21 new and modified practices are attached to this memo. The practices with original updates and the revision action updates are included in the voting draft. The initial changes to the practices remain in **black underline**, further deletions from the comment period are noted in **green ballon** **markout in the right margin**, and additions from the comment period are noted in **blue underline**. The entirely new practices remain in simple black text.

The comments submitted during the review period and the responses are summarized in an attached table. You will be asked to vote only on the practice statement and specifications for each of the 21 practices. The updated 2009 Safe Practices will include the full set of 34 practices.

NQF staff recommends that all safe practices be approved.

General Comments and Their Disposition

A synthesis of major issues raised during the review period and responses is provided below, and major issues also are discussed in the Commentary. As previously noted, a detailed table of individual comments and their disposition will be available on the NQF web site.

General Comments. Many general comments supported the 2009 safe practice update; however only a few requested changes or modifications to the practices. There were comments regarding the preventability of adverse events. While it is not known whether it is possible to prevent each and every adverse event, there is clear evidence that some adverse events, such as infection rates, can be reduced to levels far lower than they are today in most health care settings. These safe practices are intended to assist providers in their efforts to continually reduce and drive adverse events toward zero. There were also some general comments regarding the opportunity for the safe practices to be evaluated based on the new NQF measurement criteria established in August 2008. While these criteria are only applicable to measures, these comments reinforced the committee's interest in moving to a more formal grading system for the evidence

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supporting safe practices. In addition, the full Safe Practices Update report will include the full list of general and specific references.

There were several general comments addressed the retiring of the evidenced based referral, practice 24 in the Safe Practices 2006 Update. Several commenters requested that language be placed in the informed consent practice, which was unchanged and not sent out for public review. The same request was made to have clinicians inform patients *“where the evidence is the strongest for the volume-outcome relationship for specific procedures and information disclosed to patients would include mortality/survival rates and annual procedures or treatment volumes.”* The committee agreed to address evidence based referral language in the informed consent practice. The suggested language was placed in the Example Implementation Approaches section of the Informed Consent Practice.

Specific Comments by Safe Practice:

SP 4: Identification and Mitigation of Risks and Hazards. The majority of comments regarding this practice related to the addition of the CMS Candidate hospital acquired-conditions (HACs) (iatrogenic pneumothorax, delirium, and Legionnaires’ disease) to the Specific Risk Assessment and Mitigation Activities section under the Additional Specifications. Clarification was also requested regarding risk assessment tools and methods used by organizations.

Action taken: These conditions were moved to the Example Implementation Approach section as consideration for evaluation as high risk conditions. Clarification was also made regarding periodic assessment of the tools used for prospective, near real time, and retrospective risk identification and mitigation, as well as, updated references suggested by commenters.

SP 7: Disclosure. Several commenters objected to the Additional Specification regarding healthcare providers with different malpractice insurance carriers. The concern was that, as written, this statement may have unintended consequences for

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healthcare professionals and the facilities in which they work, by placing the undue expectation of bringing together two dissimilar parties (i.e., an institution and a malpractice carrier) on the shoulders of the healthcare provider in order to secure or retain employment within a facility.

Action taken: The committee reduced the rigor of the language to request that organizations have a process in place to ensure that licensed independent practitioners (LIPs) are provided with a detailed description of the organizations program for responding to adverse events, including the full disclosure of error(s) that may have caused or contributed to patient harm.

SP 8: Care of the Caregiver. A number of commenters applauded this new safe practice and agreed to the importance. One suggestion was to include language to address adverse event prevention by caregivers that is attributed to fatigue and stress by providing a supportive, positive work environment.

Action taken: This above language was included in the implementation approach section of the practice.

SP 12: Patient Care Information. One commenter provided a suggestion regarding adding a reference to technology to facilitate communication of patient care information.

Action taken: A statement was added to the Additional Specifications to include the use of technology to facilitate communication of patient care information, when appropriate.

SP 13: Order Read-back and Abbreviations. Two commenters expressed concern regarding the order read-back requesting the language include flexibility for settings of care where it would be impractical to write the verbal order prior to administering the medication.

Action taken: The Additional Specification language for order read-back was modified to include that the process of verbal orders should be avoided except when impossible or impractical for the prescriber to write the order or enter it in the computer.

SP 17: Medication Reconciliation. Many comments were received regarding this practice that focused on clarifications of the process. Another reviewer objected to a requirement of annual education for healthcare personnel who are responsible for medication reconciliation. Discussion about safe medication ordering practices was requested. One commenter requested clarification to the fact that medication reconciliation should be done within 24 hours after admission, and also suggested a list of medications be provided to the patient provider, with the term "if known" added.

Action taken: Review of medication bottles was added into the Example Implementation section. Annual education requirement was addressed in the Additional Specifications section to allow organizations to set follow up education after hire and frequency of ongoing education based on the risk of noncompliance and adverse drug events determined by the organization. Safe medication ordering practices were defined in the Pharmacist Leadership safe practice, and were also addressed in this practice through language in the Example Implementation section. The 24 hour suggestion was not incorporated since this practice goes beyond the inpatient population. The "if known" suggestion was not because the original language had been taken from existing JC NPSG language which stated "known provider" already and the committee did not adjust the original text.

SP 18: Pharmacist Leadership Structures and Systems. Two commenters recommended that physicians have oversight in the formulary over the medication management process. Another comment suggested training programs for pharmacist healthcare professionals to handle patient populations with special needs. Another comment addressed several issues such as ensuring safe and effective medication across the continuum of care as patients move from one setting to another, interdisciplinary patient safety committee, expanded formulary inclusions to include cost as well as

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medication-associated products or devices, medication use policies, important ancillary drug information, decision support tools and organization guides; additionally, this commenter suggested that attention to expertise and training for management was important for leadership in the clinical pharmacy. This same commenter, in a second transmission, addressed the fact that skills of a pharmacy leader should include typical leadership qualities and that credentialing of pharmacy leaders should be consistent with their scope of practice and that professional development certification and/or continuing education credits should be designed and implemented.

Actions taken: Physician oversight was addressed in the Additional Specifications section. Training for healthcare professionals to take care of patients with special needs was addressed in the Example Implementation section. Ensuring continuum of care across settings (ambulatory and inpatient settings) and interdisciplinary patient safety committee data reporting was added to the Additional Specifications section. Additional commenter suggestions such as expanded formulary inclusions, machine readable coding language, and use of administrative technical language were added to Additional Specifications. Pharmacist leadership certification and continuing education was addressed in the Example Implementation Approach section.

SP 20: Influenza Prevention. The only recommendation for changes to this practice is regarding the signed declination for healthcare workers who decline the influenza vaccination. The concern is the level of evidence which is a category II per CDC guidelines and the risk of distraction from the focus of the vaccination program.

Action taken: The specification for signed healthcare worker declinations was moved to the Example Implementation approach as a consideration for organizations.

SP 21: CLABSI Prevention. One commenter requested the original CDC guidelines be added more prominently to this safe practice. Another commenter requested adding other options for antiseptic agents for the insertion of central lines to include a combination of alcohol and either chlorhexidine or povidone iodine.

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Action taken: The CDC 2002 CLABSI guideline citation was added to the safe practice statement. Chlorhexidine is the preferred antiseptic per the IDSA/SHEA Healthcare Associated Infection compendium. The committee agrees that many organizations use alcohol/chlorhexidine combination, and the practice includes “chlorhexidine based products.” The committee did not include the recommendation for povidone iodine.

SP 22: Surgical Site Infection Prevention. One commenter requested including the CDC/HICPAC standard for SSI. Another requested that education of health care workers involved in surgical procedures should be documented. The final comment related to adverse event prevention and analysis to include some element of case-by-case review that takes into consideration patient compliance, patient risk, co-morbidities, and other factors.

Actions taken: The committee agrees of the lack of research defining absolute, exact preventability for SSIs. However, until such time as there is full consensus by HAI subject matter experts on preventability, the practice seems reasonable. Please refer to the Problem Section last sentence for updated verbiage reflecting the suggestion. The CDC/HICPAC standard for SSI prevention was included in the citation section and documentation of healthcare workers’ education was placed into the Additional Specification section.

SP 23: Care of the Ventilated Patient. The primary comment for the care of the ventilated patient focused on the controversy of peptic ulcer disease prevention in ventilated patients. One commenter requested the insertion of the CDC Ventilated patient guidelines in the practice.

Action taken: The Additional Specifications now address that the PUD prophylaxis data remain controversial and clinical judgment should be used based on individual patient needs. The CDC guidelines published by Tablan in 2004 had already been referenced in this practice multiple times, therefore no change was made based on this comment.

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SP 24: MDRO Prevention. One commenter requested that the CDC/HICPAC guideline for MDRO be referenced.

Actions taken: The CDC/HICPAC Guidelines for Isolation Precautions 2007 citation was added to Additional Specifications section. The CDC/HICPAC Management of Multidrug-Resistant Organism in Healthcare Settings [Siegel 2006] was already cited in the practice multiple times.

SP 25: CAUTI Prevention. One commenter recommended documentation of health care workers' education for catheter insertion, and another requested to specifically include physician education. Another commenter requested to cite CDC/HICPAC guidelines.

Actions taken: Education documentation and physician education were added into the Additional Specifications section and reference to CDC/HICPAC guidelines was added to the text.

SP 27: Pressure Ulcer Prevention. One commenter requested clarification of the children's care settings, suggesting that as written, it may be confused that children are not at risk for pressure ulcers. Also, the addition of using a pressure ulcer risk assessment plan/guide to identify the specific risks for individual patients was requested.

Action taken: The children's care setting was clarified to state that children are at risk for pressure ulcers, therefore this practice applies to "at risk" children. The pressure ulcer risk assessment plan/guide statement was added to the language in the Additional Specifications.

SP 28: VTE Prevention. One comment was received for this practice suggesting stronger language for patient education regarding discharge planning to include: 1) Follow-up/Monitoring. 2) Compliance Issues. 3) Dietary Restrictions. 4) Potential for Adverse Drug Reactions/Interactions.

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Action taken: This recommendation was added to the Additional Specifications.

SP 29: Anticoagulation. The majority of specific comments for this practice relate to the adverse drug events that are associated with anticoagulation therapy.

Recommendations were made for clinical pharmacy review of anticoagulation therapy selection and drug-drug interaction checking, documentation of the medication plan for anticoagulants in the patient's medical record, and acknowledgment of heparin-induced thrombocytopenia monitoring. One comment requested stronger language for patient involvement in their anticoagulation therapy goals.

Action taken: The committee agreed to the requests of the commenters and incorporated changes/revisions accordingly within the practice.

SP 30: Contrast Media Induced Renal Failure Prevention. Several commenters requested additions to the specifications regarding "qualified clinicians" status for screening, documenting, and monitoring patients receiving contrast media. A request to include glomerular filtration rate as an indicator of renal function versus serum creatinine was made.

Action taken: Each request for changes is now incorporated in the specifications and implementation approaches as appropriate.

SP 31: Organ Donation. There were no public comments received for organ donation.

SP 32: Glycemic Control. One comment was made that there is currently a debate over tight glucose control in critically ill patients, but did not require any change to the current text. A second comment suggested that language in the Applicable Care Setting be changed to include critically ill patients and that new devices that can monitor glucose variability be mentioned.

Action taken: Mention of the debate regarding tight glycemic control versus variability of glucose was added to the problem section. Inclusion of critically ill patients was added

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into the Applicable Care Setting section and new implantable insulin devices were suggested in the New Horizons section.

SP 34: Falls Prevention. One commenter suggested that falls with injuries should be categorized by severity level, as well as, reference to NQF's fall risk assessment standard. Also a request was made regarding individual patient assessments for falls. Another commenter suggested that a pharmacist should be involved in the fall-reduction program and that adding diuretics to the list of medications that are likely to increase the chance of a fall is appropriate.

Action taken: Requests for changes are now incorporated into the Additional Specifications, Example Implementation Approaches and the Measures Section.

SP 34: Pediatric Imaging. Only one recommendation was received for this practice. It included a request to "Shield reproductive areas and add a notation about the principles of time, distance and shielding."

Action taken: This request is addressed in the Additional specifications section to encourage consultation with the qualified physicist regarding shielding radiosensitive areas. The concept of "time and distance" do not apply to CT scanning as they do with angiography and fluoroscopy and would not be appropriate for this practice.

NQF Member Voting

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted by e-mail using the submission form that identifies the submitter, organization and which voter the comments accompany.

Please note that voting concludes on Monday, December 8, 2008 at 6:00 p.m. EDT, – no exceptions.

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