NQF

NATIONAL QUALITY FORUM

SAFE PRACTICES

Safe Practices for Better Healthcare–2010 Update

A CONSENSUS REPORT

NQF SAFE PRACTICES CONSENSUS COMMITTEE

Gregg S. Meyer, MD, MSc (Co-Chair)
Massachusetts General Hospital
Boston, MA

Charles R. Denham, MD (Co-Chair)
Texas Medical Institute of Technology
Laguna Beach, CA

James Battles, PhD
Agency for Healthcare Research and Quality
Rockville, MD

Pascale Carayon, PhD
University of Wisconsin-Madison
Madison, WI

Michael R. Cohen, MS, ScD, RPh
Institute for Safe Medication Practices
Huntington Valley, PA

Jennifer Daley, MD
Partners HealthCare System, Inc.
Boston, MA

David R. Hunt, MD, FACS
Office of the National Coordinator for Health Information Technology
Washington, DC

Mary MacDonald
American Federation of Teachers Healthcare
Washington, DC

Maura McAuliffe, PhD, CRNA
East Carolina University
Greenville, NC

Julianne Morath, MS, RN
Vanderbilt University Medical Center
Nashville, TN

Peter Pronovost, MD, PhD
Johns Hopkins University School of Medicine
Baltimore, MD

Patrick Romano, MD, MPH
University of California at Davis
Sacramento, CA

PROJECT STAFF

Helen Burstin, MD, MPH
Senior Vice President
Performance Measures

Peter B. Angood, MD
Senior Advisor
Patient Safety

Andrew Lyzenga, MPP
Project Manager
Performance Measures

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Foreword

IMPROVING THE SAFETY OF HEALTHCARE DELIVERY saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Unfortunately, 10 years after the Institute of Medicine report *To Err Is Human* issued a call to action, uniformly reliable safety in healthcare has not yet been achieved. Every day, patients are still harmed, or nearly harmed, in healthcare institutions across the country. This harm is not intentional; however, it usually can be avoided. The errors that create harm often stem back to organizational system failures, leadership shortfalls, and predictable human behavioral factors.

We can, and must, continue to do better.

Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices. This includes promoting an environment of effective reporting and learning from errors or mistakes within a blame-free culture. Collective reporting and learning from the mistakes of others is also an essential component of this process to improve healthcare safety.

The original set of National Quality Forum (NQF)-endorsed® safe practices released in 2003, updated in 2006 and 2009, were defined to be universally applied in all clinical care settings in order to reduce the risk of error and harm for patients. The current 2010 updated report adds to the evolution of these practices and acknowledges their ongoing value to the healthcare community. This update of the NQF-endorsed safe practices was conducted as an abbreviated maintenance process, with few major changes to the safe practice statements or specifications. However, the practices have been updated with the most current evidence and expanded implementation approaches; additional measures for assessing the implementation of the practices have been included in each section as well. Each practice is specific and ready for implementation and has been shown to be effective in improving healthcare safety. Systematic, universal implementation of these practices can lead to appreciable and sustainable improvements for healthcare safety.

Every individual who seeks medical care should be able to expect and receive safe, reliable care, every time, under all conditions. We thank NQF Members and the NQF Safe Practices Consensus Committee for their stewardship of this important work.

Janet M. Corrigan, PhD, MBA
President and Chief Executive Officer

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

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National Quality Forum
601 13th Street NW
Suite 500 North
Washington, DC 20005
Fax 202-783-3434
www.qualityforum.org

Executive Summary

NOW A DECADE AFTER the Institute of Medicine's report *To Err is Human,* some advances have been made in patient safety, yet the consensus is clear that there is still much to do. With the recognition that healthcare-associated infections are for the most part preventable, and that zero infections is the number we must chase, medical-related harm as the leading cause of death in America has not gone down, but gone up from the eighth leading cause in 1999 to the third leading cause.

The Safe Practices for Better Healthcare – 2010 Update presents 34 practices that have been demonstrated to be effective in reducing the occurrence of adverse healthcare events. The practices are organized into seven functional categories for improving patient safety:

- creating and sustaining a culture of safety (Chapter 2);
- informed consent, life-sustaining treatment, disclosure, and care of the caregiver (Chapter 3);
- matching healthcare needs with service delivery capability (Chapter 4);
- facilitating information transfer and clear communication (Chapter 5);
- medication management (Chapter 6);
- prevention of healthcare-associated infections (Chapter 7); and
- condition- and site-specific practices (Chapter 8).

Based on feedback from healthcare organizations, subject matter experts, and the NQF Safe Practices Consensus Committee, the 2010 update has made modest changes to the 2009 report.

In Chapters 2 through 8, the problem statements, implementation approach information, and other narrative elements that do not constitute the endorsed standards have been significantly updated. No substantive changes were made to the latest additional specifications. Chapter 9 describes selected contributions from patient advocate experts as examples of the themes that are believed to be important for patients and families to consider during their healthcare encounters. Specific recommendations regarding patients and families are embodied formally in each practice. This section has been modestly updated with input from patient advocates and organizations that have embraced the concept of involving patients and families in their safety and quality programs.

As with the previously endorsed practices, these 34 safe practices should be universally utilized in applicable healthcare settings to reduce the risk of harm resulting from processes, systems, and environments of care.

This set of safe practices is not intended to capture all activities that might reduce adverse healthcare events. Rather, this report continues the focus on 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 for multiple types of patients);
- are likely to have a significant benefit to patient safety if fully implemented; and
- have knowledge about them that consumers, purchasers, providers, and researchers can use.

The implementation of these practices will improve patient safety. Additionally, other important uses of the set are to help healthcare providers assess the degree to which safe practices already have been implemented in their settings and to assess the degree to which the practices provide tangible evidence of patient safety improvement and increased patient satisfaction and loyalty. And importantly, with this update, healthcare organization leaders and governance boards are explicitly called upon to proactively review the safety of their organizations and to take action to improve continually the safety and thus the quality of care they provide.

The safe practices are not prioritized or weighted within or across categories. This is because all are viewed as important in improving patient safety and because no objective, evidence-based method of prioritizing the practices could be identified that would equitably apply across the current heterogeneous universe of healthcare organizations that have variably implemented many—and in some cases all—of these practices. For any given healthcare provider, the choice of priority practices for implementation will depend on the provider's circumstances, including which of the practices already have been implemented, the degree of success the provider has had with implementation, the availability of resources, environmental constraints, and other factors.

This report does not represent the entire scope of NQF work pertinent to improving patient safety and healthcare quality; over the years since the publication of the original set of safe practices, NQF has completed and updated a number of projects of direct relevance to this report. In 2006, NQF endorsed 28 serious reportable events in healthcare that should be reported by all licensed healthcare facilities. In 2007, NQF completed a consensus project related to the assessment and prevention of healthcare-associated infections (HAIs). The HAI report specifically called for additional practices in HAI prevention, with a specific call for a new safe practice related to catheter-associated urinary tract infections. NQF also endorsed a set of Patient Safety Indicators developed by the Agency for Healthcare Research and Quality. Additional safety-related work included focused projects on perioperative care, the prevention of venous thromboembolism, a pressure ulcer prevention framework, and the endorsement of measures related to patient safety and medication management. Finally, the emerging priorities and goals from the National Priorities Partnership include a strong focus on avoidable harm, continuity of care, and patient safety.

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SAFE PRACTICE	PRACTICE STATEMENT
Safe Practice 1: Leadership Structures and Systems	Leadership structures and systems must be established to ensure that there is organization-wide awareness of patient safety performance gaps, direct accountability of leaders for those gaps, and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.
Safe Practice 2: Culture Measurement, Feedback, and Intervention	Healthcare organizations must measure their culture, provide feedback to the leadership and staff, and undertake interventions that will reduce patient safety risk.
Safe Practice 3: Teamwork Training and Skill Building	Healthcare organizations must establish a proactive, systematic, organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.
Safe Practice 4: Identification and Mitigation of Risks and Hazards	Healthcare organizations must systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously drive down preventable patient harm.
Safe Practice 5: Informed Consent	Ask each patient or legal surrogate to "teach back," in his or her own words, key information about the proposed treatments or procedures for which he or she is being asked to provide informed consent.
Safe Practice 6: Life-Sustaining Treatment	Ensure that written documentation of the patient's preferences for life-sustaining treatments is prominently displayed in his or her chart.
Safe Practice 7: Disclosure	Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and, as appropriate, the family should receive timely, transparent, and clear communication concerning what is known about the event.
Safe Practice 8: Care of the Caregiver	Following serious unintentional harm due to systems failures and/or errors that resulted from human performance failures, the involved caregivers (clinical providers, staff, and administrators) should receive timely and systematic care to include: treatment that is just, respect, compassion, supportive medical care, and the opportunity to fully participate in event investigation and risk identification and mitigation activities that will prevent future events.

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SAFE PRACTICE	PRACTICE STATEMENT
Safe Practice 9: Nursing Workforce	Implement critical components of a well-designed nursing workforce that mutually reinforce patient safeguards, including the following: ■ A nurse staffing plan with evidence that it is adequately resourced and actively managed and that its effectiveness is regularly evaluated with respect to patient safety. ■ Senior administrative nursing leaders, such as a Chief Nursing Officer, as part of the hospital senior management team. ■ Governance boards and senior administrative leaders that take accountability for reducing patient safety risks related to nurse staffing decisions and the provision of financial resources for nursing services. ■ Provision of budgetary resources to support nursing staff in the ongoing acquisition and maintenance of professional knowledge and skills.
Safe Practice 10: Direct Caregivers	Ensure that non-nursing direct care staffing levels are adequate, that the staff are competent, and that they have had adequate orientation, training, and education to perform their assigned direct care duties.
Safe Practice 11: Intensive Care Unit Care	All patients in general intensive care units (both adult and pediatric) should be managed by physicians who have specific training and certification in critical care medicine ("critical care certified").
Safe Practice 12: Patient Care Information	Ensure that care information is transmitted and appropriately documented in a timely manner and in a clearly understandable form to patients and to all of the patient's healthcare providers/ professionals, within and between care settings, who need that information to provide continued care.
Safe Practice 13: Order Read-Back and Abbreviations	Incorporate within your organization a safe, effective communication strategy, structures, and systems to include the following: ■ For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person who is receiving the information record and "read-back" the complete order or test result. ■ Standardize a list of "Do Not Use" abbreviations, acronyms, symbols, and dose designations that cannot be used throughout the organization.

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Safe Practice 14: Labeling of Diagnostic Studies	Implement standardized policies, processes, and systems to ensure accurate labeling of radiographs, laboratory specimens, or other diagnostic studies, so that the right study is labeled for the right patient at the right time.
Safe Practice 15: Discharge Systems	A "discharge plan" must be prepared for each patient at the time of hospital discharge, and a concise discharge summary must be prepared for and relayed to the clinical caregiver accepting responsibility for postdischarge care in a timely manner. Organizations must ensure that there is confirmation of receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge.
Safe Practice 16: Safe Adoption of Computerized Prescriber Order Entry	Implement a computerized prescriber order entry (CPOE) system built upon the requisite foundation of re-engineered evidence-based care, an assurance of healthcare organization staff and independent practitioner readiness, and an integrated information technology infrastructure.
Safe Practice 17: Medication Reconciliation	The healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care.
Safe Practice 18: Pharmacist Leadership Structures and Systems	Pharmacy leaders should have an active role on the administrative leadership team that reflects their authority and accountability for medication management systems performance across the organization.
Safe Practice 19: Hand Hygiene	Comply with current Centers for Disease Control and Prevention Hand Hygiene Guidelines.
Safe Practice 20: Influenza Prevention	Comply with current Centers for Disease Control and Prevention (CDC) recommendations for influenza vaccinations for healthcare personnel and the annual recommendations of the CDC Advisory Committee on Immunization Practices for individual influenza prevention and control.
Safe Practice 21: Central Line-Associated Bloodstream Infection Prevention	Take actions to prevent central line-associated bloodstream infection by implementing evidence-based intervention practices.

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Safe Practice 22: Surgical-Site Infection Prevention	Take actions to prevent surgical-site infections by implementing evidence-based intervention practices. *Safe Practice 22 is currently under ad hoc review by an expert panel. This practice will be updated in the coming months to reflect the review decision.*
Safe Practice 23: Care of the Ventilated Patient	Take actions to prevent complications associated with ventilated patients: specifically, ventilator-associated pneumonia, venous thromboembolism, peptic ulcer disease, dental complications, and pressure ulcers.
Safe Practice 24: Multidrug-Resistant Organism Prevention	Implement a systematic multidrug-resistant organism (MDRO) eradication program built upon the fundamental elements of infection control, an evidence-based approach, assurance of the hospital staff and independent practitioner readiness, and a re-engineered identification and care process for those patients with or at risk for MDRO infections. Note: This practice applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant *Staphylococcus aureus,* vancomycin-resistant *enterococci,* and *Clostridium difficile.* Multidrug-resistant gram-negative bacilli, such as *Enterobacter* species, *Klebsiella* species, *Pseudomonas* species, and *Escherichia coli,* and vancomycin-resistant *Staphylococcus aureus,* should be evaluated for inclusion on a local system level based on organizational risk assessments.
Safe Practice 25: Catheter-Associated Urinary Tract Infection Prevention	Take actions to prevent catheter-associated urinary tract infection by implementing evidence-based intervention practices.
Safe Practice 26: Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention	Implement the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™ for all invasive procedures.
Safe Practice 27: Pressure Ulcer Prevention	Take actions to prevent pressure ulcers by implementing evidence-based intervention practices.
Safe Practice 28: Venous Thromboembolism Prevention	Evaluate each patient upon admission, and regularly thereafter, for the risk of developing venous thromboembolism. Utilize clinically appropriate, evidence-based methods of thromboprophylaxis.

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Safe Practice 29: Anticoagulation Therapy	Organizations should implement practices to prevent patient harm due to anticoagulant therapy.
Safe Practice 30: Contrast Media-Induced Renal Failure Prevention	Utilize validated protocols to evaluate patients who are at risk for contrast media-induced renal failure and gadolinium-associated nephrogenic systemic fibrosis, and utilize a clinically appropriate method for reducing the risk of adverse events based on the patient's risk evaluations.
Safe Practice 31: Organ Donation	Hospital policies that are consistent with applicable law and regulations should be in place and should address patient and family preferences for organ donation, as well as specify the roles and desired outcomes for every stage of the donation process.
Safe Practice 32: Glycemic Control	Take actions to improve glycemic control by implementing evidence-based intervention practices that prevent hypoglycemia and optimize the care of patients with hyperglycemia and diabetes.
Safe Practice 33: Falls Prevention	Take actions to prevent patient falls and to reduce fall-related injuries by implementing evidence-based intervention practices.
Safe Practice 34: Pediatric Imaging	When CT imaging studies are undertaken on children, "child-size" techniques should be used to reduce unnecessary exposure to ionizing radiation.