

30 Safe Practices for Better Health Care

The mission of AHRQ is to improve the quality, safety, efficiency, and effectiveness of health care by:

- Using evidence to improve health care.
- Improving health care outcomes through research.
- Transforming research into practice.

AHRQ's research is designed to address the most critical aspects of patient safety improvement:

- How to identify errors and their causes.
- Collect and report information on patient safety problems.
- Improve safety through the use of evidence-based interventions, tools, and practices, including health information technology.

The goal in the United States is to deliver safe, high-quality health care to patients in all clinical settings. Despite the best intentions, however, a high rate of largely preventable adverse events and medical errors occur that cause harm to patients. Adverse events and medical errors can occur in any health care setting in any community in this country.

One reason adverse events and medical errors occur is that evidence-based information on what works to prevent them, or reduce the harm they cause, is not available. The National Quality Forum, with support from the Agency for Healthcare Research and Quality (AHRQ), has identified 30 safe practices that evidence shows can work to reduce or prevent adverse events and medical errors.

The 30 safe practices that follow have been endorsed by the membership of the National Quality Forum, which includes representatives of 215 of the Nation's leading health care provider, purchaser, and consumer organizations. These organizations strongly urge that these 30 safe practices be universally

adopted by all applicable health care settings to reduce the risk of harm to patients.

30 Safe Practices for Improving Patient Safety

Creating a Culture of Safety

1. Create a health care culture of safety.

There is a need to promote a culture that overtly encourages and supports the reporting of any situation or circumstance that threatens, or potentially threatens, the safety of patients or caregivers and that views the occurrence of errors and adverse events as opportunities to make the health care system better.

Matching Health Care Needs with Service Delivery Capability

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



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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.

Facilitating Information Transfer and Clear Communication

6. Verbal orders should be recorded whenever possible and immediately read back to the prescriber; that is, a health care 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 health care 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 or wrong-patient procedures.

In Specific Settings or Processes of Care

15. Evaluate each patient undergoing elective surgery for risk of an acute ischemic cardiac event during surgery, and provide prophylactic treatment for 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/venous thromboembolism. Utilize clinically appropriate methods to prevent both.

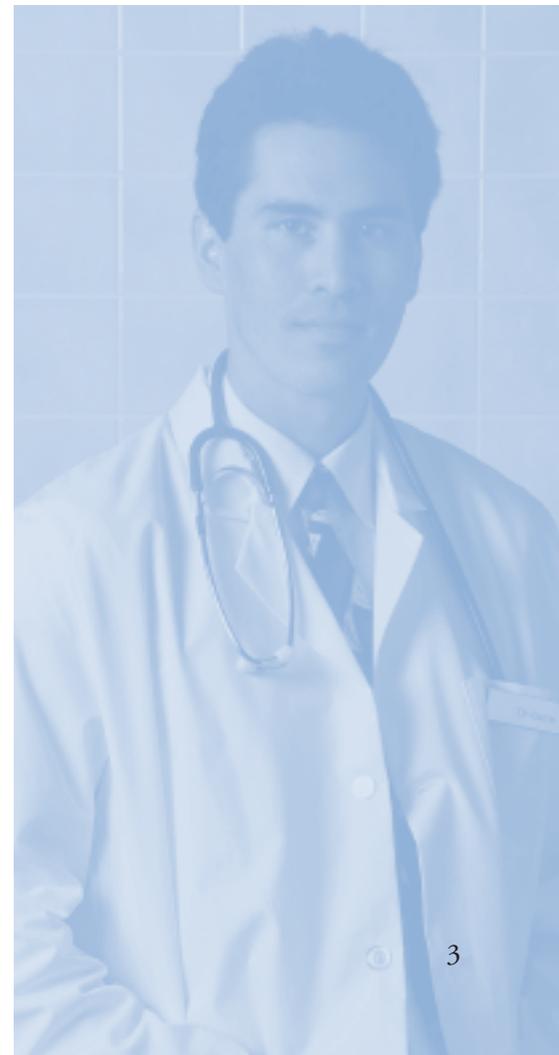
18. Utilize dedicated anti-thrombotic (anti-coagulation) services that facilitate coordinated care management.
19. Upon admission, and regularly thereafter, evaluate each patient for the risk of aspiration.
20. Adhere to effective methods of preventing central venous catheter-associated bloodstream infections.
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 health care workers against influenza to protect both them and patients.

Increasing Safe Medication Use

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 (for example, intravenous adrenergic agonists and antagonists, chemotherapy agents, anti-coagulants 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.

The National Quality Forum

The National Quality Forum is a private, non-profit public benefit corporation, created in 1999 in response to the need to develop and implement a national strategy for health care quality measurement and reporting. Established as a unique public-private partnership, the National Quality Forum has broad participation from more than 170 organizations that represent all sectors of the health care industry, including health care providers, consumers, employers, insurers, and other stakeholders. Among its members are the AARP, AFL-CIO, the American Hospital Association, the American Medical Association, the American Nurses Association, the American Society of Health-System Pharmacists, the Ford Motor Company, and General Motors.





For More Information

Detailed information on the 30 safe practices listed below is available in the National Quality Forum report, *Safe Practices for Better Healthcare: A Consensus Report*. The National Quality Forum consensus report is based, in part, on work by a team of researchers at the AHRQ Evidence-based Practice Center at Stanford University/ University of California at San Francisco. Their work is available in an AHRQ report entitled *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*.

Copies of the complete report, *Safe Practices for Better Healthcare: A Consensus Report*, are available for purchase from the National Quality Forum at www.qualityforum.org. The Web site also contains additional information about the National Quality Forum and its projects. A downloadable copy of the Executive Summary is also available from the National Quality Forum. You can access the Executive Summary through the AHRQ Web site at www.ahrq.gov/qual/nqfpract.htm.



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