A Growing National Chorus: The 2009 Safe Practices for Better Healthcare

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This article addresses the growing power of one of the many initiatives becoming harmonized across the major certifying, quality, and purchasing organizations.

Over recent years, leaders of hospital quality and safety departments have expressed great concern regarding the many measures and standards being demanded of them.

The 2009 update of the National Quality Forum (NQF) Safe Practices for Better Healthcare represents an amazing collaborative effort of organizations that we have coined the "Quality Choir" in earlier papers, which include the Agency for Healthcare Res and Quality (AHRQ), The Joint Commission (TJC), Centers for Medicare and Medicaid (CMS), the Institute for Healthcare Improvement, The Leapfrog Group, and the NQF.[1–3] The 2009 update, which is scheduled for publication in January 2009, includes synchronization of practices from evidence-based work of additional organizations, which include the Healthcare Resources and Services Administration, the World Health Organization and a joint effort of the Infectious Disease Society of America, the Society for Healthcare Epidemiology of America, the American Hospital Association, the Association for Professionals in Infection Control and Epidemiology, and the Centers for Disease Control and Prevention (CDC).

As of October 1, 2008, changes in reimbursement by CMS–whereby they will not pay for a number of Healthcare-Acquired Conditions (HACs) that are targeted by these safe practices–represent a tectonic shift in the health care market.[4] Although not a major amount of revenue per hospital, this represents the beginning of the end of blind health care purchasing and but a major first wave of the no-outcome/no-income tsunami, which will change the status quo forever. The common chorus of the major quality, certifying, and purchasing organizations is growing in volume, as is the number of voices rising from all sectors.

HARMONIZATION AND QUALITY CHOIR HISTORY

We have used a harmonization metaphor to describe the approach these organizations have taken to synchronize their requirements in patient safety, in that this term refers to musical coordination as well as coordination of data elements in information systems. Their work is channeled through the final common pathway of the NQF, whose process generates national standards that any federal agency can apply per federal law. This, in effect, becomes the sheet music for health care organizations to create their own quality choir.

The first version of the safe practices was published in May of 2003[5] and was based on an evidence-based review of practices originally undertaken by the AHRQ.[6]

The Leapfrog Group, formed in 1999, decided to measure the adoption of these practices in 2004, with the support of and in collaboration with the Texas Medical Institute of Technology (TMIT). Representing major employers from the Fortune 500 and other organizations, Leapfrog has publicly reported adoption of the practices by approximately 1200 hospitals per year, using a weighted scoring algorithm developed by TMIT with a blue ribbon board of international patient safety experts.[7]

Based on feedback from the national marketplace, the 2006 update[8] to the 2003 Safe Practices[5] was published with much more detail and standardization. The report design responded to providers requesting specificity to help them have clear direction about the adoption of Practices, while maintaining as much flexibility as possible.

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In 2008, the NQF initiated development of the 2009 update with the support of TMIT. This effort included additional harmonization partners, and all brought tremendous enthusiasm and energy to the 2009 Practices.[9] Their collective voices have become more clear, resonant, and powerful.

2009 SAFE PRACTICES DEVELOPMENT

The 2009 updated NQF Safe Practices set is composed of a total of 34 Practices that are organized into 7 functional categories.

Four elements of former Safe Practice #1, which addressed patient safety culture, were separated into 4 individual Practices for ease of adoption. Two communication-related Practices were combined into 1 Practice, 4 medication management Practices were combined into 1 Practice, and 8 new Practices were added to the set. Two Practices were retired, as other measurement strategies are being used nationally to target the same adverse events.

As defined above, there were 6 harmonization partners, and a number of additional organizations were involved in the synchronization of requirements found in the updated Safe Practices.

NEW 2009 SAFE PRACTICE FORMAT

The 2003 NQF Safe Practices report[5] had a lean format, as the NQF Steering Committee did not expect that adoption of the Practices would be measured by purchasing organizations. The 2006 report format[8] was considerably enhanced, based on input from health care providers. The Practice statement and additional specifications were defined to be the endorsed Practice, and additional sections were provided to enhance adoption success and example activities of progressive organizations. In addition, areas of recommended research were addressed. Outcomes, process, structure, and patient-centered measures were suggested, but were not part of the formal endorsed Practice sections.

The 2009 report has been further updated, with special attention to standardizing problem statements by addressing frequency, severity, preventability, and cost impact of the adverse events being addressed by each of the Practices. A specific section for "opportunities of patients and families as active participants of their care" is now included.

The Practices are written in a manner to help health care organization staff members "own" them, or, in other words, have direct accountability so that adoption can be enhanced.

The following sections of this paper address the specifics of the 2009 Practices and are organized by functional categories.

IMPROVING PATIENT SAFETY BY CREATING AND SUSTAINING A CULTURE OF SAFETY

Adoption of these 4 Practices should clearly be "owned" by governance leaders, the C-suite, and patient safety officers and leaders.

- **Leadership Structures and Systems—Safe Practice 1:** This practice outlines and defines the activities that must be undertaken by governance, administrative, and safety leaders with real specificity regarding activities in generating awareness, accountability, ability, and action. It provides clear direction to "hard-wire" information flow and direct actions that leaders need to take to prevent adverse events. Most of all, it emphasizes the importance of values and the role of governance in ensuring that the aspirations of the organization are reflected by the collective behaviors of its people.

The Governance Board is the Collective Conscience of the Organization

- **Culture Measurement and Interventions—Safe Practice 2**: This practice has no substantive changes to the 2006 practice element. Culture measurement is an evolving area and flexibility was built into the original 2006 practice element to accommodate that evolution.
- **Team Training and Team Interventions—Safe Practice 3**: Other than updated references and recognition of the AHRQ-funded TeamSTEPPS program,[10] there are no substantive changes to the practice activities.
- **Identification and Mitigation of Risks and Hazards—Safe Practice 4**: This practice integrates the information flow and actions among Risk Management, Safety, and Performance Improvement Staff and Departments. Traditional information flow and departments have not historically been integrated, and risk management departments have been focused on malpractice claims risk management, not preventive risk detection and mitigation. This practice also addresses the establishment of patient safety organizations as an outside reporting organization offering a safe harbor for patient safety work product heretofore exposed to discovery in litigation. This safe practice has to be "owned" by the CEO with implementation by other member of the C-Suite. It will require reconfiguration of department functions if the practice has not already been adopted.

It is the fiber of these leadership practices that is the connective tissue of safe health care organizations

These 4 practices, which address the establishment and sustainability of a culture of patient safety, must all be nurtured by governance and administrative leaders of the organization.

IMPROVING PATIENT SAFETY THROUGH INFORMED CONSENT, LIFE-SUSTAINING TREATMENT, DISCLOSURE, AND CARE OF THE CAREGIVER

Accountability for these practices rests on the shoulders of the C-Suite, with implementation required of operations leaders, patient safety officers, and risk managers.

- **Informed Consent—Safe Practice 5**: Obtaining informed consent is an essential part of the health care process and is, in fact, a process rather than a single act or event. The primary purpose of the informed consent process is to ensure that the patient has made an informed decision about whether to undergo a proposed treatment or procedure. Because an estimated 90 million adults in the United States (47%) have limited health literacy, policies should be implemented to ensure the use of clear informed consent documents that most patients and their families can readily

understand. This safe practice requires the organization to provide clear verbal and written communication to ensure that patients, and, when appropriate, families and legal guardians, understand with the comprehension to "teach back" the proposed treatment and its potential complications. Safe Practice 5 has no substantive changes of the 2006 practice elements.

- **Life-Sustaining Treatment—Safe Practice 6**: A patient's preferences for life-sustaining treatment are often not known by his caregivers. The published literature demonstrates that there are significant problems in all areas relevant to planning (eg, determining a patient's preferences, transmitting this information to the care setting, and respecting the patient's preferences when life-sustaining treatment decisions are made and carried out). The provision of unwanted end-of-life care is an adverse event that can be avoided by effective patient collaboration. Practice 6 describes how organizations can ensure that policies are implemented that result in written documentation of the patient's preferences, prominently displayed in his medical chart. This Safe Practice has no substantive changes to the 2006 practice elements.
- **Disclosure—Safe Practice 7**: Serious unanticipated outcomes occur in our complex health care system; however, transparent communication of these events may fail to take place. There are many reasons for this failure, including health care workers' uncertainty about what to say to patients, limited training in communication skills, concerns about malpractice liability, and insufficient institutional support.[11] This disclosure practice guides organizations through a process to ensure timely, transparent, and clear communication to patients and families when a serious unanticipated event occurs.[12] New elements to the disclosure practice include implementing a process to consider providing information to a patient safety organization,[13,14] as well as a process to consider early remediation and waiving billing for care services provided during the care episode and for subsequent treatment if the event is due to unambiguous systems failures or human error. It addresses what one could call "the first disclosure," that being the disclosure of one's error to another caregiver immediately after an event, which may prevent further harm to patients.
- **Care of the Caregiver—Safe Practice 8**: A new practice for 2009 addresses the care of clinical providers, staff, and administrators involved in serious unintentional and preventable harm to patients. The "care of the caregiver" practice guides organizations in creating systems that foster transparency and performance improvement that may reduce future harmful events. This practice also demonstrates how to provide timely and systematic care to our caregivers, including treatment that is just, respectful, and compassionate, provision for supportive medical care, and the opportunity to participate fully in the event investigation and risk identification and mitigation activities that will preclude future events. This practice not only cares for the estimated more than 1 million caregivers who are involved in preventable systems failures and human errors that harm patients, it also provides the opportunity for leaders to intervene and protect the culture of their organizations and, most importantly, improve the opportunity for avoiding similar future events.[15]

IMPROVING PATIENT SAFETY BY MATCHING HEALTH CARE NEEDS WITH SERVICE DELIVERY CAPABILITY

Accountability for these practices rests with operations leaders, patient safety officers, medical leaders, and nursing leaders.

- **Nursing Workforce—Safe Practice 9**: Nurses continue to be the primary hospital caregivers. This practice provides for nursing leaders to have more input to senior management and addresses the potential risks of having nurses operate out of safe human performance envelopes.[1] A recent time-and-motion study, with 767 nurses from 36 medical-surgical units, was conducted to determine how nurses spend their time. Patient care activities accounted for only 19.3% (81 minutes) of nursing practice time, and only 7.2% (31 minutes) of nursing practice time was used for patient assessment and reading of vital signs. On average, nurses traveled between 1 and 5 miles per 10-hour daytime shift.[16] Safe Practice 9 discusses critical components of a well-designed nursing workforce that mutually reinforce patient safeguards. This practice has no substantive changes to the 2006 practice elements.
- **Direct Caregiver Workforce—Safe Practice 10**: Increased adverse events are associated with inappropriate staffing levels and the competency of non-nursing direct caregivers. Often, when organizations cut costs to achieve financial objectives, reductions in education, quality programs, and the workforce occur. Safe Practice 10 addresses senior leadership engagement to ensure appropriate staffing levels, as well as the competency to allow direct caregivers to adequately perform their assigned tasks and patient care responsibilities. This safe practice has no substantive changes to the 2006 practice elements.
- **Intensive Care Unit Workforce—Safe Practice 11**: Patients admitted to intensive care units (ICUs) are extremely vulnerable; nearly 20% of ICU patients sustain a serious adverse event.[17] It has been estimated that if critical-care-certified physicians served all US hospitals, ICU mortality could be reduced by 150,000 hospital deaths.[18] This practice directs organizations to ensure that those who are most critically ill have skilled caregivers with specific training and certification in critical care medicine. This safe practice has no substantive changes to the 2006 practice elements.

IMPROVING PATIENT SAFETY BY FACILITATING INFORMATION TRANSFER AND CLEAR COMMUNICATION

Accountability for these practices rests with operations leaders, patient safety officers, medical leaders, and nursing leaders.

- **Patient Care Information—Safe Practice 12**: The fragmentation of care across many providers, and an inability to access key care information for patients, results in very dangerous, yet preventable, scenarios. One study reported that only 51% of potentially "life-threatening" critical test

results received appropriate attention.[19] An audit of patient charts revealed that 15% contained no documentation that clinicians were ever aware of the critical test result or that any corrective action was taken.[20] Patient care information, for the purposes of the 2009 report, is defined as "critical information regarding medical history, diagnostic test results, medications, treatment, and procedures." This practice instructs organizations how to ensure that care information is appropriately documented in a timely manner and clearly communicated to patients and all of the patient's health care professionals who need that information to provide continuity of care. This practice now includes establishing a process to communicate critical test results that are completed after the patient has been discharged from the organization.

- **Order Read-Back and Abbreviations—Safe Practice 13**: Combined into one 2009 Safe Practice, the activities defined were merged from 2 separate 2006 Practices. This combination practice addresses ineffective communication, which is the most frequently cited category of root causes of sentinel events.[21] Implementing safeguards to relay accurate patient information, such as a verbal or telephone order, includes having the person receiving the information record and read back the complete order or test result. Organizations are instructed to standardize a list of "do not use" abbreviations and dose designations that should not be used. Though now a combined practice, it does not have substantive changes to the 2006 practice elements.
- **Labeling Studies—Safe Practice 14**: The potential exists for radiographs, laboratory samples, and pathology specimens to be mislabeled, or incompletely labeled, and consequently misinterpreted across all care settings. This practice defines implementation of standardized processes to ensure accurate labeling of diagnostic studies. This safe practice has no substantive changes to the 2006 practice elements.
- **Discharge Planning—Safe Practice 15**: One in 5 hospital discharges is complicated by adverse events within 30 days, often leading to emergency department visits or hospital readmission. Practice 15 provides a roadmap for a "discharge plan" to ensure a concise discharge summary, relayed to the appropriate clinical caregivers, to mitigate adverse events and improve continuity of care. Soon-to-be-published studies will show that many as two-thirds of patients over 65 years admitted with a medical diagnosis will either be readmitted to the hospital or pass away within 12 months, according to Stephen F. Jencks, MD, MPH, Health care Consultant.[Oral Communication, Sept 3, 2008] Appropriate discharge planning and closure of accountability handovers between inpatient care teams and outpatient caregivers can have substantial impact on preventable harm. This practice has no substantive changes to the former 2006 Practice. [Oral Communication, Sept. 2, 2008, Brian Jack, MD, Vice Chairman, Academic Affairs, Family Medicine at Boston University and Boston Medical Center]
- **Safe Adoption of Computerized Prescriber Order Entry—Safe Practice 16**: Computerized Prescriber Order Entry (CPOE) is the capstone to health care system transformation; however, implementation can be disruptive. This practice defines an approach to the implementation of CPOE systems that is built upon a re-engineered, evidence-based care foundation with an assurance of health care organization readiness, and an integrated information technology infrastructure. Implementation of CPOE systems may occur with a staged, incremental, or rapid approach. There is increasing evidence of a significant risk with rapid implementation of electronic medical record systems with CPOE, even with a careful approach. Regardless of how systems are implemented, there should be verification of system performance characteristics after implementation. Automated assessment of CPOE through a flight simulator is included in this practice. This safe practice has no substantive changes to the 2006 practice elements.

IMPROVING PATIENT SAFETY THROUGH MEDICATION MANAGEMENT

The accountability for adoption and responsibility for the impact of these practices lie with the C-Suite, pharmacy leaders, and patient safety officers/leaders of the organization.

- **Medication Reconciliation—Safe Practice 17**: As many as 50% of the prescriptions taken each year are being used improperly.[22] Misuse of medications can interfere with desired treatment and cause harmful reactions, adverse drug events, and unnecessary hospitalizations.[23] At least 1.5 million preventable adverse drug events occur each year due to drug mix-ups and unintentional overdoses.[24] This practice defines how health care organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. This practice is now updated to crosswalk with TJC's National Patient Safety Goals for 2009, which address a modified medication reconciliation process for minimal patient encounters.[25]
- **Pharmacist Leadership Structures and Systems—Safe Practice 18**: An increased awareness of the lack of care coordination among providers, continued harm from adverse drug events, and substantial advancements in health information technologies has prompted an enhanced role for pharmacists to ensure effective drug use and patient safety. This enhanced role for pharmacists may change the health care organizations' view of the pharmacists' role, responsibilities, and contributions to the medication management process. This practice combines the former "Pharmacist's Role," "Standardized Medication Labeling and Packaging," "High-Alert Medications," and "Unit-Dose Medications" Safe Practices from 2006. This safe practice highlights medication management practice gaps that have resulted in patient harm, and encourages proactive risk mitigation and a strong foundation of pharmacist leadership, teamwork, and safety culture. Most importantly, this 2009 practice elevates the recognition of the critical leadership role that pharmacy directors play in the safe performance of hospital systems that operate far beyond the walls of the pharmacy. Those involved in medication-use systems have a rare full-window view of the operation of hospitals and health care organizations. The triad of imaging, laboratory, and pharmacy systems is the percussion group of hospitals: if they run well, reliability is high;

if not, reliability drops and enterprise-wide performance suffers with high cost, increased length of stay, and preventable adverse events.

IMPROVING PATIENT SAFETY THROUGH PREVENTION OF HEALTHCARE-ASSOCIATED INFECTIONS

The tragedy of healthcare-associated infections is so profound, and the impact of these practices so important, that the accountability for adoption must be owned by everyone from the governance leaders and the C-Suite down through every level of the organization to the front line.

In American hospitals alone, healthcare-associated infections account for an estimated 1.7 million infections and 99,000 associated deaths each year. Of these infections, 32% (562,000) are urinary tract infections; 22% (290,000) are surgical site infections; 15% (250,000) are lung infections; and 14% (249,000) are bloodstream infections.[26] Infection prevention begins with the most basic of infection control, hand hygiene.

The following practices have been harmonized with a thoroughly evidence-based compendium developed through a collaboration of the Infectious Disease Society of America, the Society for Healthcare Epidemiology of America, the American Hospital Association, the Association for Professionals in Infection Control and Epidemiology, and TJC.

- **Hand Hygiene—Safe Practice 19**: Up to 10% of hospitalized patients suffer from an infection acquired while they are in the hospital. Many of these infections are transmitted via the hands of health care workers. This practice recommends compliance with the current CDC Hand Hygiene Guidelines[27] to reduce the transmission of infectious agents, thereby decreasing the incidence of healthcare-associated infections. This practice has no substantive changes to the 2006 practice elements.
- **Influenza Prevention—Safe Practice 20**: Many high-risk elderly patients do not receive influenza immunizations, or are incompletely immunized despite vaccination, because of waning immune function that occurs with advanced age. Influenza and the pneumonia that often follows it are major problems in institutional care settings, where the number of frail elderly people creates an environment that is likely to allow the rapid spread of such infections.[28] Influenza causes an average of approximately 36,000 deaths each year in the United States.[29] Practice 20 recommends compliance with current CDC Influenza Vaccinations for health care personnel and the yearly Advisory Committee on Immunization Practices (ACIP) for individual influenza prevention and control.[30,31] This practice for the 2009 report is updated to include the most recent recommendations from CDC and ACIP about influenza prevention.
- **Central Line-Associated Bloodstream Infections Prevention—Safe Practice 21**: To improve patient outcomes and reduce health care costs, strategies should be implemented to reduce the incidence of Central Line-Associated Bloodstream Infections (CLABSI). This practice defines these strategies, such as the appropriate use of hand hygiene; chlorhexidine skin preparation; full-barrier precautions during insertion; avoiding the femoral site for insertion; maintaining a sterile field; creating a CVC insertion cart; asking providers daily whether catheters can be removed; and appropriate dressing and maintenance of the insertion site.[32–34] This practice is updated for the 2009 report to include more precise guidance for implementing and monitoring a CLABSI prevention program. As of October 1, 2008, the occurrence of CLABSI will not be compensated by CMS, because it is defined as a preventable healthcare-acquired condition.
- **Surgical Site Infections—Safe Practice 22**: Surgical site infections (SSI) occur in 2% to 5% of patients undergoing inpatient surgery in the United States. Approximately 8205 patients die from SSI each year. This practice focuses on evidence-based practices that organizations can implement to reduce suffering and mortality for their surgical patients. The practice includes the following care components to reduce the incidence of SSI: appropriate use of antibiotics, appropriate hair removal, maintenance of postoperative glucose control for patients who have cardiac/coronary artery bypass graft surgeries, and retaining euthermia or establishment of postoperative normothermia for patients who have colorectal surgery.[35–37] These components, if implemented reliably, can substantially reduce the incidence of SSI. This practice is updated for the 2009 report to include more precise guidance for implementing and monitoring an SSI prevention program. As of October 1, 2008, the occurrence of certain SSI events will not be compensated by CMS, because these are defined as preventable Healthcare-Acquired Conditions.
- **Care of the Ventilated Patient—Safe Practice 23**: Many ICU patients are also mechanically ventilated, which further increases the risk of morbidity from venous thromboembolism, pressure ulcers, peptic ulcer disease, dental complications, contractures, and ventilator-associated pneumonia (VAP).[38–40] This practice has been expanded beyond the original 2006 Practice, which focused only on VAP and aspiration prevention, to include the complications cited above. This practice is updated for the 2009 report to include more precise guidance for implementing and monitoring a VAP prevention program, as well as preventing other complications associated with mechanical ventilation and lack of mobility.
- **Multidrug-Resistant Organism Infection Prevention—Safe Practice 24**: Multidrug resistant organisms (MDRO), including methicillin-resistant *Staphylococcus aureus*, *Clostridium difficile*, and vancomycin-resistant enterococci, are defined as microorganisms, predominantly bacteria, that are resistant to 1 or more classes of antimicrobial agents.[41] The prevention and control of multidrug-resistant organisms is a national priority and requires that all health care facilities and agencies assume responsibility.[41,42] MDRO-colonized and -infected patients readily contaminate their environment, and health care workers coming into contact with the patient or his environment readily contaminate their hands, clothing, and equipment. This new 2009 practice focuses on evidence-based practices to prevent the infection and spread of these bacteria, including hand hygiene, contact precautions, environmental cleaning, monitoring, and strategic leadership.

- **Catheter-associated Urinary Tract Infections Prevention—Safe Practice 25**: Catheter-associated urinary tract infections are frequent healthcare-associated infections in acute care hospitals, accounting for approximately one-third of the more than 28,000 infections reported to the National Healthcare Safety Network (NHSN) in 2006–2007.[43] Practice 25 provides an organizational strategy for implementing a prevention program and monitoring symptomatic catheter-associated urinary tract infections as a prevention program. This new 2009 practice focuses on appropriate hygiene and insertion, maintenance, and removal techniques for urinary catheters. As of October 1, 2008, the occurrence of urinary tract infections (UTIs) will not be compensated by CMS, because these are defined as preventable healthcare-acquired conditions.

IMPROVING PATIENT SAFETY THROUGH CONDITION- AND SITE-SPECIFIC PRACTICES

The following practices need to be owned by governance leaders, administrators, and pertinent clinical leaders and front-line providers.

- **Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention—Safe Practice 26**: Wrong-site, wrong-procedure, wrong-person surgery can be prevented. Similarity of patient names and other characteristics, as well as symmetry between the 2 sides of the body, present opportunities for wrong-site or wrong-patient errors. These errors often result in significant adverse events, events that are now believed to be far more common than previously recognized. This practice addresses pre-operative verification, marking the intended site of the procedure, "time-out" immediately before the procedure, and monitoring to ensure consistent performance of these activities. This practice has no substantial changes and continues to be consistent with TJC's National Patient Safety Goals.[21]
- **Pressure Ulcer Prevention—Safe Practice 27**: Pressure ulcers continue to be problematic in all health care settings. All patients are at risk for developing pressure ulcers when seriously ill, immobile for a prolonged period, or unable to respond to pressure discomforts.[44,45] The use of clinical practice guidelines can effectively identify susceptible patients and define early intervention for prevention.[46] Practice 27 addresses the actions needed to prevent pressure ulcers by implementing evidence-based intervention practices. This practice for the 2009 report is updated to include the most recent literature recommendations for a comprehensive plan, as well as opportunities for patients and families to prevent pressure ulcers. As of October 1, 2008, this condition will not be compensated by CMS because it is defined as a preventable healthcare-acquired condition.
- **Venous thromboembolism Prevention—Safe Practice 28**: Deep-vein thrombosis (DVT) is a common and extremely dangerous condition in which a blood clot forms in a large vein, usually in the leg, partially or completely blocking circulation. If the clot breaks free and travels through the bloodstream, it can reach the lungs and block a blood vessel. This blockage is called a pulmonary embolism, which can be fatal within hours. Venous thromboembolism (VTE), which includes deep-vein thrombosis and pulmonary embolism conditions, is the third most common cause of hospital-related deaths in the United States and the most common preventable cause of hospital death.[47–49] About two-thirds of all VTE events are related to hospitalization. This practice addresses the evidence-based interventions to prevent VTE within organizations. This practice is updated for the 2009 report to crosswalk with the NQF's National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism, additional performance measures,[50] and the recently-published national guidelines for VTE prevention.[51] As of October 1, 2008, the occurrence of VTE will not be compensated by CMS because it has been defined as a preventable healthcare-acquired condition.
- **Anticoagulation Therapy—Safe Practice 29**: Anticoagulants, such as warfarin, unfractionated heparin, and low molecular weight heparins, are considered high-risk medications for adverse drug events. Multiple anticoagulants rank in the top 10-reported medications involved in harmful errors; heparin ranks third, warfarin ranks sixth, and enoxaparin ranks ninth.[52] Practice 29 supports standardized dosing guidelines and appropriate monitoring to prevent serious harm associated with this class of medications. This practice has evolved over time, and the focus has been narrowed for the 2009 report, to specifically address anticoagulation therapies and is now tightly linked with TJC's National Patient Safety Goal NPSG.03.05.01(updated from NPSG 3E).[21]
- **Contrast Media-Induced Complication Prevention—Safe Practice 30**: Many radiologic procedures (eg, angiography, intravenous pyelograms, and computed tomography [CT] scans) use iodine-containing contrast media. Adverse events resulting from the intravenous administration of contrast dye include allergic reactions, anaphylaxis, and kidney damage. This new 2009 Safe Practice supports the utilization of validated protocols to evaluate patients who are at risk for contrast media-induced renal failure and gadolinium-associated nephrogenic systemic fibrosis, and the implementation of a clinically appropriate method for reducing the risk of adverse events based on the patient's risk evaluations.[53,54] This practice is updated for the 2009 report to include nephrogenic systemic fibrosis, which is a scleroderma-like disease (a systemic fibrosing disease which involves skin as well as potentially involving subcutaneous tissue and internal organs in patients with underlying abnormal renal function).[55]
- **Organ Donation—Safe Practice 31**: Approximately 92,000 people in the nation are currently waiting for an organ transplant, and 17 patients die each day due to the lack of a donated organ.[56] Despite significant strides in the last 5 years to close the gap between the number of organs needed and the number available, nearly 30% of donation opportunities do not occur, whereas national surveys indicate 97% of Americans would donate a family member's organs if his wishes were known.[57] This new 2009 Safe Practice focuses on specific organizational strategies to increase awareness and educate clinicians about successful organ procurement.

Based on a national collaborative initiative run by the Healthcare Resources and Services Administration, the practice has already saved thousands of lives across the nation.[58]

- **Glycemic Control—Safe Practice 32**: The frequency of diabetes has reached epidemic proportions in the US, affecting more than 20 million individuals. In addition, another 26% of American adults have an impaired fasting glucose. Diabetes is the sixth leading cause of death by disease in the US. In 2002, 4.9 million hospital discharges in the US were associated with diabetes.[59] This practice addresses the actions necessary to improve glycemic control by implementing evidence-based intervention practices that prevent hypoglycemia associated with insulin use, and optimize the care of patients with hyperglycemia and diabetes. Glycemic control is a new practice for the 2009 report.
- **Falls—Safe Practice 33**: A fall is defined as a sudden, unintentional, downward movement of the body to the ground or other surface.[60] When a patient falls, he is at risk for serious injury, disability, and, in some cases, death. Falls occur frequently among hospitalized patients and long-term care residents,[61] and are the leading cause of injury-related death for individuals 65 and older.[62] This is a new practice in the 2009 report that addresses the evidence-based intervention practices to prevent patient falls and reduce fall-related injuries. As of October 1, 2008, the occurrence of falls will not be compensated by CMS, because it is defined to be a preventable healthcare-acquired condition.
- **Pediatric CT Imaging—Practice 34**: The annual growth of CT scans on children is estimated at 10% per year.[63] Many organizations use adult-based techniques and protocols. A change in CT examination criteria for children could reduce the radiation dose delivered to them from 50% to 90%, while retaining diagnostic accuracy. Several consensus statements suggest the assumption that low-level radiation used in diagnostic imaging may have a risk of causing cancer, albeit small.[64] This practice focuses on CT imaging studies for children and proper "child-size" techniques to reduce unnecessary exposure to ionizing radiation. This new 2009 Safe Practice is logical and well-grounded in the literature.

Two practices were retired from the 2006 report safe practice set. They were "Evidence-based Referral" and "Perioperative Myocardial Infarction/Ischemia Prevention." Although both are valuable practices, the results of such activities were felt to be measured by other nationally-endorsed measures.

A PATIENT SAFETY SCORE FOR LEADERS

The *NQF Safe Practices for Better Healthcare 2009 Update* will provide hospital governance leaders, administrators, mid-level managers, and clinical leaders in all fields with the sheet music or score to begin to harmonize enterprise-wide systems performance.

Performance against the safe practices will provide the ultimate score: lives and money saved, and value delivered to the community.

As leaders of the NQF, CMS, TJC, The Leapfrog Group, and the Institute for Health care Improvement (who were the original harmonization partners of the safe practices) have stated in unison about healthcare-associated infection prevention at a national conference on September 9, 2008[65]:

Chasing zero must be our quest…
Anything thing less is admitting failure.

We are at the end of tone-deaf health care purchasing and at the beginning of value-based purchasing by the largest payers for services in the world.[4]

They are listening for and are drawn to well-orchestrated safe care by providers who are primarily driven by moral imperatives over financial ones.

The national chorus is building and it is time to build your own quality choir—every voice counts.

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