

## National Quality Forum's Safe Practices – Relationship to The Joint Commission's and Others' Requirements\*

National Quality Forum Safe Practice (approved in October 2006) (3 new practices and 23 practices from the initial list that have materially changed; 4 practices remain unchanged from original list.)	JC Hospital Standard	JC Patient Safety Goals	Core Measures	Other user
1. Create and sustain a healthcare culture of safety.	LD.3.10			Leapfrog, IHI
2. Ask each patient or legal surrogate to “teach back” key information about proposed treatments or procedures for which he or she is asked to provided informed consent.	RI.01.03.01 (but not read back)			Leapfrog
3. Following serious, unanticipated outcomes, the patient and, as appropriate, family should receive communication about the event.	RI.01.02.01 EP 21			Leapfrog
4. Implement critical components of a well designed nursing workforce.	NR.02.03.01			
5. Ensure that non-nursing direct care staffing levels are adequate, staff is competent and have had orientation, training, and education to perform assigned direct care duties.	LD.03.06.01 HR. NR.02.03.01			Leapfrog
6. Ensure that care information is transmitted and documented in a timely and clearly understandable form to patients and patient’s healthcare providers within and between care settings.	X	NPSG.02.05.01		
7. For verbal or telephone orders or for telephonic reporting of critical test results, verify complete order or test result by having the person receiving the information record and “read-back” the complete order or test result.		NPSG.02.01.01 IPSG- Goal 2		
8. Implement standardized policies, processes, and systems to ensure accurate labeling of radiographs, laboratory specimens or other diagnostic studies.				Leapfrog
9. 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 caregivers with confirmation of receipt.	PC.04.02.01			
10. Implement a computerized prescriber order entry system built upon foundation of re-engineered evidence-based care, practitioner readiness and integrated information technology infrastructure.				Leapfrog
11. Standardize a list of “Do Not Use” abbreviations, acronyms, symbols, and dose designations that cannot be used throughout the organization.		NPSG.02.01.01		
12. The healthcare facility must develop, reconcile, and communicate an accurate medication list throughout the continuum of care		NPSG.08. (all)		Leapfrog
13. Pharmacists should actively participate in medication management systems.	MM.05.01.01			
14. Standardize methods for labeling and packaging of medications.	MM.05.01.09	NPSG.03.04.01		Leapfrog
15. Identify all “high alert” drugs and establish P/P to minimize risks associated with the use of these drugs.	MM.01.01.03	IPSG – Goal 3		IHI

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D. Nadzam – September 2008

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16. Healthcare organizations should dispense medications, including parenterals, in unit-dose, or when appropriate unit-of-use form, whenever possible.	MM.05.01.11			
17. Action should be taken to prevent ventilator-associated pneumonia by implementing ventilator bundle intervention practices.				IHI, CMS
18. Adhere to effective methods of preventing central venous catheter-associated blood stream infections and specify the requirements in explicit policies and procedures.		NPSG.07.04.01		IHI, CMS
19. Prevent surgical site infections by implementing four components of care.		NPSG.07.05.01		Leapfrog, IHI, CMS
20. Comply with current Centers for Disease Control and Prevention Hand Hygiene Guidelines.		NPSG.07.01.01		Leapfrog
21. Immunize healthcare workers and patients who should be immunized against influenza annually.	IC.02.04.01			
22. For high-risk elective cardiac procedures or other specified care, patients should be clearly informed of likely reduced risk of adverse outcome at treatment facilities that participate in clinical outcomes registries and minimize the number of surgeons performing procedures with strongest volume-outcomes relationship.				Leapfrog
23. Implement the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™ for all invasive procedures.		UP.01 thru .03 IPSG – Goal 4		
24. Evaluate each patient undergoing elective surgery for risk of an acute ischemic perioperative cardiac event and consider prophylactic treatment with beta-blockers			SCIP-Card-2	
25. Evaluate each patient upon admission, and regularly thereafter, for the risk of developing pressure ulcers.		NPSG.14.01.01		CMS, IHI
26. Every patient on long-term oral anticoagulants should be monitored by a qualified health professional using a careful strategy to ensure an appropriate intensity of supervision.		NPSG.03.05.01		
27. Ensure that written documentation of patient’s preferences for life-sustaining treatments is prominently displayed in his or her chart	RC.02.01.01 EP 4			
28. 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”).				Leapfrog
29. Evaluate each patient upon admission, and regularly thereafter, for the risk of developing venous thromboembolism/deep vein thrombosis. Utilize clinically appropriate, evidence-based methods of thromboprophylaxis.			2009	Leapfrog, CMS
30. 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.				

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National Quality Forum's Serious Reportable Events (A.K.A. "Never Events")- Approved in October 2006	JC Sentinel Event	CMS Hospital-Acquired Condition
Artificial insemination with the wrong donor sperm or donor egg (NEW since original list)		
Unintended retention of a foreign object in a patient after surgery or other procedure (changes from original).	X	X
Patient death or serious disability associated with patient elopement (disappearance) (changes from original).	X	
Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration) (changes from original).	X	
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products (changes from original).	X	X
Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility (changes from original).	X	
Patient death or serious disability associated with a fall while being cared for in a healthcare facility (changes from original).	X	X
Surgery performed on the wrong body part.	X	X
Surgery performed on the wrong patient	X	X
Wrong surgical procedure performed on a patient	X	X
Intraoperative or immediately post-operative death in an ASA Class I patient	X	
Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	X	
Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended	X	
Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.	X	X

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National Quality Forum's Serious Reportable Events (A.K.A. "Never Events")-October 2006	JC Sentinel Event	CMS Hospital-Acquired Condition
Infant discharged to the wrong person	X	
Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	X	
Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility	X	
Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	X	X
Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	X	
Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility		X
Patient death or serious disability due to spinal manipulative therapy	X	
Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances		
Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	X	
Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility	X	
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider		
Abduction of a patient of any age	X	
Sexual assault on a patient within or on the grounds of the healthcare facility	X	

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Additional Joint Commission Patient Safety Goals Relate to:

- Improving accuracy of patient identification
- Improving communication
- Additional medication safety issues
- Reduce infections (MRSA)
- Reducing the risk of falls
- Encourage patient's active involvement in their own care
- Identify safety risks inherent in its patient population
- Improve recognition and response to changes in the patient condition

Additional Leapfrog Group 'leaps':

- CPOE related to medication (with testing of system also a requirement)
- Management of ICU patients by intensivists
- Volume-based referral (for specific conditions: CABG, PCI, AAA, Pancreatic resection, Esophagectomy, Aortic Valve replacement, bariatric surgery, high-risk deliveries)
- Outcome rates for specific conditions
- Efficiency measures

Additional practices included in IHI's campaigns:

- Rapid response teams
- Evidence-based care to AMI patients
- Evidence-based care to HF patients
- Reduce surgical complications (SCIP)
- Reduce MRSA
- Getting the Board on Board

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