

THE NATIONAL QUALITY FORUM

FOR IMMEDIATE RELEASE

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**NATIONAL QUALITY FORUM
ENDORSES FOUR NEW SAFE PRACTICES FOR BETTER HEALTHCARE
AND
ANNOUNCES COMPLETION OF INITIAL SET OF VOLUNTARY CONSENSUS STANDARDS
FOR HOSPITAL CARE**

WASHINGTON, DC/April 18, 2003/—The National Quality Forum (NQF) today announced that it approved four additional “safe practices” that should be universally utilized in applicable healthcare settings to reduce the risk of harm resulting from processes, systems, or environments of care, bringing to 30 the total number of approved safe practices. A list of all 30 practices follows.

NQF also announced completion of the first set of national voluntary consensus standards for measuring the quality of hospital care. A list of the 39 measures that comprise the initial measure set follows.

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The NQF is a voluntary consensus standard-setting organization. Any party may request reconsideration of the four safe practices, only, in whole or part, by notifying the NQF in writing no later than May 17, 2003 (ATTN: Corporation Secretary, 601 13th Street, NW, Suite 500 North, Washington, DC 20005; fax 202.783.3434). For an appeal to be considered, the notification letter must include information clearly demonstrating that the appellant has interests that are directly and materially affected by the NQF-endorsed recommendations and that the NQF decision has had (or will have) an adverse effect on those interests.

A private, non-profit public benefit corporation, the NQF was created in 1999 in response to the need to develop and implement a national strategy for healthcare quality measurement and reporting. Established as a unique public-private partnership, the NQF has broad participation from nearly 190 organizations who represent all sectors of the healthcare industry, including consumers, employers, insurers, healthcare providers, and other critical stakeholders. Additional information about the NQF and these and other projects is available at www.qualityforum.org.

NQF-ENDORSED SAFE PRACTICES FOR BETTER HEALTHCARE

1. Create a healthcare culture of safety.
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 that have demonstrated superior outcomes, and 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.
6. Verbal orders should be recorded whenever possible and immediately read back to the prescriber—i.e., a healthcare 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 healthcare providers/healthcare professionals 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 procedures or wrong-patient procedures.
15. Evaluate each patient undergoing elective surgery for risk of an acute ischemic cardiac event during surgery, and provide prophylactic treatment with beta-blockers to high-risk patients.
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 periodically thereafter, for the risk of developing deep vein thrombosis (DVT)/venous thromboembolism (VTE). Utilize clinically appropriate methods to prevent DVT/VTE.
18. Utilize dedicated anti-thrombotic (anti-coagulation) services that facilitate coordinated care management.
19. Upon admission, and periodically thereafter, evaluate each patient for the risk of aspiration.
20. Rigorously adhere to effective methods of preventing central venous catheter-associated blood stream 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 periodically 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 healthcare workers against influenza to protect both them and patients from influenza.
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 (e.g., intravenous adrenergic agonists and antagonists, chemotherapy, anticoagulants and antithrombotics, 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.

***Newly approved

NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Priority Area	Measure
Acute Coronary Syndrome	1. Aspirin at arrival for acute myocardial infarction (AMI)
	2. Aspirin prescribed at discharge for AMI
	3. Beta blocker at arrival for AMI
	4. Beta blocker prescribed at discharge for AMI
	5. AMI inpatient mortality
	6. Angiotensin converting enzyme inhibitor (ACEI) for left ventricular systolic dysfunction
	7. Percutaneous coronary intervention (PCI) within 120 minutes of arrival for AMI
	8. Thrombolytic agent within 30 minutes of arrival for AMI
	9. Coronary artery bypass graft (CABG) mortality
	10. CABG volume
	11. CABG using internal mammary artery
	12. PCI volume
	13. PCI mortality
Heart Failure	14. Left ventricular function assessment
	15. Detailed discharge instructions
	16. ACEI for left ventricular systolic dysfunction
Pneumonia	17. Oxygenation assessment
	18. Initial antibiotic consistent with current recommendations
	19. Blood culture collected prior to first antibiotic administration
	20. Influenza screen or vaccination
	21. Pneumonia screen or pneumococcal vaccination
	22. Antibiotic timing
Patient Safety	23. Urinary catheter-associated urinary tract infection
	24. Central line catheter-associated infection
	25. Ventilator-associated pneumonia
	26. Patient falls
Pregnancy/Childbirth/ Neonatal Conditions	27. Vaginal birth after cesarean delivery rate
	28. Third or fourth degree laceration

Priority Area	Measure
	29. Neonatal mortality
	30. Cesarean delivery rate
Surgical Complications	31. Timing of antibiotic administration (surgical patients)
	32. Selection of antibiotic administration (surgical patients)
	33. Duration of prophylaxis (surgical patients)
Pediatric Conditions	34. Use of relievers for inpatient asthma
	35. Use of systemic corticosteroids for inpatient asthma
	36. Neonate immunization administration
Smoking Cessation	37. Smoking cessation advice/counseling for acute myocardial infarction (AMI) patients
	38. Smoking cessation advice/counseling for heart failure (HF) patients
	39. Smoking cessation advice/counseling for pneumonia patients

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