Patient Safety

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Patient safety

" *so long as it involve human , health care will never be free of **error***

*....but it can be free of **injury** " Donald berwick*

Donald Berwick

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WHAT IS THE MEAN OF PATIENT SAFETY ?

Patient safety defined as " a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery .
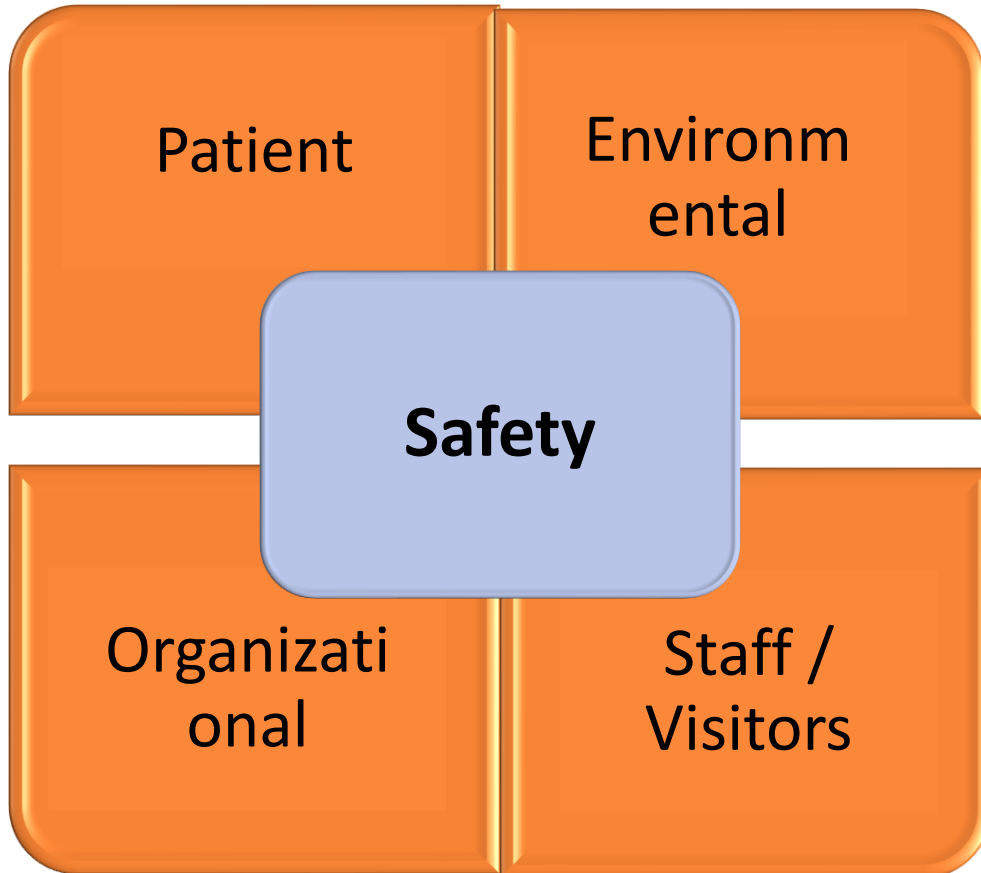*Patient safety is also an attribute of health care system :*

➢ **it minimize** *the incidence and impact of .*

➢ **maximizes** *the recovery from , adverse events ."*

AHRQ

Basic patient safety concepts

Patient	Environmental
Organizational	Staff / Visitors

Safety

- **Safety** (**do no harm**) is **the** most basic dimension of performance necessary for the **improvement** of healthcare quality.

- **Safety** is the underlying reason for **risk management, infection control**, and **environmental management programs, qualified clinical practitioners and support staff.**

- **Patient safety is a subset of safety**

So , we need to know difference between

Medical error
Commission
Omision
Hazard VS risk
Adverse event
Sentinel event
Never event
Near miss

Introduction to patient safety

In 1999, **IOM** published ***To Err is Human* report** (estimated the number of hospital deaths related to preventable medical errors was possibly as great at 98,000 per year).

In 2000, *Crossing the Quality Chasm*, laying the groundwork for a patient safety culture.

The goal in quality and patient safety is to prevent death and injury from preventable medical errors through system wide changes through:

1. developing strategies to **recognize, prevent and mitigate harm** from errors inherent in complex systems

2. **Learning** from events

3. using that **information to improve or prevent** new events

Not all errors result in harm or injury, The key is to differentiate between individual factors and factors attributed to the system or process design, then redesign the process to reduce or eliminate errors and latent conditions.

What DOES THE IOM REPORT STATE THAT WE SHOULD DO?

The causes of medical errors:

1. the decentralized and fragmented nature of health care delivery (**Poor Communication**).
2. Poor reporting (**blame culture**)
3. the errors are results of **faulty systems, processes**, and conditions that lead individuals to make mistakes, or at least fail to prevent mistakes.

•**Four-tiered approach to developing a strategy to improve patient safety:**

1. **Create leadership tool to increase the knowledge** base about patient safety (Create Safety Culture)

2. Identify and **learn from errors** by developing a nation-wide **public mandatory reporting** system

3. **Raising performance expectations** and standards for improvements in patient safety (100% IPSGs)

4. Implementing **patient safety systems** to ensure safe practices at the delivery area.

………

Lays out a comprehensive strategy that **government**, health care providers, industry, and consumers can use to begin reducing medical errors.

Create a **Center for Patient Safety** that would set national patient safety goals and track the progress being made in meeting those goals

Communication	Treatment (Operation)
Categories of Errors	
Preventative (RM)	Other Failure
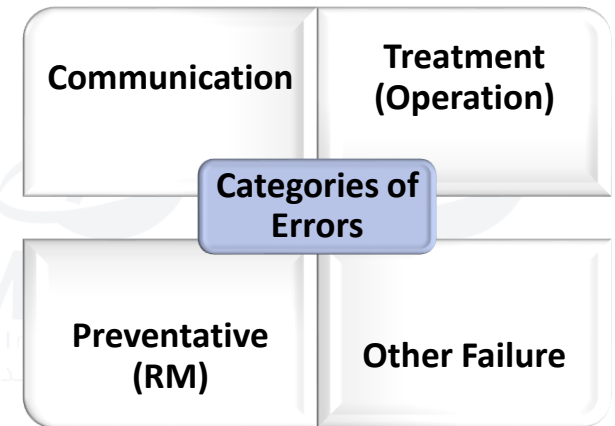
- **The focus should be on the process itself and the individual who made the error should learn from the mistake**
- **health systems need to be designed to make it harder for individual to make a mistake, and easier to do the correct thing.**

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Patient Safety	▪ Patient safety is a <u>discipline</u> in the healthcare sector that applies safety science methods toward the goal of <u>achieving a trustworthy</u> system of healthcare delivery. Patent safety is also an attribute of health care systems; it *minimizes* the *incidence* and *impact* of, and *maximizes* the *recovery from, adverse events*. **(AHRQ 2009)**
	▪ Patient safety seeks *high reliability of a system* that is filled with risk. <u>Therapeutic interventions</u> are where medical errors occur, and where *patient safety* must be focused
Medical Error	▪ An act of **omission or commission** in <u>planning or execution</u> that contribute or could contributes **to an unintended result (Outcome).**
	▪ **Omission** (failure to do the right thing) and **Commission** (doing the right thing wrong), **as well as** <u>planning</u> and <u>completing a process</u>.

Commission
- Doing something wrong
- Example: ordering medication for a patient with a documented allergy

Omission
- Failing to do the right thing
- Example: failing to prescribe medications to prevent blood clots in patients at high risk for clots

Risks VS hazard

<u>A Hazard:</u> is *a potential source of harm* or adverse health effect on a person or persons.

<u>risk</u> : is the likelihood that a person may be *harmed or suffers adverse health effects* if exposed to a *hazard*

<u>*Example*</u> :
If there was a spill of water in a room then that water would present a slipping **hazard** *to persons passing through it.*
If access to that area was prevented by a physical barrier then the hazard would remain though **the risk** *would be minimized .*

Medical Errors

- Medical error: is an unintentional preventable mistake in the provision of care that has an actual

or potential adverse impact on the patient.

Medical error :

*" an act of **omission** or **commission** in planning or execution that contribute or could contributes to an **unintended result***

Omission

سهو/اغفال

Failure to do the right thing

Commission

ارتكاب

Doing the right thing wrong

Medical Errors

- **Medical error i**s *"an act of*

ارتكاب

omission (failure to do the

right thing) *or commission*

(doing the right thing

wrong) *that contribute or*

could contributes to an

unintended result.

Error of Commission

- An act of **doing something wrong** that leads to an undesirable outcome or significant potential for such an outcome.

Example:

- Ordering a medication for a patient with a documented allergy to that medication.

Error of Omission

- An act of **failing to do the right thing** that leads to an undesirable outcome or significant potential for such an outcome.

Example:

- Failing to prescribe VTE prophylaxis for a patient after hip replacement surgery

Definitions

ERRORS OF OMISSION

ERRORS OF COMMISSION

- ☐ In healthcare, an error has been defined by the IOM as:
  - ◻ the failure of a planned action to be completed as intended (error of execution تنفيذ) or the use of a wrong plan to achieve an aim (error of planning)
  - ◻ An error may be an act of commission ارتكاب or an act of omission سهو/ إغفال

- ☐ A medication error has been defined as:
  - ◻ any error occurring in the medication use process
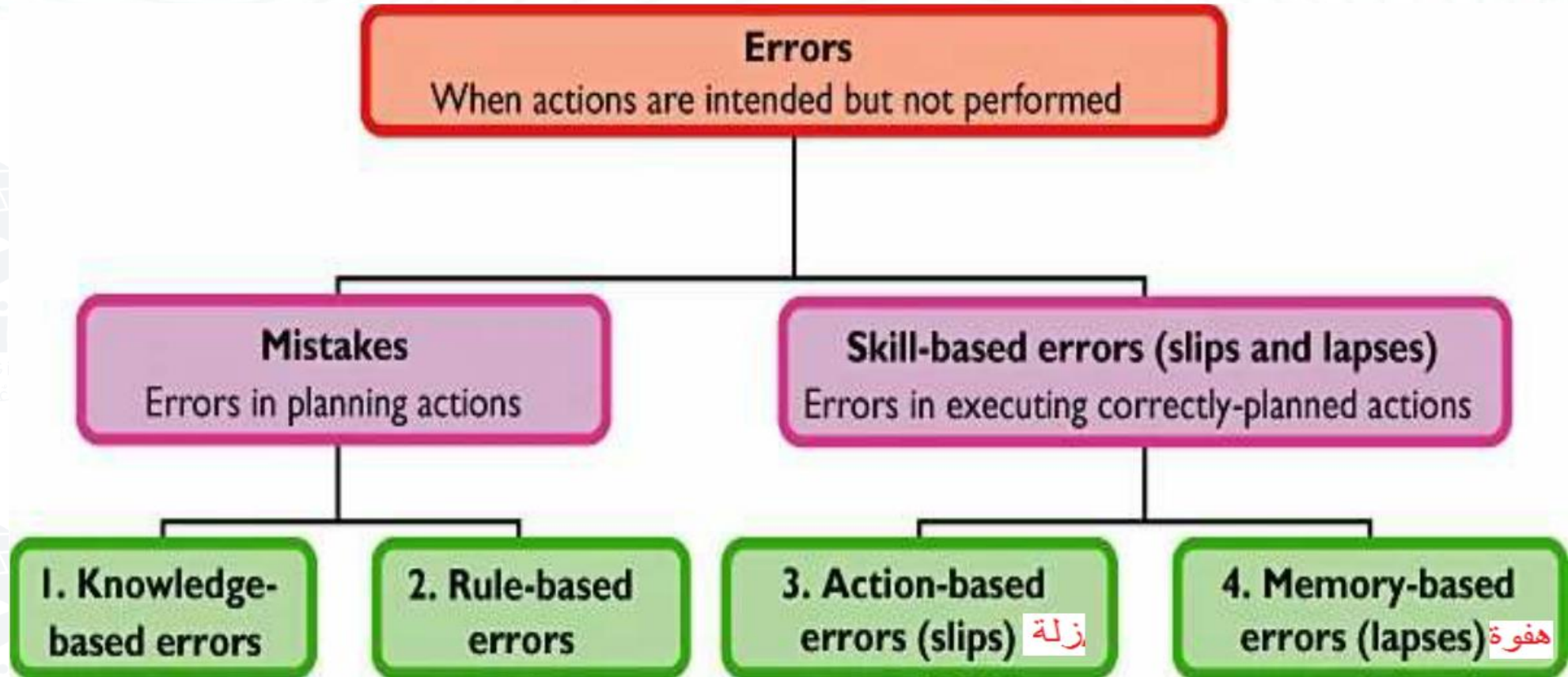
Omission

- Failure to administer an ordered dose (not late dose).
- Omitted dose is not an error when:
  - ☐ cannot take anything by mouth (NPO).
  - ☐ providers are waiting for drug level results.
 - ☐ patient refuses.

MEDICATION ERROR

Nurseslabs

NURSING TIPS

Errors
When actions are intended but not performed

Mistakes
Errors in planning actions

Skill-based errors (slips and lapses)
Errors in executing correctly-planned actions

1. Knowledge-based errors

2. Rule-based errors

3. Action-based errors (slips) زلة

4. Memory-based errors (lapses) هفوة

Medical Error

Medical Errors

- A Medical error may or may not result in adverse events.

  - Such as when a patient receives the wrong medication but there is no harm to the patient.

Patient safety Error

Adverse Event	▪ **unintended injury** to patients caused by medical management ... that results in measureable disability, prolonged hospitalization, or both **(preventable adverse events).** ▪ not **all adverse events are a result of error**
Sentinel Event	▪ <u>**never event**</u>**, an unexpected occurrence** involving <u>**death or serious physical or psychological injury or the risk**</u> <u>thereof.</u> ▪ With every sentinel event, a <u>Root Cause analysis (RCA) must</u> be completed in a timely manner with implementation of an action plan.
Near Miss	▪ <u>potential</u> medical error, which **is** <u>caught prior</u> to the administration to a patient (<u>by chance</u>). ▪ it is best to complete a Failure Mode Effectiveness Analysis (**FMEA**) or a Root Cause Analysis (**RCA**)

Medical Errors — Near Misses — Adverse Events — Non-Preventable AE — Preventable AE
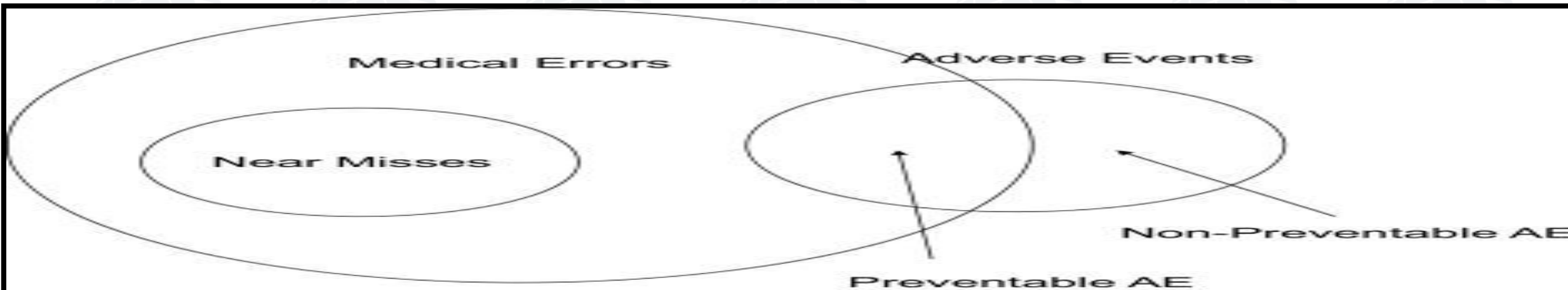
Adverse event

" _**unintended injury**_ to patient caused by medical management …. That result in measurable _**disability**_ , _**prolonged hospitalization or**_ _**both**_ "
Since not all adverse events are a result of error, many prefer to   use the term _**preventable adverse events.**_

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Adverse event

- Adverse event is an unintended injury caused by medical management rather than the underlying condition of the patient that results in measureable disability, prolonged hospitalization, or both" .

Adverse event

- Since not all adverse events are a result of error, An adverse event attributable to error is a "preventable adverse event."

- Adverse events have been classified as either

- Preventable: due to error.

- Not preventable.

Adverse Event - Definition

- Adverse Event (AE)

  - Injury caused by medical management resulting in measurable disability, not due to underlying illness

- Types of AEs

  - Preventable = due to error

  - Unpreventable

Doctor error

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Definition:

Near Miss:

An event or situation that could have resulted in an adverse event but did not (occur) either by chance or through timely intervention.

Example: Epinephrine was almost administered instead of Lidocaine but uncovered during the final check of the nurse.

Near miss? Don't ignore it, report it

- For a near miss, it is best to complete a Failure Mode Effectiveness Analysis (FMEA) or a Root Cause Analysis (RCA)

FMEA

RCA

OSHA

Sentinel event :

"… an unexpected occurrence involving ***death or serious physical or psychological injury*** "

A special Cuse variation falling outside the normal control limit of the process care

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What is a sentinel event?

- An unexpected occurrence involving death, physical or psychological injury or the risk thereof (any process variation for which recurrence carries a significant risk of a serious adverse outcome)
- Sentinel means a signal for immediate investigation and response with implementation of an action plan

SENTINEL

- Sentinel events signal the need for immediate investigation and response; an intensive in-depth analysis.

- Another name for a sentinel event is a **never event.** A never event is an event that should never happen.

- The National Quality Forum (NQF) changed the 'never event' term to 'Serious Reportable Events (SRE)'.

: Never event serious
reportable event NQF

*"Is an event that should **never happened** and if it does **, immediate investigation**   and remediation is required"*

| Centers for medicare and medicaid (CMS) | 28 | 2008 |

| National quality forum (NQF) | 29 | 2011 |

Table 2-1 Serious Reportable Events in Healthcare—2011 Update

1. **Surgical or Invasive Procedure Events**
   a. Surgery or other invasive procedure performed on the wrong site
   b. Surgery or other invasive procedure performed on the wrong patient
   c. Wrong surgical or other invasive procedure performed on a patient
   d. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   e. Intraoperative or immediately postoperative/postprocedure death in an American Society of Anesthesiologists Physical Status Classification System Class 1 patient

2. **Product or Device Events**
   a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   b. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
   c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. **Patient Protection Events**
   a. Discharge or release of a patient/resident of any age who is unable to make decisions to anyone other than an authorized person
   b. Patient death or serious injury associated with patient elopement (disappearance)
   c. Patient suicide, attempted suicide, or self-harm that results in serious injury while being cared for in a healthcare setting

4. **Care Management Events**
   a. Patient death or serious injury 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)
   b. Patient death or serious injury associated with unsafe administration of blood products
   c. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   d. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   e. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   f. Any Stage III, Stage IV, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
   g. Artificial insemination with the wrong donor sperm or wrong egg
   h. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   i. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. **Environmental Events**
   a. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
   b. Any incident in which systems designated for oxygen or another gas to be delivered to the patient contain no gas, the wrong gas, or are contaminated by toxic substances
   c. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient-care process in a healthcare setting
   d. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

Table 2-1 Serious Reportable Events in Healthcare—2011 Update (*continued*)

6. **Radiologic Events**
   a. Death or serious injury of a patient or staff associated with the introduction of a metallic object in the MRI area

7. **Potential Criminal Events**
   a. Any instance of care ordered or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
   b. Abduction of a patient/resident of any age
   c. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
   d. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

1- Of the followings NOT example for sentinel event

A. PT attempt suicide
B. Hemolytic Drug reaction
C. death of patient due to medication error
D. surgery on wrong part of the body

2- Of the followings NOT example for sentinel event
A. PT threating to suicide within 24 after admit
B. hemolytic TRANSFUSION reaction
C. death of patient due to medication error
D. surgery on wrong part of the body

1- Of the followings NOT example for sentinel event
A. PT attempt suicide
B. *Hemolytic Drug reaction*
C. death of patient due to medication error
D. surgery on wrong part of the body

2- Of the followings NOT example for sentinel event
A. *PT threating to suicide within 24 after admit*
B. hemolytic TRANSFUSION reaction
C. death of patient due to medication error
D. surgery on wrong part of the body

How to Deal with a Sentinel Event / Adverse Event
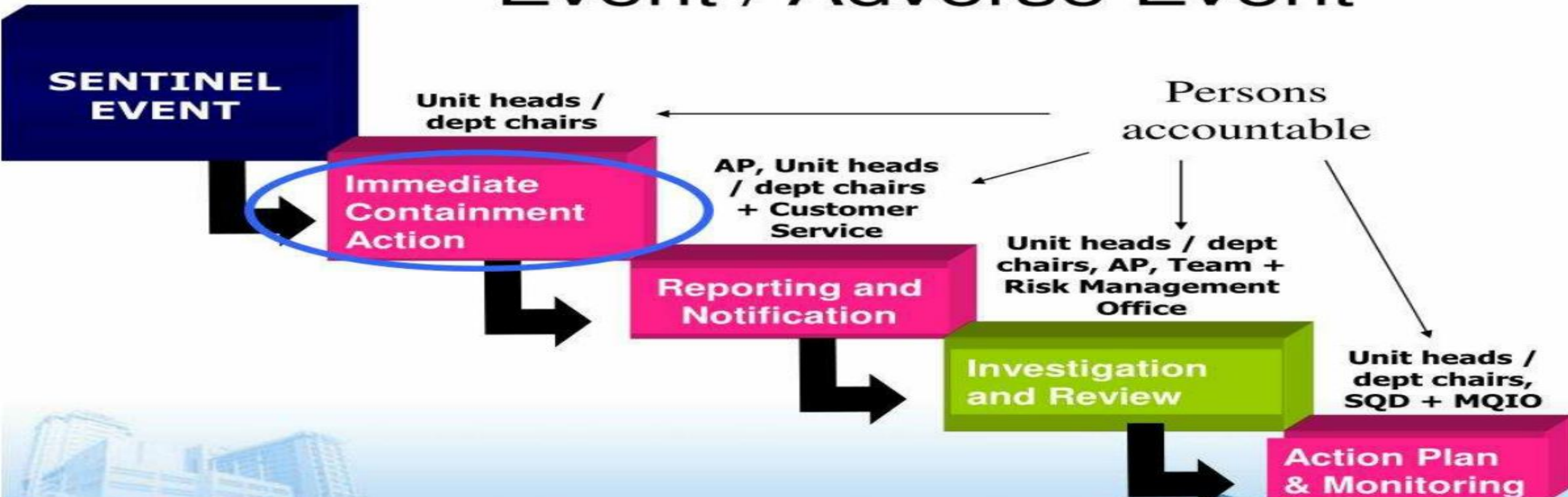
Sentinel event proces

- It is considered **special cause variation** .

- When occurs , **RCA should be conducted** to know the root cause .

- According to TJC stated that the top four root causes were **human factors** , **leadership** , **communication and assessment** .

The IOM, *To Err is Human* Report

- story

The IOM, *To Err is Human* Report

• Was released to stimulate the healthcare industry to

develop a patient safety

culture and thus to decrease

medical errors and

Preventable adverse events.

The IOM, *To Err is Human* Report

- The majority of medical errors

  are not results of 'individual recklessness'. More often,

  the
  errors are results of faulty
  systems,   processes,   and
  conditions that lead individuals to make mistakes, or at least fail to
  prevent mistakes.

Four categories of errors were identified in the IOM report

1. The communication errors include an error or delay in the diagnosis, failure to order indicated tests.

Four categories of errors were identified in the
IOM report

2. The treatment errors include an

error in the performance of a procedure or test, an error in the

administration of the treatment, an

error in the dose or method of

using a drug, and/or inappropriate

care.
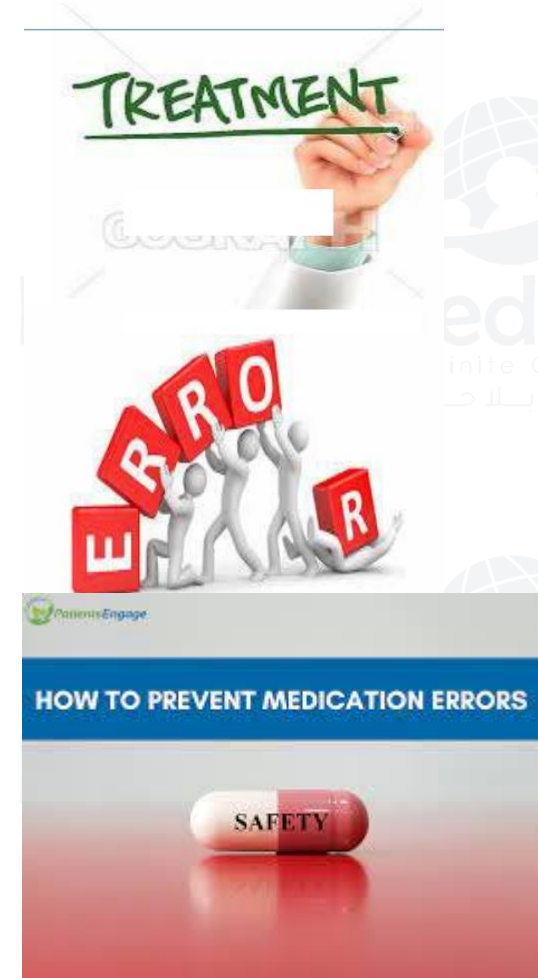
Four categories of errors were identified in the IOM report

3. Preventative errors include failure to provide prophylactic treatment and/or inadequate monitoring or follow-up of treatment.

Four categories of errors were identified in the IOM report

4. And lastly, other *Errors* include equipment failure, and other system failures.

The IOM (2000) laid out a **four-tiered approach** to developing a strategy to improve patient safety

1. Establish a national focus to create leadership tools, research, and protocols to increase the knowledge base about patient safety.

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The IOM (2000) laid out a **four-tiered approach** to developing a strategy to improve patient safety

2. Identify and learn from errors by developing a nation-wide public mandatory reporting system as well as encouraging healthcare staff, practitioners, and the organization to participate in voluntary reporting systems.

The IOM (2000) laid out a **four-tiered approach** to developing a strategy to improve patient safety

3. Raising performance expectations and standards for improvements in patient safety through the professional organizations, group purchasers, and so forth within healthcare.

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The IOM (2000) laid out a **four-tiered approach** to developing a strategy to improve patient safety

4. Implementing patient safety systems in healthcare organizations and systems to ensure safe practices at the delivery area.

- The IOM felt that if these known improvements were utilized, 50% of medical errors would have been reduced by 2004, five years after the report was released.

- Unfortunately, Agency for Healthcare Research and Quality (AHRQ) annual reports continue to indicate that deaths related to error remain similar to the statistics cited in 1999, even over fifteen years later.

- The 2013 National Healthcare Quality Report states the prevalence of harm associated with hospital stays from 2000-2007 was 25.1 per 100 admissions, and the number of preventable adverse events among adults (excluding obstetrics) per year in U.S. hospitals was 3,023,000 in 2009 (AHRQ, 2013).

Patient Safety Practices

- Patient Safety Practices were recommended for Implementation by AHRQ (AHRQ, 2013).

Patient Safety Practices

- AHRQ defines a Patient Safety Practice (PSP) as a process or structure that reduces the probability of adverse events occurring in the healthcare system across a range of diseases and procedures.

Patient Safety Practices

- The PSPs were evaluated on the evidence of the outcomes of the safe practices.

Strongly encourage implementation

- Hand hygiene.

- Barrier precautions to prevent healthcare-associated infections.
- Do Not Use" list of hazardous abbreviations.
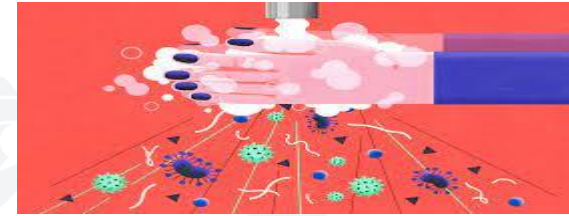
Strongly encourage implementation

- Preoperative checklists and anesthesia checklists.
- Use of real-time ultrasound for central line placement.

- Bundles that include checklists for central line insertion and care.

Strongly encourage implementation

- Bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine and subglottic-suctioning endotracheal tubes.
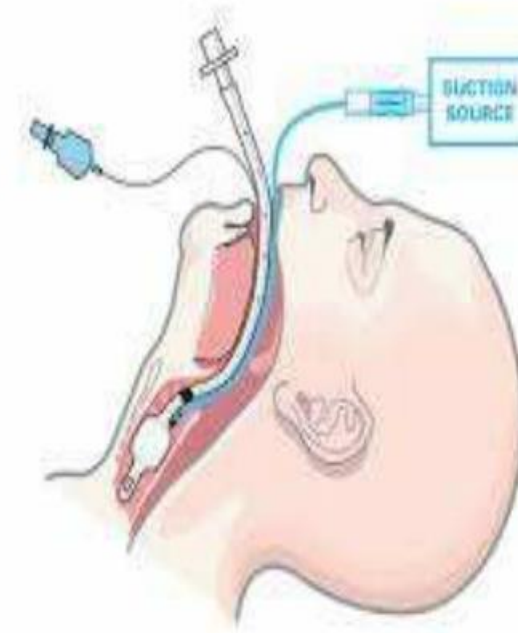
Strongly encourage implementation

- Interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols.

- Multicomponent interventions to reduce pressure ulcers.

- Interventions to improve prophylaxis for VTE.
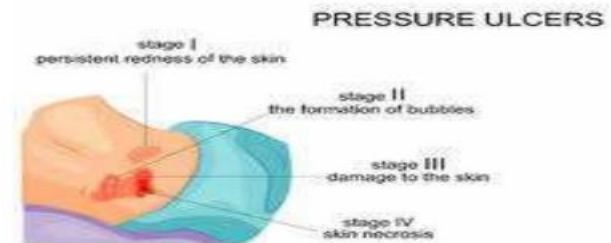
Encourage Implementation

- Multicomponent interventions to reduce falls.

- Use of clinical pharmacists to reduce adverse drug events.

- Computerized provider order entry (CPOE).

Encourage Implementation

- Medication reconciliation.

- Obtaining informed consent to improve patients' understanding of the potential risks of procedures.

- Use of surgical outcome measurements.

Encourage Implementation

- Practices to reduce radiation exposure from fluoroscopy and computed tomography scans.

- Documentation of patient preferences for life-sustaining treatment.

- Rapid response systems.

Encourage Implementation

- Utilization of complementary methods for detecting adverse events/medical errors to monitor for patient safety problems.

- Team training.

- Use of simulation exercises in patient safety efforts.

Table 2-5 Safe Practices for Better Healthcare—2010 Update

Safe Practice	Practice Statement
Safe Practice 1: Leadership Structures and Systems	Leadership structures and systems must be established to ensure 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:	Healthcare organizations must establish a proactive, systematic, organization-
Teamwork Training and Skill Building	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 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.

National Quality Forum. *Safe Practices for Better Healthcare—2010 Update: A Consensus Report* (abridged version). Washington, DC: Author; 2010.
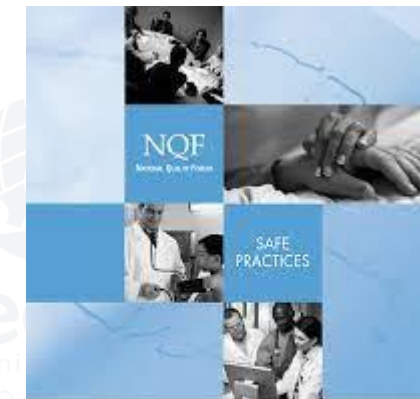
Safe Practice 6: Life-Sustaining Treatment	Ensure that written documentation of the patient's preferences for life-sustaining treatments is prominently displayed in his or her chart.
Safe Practice 7: Disclosure	Following serious unanticipated outcomes, including those that are clearly caused by systems 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 resulting from 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.
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 its effectiveness is regularly evaluated with respect to patient safety; • senior administrative nursing leaders, such as a chief nursing officer, are 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; and • 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 staff are competent, and that they have had adequate orientation, training, and education to perform their assigned direct care duties.

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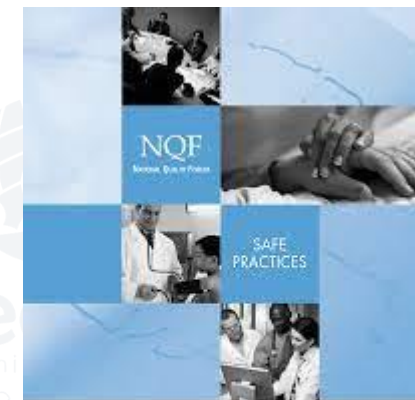
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Safe Practice 11: Intensive Care Unit (ICU) Care	All patients in general ICU (both adult and pediatric) should be managed by physicians who have specific training and certification in critical care medicine ("critical care certified").
Safe Practice 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 all of the patient's healthcare providers/professionals within and between care settings who need that information to provide continued care.

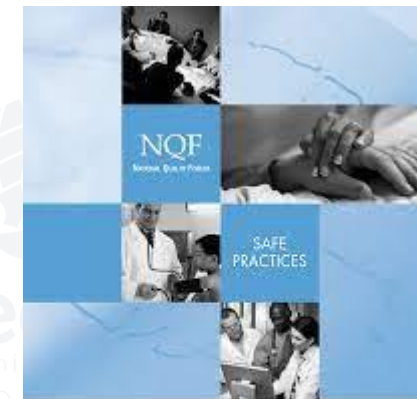| Safe Practice 13: Order Read Back and Abbreviations	Incorporate within your organization a safe, effective communication strategy, structures, and systems to include the following: • For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test 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.
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 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 there is confirmation of receipt of the discharge information by the independent licensed practitioner who will assume responsibility for care after discharge.

National Quality Forum. *Safe Practices for Better Healthcare—2010 Update: A Consensus Report* (abridged version). Washington, DC: Author; 2010.

Safe Practice 16: Safe Adoption of Computerized Prescriber Order Entry	Implement a computerized prescriber order entry system built upon the requisite foundation of reengineered 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 (CDC) hand hygiene guidelines.
Safe Practice 20: Influenza Prevention	Comply with current 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.
Safe Practice 22: Surgical Site Infection	Take actions to prevent surgical site infections by implementing evidence-based intervention practices.

National Quality Forum. *Safe Practices for Better Healthcare—2010 Update: A Consensus Report* (abridged version). Washington, DC: Author; 2010.
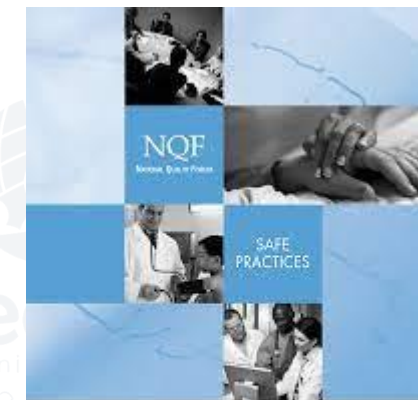
Safe Practice 23: Care of the Ventilated Patient	Take actions to prevent complications associated with ventilated patients—specifically, ventilator-associated pneumonia, venous thromboembolism, peptic ulcer disease, dental complications, and pressure ulcers.
Safe Practice 24: Multidrug-Resistant Organism (MDRO) Prevention	Implement a systematic MDRO eradication program built on the fundamental elements of infection control, an evidence-based approach, assurance of hospital staff and independent practitioner readiness, and a reengineered identification and care process for 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 *S. 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, Procedure, and 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.

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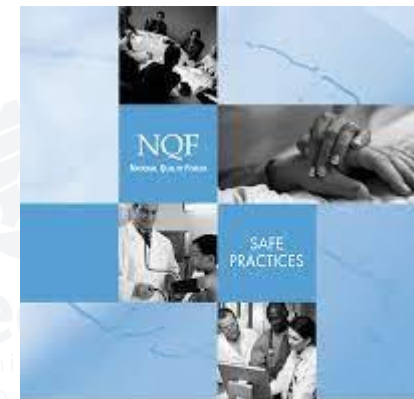
Safe Practice 27: Pressure Ulcer Prevention	Take actions to prevent pressure ulcers by implementing evidence-based intervention practices.
Safe Practice 28: Venous Thromboembolism Prevention	Evaluate each patient upon admission, and regularly thereafter, for risk of developing venous thromboembolism. Use clinically appropriate, evidence-based methods of thromboprophylaxis.
Safe Practice 29: Anticoagulation Therapy	Organizations should implement practices to prevent patient harm resulting from anticoagulant therapy.
Safe Practice 30: Contrast Media-Induced Renal Failure Prevention	Use validated protocols to evaluate patients at risk for contrast-media-induced renal failure and gadolinium-associated nephrogenic systemic fibrosis, and use a clinically appropriate method to reduce the risk for adverse events based on the patient's risk evaluations.
Safe Practice 31: Organ Donation	Hospital policies consistent with applicable law and regulations should be in place and 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 reduce fall-related injuries by implementing evidence-based intervention practices.
Safe Practice 34: Pediatric Imaging	When computed tomography imaging studies are undertaken on children, "child-size" techniques should be used to reduce unnecessary exposure to ionizing radiation.

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