Eliminating Harm Checklists

REDUCE ALL-CAUSE, PREVENTABLE HARM

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AHA/HRET HEN 2.0 ELIMINATING HARM CHECKLISTS

As a hospital field, we have long been committed to providing the safest, highest quality care possible for our patients and communities. Quality improvement is both a never-ending and an evolving journey and is something that hospitals must remain steadfastly focused on. While improvement efforts may play out differently in each organization, by joining together as part of the AHA/HRET Hospital Engagement Network (HEN) we are able to accelerate that improvement through the collection, sharing and implementation of best practices nationally. Patients across the country are benefiting from this rapid acceleration of improvement and implementation practices.

"The checklists are part of a larger change package on the topic, which include a compilation of evidence-based best practices, improvement strategies and action items along with checklists and resources that offer approaches that may be effective within your organization."

A key component to making patient care safer in your hospital is to track your data and progress towards improvement. The HEN 2.0 project, supported by Centers for Medicare & Medicaid Services (CMS) Partnership for Patients (PFP), provides a number of tools to support you in this effort. Further, to make sustainable improvements may require developing new systems of communication, fostering new staff responsibilities or modifying a clinical workflow of transition of care.

The checklists are part of a larger change package on the topic, which include a compilation of evidence-based best practices, improvement strategies and action items along with checklists and resources that offer approaches that may be effective within your organization. They also include a summary of themes from the successful practices of high-performing health organizations across the country. The checklists are a list of the top 10 priority interventions for hospitals to implement to improve performance in each of the harm areas.

The collaborative nature of the HEN project allows a broad network of people to work together towards improving patient care. These checklists, their associated change packages and the experiences of your colleagues across the country are intended to complement existing improvement efforts, literature reviews and other evidence-based tools and resources. As you know, improvement is never-ending and change can be necessary to adjust, to modify and to transform the care we provide to impact your patients and communities for the better. We encourage you to utilize this resource as you guide such changes to reduce patient harm and readmissions at your organization.

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How to Use these Checklists

- Share the checklists with your leadership and quality improvement teams
- Identify the most relevant checklists that align with organizational priorities and areas identified that are in the most need of harm reduction
- Share selected checklists and change packages with key staff
- Review strategies and action items at meetings
- Adopt the most relevant strategies to be rapidly implemented in your organization
- Share experiences, challenges and successes with HEN colleagues

For more information about the AHA/HRET HEN 2.0 project, and to access the full change packages for each harm area please visit www.hret-hen.org

ADVERSE DRUG EVENTS (ADE) TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions to prevent ADEs in your facility

Reference: www.hret-hen.org

ADE Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible and By When?)**
Standardize concentrations and minimize dosing options where feasible.	☐	☐	☐	
Minimize or eliminate pharmacist or nurse distraction during the medication fulfillment and administration process.	☐	☐	☐	
Use data and information from alerts and overrides to redesign standardized processes.	☐	☐	☐	
Set dosing limits for insulin and opioids.	☐	☐	☐	
Reduce sliding scale variation (or eliminate sliding scales).	☐	☐	☐	
Coordinate meal and insulin times.	☐	☐	☐	
Target inpatient blood glucoses to safe levels: 140-180 mg/dl (some surgical patients may have net benefit at 100-180 mg/dl). No patient should have a glucose target <100.	☐	☐	☐	
Implement pharmacist-driven warfarin management.	☐	☐	☐	
Use alerts to avoid multiple prescriptions of opioids and sedatives.	☐	☐	☐	
Use effective tools to reduce over-sedation from opioids (e.g. risk assessment tools such as "STOP BANG" and sedation assessment tools such as the Richmond Agitation Sedation Scale or the Pasero Opioid-Induced Sedation Scale).	☐	☐	☐	

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AIRWAY SAFETY TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN

Purpose of Tool: A checklist to review current or initiate new interventions for recognition and prevention of airway events and harm in your facility

Reference: www.hret-hen.org

Airway Safety Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible and By When?)**
Adopt an assessment tool to identify patients at high risk for respiratory depression or airway compromise. Use this to implement appropriate monitoring guidelines based on patient risk factors for airway compromise and respiratory depression. Educate family for rapid response team activation.	☐	☐	☐	
Integrate an identification process in the EMR or medical record to alert the health care team of the potential for a difficult airway.	☐	☐	☐	
Adopt the Pasero sedation scale (or another validated tool) to assess sedation levels for patients receiving opioids. Use a change in the scale to trigger a rapid response team evaluation.	☐	☐	☐	
Adopt and utilize a standardized airway assessment tool (such as LEMON: Look, Evaluate, Mallampati, Obstruction, Neck) to identify patients with difficult airways.	☐	☐	☐	
Develop airway carts to ensure necessary equipment is readily available to address unanticipated airway events in each relevant unit.	☐	☐	☐	
Develop, adopt and utilize a difficult airway algorithm.	☐	☐	☐	
Adopt spontaneous awakening trials (SATs), coordinated with spontaneous breathing trials (SBTs) to promote early weaning and extubation.	☐	☐	☐	
Update standards for airway device repositioning and for skin and mucosal inspection to ensure skin and mucosa are intact and not at risk for injury.	☐	☐	☐	
Implement simulation training for the health care team in airway assessment, difficult-airway management and airway placement.	☐	☐	☐	
Cultivate a process for timely root cause analysis with the bedside staff for airway safety issues, such as delays in recognition, delays in airway placement, hypoxemia during intubation, multiple intubation attempts, airway dislodgement and skin injury.	☐	☐	☐	

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CENTRAL-LINE BLOODSTREAM INFECTIONS (CLABSI) TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current interventions or initiate new interventions for CLABSI prevention in your facility

Reference: www.hret-hen.org

CLABSI Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible and By When?)**
Implement the Insertion Bundle: Procedural pause, hand hygiene, aseptic technique for insertion and care, site selection of subclavian (preferred) or internal jugular (acceptable), avoidance of femoral vein in adults, maximal sterile precautions and skin prep with 2% chlorhexidine.	☐	☐	☐	
Implement an insertion checklist to promote compliance and monitoring.	☐	☐	☐	
Implement a "Stop the Line" approach to the insertion bundle. If there is an observed violation of infection control practices (e.g., maximal sterile barrier precaution, break in sterile technique), line placement should stop and the violation corrected.	☐	☐	☐	
Adopt the maintenance bundle with dressing changes (every seven days for transparent dressings), line changes, and IV fluid changes. Incorporate dressing changes into daily assessment and review. Can be part of charge nurse's checklist along with the daily review of line necessity.	☐	☐	☐	
Incorporate a daily review of line necessity and maintenance bundle into workflow, e.g., charge nurse rounds. Use an electronic health care record prompt.	☐	☐	☐	
Use a chlorhexidine impregnated sponge dressing.	☐	☐	☐	
Use 2% chlorhexidine impregnated cloths for daily skin cleansing.	☐	☐	☐	
Do not routinely replace CVCs, PICCs, hemodialysis catheters or pulmonary artery catheters.	☐	☐	☐	
Use a suture-less securement device.	☐	☐	☐	
Use ultrasound guidance to place lines if this technology is available.	☐	☐	☐	

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C. DIFFICILE TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for C. difficile infection prevention in your facility

Reference: www.hret-hen.org

C. difficile Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible and By When?)**
Develop or enhance your antibiotic stewardship program to ensure optimal antibiotic prescribing and reduce overuse and misuse of antibiotics.	☐	☐	☐	
Evaluate the use of antibiotics by infection type and by unit to better understand where the opportunities for stewardship exist; be sure to include patients with urinary tract infections and lower respiratory infections.	☐	☐	☐	
Evaluate the use of antimicrobials among patients with C. difficile, and provide feedback to medical staff and facility leadership.	☐	☐	☐	
Develop processes to minimize testing of patients at low probability for C. difficile to minimize false positive polymerase chain reaction results for C. difficile.	☐	☐	☐	
Establish a lab-based alert system to immediately notify the infection prevention team and providers of newly-identified patients with positive C. difficile lab results; ensure the system includes holiday and weekend notification.	☐	☐	☐	
Remembering that C. difficile is a clinical diagnosis and not a lab diagnosis, develop processes where discussion occurs between physicians and other clinicians when a lab test for C. difficile is reported as positive.	☐	☐	☐	
Establish cleaning protocols for a cleaning solution that is effective against C. difficile spores.	☐	☐	☐	
Utilize a monitoring system to evaluate and validate effective room cleaning, and provide feedback, reward and recognition to those responsible.	☐	☐	☐	
Engage and educate patients, visitors, families and community partners (e.g. home care agencies, nursing homes), to prevent C. difficile across the continuum of care.	☐	☐	☐	
Establish and maintain an effective, creative, innovative and engaging hand hygiene program.	☐	☐	☐	

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CULTURE OF SAFETY TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for establishing a culture of safety in your facility

Reference: www.hret-hen.org

Safety Culture Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible and By When?)**
Include patient and worker safety in presentations to the board.	☐	☐	☐	
Use standard approach to distinguish human errors and at-risk behaviors from reckless behavior.	☐	☐	☐	
Create a process to quickly attend to the emotional needs of health care workers involved in an adverse event.	☐	☐	☐	
Identify process errors, equipment absence or failures that lead to at-risk behavioral choices and create action plans to address findings.	☐	☐	☐	
Implement Leadership WalkRounds™.	☐	☐	☐	
Standardize handoff communication.	☐	☐	☐	
Analyze and aggregate adverse events and near misses to determine common causes.	☐	☐	☐	
Conduct a hazard assessment for conditions that might contribute to slips, trips and falls as well as needle stick injuries, musculoskeletal injuries and workplace violence.	☐	☐	☐	
Implement a Safe Patient Handling program.	☐	☐	☐	
Train staff on the risk factors for violence in a health care setting and the control measures available to prevent violent incidents.	☐	☐	☐	

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EARLY ELECTIVE DELIVERY (EED) TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current EEDs or initiate new interventions for elimination of elective deliveries prior to 39 weeks gestation

Reference: www.hret-hen.org

Early Elective Delivery Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible and By When?)**
Educate the hospital governing board about the dangers of early elective deliveries (EED) and what the hospital's role in prevention can be.	☐	☐	☐	
Use prenatal classes as an opportunity to educate patients about the dangers of EED and clearly articulate the hospital's policy on scheduled inductions. Provide information to patients about resources, websites and social media outlets that educate mothers-to-be about their babies' development at each week of the pregnancy.	☐	☐	☐	
Partner with a physician willing to champion the effort to reduce EED. This physician does NOT have to be an obstetrician; a neonatologist or pediatrician can be very successful in this role.	☐	☐	☐	
When writing a "hard stop" policy, have physicians and hospital leaders involved from the start in the creation of the policy.	☐	☐	☐	
Use prescriptive language in the "hard stop" policy that details the exact steps to be taken and by whom within the chain of command when an elective delivery is attempted to be scheduled that does not meet the criteria determined by the medical staff.	☐	☐	☐	
Use policies, scheduling forms, educational materials and data-collection tools that are already created and available publicly from the March of Dimes, CMQCC and the National Quality Forum.	☐	☐	☐	
Review data as concurrently as possible with all stakeholders.	☐	☐	☐	
Review all EED in the past 12 months to determine if any were admitted to NICU; use those stories as motivation to gain buy-in from stakeholders.	☐	☐	☐	
Pick a system for determining gestational age in your organization and stick to it to prevent confusion when scheduling inductions.	☐	☐	☐	
Don't try to include all possible medical indications for induction in the "hard stop" policy. The policy should have a process for immediate review of cases that do not meet criteria for early delivery to determine treatment options.	☐	☐	☐	

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FAILURE TO RESCUE (FTR) TOP TEN CHECKLIST

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Purpose of Tool: A checklist to review current or initiate new interventions for FTR prevention in your facility.

Reference: www.hret-hen.org

FTR Top Ten Checklist

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Develop a simple system for activating the Rapid Response Team (RRT) or Medical Emergency Team (MET) that is easily accessible for all staff, patients and families.	☐	☐	☐	
To identify at-risk patients, use objective assessment criteria based on physiologic changes in patient status, e.g. the Modified Early Warning System (MEWS).	☐	☐	☐	
Establish an RRT or MET which includes clinical personnel with the skills to be able to (a) provide initial diagnoses; (b) undertake initial therapeutic interventions, (c) make transfer decisions, and (d) consult and collaborate with other care providers as appropriatel.	☐	☐	☐	
Develop and implement a process to inform staff, patients, and families of simple and accessible ways to activate the RRT or MET.	☐	☐	☐	
Utilize electronic medical record features to flag changes in vital signs that may signal impending deterioration of a patient's condition.	☐	☐	☐	
Use standardized tools to document RRT or MET assessments and treatment recommendations.	☐	☐	☐	
Establish and implement standardized language to describe changes in patient conditions.	☐	☐	☐	
Use a standardized method of communicating changes in a patient's condition to the RRT or MET, e.g. SBAR ("Situation, Background, Assessment, Recommendation").	☐	☐	☐	
Establish and ensure that the RRT or MET has all needed equipment and supplies readily available.	☐	☐	☐	
Establish proactive rounding by the RRT or MET on all patients discharged from ICU within the last 24 hours to assess condition.	☐	☐	☐	

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FALLS TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current interventions or initiate new strategies for fall prevention in your facility

Reference: www.hret-hen.org

Evidence-Based Interventions Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible And By When?)**
Analyze falls data to identify trends in the patient population, contributing factors to all falls and falls with injury. Design targeted interventions to address the top contributing factors in your organization or unit.	☐	☐	☐	
Assemble a multidisciplinary falls team to plan the fall prevention program or assess the current team's efficacy and make changes as necessary using PDSA methodology.	☐	☐	☐	
Assess fall and injury risk on admission, daily and with changes in the patient's condition.	☐	☐	☐	
Communicate risk across the team: hand-off forms, visual cues, huddles and whiteboards.	☐	☐	☐	
Round every 1-2 hours on patients; address the 5 P's — pain, position, personal belongings, pathway and potty. Assess effectiveness of rounds through direct observation and patient interviews. Adjust rounds workflow with staff input to improve outcomes as necessary.	☐	☐	☐	
Implement patient specific interventions to prevent hazards of immobility: rehab referral, progressive activity and ambulation program.	☐	☐	☐	
Individualize interventions for patients at high-risk for injury: padded floor mats, hip protectors, individualized toileting schedule, more frequent rounds and direct observation through sitters or video surveillance.	☐	☐	☐	
Review medications: avoid unnecessary hypnotics and sedatives, and remove culprit medications from order sets. Target high-risk patients and post fall patients for pharmacist medication review.	☐	☐	☐	
Include patients, families and caregivers in efforts to prevent falls. Educate using "teach back" regarding fall prevention measures and encourage family members to stay with high-risk patients.	☐	☐	☐	
Conduct post fall huddles at the bedside with the patient and family immediately after the fall; analyze how and why the fall occurred, and implement change(s) to prevent future falls.	☐	☐	☐	

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HOSPITAL-ACQUIRED PRESSURE ULCERS (HAPU) TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for HAPU prevention in your facility

Reference: www.hret-hen.org

HAPU Top Ten Checklists				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Analyze HAPU data for trends by unit for patient characteristics, anatomical location and other contributing factors.	☐	☐	☐	
Learn from HAPUs by conducting a Root Cause Analysis on stage III, IV and unstageable ulcers.	☐	☐	☐	
Conduct a pressure ulcer risk assessment within 4 hours of admission. Reassess at intervals defined by patient care need.	☐	☐	☐	
Activate HAPU prevention bundles for high-risk patients. Create bundles that include interventions that mitigate contributing factors identified in trended HAPU data. Involve staff in the creation and implementation of the bundles.	☐	☐	☐	
Assess reliability of admission total body skin assessments to identify opportunities to improve present on admission documentation.	☐	☐	☐	
Assess staff skill in comprehensive skin assessment and provide education, case studies and rounds to increase awareness of early detection of pressure ulcers and the protective measures to be taken to prevent progression.	☐	☐	☐	
Investigate clinical practices and reporting of Medical Device Related Pressure Ulcers (e.g., oxygen tubing, trach, cervical collars, orthotics).	☐	☐	☐	
Establish a partnership with nutritional services to assure timely nutritional assessments and implementation of interventions for high-risk patients.	☐	☐	☐	
Conduct an assessment of adequacy of support surfaces (e.g., ER carts, OR Tables, ICU units, med surg units) and shear prevention devices (e.g., lifts, glide sheets). Engage executive leadership in planning for replacement as needed.	☐	☐	☐	
Design a process to engage patients and families in assessing for early warning signs of HAPU and participating in preventative measures.	☐	☐	☐	

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IATROGENIC DELIRIUM TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: Checklist to review current or initiate new interventions for iatrogenic delirium prevention in your facility

Reference: www.hret-hen.org

Iatrogenic Delirium Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Use a validated tool to regularly assess patients for delirium.	☐	☐	☐	
Include Richmond Agitation Sedation Scale (RASS)/delirium screening (or a validated agitation scale) in multidisciplinary rounds and hand-off communication.	☐	☐	☐	
Treat pain before agitation using scheduled pain management protocol.	☐	☐	☐	
Avoid using benzodiazepines in patients at high risk for delirium.	☐	☐	☐	
Administer sedation using a goal according to a scale such as RASS or Modified Ramsey Score as ordered by a physician.	☐	☐	☐	
Develop a process that ensures daily reduction or removal of sedative.	☐	☐	☐	
Implement an early, progressive mobilization program.	☐	☐	☐	
Provide cognitively stimulating activities multiple times per day and enlist family engagement to provide a calm, familiar environment.	☐	☐	☐	
Implement a non-pharmacological sleep protocol.	☐	☐	☐	
Monitor incident reports for possible cases in which delirium may have been a factor.	☐	☐	☐	

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OBSTETRICAL (OB) HARM TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for OB-harm prevention in your facility

Reference: www.hret-hen.org

OB Harm Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Implement policies and protocols that align with nationally recognized evidence based practices, such as the ones developed by the Council on Patient Safety in Women's Healthcare. (www.SafeHealthcareforEveryWoman.org)	☐	☐	☐	
Complete an intensive, multi-disciplinary review of all cases that meet the criteria of Severe Maternal Morbidity or Mortality, in an effort to address systems issues and improve outcomes for patients.	☐	☐	☐	
Develop protocols and policies to address specific support for patients, families AND staff following a significant adverse event in maternal health.	☐	☐	☐	
Implement standardized language such as NICHD to describe changes in fetal heart rates and ensure a shared mental model about the condition of baby during labor.	☐	☐	☐	
Utilize an obstetric early warning system such as the Modified Early Obstetric Warning System (MEOWS) as a trigger tool for an impending obstetric emergency.	☐	☐	☐	
Develop an organization specific responses and clinical decision guide for triggers in the early warning system that includes expectations for response times for all team members.	☐	☐	☐	
Utilize simulation drills to practice the response to obstetric emergencies.	☐	☐	☐	
Use data from past adverse events, simulation drills and early warning trigger tools to identify opportunities for and drive improvement.	☐	☐	☐	
Include frontline maternal health staff members in quality improvement education.	☐	☐	☐	
Consider the use of alternative staffing of clinicians through the use of nurse midwives, laborists, obstetric hospitalists, doulas or a dedicated obstetric emergency department as methods to increase patient safety.	☐	☐	☐	

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OBSTETRICAL (OB) HEMORRHAGE TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for OB hemorrhage prevention in your facility

Reference: www.hret-hen.org

OB Hemorrhage Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Develop a hemorrhage cart with sutures, balloons, medications and a copy of the hospital's hemorrhage protocol to be kept in a secure, easily accessible area for nursing staff.	☐	☐	☐	
Develop a hospital decision making guide for the response to hemorrhage using an evidence based example, such as the Maternal Hemorrhage Toolkit found on www.CMQCC.org, with the involvement of the blood bank, nurses and physicians.	☐	☐	☐	
Schedule simulation drills to practice the response to obstetrical emergencies, such as hemorrhage, on a regular basis.	☐	☐	☐	
Place copies of the hospital's hemorrhage protocol in prominent places in each patient room.	☐	☐	☐	
Document cumulative blood loss during delivery (instead of estimated blood loss) by using graduated drapes, weighing sponges and drapes.	☐	☐	☐	
Utilize a risk-assessment tool at prenatal visits, on admission, during labor and after delivery to document and alert staff of a patient's risk of hemorrhage.	☐	☐	☐	
Establish a culture of huddles for high risk patients and post event debriefings.	☐	☐	☐	
Review all hemorrhages that require four or more units of packed red blood cell transfusion with a perinatal improvement team to identify systems issues.	☐	☐	☐	
Include members from the blood bank, laboratory, pharmacy and unit secretary staff in the multidisciplinary perinatal quality improvement team tasked with customizing a massive transfusion plan for the organization.	☐	☐	☐	
Utilize alerts within the electronic medical record to set up parameters for cumulative blood loss to alert clinicians of an impending hemorrhage.	☐	☐	☐	

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SEVERE PREECLAMPSIA TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for severe preeclampsia prevention in your facility

Reference: www.hret-hen.org

Severe Preeclampsia Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Develop a hospital decision-making guide for the response to severe preeclampsia using an evidence-based example, such as the Preeclampsia Toolkit found on www.CMQCC.org.	☐	☐	☐	
Schedule simulation drills to practice the response to obstetrical emergencies, such as severe preeclampsia in the Emergency Department, on a regular basis, and use the feedback after the event to improve future responses.	☐	☐	☐	
Place copies of the hospital's severe preeclampsia protocol in prominent places in each patient room for staff members to access in an emergency.	☐	☐	☐	
Believe the blood pressure and treat it. Time wasted trying different patient positions and blood pressure cuff sizes to get a lower BP result can result in stroke.	☐	☐	☐	
Use policies, protocol examples and educational materials that are already created and available publicly from California Maternal Quality Care Collaborative (CMQCC) and the Council on Patient Safety for Women's Healthcare for the prevention of harm from severe preeclampsia.	☐	☐	☐	
Implement an emergency-medication kit for severe preeclampsia and keep it in all areas of the hospital that may treat obstetric patients, including the emergency department.	☐	☐	☐	
Review all obstetric adverse events, such as admission to the ICU, utilizing an intensive review format such as a root cause analysis (RCA) format.	☐	☐	☐	
Utilize alerts within the electronic medical record to set up parameters for blood pressure to alert clinicians of an impending emergency.	☐	☐	☐	
Establish a culture of huddles for high risk patients and post-event debriefings.	☐	☐	☐	
Hospitals that do not provide obstetric services should still be prepared to treat and transfer postpartum patients with severe preeclampsia, as the condition can occur up to six weeks post-partum. A medication kit with antihypertensive medication, a copy of the hospital's protocol for treatment of severe preeclampsia as well as instructions for transfer to the nearest regional perinatal center is of great assistance in these situations.	☐	☐	☐	

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READMISSIONS TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current, or initiate new interventions to prevent avoidable readmissions in your facility

Reference: www.hret-hen.org

Preventable Readmissions Top 10 Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible And By When?)**
Enhance admission assessment of discharge needs and begin discharge planning on admission. Perform a formal assessment of risk of readmission and align interventions to a patient's needs and risk stratification level.	☐	☐	☐	
Accurate medication reconciliation at admission and with any change in level of care and at discharge.	☐	☐	☐	
Patient education—be culturally sensitive, incorporate health literacy concepts, include information on diagnosis and symptom management, medication and post-discharge care needs.	☐	☐	☐	
Identify primary caregiver, if not the patient, and include that individual in education and discharge planning.	☐	☐	☐	
Use teach-back to validate patient and caregiver's understanding.	☐	☐	☐	
Send discharge summary and after hospital care plan to PCP within 24 to 48 hours of discharge.	☐	☐	☐	
Collaborate with post-acute care and community based providers including SNFs, rehabilitation facilities, long-term acute care hospitals, home care agencies, palliative care teams, hospice, medical homes and pharmacist.	☐	☐	☐	
Before discharge, schedule follow-up medical appointments and post-discharge tests and labs.	☐	☐	☐	
For patients without a primary care physician, work with health plans, Medicaid agencies and other safety net programs to identify and link patient to a PCP.	☐	☐	☐	
Conduct post-discharge follow-up calls within 48 hours of discharge, reinforce components of after hospital care plan using teach-back and identify any unmet needs such as access to medication, transportation to follow-up appointments, etc.	☐	☐	☐	

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SEPSIS MORTALITY REDUCTION TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new sepsis mortality reduction interventions in your facility

Reference: www.hret-hen.org

Sepsis Mortality Reduction Top Ten Checklist

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible And By When?)
Collect and analyze sepsis mortality data.	☐	☐	☐	
Gather a program planning team and inclusive of organizational leaders, physician champions, sepsis advisors and multidisciplinary members from the, ED, ICU and med/surg to develop a strategy for implementation of improvement ideas.	☐	☐	☐	
Adopt a sepsis screening tool or system in the ED and/or in one inpatient department.	☐	☐	☐	
Screen every adult patient during initial evaluation in the ED and/or once a shift in one identified inpatient department.	☐	☐	☐	
Develop an alert mechanism to provide for prompt escalation and action from care providers with defined roles and responsibilities.	☐	☐	☐	
Develop standard order set or protocol linking blood cultures and lactate lab draws (blood culture = lactate level) and ensure lactate results are available within 45 min. Consider a lactate of > 4mmol/L a CRITICAL result to prompt notification.	☐	☐	☐	
Place broad-spectrum antibiotics in the ED medication delivery system to allow for antibiotic administration within 1 hour (collaborate with Pharmacy and Infectious Disease Specialist for appropriate selection).	☐	☐	☐	
Develop an order-set or protocol for 3-hour resuscitation bundle and the 6-hour septic shock bundle that uses an "opt-out" process instead of an "opt-in" for all bundle elements with the explicit end goals of therapy and assessment of volume status.	☐	☐	☐	
Develop a process for rapid fluid infusion of isotonic solution 30ml/kg for patients with septic shock for timely resuscitation.	☐	☐	☐	
Utilize a "TIME ZERO" method that also displays visual cues for the health care team for timing of interventions for the sepsis.	☐	☐	☐	

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SURGICAL SITE INFECTIONS (SSI) TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to checklist to review current SSI interventions or initiate prevention in your facility.

Reference: www.hret-hen.org

SSI Top Ten Checklist				
Process Change	**In Place**	**Not Done**	**Will Adopt**	**Notes (Responsible and By When?)**
Develop and follow standardized order sets for each surgical procedure to include antibiotic name, timing of administration, weight-based dose, re-dosing (for longer procedures) and discontinuation.	☐	☐	☐	
Ensure preoperative skin antisepsis (basic soap and water shower) antiseptic agent (e.g., chlorhexidine gluconate (CHG) cloths).	☐	☐	☐	
Develop standardized perioperative skin-antiseptic practices utilizing the most appropriate skin antiseptic for the type of surgery performed.	☐	☐	☐	
Develop a standardized procedure to assure normothermia by warming ALL surgical patients.	☐	☐	☐	
Develop and implement protocol to optimize glucose control in ALL surgical patients.	☐	☐	☐	
Administer supplemental oxygen during the preoperative, intraoperative and postoperative periods.	☐	☐	☐	
Develop protocol to screen and/or decolonize selected patients with *Staphylococcus aureus*.	☐	☐	☐	
Adhere to established guidelines (e.g., HICPAC, AORN) to assure basic aseptic techniques (e.g., traffc control, attire) are adhered to uniformly.	☐	☐	☐	
Utilize a Safe Surgery Checklist to drive development of a culture of safety that provides an environment of open and safe communication among the surgical team.	☐	☐	☐	
Establish a system where surgical site infection data are analyzed and shared.	☐	☐	☐	

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UNDUE RADIATION EXPOSURE TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to assess current practices to prevent undue radiation exposure in your facility.

Reference: www.hret-hen.org

Undue Radiation Exposure Top Ten Checklist

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Develop a process to collect, store and analyze patient dosimetry data.	☐	☐	☐	
Create and implement a "Don't" list of exams that have little proven value or do not change the course of treatment.	☐	☐	☐	
Participate in the National Dose Index Registry.	☐	☐	☐	
Require informed consents specific to ionizing-radiation examinations.	☐	☐	☐	
Eliminate routine ionizing-radiation orders (e.g., a daily chest x-ray).	☐	☐	☐	
Provide patients with tools to track their personal medical imaging history.	☐	☐	☐	
Assess staff or practitioner knowledge about the risks and benefits of ionizing radiation.	☐	☐	☐	
Develop a toolkit with educational materials about radiation safety for ordering practitioners.	☐	☐	☐	
Analyze data and information from EMR alerts and redesign and improve standardized processes.	☐	☐	☐	
Develop specific criteria for the use of ionizing radiation in special cases (e.g., for infants, small children and pregnant women).	☐	☐	☐	

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VENOUS THROMBOEMBOLISM (VTE) TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to assess current practices to prevent harm from VTE-associated events

Reference: www.hret-hen.org

VTE Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Adopt a VTE risk assessment screening tool.	☐	☐	☐	
Assess every patient upon admission for his/her risk for VTE using the VTE risk assessment screening tool.	☐	☐	☐	
Adopt a standardized risk-linked menu of choices for VTE prophylaxis.	☐	☐	☐	
Develop standard written order sets which link risk assessment results to specific prophylaxis options.	☐	☐	☐	
Use protocols for dosing and monitoring all chemoprophylaxis agents.	☐	☐	☐	
Enlist pharmacists to provide key real-time decision support for prophylaxis option selection, discuss contraindications and options and assist with protocol development.	☐	☐	☐	
Give nurses the same risk assessment and prophylaxis tools that you give physicians and utilize nurses to perform independent periodic checks throughout the course of the hospitalization.	☐	☐	☐	
Use measure-vention strategies to find under or over prophylaxis within 24 hours of admission, and if possible, throughout the hospitalization.	☐	☐	☐	
Educate patients and families regarding the importance of ambulation, oral medications or injections and sequential compression devices in VTE prevention.	☐	☐	☐	
Use success stories of patients or groups of patients at high risk for VTE where VTE was prevented due to proper risk assessment, prophylaxis and measure-vention throughout the hospitalization.	☐	☐	☐	

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VENTILATOR ASSOCIATED EVENTS (VAE) TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new VAE reduction interventions in your facility

Reference: www.hret-hen.org

VAE Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Include all elements of the bundle in charge nurse rounds and nurse-to-charge-nurse reports.	☐	☐	☐	
Enlist a multidisciplinary approach. Nurses, physicians and respiratory therapy staff need to work together to ensure bundle items such as head of bed (HOB), spontaneous awakening trials (SAT), spontaneous breathing trials (SBT) and oral care are done according to recommendations.	☐	☐	☐	
Elevate HOB to between 30-45 degrees (use visual cues, designate one person to check for HOB every one to two hours).	☐	☐	☐	
Establish a process to perform routine oral care every two hours with antiseptic mouthwash and Chlorhexidine 0.12percent every 12 hours (create visual cues, partner with respiratory therapy in performing oral care). Make the above oral care part of the ventilator order set as an automatic order that requires the physician to actively exclude it. Include the Chlorhexidine oral care on MAR.	☐	☐	☐	
Include peptic ulcer disease prophylaxis (PUD) on ICU admission and ventilator order sets as an automatic order that requires the physician to actively exclude it.	☐	☐	☐	
Include venous thromboembolism (VTE) prophylaxis on ICU admission and ventilator order sets as an automatic order that would require the physician to actively exclude it.	☐	☐	☐	
Invite families to participate in care by encouraging them to ask if prevention efforts have been completed, such as oral care and HOB elevation. Educate families on the risk of VAE, preventive measures put in place and what they can do to help (e.g. perform oral care or passive range of motion exercises if willing).	☐	☐	☐	
Perform and coordinate SAT and SBT to maximize weaning opportunities when patient sedation is minimal - coordination between nursing and respiratory therapy to manage SAT and SBT, perform daily assessment or readiness to wean and extubate.	☐	☐	☐	
Establish a process for timely physical and occupational therapy evaluation for patients on ventilator support to establish a plan for progressive mobility.	☐	☐	☐	
Manage delirium by assessing patients for delirium at least once daily. Sedation should be goal oriented and should be administered, as ordered, by the physician according to a scale such as Richmond Agitation Sedation Scale (RASS).	☐	☐	☐	