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Introducing the Patient Safety Professional: Why, What, Who, How, and Where?

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Abstract

Background—Hospital-acquired complications such as nosocomial infection, falls, and venous thromboembolism are well-known to be frequent and morbid. Unfortunately, prevention remains challenging. Two widely-touted prevention strategies – checklists and reminders – have inherent barriers that limit their utility as general solutions to these endemic problems. Likewise, relying upon additional vigilance and efforts of those already caring for patients may guarantee that hospital-acquired complications persist, given the time pressures already constraining bedside clinicians. Consequently, we recommend a new type of clinical role in the hospital setting, the “Patient Safety Professional” (PSP), be considered to ensure that each patient receives individualized prevention strategies to minimize the hazards of hospitalization.

The Role of the PSP—We envision the PSP would be an advanced practice registered nurse who would: 1) assess assigned patients for hospital-acquired complications following explicit protocols relevant to a short list of safety targets; 2) prioritize identified complications based on morbidity, mortality, and hospital costs; and 3) develop and implement plans to decrease hospital-acquired complications, in consultation with physicians and staff nurses on the unit. We have recently hired such an individual at our hospital and describe – through several vignettes – what our PSP does on a daily basis.

Evaluation of the PSP—The roll-out, benefits, and costs of PSPs should be carefully evaluated before widespread dissemination is considered. Process measures and clinical outcomes should be monitored. Physician, nurse, and patient satisfaction also need to be assessed.

Conclusions—Far from replacing the duties of front-line physicians and nurses assigned to care for the patient, we believe that a PSP will strengthen the safety net for hospitalized patients and serve as an expert resource.

Introduction

That hospitalization poses numerous hazards to patients has been known for decades.^{1, 2} While the Institute of Medicine’s report, “To Err is Human,”² dramatically drew attention to

the dangers lurking in hospitals, much work remains.³ The hazards of hospitalization range from rare, but catastrophic “never events”⁴ – operating on the wrong patient, amputating the wrong limb, or transplanting obviously ABO-incompatible organs – to less newsworthy problems that occur every day in hospitals around the world. These more endemic hospital-acquired problems, which likely account for far greater morbidity and mortality than “never events,” include healthcare-associated infection, venous thromboembolism, delirium, falls, and pressure ulcers.

While checklists and reminders constitute the two most widely-recommended prevention strategies for common patient safety problems in the hospital, we would argue that they have inherent barriers that limit their utility. Widespread interest in checklists,⁵ for example, intensified with the success of the Keystone intensive care unit (ICU) initiative to reduce catheter-related bloodstream infections.⁶ However, the first author of that success story, Dr. Peter Pronovost, has emphasized that the focus on checklists can divert attention from how safe patient care is truly achieved by writing: “The answer to the question of what a simple checklist can achieve is: on its own, not much.”⁷ Indeed, Bosk and colleagues argue that checklists used alone and without attention to adaptation based on local culture and the specifics of the patient safety issues at hand, would fall prey to the same fate as guidelines: often unused even when well-conceived.⁷

Similarly, computer-based reminders represent a widely cheered quality improvement strategy and one that is commonly believed to provide an inexpensive and simple way of improving adherence to recommended practices. However, reminders require computerized order entry or electronic medical record systems, which remain rather limited in U.S. hospitals⁸ not part of the Veterans Health Administration largely due to the huge expense and decision support resources required. Even once the hurdle of implementing these costly and complex clinical information systems have been overcome, computer reminders typically achieve improvements in target processes of care on the order of only 5% or less.⁹

The Comprehensive Unit-Based Safety Program (CUSP) is another possible human solution. The CUSP model, developed at Johns Hopkins Hospital, has been traditionally utilized in the ICU setting. However, recently Holzmüller and colleagues¹⁰ found that on a surgical oncology floor a team-based daily goals sheet focused communication by identifying barriers to discharge and stressing short-term goals. The daily goal sheet, along with cohorting of patients (no easy task), and interdisciplinary rounding, reduced the number of calls to the physician team to clarify the plan of care and specify orders. Similarly, Timmel and colleagues¹¹ found that a daily goals sheet, patient cohorting, and interdisciplinary rounds improved safety climate scores, teamwork climate, and nurse turnover rates on a surgical inpatient unit. Actual adverse events, however, were not reported.

Given the lack of off-the-shelf interventions or “systems” solutions for a large number of patient safety problems we propose that a human solution may be needed. There are (at least) two possibilities for that human solution: 1) insist that physicians, nurses, and pharmacists already caring for patients each work harder by adding on a list of patient safety tasks that they need to review and complete for each patient; or 2) give the job of managing patient safety to someone who can focus entirely on these tasks. Realizing the impracticability of the former, which we will discuss in greater detail as we proceed, we recommend a new type of clinical role be considered in the hospital setting, the “Patient Safety Professional” (PSP), to ensure that each patient receives individualized prevention strategies to minimize the hazards of hospitalization. A PSP would monitor patients daily and enhance quality of care by assessing and facilitating the use of evidence-based recommendations to prevent various endemic adverse events during hospitalization. The

Table outlines several of the patient safety and quality of care problems conceivably addressed by a PSP.

Even more important than the overall safety surveillance function would be the focus by the PSP on improving care by strengthening the safety net for hospitalized patients and serving as an expert resource to ensure that preventive evidence-based practices are being followed during hospitalization. We expand on this idea by describing why we believe PSPs are necessary and what their jobs would entail, who might fill the role of a PSP, how we can justify the additional resources, and, finally, where this strategy should be implemented. Importantly, we have hired such an individual at our hospital and describe – through vignettes – what our PSP does on a daily basis. We are not aware of another hospital in North America that has such an individual.

Why Do We Need PSPs?

While the size and number of American hospitals has shrunk, patient acuity has risen.¹² Front-line care providers alone may no longer provide a sufficient buffer between the system and the patient, necessitating a new role to strengthen the safety net for hospitalized patients. Indeed, relying solely upon the nurses and physicians already caring for the patient may guarantee that hospital-acquired complications persist. In general, educational programs for physicians and nurses do not currently prepare them with the requisite set of competencies that promote quality and patient safety.¹³ While we would like to believe that the nurses and physicians assigned to a patient would assume the important task of ensuring that evidence-based preventive measures are consistently applied to each and every one of those patients, relying solely on their efforts is unlikely to be a failsafe strategy.

Moreover, our own medical and nursing experience at a dozen different hospitals in both the United States and Canada suggests such expectations are simply not practical given the various time pressures on bedside nurses and physicians. In addition to time, the sheer intellectual effort involved in diagnosing and managing hospitalized patients makes relying on the patient's inpatient physician alone to prevent hospital-acquired infections and complications problematic. For instance, when a physician assumes care of a new inpatient service (e.g., at the beginning of a month), at which time most patients already have clear diagnoses and established management plans, it is not uncommon to observe that some patients are currently not receiving venous thromboembolism (VTE) prophylaxis, that a patient on long-term glucocorticosteroids has not been receiving a bisphosphonate, or that a urinary catheter is present that serves no medical purpose. However, as new patients are admitted, the task of sorting through multiple, fresh diagnostic and management issues can easily lead to oversights in routine processes, such as VTE prophylaxis, the presence and early management of pressure ulcers, and the necessity of indwelling catheters.

Since physicians focus on diagnosis of the patient's problems, instituting the appropriate management, interfacing with consultants and family members, and planning for discharge, preventing hospital-acquired complications typically takes a low priority. Bedside nurses are also extremely busy attending to patients' needs. Among many other tasks related to direct patient care bedside nurses monitor patients' clinical status, administer medications, and interact with other members of the healthcare team as well as patients' families.

Given the current workloads of inpatient physicians and bedside nurses, we believe that it is impractical to assume that these individuals can consistently ensure that each and every patient receives the necessary methods to prevent hospital-acquired complications. No wonder the rates of prophylaxis against VTE average only approximately 50%¹⁴ or that for between 20% and 50% of the days a patient has a urinary catheter it is medically

unnecessary.¹⁵ One way of strengthening the safety net for hospitalized patients is in the form of PSPs.

What Would PSPs Do?

The job of the PSP would consist of: a) assessing patients on his/her assigned unit for risk of hospital-acquired complications following explicit protocols relevant to a short list of safety targets; b) prioritizing identified complications based on morbidity, mortality, and hospital costs; c) developing a plan to decrease hospital-acquired complications, in consultation with physicians and staff nurses on the unit; d) implementing the plan (to be carried out by nurses, physicians, the PSP – depending on the patient safety issue); and e) evaluating the effectiveness of the plan by measuring pre-identified outcomes, and making revisions if necessary. This type of approach would ensure that the PSP is monitoring his/her own unique environment and unit culture to devise specific interventions for that unit. Vignettes #1 and #2, written by our PSP, provide more detail regarding the daily routine.

Vignette #1 – “Daily Routine”

I am a Clinical Nurse Specialist working as a patient safety professional in a Veterans Affairs (VA) Medical Center. I arrive at work by 7am to start my day, which consists of personally assessing approximately 20 patients on a general medical floor. I begin each day by assessing patients by focusing on prevention measures for the following hospital-acquired complications: catheter-associated urinary tract infection (CAUTI), venous thromboembolism (VTE), pressure sores and falls. Before entering the room I review the flow chart for any other pertinent data, such as the Morse Fall Scale Score, which is used to determine if the patient is in the low or high risk level of falling; 50 or less is low risk while 51 or greater is high risk.

I then enter the patient's room and introduce myself as follows. “Good Morning Mr. /Ms _____ my name is Debbie Zawol. I'm the Clinical Nurse Specialist working here on the fifth floor with the nurses as the Patient Safety Professional. Our goal is to cause you no harm with special focus on preventing urinary catheter infections, bloods clots, pressure sores and falls...” Their usual response is “Great, sounds good to me”. I then begin the assessment process.

For example, I ask the patient how s/he goes to the bathroom. This information lets me know if the patient has a catheter, or uses a urinal or ambulates with or without devices. If the patient has an indwelling Foley catheter I check to see if the Foley care is being performed: Is the catheter clean? Are there crustations forming? Is the bag hanging below the patient's bladder? Is tubing is secured to patient's thigh? Are there any signs of infection? I ask the nurse if s/he knows why the patient has the catheter. If the indwelling urinary catheter does not meet the criteria of insertion, the doctor is contacted to inform him/her of the removal. On occasion when reviewing charts, I have found no indication for continuing the indwelling urinary catheters.

As another example, I ask the patient if s/he has any sores on his/her body anywhere. I have found on several occasions patients will tell me about recurring pressure sores that may be almost healed but easily could break down, especially when confined in a hospital bed. Later, I review the Braden Scale Score, which is used to assess patient risk of skin breakdown. If the Braden Scale Score is 12 or less the nurse will request a wound care consult, which is a click of one key in the electronic file at the end of the skin assessment notes. When the patient is unable to turn without assistance, I then reinforce putting the patient on a turning schedule

every 2 hours, if not already started. When there are signs of skin breakdown or the nurse has documented problems I ensure the wound care nurse has been consulted. Upon my chart review I have found documentation of stage I and II pressure sores but no consult to the wound care nurse.

Using VTE prevention as an example, the PSP would evaluate daily each patient to ascertain whether or not VTE prophylaxis was prescribed, likely also evaluating the patient's risk of VTE using a risk assessment tool.¹⁶ In those patients deemed at sufficient risk to warrant VTE prophylaxis – this will vary by unit and hospital – appropriate pharmacologic prophylaxis with a heparin-based product would be given unless contraindicated; mechanical sequential compression devices would be used in patients with contraindications to heparin products. Standing orders at the time of hospital admission coupled with explicit protocols would allow PSPs to institute VTE prophylaxis themselves. As we have observed in our own hospitals, even if sequential compression devices are ordered by the physician, patients may not wear them either because they were not delivered to the bedside for some reason or because wearing them is burdensome. The PSP would be yet another person who would help ensure VTE prophylaxis is being used on every appropriate patient.

Vignette #2 – “Venous Thromboembolism (VTE) Assessment”

I review the chart for VTE prophylaxis or contraindications. If there is no VTE prophylaxis ordered I will have the nurse call the physician so s/he will become familiar with the VTE prevention measures.

I look at the foot of the bed for the sequential compression device (SCD). If the SCDs are off the patient I reattach the SCDs; if they are on the patient, I ensure the machine is on. I educate the patients about why prophylaxis is necessary. On occasion I have found the SCDs were ordered by the physician, verified by the nursing staff in the computerized chart, but never implemented. I will retrieve the SCD machine and leg attachments that are kept in the equipment room on the floor and place the SCDs on the patient.

A similar approach – standing orders and explicit protocols developed at each hospital – would apply to the prevention of catheter-related urinary tract infection (with the focus on removing indwelling Foley catheters) and other endemic patient safety problems.

In some hospitals, infection preventionists may already perform some of the functions we would assign to a PSP. However, the primary goal of infection control programs is to eliminate hospital-acquired infections through the use of surveillance and sound epidemiological principles,¹⁷ while PSPs would be focused on individual patients and would be charged with reducing a broader range of hospital-acquired complications. In addition, the PSP would focus on finding local solutions to identified problems, solutions that may vary unit by unit, let alone hospital by hospital. Studies have reported striking differences in error rates across units within the same institution,¹⁸ suggesting that unit level influences are powerful contributors to hospital-acquired complications.

We envision an individual – such as an advanced practice registered nurse (APRN) – who conducts a safety assessment on every hospitalized patient in the unit(s) assigned to him or her in order to ensure that evidence-based preventive methods are being used. The safety assessment would consist of two components: a risk assessment for various hospital-acquired complications, such as those listed in the Table, and an assessment of the efficacy of preventive measures in place. If preventive measures are either not in use or ineffective, the PSP would implement a plan to institute appropriate measures, and may wish to document findings as “safety progress notes” in the medical record.

Having safety progress notes documented in the medical record would be one way to monitor the ongoing presence of invasive devices which, surprisingly, are often poorly documented in hospital charts. For example, urinary catheters are often present without any documentation in the medical record that they exist.¹⁹ Specifically, there is often no order for a catheter and no mention of the catheter in either the physician or nursing notes. But we know this “immaculate catheter” is present since we have noticed it emerging from the patient. Less commonly, the presence of central venous catheters in patients transferred from intensive care can easily be overlooked, thereby remaining in place far past the time they are still necessary for intravenous access.

By functioning in the manner we have just described, PSPs will not merely be identifying unmet targets of care and bringing them to the attention of front-line personnel for subsequent action, which could end up overwhelming and perhaps even annoying other staff members. Rather, through their implementation function, PSPs will be able to fix many problems without waiting for physicians’ orders. For instance, if a urinary catheter is in place unnecessarily, a PSP will remove the catheter using pre-existing catheter removal guidelines which s/he helped develop. Similarly, if a patient should be receiving VTE prophylaxis but is not, the PSP would speak with the physician to make sure these are ordered or – using standing orders authorizing the use of VTE prophylaxis in various circumstances – order the appropriate VTE preventive measure themselves.

We also envision PSPs providing additional benefits to the organization. Specifically, such an individual could serve as an educational resource or consultant to other clinicians and take responsibility for staying up to date on new advances and recommendations in the area of patient safety. Additionally, a PSP could improve the coordination of services between care providers such as ensuring the receipt of services that might be provided by other ancillary providers (e.g., dietitians, physical or occupational therapists). Finally, the PSP could perform additional tasks, described in the vignette below, that make patients feel welcome and special.

Vignette #3 – “The Most Important Patient in the World”

At the end of each patient assessment I always say: “What can I do for you today?” I pause and wait for a response. My goal is to make every patient feel that s/he is the most important patient in the world at that moment. I may give him/her a warm blanket, warm up his/her coffee, put non-skid socks on his/her feet, assist him/her to the bathroom, put lotion on his/her feet, or give him/her my arm to hold as we ambulate down the hallway. One vivid episode is that a patient’s prosthetic leg sleeve/liner was lost for several days. He had been transferred several times during his hospitalization. When I was informed about the situation I went to the patients’ belongings room in the basement of the medical center and dug through several bags of his belongings to find this sleeve/liner (worth about \$400). He was very happy to finally be able to put on his prosthetic leg.

Another patient asked me to write a note of recognition to a radiation technician who made a special effort to help him get through throat radiation. I have also called the maintenance department when a patient’s room heater was not working. I contact the linen department when we don’t have enough pillows to turn our patients from side to side to prevent pressure sores. I also retrieve lip balm, water, juice, extra food, and anything else the patient needs to be safe and happy. These are just a sampling of the various things that I try to tackle that matter to the patient.

A couple days per week nursing students from the local college take care of our patients as well. I use every opportunity to reinforce the safety and prevention

practices to the students such as preventing pressure sores by turning patients every 2 hours and preventing falls by removing all obstacles from the floor and learning about the patient's limitations.

Who Would be Able to Perform the Necessary Functions?

So far we have discussed why we need PSPs and what these individuals would do. Now we address the issue of who they would be. Clinical nurse specialists (CNS) would be ideal candidates since these individuals are trained to conduct systems assessments, and often have expert interpersonal skills, including in communication and collaboration,²⁰ crucial abilities with demonstrated effectiveness in reducing hospital-acquired complications.²¹ A CNS is a subcategory of advanced practice registered nurse (APRN). APRNs are educationally prepared at the master's level or above. Other types of APRNs include nurse practitioners, nurse midwives, and nurse anesthetists.²² The CNS is the most likely candidate for the PSP role along with the newest category of APRN, the doctorate of nursing practice (DNP).

The role of the CNS was created to improve patient care by improving nursing care.²² Through their education, CNSs learn how to be change agents, educators, consultants, and expert clinicians.²² They attend to the system of care as much as to patient care,²² and it is this blend of system and patient attention which could be used to reduce hospital-acquired complications that hamper patient safety.

PSPs may not necessarily be individuals new to the organization – it may actually be less threatening to existing staff if the PSP is someone who is already known by the physicians and nurses. Of the more than 70,000 CNSs in the country,²³ 68% of them work in hospitals.²² Since CNSs already function on many inpatient hospital units, training them to take on the PSP role would be an efficient and effective way of quickly making patient safety improvements. CNSs graduate from master's programs with the raw skills, which could then be honed and focused on the promotion of patient safety. Given the tight labor supply of trained individuals in the medical field, we realize that in order for the PSP concept to be practical, it must be flexible and adapt to local needs and resources.

How will this Idea be Operationalized?

We have hopefully convinced some readers that the idea behind the PSP has merit and should be pursued at least in some clinical settings. The next issue is how it will happen. Newly graduated registered nurses who hire into a hospital undergo rigorous orientation programs extending for months in some cases, such as for nurses entering into highly specialized units. It is interesting that overall no comparable orientation exists for CNSs newly graduated from a master's program, so that when they are hired many CNSs are unclear as to their roles or accountabilities. Localized training, which we envision taking days not months, would prepare CNSs to function as PSPs taking into account the unique characteristics and features of the setting. Core competencies for graduates of APRN programs have been identified by the American Association of Colleges of Nursing,²⁰ and could easily be adapted to embrace patient safety specific content. Because the role of the PSP so closely mirrors the nursing process (assess, plan, implement, evaluate), training would focus on application of the process to the identification and eradication of those hospital-acquired complications currently plaguing the institution.

Another important consideration is how much a PSP would cost and who would pay for this individual. Medicare's decision to deny reimbursement for the extra cost of treating preventable complications during hospitalization will likely spur efforts by hospitals to reduce the incidence of endemic complications such as hospital-acquired infection, falls, and

pressure ulcers. Faced with an added incentive to prevent complications, hospitals may decide that the additional cost of PSPs is worth it. The possibility exists that the net effect of PSPs as with other APRNs will be cost saving.²⁴ Thus, in addition to the moral and ethical reasons for hospitals to focus on the prevention of hospital-acquired complications there are also financial considerations that may make PSPs a reasonable innovation for hospital decision-makers to consider.

The next logistical hurdle is obtaining support from key individuals in the organization and buy-in from front-line clinicians. The importance of having both nurse and physician champions who are committed advocates of the PSP cannot be overstated. These champions should not simply be appointed but should be individuals who embrace the PSP concept and can help to demonstrate the value of the PSP as not just someone who watches and monitors but as a collaborator who is also there to help get things done.²⁵

As mentioned above, we are piloting the role of the PSP at one of the hospitals in which some of us work, the Ann Arbor Veterans Affairs Medical Center. We have recently hired a unit-based PSP, an advanced practice registered nurse who assesses unit patients for hospital-acquired complications following explicit protocols relevant to a list of safety targets. We have implemented the PSP initially as a unit-based role so that she can be well integrated into the culture of the medical unit. However, as time progresses, the scope of the role may evolve to be service-based (medicine service, for example). The PSP is currently assigned to inpatient medicine under the Chief of Medicine and is directly responsible to him. We are currently evaluating the performance of the PSP – with the assistance and support of our patient safety officer – based on the following metrics: 1) VTE prophylaxis, 2) falls, 3) pressure ulcers, and 4) urinary catheters (appropriate indications and discontinuation), which are the 4 priority areas on this unit.

When and Where Should We Begin?

Where should PSPs begin their work? We believe that either a medical or surgical floor – rather than an ICU – would be the most appropriate place to begin for several reasons. First, evidence-based practices exist in the literature for these patient groups (e.g., urinary catheter removal protocols) and many of these practices require a human component. Second, the patient to nurse ratio on the floors is high enough so that adding an additional person to ensure that VTE prophylaxis is used or to find out exactly how long that urinary catheter has been in place and pull it out if needed, will assist the current nursing staff. Finally, despite the much greater number of patients on the regular wards compared to the number of patients in ICUs, the ICU has been the focus for many hospital-based quality improvement interventions while the regular wards have not been targeted to the same extent.

Importantly, the roll-out, benefits, costs of PSPs should be carefully evaluated before widespread dissemination is considered. In order to provide decision-makers and hospital administrators with the type of information they require, several types of outcomes should be monitored including process measures (e.g., rates of VTE prophylaxis, proportion of urinary catheters that are medically necessary) as well as actual clinical outcomes (e.g., rates of pulmonary embolism, hospital-acquired infection, contrast-induced nephropathy, falls). Satisfaction – physician, nurse, and patient – should also be monitored closely. Finally, performing a formal economic evaluation alongside the efficacy study will allow us to understand the resource costs and possible economic benefits associated with this intervention. In order to evaluate this novel innovation, we recommend that either a cluster randomized trial – with randomization at the ward level – or a quasi-experimental study be performed. The quasi-experimental study could consist of a cross-over design that relies upon both formative and summative evaluations.

There are still some unresolved issues regarding implementation of the PSP. First, the PSP may be considered a “work-around” for what many would consider essential components of care. Thus, front-line staff may take these patient safety responsibilities less seriously. Also, fragmentation of care is a possibility. Importantly, we will evaluate these issues in our ongoing pilot study. While infection preventionists oversee and take responsibility for infection prevention they also work to share results and distribute accountability with the front-line staff. Similarly the PSP would work with front-line staff to oversee patient safety while also keeping the staff informed (through data feedback) so that responsibility for superb patient care rests with front-line staff.

Conclusions

Given the known hazards of hospitalization, we propose the creation and evaluation of the PSP. As currently envisioned, this individual would assess hospitalized patients daily to ensure that evidence-based recommendations are routinely being used – and tailored to the local hospital- and unit-based context – to prevent various endemic hospital-acquired complications. Far from replacing the duties of front-line physicians and nurses assigned to care for the patient, we believe that a PSP would strengthen the safety net for hospitalized patients and be an expert resource. Before widespread adoption, however, we strongly believe that this novel idea should be carefully studied. If PSPs improve the quality and safety of care in a cost-efficient manner and positively affect satisfaction of nurses, physicians, and patients, we would hope and expect that this intervention would be applied widely. If it does not work, then we must try other innovations to improve the care our hospitalized patients receive.

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Table

Examples of the Types of Patient Safety Problems that a Patient Safety Professional Could Address

Patient Safety Category	Specific Obstacle to Safety	Interventions to remove obstacles to safety
Hospital-acquired infections	*Catheter-related urinary tract infection	Ensure removal of unnecessary urethral catheters
	*Community-acquired infectious illness	Ensure pneumococcal and influenza vaccination prior to discharge in appropriate patients
Hospital-acquired complications	*Contract-induced nephropathy	Ensure that patients who receive intravenous radiographic contrast receive adequate and appropriate intravenous fluids and N-acetylcysteine
	*Pressure ulcers	Ensure skin exams are performed in patients at risk for developing pressure ulcers and that interventions (e.g., appropriate mattresses, frequent turning) are implemented as indicated
	Malnutrition	Ensure nutritional needs are being addressed
	*Falls	Ensure patients at high-risk for falls are identified and possible interventions (e.g., hip protectors, bed alarms) are instituted
	Deconditioning	Ensure that patients are mobilized as soon as possible, including those in critical care areas
	*VTE prophylaxis	Ensure that all at-risk hospitalized patients receive appropriate VTE prophylaxis
	Pain	Ensure that pain is recognized and adequately treated
	Delirium	Prevent delirium among elderly patients and those experiencing sensory deprivation and/or overload; recognize mental status changes when they do occur
Other potential safety or quality targets	Depression	Screen for depression among elderly patients and those with multiple chronic illnesses
	Resuscitation preferences unknown	Ensure that resuscitation preferences for patients with advanced illnesses are addressed

* Issues that a patient safety professional (PSP) should address and in which the locus of control is within the PSP's job description (i.e., standing orders could allow the PSP to address the issue directly)

VTE = venous thromboembolism