UCLA Health System advocates the National Quality Forum (NQF) endorsed safe practices.This set of safe Practices encompasses 34 practices that have been demonstrated to be effective in reducing the occurrence of adverse healthcare events. Most currently updated in 2010, they includes the following guideline

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 that there is 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: Teamwork Training and Skill Building	Healthcare organizations must establish a proactive, systematic, organization-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 in order 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.
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 due to 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.

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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 that its effectiveness is regularly evaluated with respect to patient safety. Senior administrative nursing leaders, such as a Chief Nursing Officer, as 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. 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 the staff are competent, and that they have had adequate orientation, training, and education to perform their assigned direct care duties.
Safe Practice 11: Intensive Care Unit Care	All patients in general intensive care units (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 to 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.

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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 that 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 that there is confirmation of receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge.
Safe Practice 16: Safe Adoption of Computerized Prescriber Order Entry	Implement a computerized prescriber order entry (CPOE) system built upon the requisite foundation of re-engineered 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 Hand Hygiene Guidelines.
Safe Practice 20: Influenza Prevention	Comply with current Centers for Disease Control and Prevention (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.

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Safe Practice 22: Surgical-Site Infection Prevention	Take actions to prevent surgical-site infections by implementing evidence-based intervention practices.
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 Prevention	Implement a systematic multidrug-resistant organism (MDRO) eradication program built upon the fundamental elements of infection control, an evidence-based approach, assurance of the hospital staff and independent practitioner readiness, and a re-engineered identification and care process for those 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 Staphylococcus 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, Wrong-Procedure, Wrong-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.
Safe Practice 28: Venous Thromboembolism Prevention	Evaluate each patient upon admission, and regularly thereafter, for the risk of developing venous thromboembolism. Utilize clinically appropriate, evidence-based methods of thromboprophylaxis

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Safe Practice 29: Anticoagulation Therapy	Organizations should implement practices to prevent patient harm due to anticoagulant therapy.
Safe Practice 30: Contrast Media-Induced Renal Failure Prevention	Utilize validated protocols to evaluate patients who are at risk for contrast media-induced renal failure and gadolinium-associated nephrogenic systemic fibrosis, and utilize a clinically appropriate method for reducing the risk of adverse events based on the patient's risk evaluations.
Safe Practice 31: Organ Donation	Hospital policies that are consistent with applicable law and regulations should be in place and should 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 to reduce fall-related injuries by implementing evidence-based intervention practices.
Safe Practice 34: Pediatric Imaging	When CT imaging studies are undertaken on children, "child-size" techniques should be used to reduce unnecessary exposure to ionizing radiation.