

## **Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices.**

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Shekelle PG, Wachter RM, Pronovost PJ, et al. Making Health Care Safer II: An Updated Critical Analysis Of The Evidence For Patient Safety Practices.; 2013:Evid Rep Technol Assess (Full Rep).(211):1-945.  
<https://pubmed.ncbi.nlm.nih.gov/24423049/>.

<https://psnet.ahrq.gov/issue/making-health-care-safer-ii-updated-critical-analysis-evidence-patient-safety-practices>

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The seminal AHRQ [Making Health Care Safer](#) report, issued in 2001, used evidence-based medicine principles to identify key patient safety practices (PSPs). Although its recommendations were somewhat [controversial](#), the report galvanized patient safety efforts at hospitals nationwide and provided a stimulus for further rigorous research on PSPs. In doing so, the report laid the foundation for the most prominent [successes](#) of the safety field. This newly issued follow-up report combines traditional systematic review methodology with the judgments of key stakeholders and technical experts in the field. The authors critically examine the evidence supporting 41 separate PSPs and ultimately arrive at a list of 10 strongly encouraged practices. These practices, if implemented, should result in reduced harm from a wide range of safety threats, including [health care–associated infections](#), [medication errors](#), and pressure ulcers. The report also examines how cost, implementation, and [contextual](#) considerations may affect the real-world effectiveness of PSPs, details how foundational concepts such as [human factors engineering](#) should be incorporated into safety efforts, and provides a blueprint for future research in patient safety. Formal systematic reviews of 10 key PSPs are also being published simultaneously in a special [supplement](#) to the *Annals of Internal Medicine*.