ECRI Institute for Safe Medication Practices PSO

Top 10 Patient Safety Concerns for 2023

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Learning Objectives

- Describe how ECRI and the ISMP PSO use a learning system approach to create and disseminate the list of Top 10 Patient Safety Concerns.
- Discuss the impact of each of the ECRI Top 10 Patient Safety Concerns for 2023.
- Evaluate the role implicit bias plays in the Top 10 Patient Safety Concerns.
- Review how elements of a total systems approach to safety and recommendations for improvement can be used to address each of the concerns.

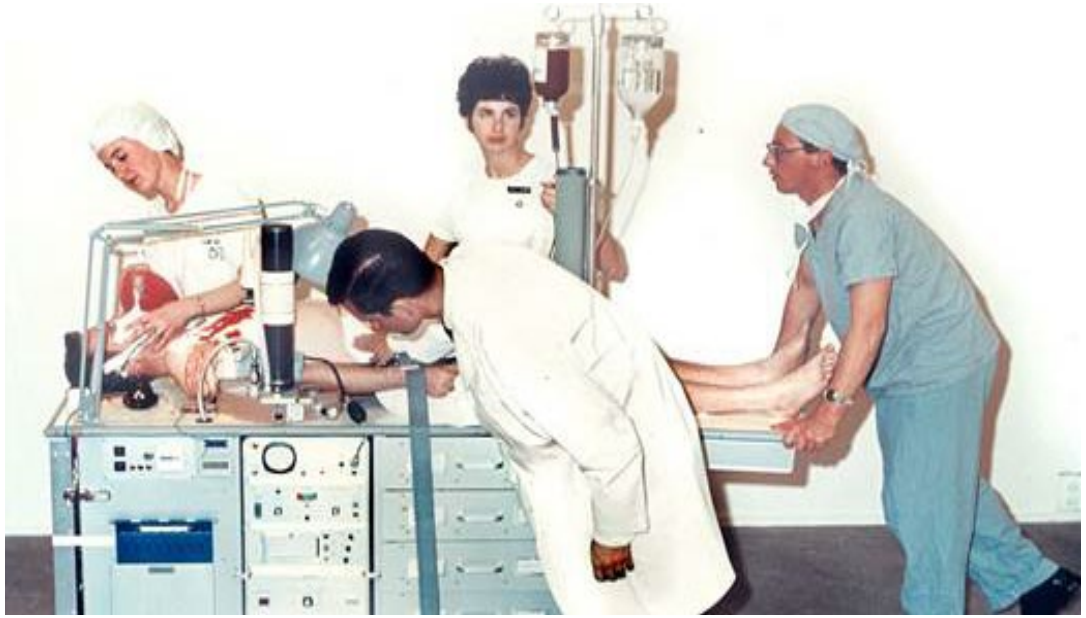
Disclaimer

Materials in this presentation are intended for educational purposes only and are not legal, medical, or business advice.

Consult legal counsel for advice specific to your organization.

How ECRI Started

A fiercely independent, nonprofit, mission focused organization committed to improving the safety, quality, and cost effectiveness of healthcare through evidence-based research and testing, benchmarking, and collaboration with the healthcare community



"Anger is a great source of energy. I focused it on improving technology and patient safety."

— Joel J. Nobel, MD, Founder of ECRI

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Our Focus & Impact | Evidence That Empowers.

We integrate evidence-based intelligence, comprehensive clinical data, supply chain solutions and independent testing to empower healthcare organizations to achieve improved outcomes

Evidence-Based Intelligence & Smart Analytics

1 of 9 federally designated Evidence-based Practice Centers by the U.S. AHRQ

Over 250 renowned Subject Matter Experts review more than 2,000 healthcare technologies, procedures, and care processes, representing 40% of all procedure types

We perform Horizon Scanning of new technologies for PCORI (U.S. government) and IHSI (a consortium of European governments)

We incorporate clinically-informed human factors engineers to improve clinical workflows, safety and devices

Comprehensive Clinical Data & Analysis

The largest Patient Safety reporting and learning system in North America

5.0+ Million Patient Safety events analyzed

Worldwide thought leader in Medication Safety through our ISMP affiliate

One of the nation's top expert Accident and Forensics Investigation & RCA teams

Leader in Infection Prevention and sterile processing

Independent Testing & Real Time Supply Chain Solutions

The only independent medical device testing laboratory in the U.S. which also incorporates human factors testing

The U.S.' largest GPO-agnostic Price Benchmarking Database covering over 30% of single use spend per year and 2/3's hospitals

Recall Software that delivers tens of thousands of daily notifications on harmful products

The only device functional equivalents service covering 80% of categories with a clinical basis (KPIs)

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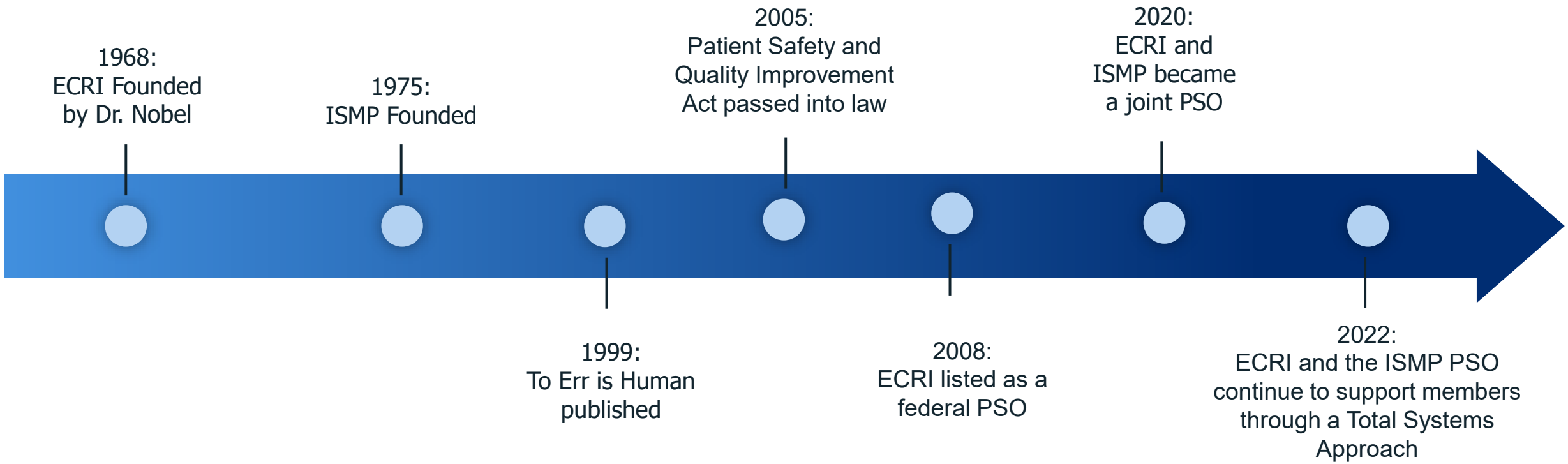
About ECRI and the Institute for Safe Medication Practices Patient Safety Organization

A component PSO of ECRI, steeped in history in advancing patient safety, and positioned to continue to fulfill its global mission.



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Serving our PSO Members

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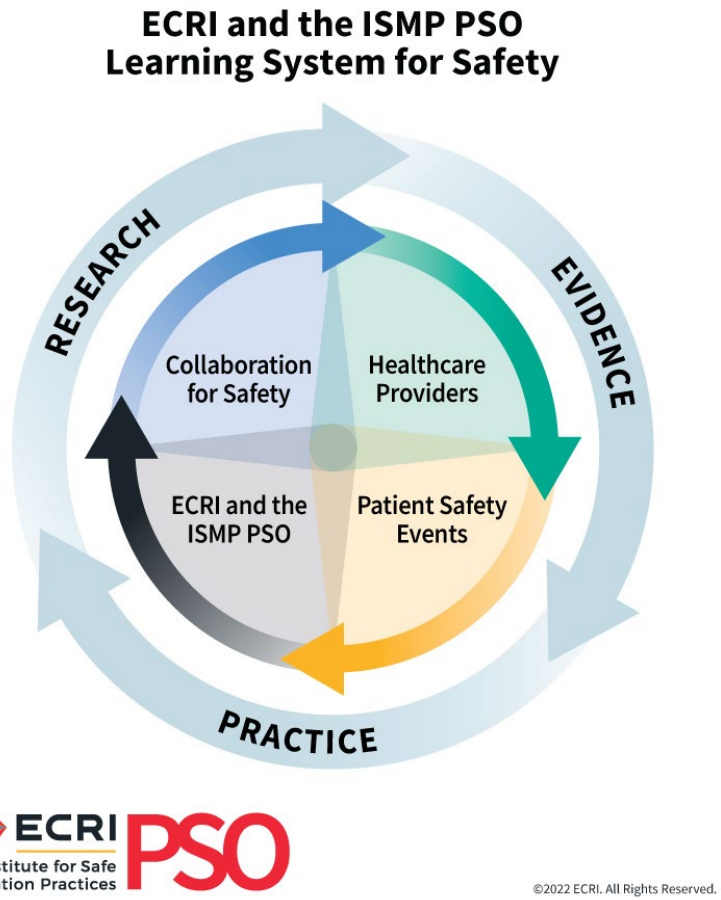
Patient Safety Work Product
Confidential

PSO as a Learning System for Safety

- Patient Safety Event Data
- Root Cause Analysis Findings
- Institute for Safe Medication Practice Error Reports
- Culture of Safety Assessments
- Safe Table Discussion
- Collaborative Learning



How We Selected the Top 10

- Multidisciplinary personnel throughout ECRI and our affiliate, ISMP, proposed topics, supporting each topic with:
  - Scientific literature
  - Trends in event reports, root cause analyses, and research requests submitted to ECRI and the ISMP PSO
  - Medical device alerts, problem reporting, and evaluation
  - Reported medication safety problems
  - Accident investigations
  - Lessons learned from consultation work
  - Other internal and external data sources

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Selection Criteria

An interdisciplinary team analyzed the supporting evidence and evaluated each topic using the following criteria:

- **Severity.** How serious would the harm to patients be if this safety concern were to occur?
- **Frequency.** How likely is it that the safety concern will occur?
- **Breadth.** If the safety concern were to occur, how many patients would it affect?
- **Insidiousness.** Is the problem difficult to recognize or challenging to rectify if it occurs?
- **Profile.** Would the safety concern place a lot of pressure on the organization?

Based on these criteria, the interdisciplinary team chose and ranked the Top 10 patient safety concerns.

The Top 10 Report: Grounded in Total Systems Safety

Adapted from: NSC

This Top 10 report:

- Supports advancement of safety through four foundational areas:
  1. Developing cultures, leadership, and governance that reflect a deep commitment to safety
  2. Engaging patients and families as partners in designing and producing care
  3. Fostering a healthy, safe, and resilient environment for the workforce
  4. Supporting continuous and shared lessons learned to improve safety and quality of care and reduce the risk of harm

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Target Your Focus: Top 10 Patient Safety Concerns

- Step 1: Score the top concerns for your organization

Add header

ECRI's Top 10 Patient Safety Concerns Scorecard: 2023

Patient Safety Concern	Risk Score			Gap Analysis		Priority (High, Medium, Low)	Actions Required	Assigned to	Deadline
	Patient Harm 1 to 10 (Lowest to Highest)	Likelihood 1 to 10 (Lowest to Highest)	Risk Score (Harm × Likelihood)	Optimal Approach	Current Practice				
EXAMPLE: Patient Safety Concern X	7	9	63	Use this section to describe best practices. For suggestions, start with ECRI's Top 10 report.	Use this section to describe your organization's current practices.	Use the drop-down list to indicate your organization's priority level for this particular patient safety concern.	List your organization's actions to improve its approach to this particular patient safety concern.	Identify the individuals responsible for the improvement initiative.	Assign a date for completing the required actions.
1. The pediatric mental health crisis									
2. Physical and verbal violence against healthcare staff									
3. Clinician needs in times of uncertainty surrounding maternal-fetal medicine									
4. Impact on clinicians expected									

- Step 2: Prioritize your action planning

FACES Tool

	Low		Medium	High	
Criteria:	1	2	3	4	5
Feasibility: Can the change be implemented relatively easily or quickly?					
Acceptability: Will those being impacted by the intervention readily accept the change?					
Cost/Benefit: Does the benefit of the intervention outweigh the costs?					
Effectiveness: How effective will the invention be at eliminating the problem or reduces its consequences?					
Sustainability: How well will the intervention last over time?					

Source: Wiegmann, D. A., Wood, L. J., Solomon, D. B., & Shappell, S. A. (2021).

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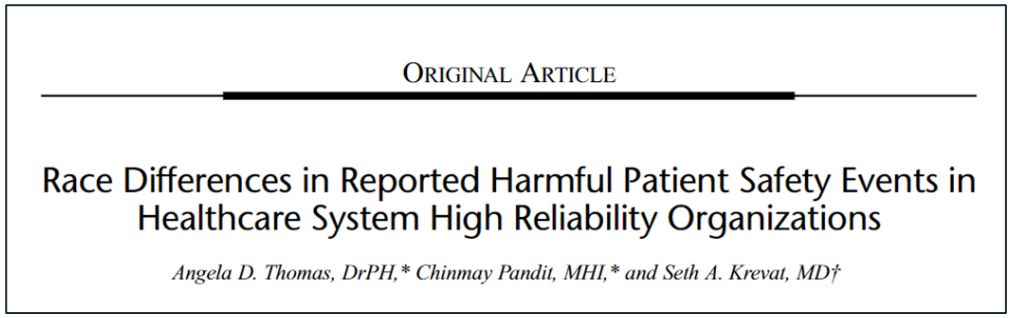
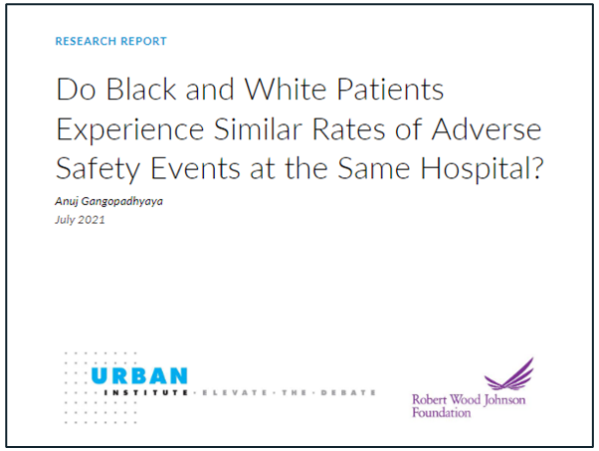
Advancing Health Equity

- **Bias**: unreasoned distortion of judgment in favor of or against a person or group
- **Explicit Bias:** expressed bias in which the person is aware of their prejudices and attitudes towards certain groups
- **Implicit Bias**: form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behavior


ORIGINAL ARTICLE

Race Differences in Reported Harmful Patient Safety Events in Healthcare System High Reliability Organizations

Angela D. Thomas, DrPH, Chinmay Pandit, MHI,* and Seth A. Krevat, MD†*


RESEARCH REPORT

Do Black and White Patients Experience Similar Rates of Adverse Safety Events at the Same Hospital?

Anuj Gangopadhyaya

July 2021

URBAN INSTITUTE · ELEVATE · THE · DEBATE

Robert Wood Johnson Foundation


ORIGINAL RESEARCH

Inpatient patient safety events in vulnerable populations: a retrospective cohort study

Lucy B Schulson [1,2] Victor Novack,[3,4] Patricia H Folcarelli,[5,6] Jennifer P Stevens,[3,7] Bruce E Landon[3,6,8]

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The List

Top 10 Patient Safety Concerns 2023

1. The pediatric mental health crisis
2. Physical and verbal violence against healthcare staff
3. Clinician needs in times of uncertainty surrounding maternal-fetal medicine
4. Impact on clinicians expected to work outside their scope of practice and competencies
5. Delayed identification and treatment of sepsis
6. Consequences of poor care coordination for patients with complex medical conditions
7. Risks of not looking beyond the “five rights” to achieve medication safety
8. Medication errors resulting from inaccurate patient medication lists
9. Accidental administration of neuromuscular blocking agents
10. Preventable harm due to omitted care or treatment

The Pediatric Mental Health Crisis

Concern #1

The Pediatric Mental Health Crisis

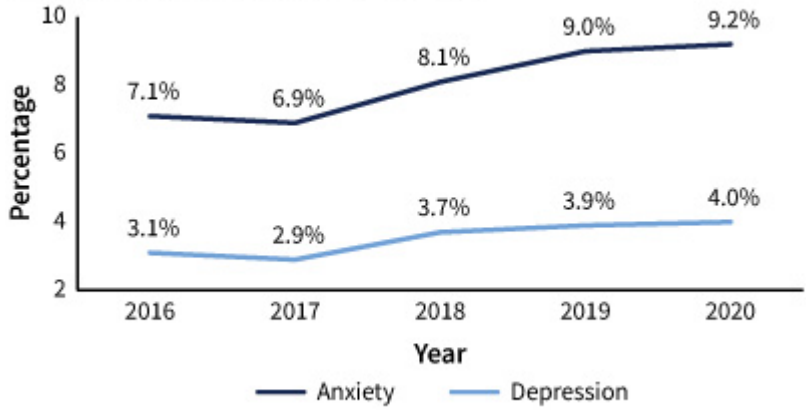
Concern for pediatric mental health was already high during the 2010s due to the growing use of social media, limited access to pediatric behavioral health providers, drug and alcohol use, gun violence, and socioeconomic impact, among other stressors.

Source: Office of the Surgeon General

However, pediatric mental health issues have been exacerbated by the COVID-19 pandemic, with a **29% increase in children age 3 to 17 experiencing anxiety** and a **27% increase in depression** in 2020 compared with 2016.

Sources: AAP; Lebrun-Harris et al.

Figure. Percentage of Children Age 3–17 Years Experiencing Anxiety and Depression, 2016–2020



Source: Lebrun-Harris et al.

The increase in children experiencing extreme anxiety and depression has led to an increase in suicidal ideation, with **more young people age 12 to 25 years presenting to the emergency department (ED) for suspected suicide attempts**. Although adolescent suicide attempts had decreased during spring 2020, **the mean weekly number of ED visits for suspected suicide attempts among those age 12 to 17 was 22% higher in summer 2020 and 39% higher during winter 2021 compared with the corresponding periods in 2019**.

Source: CDC

The Pediatric Mental Health Crisis

Hospital Physician practice

Culture, Leadership, and Governance

- Secure leadership support and resources to evaluate the organization's **pediatric behavioral health services.**
- Form a strategic team of leaders and frontline staff to evaluate the facility's **current strengths and gaps** in meeting pediatric patients' behavioral health needs.

Patient and Family Engagement

- Implement **universal screening** for depression, anxiety, abuse, substance use, and suicidal ideation for pediatric patients during every office and hospital visit.
- Refer patients using **warm handoffs** to pediatric behavioral health services for a complete assessment if concerns are identified during the screening.

Workforce Safety

- Support healthcare workers who may be impacted by caring for **increasing numbers** of pediatric patients who present with mental health concerns and suicidal ideations.
- Form a **behavioral emergency response team**.

Learning System

- **Train staff** on the urgency of this mental health crisis, its pervasive effects, warning signs, and potential long-term health consequences.
- Create an **interdisciplinary mental health team** to evaluate relevant policies and procedures. Verify that treatment protocols reflect evidence-informed practices and provide organizational training on how to implement and monitor outcomes for a trauma-informed approach to care.

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Sources: AAP; Children's Hospital Colorado; Forkey et al.; Office of the Surgeon General; SAMHSA

Physical and Verbal Violence against Healthcare Staff

Concern #2

Physical and Verbal Violence against Healthcare Staff

Violence directed toward healthcare staff may come from other staff members (disruptive providers, bullying) or from patients or family members. **Any violence toward staff is unacceptable.**

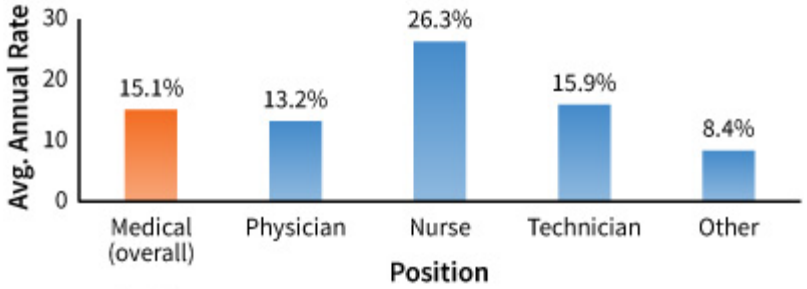
Source: BLS

Data reporting is limited and inconsistent. In addition, **many health professionals appear to accept** that a certain amount of violence directed toward them is an **expected part of the job**, thus normalizing the abnormal.

Source: Joint Commission

Healthcare workers suffer from more workplace violence than any other professionals except law enforcement and security personnel and mental health workers.

Figure. Average Annual Rate of Nonfatal Medical Workplace Violence per 1,000 Workers, Age 16 or Older, 2015 to 2019



Source: BJS/ BLS/NIOSH

In January 2022, Joint Commission **accreditation standards began requiring leadership to develop and enforce a workplace violence prevention program**. Joint Commission also states that effective workplace violence programs encourage reporting incidences of threatening language and verbal abuse in addition to physical abuse.

Source: Joint Commission

Physical and Verbal Violence against Healthcare Staff

Culture, Leadership, and Governance

- Charge organizational leaders with **assessing the risk of workplace violence** and providing resources (e.g., time, staffing, training) to reduce such events.
- Formalize a **workplace violence program** utilizing an oversight committee that monitors related **metrics**.
- Establish a **zero-tolerance policy** that extends to all who come into contact with organizational personnel.
- Set an organizational tone that any violence against healthcare workers is **unacceptable**.

Patient and Family Engagement

- Set realistic expectations by clearly communicating patient and visitor **codes of conduct**.
- **Educate patients, families, and the community** about the impact of workplace violence.

Workforce Safety

- Utilize a behavioral emergency response team of trained individuals; **ensure that employees know when and how to activate this team**.

Learning System

- **Review reported incidents** and create improvement plans to address identified system failures.
- Offer training for **prevention, early recognition, management, and de-escalation** of violent situations through simulation drills involving various violent scenarios.

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Sources: AHA/IAHSS; AMA; ANA; CMS; ECRI; Joint Commission; OSHA "Workplace"

Clinician Needs in Times of Uncertainty Surrounding Maternal-Fetal Medicine

Concern #3

Clinician Needs in Times of Uncertainty Surrounding Maternal-Fetal Medicine

Uncertainty has now arisen in many states regarding which reproductive services may be provided and when. This uncertainty can lead to **refusals of or delays in care** that ultimately may not be considered to violate the law.

Although some states with abortion bans allow abortions to save the life of or prevent harm to the pregnant patient, there is often **little guidance on where the line is**. If clinicians wait too long, patients may suffer serious harm.

Sources: AMA et al.; Coleman-Lochner et al.; ASRM

Cross-border care complicates matters, particularly given state variability (see "Table. Restrictiveness of State Abortion Laws"). Concerns may relate to nonresident patients, prescribing across state lines and via telehealth, and provision of assistance or funds (e.g., travel reimbursement).

Source: Sneed

Table. Restrictiveness of State Abortion Laws

State generally prohibits abortion	AL, AR, ID, KY, LA, MO, MS, OK, SD, TN, TX, WV
State has expressed desire to prohibit abortion	AZ, GA, IA, IN, NC, ND, NE, OH, PA, UT, WI, WY
State law does not provide right to abortion	NH, NM, VA
State provides right to abortion, with access limitations	AK, CO, DC, DE, FL, KS, MA, MD, ME, MI, MT, NV, RI, SC
State provides right to abortion and expanded access	CA, CT, HI, IL, MN, NJ, NY, OR, VT, WA

Source: Center for Reproductive Rights (as of February 2, 2023)

Legal uncertainty has **affected nonreproductive services** as well. For example, some patients have experienced delays getting methotrexate for other conditions (e.g., arthritis). Similar concerns may arise with chemotherapy.

Sources: AMA et al.; Coleman-Lochner et al.

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Clinician Needs in Times of Uncertainty Surrounding Maternal-Fetal Medicine

Culture, Leadership, and Governance

- **Convene leaders and clinical councils** to review all maternal-fetal care processes that may be impacted by changes in state law.
- Leaders should engage **in two-way communication channels to hear safety concerns** from frontline staff and to share guidance for the clinical care of patients, e.g., tiered safety huddles.

Patient and Family Engagement

- Monitor sources **of patient safety event and patient experience** data to assess for inequities and disparities in care related to maternal-fetal care.
- **Create patient education materials** to be shared with all frontline staff, including support and administrative staff that encounter patients seeking maternal-fetal services impacted by state laws.

Workforce Safety

- Ensure clinicians have **guidance to mitigate challenging situations** that could lead to potential conflicts including Emergency Medical Treatment and Labor Act requirements.

Learning System

- Track, analyze, and share lessons learned from all **instances of harm that result from delays or missed diagnostic opportunities** related to the care of patients seeking treatment for maternal-fetal issues.
- Leverage health systems, PSOs, and other professional organizations that span across states to **create learning networks that guide healthcare organizations and clinicians** away from fragmentation of care and promote a collective mental model for providing safe care.

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Impact on Clinicians Expected to Work Outside Their Scope of Practice and Competencies

Concern #4

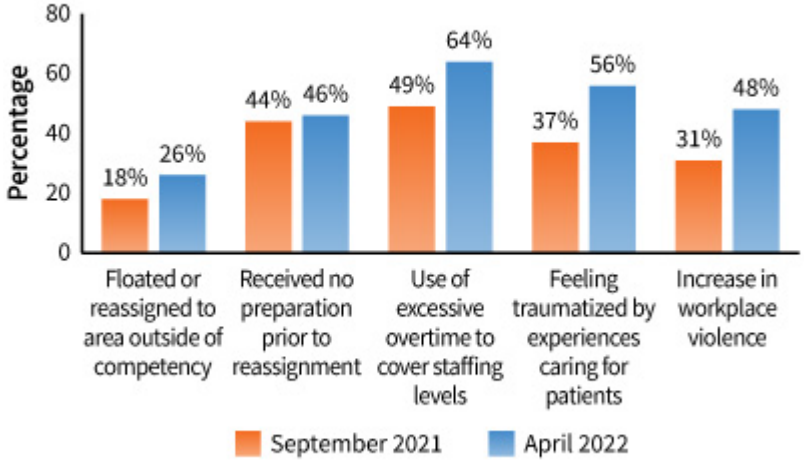
Impact on Clinicians Expected to Work Outside Their Scope of Practice and Competencies

Healthcare organizations have a legal and ethical duty to ensure clinical staff **perform within their scope of practice and verified competencies**. When they do not, patients, staff, and the organization face significantly increased risk of harm and liability.

Many healthcare workers are still **asked to step outside these boundaries**, especially during public health emergencies and other societal circumstances such as staff shortages and turnover, increased patient volume, supply chain disruption, and rural facility closings.

A 2022 national survey of registered nurses found that **26% reported being floated or reassigned** to a clinical area outside their competency or that required new skills, and **46% reported not receiving any preparation** before reassignment.

Figure. Reported Resident Nurse Challenges Related to Preparation and Safety



Source: National Nurses United

Education and training of healthcare workers in patient and worker safety has been an **underused and undervalued tool** as most medical education programs lack an emphasis on safety as a core component of care delivery.

Source: WHO

Impact on Clinicians Expected to Work Outside Their Scope of Practice and Competencies

Culture, Leadership, and Governance

- Implement targeted patient and worker safety **improvement initiatives** regarding clinical best practices.

Patient and Family Engagement

- Utilize patient and family advisory councils to **solicit feedback regarding how care is provided**. Examine trends to identify competency gaps.

Workforce Safety

- **Empower staff to report concerns** that may place themselves, their coworkers, or patients at risk, including their objection to reassignment, performing tasks outside their scope of practice, or their need for additional training.

Learning System

- Use a **clinically informed human factor engineering approach**, including usability assessments, to identify high-risk processes that require focused competency training.

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Delayed Identification and Treatment of Sepsis

Concern #5

Delayed Identification and Treatment of Sepsis

Each year, at least **1.7 million adult Americans develop sepsis and approximately 30% do not survive**, making it the **leading cause of death in U.S. hospitals**.

Sources: CDC; Sepsis Alliance "What"

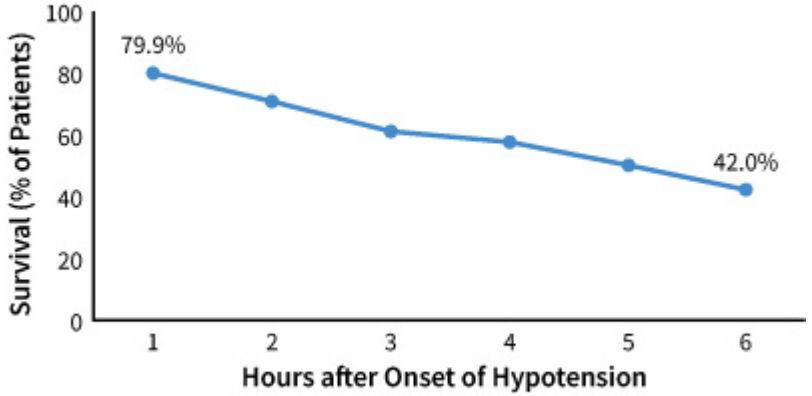
Rapid identification and treatment are vital. **Intravenous antimicrobials should be administered immediately**—ideally within an hour of recognition—for patients with shock and possible sepsis and for patients with a high likelihood of sepsis (including those without shock). Antimicrobials should be administered within three hours for patients with possible sepsis without shock.

However, rapid treatment should be weighed against potential harm associated with administering unnecessary antimicrobials. The administration of appropriate, narrow-spectrum antibiotics demands that a pathogen detection test be extremely sensitive with a high negative predictive value.

Sources: Evans et al.; He et al.

Starting antimicrobials within the first hour of recognizing septic shock is associated with a **79.9% survival rate**. Over the first six hours, survival decreases by **7.6 percentage points**, on average, for each hour that antimicrobials are delayed.

Figure. Decreasing Sepsis Survival with Delay in Antimicrobial Initiation



Source: Kumar et al.

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Delayed Identification and Treatment of Sepsis

Culture, Leadership, and Governance

- Implement clinically informed human factor engineering principles to **understand the usability of sepsis prevention, diagnostic, and treatment equipment and technology**.

Patient and Family Engagement

- Educate patients and family members in all settings and in a variety of circumstances (e.g., on admission, at clinic appointments, during bedside rounds, at discharge) **about infection prevention and control, sepsis warning signs, and steps to take if such signs occur**.

Workforce Safety

- Utilize **daily safety huddles to provide real-time notifications to staff of recalls and hazards** that can increase the risk of infection and sepsis.

Learning System

- Enlist clinical leaders, clinical councils, and individuals with sepsis expertise in informing sepsis event investigations. **The findings and action plans should be shared** across the organization.

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Consequences of Poor Care Coordination for Patients with Complex Medical Conditions

Concern #6

Consequences of Poor Care Coordination for Patients with Complex Medical Conditions

In the United States, **6 in 10 adults have one chronic disease**, and **4 in 10 have two or more**. This prevalence also increases by age as senior housing and nursing home residents average more than 12 chronic conditions.

Sources: NCCDPHP "Chronic"; NORC

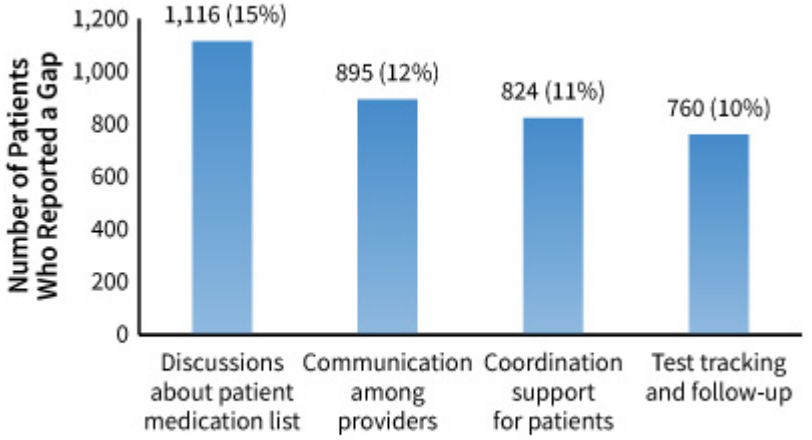
Because chronic conditions affect more than 50% of the population, management of chronic conditions costs nearly **$3.69 trillion per year** in the U.S., accounting for 90% of total healthcare expenditures.

Source: NCCDPHP "Health"

Patients with complex needs—such as those with multiple chronic conditions—are prone to care fragmentation, higher healthcare utilization and costs, and **worse health outcomes** than other patients.

In a recent survey of 7,568 patients, nearly 40% (2,884) reported at least one gap in care coordination and nearly 10% reported at least one preventable outcome such as repeat tests, medication interactions, and ED visits or hospital admissions.

Figure. Patient-Reported Gaps in Care Coordination



Source: Kern et al.

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Consequences of Poor Care Coordination for Patients with Complex Medical Conditions

Culture, Leadership, and Governance

- Establish **multidisciplinary care coordination teams** of providers, nurses, pharmacists, social workers, and community health workers.

Patient and Family Engagement

- Improve **culturally and linguistically competent care** by providing interpreters and translated patient education and decision-making materials when appropriate.

Workforce Safety

- Ensure staff are equipped to **address and de-escalate frustrated patients and/ or family members**. Provide safety mechanisms for backup when needed.

Learning System

- Consistently **improve causal analysis** of coordination- and communication related adverse events to optimize results, action plan quality, and implementation efficiency.

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Risks of Not Looking beyond the "Five Rights" to Achieve Medication Safety

Concern #7

Risks of Not Looking beyond the "Five Rights" to Achieve Medication Safety

The five “rights”—right patient, drug, dose, route, and time—have been held up as the standard for prevention of medication errors. They are emphasized in nursing education and in practice.

Strict adherence to the five rights falsely implies that medication errors will be prevented. However, **the five rights should be viewed as foundational goals or as a medication safety framework**—not as strategies to achieve medication safety.

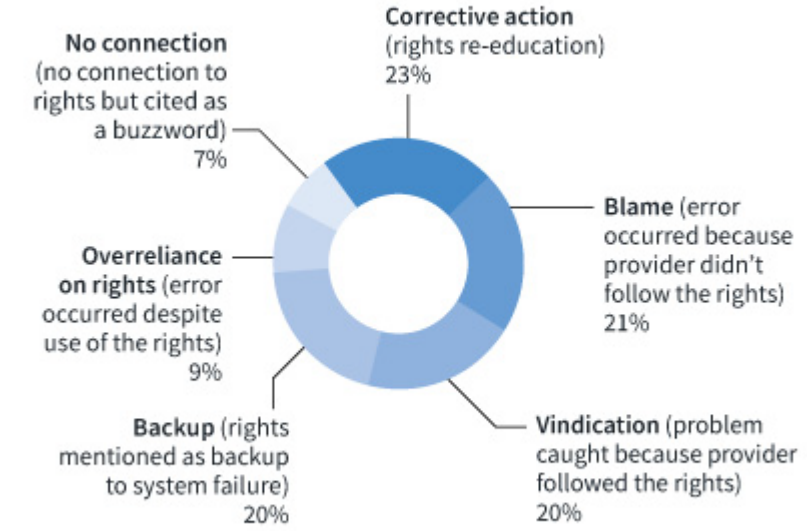
Nurses and other practitioners cannot be held solely accountable for adhering to the rights; they can be held accountable only for following their organizations’ medication safety procedures.

Source: ISMP

Failure to back up the five rights with high-leverage strategies and actionable procedures—or to identify which system processes failed when medication errors occur—undercuts medication safety.

A search of ECRI and the ISMP PSO’s database returned 81 events submitted between January 1, 2021, and October 7, 2022, that referenced the five rights, which were grouped into the following categories:

Figure. Categories of Reported Events Referencing the Five Rights



Source: ECRI and ISMP PSO

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Risks of Not Looking beyond the "Five Rights" to Achieve Medication Safety

Culture, Leadership, and Governance

- Recognize the **limitations of the five rights** and how emphasizing clearly defined procedures over goals can improve patient safety.

Patient and Family Engagement

- Promote patient and family involvement in their care across all healthcare settings. Active, involved, and aware **patients are a valuable resource for identifying errors**.

Workforce Safety

- Avoid misusing the five rights to **blame or punish individual staff** involved in medication errors. Instead, focus on evaluating and improving procedures to advance medication safety for all staff and patients.

Learning System

- Utilize errors as opportunities to **identify system process weaknesses** and specific strategies for building safer work environments for patients and caregivers.

Medication Errors Resulting from Inaccurate Patient Medication Lists

Concern #8

Medication Errors Resulting from Inaccurate Patient Medication Lists

Inconsistent knowledge and record keeping about medications cause up to **50% of medication errors in hospitals and up to 20% of adverse drug events**. At least one in six patients may have a clinically significant medication discrepancy on intrahospital transfers.

Sources: IHI; Duguid

Medication reconciliation errors at hospital admission are noted in 36% of patients and occur mostly during the medication history gathering phase.

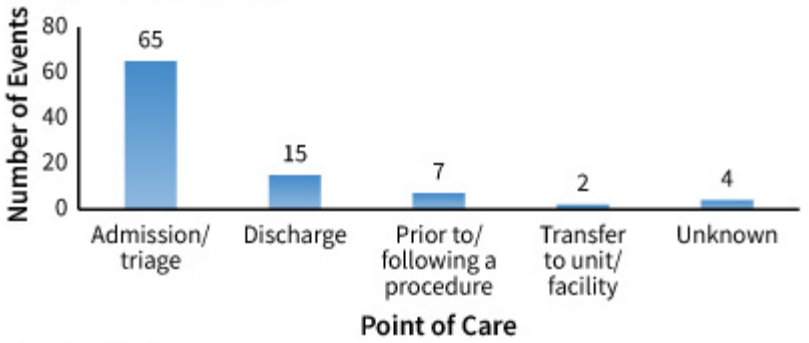
Source: AHRQ

Discrepancies also occur at discharge and may cause problems in general practice. Up to **91% of medication reconciliation errors are clinically significant** and 1% to 2% are serious or potentially life-threatening.

Source: Harper et al.

The following 5.5-year study of care **transitions revealed 93 serious events related** to medication reconciliation.

Figure. Transitions of Care Associated with Medication Reconciliation Errors



Source: Harper et al.

Multidisciplinary medication reconciliation teams should review current processes, identify gaps and opportunities for improvement, and lead process design and redesign within the healthcare facility or practice.

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Medication Errors Resulting from Inaccurate Patient Medication Lists

Culture, Leadership, and Governance

- Identify and address **organizational factors** that contribute to rushed or inaccurate medication histories, such as shortened appointment times and incomplete medication lists.

Patient and Family Engagement

- Engage patients when prescribing new medication and prior to medication administration to reinforce the importance of **maintaining a current medication list** and bringing it to every healthcare encounter.

Workforce Safety

- Nurture a culture of **high reliability**, where staff are sensitive to operations and feel safe to report system issues that can lead to medication reconciliation errors.

Learning System

- Develop a **flowchart of current processes** to highlight unnecessary steps, define roles and responsibilities, and provide information to standardize processes and target improvements.

Accidental Administration of Neuromuscular Blocking Agents

Concern #9

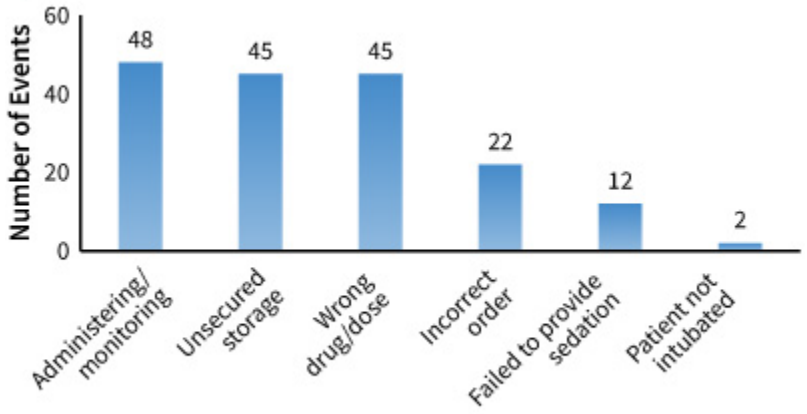
Accidental Administration of Neuromuscular Blocking Agents

Hospital Ambulatory surgery

Neuromuscular blocking agents (NMBs)—which paralyze skeletal muscles during mechanical ventilation—are high-alert medications because of their well-documented history of causing catastrophic injuries or death when used in error.

ECRI and the ISMP PSO analyzed 261 events related to NMBs. Of these, 174 events demonstrated that errors with these medications can cause harmful events during all nodes of the medication use process.

Figure. Errors Involved in NMB-Related Events



Source: ECRI and the ISMP PSO

A separate 2009 analysis of 154 events over a five-year period showed that a **NMB was not the intended drug in approximately half of all wrong-drug errors**.

Source: PA PSA

ISMP has received **well over one hundred reports concerning accidental NMB administration since 1996**. Most NMB errors resulted from administering or compounding a NMB instead of the intended drug.

Administering a NMB to a patient who does not have ventilator support is deadly. Even when the error is caught quickly, nonventilator-assisted patients can suffer **severe psychological trauma** recalling the feeling of not being able to breathe.

Source: ISMP "Paralyzed"

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Accidental Administration of Neuromuscular Blocking Agents

Hospital Ambulatory surgery

Culture, Leadership, and Governance

- Institute policies that:
  - Eliminate the **storage of NMBs** where they are not routinely needed.
  - Place NMBs in a **sealed box or rapid sequence intubation kit** in areas where NMBs are needed (e.g., ICU).
  - **Limit availability** in automated dispensing cabinets to perioperative, labor and delivery, critical care, and ED settings.

Patient and Family Engagement

- Design a **communication, disclosure, and optimal resolution** process to engage patients and families when a medication error occurs.

Workforce Safety

- Assess clinical workflows to **identify latent and active failures** that may contribute to unsafe working environments that lead to increased risk of staff committing medication errors.

Learning System

- Review and incorporate strategies from organizations such as ISMP and the Joint Commission **into high-alert medication safety protocols.**

Preventable Harm Due to Omitted Care or Treatment

Concern #10

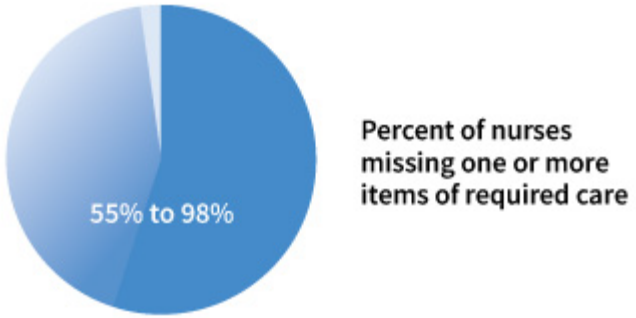
Preventable Harm Due to Omitted Care or Treatment

Missed care opportunities—instances where care deemed necessary as a course of treatment is delayed, partially completed, or skipped entirely—have become more common in healthcare, both in the United States and internationally.

Source: AHRQ

Missed care opportunities can occur across the healthcare spectrum in a variety of specialties (e.g., radiology, physical therapy, dietary, respiratory therapy) and in a variety of settings (e.g., acute care, outpatient).

Figure. Nurse Reports of Missing Items of Required Care



Source: Jones et al.

Source: Kukielka

In an analysis of 1,064 **adverse events related to staffing shortages** reported from January 2020 to February 2022, ECRI and the ISMP PSO found that **49% (526) occurred in the treatment category** (e.g., daily care, coordination of care, medication administration).

Source: ECRI and the ISMP PSO

Consequences of missed care include delayed or omitted medications or treatments, complications (e.g., pressure injuries, falls, ventilator-associated pneumonia), increased length of stay, decreased employee satisfaction, and decreased patient satisfaction.

Sources: AHRQ; Jones et al.

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Preventable Harm Due to Omitted Care or Treatment

Culture, Leadership, and Governance

- Consider **creative staffing strategies** to mitigate the risk of missed care opportunities (e.g., hiring a full-time ambulation specialist will alleviate the burden on nurses to turn patients).

Patient and Family Engagement

- Conduct **purposeful rounding** and bed shift reports to involve patients, families, and caregivers in plans of care.

Workforce Safety

- Address any environmental safety issues, including medical equipment needs, during **daily tiered huddles**.

Learning System

- Conduct **RCAs on all serious safety events** related to missed care opportunities.

Summary

- ECRI and the ISMP PSO uses a learning system approach to create and disseminate the list of Top 10 Patient Safety Concerns.
- Outlined the impact of each of the ECRI Top 10 Patient Safety Concerns for 2023.
- Discussed how to understand the role implicit bias plays in the Top 10 Patient Safety Concerns.
- Reviewed how elements of a total systems approach to safety and recommendations for improvement can be used to address each of the concerns

Next Steps

- Step 1: Score the top concerns for your organization

Add header

ECRI's Top 10 Patient Safety Concerns Scorecard: 2023

Patient Safety Concern	Risk Score			Gap Analysis		Priority (High, Medium, Low)	Actions Required	Assigned to	Deadline
	Patient Harm 1 to 10 (Lowest to Highest)	Likelihood 1 to 10 (Lowest to Highest)	Risk Score (Harm × Likelihood)	Optimal Approach	Current Practice				
EXAMPLE: Patient Safety Concern X	7	9	63	Use this section to describe best practices. For suggestions, start with ECRI's Top 10 report.	Use this section to describe your organization's current practices.	Use the drop-down list to indicate your organization's priority level for this particular patient safety concern.	List your organization's actions to improve its approach to this particular patient safety concern.	Identify the individuals responsible for the improvement initiative.	Assign a date for completing the required actions.
1. The pediatric mental health crisis									
2. Physical and verbal violence against healthcare staff									
3. Clinician needs in times of uncertainty surrounding maternal-fetal medicine									
4. Impact on clinicians expected									

- Step 2: Prioritize your action planning

FACES Tool

	Low		Medium	High	
Criteria:	1	2	3	4	5
Feasibility: Can the change be implemented relatively easily or quickly?					
Acceptability: Will those being impacted by the intervention readily accept the change?					
Cost/Benefit: Does the benefit of the intervention outweigh the costs?					
Effectiveness: How effective will the invention be at eliminating the problem or reduces its consequences?					
Sustainability: How well will the intervention last over time?					

Source: Wiegmann, D. A., Wood, L. J., Solomon, D. B., & Shappell, S. A. (2021).

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Accessing the Report

Accessing the Report

- Members: Log in at ecri.org to access the full report
- Nonmembers: Register at https://www.ecri.org/components/HRC/Pages/2023Top10.aspx to access the full report

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Thank You

Learn more about how we can support your total systems approach to safety at ecri.org/pso