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Addressing Top Risk Management and Patient Safety Challenges for Ambulatory Care Settings

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About ECRI

- Independent, nonprofit organization improving the safety, quality, and cost-effectiveness of care across all healthcare settings and the trusted expert for healthcare leaders and agencies worldwide. https://www.ecri.org/
- AHRQ Evidence-Based Practice Center https://www.ecri.org/solutions/evidence-based-medicine/
- Federally designated Patient Safety Organization https://www.ecri.org/solutions/patient-safety-organization/
- The Institute for Safe Medication Practices (ISMP) is an ECRI affiliate https://www.ismp.org/
- For assistance with ECRI resources:
  - clientservices@ecri.org
    (610) 825-6000 ext. 5891
  - Health System Risk Management
    healthsystemrm@ecri.org

Learning Objectives

1. Identify top organizational, patient safety, and malpractice risks in ambulatory care settings
2. Explore the relationship between risk management, patient safety, quality improvement, and compliance activities
3. Evaluate how a strong culture of safety can mitigate malpractice risk
4. Understand the importance of addressing health disparities and improving patient engagement to support patient safety and reduce risk
5. Learn systems-based strategies to improve risk management processes in ambulatory care settings

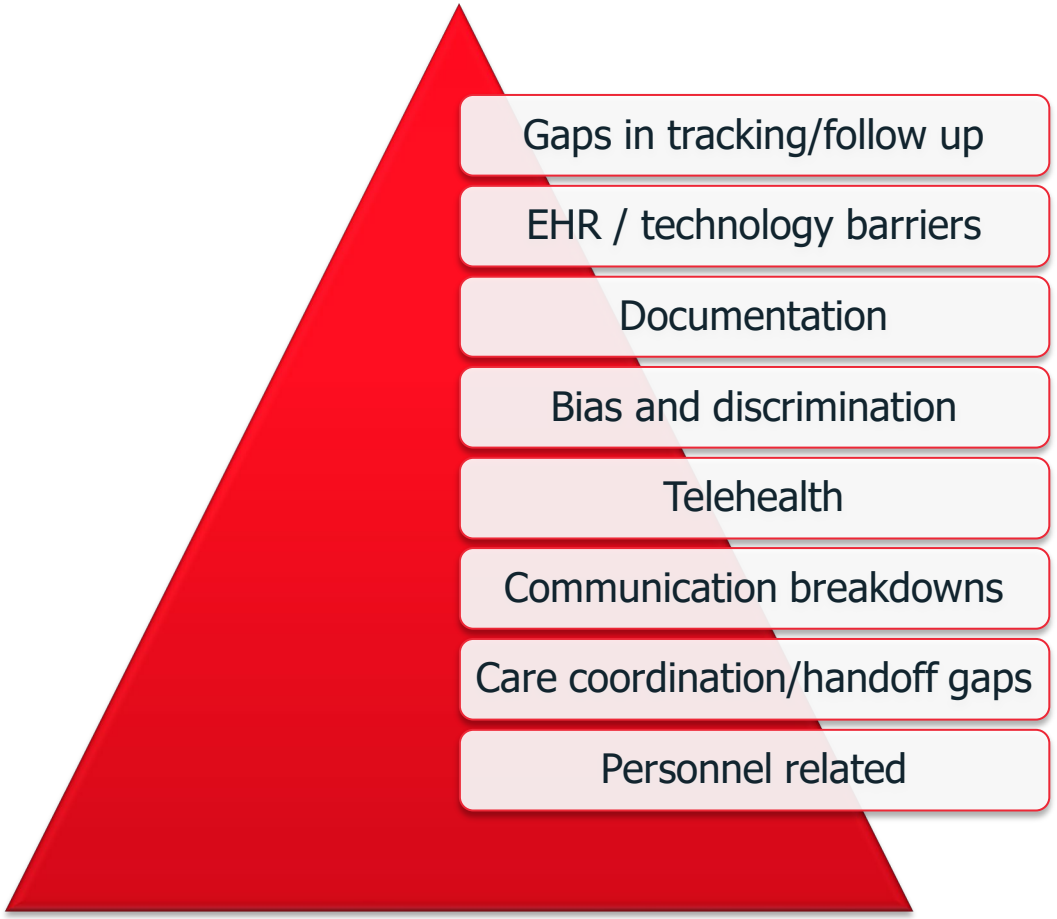
1. Identify top organizational, patient safety, and malpractice risks in ambulatory care settings

Patient Safety Events/Malpractice Claims - All Healthcare Settings

Top Allegations

Diagnostic error
Treatment error/failure/omission
Medication errors
Surgical/procedural error
Failure to monitor/failure to rescue
Inadequate informed consent
Falls
Medical device-related
Infection-related

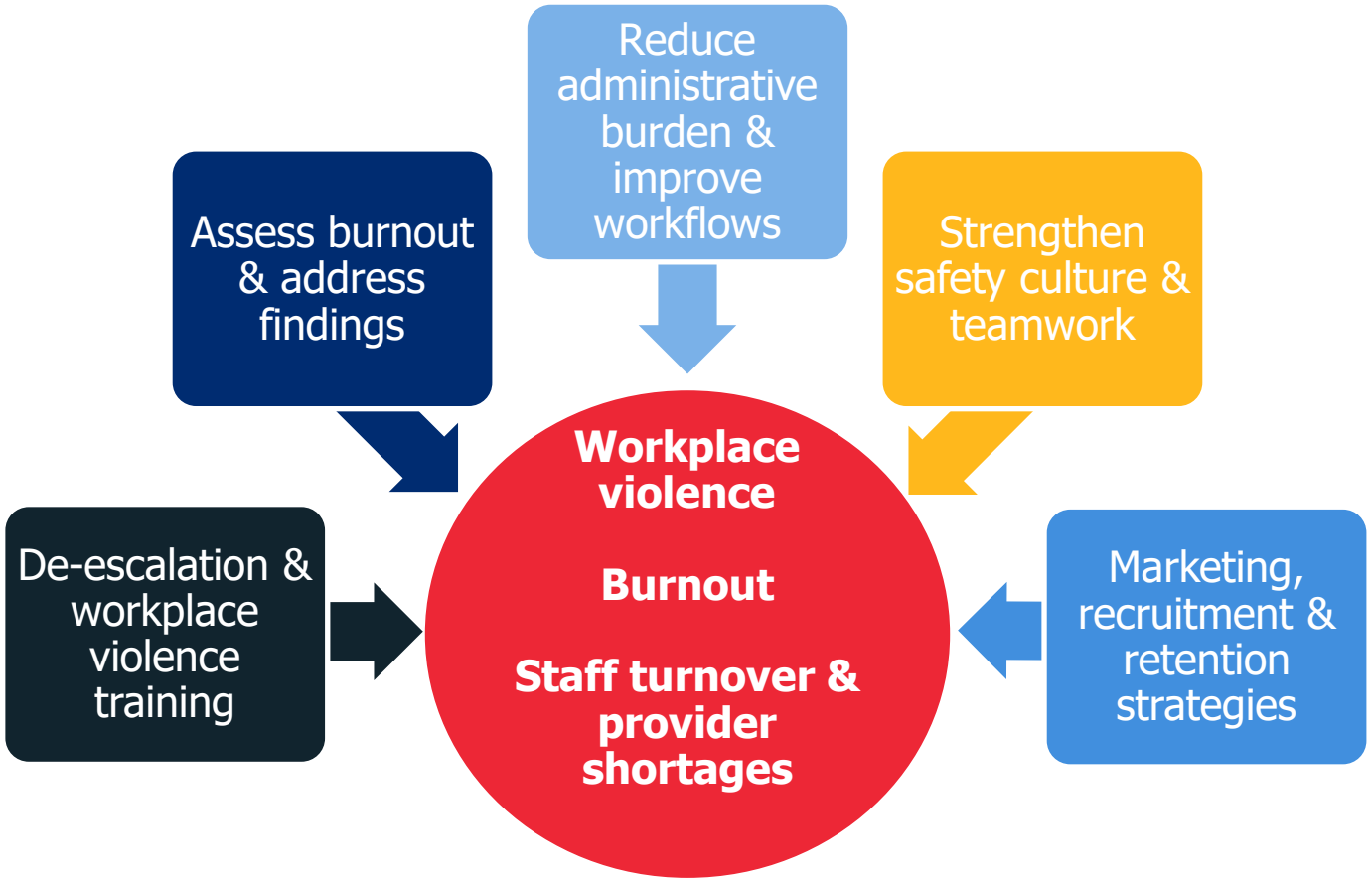
Contributing Factors



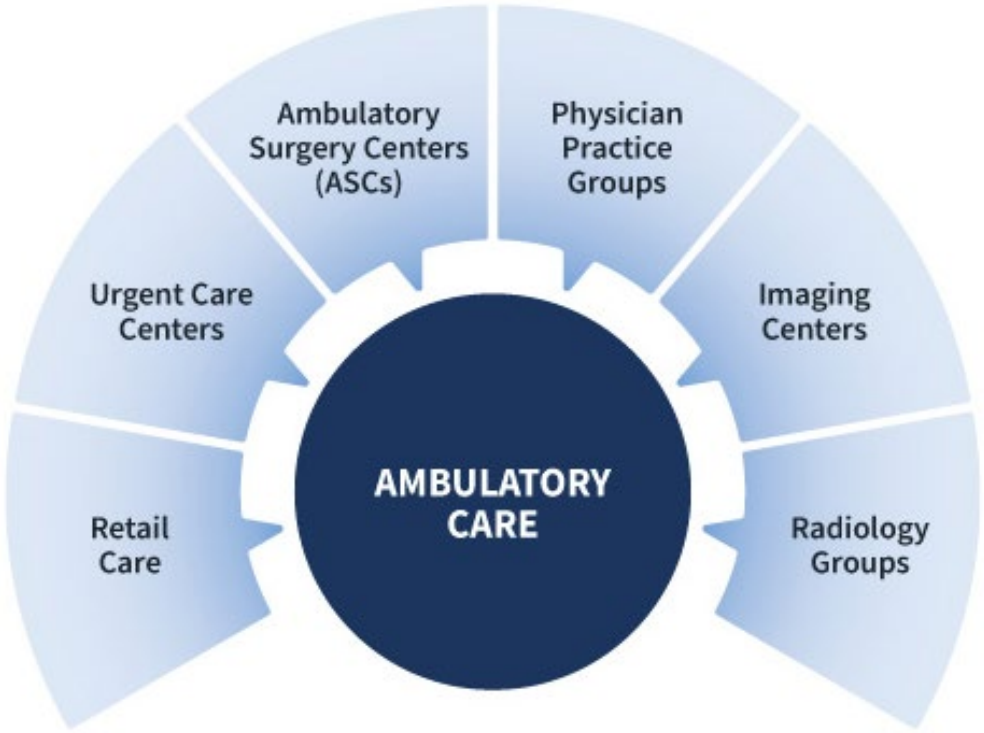
Personnel Related Risks

- Harm to clinician
- Adverse patient safety events and medical errors
- Decreased quality of care
- Decreased patient satisfaction
- Decreased individual and organizational productivity
- Organizational damage (reputational, financial)
- Increased risk of malpractice liability

Address Personnel Risks



Ambulatory Care / Outpatient Practice Settings



ECRI Outpatient Services Resources Collection.
https://www.ecri.org/components/HRC/Pages/ResourceCollection_OutpatientServices.aspx

- Medical offices/practice groups
- Urgent care
- Ambulatory surgery
- Aging services

Clinical Risks in Primary Care

Missed, delayed or wrong diagnoses

Incorrect or delayed treatment

Medication errors

Staff training/ credentialing & privileging

Infection

Communication breakdowns

Failure to track/follow up

Informed consent/refusal

Medical Error

- Medical error is the third leading cause of death[†]
- 400,000+ preventable patient deaths annually[*] (hospital data)
- Approximately 160 million medication errors occur each year in **primary care**[§]

Healthcare disparities (e.g., racial and ethnic, access, language) cause disproportionate impact on vulnerable populations.

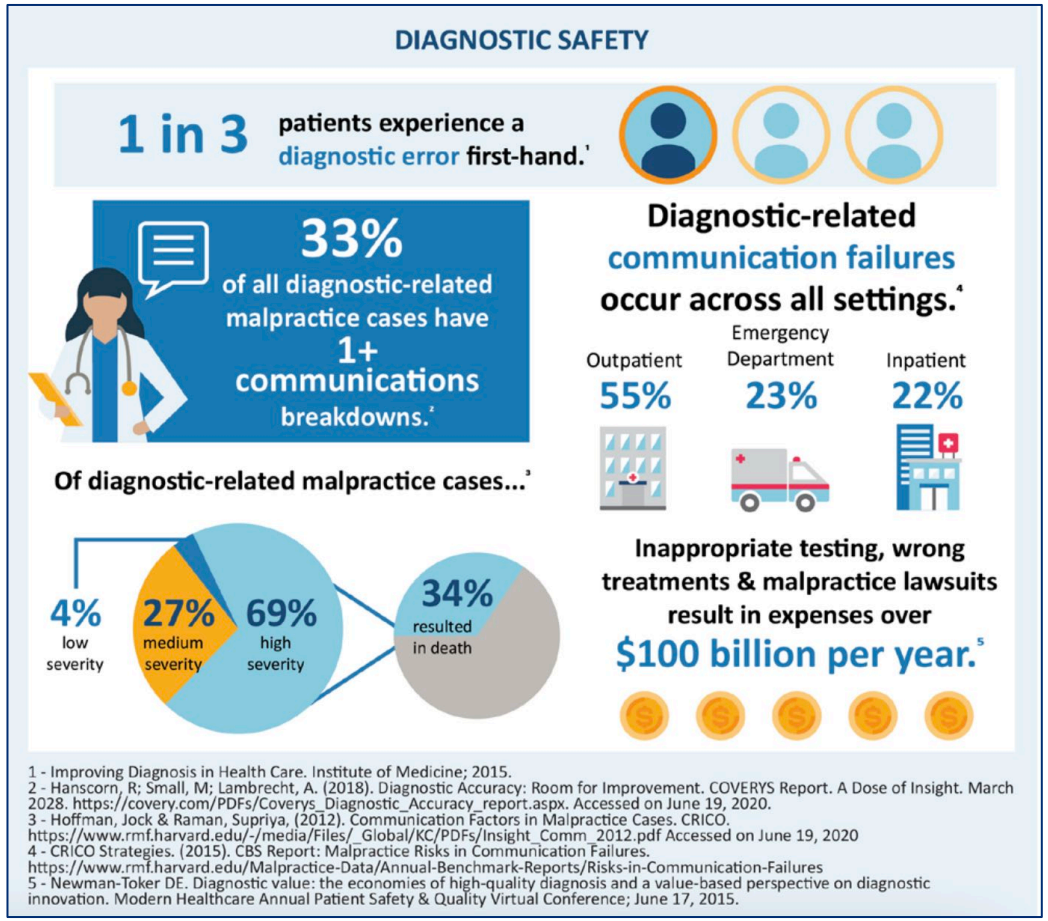
Sources: [†]Makary and Daniel; [*]James; [‡]Singh et al.

§ AHRQ. Patient Safety Issues in Primary Care Are Real. https://www.ahrq.gov/data/infographics/patient-safety-issues.html

Serious Adverse Events / Malpractice Allegations in Primary Care

- Cancer
- Cardiovascular (MI, CHF)
- Infection (pneumonia, meningitis (pediatric), UTI, pyelonephritis)
- Renal failure
- Self-harm/suicide
- Obstetric
- Medication errors

Communication Breakdowns



Communication breakdowns are a leading cause of adverse patient safety events and play a prominent role in malpractice claims.

33% of diagnosis-related malpractice cases include communication breakdowns.

55% of diagnostic-related communication failures occur in **outpatient settings**.

https://www.improvediagnosis.org/news_posts/the-administration-and-congress-agree-reducing-harm-from-diagnostic-error-is-an-urgent-patient-safety-priority/

Case Study*

** Case studies are based on reality, but not on particular events.*

- Steven is a patient well known to providers and staff at ABC Medical Office who have treated him for diabetes and long-term complications of a spinal cord injury that left him disabled. Steven is well-known in the community as an advocate for individuals who have experienced spinal cord injuries.

- During a follow-up appointment with Ann, a behavioral health nurse practitioner, Steven reports feeling sad and unusually tired for the past few months, and tells her he is having a hard time participating in his usual activities.

- They agree that Steven will try amitriptyline, an antidepressant. Ann completes a comprehensive informed consent discussion with Steven, orders baseline liver function tests (LFTs), and recommends regular monitoring of liver function because of the risk of liver damage associated with amitriptyline, especially in combination with Steven's other prescriptions. He has baseline labs drawn with normal results.

Case Study, con't.

- At his six-week follow-up appointment, Steven reports a minimal improvement in his mood, but he continues to report fatigue and decreased appetite.
- Noting the normal baseline LFTs, Ann increases Steven's amitriptyline dosage and instructs him to have his blood drawn again in six weeks.
- Steven follows Ann's instructions, but Ann is on leave when his follow-up labs are drawn. Ann set up coverage with her colleague Bill before she left, but because of a family crisis, Bill is called away from work suddenly and no one else is assigned to cover for Ann.
- When she returns from leave, Ann discovers a notification that Steven was hospitalized for drug-induced liver failure as well as an unaddressed critical LFT result. She reviews medical records and realizes she had prescribed a higher medication dose than intended.
- Later that week, the risk manager, Sam, receives a demand letter from an attorney representing Steven and his family requesting financial compensation for the event, and a staff member reports seeing something on social media about the event.

Case Study: What Next?

1. What should Ann should do when she discovers the events?
2. What should Sam do upon notification of the event? attorney letter? social media comments?
3. What other steps should be taken?
4. Could these events have been prevented? How?

Diagnostic Error

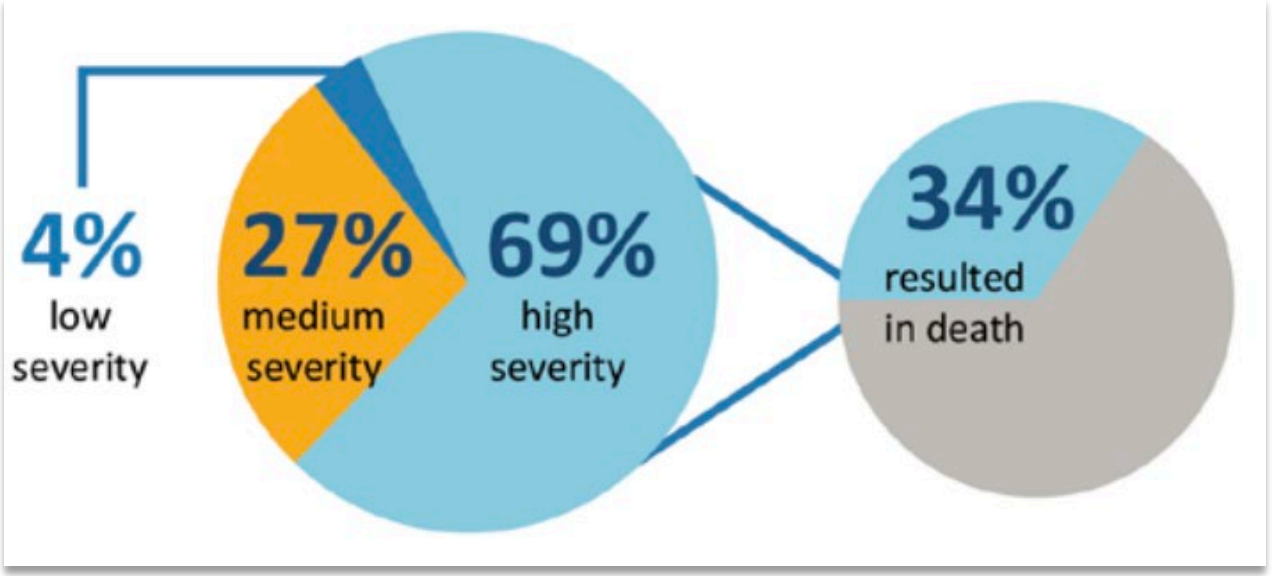
Nearly 800,000 Americans become permanently disabled or die annually across care settings due to misdiagnosis of dangerous diseases (1)

About 5% of adults (>12 million people) experience a diagnostic error in **outpatient settings** each year; over half include the possibility of harm (2)

Diagnostic error accounts for the majority of malpractice claims in **primary care**. (3)

1. https://qualitysafety.bmj.com/content/qhc/early/2023/08/07/bmjqs-2021-014130.full.pdf (2023)
2. https://qualitysafety.bmj.com/content/23/9/727
3. https://bmjopen.bmj.com/content/bmjopen/3/7/e002929.full.pdf

Diagnostic-Related Malpractice Cases



https://www.improvediagnosis.org/news_posts/the-administration-and-congress-agree-reducing-harm-from-diagnostic-error-is-an-urgent-patient-safety-priority

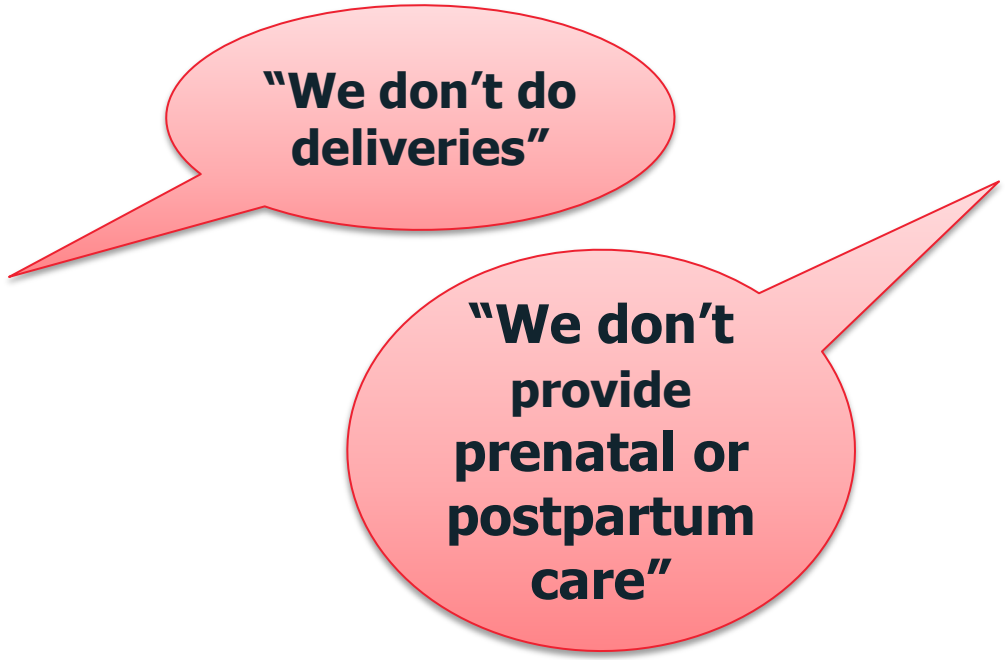
Malpractice Claims Equation

- Diagnostic error
- Patient injury/adverse event
- Treatment failure
- Medication errors

- Inadequate patient education
- Lack of patient/family engagement
- Insufficient informed consent
- Gaps in hand-off/care transition processes
- Breakdowns in teamwork
- Poor documentation

Obstetric Risk

- The U.S. has the worst maternal mortality rate among high-income countries—and it is still rising
- 80% of maternal deaths are considered preventable
- Most maternal deaths and serious complications occur postpartum—even days, weeks, or months after delivery
- There are profound disparities in outcomes for Black, Native American, and Alaska Native women as compared to White women, which persist across variations in socioeconomic and educational status
- Potential for high-severity adverse events
- High payouts for malpractice claims



ALL healthcare organizations that provide care to patients of childbearing age/potential may encounter patients experiencing pregnancy-related complications.

https://www.ecri.org/components/HRC/Pages/ResourceCollection_Obstetrics.aspx
https://saferbirth.org/patient-safety-bundles/

Urgent Care – Top Medical Conditions and Risk Areas (Claims Data)

Table 3

Outcomes of the top five resulting medical conditions cited in closed claims in adult emergency departments or urgent care settings.

Top 5 resulting medical conditions	Closed claims	Paid claims	% Paid-to-closed	Average indemnity	Average defense expense	% of all closed claims	% of all paid claims
Cardiac or cardiorespiratory arrest	617	187	30.3	$340,622	$54,410	9.1%	10.4%
Myocardial infarction, acute	269	105	39.0	$306,487	$46,447	4.0%	5.8%
Aortic aneurysm	153	47	30.7	$369,872	$43,163	2.3%	2.6%
Pulmonary embolism	147	50	34.0	$302,996	$29,819	2.2%	2.8%
Appendicitis	134	39	29.1	$159,815	$28,432	2.0%	2.2%

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7972370/

- Diagnostic error
- Delay in treatment/failure to transfer
- Scope of practice
- Oversight of advanced practice clinicians
- Medication errors/dispensing samples
- Staff training/competency validation
- Medical emergency preparation and response
- Infection prevention/control
- Procedural consent/time-out

Urgent Care – Risk Management Resources

- ED risk guidance is often applicable. See: ECRI Resource Collection – Emergency Department https://www.ecri.org/components/HRC/Pages/ResourceCollection_EmergencyDepartment.aspx
- Urgent Care Association - Data https://urgentcareassociation.org/about/urgent-care-data/
- Victorian Managed Insurance Authority: Preventing patient harm in emergency and urgent care settings

Risk Areas for Ambulatory Surgery Centers

- Patient Screening and Selection
- Physician Credentialing and Staff Competence
- Informed Consent
- Anesthesia
- Handling Emergencies
- Falls Prevention
- Infection Control
- Procedural Time-Out
- Patient Education
- Discharge Considerations
- Medical Device Tracking and Reporting

Risk Management Guidance for Ambulatory Surgery

- Assess ambulatory surgery services to identify strengths and opportunities for improving safety and quality.
- Implement a quality assessment and improvement program for the ambulatory surgery unit/facility.
- Ensure compliance with applicable facility accreditation standards.
- Use the Universal Protocol for a consistent pre-procedure verification.
- Apply effective credentialing procedures for providers.
- Develop an emergency preparedness plan; prepare for clinical emergencies.
- Discharge patients according to approved discharge criteria and the order of a physician.
- Provide written discharge instructions for follow-up care

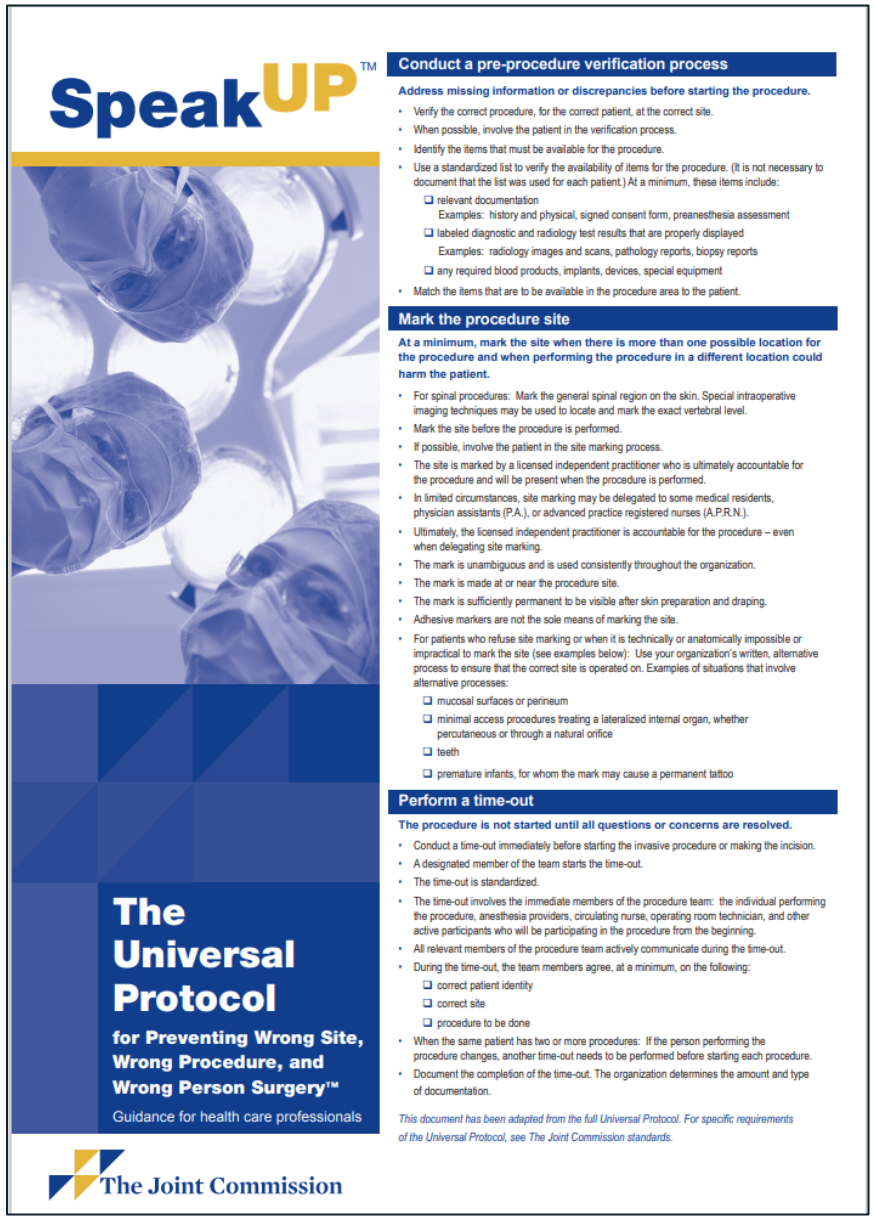
ECRI Office-Based Surgery and Anesthesia
https://www.ecri.org/components/HRC/Pages/OutPt3.aspx

ECRI Ambulatory Surgery
https://www.ecri.org/components/HRC/Pages/OutPt1.aspx?tab=1

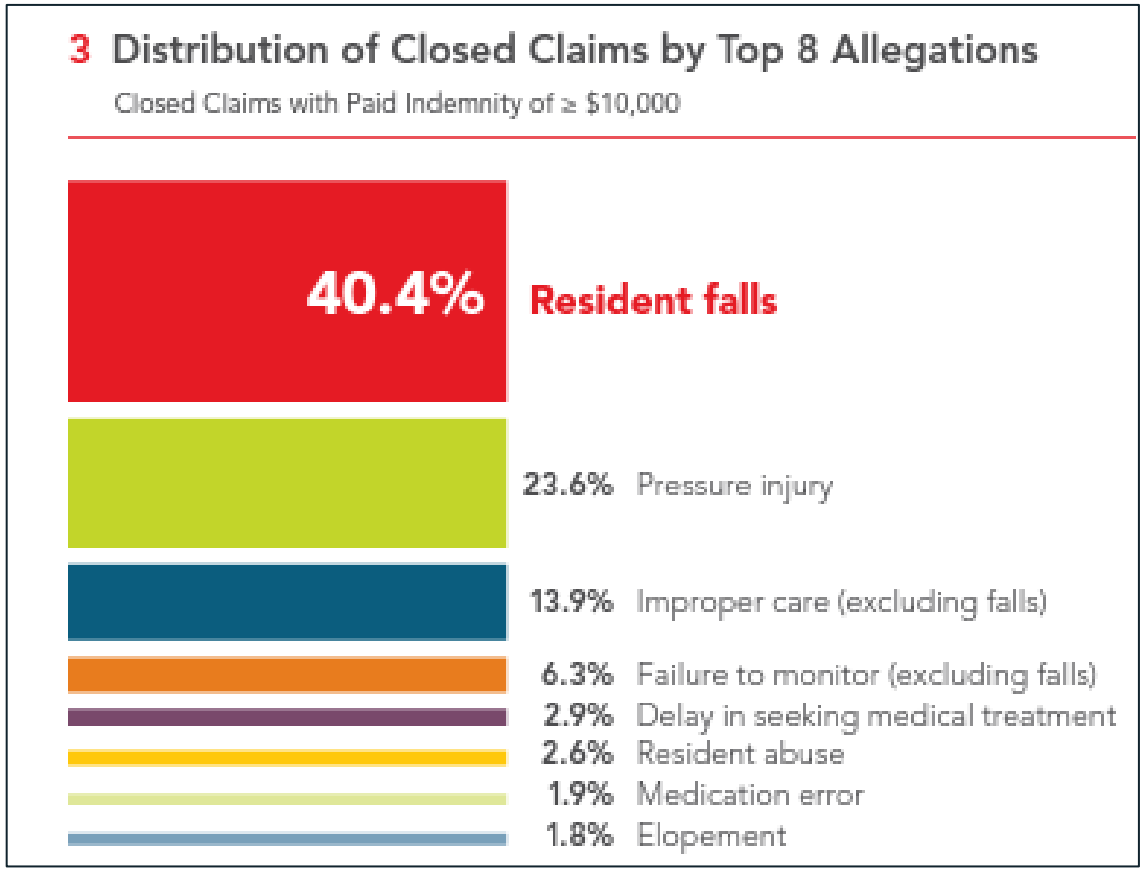
Universal Protocol

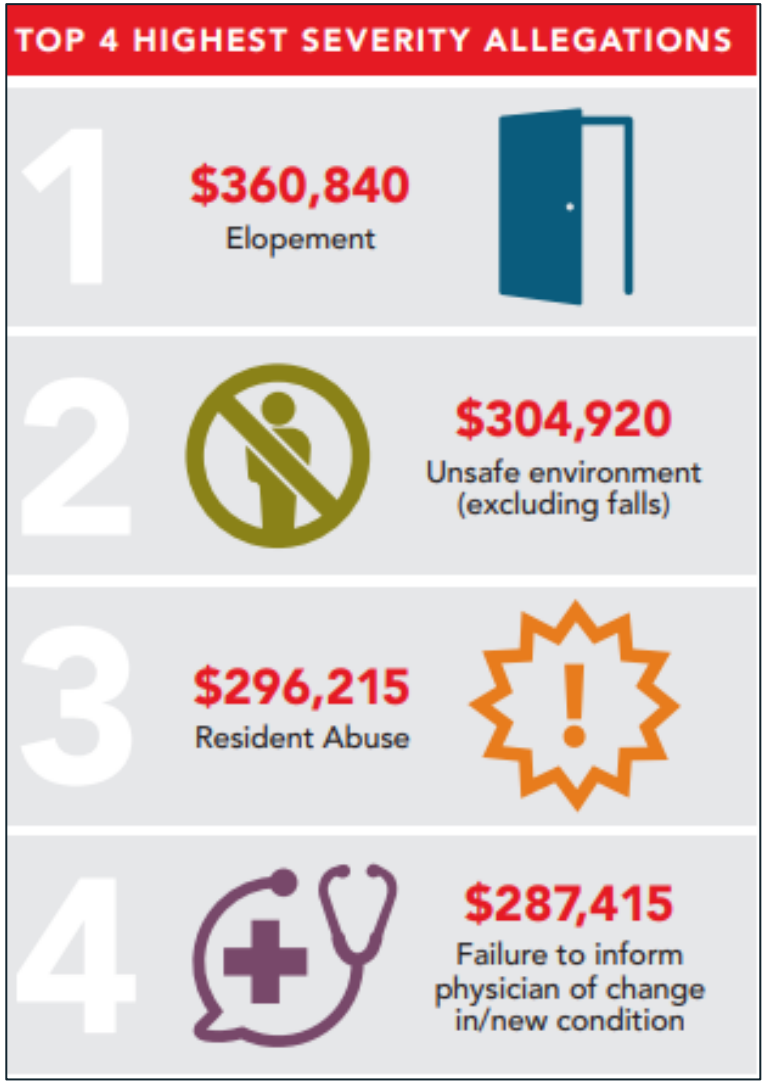
- The Joint Commission Universal Protocol
  - Conduct a pre-procedure verification process
  - Mark the procedure site
  - Perform a time-out

https://www.jointcommission.org/standards/universal-protocol



Aging Services Risks





Aging Services Claim Report: 11th Ed.
https://www.cna.com/web/guest/cna/industries/healthcare

Aging Services – ECRI Risk Management Resources

Risk	Resources
Falls	Falls Essentials https://www.ecri.org/components/HRC/Pages/Essentials_Falls.aspx
Pressure injuries	Pressure Injury Essentials https://www.ecri.org/components/HRC/Pages/Essentials_Falls.aspx
Monitoring, diagnosis, treatment, care coordination	Direct Resident and Patient Care Resource Collection https://www.ecri.org/components/CCRM/Pages/ResourceCollection_DirectCare.aspx Diagnosis Resource Collection https://www.ecri.org/components/HRC/Pages/ResourceCollection_Diagnosis.aspx Communication Resource Collection https://www.ecri.org/components/CCRM/Pages/ResourceCollection_Communication.aspx
Resident abuse	Preventing Abuse, Neglect, and Exploitation of Older and Vulnerable Adults https://www.ecri.org/components/CCRM/Pages/ResCare1.aspx
Medication error	Medication Safety https://www.ecri.org/components/CCRM/Pages/ResCare3.aspx
Elopement	Wandering and Elopement https://www.ecri.org/components/CCRM/Pages/SafEnv1.aspx

2. Explore the relationship between risk management, patient safety, quality improvement, and compliance activities

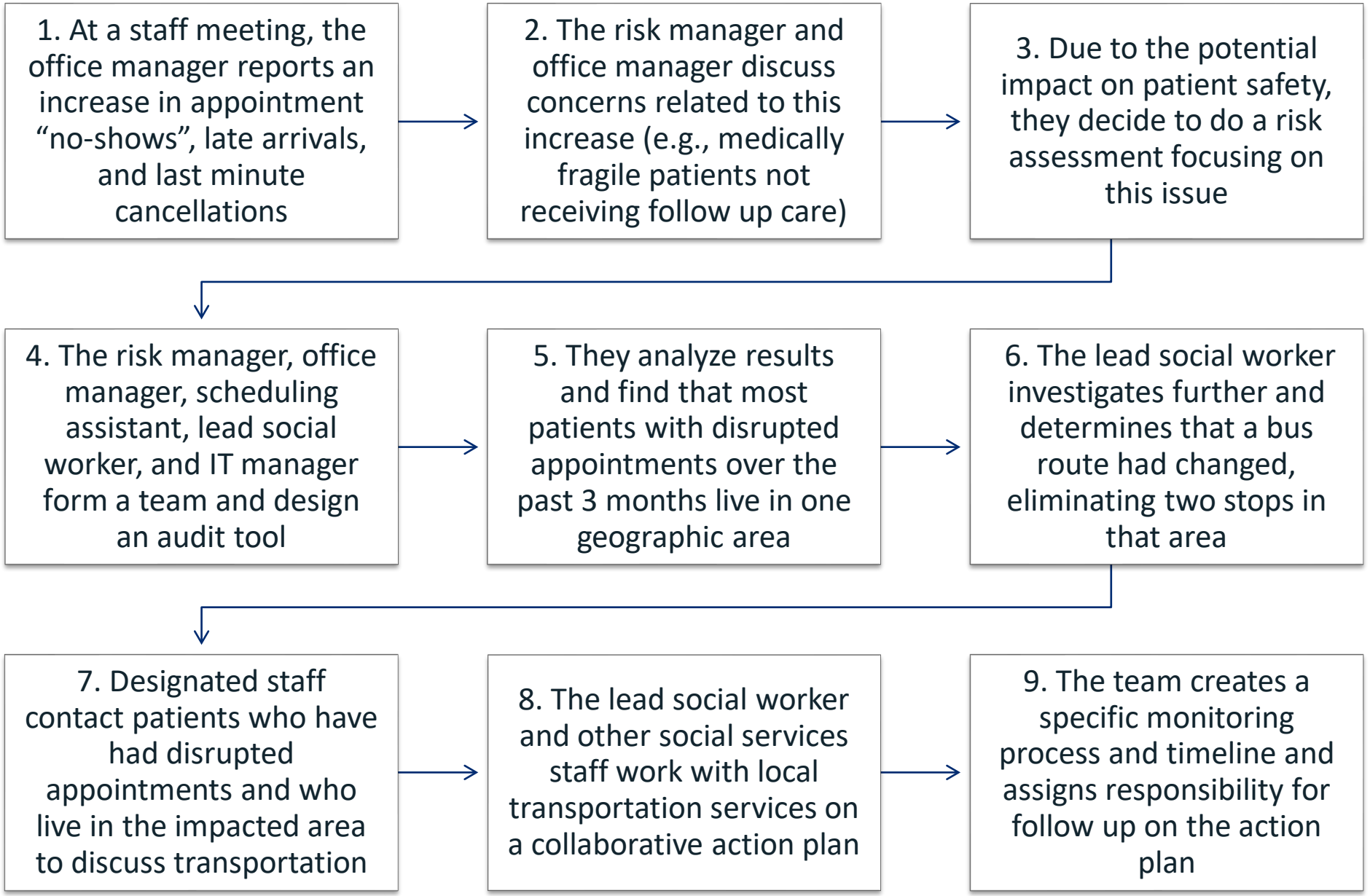
Why Do We Need a Risk Management Program?

- Ensure patient safety
- Support organizational culture of safety
- Reduce malpractice and other legal liability
- Ensure regulatory compliance
- Meet accreditation and quality standards
- Address workflow barriers that impede delivery of safe, high-quality patient care
- Ensure facility and staff safety and security
- Protect reputation and financial resources

Risk Management + Overlapping Functions

Risk Assessments: One Part of an Ongoing Cycle

Figure. The Risk Management Decision-Making Process


1. At a staff meeting, the office manager reports an increase in appointment “no-shows”, late arrivals, and last minute cancellations
2. The risk manager and office manager discuss concerns related to this increase (e.g., medically fragile patients not receiving follow up care)
3. Due to the potential impact on patient safety, they decide to do a risk assessment focusing on this issue
4. The risk manager, office manager, scheduling assistant, lead social worker, and IT manager form a team and design an audit tool
5. They analyze results and find that most patients with disrupted appointments over the past 3 months live in one geographic area
6. The lead social worker investigates further and determines that a bus route had changed, eliminating two stops in that area
7. Designated staff contact patients who have had disrupted appointments and who live in the impacted area to discuss transportation
8. The lead social worker and other social services staff work with local transportation services on a collaborative action plan
9. The team creates a specific monitoring process and timeline and assigns responsibility for follow up on the action plan

Monitor the Risk Management Program

- Set goals
- Review on an annual basis
- Make necessary changes based on:
  - Results from safety culture surveys, event reports, etc.
  - Changes in policies/procedures
  - Regulatory changes or updates
  - Organizational priorities
- Report to the board of directors regularly

What is the Value of a Risk Management Program?

Secure organizational commitment to improvement

Review adverse events and near misses to prevent future occurrence

Promote system improvement and liability reduction

Encourage open communication regarding patient adverse outcomes

Establish a culture of safety--one that is fair-minded but holds individuals accountable

3. Evaluate how a strong culture of safety can mitigate malpractice risk

Polling Question: Word Cloud

- In one or two words, describe what a “culture of safety” means to you.

Culture of Safety—Key Features

Acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations

A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment

Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems

Organizational commitment of resources to address safety concerns

AHRQ. Culture of Safety. https://psnet.ahrq.gov/primer/culture-safety

Foundations of a Culture of Safety: *Leadership*

A culture of safety starts at the top

Patient safety is an urgent organizational priority

Resources are allocated for safety initiatives

Foundations of a Culture of Safety: *Open Communication*

- Speaking up about safety concerns is encouraged
- Transparency and a spirit of inquiry are valued
- There is a system to facilitate event reporting

Foundations of a Culture of Safety: *Teamwork*

- Mutual respect for all team members
- Collaborative patient care
- Commitment to standardized safety processes

Foundations of Culture of Safety: *Just Environment*

- Focus on nonpunitive analysis of systems rather than blaming people
- Fairness balanced with individual accountability
- Support for staff involved in adverse events

Safety Culture and Event Reporting

Event Reporting

1

Clearly define what should be reported

- Events
- Near misses
- Unsafe or hazardous conditions

2

Educate providers and staff on how to report

- Standardized form (online or paper) with categories or types of events

3

Analyze events and near misses for causes and contributing factors

- Root-cause analysis

4

Act on opportunities for improvement

5

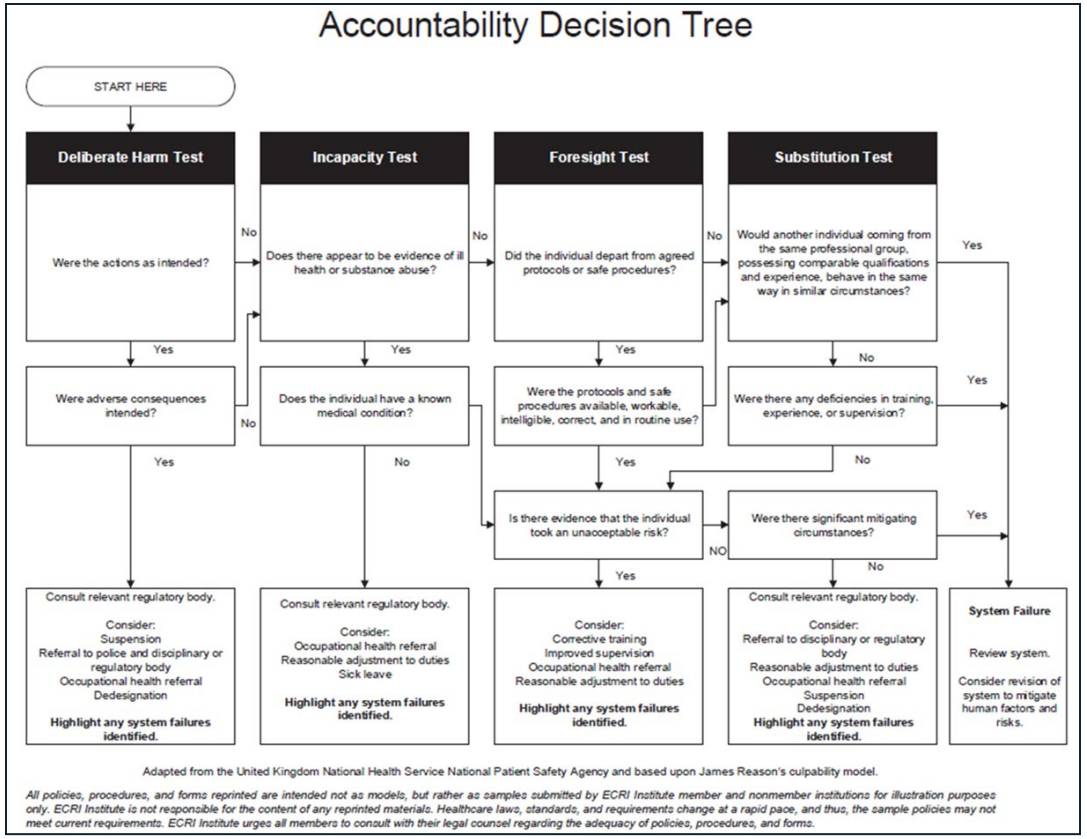
Provide feedback to providers and staff on changes made – including for "good catches"

Event Reporting and Management Resource Collection
https://www.ecri.org/components/HRC/Pages/ResourceCollection_EventReporting.aspx

Just Environment: Accountability Questions

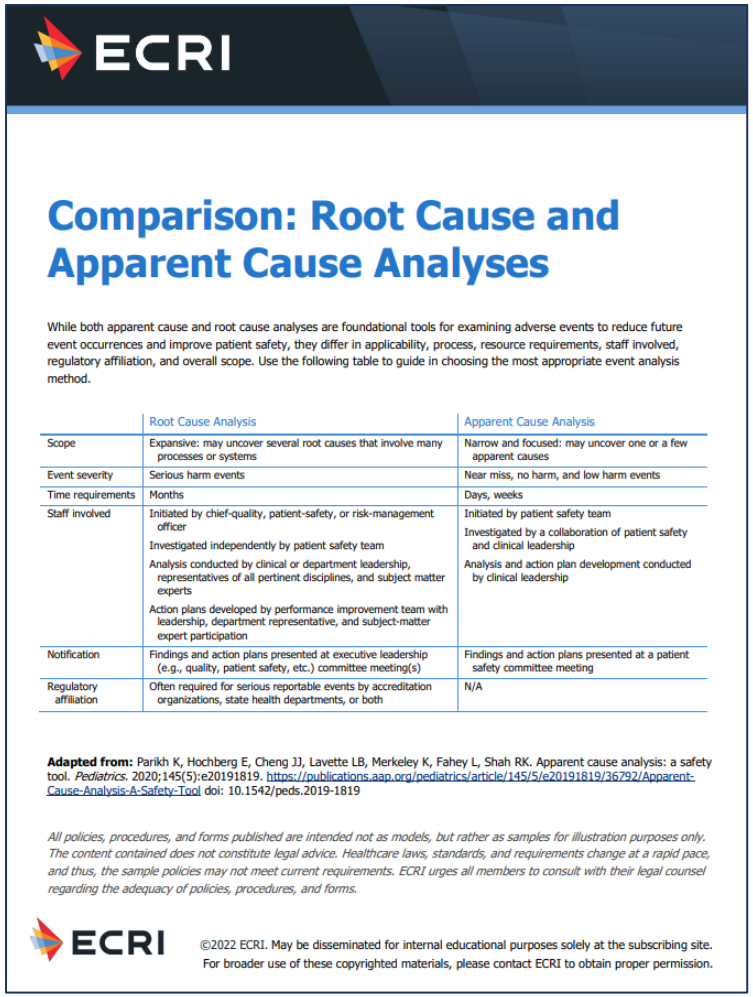
Four tests to evaluate caregiver actions in a patient safety event and determine an organization's response:

- **Deliberate harm**: Were the actions intended?
- **Incapacity**: Does there appear to be evidence of ill health or substance abuse?
- **Foresight**: Did the individual depart from agreed protocols or safe procedures?
- **Substitution**: Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?



https://www.ecri.org/components/HRC/Documents/SPT/Accountability-Decision-Tree.pdf

Event Response and Analysis



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Comparison: Root Cause and Apparent Cause Analyses

While both apparent cause and root cause analyses are foundational tools for examining adverse events to reduce future event occurrences and improve patient safety, they differ in applicability, process, resource requirements, staff involved, regulatory affiliation, and overall scope. Use the following table to guide in choosing the most appropriate event analysis method.

	Root Cause Analysis	Apparent Cause Analysis
Scope	Expansive: may uncover several root causes that involve many processes or systems	Narrow and focused: may uncover one or a few apparent causes
Event severity	Serious harm events	Near miss, no harm, and low harm events
Time requirements	Months	Days, weeks
Staff involved	Initiated by chief-quality, patient-safety, or risk-management officer Investigated independently by patient safety team Analysis conducted by clinical or department leadership, representatives of all pertinent disciplines, and subject matter experts Action plans developed by performance improvement team with leadership, department representative, and subject-matter expert participation	Initiated by patient safety team Investigated by a collaboration of patient safety and clinical leadership Analysis and action plan development conducted by clinical leadership
Notification	Findings and action plans presented at executive leadership (e.g., quality, patient safety, etc.) committee meeting(s)	Findings and action plans presented at a patient safety committee meeting
Regulatory affiliation	Often required for serious reportable events by accreditation organizations, state health departments, or both	N/A

Adapted from: Parikh K, Hochberg E, Cheng JJ, Lavette LB, Merkeley K, Fahey L, Shah RK. Apparent cause analysis: a safety tool. *Pediatrics*. 2020;145(5):e20191819. https://publications.aap.org/pediatrics/article/145/5/e20191819/36792/Apparent-Cause-Analysis-A-Safety-Tool doi: 10.1542/peds.2019-1819

All policies, procedures, and forms published are intended not as models, but rather as samples for illustration purposes only. The content contained does not constitute legal advice. Healthcare laws, standards, and requirements change at a rapid pace, and thus, the sample policies may not meet current requirements. ECRI urges all members to consult with their legal counsel regarding the adequacy of policies, procedures, and forms.

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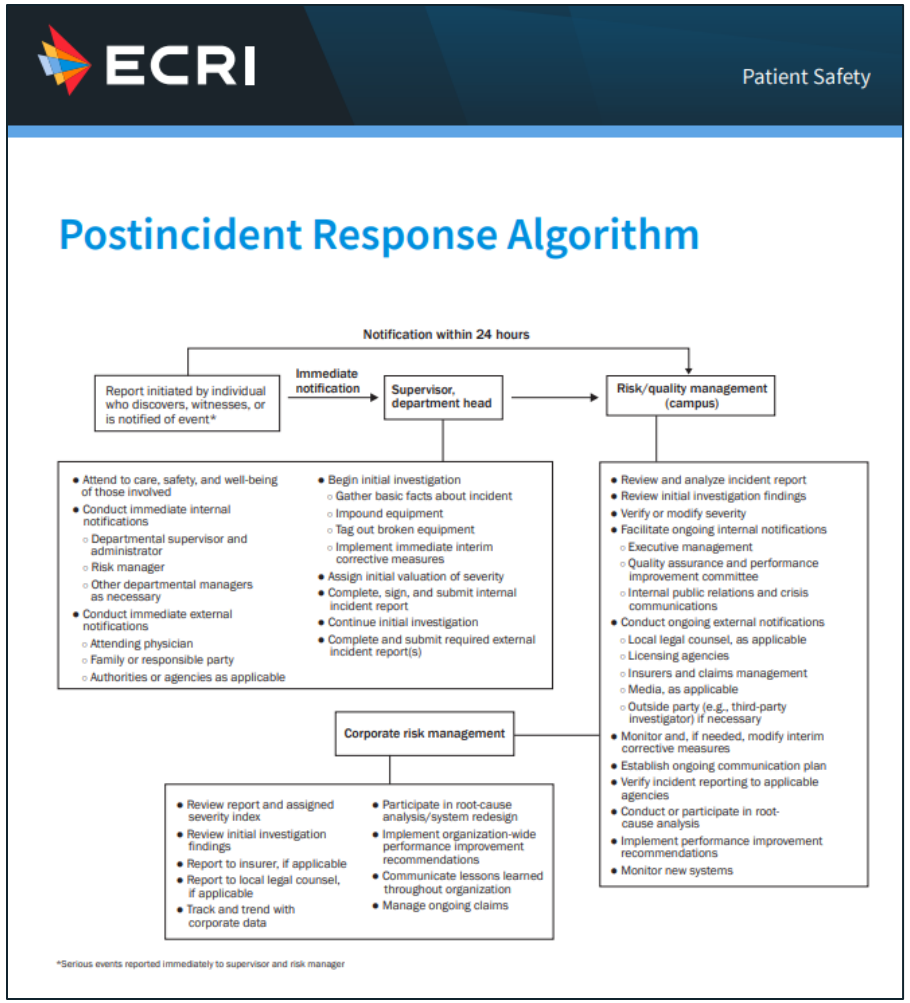


ECRI Patient Safety

Postincident Response Algorithm

https://www.ecri.org/components/HRC/Documents/SPT/Comparison_RootCauseandApparentCauseAnalysis.pdf

https://www.ecri.org/components/CCRM/Documents/SPT/QualRisk/QualRiskpol34.pdf

Fur

Polling Question

- Problem: A large crack in the top of a support of the World's Best Steel Roller Coaster went unnoticed for at least a week, until a guest spotted and reported it.
- Question: Who is most to blame for this incident?

A. The park CEO

B. The park supervising engineer

C. The ride operator manager

D. The daily inspection crew team lead

E. All of the above are equally to blame

F. Nobody should be blamed

Fury 325 Near Miss – How Did This Happen?

Problem statement	A large crack in the top of a support of the World's Best Steel Roller Coaster went unnoticed for at least a week, until a guest spotted and reported it.
Why?	Nobody was assigned to inspect the supports in that part of the coaster.
Why?	The engineering manager who makes daily inspection assignments was in the hospital due to a sudden illness, and no one took over his duties.
Why?	There was no plan in place to ensure all daily inspection responsibilities were assigned if the supervisor was absent.
Why?	Inspection assignment procedures were in the middle of being transitioned from a manual process to a computerized process.
Why?	N/A
Root cause(s)	1. No interim measures were put into place to ensure all assignments were being made during the transition from a manual to a computerized assignment system 2. There was no process to ensure oversight of inspection assignments in the supervisor's absence

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fivewhys.pdf

4. Understand the importance of addressing health disparities and improving patient engagement to support patient safety and reduce risk

Health Equity and Patient Safety

https://www.nimhd.nih.gov/resources/understanding-health-disparities/diversity-and-inclusion-in-clinical-trials.html

https://jamanetwork.com/journals/jama-health-forum/fullarticle/2805595

https://www.kff.org/racial-equity-and-health-policy/issue-brief/use-of-race-in-clinical-diagnosis-and-decision-making-overview-and-implications/

https://www.ahrq.gov/health-literacy/professional-training/lepguide/exec-summary.html#common

https://www.rwjf.org/en/insights/our-research/2021/07/do-black-and-white-patients-experience-similar-rates-of-adverse-safety-events-at-the-same-hospital.html

https://pubmed.ncbi.nlm.nih.gov/30585888/

https://pubmed.ncbi.nlm.nih.gov/36728348/

Racial and ethnic minority groups, those best served in a language other than English [LEP], LGB and gender-diverse patients, patients with disabilities, and other vulnerable populations often experience marked health disparities.

Inequities stem from many interrelated factors, including historic racism, persistent discrimination, and embedded bias in clinical research, treatment algorithms, and diagnostic processes.

Individuals with LEP and those from racial and ethnic minorities experience more frequent and more harmful patient safety events.

Healthcare staff are less likely to report adverse events and observations of potential malpractice when the affected patient is Black.

Racial and Ethnic Disparities in Healthcare
Concern #1—Top 10 Patient Safety Concerns for 2021

Health System Risk Management - Guidance

Racial and Ethnic Disparities in Healthcare

Concern #1—Top 10 Patient Safety Concerns for 2021

Published 3/12/2021

The Problem

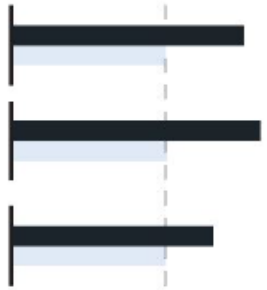
"The experiences of people of color in our health systems reveal that implicit and explicit bias and structural racism are driving health inequities like maternal mortality." — Joia Crear-Perry, MD, FACOG, Founder and President, National Birth Equity Collaborative

Health disparities are health differences between different groups of people, such as differences in the following:

- How many people are screened for diseases
- How many people contract certain diseases
- How severe the diseases are
- How many people have complications related to diseases
- How many people die from diseases
- Whether people can access healthcare

Maternal mortality is **3.3 times as high** among Black mothers as among white mothers.

Source: Brookings Institution



Black adults are **50% more likely** to have a stroke than white adults,

Black men are **60% more likely** to die from a stroke than white men,

and Black women are **30% more likely** to die from a stroke than white women.

Sources: OMH; Kochanek et al.

The Hispanic or Latinx population makes up **18.5% of the U.S. population** but **32.5% of COVID-19 deaths** when weighted for population distribution in hard-hit areas.

Source: NCHS

https://www.ecri.org/components/HRC/Pages/2021Top10_1.aspx?tab=1

Bias and Racism in Addressing Patient Safety Concern #3--Top 10 Patient Safety Concerns for 2022

Although patients from racial and ethnic minority groups are more likely to experience an adverse event while in the hospital, providers are **significantly less likely to report harmful events for patients from minority groups** than for white patients.

In one study, the odds of reporting patient safety events in African American patients were only **0.65 times** the odds of reporting in white patients.

Sources: Thomas et al.; Thurtle et al.

Black adult patients experienced significantly worse patient safety events in 6 of 11 health indicators compared with white adult patients of the same gender, treated in the same hospital, and with similar insurance coverage.

Source: Gangopadhyaya

https://www.ecri.org/components/HRC/Pages/2022Top10_3.aspx

Patient Engagement and Patient-Centered Care

Patient engagement and patient-centered care

- Reduces the risk of preventable harm
- Decreases risk of malpractice claims
- Increases patient satisfaction
- Improves outcomes
- Can lessen medical costs

Considerations for increasing patient engagement

- Provide culturally and linguistically appropriate services
- Address social determinants of health
- Practice teach back with patients
- Use warm handoffs to promote collaborative communication

5. Learn systems-based strategies to improve risk management processes in ambulatory care settings

Diagnostic Error—Why and What Can Be Done?

Why?

- Complex process
- Cognitive bias
- Diagnostic overshadowing
- Many contributing human factors and system elements
  - communication barriers
  - care coordination problems
  - distractions
  - EHR issues
  - lost results
  - delayed consultation
  - failed testing equipment
  - anything that causes extreme stress or burnout

What can be done?

- Increase awareness of clinical cognitive biases & how they link to diagnostic error
- Enhance environmental conditions to support analytical thinking
- Engage patients and their families in the diagnostic process
- Capture and analyze diagnostic errors and near misses
- Leverage tools and technologies (algorithms, checklists)
- Support organizational learning (simulation training)
- Enhance clinical decision-making (clinical decision support, diagnostic time-outs), peer consultation)

Workflow and Organizational Risks

TRACKING

HIPAA

EHR

TRAINING

TRIAGE

AFTER HOURS

EMERGENCY PREPAREDNESS

SCHEDULING

TURNOVER

TELEHEALTH

EVENT REPORTING

PATIENT GRIEVANCES

MEDICATION SAFETY

INFECTION CONTROL

COMPLIANCE

Key Risk: Documentation

Thorough, accurate, complete documentation is critical to provide safe patient care.

Poor documentation is also a potential source of liability for an institution or a provider.

The medical record is a legal document. If a medical record is inappropriately modified, amended, or destroyed—even if the care was appropriate—it may undermine the defense of a medical malpractice claim or response to an investigation.

Accuracy of documentation outside of the medical record is essential as well (e.g., equipment checklists, appointment logs, provider and staff schedules, policy and procedure updates)

Documentation is a **learned skill** – and sometimes it is learned incorrectly

Other Patient Safety Interventions to Consider

Culture of safety assessment or pledges

Implement (or improve) a standardized safety process (e.g., SBAR, timeout, huddles, walk rounds, maternal safety bundles)

Review patient education materials for accessibility and appropriateness

Evaluate informed consent policies, processes, and documents

Address EHR barriers

https://saferbirth.org/patient-safety-bundles/

Best Practice Resources

Develop a Strong Risk Management Program to Support Patient Safety

- ECRI Resource Collection: Risk Management Fundamentals https://www.ecri.org/components/HRC/Pages/ResourceCollection_RiskManagement.aspx
- IHI Self-Assessment Tool - A National Action Plan to Advance Patient Safety https://www.ihi.org/Engage/Initiatives/National-Steering-Committee-Patient-Safety/Pages/self-assessment-tool-national-action-plan-to-advance-patient-safety.aspx
- IHI Patient Safety Essentials Toolkit https://www.ihi.org/resources/Pages/Tools/Patient-Safety-Essentials-Toolkit.aspx

Support Diagnostic Excellence

- ECRI Essentials: Missed Diagnoses https://www.ecri.org/components/HRC/Pages/Essentials_Missed-Diagnoses.aspx
- ECRI Resource Collection: Diagnosis https://www.ecri.org/components/HRC/Pages/ResourceCollection_Diagnosis.aspx

Assess and Strengthen Your Culture of Safety

- ECRI Essentials: Culture of Safety https://www.ecri.org/components/HRC/Pages/Essentials_Culture-of-Safety.aspx
- AHRQ Culture of Safety Assessments https://www.ahrq.gov/sops/about/patient-safety-culture.html

Provide Culturally and Linguistically Competent Care

- https://www.ecri.org/components/HRC/Pages/Eth5.aspx
- ECRI Resource Collection: Patient and Public Relations https://www.ecri.org/components/HRC/Pages/ResourceCollection_EventReporting.aspx

Improve Workflow to Reduce Administrative Burden

- American Medical Association Steps Forward https://edhub.ama-assn.org/steps-forward

Risk Management Matters