

*Executive Brief*

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# Top 10 Patient Safety Concerns for Healthcare Organizations 2018



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## **WANT MORE?**

This executive brief summarizes ECRI Institute's Top 10 list of patient safety concerns for 2018. *Healthcare Risk Control (HRC)* and ECRI Institute PSO members can access the full report, which discusses each topic in more detail, by logging in at <https://www.ecri.org>.

Additionally, page 14 of this brief lists ECRI Institute resources that provide more in-depth guidance for each topic.

# Top 10 Patient Safety Concerns for Healthcare Organizations 2018

Healthcare is striving to become an industry of high-reliability organizations, and part of being a high-reliability industry means staying vigilant and identifying problems proactively. This annual Top 10 list helps organizations identify looming patient safety challenges and offers suggestions and resources for addressing them.

## Why We Create This List

ECRI Institute creates this annual list of Top 10 patient safety concerns to support healthcare organizations in their efforts to proactively identify and respond to threats to patient safety.

This report offers perspectives from some of our many experts, as well as links to further guidance on addressing these issues.

### ECRI Institute's Top 10 Patient Safety Concerns for 2018

- 1 Diagnostic errors
- 2 Opioid safety across the continuum of care
- 3 Internal care coordination
- 4 Workarounds
- 5 Incorporating health IT into patient safety programs
- 6 Management of behavioral health needs in acute care settings
- 7 All-hazards emergency preparedness
- 8 Device cleaning, disinfection, and sterilization
- 9 Patient engagement and health literacy
- 10 Leadership engagement in patient safety

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## How We Identified the Concerns

In selecting this year's list, ECRI Institute relied both on data regarding events and concerns and on expert judgment. Since 2009, when our patient safety organization (PSO), ECRI Institute PSO, began collecting patient safety events, we and our partner PSOs have received more than 2 million event reports. That means that the 10 patient safety concerns on this list are very real. They are causing harm—often serious harm—to real people.

The process synthesized data from these varied sources:

- Review of events in the ECRI Institute PSO database
- PSO members' root-cause analyses and research requests
- Topics reflected in weekly *HRC Alerts*
- Voting by a panel of experts from inside and outside ECRI Institute

But this is not an exercise in simple tabulation. The list does not necessarily represent the issues that occur most frequently or are most severe. Most organizations already know what their high-frequency, high-severity challenges are. Rather, this list identifies concerns that might be high priorities for other reasons, such as new risks, existing concerns that are changing because of new technology or care delivery models, and persistent issues that need focused attention or pose new opportunities for intervention.

# Top 10 Patient Safety Concerns for Healthcare Organizations 2018

## How to Use This List

**Use this list as a starting point for conducting patient safety discussions and setting priorities.**

This list is not meant to dictate which issues provider organizations should address. Rather, it's intended to serve as a catalyst for discussion about the top patient safety issues faced by your organization.

**Determine whether your organization faces similar issues that should be targeted for improvement.** You can investigate whether these problems are occurring in your organization and whether you have processes and systems in place to address them.

**Develop strategies to address concerns.** This report offers a few key recommendations for each topic and links to other ECRI Institute resources that provide more in-depth guidance. Some resources are available without charge; others are benefits of ECRI Institute membership programs or are available through our partner PSOs. Contact client services at (610) 825-6000, ext. 5891, or [clientservices@ecri.org](mailto:clientservices@ecri.org) for information on purchasing resources that are not part of your membership.

**Consider applications across care settings.** Although not all patient safety concerns on this list apply to all healthcare organizations, many are relevant to a range of settings across the continuum of care.



# 1 Diagnostic Errors

According to both studies and claims analyses, diagnostic errors are common, and they can have serious consequences. Miscommunication is a common issue, but often not the only one. **“It’s a multifactorial problem,”** says Gail M. Horvath, MSN, RN, CNOR, CRCST, patient safety analyst and consultant, ECRI Institute. **“Diagnostic errors are the result of cognitive, systemic, or a combination of cognitive and systemic factors.”**

Diagnostic errors are also challenging to measure and learn from because they often go undetected until after the patient leaves the hospital or emergency department (ED). Healthcare organizations should capture data on diagnostic errors and near misses. Sources may include the event-reporting system, malpractice and payment claims, patient complaints, patient surveys, autopsies, and record reviews. The organization can then make changes to address gaps. Discussing the topic in multiple forums, such as grand rounds and debriefings, can support ongoing analysis and learning for clinicians.



## 2 Opioid Safety across the Continuum of Care

The opioid epidemic has brought attention to outpatient prescriptions and illicit drugs. But the impact stretches across the healthcare continuum. To better connect patients with opioid use disorder to treatment, hospitals and emergency departments (EDs) can seek ways to better engage patients before providing a referral. They may even initiate medication-assisted treatment themselves.

Opioids are also given in hospitals and EDs to treat pain. ECRI Institute PSO's [Deep Dive on opioid safety in acute care](#) revealed an array of challenges. **“It’s a patient safety concern because of the seriousness of the side effects,”** says Stephanie Uses, PharmD, MJ, JD, patient safety analyst and consultant, ECRI Institute. Strategies include comprehensively assessing patients, using nonpharmacologic modalities and nonopioid pain medications, and accounting for patients’ individual needs, opioid tolerance, and comorbidities. Sedation scales and, for high-risk patients, continuous monitoring can help detect respiratory depression.



# 3 Internal Care Coordination

Poorly coordinated care puts patients at risk for safety events such as medication errors, lack of necessary follow-up care, and diagnostic delays. Like so many preventable errors in healthcare, these risks come down to a failure to communicate. Providers, including multiple specialists, must inform one another at every step in the care process of the patient’s condition, medication regimen, and medical history.

**“Many handoff tools are available to ensure the vital information is communicated and the process is standardized,”** said Elizabeth A. Drozd, MS, T (ASCP) SBB, CPPS, senior patient safety analyst, ECRI Institute.

Additional tools such as checklists and safety huddles can help ensure providers communicate effectively at every stage of the patient’s care. Communication training and leadership support are also essential. Whenever multiple providers and specialists are responsible for a patient’s treatment, care coordination will continue to be an issue that must be addressed.



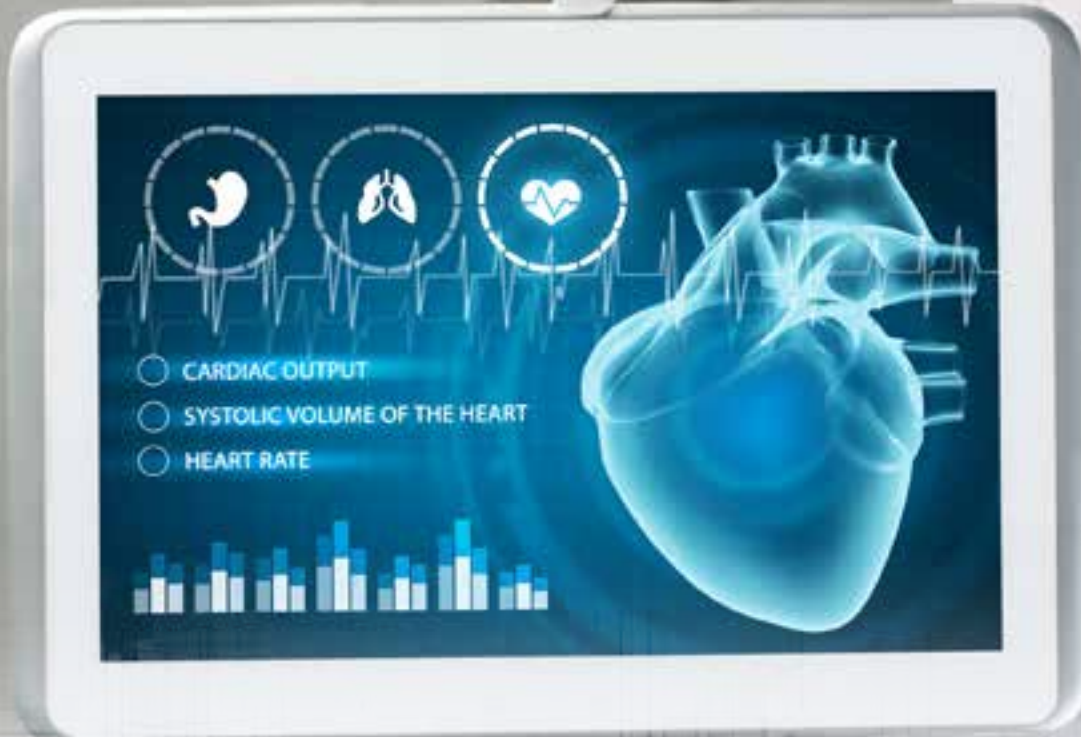


# 4 Workarounds

Workarounds are pervasive in healthcare. They occur when staff bend work rules to circumvent or temporarily fix a real or perceived barrier or system flaw. As workarounds become entrenched in unit-level work, they are difficult to detect. **“We hear, ‘It’s the way we do things here.’ That’s not good,”** says Kelly C. Graham, RN, patient safety analyst and consultant, ECRI Institute. Instead of alerting someone to the problem underlying the behavior, staff may permit the unsafe conditions to continue until someone is harmed.

Organizations should encourage staff to speak up about workarounds by fostering an open, nonpunitive environment where staff feel at ease talking about them. A gap analysis of processes susceptible to workarounds can help identify mismatches between scripted and actual practices.

In developing policies and procedures, seek staff input to determine whether the approach is feasible. Finally, given that workarounds often occur with technology, ensure that an ongoing maintenance plan is in place for the technology to perform reliably.



# 5 Incorporating Health IT into Patient Safety Programs

A health information technology (IT) safety program can play a pivotal role in improving the safety and quality of healthcare, but its success depends on the ability of users to recognize, react to, and report health-IT-related events for analysis and action. If staff fail to recognize health IT issues when they emerge, then they may not know how to intervene.

When health IT systems are poorly designed, or when the organization’s culture fails to embrace health IT safety, patients can suffer. **“It is not only how we use it in daily workflow, but also how we use it effectively by optimizing the benefits and reducing the risks,”** says Robert C. Giannini, NHA, CHTS-IM/CP, patient safety analyst and consultant, ECRI Institute.

Facilities should focus on integrating health IT safety into the existing safety program, collaborating with stakeholders, and embedding health IT safety into the organization’s culture.



# 6 Management of Behavioral Health Needs in Acute Care Settings

When acute care patients' behavioral health needs go unmet, issues such as self-harm or violence toward others, leaving against medical advice, poor behavioral health outcomes, or interference with care of the acute medical condition can result. When these things happen, **“we’ve created problems as opposed to treating problems,”** says Nancy Napolitano, patient safety analyst and consultant, ECRI Institute.

Hospitals and EDs can identify needs in the community served and seek creative ways to develop competencies in behavioral health. Other strategies include assessing the behavioral health needs of all patients, training staff to work with patients who have behavioral health needs, and conducting frequent drills on how to de-escalate behavioral health crises. Organizations should consider working with other partners, such as psychiatrists, behavioral health treatment programs, clinics, medical schools and teaching programs, and law enforcement. **“Relationships and partnerships are what get you what you need,”** says Napolitano.



# 7 All-Hazards Emergency Preparedness

The year 2017 saw major hurricanes, wildfires, mass shootings, and ransomware attacks. Each of these emergencies brought a host of challenges for healthcare facilities. Some resulted in mass casualties. Others led to power outages or computer shutdowns, which forced organizations to alter their day-to-day operations. Facilities that were prepared for these disasters fared better than those that were not.

“I don’t know that there’s any way to prevent any future natural disasters, or even most intentional disasters,” says Patricia Neumann, MS, RN, MT (ASCP), HEM, senior patient safety analyst/consultant, ECRI Institute. **“Obviously preparing is a whole lot better than having to recover.”**



# 8

## Device Cleaning, Disinfection, and Sterilization

Failure to follow proper cleaning, disinfecting, and sterilization protocol at any point can result in a compromised device—and devastating effects for patients. To avoid outbreaks of potentially deadly diseases, a proactive approach is important. **“Once you have an outbreak, everything needs to be examined,”** says Scott R. Lucas, PhD, PE, director of accident and forensic investigation, ECRI Institute. **“This is a lot less stressful to do before we have bioburden and contaminants showing up in our trays.”**

Healthcare facilities must ensure that sufficient staff and equipment are available to handle the reprocessing workload; that staff follow current guidelines and manufacturer recommendations; and that the facility’s water and environmental filtration system undergoes regular surveillance and maintenance. Additionally, facilities should work to create a team environment for members of the surgical and central sterile processing teams.



# 9

## Patient Engagement and Health Literacy

Patients have many responsibilities in managing their health. However, **“we don’t do a great job of engaging patients and making sure they understand their health and healthcare,”** says Josi Wergin, CPHRM, CPASRM, ELS, risk management analyst, ECRI Institute, **“and we underestimate how often those failures lead to serious harm.”**

Healthcare organizations should involve patients and families in identifying, planning, and testing health literacy and patient engagement initiatives. Experts recommend taking “universal precautions” for health literacy—making all materials and discussions easy to understand.

Ways to engage patients include bedside rounds, daily goal sheets, and patient coaching. Eliciting patients’ goals and connecting them with recommended actions is a key step. If patients still do not adhere to the plan of care, investigate why, Wergin suggests. Organizations can also partner with government and community groups to tackle social determinants of health.



# 10 Leadership Engagement in Patient Safety

Leadership engagement in patient safety efforts is essential to their success. Engagement of leadership must be on both an intellectual and an emotional level. “The c-suite and the board, as a result of your persuasion, have to be willing to listen to what you’re saying,” explains Carol Clark, BSN, RN, MJ, patient safety analyst, ECRI Institute. **“It all starts with emotional and intellectual engagement.”** Without leadership investment, options for patient safety initiatives are limited.

To build support, the patient safety, risk, or quality manager should recruit champions across the organization who can support the cause both up and down the chain of leadership. Then, once the risk manager has achieved champion buy-in, “you have to take this with your champions to the c-suite and board of trustees. You have to engage them intellectually and emotionally. You present crisp, on-target data that demonstrate the need,” says Clark.

# Top 10 Patient Safety Concerns

## for Healthcare Organizations

# 2018

### ECRI Institute Resources for Addressing the Top 10 Patient Safety Concerns

The following ECRI Institute resources provide more in-depth guidance on specific topics. Resources marked with asterisks are publicly available; others are benefits of ECRI Institute membership programs but may be available for purchase separately. Log in at <https://www.ecri.org> to access resources available through your membership. Contact client services at (610) 825-6000, ext. 5891, or [clientservices@ecri.org](mailto:clientservices@ecri.org) for information on purchasing resources that are not part of your membership.

#### 1. Diagnostic Errors

- [Diagnostic Errors: Monumental Problem or Enormous Opportunity?](#)
- [Diagnostic Errors: Why Do They Matter, and What Can You Do?](#)
- [Learning Opportunities: Five Ways to Reduce Risk of Diagnostic Error](#)
- [Making the Wrong Call: Diagnostic Errors](#)

#### 2. Opioid Safety across the Continuum of Care

- [ECRI Institute PSO Deep Dive™: Opioid Use in Acute Care\\*](#)
- [Self-Check Tool: Opioid Prescribing](#)
- [Pain Management](#)
- [Implementing Monitoring for Opioid-Induced Respiratory Depression in Medical-Surgical and Other General Care Units](#)

- [ECRI Institute's 2016 Annual Conference: Health Systems and Addiction: The Use and Misuse of Legal Substances\\*](#)
- [Ask HRC: Patients with Opioid Use Disorder in Acute Care](#)
- [Patients in Acute Care with Illegal Drugs](#)

#### 3. Internal Care Coordination

- [ECRI Institute PSO Deep Dive™: Care Coordination](#)
- [Communication](#)
- [ECRI Institute PSO Plus: Handoff Communication](#)
- [Discharge Planning](#)
- [Patient-Centered Care](#)
- [Acute and Postacute Care Providers: Shared Care, Shared Risks, Shared Responsibilities, and Shared Outcomes](#)
- [Health Literacy](#)



## 4. Workarounds

- [ECRI Institute's 2017 Annual Conference: Workflow, Workarounds, and Overworked Health Systems: Innovations and Challenges for Quality, Safety, and Technology\\*](#)
- [ECRI Institute PSO Deep Dive™: Patient Identification](#)
- [ECRI Institute PSO Deep Dive™: Laboratory Testing](#)
- [Bar-Coded Medication Administration Systems](#)
- [Implementing Computerized Provider Order Entry](#)
- [Patient Identification](#)
- [Partnership for Health IT Patient Safety\\*](#)
- [Electronic Health Records](#)

## 5. Incorporating Health IT into Patient Safety Programs

- [Safe Practice Recommendations for Developing, Implementing, and Integrating a Health IT Safety Program](#)
- [Self-Assessment Questionnaire: Establishing a Health Information Technology Safety Program](#)
- [ECRI Institute PSO Deep Dive™: Health Information Technology](#)

- [Electronic Health Records](#)
- [Culture of Safety](#)
- [Wrong-Record, Wrong-Data Errors with Health IT Systems](#)
- [Partnership for Health IT Patient Safety\\*](#)
- [Top 10 Health Technology Hazards for 2018](#)

## 6. Management of Behavioral Health Needs in Acute Care Settings

- [Patient Violence](#)
- [Suicide Risk Assessment and Prevention in the Acute Care General Hospital Setting](#)
- [Assessing and Managing the Behavioral Health Needs of the Medical Patient](#)
- [Managing Behavioral Health Needs of Adult Medical Inpatients](#)
- [Behavioral Rapid Response Teams for Acute Care Medical Units](#)
- [Behavioral Health: Environmental Assessment](#)

## 7. All-Hazards Emergency Preparedness

- [ECRI Institute Disaster Preparedness and Recovery Resource Center\\*](#)
- [Emergency Management](#)
- [Violence in Healthcare Facilities](#)

- [Powerless: Layer Backup Strategies to Weather Power Outages](#)
- [Hospital Relations with Police](#)
- [Selecting an Approach to Overhead Emergency Communications](#)
- [Duty to Warn or Protect](#)

## 8. Device Cleaning, Disinfection, and Sterilization

- [Reprocessing of Flexible Endoscopes](#)
- [Endoscope Reprocessing: The Importance of Being Proactive](#)
- [Overview of Infection Prevention and Control](#)
- [Top 10 Health Technology Hazards for 2018](#)
- [If It's Not Clean, It's Not Sterile: Reprocessing Contaminated Instruments](#)
- [ECRI Institute CRE and Duodenoscope Resource Center\\*](#)

## 9. Patient Engagement and Health Literacy

- [Health Literacy](#)
- [Health Literacy: Handout for In-Person Communication](#)
- [Health Literacy: Checklist for Creating or Evaluating Materials](#)
- [Healthcare Literacy and Patient Safety](#)
- [Culturally and Linguistically Competent Care](#)
- [Ask HRC: Working with Patients Who Do Not Comply with Physician Instructions](#)

## 10. Leadership Engagement in Patient Safety

- [Culture of Safety](#)
- [Demonstrating Risk Management Value](#)
- [Event Reporting and Response](#)
- [Patient Safety, Risk, and Quality](#)
- [Quality-of-Care Measures](#)
- [The Role of the Patient Safety Officer](#)
- [Storytelling Engages Staff in Problem Solving](#)

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\* Publicly available without login.

# Follow the safest route to avoid risk and improve quality...

## We can lead the way.

Join the many healthcare professionals who rely on ECRI Institute for proven patient safety and risk reduction strategies across the continuum of care.

You can benefit from collaboration with our experienced healthcare analysts and researchers.

Turn to ECRI Institute to:

- ▶ Improve culture of safety
- ▶ Proactively assess risk
- ▶ Prevent adverse events
- ▶ Benefit from actionable safety recommendations

Keep moving  
in a safer direction.  
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