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LOSING GROUND ON ZERO HARM

Survey of 100 hospital executives and clinical leaders reveals gaps in incident reporting are leading to an emerging crisis

OVERVIEW

Safety event reporting is critical to ensuring the identification of harmful incidents that affect patients, staff members, and visitors. It's also key to ensuring the prevention of future, similar incidents. All too often, however, safety events go unreported and unresolved, resulting in unnecessary harm—and in some cases, avoidable deaths.

This report, based on a survey of 100 hospital executives and clinical leaders, reveals that fewer than 40% characterize their organizations' safety event reporting mechanisms as "very effective." In addition, only 21% say their organization identifies and reports most events.

Why are there so many gaps in safety event reporting, how are the resulting blind spots impacting patient care, and what can hospitals do to implement stronger reporting mechanisms?

Here, we explore the biggest drivers contributing to the low rate of reported events and the consequences, and we share the strategies successful hospitals are using to ensure more events are identified, documented, and prevented.

KEY FINDINGS

Safety event reporting encompasses the tracking, collection, assessment, and management of patient, staff, and visitor-related safety events.

99%
of hospital leaders say a robust safety event reporting system is "very important" or "important" to hospital safety

37%
characterize their safety event reporting mechanisms as "very effective"

51%
say the number of safety events has increased in the past two years, but only 41% say the number of reported events has increased

86%
say automated event reporting is "extremely" or "very" crucial to ensuring safety events are identified

FOUR TAKEAWAYS

1. Hospital leaders say failure to report safety events in a timely manner is their second biggest safety problem behind hospital-acquired infections (HAIs).

Hospital leaders realize the significant impact of safety event reporting on patient, staff, and visitor safety performance, and many are shifting their priorities accordingly. In fact, hospital leaders now rank safety event reporting among their top three safety improvement priorities in 2022.

What is the biggest safety problem in hospitals?

#1. HAIs/HACs

#2. (Tie): Failure to report safety events in a timely manner/reducing medication errors

#3. Antibiotic overuse/misuse

#4. Falls

#5. Opioid over-prescribing/misuse/abuse

#6. Other*

**Other responses included communication gaps and staffing challenges*

What is your top safety improvement priority in 2022?

#1. Reducing HAIs and HACs

#2. Improving staff safety

#3. Ensuring the reporting of safety events in a timely manner

#4. Reducing falls and other safety accident

#5. Reducing medication errors

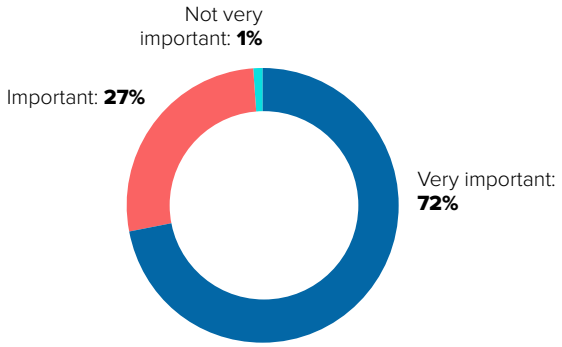
#6. Reducing antibiotic overuse/misuse

#7. Reducing opioid over-prescribing/misuse/abuse

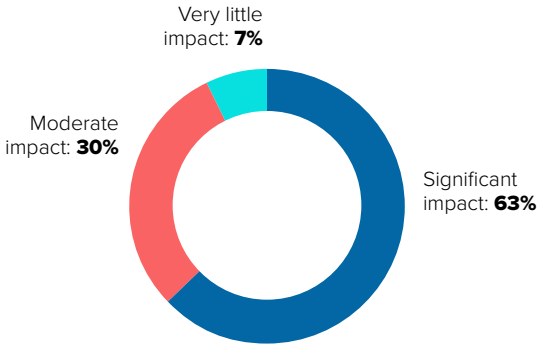
Why are so many hospitals flagging and prioritizing safety event reporting? Nearly all survey respondents (93%) say it impacts overall hospital safety, and nearly three-quarters (72%) say it is “very important” to creating a continuous cycle of safety improvement.

Hospital leaders also cite trickle-down benefits from strong safety event reporting mechanisms, including workflow and efficiency advantages for team members across departments.

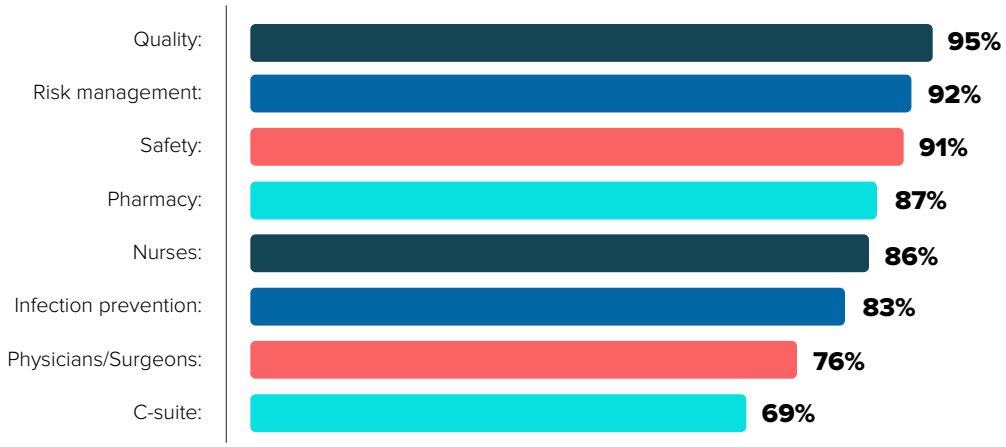
How important to ensuring safety improvement at hospitals is a robust safety event management and reporting system?



How much of an impact do you think safety event reporting has on hospital safety overall?



Which team members would benefit from an optimal safety event reporting system?



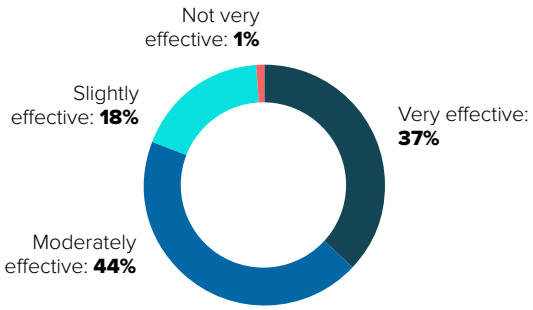
Visitors and Visibility: How an Increase in Visitor Restrictions is Increasing Patient Safety Events

Two-thirds of hospital leaders (66%) say restricted family and visitation policies due to the pandemic contributed to an increase in safety events over the last two years, as less monitoring by family members leads to more unidentified safety problems.

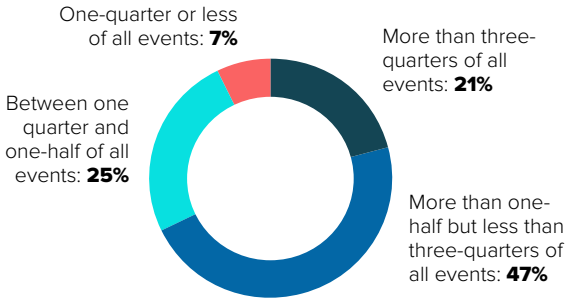
2. Despite widespread acknowledgment of the benefits of safety event reporting, many hospitals describe low rates of event reporting—and low rates of action taken to prevent future events.

Only about one-third of hospital leaders (37%) characterize their safety event reporting mechanisms as "very effective," and 32% say their organizations identify and report fewer than 50% of all events that occur.

How effective is your safety event reporting system?

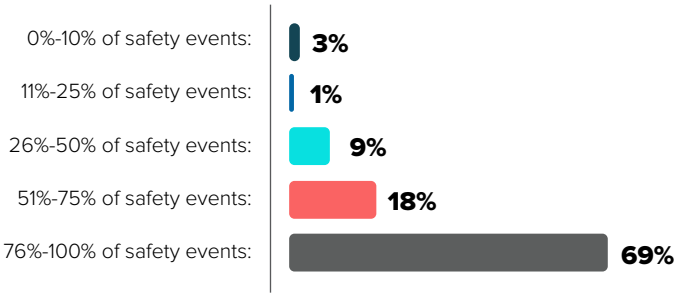


What percentage of safety events do you believe your hospital is identifying and reporting?

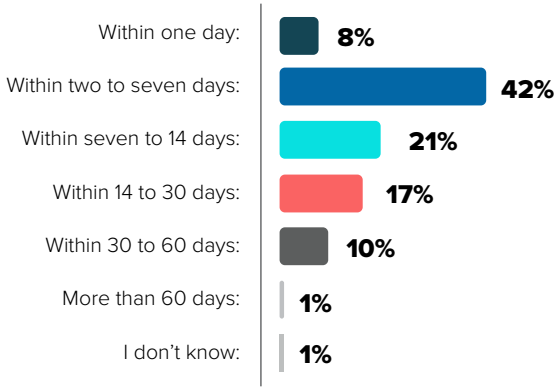


About two-thirds of respondents say that more than 75% of reported safety events are addressed. However, the survey reveals troubling findings regarding delays in actions taken to address events. Fewer than 10% of survey respondents say their hospitals take steps within one day to prevent similar events, and only half think their hospitals take steps within one week.

What percentage of safety events that are reported are addressed?



Once events are identified, how quickly does your hospital take steps to prevent them in the future?



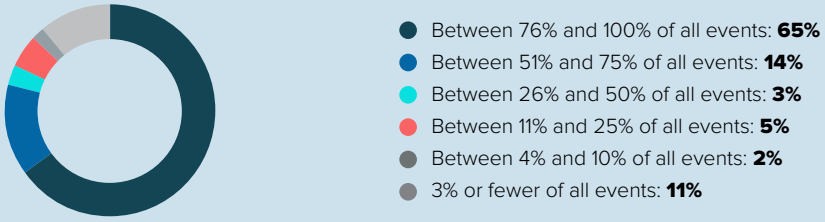
Troubling Findings: Sentinel Events

A sentinel event is a patient safety event that results in death, permanent harm, or severe temporary harm with intervention required to sustain life. While organizations are not required to report these events to The Joint Commission, reporting is encouraged for accredited health systems. Self-reporting raises the level of transparency and credibility of an organization and promotes a culture of safety, which enhances patient trust and employee retention.

According to Becker's Hospital Review[1], The Joint Commission estimates it receives reports on less than 2% of all sentinel events that occur in healthcare.* This is alarming considering the agency said it received no voluntary reports of hospital-acquired infections in 2020 even though the CDC reported a 24% increase in central-line-associated bloodstream infections, a 35% increase in ventilator-associated events, and a 15% increase in hospital-onset Staphylococcus aureus (MRSA) bloodstream events between 2019-2020.

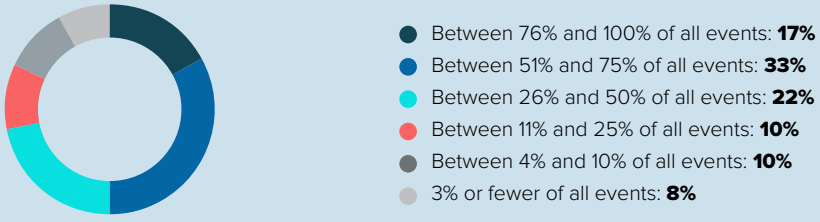
The findings in this survey indicate troubling trends about lack of sentinel event reporting by hospitals and health systems. **More than 10% of respondents say their organizations report just 3% or fewer of these events.**

What percentage of sentinel events do you believe your organization reports?



Survey respondents were even more critical regarding the rate of sentinel events reported when asked to weigh in on the number of events they believe other organizations report. Only 17%, for example, say they believe most hospitals report more than three-quarters of sentinel events.

What percentage of sentinel events do you believe most hospitals report?



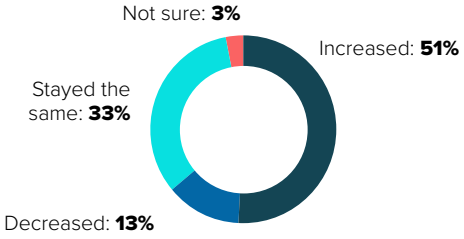
*In February 2022, Becker's Hospital Review released findings[1] from The Joint Commission related to the number of sentinel events that occurred in hospitals nationwide in 2021. While Becker's acknowledged that the number reported reached the highest annual level seen since the accrediting body started publicly reporting them in 2007, the number reported was only 1,197.

3. The low rate of reported and addressed events raises significant patient safety concerns given that the number of safety events has increased over the past two years.

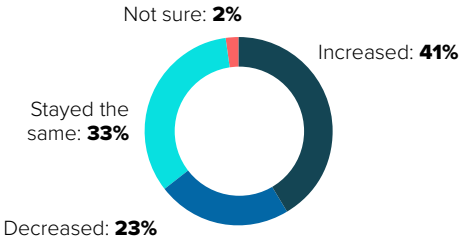
The low rate of reported events in general, as well as the delayed response to reported events, is concerning, particularly because many hospital leaders say the number of patient, staff, and visitor safety events at their organizations has increased over the past two years. If these events aren't reported and acted upon, more avoidable safety problems will likely go unchecked.

While more than half of hospital leaders (51%) say the number of safety events has increased since the beginning of the pandemic, just 41% say the number of reported events has increased. Only 42% report an increase in the number of events addressed.

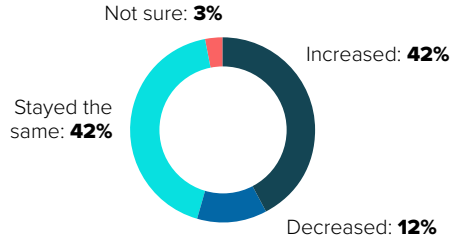
How has the pandemic impacted the total number of safety events at your hospital over the past two years?



How has the pandemic impacted the total number of reported safety events over the past two years?



How has the pandemic impacted the total number of safety events addressed over the past two years?



Overcoming Labor Challenges Associated With Safety Event Reporting

More than three-quarters (86%) of hospital leaders surveyed say staff burnout has led to a patient safety decline. Advanced safety event reporting solutions that offer form auto-population and automated event escalation can help by increasing the rate of reported events while alleviating the burden on staff related to event reporting.

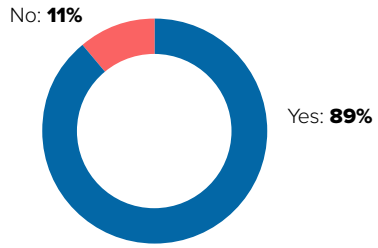
When real-time standardized and normalized data is pulled from clinical surveillance data feeds, it can populate event reporting forms automatically. Auto-populated form fields reduce the amount of typing, clicks, and time required of staff.

An effective safety event reporting solution also detects and escalates safety events without any staff input, as the technology aggregates events and analytics over time. Automation also contributes to streamlined communication of event analysis and action plans, which support enterprise-wide safety for employees.

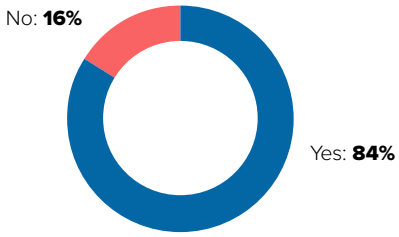
4. Hospital leaders say anonymous event reporting and automated event reporting can positively impact rates of reported events.

About three-quarters (77%) of hospital leaders say their organization enables staff to report safety events anonymously. Of those who have this functionality, 84% say it leads to a greater number of safety events reported.

Does your organization enable staff members to document safety events anonymously?



Do you believe this leads to more safety events being reported?

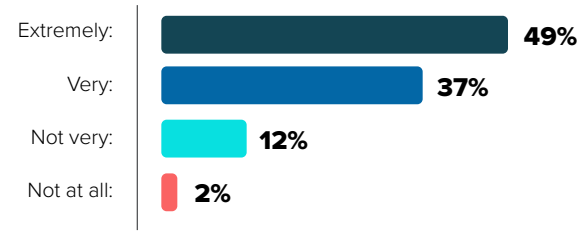


What Is Automated Incident Reporting?

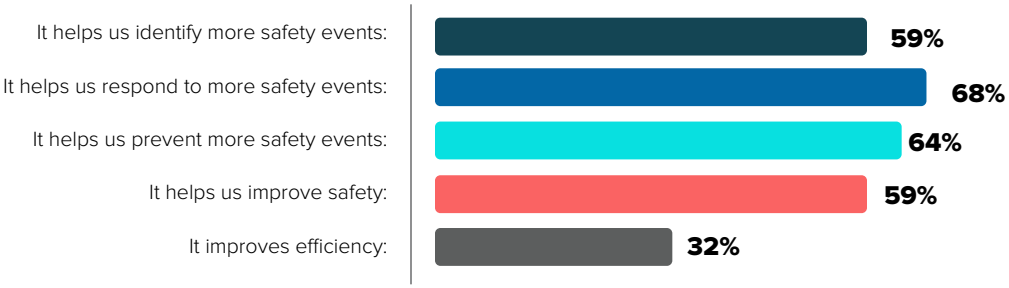
Also known as electronic case finding, automated incident reporting uses software algorithms and/or rules engines to identify safety events that have occurred. Automation used in combination with staff reporting ensures that more safety events are captured quickly.

About 60% of respondents say their organizations automatically identify and log safety events. Among those who do, nearly 90% say this capability is crucial to ensuring that more events (and more types of events) are identified.

How crucial is automated event reporting to ensuring that more events are identified?

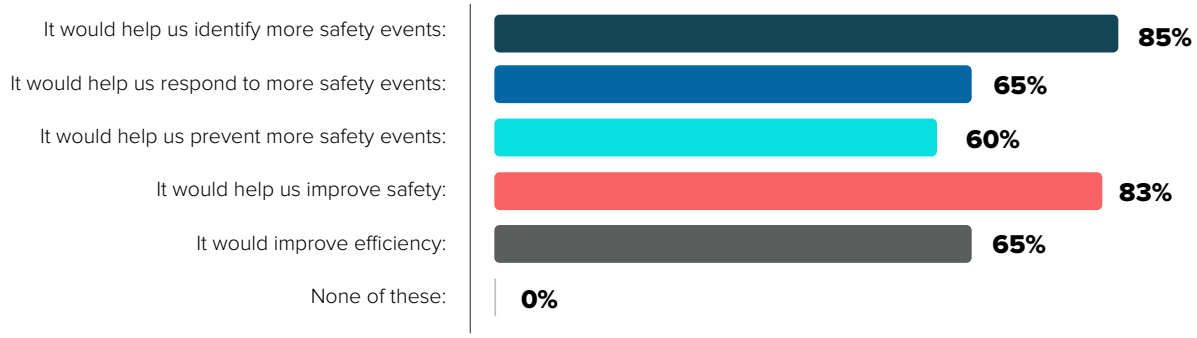


How does the ability to automatically identify safety events affect your organization?



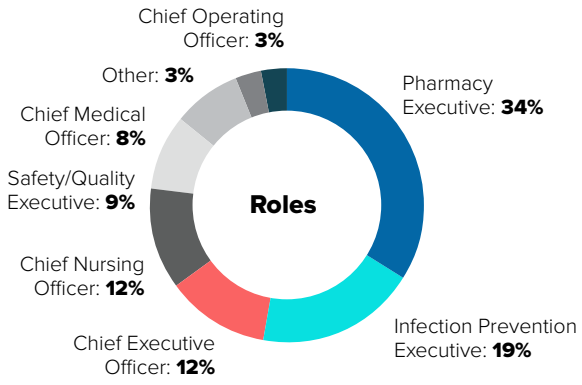
Those who do not have a system to automatically identify and log safety events also appreciate the high value of the capability.

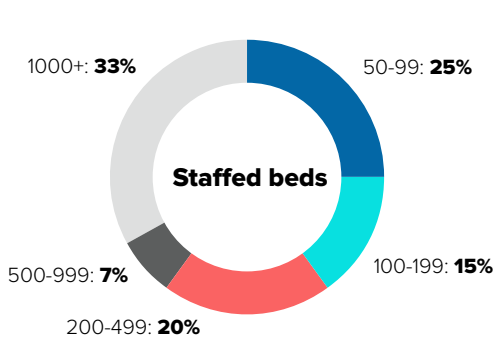
How would the ability to automatically identify and log events help your organization?

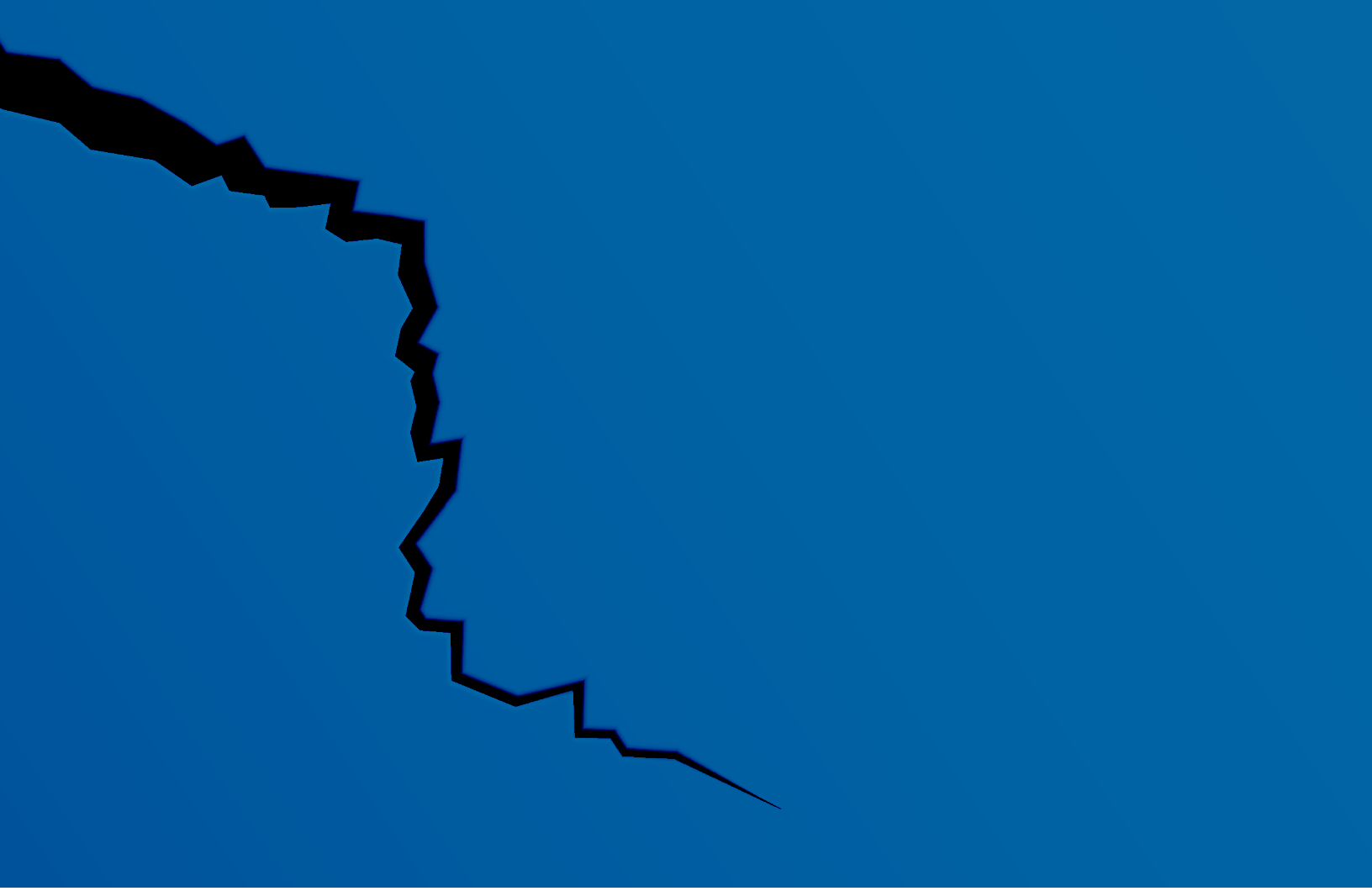


METHODOLOGY

This report highlights findings from a January 2022 survey of 100 hospital executives and clinical leaders. The respondents hailed from hospitals and health systems of various sizes across the country, with most employed by short- and long-term acute care hospitals and critical access hospitals. Healthcare consultancy Sage Growth Partners conducted the survey.







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Mackenzie Bean. Sentinel event reports up slightly from 2020, Joint Commission finds. Becker's Hospital Review. 2021: https://www.beckershospitalreview.com/patient-safety-outcomes/sentinel-event-reports-up-slightly-from-2020-joint-commission-finds.html