HealthManagement
Promoting Management and Leadership

Top 10 Patient Safety Concerns 2024: How to Identify and Address Current Concerns

The healthcare industry faces numerous challenges including adapting to new technologies, navigating changes in care delivery settings, and addressing complex risks like staff burnout and workplace violence. Despite these challenges, ensuring patient and workforce safety remains paramount. An annual report from the Emergency Care Research Institute (ECRI) and the Institute for Safe Medication Practices (ISMP) highlights the industry's top 10 patient safety concerns. These concerns, drawn from evidence-based research and expert insights, range from emerging risks to unresolved issues, all presenting opportunities for organisations to reduce harm. The report guides healthcare leaders to implement proactive strategies and solutions, aiming to mitigate risks, improve outcomes, and enhance the well-being of patients and the healthcare workforce.

Emergency Care Research Institute (ECRI) and Institute for Safe Medication Practices (ISMP) Methodology

ECRI and ISMP's top 10 patient safety concerns reflect their extensive expertise in patient safety and risk management, drawing on a diverse team of experts across various fields. They analyse a vast database of patient safety events to improve care, with ISMP renowned for its leadership in medication safety. The selection process for these concerns involves proposing and evaluating topics supported by scientific literature, event reports, and other data sources. Nominators consider factors such as impact on healthcare disparities, worker safety, and patient well-being. This year, ECRI and ISMP also solicited nominations from their members. An interdisciplinary team then assesses each topic based on severity, frequency, breadth of impact, insidiousness, and organisational pressure, resulting in the ranking of the top 10 patient safety concerns.

Patient Safety Concern #1: Challenges Transitioning Newly Trained Clinicians from Education into Practice

The COVID-19 pandemic has disrupted the typical hands-on educational experiences for clinicians, potentially increasing the risk of harm to patients as new clinicians transition into practice. While employment rates for new clinicians remained positive compared to other industries, concerns are growing among physicians and nursing leaders about the difficulty of this transition. Many new nurses feel unprepared to practice independently, leading to reduced confidence, burnout, and decreased attention to safety culture.

During the pandemic, medical residents and new nurses missed out on crucial learning opportunities, leading to concerns about their preparedness for clinical practice. Additionally, there is a discrepancy in safety event reporting between new and more experienced clinicians, possibly indicating reduced mindfulness around safety culture among new clinicians.

The transition into practice for new clinicians is further complicated by ongoing staffing challenges in healthcare, including shortages of trainers and training programs, an impending shortage of experienced healthcare professionals, and increased burnout rates among healthcare staff, including new clinicians. These challenges contribute to the overall strain on the healthcare workforce and may impact patient care.

Action Recommendations
Preparing new clinicians for Transition to Practice (TTP) is a joint responsibility of leaders in educational institutions and healthcare organisations. By adopting a total systems safety approach, leaders can evaluate and revamp the academic and clinical environments where clinicians are trained, onboarded, mentored, and supported. Involving newly trained clinicians in system design and problem-solving is crucial, as their perspective is valuable. It's essential to recognise that necessary changes reflect system-level deficiencies rather than the shortcomings of individual clinicians.

- **Culture, Leadership & Governance**
  - Utilise a total systems safety approach to design a robust safety and clinical operating system that identifies and addresses risks

associated with inexperienced clinicians.
    - Foster collaborative partnerships between academic and healthcare institutions to enhance opportunities for live hands-on learning and simulation-based learning for interprofessional skill development.
    - Strengthen Transition to Practice (TTP) programs by implementing intensive preceptorships overseen by experienced clinicians, prioritising training to build experience and confidence to meet practice standards.
    - Incorporate diversity, equity, and inclusion (DEI) leaders in the development of new clinician mentorship and training programmes, establish diverse preceptors, and explore initiatives like the Accreditation Council for Graduate Medical Education's Equity Matters program to support DEI improvement efforts.

- **Patient and Family Engagement**
    - Aid new clinicians in enhancing patient engagement skills by utilising tools like AHRQ's 60 Seconds To Improve Diagnostic Safety, enabling patients to share their health story uninterrupted for one minute, followed by clinician questions to enhance comprehension.
    - Solicit feedback from patient and family advisory councils on ways newly trained clinicians can enhance the patient-centred care experience.

- **Workforce Safety & Wellness**
    - Utilise data-driven approaches to enhance workplace safety for newly trained clinicians, including measuring attitudes, perceptions, and beliefs regarding workplace safety using tools like AHRQ's Workplace Safety Supplemental Item Set for the Hospital SOPS.
    - Implement wellness programmes such as the AMA's Joy in Medicine™ Health System Recognition Program or the ANA's Healthy Nurse Healthy Nation Program to foster resilience and meaning in work, aiming to reduce burnout and support clinician well-being.
    - Foster a culture of safety that encourages newly trained clinicians to report safety events impacting themselves, coworkers, and patients, including unsafe working conditions or tasks beyond their competency. Monitor the impact of these initiatives using data from a culture of safety survey.

- **Learning System**
    - Supplement live hands-on learning with simulation-based education to address complex issues like identifying sepsis, understanding bias in diagnostic errors, and enhancing professional and personal skills such as leadership, communication, decision-making, situational awareness, stress management, and fatigue coping.
    - Integrate patient safety training as a fundamental component of education for all new health professionals at academic and healthcare organisation levels. Implement regular safety-competency assessments and action plans to enhance safety skills and behaviours.
    - Utilise clinician-led continuous improvement structures like shared-governance councils and resident/fellow quality improvement projects to facilitate collaboration and innovation among new and experienced clinicians. Examples include programmes like ACGME's Back to Bedside initiative, empowering residents and fellows to develop transformative projects that promote meaning and joy in work.

Patient Safety Concern #2: Workarounds with Barcode Medication Administration Systems

Barcode medication administration (BCMA) systems are crucial for preventing medication errors, but scanning or labelling errors can lead to staff developing workarounds, compromising patient safety. Workarounds occur when barcodes can't be scanned or are damaged, missing, or difficult to scan, or when medications aren't in the system. These may stem from inadequate staff training, improper system configuration, or staff misunderstanding of technology's safety value. Examples of unsafe BCMA practices include administering unscanned medication, retroactively charting, proxy scanning, and ignoring system alerts. An examination of technology-related medication safety issues reported to ECRI and the ISMP PSO in 2019 found that 66% were related to barcode scanning issues, making it the most reported technology issue.

Action Recommendations
BMCA systems are valuable tools that reduce medication administration errors, but only when used correctly. Staff must be trained on the proper use of the system, and procedures must be established to quickly address problems.

- **Culture, Leadership & Governance**
    - Form a multidisciplinary team to review practices causing BCMA workarounds, and devise modifications and configurations to resolve system issues and promote safe clinical workflow.
    - Collaborate between clinical leaders and human resources partners to implement a just culture approach for addressing staff behaviours associated with BCMA workarounds.
    - Establish an escalation process for unscannable barcodes, including protocols for reporting scanning issues, emphasising the dangers of proxy scanning, and designating responsibility for monitoring barcode-related issues.

- **Patient and Family Engagement**
    - Inform patients and families that practitioners will scan each medication before administration and encourage them to speak up if this process is not followed.
    - If an adverse event arises due to a BCMA system workaround, adhere to organisational disclosure procedures to communicate the error to patients and/or their families.

- **Workforce Safety & Wellness**
    - Employ clinically informed human-factors-engineering methods to evaluate challenges in integrating BCMA technology into clinical workflows.
    - Establish a reporting and recognition system to commend staff members who speak up and report near-miss events concerning barcode scanning issues.

- **Learning System**
    - Establish improvement goals aligned with national benchmarks and safety standards for BCMA processes and communicate data to leaders and frontline staff.
    - Analyse reported serious safety events associated with BCMA to identify contributing factors, such as workarounds or equipment malfunctions.

- Report barcode scanning issues to the product manufacturer, the US Food and Drug Administration, and ISMP/ECRI for further evaluation and resolution.

Patient Safety Concern #3: Barriers to Access Maternal and Perinatal Care

Limited access to obstetric and reproductive care poses significant risks, including pregnancy-related deaths, preterm deliveries, low-birthweight babies, and infant mortality, particularly affecting people of colour and vulnerable populations. Approximately 2.2 million women of reproductive age in the US reside in maternity care deserts, with no access to obstetric care, birth centres, or OB-GYN providers. Another 4.7 million have restricted access to care around childbirth. A projected deficit of 22,000 obstetricians by 2050 exacerbates the problem, alongside inconsistent reimbursement for obstetric services. Barriers to care contribute to preventable maternal deaths, with the US maternal mortality rate ranking worst among affluent countries. The reversal of Roe v. Wade further complicates matters, as providers face legal and ethical dilemmas, impacting decisions on practising obstetrics. States with restricted abortion access exhibit fewer maternity care providers, more care deserts, higher maternal mortality rates—especially among women of colour—and greater racial disparities in healthcare systems compared to states with accessible abortion services.

Action Recommendations
Evolving legal and professional landscapes around reproductive care, together with ongoing challenges for physicians regarding medical malpractice insurance coverage and the reduction of obstetric services, present patient barriers to adequate, accessible maternal and perinatal care.

- **Culture, Leadership & Governance**
  - Prioritise the reduction of preventable maternal harm as a key quality improvement objective, aligning with national maternal health initiatives.
  - Advocate for public policies, with board support, to extend insurance coverage to 12 months postpartum, promote family planning services, reimburse community partnerships with midwife and doula care, and support maternal home visiting programmes. Develop obstetric workforces to provide care in maternity care deserts, addressing gaps in access to maternal healthcare services.
- **Patient and Family Engagement**
  - Encourage pregnant and postpartum patients to voice concerns about potential serious pregnancy-related complications.
  - Allocate sufficient time during obstetric discharge for discussions about maternal support resources, including scheduling a postpartum visit.
  - Implement health-literacy universal precautions and promote culturally and linguistically appropriate care to enhance patient understanding and engagement.
- **Workforce Safety & Wellness**
  - Establish a great-catch reporting programme to acknowledge staff members who identify potential harm to pregnant and postpartum patients, prevent harm, and drive impactful system changes.
  - Create plans to ensure both physical and psychological safety for staff providing perinatal care during stressful or traumatic situations, such as implementing peer support programmes.
- **Learning System**
  - Utilise simulation, scenarios, and feedback to train healthcare teams in responding to obstetric and neonatal emergencies and common postpartum complications.
  - Create improvement plans after maternal or perinatal safety events, consulting OB-GYN experts to implement and ensure compliance with evidence-based clinical bundles, such as the Obstetric Haemorrhage Patient Safety Bundle.

Patient Safety Concern #4: Unintended Consequences of Technology Adoption

The widespread adoption of healthcare technologies, such as electronic health records (EHRs), has brought about significant risks, including patient harm and provider burnout. Emerging technologies like artificial intelligence (AI) and machine learning raise concerns about similar safety issues. While AI has shown promise in healthcare, its effectiveness relies on quality data, and unreliable AI functionality can lead to misdiagnoses or inappropriate care decisions. Challenges with AI applications include obtaining high-quality data, addressing bias, scaling and integration, transparency, privacy, and liability issues, all of which can compromise patient safety. Additionally, bias within AI data can affect accuracy and effectiveness, as AI algorithms may be biased towards specific patient populations used in training.

Action Recommendations
The untested nature of emergent technologies can hinder the ability to fully assess their effectiveness or understand and mitigate their risks. Organisations must establish processes for evaluating, implementing, and maintaining these technologies to prevent unintended consequences and to address emerging issues.

- **Culture, Leadership & Governance**
  - Form a multidisciplinary committee comprising representatives from leadership, clinical services, human factors engineering, clinical engineering, patient safety, and risk management to evaluate new technologies and assess associated risks.
  - Develop policies for implementing technology that integrates artificial intelligence (AI), covering pre-deployment and ongoing validation, testing protocols, risk assessments, investigation and resolution of issues, and maintenance throughout the technology's lifecycle.
- **Patient and Family Engagement**
  - Be ready to respond to questions and apprehensions from patients and families regarding the potential risks of AI technology, such as privacy, accuracy, and bias.

- Involve patient and family advisory councils to grasp the patient's viewpoint on the influence of digital solutions on health literacy and shared decision-making.

- **Workforce Safety & Wellness**
  - Recognise challenges such as staffing shortages, burnout, and cognitive overload that may lead to overreliance on or misuse of AI and other emerging technologies.
  - Employ clinically informed human-factors-engineering methods to evaluate clinical workflows, assessing the potential impact of new technologies, including alterations to the Electronic Health Record (EHR).

- **Learning System**
  - Ensure staff receive adequate training on equipment utilising AI and stress the importance of reporting unusual results. Encourage reliance on clinical judgment, seeking second opinions, and reporting anomalies for investigation and resolution.
  - Validate AI applications using historical organisational data to identify inequitable or inadequate performance or inherent biases before implementation. Continuously monitor for these factors post-implementation.

Patient Safety Concern #5: Decline in Physical and Emotional Well-Being of Healthcare Workers

The healthcare industry has long faced challenges with stressful work environments impacting the well-being of healthcare workers, which were exacerbated by the COVID-19 pandemic. Key issues include significant job losses, widespread burnout, anxiety, and depression among healthcare workers, persistent burnout in medical staff, workplace violence incidents, and ongoing supply chain vulnerabilities. These stressors have led many healthcare workers to consider leaving the profession, creating a cycle that increases stress for remaining staff and may compromise both patient safety and staff well-being.

Action Recommendations

Supporting the physical and emotional well-being of healthcare workers requires a multipronged systems-safety approach to improving staff levels, workplace violence prevention programmes, mental health resources for staff, and organisational resilience.

- **Culture, Leadership & Governance**
  - Leaders exemplify behaviour by nurturing a culture of physical and psychological safety, promoting openness about behavioural health needs, maintaining transparency, and fostering personal connections with staff.
  - Secure board support to prioritise workforce well-being, allocating dedicated resources to support initiatives.
  - Involve departmental leaders and managers in enhancing staff awareness of well-being resources, including peer support and self-care activities to achieve work-life balance.
  - Investigate methods to enhance staff recruitment and retention efforts, such as collaborating with local healthcare education providers for candidate pipelines, offering hiring incentives, and reassessing employee benefits.

- **Patient and Family Engagement**
  - Utilise patient and family engagement committees to identify areas of concern, prioritise issues, share positive feedback, and acknowledge team members committed to enhancing satisfaction.
  - Clearly communicate patient and visitor codes of conduct to foster safe and healthy relationships between patients and providers.

- **Workforce Safety & Wellness**
  - Deploy a behavioural emergency or crisis response team comprising trained individuals to de-escalate situations prone to violence.
  - Establish a peer support programme equipped with a team trained in psychological first aid to assist staff in coping with stressful or traumatic workplace events.

- **Learning System**
  - Utilise organisational data, including adverse events, staffing, workloads, culture of safety, and employee engagement, to pinpoint issues and their root causes, and collaborate with staff to develop effective wellness solutions.
  - Evaluate current physical and behavioural health resources, measure utilisation, gather feedback, and identify areas for enhancement. Involve perspectives from various teams including human resources, clinical, operational, facilities, quality, technology, and patient experience.

Patient Safety Concern #6: Complexity of Preventing Diagnostic Error

Frequent diagnostic errors and delayed diagnoses pose significant risks to patients, leading to missed treatment opportunities and potential harm. Studies indicate that women and minorities face a higher risk of diagnostic errors, associated with factors like gender, race, and ethnicity. Various population and risk factors, including race, ethnicity, socioeconomic status, and language, may contribute to diagnostic inequities. Improving diagnostic safety starts with accurately measuring harm, with about half of serious diagnostic errors linked to 15 diseases, providing an opportunity to reduce harm significantly. Effective management of medical tests, considering that 40% of primary care encounters involve some form of testing, offers a significant avenue to reduce errors and patient harm.

Action Recommendations

The diagnostic process is a complex, collaborative process that involves clinical reasoning and information gathering. Beyond the clinician’s own skill, system factors—latent and active—may inhibit diagnostic excellence. A comprehensive approach must range from the individual clinician to organisational strategies.

- **Culture, Leadership & Governance**

- Employ various mechanisms such as workflow management tools, interventions, notifications, checklists, alerts, and dashboards, to ensure timely and appropriate communication of actionable patient data.
- Give precedence to health information technology infrastructure that facilitates the interoperability of patient data and diagnostic results.
- Align improvement objectives with established benchmarks and offer feedback on diagnostic performance to clinicians and organisational leaders.
- Evaluate the organization's support for the diagnostic process and communication regarding diagnoses.

- **Patient and Family Engagement**
  - Ensure continuous communication among patients, families, caregivers, and providers during and after care visits.
  - Create shared decision-making tools to facilitate discussions about diagnosis and treatment between patients and families.
  - Establish processes for communication, apology, and resolution in cases of unanticipated outcomes resulting from diagnostic errors.

- **Workforce Safety & Wellness**
  - Create staff training materials to improve understanding of cognitive bias and empathetic listening.
  - Offer peer support to team members involved in diagnostic-error events that led to patient harm.

- **Learning System**
  - Utilise evidence-based tools to measure diagnostic errors, incorporating quality and safety event data, patient experience, claims, complaints, electronic health record (EHR) data, reports from clinicians and staff, and clinical surveillance.
  - Offer evidence-based resources, such as those from the Society to Improve Diagnosis in Medicine, to facilitate organisational learning.
  - Analyse social determinants of health data and devise strategies to recognise and mitigate disparities in the diagnostic process.
  - Enhance the causal analysis process to pinpoint improvement opportunities for latent and active system failures in the diagnostic process, and disseminate lessons learned throughout the organisation.

Patient Safety Concern #7: Providing Equitable Care for People with Physical and Intellectual Disabilities

More than a quarter of US adults have a disability, yet only a minority of physicians feel very confident in providing equitable care to these patients. People with disabilities face higher rates of adverse health conditions, including COVID-19, mental health issues, and abuse. They also experience health disparities due to diagnostic overshadowing, where symptoms are incorrectly attributed to a disability rather than a coexisting condition. Despite the Americans with Disabilities Act (ADA), barriers to accessible care persist, including attitudinal, communication, physical, policy, programmatic, and transportation-related barriers. Consequently, a significant portion of adults with disabilities lack a dedicated healthcare provider and miss routine checkups.

Action Recommendations

Healthcare organisations must ensure that adequate infrastructure and system processes are in place so clinicians can provide equitable care for patients with all types of disabilities.

- **Culture, Leadership & Governance**
  - Ensure full and equitable access to services for individuals with disabilities per the Americans with Disabilities Act (ADA) and relevant state and local regulations, including compliance with provisions for service animals, parking, and mobility and communication devices.
  - Establish organisational objectives aimed at promoting disability-competent healthcare values.

- **Patient and Family Engagement**
  - Evaluate and record the patient's health literacy and ability to give informed consent, allocating adequate time for comprehension and questions. Adhere to legal and ethical protocols if the patient is unable to consent.
  - Collaborate with the patient and their family to develop a shared care plan, facilitating care coordination.
  - Communicate and arrange necessary accommodations with the patient before their visit, ensuring this information is clearly documented in the electronic health record (EHR).
  - Incorporate an individual with a disability into the patient and family advisory council.

- **Workforce Safety & Wellness**
  - Staff should communicate the presence of service animals during each handoff. If a staff member has allergies, designate another staff member to provide care rather than denying care to the patient.
  - Train staff in the safe use of equipment such as patient lifts, exam tables, scales for patients with mobility challenges, and communication aids.

- **Learning System**
  - Conduct thorough analyses of safety events affecting patients with intellectual and physical disabilities to identify contributing factors, including instances of diagnostic overshadowing and diagnostic errors.
  - Offer feedback and educational initiatives to clinicians aimed at enhancing competency and reducing unconscious bias when providing care for patients with disabilities.

Patient Safety Concern #8: Delay in Care Resulting from Drug, Supply, and Equipment Shortages

Drug, supply, and equipment shortages disrupt patient care in healthcare, causing delays in treatment, worsened outcomes, and increased costs. Factors such as shortages of raw materials, production centralization, and decisions by limited-source vendors contribute to unpredictable shortages, worsened by natural disasters and global issues. Despite efforts, the healthcare supply chain struggles post-COVID-19, with 93% of executives reporting ongoing shortages. In mid-2023, the US faced shortages for 309 drugs critical for many patients. Clinical departments, including surgery, emergency care, and oncology, are affected, leading to serious adverse effects. Shortages contribute to errors, with 24% of

respondents aware of shortage-related errors in the last six months. Organisations often resort to substitutes, necessitating new workflows and training, increasing error risks.

Action Recommendations

Drug, supply, and equipment shortages remain persistent and can impact the ability to treat patients and protect staff, emphasising the importance of prioritising and improving inventory management and supply chain decision-making.

- **Culture, Leadership & Governance**
  - Regularly conduct inventory checks and risk assessments to identify critical supplies and prioritise them.
  - Leaders should advocate for transparency from suppliers to understand sourcing and alternative acquisition plans.
  - Evaluate the feasibility and benefits of shifting suppliers to more stable locations to mitigate geopolitical risks. Compare costs and benefits between sole-source and multisource agreements to ensure resilience in the supply chain.
- **Patient and Family Engagement**
  - Inform patients promptly about any shortages affecting their recurring medications, supplies, or equipment.
  - Employ shared decision-making when considering alternative treatments, ensuring patients are involved in the process. Reevaluate informed consent requirements, especially when alternative treatments are being considered.
- **Workforce Safety & Wellness**
  - Ensure the availability of quality personal protective equipment (PPE) and maintain sufficient supplies.
  - Implement a tiered safety huddle process to promptly communicate alerts regarding medication and supply shortages, hazards, and recalls to all relevant clinical and operational team members.
- **Learning System**
  - Monitor drug shortages through various data sources.
  - Analyse supply chain data to identify challenging supplies and diversify vendor relationships.
  - Track and analyse adverse events related to shortages to inform supply chain decisions and management.

Patient Safety Concern #9: Misuse of Parenteral Syringes to Administer Oral Liquid Medications

Using parenteral syringes for oral/enteral liquid medications poses a risk of wrong-route misadministration if injected into an IV line. This error can lead to serious consequences, including infection and even patient death. Oral/enteral syringes have hubs that prevent attachment to standard IV lines, reducing this risk. However, healthcare providers may be unaware of these differences, leading to inadvertent IV administration. Examples include administering oral oxycodone or liquid-filled capsules like nimodipine intravenously, resulting in fatalities.

Action Recommendations

The use of oral/enteral syringes is an effective risk-reduction strategy. Organisations must maintain the availability of oral and/or enteral syringes and educate staff on the importance of using them when preparing and administering oral liquid medications.

- **Culture, Leadership & Governance**
  - Invest in technology-enabled processes to ensure an adequate supply of oral and/or enteral syringes in all patient care areas.
  - Make it an organisational goal to convert to ENFit enteral devices as soon as practical.
  - Engage nursing leaders to emphasise to all nurses the importance of never using parenteral syringes for oral liquid medications. Explain the rationale behind using oral and/or enteral devices as a forcing function to prevent wrong-route misconnections.
- **Patient and Family Engagement**
  - Educate patients and families about organisational policies for preventing wrong-route medication errors.
  - Provide education to families and caregivers of hospital patients discharged with feeding tubes, emphasising the importance of having access to compatible enteral syringes.
- **Workforce Safety & Wellness**
  - Implement a peer support programme to offer emotional support to team members who are involved in serious medication safety events.
- **Learning System**
  - Conduct root cause analyses for all serious safety events involving parenteral syringes used for oral or enteral medications to identify active and latent contributing system factors.
  - Establish an internal review and response process for addressing concerns or reported events related to improper use of parenteral syringes for administering oral liquid medications within the organization, and gather feedback from staff.

Patient Safety Concern #10: Ongoing Challenges with Preventing Patient Falls

Patient falls continue to pose a significant threat to patient safety, representing the primary sentinel event reported to the Joint Commission and resulting in serious harm and fatalities despite extensive efforts to address their occurrence. Studies indicate disparities in fall-related deaths among different racial groups and age categories, with seniors and sensory-impaired individuals being particularly vulnerable. The prevalence of patient falls remains high across various healthcare settings, including hospitals, critical access hospitals, ambulatory care facilities, home care, and behavioural health centres. Contributing factors to falls with injury include communication issues, staff performance, management/workforce issues, and equipment-related factors. Fall prevention has been designated as a National Patient Safety Goal for hospitals and long-term care facilities, underscoring the ongoing need to address this critical patient safety issue.

Action Recommendations

While patient falls may not be eliminated within healthcare settings, adherence to protocols and interdisciplinary approaches to caring for at-risk patients can significantly decrease the frequency and severity of falls and injuries.

- **Culture, Leadership & Governance**
  - Appoint an executive sponsor responsible for fall prevention efforts, overseeing staffing plans, adoption of technology, and patient-handling programmes.
  - Employ a just culture approach in reviewing fall-related safety events to assess staff actions and decisions.
  - Assess the culture of safety survey data to identify areas for enhancing communication and teamwork regarding patient falls.
- **Patient and Family Engagement**
  - Develop a strategy to involve patients and families, including non-English speakers, in creating fall prevention strategies.
  - Implement purposeful rounding to evaluate individual patient needs like toileting and mobility preferences.
  - Customize interventions for patients with varying fall risks according to the latest fall prevention research.
- **Workforce Safety & Wellness**
  - Introduce comprehensive fall prevention training for staff, covering identification and reporting of fall risks.
  - Utilize a tiered safety-huddle system to promptly address staffing, safety, and environmental issues that could increase patient fall risk.
- **Learning System**
  - Establish an interdisciplinary falls management team tasked with developing and executing a program encompassing prevention strategies, data tracking, fall risk evaluations, and ongoing improvement initiatives.

Source: ECRI

Image Credit: iStock

Published on : Tue, 19 Mar 2024