Practice Statement: Healthcare organizations must systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously drive down preventable patient harm.

Objective: Ensure that patient safety risks and hazards are continually identified and communicated to all levels of the organization, that mitigation activities are aggressively undertaken to minimize harm to patients, and that patient safety information is communicated to the appropriate external organizations.

Rationale: Healthcare organizations are fraught with system failures that compromise care by making it more fragmented and complex. Opportunities for these organizations to learn from their failures are often impeded by their own structures and cultures. System-related harm to patients is much more frequent than previously thought—especially in older patients. Tools are available, such as the Institute for Healthcare Improvement-recommended Global Trigger Tool, which can be the basis for identifying risk and estimating the frequency of adverse events in an organization. The activities of identifying and mitigating risks and hazards are typically not systematically integrated across an organization. Even in hospitals where these systems are in place, clinicians significantly underreport medical errors. Rarely is risk identification fully linked to mitigation activities or performance improvement programs, nor is it routinely tied to the impact of disclosure or non-disclosure of medical errors causing harm. The severity of harm resulting from the absence of coordinated patient safety programs cannot be accurately estimated.

Evidence for Rationale:

Impact:
Evidence of High Impact:

Opportunity:
- Opportunity for improvement exists, based on the coefficient of variation for the measure.