NQF Safe Practice #4: Identification and Mitigation of Risks and Hazards
NQF# Not NQF Endorsed
Developer: TMIT
Data Source: Leapfrog Hospital Survey
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: · Denham CR. From harmony to healing: join the quality choir. J Patient Safe 2006 Dec;2(4):225-32. · Denham CR. Is your hospital as safe as your bank?...time to ask your board. J Patient Saf 2009 Jun;5(2):122-6. · Griffin FA, Classen DC. Detection of adverse events in surgical patients using the Trigger Tool approach. Qual Saf Health Care 2008 Aug;17(4):253-8. · Griffin FA, Resar RK. IHI Global Trigger Tool for Measuring Adverse Events (2nd Edition). White Paperse:13. Cambrdige (MA):Institute for Healthcare Improvement (IHI);2009. · Kaldjian LC, Jones EW, Wu BJ, et al. Disclosing medical errors to patients: attitudes and practices of physicians and trainees. J Gen Intern Med 2007 Jul;22(7):988-96. · Kaldjian LC, Jones EW, Wu BJ, et al. Reporting medical errors to improve patient safety: a survey of physicians in teaching hospitals. Arch Intern Med 2008 Jan 14;168(1):40-6. · Levinson D. Department of Health and Human Services. Office of Inspector General. Adverse events in hospitals: overview of key issues. 2008 Dec. OEI-06-07-00470. · Reason JT, Carthey J, de Leval MR. Diagnosing “vulnerable system syndrome”: an essential prerequisite to effective risk management. Qual Health Care 2001 Dec;10 Suppl 2:ii21-5
Impact: **Evidence of High Impact:** · National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010.
Opportunity: · Opportunity for improvement exists, based on the coefficient of variation for the measure.

NQF. Safe practices for better healthcare-2010 update: A consensus report.