Health System Risk Management - Guidance

Top 10 Patient Safety Concerns 2024

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The healthcare industry is currently at a crossroads. Organizations are adapting clinician workflows to new technologies, steering through changes in care delivery settings, mitigating complex risks like staff burnout and workplace violence, and navigating an uncertain economic and global political climate. Despite these challenges, ensuring patient and workforce safety across the healthcare continuum must remain a top priority for all healthcare organizations.

This annual report from ECRI and the Institute for Safe Medication Practices (ISMP) presents the top 10 patient safety concerns currently confronting the healthcare industry. Drawing on ECRI and ISMP's evidence-based research, data, and expert insights, this report sheds light on issues that leaders should evaluate within their own institutions as potential opportunities to reduce preventable harm. Some of the concerns represent emerging risks, some are well known but still unresolved, but all of them pertain to areas where organizations can make meaningful change. The Top 10 Patient Safety Concerns 2024 is a guide for a systems approach to adopting proactive strategies and solutions to mitigate risks, improve healthcare outcomes, and ultimately, enhance the well-being of patients and the healthcare workforce.

The List for 2024

1. Challenges Transitioning Newly Trained Clinicians from Education into Practice
2. Workarounds with Barcode Medication Administration Systems
3. Barriers to Access Maternal and Perinatal Care
4. Unintended Consequences of Technology Adoption
5. Decline in Physical and Emotional Well-Being of Healthcare Workers
6. Complexity of Preventing Diagnostic Error
7. Providing Equitable Care for People with Physical and Intellectual Disabilities
8. Delay in Care Resulting from Drug, Supply, and Equipment Shortages
9. Misuse of Parenteral Syringes to Administer Oral Liquid Medications
10. Ongoing Challenges with Preventing Patient Falls

The 2024 Top 10: Vulnerabilities in Safety and Clinical Operating Systems

To effectively understand where vulnerabilities lie, organizations must examine all elements of the system—people, organizations, tasks and processes, tools and technology, and the physical environment.

Each concern in this year's list represents a failure in at least one of these areas, in fact, many overlap and find causes in multiple areas.

Supporting Total Systems Safety

Total systems safety focuses on creating greater efficiency and resilience in clinical and safety operations. It incorporates principles of human factors, systems design engineering, health equity, and advanced safety science to redesign individual components of systems to be more transparent and aligned, leading to safer and more effective care.

Method for Selecting our List

The top 10 list reflects ECRI and ISMP's broad patient safety and risk management expertise. Our interdisciplinary staff includes experts in medicine, nursing, pharmacy, patient safety, quality, risk management, clinical evidence assessment, health technology, and many other fields. Our patient safety organization (PSO), ECRI and the ISMP PSO, analyzes our patient safety data—a database of nearly six million events—to improve patient care and ISMP is globally recognized as a leader in medication safety.

As part of the topic nomination process, ECRI and ISMP staff proposed important patient and workforce safety concerns to be evaluated. Nominators supported their proposals with information and evidence drawing from scientific literature; trends in event reports, causal analyses, and research requests submitted to ECRI and the ISMP PSO; reports submitted to the ISMP National Medication Errors Reporting Program and the ISMP National Vaccine Errors Reporting Program; medical device alerts, problem reporting, and evaluation; reported medication safety problems; accident investigations; lessons learned from consultation work; and other internal and external data sources. Nominators were also asked to consider whether their concerns impact healthcare disparities, worker safety, and/or patient and family safety.

For the first time this year, ECRI and ISMP also asked our members to nominate topics and share the patient safety issues that concern them most.

A cross-disciplinary team of ECRI and ISMP experts then analyzed the supporting evidence and evaluated each topic using the following criteria:

- **Severity.** How serious would the harm be to patients if this safety issue were to occur?
- **Frequency.** How likely is it for the safety issue to occur?
- **Breadth.** If the safety issue were to occur, how many patients would be affected?
- **Insidiousness.** Is the problem difficult to recognize or challenging to rectify once it occurs?
- **Profile.** Would the safety issue place a lot of pressure on the organization?

Based on these criteria, the interdisciplinary team chose and ranked the top 10 patient safety concerns.

Ongoing Patient Safety Concerns

Over the years, several patient safety issues have made repeat appearances on ECRI's list of top 10 patient safety concerns. See Ongoing Patient Safety Challenges for a list of perennial patient safety issues.

Prioritizing Strategies and Measuring Improvement

To master each concern presented in this year's list, readers can look to our action recommendations, which are framed around the four foundational drivers of safety.

This annual top 10 report propels the implementation of evidence-based recommendations to support the ultimate aim of reducing preventable harm. It shares lessons from ECRI and ISMP's analysis of a wide range of data sources and offers strategies to support continuous improvement in healthcare. This report also illustrates ECRI and ISMP's deep understanding of how systems can contribute to harm—or drive patient safety.

Each item on our top 10 list includes several action recommendations and resources for addressing each concern. No organization can tackle all 10 items and implement all suggested strategies immediately. Organizations must calculate each item's risk score and conduct a gap analysis to evaluate their current practices against our recommendations. To help with this process, organizations can use this year's scorecard.

Healthcare leaders must be intentional about implementing solutions in their own complex, unique organizations. Superficial attempts to improve patient safety will not be enough to make meaningful changes.

Before implementing suggested strategies, leaders must establish systems and processes for measuring and analyzing improvements and be ready to modify or discontinue any strategy based on the results analysis.

Safety concerns can have clinical, cultural, efficiency, and financial impact on an organization. Measuring the results of change should be multimodal—with structural-, process-, and outcomes-related metrics. Sources of data may include event reports; medication-safety data; survey results, including results from culture of safety, employee satisfaction, and patient experience surveys; morbidity and mortality data; length of stay statistics; focus group discussions; and direct observation data. Additionally, organizations should segment data to gain a deeper understanding of inequities that may create disparities in both patient and workforce outcomes.

TOPICS AND METADATA

Topics

Behavioral Health; Culture of Safety; Ethics; Infection Control; Laws, Regulations, Standards;

Medication/Drug Safety; Occupational Health; Quality Assurance/Risk Management; Transitions of Care; Workplace Violence

Roles

Behavioral Health Personnel; Clinical Practitioner; Corporate Compliance Officer; Healthcare Executive; Human Resources; Infection Preventionist; Legal Affairs; Medical Staff Coordinator; Nurse; Patient Safety Officer; Pharmacist; Public Health Professional; Quality Assurance Manager; Regulator/Policy Maker; Risk Manager

Information Type

Guidance

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- Scorecard
- Customizable Risk Map
- Ongoing Patient Safety Challenges