

ARTICLE

Don't Let Operational Challenges Drown out Alarm on Rising Adverse Events

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Sentinel Events Have Soared Over Already High Pre-Pandemic Numbers, New Report Shows

Sentinel events in 2022 increased by 19% over the previous year's numbers—a spike of 78% since 2020, according the latest annual review of sentinel event data released by the Joint Commission last week. About 1 in 5 sentinel events is associated with a patient death.

Modern Healthcare and Becker's highlighted these and other bleak statistics in articles that quickly followed the Joint Commission's data release. Meanwhile, quality and patient safety leaders have been sounding the alarm since the pandemic began in 2020.

But have these alarms cut through the din of today's overwhelming operational challenges?

Operational Issues Pose a Challenge to Patient Safety and Quality Improvement—But the Numbers Underscore the Necessity

It would be a vast understatement to say healthcare is in the midst of many challenges today. The delivery of care has been taxed by supply chain and capacity challenges, care model disruptions, and unprecedented levels of workforce burnout and turnover. Add to that increasing financial strain, with budget shortfalls and reductions in workforce. All this is at a time when patient needs have grown more complex as the result of delays in diagnosis, exacerbations of chronic conditions, the growing behavioral health crisis, and more.

It's easy to see how this roar could drown out the alarm sounding on major quality and safety concerns. But pay attention to the numbers.

20% of sentinel events were associated with patient deaths, according to the Joint Commission. Top of the list for contributors to this dramatic rise in sentinel events was falls, which increased 27% over the last year and made up 42% of all sentinel events. 70% of these events caused severe patient harm, and 5% resulted in patient death. The next biggest drivers were delay in treatment, retained foreign objects, and wrong surgery, each making up 6% of sentinel events. Other sentinel events stemmed from suicide, assault, fire, perinatal events, self-harm, and medication management.

While not all hospitals report sentinel events to the Joint Commission and variation exists within reporting, these numbers represent the tip of the iceberg in patient safety and underscore the great need for continued improvement in keeping patients safe.

While Close to Half of Adverse Events Are Preventable, Few Hospitals Have a Track Record of Reducing Them

Beyond sentinel events, numerous articles have highlighted the rising frequency of adverse events generally since the pandemic began in 2020. These adverse events include double-digit increases in central line-associated bloodstream infections, catheter-associated urinary tract infections, falls, and pressure ulcers.ⁱⁱⁱ

But studies of adverse events even before the pandemic pointed to a strong need for improvement. Earlier this year, David Bates, MD, and colleagues published a study on adverse events in which the authors looked at 11 hospitals in 2018.ⁱⁱⁱ Notable as pre-pandemic data, the study demonstrates that adverse events occur for nearly 1 in 4 hospital admissions (24%). The study also found that 23% of adverse events were deemed preventable. In fact, 7% of all admissions experienced a preventable adverse event. The most frequent adverse events were medication-related (39%); surgical or procedural (30%); nursing care, such as falls (15%); and hospital-acquired infections (12%).

The most recent annual patient harm report from the Office of the Inspector General (OIG) studied Medicare inpatients in 2018. It found that 25% of patients experienced patient harm—12% experienced serious harm, leading to further interventions or death, and 13% experienced temporary harm events. **Overall, 43% of harm events**

were considered preventable. Comparing these data to 2010, the first year in which the OIG reported on patient harm events, there was no significant improvement. In 2010, 27% of patients experienced harm, and 44% of these events were considered preventable.

The study also found that Medicare spends hundreds of millions of dollars monthly because of patient harm. And both patients and hospitals share in the expense for extended stays and additional resources required after patients are harmed.

But how can organizations address these major quality and safety concerns now, if it was a challenge to take on these issues pre-pandemic?

Prioritizing High Reliability Can Address Both Patient Safety and Operational Issues

There are many challenges and competing priorities in healthcare today. With quality and safety remaining unchanged and even worsening over the last 2 decades—especially during the past 2 years—it's understandable that leaders may think they need to defer improvement work until the environment is more stable.

However, the last few years have proven that despite many efforts focused on quality and safety, patient care delivery is not resilient to either the daily or the pandemic-induced stresses in the system. Quite the opposite: These stresses are hurting patients.

And there are many other reasons deferring quality and safety improvement is not an option. Patients rightfully demand better. Various governmental and commercial value-based programs already in place are allocating payments based on quality and avoiding harm—a practice that is expected to increase. And the Department of

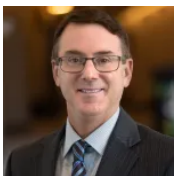
Health and Human Services is recommending a broadened list of hospital-acquired conditions the Centers for Medicare and Medicaid Services captures. It also is recommending a broader scope for regulatory surveyors that includes assessing patient harm and vulnerabilities.

The key to meaningfully improving quality and safety is not asking hard-working staff to work faster, harder, and better. The key is changing how organizations approach quality and safety altogether. It cannot be one more thing provider organizations take on. Rather, it must be the holistic way that they do everything.

Taking the approach of becoming a highly reliable organization should address not only quality and safety concerns but also improve the pressing operational issues that might otherwise stand in the way. These challenges include cost of care, inefficiencies, liability exposure and expense, and staff engagement, retention, and well-being. Improved quality and safety lead to more efficient and effective care, and direct savings that can add up to millions of dollars for hospitals.

It is not the time to wait for the many crises to pass. It is the time to invest in high reliability. Doing so will simultaneously improve the bottom line, workforce issues, and—most importantly—patient outcomes.

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