The Joint Commission
Journal on Quality and Patient Safety®

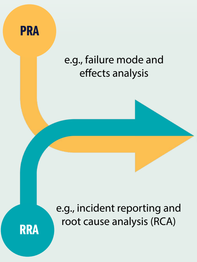
Combined Proactive Risk Assessment

Unifying Proactive and Reactive Risk Assessment Tools

Healthcare facilities aim for zero avoidable patient harm. Toward that aim, healthcare organizations identify, assess, and remediate sources of risk, learning lessons from failures and close calls. Modified risk management techniques have been adopted from other high reliability industries, such as aviation, and often approach proactive and reactive risk assessment as independent activities.

A study from the June/July 2022 issue of *The Joint Commission Journal on Quality and Patient Safety* (JQPS) suggests that conducting risk assessments separately does not identify system vulnerabilities as effectively as combining proactive risk assessment (PRA) and reactive risk assessment (RRA) tools. The study suggests these two tools complement one another and proposes Combined Proactive Risk Assessment (CPRA) as an innovative, approachable, scalable, and generalizable technique for identifying vulnerable points in healthcare processes.

CPRA combines and merges components of PRA and RRA.



CPRA aligns patient safety reporting data with process steps and failure modes to assess risk. The technique involves aggregating similar categories of patient safety reports, combining multiple PRAs conducted on the same topic, and combining components of PRA and RRA.

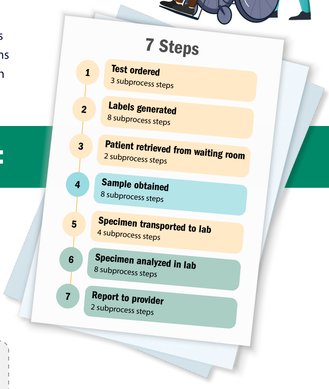
How to Conduct a CPRA:

1. Review or conduct one or more PRAs to create a robust process flow diagram and list of potential failure modes.
2. Identify relevant patient safety reports and overlay them onto the process flow diagram and failure modes.
3. Review relevant patient safety reports to identify additional failure modes not identified by the PRA(s).
4. Conduct a meaningful analysis of the resulting information.

How the Study Tested CPRA:

PRAs from several Veterans Health Administration (VHA) facilities and data from the VHA National Center for Patient Safety related to outpatient blood draws were used to develop a comprehensive flow diagram and list of potential failure modes, which were **grouped into seven steps with 35 subprocess steps**.

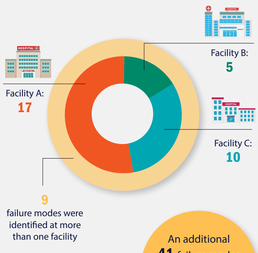
Individual concept sheets were prepared for the outpatient blood draw process and the content was translated into search query syntax. The search terms were applied to the free text event narrative portion of the patient safety reports.



Findings of the VHA Study:

Aggregating PRAs from multiple facilities identified **220%** more failure modes and integrating incident reports into PRA identified **310%** more failure modes than the single facility average.

Aggregating PRAs from multiple facilities identified **32** distinct failure modes.

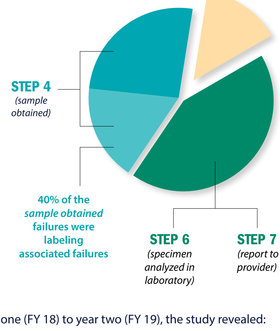


9 failure modes were identified at more than one facility

no failure mode was identified by all 3

An additional **41** failure modes were identified during the mapping process.

Overlaying safety reports onto a comprehensive process flow diagram revealed **86%** of events occurred during three of the seven process steps.



The overlay also revealed changes over time. From year one (FY 18) to year two (FY 19), the study revealed:

- A **655%** increase for **failure mode specimen not obtained**
- A **176%** increase in **failure mode unviable sample**
- A **24%** reduction in **failure mode identification failure**

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The study shows that the CPRA technique is promising for increasing the return on investment of safety reporting systems, monitoring risk within key healthcare processes, and proactively directing safety and quality improvements resources based on real data. The process does not require sophisticated software and it may aid in assessing key healthcare processes at an enterprise level.

To learn more about this study, visit:
https://www.jointcommissionjournal.com/article/S1553-7250(22)00062-9/fulltext