



NEWS RELEASE

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Innovative Combined Proactive Risk Assessment identifies vulnerable points in healthcare processes

Study in June/July 2022 issue of The Joint Commission Journal on Quality and Patient Safety

(OAKBROOK TERRACE, Illinois, June 14, 2022) – Healthcare facilities aim for zero avoidable patient harm. Toward that aim, healthcare organizations continuously identify, assess and remediate sources of risk. Reactive risk assessments (RRAs) such as incident reporting and root causes analysis and proactive risk assessments (PRAs) like failure mode and effects analysis are tools to reduce risk; however, they are generally conducted independently.

A new study in the June/July issue of *The Joint Commission Journal on Quality and Patient Safety* (JQPS), "[Combined Proactive Risk Assessment: An Approachable Method for Unifying Proactive and Reactive Risk Assessment Techniques in Healthcare](#)," suggests that RRA and PRA 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 aligns patient safety reporting data with process steps and failure modes to assess risk. The study used PRAs from several Veterans Health Administration (VHA) facilities and national patient safety data from the VHA National Center for Patient Safety's database related to outpatient blood draws to develop a comprehensive process flow diagram and list of potential failure modes.

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. Overlaying safety reports onto a comprehensive process flow diagram revealed 86% of events occurred during three of seven process steps. Accuracy of this technique was generally above 85%.

The study shows that CPRA is promising for increasing the return on investment of safety reporting systems, monitoring risk within key healthcare processes, and proactively directing safety and quality improvement resources based on real data.

“Bender et al. took a different approach, aggregating all IRs related to a specific healthcare process and categorizing them to create concept sheets,” notes an [accompanying editorial](#) by Gregory Hagley, PT, DPT, MAS. “This allows all IRs – even descriptions of near misses – to be used to mitigate risks for future patients.”

Also featured in the June issue:

- [Reduction of Unnecessary Gastrostomy Tube Placement in Hospitalized Patients](#) (Columbia University Irving Medical Center, New York)
- [Ensuring Quality in Patients Receiving Enteral Nutrition Catheters](#) (editorial)
- [Systems-Level Factors Affecting Registered Nurses During Care of Women in Labor Experiencing Clinical Deterioration](#) (Medical University of South Carolina, Charleston)
- [Utility of an Electronic Health Record Report to Identify Patients with Delays in Testing for Poorly Controlled Diabetes](#) (Johns Hopkins Health System, Baltimore)
- [Handoffs and Teamwork: A Framework for Care Transition Communication](#) (Cincinnati Children’s Hospital Medical Center, Cincinnati)
- [Hospital Planning for Contingency and Crisis Conditions: Crisis Standards of Care Lessons from COVID-19](#) (commentary)

For more information, visit [The Joint Commission Journal on Quality and Patient Safety website](#).

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Note for editors

The article is “[Combined Proactive Risk Assessment: An Approachable Method for Unifying Proactive and Reactive Risk Assessment Techniques in Healthcare](#)” by John A. Bender, MSIRIA, MBA, MHA; Stephen Kulju, MS, CCE; and Christina Soncrant, MPH. The article appears in *The Joint Commission Journal on Quality and Patient Safety*, volume 48, number 6 (June 2022), published by Elsevier.

The Joint Commission Journal on Quality and Patient Safety

[The Joint Commission Journal on Quality and Patient Safety](#) (JQPS) is a peer-reviewed journal providing healthcare professionals with innovative thinking, strategies and practices in improving quality and safety in healthcare. JQPS is the official journal of [The Joint Commission](#) and [Joint Commission Resources, Inc.](#) Original case studies, program or project reports, reports of new methodologies or the new application of methodologies, research studies, and commentaries on issues and practices are all considered.