PressGaney

ANNUAL REPORT

# 2023 Press Ganey PSO annual report executive summary

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# Foreword from Dr. Gandhi

Our goal of zero harm in patient and workforce safety has never been more important. Patient safety has seen backslides in the past three years due to the COVID pandemic. The pandemic has also highlighted the critical importance of a broader definition of harm, that defines harm as physical and emotional harm to patients and caregivers across the entire continuum of care, as well as the importance of addressing inequities that contribute to all of these kinds of harm.

I had the privilege of co-chairing the National Steering Committee for Patient Safety, a group of 27 national organizations that created Safer Together: A National Action Plan to Advance Patient Safety. This plan outlines four foundational areas essential to advancing patient safety, each with focused recommendations, strategies, and tactics:

- Leadership and culture
- Patient and family engagement
- Workforce safety
- The learning system

Moving forward, Health and Human Services is planning to co-create The National Healthcare System Action Alliance to Advance Patient Safety in 2023 in partnership with healthcare systems, federal partners, patients and families, and other stakeholders to support healthcare delivery organizations in implementing recommendations of the National Action Plan and similar frameworks. We encourage Press Ganey PSO members to utilize Press Ganey expertise and solutions to implement the National Action Plan.

## This plan outlines four foundational areas essential to advancing patient safety

The learning system foundational area focuses on a commitment to continuous learning within organizations by creating and strengthening internal processes that promote transparency, improvement, and reliability, and through sharing of events, best practices, and lessons learned as part of local, regional, state, or national learning networks, such as Patient Safety Organizations (PSOs). The National Action Plan specifically highlights the importance of optimizing PSOs.

The Press Ganey PSO is the fastest-growing PSO in the country, with the most current data, and with high reliability principles and methodologies embedded into its data collection and analysis. Our focus is not only on legal protection of data submitted, but on cross-industry sharing and learning, robust analysis of submitted events, numerous high reliability-based learning forums each month, and safety alerts. In this annual report from the Press Ganey PSO, we share key insights for the field to help optimize the value of the PSO and the learnings obtained. We are grateful to all the organizations that are part of the Press Ganey PSO and all of the healthcare leaders and workforce who have the shared commitment to transparency and optimizing our learning system to accelerate our progress to zero harm.

Thank you for all you do to reduce harm,

Tejal Gandhi, MD, MPH, CPPS
Chief Safety and Transformation Officer, Press Ganey

 

# Executive summary

The Press Ganey PSO includes 114 health systems across the U.S. These systems come together to share insights on patient safety events and best practices, and ultimately pave a path forward toward zero harm. Members have submitted 4.1 million safety events to the Press Ganey PSO since its inception in 2016—and nearly 800,000 events in 2022 alone.

## Press Ganey PSO

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health systems
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This report serves to inform healthcare industry leaders on crucial patient safety trends at the national level.

Insights

# Looking at 2022 data, we learned the following.

1. **The most frequent patient safety events** include Care Management events, Medication events, and Delay in Diagnosis and Treatment events.
2. **Events that most frequently caused serious harm** include Care Management events, Procedural events, and Falls.
3. The percentage of **Pressure Ulcers nearly doubled** from 2021 (4.6%) to 2022 (8.9%).
4. **Emergency Department, Medical/Surgical Units, and the Intensive Care Unit** experienced errors most frequently in 2022.
5. **Cause analysis data** showed an increase of 4% in knowledge-based performance errors from 2021 to 2022; fifty eight percent of these errors resulted in Serious Safety Events, 22% in death.

## Areas to improve harm

The Press Ganey PSO produced seven Safety Alerts in 2022, providing healthcare leaders with early warning of issues where there is a specific safety issue that without immediate action being taken could result in serious harm. Safety Alerts in 2022 included data insights and HRO-based recommendations for avoiding harm for the following issues:

- Knowledge-Based Performance Risk
- Ambulatory Diagnostic Error
- Handoffs to Ancillary Departments Require Safety Audit
- Bias Leads to Patient Harm
- Oral Steroids for Bariatric Patients
- Missed Dialysis ED Patients Require Proactive Protocol Development
- Inspect and Update Sodium Chloride Stock

## Recommended actions

The full report provides key recommended actions for organizations to advance in high reliability principles and practices and accelerate their journey toward zero harm:

1. **Submit safety event data to the Press Ganey PSO.** Learning from your own organization is important, but sharing and benchmarking data is also imperative. Submitting to the PSO lets you compare internal data against the PSO's aggregate to identify trends and learn from others.

2. **Improve database coding.** In 2022, 29% of events in the PSO database were coded as Other Care Management and 8% as Other. What's more, 11% weren't coded at all—up from 9% in 2021. Without standardized taxonomies and consistent classification processes, meaningful insights may be lost.

3. **Perform common cause analysis (CCA).** Organizations need to understand common contributors across multiple events—especially when determining where to focus limited resources. Using CCA to examine multiple events lets organizations identify the magnitude of system vulnerabilities—and prioritize an approach to fix those gaps. Press Ganey PSO members are sharing cause analysis and in 2022 we saw the cause analysis participation rate reach 18% of all members. This indicates the maturity of safety programs to invest in learning from events in a structured analysis.

4. **Plan for risk with new or interim staff.** Cause analysis data shows an increase of 4% in knowledge-based performance errors from 2021 to 2022. Fifty-eight percent of these errors resulted in Serious Safety Events, 22% in death. In the face of an ongoing workforce crisis, organizations have been forced to shift staff to high-volume units, rely on contractors, fast-track new graduates' responsibilities, and implement other stopgaps that mean staff members are working under new, unfamiliar conditions—known as "knowledge-based performance." Importantly, the risk of an error in knowledge-based performance is 30–60%. Healthcare leaders must ensure that new and interim staff are equipped with the strategies, tools, and training to work confidently and competently.

The Press Ganey PSO launched the PGConnect community in 2022 to provide another channel for members to share and learn from each other. PGConnect has rapidly become a home for members to share ideas and help each other implement best practices. The collective expertise represented in this community is perhaps the most direct path to action for any member organization.

## Join PGConnect

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