Background and importance of diagnostic safety: Culture of diagnostic safety in medical offices

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International Journal for Quality in Health Care 2003; **Volume 15, Supplement 1**: pp. i25–i30 10.1093/intqhc/mzg068

The US Agency for Healthcare Research and Quality's activities in patient safety research

GREGG S. MEYER[1,3], JAMES BATTLES[2], JAMES C. HART[2] AND NING TANG[3]

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Abstract

Purpose. To update the international community on the US Agency for Healthcare Research and Quality's (AHRQ) recent and current activities in improving patient safety.

Data sources. Review of the literature concerning the importance of patient safety as a health care quality issue, international perspectives on patient safety, a review of research solicitations, and early results of funded studies.

Study selection. A representative sample of patient safety studies from those currently being funded by AHRQ.

Results. In response to a growing interest in patient safety in general and a recent US Institute of Medicine report on patient safety in particular, the US Agency for Healthcare Research and Quality has refocused its quality research mission. In the fiscal year 2002, AHRQ spent US$55 million on patient safety research. This investment was spread across six complementary research areas: (1) health systems error reporting, analysis, and safety improvement research demonstrations; (2) Clinical Informatics to Promote Patient Safety (CLIPS); (3) Centers of Excellence for patient safety research and practice (COE); (4) Developmental Centers for Evaluation and Research in Patient Safety (DCERPS); (5) The Effect of Health Care Working Conditions on Quality of Care; and (6) Partnerships for Quality: Patient Safety Research Dissemination and Education. Internal teams of researchers at AHRQ have published studies on patient safety, such as documenting the impact of medication errors. In addition to funding research on patient safety, AHRQ is an integral partner in several national and international collaborations to form strategic synergies that build upon each member organization's strengths, reduce redundant efforts, and

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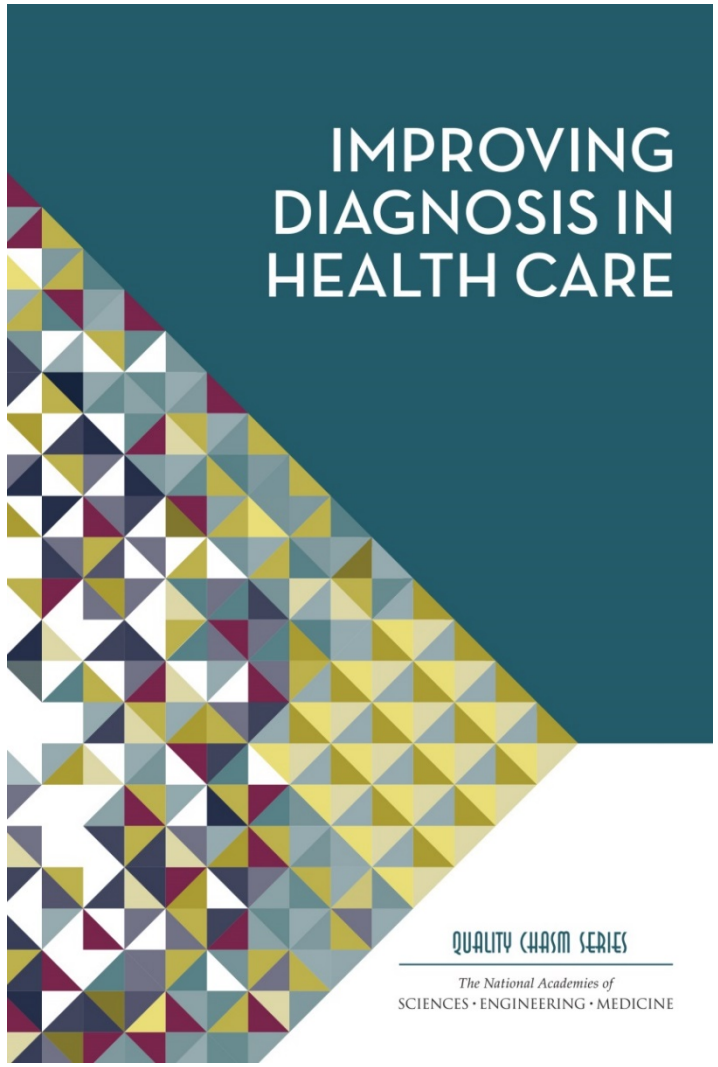
Only 1 of 93 initial AHRQ Safety Grants focused on Diagnostic Errors

IOM Report September 2015



Diagnosis Errors are...

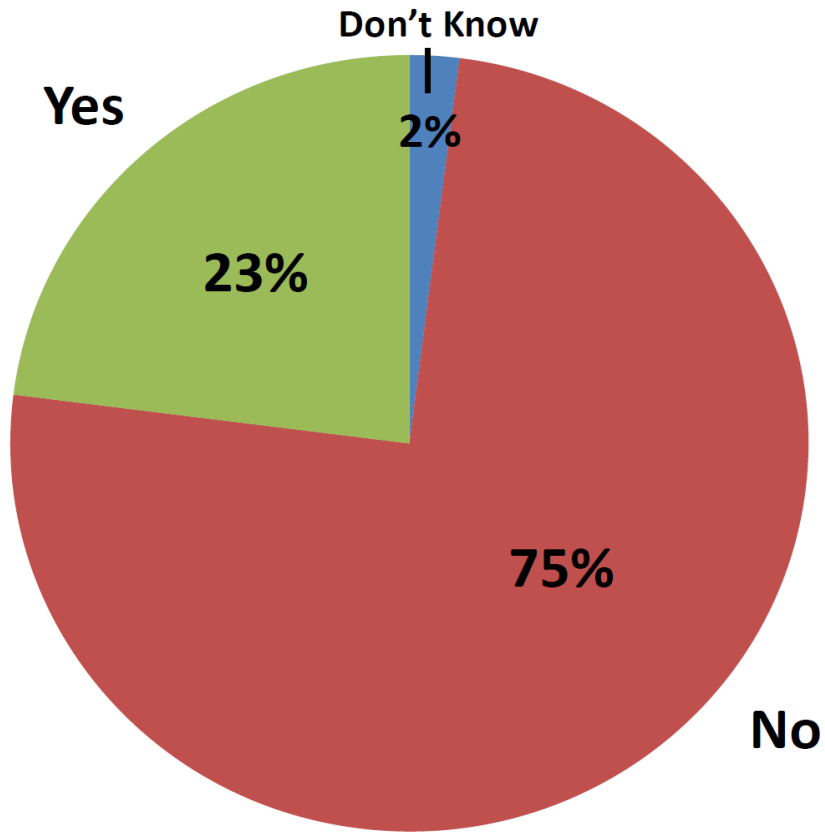
- Frequent
- Important
- Overlooked
- Matter
- Not easy to measure

Frequent - #1 Type of Errors

- Patient reports
- Malpractice claims
  - Particularly in ambulatory setting
- Safety experts' ranking

MA Residents Involved in a Medical Error Situation

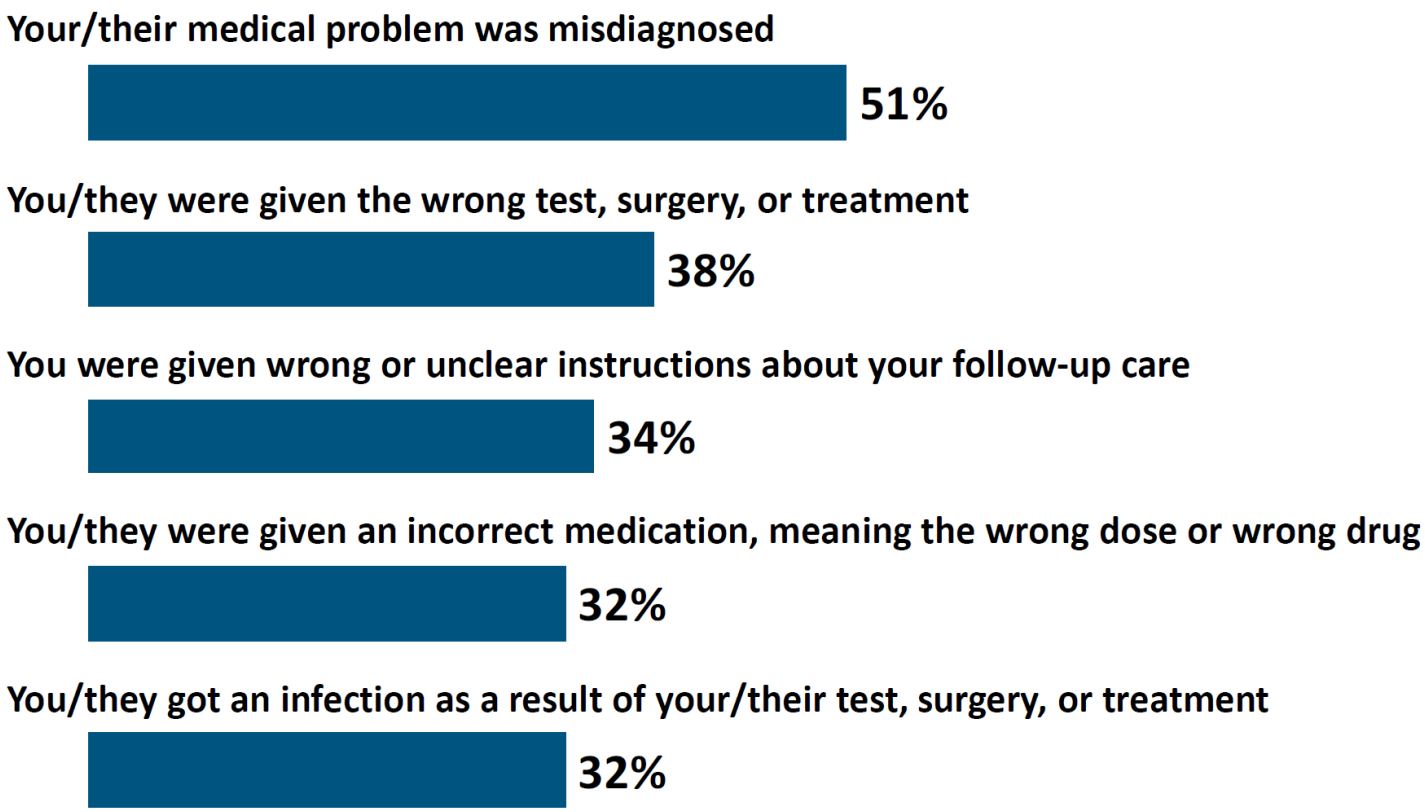
% saying personally involved in a situation where a preventable medical error was made in their own care or in the care of someone close to them



Harvard School of Public Health / Betsy Lehman Center for Patient Safety and Medical Error Reduction / Health Policy Commission
The Public's Views on Medical Error in Massachusetts, September 2 – 28, 2014.

Most Common Types of Medical Error Experienced by MA Residents

% saying…
(Among the 23% who said they or a person close to them experienced a medical error)



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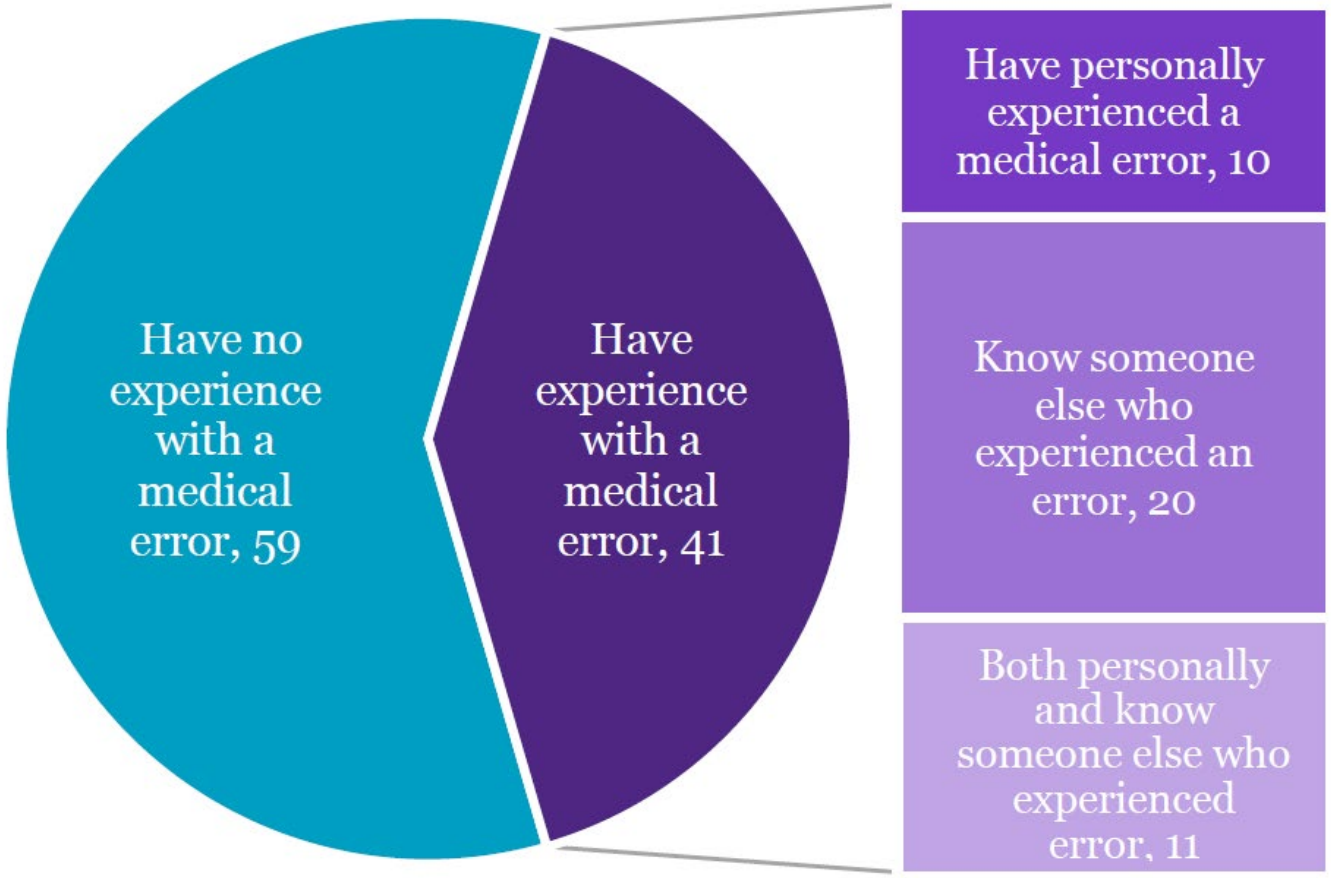
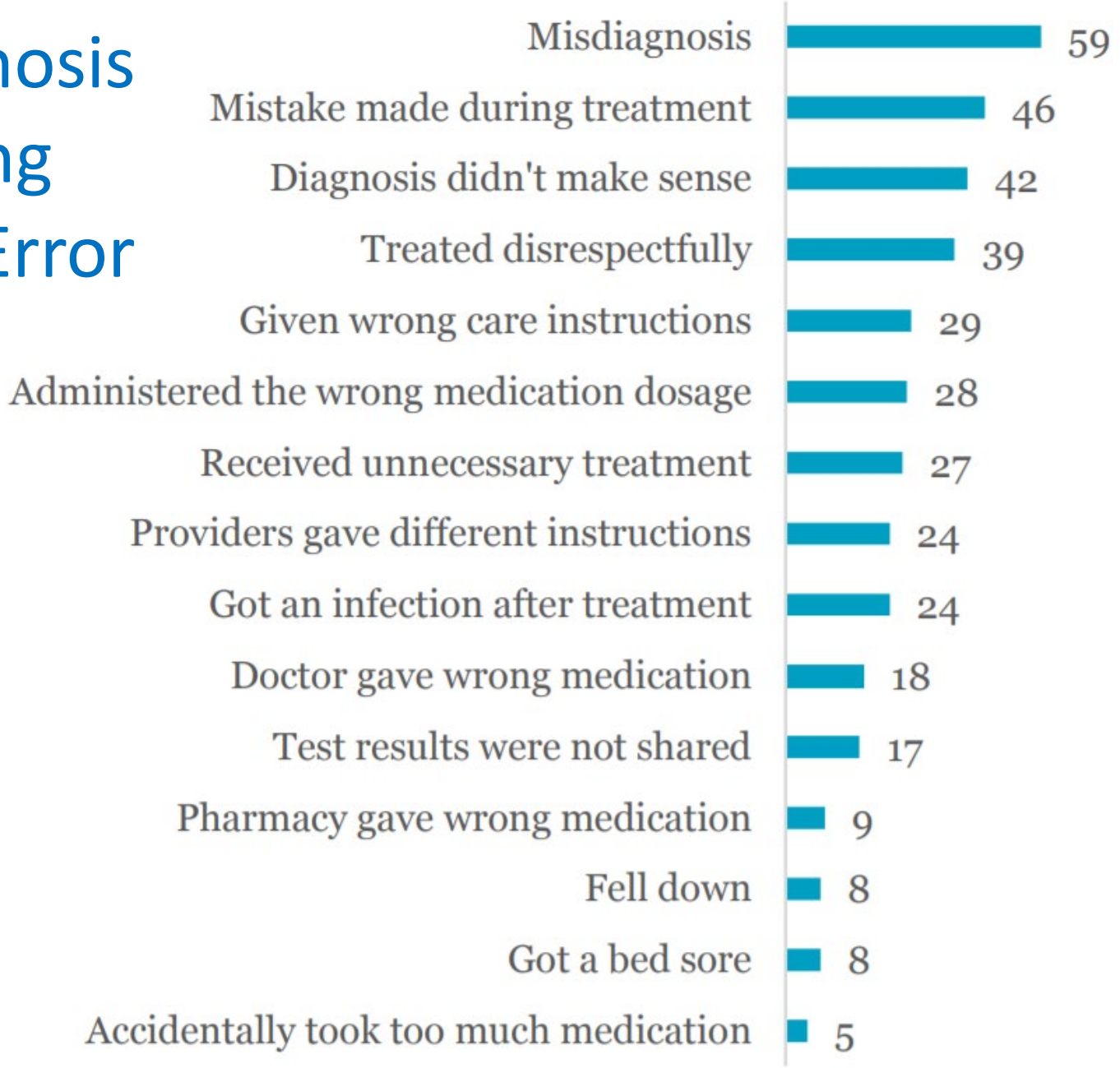
21% Experienced Medical Error



IHI/NPSF 2017 Survey

Misdiagnosis Leading Type of Error



Institute for Healthcare Improvement NPSF
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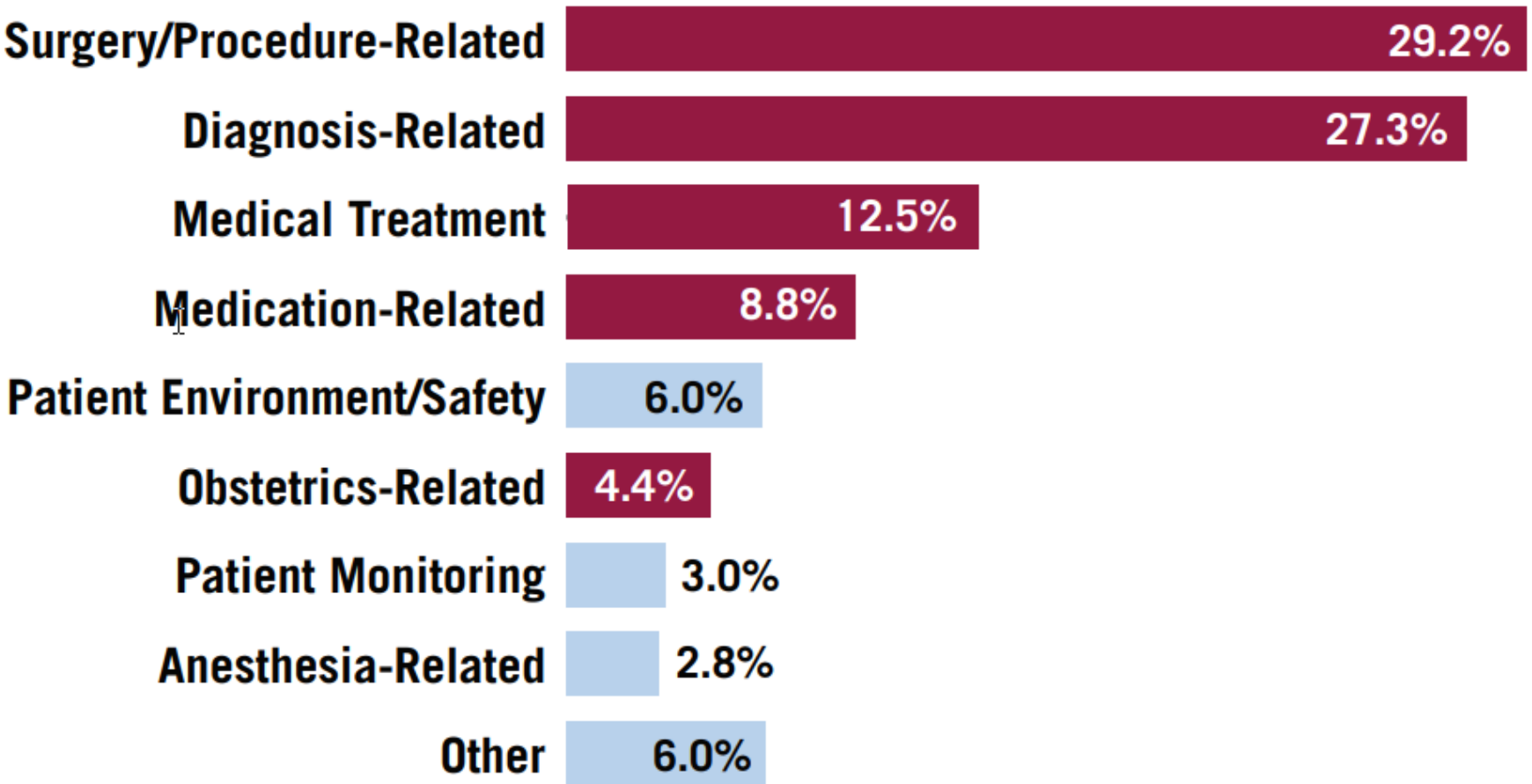
Top Allegation Types

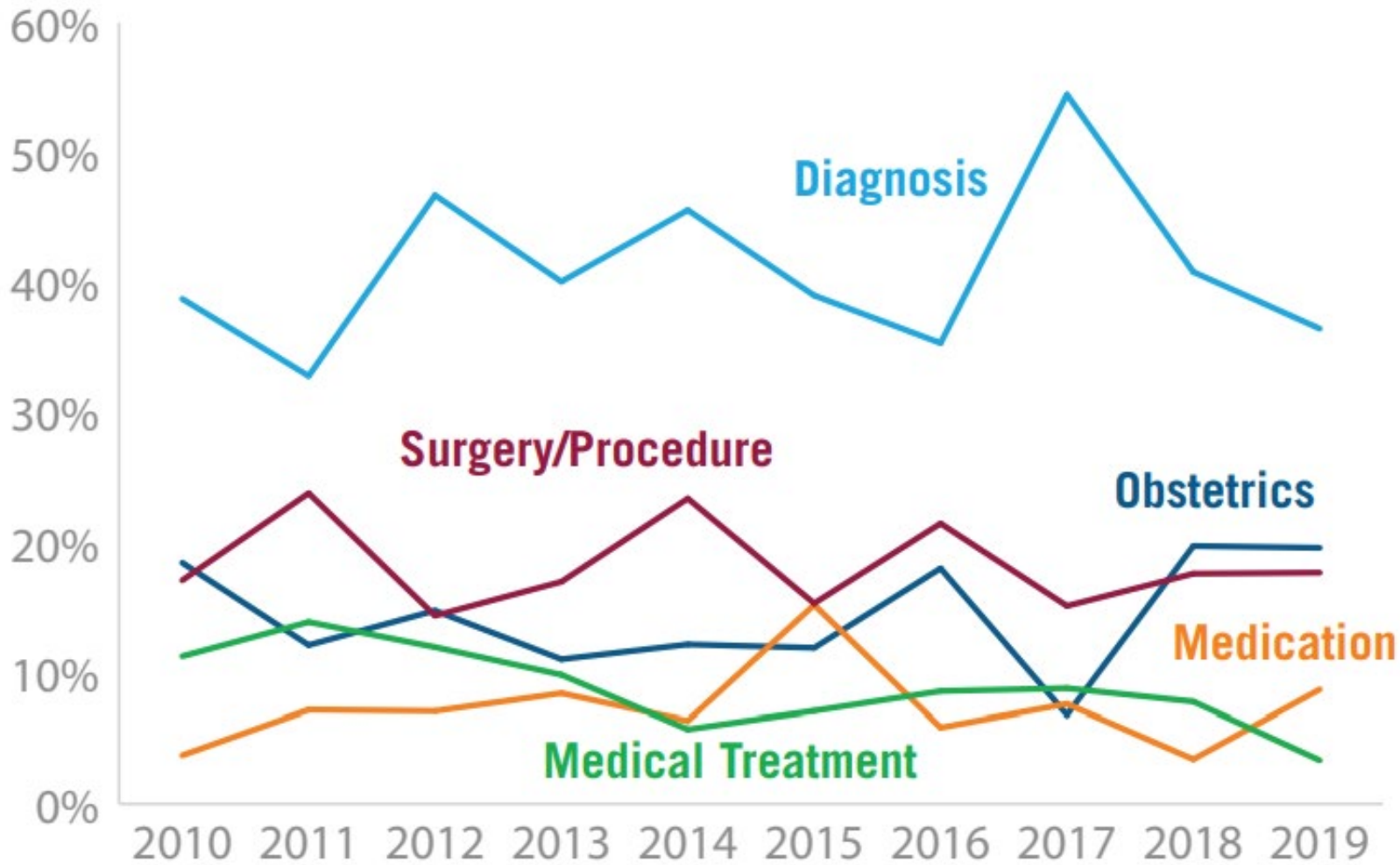


N = 11,907 events closed between 2010-2019.

COVERYS

Closed With Indemnity Paid

Top 5 Allegation Types



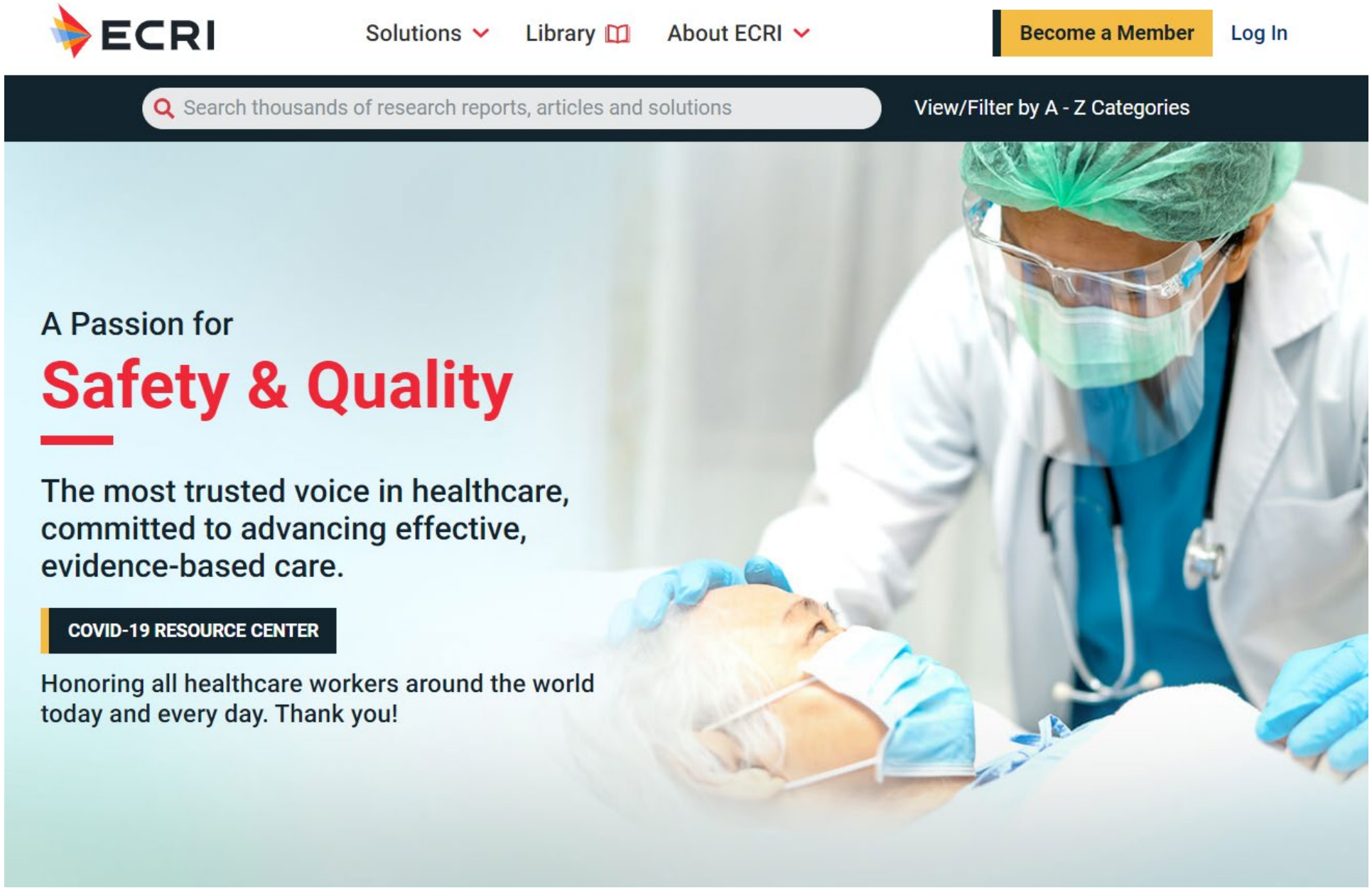
crico COVERYS

Cases Closed: Allegations by Close Year

	2005	2006	2007	2008	2009	TOTAL
Diagnosis-related	72	82	79	83	81	397
Medication-related	11	13	14	14	16	68
Medical Treatment	14	4	10	8	5	41
Communication	2	4	1	5	3	15
Violation of Rights	5	0	2	3	1	11
Safety & Security	0	2	1	2	3	8
OB-related Treatment	2	2	0	0	2	6
Surgical Treatment	1	1	0	1	0	3
Breach of Confidentiality	1	1	0	0	0	2
Total Number of Cases	**108**	**109**	**107**	**116**	**111**	**551**

N=551 CRICO and Coverys outpatient PL cases closed 2005–2009 naming General Medicine staff/fellow physicians (excl. Hospitalists) and excluding ED locations.

Schiff et al JAMA Intern Med 2013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2018 Top Patient Safety Concerns

1. Diagnostic errors
2. Opioid safety across the continuum of care
3. Care coordination within a setting
4. Workarounds
5. Incorporating health IT into pt safety programs
6. Management behavioral health in acute care
7. All-hazards emergency preparedness
8. Device cleaning, disinfection, and sterilization
9. Patient engagement and health literacy
10. Leadership engagement in patient safety

2019 Top 10 Patient Safety Concerns

1. Diagnostic Stewardship & Test Result Management Using EHRs
2. Antimicrobial Stewardship
3. Burnout and Its Impact on Patient Safety
4. Patient Safety Concerns Involving Mobile Health
5. Reducing Discomfort with Behavioral Health
6. Detecting Changes in a Patient's Condition
7. Developing and Maintaining Skills
8. Early Recognition of Sepsis across the Continuum
9. Infections from Peripherally Inserted IV Lines
10. Standardizing Safety Efforts across Large Systems

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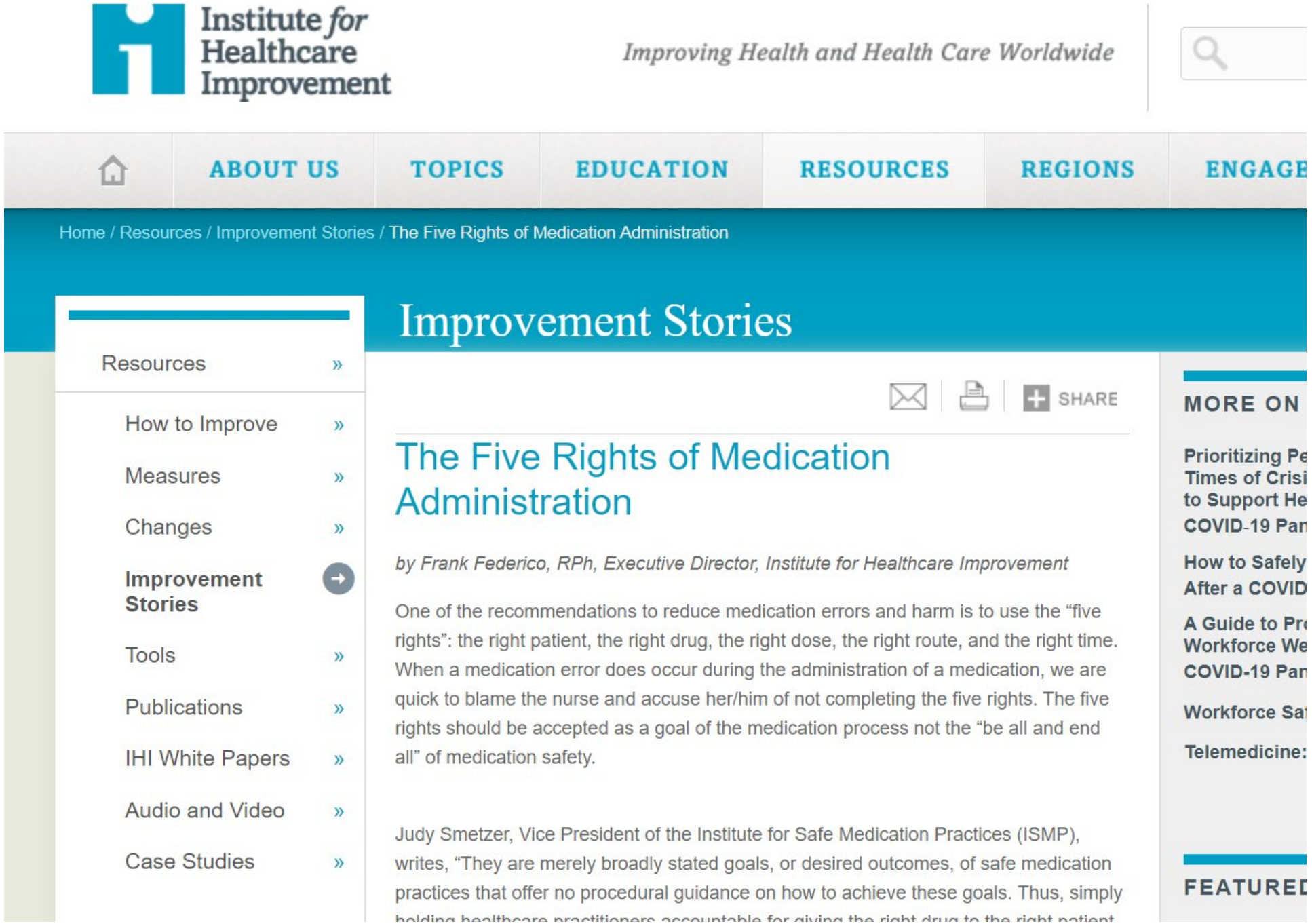
8. Early Recognition of Sepsis across the Continuum
9. Infections from Peripherally Inserted IV Lines
10. Standardizing Safety Efforts across Large Systems

2020 Top 10 Patient Safety Concerns

1. Missed and Delayed Diagnoses
2. Maternal Health across the Continuum
3. Early Recognition of Behavioral Health Needs
4. Device Problems
5. Device Cleaning, Disinfection, and Sterilization
6. Standardizing Safety across the System
7. Patient Matching in the EHR
8. Antimicrobial Stewardship
9. Overrides of Automated Dispensing Cabinets
10. Fragmentation across Care Settings

Overlooked/neglected: Why?

- Hard to define/agree on “error”
  - Is it a shortcoming in diagnostic process…
  - Or is it getting/giving the “wrong diagnosis”
- How to even know whether diagnosis was right or wrong?
  - Spotty follow-up
  - Most diagnoses resolve,…or evolve w/errors unnoticed
- Elusive to capture with “metrics”
  - *Immature* measures for rating cases, docs, organizations
  - So much variation in disease, patient, hard to fairly measure, adjust, compare, make judgments
- Defy easy “fixes”
  - Humans hard-wired to use heuristics, succumb to biases
  - Technical fixes to date not magic bullets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The Five Rights of Medication Administration
by Frank Federico, RPh, Executive Director, Institute for Healthcare Improvement
One of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time. When a medication error does occur during the administration of a medication, we are quick to blame the nurse and accuse her/him of not completing the five rights. The five rights should be accepted as a goal of the medication process not the "be all and end all" of medication safety.
Judy Smetzer, Vice President of the Institute for Safe Medication Practices (ISMP), writes, "They are merely broadly stated goals, or desired outcomes, of safe medication practices that offer no procedural guidance on how to achieve these goals. Thus, simply
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5
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Dose
Time
Route
Improving medication safety
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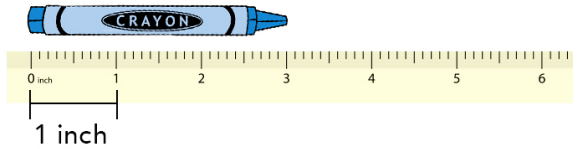
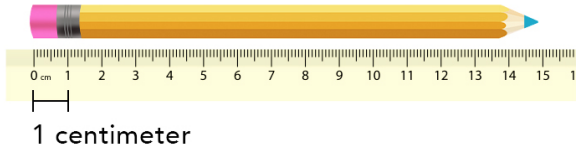
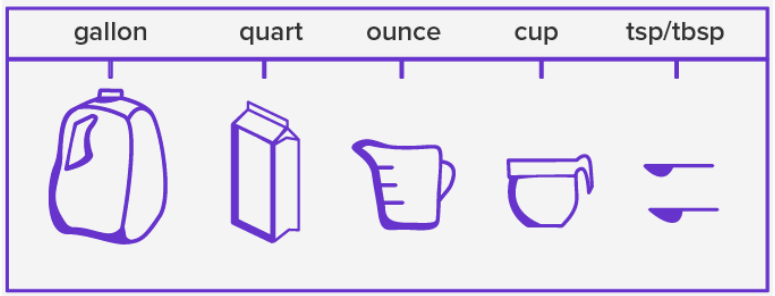
Dose
Time
Route
But if DIAGNOSIS is WRONG
treatment likely is Not Right
Improving medication safety
eMEDs

Instruments to Measure







Self-Measurement/Learning Tools

- Guiding light, beacon to see way forward in the dark
- Not *metric* to be "gamed" but *mirror* to better see how doing and ways to improve and monitor progress

When I walk into a workplace and see workers measuring themselves…I see quality

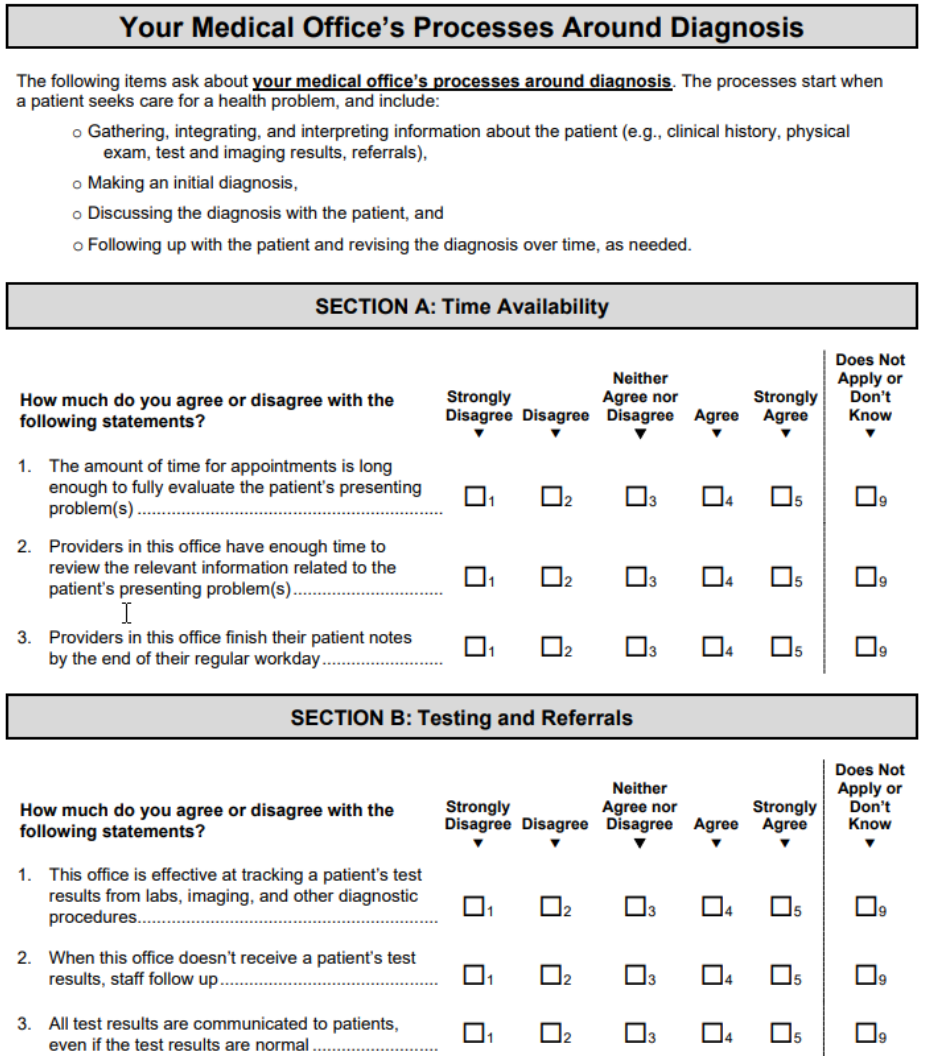
W. Edwards Deming

AHRQ SOPS Surveys

- 2-decade track record of meaningful validated self assessment
- Creative combining of specific process questions and overall safety climate

Diagnostic Safety Supplemental Items

- Amazing discussions, disagreements, breakthroughs, insights, compromises among respected expert colleagues
- Not easy to draft nor perfect, but state-of-the art best consensus



Your Medical Office's Processes Around Diagnosis

The following items ask about **your medical office's processes around diagnosis**. The processes start when a patient seeks care for a health problem, and include:

- Gathering, integrating, and interpreting information about the patient (e.g., clinical history, physical exam, test and imaging results, referrals),
- Making an initial diagnosis,
- Discussing the diagnosis with the patient, and
- Following up with the patient and revising the diagnosis over time, as needed.

SECTION A: Time Availability

How much do you agree or disagree with the following statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. The amount of time for appointments is long enough to fully evaluate the patient's presenting problem(s)	☐1	☐2	☐3	☐4	☐5	☐9
2. Providers in this office have enough time to review the relevant information related to the patient's presenting problem(s)	☐1	☐2	☐3	☐4	☐5	☐9
3. Providers in this office finish their patient notes by the end of their regular workday	☐1	☐2	☐3	☐4	☐5	☐9

SECTION B: Testing and Referrals

How much do you agree or disagree with the following statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. This office is effective at tracking a patient's test results from labs, imaging, and other diagnostic procedures	☐1	☐2	☐3	☐4	☐5	☐9
2. When this office doesn't receive a patient's test results, staff follow up	☐1	☐2	☐3	☐4	☐5	☐9
3. All test results are communicated to patients, even if the test results are normal	☐1	☐2	☐3	☐4	☐5	☐9