



Diagnostic Errors: A Real Threat to Patient Safety

Today's Moderator

Today's speaker is Rachel Rosen, RN, MSN, Senior Patient Safety & Risk Consultant, MedPro Group
(Rachel.Rosen@medpro.com)

Rachel has more than 20 years of experience in patient safety, quality, and risk management — both as an internal leader and as an external consultant.

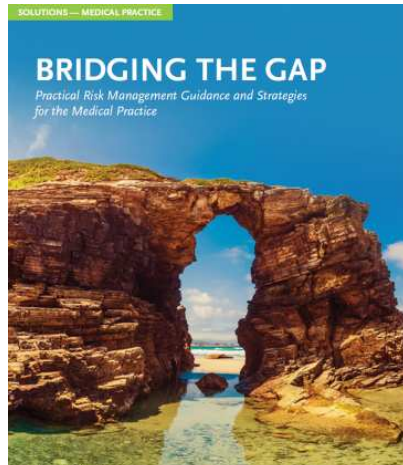
Her healthcare industry customers have included multihospital systems, large acute hospitals, long-term acute care facilities, critical access hospitals, healthcare services, and managed care organizations.

Rachel has extensive experience in standards preparation and compliance, strategic organizational improvement planning and implementation, quality measurement, patient satisfaction, and medical staff quality and peer review.

Rachel is a graduate of Ball State University with a bachelor of science degree in nursing, and she earned a master of science degree in nursing administration from Indiana University. Rachel is a member of the American Society for Healthcare Risk Management and the Indiana Society for Healthcare Risk Management.



Are you aware of our vast resources?




Question:
Recently, my office had a claim where a patient's injury was the result of a procedure performed by a physician who was not board certified in that specialty. Do you have any tips to help my office manage these types of claims?

Answer:
Increasing the number of board-certified physicians provides an additional layer of protection for your office. Board-certified physicians have completed a rigorous process of education, training, and examination, and are held to a higher standard of care than non-board-certified physicians. This includes a thorough understanding of the specialty's standards of care.

It is also important to ensure that the medical records are accurate and complete. This includes documenting the patient's history, physical examination, and the procedure performed. It is also important to ensure that the patient is properly informed of the risks and benefits of the procedure.

- Examples of situations where a physician is not board certified in the specialty:
- Transfer of patients from a hospital to a clinic
 - Transfer of patients from a clinic to a hospital
 - Transfer of patients from a hospital to a long-term care facility
 - Transfer of patients from a long-term care facility to a hospital

Risk Management Review

Wrong Site Orthopaedic Surgery Leads to Suboptimal Outcome and Malpractice Lawsuit

Theodore Passmore, JD, HRM, RPLU, CPHRM, FAIHRM

Introduction

As knowledge and technology advance, the delivery of healthcare is becoming increasingly complex, requiring greater teamwork and better communication. Despite best efforts, mistakes will occur. How these mistakes are handled can be critical in ensuring a favorable patient outcome and avoiding a professional liability lawsuit.

This interesting case from the Northwest illustrates how a surgical error was mis-handled, resulting in a claim that was not defensible.

Facts

The patient was a 65-year-old male who had a long history of osteoarthritis, including degenerative disease in both knees. He presented to an orthopaedic surgeon, Doctor A, for consultation because the pain in his knees was becoming intolerable and was affecting his mobility.



Maintaining Your Balance Hospital and Acute Care Staff



LITIGATION SUPPORT

Maintaining Your Balance Healthcare Providers

Following the testing, the right knee was found to be the source of the patient's pain. The patient's attorney was causing the surgeon to be negligent in ensuring a favorable patient outcome and avoiding a professional liability lawsuit.

During the procedure, Dr. A took various measurements. The manufacturer's representative entered the measurements into a computer program, which then indicated which implant components were appropriate for the case. When the femoral measurements were complete, the manufacturer's representative retrieved the appropriately sized femoral component from the hospital's stock. However, it was the femoral component for a right knee.

WEBINAR

The Impact of Disruptive Behavior on Patient Care and Practice, and Strategies to Mitigate Risks

17 MARCH 15
12:00-1:00 p.m. ET

19 MARCH 15
5:00-6:00 p.m. ET



Join Us on Twitter

Join us on Twitter @MedProProtector!

*Risk management and patient safety information
delivered in a convenient, flexible format*

Articles

Tools

Announcements

Case studies

Resources

Risk Q&A

Videos

And more!

Not on Twitter? Give It a Try!

Twitter is an easy, quick way to stay current with healthcare news and trends, receive information and resources, connect with individuals and organizations, and receive risk management info from MedPro! Opening an account is simple — visit www.twitter.com.



Designation of continuing education credit

Medical Protective is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Medical Protective designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



Disclosure

Medical Protective receives no commercial support from pharmaceutical companies, biomedical device manufacturers, or any commercial interest.

It is the policy of Medical Protective to require that all parties in a position to influence the content of this activity disclose the existence of any relevant financial relationship with any commercial interest.

When there are relevant financial relationships, the individual(s) will be listed by name, along with the name of the commercial interest with which the person has a relationship and the nature of the relationship.

Today's faculty, as well as CE planners, content developers, reviewers, editors, and Patient Safety & Risk Solutions staff at Medical Protective have reported that they have no relevant financial relationships with any commercial interests.



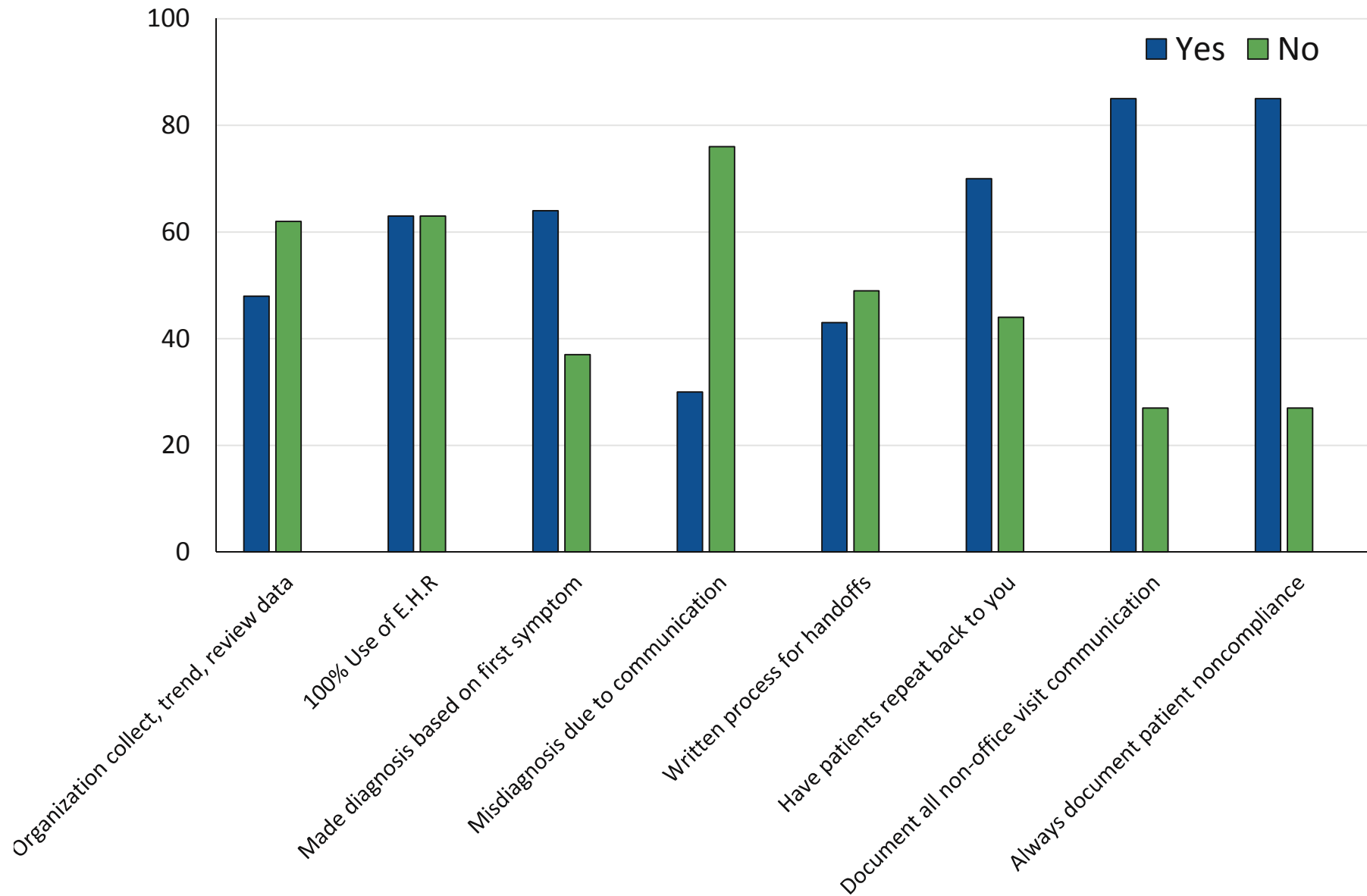
Objectives

At the conclusion of this program, you should be able to:

- Discuss claims data and trends related to diagnostic and other medical errors.
- Identify and analyze contributing factors/root causes of diagnostic errors that affect patient safety.
- Design and implement processes and systems that reduce and prevent diagnostic and other medical errors.
- Identify at least one risk-reduction strategy that you can implement in your practice.



Registration Polling Results



Today's Program

Today's speaker is Melanie Osley, RN, MBA, CPHRM, CPHQ, ARM, DFASHRM, Senior Patient Safety & Risk Consultant, MedPro Group (Melanie.Osley@medpro.com)

Melanie provides risk management services for MedPro Group insureds in the Northeast, ranging from Maine to Maryland. Melanie has worked in healthcare for more than 25 years, with 20 of those years dedicated to healthcare professional liability. Her experience includes working with self-insured hospitals, off-shore insurance captives, and physician insurance carriers.



Melanie speaks frequently on topics that include quality initiatives, patient safety, insurance models, and risk management. In addition, she has published numerous articles for peer-reviewed journals and texts. Melanie is a member of the American Society of Healthcare Risk Management (ASHRM) and the Connecticut and Massachusetts Societies of Healthcare Risk Management. Melanie's clinical specialty areas include prior certification in both critical care (CCRN) and emergency (CEN) nursing, and advanced cardiac life support instructor (ACLS) status. She has also completed the Fundamental Critical Care Support course offered by the Society of Critical Care Medicine.

Melanie earned a bachelor of science in law enforcement from the University of Evansville and a bachelor of science in nursing from the University of Maryland. She completed an MBA in healthcare administration at City University (WA), is a certified paralegal, and holds a current Connecticut insurance adjuster's license. She is certified in both healthcare quality and risk management, and has designations as a Distinguished Fellow of ASHRM in New England (DFASHRM), and an Associate in Risk Management from the Insurance Institute of America.



Today's Program

Today's speaker is Viviane Jesequel, RN, HCRM, Senior Patient Safety & Risk Consultant, MedPro Group
(Viviane.Jesequel@medpro.com)

Viviane provides comprehensive risk management services to healthcare systems, hospitals, clinics, and physicians in Florida. She has more than 25 years of experience in the healthcare industry and has achieved an understanding of the challenges and opportunities facing both clinicians and hospitals.

Viviane has been actively involved in healthcare risk and quality management for many years. In previous positions, she provided services to hospitals, nursing homes, physicians, and other allied health professionals.

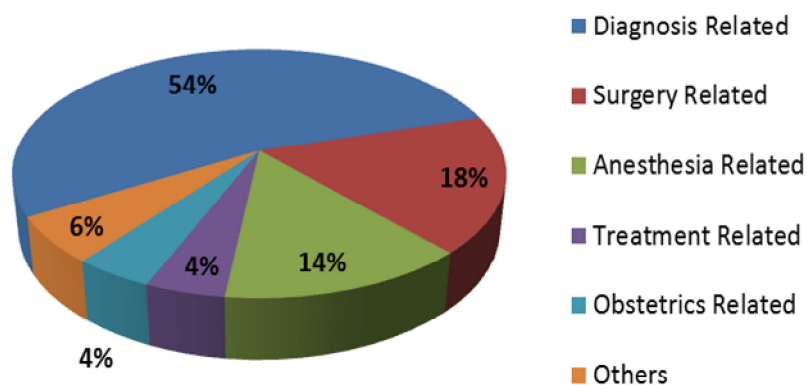
Viviane's expertise includes consulting with clients regarding patient safety and quality/performance improvement, identifying and evaluating potential liability exposures, and developing solutions to reduce or eliminate loss severity.

Viviane earned her RN degree from Mount Saint Mary College in New York. She also earned a bachelor of science degree in business administration from Mount Saint Mary College, and she is licensed as a healthcare risk manager by the state of Florida.

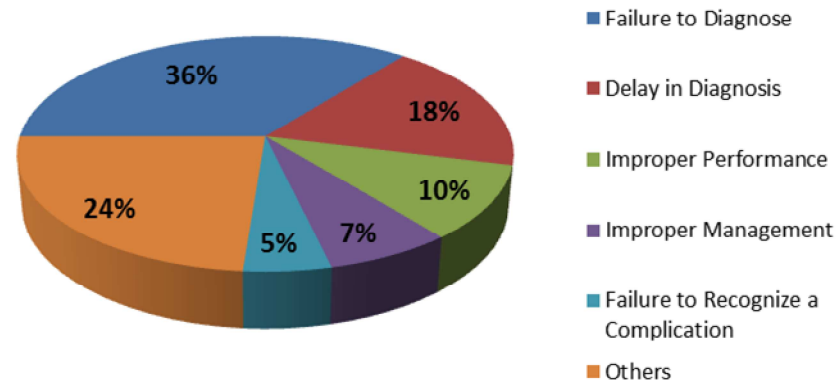


NPDB: Countrywide Allegations

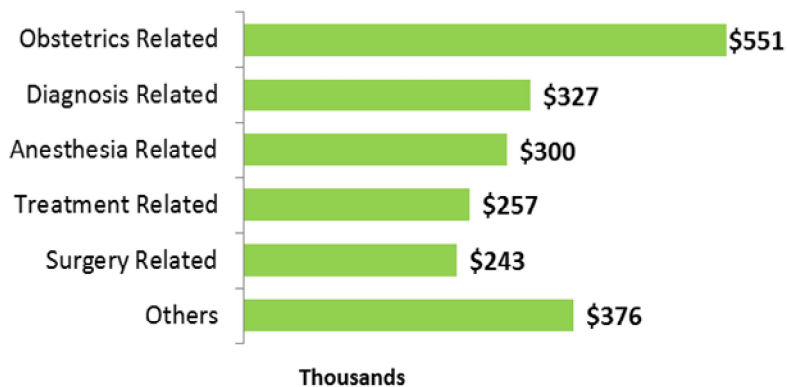
Percentage of Claims by Allegation Group, 2004-2013



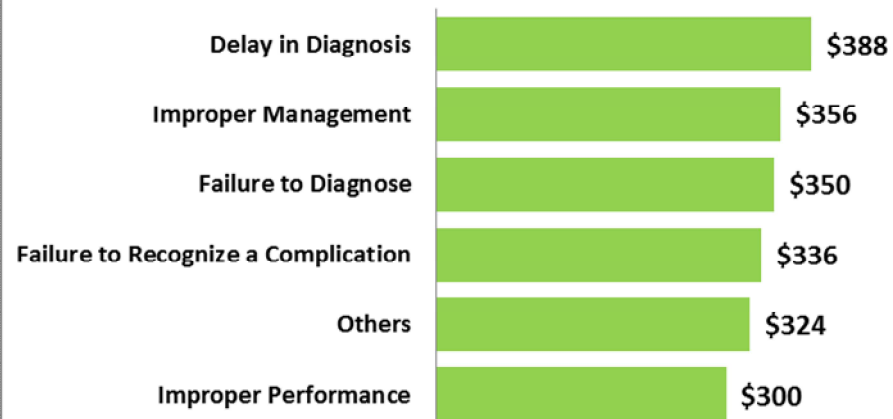
Diagnosis Related: Top Allegations



Average Indemnity by Allegation Group, 2004-2013

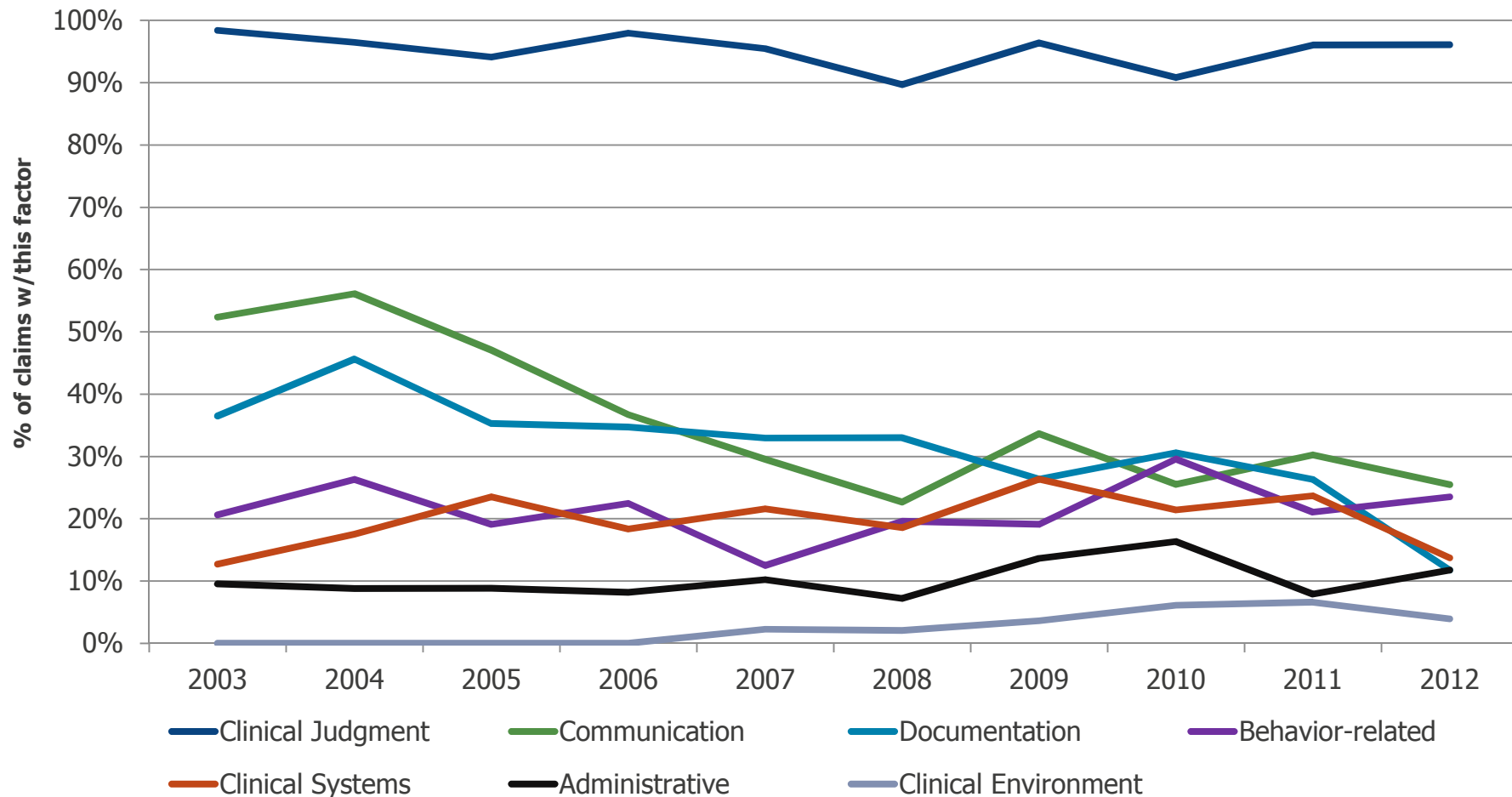


Diagnosis Related: Average Indemnity



Source: National Practitioner Data Bank Public Use File, Dec. 2013. Indemnity paid physician claims 2004-2013. Data does not include payments by patient compensation funds.

Top Root Causes/Contributing Factors — Diagnostic Allegations



Contributing factors are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims. These factors reflect issues that may be amenable to loss-prevention strategies. A claim may have several contributing factors identified, or none.



Clinical Judgment



Case Study: Failure to Accurately Dx. Cardiac Condition

Patient: 34-year-old male.

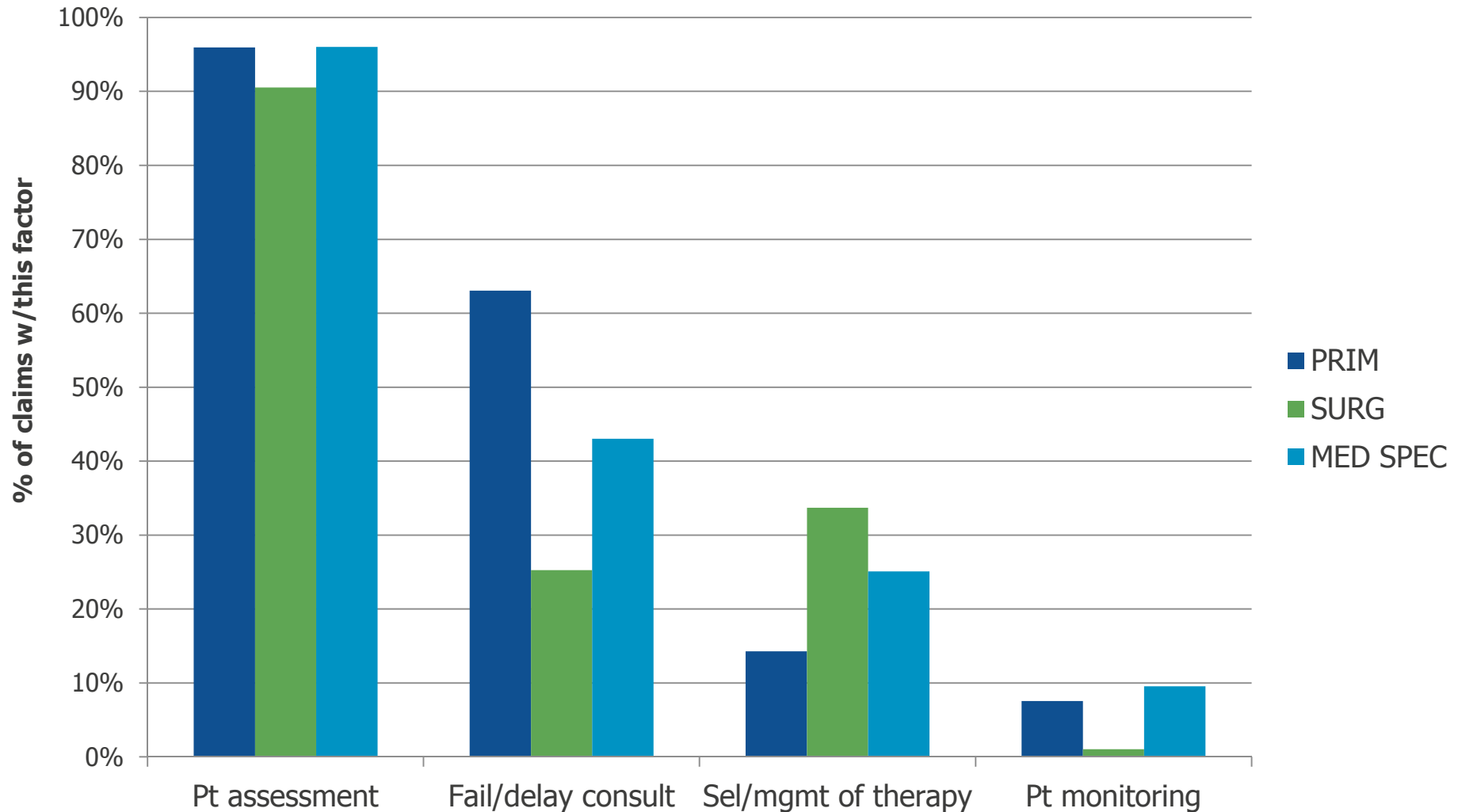
Chief complaint: Presented in ED with sternal pain after lifting a boat in his backyard.

Case overview: Pain increased when raising arms. ECG was negative. Cardiac enzymes were not obtained because muscle strain was determined diagnosis. Patient discharged to internist who okayed vacation.

Outcome: Two days later, patient died.



Specialty Comparisons: Focus on Clinical Judgment – Diagnostic Allegations



Source: MedPro physician claims, originating in physician office/clinic, opened years 2003-2012

Issues With Clinical Judgment

- The most prevalent risk issue in all allegations
- A broad category, including:
 - Patient assessment
 - Selection and management of therapy
 - Failure or delays in obtaining consults/referrals
 - Other factors
- Tends to present the most difficulty in terms of finding simple fixes



When the Patient's Symptoms Don't Fit a Pattern

- Information may be missing or incomplete.
- Cases may not be “typical.”
- Depends on clinical element selected, importance assigned to each, and how information is arranged and processed.
- Conclusions (diagnoses) may vary significantly.



Cognitive Mistakes

- Anchoring — a snap judgment, diagnose on the first symptom or lab abnormality
- Availability — using a prior experience, maybe what's most available in your memory to diagnose
- Attribution — to mentally invoke a stereotype and attribute symptoms



Clinical Judgment: Risk Strategies

- Perform complete assessment.
- Update and review patient's medical history on a regular basis.
- Review and update problem lists, medication lists, and allergies.
- Enable prompt access to diagnostic information.
- Implement and utilize clinical pathways.
- Formalize procedures for:
 - Over-reads — ECGs, imaging.
 - Peer review/quality improvement.



Clinical Reasoning Toolkit



Society to Improve Diagnosis in Medicine

Better Outcomes Through Better Diagnosis

HOME EDUCATION & RESEARCH ABOUT US CONFERENCE & EVENTS NEWS GET INVOLVED

Clinical Reasoning Toolkit



The SIDM Education Committee recognizes **the need to provide clinicians and teachers on the front lines of patient care and medical education** with a centralized resource for learning about the cognitive processes that underlie diagnostic reasoning.

In the SIDM **Clinical Reasoning Toolkit**, users will find a collection of books, articles (links only), slide presentations, and videos grouped into four major topics. The Toolkit assembles and organizes materials for self-directed learning, but is not a fully integrated curriculum.

After reviewing the resources in this collection, users will be able to better analyze, teach, and improve the diagnostic process and share in our goal of making diagnosis safer and more reliable.

SIGN IN

 Remember Me
[Sign In](#) 
[Forgot your password?](#)
[Join SIDM Today](#)



Communication



Issues With Communication

- Between providers
 - Consultation reports (consult vs. referral)
 - Coordination of care
- Between physician and patient
 - Phone calls
 - Informed consent
 - Education
 - Follow-up instructions



Issues With Communication

- Poor communication with staff and other providers involved in patient care
- Inadequate communication of pertinent clinical findings to radiologists and other providers
- Lack or delayed reporting of critical values
- Physician/staff distractions or lack of teamwork
- Care across multiple locations/providers



Approximately 80% of serious medical errors involve miscommunication during handoff.



Communication: Risk Strategies

- Standardize processes for handoffs, on-call, and after-hours care.
 - Identify all points of handoffs.
 - Determine the critical elements of each handoff identified.
 - Develop a policy and procedure — who, what, where, when, and how.
 - Use all this information to establish a checklist.
- Establish reliable call structure and response plans.
- Establish tickler system for high-risk patients.



Safer Sign Out



The screenshot shows the top navigation bar of the Safer Sign Out website. On the left is the logo, which consists of a blue square containing a white sunburst and two hands shaking, followed by the text 'SAFER SIGN OUT' in white. To the right of the logo are navigation links: 'Safer Sign Out »', 'Getting Started »', 'Resources »', 'Innovation Partners »', and 'Contact Us'. On the far right of the navigation bar is the EMPSF logo, which features a white sunburst above the text 'EMPSF' in white. Below the navigation bar is a search bar with a magnifying glass icon and the word 'search'.

Lead The Way In Safety With A Safer Sign Out

Safer Sign Out is a patient-centered, team-based innovation that was developed by emergency physicians to improve the safety and reliability of end of shift patient "handoffs."

The Emergency Medicine Patient Safety Foundation (EMPSF), in collaboration with our innovation partners, brings you the *Safer Sign Out* protocol to help reduce risk, increase effectiveness and improve clinician and patient satisfaction.

[read more](#)



Communication Strategies to Enhance the Relationship

- Explain the recommended procedure.
- Start with the diagnosis and educate the patient.
- Offer explanation and rationale on why this is an appropriate treatment plan.
- Go over treatment plan step by step.
- Ask the patient to repeat back proposed treatment plan and/or informed consent discussion.
- Provide written documentation for patient to take home, and document in chart.
- Reinforce patient teaching (staff).



Teach Back

“I want to be sure that I did a good job explaining your problem. Can you tell me:

- What your problem is?
- What you need to do?
- Why you need to do it?”



Printed Material — CDC's Simply Put

- Instructions should be written for 4th–6th grade level.
- Font size of at least 12–14 points.
- *Italics are difficult to read.*
- ALL CAPS ARE DIFFICULT TO READ.
- Eliminate technical jargon.
- Most important information at the beginning and repeated at the end.



Health Literacy Information and Tools (CDC)



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

A-Z Index [A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#) <#>

Health Literacy: Accurate, Accessible and Actionable Health Information for All

Health Literacy

- Introduction
- Learn about Health Literacy
- Get Training
- Plan and Act
- Steps to Developing an Organizational Plan
- Develop Materials
- Research and Evaluate
- Share and Interact
- Health Literacy Activities by Region
- Health Literacy Activities by State
- Science Says: Findings You Can Use
- Health Literacy Blog

Recommend 62 Tweet 81 Share

Health Literacy: the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions.

Spotlight

- Encourage plain language in your organization with these new materials.

- Email page link
- Print page
- Get email updates
- Subscribe to RSS
- Listen to audio/Podcast

Health Literacy
BLOG
[Visit our Blog](#)

Contact Us:

- Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30333
- healthliteracy@cdc.gov
- 800-CDC-INFO
(800-232-4636)
- TTY: (888) 232-6348
- [Contact CDC-INFO](#)

CDC Featured Resources

[Simply Put](#) [PDF - 1.87MB]

[Improving Health Literacy for Older Adults](#)

[Online Training for Health Professionals](#)

Health Literacy Activities by State



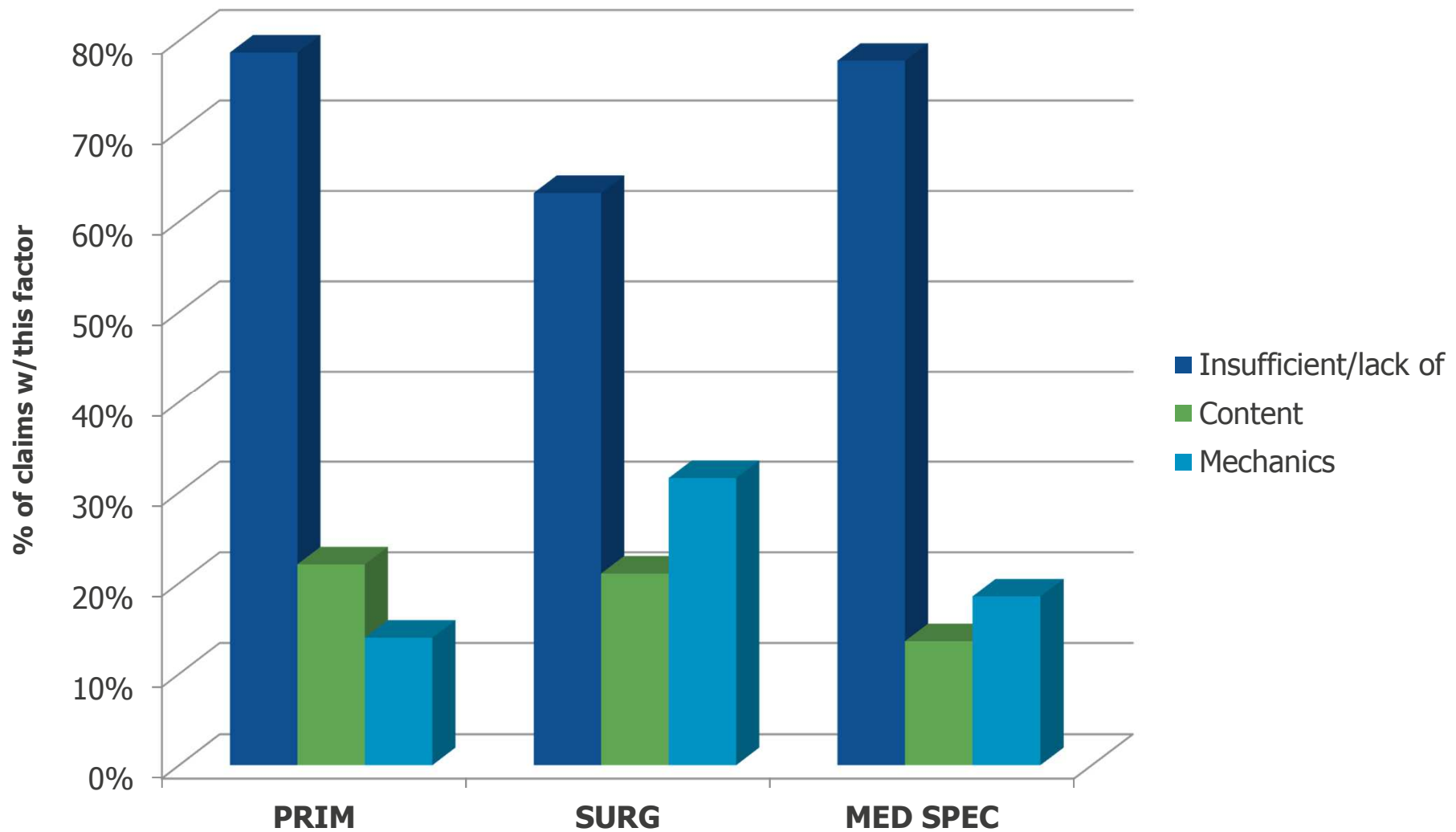
Click on any highlighted state to view health literacy activities.



Documentation

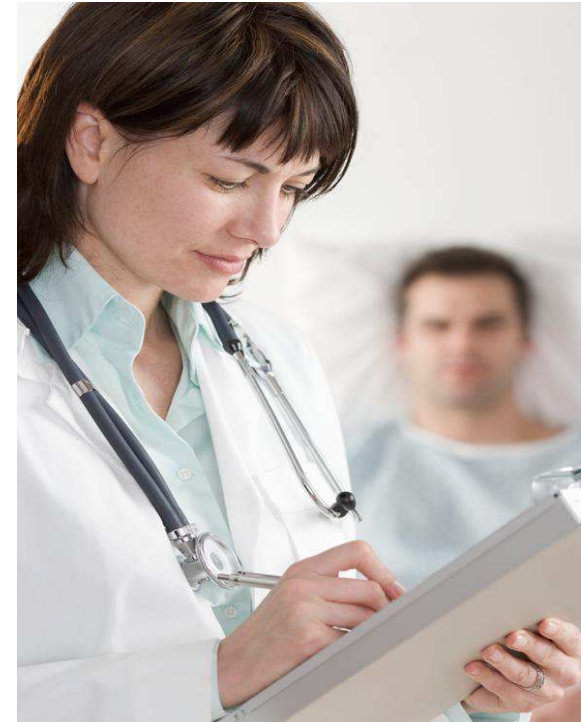


Specialty Comparisons: Focus on Documentation – Diagnostic Allegations



Issues With Documentation

- Patient compliance, including missed/cancelled appointments
- Treatment plan changes
 - Receipt of diagnostic results
 - Follow-up
 - Patient response
 - Telephone conversations
- After-hours contact
- Consults



Issues With Electronic Health Records (EHRs)

- Documentation gaps in transition from paper to electronic
- New error pathways, particularly when trying to force old habits on new system
- Inconsistencies in use and following policy
- Flow of information not intuitive
- Build up of incomplete charts
- Failure to use system capabilities, e.g., alerts/reports
- Hybrid systems
- First-year of use



EHR: Risk Strategies

- Adopt collaborative strategies to include all system users when evaluating the need to make changes or updates.
- Set stringent documentation guidelines and eliminate workaround processes.
- Tailor the system's alert function to specific patient populations.
- Use system reporting functions to support an active performance improvement plan for risk reduction.
- Develop a comprehensive policy to define the legal patient record.



Health IT Tools and Resources


U.S. Department of Health & Human Services
www.hhs.gov



AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

www.ahrq.gov

HEALTH INFORMATION TECHNOLOGY

Best Practices Transforming Quality, Safety, and Efficiency

Health IT Home | AHRQ | Contact Us | Site Map | Print | Stay Informed



HOME

PROGRAM OVERVIEW

EVENTS

AHRQ-FUNDED PROJECTS

HEALTH IT TOOLS AND RESOURCES

Workflow Assessment for Health IT Toolkit

AHRQ-Funded Project Resources Archives

AHRQ Health IT Projects Publication Database

Children's Electronic Health Record (EHR) Format

Consumer Health IT Human Factors Design Guide

Guide for Consumer Health IT Developers and Designers

Health Information Exchange (HIE) Evaluation Toolkit

Health IT Bibliography


Health IT Costs and Benefits Database

Home » [Health IT Tools and Resources](#)

Health IT Tools and Resources

AHRQ and its community of contractors and grantees have developed tools to help health care organizations plan for, implement and evaluate health information technology (IT). These tools describe and recommend strategies for addressing some of the common challenges organizations encounter when working with health IT systems. The tools are freely available, but proper citation should be used when referenced on the Web or in print.

Tools and Resources



Workflow Assessment for Health IT Toolkit

This toolkit is designed for people and organizations interested or involved in the planning, design, implementation, and use of health IT in ambulatory care.



Health IT Evaluation Measures: Quick Reference Guides

These Health IT Evaluation Measures: Quick Reference Guides provide details about individual measures that can be incorporated into a health IT evaluation plan.



AHRQ Funded Project Resources Archives

This toolkit provides sample resource documents, such as project schedules, business associate agreements, and requests for proposals (RFPs) from organizations that have successfully adopted health IT applications



Health IT Evaluation Toolkit

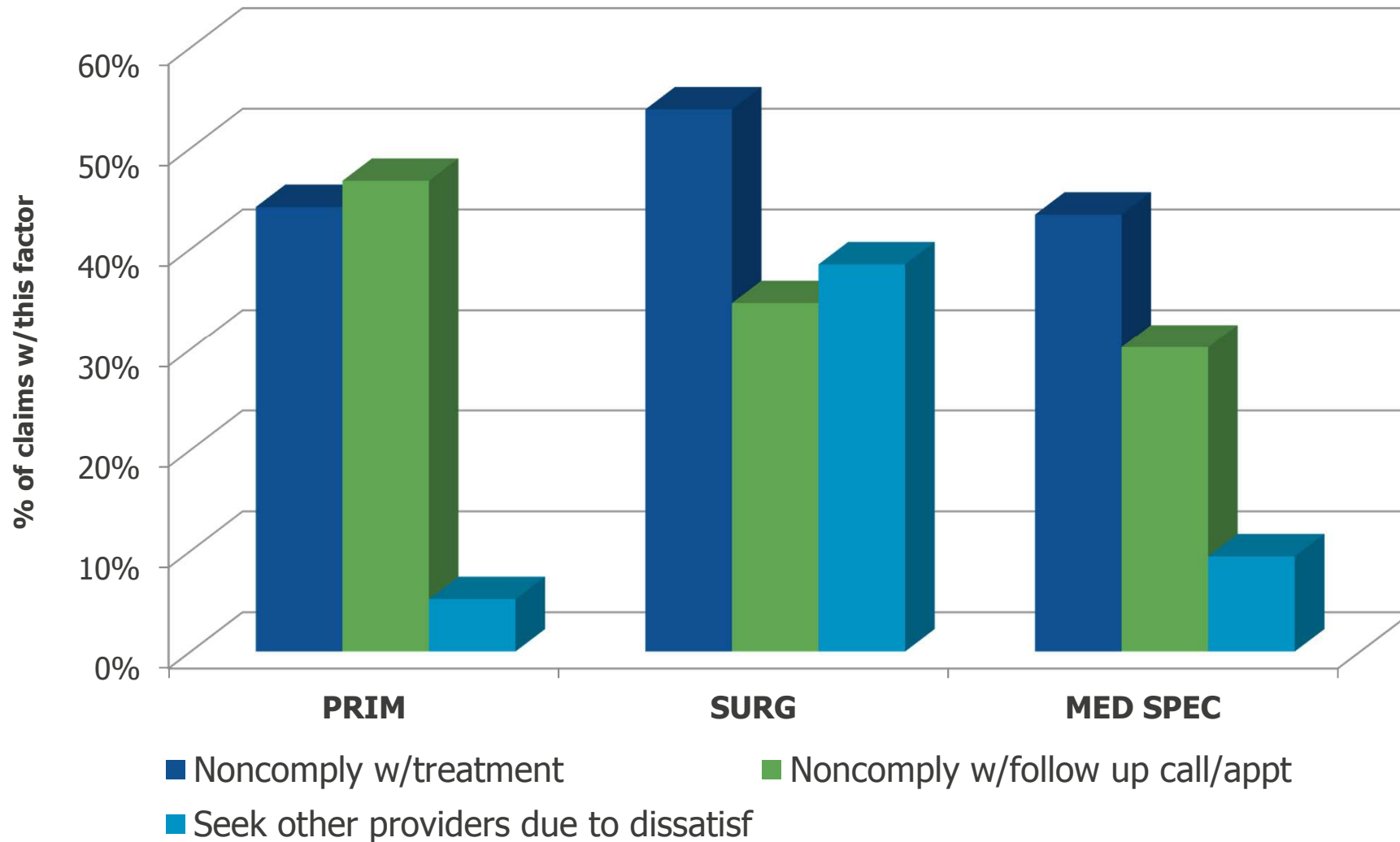
Evaluations allow us to determine whether or not what one has set out to accomplish has been accomplished, and to help us to understand what has worked in a given project and what has not.



Behavioral Issues



Specialty Comparisons: Focus on Patient Behavioral Issues – Diagnostic Allegations



Patient Behavioral Issues: Risk Strategies

- Establish expectations upfront.
- Address and document all noncompliance.
- Use health history to screen.
- Make appropriate referrals.
- Negotiate the process of care.
- Access community resources.
- Ensure adequate follow-up care.
- Set firm limits.
- Terminate relationship as a last resort.



Provider and Staff Behavior: Risk Strategies

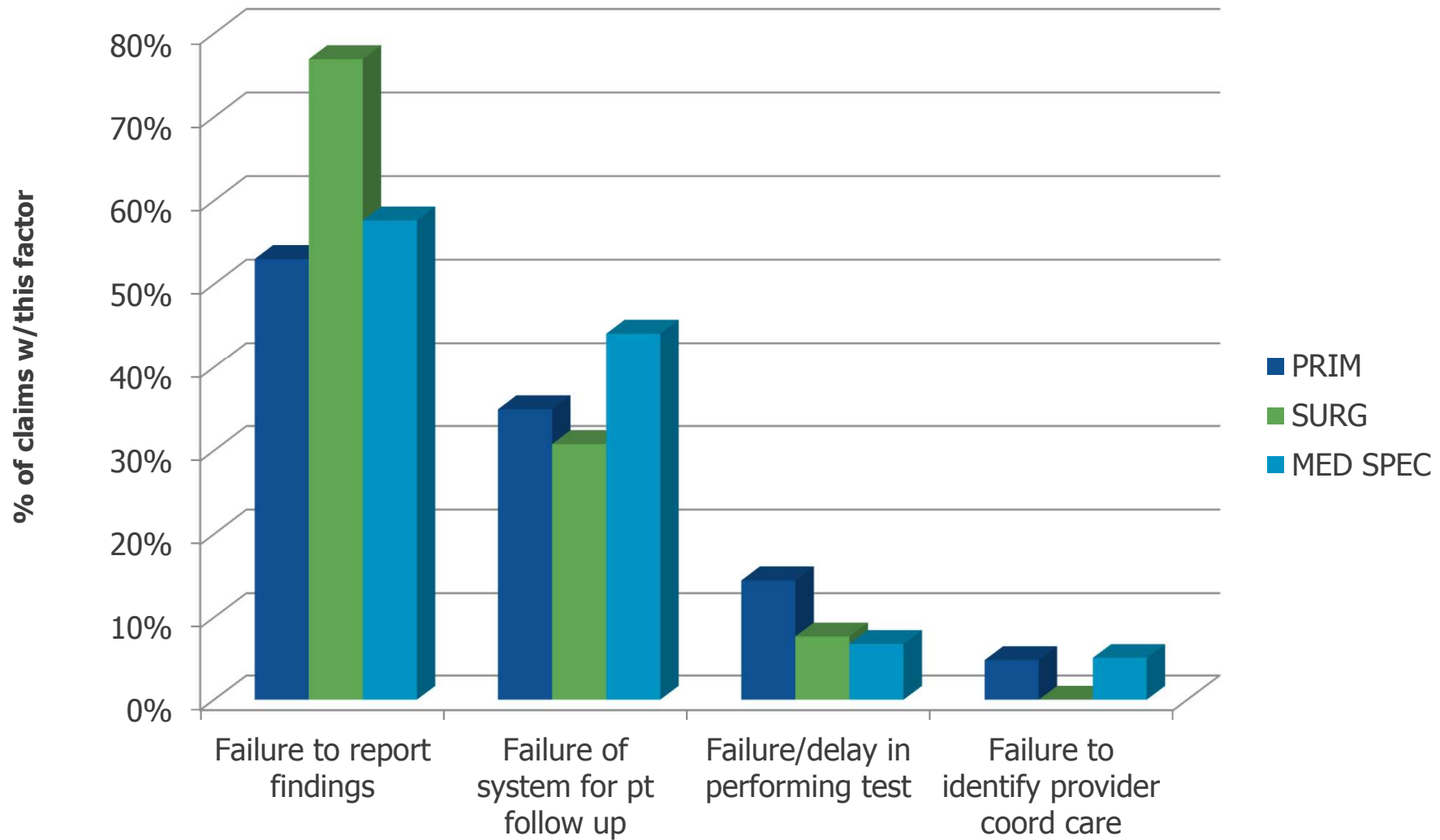
- Acknowledge your own emotional response to patients.
- Elicit feedback on your communication skills.
- Improve your listening and understanding skills.
- Improve partnership with the patient.
- Improve skills at expressing negative emotions.
- Increase empathy.



Clinical Systems and Administrative Factors



Specialty Comparisons: Focus on Clinical System Issues – Diagnostic Allegations



Source: MedPro physician claims, originating in physician office/clinic, opened years 2003-2012

Clinical Systems/Administrative Factors: Risk Strategies

- Standardize process for tests/referrals/consults.
 - Returned and reviewed.
 - Initialed by physician.
 - Patient informed and included.
- Verify patient identifiers.
- Report critical values immediately.
- Assign responsibility.
- Utilize process improvement methodologies.



Improving Your Office Testing Process

U.S. Department of Health & Human Services Home About Us Careers Contact Us Español FAQ Email Updates

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

Health Care Information For Patients & Consumers **For Professionals** For Policymakers Research Tools & Data Funding & Grants Centers, Portfolios & Initiatives News & Events A A A

Home > For Professionals > Quality & Patient Safety > Quality Measure Tools & Resources > Tools & Resources >

Page 1 of 11 Table of Contents Download Next Page


Clinicians & Providers
Education & Training
Hospitals & Health Systems
Prevention & Chronic Care
Quality & Patient Safety

Improving Your Office Testing Process

Publication # 13-0035

A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement

This toolkit provides information and resources to help physicians' offices, clinics, and other ambulatory care facilities assess and improve the testing process in their offices.



Summary

- Significant opportunity exists to reduce diagnostic errors.
- Root cause analysis of diagnostic errors and surgical complications identifies clinical judgment issues as the top driving force behind these errors.
- Effective strategies to reduce medical and diagnostic errors include designing and implementing processes and systems to address issues with:
 - Clinical judgment
 - Communication
 - Documentation
 - Behavior-related issues
 - Clinical systems
 - Administrative
 - Technical skill



What questions do
you have?



Thank You!

