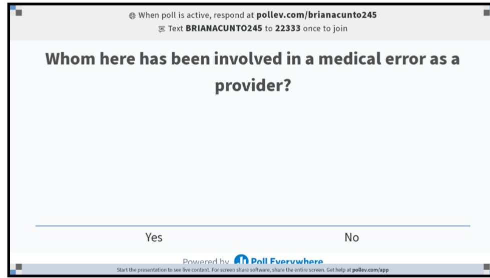

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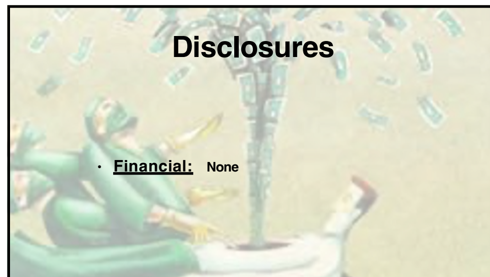

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OBJECTIVES

- Understand the various types of errors and their causes
- Describe the appropriate steps to take after an error has occurred
- Discuss the AHRQ report on Diagnostic Error in the ED

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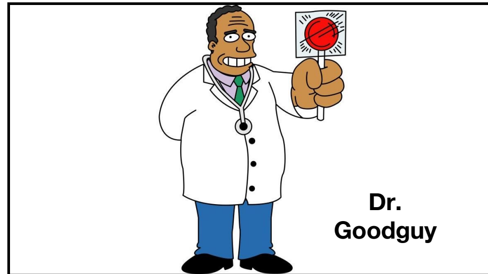

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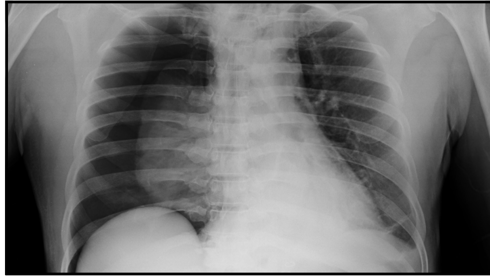

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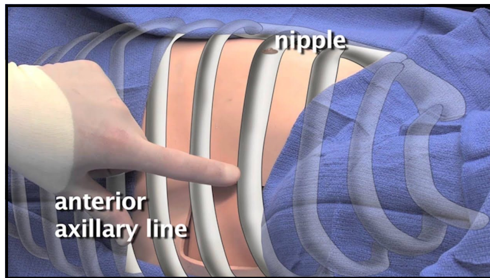

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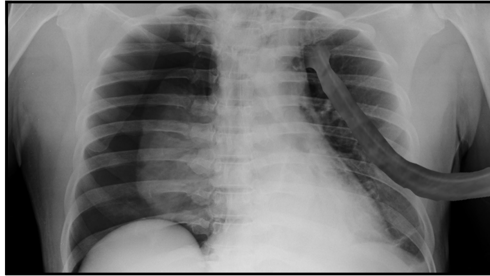

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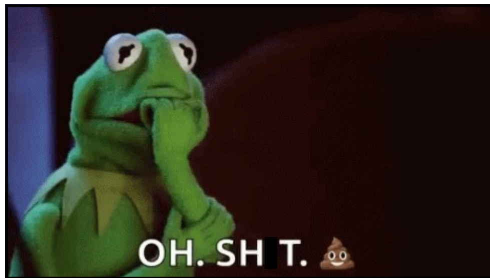

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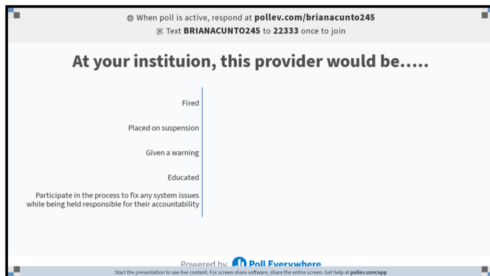

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In the Aftermath of the Error, What Dr. Goodguy Did Well

- **Disclosed the error to the patient and his family**
- **Mitigated the immediate danger to the patient due to the ongoing medical condition that was present.**

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In the Aftermath of the Error, What Dr. Goodguy Did Not Do Well

- **Did not follow institutional policies around serious occurrence**
- **Did not fill out an incident form**
  - **Legal and Risk Management were not aware**
  - **Insurers were not aware**
  - **Mandatory reporting to Federal, State, Local and accrediting agencies could not occur**

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Identifying Sentinel Events

Sentinel events are a subcategory of adverse events. A *sentinel event* is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the health care organization's emergency department (ED)
- Surgery or other ***invasive procedure*** performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome
- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe harm to the patient

https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures

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- Fall in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following:
  - Any fracture
  - Surgery, casting, or traction
  - Required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury
  - A patient with coagulopathy who receives blood products as a result of the fall
  - Death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures

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Dr. Goodguy's Error could be classified as a(n)

- Mistake
- Slip
- Latent Error
- Active Error
- At Risk Behavior

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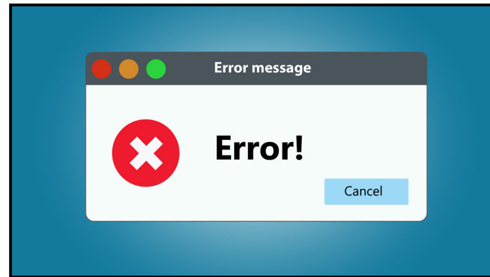

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MISTAKES

- You don't know the right thing to do because you haven't been taught
- Incorrect choices
- Lack of experience, training, or negligence

https://www.ismp.org/resources/differences-between-human-error-risk-behavior-and-reckless-behavior-are-key-just-culture
MedIQ. Culture of Safety Module 3: Error Causation and Response

23

SLIPS

- You know the right thing to do, but unintentionally don't do it.
- Failures of schematic behaviors
- Lapses in concentration
- Occur in the face of competing sensory or emotional distractions, fatigue, or stress
  - Training/Education will NOT decrease slips
  - Add extra step to process to prevent SLIPS

https://www.ismp.org/resources/differences-between-human-error-risk-behavior-and-reckless-behavior-are-key-just-culture
MedIQ. Culture of Safety Module 3: Error Causation and Response

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ACTIVE ERRORS

- Occur at the point of contact between a human and some aspect of a larger system.
- They are readily apparent
- Typically involve someone at the frontline
  - Push wrong button
  - Ignore warning light

https://psnet.ahrq.gov/primer/root-cause-analysis
MedIQ. Culture of Safety Module 3: Error Causation and Response

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LATENT ERRORS

- Less apparent failures of organization or design that allows harm to patients.
  - Organization uses different types of infusion pumps

https://psnet.ahrq.gov/primer/root-cause-analysis
MedIQ. Culture of Safety Module 3: Error Causation and Response

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AT RISK BEHAVIORS

- Behavioral choice that increases risk where risk is not recognizes or is mistakenly believed to be justified.

https://www.ismp.org/resources/differences-between-human-error-risk-behavior-and-reckless-behavior-are-key-just-culture
MedIQ. Culture of Safety Module 3: Error Causation and Response

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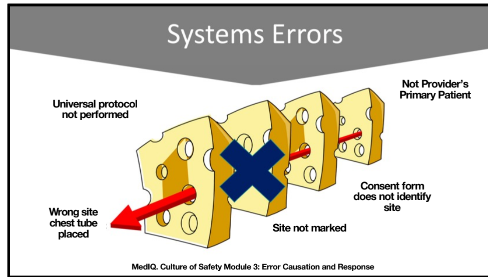

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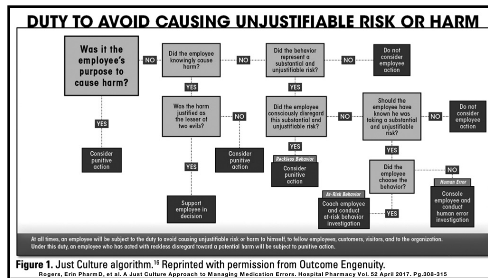

Figure 1. Just Culture algorithm.[16] Reprinted with permission from Outcome Engenuity.
Rogers, Erin PharmD, et al. A Just Culture Approach to Managing Medication Errors. Hospital Pharmacy Vol. 52 April 2017. Pg.308-315

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At my institution.....

Individuals are soley held accountable for mistakes

The system failures are examined first and where appropriate individuals are held accountable

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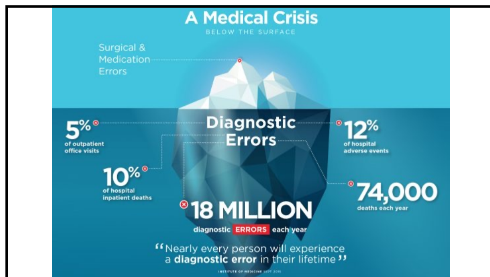

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Whom here has made a diagnostic error?

Yes No

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Comparative Effectiveness Review
Number 258

Diagnostic Errors in the Emergency Department: A Systematic Review

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857
www.ahrq.gov

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Conclusions. Although estimated ED error rates are low (and comparable to those found in other clinical settings), the number of patients potentially impacted is large. Not all diagnostic errors or harms are preventable, but wide variability in diagnostic error rates across diseases, symptoms, and hospitals suggests improvement is possible. With 130 million U.S. ED visits, estimated rates for diagnostic error (5.7%), misdiagnosis-related harms (2.0%), and serious misdiagnosis-related harms (0.3%) could translate to more than 7 million errors, 2.5 million harms, and 350,000 patients suffering potentially preventable permanent disability or death. Over two-thirds of serious harms are attributable to just 15 diseases and linked to cognitive errors, particularly in cases with "atypical" manifestations. Scalable solutions to enhance bedside diagnostic processes are needed, and these should target the most commonly misdiagnosed clinical presentations of key diseases causing serious harms. New studies should confirm overall rates are representative of current U.S.-based ED practice and focus on identified evidence gaps (errors among common diseases with lower-severity harms, pediatric ED errors and harms, dynamic systems factors such as overcrowding, and false positives). Policy changes to consider based on this review include: (1) standardizing measurement and research results reporting to maximize comparability of measures of diagnostic error and misdiagnosis-related harms; (2) creating a National Diagnostic Performance Dashboard to track performance; and (3) using multiple policy levers (e.g., research funding, public accountability, payment reforms) to facilitate the rapid development and deployment of solutions to address this critically important patient safety concern.

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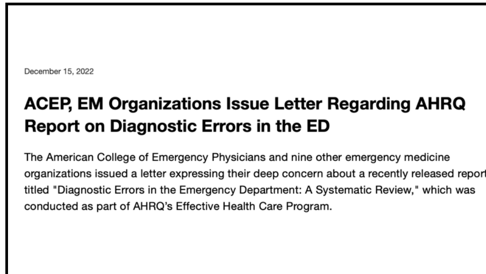

December 15, 2022

ACEP, EM Organizations Issue Letter Regarding AHRQ Report on Diagnostic Errors in the ED

The American College of Emergency Physicians and nine other emergency medicine organizations issued a letter expressing their deep concern about a recently released report titled "Diagnostic Errors in the Emergency Department: A Systematic Review," which was conducted as part of AHRQ's Effective Health Care Program.

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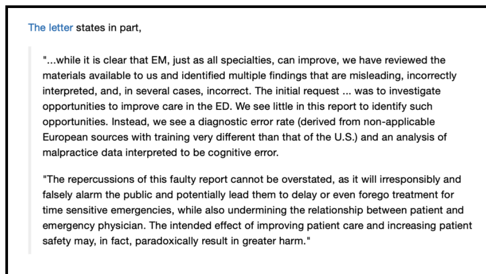

The letter states in part,

> "...while it is clear that EM, just as all specialties, can improve, we have reviewed the materials available to us and identified multiple findings that are misleading, incorrectly interpreted, and, in several cases, incorrect. The initial request ... was to investigate opportunities to improve care in the ED. We see little in this report to identify such opportunities. Instead, we see a diagnostic error rate (derived from non-applicable European sources with training very different than that of the U.S.) and an analysis of malpractice data interpreted to be cognitive error.
>
> "The repercussions of this faulty report cannot be overstated, as it will irresponsibly and falsely alarm the public and potentially lead them to delay or even forego treatment for time sensitive emergencies, while also undermining the relationship between patient and emergency physician. The intended effect of improving patient care and increasing patient safety may, in fact, paradoxically result in greater harm."

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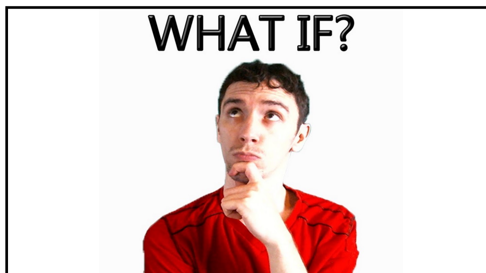

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