In 2015, the Institute of Medicine report, “Improving Diagnosis in Healthcare”, highlighted the importance of improving diagnoses and reducing diagnostic errors. This report estimated that 5% of U.S. adults seeking outpatient care each year experience a diagnostic error, diagnostic error contributes to some 10% of patient deaths and diagnostic errors account for 6 – 17% of adverse events in hospitals.


In a recent report by Coverys, a nationally recognized professional liability insurer, it was noted that 10 – 20% of all diagnoses are inaccurate. The report also indicates that there are ways to improve the diagnostic accuracy, and reduce diagnostic error. Coverys’ report, “Diagnostic Accuracy: Room for Improvement”, reviewed 10,618 closed medical professional liability claims between 2013-2017 to provide insight into the root causes of diagnosis-related claims. (https://www.coverys.com/PDFs/Coverys_Diagnostic_Accuracy_Report.aspx).

Coverys’ report indicates that 53% of diagnostic-related claims include risk management issues involving poor clinical decision making; 54% are high-severity cases and 36% result in death; and 36% of diagnostic-related claims stem from outpatient locations.

Developing timely and accurate diagnoses requires numerous steps and practitioners. The first two steps: evaluation of the patient and conducting diagnostic/lab testing, have the highest risk. In these steps, listening, communicating and data interpretation are critical.

Key Steps and Risks in Diagnostic Process (Coverys):

52% Diagnostic/Lab Testing, Interpretation and Transmittal of risks include failure to:

- Properly perform tests;
- Receive and transmit results;
- Clearly communicate between providers and lab/radiology, and providers to patients; and
- Repeat tests or order additional tests.

33%: H&P/Patient Evaluation Risks include failure to:

- Obtain a complete patient history;
- Obtain a complete family history;
- Conduct a complete and relevant physical; and
- Review patient history notes, if applicable.

9% Referral Management risks include failure to:

- Appropriately hand off or refer to a specialist;
- Obtain a report from a specialist and communicate findings to the patient;
- Ensure a patient returns for follow up with referring physician; and
- Properly document notes and labs from a specialist into the patient’s record.

5% Physician-Patient Follow Up risks include failure to:

- Maintain/document adequate connections with a patient post-diagnosis;
- Seek information about new symptoms; and
- Evaluate/document treatment effectiveness and possible next steps.

The following is the list of recommendations from the Coverys’ report to help improve diagnostic accuracy:

- Honestly examine diagnostic culture and other influences that create overconfidence in medical diagnostics;
• Document any uncertainty about a diagnosis in the electronic health record;
• Find ways to include the patient in decision making;
• Constantly innovate and organize when it comes to processes, checklist and protocols;
• Keep the location in mind – reaching a timely and accurate differential diagnosis in the emergency department may require different processes, skills, and talents than in an outpatient setting;
• Use technology and decision support tools;
• Implement resources and tools to support centralization of information;
• Seek ways to include more formal and concentrated training on communication skills for all providers;
• Seek continuing medical education about diagnostics;
• Be conscious of factors that may impede seeking a diagnosis; and
• Slow down.

Coverys’ report notes that 35% of diagnostic-related claims originate in offices/clinics. They posit various reasons for this: failure to measure compliance with published practice guidelines, no robust peer review, patient populations that lack resources necessary to adhere to treatment regimens, and no access to clinical support tools. It is important to remember that any location or service listed on a hospital’s license is also subject the mandatory reporting of SEs, including physician practices. Hospital-owned practices must be part of the ongoing surveillance for SEs and staff in these outpatient settings must receive training to be able to identify a possible SE, know how to report it, and be included in root cause analyses. In the coming year, the SET will be conducting on site reviews specific to outpatient settings in an effort to bring attention to the patient safety risks associated with these areas.

Violence in health care settings has received increased attention recently. The Joint Commission released a Sentinel Event Alert in April 2018 about physical and verbal violence against health care workers; and also addressed the issue in Sentinel Alert Issues 40 and 57.

The National Institute for Occupational Safety and Health (NIOSH) also released a publication about workplace violence in health care. OSHA identified that, from 2002 to 2013, incidents of serious workplace violence (those requiring days off for the injured worker to recuperate) were four times more common in healthcare than in private industry, on average.

Workplace violence is defined by OSHA as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. The U.S. Department of Labor provides a broader definition as “an action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior, intimidating or harassing behavior, and threats.”

OSHA cites the following risk factors as contributing to health care workplace violence:
• Perception that violence is tolerated and reporting incidents will have no effect;
• Lack of access to emergency communication such as call bells or cell phones;
• Lack of training and policies for staff to recognize and de-escalate assaultive and hostile behavior from patients, visitors or staff;
• Poor environmental design that may block vision or escape routes;
• Poor lighting in hallways or exterior areas;
• Understaffing in general, and especially during meal times and visiting hours;
• Inadequate mental health staff and security;
• Long wait times and overcrowded waiting rooms;
• Working with people who have a history of violence or who may be delirious or under the influence of drugs; and
• Lack of community mental health care.
An effective workplace violence prevention program can also fit into a broader safety and health management system, can help the facility improve employee and patient safety, and improve the quality of patient care.

The Joint Commission provides the following recommendations to reduce or eliminate violence in health care facilities:

- Clearly define workplace violence and put systems into place across the organization that enable staff to report workplace violence incidents, including verbal abuse;
- Recognize that data comes from several sources; capture, track and trend all reports of workplace violence including verbal abuse and attempted assaults even when no harm occurred;
- Provide appropriate follow up and support to victims, witnesses and others affected by workplace violence, including psychological counseling and trauma informed care if needed;
- Review each case of workplace violence to determine contributing factors. Analyze data related to workplace violence and conditions to triage for interventions;
- Develop quality improvement initiatives to reduce incidents of workplace violence;
- Train all staff, including security, in skills of de-escalation, self-defense, and responding to codes; and
- Evaluate workplace violence reduction initiatives.

The National Quality Forum has identified as a ‘never event’ the serious injury of a staff member resulting from the physical assault that occurs within or on the grounds of a healthcare facility. Therefore, these types of injuries must be reported to the SET.

Resources:

www.osha.gov/Publications/osha3148.pdf
www.osha.gov/Publications/OSHA3827.pdf
www.osha.gov/Publications/OSHA3828.pdf
https://www.jointcommission.org/wpv_healthcare_jcr_newsletters/
UPDATES FROM THE SENTINEL EVENT TEAM

- The SET is planning a collaborative education session in late summer. The focus will be on mental health and how to overcome some of the challenges with delivery of care. Additional details are to follow.

- As the SET Manager, I want to take this time to announce that Madeline Orange is leaving the SET. She is returning to California! Her efforts have been greatly appreciated and she will be sorely missed in her role with the SET. Join me in wishing her the best on the “other coast”. GOOD LUCK MADELINE!