

Diagnostic error is defined as failure to

- (a) establish an accurate and timely explanation of a patient's health problem(s) and
- (b) communicate that explanation to the patient

Diagnostic error definition

Diagnostic errors are diagnoses that are delayed, wrong, or missed altogether

World

Patient Safety
Day 17 September 2024

Diagnostic error

Surgical diagnostic errors are attributable most commonly to errors in clinical decision making (47%) and communication (60%)

Surgical diagnostic errors attributable to errors in clinical decision making

Nearly 75% of serious misdiagnoses-related harms are attributable to diseases in just three major categories – vascular events, infections, and cancers

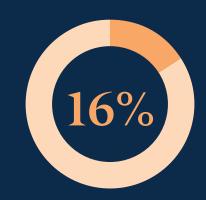
Diagnostic error occurs in all phases of surgical care

Diagnostic error occurs in all phases of surgical care (34% occur pre-op, 31% intra-op and 45% post op)





The scale broblem



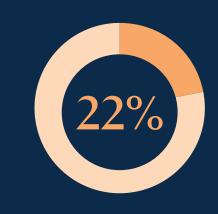
diagnostic errors accounts for **16%** of preventable harm that arises in healthcare globally



most people will experience at least **one diagnostic error** in their lifetime



10–15% of all diagnoses are erroneous



diagnostic errors account for **22%** of paid malpractice claims in acute care



diagnostic errors remain the

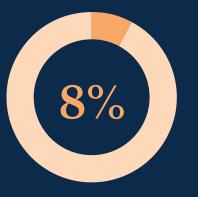
most common, most
catastrophic, and most
costly of serious medical errors
in closed malpractice claims



over 50% of patients involved in surgical error experience at least moderate harm, and this is fatal in 1 in 7



misdiagnosis accounts for up to 80,000 deaths and **16,000 serious harms** in US hospitals annually



8% of adverse events in medicine are related to harmful diagnostic errors

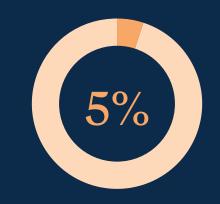


14% of adverse events in hospitalized patients are related to harmful diagnostic errors



diagnostic error occurs in **4%** of primary care

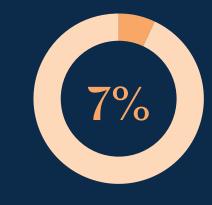
consultations



diagnostic error occurs in 5% of outpatient consultations



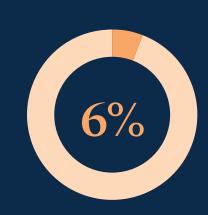
diagnostic error occurs in **0.7%** of adult hospitalizations



diagnostic error occurs in **7%** of patients transferred to intensive care



diagnostic error occurs in 30% of Accident & Emergency patients



diagnostic error occurs in **6%** of medical 7-day readmissions





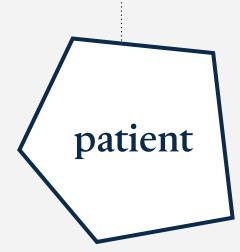
Cause problem



PERSON



Inadequate knowledge
Inadequate skills
Cognitive bias
Tunnel vision
Intrinsic bias



Extremes of age
Health complexity
Atypical presentation
Rare condition
Cultural differences



TASKS



Challenging job demands

Time pressure

Distractions

High cognitive load

High stress

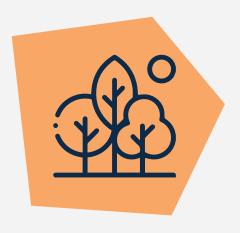


Poor information gathering
Poor information processing
Poor pattern recognition
Poor clinical reasoning
Poor handover
Poor investigation governance
Poor communication
Poor documentation



TECHNOLOGY AND TOOLS

Inadequate administrative procedures
Inadequate documentation tools
Inadequate access to information
systems
Inadequate use of technology to
highlight abnormal results
Inadequate systems to track diagnostic
information over time



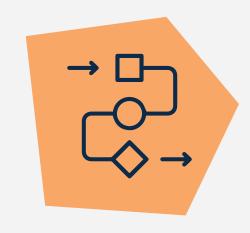
ENVIRONMENT

Chaotic work environment
Overcrowding
Boarding
Overbooking
Interhospital transfer



ORGANIZATION

Poor work schedules
Lack of continuity of care
Inadequate staffing
Delays in outpatient review
Delays in investigations
Delays in actioning results
Lack of reliable measurement of
diagnostic safety
Lack of feedback on diagnostic performance
Inadequate targeting of high risk groups
Inadequate health education



PROCESS

Diagnostic process complex Inherent diagnostic uncertainty Not all symptoms are diagnosable Available information often incomplete Diagnostic errors hard to measure Diagnostic standards hard to define





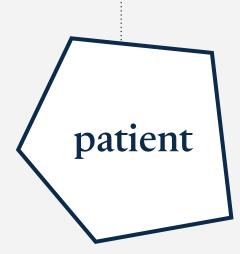




PERSON



Regular training
Involve patients
Seek feedback on decisions
Address personal biases
Be an effective team player



Share all symptoms and medical history
Take an active role in care
Ask for information
Be clear what matters most to you
Raise any concerns



TASKS

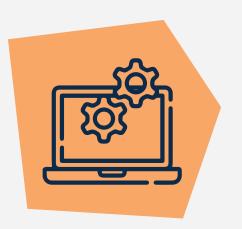


Improve job demands
Ensure sufficient time
Reduce distractions
Reduce stress



Improve task performance

Assess patients thoroughly
Be aware of red flags
Capture insights from wider team
Improve handover
Communicate effectively



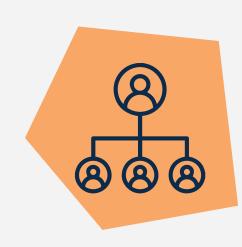
TECHNOLOGY AND TOOLS

Improved Electronic Health Record
Diagnostic Time Out Checklist
Electronic Trigger Tools
Closed loop system for results
Safety netting systems
Early Warning Scores
Al & machine learning



ENVIRONMENT

Prevent overcrowding
Reduce boarding
Limit patient transfers
Optimize patient flow
Do not overbook clinics/lists



ORGANIZATION

Improve continuity of care
Ensure safe staffing levels
Improve teamwork
Develop pathways for common presentations
Target high risk groups
Ensure blame free culture focused on improvement
Champion diagnostic safety in policies
Train staff on diagnostic safety
Measure diagnostic safety
Provide diagnostic safety feedback
Promote patient education



Howthe RCSEd can help

PATIENTS/ CARERS

Resource for the surgical journey
Supporting literacy
When things go wrong in surgical care
Listen to the voice of patients

PERSON

World Patient Safety Day 17 September 2024

CLINICIANS Courses to:

Improve Communication, Teamwork, Situational awareness
Include patients in decisions about their care

Make safe diagnoses

Examinations to ensure clinicians:Meet the required standards to

deliver safe diagnostic care

Resource to:

Improve clinician wellbeing

Structured review of diagnostic error in surgical practice
Team Based Quality Reviews
Making Sense of Mistakes Workshop

Guidance on Duty of Candour Peri-operative care provision

ENVIRONMENT

Environment for learning
Anti-Bullying & Undermining
Lets Remove It Sexual Misconduct
campaign
Addressing Conflict in Surgical
Teams Workshop
Raising Concerns, Whistleblowing

and Speaking Up
Improving the Working
Environment for Safe Surgical Care
Improving Safety out of Hours

TASKS

Training Courses:
Competent diagnostic
task performance in the
workplace
NCEPOD Steering Group:
advise on national audits into
safe diagnoses

TECHNOLOGY AND TOOLS



Shine Surgical Ward Round Tool Kit Recognition and Prevention of Injury and Deterioration