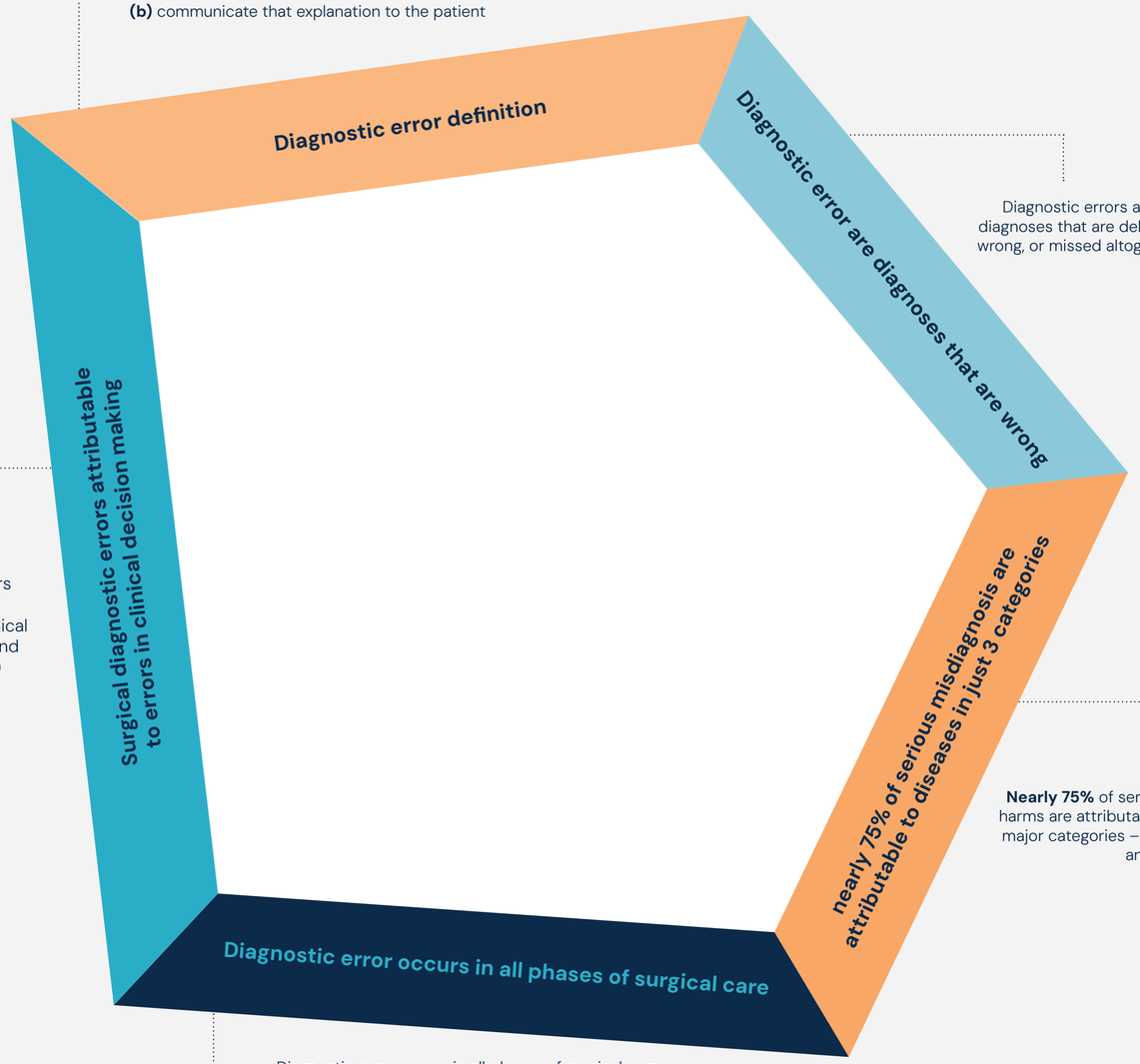
The ROYAL COLLEGE of SURGEONS of EDINBURGH

World Patient Safety Day 17 September 2024

# Diagnostic error




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

**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 (**34%** occur pre-op, **31%** intra-op and **45%** post op)

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

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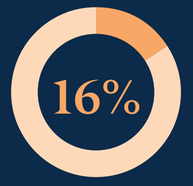
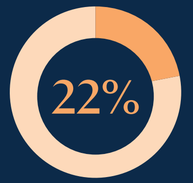
# The scale *of* the problem




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

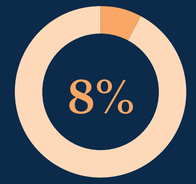



diagnostic errors account for **22%** of paid malpractice claims in acute care

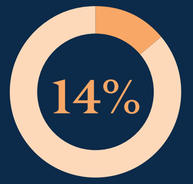

diagnostic errors remain the **most common,** most catastrophic, and most costly of serious medical errors in closed malpractice claims


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

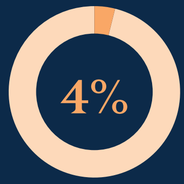

misdiagnosis accounts for up to 80,000 deaths and **16,000 serious harms** in US hospitals annually



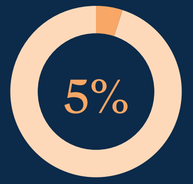

**8%** of adverse events in medicine are related to harmful diagnostic errors




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

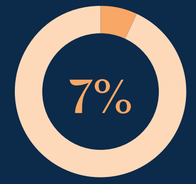



diagnostic error occurs in **4%** of primary care consultations



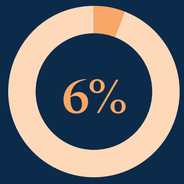

diagnostic error occurs in **5%** of outpatient consultations


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

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# Cause *of* the problem


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# Solutions

## PERSON

### clinician

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

### patient

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

### job demands

**Improve job demands**
Ensure sufficient time
Reduce distractions
Reduce stress

### task performance

**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
AI & 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

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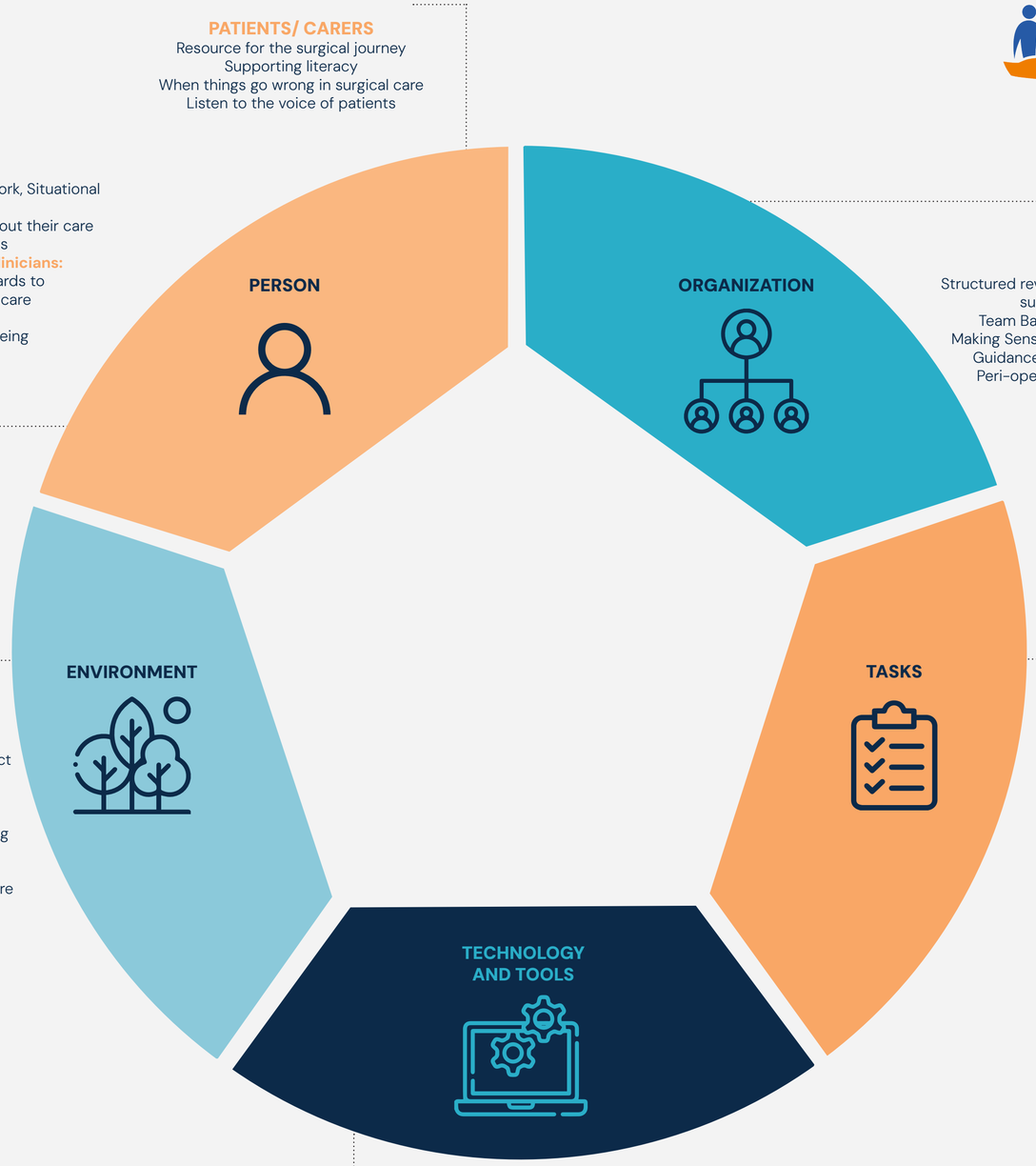
# How *the* RCSEd can help

## Diagnostic Safety




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

**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

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

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

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