Medical Errors: System Approaches

Ken Brummel-Smith, M.D.
Charlotte Edwards Maguire Professor and Chair, Department of Geriatrics
Florida State University College of Medicine
Effective Systems

- Culture of safety
- Clear policies and procedures
  - Discussing
  - Disclosing
  - Remedies
- Top-down leadership
- Team training
- Tort reform
Types of Errors

- Observable errors
  - Slips – the action conducted is not what was intended
    - Turning the wrong nob of the machine
  - Mistake – the action did not achieve its intended outcome because it wasn’t the right thing to do
    - Amputating the wrong leg

- Non-observable error
  - Lapse – an intended task is not completed
    - Not recalling if a drug was administered
Active and Latent Errors

- **Active errors** - occur at the level of the frontline operator, and their effects are felt almost immediately.

- **Latent errors** tend to be removed from the direct control of the operator. **
  - Poor design
  - Incorrect installation
  - Faulty maintenance
  - Bad management decisions
  - Poorly structured organizations
Creating a Culture of Safety

- Highest leadership – especially physicians
- Celebrate successes
  - Share data
- In-depth discussion of events
  - Near misses to adverse events
- Standardized reporting systems
  - Mandatory – serious injuries and death
  - Voluntary – system improvement
Hierarchy of Reporting

- **Serious, preventable adverse events**: Mandatory reporting, Public disclosure
- **Near misses, lesser injuries**: Voluntary reporting, Confidentiality protected
Creating a Culture of Safety

- Health system change
- Standardization and simplification
- Interdisciplinary team training
  - Check-backs
  - “Stop the line”
- AHRQ TeamSTEPPS Training
Creating a Culture of Safety

- Performance standards
  - Re-examination and re-licensing
  - Certification & maintenance of certification

- Pharmaceuticals
  - Improve pre-and post-marketing reporting
  - Naming & packaging
  - Remove industry influence
  - Patient identification systems
  - EHR
  - CPOE
Legal Protections

- Extend peer review protections to data related to patient safety & quality improvement
- Allow national sharing of this data
- Rules of evidence
  - Remedial action
  - Peer review privilege
- Confidentiality by practice
- Anonymous reporting
Malpractice Changes

- **Tort Reform**
  - Limits on noneconomic damages
  - Stop joint and several liability
  - Criteria for expert witnesses
  - Reducing awards if plaintiff’s action contributed to the outcome
  - Limits on attorney’s compensation
Enterprise Liability

- Only the system can be sued
  - Represents the systemic nature of medical errors
  - Physician pays the health system (hospital or health plan)
- System has incentive to prevent errors
- System is encouraged to rectify unprofessional providers
- Promotes uniform reporting and teamwork
No-fault Systems

- Deals with avoidable adversities
  - Patient must only prove it occurred, not who is at fault
  - Compensation is calculated on pre-set formulas
- Expert group decides whether standard of care was breached
- Would increase modest awards and decrease huge awards
- Florida has this for newborn injuries

Limited data available on outcomes
Summary – Systems Change

- Provide leadership
- Respect human limits in the design process
- Promoting effective team functioning
- Anticipate the unexpected
- Create a learning environment
Leadership

- Safety is a priority corporate objective
- Safety is everyone’s responsibility
- Clear assignments for safety oversight
- Provide human and financial resources for error analysis and systems redesign.
- Develop effective mechanisms for identifying and dealing with unsafe practitioners.
Respect Human Limits

- Design jobs for safety
- Avoid reliance on memory
- Use constraints and forcing functions
- Avoid reliance on vigilance
- Simplify key processes
- Standardize work processes
Effective Teams

- Train in teams those who are expected to work in teams
- Include the patient in safety design and the process of care
- AHRQ TeamSTEPPS training
Anticipate The Unexpected

- Adopt a proactive approach: examine processes of care for threats to safety and redesign them before accidents occur
- Design for recovery
- Improve access to accurate, timely information
Create a Learning Environment

- Use simulations whenever possible
- Encourage reporting of errors and hazardous conditions
- Ensure no reprisals for reporting of errors
- Develop a working culture in which communication flows freely regardless of authority level
- Implement mechanisms of feedback and learning from error