

Medical Errors: System Approaches

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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

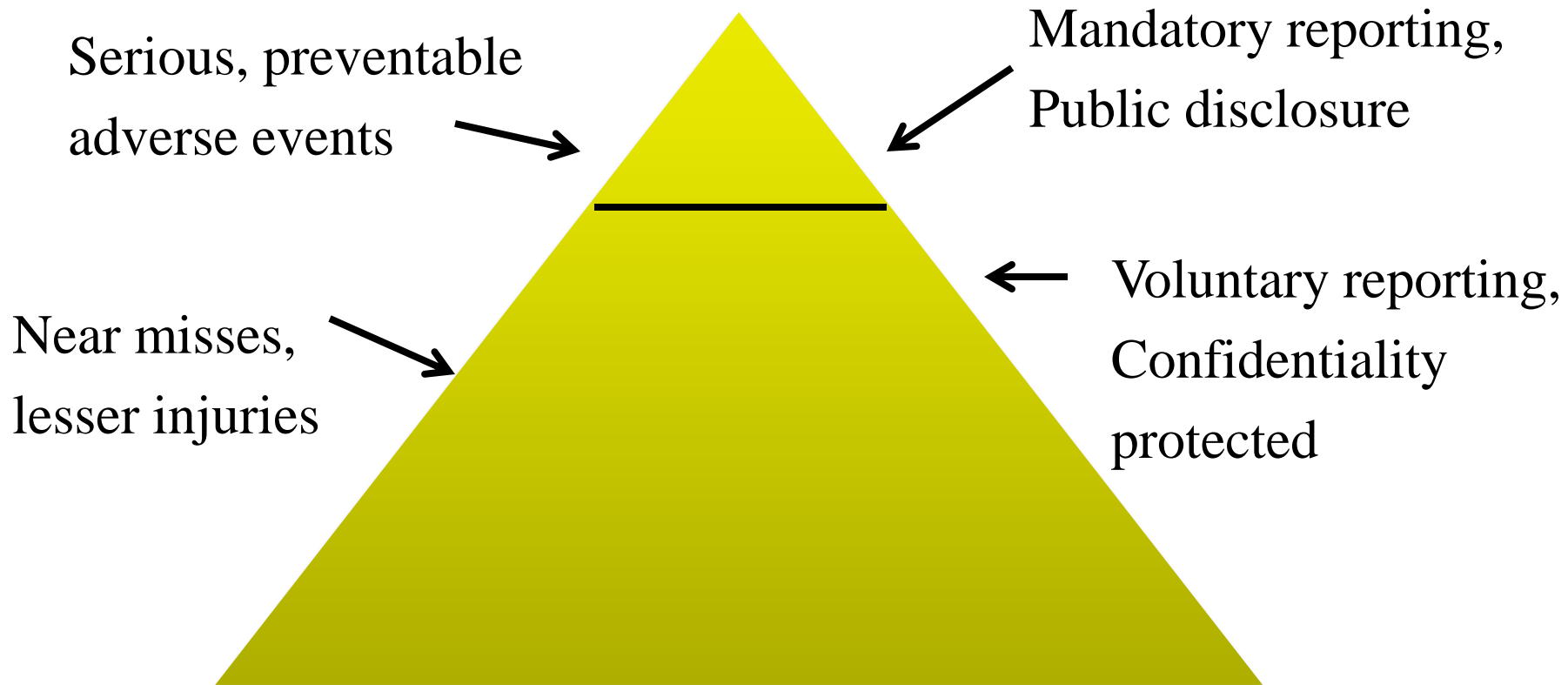
- Active errors - occur at the level of the frontline operator, and their effects are felt almost immediately
- Latent errors tend to be removed from the direct control of the operator **
 - Poor design
 - Incorrect installation
 - Faulty maintenance
 - Bad management decisions
 - Poorly structured organizations



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





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