RISK PROFILE

CARE – Diagnostic Errors

Diagnostic errors, such as missed, incorrect or delayed diagnoses, are complex and diverse safety issues that can cause serious patient harm. The complexity, time-dependent, and team-based nature of the diagnostic process makes the detection and measurement of diagnostic errors a challenging task. When a diagnosis is incorrect or unknown, the patient may receive improper treatment for a present condition, treatment for a condition not actually present or may not receive treatment. This document contains information entered by HIROC subscriber organizations (acute and non-acute) in the Risk Register application to help you in your assessment of the risk.

Key Controls / Mitigation Strategies

- Incident Management:
  - √ Comprehensive incident documentation system, including a reporting and review framework in place to systematically monitor diagnostic errors and potential contributing factors
  - √ Process to review and identify where risk is most likely
- Systems, Policies and Procedures:
  - √ Facilitate and support effective interdisciplinary teamwork in the diagnostic process
  - √ Policies regarding oversight of trainees and daily patient assessments
  - √ Process for timely access to ancillary testing and consultants
  - √ Establish communication and escalation pathways
  - √ Develop second reading process for confirmation of all new diagnosis that may lead to significant clinical intervention, including new malignancies
  - √ Process to ensure staff refer to surgical booking form or preadmission plan to note tests done (e.g. hematology, chemistry, diagnostic tests)
  - √ Process to ensure all test results are available and communicated to the most responsible provider in timely manner
  - √ Process to address reporting delays in timely manner
  - √ Establish effective test-result management systems and strategies

- √ Standardized format/process for communicating pathology results using uniform, cancer-specific grading systems and terminology
- √ Support a culture around high-quality diagnostic services.
- √ Regular laboratory division operational leadership meetings to discuss and address issues related to laboratory testing
- √ Process for effective and up to date utilization of appointment management
- √ Lab Specimen specific policies:
  - » Departmental-specific specimen policies
  - » Specimen sign-off process, specimen handling and 2 unique patient identifiers
  - » Labelling/Barcoding
- √ Documentation
  - » Standard documentation protocols
  - » Document control practices to ensure critical documentation for laboratory operation is current and controlled

• Equipment / Technology:

- √ Use of diagnostic health information technology and tools:
  - » Alerts, reminders, web-based patient portals (e.g. My Chart)
  - » Centralized electronic patient health record
  - » Standard care pathways and decision aids
- √ Equipment replacement process:
  - » Early communication of upcoming capital equipment purchase (e.g. equipment replacement) and construction/renovation requirements
  - » Ongoing coordination in prioritizing and planning equipment replacement projects

  - » Timely communication and engagement of appropriate stakeholders (e.g. contractors, information technology leads)
  - » Frequent status updates on progress of replacement plans (e.g. coordination challenges, delays)
- √ Increase frequency of preventative maintenance and controls
- √ Digital technology with augmented intelligence to support decision making and amplify diagnostic capabilities
- √ Diagnostic imaging peer review software
- √ Upgrade obsolete technology that prevents radiologists and other providers from visualizing, reviewing or diagnosing due to access issues or poor image quality

• Education / Training:

- √ Patient and family education in the diagnostic process
- √ Ongoing staff education to minimize cognitive biases in the diagnostic process
- √ Just culture education, effective teamwork and error prevention training
- √ Ongoing updates and education on policies and processes (e.g. training on testing for specific specimens, revised processes and forms, test result management)
- √ Implement safety coaches to assist with the uptake of error prevention techniques
- √ Share safety learnings
- √ Clinical case conference; department specific rounds/councils
- √ Strategies and interventions to improve care documentation

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Monitoring / Indicators:

- √ Independent audits (e.g. prospective surveillance)
- √ Monitor chart audits (e.g. emergency department return visits associated with diagnostic error)
- √ Data collected through incident reporting systems including safety events due to diagnostic errors and incorrect labeling of specimens
- √ Frequency of unavailable or improper diagnostic tests, including biopsy results and addendum reports, preoperatively/prior to surgery
- √ Claims data related to diagnostic errors
- √ Downtime monitoring
- √ Patient experience survey results
- √ Report out of patient complaints related to diagnostic errors
- √ Appropriate number of trained medical and scientific staff and effective workload monitoring
- √ Mortality and Morbidity Committee review of safety reports
- √ Peer review process:
  - » Diagnostic imaging peer review process and software to reduce reporting discrepancy and eliminate errors
  - » Ancillary reviews for emergency department and diagnostic imaging follow-up process
  - » Physician peer review program

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- √ Quality assurance:
  - » Pathology specific:
    - Consistent / standardized quality assurance processes
    - Pathology quality assurance committee
    - Pathology standards committee
- √ Adoption of local, regional, provincial quality control processes and initiatives
- √ Point of care testing quality assurance
- √ Medical quality assurance compliance audit and monitoring
- √ Quality assurance oversight for all laboratory services
- √ Accreditation in place for all laboratory services

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This is a resource for quality assurance and risk management purposes only and is not intended to provide or replace legal or medical advice or reflect standards of care and/or standards of practice of a regulatory body. The information contained in this resource was deemed accurate at the time of publication, however, practices may change without notice.

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