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Pediatric Congress 2017: What causes diagnostic errors: Behavioral determinants of the health care team? - Jennifer Tavares-Kitchen - Advocate Children's Hospital

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Introduction:

Diagnosis is one of the most important tasks performed by primary care providers. Diagnostic errors can prompt patient damage from wrong or delayed testing or treatment. They have emerged as a global priority in patient safety. This monograph brings issues to light among the World Health Organization (WHO) Member States about methodologies that could be executed to decrease diagnostic errors in primary care. After outlining the methodology taken to incorporate information, the monograph depicts the significance of inspecting diagnostic errors; the most widely recognized kinds of diagnostic errors in primary care, and potential solutions. Diagnostic error defined as the failure to establish an accurate and timely explanation of the patient's health problem(s) or communicate that explanation to the patient. Basically, these are diagnoses that are postponed, wrong, or missed altogether.

The implementation of patient safety initiatives that focus on the prevention of process-driven medical errors has been very successful in reducing hospital acquired infections and medication and surgical errors. Cognitive errors, in any case, that results in delayed, missed or wrong analysis (a significant number of which bring about serious harm and huge financial penalties) keep on persist. They are rarely reported or addressed to and no hospital in the USA is counting diagnostic errors, in spite of the way that they are more basic in deciding results than some other kind of error. Exact causes and intervention strategies continue to be elusive. Various theories have been proposed and several contributory factors have been identified, but the debate on a precise and preventative model continues with no consensus. Most of the published literature relies on retrospective analysis and autopsy findings of such errors. We have chosen to launch a prospective study to distinguish diagnostic errors in real time and to examine the causes and the components required to build up a standardized and effective model of prevention.

Materials & Methods:

The study started in March 2017 and is ongoing. In the first phase of our study, we decided to analyze how the patient care delivery model functions on the inpatient units. We utilize the Family Centered Patient Rounds model. The team is headed by a faculty member (hospitalist) in addition to the nurses and trainees (residents and medical students). We focused on the medical-surgical floors and did not include the critical care units. Medical students were relegated to watch the function of the team for the full term of the 12-hour shift s and finished these perceptions for 15 move s covering the morning, evening and weekend shift s on two separate units. The observation parameters included the frequency and length of time each of the team members spent on bedside care, medication delivery, utilization of the Electronic Medical Record (EMR) and supervision of care. We also defined what constitutes a medical error and requested voluntary counting and reporting of such errors as they occur. The observational periods for the nursing staff were completed. The observational periods for the rest of the team members are still ongoing. The shortest and longest time periods a medical caretaker spent in finishing their assignments were recorded and the medians were determined.

Results & Conclusion:

Nurses spent, around 15 minutes at the bedside, five minutes on directing prescriptions, 45 minutes on the EMR per understanding per 12-hour shift and 150 minutes participating in the Family Centered Rounds and signing off on their patients. This is around four hours out of a 12-hour shift, the rest of which is spent on activities related with the patient, yet not direct care. Beginning observations for the rest of the team members show that time accessibility and direct supervision of the learners by senior doctors could be improved. These outcomes recommend that basic components of a model to prevent diagnostic errors, for example, continuous and customary evaluation of a patient's condition and progress after affirmation, checking and interpreting or requesting further diagnostics, may have been compromised. It is difficult not to conclude that the first step in developing a model to prevent diagnostic errors ought to be modifying how members of the health care team function on the inpatient units. A special task force has been formed to investigate this issue and make recommendations.

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