

8 STRATEGIES FOR HOSPITALS AND CLINICS TO PREVENT MEDICAL ERRORS

In the latest survey¹, Iowans have provided a collective voice about their healthcare experiences with Iowa hospitals, clinics and nursing homes. These views are highlighted as follows:

- Nineteen percent of Iowans say they have personally experienced a preventable medical error in their own care or in the care of someone close to them during the past five years.
- Nine in 10 Iowans who experienced a medical error say the error was preventable.
- Only four in 10 Iowans say they were informed by the medical provider of the medical error.
- The majority of medical errors (59 percent) occurred at the hospital, while 30 percent of errors occurred at the doctor's office or clinic.
- The most common error reported by Iowans was a mistake made during a test, surgery or treatment (60 percent), while the second most common error was related to being misdiagnosed (55 percent). The third most common type of error reported was the patient was given the wrong test, surgery or treatment (44 percent).
- Six in 10 Iowans who experienced a medical error reported having serious health consequences while another 23 percent indicated minor health consequences.

When given a list of 19 factors that might cause medical errors, Iowans rated each using a four-point scale where one means "not important" and four means "very important." Respondents, whether they experienced a medical error or not, provided the top five causes of medical errors in Iowa:

1. Doctors and nurses who are overworked, stressed or tired – 3.65
2. Doctors or other staff not knowing about the medical care that a patient received somewhere else – 3.61
3. Doctors and other staff in a hospital or medical office not working together or communicating well as a team – 3.58
4. Hospitals or medical offices not being organized well enough to make sure patients don't get the wrong drug or the wrong dose of a drug – 3.54
5. Medical staff not listening, or ignoring patients' concerns – 3.52

HOW CAN HOSPITALS AND CLINICS PREVENT MEDICAL ERRORS?

Although medical errors have become much too common, most are preventable. The most common errors and their causes, as mentioned above, require the willingness of providers to embrace various approaches to solving them. Each hospital and clinic have strengths and weaknesses, much of it due to the type of organizational culture it employs, whether good or bad. If all organizational activities, including all job titles and departments, revolve around patient-safety initiatives, clinical outcomes will most assuredly reflect safer and appropriate care.

Below are **eight strategies** that hospitals and clinics can adopt to make a big difference in reducing medical errors.

- 1 Embrace a culture of safety** – Patient safety should not be just a motto, but rather, serve as the reason a healthcare organization exists. Embedding a vision for total patient and workforce safety should be the core value for all healthcare organizations. Having a successful culture of safety begins and ends with stellar communication protocols. An excellent resource to use when developing a successful culture of safety was recently compiled by the American College of Healthcare Executives and the National Patient Safety Foundation.²

¹ Heartland Health Research Institute. *Iowa Patient Safety Study: Iowans' Views on Medical Errors*® 2017

² American College of Healthcare Executives and NPSF Lucian Leape Institute. *Leading a Culture of Safety: A Blueprint for Success*. Chicago, IL: American College of Healthcare Executives; 2017. <http://www.npsf.org/page/cultureofsafety>

2

Treat staff burnout as an organizational priority – Job burnout for doctors, nurses and other healthcare workers is a national health crisis and – based on the Iowa study – it's a big problem in Iowa. Leadership and boards in healthcare organizations must give paramount attention and commitment to this problem and make necessary changes to improve the healthcare work environment. The consequences of medical staff burnout directly threaten patient safety, quality of care and, consequently, healthcare costs. Embracing medical staff well-being is critical for organizations to deliver long-term clinical and financial success. To restore the joy of careers in medicine, organizations must seek best practices that commit to developing strategies and tactics that inspire and empower workers to do their jobs well.

3

Adopt a structure to improve patient handoffs – The passing of patients between hospitals and other caregivers is a major concern in the exchange process. Specifically, adequately exchanging critical healthcare information from one caregiver to another during a shift change can run the risk of harming the patient due to miscommunication – a highly-cited problem according to Iowans. Using checklists and other proven tools can help ensure that nothing will be missed during the handoff conversations between the sender and receiver. This is crucial to preventing mistakes.

4

Develop and nurture a patient and family-led advisory council – To promote a patient-centered culture, health systems can leverage the unique knowledge and opinions of their patients to improve the patient experience and quality-of-care. The council would require appropriate investment and buy-in from leadership and physicians to ensure the council structure will create necessary cultural change.

5

Be vigilant about reducing infections – Hospital-acquired infections can be the most dangerous to patients during their hospital stay. Hospitals must be vigilant about following federal guidelines for disinfecting patient rooms, surgical tools, labs and other areas. Staff must follow best practices for hand hygiene.

6

Work to avoid diagnostic errors – Patients often receive the wrong diagnosis, a delayed diagnosis, an over-diagnosis, or a partial diagnosis. To avoid this common but harmful medical error, hospitals and clinics should involve the entire care team who are jointly responsible for providing care to the patient. Each team member, from physicians to radiologists, can provide their own expertise and not be afraid to speak up if there are any inconsistencies.

7

To avoid medication errors, find opportunities to include pharmacists – Involving pharmacists when making rounds with patients will help doctors get direct information about how different drugs may interact and adversely affect patients. Catching common mistakes of ordering the wrong dosage or drug can avoid potentially-harmful mistakes.

8

Electronic health records (EHR) systems must be interoperable – A seemingly constant complaint by healthcare providers is that the use of EHRs takes precious time away from patients, which can be another source or cause of eventual medical errors. However, EHRs are here to stay. Placing a larger focus on ensuring that EHR systems can 'communicate' between different providers and facilities to share key health information is critical for patient safety. Working closely with EHR vendors and IT staff to make sure the organization's EHR system can be updated to meet future requirements is also critical to a safe-care process.

To read the full report: "Iowa Patient Safety Study: Iowans' Views on Medical Errors³ 2017," please visit our Heartland Health Research Institute website.

³Lieber, James B., How Medical Error Became America's Third Largest Cause of Death, and What Can Be Done About It. OR Books (2015)