Child Health Patient Safety Organization

Patient Safety Action Alert

April 2020

Take Action to Reduce Risk of Similar Harm

Improving Communication in the Diagnostic Process

Child Health PSO has identified a safety concern related to communication failures in the diagnostic process. This alert was developed after conducting a common cause analysis of the Child Health PSO database. In collaboration with industry experts, including Children's Hospital Association Chief Medical Officer, Chief Medical Information Officer, Chief Nursing Officer Forums and PSO member experts, pivotal points of communication were identified that organizations should consider exploring to mitigate communication failures that lead to diagnostic errors.

Resultant Harm

Child Health PSO found over half of member children's hospitals reported failures in communication (e.g., handoffs/handovers, diagnostic timeouts, escalation plans). Of those cases, the most serious harm, ranging from moderate permanent harm to death, occurred 57% percent of the time. The harm noted in these cases is disproportionally higher to the harm distribution for all PSO submitted cases.

Fundamental Issue

An organization's performance is resilient if it can function as required under expected and unexpected conditions[1]. Communication failures are complex for a variety of reasons. Contributing to the complexity is the inability to overcome misinterpretations and incorrect assumptions of information.

For example:

- Diagnostic Tests
  - Results are misinterpreted and/or not followed-up in a timely manner (e.g., lack of follow-up call after emergency department visit).
- Differential Diagnoses
  - Alternative diagnoses are not identified and managed within the care team.
- Escalation Plans
  - Plans for escalation are not established prior to patient status changes. Such plans should include when to escalate, how to escalate and to whom to escalate.
- Questioning Attitude-Culture
  - Members of the care team don't feel empowered to question the decision/authority of another team member.
- Stating "I Don't Know"
  - Members of the care team lack mechanisms or the confidence to communicate uncertainty with patients, families and other team members (e.g., providing an answer when unsure of situation vs. deferring to expertise or following up later).

What can I do with this alert?

- Forward to the recommended target audiences for evaluation.
- Include in your daily safety brief.
- Create loop-closing process for evaluating risks and strategies implemented to decrease risk of repeat harm.
- Let us know what is working and what additional information you need.

Leverage your PSO membership

Learn from each other to reduce patient harm and serious safety events.

Target Audiences

- Allied health care teams (e.g., respiratory)
- Ambulatory care
- Clinical educators
- Clinical staff and leaders
- Emergency/urgent care
- Legal/risk management
- Medical leaders
- Nursing leaders
- Organizational leaders
- Patient safety
- Primary care
- Quality improvement
- Specialty care services
- Surgical leaders

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Recommended Actions

Access Child Health PSO's actionable learning toolkit, Improving Communication to Enhance Diagnostic Safety.

1. Recognize key communication vulnerabilities in the following case studies:
   - The Voice of the Patient
   - Conveying an Escalation Plan
   - It's Okay to Say "I Don't Know"
   - Questioning Attitude
   - Communicating Diagnostic Results
2. Assess your internal communication gaps in the diagnostic process using the Gap Analysis tool.
3. Conduct a pause in patient care to re-evaluate the patient's diagnosis and medical response to treatment using the Team Diagnostic Timeout template. The template can be customized for your organizational needs.
4. Review additional resources available from the industry to amplify organizational knowledge.

Source

[1] Hollnagel, E. (2018). *Safety-II in Practice Developing the Resilience Potentials.* New York: Routledge.

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Has a patient experienced an event at your organization that could happen in another hospital?

- Child Health PSO members should submit event details into the Child Health PSO portal.
- Contact Child Health PSO staff to share risks, issues to assess, and mitigation strategies with member hospitals.

Over 60 children's hospitals are actively engaged with Child Health PSO. We currently are enrolling new members.

Contact Us

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