Pinpointing Your Errors

Amanda McGowan, editor

Errors happen in any facility at one time or another. Health care professionals are human and as such, mistakes happen.

After talking with professionals in the medical field, it seems that often, when a negative outcome occurs due to an error, infection, etc., it’s difficult to specify the root cause of the problem. For example, when a patient develops a surgical-site infection, it’s not always clear-cut where that infection originated. Was it a faulty prep process? Were antibiotics not administered at the adequate time or dose? The list of what could have caused the infection is ongoing.

In his book, *Complications: A Surgeon’s Notes on an Imperfect Science*, Atul Gawande describes an experience in the Morbidity and Mortality Conference (M & M), the one place in which doctors can talk candidly about their mistakes. They talk about what went wrong, how and why the error occurred, and what the doctor could have done differently to achieve a different outcome.

While surgeons certainly take these M & M sessions very seriously to learn from each others’ mistakes and prevent them in the future, Dr. Gawande notes that many experts view this as a rather “shabby” attempt at analyzing errors in a hospital. He writes: “It isn’t enough to ask what a physician should or could have done differently so that he and others may learn for next time. The doctor is often only the final actor in a chain of events that set him or her up to fail. Error experts, therefore, believe that it’s the process, not the individual, which requires closer examination and correction.”

Recently, Medgadget reported [1] that a graduate student in Venice has developed a specialized computer that is designed to do just that—to help clinicians and administrators analyze the entire situation in which an error occurred to figure out who or what is the root cause of the mistake, whether it's an individual or the system in place to care for patients.

The interactive table, called Tondo, is intended to promote collaboration and openness in a medical institution, while facilitating a more natural interaction with electronic clinical data, Medgadget reports.

"This project aims to avoid errors in the future and to make people less defensive during the clinical audit, which is a meeting organized by doctors, nurses and technical staff to analyze and prevent medical mistakes," the student Valeria Donati, told the online journal.

With Tondo, the clinical staff can analyze day-by-day the history of a patient during hospitalization and look at all the exams and tests taken of the patient to find where and when the error happened. With the software in the table, physicians can identify active and latent errors. The active errors have been made by a person. Latent errors are called 'systemic errors' and they are oftentimes hidden behind an active one, Donati says. Through its intuitive interface, Tondo analyzes the whole history of a person and helps concretely plan how to avoid errors in the future.

This is not the first or only effort made to identify the root cause of errors in a hospital. Electronic Medical Records (EMRs) in general were developed not only to improve accuracy and efficiency, but to better document the patient's care throughout their time in the hospital. Video cameras have been set up in operating rooms to help find out why, for example, a wrong-site surgery may have occurred.

All of these new technologies work to better track and document the patient care process in order to analyze medical errors and prevent them from happening in the future. However, with this new technology also comes increased accountability on health care professionals. Further, the ability to more accurately identify whom or what is to blame for an error arguably fosters higher risks for a medical malpractice suit. Or, perhaps, it just makes these medical malpractice suits more clear cut—either malpractice was committed or not and here is the documentation.

All in all, analyzing medical errors is first-and-foremost about patient safety, and necessary to ensure the best patient care. Knowing that a facility's doctors, staff and the system as a whole are functioning well together to provide the highest-level of care possible is the ultimate goal of any medical institution. With these new methods of error analysis may come a renewed—and enhanced—level of accountability on health care professionals, but it will also ensure everyone is doing their jobs and doing the best they can to do it right.

Thoughts? E-mail me at amanda.mcgowan@advantagemedia.com [2]

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