

238: CARING FOR THE CAREGIVER: RISK MANAGEMENT IN AMBULATORY HEALTH CARE

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Background:

Investigation of factors leading to erroneous decision making by medical staff began only in the 1980s. One of the main barriers to effective risk management (RM) is the caregivers' negative attitude towards reporting of adverse events, based on fear of disciplinary action and disbelief in reporting as contributing to safer systems.

Objective:

To recruit medical staff participation in reporting and learning from adverse events.

Context:

Maccabi Healthcare Services, a provider of ambulatory services to 1.6 million members in Israel.

Methods: In 1997 a RM program was established to minimize risks and improve quality of care. Based on the assumption that errors inevitably occur and usually derive from faulty system design, not negligence, the program defined the caregiver as its main client. Reporting physicians were granted official immunity from disciplinary action. A telephone hotline was established for direct reporting and for providing medical staff with professional guidance as well as personal support when confronting results of an error.

Results:

Prior to the onset of RM activities, physicians rarely reported adverse events. With increased awareness of RM strategies, the number of events reported increased, to an average of 50 per month in 2001. More than 2000 events have been reported; of these, 1500 were judged to be sources for organizational learning and thorough debriefing. In 2001, 40% of all reports were submitted by the physicians involved, as compared with 17% in 1997. Half of the events resulted in no patient injury ("near misses"). Root cause analysis of the events indicated 5 categories of error (table).

Table: Distribution of Adverse Events by Error Category

Error Category	Example/s	No. (%)
Process of care	Failure to order a relevant test; inadequate review of patient's history	384 (33%)
Treatment	Prescription of an incorrect dose of medication; performance of an inappropriate procedure	261 (22%)
Judgment	Delayed or incorrect diagnosis due to underestimation of symptom severity or failure to interpret relevant data	215 (18%)
Laboratory and imaging	Failure to notice a suspicious lesion in radiology; misinterpretation of test results	188 (15%)
Physician-patient communication	Inadequate provision of instructions to patient; patient non-compliance resulting from physician's inattention to psychosocial aspects of disease condition	126 (12%)
Total errors		1174 (100%)

More than 400 recommendations were formulated for elimination of errors and improvement of care. The great majority (80%) of lessons were targeted at organization-wide processes. The remaining 20% of lessons dealt with personal issues, treated with instruments such as conversations with the physician meant to prevent future exposure to risk.

Conclusion:

An attitude of caring for the caregivers, especially when they confront the results of patient injury, encouraged staff reporting of events, which enabled construction of a large database for error analysis. The lessons learnt from these events helped create an organizational culture of concern for patient safety.