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NEWS RELEASE

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Safety recommendations to address diagnostic errors

Study in November 2022 issue of The Joint Commission Journal on Quality and Patient Safety

(OAKBROOK TERRACE, Illinois, October 25, 2022) – Reducing diagnostic errors (such as missed, delayed or wrong diagnoses) is a major challenge for most healthcare organizations. The complexity of defining and measuring diagnostic errors poses challenges in developing solutions compared to other types of patient safety concerns. A need exists for pragmatic guidance for healthcare organizations to address diagnostic errors.

A new study in the November 2022 issue of *The Joint Commission Journal on Quality and Patient Safety*, "Developing the Safer Dx Checklist of Ten Safety Recommendations for Healthcare Organizations to Address Diagnostic Errors," identified potential practices based on literature reviews, reports by national and international organizations, interviews with quality/safety leaders and input from additional experts.

After preparing an initial list of practices, the researchers conducted a Delphi expert panel, followed by an online expert panel, to prioritize 10 practices. The prioritization process considered impact on patient safety and feasibility of practice implementation with a one- to three-year time frame. The top 10 practices were developed into a checklist paired with implementation guidance, which was followed by cognitive walkthroughs of the checklist for a face-validity check with end users. Data from each study step was analyzed to look for themes related to prioritization or checklist implementation.

A total of 71 practices for prioritization were identified through the Delphi panel of 28 experts; 65% of participants reached consensus on 28 practices. The multidisciplinary panel of 10 experts helped prioritize and refine the top 10 practices, which highlighted the following focus areas to help healthcare organizations address diagnostic error:

1. Organizational leadership builds a "board-to-bedside" accountability framework
2. A just culture and psychologically safe environment for diagnostic safety
3. Creation of feedback loops to increase information flow
4. Multidisciplinary perspectives, including cognitive science and human factors, in analysis of diagnostic safety events
5. Patient and family feedback to identify and understand diagnostic safety concerns
6. Patient review of their health records and mechanisms in place to help patients understand, interpret, and/or act upon diagnostic information
7. Prioritization of equity in diagnostic safety efforts by segmenting data to understand root causes and implementing strategies to address and narrow equity gaps
8. Standardized systems and processes to encourage direct, collaborative interactions between treating clinical teams and diagnostic specialties
9. Standardized systems and processes to ensure reliable communication of diagnostic information between care providers and with patients and families during handoffs and transitions
10. Standardized systems and processes to close the loop on communication and follow up on abnormal test results and referrals

The study was led by Hardeep Singh, MD, MPH, a professor of medicine at Michael E. DeBakey VA Medical Center and Baylor College of Medicine, Houston.

"The list is thoughtful and clear, and we were particularly delighted to see a call to focus on diagnostic equity, transitions of care and the critical role of patients and families on the diagnostic team and in the diagnostic learning system," notes an accompanying editorial. "The Safer Dx Checklist provides an actionable list of priorities for hospital leaders to pursue, starting now."

Also featured in the November issue:

- The Journey to Achieve Healthcare Equity: The New Joint Commission Accreditation Standard and Call for Papers (editorial)
- Variations in Code Team Composition During Different Times of Day and Week and by Level of Hospital Complexity (Stanford University School of Medicine, California)
- Improving Sepsis Management Through the Emergency Quality Network Sepsis Initiative (cross-sectional analysis of data for 220 emergency departments)
- Mi Plan: Using a Pediatric-Based Community Health Worker Model to Facilitate Obtainment of Contraceptives Among Latino Immigrant Parents with Contraceptive Needs (Johns Hopkins School of Medicine, Baltimore)
- An Asset-Based Quality Improvement Tool for Healthcare Organizations: Cultivating Organization-Wide Quality Improvement and Healthcare Professional Engagement (Banner Health, Gilbert, Arizona)
- An Injury Mitigation Program Highlights the Importance of Adhering to Current Infection Control Policies (research note)
- How to Mitigate the Effects of Cognitive Biases During Patient Safety Incident Investigations (commentary)
- High Primary Cesarean Section Rates: Strategies for Improvement (commentary)

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Note for editors

The article is "Developing the Safer Dx Checklist of Ten Safety Recommendations for Healthcare Organizations to Address Diagnostic Errors," by Hardeep Singh, MD, MPH; Umair Mushtaq, MBBS, MS; Abigail Marinez, MPH; Umber Shahid, DrPH; Joellen Huebner, MPH; Patricia McGaffigan, RN, MS, CPPS; and Divvy K. Upadhyay, MD, MPH. The article appears in *The Joint Commission Journal on Quality and Patient Safety*, volume 48, number 11 (November 2022), published by Elsevier.

The Joint Commission Journal on Quality and Patient Safety

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