Dansk Selskab for PatientS!kkerhed

Danish Society for Patient Safety

Improving diagnostic safety in Danish healthcare: Learning from compensable patient injuries

Resume

Internationally, there is a growing awareness on diagnostic errors as a major – and so far, overlooked patient safety problem.

Danish Society for Patient Safety and Danish Patient Compensation Association has analyzed the area more closely in Danish context. The analysis is based on records from the Patient Compensation Association (compensable patient injuries).

To systematize the analysis, we developed/adapted a tool, making it possible to identify what phase in the diagnostic process was affected by error.

In Denmark – as internationally, diagnostic error is not uncommon. During the 10-year period 2009-2018 the Danish Patient Compensation Association recognized 7629 cases of patient injury related to diagnostic error.

Our theory was, that it is possible to learn from these cases to improve diagnostic safety.

225 cases from the Danish Patient Compensation Association records were audited, all of them recognized by the association as a diagnostic error leading to compensation. The records contain expert argumentation for the compensation and all background material, medical charts, hospital records, lab results, x-ray-pictures etc. These data are unique from an international perspective because the Danish compensation system is independent of individual financial interests.

The cases were divided between 3 independent reviewers, all experienced medical specialists. During the review period they met twice to ensure methodological consistency.

To systematize the analysis, we developed a tool, making it possible to identify which phase in the diagnostic process was affected by error. Our tool was translated and adapted from a tool originally designed by the American organization CRICO (The Risk Management Foundation of the Harvard Medical Institutions Incorporated) to analyze and learn from malpractice claims.

Reviewers found:

- 80 % of cases: error in the initial diagnostic assessment
- 27 % of cases: error in testing and results processing
- 33 % of cases: error in follow up and coordination

- 40 % of cases was related to emergency care (medical conditions or injury)
- 25 % of cases was related to cancer diagnostics

Preliminary results of the analysis were presented at a workshop and two conference sessions, encouraging stakeholders to discuss the subject and generate ideas for solutions.

The results of the analysis and the recommendations based on these will be published in a report whose primary target group is healthcare leaders and decision-makers as well as healthcare professionals.

References:

National Academies of Sciences, Engineering, and Medicine. 2015. Improving Diagnosis in Health Care. Washington, DC: The National Academies Press

Malpractice Risks in the Diagnostic Process, Annual Benchmarking Report 2014, CRICO
https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/Risks-in-the-Diagnostic-Process