Assessment & Diagnosis

Risk: Missing/dismissing signs and symptoms

Failure to appreciate history, signs, and symptoms of a patient's critical illness.

CLOSED MALPRACTICE CASE

A 57-year-old male with a history of two MIs, sleep apnea, and hypertension was seen for complaints of jaw pain (8/10 severity) and chest "tightness." Vital signs at visit reported as normal; exam revealed good range of motion in jaw. Provider felt jaw pain may be related to CPAP mask patient used for sleep apnea and diagnosed temporomandibular joint (TMJ) disorder. This patient had two previous EKGs showing myocardial damage, however, the provider did not retrieve them at the time of the visit and no cardiac workup was performed. Five days later, the patient presented to the ED with nausea and vomiting. Upon evaluation, he was diagnosed with an MI, then progressed into cardiogenic shock. Further testing revealed a lateral wall myocardial rupture, requiring surgery. The patient's condition worsened, he suffered kidney and liver failure, and subsequently expired from advanced system failure.

DIAGNOSTIC PROCESS OF CARE IN AMBULATORY DIAGNOSIS CASES, 2009–2013

Diagnostic processing, including narrow diagnostic focus, is the most common contributing factor in ambulatory cases alleging a missed or delayed diagnosis.

	PERCENT OF CASES*	
STEP	CRICO (N=194)	CBS† (N=2,685)
1. Patient notes problem and seeks care	2%	1%
2. History and physical	8%	7%
3. Patient assessment/evaluation of symptoms	39%	26%
4. Diagnostic processing	45%	34%
5. Order of diagnostic/lab test	43%	31%
6. Performance of tests	6%	3%
7. Interpretation of tests	32%	23%
8. Receipt/transmittal of test results to provider	3%	5%
9. Physician follow up with patient	26%	18%
10. Referral management	11%	19%
11. Provider-to-provider communication	13%	12%
12. Patient compliance with follow-up plan	8%	15%

*A case will often have multiple factors identified.
†CBS is CRICO's Comparative Benchmarking System.

PATIENT SAFETY VULNERABILITIES

1. Fixation on a patient complaint without full assessment of the patient's symptoms and history, or unresponsiveness to the repetition of a complaint, may lead to a narrow diagnostic focus and missed diagnosis.

   SAFER CARE: Increase clinician awareness regarding the tendency toward cognitive fixation. Techniques to avoid this include expanding differential diagnosis, seeking additional information from the patient and the medical record, and engaging a peer consult for patients with continued, unresolved symptoms.

2. Lack of a complete patient history may result in a missed diagnosis.

   SAFER CARE: Establish a process to retrieve and update pertinent patient medical records. Use trigger tools to ensure critical information is not missed.

Assessment & Diagnosis, continued

Risk: Missing/dismissing signs and symptoms

QUICK ASSESSMENT

1. Has this type of event happened at our practice?
2. What type of triggers or templates does our practice use to obtain and update patient history that may be missed (e.g., family history, previous testing or procedures)? Whose responsibility is it to update this information?
3. Do we cut and paste information in medical records (without reviewing it)?
4. Do we have a process to retrieve and update pertinent patient medical records?
5. Does our culture support/encourage providers to ask for peer help when the patient situation is confounding?

IMPROVEMENT OPPORTUNITIES

RECOMMENDED PRACTICE	CURRENT STATE	HOW TO IMPROVE (IF NECESSARY)
1. To avoid narrow diagnostic focus, broaden the list of diagnostic possibilities via H&P		
2. Seek a consult for patients who return repeatedly for the same symptoms		
3. Use checklists for triggering questions related to patient history that may be missed (e.g., family history, previous testing)		
4. Embed decision support tools in electronic health record to assist in maintenance of patient's medical and family history		

CRICO Safer Care **materials are designed to help all members of a multidisciplinary team reduce the risk of patient harm in the course of diagnosis and treatment. Office-based events that trigger malpractice cases present valuable opportunities to identify vulnerabilities in communication, clinical judgment, and patient care systems. Successful practices shared by local and national peers inform the Safer Care recommendations. CRICO works closely with your organization's Patient Safety and Risk Management staff to build expert resources for individual and team-based education and training.**

Email comments, resources, or questions to safercare@rmf.harvard.edu.

Additional Resources

www.rmf.harvard.edu/safercare

Please visit the CRICO website for related:

- CME Bundles
- Podcasts
- Clinical Decision Support
- Slideshow presentations to share with your team
  Open Presentation PDF
- Plus, additional topics in the *Safer Care* series

How to Earn Category 2 Risk Management Credits

This *Safer Care in the Office Setting* module is suitable for 0.25 Category 2 risk management credit for MA physicians. Risk Management Study is self-claimed; complete, date, and keep this page for your record keeping.

About CRICO

CRICO's mission is to provide a superior medical malpractice insurance program to our members, and to assist them in delivering the safest health care in the world. CRICO, a recognized leader in evidence-based risk management, is a group of companies owned by and serving the Harvard medical community.