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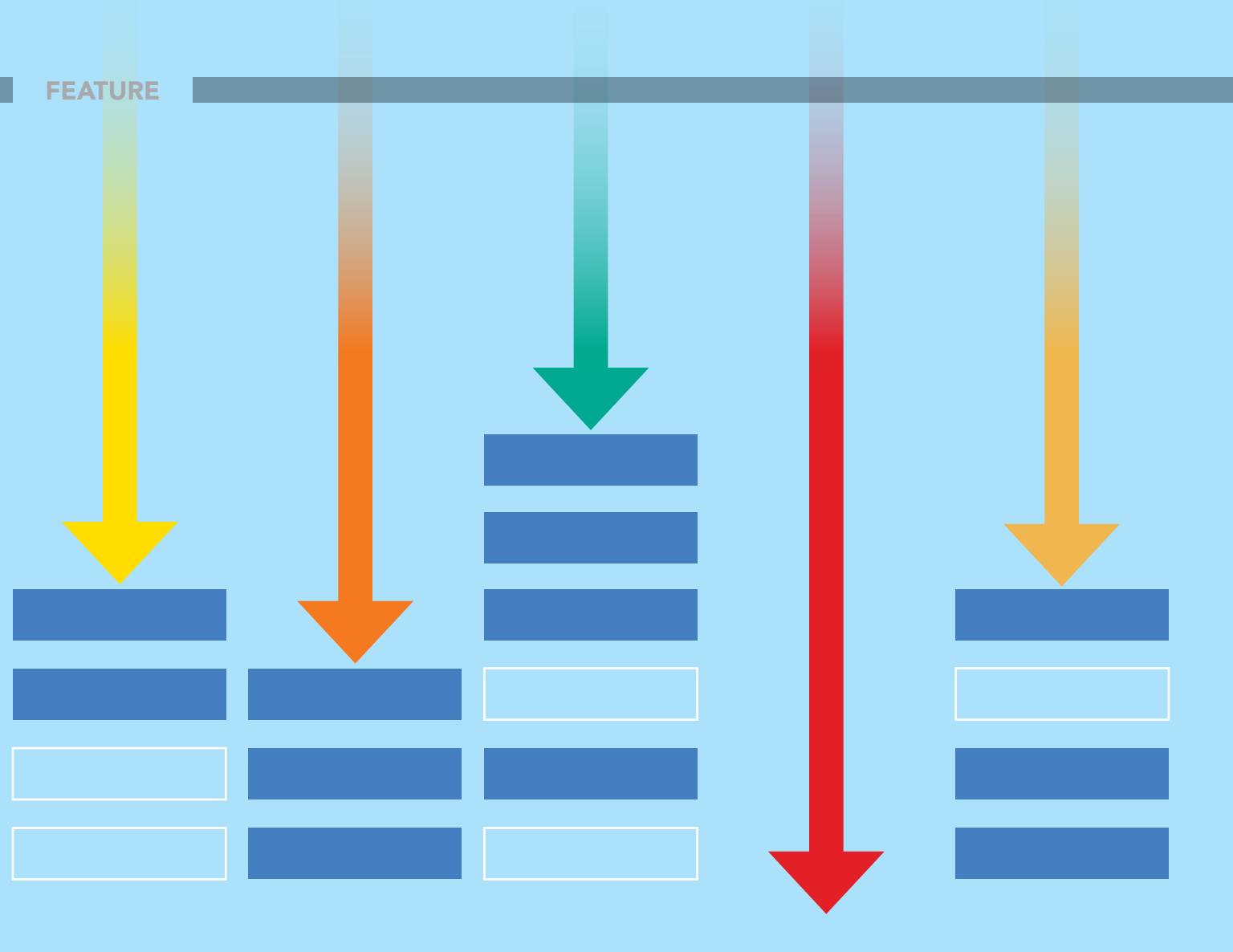
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Anatomy of Systemic Errors: Reducing Gaps in Healthcare

Kayur V. Patel, MD, MRO, FACP, FACHE, FAAPL, FACEP and Kush Patel

Keywords: medical errors, root cause analysis, healthcare administration, healthcare systemic issues

Medical errors rank as the third leading cause of death in the United States. It is imperative to recognize that the majority of these errors stem from flawed systems rather than the actions of individual healthcare personnel. To proactively address this issue, healthcare professionals must collaboratively strive to foster a culture of safety within their ecosystem.

Effectively tackling and remedying these problems necessitates a comprehensive understanding of their root causes. In this discussion, we will delve into an approach for root cause analysis, examining the systemic issues that contribute to medical errors, and proposing strategies to cultivate a culture of safety within your healthcare system.

Medical Errors are the 3rd leading cause of death in the United States, accounting for over 250,000 deaths each year (Johns Hopkins Medicine, 2016). Medical errors do not necessarily result from mistakes made by individuals considered incompetent; rather, they stem from well-intentioned individuals operating within flawed systems. Despite the considerable financial resources invested in the U.S. healthcare system, the consistent delivery of safe care remains elusive. The system's persisting broken, and fragmented nature can be attributed to the absence of open discussions and the sharing of mistakes. Alternatively, there are some who dispute that medical errors are actually the third cause of death due to the fact that medical errors are not typically listed as a cause of death on a formal death certificate (Jarry, 2019).

Root cause analysis is a systematic process designed to identify the fundamental causes of a problem. In the realm of medical errors, this analytical approach proves invaluable for healthcare organizations as it enables the identification of systemic issues that contribute to such errors. By pinpointing these root causes, organizations can enact essential changes, thereby preventing the recurrence of similar errors in the future.

SYSTEMS THINKING

All entities coexist within systems. Within the healthcare domain, key system elements encompass the patient, healthcare professionals, equipment, and the care environment. Systems thinking involves comprehending the interconnected nature of these components within a shared process and purpose. In numerous public services, healthcare included, this necessitates concentrating on the well-being of the service user and addressing the multiple systems supporting clinical care.

When problems arise for a patient, especially in instances of perceived

professional lapses or oversight, adopting a systems-oriented perspective can be challenging. Traditionally, various industries have often attributed personal blame to individuals directly involved in critical situations — be it the last person handling aircraft controls or, in healthcare scenarios, the last healthcare provider attending to the patient.

SYSTEMIC ISSUES IN HEALTHCARE

One of the main conclusions of the Institute of Medicine (IOM)'s first report, 'To Err is Human' in 1999, is that the majority of medical errors do not result from individual recklessness or the actions of a particular group — this is not a "bad apple" problem (2000). It is good people working in inadequate systems!

The majority of medical errors originate from systemic failures rather than human errors, a concept underscored by the adage "To Err is Human." To address this, the leadership of a healthcare system must actively cultivate a culture that encourages reporting from both medical staff and patients. This open reporting framework allows individuals to express concerns about potential lapses in care delivery or issues related to patient safety. Subsequently, systematically reviewing these reported concerns becomes imperative to discern their root causes. The anatomy of systemic failure can be dissected into the following eight categories.

1. Communication

Communication breakdowns stand out as a pervasive and multifaceted contributor to medical errors, manifesting at different junctures in the intricate web of healthcare delivery. Whether through verbal exchanges or written interactions, these breakdowns can sow misunderstandings among healthcare providers, patients, and their families, as well as between disparate healthcare settings. To address and mitigate these challenges, healthcare organizations

play a pivotal role in instituting protocols that systematically promote effective communication.

One strategic measure involves the implementation of standardized handoff procedures, particularly during critical transitions of care such as shift changes. Standardization in handoff protocols ensures that crucial patient information is conveyed consistently, reducing the risk of oversight or miscommunication. Additionally, the adoption of clear documentation practices becomes paramount, enhancing the accuracy and accessibility of patient information across the continuum of care. This meticulous approach not only aids in maintaining the continuity of care but also acts as a safeguard against potential errors stemming from ambiguous or incomplete information.

In essence, a proactive focus on communication protocols represents a linchpin in the efforts to enhance patient safety. By addressing breakdowns through standardized handoffs and clear documentation practices healthcare organizations can contribute significantly to the creation of an environment where information flows seamlessly, fostering a culture of clarity, collaboration, and ultimately, safer patient care.

2. Inadequate Information Flow

The inadequacy of information flow in healthcare poses a substantial risk, as it may compel healthcare providers to make critical decisions based on incomplete or inaccurate data. This heightened risk translates into potential medical errors, ranging from administering incorrect medications to performing improper medical procedures. To address and mitigate these challenges, healthcare organizations are increasingly adopting technological solutions, such as electronic health records (EHRs), to enhance the seamless flow of information.

The majority of medical errors originate from systemic failures rather than human errors, a concept underscored by the adage “To Err is Human.” To address this, the leadership of a healthcare system must actively cultivate a culture that encourages reporting from both medical staff and patients.

Electronic health records serve as a comprehensive and centralized repository of patient information, facilitating real-time access to critical data by authorized healthcare professionals. This reduces the likelihood of errors resulting from incomplete information and enhances the accuracy of decision-making processes. Furthermore, leveraging other technologies, such as integrated communication platforms and decision support systems, can further streamline information flow, fostering collaboration among healthcare teams and ensuring that providers have the necessary data to make informed and accurate decisions.

In summary, the integration of electronic health records and other advanced technologies represents a strategic response to the challenges posed by insufficient information flow in healthcare. By embracing these solutions, healthcare organizations fortify the foundation of patient care and contribute to a culture of precision, where decisions are grounded in comprehensive and up-to-date information, ultimately minimizing the risk of medical errors.

3. Human Factors

Human-related challenges in healthcare encapsulate a spectrum of factors, including insufficient training and knowledge, mislabeling of specimens, as well as issues stemming from fatigue, burnout, and stress among healthcare providers. These multifaceted elements pose a considerable

risk, potentially leading to errors by healthcare professionals or a failure to adhere to established protocols critical for patient safety. Addressing these challenges necessitates proactive strategies implemented by healthcare organizations, with a focus on mitigating burnout and promoting an improved work-life balance for healthcare providers.

Instituting initiatives to mitigate burnout involves recognizing and addressing the systemic factors contributing to stress among healthcare professionals. This may include restructuring work schedules, providing mental health resources, and fostering a supportive organizational culture that values the well-being of its staff. Additionally, offering comprehensive training programs and continuous professional development opportunities ensures that healthcare providers stay abreast of the latest medical advancements, reducing the likelihood of errors due to insufficient knowledge.

Ultimately, healthcare organizations play a pivotal role in cultivating an environment that empowers healthcare providers to deliver optimal care. By proactively addressing human-related challenges through targeted strategies, organizations contribute to the individual well-being of healthcare professionals and the broader goal of enhancing patient safety and the overall effectiveness of healthcare delivery.

4. Patient-Related Issues

Patient-related challenges in healthcare encompass a range of factors, including non-compliance and insufficient patient education, which can contribute to medical errors, such as patients failing to adhere to prescribed medication regimens. Addressing these challenges requires a multifaceted approach from healthcare organizations, emphasizing the importance of patient education programs and strategies aimed at enhancing patient engagement.

Implementing robust patient education programs is crucial to ensuring that individuals possess the necessary information to make informed decisions about their healthcare. This includes educating patients about their medical conditions, treatment options, and the significance of following prescribed regimens. Health literacy initiatives can play a vital role in empowering patients to participate in their care actively, reducing the risk of errors associated with lack of understanding or non-compliance.

Furthermore, strategies aimed at enhancing patient engagement involve fostering open communication channels between healthcare providers and patients. This may include the use of technology, such as patient portals, to facilitate easy access to health information and encourage active involvement in the decision-making process. Shared decision-making

models, where healthcare providers collaborate with patients to develop personalized care plans, can also contribute to improved adherence and reduced likelihood of errors.

In conclusion, mitigating patient-related challenges requires a proactive and patient-centered approach. Healthcare organizations, by implementing comprehensive patient education programs and strategies to enhance engagement, not only empower individuals to take charge of their health but also contribute significantly to the prevention of medical errors associated with non-compliance and insufficient understanding of prescribed treatments.

5. Organizational Transfer of Knowledge

The organizational transfer of knowledge in healthcare addresses critical challenges pertaining to training and education within healthcare institutions. Inadequacies in these areas can lead to healthcare providers lacking the essential skills and knowledge necessary to execute their duties effectively, potentially compromising patient care and safety. To rectify these challenges, healthcare organizations must proactively institute comprehensive training and education programs tailored to the specific needs of their healthcare providers.

Effective training programs should not only cover the foundational skills required for medical tasks but also stay abreast of the latest advancements in medical practices, technology, and patient care methodologies. Incorporating continuous education into the professional development of healthcare providers ensures that they remain competent and adaptable in a rapidly evolving healthcare landscape. This includes initiatives such as workshops, seminars, and online courses, fostering a culture of lifelong learning within the healthcare workforce.

Moreover, organizational commitment to the transfer of knowledge involves creating a supportive environment where healthcare providers feel encouraged to seek further education and training. Allocating resources for professional development, mentorship programs, and knowledge-sharing platforms can enhance the overall competency and expertise of the healthcare workforce. Ultimately, by addressing challenges in the transfer of knowledge through comprehensive training and education initiatives, healthcare organizations contribute to the continuous improvement of patient care standards and the overall effectiveness of healthcare delivery.

6. Staffing Patterns and Workflow

The critical challenges associated with staffing patterns and workflow in healthcare organizations revolve around the delicate balance of staffing levels and resource allocation. Insufficient attention to these factors can lead to healthcare providers being overworked and overstressed, significantly heightening the risk of medical errors. To address these challenges effectively, healthcare organizations must adopt staffing models and resource allocation strategies that prioritize patient safety as a paramount consideration.

Ensuring optimal staffing levels involves quantifying the number of healthcare professionals and considering their skill mix and distribution across different roles and responsibilities. Adequate staffing enables healthcare providers to manage their workload effectively, reducing the likelihood of fatigue-induced errors and ensuring that patients receive high-quality care. Moreover, thoughtful resource allocation, including the provision of necessary equipment and technology, further supports healthcare providers in delivering safe and efficient patient care.

Adopting patient safety-centered staffing models goes beyond meeting regulatory requirements; it becomes a strategic imperative for healthcare organizations to safeguard the well-being of patients and healthcare professionals. This may involve implementing innovative scheduling practices, utilizing technology to optimize workflow, and regularly evaluating and adjusting staffing levels based on patient acuity and organizational needs. In doing so, healthcare organizations contribute to the creation of an environment where patient safety is not compromised by systemic issues related to staffing and resource allocation.

7. Technical Failures

Technical failures in healthcare, encompassing challenges associated with medical equipment and technology, present a considerable risk, potentially leading to medical errors such as inaccurate readings or incorrect medication dosages. Recognizing the critical role that technology plays in patient care, healthcare organizations must proactively address these challenges. One effective strategy involves the establishment of rigorous equipment maintenance and testing protocols to ensure the proper functioning and accuracy of medical devices.

These protocols should encompass regular inspections, calibration checks, and preventive maintenance routines, conducted by qualified personnel. Implementing a comprehensive schedule for equipment upkeep not only minimizes the risk of technical failures but also enhances the longevity and reliability of essential medical tools. Additionally, healthcare organizations should prioritize investing in state-of-the-art technologies that come equipped with built-in safety features and redundancies, further reducing the likelihood of technical errors.

Furthermore, fostering a culture of technological literacy among healthcare professionals is crucial. Training programs and continuous education initiatives can empower staff to understand, operate, and troubleshoot medical equipment effectively, contributing to early detection and resolution of technical issues. In essence, by instituting robust maintenance protocols and promoting technological proficiency, healthcare organizations fortify their capacity to deliver safe and precise care while mitigating the inherent risks associated with technical failures in healthcare settings.

8. Inadequate Policies

Issues stemming from insufficient policies within healthcare organizations underscore challenges related to the formulation and implementation of policies and procedures. These challenges can lead to confusion and inconsistencies in practice, thereby increasing the likelihood of medical errors. To address and rectify these concerns, healthcare organizations must adopt a strategic approach by instituting evidence-based policies and procedures that undergo regular and systematic review and updating.

The development of policies and procedures grounded in evidence-based practices ensures that healthcare providers follow guidelines founded on the latest scientific knowledge and best practices. Regular reviews of these policies are essential, considering the dynamic nature of the healthcare landscape, technological advancements, and evolving patient care methodologies. Such a proactive approach guarantees that policies remain current, relevant, and aligned with the highest standards of patient safety and quality care.

Additionally, healthcare organizations should foster a culture of continuous improvement where

feedback from healthcare professionals is actively sought and considered in policy refinement. Transparent communication channels and a collaborative approach to policy development contribute to a shared understanding and adherence to established guidelines. In essence, by instituting evidence-based policies that undergo regular scrutiny and refinement, healthcare organizations demonstrate a commitment to minimizing errors, fostering consistency in practice, and ensuring the highest standards of patient care.

PROMOTING A CULTURE OF SAFETY

Promoting a culture of safety within the healthcare industry is of paramount importance as it directly impacts patient well-being and organizational effectiveness. By prioritizing safety, healthcare providers mitigate the risk of medical errors and enhance the overall quality of care delivered to patients. This cultural emphasis on safety encourages healthcare professionals to be vigilant, proactive, and committed to upholding the highest standards in patient safety protocols.

The ethical imperative of patient safety and promoting a culture of safety has tangible benefits for healthcare organizations. Reduced medical errors lead to lower rates of malpractice claims and legal liabilities, safeguarding the institution's reputation and financial stability. Furthermore, a safety-oriented culture attracts and retains high-caliber healthcare professionals who are drawn to environments that prioritize their well-being and emphasize continuous improvement in safety practices.

Fostering a safety culture in the healthcare industry is indispensable for safeguarding patients, promoting organizational resilience, and attracting and retaining top talent. It is a holistic approach that integrates ethical considerations, organizational efficiency, and

the well-being of patients and healthcare professionals.

To foster a safety-oriented culture within the healthcare industry, healthcare organizations can undertake the following measures:

1. Foster Open Communication

In the healthcare industry, fostering open communication is an indispensable element in cultivating a safety-oriented culture. Establishing transparent channels of communication is pivotal for the timely identification and resolution of systemic issues that may contribute to medical errors. To achieve this, healthcare organizations can implement robust protocols designed to facilitate effective interaction among their teams. These protocols may encompass standardized handoff procedures during shift changes, ensuring that critical information is conveyed seamlessly, and clear documentation practices to enhance the accuracy and accessibility of patient information.

By prioritizing open communication, healthcare professionals are empowered to share concerns, report incidents, and engage in collaborative problem-solving. This proactive approach enables the identification of potential risks at an early stage, facilitating the implementation of preventive measures to enhance patient safety. Moreover, a culture that values open communication contributes to the continuous learning and improvement of healthcare practices, creating an environment where lessons from adverse events are shared constructively to prevent recurrence.

In essence, establishing open communication protocols is a strategic initiative for healthcare organizations, serving as a linchpin in creating a culture that prioritizes safety, efficiency, and ongoing improvement in patient care.

2. Encourage Learning from Mistakes

Encouraging the process of learning from mistakes is a critical component in advancing the quality and safety of healthcare delivery. Gleaning insights from errors serves as a powerful mechanism for identifying gaps within healthcare systems and catalyzing essential improvements. To achieve this, healthcare organizations should actively promote a culture that not only acknowledges the inevitability of mistakes but also prioritizes continuous improvement and professional development.

In cultivating an environment conducive to learning from mistakes, healthcare institutions can establish structured mechanisms for incident reporting and analysis. This involves creating confidential reporting systems where healthcare professionals feel secure in sharing their experiences without fear of retribution. Additionally, organizations can institute regular reviews of adverse events, employing a non-punitive approach that focuses on understanding the root causes of errors rather than assigning blame.

By emphasizing continuous improvement and professional development, healthcare professionals are encouraged to engage in reflective practices that enhance their skills and knowledge. This proactive approach not only mitigates the recurrence of errors but also contributes to the overall resilience of the healthcare system. Ultimately, a culture that values learning from mistakes fosters a dynamic and adaptive healthcare environment, where insights gained from errors

serve as catalysts for positive change and the continuous enhancement of patient care practices.

3. Implement Root Cause Analysis

Implementing root cause analysis is a crucial procedural step for healthcare organizations seeking to enhance patient safety by delving into the intricate layers of medical errors. This systematic approach serves as a structured investigative process, allowing healthcare institutions to pinpoint the fundamental causes and contributing factors behind adverse events. By engaging in root cause analysis, organizations move beyond surface-level identification of errors and delve into the systemic issues that underlie them, fostering a comprehensive understanding of the complexities involved.

The process involves a meticulous examination of events, employing tools such as the "5 Whys" technique to iteratively explore the deeper layers of causation. This methodical inquiry allows healthcare professionals to move beyond immediate, observable causes and address the underlying factors that create an environment conducive to errors. Additionally, root cause analysis serves as a preventive strategy, enabling organizations to implement targeted interventions and systemic improvements to avert similar incidents in the future.

Through the implementation of root cause analysis, healthcare organizations demonstrate a commitment to a culture of continuous improvement. This analytical approach not only aids in the resolution of specific incidents but also contributes to the

development of proactive strategies to mitigate risks and enhance overall patient safety. In essence, root cause analysis is an invaluable tool for healthcare institutions striving to cultivate a learning culture that evolves in response to the insights gained from thorough and systematic analysis of medical errors.

4. Prioritize Patient Safety

Prioritizing patient safety is the cornerstone of exemplary healthcare delivery, demanding a holistic commitment that permeates every facet of organizational strategy and practice. Healthcare organizations underscore this commitment by integrating staffing models and resource allocation strategies explicitly designed to prioritize patient safety. This involves ensuring adequate staffing levels and resources to respond effectively to patient needs, fostering an environment where the well-being and safety of patients are paramount considerations in decision-making.

Moreover, the commitment to patient safety extends to the implementation of evidence-based policies and procedures. By anchoring practices in the latest scientific knowledge and best practices, healthcare organizations create a framework that aligns with the highest standards of safety and quality care. These policies should not be static but subject to regular review and updates to incorporate emerging research findings, technological advancements, and lessons learned from internal assessments.

In essence, a steadfast dedication to patient safety requires a proactive

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and dynamic approach. It involves a continuous evaluation of systems, policies, and procedures to ensure their alignment with the evolving landscape of healthcare knowledge and the unique needs of patients. By consistently prioritizing patient safety in staffing, resource allocation, and the implementation of evidence-based practices, healthcare organizations demonstrate a commitment to delivering care that is not only effective but fundamentally safe. This commitment becomes a driving force in cultivating a culture where patients can trust in the quality and safety of the healthcare they receive.

CONCLUSION

The prevalence of medical errors in the United States is an ongoing challenge that demands our attention and action. Shockingly, these errors have persistently remained at high levels over the past three decades. This raises crucial questions: Have we become desensitized to these statistics over time? Have we accepted them as the norm in the healthcare industry? Or perhaps our culture has improved, and we are reporting these events more diligently?

Regardless of the reasons behind these persistently high numbers, one thing remains undeniable: we have an issue that has persisted for far too long, and we have yet to make significant improvements.

Addressing the root causes of medical errors is paramount, especially when 80% of these errors are linked to systemic factors rather than individual errors. Shifting our focus towards a systematic approach to error assessment and prevention can be the catalyst for change that we desperately need. Currently ranked as the third leading cause of death in the United States, medical errors demand our utmost attention.

To effect change, we must foster an environment where healthcare professionals feel empowered to identify and openly discuss the root causes of errors. Open communication channels, a culture that encourages learning from mistakes, rigorous root cause analysis, and an unwavering commitment to patient safety are all essential components of this transformation.

Every near-miss and adverse event should trigger a systematic response, driving us to comprehensively address the underlying issues. In this collective effort, healthcare professionals and organizations play pivotal roles in shaping a culture where safety is not merely a goal but an ingrained ethos. Through this commitment, we can work towards reducing the incidence of medical errors, continually improving patient care, and ultimately achieving better healthcare outcomes for all.

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Kayur V. Patel, MD, MRO, FACP, FACHE, FAAPL, FACEP is a Practicing Emergency Department Physician. He is trained in both Emergency Medicine and Internal Medicine.

Dr. Patel is also a highly experienced physician executive. He has over twenty years of practical experience in medical management. This includes serving as the Former Chief Medical Officer of an HCA facility, the former Medical Director for Emergency Medicine and Occupational Health, the former Director to Health Care Excel, the Quality Improvement Organization for Indiana.

A frequent speaker on the subject of quality in healthcare, Dr. Patel has a special clinical interest in Pulmonary Embolism and Thrombolytics in an Acute Stroke.

Dr. Patel currently serves as a consultant to KEPRO, the Quality Improvement Organization (QIO) for more than 30 states. His primary responsibility is to review medical records to see whether they meet the Standard of Care



Kush Patel currently a medical school student with special interest in pursuing Internal Medicine and learning more about the framework in which healthcare operates.

His experience working as an Emergency Room Medical Scribe and EMT allowed him to witness the healthcare system from a different lens.

As a former Firefighter, Kush understands the importance of a team approach within an organized system in improving outcomes.

Kush's vision is to use his background and education to implement changes in how healthcare is delivered in his community and globally.

LNC PRACTICE TIP: POTENTIAL CAREER BUSTERS

BY Mary K. Flanagan, BSN, RN, CNOR(E), LNCC, Certified Perioperative Nurse Emeritus, Legal Nurse Consultant Certified AND Lisa Mancuso, BSN, RN, CCRN, CLCP, LNCC, President, AALNC 2022-2024

1. Failure to meet deadlines:

Your attorney-client or retaining LNC client has their deadline: if you are late, you will make your client late. Before accepting an assignment, ensure you have all the information you need (i.e., the volume of records, asked-for work products, written report v. verbal report) to know if you can meet a deadline. Refusing a project is better than delivering work products past the due date.

2. Failure to respond:

Neglecting to respond promptly to your clients will tarnish your reputation. And in the legal world, reputation is everything. Is the paralegal asking for your updated CV and fee schedule? Provide it promptly. Does your retaining LNC need edits on your report? Take care of it immediately. We all have different definitions of "prompt", so if you can't produce something timely, make sure you at least acknowledge the phone call

or email within 24-48 hours. If you will be away and not checking your messages, set your voicemail greeting and automatic email reply to reflect this.

3. Lack of flexibility:

Many LNCs are balancing clinical, business, and family responsibilities. Most attorneys keep regular business hours. It's up to you, the retained LNC, to accommodate the client. Have protected time set aside during the week to be available to that client, whether an attorney or fellow LNC.

4. Inappropriate email addresses:

Consider having a dedicated appropriate/professional email address for your business when you start. If your email address is "tiredmom", "hotnurse" or "bunnylove," (we've seen these!), a potential client might pass you by.

Attorney clients and hiring LNCs may not remember your work prod-

ucts, but they will remember your professionalism. You want to avoid being the LNC who does not get hired again because the assistant or paralegal found you nonresponsive and had to hunt you down. Equally, a hiring LNC could find themselves in a difficult position when negotiating a new deadline for their attorney due to your delay. While having excellent technical skills as an LNC is crucial, if you are challenging to work with, those skills won't matter.

As we were all green clinical nurses once, we were also novice LNCs. It's never comfortable to be "green." Learning how we fit into a new industry can be exhausting and stressful. We hope these tips answers questions and, ideally, generate more! We would love to hear from you in the Novice LNC Shared Interest Group at [AALNC.org](#)—let's keep the conversation going! ■

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