QuickSafety
An advisory on safety & quality issues

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Preventing delays in treatment

Issue:

A delay in treatment is when a patient does not get a treatment – whether it be a medication, lab test, physical therapy treatment, or any kind of treatment – that had been ordered for them in the time frame in which it was supposed to be delivered. This would also apply to not being able to get an initial appointment or follow-up appointment in a timely manner. It is a form of diagnostic error that may result in patient harm or death. For health care organizations and providers, it is a missed opportunity.

A related form of diagnostic error is delay in diagnosis, which is defined as a non-optimal interval of time between onset of symptoms, identification, and initiation of treatment.[1] A delayed diagnosis occurs when the correct diagnosis is delayed due to failure in or untimely ordering of tests (e.g., lab work, colonoscopies or breast imaging studies). Whether due to delay in diagnosis, misunderstanding of the disease, misdiagnosis, or failure to treat, delay in treatment can reduce the number of treatment options a patient can pursue.

In 2014, The Joint Commission's Office of Quality and Safety analyzed 73 sentinel events that were the result of delays in treatment; 48 of these events resulted in death of the patient. From 2010-2014, 522 sentinel events were due to delays in treatment, with 415 of these events resulting in patient death, 77 resulting in permanent loss of function, and 24 resulting in unexpected additional care or extended stay. In addition, an Agency for Healthcare Research and Quality (AHRQ) study found that 28 percent of 583 diagnostic mistakes were life threatening or had resulted in death or permanent disability.[2]

Leading root causes from the 73 sentinel events included inadequate assessments, poor planning, communication failures, and human factors. The missed opportunity may result from cognitive and/or system factors, or may be attributable to more blatant factors, such as lapses in accountability or clear evidence of liability or negligence. Causes may include poor scheduling systems, understaffing, poor communications, misdiagnosis, and more. A recent journal article suggests a system-centric versus physician-centric approach to diagnostic error since delay in diagnosis may occur due to factors outside the clinician's immediate control or when a clinician's performance is not contributory.[3]

Safety Actions to Consider:

All health care organizations should actively commit to avoiding treatment delays. While there is no easy remedy, the following actions can help prevent delays in treatment:

- Avoiding cognitive shortcuts (i.e., "better thinking")
- Improving health information technology (HIT) (i.e., electronic health records (EHR), scheduling systems, call back systems, improved care transitions) to ensure accurate and timely communication of patient information
- Making problem lists (list of all of the patient's active and inactive medical problems and diagnoses) more dynamic
- Incorporating diagnostic checklists into the electronic record
- Promoting provider-to-provider communication
- Engaging leadership in developing solutions
- Focusing organization attention on the scheduling process and on ordering tests and reporting test results
- Improving access to care
- Implementing a standardized communications method, such as SBAR (Situation Background Assessment Recommendation).

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- Maintaining adequate staffing levels (i.e., expect the unexpected)
- Increasing patient and family engagement/activation: As organizations become more reliable, they also become more sensitive to their operations. The Joint Commission seeks to help accredited organizations develop the skills, competence and knowledge required to eliminate delays in treatment; this includes greater levels of patient engagement/activation. The Joint Commission's Speak Up™ program encourages patients to:
  Speak up if they have questions or concerns
  Pay attention to the care they receive
  Educate themselves about their illnesses
  Ask a trusted family member or friend to be their advocate
  Know the medicine they receive
  Use hospitals, clinics and surgery centers that have been carefully checked out
  Participate in all decisions about their care

Resources:

1. Reference.MD: Definition of delayed diagnosis (accessed January 20, 2015)
2. Schiff GD, et al.: Diagnostic Error in Medicine: Analysis of 583 Physician-Reported Errors. *Archives of Internal Medicine.* 2009;169(20):1881-1887 (accessed January 20, 2015)
3. *The Joint Commission Journal on Quality and Patient Safety*: Addressing Diagnostic Error: The Challenge for Health Care Organizations. March 2014 Volume 40 Number 3
Note: This is not an all-inclusive list.

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