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INSIDE

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Best Practices for Recruiting Peer Review Committee Members

Well-run peer review committees are essential to maintaining high-quality performance for physicians and nurses, but recruiting for those committees can be challenging. Physicians and nurses may resist the time commitment or fear legal and professional repercussions from passing judgment on their peers.

Those fears can be dispelled by educating physicians and nurses about the peer review process. Savvy recruiting techniques can help create effective peer review committees.

The overall purpose of peer review committees is to understand objectively what happened in a particular clinical case, compare that to the standard of care or best practice, and look for gaps, says **Michael Loftus**, MD, chief medical officer (CMO) at Jersey City (NJ) Medical Center.

"When you look for people to staff those types of committees, it is important that they have subject matter expertise about either the specific clinical realm you are reviewing or expertise in peer review and quality assurance," Loftus says. "Even if the person is not a cardiologist, someone with experience in quality improvement and human factors analysis can provide meaningful contributions to the committee."

It also is important to recruit physicians and nurses who are known to be open-minded and fair. Peer review hinges on transparent discussions, true identification of root causes and gaps, and using that knowledge to improve.

"That last step, learning from the process, is the key to a safety culture or a just culture," Loftus says. "You need people on the committee who will identify the system and process issues that lead to individual human error. The peer review part that focuses on an individual error is only the beginning of understanding how a process broke down."

Loftus says not following through after a review is a common problem with peer review committees. "Often, these committees may do a great job of reviewing cases, they may come to a conclusion about whether there was a gap in care or not, and they may even discuss internally what could be done better," Loftus explains. "But the

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dissemination of lessons learned and the actual improvement that can come from it is the part that falls short too often. It's an extra step, and it takes work beyond the review and conclusion, the regulatory box-checking that must happen."

Committee members should be able to look beyond the individual error and ascertain what process failures made it possible for an individual's error to reach the patient and cause harm. The best committees include a mix of backgrounds, training, and titles. A peer review committee that is interdisciplinary within the physician or nursing professions will be most effective.

Seek a Mix of Reviewers

It is common for peer review committees to be populated by the most senior physician and nurse leaders who self-select for peer review as part of leadership commitment. Those members can provide valuable input, but Loftus says it also is important to put frontline caregivers on the committees, not just senior managers and leadership.

"Some committees even have patient family representatives, which has pros and cons, but the idea is that you will have a more effective review and discussion when you have a variety of voices rather than multiple members with the same background and expertise," Loftus says.

The actual recruiting for service on a peer review committee should be personal and direct. Once one identifies a likely candidate, a phone call or personal conversation with the potential member is best. Explain why that person is a good candidate and what serving on the committee entails. Be prepared to answer questions about the time commitment, confidentiality, and legal liability. With the right culture, Loftus says physicians and nurses will see serving on a peer review committee as an honor.

"They can see it as an opportunity to reflect on and represent the expertise of their peers in a way that benefits them," he says. "Not as a finger-pointing, 'I hold your career in the balance'-type of role, but rather as someone who is expected to be fair and hear both sides of a case before objectively deciding where there was a gap in care."

Time Commitment a Concern

Physicians and nurses often see service on a peer review committee as a thankless job that requires a significant time commitment, says **Michael B. Brohman**, JD, shareholder with the Roetzel & Andress law firm in Chicago.

"The time required is probably the biggest deterrence to serving on a peer review committee," he says. "If you have someone who is going to fight the recommended action, then you're probably going to have to give testimony, deal with lawyers, and spend time showing that what your committee did was the appropriate recommendation."

Brohman advises appealing to one's sense of duty to their profession and their peers.

"You can emphasize the good they are doing, how their work will benefit their fellow nurses and physicians, the patients, and the facility," Brohman offers. "This is probably one of the most important jobs at a hospital. Peer review is being judged by a jury of your peers. It is much more advantageous to be

judged by people who are familiar with the issues, and what might be involved in a particular kind of care."

Recruiting Can Be Difficult

Recruiting people to serve on hospital staff committees can be frustrating and difficult, notes **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix. Even with some compensation, many might be leery of committing to work that can be difficult and time-consuming.

Owens notes an Arizona court once ruled, "Review by one's peers within a hospital is not only time-consuming, unpaid work, it is also likely to generate bad feelings and result in unpopularity."[1]

On the other hand, many physicians or nurses could be convinced to participate in staff self-governance for many different reasons, Owens says.

Those motivations can include good citizenship, a leadership personality that makes the physician or nurse want to run things or direct operations, camaraderie, and even curiosity. Based on long years of experience working with hospital and medical staff leadership, Owens says she has learned physicians listen to their colleagues in deciding whether to join committees. "Recruiting medical staff members into leadership roles is not the work of a day," Owens says. "It has to be a process of ongoing cultivation, over a period of months or even years."

While the CMO, chief executive officer (CEO), and chief nursing officer (CNO) certainly play important roles in recruiting physicians and nurses into leadership roles, Owens says it has been her observation physicians and nurses listen to their peers in deciding whether to take the plunge. Perhaps the best approach is for leaders to develop physician and nurse champions.

The likely best champions for physicians and nurses are the chief of staff and CNO, respectively. These champions should provide the encouragement and tools to bring other physicians and nurses along to the committee. Similarly, the past chief of staff can be an important recruiter for the medical staff committees.

High-Functioning Staff Attracts Participants

A well-run, efficient peer review committee will attract more participants. "There is nothing worse for a recruiting effort than for a physician [or nurse] to hear that meetings take untold hours, no one really knows who is in charge, or that the administration just steamrolls the process," Owens says. "Having a process that basically functions and gets the job done, particularly one that is under control with respect to hours devoted to it, is a critical recruiting component."

There is no magic bullet for achieving that kind of efficiency, but creating good documents that put guardrails around the process can be helpful. Still, even if the medical staff or nursing services are not running smoothly, some physicians or nurses may be drawn to the challenge of fixing the problems.

Recruiting Takes Time

Similar to charitable boards, medical and nursing leadership recruiting seems to work best if it is ongoing, with physicians and nurses brought into relatively low-stress positions and groomed to take on more responsibility.

"Even beyond this, patiently keeping in touch with physicians over time can yield leaders," Owens says. "Perhaps a physician will become interested in participating once his children are grown, or when her practice has really taken off. It seems to pay not to give up on physicians [or nurses]."

Selecting the right individuals for a peer review committee is similar to selecting the right people for any

other team, says **Eric Dickerson**, managing director of the academic medicine practice for Kaye/Bassman, an executive recruiting firm in Plano, TX. He notes peer review can take many forms, from standing quality improvement peer committees to those formed for the assessment of credentialing or hiring.

The minimum bar would be selecting individuals who are well-rounded in both clinical and academic pursuits in a specific specialty or field. Additional attributes that could help identify quality members of a committee would be good attention to detail, critical thinking skills, and the ability to ascertain complex views.

Dickerson notes peer review committees are about more than investigating bad outcomes and searching for possible dangers to patients. "The focus of a peer review committee is to develop, improve, and help the physician [and the nurse]. If you've got a bad apple, you need to separate it from the rest of the bushel, but that's not necessarily the intention of the committee," he explains. "It's about assessing where this person is going in their career, and have they provided the amount of information and clinical outcomes to get where they want to go?"

For instance, someone on a peer review committee must be able to assess a junior colleague in a way that considers his or her level of training and experience, rather than holding the person accountable to the performance one would expect of a more highly trained and experienced physician or nurse. A key concern when recruiting for peer review committees is to look for people who are fair-minded and will approach the committee's work as a way of helping and supporting peers.

"What you want to avoid is anyone who would approach it from a negative standpoint. Avoid people who have agendas, people who like to gossip, or those who want to be in the know about everything without good reason," Dickerson says. "Seek out one who is looking to provide a quality peer review but also to learn from others through the peer review process." ■

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Layers of Legal Protections for Peer Review Committees

When approached to serve on a peer review committee, physicians and nurses often respond with concerns about facing legal liability for their honest assessments of their peers' work. Most of those concerns can be dispelled by explaining there are multiple layers of protection from liability.

A hospital's executive and officers (E&O) liability insurance usually will apply to peer review committee members, says **Carol Michel**, JD, partner with Weinberg Wheeler Hudgins Gunn & Dial in Atlanta. There also are protections under federal law providing immunity for participation in peer review activities, particularly the Healthcare Quality Improvement Act, which provides immunity to good-faith peer review of physicians and dentists while also creating the National Practitioner Data Bank.[1] There are state-level statutes to provide immunity for peer review participants, although those laws vary widely.[2,3]

"They want to promote this type of peer review and allow candid discussions about the performance and quality of care provided by physicians, without the fear of subjecting themselves to liability," Michel says.

Lawsuits can be filed against peer review committee members, but they are unlikely to succeed, says **Michael B. Brohman**, JD, shareholder with Roetzel & Andress in Chicago.

"Usually, that aspect of a lawsuit is dismissed, so long as the peer review committee followed the hospital bylaws and gave the practitioner the due process rights he or she is entitled to," Brohman explains. "There usually are a number of procedures the hospital must follow as far as interviewing people, interviewing the subject of the peer review, and then other steps if you get to a formal hearing. The fact that

you have immunity from liability is a big plus, as long as you are careful to follow the proper procedures."

Michel notes protections against liability in the peer review process are founded on the assumption that the peer review participant is operating in good faith and is not participating for malicious reasons. Any evidence indicating the reviewer is intentionally trying to harm or discriminate against a peer could void those protections. "Provided they are coming into the process for the right reason, which is to improve the services provided to patients at the facility, I do believe the protections are there and they can do so without unreasonable fear for facing potential liability," Michel says. "If you enter into this process for the wrong reasons, then that may not hold up."

Federal law provides immunity under appropriate circumstances, but it does not recognize the peer review as a federal privilege.[1] That means that in some federal claims, such as discrimination allegations, the federal privilege may not apply.

"In that situation, the peer review records may be discoverable in a case that, for instance, asserts a federal claim like discrimination or maybe even antitrust," Michel says. "That has occurred in a few jurisdictions where the hospital requested that the privilege would apply, but the documents were still discoverable."

It also is important to protect peer review information. Do not leave peer review records unsecured or in an area available to someone outside the peer review process. Members must not discuss the committee's work with anyone else. Doing so could make committee members vulnerable to liability.

"It requires some diligence and attention to the process," Michel says. "It requires that each person in the process know their responsibilities according to the facility's bylaws, and also their state law as it pertains to that process. There are protections, but for all of those protections to apply there are obligations they have to follow."

States Provide Protection

In many states, there is a "privilege of self-critical analysis" that applies to communications that are made in the context of peer review, says **Daniel B. Frier**, JD, founding partner of Frier Levitt in Pine Brook, NJ. That privilege protects information exchanged during the good faith exchange of a peer review process.

The extent of that protection can vary from state to state, but Frier says hospitals can add to it by providing indemnification by explicitly covering peer review under the E&O coverage or a pledge of indemnification for peer review participation.

"Even if they are sued unsuccessfully, a lawsuit can carry a great deal of expense. The hospital can agree to cover those costs, provided the peer review participant acted in good faith," Frier says. "Peer review panels can incur liability when members have a conflict of interest with the subject being reviewed. If a member had a previous run-in or is a competitor with that person, had some sort of prior relationship that created a bias or conflict of interest, that needs to be disclosed and addressed."

An additional layer of protection can be provided by the hospital having a provision in its bylaws that physicians and nurses submit to a peer review process in the event it becomes necessary and agree to hold harmless anyone who participates in that process in good faith. This provides an explicit consent to the peer review process that prohibits any legal action, again assuming the participants act in good faith.

Frier says in 25 years, he has never seen anyone sued for service on a peer review committee, and would expect any such suit to be dismissed quickly.

"That would be a dangerous precedent to allow a medical professional to be sued and held liable for a good-faith participation in the peer review process," Frier

says. "That's why it is no great risk for the hospital to provide indemnification for peer review participants." ■

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Be Serious About Promoting Successes

Quality improvement professionals put a great deal of work in improving quality of care and patient safety, with projects both grand in scale and small but significant. But once an organization achieves success, how do leaders make sure the right people know about it?

Improving quality is its own reward, of course, but it is a valid goal to want immediate supervisors, the organization's C-suite, and maybe even the general public to know about these successes. Making that happen can require a specific strategy, because just hoping anyone notices is not a plan.

Promoting work internally requires an understanding of the organization's culture, says **Kris Ruby**, CEO of Ruby Media Group and Medical Practice PR in White Plains, NY. It is a legitimate goal to make others aware of quality improvement successes.

However, when publicizing success at work, there can be a fine line between receiving credit and showboating.

"At some hospitals, there can be a lot of politics involved with this. They don't necessarily like the idea of someone getting a lot of attention for their work," Ruby says. "One way around this is to tout this as the success of your department or program, and all the people who worked on the project, so you avoid making it look like you're trying to get a lot of attention for yourself."

Moreover, the achievement can be positioned as an accomplishment for the hospital or health system, making it a point of pride for everyone. The quality improvement department still will be remembered for the success.

Ruby advises working closely with the hospital communications department to feature achievements in internal newsletters and other outlets.

Rules for External Publicity

External publicity for healthcare professionals may require some caution. Most hospitals and health systems have put rules in place that require employees to work with the communications or public relations department for any kind of interaction with external media. Always let a supervisor and the communications department know before agreeing to an interview with an external media outlet. "If you work at a hospital, you can't go spouting off on Twitter without making sure you have corporate approval before you do a media interview. I have seen too many doctors ignore what they sign in their employment contract on the media/PR clause. Ultimately, it can cost them their good standing at the hospital," Ruby says. "It can even result in being put on notice if they have repeat offenses in this area. Pay attention to what you signed before doing media interviews."

Play within the rules of your organization. When there is quality improvement achievement, publicize it to the community as well as within the hospital.

"I believe that patients expect an improvement in quality as a baseline. You want to let patients know about things like new technology, new procedures, new services offered," Ruby says.

Two Steps for External Publicity

When it comes to external publicity, such as a story in the local newspaper, Ruby says there are two steps. First, gain the publicity. Second, publicize the media attention. If an organization achieves step 1 without

moving to step 2, that is not successful self-promotion.

"If you got featured in a local newspaper or magazine or on your local television news, and nobody sees it, it's almost like you never got the coverage at all," Ruby says. "People get featured, and they assume everyone in the world is going to watch the show live, read that interview, listen to that interview. That's just unrealistic in the world we live in."

This means securing copies of the television news spots or the newspaper coverage, and providing those to the people the organization wants to see that success. That might mean forwarding a copy of the newspaper article or a recording of the news segment to the management team, or passing it on to other news outlets that might be interested. Ruby notes online material can be fleeting. A user may bookmark a page that highlights a quality improvement program on a news site. Six months later, that material may be gone. For that reason, she advises printing the material or taking screen shots to preserve it.

"I can't tell you how many times I've seen someone depend on a link, and then when they go there later the link is gone. It's like the whole thing never happened," Ruby says. "Screenshot the coverage because that may be the only copy you ever have of it. It's a real shame when you've been featured and you're proud of that publicity for yourself and your colleagues, and then it's gone." For healthcare professionals, Ruby says the best way to make the news public is to position oneself as a subject matter expert in the field. Thus, when the media is looking for an industry expert to speak on a topic, they think of that expert first.

"Because social media has changed the media landscape, some items that were traditionally put out over the wire can now be replaced by a tweet or long-form blog post instead," Ruby says. "If you want to get news to the public, first look at what news the public is interested in, and then share your point of view on it." ■

SOURCE

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Insulin Pen Project Improves Patient Safety with EMR Modification

Staff at a Maryland hospital discovered a patient safety issue with insulin pens that was traced to the electronic medical record's (EMR) inability to generate patient-specific labels efficiently. A root cause analysis revealed the process gaps, and staff developed a solution that ensures patients receive insulin doses only from their own pens.

The project was a high priority because of the potential danger from improper dispensing and use of insulin pens, says **Vaishali Khushalani**, MS, PharmD, medication safety officer and pharmacy residency program coordinator at Greater Baltimore Medical Center (GBMC) in Towson, MD.

Insulin is a high-alert medication, and insulin pens cannot be shared among patients. Sharing pens can expose patients to bloodborne pathogens like hepatitis B. Staff at GBMC determined there was a patient safety issue involving the labeling and dispensing of insulin pens. The quality improvement effort began when a nurse needed to give

a dose of insulin to a patient in the ICU. She went to retrieve the insulin pen from a bin in the medication room and found several pens. There were three NovoLog pens labeled for that patient, but there was another NovoLog pen in the same bin labeled for another patient.

This caused the nurse to wonder if the other patient had received insulin from a pen labeled for the first patient, so she reported the incident, and the second patient was tested for bloodborne pathogens. The tests were negative.

Barcode Labels at Issue

The quality department conducted a root cause analysis and found that although the hospital used barcode scanning for the insulin pens, staff had to scan the manufacturer's National Drug Code (NDC) barcode instead of a label that was both patient- and dose-specific.

Scanning the NDC barcode was standard process for bulk items, including insulin pens, because the hospital's EMR could not generate labels that were patient- and product-specific, and would scan for multiple orders of something like insulin pens.

If the patient required a change in dose or frequency, a new label would have meant sending a new pen with an updated label each time, after retrieving the existing pen. To avoid that kind of delay, the hospital instructed nurses to scan the NDC barcode instead.

"Sending a new pen with a new label every time the dose was changed would be very wasteful," Khushalani explains. "We decided at that time, like many other institutions, that scanning the NDC code was proper because it would tell the nurse that you are correctly scanning insulin aspart."

However, that created a scenario in which a nurse might accidentally scan an insulin pen from one patient and administer it to another.

Multiple Pens Dispensed

An additional problem was pharmacists often had to dispense multiple insulin pens to a single patient, using a manual process that required them to remember to review each patient's chart for changes to the order. If a pen had been dispensed already, they were to cancel the new order for an insulin pen, but that was not always caught. Multiple pens could be dispensed when they were not needed.

"We were dispensing a whole lot of pens. We had a system that told pharmacists to see if a pen had been dispensed when verifying the dose, and if so, don't send it," Khushalani says. "But that was just a reminder. We didn't have anything in the system to force that not to happen."

When searching for solutions, the biggest barrier was the hospital's Epic EMR. GBMC first tried to work with Epic to find a solution that would allow the kind of patient- and medication-specific labeling that would allow for the multiple doses and dose changes. However, the company was unable to meet these needs.

GBMC then sought help from other hospitals. Johns Hopkins University reported they had found a way for the Epic EMR to do what GBMC needed. The hospital worked with Epic and Hopkins to modify the GBMC EMR.

"This new barcode links to the patient and all the insulin aspart orders that a patient could have. When a nurse scans the patient barcode, what shows up is all the patient's insulin aspart orders, and they can document appropriately," Khushalani says. "If they scan that barcode and it is for a different patient, that is a hard stop."

One Pen Per Patient

The hospital also wanted to ensure every patient prescribed an insulin pen received such an item.

"We have had a robust process improvement culture in this institution, so we were oriented to process redesign," Khushalani says. "We started looking at our metrics for sending new pens when there was a new order, seeking to ensure that for every patient who has an order for an insulin pen, we send a pen."

The hospital developed a daily report on all missed insulin pen dispenses that was presented to the executive team. They used a Pareto chart to identify the most common reason for patients not receiving insulin pens: The pharmacist simply forgot to dispense it.

"We wanted to put something in the system that would remind the pharmacist, so we added a best practice advisory during the verification process that asks if you have dispensed the pen," Khushalani says. "They have to answer 'already dispensed' or 'I'm going to dispense.' What we really wanted was to have it require the pharmacist to dispense the pen now instead of saying you will do it, but Epic is not capable of doing that for us now."

That prompt resulted in a sharp decrease in failures to dispense insulin pens. GBMC also tracks misses by individual pharmacists and intervenes with reminders for them as necessary.

The data also revealed there was a higher incidence of failure to

dispense insulin pens on the night shift. The hospital began sending an automatic email in the middle of the night to remind night shift pharmacists to catch up on non-dispenses.

Misses Drop Sharply

The day shift pharmacists also began their shifts with a review of night shift insulin pen orders dispensed overnight, acting on any that had not been sent to the patient.

"Within a few months, there were hardly any misses. In May, we had about 67 pharmacist failure-to-dispenses, but by December we were down to 14," Khushalani reports. "Most days are zero to two. We'd like that to be zero, but we'd need a little more help from the EMR system to do that."

Khushalani says one of the lessons is to never take no for an answer when trying to find a solution to quality and patient safety issues. Initially stymied when they tried to modify the EMR to help with insulin pen dispensing, GBMC found a solution by contacting other institutions.

"Support from leadership is so important. The culture of safety is highly valued here. A really big, helpful push was how our chief medical officer and our vice president of quality were involved and pushing this project right from the beginning," Khushalani says. "The other thing that was quite helpful was that we had a mechanism in place with Lean management to address these issues once they were identified." ■

SOURCE

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Diagnostic Errors Continue, Technology Part of Solution

Diagnostic errors continue to plague the healthcare system, but some progress is happening thanks to technology that can reduce the chance of an error reaching the patient and causing harm. Optimal results may require a more deliberate training program for those using the technology.

There remains some degree of art involved in medicine, with providers using their training and experience to interpret data, says **Adam Saltman**, MD, PhD, chief medical officer at Eko, a digital heart health company in Athens, OH. That means there always will be some risk of diagnostic errors. Still, technology is increasingly providing backups and assistance in making those judgment calls.

On the other hand, clinicians must be wary of turning over too much of their diagnostic skills to software and machinery.

"Sometimes, errors are due to physicians relying on diagnostic outputs too much, not really looking at them and saying, 'wait a minute, this doesn't make sense, I need to interpret this correctly,'" Saltman observes. "We've had more diagnostic technology than we've ever had before. Years ago, people were depending much more [on] physical exams and the physician's skill and experience. We don't want to go back to those times necessarily, but we don't want to give up that valuable input."

Saltman says that in his experience as a cardiothoracic surgeon, he saw people take diagnostics as "almost an absolute, like they felt the output of a diagnostic test was 100%, that it was 100% sensitive and specific, that it always gave a right or wrong answer."

Saltman considers that is an educational problem. Clinicians should understand there is no diagnostic test that is 100% accurate. The key is understanding how to best work with diagnostic technology to incorporate it into the diagnostic process.

Saltman expects the future of reducing diagnostic errors to involve more and better technology, but also a better understanding of what the diagnostic outputs of particular software or machinery really mean.

Leapfrog Endorses Tech Solutions

The Leapfrog Group reported computerized physician order entry (CPOE) systems can be "remarkably effective" in reducing serious medication errors.[1] Hospitals that have fully implemented CPOE "outperform hospitals that have not fully implemented CPOE on

multiple measures of medication error," the group reported.

CPOE reduced error rates by 55%, and rates of serious medication errors fell by 88% in a study from Boston's Brigham and Women's Hospital. The CPOE system's structured orders and medication checks accounted for the safety improvement.

Leapfrog also noted length of stay at a facility in Indianapolis fell by 0.9 days, and hospital charges decreased by 13% after implementation of CPOE.

In another report, Leapfrog noted bar code medication administration systems were associated with reducing medication administration errors by up to 93%.[2]

Pandemic Plays a Role

The COVID-19 pandemic may result in an increase in diagnostic errors soon, just because people cannot seek routine and elective healthcare, according to **David Richman**, JD, partner with Rivkin Radler in Uniondale, NY.

"You probably will begin to see filings in connection with failure to diagnose in the midst of the pandemic, either because resources were limited by COVID-19 or physicians were so inundated with patients with the virus or at risk of the virus that other conditions may have been missed," Richman explains. "There's been an uptick in mortality associated with cancer because people weren't going in for treatment or screenings. There has been an uptick in people dying of cancer in the midst of the pandemic."[3-5]

Regardless of the pandemic's effect, diagnostic errors continue to be a significant threat to patient safety and a medical malpractice risk. "Diagnostic errors have had a great impact on the cost of patient care because the cost of lawsuits has caused physicians and hospitals to practice defensive medicine, which has given rise to overtreatment, overdiagnosis, and overtesting," Richman says.[6] "That carries with it tremendous costs. Even with advanced technology, you may have physicians rendering diagnoses with more confidence because they think the technology backs them up, but you're always going to have misses."

Digitizing Can Reduce Errors

There is a distinction between medical errors and technology errors, according to **Pouria Sanae**, CEO of ixlayer, a company in San Francisco that provides technology-based solutions in diagnostic testing.

"Our goal is to minimize these errors by digitizing the process. Software solutions that can operate without manual input on all sides — the patient, the physician, and the lab — are the first line of defense to help fix problems that have plagued the health system for decades," Sanae says. "Our nation's doctors and hospitals rely heavily on faxes, even handwritten slips, to treat their patients."

Digital tools can help minimize the human error. As health IT becomes a more critical part of healthcare organizations, these digital advancements and solutions can help minimize errors and provide more accuracy when it comes to testing, one of the core tenets of diagnostics.

Lack of understanding in functionality and usability of diagnostic products or systems can increase the chance of diagnostic errors or hinder the technology's ability to improve patient care, according to **Tanya Specht**, RDMS, RDCS, RMSKS, clinical marketing manager with Exo, a health information and devices company in Redwood City, CA.

"A hospital may have a great diagnostic imaging system that produces the best images in the world, but that means nothing if its physicians do not know how to use it," she says. "Physicians often lack complete understanding of existing medical devices available to them for diagnostics."

Training Is Key

Some may receive training when a product or system is installed, and they will be well-versed in its use, according to **Jonathan Bowman**, RDMS, RDCS, RVT, ultrasound clinical sales manager with Exo. But there are some who cannot make the training session or others who join an organization without ever receiving training.

"Their inability to understand how to use the product/system correctly could lead to physicians putting in wrong information or leaving pertinent details out," Bowman says. "Additionally, some physicians may need a refresher course on how to take quality medical images, no matter their seniority level."

Specht and Bowman offer this advice for better using technology to reduce diagnostic errors:

• Implement continual training on all products and systems available within each department.

For example, when a facility purchases an ultrasound machine, it may or may not come with a day

of training. But depending on the complexity of the system and the rate at which that hospital brings on new employees, it is likely additional days of training will be needed.

• Train users how to produce good diagnostic images.

Work with the medical imaging provider to create exams that clinicians can complete as part of the continual training program. Image quality could be evaluated by the provider or graded by senior-level clinicians to ensure they are recognizing pathology.

Evaluation could include grading images before and after completing the continual training program to see if individuals improved and by how much.

• Use simple medical devices and systems.

Technology should be intuitive enough that anyone can pick up and start learning through hands-on use or by simple tutorial, rather than through days of training — similar to operating a smartphone out of the box. The industry should move away from diagnostic tools that are loaded with keyboards, sliders, and knobs that increase the learning curve.

• Conduct quality reviews on images taken.

Look for programs and software that can be integrated within the current diagnostic system to grade the quality of images taken. This should be used as a tool to create an environment within the hospital of continual learning.

For example, an educational emergency department with an ultrasound program could use software or program to review all the ultrasound images to ensure they meet the level of quality expected.

• Streamline scanning, documentation, and billing into one program.

It is much harder for users to drop the ball when they do not have to switch between programs and enter multiple reports. Streamlining this process will help reduce clerical errors. ■

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CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes;
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general;
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

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CE QUESTIONS

1. **In the insulin pen project at Greater Baltimore Medical Center, what was one of the solutions the hospital implemented?**

   a. The hospital began sending an automatic email in the middle of the night to remind night shift pharmacists to catch up on non-dispenses.
   b. Insulin pen dispenses required sign-off by a senior pharmacist.
   c. Insulin pens were distributed only once per day.
   d. Pharmacists visited each unit every day to ensure they had received their insulin pens.

2. **What might happen with diagnostic error lawsuits?**

   a. The COVID-19 pandemic will have no effect.
   b. The COVID-19 pandemic will cause a sharp drop off in diagnostic error lawsuits.
   c. There probably will be filings in connection with failure to diagnose during the pandemic.
   d. Pandemic-related legislation will prevent the filing of diagnostic error lawsuits.

3. **What is a common failing of peer review committees?**

   a. Not following through with action after conducting a review
   b. Not meeting often enough
   c. Not putting enough members on the committee
   d. Not announcing the peer review's findings to the entire organization

4. **What might be the biggest deterrence to serving on a peer review committee?**

   a. Believing that you are overqualified to judge the performance of peers
   b. The time required to serve on the committee
   c. Peers know you are serving on the committee
   d. Not wanting a record of your comments during peer review