AGENDA

12:00 – 12:05  Introduction and objectives
- Report on action items from previous M&Ms

12:05 – 12:20  Case presentation
   Presenter: Chief Medical Resident

12:20 – 12:45  Adverse event review and discussion
   Facilitator: Quality Improvement Faculty

12:45 – 12:55  Summary

Cases

Brief case summary

Session Objectives

Major teaching points
Useful Terms

General
- **Quality improvement**: systematic evaluation and modification of existing local practices to correct deficiencies and improve the system
  - Differentiate from **research**: systematic, hypothesis-driven investigation to develop or contribute to generalized knowledge
- **Adverse event**: injury from medical care
- **Error**: doing the wrong thing (commission) OR not doing the right thing (omission)
  - Note that not all adverse events are due to errors, BUT adverse events that are due to errors are potentially PREVENTABLE

Cognitive Factors
*Cognitive errors can occur in the process of diagnosis and can affect the formulation of differentials and ultimately decision-making. They can become sufficiently systematic such that clinicians can make the mistakes repeatedly. These are some important examples:*
- **Availability bias**: judges diagnoses to be more likely or frequent because they readily come to mind or if they were recently seen
- **Anchoring bias**: locks onto initial impressions and foregoes new differential diagnoses in spite of new information
- **Premature closure**: accepts a diagnosis before it has been fully verified; lose capacity to explore new differentials
- **Diagnosis momentum**: once labels or diagnoses are attached to patients (charts, previous providers, families) they tend to stick – if it had previously been a possibility, it gains momentum and becomes definite
- **Confirmation bias**: seeks confirming evidence to support a diagnosis rather than looking at all evidence objectively, even refuting evidence

Systems Factors
- **Materials**: may be defective, or in short supply
- **Personnel/people**: lack of skills, knowledge, motivation or capacity
- **Processes**: lack of an existing procedure or deviation from written procedure