

Policy Statement

<i>Title:</i>	Reducing Medical Errors: Developing Commission Case Studies for Hospitals and other Entities	<i>Number:</i> MD2012-04
<i>References:</i>		
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<i>Approved By:</i>	 Mimi Pattison, MD, FAAHMP, Chair	

To improve patient safety in the state of Washington by taking an active role in the effort to reduce medical errors by sharing case studies with the Washington State Hospital Association and other health care systems or entities in the medical community.

Background and Analysis

The Medical Quality Assurance Commission promotes patient safety and enhances the integrity of the medical profession through licensing, discipline, rule-making and education. The Commission wishes to promote patient safety by assisting the medical profession in reducing medical errors.

The Commission recognizes a concerted effort in our state to reduce medical errors. The Washington State Hospital Association has a nationally-recognized Patient Safety Program.¹ In this program, the 97 hospitals in our state collaborate to share information to improve patient safety, including reducing adverse events.

The Washington State Department of Health has implemented a quality improvement program designed to find the root cause of the event and ensure measures are taken to prevent or reduce medical errors.²

¹ The Joint Commission and the National Quality Forum awarded the Washington State Hospital Association the 2010 Eisenberg Award for innovation in patient safety and quality. The American Hospital Association awarded WSHA the 2011 inaugural Dick Davidson Quality Milestone Award.

² Chapter 70.56 RCW.

At each of its meetings, the Commission reviews cases involving medical errors. While some of these are attributable to the fault of a single practitioner, others are the result of a systemic problem. The Commission recognizes that jurisdictional constraints limit its ability to adequately address errors caused by systemic issues. The Commission believes that even if a medical error is outside the scope of the Commission's authority, it can bring these errors to the attention of entities that can use the information to prevent or reduce medical errors.

The Commission believes that cases involving medical errors, particularly the ones that demonstrate systemic problems, can be valuable learning tools to hospitals, individual practitioners, and health systems across the state. The Commission can disseminate case studies to the medical community by sending them to the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), and other interested entities; publishing one or more of them in the Commission newsletter; and maintaining a data base of case studies on its web site. The Commission believes that this effort will help the medical community to reduce medical errors and enhance patient safety in our state.

Procedure

1. When the Commission closes a case involving a medical error--whether prior to an investigation, after an investigation, or after informal or formal disciplinary action---the Commission decides whether facts of the case and key learnings would be valuable to the medical community. If so, the Commission designates the case as a Commission Case Study (CCS).
2. The Reviewing Commission Member and the assigned staff attorney develop a CCS. A CCS consists of a de-identified summary of the relevant facts of the case and a root-cause analysis.
3. The staff attorney submits the CCS to the Legal Manager for review.
4. The Legal Manager will distribute the CCS packet on a quarterly basis to WSHA, the WSMA, and other interested entities; the Legal Listserv; and the Research and Education Manager.
5. The Research and Education Manager will place the CCS on the Commission Website and provide the CCSs to the Commission's newsletter editorial board to consider for publication in the quarterly newsletter.