Administrative Errors

Technical Series on Safer Primary Care

World Health Organization

Administrative Errors: Technical Series on Safer Primary Care
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Preface

Safer Primary Care

Health services throughout the world strive to provide care to people when they are unwell and assist them to stay well. Primary care services are increasingly at the heart of integrated people-centred health care in many countries. They provide an entry point into the health system, ongoing care coordination and a person-focused approach for people and their families. Accessible and safe primary care is essential to achieving universal health coverage and to supporting the United Nations Sustainable Development Goals, which prioritize healthy lives and promote well-being for all.

Health services work hard to provide safe and high quality care, but sometimes people are inadvertently harmed. Unsafe health care has been recognized as a global challenge and much has been done to understand the causes, consequences and potential solutions to this problem. However, the majority of this work up to now has focused on hospital care and there is, as a result, far less understanding about what can be done to improve safety in primary care.

Provision of safe primary care is a priority. Understanding the magnitude and nature of harm in primary care is important because most health care is now offered in this setting. Every day, millions of people across the world use primary care services. Therefore, the potential and necessity to reduce harm is very considerable. Good primary care may lead to fewer avoidable hospitalizations, but unsafe primary care can cause avoidable illness and injury, leading to unnecessary hospitalizations, and in some cases, disability and even death.

Implementing system changes and practices are crucial to improve safety at all levels of health care. Recognizing the paucity of accessible information on primary care, World Health Organization (WHO) set up a Safer Primary Care Expert Working Group. The Working Group reviewed the literature, prioritized areas in need of further research and compiled a set of nine monographs which cover selected priority technical topics. WHO is publishing this technical series to make the work of these distinguished experts available to everyone with an interest in *Safer Primary Care.*

The aim of this technical series is to provide a compendium of information on key issues that can impact safety in the provision of primary health care. It does not propose a "one-size-fits-all" approach, as primary care is organized in different ways across countries and also often in different ways within a given country. There can be a mix of larger primary care or group services with shared resources and small services with few staff and resources. Some countries have primary care services operating within strong national support systems, while in other

countries it consists mainly of independent private practices that are not linked or well-coordinated. The approach to improving safety in primary care, therefore, needs to consider applicability in each country and care setting.

This technical series covers the following topics:

Patients

- Patient engagement

Health workforce

- Education and training
- Human factors

Care processes

- Administrative errors
- Diagnostic errors
- Medication errors
- Multimorbidity
- Transitions of care

Tools and technology

- Electronic tools

WHO is committed to tackling the challenges of patient safety in primary care, and is looking at practical ways to address them. It is our hope that this technical series of monographs will make a valuable and timely contribution to the planning and delivery of safer primary care services in all WHO Member States.

1 Introduction

1.1 Scope

This monograph describes different types of administrative errors in primary care. It aims to raise awareness about issues that would need to be addressed to support safer primary care. After outlining the approach taken to compile information, the monograph describes the importance of examining administrative errors and the most common types of these errors encountered in primary care.

1.2 Approach

To compile information for this monograph, World Health Organization (WHO) sought the advice of experts in the field recommended by the Safer Primary Care Expert Working Group and reviewed relevant research and published literature.

International experts in delivering safe primary care provided feedback, shared examples of strategies that have worked well around the world, and gave practical suggestions about potential priorities for the WHO Member States to improve the safety of primary care services.

1.3 Defining administrative errors

Patient safety has been defined as the absence of preventable harm to a person using health care services. A patient safety incident is an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. Such incidents arise from either unintended or intended acts. Errors may thus be defined as a failure to carry out a planned action as intended or the application of an incorrect plan. Errors may manifest by doing the wrong thing (errors of commission) or by failing to do the right thing (errors of omission) at either the planning or execution phase *(1)*.

For the purposes of this monograph, the term "administrative" is defined as relating to the systems and processes used in primary care services. The monograph focuses on failures to carry out a planned action or undertaking an incorrect action as part of the systems and processes involved in delivering primary care. This includes a broad range of errors, including those associated with records, tests and transitions of care. The purpose is not to cover all such errors in depth, rather to highlight the wide scope of administrative and process errors.

It is acknowledged that there are varying classifications and that the errors described here may sometimes be dealt with separately in other discussions.

Some researchers consider the tasks of office administration separately from other types of administrative processes *(2).* Communication errors, such as information management mistakes, are considered administrative errors by some, but not others *(3).* Other categorizations may not include the term "administrative errors" at all and instead use other terms, such as "technical errors" and "communication breakdown", which may be considered as types of administrative errors *(4).*

Other monographs in this technical series provide more details on diagnostic and medication errors and, the administrative processes associated with these facets of care.

2 Administrative errors

2.1 Frequency

A review of published literature found that medical errors in primary care occurred between five and 80 times per 100,000 consultations *(5).* Administrative errors are the most frequently reported type of errors occurring in primary care, but it is difficult to be certain how often they occur. It is estimated that from 5% to 50% of all medical errors in primary care are administrative errors *(6,7).*

Most estimates rely on self-reporting, which may be influenced by who is reporting, whether there is sufficient time or an adequate and suitable process for reporting, and what the reporter perceives as a significant error to notify. Often reporting is not anonymous and there may be a fear of litigation or other negative consequences associated with reporting an error.This may contribute to a lower reporting of serious medical errors and issues relating to gaps in professional knowledge and skills.

A variety of error categorization systems and study methodologies have been used in primary care, thus making it difficult to directly compare one study with another. One study examined a representative stratified random sample of family practitioners and found that approximately one error was reported per 1000 consultations per year *(8)*. Of these, about 70% were errors related to the processes of providing healthcare and 30% were associated with gaps in the knowledge and skills of health professionals. Most of the process errors in this study would fall into the definition of administrative errors. As outlined above, the actual rate of errors is likely to be higher as many may not be acknowledged as errors and may not be recorded.

2.2 Harm

Administrative errors could be perceived to be less harmful than medication or diagnostic errors. However, there is much blurring and overlap among these