Child Health Patient Safety Organization®

SAFETY WATCH

Stay aware of these known risks to avoid preventable harm.

Procedural anchoring bias

Cognitive bias can occur at any phase of the procedural process. Anchoring is a type of cognitive bias in which a health care provider fixates on certain information while disregarding other pertinent details. For example, although elevated vital signs may be associated with postoperative pain, anchoring bias occurs when other causes are not considered or evaluated.

Causes

Causes of procedural anchoring bias may include:

- Accepting another provider's evaluation and expertise without independently validating and considering alternative diagnoses.
- Assuming a similar diagnosis or procedure from a previous experience will require the same treatment and follow the typical postoperative course.
- Providing or receiving communication or hand-off information that produces certain conclusions or preconceptions.

Harm

Cognitive bias "may result in surgical diagnostic error that leads to delayed surgical care, unnecessary procedures, intraoperative complications, and delayed recognition of postoperative complications." Biases can affect health care providers' medical decision-making and judgment and prevent them from seeking further assessment or guidance.

Harm Range

Significant harm to patients, including death.

Biases can affect health care providers' medical decision-making and judgment.

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Immediate Recommendations

- Develop or establish a process to promote/support the provider to complete a baseline assessment and assessments after any perceived changes in the patient's condition and develop a comprehensive differential diagnosis.
- Implement a post-procedural diagnostic timeout to avoid groupthink and inspire communication and collaboration among the multidisciplinary team.
- Promote patient and family involvement in the plan of care as crucial members of the health care team.
- Establish an escalation-of-care plan outlining who to involve in the decisions, who should be notified, the appropriate form of communication, and triggers and baseline parameters.
- Use a hand-off tool to provide all pertinent information in an objective, non-biased manner.

Resources

- Improving Communication in the Diagnostic Process Action Alert
- Diagnostic Safety Toolkit

References

- British Journal of Surgery, Cognitive Biases in Surgery: Systematic Review, Oxford Academic, 2023
- The Journal of Pediatrics, Cognitive Bias in an Infant with Constipation, ScienceDirect, 2024
- Surgical Clinics of North America, Cognitive Bias and Dissonance in Surgical Practice: A Narrative Review, NIH PubMed, 2023
- The HPI SEC & SSER Patient Safety Measurement System for Healthcare. Virginia Beach, VA: Healthcare Performance Improvement, LLC; 2009

Data for the Safety Watch is compiled from Child Health PSO safety analysis.

Find solutions

Members can find detailed prevention plans in Child Health PSO's Riskonnect Action Plan repository where children's hospitals share deidentified mitigation processes for various issues.

Join Child Health PSO

Over 55 children's hospitals are actively engaged with Child Health PSO, and we are currently enrolling new members. Join the only PSO solely dedicated to children's hospitals.