Prevention of Medical Errors within Eyecare

2 hours

April Jasper, OD, FAAO

Course Description:

The different types of medical errors are presented including root cause analysis, error reduction, and future prevention that may be useful within a primary optometric eye care setting. Also presented are situations where medical error can sometimes lead to medical malpractice.

Course Objectives:

1. Learn the history of medical errors training
2. Review definitions and categories of medical errors that can occur
3. Identify causes of medical errors within the optometric eye care setting
4. Implement prevention of medical errors
5. Explain why medical errors lead to malpractice and discuss methods to prevent malpractice claims in eye care
6. Review Root Cause Analysis and its role in prevention of medical errors

Course Outline:

1. Why is there a required course in medical errors - Where are we now?

    A. Florida medical errors requirement
        1. Statute 64B13-5.001
        2. "Licensees are required to complete a 2-hour course relating to prevention of medical errors as part of the licensure and renewal process. The course shall be approved by the Board and shall include a study of root-cause analysis, error reduction and prevention, and patient safety. The 2-hour course shall count towards the total number of continuing education hours required for licensure renewal. If the course is being offered by a facility licensed pursuant to Chapter 395, F.S., for its employees, the Board approves 1 hour of the 2-hour course to be specifically related to error reduction and prevention methods used in that facility."

    B. 1999 Institute of Medicine Report
        1. The hidden epidemic

2. 1 in 25 hospital patients injured by medical errors

3. Medication errors cause ~7,000 deaths per year
4. As high as ~98,000 deaths per year secondary to all medical errors (Numbers often quoted have a large range from a low of 44,000 to a high of 195,000 in more recent studies)
5. Cost of ~$30 billion per year

C. Agency for Healthcare Research and Quality
1. Definition of the problem
2. More frequently an organization problem than single individual error

D. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
1. Where regulations and education come into play

2. Types of medical errors

A. What is an error
1. Error of exclusion
(Planned action in the patient management is not completed.)
2. Error of planning
(Use of wrong plan in the patient management
3. Adverse event
(Injury secondary to patient management and not due to the underlying medical condition of the patient.)

B. Active errors
1. Error at the level of the operator that was under their direct control.

C. Latent errors
1. Error that does not occur during the direct control of the operator
2. While not under direct control of the operator it can involve the patient management that the operator selected (i.e. wrong diagnosis)

3. Factors that can lead to increased risk of medical errors

A. Fatigue
B. Alcohol/Drugs
C. Illness
D. Inattention/distractions
E. Emotional states
F. Unfamiliar situations/conditions

G. Equipment problems
H. Inadequate labeling/instructions
I. Communication problems
J. Handwriting
K. Sound alike drugs
M. Office set-up/record keeping

4. Risk Management in the Ophthalmic Subspecialties and related fields.

A. Medication errors
   1. Omission errors
   2. Dosing errors
   3. Unauthorized drug errors
   4. Drug interactions
   5. Allergies to drugs
   6. Refills
   7. Samples
   8. Generics
   9. Comanaging
   10. Nursing and pregnancy

B. Cataract Surgery
   1. Informed consent
   2. Endophthalmitis

C. Cornea and external disease and contact lenses
   1. Post op instructions
   2. Suture removal

D. Emergencies
   1. Physician-patient relationship
   2. Responsibility
   3. Communication
   4. Exam

E. Glaucoma
   1. Risk factors
   2. Pediatric Glaucoma
   3. Technology

F. Neurooptha lmology

1. Optic atrophy
2. Headaches

G. Pediatric Ophthalmology
1. The unaccompanied minor
2. Abandonment

H. Refractive Surgery
1. Statistics
2. Patient Expectations

5. Reduction of medical errors

A. Diagnosis
B. Treatment
C. Medication
D. Recall
E. No-Show
F. Technology
G. Special population issues
1. Elderly patients
2. Infants and children
3. Communication
a. language barriers
b. literacy barriers
c. hearing/speech barriers

6. Medical errors and reporting

A. Barriers to reporting errors
B. Statute 395.0197
1. When reporting medical errors is required

7. Case presentations

A. Glaucoma
1. Vision loss
2. Failure to warn
3. Failure to diagnose

B. Abnormal pupil

8. Sequence of events in a medical malpractice lawsuit

9. The 5 most effective risk prevention strategies

   A. Good results
   B. The physician patient relationship
   C. Informed consent
   D. Documentation
   E. Medical Records

10. Root Cause analysis review and how it helps to prevent Medical Errors
   A. The 5 Why's
   B. Relating RCA to Optometry