PREVENTION OF MEDICAL ERRORS IN THE OPTOMETRIC PRACTICE

Alice Sterling, O.D.

Course Description:

This course is designed to meet the requirements set forth in Florida Statute 456.013 by the state legislature to reduce the risk of medical error and to improve patient safety. Root cause analysis, patient safety, error reduction and error prevention will be presented. This is a two hour course.

Course Outline:

I. History of course requirement
   a) Institute of Medicine Report
      1) 1 out or 25 hospital patients injured by medical errors
      2) Medication errors cause 7,000 deaths each year
      3) 44,000 – 95,000 estimated deaths/year due to medical error
      4) Costs more than $30 billion/year
   b) Agency for Healthcare Research and Quality
   c) Joint commission on the Accreditation of Healthcare Organizations
   d) Florida Statute change – 64B-13-5.001 – 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.

II. Types of medical error
   a) Definition of error
      1) Error of execution – planned action in the patient management is not completed
      2) Error of planning – use of the 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 – error at the level of the operator that was under their direct control
   c) Latent errors – error that does not occur during the direct control of operator

III. Factors leading to medical errors
   a) Fatigue
   b) Alcohol/drugs
   c) Illness
   d) Distractions
   e) Emotional state
   f) Unfamiliar conditions
   g) Equipment problems
   h) Inadequate instructions
   i) Communication problems
   j) Handwriting
   k) Sound alike drugs
   l) Record keeping

IV. Medication errors
   a) Omission errors
   b) Dosing errors
   c) Unauthorized drug errors

V. Root cause analysis (RCA)
   a) JCAHO requirement – A thorough, credible root cause analysis be performed for each reported sentinel event. The goal of RCA is to find out
      1) What happened
      2) Why did it happen
      3) How to prevent recurrence
   b) RCA is a tool for identifying error prevention strategies. It is a process for discovering basic and contributing causes of error with the continuing goal of preventing recurrence.
   c) RCA is an interdisciplinary process involving:
      1) Experts from all services involved
      2) Those who are the most familiar with the situation
      3) Identification of changes needed
      4) Impartiality
      5) Relevant literature
      6) consistency
   d) VA National Center for Patient Safety determines a thorough RCA must include:
      1) Determination of human and other factors
      2) Determination of related processes and systems
      3) Analysis of underlying cause and effect systems through a series of WHY questions
      4) Identification of risk and their potential contributions
      5) Determination of potential improvement in processes or systems

VI. Reduction of medical errors
   a) Make the correct diagnosis
   b) Provide the correct treatment plan
   c) Prescribe medication accurately
   d) Assure proper recall/follow up
   e) Keep equipment accurately operating
   f) Have plan for special population issues
      1) Elderly
      2) Infants/children
      3) Communication barriers
      4) Handicapped

VII. Reporting medical errors
   a) Barriers to reporting errors
   b) Statute 395.0197

VIII. Malpractice
   a) Medical errors vs malpractice
   b) Areas of risk
   c) Occurrence and process
   d) Prevention of malpractice

IX. Prevention of malpractice
   a) Proper work-up and diagnosis
   b) Proper chart documentation
   c) Proper patient communication
   d) Proper clinic protocols
   e) Proper referral
   f) Good patient relationships

X. Case presentations related to optometry
   a) Glaucoma
   b) Corneal ulcers
   c) TIAs
   d) Staff
   e) Co-management
   f) Unknown vision loss
   g) Diplopia
   h) Visual field loss
   i) Contact lenses
   j) Other optic nerve disorders
   k) Pediatrics

Website references:

Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov/QUAL/errorssix.htm

FDA Safety Information and Adverse Event Reporting Program – www.fda.gov/medwatch/how.htm

MEDERRORS – www.mederrors.com