Prevention of Medical Errors and the Optometric Practice

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

COURSE OBJECTIVES
1. To be aware of how the need for a medical errors course came about.
2. Describe, in general, the different types of medical errors that can occur.
3. Review causes of medical errors that can occur within the primary optometric eyecare setting.
4. What techniques and record keeping can reduce medical errors.
5. When can medical errors lead to possible malpractice and how to reduce the risk of medical/optometric malpractice.

COURSE OUTLINE
A. Why is there a required course in medical errors
   1. 1999 Institute of Medicine Report
      - the hidden epidemic
      - 1 in 25 hospital patients injured by medical errors
      - medication errors cause ~7,000 deaths per year
      - 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)
      - cost of ~$30 billion per year
   2. Agency for Healthcare Research and Quality
      - current state of the problem
      - more frequent a organization problem than single individual error
   3. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
      - where regulations and education come into play
4. Florida medical errors requirement
   - Statute 64B13-5.001
   - “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.”

B. Types of medical errors
   1. What is an error
      a. Error of execution
         - planned action in the patient management is not completed
      b. Error of planning
         - use of the wrong plan in the patient management
      c. Adverse event
         - injury secondary to patient management and not due to the underlying medical condition of the patient
   2. Active errors
      - error at the level of the operator that was under their direct control
   3. Latent errors
      - error that does not occur during the direct control of the operator
      - while not under direct control of the operator it can involve the patient management that the operator selected (i.e. wrong diagnosis)

C. Factors that can lead increased risk of medical errors
   1. Fatigue
   2. Alcohol/drugs
   3. Illness
   4. Inattention/distractions
   5. Emotional states
   6. Unfamiliar situations/conditions
   7. Equipment problems
   8. Inadequate labeling/instructions
   9. Communication problems
   10. Handwriting
   11. Sound alike drugs
   12. Office set-up/record keeping

D. Medication errors
   1. Omission errors
   2. Dosing errors
   3. Unauthorized drug errors
*To reduce medication errors always remember the “six rights”:
1. Right patient
2. Right drug
3. Right dose
4. Right dosage form
5. Right route
6. Right time

Woods Lucky #7: Right patient medication education

E. Root cause analysis
   1. JCAHO requirement
   2. What conditions within the system or practice cause a medical error.
   3. Where can the system or practice set-up be improved to reduce the likelihood of another similar event.
   4. Action plan and outcomes

F. Reduction of medical errors
   1. Making the correct diagnosis
   2. Providing the correct treatment based on the diagnosis
      - evidence-based medicine
   3. Making sure the correct medication is Rx’ed
   4. Correct follow-up/automated recall systems
      - how to deal with the no-show patient
   5. Equipment issues
   6. Special population issues
      a. Elderly patients
      b. Infants and children
      c. Communication
         - language barriers
         - literacy barriers
         - hearing/speech barriers

G. When do you have to report medical errors
   1. Barriers to reporting errors
   2. Statute 395.0197
      - when reporting medical errors is required

H. When medical errors become malpractice
   1. How medical errors are, and are not, related to malpractice
   2. Areas of risk in primary optometric eyecare for malpractice
Case presentations
  a. Vision loss of unknown etiology
  b. Nerve at risk
     - Pallor/atrophy
     - AION
     - Papilledema
  c. Diplopia
     - CNIII palsy
     - CNVI palsy
  d. Corneal
  e. Contact lenses
  f. Co-management

3. How malpractice claims occur and the process
4. Malpractice prevention
   - Proper work-up and diagnosis
   - Proper chart documentation
   - Proper patient communication
   - Proper clinic protocols
   - Proper referrals (and relationships)
   - GOOD patient relationships

REFERENCES


4. In Hospital Deaths from Medical Errors at 195,000 per Year USA. Medical News Today Aug 9, 2004.

WEB SITES
1. Agency for Healthcare Research and Quality (AHRQ):
   www.ahrq.gov/QUAL/errorsix.htm
2. FDA Safety Information and Adverse Event Reporting Program:
   www.fda.gov/medwatch/how.htm
3. MEDERRORS:
   www.mederrors.com/