Prevention of Medical Errors for Optometry

2021

Why Are We Here (since 2002)

- 456.013
- 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.

Florida Required Reporting

Requires reporting of mistakes that lead to serious patient injuries, such as life threatening situations and epidemic outbreaks.

Also report serious adverse events:

- wrongful deaths
- brain injuries
- wrong limb removals
- incorrect surgeries

Commission on Excellence in Health Care

Established in 2000 by FL legislature

Chaired by Secretaries of:
- Department of Health
- Agency for Health Care Administration

42 Members:
- Professional Associations, Health lawyers, Medical schools, Health insurance carriers, Consumer advocates, Legislators

Other FL Initiatives

In 2004, legislation was passed requiring the state to inform the public about important performance outcome indicators for healthcare facilities (eg, volume of cases, average length of stay, complication rates, mortality rates, infection rates for various medical conditions). This information is available online since 2005

At: www.floridahealthfinder.gov

This legislation also established the FL Patient Safety Corporation, a voluntary statewide reporting program to track and analyze near misses

History of Course Requirement

Institute of Medicine Report

Agency for Healthcare Research and Quality

Joint Commission on the Accreditation of Healthcare Organizations

Florida Statute 456.013

Institute of Medicine Report

- 1 in 25 hospital patients injured by medical errors
- Estimated 44,000 to 98,000 deaths/year secondary to all medical errors
- 7,000 deaths/year related to medication errors
- Cost to economy – $17 to $29 billion

Costs

- Includes lost income, lost household production, disability and healthcare costs
- Adverse effects: $37.6 to $50 billion
- Preventable Adverse events: $17 to $29 billion
- Preventable mistakes in hospitals alone cost 2-4% of national healthcare expenditures

A Hidden Epidemic

- Breast cancer – 42,297 deaths/year
- Motor vehicle accidents – 43,458 deaths/year
- AIDS – 16.516 deaths/year

Goals Set as Result of Report

By the 5 year mark:

- Decrease medical errors by 50%
- Decrease nosocomial (infections acquired within 48 hrs of hospital admission) by 90%
- Eliminate “never events” (such as wrong side surgery)

Recent Estimates from JAMA

- 106,000 deaths/year from negative effects of medicines
- 80,000 deaths/year from infections incurred in the hospital
- 20,000 to 44,000 deaths/year from hospital errors
- 7,000 medical malpractice deaths/year attributed to medication errors in hospital
- Total of 195,000 to 225,000 deaths/year due to medical negligence of some nature.

Agency for Healthcare Research and Quality (AHRQ)

- AHRQ has shown that medical errors result most frequently from: systems errors, the organization of healthcare and how resources are provided in the delivery system

- Only rarely are medical errors the result of carelessness or misconduct of a single individual

Joint Commission on the Accreditation of Healthcare Organization (JCAHO)

- Where regulation and education join forces
- Root Cause Analysis comes from JCAHO

Of randomly selected Americans, 42% said that they had personal knowledge of medical error that had happened to themselves, a relative or a friend.

1997 poll National Patient Safety Foundation (an independent group established by AMA)

- University of Chicago expanded on this 1997 report in 2017 using 2,500 respondants.

- 21% had personally experience a medical mistake
- 31% reported medical errors for family member or person whom they were overseeing for medical care.
- Ambulatory sites were more commonly reported for errors than hospitals.

IOM/HMD defines an error as

- Failure of a planned action to be completed as intended (an error of execution) – the right drug but the wrong dose

- The use of the wrong plan to achieve an aim (error of planning) – wrong diagnosis or treatment plan

IOM/HMD defines an adverse event as

- An injury secondary to patient management and not to the underlying medical condition of the patient.

Preventable Adverse Event

An adverse event attributable to error is a preventable adverse event, also called a sentinel event, because is signals the need to ask why the error occurred and make changes in the system.

Sentinel Event Alerts

- Wrong site surgery
- High alert medications
- Look alike/sound alike medicines
- Needles/sharps injuries
- Dangerous abbreviations
- Delays in treatment
- Op/post-op complications
- Falls

Active vs Latent Errors

- Active errors occur at the level of the frontline operator and their effects are felt almost immediately

- Latent errors tend to be removed from the direct control of the operator. This includes poor design, incorrect installation, faulty maintenance, bad management decisions and poorly structured organizations.

Factors & Situations that increase risk of error

- Fatigue
- Alcohol/drugs
- Illness
- Inattention/distractions
- Emotional state
- Unfamiliar conditions
- Equipment problems
- Communication problems

Factors & Situations that increase risk of error…

- Handwriting
- Sound alike drugs
- Record keeping

Medication Errors

- Omission errors – failure to administer an ordered medication dose
- Improper dose/quantity errors – any medication dose, strength or quantity that differs from that prescribed
- Unauthorized drug errors – any medication dispensed/administered that was not authorized by the prescriber (including the wrong drug)

Doctor's "Rights" when prescribing drugs

- Right patient
- Right drug
- Right dose
- Right dosage form
- Right route
- Right time

Patient Responsibilities

- Provide list of medicines, supplements and allergies to medicines (without sulking over the paperwork)
- If you don't understand, ask for clarification
- Don't get to the pharmacy and decide the drug is too expensive and leave without it. Ask the pharmacist to call and find a viable substitute.

Doctor's Responsibilities

- Educate the patient
- Clearly list allergies and medicines
- Adjust the dose for children and elderly
- Limit access to high hazard drugs
- Computerize – e prescribe
- Avoid abbreviations that are not standard
- Consider unit doses when available (Z pak)

Educate the Patient

- Don’t rely on the pharmacist
- Review the name of the drug and ask the patient to confirm it at dispensing
- Why the patient is taking this medicine
- How much to take and how often
- What are the side effects and what to do if patient experiences any of them
- Is it safe to take with other medicines or supplements
- What food, drinks or activities to avoid

Special Considerations

- Elderly
- Infants and Children
- Communication Barriers
  language
  literacy
  hearing

Elderly

- Medication errors can have life-threatening or even fatal effects due to the declining ability of the aging body to metabolize drugs
- Visual, hearing or cognitive problems may lead to misunderstanding of instructions or failure to question an incorrect or unfamiliar drug
- Advisable to have a family member or able advocate in the room during the exam

Infants and Children

- The younger the patient, the greater the risk of serious medication errors.
- Alert the parents to watch for adverse reactions. Explain what they might be
- Malpractice decisions will favor children

Communication Barriers

- Use an interpreter, preferably someone who lives in their household and can stay in the exam room for the entire exam
- Use staff members who are bilingual
- Write out any special instructions the patient needs to follow.
- Enter into exam notes how you communicated during the exam

Intra/Inter-professional Communication

Communication goes both ways

- Why are you referring the patient and what have you done so far
- Expect a letter/report back
- Read the report and document the date

Send reports to PCP or specialist for:

- High risk medicines
- Diabetics

Root Cause Analysis

- It is a requirement of JCAHO
- A thorough, credible root cause analysis must be performed for each reported sentinel event.

The Goal of Root Cause Analysis

- What happened
- Why did it happen
- How to prevent recurrence

Root Cause Analysis (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.

RCA in an interdisciplinary process involving

- Experts from all services involved
- Those who are the most familiar with the situation
- Asking a series of “why” questions at each level of cause and effect
- Identification of changes needed.
- As great a degree of impartiality as possible
- Resourcing relevant literature
- Consistency
- Developing an action plan

VA National Center for Patient Safety wording on RCA

- Determination of human and other factors
- Determination of related processes and systems
- Analysis of underlying cause and effect systems through a series of “why” questions
- Identification of risks and their potential contributions
- Determination of potential improvement in processes and systems

Reducing Medical Errors

Make correct medical diagnosis

- Know when to refer
- Inconveniencing the patient should not rule your decision to refer
- You are not an expert on everything
- Have the proper equipment needed for proper diagnosis including culturing

Reducing Medical Errors

Provide the Correct Treatment Plan

- Which may mean referring
- Make sure the patient comprehends
- Include proper recall/follow up

Reducing Medical Errors

Prescribe Medication Correctly

Advise patient to be their own advocate

Don’t re-new without a review

Reducing Medical Errors

Keep equipment accurately operating

Have the proper equipment for diagnosing

Clean equipment properly in front of patient

Reducing Medical Errors

Doctor Education

- Prevention of Medical Errors
- Jurisprudence
- Management of Disease
- Full scope therapeutic drug use

Reducing Medical Errors

Education the staff

- Phone triage
- Proper training on equipment
- Proper pre-testing
- Infection prevention review
- Proper protocol for common emergencies
- Review of standard of care
- Encourage licensing, certification and CE
- OSHA
- CPR?

Reducing Medical Errors

Communication, Communication

According to NY Times (June 2015): To be sued less, doctors should consider talking to patients more. Patients do not like to be rushed or talked down to. Doctors who use humor and spend more time talking to patients are less likely to be sued.

RETURN PHONE CALLS

Patients do not care how much you know until they know how much you care.

When a patient decides they do not like you, the patient begins to look for what is wrong with your office.

Then they file a complaint with the DOH….but that’s another lecture….

Reporting Errors

- Mistaken attitude in healthcare that errors are solely the fault of individual doctors has created a major barrier to reporting
- Efforts have focused almost entirely on making providers more careful, thus reinforcing fear of punishment when they fail
- When the fear of punishment is removed, reporting of errors increases 10 to 20 fold

Reporting Errors

Florida Statute 395.0197 mandates internal reporting of any adverse event over which healthcare personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which results in one of the following:

Reporting Errors

Death
Brain or spinal damage
Permanent disfigurement
Fracture or dislocation of bones or joints
A resulting limitation or neurological, physical or sensory function continuing after release
Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention
Any condition that required the patient be moved to another facility for more acute level of care

Reporting Errors

The risk management reporting system must:

- Investigate and analyze the frequency and causes of adverse events to patients
- Educate facility staff and agents
- Analyze patient grievances related to patient care

Risk Management Plan

- A written plan helps everyone, especially new employees, be aware of your goals for excellence in eye care
- A template makes it easy to record exactly what occurred in case litigation ensues
- These reports do not go into patient file, are not to be mentioned in patient record and not to be copied
- Are to be used by healthcare providers and legal council
- Are to be kept by risk manager (you)

Types of Incidences to Document

- Errors in patient care, wrong medications – for example giving Diamox to a patient with sulfa allergies
- Patient complaints
- Equipment failure
- Fainting incidences
- Dilated patient misjudging the curb while leaving your office

Damage Control

- See patient regularly
- Explain what happened
- Avoid terms like: mistake, error, apology
- Express concern, show compassion
- Don't hurry the situation
- Return phone calls promptly
- If lawyer contacts you – avoid speaking with the patient or their lawyer then notify your malpractice carrier. Their lawyer will advise you

Real Examples

- My Dad's hospital experience
- My patient's wrong power implant
- My office building trip and fall patient

Report from Medscape 2015

- 70% said they were surprised when they received a letter of being sued
- Only 20% of those surveyed went to trial
- 40% said their lawsuit was dismissed
- 32% reached a settlement
- 30% of the cases had no reward
- 20% of the cases were under $100K
- 29% of the cases were over $100K
- 5% of the cases were over $1 million

Specifics in Optometry

- Glaucoma
- Central Corneal Ulcers
- Tobrex vs Tobradex
- PVD vs Retinal Detachment
- Fundus photo instead of dilating
- Recalcitrant CL wearer
- Insurance guided practice