Prevention of Medical Errors
Richard Soden, OD

Financial Disclosure:

Richard Soden has no financial interests to disclosure

Description:

The number of people who are injured or die from medical errors continues to increase annually. This course will review the common causes of medical errors in health care offices with an emphasis and prevention. This course will focus on how optometrists can minimize and prevent medical errors in their practices.

Goals:

- To fulfill Florida State Statute 456.017 (7)
- To discuss the types of Medical Errors
- To reduce the risk of medical errors occurring in an optometric office
- To improve patient safety
- To offer recommendations in this area

Course Outline:

1. Statistics on Medical Errors
2. Epidemiology of Medical Errors
3. Types of Errors
   a. Surgical Errors
   b. Medication Errors
   c. Inpatient vs. Outpatient Errors
   d. Human Errors
   e. Equipment Errors
   f. Diagnostic errors
   g. Incorrect drug dosing
   h. Drug interactions
   i. Adverse events; Infections
   j. Equipment failure
k. Misread lab reports (VF’s)
l. Misinterpretation of orders

4. Types of Errors
   a. Active
   b. Latent

5. Factors Affecting Errors
   a. Fatigue
   b. Alcohol and drugs
   c. Illness
   d. Inattention/Distraction
   e. Emotional states of the provider
   f. Doctors who work in multiple places (different equipment, different formularies, etc)
   g. Difficultly reading other people’s handwriting
   h. Communication problems between staff and providers

6. Sentinel Events
7. Reporting of Medical Errors
   a. Florida Law
   b. NYPORTS

8. Reducing Medical Errors
   a. Processes
   b. Short term blame vs. long term fixes

9. Error Analysis – Root Cause Analysis
   a. What is it?
   b. How can it be used to solve problems?
   c. Compiling the appropriate team
   d. Drilling down the problem
   e. When can optometrists use root cause analysis techniques
   f. How can root cause analysis be used to reduce medical errors
   g. How root cause analysis can lead to better prevention
   h. How root cause analysis be used to improve patient safety

10. Error Prevention in Optometric Practices
11. Improving patient safety in health care office

   a. Creating a “culture of patient safety
   b. Expired medications
   c. Prevention of falls and trips
   d. Documentation
   e. Communication

12. Clinical Guidelines and Best Practices

13. Wrap-up and questions