

OOPS! I DID IT AGAIN...

PREVENTING MEDICAL ERRORS

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Course description: This course includes a discussion of root-cause analysis, error reduction and prevention, and patient safety. It is highlighted by a review of common clinicolegal pitfalls for optometric practitioners, citing actual malpractice litigation cases. This two-hour presentation also fulfills the Florida continuing education requirement for Medical Errors.

Medical Errors – here’s the law that made this all possible...

64B13-5.001 Hours Requirement (Effective: 12/25/2006)

- 1) As a condition to the renewal of a biennial license, each licensed practitioner shall be required to maintain professional competency by completing 30 clock hours of continuing education in subjects relating to optometry that have been approved by the Board. Licensed practitioners shall not be required to complete the continuing education requirements during the biennium in which they are initially licensed but must complete one hour of approved continuing education in acquired immune deficiency syndrome that complies with the requirements of Section 456.033, F.S. Credit for continuing education will be allowed on the basis of an hour for hour. To receive one hour credit, a licensed practitioner must attend not less than 50 minutes. There will be no fractional hour credits.
 - a) For licensed practitioners who are certified optometrists, at least 6 of the required 30 hours must be of “transcript quality.” For purposes of this rule, the phrase “transcript quality” refers to coursework in ocular and systemic pharmacology and the diagnosis, treatment and management of ocular and systemic conditions and diseases. Transcript quality CE must be sponsored by a school or college of optometry or equivalent educational entity as approved by the Board and must require a test and passing grade.
 - b) Attendance at a continuing education program must be certified by the lecturer or someone in charge of the program. An instructor of a course may credit the hours taught towards completion of the instructor’s required continuing education only once, regardless of the number of times the course is taught. However, the instructor of a course may not credit the hours taught towards completion of the “transcript quality” portion of the continuing education requirement. Continuing education hours must be obtained during the biennium preceding license renewal.
 - c) Licensed practitioners shall be permitted to earn two of the 30 clock hours of continuing education credit upon demonstrating successful completion of approved training in cardiopulmonary resuscitation given by the American Heart Association or the American Red Cross.
 - d) Licensed practitioners shall be permitted to earn two hours of the 30 clock hours in the area of practice management.
 - e) As part of the 30 clock hours, licensed practitioners shall be required to obtain two hours in the area of Florida jurisprudence. A licensed practitioner may earn two hours in Florida jurisprudence by attending a meeting of the Board for no less than four (4) continuous hours. Licensed practitioners will be required to sign-in and sign-out with board staff. Those licensed practitioners present for disciplinary purposes are not eligible to earn the two clock hours for the Board meeting. Out of state licensed practitioners who do not practice in Florida at any time during the biennium, shall be permitted to satisfy the requirement of two hours in Florida jurisprudence by certifying that they have obtained and read a copy of the current provisions of Chapters 456 and 463, F.S., and Rule Chapter 64B13, F.A.C.
- f) **As part of the 30 clock hours, licensed practitioners 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. 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.**
- 2) The Board shall audit an appropriate number of randomly selected licensed practitioners to assure that the reports of completion of continuing education are valid. At the time of audit, each designated licensed practitioner must provide to the Board office appropriate documentation of completion of the required continuing education. All licensed practitioners are responsible for maintaining appropriate records of completed continuing education for the past two bienniums.

History

- **1999:** Institute of Medicine – *“To Err Is Human: Building a Safer Health System”*
 - This report revealed a heretofore undisclosed reality – medical errors
 - Seventh leading cause of death in US; 44,000 - 98,000 (in-patient)
 - Cost the U.S. economy as much as \$29 billion each year
- **2000:** Congress approved a \$50 million annual appropriation for research on client safety, primarily by the Agency for Healthcare Research and Quality (AHRQ).
- **2005:** President Bush signed into law S.544, the *Client Safety and Quality Improvement Act*, which established a voluntary confidential reporting system to create a national database of medical errors for analysis and development of evidence-based client safety measures.
- **Today:** Twenty-three states (including Florida) have mandatory or voluntary systems for reporting medical errors in hospitals and other healthcare organizations.

Types of Medical Errors

- An error is defined as:
 - *“the failure of a planned action to be completed as intended”* (error of execution)

OR

 - *“the use of a wrong plan to achieve an aim”* (error of planning)
- Errors of **commission** involve ACTION; errors of **omission** involve INACTION.
- **Adverse Event** - an injury caused by medical management rather than the underlying condition of the client.
 - An adverse event attributable to error is a *preventable adverse event* or a *sentinel event*; signals the need to ask why the error occurred and make changes in the system.
- **Active errors** - occur at the level of the individual; effects are felt almost immediately.
- **Latent errors** - errors in system design, faulty installation or maintenance of equipment, or ineffective organizational structure. The effects may not appear for months or years but can lead to a cascade of active errors, ending in catastrophe.
- **Close calls or near misses** - potential adverse events, errors that could have caused harm but did not, either by chance or because something or someone in the system intervened.
- Surgical Errors
 - “wrong-site”
 - “wrong-procedure”
 - “wrong-person”
- Misdiagnoses
- Medication Errors
 - The primary contributing factors to medication errors include distractions, workload increases, and staffing issues (e.g. inexperienced or insufficient staff)
 - **Legibility** of written prescriptions is also crucial
 - Florida law now requires that all physicians either print legibly or type prescriptions, and include the name and strength of the drug prescribed, the quantity of the drug prescribed *in both textual and numerical formats*, and the directions for taking the drug.

- **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** (the medication dispensed and/or administered was not authorized by the prescriber); this category includes dispensing or administering the wrong drug

Factors that Increase the Risk of Errors

- Fatigue
- Alcohol and/or other drugs
- Illness
- Inattention/Distraction
- Emotional states
 - E.g. anger, anxiety, fear and boredom
 - A heavy workload, conflict with other staff or patients, and other sources of stress also increase the likelihood of errors.
- Unfamiliar situations or problems
- Communication problems
- Hard-to-read handwriting

Reporting Errors

- Statute 395.0197 mandates internal reporting of any adverse incident “*over which health care 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:*
 - (a) *Results in one of the following injuries:*
 1. *Death;*
 2. *Brain or spinal damage;*
 3. *Permanent disfigurement;*
 4. *Fracture or dislocation of bones or joints;*
 5. *A resulting limitation of neurological, physical, or sensory function that continues after discharge from the facility;*
 6. *Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or*
 7. *Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient’s condition prior to the adverse incident.”*
- Many practitioners still mistakenly believe that reporting errors will invariably result in punishment; this is a major barrier.
- When the fear of punishment is removed, reporting of errors increases by as much as 10 to 20 fold.

Root Cause Analysis

- The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires that healthcare institutions analyze serious medical errors to determine the root cause (*root cause analysis* or RCA), and develop an action plan to prevent those errors in the future.
- RCA can be thought of as a tool for identifying error prevention strategies. The goals of RCA are to determine:
 - *What* happened?
 - *Why* did it happen?
 - What can be done to prevent it from happening *again*?
- Crucial features – root cause analysis must be:
 - *Interdisciplinary*, involving experts from the frontline services;
 - *Cooperative*, involving of those who are the most familiar with the situation;
 - *Persistent*, asking WHY at each level of cause and effect;
 - *Open*, identifying changes that need to be made to systems;
 - As *impartial* as possible
- According to the VA National Center for Patient Safety (2002), a **thorough** RCA must include:
 - 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 or systems
- A **credible** RCA must:
 - Include participation by the leadership of the organization and those most closely involved in the processes and systems.
 - Be internally consistent.
 - Include consideration of relevant literature.

The JCAHO requires that a thorough, credible root cause analysis and corrective action plan be performed for each reported sentinel event within 45 days of the event's occurrence or of the organization's becoming aware of the event. According to JCAHO research, the leading root causes of sentinel events between 1996 and 2004 were communication, orientation/training, client assessment, and staffing.

Error Reduction & Prevention – medical errors can be diminished by developing...

- Improved Communication
 - Doctor ↔ patient
 - Know all medications (including vitamins, herbals & OTCs) the patient is taking.
 - Inquire about allergies and past adverse reactions to medications
 - Doctor ↔ pharmacist
 - Always write prescriptions legibly so that patient & pharmacist can read them

- Return phone calls / faxes promptly

JCAHO DO-NOT-USE LIST		
DO NOT USE	POTENTIAL PROBLEM	USE INSTEAD
U (unit)	Mistaken for "0" (zero), the number "4," (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous), or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)	Decimal point is missed	Write X mg
Lack of leading zero (.X mg)	Decimal point is missed	Write 0.X mg

- Medical record documentation
 - Maintain complete & legible medical records
 - Never alter a chart note after-the-fact
- Prescription documentation
 - Place carbon or other copy of written Rx in record
 - Use computer generated (EMR) prescriptions
- Increased attention to disease and medication guidelines
 - PDA capability
 - Medication links
 - Treatment resources
- Professional continuing education

At-Risk Populations – the following may be more prone to incurring medical errors:

- Elderly patients
- Pediatric patients
- Mentally- or emotionally-challenged individuals
- Patients with a language barrier

Enhancing patient safety

- For the doctor...
 - Make a proactive commitment to safety in practice
 - Adhere to infection prevention protocols
 - Adopt a policy of continuous quality improvement
 - Review the literature routinely
 - Improve communication with patients
 - Encourage patients to ask questions and take an active role in their health care
 - Reduce prescriptive errors

- For the patient...
 - Be an active, interested party in your own health care
 - Inform your doctor of all drugs, vitamins, etc. that you take
 - Inform your doctor of any allergies or reactions to medicine in the past
 - Review all prescriptions for medication and ask “what is this for?”
 - Bring along a companion or designate a patient advocate to assist in asking questions, recall of information

Optometric Malpractice – What are the most common errors that result in lawsuits?

- Failure to diagnose glaucoma
- Failure to diagnose retinal detachment
- Failure to diagnose intraocular tumors
- Malpractice is defined as “*the improper or immoral conduct of a professional in the performance of his duties, done either intentionally or through carelessness or ignorance or negligence.*”
 - Such malpractice negligence is **culpable** and is punishable under law by **compensatory damages** to the victim of the malpractice.
 - Malpractice is commonly applied to physicians, surgeons, dentists, lawyers, and public officers to denote negligent or unskillful performance of duties where professional skills are obligatory.
- The majority of malpractice cases originate from medical procedures in which a patient has been caused harm either emotionally or physically.
- Review of actual malpractice cases involving OD’s...
 - ★ **Has there been harm caused to the individual?**
 - Is there evidence of negligence?
 - Did the doctor meet the “standard of care”? Should he/she have acted or performed differently?
 - Did the doctor do all that he/she could to avert the outcome?
 - Is there evidence of culpability?
 - Is the doctor responsible – directly or indirectly – for the poor outcome? Or, is the poor outcome due to another cause, e.g.
 - A natural result of the disease process regardless of treatment, or
 - A result of poor compliance by the patient (contributory negligence).
 - Deposition:
 - **Not written = not done = not true** (with apologies to Joe Sowka!)
 - Deposition may not CONTRADICT the records, but it may help to augment and clarify the records. Testimony should NEVER contradict the deposition.
 - Expert witnesses
 - *“In medical malpractice cases, the plaintiff must prove negligence through the use of expert testimony, unless an understanding of the doctor's alleged lack of due care or skill requires only common knowledge or experience.”*
 - Expert witnesses have the obligation of communicating the standard of care and educating the attorneys, judge and/or jury.