

# Prevention of Medical Errors in Optometry

CARL SPEAR OD, MBA, FAAO  
APRIL JASPER OD, FAAO

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## Prevention of Medical Errors

Go to: [PollEv.com/ome](https://PollEv.com/ome) or text **OME** to **22333** once to join

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CARL H SPEAR OD, MBA, FAAO



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LUXOTTICA  
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2020 Family  
Blessings

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## Course Objectives:

To be aware of the history of medical errors training

Definition and categories of medical errors that can occur

Causes of medical errors within the optometric setting

Discuss how to prevent medical errors as well as root cause analysis

Why medical errors lead to malpractice

Discussion of methods to prevent malpractice claims in eye care

Review Root Cause Analysis and its role in prevention of ME

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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).

## What is a Medical Error?

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## Study Suggests Medical Errors Now The 3<sup>rd</sup> Leading Cause of Death in the U.S.

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Analysis

**Medical error—the third leading cause of death in the US**

BMJ 2016;353:doi:https://doi.org/10.1136/bmj.2016.021139 (Published 03 May 2016)

Cite this as: BMJ 2016;353:doi:https://doi.org/10.1136/bmj.2016.021139

ILLUSTRATION: Medical error—the third leading cause of death in the US

Article · Related content · Metrics · Responses · Peer review

Health & Safety · Professor Michael David, research fellow

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News and Publications

Overview

Articles from Johns Hopkins

5 Newsletters

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**Study Suggests Medical Errors Now Third Leading Cause of Death in the U.S.**

Physicians advocate for changes in how deaths are reported to better reflect reality

FOR THE

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What is the average age of the person who files a malpractice complaint?

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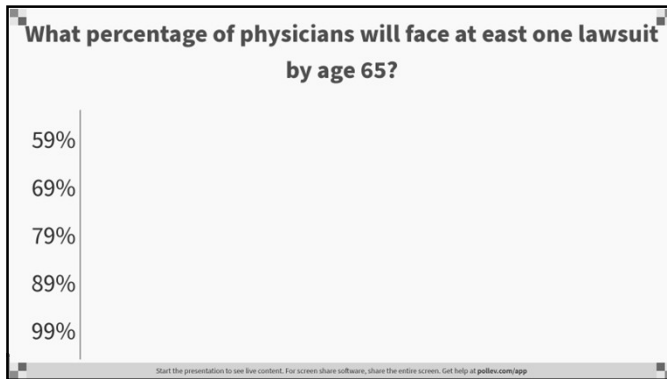
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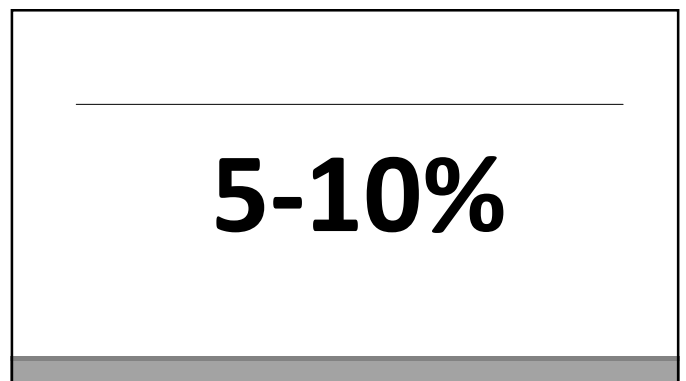
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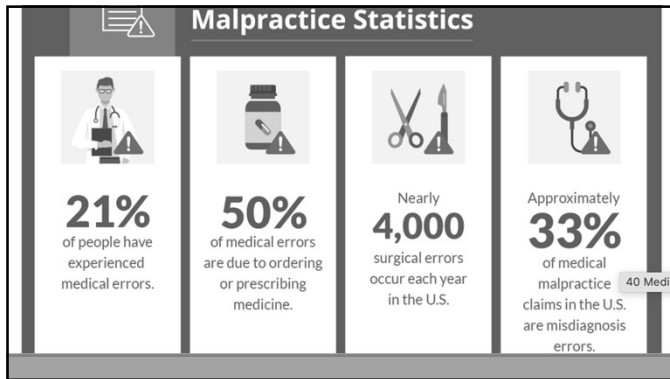
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- 10% of all deaths in the United States are the result of medical error.
- \$2.16 billion in medical malpractice claims were filed by members of the armed services in 2019.
- 5% to 10% of all physicians have had sexual contact with patients.
- 68 liability claims have been filed per 100 physicians.
- 49.2% of physicians age 55 and older have been sued.
- 39.4% of male physicians have been sued.
- 22.8% of female physicians have been sued.
- About 15,000 to 18,000 lawsuits are filed each year alleging medical malpractice or negligence.
- More than 30% of physicians pay more than \$10,000 for medical malpractice insurance annually.
- 16% of psychiatrists have been sued, the lowest of any specialty.

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### Johns Hopkins 8 Yr. Safety Study (Dr. Makary and Michael Daniel)

- More than 250,000 U.S. deaths per year due to medical error
- 700 U.S. deaths per day due to medical error
- Medical Error's 3<sup>rd</sup> leading cause of death in the U.S.
- 10% of all U.S. deaths are now due to medical error
- New numbers result in better data collection
- The CDC calculates off death certificates which since 1949 use ICD billing codes (with no option for medical error)

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### Johns Hopkins 8 Yr. Safety Study

- Researches caution that errors aren't due to inherently bad doctors
- Errors represent systemic problems including:
  - Poorly coordinated care
  - Fragmented Insurance networks
  - Absence or underuse of safety nets and other protocols
  - Unwarranted variation in physician practice patterns that lack accountability

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## Has COVID Changed Anything?

<https://www.aac.org/Membership/Join-Us/Benefits/Additional-Member-Only-Benefits/ACC-and-The-Doctors-Company/The-Doctors-Company-Updates/2021/06/08/14/04/Malpractice-Claims-from-the-COVID-19-Pandemic-More-Questions-Than-Answers>

### Defending Claims Regarding Treatment vs. Regarding Infection Control

We are very confident in our ability to protect our members against claims where they are being sued over the treatment of the disease. Claims arising out of treatment are not concerning to us because there is no cure for COVID-19—one can only treat the symptoms as the virus runs its course.

On the other hand, suits harder to defend would be those that revolve around transmitting the disease because providers didn't follow guidelines from the Centers for Disease Control and Prevention (CDC) or there wasn't enough personal protective equipment (PPE).

That's why we stress the importance of following CDC guidelines, and why we've taken proactive steps to communicate with the entire medical community throughout the pandemic as part of our commitment to serve those who provide care.

Written by **Robert E. White Jr.**, Chief Operating Officer of The Doctors Company.

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Office Patient Experience Pharmacy Care Coordination Legal & Regulatory Compensation Payor Claims Rates

## Sharp drop in patient safety, infection control amid pandemic: 3 new findings

Gabrielle Mason - 10 hours ago Print | Email  
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Below are three new findings:

1. Central-line associated bloodstream infections in U.S. hospitals increased 28 percent in the second quarter of 2020, compared to the second quarter of 2019, according to CDC data. In the five years preceding the pandemic, central-line associated bloodstream infections had decreased by 31 percent.
2. A study of 148 HCA Healthcare-affiliated hospitals through 2020 found central line-associated bloodstream infections, catheter-associated urinary tract infections, and methicillin-resistant staphylococcus aureus bacteremia all increased as the COVID-19 burden increased.

Here are increases for the following infections over seven months of 2020:

**Central line-associated bloodstream infections:** 60 percent increase

**Methicillin-resistant Staphylococcus aureus:** 44 percent increase

**Catheter-associated urinary tract infections:** 43 percent increase

3. Rates of hospital-onset bloodstream infections and multidrug resistant organisms, vancomycin-resistant enterococcus and Gram-negative organisms were each significantly associated with COVID-19 surges, the study found.

There are numerous potential explanations for the increases in adverse events, including but not limited to, vast numbers of very ill patients, staff burnout and shortages, and supply chain disruptions.

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## Arkansas Healthcare Workers Walking OFF



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Elsevier Public Health Emergency Collection

Public Health Emergency COVID-19 Initiative

Br J Oral Maxillofac Surg. 2020 Jun; 58(5): 577-580. PMID: PMC7152882  
Published online 2020 Apr 13; doi: 10.1016/j.bjoms.2020.04.002

**Operating during the COVID-19 pandemic: How to reduce medical error**

R. Ellis<sup>a</sup>, A.G.C. HayDent<sup>a,\*</sup> and P.A. Brennan<sup>a</sup>

<sup>a</sup> Author information • Article notes • Copyright and License information • Disclaimer

This article has been cited by other articles in PMC.

**Abstract** Go to:

Our professional and private lives changed on March 11 2020 when the coronavirus disease 2019 (COVID-19) was declared a pandemic by the WHO. By March 16, surgical training was suspended, MRCS and FRCS examinations cancelled and all courses postponed. In theory, essential cancer surgery, emergency and trauma operating will continue. All elective, non-essential cases are currently cancelled. While we adapt to our new ways of working, we remind ourselves that surgeons are flexible, resilient and, ultimately, we are doctors in the first instance. We present a short article on operating during the COVID-19 pandemic.

**Keywords:** COVID-19, Pandemic, Operating, Surgeons, Human Factors

**Introduction** Go to:

The COVID-19 pandemic is likely to be the harshest public health crisis that we will encounter in our

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Operating on the challenging, uncomfortable and sometimes full PPE can be daunting when first used. However, once you get used to it, it can be a great way to protect yourself and your patients. It is important to have a good understanding of the equipment and to use it correctly. It is also important to have a good understanding of the risks and to take appropriate precautions.



Wearing face masks and hoods can also significantly reduce the clarity of verbal communication between theatre staff. Additionally, it may be more difficult than usual to read non-verbal cues. Therefore, care must be taken to ensure open, focused channels of communication are established between all team members throughout the entire procedure. We must use names to address individual team members and ask people to repeat our requests back to us to ensure a shared understanding.

Situational awareness may be impaired given the circumstances, therefore care should be taken to ensure all team members are aware of our expectations for the procedure including volume of blood loss and duration. Consider allocating roles for various members of the team to raise the alarm if these exceed what is expected.

Operating in full PPE can also be exhausting, when performing long procedures, breaks may be required to prevent fatigue. Dehydration and hunger are also linked to an increased risk of surgical error, therefore it is imperative that we look after ourselves at work.<sup>1,2</sup> Lack of sleep has been attributed to slower cognitive processing and decision making, increasing the risk of error.<sup>3</sup> Despite increasing workloads during this pandemic it is essential that clinicians take care of their own health to optimise their ability to care for others.

Burn out amongst clinicians may become more common in such a demanding environment. It is important that we look out for this in ourselves and our colleagues, recognising and dealing with this early before it can lead to suboptimal performance.<sup>4,5</sup> Many clinicians are away from families in order to avoid risk to loved ones. There are also more widespread concerns causing stress and anxiety: COVID-19 testing (patients and healthcare workers), distrust of governmental decisions, unnecessary "take" news and scaremongering, concern over inconsistent policies by different trusts in the UK on PPE use (NHS) standards versus PPE advice, concern for an overstretched health service that cannot deliver care, and, normal concerns for their own health and that of their families. Trusts have access to support for healthcare workers suffering from burn out which should be utilised at the earliest opportunity.

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## 4 Steps to take:

1. Single point of contact with regular feedback.
2. Self Care (food, sleep, family contact and accountability partner)
3. Be kind to your team
4. Be adaptable

NCBI Resources | How To | PMC

Public Health Emergency COVID-19 Initiative

Br J Oral Maxillofac Surg. 2020 Jun; 58(5): 581-584. PMID: PMC7151389  
Published online 2020 Apr 11; doi: 10.1016/j.bjoms.2020.04.003

**Reducing medical error during a pandemic**

A.G.C. HayDent<sup>a,\*</sup>, J.B.T. Harris<sup>b</sup>, E. Collins<sup>a</sup>, A. Miles<sup>a</sup> and P.A. Brennan<sup>a</sup>

<sup>a</sup> Author information • Article notes • Copyright and License information • Disclaimer

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Middle East Afr. J Ophthalmol. 2020 Apr-Jun; 27(2): 73-78.  
Published online 2020 Jul 20. doi: 10.4103/meajo.MEAJO\_237\_20

PMCID: PMC7442084  
PMID: 32874038

### Guidelines and Recommendations for Tonometry Use during the COVID-19 Era


Ermar M. Almazyad,<sup>1</sup> Sally Ameen,<sup>2</sup> Mohammad A. Khan,<sup>3</sup> and Rizwan Malik<sup>4</sup>

► Author information ► Article notes ► Copyright and License information ► Disclaimer

**American Academy of Ophthalmology** The American Academy of ophthalmology supports the use of diluted bleach for the disinfection of reusable tonometer tips for SARS-CoV-2 and adenovirus. If a tonometer tip is cleaned with alcohol and allowed to dry in room air, 70% alcohol solutions should be effective at disinfecting tonometer tips from SARS-CoV-2. However, alcohol will not effectively sterilize the tip against adenoviruses. That is because the virus causing COVID-19 is an enveloped virus, unlike the nonenveloped adenoviruses, that are much more resistant to alcohol. Ultimately, It is preferred to use single-use, disposable tonometer tips if available.<sup>[24-28]</sup>

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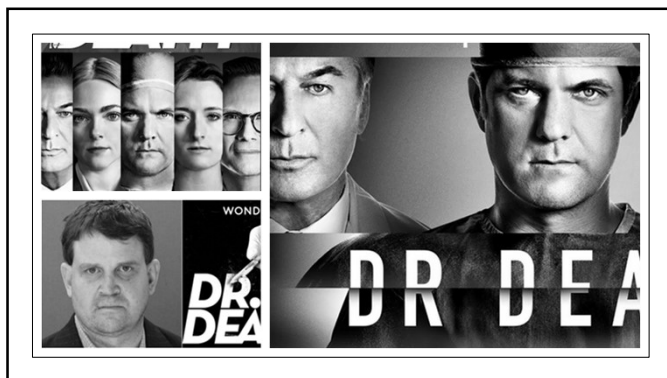
## The Scope of the Problem



- 1999 Institute of Medicine published report “To Err is Human: Building a Safer Health System”
- This report resulted in Federal Funding (50 million in 2000 to the Agency for Healthcare research and Quality) for patient safety initiatives
- Accreditation and reporting standards tightened
- Research on effectiveness of patient safety measures increased

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## Dr. Death

Dec 12, 2018 Dallas' Fifth Court of Appeals affirmed the conviction and sentence to life in prison of Dr. Duntsch, neurosurgeon who intentionally or knowingly caused serious bodily injury to an elderly patient during surgery.

- In 2013 he was charged with criminal negligence using deadly weapons: his hands, surgical tools and a pedicle screw
- Key to the prosecutions case was a rambling email Duntsch sent to a girlfriend where he called himself a “cold-blooded killer”

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## 1999 Institute of Medicine Report

### “To Err Is Human”

- Building a Safer Health System
- At least 44,000 people and as many as 98,000 people, die in hospitals each year as a result of preventable medical errors
- That is more than die from motor vehicle accidents, breast cancer and AIDS

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## 1999 Institute of Medicine Report

### Medical Errors (as defined in this report):

- 1) Error of Execution: The failure of a planned action to be completed as intended
- 2) Error of Planning: The use of a wrong plan to achieve an aim

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## 1999 Institute of Medicine Report

Medical Errors (as defined in this report):

- **Sentinel Events** : Medical errors, “adverse events” which, in retrospect, are considered preventable, those which signal a need for immediate investigation

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## 1999 Institute of Medicine Report

### Sentinel Events:

- An unexpected occurrence involving death or serious physical (loss of limb or function) or psychological injury, or the risk thereof, the latter phrase including the recognition of a variation in process when an unanticipated occurrence carries the risk of serious outcome

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## 1999 Institute of Medicine Report

### Sentinel Events:

- Example: The death of a patient who underwent a successful surgical procedure but died from pneumonia acquired during the postoperative period

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## 1999 Institute of Medicine Report

### Medical Errors

- |                          |  |
|--------------------------|--|
| 1) Adverse drug events   | 6) Restraint-related injuries or death |
| 2) Improper transfusions | 7) Falls                               |
| 3) Surgical injuries     | 8) Burns                               |
| 4) Wrong site surgeries  | 9) Pressure Ulcers                     |
| 5) Suicides              | 10) Mistaken patient identities        |

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## 10 most common sentinel events of 2017

Megan Knowles • Thursday, July 5th, 2018 Print | Email

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Unintended retention of a foreign body was the most frequently reported sentinel event for 2017, according to a recent report by The Joint Commission.

The Joint Commission defines a sentinel event as a patient safety event that results in death, permanent harm, severe temporary harm or intervention required to sustain life. The organization requires hospitals to conduct a root-cause analysis after a sentinel event occurs.

In March 2018, The Joint Commission updated its sentinel event statistics for 2017. The organization reviewed 805 reports of sentinel events reported during the 2016-17 calendar year.

Here are the 10 most frequently reported sentinel events for 2017, according to The Joint Commission:

1. Unintended retention of a foreign body — 116 reported
2. Fall — 114
3. Wrong-patient, wrong-site, wrong-procedure — 95
4. Suicide — 89
5. Delay in treatment — 66
6. Other unanticipated event, such as asphyxiation, burn, choking on food, drowning or being found unresponsive — 60
7. Criminal event — 37
8. Medication error — 32
9. Operative/postoperative complication — 19
10. Self-inflicted injury — 18

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## 1999 Institute of Medicine Report

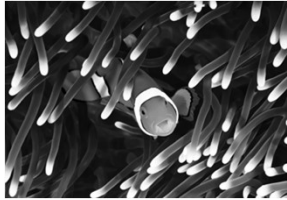
### High Error Rates Most Common In:

- Intensive Care Units
- Operating Rooms
- Emergency Departments

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## Barriers to Reporting Errors:

STATUTE 395.0197: WHEN REPORTING MEDICAL ERRORS IS REQUIRED

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## Even in Optometry

❖ Emergency patient with decreased vision and dilated pupil as a result of using husbands old meds (Atropine) from treatment of his iritis for her dry eye

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## 1999 Institute of Medicine Report

### The Cost of Medical Errors:

Estimated between \$17 and \$29 Billion per year including hospital care and...

- 1) Expense of additional care
- 2) Lost Income
- 3) Lost Productivity
- 4) Disability

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## 1999 Institute of Medicine Report

### Cause of Errors:

- Decentralized and fragmentation of the health care delivery system
- Multiple Providers in different settings, none of whom has access to complete information
- Medical Liability system that impedes efforts to uncover and learn from errors

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## 1999 Institute of Medicine Report

### Cause of Errors:

- Third party purchasers of health care provide little financial incentive for health care organizations and providers to improve safety and quality
- Not bad Doctors
- Faulty Systems
- Faulty Processes and Conditions that lead people to make mistakes or fail to prevent them

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## 1999 Institute of Medicine Report

### Causes of Errors:

- Example: Stocking patient care units in hospitals with certain full-strength drugs, even though they are toxic unless diluted, has resulted in deadly mistakes

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Dennis Quaid



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## 1999 Institute of Medicine Report

### What must be done:

- Design health systems at all levels to make it harder for people to do something wrong and easier for them to do it right
- Be vigilant
- Hold people accountable for their actions
- Do not blame the individual but the system and then fix it

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## 1999 Institute of Medicine Report

### What must be done:

- Establish a national focus to create leadership, research, tools and protocols to enhance the knowledge base about safety
- Identify and learn from errors by establishing a nationwide public mandatory reporting system

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## 1999 Institute of Medicine Report

### What must be done:

- Raise performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of healthcare
- Implementing safety systems in health care organizations to ensure safe practices at the delivery level

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## Then What Happened?


- 1) Federal funding for patient safety initiatives increased
- 2) Accreditation and reporting standards tightened
- 3) Research on effectiveness of patient safety measures increased
- 4) The Joint Commission in 2002 created National Safety Goals and began enforcing these new standards by shifting from preannounced site inspections to unannounced visits

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## Then What Happened?

- 5) The National Quality Forum (NQF) released its initial list of Serious Reportable Events (SREs) updated in 2011
  - These errors are also called “never events”
  - More than 400,000 Medicare “never events” occurred in the U.S. in 2008, est. cost of \$3.7 billion

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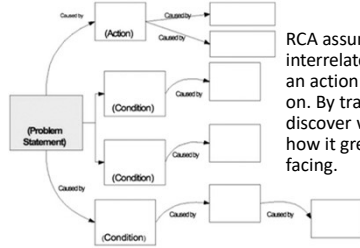


## Root Cause Analysis (RCA)

- Popular and often used technique that helps people answer the question of why the problem occurred in the first place.
- It seeks to identify the origin of a problem using a specific set of steps, with associated tools, to find the primary cause of the problem, so that you can:
  - 1) Determine what happened.
  - 2) Determine why it happened.
  - 3) Figure out what to do to reduce the likelihood that it will happen again.

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RCA assumes that systems and events are interrelated. An action in one area triggers an action in another, and another, and so on. By tracing back these actions, you can discover where the problem started and how it grew into the symptom you're now facing.

Gano D. Apollo root cause analysis: a new way of thinking. 1. Yakima: Apollonian Publications; 1999.

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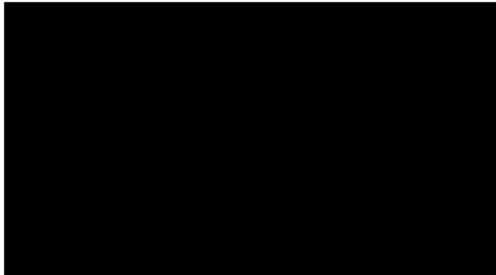
## 3 Basic Types of Causes of Errors

- Physical causes** – Tangible, material items failed in some way (for example, a car's brakes stopped working).
- Human causes** – People did something wrong or did not do something that was needed. Human causes typically lead to physical causes (for example, no one filled the brake fluid, which led to the brakes failing).
- Organizational causes** – A system, process, or policy that people use to make decisions or do their work is faulty (for example, no one person was responsible for vehicle maintenance, and everyone assumed someone else had filled the brake fluid).

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## The 5 Why's



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## 5 Steps to RCA



Define	Define the problem
Collect	Collect the data
Identify	Identify possible causal factors
Identify	Identify Root Cause
Recommend & Implement	Recommend & Implement solutions

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## Checklist Manifesto

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Dr. Atul Gawande

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### The Checklist:

*"A strategy for overcoming failure, one that builds on experience and takes advantage of the knowledge people have but somehow also makes up for our inevitable human inadequacies."*

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### How do Checklists Work?

*"They remind us of the minimum necessary steps and make them explicit."*

*"They not only offer the possibility of verification but also instill a kind of discipline of higher performance."*




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### Where did The Checklist begin?

-  October 30, 1935 at Wright Air Field in Dayton, Ohio
-  U.S. Army Air Corps flight competition for new military long-range bomber
-  The Boeing Model 299 could fly faster and farther and carry 5x the number of bombs the Army requested
-  Best pilot Major Player P. Hill
-  Crashed after 300 feet in the air

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### Next

-  Boeing lost the competition and almost went bankrupt
-  Boeing investigated and found the complicated nature of the plane caused pilot error (new locking mechanism not released)
-  A group of pilots developed a pilot's checklist

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## And Then



The Model 299 went on to be flown 1.8 million miles with no further accidents



The army ordered 13,000 and called them the B-17



The B-17 was used to gain a decisive advantage in World War II



Ultimately enabled the U.S. to win the war

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## Who Used A Checklist?

1960's Nurses began to use Checklist to record Vital Signs in hospitals

2001 Dr. Peter Pronovost a critical care specialist at Johns Hopkins Hospital developed a checklist for putting in a central line

He tracked the results for a year and found the infection rate went from 11% to 0.

After 15 months found that the checklist had prevented 43 infections and 8 deaths and saved 2 Million in costs

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## Who Used A Checklist

Michigan Health and Hospital Association asked Provost to help them initiate this checklist

2003

Dr. Gawande was asked by World Health Organization to help develop a surgical checklist

Late 2006

2006

The findings were published

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## Who Was Involved?

International team of researchers working with the "WHO Safe Surgery Saves Lives" developed and tested the surgical safety checklist in 8 hospitals in 8 countries

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## Prevention of Surgical Errors

- The Study involved 4,000 patients in diverse populations and variety of economic conditions
- Mortality rates were reduced by half and complications by 1/3<sup>rd</sup> after the checklist was implemented

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## Best Practices in Medical: by Solving our Patients Problems

Protocols & Checklists  
Create:

1. Consistency
2. Efficiency
3. Accuracy
4. Empathy

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## CMS Rules regarding Medical Errors

- 2007 Medicaid funds will be denied for treatment of preventable errors, injuries and infections
- 2011 expansion of rule prohibits use of Federal Medicaid funds to pay doctors and hospitals for treatment of services related to **"never events"**
- The 2011 changes also say the bills cannot be transferred to the beneficiary
- States were given until July of 2012 to implement this new CMS policy

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## What Are "Never Events"?

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage 3 and 4 pressure ulcers
- Falls and Trauma
- Fractures and dislocations
- Intracranial injuries
- Burns
- Electric Shock
- Catheter-associated urinary tract infections
- Vascular catheter-associated infection
- Crushing injuries

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## "Never Events"

### Manifestations of poor glycemic control:

1. Diabetic Ketoacidosis
2. Nonketoacidosis
3. Nonketotic Hyperosmolar coma
4. Hypoglycemic coma
5. Secondary diabetes with ketoacidosis
6. Secondary diabetes with hyperosmolarity

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## "Never Events"

### Surgical site infection following:

1. Coronary artery bypass graft (CABG) – Mediastinitis
2. Bariatric Surgery
3. Laparoscopic gastric bypass
4. Gastroenterostomy
5. Laparoscopic gastric restrictive surgery
6. Orthopedic procedures
7. Spine
8. Neck
9. Shoulder
10. Elbow

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## "Never Events"

- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement – with pediatric and obstetric exceptions
- Surgery on the wrong patient, wrong surgery on a patient, and wrong-site surgery

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<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HAC/Hospital-Acquired-Conditions>

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## CMS rule on “Never Events”

- The new Medicaid policy also allows states the option of expanding the nonpayment policy to nursing homes and other healthcare settings and to add other types of never events
- It is expected that this policy will improve pt care and save an est. \$35billion between 2011 and 2017
  - (Kaiser Health News, 2011)

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## The Scope of the Problem

2001 Florida Legislature passed the law regarding Medical Errors required course

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## Florida Medical Errors Requirement

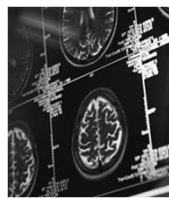
Statute 64B13-5.001

- "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."

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## 2010 Study from Department of Health and Human Services



1 in 7 Medicare recipients is harmed by:

- Hospital acquired infections
- Poorly administered medication
- Faulty bedside care during in-hospital medical care
- Combined these account for an estimated 180,000 deaths annually
- ***This represents only 0.58% of all annual hospital admissions (which are in excess of 33 million) per year***

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## The Scope of the Problem

- 1 in 3 people who enter a U.S. hospital will experience an adverse event (an injury or illness from a medical error) (Classen et al., 2011)
- Every week in the U.S. there are 40 wrong-site or wrong-patient surgeries performed (Dentzer, 2011)
- In 2008, nearly 2 million people were harmed by adverse drug events (medication side effects or the wrong type or wrong dose of medication) (AHRQ, 2011a)
- In Florida, 168 patients died in 2010 and another 386 were victims of serious mishaps, including medication errors, wrong-site surgeries, and foreign objects such as tools or sponges left behind after operations (Sun Sentinel, 2011)

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## Research on Why Humans Make Errors

### 1. Active Errors:

- Tend to occur at the level of the individual, and their effects are felt almost immediately
  - (Reason, 1990)

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## There are Two Types of Errors

### 2. Latent Errors:

- These are more likely to be beyond the control of the individual, that is, they are errors in system or process design, faulty installation or maintenance of equipment, or ineffective organizational structure.
- The effects of these errors may not appear for months or even years, but they can lead to a cascade of active errors, ending in catastrophe

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## Factors that Increase the Risk of Errors

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## Factors that Increase the Risk of Errors

- Fatigue
- Alcohol and Drugs
- Illness
- Inattention or Distraction
- Emotional States
- Unfamiliar situations or problems
- Equipment Design flaws
- Inadequate labeling or instructions

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## Factors that Increase the Risk of Errors

-  **Communication problems between providers and staff is one of the most common reasons for error**
-  **Hard to read handwriting**
-  **EHR systems improperly set up or functioning as well as unfamiliarity with them by the personnel**

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## Reduction of Medical Errors

1. Recall
2. No-Show
3. Technology
4. Communication



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## Mayo Clinic & American College of Surgeons Study

ORIGINAL ARTICLES

### Burnout and Medical Errors Among American Surgeons

Tait D. Shanafelt, MD,\* Charles M. Babik, MD,† Gerald Buckhagen, MD,‡§ Tim Russell, MD,† Lette Eberly, MD,\* Daniel Sessler, BA,\* Paul Colwell, MD,† Paul J. Novotny, MS,\* Jeff Sloan, PhD,\* and Julie Freckling, MD,†¶

**Objective:** To evaluate the relationship between burnout and perceived major medical errors among American surgeons.

**Background:** Despite efforts to improve patient safety, medical errors by physicians remain a serious cause of morbidity and mortality.

**Methods:** Members of the American College of Surgeons were sent an anonymous, cross-sectional survey in June 2008. The survey included self-reporting of major medical errors, a validated burnout questionnaire, and standardized assessments of burnout and quality of life (QOL). Results of 760 participating surgeons, 50% of whom reported having had made a major medical error in the last 12 months. Over 70% of surgeons attributed the error to individual rather than system-level factors. Burnout was

Although a variety of definitions of "medical error" or "medical malpractice" in the literature exist, with potential for confusion, the present study used the following definition: "A medical error is a preventable adverse event, which is an avoidable risk of error and negligent practice."<sup>1</sup> It is also important to note that, even when a patient or no direct harm to patients occurred, the risk of "being prosecuted" reportedly >7000 operations at one academic medical center suggested the

From the \*Department of Internal Medicine, Divisions of Hematology (T.D.S.) and Primary Care Internal Medicine (L.D.), Mayo Clinic, Rochester, MN; †American College of Surgeons, Chicago, IL; ‡Department of Surgery, Johns Hopkins University, Baltimore, MD; and §Winchester Surgical Clinic, Winchester, VA.

Reprints: Tait D. Shanafelt, MD, Mayo Clinic, Department of Internal Medicine, Division of Hematology, 200 First Street, Rochester, MN 55905. E-mail: shanafelt.tait@mayo.edu.


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DOI: 10.1097/SLA.0b013e3181b6ab03

Annals of Surgery • Volume XXX, Number X, XXX 2009

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### Mayo Clinic & American College of Surgeons Study

- 8.9% of participating U.S. surgeons reported the belief that they've made a major medical error within last 3 months
- 1.5% believe their error resulted in a patient's death
- Suicide ideation doubles in that 3-month window, depression triples amongst these physicians
- Studies also find a strong link with burnout in these physicians

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### Mayo Clinic & American College of Surgeons Study



- 70% of surgeons attribute their major medical error to:
  - Lapse in judgement
  - Stress/burnout
  - Lapse in concentration
  - Fatigue
- Strategies to reduce emotional distress and burnout are the most effective at reducing medical errors

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### NEJM Catalyst July 21, 2016 “Getting Back to Medicine as a Community”

- Key Drivers Preventing Burnout:
  - Finding meaning that from our work
  - What are the contributors to that meaning, and what are the things that maybe erode that meaning?
- COMPASS groups (Colleagues Meeting to Promote and Sustain Satisfaction)
- 6-10 physicians meet every other week for an hour to discuss a short curriculum intended to reduce isolation and engage with peers and colleagues with topics relevant to their experience, relevant to well-being, with an idea of focusing on that meaning driver of burnout
- 97% approval score

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### RAND Study


Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy

The RAND researchers:  
Mark W. Freiberg • Peggy G. Chen • Kristin A. Van Buren • Frances M. Austin  
Chou-Ping • John F. Calman • Steven M. Weller • Emma Pichler  
Dennis D. Dunlop • Robert M. Brunt

Finally, our finding that physicians are more satisfied when they perceive that they are meeting their patients' needs by delivering high-quality care and dissatisfied when they perceive barriers to delivering high-quality care suggests an additional way of thinking about the relationship between physician professional satisfaction and the quality of care that patients receive. Aside from viewing better patient care as a potential consequence of better physician professional satisfaction, it may be useful to think of physician dissatisfaction, when it is caused by perceived quality problems, as an indicator of potential delivery system dysfunction.

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### Hot off the Press (2015):

3<sup>rd</sup> in this series by Institutes of Medicine:  
“Improving Diagnosis in Health Care”

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1. To Err is Human: Building a Safer Health System
2. Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century  
-This report defines quality care broadly and sets out a vision to close the gap between quality care and what care patients actually receive
3. Improving Diagnosis in Health Care

### Institute of Medicine: Quality Chasm Series

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## Errors in Diagnosis

"Improving Diagnosis in Health Care"

- 473 pages outlining errors in diagnosis and the committee's recommendations for improvement

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## Data regarding Errors in Diagnosis

- 5% of U.S. adults who seek outpatient care each year experience a diagnostic error
- Postmortem exam research spanning decades has shown diagnostic errors contribute to approximately 10% of deaths
- Medical record review suggest diagnostic errors account for 6 - 17% of hospital adverse events.



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## Errors in Diagnosis

- Diagnostic errors are the leading type of paid medical malpractice claims
- Diagnostic errors are almost twice as likely to have resulted in the patient's death compared to other claims
- The committee concluded that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences.
- The committee concluded that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences

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## Errors in Diagnosis

Poor attention has been given because:

- Data is sparse
- Few reliable measures exist
- Often error found only in retrospect (few autopsies in US)

Unique because patients are central to the solution

Diagnosis is a collaborative effort

- Video of Dallas hospital misdiagnosing Ebola

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### COMMENTARY

#### Being a Patient Is Still Hazardous to Your Health

George D. Lundberg, MD

June 28, 2021

How safe is it to be a patient in the United States today? Compared with what? Being a patient in another country? It depends on the country. Compared with not being a patient? Not very safe at all.

Being a patient can be hazardous to your health. I first recognized that fact at the autopsy table even before medical school. A young child in Tuscaloosa, Alabama, dead after a tonsillectomy/adenoidectomy in 1953, asphyxiated on her own blood. As a pathology resident in San Antonio from 1958 to 1962, I autopsied many patients with cancer who were killed by their chemotherapy treatment, not by their cancer.

So, are we more safe? I don't know. Have we created the necessary "culture of safety"? I would have to answer with a resounding NO.

As long as the medical (meaning, non-forensic) autopsy remains vanishingly rare in most American hospitals, not only will we not know, but worse, the culture does not want to know. My question to the hospital industry has always been, "How do you evaluate the quality of care given to your sickest patients, the ones who die?" Until the instant answer is autopsy and medical mortality review, there will be no culture of safety.

And for the non-dead, imagine consulting an American physician today with the principal complaint of pain, and almost always walking out of the doctor's office without a prescription for some opioid. Any exposure to an opioid begins an upward likelihood of addiction. While we have made major progress since its catastrophic peak in 2012, in 2019 there were still 46 opioid prescriptions per 100 Americans, with huge geographic variance. Far too many. Unsafe at any dose.

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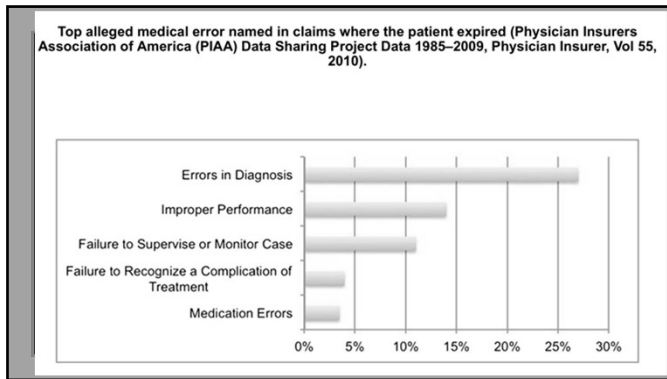
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## Errors in Diagnosis: Gaining Broad Public Attention



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## Errors in Diagnosis

Most commonly reported system failure resulting in errors of diagnosis:

- Inadequate coordination of care and teamwork
  - (Singh et al., 2010)

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## Hosts of Flip or Flop (Before Jan 2017)



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## Hosts of Flip or Flop



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## Errors in Diagnosis

### Report Highlights:

- We need training in clinical reasoning, teamwork and communication
- Improvements needed in HIT
- Development of better data collection processes to monitor errors is needed
- Development of organizational culture that values open discussion and feedback on diagnostic performance needed.

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## Errors in Diagnosis

Most frequently found in the testing phase:

- Failure to order labs
- Failure to report lab results
- Failure to follow up with lab results

Clinical Assessment

History taking

Physical exam

Referral or consultation errors or delays



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## "The Incidence of Diagnostic Error in Medicine" by Mark L. Graber

*The most fundamental principle of performance improvement is that "You can't fix what you don't measure".*

*Efforts to begin addressing the diagnostic error must begin with measurement. In no area of patient safety is this need more acute than in trying to identify the true incidence of DE and the harm associated with them.*



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## How to Identify Errors in Diagnosis

1. Use trigger tools
2. Encourage and facilitate voluntary prompted reports from patients
3. Encourage and facilitate error reporting from physicians

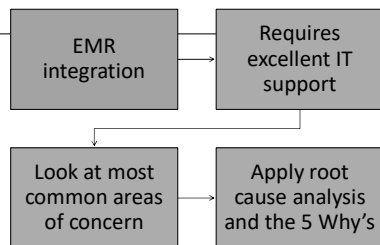


Qualitysafety.bmj.com

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## How to Prevent Errors in Optometry



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## Most Common Malpractice Cases in Optometry

- 1) Failure to diagnose Retinal Detachment
- 2) Failure to detect Glaucoma
- 3) Failure to detect Tumor
- 4) Failure to warn of seriousness of the disease Glaucoma and AMD



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## Technology & Integration



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## What Types of Screening Tests:

- OHTS: 84% of Disc Hemes not seen until photos  
 Pupils: Asymmetry diagnostic for glaucoma<sup>1</sup>  
 Fields: Screening allows early detection  
 OCT: Decrease prevalence 38% in at risk population



Photos



Visual Field



OCT



Pupils

<sup>1</sup> Stable HAPDs that are difficult to assess with traditional methods have been shown to be clinically significant in glaucoma suspects<sup>12</sup>

<sup>12</sup> Taylor AJ et al. IOVG 2014

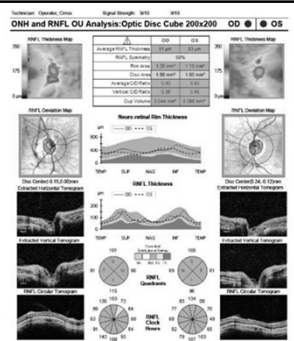
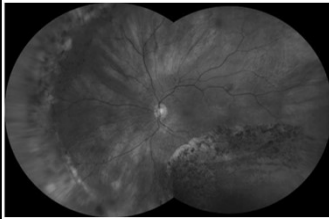
<sup>13</sup> Taylor AJ et al. IOVG 2014

<sup>14</sup> A recent study by Bunting and colleagues used a sophisticated model to estimate both clinical impact and cost while using spectral-domain OCT to identify glaucoma suspects. Incorporating this screening would decrease the prevalence of glaucoma from 75% to 38%, reduce the prevalence of severe vision loss from 27.7% to 23.7%, and double the diagnosis of mild visual field loss from 9.2% to 18.7%.

<sup>15</sup> Bunting GS, Nguyen A, Yang L et al. A comparative effectiveness analysis of visual field outcomes after prolonged glaucoma screening using SD-OCT in African American communities. Invest Ophthalmol Vis Sci. 2014;55(24):8491-8500.

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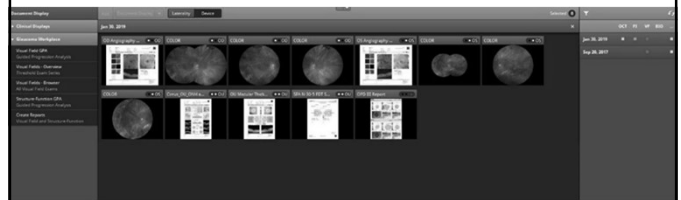
## Screening Tests



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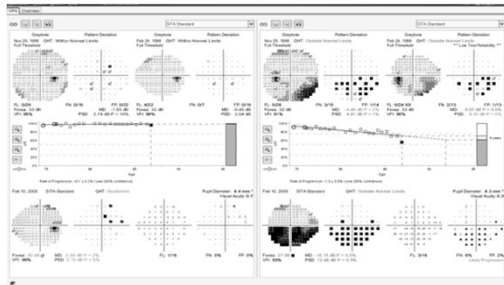
## Review Measurements with Patients



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## Interactive Guided Progression Analysis (GPA)

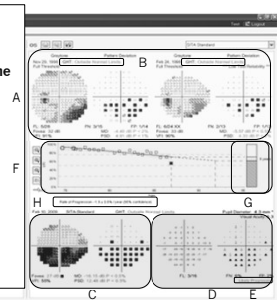


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## Interactive Guided Progression Analysis (GPA)

- A - Baseline visual fields
- B - Glaucoma Hemifield Test
- C - Current visual field
- D - GPA / Deviation from Baseline (Event Analysis)
- E - GPA Alert
- F - VFI plot: Visual Field Index Display of the Trend (3-5yrs) under current conditions (Trend Analysis)
- G - VFI Bar: Remaining useful vision
- H - Rate of Progression / Significance



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## Medication Errors



In any given week **four** out of every **five** U.S. adults will use prescription medicines, over the counter drugs, or dietary supplements of some sort, and nearly one third of all adults will take five or more different medications

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## Medication Errors

Medication Error Defined:

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer.

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## Even in Optometry

- ❖ Post Op Pt: "Doc I am not happy, eye is still red, itchy, crusty"
- ❖ Asked for the drops
- ❖ Oh yeah, I have bugs in my drops
- ❖ I told you we needed an exterminator

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## Medication Errors

Such events may be related to professional practice, healthcare products, procedures, and systems including:

- Prescribing
- Dispensing
- Order communication
- Distribution
- Product labeling
- Administration
- Packaging
- Education
- Nomenclature
- Monitoring and Use
- Compounding

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## Medication Errors

Wait! I can't read it, and no one speaks my language

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## Medication Errors

Considered ADEs

They most often occur in prescribing and administering and include:

- Omission errors
- Improper dose/quantity errors
- Unauthorized drug errors

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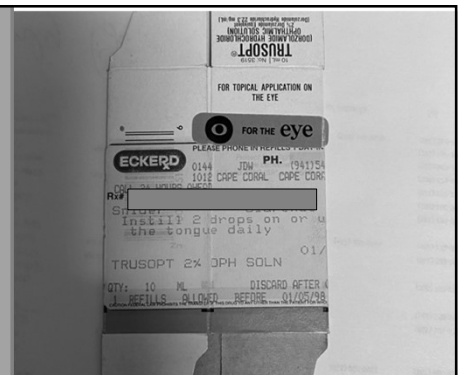
## Medication Errors

- Omission Errors:
  - Failure to administer an ordered medication dose.
  - Fatal medication errors are most common with anticoagulants and antibiotics
- Improper dose/quantity Errors:
  - Any medication dose, strength, or quantity that differs from prescribed

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## What is Wrong With This Rx?



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## Medication Errors

- Unauthorized Drug errors:
  - The medication dispensed and/or administered was not authorized by the prescriber
  - This category includes dispensing or administering the wrong drug

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100 Lomb Street  
London, NE 10020

Fales & Fales, P.A.

HOME ABOUT FIRM PRACTICE AREAS RESULTS EMPLOY REVIEWS BLOG

**Why Does It Happen?**

Most dispensing mistakes are due to human error. Frequently cited causes include:

- Pressure to work quickly.** With a long line of customers at the pharmacy counter, pharmacists often report that they feel pressured to work fast so that everyone can receive their medication in a timely manner.
- Human miscommunication.** There have been cases where patients received the wrong prescription, the medication intended for someone else with the same first and last name, larger pharmacies with a high volume of customers are especially prone to this error.
- Computer Coding Errors.** Some pharmacy dispensing errors are due to inaccurate computer coding and making wrong selections on electronic medical records.

**What's the Bottom Line?**

Taking the wrong prescription can be a frightening experience. Depending on the medication and the dosage, side effects can include nausea and the threatening danger. If you become ill as a result of a pharmacy error, seek medical care immediately. There is potential for much evidence as you can, including the bottle, drug label, drug inventory, and the original prescription log.

If you or a loved one has been injured because your pharmacist dispensed a medication that caused harm instead of healing, contact Fales & Fales, P.A. Prescription drug errors can lead to serious illness, disability, and even wrongful death. We have successfully handled pharmacy prescription error cases and will seek the damages you need to recover lost income, current and future medical costs, and your other losses.

## Can I Sue for Being Given the Wrong Drug?

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## Medication Errors

When all types of medication errors other than errors of omission are taken into account, a hospital patient can expect on average to be subjected to more than one medication error each day

The error rate is even higher in long-term care facilities

- (IOM Brief July 2006)

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**ISMP**  
International Society for Medication Management

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**Start the New Year Off Right by Preventing These Top 10 Medication Errors and Hazards**

January 1, 2018

Referring to ISMP and the 50th anniversary of the Institute of Medicine report, "To Err is Human," ISMP has identified the Top 10 Medication Errors and Hazards. Table 1 lists these errors and the 2017 ISMP medication safety survey data. We hope this information will help you identify and prevent medication errors that have caused the most serious consequences to patients. Although these errors have been identified and discussed, all medication errors can be prevented. Some have been corrected and can be avoided in a structured safety system and practice change. The bottom line is that medication errors are preventable and the resulting harm if you have not already taken action to mitigate the risk. Links to additional content on medication safety and patient safety are provided along with the descriptions below. Please take a moment to sign into your ISMP account for access. We hope that knowing about these errors and hazards will help your 2018 medication safety improvement plan!

A one-year subscription grants you access to even more information!

[Subscribe Now](#)

**Table 1. Top 10 Medication Errors and Hazards**

1. Selecting the wrong medication after entering the first few letters of the drug name
2. Daily instead of weekly oral methotrexate for non-oncologic conditions
3. Errors and hazards due to look-alike labeling of manufacturers' products
4. Misheard drug orders/recommendations during verbal/telephone communication
5. Unsafe "overrides" with automated dispensing cabinets
6. Unsafe practices associated with adult IV push medications
7. Wrong route (intraspinal injection) errors with tetracycline acid
8. Unsafe labeling of prefilled syringes and infusions by S03B compounds
9. Unsafe use of syringes for vinca alkaloids
10. 1,000-fold overdoses with zinc

## 2020 Top Medication Errors

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## Even in Optometry

❖Pt developed Glaucoma from use of steroid cream daily on upper eyelid for two years

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## Even in Optometry

❖Pt's iritis not improving after treatment for 2 days with Homatropine and Predforte (in wrong box)

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## How to Prevent Medication Errors

### Six Rights:

1. Right patient
2. Right drug
3. Right dose
4. Right dosage form
5. Right route
6. Right time

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"As a former nurse, trauma surgeon, and public health director [I realized] there was a wall between us and the people we were trying to serve.

Health care professionals do not recognize that patients do not understand the health information we are trying to communicate.

We must close the gap between what health care professionals know and what the rest of America understands."



**Dr. Richard Carmona,**  
**Former U.S. Surgeon General**

- mentioned health literacy in 200 of last 260 speeches

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## Health Literacy:

### Hidden Barriers and Practical Strategies

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## Hidden Barriers to Communicating with Patients

### Clients/Patients:

Education/Literacy/Language

### Health Literacy: The capacity to

- Obtain, process, understand basic health information and services
- Make appropriate health care decisions (act on information)
- Access/navigate health care system

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## Using a Health Literacy Universal Precautions Approach

### Structuring the delivery of care as if everyone may have limited health literacy

- You cannot tell by looking
- Higher literacy skills ≠ understanding
- Anxiety can reduce ability to manage health information
- Everyone benefits from clear communications

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## National Assessment of Adult Literacy

- National assessment of health literacy skills of US adults
- Assessed both reading and math skills
- Focused on health-related materials and tasks
- 36% of adults were identified as having serious limitations in health literacy skills

ies  
The Health Literacy of  
America's Adults  
Results From the 2003  
National Assessment  
of Adult Literacy



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## IOM Report on Health Literacy

- Health information is unnecessarily complex
- Clinicians need health literacy training

**Healthy People 2020** Improve health communication/health literacy

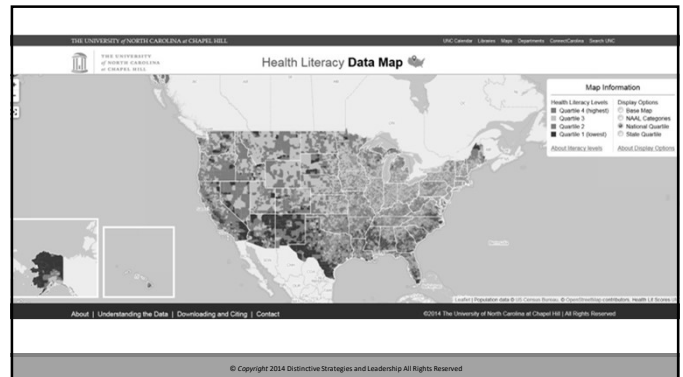
### Joint Commission (1993)

- Patients must be given information they understand



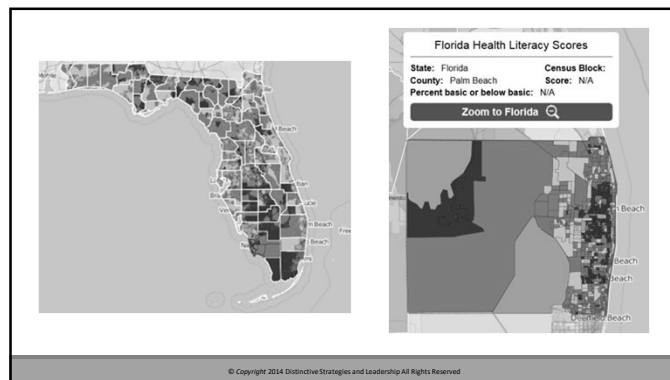
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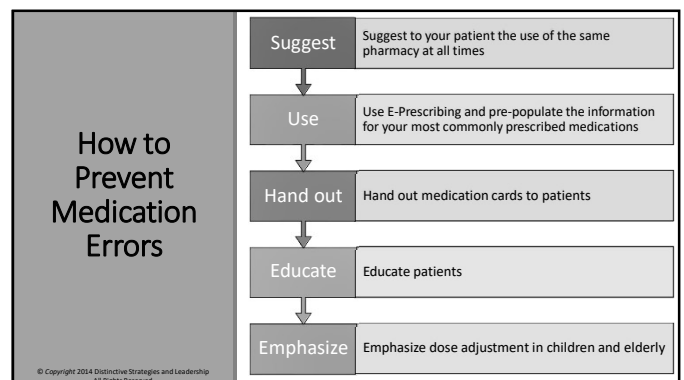
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## Drop Instructions Handout

**DROP INSTRUCTIONS**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

*Please read these instructions carefully and follow the directions for use of your medication.*

**Alphagan**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

**Betoptic**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

**Timolol**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

**Atenol**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

**Timolol**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

**Solimedin**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

**Caripipin**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

**Caripipin**  
Use one drop in \_\_\_\_\_ eye(s) \_\_\_\_\_ times.

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## Patient Education Handout

# GLAUCOMA

**RECOMMENDED TREATMENT:**

• Use Proper Use Drop Instructions Handout

Other Prescription Medication:

• Patient Refused for Surgery

**NEXT APPOINTMENT:**

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Location: \_\_\_\_\_

Patient Refused to: \_\_\_\_\_

*\*Failure to adhere to prescribed treatment and follow up care can result in vision loss or even blindness.*

**GLAUCOMA**

**HOW DO I KNOW IF I HAVE GLAUCOMA?**

Glaucoma is a group of eye diseases that can cause blindness. It is often called the "silent thief of sight" because it usually has no symptoms. The only way to know if you have glaucoma is to have a comprehensive eye exam. Your doctor will check your vision, measure the pressure in your eyes, and look at the optic nerve and the back of your eye. If you have glaucoma, your doctor will prescribe eye drops or surgery to lower your eye pressure and prevent further vision loss.

**OPEN ANGLE GLAUCOMA**

Open angle glaucoma is the most common type of glaucoma. It develops slowly and usually has no symptoms. The only way to know if you have open angle glaucoma is to have a comprehensive eye exam. Your doctor will check your vision, measure the pressure in your eyes, and look at the optic nerve and the back of your eye. If you have open angle glaucoma, your doctor will prescribe eye drops or surgery to lower your eye pressure and prevent further vision loss.

**CLOSED ANGLE GLAUCOMA**

Closed angle glaucoma is a less common type of glaucoma. It develops more quickly than open angle glaucoma and can cause symptoms such as eye pain, redness, and blurred vision. The only way to know if you have closed angle glaucoma is to have a comprehensive eye exam. Your doctor will check your vision, measure the pressure in your eyes, and look at the optic nerve and the back of your eye. If you have closed angle glaucoma, your doctor will prescribe eye drops or surgery to lower your eye pressure and prevent further vision loss.

**WHAT MUST I DO NOW THAT I HAVE BEEN DIAGNOSED?**


**PREVENTION:**

- Your doctor will prescribe eye drops to lower your eye pressure.
- Research is underway for gene therapy. There is hope that gene therapy will be a breakthrough in the treatment of glaucoma.
- If you have glaucoma, you should have a comprehensive eye exam every year. Your doctor will check your vision, measure the pressure in your eyes, and look at the optic nerve and the back of your eye. If you have glaucoma, your doctor will prescribe eye drops or surgery to lower your eye pressure and prevent further vision loss.
- If you have glaucoma, you should have a comprehensive eye exam every year. Your doctor will check your vision, measure the pressure in your eyes, and look at the optic nerve and the back of your eye. If you have glaucoma, your doctor will prescribe eye drops or surgery to lower your eye pressure and prevent further vision loss.

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## Glaucoma Patient Care Agreement

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The image shows a document titled "Glaucoma Patient Care Agreement" with a header for "Distinctive Strategies and Leadership LLC". The document includes a "Dear Patient" section, a "TREATMENT" section with 9 numbered points, and a signature line at the bottom.

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## Prevention

- Remember that Falls are considered a medical error
- Assess each patient for risk of falls
  - i.e. Over 65 y.o. (1/3 of these pts suffer falls each year)
- Assess your office daily for risk for patients falling including walkways and entries
- Evaluate chairs for stability and risk for falls

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## Malpractice and How to Avoid it

1. Put patients needs over all else (insurance and doctor needs)
2. Do not make the findings fit the diagnosis
3. Insist that everything make sense
4. Do not disregard patient complaints
5. Check drug facts and print medical rx's or e-prescribe

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## Malpractice and How to Avoid it

6. Document!
7. Dilate!
8. Fields!
9. Be consistent in data collection and examination
10. Be complete in data collection and examination

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The image shows three small photographs: a pile of white contact lenses, a person sitting on a bench outdoors, and a close-up of a contact lens on a finger.

## Cases in Optometry

- ❖ Brain Aneurysm
- ❖ Contact lens patient and Retinal Detachment
- ❖ Red eye and Red eye remover
- ❖ Graves Disease

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## Don't forget

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Monitor Corneal Infiltrates

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Follow up after starting Steroid drops

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Don't miss Giant Cell Arteritis or result could be blindness

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Optic Atrophy assume tumor

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CN 111 palsy: 20% die within first 48 Hrs.

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Video: Dr.  
Atul  
Gawande

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Thank You!

*APRIL JASPER OD, FAAO*  
*DR@APRILJASPER.COM*

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