Medical Error Prevention for Physicians and Physician Assistants

Presented by:

The Florida Professional Liability Self-Insurance Programs

Disclosure Statement: The Florida Professional Liability Self-Insurance Program has disclosed that they have no relevant financial relationships. No one else in a position to control content has any financial relationships to disclose.

Requirements for Successful Completion:

This CME activity consists of an educational component (slides, audio/online lecture) which is followed by an online post-test. Certificates are awarded upon successful completion (80% proficiency) of the post-test. In order to receive credit, participants must view the presentation in its entirety.

Release Date: 07/01/2020 **Expiration Date:** 06/30/2022

Target Audience: Primary Care Physicians, Specialty Physicians, Physician Assistants, and Residents.

Learning Objectives: As a result of the participation in this activity, participants should be able to:

- 1. Define "medical error" and discuss the multiple factors propelling medical error prevention and patient safety efforts.
- 2. Review Joint Commission and state agency standards, regulations relating to Sentinel/Adverse events, and the processes of Failure Mode and Effect Analysis and Root Cause Analysis.
- 3. Discuss patient safety origins and Joint Commission Patient Safety Goals.

CME Advisory Committee Disclosure:

Conflict of interest information for the CME Advisory Committee members can be found on the following website: https://cme.ufl.edu/disclosure/.

Accreditation: The University of Florida College of Medicine is accredited by the Accreditation Council for continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Credit: The University of Florida College of Medicine designates this enduring material for a maximum of 2 AMA PRA Category 1 Credits[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Contact: If you have any questions please feel free to contact SIPHELP at (352) 273-7006 or at SIPHELP@ad.ufl.edu.

Bibliographic Sources:

- 1. Blanco J, Lewko JH, Gillingham, D. Fallible decisions in management: Learning from errors. Disaster Prevention and Management. 1996;5(2):5-11
- 2. Rooney JJ, Vanden Heuvel LN, Lorenzo DK. Reduce Human Error. Quality Progress. 2002 September;27-36
- 3. Summary of Code 15 Injuries by Outcomes Reported by Hospitals 2011. Agency for Health Care Administration. Florida Center for Health Information and Policy Analysis. Risk Management Patient Safety Program.
- 4. Fatal Falls: Lessons for the Future (2000, July 12). Retrieved September 20, 2010, from The Joint Commission www.jointcommission.org
- 5. Sentinel Events (SE). Comprehensive Accreditation Manual for Hospitals: The Official Handbook. CAMH Refreshed Core (2011 January). Retrieved from The Joint Commission www.jointcomossion.org
- 6. Sentinel Events (SE). Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing. CAMLAB Refreshed Core (2011 January). Retrieved from The Joint Commission www.jointcomossion.org
- 7. Sentinel Events and Root Cause Analysis. Retrieved from The Joint Commission www.jointcomossion.org
- 8. Sentinel Event Data, Root Causes by Event Type 2004-2012. Retrieved from The Joint Commission www.jointcomossion.org/SentinelEventPolicyandProcedures

- 9. Hospital National Patient Safety Goals 2012. Retrieved from The Joint Commission www.jointcomossion.org
- 10. Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year 2010, 2011 and 2012. Retrieved from The Joint Commission www.jointcomossion.org
- 11. Maternal Mortality in the United States: A Human Rights Failure. AHRP, March 2011
- 12. Diagnostic Error in Acute Care. Reprinted article: Pennsylvania Safety Advisory, September 2010
- 13. Has Misdiagnosis of Appendicitis Decreased Over Time? The Journal of the American Medical Association, October 10, 2001.
- 14. Practice Advisory for Preanesthesia Evaluation. Anesthesiology 2002: Amended by ASA House of Delegates on October 15, 2003: 485-493.
- 15. McDonald, C., Hernandez, M.B., Goffman, Y., Suchecki, S., Schreier, W. The five most common misdiagnoses: a metaanalysis of autopsy and malpractice data. The Internet Journal of Family Practice. Volume 7 Number 2 2009.
- 16. Gallegos, A. Communication Failures over diagnostic tests prompting more lawsuits. American Medical News. http://www.ama-assn.org/amednews/2011/11/14/prse1115.htm
- 17. Don't get caught unprepared for ICD-10. American Health Information Management Association 2012
- 18. Bratzler, D.W. and Hunt, D.R. The Surgical Infection Prevention and Surgical care Improvement Projects. National Initiatives to Improve Outcomes for Patients Having Surgery. Clinical Infectious Diseases 2006; 43:322-30
- 19. Pope, J.V. and Edlow, J.A. Avoiding Misdiagnosis in Patients with Neurological Emergencies. Emergency Medicine International doi:10.1155/2012/949275
- 20. New Evidence Supports the Role of Specialization in Reducing Diagnostic Error. PR Newswire Association, June 7, 2011.
- 21. D.L. Hepner, MD. The role of testing in the preoperative evaluation. Cleveland Clinic Journal of Medicine 2009 DOI: 10.3949/ccjm.76.s4.04
- 22. Medical error. Wikipedia, the free encyclopedia. http://en.wikipedia.org/wiki/Medical_errors
- 23. Why Does Misdiagnosis Occur? http://www.rightdiagnosis.com/intor/why.htm
- 24. Sentinel Event Alert: Operative and Post-Operative Complications: Lessons for the Future. Issue 12 February 4, 2000. Retrieved from The Joint Commission www.jointcomossion.org
- 25. Acute abdomen. Wikipedia, the free encyclopedia. http://en.wikipedia.org/wiki/Acute_abdomen
- 26. 9133: Medical Error Prevention and Root Cause Analysis. http://www.netce.com/coursecontent.php?courseid=664
- 27. Anderson, R>E. Delayed Diagnosis of Cancer. The Doctors Company www.thedoctors.com/patientsafety
- 28. Preventing Malpractice Claims Entailing Misdiagnosis of Cancer. Florida Obstetric and Gynecologic Society http://www.flobgyn.org/display.php?n=45
- 29. Greco, R.J. and Ranum, D. Preoperative Pregnancy Evaluation. The ASF Source-Winter/Spring 2012
- 30. Speak Up. The Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery. Retrieved from The Joint Commission www.jointcomossion.org
- 31. Max, J. The Lost Art of the Physical Exam. Yale Medicine, Winter 2009
- 32. Care Without coverage: Too Little, Too Late. Institute of Medicine May 2002
- 33. Ansted, C.J. In the Shadows of Patient Safety-Addressing Diagnostic Errors in Clinical Practice: Heuristics and Cognitive Dispositions to Respond. CME Outfitters, LLC
- 34. Lee, A. The Process of Clinical Diagnosis: Steps to Evaluate and Manage Any Medical Issues. January 18, 2009. http://anthony-lee.suite101.com/the-process-of-clinical-diagnosis-a90627
- 35. Patient Safety Primers: Diagnostic Errors. Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network.
- 36. Zhang, J., Patel, V.L. and Johnson, T.R. Medical Error: Is the Solution Medical or Cognitive? Journal of the American Medical Informatics Association Volume 9 Nov/Dec Supplement 2002.
- 37. Newman-Toker, D.E. and Pronovost P.J. Diagnostic Errors---The Next Frontier for Patient Safety. 2009 American Medical Association. (Reprinted) JAMA, March 11, 2009-Vol 301, No. 10
- 38. Preventive Action: current Loss Trends and Statistics. Quarterly Risk Management Newsletter for Policyholders of FPIC. First Quarter 2011 ~ Vol. 24 No. 1
- 39. Medical Diagnosis. Wikipedia, the free encyclopedia. http://en.wikipedia.org/wiki/Medical Diagnosis
- 40. Trowbridge, R. and Salvador, D. Addressing Diagnostic Errors: An Institutional Approach. A Newsletter From The National Patient Safety Foundation Volume 13: Issue 3 2010
- 41. Access to Health Services Healthy People
- http://www.healthypeople.gov/202/topicsobjectives2020/overview.aspx?topicid=1

- 42. Schiff, G.D. Commentary: Diagnosis Tracking and Health Reform. American Journal of Medical Qual9ty 1994 9: 149. DOI: 10.177/0885713X9400900403
- 43. Joseph Platz, MD; Neil Hyman, MD, FACS: Tracking Intraoperative Complications; Journal of the American College of Surgeons, Volume 215, pages 516-523, October 2012.
- 44. Badger, William J.; Moran, Michael E.; Abrahan, Christa; Yarlagadda, Bharat and Perrotti, Michael: Missed Diagnoses by Urologists Resulting in Malpractice Payment, The Journal of Urology, Volume 178, December 2007.
- 45. Justin R. Lappen, MD: History-Taking and Interview Techniques and the Physicians-Patient Relationship, November 2011.
- 46. Top Cancer Claims in the Data Sharing Project; Inside Medical Liability, Third Quarter 2013
- 47. MacDonald, Owen W., Group Publisher, QuantiaMD: Physician Pwespectives on Preventing diagnostic Errors, QuantiaMD December, 2011.
- 48. Lippman, Helen, MA; Davenport, John, MD, JD: Sued for misdiagnosis? It could happen to you; The Journal of Family Practice | September 2010 | Volume 59, No. 9.
- 49. Schiff, G.D. Minimizing Diagnostic Error: The Importance of Follow-up and Feedback. The American Journal of Medicine, 2008, Volume 121 (5A), S38-S42.
- 50. Schiff, G.D., Kim, S., Abrams, R., Cosby, K., Lambert, B., Elstein, A.S., Hasler, S., Krosnjar, N., Odwazny, R., Wisniewski, M.F. and McNutt, R.A. Diagnosing Diagnosis Errors: Lessons from a Multi-Institutional Collaborative Project. Advances in Patient Safety: Volume 2.