

Prevention of Medical Errors  
*Presentation Outline*  
Florida Society of the American College of Osteopathic Family  
Physicians

*Sunday, August 2, 2009*

**Andrew S. Gross, DO, FACOFP**  
**Miguel Lob, Pharm.D.**

1. Improving our Patient's Care
2. The Florida Required Curriculum: "Two Hour Prevention of Medical Errors" course
3. Investigating Causes of Failures & Mishaps
  - Root Cause Analysis
  - Amendment 7: A New Issue for Peer Review!
4. Error Reduction and Prevention: Evolving to be Better Physicians
  - Continuing Medical Education:
  - Quality Assurance and Peer Review.
  - Managed Care Reviews.
  - Preventing Misunderstandings
  - Prescription Legibility Rule- Florida Statute Section 456.42  
"Legibly Printed or Typed so as to be capable of being understood by the pharmacist filling the prescription."  
Contain name of prescribing practitioner.  
Contain name and strength of drug prescribed.  
Quantity of drug in text and numerical formats.  
Date with month written out in textual letters.  
Signed by the prescribing practitioner on the date written.
5. Joint Commission (JCAHO) is focusing on compliance of avoiding use of "unapproved" abbreviations.
6. Computers Help Reduce Errors!
  - Electronic Medical Records and Hospital Computerized Order and Record Systems are improving quality and reducing errors.
7. Diagnostic Inaccuracies and system failures
  - Timely Screening Exams and Drug Monitoring
  - Follow-up Visits

- Are you aware of results of pending studies that aren't available at your visit or time of hospital rounds?
- Use of Clinical Guidelines.
- Use and Follow-up of Consultants.

8. Creating Safety Systems in the Office

9. Creating Safety Systems in the Hospital

- 2009 National Patient Safety Goals Critical Access Hospital Program Joint Commission goals for patient safety

Are available from the Joint Commission Website:

[http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/09\\_hap\\_npsqs.htm](http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/09_hap_npsqs.htm)

- 2008 National Patient Safety Goals
  - Goal 1) Improve the accuracy of patient identification.
  - Goal 2) Improve effectiveness of communication among caregivers.
  - Goal 3) Improve safety of using medications.
  - Goal 4 – 6) No longer apply.
  - Goal 7) Reduce the risk of health care-associated infections.
  - Goal 8) Accurately and completely reconcile medications across the continuum of care.
  - Goal 9) Reduce the risk of patient harm resulting from falls.
  - Goal 10 – 12) No longer apply.
  - Goal 13) Encourage patients' active involvement in their own care as a patient safety strategy.
  - Goal 14) No longer applies
  - Goal 15) The organization identifies safety risks inherent in its (patient) population. (This requirement only applies to psychiatric hospitals and patients being treated for emotional and behavioral disorders in general hospitals)
  - Goal 16) Improve recognition and response to changes in a patient's condition.

10. Creating Safety Systems in the ECF

11. Florida's Five Most Misdiagnosed Conditions

- a. Wrong Site or Wrong Patient Surgery
- b. Cancers
- c. Cardiac Conditions
- d. Timely Diagnosis of Surgical Complications
- e. Failing to Diagnose Pre-existing Conditions prior to prescribing contraindicated medications.