Medical Errors

Questions

1 Based on the IOM report, deaths resulting from adverse events ranks as the _____ cause of death:
   a. First
   b. Second
   c. Eight
   d. Tenth

2 A tool for prevention of errors that encompasses failure points is called:
   a. Failure Mode and Effects Analysis (FMEA)
   b. Root Cause Analyses (RCA)
   c. Process Analysis
   d. Process Improvement

3 A tool to analyze the cause of errors after an accident has occurred is called:
   a. Failure Mode and Effects Analysis (FMEA)
   b. Root Cause Analyses (RCA)
   c. Process Analysis
   d. Process Improvement

4 Which of the following is a reason that processes/systems fail
   a. Use of automation/computers
   b. Standardization
   c. Complexity
   d. Simplification

5 The model for culture change that best explains the term “Monday morning quarterbacking” is:
   a. Swiss Cheese Model
   b. Blunt and Sharp End
   c. Hindsight Bias
   d. Hazard Analysis

6 The model for culture change that best explains that multiple factors cause an error is:
   a. Swiss Cheese Model
   b. Blunt and Sharp End
   c. Hindsight Bias
   d. Hazard Analysis

7 The model for culture change that focuses on factors other than the caregiver – patient incident is:
   a. Swiss Cheese Model
   b. Blunt and Sharp End
   c. Hindsight Bias
   d. Hazard Analysis

8 True/False.
The right way to give medications includes the right patient, drug, dose, dosage form, route, time and education.
   a. T
   b. F

9 According to the IOM, and error is:
   a. A Near-miss event
   b. Reportable to the federal government
   c. Injury caused by medical management rather than underlying disease/condition of the patient
   d. Made of two types- planning and execution

10 To ensure safe surgery practices which item should be included in your process/policy:
   a. Having someone watch during the surgery to be sure it is done correctly
   b. Having an advance directive on your chart
   c. Marking the correct surgery site
   d. Noting the dominant hand of your surgeon to be sure it is the same as the side of the surgery site

11 Falls prevention program includes several components. What is an important step in this program:
   a. Patient teaching
   b. Correcting environmental risks
   c. Assessment of the patient and their risk to fall
   d. Evaluation of the program
   e. All of the above

12 Reason to have a team involved in analyzing systems and processes:
   a. Multiple perspectives of a process
   b. Different content expertise
   c. Creates defined parameters
   d. They can test the risk of near misses
   e. A+B

13 The greatest cause of errors in healthcare is due to systems/processes failures
   a. True
   b. False

14 A key barrier to reporting errors is:
   a. No guidelines
   b. Having the report automated
   c. Fear of punishment
   d. Not knowing about the error
   e. A,C,D