Sri Lakshmi Narayana Institute of Medical Sciences

Date 02/05/2019

From
Dr.R.Venkataramanan,
Professor and Head,
otorhinolaryngology,
SLIMS
Bharath Institute of Higher Education and Research,
Puducherry.

To
The Dean,
SLIMS
Bharath Institute of Higher Education and Research,
Puducherry.

Sub: Permission to conduct value-added course: : Preventing Medical Errors in Audiology reg.

Dear Sir,

With reference to the subject mentioned above, the department proposes to conduct a value-added course titled: Simulation Based Training In Audiology on May 2019 to Aug 2019. We solicit your kind permission for the same.

Kind Regards

Dr.R.Venkataramanan

FOR THE USE OF DEANS OFFICE

Names of Committee members for evaluating the course:
The Dean:
The HOD:
The Expert:

`

The committee has discussed about the course and is approved.

Dean

(Sign&Seal)

DEAN
Prof.K.BALAGURUNATHAN,M.S
(General surgeon)
SRI LAKSHMI NARAYANA
INSTITUTE OF MEDICAL SCIENCES
OSUDU PONDICHERRY

SUBJECT EXPERT
(Sign &Seal)

Dr. R. VENKATARAMANAN, MS.,
Reg. No: 72549
Professor ENT
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502.

HOD (SIGN AND SEAL)

OFFICE OF THE DEAN

Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,
PUDUCHERRY - 605 502.
[Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME (P -II) dt. 11/07/2011]
[Affliated to Bharath University, Chennai - TN]

Ref. No. SLIMS/Dean Off/VAC/024 **Date:03/05/19**

From
The Dean
Sri Lakshmi Narayana Institute of Medical sciences,
Pondicherry – 605502

To
The Registrar,
Bharath Institute of Higher Education and Research,
Chennai - 600073.

Respected Sir

Sub: Request for permission and approval of Syllabus for certificate course (Value Added course) for the academic year 2018-19 - Reg
Ref: Requesting letter received from Departments

*****

With reference to the above, herewith forwarding the proposed list of Value-added courses for necessary permission and approval of syllabus to conduct the same.

This is for your kind information and needful action.

Thankingyou

Yours faithfully

[DEAN]

DEAN
Prof.K.BALAGURUNATHAN,M.S
(General surgeon)
SRI LAKSHMI NARAYANA
INSTITUTE OF MEDICAL SCIENCES
OSUDU PONDICHERRY

Encl's:

1. Requesting letter received from department
2. Syllabus of thecourse
3. Details of faculty handlingcourse

Sri Lakshmi Narayana Institute of Medical Sciences, Puducherry

VALUE ADDED COURSE : Preventing Medical Errors in Audiology

COURSE CO-ORDINATOR DETAILS

Faculty Name: Dr.S.Ganesh

Email ID:e n t s l i m s @ g m a i l . c o m

Bharath
INSTITUTE OF HIGHER EDUCATION AND RESEARCH
(Declared as Deemed - to - be - University under section 3 of UGC Act 1956)

Ref. No. BHIER/ VAC/B-02 **Date:05.05.2019**

From

The Registrar,
Bharath Institute of Higher Education and Research,
Chennai - 600073.

To

The Dean
Sri Lakshmi Narayana Institute of Medical sciences,
Pondicherry – 605502

Sir / Madam,

Sub: Approval of Syllabus to conduct certificate course (Value Added course) for the academic year 2018-2019 – Reg.

Ref: Ref. No. SLIMS/Dean Off/VAC /024 Dated: 03.05.2019

*****

With reference to the above, it is to inform that the proposal submitted to conduct Value Added Course has been accepted and approved by BIHER, council meeting. List of the VAC are mentioned below for the academic year 2018– 2019. The abstract of the VAC course completion detail should be submitted to the Registrar office.

Thanking you Yours faithfully

REGISTRAR

OFFICE OF THE DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,
PUDUCHERRY - 605 502.
[Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME (P -II) dt. 11/07/2011]
[Affiliated to Bharath University, Chennai - TN]

Circular

.

07/05/2019

Sub: Organising Value-added Course: Preventing Medical Errors in Audiology **reg.**

With reference to the above mentioned subject, it is to bring to your notice that SLIMS,**Bharath Institute of Higher Education and Research**, is organising **"Preventing Medical Errors in Audiology"**. The course content and registration form is enclosed below.

The application must reach the institution along with all the necessary documents as mentioned. The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 15/05/2019. Applications received after the mentioned date shall not be entertained under any circumstances.

DEAN

DEAN
Prof.K.BALAGURUNATHAN,M.S
(General surgeon)
SRI LAKSHMI NARAYANA
INSTITUTE OF MEDICAL SCIENCES
OSUDU PONDICHERRY

Encl: Copy of Course content

VALUE ADDED COURSE

1. Name of the programme &Code

Preventing Medical Errors in Audiology – A value added course for the medical students.
& **ENT 10**

.

2. Duration &Period

30 hrs & May 2019-Aug 2019

3. Information Brochure and Course Content of Value Added Courses

Enclosed as Annexure- I

4. List of students enrolled

Enclosed as Annexure- II

5. Assessment procedures:

Pre test and post test which includes 10 mcqs - *Enclosed as Annexure- III*

6. Certificate model

Enclosed as Annexure- IV

7. No. of times offered during the same year:

1 time May 2019- Aug 2019

8. Year of discontinuation:2019

9. Summary report of each program year-wise

Value Added Course- May 2019- Aug 2019					
Sl. No	**Course Code**	**Course Name**	**Resource Persons**	**Target Students**	**Strength & Year**
1	ENT 10	Preventing Medical Errors in Audiology	1.Dr.Venkataramanm 2. Dr. Nithish Thimothy.R	3rd year MBBS students	13 students & 2019

10. Course FeedBack

Enclosed as Annexure- V

RESOURCE PERSON
1. **Dr.R. VENKATARAMANAN**
2. **Dr.R.NITHISH TIMOTHY**

COORDINATOR
Dr.S. GANESH

COURSE PROPOSAL

1. NAME OF THE PROGRAMME

Preventing Medical Errors in Audiology – A value added course for the medical students.

2. AIM

Training the students to prevent medical errors in audiology

3. OBJECTIVES

a) To teach the students how to Prevent Medical Errors in Audiology and how to manage it

4. METHODOLOGY

Students who are interested in participating in value added course are enrolled and the course is conducted for them during the non college hours for a period of 30 hours from May 2019 – Aug 2019 . This course is conducted every 6 months.

Course Audience: 3rd year MBBS students

Course Coordinator: Dr. S.Ganesh

Course Faculties with Qualification and Designation:

1.Dr. R. Venkataramanan

2.Dr. R.Nithish Thimothy

Schedule followed during the course

No	Topic	Title	Duration	Date and time
1	Preventing Medical Errors in Audiology	Introduction & Learning outcomes-Errors and Liability overview	6hrs	4pm-6pm(3/5/19),4pm-6pm(9/5/19),4pm-6pm(16/5/19)
		Administrative Errors	6hrs	4pm-6pm(24/5/19),4pm-6pm(30/5/19),4pm-6pm(4/6/19),
		Clinical Errors	6hrs	4pm-6pm(6/6/19),4pm-6pm(11/6/19),4pm-6pm(14/6/19)
		Treatment Errors	6hrs	4pm-6pm(20/6/19),4pm-6pm(10/7/19),4pm-6pm(18/7/19)
		Preventive errors and Risk Management	6hrs	4pm-6pm(24/7/19),4pm-6pm(8/8/19),4pm-6pm(14/8/19)
		TOTAL	30HRS	

REFERENCE BOOKS: 1) SCOTT BROWN 7th edition

2) ANIRBAN BISWAS 4th edition

Medical Errors for Audiologists to Avoid

- ❑ Historical perspective
- ❑ Definitions of important terms
- ❑ Standard of care
- ❑ General steps for preventing errors and minimizing liability
- ❑ Professional responsibility, professional liability, and risk management in audiology
- ❑ Patient tips to prevent medical errors
- ❑ Guidelines for patient referral to physicians (otolaryngology)
- ❑ Questions and answers

Medical Records:

Reasons for Demise on Actual Death Certificates

- **"Went to bed feeling well … woke up dead."**
- **"Don't know … never fatally ill before."**
- **"Nothing seriously wrong."**
- **"Blow to head. (Contributory cause was another man's wife.)"**
- **"Don't know … died without the aid of a doctor."**

St. Louis Genealogical Society

Types of Medical Errors: Early Published Paper

Leape, Lawthers, Brennan et al. (1993) Preventing Medical Injury, Quality Review Bulletin, 19, 144-149

- **Diagnostic Errors**
  - **Error or delay in diagnosis**
  - **Failure to employ indicated tests**
  - **Use of outmoded tests or therapy**
  - **Failure to act on results of monitoring or testing**
- **Treatment Errors**
  - **Error in the performance of an operation, procedure, or test**
  - **Error in administering the treatment**
  - **Error in the dose or method of using a drug**
  - **Avoidable delay in treatment or in responding to an abnormal test**

Types of Medical Errors: Early Published Paper

(From: Leape, Lawthers, Brennan et al. (1993) Preventing Medical Injury, Quality Review Bulletin, 19, 144-149)

- **Preventive Errors**
  - **Failure to provide prophylactic treatment**
  - **Inadequate monitoring or follow-up of treatment**
- **Other Errors**
  - **Failure of communication**
  - **Equipment failure**
  - **Other system failure**

Types of Medical Errors: Widespread Recognition

1999 Institute of Medicine Report

November 1999

INSTITUTE OF MEDICINE

Shaping the Future for Health

TO ERR IS HUMAN:
BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be--and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.

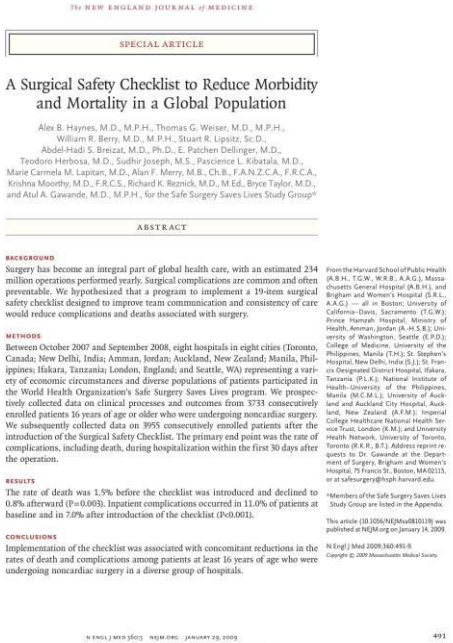
Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

Beyond their cost in human lives, preventable medical errors exact other significant tolls. They have been estimated to result in total costs (including the expense of additional care necessitated by the errors, lost income and household productivity, and disability) of between $17 billion and $29 billion per year in hospitals nationwide. Errors also are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort. Health professionals pay with loss of morale and frustration at not being able to provide the best care possible. Society bears the cost of errors as well, in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

A variety of factors have contributed to the nation's epidemic of medical errors. One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system--or "nonsystem," to some observers. When patients see multiple providers in different settings, none of whom has access to complete information, it becomes easier for things to go

Errors...are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals.

Medical Errors Is A Serious Problem in Health Care: Influential Publication of Meta-Analysis in the New England Journal of Medicine (2009)



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

Alex B. Haynes, M.D., M.P.H., Thomas G. Weiser, M.D., M.P.H., William R. Berry, M.D., M.P.H., Stuart R. Lipsitz, Sc.D., Abdel-Hadi S. Breizat, M.D., Ph.D., E. Patchen Dellinger, M.D., Teodoro Herbosa, M.D., Sudhir Joseph, M.S., Pascience L. Kibatala, M.D., Marie Carmela M. Lapitan, M.D., Alan F. Merry, M.B., Ch.B., F.A.N.Z.C.A., F.R.C.A., Krishna Moorthy, M.D., F.R.C.S., Richard K. Reznick, M.D., M.Ed., Bryce Taylor, M.D., and Atul A. Gawande, M.D., M.P.H., for the Safe Surgery Saves Lives Study Group*

ABSTRACT

BACKGROUND

Surgery has become an integral part of global health care, with an estimated 234 million operations performed yearly. Surgical complications are common and often preventable. We hypothesized that a program to implement a 19-item surgical safety checklist designed to improve team communication and consistency of care would reduce complications and deaths associated with surgery.

METHODS

Between October 2007 and September 2008, eight hospitals in eight cities (Toronto, Canada; New Delhi, India; Amman, Jordan; Auckland, New Zealand; Manila, Philippines; Ifakara, Tanzania; London, England; and Seattle, WA) representing a variety of economic circumstances and diverse populations of patients participated in the World Health Organization's Safe Surgery Saves Lives program. We prospectively collected data on clinical processes and outcomes from 3733 consecutively enrolled patients 16 years of age or older who were undergoing noncardiac surgery. We subsequently collected data on 3955 consecutively enrolled patients after the introduction of the Surgical Safety Checklist. The primary end point was the rate of complications, including death, during hospitalization within the first 30 days after the operation.

RESULTS

The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward (P=0.003). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist (P<0.001).

CONCLUSIONS

Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

From the Harvard School of Public Health (A.B.H., T.G.W., W.R.B., A.A.G.), Massachusetts General Hospital (A.B.H.), and Brigham and Women's Hospital (S.R.L., A.A.G.) — all in Boston; University of California–Davis, Sacramento (T.G.W.); Prince Hamzah Hospital, Ministry of Health, Amman, Jordan (A.-H.S.B.); University of Washington, Seattle (E.P.D.); College of Medicine, University of the Philippines, Manila (T.H.); St. Stephen's Hospital, New Delhi, India (S.J.); St. Francis Designated District Hospital, Ifakara, Tanzania (P.L.K.); National Institute of Health–University of the Philippines, Manila (M.C.M.L.); University of Auckland and Auckland City Hospital, Auckland, New Zealand (A.F.M.); Imperial College Healthcare National Health Service Trust, London (K.M.); and University Health Network, University of Toronto, Toronto (R.K.R., B.T.). Address reprint requests to Dr. Gawande at the Department of Surgery, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115, or at safesurgery@hsph.harvard.edu.

*Members of the Safe Surgery Saves Lives Study Group are listed in the Appendix.

This article (10.1056/NEJMsa0810119) was published at NEJM.org on January 14, 2009.

N Engl J Med 2009;360:491-9.

Medical Errors for Audiologists to Avoid:

10 Medical Errors That Changed Standard of Care (Barry Bialek, MD)

- **Trauma Care: introduction of Advanced Trauma Life Support (1980)**
- **Anesthesia Monitoring (1982)**
- **Fetal Heart Monitoring (1980)**
- **Wrong Site Amputation (JCAHO)**
- **Sponge Counts**
- **Fatal Allergies**
- **Potassium Mishaps**
- **Decubitus Ulcers**
- **Lifting Techniques**
- **Breast Exams**

Medical Errors for Audiologists to Avoid:

10 Medical Errors That Changed Standard of Care
(www.hospitalsafetyscore.org)

Hospital Errors are the Third Leading Cause of Death in U.S., and New Hospital Safety Scores Show Improvements Are Too Slow

Washington, D.C., October 23, 2013 – New research estimates up to 440,000 Americans are dying annually from preventable hospital errors. This puts medical errors as the third leading cause of death in the United States, underscoring the need for patients to protect themselves and their families from harm, and for hospitals to make patient safety a priority.

Press Inquires

We are happy to help members of the press inform the public about the Hospital Safety Score. For interview requests or additional information for print, electronic and broadcast journalists, please contact:

Ashley Duvall
(908) 325-3865

If you are a hospital looking for a template press release to announce your Hospital

Medical Errors for Audiologists to Avoid (www.scientificamerican.com)

SCIENTIFIC AMERICAN™

How Many Die from Medical Mistakes in U.S. Hospitals?

An updated estimate says it could be at least 210,000 patients a year, more than twice the number in a frequently quoted Institute of Medicine report

By Marshall Allen and ProPublica | September 20, 2013

It seems that every time researchers estimate how often a medical mistake contributes to a hospital patient's death, the numbers come out worse.

Flickr/U.S. Naval Forces Central Command/U.S.

In 1999, the Institute of Medicine published the famous "To Err Is Human" report, which dropped a bombshell on the medical community by reporting that up to 98,000 people a year die because of mistakes in hospitals. The number was initially disputed, but is now widely accepted by doctors and hospital officials 2014 and quoted ubiquitously in the media.

Ongoing Concern About Medical Errors:
The Problem Is Not Going Away

The Boston Globe Metro

Brigham and Women's airing medical mistakes

Hospital reports errors to staff in drive for improvement

By Liz Kowalczyk | GLOBE STAFF APRIL 09, 2013

PAT GREENHOUSE/GLOBE STAFF

From left, Courtney Moller, Bridget Soullion, Dr. Kathy Selvaggi, who was involved in a flawed case, and Amy Fang.

The patient, dying of metastatic cancer, had arrived at the hospital several weeks earlier in agony. But doctors at Brigham and Women's Hospital fashioned a medication regimen that at last eased her suffering, and on the day she was transferred to a rehabilitation hospital, they recalled seeing her smile.

Hours later, the patient was back in the Brigham emergency department, and once again in excruciating pain. Delays in transferring her, a language barrier, and a communications breakdown between doctors meant she did not get her medications on time.

The Boston Globe Metro

Surgical errors rise in Mass. despite new controls

Many preventable mistakes cited, but few of them caused serious harm

By Liz Kowalczyk | GLOBE STAFF JULY 07, 2013

Massachusetts hospitals are reporting more errors during surgery and invasive procedures, even after an intensive, decade-long campaign to reduce these mistakes — called "never events" because they're preventable and, with reasonable precautions, simply shouldn't happen.

Errors disclosed to state health officials since 2011 included anesthesia injected into the wrong leg, a guidewire left inside a patient's vein, and a catheter threaded into a patient who didn't need one, according to hospital safety leaders.

Several of them said the reported number of such incidents is rising as more care shifts to outpatient clinics, procedure rooms, and physicians' offices, where administrators and caregivers generally have been less vigilant about implementing safety protocols of the sort required in most hospital operating rooms. Hospital leaders said they are doing a better job recognizing and reporting these errors and training staff.

Many of the errors driving the increase are the sort which some caregivers view as less serious — improperly inserting medication tubing or administering local anesthesia, for example, and not removing the wrong kidney or cutting into the wrong side of the brain. But these less harmful mistakes still can cause pain and anxiety for patients.

Medical Errors are the Third Most Common Cause of Death: *The Latest Statistics (May 2016)*

The Washington Post

To Your Health

Researchers: Medical errors now thirdleading cause of death in United States

By Ariana Eunjung Cha May 3

Nightmare stories of nurses giving potent drugs meant for one patient to another and surgeons removing the wrong body parts have dominated recent headlines about medical care. Lest you assume those cases are the exceptions, a new study by patient-safety researchers provides some context.

Their analysis, published in the BMJ on Tuesday, shows that "medical errors" in hospitals and other health-care facilities are incredibly common and may now be the third-leading cause of death in the United States — claiming 251,000 lives every year, more than respiratory disease, accidents, stroke and Alzheimer's.

Medical errors rank behind heart disease and cancer as the third leading cause of death in the U.S., Johns Hopkins researchers say.
iStockphoto

A study by researchers at Johns Hopkins Medicine says medical errors should rank as the third leading cause of death in the United States — and highlights how shortcomings in tracking vital statistics may hinder research and keep the problem out of the public eye.

The authors, led by Johns Hopkins surgeon Dr. Martin Makary, call for changes in death certificates to better tabulate fatal lapses in care. In an open letter, they urge the Centers for Disease Control and Prevention to immediately add medical errors to its annual list reporting the top causes of death.

Medical Errors for Audiologists to Avoid:

Changing Attitudes About Preventing Medical Errors

- **System approach**
  - **Introduce systems to prevent errors and promote safety**
  - **Medical checklists**
  - **Computerized systems for medications**
  - **Regular training and "in-services"**
  - **No fault, no blame approach to encourage disclosure of errors**
- **Add accountability and blame for health care workers who don't** follow rules (e.g., hand-washing or pre-surgery "time out")
  - **Mandatory training for health care workers**
  - **Loss of patient care privileges**
  - **Loss of operating room time**
  - **Loss of pay for defined periods**

Medical Errors for Audiologists to Avoid:

Ongoing Weaknesses in Preventing Medical Errorts

- **Most patients who suffer harm do not file formal complaints**
  - **1 in 7 Medicare patients harmed each month**
  - **15,000 Medicare patients (1.5%) are victims of an event that leads to death per month**
- **Hospital failure to report unexpected harm to patients, or** "sentinel adverse events"
  - **States report only 12% of harmful events reported to HHS inspector general**
  - **Hospitals report only 1% of harmful events**
- **A few "rotten apples" are the cause of most medical errors**
  - **Physicians almost never lose hospital privileges**
  - **Physicians almost never lose license to practice**

Medical Errors for Audiologists to Avoid:

Historical Perspective

- **Five common preventable medical errors**
  - **Medication error**
  - **Too many blood transfusions**
  - **Too much oxygen for premature babies**
  - **Health care-associated infections**
  - **Infections from central lines**
  - **The impact of culture (safety is #1 priority)**
- **What are the most common audiology errors**
  - **?**
  - **?**
  - **?**
  - **?**

Medical Errors for Audiologists to Avoid

- **Historical perspective**
- **Definitions of important terms**
- **Standard of care**
- **General steps for preventing errors and minimizing liability**
- **Professional responsibility, professional liability, and risk** management in audiology
- **Patient scenarios … Errors and steps to prevent them (You make the call!)**
- **Guidelines for patient referral to physicians** (otolaryngology)
- **Questions and answers**

Medical Errors for Audiologists to Avoid:

Defining Professional Liability

"An individual who causes injury to another either intentionally or unintentionally can be held liable for the action. By virtue of advanced knowledge, training, and skill, a professional has a responsibility to conform to certain standards of conduct to protect the public from unreasonable risks.

… The responsibility of licensed and/or certified professionals to conform to those standards may be referred to collectively as professional liability."

ASHA Technical Report (1994). ***Professional Liability and Risk Management for the Audiology and Speech-Language Pathology Professions***

Medical Errors for Audiologists to Avoid: Definitions of Important Terms

- **Civil professional liability**
  - **Tort *from Latin for twisted or distorted*): Any wrongful** act, damage, or injury done willfully or negligently
  - **Action in tort is a private legal action in which**
    - ✓ **A plaintiff seeks a remedy (generally monetary) for damages to health, property, peace of mind, or reputation**
    - ✓ **The defendant is the health care provider to provided services to the plaintiff**
    - ✓ **Plaintiff must prove defendant fault before payments are required from defendant**

Medical Errors for Audiologists to Avoid: Definitions of Important Terms

- **Civil professional liability**
  - **Intentional tort**
    - ✓ **Illegal actions were intentional**
    - ✓ **A reasonable person would conclude that the alleged result was substantially certain to follow the action, e.g.,**
      - **Assault (attempt to do violence)**
      - **Battery (unauthorized physical contact), e.g. failure to obtain consent to treat**
      - **Defamation of character**
      - **Violation of confidentiality, e.g., unauthorized release of PHI**

Medical Errors for Audiologists to Avoid: Definitions of Important Terms (2)

- **Unintentional tort**
  - **Most common form of negligence in civil litigation**
  - **Defendant failed to exercise standard degree of care,**

  e.g.,
  - ✓**Negligence**
  - ✓**Misdiagnosis**
  - ✓**Incorrect or inadequate treatment**
  - ✓**Injuries from equipment or premises**

Medical Errors for Audiologists to Avoid: Definitions of Important Terms (2)

- **Unintentional tort**
  - **Four elements of unintentional tort**
    - ✓ **A legal duty, that is, a practitioner/patient** relationship, exists between audiologist and plaintiff
    - ✓ **Breach of legal duty exists (e.g., Improper diagnosis)**
    - ✓ **Cause and effect established ("proximate cause") between breach of duty and injury**
    - ✓ **Injury results in actual loss or damage**

Medical Errors For Audiologists to Avoid: Definitions of Important Terms (3)

- **Criminal (versus civil) liability**
  - **Commission of misdemeanors or felonies during conduct of professional activities, e.g.,**
    - ✓ **Battery**
    - ✓ **Fraud**
    - ✓ **Grand larceny**
    - ✓ **HIPAA violations**
  - **Often criminal liability reflects ignorance of regulations, e.g.,**
    - ✓ **Medicare and Medicaid law**
    - ✓ **State insurance codes**
  - **Audiologist is subject to fines and incarceration**

Medical Errors for Audiologists to Avoid: Definitions of Important Terms (4)

- **Employer liability**
  - ✓ **Employer has "vicarious" responsibility ("respondeat superior") for those who work for them**
  - ✓ **Unlicensed person inadequately supervised by licensed** audiologist
  - ✓ **Support staff under supervision of an audiologist**
- **Product liability**
  - ✓ **Audiologist drawn into third party liability litigation following dispensing of a product or device, e.g.,**
    - **Ingestion of hearing aid battery by a child**
    - **Allergic reaction an ear mold or to electrode paste**
    - **Malfunctioning FM systems**
    - **Defective cochlear implants**

Medical Errors for Audiologists to Avoid

- Historical perspective
- Definitions of important terms
- Standard of care
  - Definition
  - Practice guidelines for audiologists
  - State rules and regulations
- General steps for preventing errors and minimizing liability
- Professional responsibility, professional liability, and risk management in audiology
- Patient scenarios … Errors and steps to prevent them
- Guidelines for patient referral to physicians (otolaryngology)
- Questions and answers

Medical Errors or Audiologists to Avoid:

Evidence Based Clinical Practice

"Those who fall in love with practice without science are like a sailor who steers a ship without a rudder or compass, and who can never be certain whither he is going."

Leonardo Da Vinci (1452-1519)

Medical Errors for Audiologists to Avoid:

Standard of Care

- **Consistent with local, regional or national clinical practice**
- **Follows guidelines or recommendations on clinical practice approved by national multi-disciplinary professional committees or panels, e.g., Joint Committee on Infant Hearing**
- **Follows guidelines or recommendations on clinical practice approved by national professional organizations, e.g., AAA or ASHA**
- **Is consistent with statements of**
  - **Scope of Practice**
  - **Code of Ethics**
- **Is in compliance with Federal guidelines for clinical practice and services, e.g., Joint Committee on Accreditation of Healthcare Organizations (JCAHO)**

Medical Errors for Audiologists to Avoid:

A Sample of Legal Definitions of Standard of Care

- **In tort law, the standard of care is the degree of prudence and caution required of an individual who is under a duty of care.**
  (en.wikipedia.org/wiki/Standard of_care)
- **In tort law, the degree of caution that a reasonable person should exercise in a given situation so as to avoid causing injury**
  (en.wiktionary.org/wiki/standard_of_care)
- **The degree or level of service, attention, care and protection that a person owes another person according to the law (see also Duty of care).**
  (www.ibc.ca/en/need_more_info/glossary/S.asp)
- **It's the level of care, which an average practitioner would practice. Or in other words how a similar qualified practitioner would manage their patient's care under similar circumstances. Medical Malpractice claims must establish the standard of care and show that the standard has been breached.**
  (www.gmlaw.com/medical-malpractice-resources-terms.cfm)

Common Evidence Grading System: Four Categories

- **Grade 1**
  - **1a: Well-designed meta-analysis of randomized controlled trials**
  - **1b: Well-designed randomized controlled trials**
- **Grade 2**
  - **2a: Well-designed controlled studies without randomization**
  - **2b: Well-designed quasi-experimental studies**
- **Grade 3: Well-designed non-experimental studies, i.e.,**
  - **Correlational studies**
  - **Case studies**
- **Grade 4:**
  - **Expert committee reports, consensus conferences and clinical experience**

Examples of Current Practice Guidelines in Audiology

(More are coming)

- **2007 Joint Committee on Infant Hearing (JCIH) Position Statement**
- **2008 Guidelines on Identification, Diagnosis, and Management of Auditory Neuropathy Spectrum Disorder in Infants and Young Children**
- **2010 American Academy of Audiology Clinical Practice Guidelines: Diagnosis, Treatment, and Management of Children and Adults with Central Auditory Processing Disorders**
- **2010 American Academy of Audiology Clinical Practice Guidelines: Childhood Hearing Screening**
- **2012 American Academy of Audiology: Audiologic Guidelines for the Assessment of Hearing in Infants and Young Children**
- **2013 American Academy of Audiology Clinical Practice Guidelines: Pediatric Amplification**
- **American Academy of Audiology Clinical Practice Guidelines: Otoacoustic Emissions (in progress)**

Example of A Practice Guideline in Audiology: Year 2007 JCIH Position Statement Protocol for Evaluation for Hearing Loss In Infants and Toddlers from Birth to 6 months

- Child and family history
- Evaluation of risk factors for congenital hearing loss
- Parental report of infant's responses to sound
- Audiological assessment
  - Auditory brainstem response (ABR)
    - ✓ Click-evoked ABR with rarefaction and condensation stimulation if there are risk factors for auditory neuropathy
    - ✓ Frequency-specific ABR with air-conduction tone bursts
    - ✓ Bone-conduction stimulation (as indicated)
    - ✓ Auditory steady state response (ASSR) is optional
  - Otoacoustic emissions (distortion product or transient OAEs)
  - Tympanometry with 1000 Hz probe tone
  - "Clinical observation of infant's auditory behavior. *Behavioral observation alone is not adequate for determining whether hearing loss is present in this age group …*"

Example of A Practice Guideline in Audiology: Year 2007 JCIH Position Statement Risk Indicators Associated with Permanent Congenital, Delayed-Onset, or Progressive Hearing Loss in Childhood (1)

- **Caregiver concern regarding hearing, speech, language, or developmental delay.**
- **Family history of permanent childhood hearing loss**
- **NICU stay of > 5 days or**
  - **ECMO**
  - **Assisted ventilation**
  - **Exposure to ototoxic medicines**
  - **Hyperbilirubinemia requiring exchange transfusion**
- **In utero infections, e.g.,**
  - **CMV**
  - **Herpes**
  - **Rubella**
  - **Syphillis**
  - **Toxoplasmosis**
- **Craniofacial anomalies, including involvement of the**
  - **Pinna**
  - **Ear canals**
  - **Ear tags and pits**
  - **Temporal bone anomalies**

Example of A Practice Guideline in Audiology: Year 2007 JCIH Position Statement Risk Indicators Associated with Permanent Congenital, Delayed-Onset, or Progressive Hearing Loss in Childhood (2)

- **Physical findings associated with a syndrome, e.g., white forelock**
- **Syndromes associated with hearing loss, e.g.,**
  - **Neurofibromatosis**
  - **Osteopetrosis**
  - **Usher syndrome**
  - **Waardenburg**
  - **Alport**
  - **Pendred**
  - **Jervell**
  - **Lange-Nielson**
- **Neuro-degenerative disorders, e.g.,**
  - **Hunter syndrome**
  - **Sensory motor neuropathies**
    - ✓ **Friedreich ataxia**
    - ✓ **Charcot-Marie-Tooth syndrome**
- **Culture positive post-natal infections associated with sensorineural hearing loss, e.g., Confirmed bacterial and viral meningitis**
- **Head trauma requiring hospitalization**
- **Chemotherapy**

Example of A Practice Guideline in Audiology: Year 2007 JCIH Position Statement Recommendations for Audiologic Follow up for Infants with Risk Indicators Associated with Permanent Congenital, Delayed-Onset, or Progressive Hearing Loss

- Prior (2000 JCIH) recommendations for follow up at 6-month intervals of all NICU graduates (approximately 400,000 babies annually) placed an excessive burden on audiologists
- 2007 JCIH shifts responsibility for surveillance of all infants to the primary care provider who will refer to audiologists as needed, e.g.,:
  - Concerns or findings consistent with hearing loss
  - Risk factors for delayed/late onset or progressive hearing loss
- 2007 JCIH recommends at least one audiologic referral for low risk infants by age 24 to 30 months
- Early and more frequent referral (every 6 months) to audiologists for risk factors associated with delayed onset/progressive hearing loss:
  - Family history
  - CMV
  - ECMO therapy
  - Potentially ototoxic chemotherapy (e.g., cisplatin)
  - Neurodegenerative disorders

Medical Errors for Audiologists to Avoid

- **Historical perspective**
- **Definitions of important terms**
- **Standard of care**
- **General steps for preventing errors and minimizing liability**
- **Professional responsibility, professional liability, and risk** management in audiology
- **Patient scenarios … Errors and steps to prevent them (You make the call!)**
- **Guidelines for patient referral to physicians** (otolaryngology)
- **Questions and answers**

Medical Errors for Audiology to Avoid

"An ounce of prevention is worth a pound of cure."

Benjamin Franklin (1706-1790)

Medical Errors for Audiologists to Avoid:
General Preventive Strategies and Steps (1)

- **Awareness and education of the audiologist**
  - **Identify potential risks**
  - **Reduce risks by providing accepted standard of care**
  - **Practice within the scope of audiology**
  - **Remain up to date with professional developments** through formal and informal continuing education
  - **Know**
    - ✓ **State licensing laws**
    - ✓ **Code of ethics**
    - ✓ **Patient Bill of Rights**
    - ✓ **Policies and procedures of your institution**

Medical Errors for Audiologists to Avoid:
General Preventive Strategies and Steps (2)

- **Make appropriate patient referrals**
  - **Refer when you do not have knowledge, expertise, or** credentials to provide a service the patient needs
  - **Verify licensure, certification, and other qualifications of professionals you refer patients to**
  - **"When in doubt … refer out!"**
    - **Maintain professional credentials in audiology, e.g.**
      - **State license with required continuing education**
  - **ABA certification with required continuation education**
  - **ABA specialty certification**

Medical Errors for Audiologists to Avoid:
General Preventive Strategies and Steps (3)

- **Effective communication with patient and family, e.g.,**
  - **Establish positive relationship with patient and family**
  - **Explain all test findings, treatment options, and treatment** goals
  - **Fully disclose fees, billing schedules, etc**
  - **Provide written warranties and warnings**
  - **Secure patient signature on informed consent, release of information, and other documents**
  - **Maintain adequate verbal and written communication with** patient and family

Medical Errors for Audiologists to Avoid:
General Preventive Strategies and Steps (4)

- **Documentation, record keeping, and reporting**
  - **Written documentation in official medical or clinic records**
  - **Documentation is legible and thorough**
  - **Make corrections appropriately**
  - **Document all contacts with patient and family (face to** face, telephone, email)
  - **Document all contacts with professionals regarding the patient**
  - **Retain all correspondence between audiologist with or** about the patient
  - **Remember … if it's not documented in writing, then it didn't happen**

Medical Errors for Audiologists to Avoid:
General Preventive Strategies and Steps (5)

- **Compliance with state and federal privacy and security regulations, e.g.,**
  - **Health Insurance Portability and Accountability Act (HIPAA)** of 1996
- **Follow accepted policies for infection control, e.g.,**
  - **Compliance with Joint Commission**
  - **Institutional policies**
- **Equipment calibration**
  - **Periodic physical calibration with documentation**
  - **Daily biological checks**
- **Meet or exceed national standards of care for audiology**

Medical Errors for Audiologists to Avoid

- **Historical perspective**
- **Definitions of important terms**
- **Standard of care**
- **General steps for preventing errors and minimizing liability**
- **Professional responsibility, professional liability, and risk** management in audiology
- **Guidelines for patient referral to physicians (usually an otolaryngologist)**
- **Questions and answers**

Medical Errors for Audiologists to Avoid

- Historical perspective
- Definitions of important terms
- Standard of care
- General steps for preventing errors and minimizing liability
- Professional responsibility, professional liability, and risk management in audiology
- Patient tips to prevent medical errors
- Guidelines for patient referral to physicians (mostly to otolaryngologists)
- Questions and answers

20 Patient Tips to Help Prevent Medical Errors

Agency for Healthcare Research and Quality (www.ahrq.gov/)

The term "Doctor" is used for a health care provider … like an audiologist.

- **Medicine (9 questions), e.g.,**
  - **Make sure your doctors know about every medicine you are taking**
  - **Bring all of your medicines and supplements to your** doctor visits
  - **Make sure your doctor knows about any allergies and adverse reactions you have had to medicines (or ear molds, electrode gel, etc)**
  - **When your doctor writes prescription for you, make sure you can read it**
  - **Ask for information about your medicine in terms you can understand …**

20 Patient Tips to Help Prevent Medical Errors

Agency for Healthcare Research and Quality (www.ahrq.gov/)

The term "Doctor" is used for a health care provider … like an audiologist.

- ❑ **Hospital Stays (2 questions)**
- ❑ **Surgery (2 questions)**
- ❑ **Other Steps**
  - **Speak up if you have questions or concerns**
  - **Make sure someone coordinates your care**
  - **Make sure your doctor has all important health information**
  - **Ask a family member or friend to go to appointments with you**
  - **Know that more is not always better (may be better off without treatment)**
  - **If you have a test, don't assume no news is good news**
  - **Learn about your condition and treatments … ask your doctor and use other reliable sources**

Medical Errors for Audiologists to Avoid

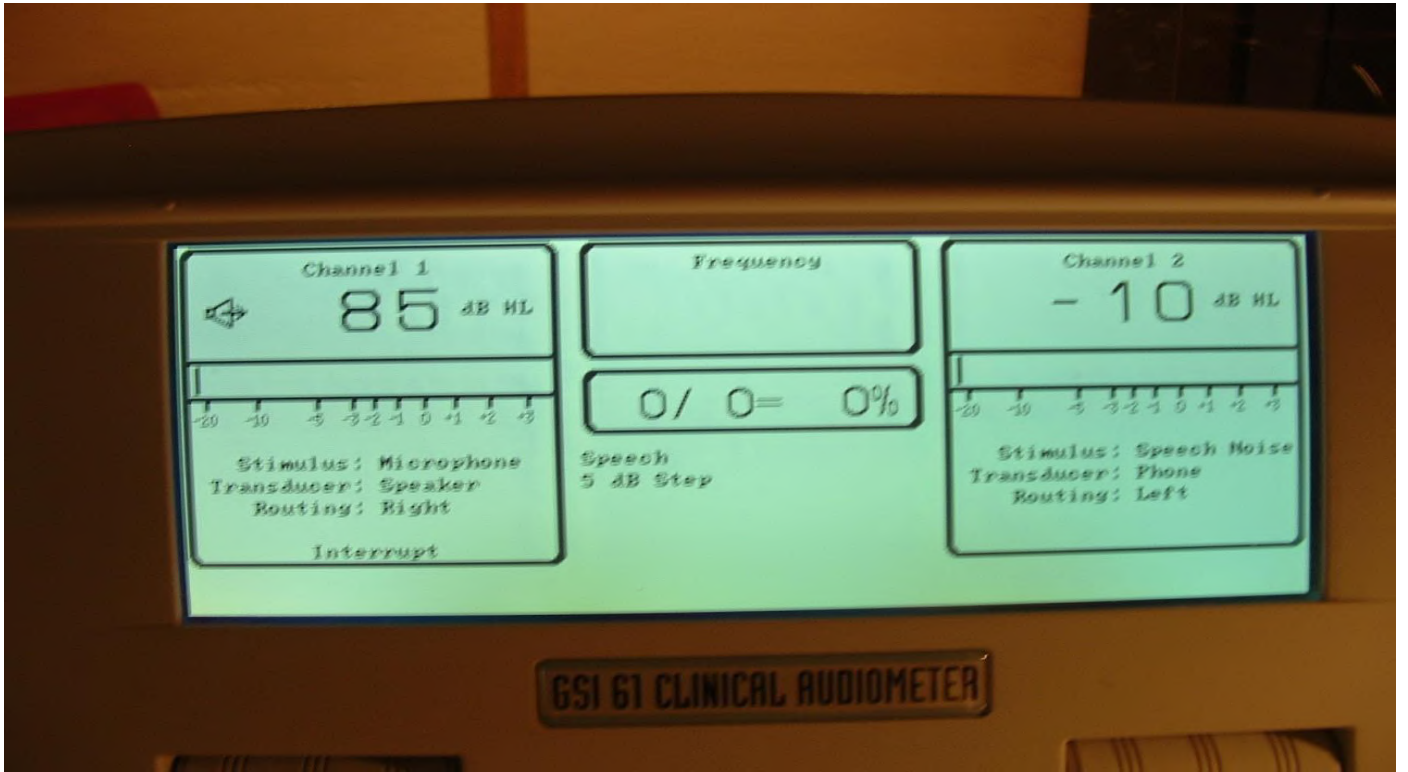
"I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing."

Hippocratic Oath (c. 460-400 B.C.)

"…I will keep pure and holy both my life and art …"

You've just stepped into the control room to begin a hearing assessment, and you see these audiometer settings. What's wrong with this picture?

You've just stepped into the control room to begin an audiologic assessment, and you see this audiometer screen. What's wrong with this picture?



Medical Errors for Audiologists to Avoid

- **Historical perspective**
- **Definitions of important terms**
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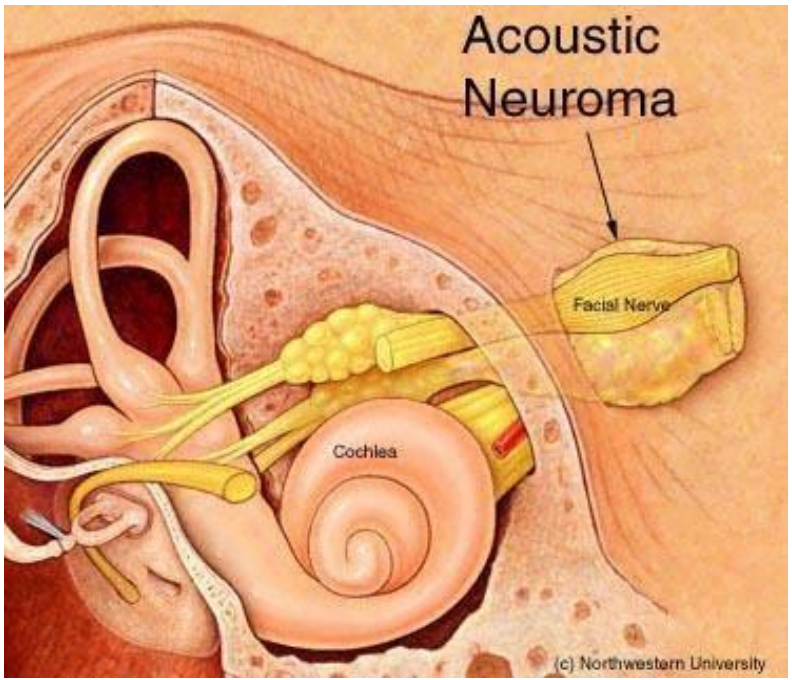
- **Guidelines for patient referral to physicians (mostly to** otolaryngologists)
- **Questions and answers**

Retrocochlear Auditory Dysfunction: A High Risk Patient Population



85% of tumors in CPA are acoustic tumors

Another 10% are meningiomas

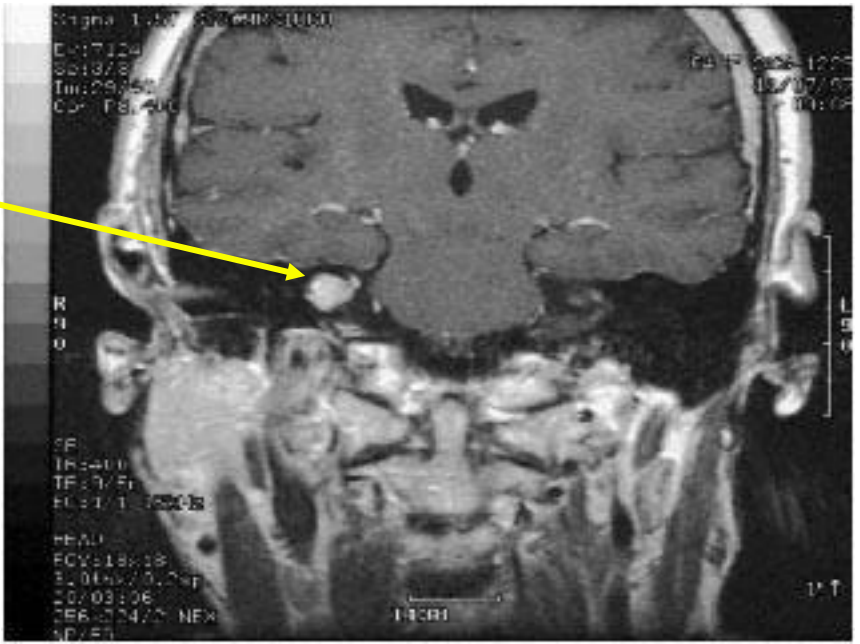
Chance of an acoustic tumor in a lifetime is 1/1000

Medical Errors for Audiologists to Avoid: Two Legal Cases Involving "Failure to Diagnose an Acoustic Tumor"

- **Each of two plaintiffs (two separate cases) were adults with vestibular schwannoma**
  - **Tumors were suspected \after second visit to otolaryngologist**
  - **MRI confirmed tumor**
  - **Tumors were removed surgically**
  - **Plaintiffs claimed hearing would have been spared with earlier diagnosis and/or tinnitus would have been avoided**
- **Defendants were general otolaryngologists**
  - **Conducted complete history and physical examination**
  - **Only performed (automated) screening audiometry**
  - **Questions: What is standard of care *for physicians?***
  - **What are the guidelines for physicians for referral of patients for MRI to rule out vestibular schwannoma?**

Detection of an Acoustic Tumor with MRI

Tumor



Medical Errors for Audiologists to Avoid:

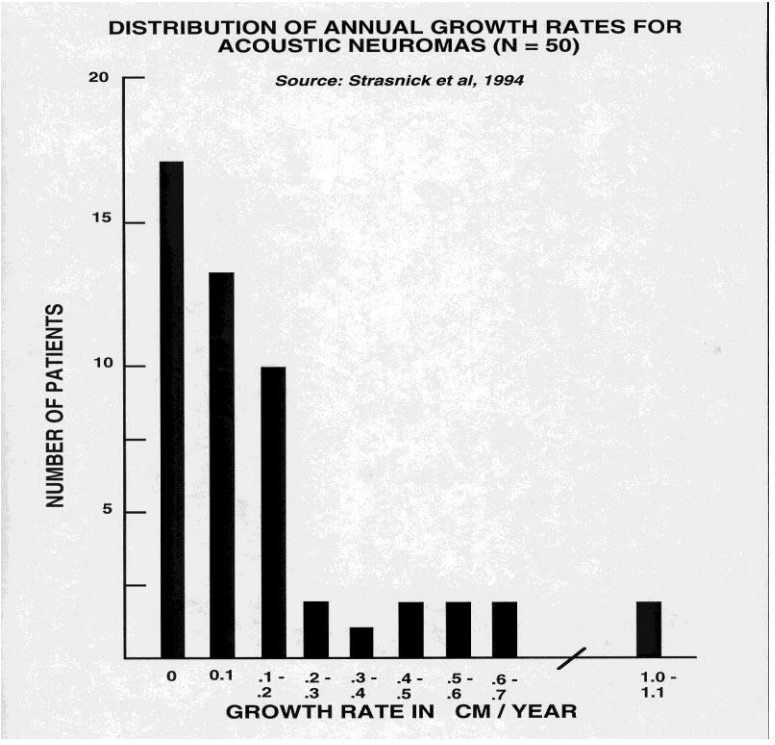
AAO-HSN Criteria for Identifying Candidates for MRI to Rule Out Vestibular Schwannomas*

- **Asymmetric pure-tone air-conduction sensorineural thresholds**
  - **Asymmetric SNHL of 25 dB or more at any two consecutive test frequencies**
  - **Unilateral or asymmetric hearing impairment by AAO-HNS criteria**
    - ✓ **Average difference in air-conduction thresholds between ears of 15 dB or greater at 500, 1000, 2000, and 3000 Hz**
- **Asymmetric word recognition scores**
  - **Statistically significant difference in word recognition scores (WRS) between ears using Thornton & Raffin (1978) data and NU6 word lists**
- **Persistent unilateral or asymmetric tinnitus**

** Same guidelines should be used by audiologists for referral of patients to otolaryngologists to rule out vestibular schwannomas*

Tumor Growth Rate is *Very* Slow:

"Growth Spurts" are Alleged by Plaintiffs



Medical Errors for Audiologists to Avoid:

*AAO-HSN Criteria for Audiologist Referral to a Physician**

- **History of active drainage from the ear within the previous 6 months**
- **History of sudden or rapidly progressing hearing loss within the previous 6 months**
- **FDA rules for unilateral or asymmetrical hearing loss**
  - **Air-conduction PTA (500, 1000, 2000, 3000 Hz) difference of > 15 dB**
- **Sudden or recent onset within the previous 6 months**
- **Bilateral hearing loss greater than 90 dB**
- **Complain of hearing impairment with positive history of:**
  - **Tuberculosis**
  - **HIV**
  - **Auto-immune disease**
  - **Von Recklinghausen's NF**
  - **Syphilis**
  - **Meniere's disease**
  - **Otosclerosis**
  - **Paget's disease of the bone**

Medical Errors for Audiologists to Avoid:

FDA (1977) Criteria for Audiologist Referral to a Physician for Hearing Aid Use

- **Visible congenital or traumatic deformity of the ear**
- **History of active drainage from the ear within the previous 90 days**
- **History of sudden/rapidly progressing hearing loss within previous 90 days**
- **Acute or chronic dizziness**
- **Unilateral hearing loss of sudden/recent onset within the previous 90 days**
- **Audiometric air-bone gap > than 15 dB at 500, 1000, and 2000 Hz**
- **Pain or discomfort in the ear**
- **Child under 18 years of age**
- **Visible evidence of significant cerumen accumulation or a foreign body in the ear canal**
  - **NOTE: Cerumen, including cerumen impaction, is *not* a criterion as cerumen management is within the scope of practice of audiology in the state of Florida**

Annexure 2
Bharath Institute of Higher Education and Research
SLIMS

1	U16MB267	ARIVUMATHI .R
2	U16MB268	ARJUN.S
3	U16MB269	ASHVANTH KUMAR .A
4	U16MB270	ASMITHA S.V
5	U16MB271	AVIDI. VENKATA SAISUSHMA
6	U16MB272	AVIRAL PATPATIA
7	U16MB273	BALACHANDRAN
8	U16MB274	BALAJI .S
9	U16MB275	BHASKARAN .K.C
10	U16MB276	BHAVANI . K.M
11	U16MB277	BLESSY AMALA RISHA .J
12	U16MB278	CAREENA DANIEL
13	U16MB279	CHANDRA PRAKASH.M

ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES PUDUCHERRY

TOPIC: Medical errors in audiology (ENT10)
STUDENT NAME:
UNIVERSITY NO:

1. According to the presenter, which of the following statements is NOT true?
   a. Considering the number of procedures and the progress that has been made, healthcare is as safe as could be expected.
   b. More people die from medical errors than from auto accidents or AIDS.
   c. The fostering of a culture where people discuss near misses, speak up about risks and problems and express a genuine interest in quality of care is crucial to improving patient outcomes and safety.
   d. Patient empowerment through education of treatment options and plans is a key part of improving quality.

2. According to the presenter, root cause analysis:
   a. Helps us understand how and why something happened
   b. Helps us problem solve and improve safety
   c. Both A and B
   d. None of the above

3. The development of established standards of care:
   a. Establishes uniformity across individuals in an organization & sets expectations for acceptable performance
   b. Takes away from the unique individual skill set
   c. Is not needed in audiology since we are a doctorate-level profession
   d. None of the above

4. A precaution for earmold impressions include:
   a. Appropriate bracing b. Examination of the ear canal pre block placement
   c. Examination of the ear canal post block placement d. All of the above

5. The first step in improving patient safety is to:
   a. Find out how much it costs
   b. Understand why it happened and get the evidence
   c. Discuss with your legal team if it should be reported or ignored
   d. Ask the patient what type of compensation they are seeking

6. According to the presenter, the most common adverse incident in this presentation was:
   a. Dome dislodgements
   b. Patient falls related to ENG techniques
   c. Occurrences related to ear impressions
   d. Transient hearing loss related to acoustic reflex testing

7. A common errors in cerumen removal is:
   a. Ignoring contraindications b. Neglecting to clean and disinfect cerumen tools
   c. Canal abrasions d. All of the above

8. Proper infection control protocols include:
   a. Handwashing between patients and after handling hearing aids
   b. Disinfecting hearing aids, tools and patient contact surfaces after every contact
   c. Changing disinfectant solution daily and proper storage of tips
   d. All of the above

9. Which of the following is true about hearing aid verification procedures?
   a. If the patient likes the sound quality, probe mic measures arenâ€™t important.
   b. The first fit algorithm is scientifically proven to be the best approach.
   c. Many licensed providers neglect to perform any type of fitting verification.
   d. Digital hearing aids cannot be tested with probe microphones.

10. What is an important step in improving patient safety in audiology?
   a. Find out how and why it happened
   b. Provide quality oversight
   c. Foster a culture of transparency and education
   d. All of the above

PRE TEST

5. The first step in improving patient safety is to:
   a. Find out how much it costs
   b. Understand why it happened and get the evidence
   c. Discuss with your legal team if it should be reported or ignored
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ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

PUDUCHERRY

(1)

TOPIC: Medical errors in audiology (ENT10)

STUDENT NAME: Arjun .S

UNIVERSITY NO: U16MB268

1. According to the presenter, which of the following statements is NOT true?

a. Considering the number of procedures and the progress that has been made, healthcare is as safe as could be expected.

b. More people die from medical errors than from auto accidents or AIDS.

c. The fostering of a culture where people discuss near misses, speak up about risks and problems and express a genuine interest in quality of care is crucial to improving patient outcomes and safety.

d. Patient empowerment through education of treatment options and plans is a key part of improving quality.

2. According to the presenter, root cause analysis:

a. Helps us understand how and why something happened

b. Helps us problem solve and improve safety

X c. Both A and B

d. None of the above

3. The development of established standards of care:

a. Establishes uniformity across individuals in an organization & sets expectations for acceptable performance

X b. Takes away from the unique individual skill set

c. Is not needed in audiology since we are a doctorate-level profession

d. None of the above

4. A precaution for earmold impressions include:

a. Appropriate bracing

b. Examination of the ear canal pre block placement

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d. All of the above

5. The first step in improving patient safety is to:

a. Find out how much it costs

b. Understand why it happened and get the evidence

X c. Discuss with your legal team if it should be reported or ignored

d. Ask the patient what type of compensation they are seeking

6. According to the presenter, the most common adverse incident in this presentation was:

a. Dome dislodgements

b. Patient falls related to ENG techniques

X c. Occurrences related to ear impressions

d. Transient hearing loss related to acoustic reflex testing

7. A common errors in cerumen removal is:

a. Ignoring contraindications b. Neglecting to clean and disinfect cerumen tools

X c. Canal abrasions d. All of the above

8. Proper infection control protocols include:

a. Handwashing between patients and after handling hearing aids

b. Disinfecting hearing aids, tools and patient contact surfaces after every contact

X c. Changing disinfectant solution daily and proper storage of tips

d. All of the above

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ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

PUDUCHERRY

TOPIC: Medical errors in audiology (ENT10)

2

STUDENT NAME: Balaji. S

UNIVERSITY NO: U16MB274.

1. According to the presenter, which of the following statements is NOT true?

a. Considering the number of procedures and the progress that has been made, healthcare is as safe as could be expected.

b. More people die from medical errors than from auto accidents or AIDS.

c. The fostering of a culture where people discuss near misses, speak up about risks and problems and express a genuine interest in quality of care is crucial to improving patient outcomes and safety.

d. Patient empowerment through education of treatment options and plans is a key part of improving quality.

2. According to the presenter, root cause analysis:

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X c. Both A and B

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X d. None of the above

4. A precaution for earmold impressions include:

a. Appropriate bracing

b. Examination of the ear canal pre block placement

X c. Examination of the ear canal post block placement

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POST TEST

5. The first step in improving patient safety is to:

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d. Digital hearing aids cannot be tested with probe microphones.

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a. Find out how and why it happened b. Provide quality oversight

c. Foster a culture of transparency and education d. All of the above

(9)

ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

PUDUCHERRY

TOPIC: Medical errors in audiology (ENT10)

STUDENT NAME: Balaji. S

UNIVERSITY NO: U16MB214.

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b. Examination of the ear canal pre block placement

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   d. All of the above

9. Which of the following is true about hearing aid verification procedures?

   a. If the patient likes the sound quality, probe mic measures arenâ€™t important.

   b. The first fit algorithm is scientifically proven to be the best approach.

   c. Many licensed providers neglect to perform any type of fitting verification.

   d. Digital hearing aids cannot be tested with probe microphones.

10. What is an important step in improving patient safety in audiology?

    a. Find out how and why it happened b. Provide quality oversight

    c. Foster a culture of transparency and education d. All of the above

8

ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

PUDUCHERRY

TOPIC: Medical errors in audiology (ENT10)

STUDENT NAME: Ayun .S

UNIVERSITY NO: U16MB268 .

1. According to the presenter, which of the following statements is NOT true?

a. Considering the number of procedures and the progress that has been made, healthcare is as safe as could be expected.

b. More people die from medical errors than from auto accidents or AIDS.

c. The fostering of a culture where people discuss near misses, speak up about risks and problems and express a genuine interest in quality of care is crucial to improving patient outcomes and safety.

d. Patient empowerment through education of treatment options and plans is a key part of improving quality.

2. According to the presenter, root cause analysis:

a. Helps us understand how and why something happened

b. Helps us problem solve and improve safety

c. Both A and B

d. None of the above

3. The development of established standards of care:

a. Establishes uniformity across individuals in an organization & sets expectations for acceptable performance

b. Takes away from the unique individual skill set

c. Is not needed in audiology since we are a doctorate-level profession

d. None of the above

4. A precaution for earmold impressions include:

a. Appropriate bracing

b. Examination of the ear canal pre block placement

c. Examination of the ear canal post block placement

d. All of the above

ANNEXURE 4

Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research

(Deemed to be University under section 3 of the UGC Act 1956)

CERTIFICATE OF MERIT

This is to certify that _____has actively participated in the Value Added Course on Preventing Medical Errors in Audiology held during May 2019 – Aug 2019 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

Dr.R.Venkataramanan
RESOURCE PERSON

Dr.S.Ganesh
COORDINATOR

Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research

(Deemed to be University under section 3 of the UGC Act 1956)

CERTIFICATE OF MERIT

This is to certify that Dr.Balaji.S (U16MB274) has actively participated in the Value Added Course on Preventing Medical Errors in Audiology held during May 2019 – Aug 2019 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry-605 502, India.

Dr.R.Venkataramanan
RESOURCE PERSON

Dr.S.Ganesh
COORDINATOR

Annexure 5

Course/Training Feedback Form

Student Feedback Form

Course Name: Preventing Medical Errors in Audiology

Subject Code: **ENT10**

Name of Student: _____ Roll No.: _____

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					
2	Course contents met with your expectations					
3	Lecturer sequence was well planned					
4	Lectures were clear and easy to understand					
5	Teaching aids were effective					
6	Instructors encourage interaction and were helpful					
7	The level of the course					
8	Overall rating of the course	1	2	3	4	5

**** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory***

Suggestions if any:

Annexure 5

Course/Training Feedback Form

Student Feedback Form

Course Name: Preventing Medical Errors in Audiology

Subject Code: **ENT10**

Name of Student: BALAJI S Roll No.: U16HB274

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear	✓				
2	Course contents met with your expectations		✓			
3	Lecturer sequence was well planned	✓				
4	Lectures were clear and easy to understand	✓	✓			
5	Teaching aids were effective			✓		
6	Instructors encourage interaction and were helpful			✓		
7	The level of the course			✓		
8	Overall rating of the course	1	2	3	4	5

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

good

Annexure 5

Course/Training Feedback Form

Student Feedback Form

Course Name: Preventing Medical Errors in Audiology

Subject Code: **ENT10**

Name of Student: CAREENA DAIEL Roll No.: U16YB278

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear	✓				
2	Course contents met with your expectations		✓			
3	Lecturer sequence was well planned			✓		
4	Lectures were clear and easy to understand	✓				
5	Teaching aids were effective		✓			
6	Instructors encourage interaction and were helpful				✓	
7	The level of the course		✓			
8	Overall rating of the course	1	2	3	4	5

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

good

ANNEXURE 6

Date : 15/8/2019

From
Dr.Venkataramanan.R,
Dept of Otorhinolaryngology,
SLIMS
Bharath Institute of Higher Education and Research,
Puducherry.

Through Proper Channel

To
The Dean,
SLIMS,
Bharath Institute of Higher Education and Research,
Puducherry.

Sub: Completion of value-added course: Preventing Medical Errors In Audiology reg.

Dear Sir,

With reference to the subject mentioned above, the department has conducted thevalue-added course titled:**Preventing Medical Errors in Audiology**on May 2019 to Aug 2019. We solicit your kind action to send certificates for the participants, that is attached with this letter. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards
Dr.R.Venkataramanan