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Jennifer Acton

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Main contact short bio

Jennifer is an optometrist and Senior Lecturer at Cardiff University. She completed her PhD at Aston University and postdoctoral fellowships at Columbia University and New York University. Her research interests include clinical and public health research related to eyecare.

Area (Health Board or CCG areas and country in which this research was conducted)	Wales & England
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Key words:

| Patient safety, eye care, optometry

Funding & commercial relationships

| KESS2 East Wales, Optometry Wales

I am happy for our presentation at the symposium to be recorded and made available for attendees and others to view |

I am happy for this abstract to be published |

Submission questions

Title of presentation

A preliminary characterisation of patient safety incidents in eye care

Abstract, must include the following four headings: Purpose, Methods, Results, Conclusions

Purpose

Investigating patient safety incidents is essential to reducing future harm and for quality improvement. This presentation describes a preliminary exploration of eye-related patient safety incident reports as reported to a national database from secondary care, and as suggested by optometrists working in primary care.

Methods

A random sample of 151 (recorded during 2005-2015) eye-related patient safety incident reports were identified from a national database of incident reports. Using an iterative approach to coding, reports were coded according to incident type, contributory factors, incident outcome and incident severity.

Fifty-two optometrists attending a workshop were asked to suggest incidents they had seen occur or could occur in practice. Once categorised, the most frequent and most harmful incidents were identified through voting, using the Nominal Group Technique.

Results

Database reports consisted of administration (31%), medication (17%) and documentation (15%) incidents. Contributory factors included staff factors (71%), organisation factors (64%) and continuity of care (32%). Outcomes included organisational inconvenience (58%) and local outcomes (46%) e.g. ocular pain. Moderate and severe harm were noted in 13% and 3% of reports, respectively.

Of 145 incidents suggested by optometrists, diagnostic incidents were perceived as the most severe (68%), whilst administration-related incidents were most frequent (75%).

Conclusions

Diagnostic- and administrative-related incidents pose challenges for safety in eye care. The results suggest human and organisational factors as contributors to incidents, indicating a potential need to reevaluate guidelines and training.

Authors & affiliations

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Dr, Andrew, Carson-Stevens, Clinical Reader of Patient Safety and Quality Improvement, Cardiff University, Division of Population Medicine, Andrew Carson-Stevens is an academic general practitioner leading research to investigate the frequency and avoidability of healthcare-associated harm and the development of interventions to mitigate risk to patients. He is a long-standing adviser to the World Health Organization on patient safety., carson-stevensap@cardiff.ac.uk

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