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Chapter 3: Preventing Medical Errors for Psychologists
2 CE Hours

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Learning objectives

This workshop is designed to help you:
• Define medical error as it pertains to the practice of licensed mental health practitioner psychotherapy.
• Recognize causal factors behind medical errors.
• Analyze how medical errors affect mental health clients.
• Provide licensed mental health practitioners with examples of their legal responsibility to report medical errors.

Overview

The term “medical error” can be defined and governed by various entities, such as state legislatures, mental health associations, and best practice institutions, for the purpose of preserving the health, safety and welfare of the public. Mental health professionals have a responsibility to be aware of medical errors, and to learn strategies to minimize potential risk.

Remember – Medical errors can occur at any point in treatment, even in preventive care, and are not limited to patient injury or death.

As more and more mental health clients are treated for complex physical and mental co-occurring conditions, mental health professionals often work with teams of intervention specialists. Any of these professionals or work roles can create and contribute to medical errors with mental health clients. They are part of the hierarchical medical community and include:

○ Psychiatrists.
○ Psychologists.
○ Physician’s assistants.
○ Nurse practitioners.
○ Mental health professionals, such as clinical social workers, marriage and family therapists, and mental health counselors.

Other medical community members include:

○ General medical practitioners.
○ Surgeons.
○ Medical specialists, such as ob/gyns, pediatricians, internists and so on.
○ Nutritionists.
○ Physical and occupational therapists.
○ Pain management specialists.

Increasingly, mental health professionals are in contact with mental health clients who are following medication protocols and other medical therapies, many of which are potentially lethal when taken improperly.

Mental health professionals are often in contact with doctors and other licensed medical personnel, and in a position to communicate concerns to both providers and clients. Mental health professionals are susceptible to making medical errors, as well as obligated to report any medical errors by others.

Health care personnel and institutions are held accountable for establishing a safe health care environment for clients/patients. Careful review and analysis of sentinel events and near-misses (situations in which medical error occurred but did not cause harm to the client/patient), suggests examination of sentinel events can be essential to determining whether adverse events, such as client/patient injury or death, were caused by the person’s diagnosed condition, a medical intervention, or inaction on the part of the mental health or medical personnel.

Sentinel events signal the need for immediate attention and investigation in order to reduce occurrence of medical error. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires health care organizations to establish internal processes to recognize sentinel events, conduct cause analyses, identify and document areas of risk, and implement a risk-reduction plan that outlines risk-reduction measures. Usually, all personnel involved in the systems and processes under review must participate (JCAHO, 2013).

Whether working as a mental health practitioner within a health care organization such as a hospital and subject to JCAHO rules and regulations or working in private practice, medical error is defined as: An event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than just the condition for which such intervention occurred, and includes intentional or unintentional mistake in practice and judgment that creates harm to a patient/client. The intervention could be medical or specialized medical procedures, such as diagnosis and treatment of a mental health illness (JCAHO, 2013).

The Institute of Medicine defines an error as the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim. For example, using guided imagery may be helpful for a client who needs stress management techniques, but is contraindicated for actively psychotic patients (Institute of Medicine, 1999).

An error of commission occurs as a result of an action taken. Errors of commission would include breaches of confidentiality; treating outside of area of expertise and training; and not reporting elder/child abuse. An error of commission in behavior health would be treating actively psychotic patients (JCAHO, 2013).

According to the malpractice insurance Trusts, this is a frequent complaint against mental health professionals, often resulting in malpractice charges. When individuals are treated for diagnoses for which the clinician lacks training, education and supervision, there is a high risk for unsuccessful treatment. It is important to understand one’s limits of expertise and make appropriate referrals for clients who present with issues outside the clinician’s area of expertise.

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JCAHO defines an error of omission occurs as a result of an action not taken. Errors of omission may or may not lead to adverse outcomes.

In summary, a medical error is a failure of a planned intervention or the use of a wrong plan, as well as oversight of proper use of ethical protocol that causes an adverse event or near-miss that is preventable under the current state of knowledge.

While the consequences of medical errors can be devastating, in reality, medical errors are not unique. Medical errors are simply errors in a medical context. As such, we can turn to what we know about the nature of human error in general to understand why medical errors occur, what factors produce them, and how to design to reduce them (Reeves, 2010).

Cognitive psychologists often distinguish between skill-based performance, rule-based performance, and knowledge-based performance. Skills are highly practiced behaviors that we perform routinely, with little conscious effort. They’re literally automatic. Rule and knowledge-based performance require more mental involvement or conscious deliberation. We rely on them when skill-based performance won’t work, typically in exceptional or novel situations.

Slips and lapses are errors in the performance of skill-based behaviors, typically when our attention is diverted. A common mechanism for a slip is “capture,” in which a more frequently performed behavior takes over a similar, but less familiar one. For example, a capture error is made when a nurse incorrectly programs a new infusion pump because the sequence of steps is similar but not identical to the pump he is most familiar with (Reeves, 2010).

Description errors are slips that occur when the objects of different actions are close together or visually similar, as when the wrong control on an EKG is adjusted because it’s close to other controls that look the same.

Loss of activation errors are lapses where the goal is forgotten in the middle of a sequence of actions (e.g., a radiologist forgetting what he is looking for after retrieving and displaying a comparison study), or we omit a step in a routine sequence (e.g., the failure to complete a double-check for blood type in an organ transfer protocol) (Reeves, 2010).

Mistakes are errors in rule- or knowledge-based performance. They arise when we misinterpret a situation or misapply a rule (usually, a rule that is frequently used and seems to fit the situation well enough). Mistakes include errors in perception, judgment, inference, and interpretation.

As with slips and lapses, attention plays a key role in mistakes. Whereas attention’s job is to monitor skill-based performance, our attention is actively engaged in the analytical reasoning and problem-solving of rule- and knowledge-based performance. As a result, slips, lapses, and mistakes are all more common when situational factors divert our attention.

Some situational factors that may contribute to such errors include psychological factors like:

- Fatigue.
- Sleep loss.
- Alcohol and drugs.
- Multi-tasking.
- Stress.
- Boredom.
- Frustration.
- Emotional elements, such as fear, anxiety, and anger.

### MEDICAL ERROR HARM

Examples of medical error harm include:

- **Permanent loss of trust by client/patient** – As a result of medical error, mental health clients can:
  - Lose trust that their personal information will be properly shared.
  - Lose trust in the psychological or medical community because of the medical team’s inability to share pertinent information to specific team members ONLY.

  In 1996, the U.S. Supreme Court decision in *Jaffee v. Redmond* established the psychotherapist/patient privilege in the federal courts, on grounds that only the trust such as a guarantee of confidentiality could provide and would foster effective psychotherapeutic treatment (Georgia Law Review Association, 2000).

  The passage of the federal Health Insurance Portability and Accountability Act (HIPAA) has placed significant responsibility on health care providers to preserve patient privacy and confidentiality (Institute of Medicine, 2009). HIPAA provides special protections for psychotherapy notes. For example, for them to qualify as “therapy notes,” they must meet certain conditions, which include:
  - Being maintained separately from the patient’s other health care records.
  - Not being the only source of information for treatment or payment.
  - Being solely for the use of the provider that created them.
  - Outside of very limited exceptions explicit within the statute, they may not be disclosed under virtually any circumstances without the patient’s expressed authorization.

- Loss of trust to the extent that they drop out of medical and psychological treatment and consequently relapse or exacerbate their conditions.
- Loss of trust that accurate information will be passed to them and other support services, or that information will not be withheld from them.

  Family, friends, co-workers or other supportive caregivers can also lose trust and subsequently affect a mental health client’s psychological, financial, and physical conditions.

- **Reversal or relapse of mental health and other physical conditions in a client/patient** – Mental health clients can experience a reversal in their mental or physical conditions. As a result of medical error, a client may:
  - Choose to discontinue medication when medications are not reviewed or renewed, or when clients are not able to finance their health and well-being.
  - Take the wrong medication and cause an overdose or other physical or mental harm when the medical team works at cross purposes because of poor communication or separate diagnosis.
  - Halt necessary medical visits, causing mental illness relapse or reversal in their physical and mental functions when they are under the impression that they are not in need of continuing medical or mental health supervision or when a mental health practitioner or medical staff fails to schedule necessary sessions or appointments.
  - Abuse medications to the extent that multiple and inappropriate medications are taken when mental health practitioners are not in communication with other team members, or medical practitioners fail to document or properly communicate with one another.
● Seek unnecessary additional treatment when a mental health practitioner recommends unconventional medical or mental health practices or practices that do not have significant data to back them up.

**Loss of funds by client/patient or client/patient’s family** – Mental health clients may become negatively impacted financially if mental health professionals demonstrate insensitivity to or take advantage of their clients’ inherent vulnerability to suggestions or recommendations. For example, they may:
- Seek unnecessary treatment protocols that have neither best practice nor scientific merit.
- Continue treatments long after they are needed because of a medical error in billing or profit-minded-only practitioners.
- Pay exaggerated fees for service because of an overexaggerated sense of importance of the mental health practitioner.

**Loss of client/patient’s necessary support systems** – As a result of medical errors by mental health professionals, mental health clients can:
- Lose important wraparound services because of poor communication among the intervention team or through lack of necessary paperwork that could be explained by staff.
- Lose family support if psychological and financial assistance is withdrawn or reduced through lack of follow-up with insurance or completed recommendations by any team member.
- Follow improper advice and sabotage healthy relationships if support team members are not fully informed about a client’s background.

**Loss of client/patient safety** – Safety systems extended to mental health clients must encompass all elements of practice, including personnel, operational processes, technologies, environment and materials.

As a result of medical errors, mental health clients can lose the ability to feel psychologically or physically safe. They can:
- Experience anxiety or apprehension about new or particular environmental settings and the introduction of new or other medical/mental health professionals as well as treatment protocols when proper referrals are not completed or appropriate information shared.
- Place themselves in unnecessary physical or emotional danger because of their inability to use sound judgment, causing them to be exposed to toxic substances and over-medicated and to continue to be involved with dangerous individuals, such as an abusive spouse or partner.

**Worsen existing or create new physical or mental health conditions** – Experiencing trauma as a result of medical error can cause mental health clients to develop acute stress or post-traumatic stress disorder.

As a result of trauma incurred through medical error, clients’ medical conditions can worsen or they can acquire a new mental health diagnosis, such as post-traumatic stress disorder or another anxiety disorder, such as acute stress disorder, panic disorder, phobias, or generalized anxiety disorder. Clients are susceptible as well to acquiring mood disorders, such as depression.

Panic disorders can result from trauma created by medical errors as well as mood, behavior, other anxiety conditions and regressed mental health conditions.

Trauma caused by medical error can substantially affect the quality of life for clients. Mary Ann is an example of how someone can be traumatized by a medical error made by a physician.

**Case study:** Mary Ann had been seen by John, a licensed social worker, for her depression for two years. At age 15, Mary Ann’s mother took her for her first gynecological appointment. During her appointment, her doctor took her aside and stated that she was very pretty. He also stated that if she ever needed his help in understanding how to reach orgasm, he would be happy to spend time explaining the process.

Mary Ann was confused and upset by her doctor’s behavior. She began to awaken with nightmares and found herself crying more than usual. During one session, she tentatively approached John, trying to understand why she would be so shaken by her medical visit. John reported the incident to the doctor’s state licensing board.

Mental health clients may experience weakened nervous, autonomic, immune, and endocrine system function, in addition to a decline in their general physical well being from trauma created by medical error. In Mary Ann’s case, her trauma reactions were reduced by her disclosure to her therapist and her subsequent reprocessing and integration of her experience with her gynecologist.

**Loss of client/patient’s life or permanent physical or mental damage or disfigurement** – Death or limitation of neurological, physical or sensory function can occur as a result of medical error. Because of medical errors, mental health clients may:
- Take unnecessary personal risks and engage in passive suicide behaviors.
- Lose their lives from consuming excessive medication or the wrong type of medication.
- Experience drug or alcohol overdose.
- Commit suicide.
- Cause harm to others.

Remember – Relatives and friends of mental health clients can be traumatized by client loss of life or harm to others.

### MEDICAL ERROR CATEGORIES AND OCCURRENCES

Medical errors generally occur when there is direct, (active) client involvement or indirect, (latent) client involvement through contact with other professionals, family, agencies, hospitals and so on.

Regardless of whether the errors occur through direct or indirect client involvement, they can happen as a result of omission or commission acts. Omission acts represent negligence or omission of information. Commission acts are overt/covert actions that cause medical error.

Mental health professionals have serious responsibilities to their clients, colleagues and to the mental health profession. The focal point of these interrelated responsibilities is a fiduciary relationship in which the client places trust in the practitioner with the expectation that the practitioner is working in the client’s best interest. This expectation is the foundation of a therapeutic relationship.

Through the therapeutic relationship, each party assumes separate and distinct roles. Practitioners bear the burden of accountability within the relationship because they assume an expert role. This role impacts the client/practitioner interpersonal dynamic, and creates a power differential within the relationship.

By virtue of expertise through education, degree, license, skills, and experience, mental health professionals generally acquire an authoritative advantage over clients, thus, setting the stage for potential misuse of power. With any position of power comes the risk for abuse, which can range from minor improprieties to egregious misconduct and crime.

**Remember:** Licensed practitioners are bound by their professional affiliation to act responsibly, even when the client does not.
The greatest risk for committing medical error occurs through:

- Multiple professional involvement.
- Misdiagnosis.
- Intimacy.
- Overtreatment.
- Lack of involvement.

Mental health professionals are responsible for maintaining protective boundaries that ensure their clients' physical and emotional safety. Common medical errors can occur when mental health professionals:

- Omit professional background information.
- Relay false client/patient or their own personal information.
- Inappropriately share or distort information.
- Are inappropriately assigned to a client.
- Attempt to treat out of the realm of expertise.
- Do not consult with medical professionals.
- Do not thoroughly collect background histories.
- Do not thoroughly complete assessments.
- Provide inadequate safety or security of physical environment.
- Assign false diagnosis.
- Recommend inappropriate or dangerous treatment protocol.

While most medical errors are unintentional, some are intentional. Most fall under the following categories:

- **Negligence** – Mental health professionals make mistakes when they:
  - Are overly fatigued.
  - Are in a hurry.
  - Are inattentive and distracted.
  - Do not access or thoroughly review client records.
  - Are negligent about writing, recording, reading or sharing critical reports, reviews or correspondence.
  - Do not paying attention to laws and regulations on confidentiality and consent.
  - Are physically or mentally ill.
  - Do not provide an adequate physical professional environment.
  - Impose religious or spiritual beliefs onto clients.
  - Lack follow-up.
  - Are negligent about gaining correct medication information.

- **Habituated behavior** – When mental health professionals fall into habits of poor professional behavior or continuously take work shortcuts, it can be exhibited through the following behavior:
  - Slow response and follow-up with client calls or crises.
  - A lack of concern for a client’s well-being.
  - Inattentive to or minimization of client concerns and self-reporting.
  - Poor communication with clients, their families or other treatment team members.
  - Disregard for professional boundaries.
  - Continued disregard for physical environment that would cause safety hazard to clients, such as unsafe or toxic exposure to fumes, cigarette smoke, dangerous structure, or crime.

- **Lack of knowledge** – Mental health professionals can demonstrate ignorance or lack of skill when they fail to understand or demonstrate the following:
  - Best practice knowledge – It is important that licensed mental health practitioners through various ways stay current in their psychotherapy practice.
  - Professional development – Professional development includes ongoing consultation and supervision, peer review, coursework, certification training, seeking additional schooling through graduate degree work or academic participation, professional membership and periodical reading.
  - Knowledge of current laws and regulations – Regulations on the practice of psychotherapy change. It is best to keep abreast of these changes through legislation and association participation. Every state has a state website that provides information on proposed laws.

- Necessary certification training – Certification is usually required before practicing a new psychotherapeutic technique. It is always best to affiliate with other practitioners who are participating in the same type of protocol.
- Thorough client/patient social histories or background information – Medical error occurs when medical or mental health practitioners do not diagnosis and treat from the same background information. Obtaining releases of information is essential when providing and coordinating appropriate client service.
- Consultation with experts – Experts are fundamental reality checks for mental health practitioners when they are challenged.
- Understand personal and professional capabilities and limitations.
- Obtain sufficient experience to justify decision-making or behavior.
- Avoid wrong referral or inappropriate referral.
- Provide accurate diagnoses, including the correct Axis II diagnosis.

- **Intentional harm** – Intentional harm by mental health professionals is reflected through medical error when they:
  - Unnecessarily or inappropriately assign diagnoses in order to continue treatment and bill for more fees.
  - Knowingly or flagrantly overcharge a client or wrongly submit a bill to a client, insurance companies or other third-party payers. Failure to maintain billing records properly can be a criminal offense as well.
  - Project personal need onto the client through negative counter-transference, which refers to projecting feelings and behaviors onto clients that reflect the practitioner’s psychological and personal history and negatively impact the therapeutic relationship.
  - Do not adhere to professional boundary ethics, such as ignoring proper consent protocol or becoming physically demonstrative.
  - Accept favors, free merchandise, or confidential information, such as stock tips from clients.
  - Commit intentional harm that includes actual crime, particularly when mental health professionals do not adhere to strict professional guidelines and ethics. Intentional harm can be considered a crime when mental health professionals mindfully:
    - Become romantically or sexually involved with clients.
    - Romantic or sexual innuendos are medical errors. Physical touch does not need to occur for a wrong action.
    - Falsely bill or charge fees to clients or insurance.
    - Administer inappropriate or grossly wrong methods of treatment.
    - Fail to contact medical personnel or law enforcement when clients threaten to or actually harm themselves or others.
    - Fail to report child abuse or make other appropriate reports to monitoring agencies or personnel.
    - Prescribe medications without sufficient licensing or expertise.

**Case study:** Sam was briefly hospitalized for suicidal ideation and severe depression. Because he’d not seen a psychiatrist before his admission, he was assigned a very busy doctor who supervised residents at the same hospital. After an initial consultation, the psychiatrist turned the case over to the resident doctor. However, the resident doctor was unable to consult regularly with his supervisor. While in session one day, Sam disclosed that he was not sleeping at all. The resident adjusted Sam’s medication with the subsequent result that Sam’s ulcer was severely affected, requiring a medical procedure.

- Abandon clients. It is imperative that mental health professionals do not abandon their clients because of a failure to pay or incompatibility. It is the professional’s job to transition clients and pursue alternative treatment avenues before closing a case.
A recent study published in the International Journal of Clinical Pharmacy, (Nov. 15, 2013) involving Aston University (UK), South Essex Partnership University NHS Foundation Trust (SEPT) and the University of East Anglia (UK) found medication errors were common on admission to mental health services. At the conclusion of the study, it was found that medication errors occurred in 212 of 377 (56.2 percent) of patients admitted to an assessment ward between March to June 2012.

The errors were corrected by a simple pharmacy-led intervention undertaken by the trust’s own dedicated pharmacy service. The researchers indicated that if these errors had not been corrected, more than three-quarters of patients would have been exposed to moderate harm. The errors involved various medicines, including anti-psychotics, heart medicines and medicines for diabetes, which are used to treat a range of diseases, including Alzheimer’s disease, schizophrenia and bipolar disorder (previously referred to as manic depression).

REPORTING REQUIREMENTS

Mental health professionals have an obligation to report medical error by other practitioners to governing bodies as well as to client caregivers and clients themselves.

Generally, each state has an oversight or governing agency where practitioners can make reports and access complaint forms. They can differ in complaint procedure and action. Nationally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) conducts investigations. Professional associations monitor membership and usually have established protocols to investigate complaints as well. These oversight or governing entities gather and analyze complaints, and determine probable cause and disciplinary action. If a complaint is determined to be a possible violation of law, it will be investigated by a legal designate.

Root-cause analysis

Understanding why an event occurred is the key to developing effective recommendations.

Root-cause analysis (RCA) is a process designed for use in investigating and categorizing the root causes of events with safety, health, environmental, quality, reliability and production impacts. The term “event” is used to generically identify occurrences that produce or have the potential to produce these types of consequences. RCA is a tool designed to help identify not only what and how an event occurred, but also why it happened. Only when investigators are able to determine why an event or failure occurred will they be able to specify workable corrective measures that prevent future events of the type observed.

In general, JCAHO utilizes root-cause analysis to examine what factors and associated processes relate most directly to the medical error event as well as root causes. In addition, JCAHO will examine other risk factors and possible improvements or systems inserted to reduce risk of further error. Personnel are assigned responsibility for implementing necessary improvements. The improvements are evaluated to determine their degree of efficacy.

The following glossary defines common terms used in medical error analysis:

Adverse event: An injury that was caused by medical management and that results in measurable disability.

Error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures and systems.

Unpreventable adverse event: An adverse event resulting from a complication that cannot be prevented given the current state of knowledge.

Medical error: An adverse event or near-miss that is preventable with the current state of knowledge.

Near miss: An event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention.

System: A regularly interacting or interdependent group of items forming a unified whole.

Systems error: An error that is not the result of an individual’s actions but the predictable outcome of a series of actions and factors that comprise a diagnostic or treatment process.

Since the inception of its sentinel event policy in 1995, JCAHO has compiled data on more than a thousand incidents. Root causes for medical error include:

- Inadequate safety or security of the physical environment.
- Inadequate assessment or incomplete reassessment of the patient.
- Inappropriate assignment of the patient.
- Incomplete examination of the patient.
- Infrequent or incomplete patient observations.
- Inadequate staffing or lack of staff competency.
- Factors related to the unavailability or miscommunication of information among health care personnel and other caregivers.

Reporting requirements in Florida

The state of Florida has some specific reporting requirements that are required by law.

Florida “Duty to Protect” Act

The Florida Mental Health Act (Title XXIX Chapter 394) addresses involuntary confinement of a person who is deemed to be a danger to self or others. (394.463). The criteria for involuntary confinement are as follows:

Criteria – A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she is mentally ill and because of his or her mental illness:

1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

3. Without care or treatment, the person is likely to suffer from neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

4. There is a substantial likelihood that without care or treatment, the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.
Florida child abuse reporting
Failure to report suspected child abuse or neglect is a medical error of omission. The following must be reported in Florida.

Any person, including a health care provider, who knows or has reasonable cause to suspect child abuse, abandonment or neglect by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, must report such knowledge or suspicion to the Department of Children and Families (DCF) Central Abuse Hotline. F.S. 39.201(1).

HIPAA compliance for reporting child abuse: A health care provider may disclose PHI to a public authority or other appropriate government authority authorized by law to report of child abuse or neglect (45 CFR 164.512(b)(1)(ii)).

In addition, the Florida Agency for Healthcare Administration requires a report of any adverse (sentinel) event to be made in writing within one day and a completed written investigation inclusive of root-cause analysis and a corrective action plan must be submitted within 15 days of the event (Florida Statute 395.0197).

Florida regulatory medical error amendments
Let’s take a look at some additional laws in Florida related to medical error.

Florida Statute 381.028 addresses adverse medical incidents and states:
- In addition to any other similar rights provided herein or by general law, patients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.
- In providing such access, the identity of patients involved in the incidents shall not be disclosed, and any privacy restrictions imposed by federal law shall be maintained.

The Florida Comprehensive Medical Malpractice Reform Act – also known as Florida Statute 395.0197 – addresses the way hospitals, clinics and doctors’ offices handle medical errors. Florida’s Comprehensive Medical Malpractice Reform Act requires that all hospitals create a risk management program that educates hospital staff about adverse incidents, investigates such incidents and reports them to state authorities.

The law mandates that hospitals must report adverse incidents, including patient deaths, wrong-site surgery, surgery on the wrong patient, the removal of surgical objects left inside a patient and the performance of medically unnecessary surgery. Hospitals must file formal reports with the state’s Agency for Health Care Administration.

Statute 395.0197
1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

- Such education and training of all nonphysician personnel as part of their initial orientation; and
- At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required to complete continuing education coursework pursuant to chapter 456 or the respective practice act.

2. Each licensed facility shall hire a risk manager, licensed under s. 395.10974, who is responsible for implementation and oversight of such facility’s internal risk management program as required by this section. A risk manager must be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.

3. For purposes of reporting to the agency pursuant to this section, the term “adverse incident” means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:

- Results in one of the following injuries:
  1. Death;
  2. Brain or spinal damage;
  3. Permanent disfigurement;
  4. Fracture or dislocation of bones or joints;
  5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;
  6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or
- Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient’s condition prior to the adverse incident;

4. Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.

PREVENTING MEDICAL ERROR

To avoid committing medical errors, mental health practitioners need to be proactive and conscientious, beginning with first contact and working with a continuum of care model by following an appropriate chain of communication that is initiated by obtaining consent, face-to-face or phone conference, staff meetings and written communication.

Remember – Confidentiality rules and regulations apply to e-mail communication.

Mental health practitioners often use clinical prediction to determine the options and best course of action most suitable for the situation they are addressing. Therefore, it is important to understand what causes mistakes in clinical prediction.

Although the general public tends to attribute errors to practitioner incompetence, it appears that errors stem more from the social and psychological constraints imposed on practitioners than from practitioner ignorance or carelessness (Bosk, 1989). The social context in which practitioners operate can have a profound effect on the practitioner’s predictive capacities. The following social constraints are typically cited: lack of necessary information; administrative pressures (i.e. deadlines, excessive paperwork) high caseloads; fear of legal reprisal; and lack of necessary training, experience, or both (Fishman, 1991). In addition, the confusion and uncertainty that pervade clinical work often undermine the predictive capacities of clinicians (Davis, 1972). Clients’ problems are generally complex and involve multiple actors, interests, and issues; clear-cut facts or answers are often difficult to find; causes are generally elusive; and clients’ motivations are frequently impossible to understand or explain. This kind of informational morass often incapacitates the predictive capabilities of even the most skilled practitioner.
Reducing prediction errors

Current research on clinical prediction has identified some basic steps practitioners can take to predict more accurately:

- Look for historical patterns.
- Know the demographics.
- Know the current stressors.
- Be aware of significant cues.
- Make short-term predictions.

Although a number of authors (Cocozza and Steadman, 1978; Kahneman et al., 1982) have tried to document the prognostic incapacity of clinicians, the courts and the general public increasingly expect practitioners, particularly in mental health, to be able to officially and accurately predict individual behavior. These expectations often become entrenched in administrative law or agency regulations, which add further stress to practitioner involvement in case situations.

There are many steps practitioners can take to prevent medical error and ensure best-practice treatment in addition to assessing for medical error by other professionals. Practitioners must be mindful about their personal capabilities and seek medical or mental health assistance when needed.

Mental health practitioners should also:

- Gather complete client background by:
  - Gathering a thorough medical and social history.
  - Assessing for substance abuse.
  - Obtaining consent or waiver for release of information for all other treating professionals.
  - Obtaining medical and psychological test results.
  - Gathering a compliance or non-compliance history.
- Obtain informed client consent. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that a client:
  - Has the capacity to consent.
  - Has been adequately informed of significant information about treatment processes and procedures.
  - Has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist.
  - Has freely and without undue influence expressed consent.
  - Has provided consent that is appropriately documented.
  - When, because of age or mental status, persons are legally incapable of giving informed consent, mental health professionals must gain consent from a legally authorized person; such substitute consent is legally permissible.
- Thoroughly assess client by:
  - Understanding clients’ medications and their medication protocol. (If client’s medication has not been routinely reviewed, appears ineffective or has been abused, and has been overly prescribed, the practitioner is obligated to contact the prescribing physician, but NOT suggest alteration to client.)
  - Observe client for signs that indicate a previous misdiagnosis or lack of diagnosis.
  - Observe client for signs of personality disorders.
  - Observe client for signs of violence or paranoia.
  - Examine client for indicators of substance abuse.
  - Monitor client for signs of medical treatment noncompliance through ongoing medication reviews that include self-report of side effects.
- Build client trust by:
  - Reviewing guidelines for practitioner/client affiliation, such as professional practice boundaries and client rights.
  - Reviewing fees for professional service.
  - Discussing mental health treatment protocols.
- Sharing under what circumstances confidentiality can legally be breached, such as reporting child abuse.
- Avoiding intimidation or abusing professional authority.
- Work at partnering with clients.
- Being consistently on time, returning phone calls and responding to other communication.
- Being authentic about advocating on behalf of client.
- Using proper channels to investigate a complaint.
- Being honest.
- Encouraging clients to ask questions and seek out answers about their medical treatment as an active member of their health care team.
- Teaching assertiveness and encouraging questions, and modeling behavior.
- Understanding professional limitations and making referrals.

Case study – Sara had established an excellent therapeutic relationship with her client, Georgia, an older woman. As time progressed, however, it was evident that Georgia was experiencing lapses in judgment and forgetfulness. At Sara’s request, Georgia consulted with her physician, who referred her to a neurologist who diagnosed her with early Alzheimer’s disease. The neurologist in turn referred Georgia to a mental health practitioner who specialized in Alzheimer’s.

Sara’s bond with Georgia was blurred as she continued to see Georgia regularly, often comparing her work to the other specialized practitioner. Sara encouraged her elder client not to mention that she was continuing to see her and checking in frequently with about her medical or mental health treatment progress.

- Maintain proper record keeping. General guidelines for providers of psychological services recommend that records be accurate, current and pertinent to the records of essential maintained psychological services. APA guidelines define “records” as any information, including information stored in a computer that may be used to document the nature, delivery, progress, or results of psychological services. They also set minimum standards for documenting. Mental health professionals should maintain proper records by:
  - Charting immediately following a session – This can be somewhat challenging when clients are scheduled back to back. However, it is necessary to schedule charting time between sessions to avoid exaggeration or misrepresentation of client information.
  - Keeping notes and assessment forms current – It is not uncommon to read a file with contradictory and confusing background information. Unless charts are shared, medical and mental health professionals can work at cross-purposes. As a licensed mental health professional, it is imperative to obtain releases and contact the other treating individuals. It is important to record a lack of response after the query.
  - Reviewing forms, (especially consents and medical protocols verbally with clients). Forms must be individualized to meet the needs of each client. Serious errors have been made when support staff has pulled out the wrong form or falsely recorded information. Check forms!
  - Recording client information changes in the file – This includes basic contact information as well as medication alterations.
  - Including a client’s response to changes in medications or mental health treatment.
  - Noting changes in client compliance.
  - Noting other practitioner advice or treatment.
  - Maintaining neat and orderly files.
Maintaining client files for the legally required period – The length of time varies from state to state.

Keeping files in a secure location and all information confidential – It is not uncommon for clients to request their file/records several years after completing treatment.

Case study: Alexa had provided expert opinion during a child sexual abuse investigation several years ago. She’d kept her records in a locked file cabinet. They were not accessible to anyone but herself. She had moved during the time between her investigation and when a request was made for the case records. And while the required timeline for keeping files had lapsed, she was able to access the information that provided validation for her prior assessment.

In 2003, the U.S. Department of Health and Human Services (HHS) issued new guidelines that apply specifically to psychiatrists. Because of HIPAA guidelines, psychiatrists now must maintain two sets of records for each patient, regular medical records and separate psychotherapy records titled “psychotherapy notes.”

The 2009 Health Information Technology for Economic and Clinical Health Act (HITECH) encourages psychologists to adopt integrated electronic health records by 2014. States are now actively engaged in defining these new processes under HITECH. The law’s initial goal is to promote health professionals’ adoption of electronic health records. The next stage of the law’s implementation involves integrating medical records through interfacing with large, centralized data systems such as health information exchanges or through systems of transactional, interoperable exchanges with other providers or organizations.

Lastly, while the initial 2007 draft of APA’s official Record Keeping Guidelines suggested that psychologists maintain client files for a minimum of seven years, this wording no longer exists. Instead, it is noted that the psychologist strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional and ethical requirements (APA, 2007). More often then not, confidentiality is breached informally. According to one study, more than half of psychologists have unintentionally disclosed confidential data.

- Stay current in best practice methodologies by:
  - Participating in peer review and supervision.
  - Utilizing consultants.
  - Participating in professional enhancement courses in standards of practice.

- Professally terminating or concluding treatment. Mental health professionals should establish a plan for the custody and control of records in the event of the practitioner’s death, and should plan for the safe and effective transfer of client records to another practitioner. Considerations for terminating or concluding care include:
  - Assessing professional and personal limitations.
  - Develop a plan for termination that reflects client consideration with attention to the possibility that it will be received with emotion or distress.

Modern community-based mental health services are fragmented, particularly following the establishment of specialist teams for home treatment, assertive outreach and early intervention. This has created numerous interfaces that patients frequently cross between primary and secondary care and different parts of the services. Primary clinicians may not be aware of medication supplied by secondary care colleagues, resulting in unintended drug interaction.

Transitional care, when patients cross organizational boundaries, is associated with medication reconciliation errors (Morcos, Francis, & Duggan, 2002). Communication difficulties, complex medicine regimens, unclear roles and responsibilities, patient factors and the involvement of multiple professionals may increase the risk of medicine reconciliation errors.

Primary care clinicians should be aware that transition across the primary-secondary care interface may be particularly associated with risk as various organizations (inpatient units, hospital pharmacy, general practice, community pharmacy and community mental health teams) are potentially involved.

A study within a mental health trust found that discrepancies in the medication record in the medical notes occurred in 69 percent of discharges and 43 percent of admissions, and of these, 24 percent and 18 percent, respectively, were judged to be potentially harmful (Morcos, Francis, and Duggan, 2002). Research on medicine reconciliation is a priority, and should focus on potentially high-risk groups, such as mental health patients (National Institute for Clinical Excellence, 2007).

Training issues
A lack of training and familiarity with certain classes of medicines may increase the risk of errors (Maidment, Haw, Stubbs et al., 2008). However, while there is some evidence that the use of psychotropics within primary care is associated with an increased risk of error, robust data is currently lacking.

Cognitive impairment
Patients intercept nearly a quarter of errors, but both medication and mental illness impair cognition and decision-making facilities, and people with mental health problems maybe less articulate and less likely to question a prescription, a change in medicine, whether monitoring is needed, or identify potential adverse events or a potential error (Barber, Allred, Raynor et al., 2009).

Alternatively, if the patient does not identify an error, it may ignored due to capacity concerns.

This potential lack of advocacy may mean that medication is not regularly reviewed; the recent UK all-party parliamentary report on dementia identified the lack of regular reviews of the medication regimens of people with dementia.

Primary care clinicians need to be aware that someone with mental health problems may not identify a medication error, placing additional responsibilities on clinicians and caregivers (Maidment, Paton, and Lelliott, 2006).
PATIENT SAFETY

Patient safety is the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of health care (U.S. National Patient Safety Foundation, 1999).

In the earliest studies on patient safety in the 1950s, medical errors were largely considered “diseases of medical progress” and dismissed as “the price we pay for modern diagnosis and therapy.” These reports tended to be limited to unusual patient reactions or those of magnitude and consequence.

The issue of patient safety plays a prominent role in health care. Its prominence is fueled by an expanding body of literature that shows a high incidence or error in medicine, coupled with well-publicized medical error cases that have raised public concern about the safety of modern health care delivery (American Hospital Association, 1999).

As empirical evidence on medical error expands, medicine’s vulnerability to error is becoming apparent. Medical errors are a leading cause of death in North America. In 1999, between 44,000 and 98,000 patients were estimated to die each year in the U.S. as a result of medical errors (American Hospital Association, 1999). However, updated studies have shown an increase to an estimated 210,000 U.S. patient deaths annually as of 2013 (American Hospital Association, 2013).

To reduce the incidence of errors, health care providers must identify their causes, devise solutions and measure the success of improvement efforts. Moreover, accurate measurements of the incidence of error, based on clear and consistent definitions, are essential prerequisites for effective action.

It is also important to recognize that what is considered to be a medical error has been influenced by differing contexts and purposes, such as research, quality control, ethics, insurance, legislation, legal action and statutory regulation (Institute of Medicine, 1999). As a result, a lack of standardized nomenclature and the use of multiple and overlapping definitions of medical error has hindered data synthesis and analysis, collaboration and evaluation of the impact of changes on health care delivery.

CONCLUSION

Medical error is a serious consideration in the rapidly changing health care arena and is defined as “a failure of a planned intervention or the use of a wrong plan; as well as oversight of proper use of ethical protocol that causes an adverse event or near-miss that is preventable under the current state of knowledge.”

Mental health professionals have a responsibility to be aware of medical errors, as well as learn strategies to minimize potential risk for error. Medical errors can occur at any point in treatment, even in preventive care, and are not limited to patient injury or death.

Depending on where they practice, mental health professionals are governed by oversight entities that include state licensing boards, professional associations and the Joint Commission on Accreditation of Healthcare Organizations.

Mental health professionals often work within health care teams to provide client/patient care, and are in a position to communicate concerns to other providers and clients. Consequently, they are susceptible to making medical errors and obligated to report medical errors by others.

Client/patient harm caused by medical error includes permanent loss of trust, medical reversal or relapse, loss of funds, loss of necessary support systems, loss of client/patient safety, exacerbated medical/physical conditions, loss of life, and permanent physical or mental damage or disfigurement.

Medical errors occur when health care practitioners demonstrate negligence, poor habituated behavior, lack of knowledge, and intentional harm.

Medical errors can be reduced by gathering thorough client/patient background, thorough assessments, building client trust, maintaining proper record keeping, and keeping current in best practice methodologies.

References


COnCLusiOn

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11. The Institute of Medicine defines an error as the failure to complete a __________ as intended or the use of a wrong plan to achieve an aim.
   a. Incident report.
   b. Planned action.
   c. Full assessment.
   d. Treatment plan.

12. __________ would include breaches of confidentiality; treating outside of area of expertise and training; and not reporting elder/child abuse.
   a. Unintentional errors.
   b. Intentional errors.
   c. Errors of commission.
   d. Errors in judgment.

13. A __________ is an error that is not the result of an individual’s actions but the predictable outcome of a series of actions and factors that comprise a diagnostic or treatment process.
   a. Systems error.
   b. Mistake.
   c. Slip.
   d. Mental error.

14. Because of HIPAA guidelines, psychiatrists now must maintain two sets of records for each patient; regular medical records and separate psychotherapy records titled, “__________.”
   a. Psychotherapy notes.
   b. HIPAA notes.
   c. Non-medical notes.
   d. Client therapy notes.

15. __________ is the avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of health care.
   a. Patient safety.
   b. Quality outcomes.
   c. Preventative care.
   d. Long-term care.