Mental Health Counselors of Central Florida

Preventing Medical Errors *for* Mental Health Professionals

Alicia M. Homrich, PhD
Licensed Psychologist
Licensed Marriage and Family Therapist
National Certified Counselor
Professor, Rollins College

Objectives

- Participants will be able to describe:
  - Medical error terminology and definitions
  - Factors that impact the occurrence of medical errors in mental health practice
  - The most common errors in mental health practice.
  - Root cause analysis
  - Error reduction and prevention measures

Caution!

- The information presented today is intended as a broad overview of error in healthcare, presented in good faith conformance with Florida statutory and administrative code requirements.
- This information is for educational purposes and should not be construed as legal advice.
- **If you have legal or ethical issues, you are advised to contact your professional insurance carrier or a health care attorney**
  - **(www.martindale.com).**

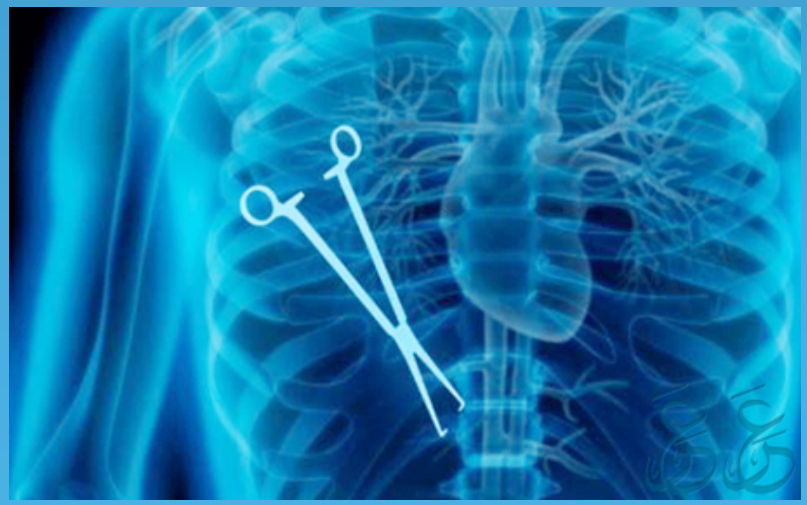
Standard of Care

- **Standard of Care** – a legal concept applied to the specific fact pattern of a case in litigation (must have harm and fault)
- **Quality of Care** – the adequacy of total care the patient receives from health care providers including third party payees (does not have to have harm and fault)

(Simon, 2006)

Medical Errors are a Public Health Nightmare

- The burden of harm conveyed by the collective impact of all of our health care quality problems is staggering. (Chassen et al., 1998)



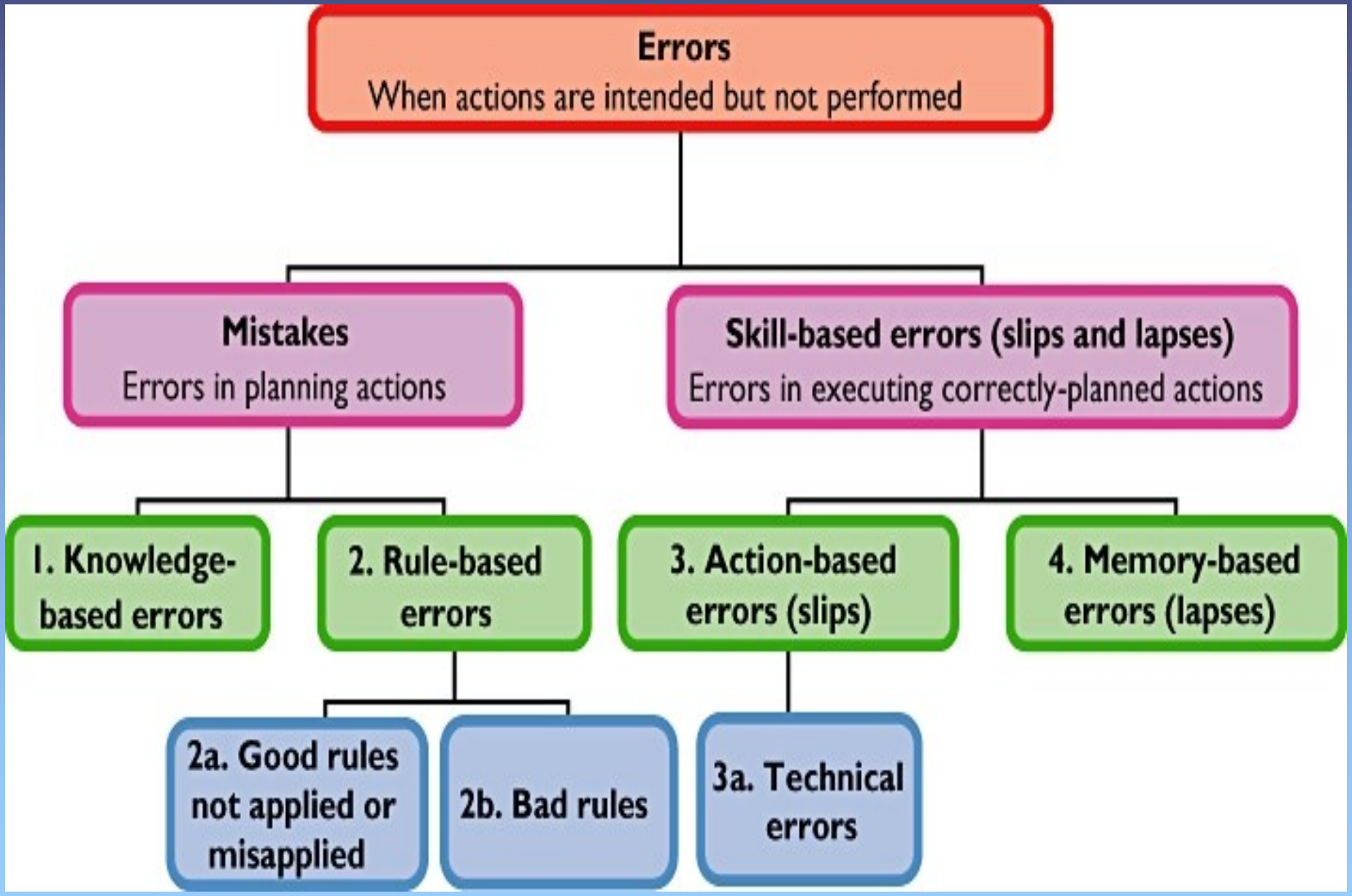
General Definition of Medical Errors

- **Medical Errors** in the mental health professions are those events that result from an absence of knowledge of *Minimum Professional Standards* or dismissing these standards.

As a generally accepted definition, a **medical error** occurs when a health-care provider chooses an inappropriate method of care

or chooses the right solution of care but executes it incorrectly.

Medical errors are often described as human errors in healthcare.


Errors
When actions are intended but not performed
Mistakes
Errors in planning actions
Skill-based errors (slips and lapses)
Errors in executing correctly-planned actions
1. Knowledge-based errors
2. Rule-based errors
3. Action-based errors (slips)
4. Memory-based errors (lapses)
2a. Good rules not applied or misapplied
2b. Bad rules
3a. Technical errors

Definition of Errors

- **Errors** are: failures of planned actions to be completed as intended (error of execution)
- or, the use of wrong plans to achieve what is intended (error of planning).
- May be due to act of commission, omission, misdiagnoses or the context.
- Harm is not a criteria of an error.

Research suggests that individual clinicians tend to define error differently;

generally seeing only errors that result in harm as real errors. The more harm the greater the error.

For example, the therapist who doesn't write a treatment plan and only writes brief notes, may not view those actions as errors at all.

Yet, a regulatory body *(such as the Board of Psychology or Board of Clinical Social Work, Marriage and Family Therapy, & Mental Health Counseling)* may view that every variation from the prevailing standard of care or standard of practice is an error for which the health care professional could be held accountable.

Adverse Event Definition

- **Adverse events** – injuries caused by therapeutic interaction or improper intervention (not the psychological condition of client)
- A large proportion of adverse events are the result of errors and are known as:

Preventable Adverse Events

Human Contributions to Errors

- **Active error** – a particular adverse event that occurs at the point of contact between a client and a professional.

Compile a list of as many examples of active errors as possible!

*An **active error** is a particular adverse event that occurs at the point of contact between a client and a professional.*

Examples of Active Errors

- Improper diagnosis assignment
- Improper course of treatment or interventions for clients
- Improper assessment, scoring, or results
- Incomplete or inaccurate documentation
- Poor confidentiality practices
- Boundary violations

Examples of Active Errors

- Therapist bias
- Suggestive interviewing
- Therapist incompetence
- Misuse of the Baker Act (FS 394)
  - Ex: Involuntarily hospitalizing a person in assisted living to handle behavioral issues when the Baker Act criteria is not met

Examples of Active Errors

- Misuse of the Marchman Act (FS 397)
  - Ex: Claiming the Marchman Act to force a person into involuntarily treatment for a mental illness.
- Failure to fulfill Florida's mandated reporting laws and obligations
- Not making needed referrals, or offering more than one referral option
- Failing to obtain adequate training

Examples of Active Errors

Confidentiality Violations

- Failing to obtain release of information ROI
- Providing information to a spouse or family member without obtaining release
- Exposing or identifying client in a public setting
- Discussing identifying information about the client to another person

Human Contributions to Errors

- Fatigue
- Interruptions
- Distractions
- Miscommunication
- Heavy workload
- Complexity
- Inconsistency

ALL LEAD TO …

Ethical and Legal Violations

The slippery slope!

Allegations against counselors:

- 14.4% Sexual misconduct
- 13.6% Breach of confidentiality
- 10% Beyond scope of practice
- 8.5%. Failure to properly assess
- 6.8% Failure to treat
- 6.3% Failure to release records
- 6.1% Billing
- 4.8% Multiple relationships

CNA and HPSO Claim Report (2014)

Human Contribution to Errors

- **Latent errors** – factors or conditions in the design of the organizational processes that allowed the error to occur.

  = *Accidents waiting to happen*.

- Latent conditions are less apparent and not under the direct control of front-line therapists

Examples of Latent Errors?

- Technological systems and processes
  - Lack of training in client record keeping
  - Lack of secure record storage
- Decisions of administrators regarding process and procedures in an agency that compromise ethical and legal therapuetic practice

Error Process

- Organizational processes
- Create error producing environment
- Therapist makes an error at human end of interface
- Breaching safety protocols
- Resulting in damaging outcomes

Perpetuation of Errors

- Reluctance to discuss mistakes with colleagues;
- Emotional problems *(including fear, guilt, anger, embarrassment, and humiliation)* that follow from making mistakes;
- Ineffective coping responses such as denial or other blaming.

JCAHO Sentinel Events

- **Sentinel Event** is defined as an unanticipated event resulting in death or serious physical or psychological injury, or risk thereof.
- Not synonymous with medical errors.
- Accredited institutions in the medical field must identify and respond to all sentinel events, including conducting a root cause analysis.

Sentinel Event Examples

- Telling a victim of domestic violence not to leave her partner.
- Letting a client believe they are doing no harm to their child by staying in an abusive relationship.
- Failing to involuntarily hospitalize a suicidal client when they have expressed intent

Root Cause Analysis

- **Root cause analysis** -- is a systematic process for identifying "**root causes**" of problems or events and an approach for responding to them. RCA is based on the basic idea that effective management requires more than merely "putting out fires" for problems that develop, but finding a way to prevent them.
- Retrospective error analysis to identify the basic or causal factors resulting in adverse events
- Should focus primarily on system and processes, not on individual performance

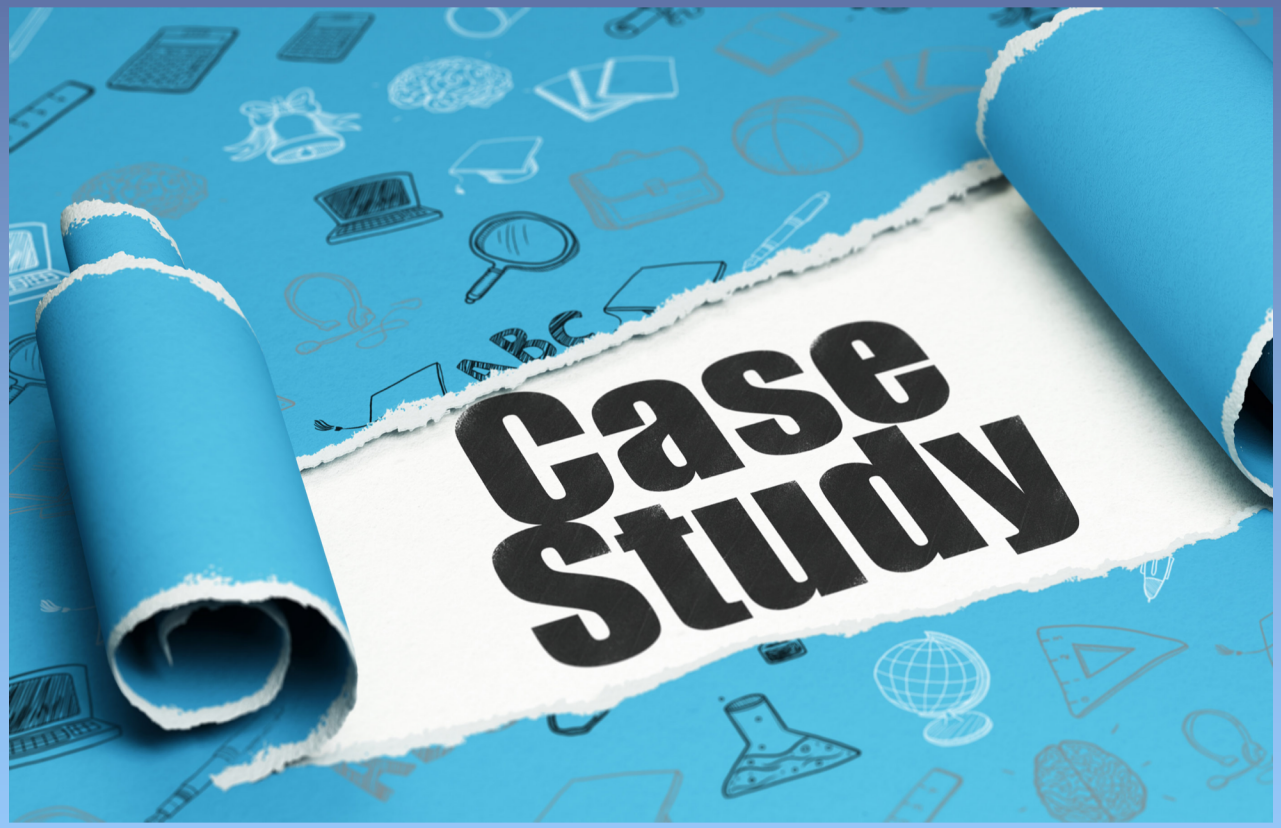
Root Cause Analysis

- It seeks answers to questions such as:
  - -What happened?
  - -Why did it happen?
  - -How can I prevent that error from happening again?

Steps in Root Cause Analysis

1. Verify the incident and define the problem
2. Commission Root Cause Analysis investigation by an interdisciplinary team
3. Map a timeline (event and causal factor chart)
4. Identify contributing/causal factors
5. Analyze the critical events (cause and effect chart)
6. Identify root causes
7. Identify and select the best solutions
8. Plan and implement corrective action
9. Reevaluate

www.health.vic.gov


Case
Study

Medical Error Prevention and Reduction Strategies

Your thoughts?

Error Reduction and Prevention Strategies

- Collect error data
- Identify root cause analysis of errors
- Institute plan for educating/training self and staff about legal, ethical, and best practice standards
- Make changes in the systems processes

Change Systems Processes: Structure, Environment, and People

- Simplification
- Standardization
- Process design that includes prompts
- Environment improvements
- Training
- Teamwork
- Communication

Error Reduction and Prevention Strategies

- Provide accurate information to clients
- Use informed consent & release forms
- Document carefully & accurately

Error Reduction and Prevention Strategies

- Consult ---
- ethics and laws that govern your license
- colleagues and other trusted mental health counselors
- medical doctors and psychologists
- professional organizations
- professional liability insurance provider
- research on standards of care and best practices

Cultural Competence in Error Reduction

- Language barriers
- Literacy
- Social-behavioral differences
- Expectations of client's culture

Summary

Preventing medical errors depends upon:

- Professional integrity
- Responsible decision making
- Maintaining professional standards of practice (ethics, laws, rules)
- Analyzing errors when they occur
- Taking measure to prevent reoccurance

Alicia M. Homrich, Ph.D.

ahomrich@rollins.edu