PREVENTION OF MEDICAL ERRORS
A MENTAL HEALTH PERSPECTIVE

INTRODUCTION

This course is designed to give licensed mental health professionals an understanding of medical errors and their impact on mental health practice.

At the end of this 2 hour workshop, participants will be able to:

1. Describe medical errors as they occur in health care
2. List types of errors/situations in behavioral healthcare.
3. Describe root cause analysis in investigation of medical errors
4. Define three ways to improve patient safety
5. Describe safety needs of special needs populations particularly at risk for medical errors.

In the late 1990's President Clinton established task forces to look at the quality of health care. From these task forces, the Institute of Medicine (IOM) was formed. The disturbing findings in the Institute of Medicine's 1999 report To Err is Human and a later report titled Crossing the Quality Chasm: A new Health System for the 21st Century (2001)
resulted in President Clinton's directing the Quality Interagency Coordination Task Force to evaluate the recommendations in that report and to respond with strategies to identify prevalent threats to patient safety and reduce medical errors.

MANDATES FOR CONTINUING EDUCATION

In 2000 Florida legislatively appointed the Florida Commission on Excellence in Healthcare. This commission focused on issues of quality of healthcare, patient safety and the reduction of healthcare errors. In July, 2001, the Florida Legislature proposed rule 64B9-5.011 to implement the requirement for a 2-hour course on the prevention of medical errors as required by s. 456.013(7)F.S. This was formally adopted at the February, 2002 Board meeting and mandates a two hour course on the prevention of medical errors as a part of the total hours of continuing education required for initial licensure and biennial renewal. In addition the Joint Commission on the Accreditation of Healthcare Organizations mandates the reporting and analysis of medical errors.

The first section of this home study provides an overview of medical errors in healthcare and the second section will address behavior health issues.

While it may initially be clear why this offering is required for medical health professionals, it may not be so apparent for mental health professionals. However, there is a growing body of evidence regarding errors in behavioral health practice. This course will provide examples of how medical errors affect mental health in specific areas of clinical practice and how clinicians can avoid making these potentially serious mistakes.

PART I – MEDICAL ERRORS – AN OVERVIEW

THE PROBLEM

CASE EXAMPLES

One need only pick up a daily newspaper to read of yet another tragedy as the result of a medical error. The following are examples of errors that occurred in Florida.

- Arlene Meisenburg, a 62 year old woman from Orlando, had successful surgery. However, seven months later, a 30 x 16 inch surgical towel was discovered left inside her.
- Willie King, of Tampa, was scheduled to have his right leg amputated. When he awoke from the surgery, his left leg was missing.
- Tallahassee, resident Carl Graham's CAT scan indicated the tumor on the left lung. When he awoke from surgery, he had incisions on both the left and right side of this chest. Apparently the surgeon had started the surgery on the wrong side.

Unfortunately these types of incidents are so common that the advisory commission on Consumer Protection and Quality concluded: "Exhaustive research documents the fact that today, in America, there is no guarantee that any individual will receive high-quality care for any particular health problem. The health care industry is plagued with over utilization of services, underutilization of services and errors in health care practice."

However, it still may be shocking to some to realize that Medical Errors is the 8th leading cause of death in the U.S. Estimates from various sources (CDC, IOM) give figures from 44 to 100 thousand deaths per year from preventable medical errors making this higher than death from motor vehicle accidents (43,458), breast cancer (42,297) or HIV AIDS (16,516).

In mental health we treat populations that are especially at risk for these types of errors, often due to their inabilities to communicate effectively with their health care providers. These communications problems may be the result of dementia, psychosis or children who are pre-verbal.

WHAT ARE THE COSTS?

The costs from medical errors include lost income, disability and health care. Currently the total national costs are approximately $37.6 billion & $50 billion each year for adverse events with health care costs representing almost half that total.

Currently, preventable adverse events represent between 2% to 4%
of national health expenditures

And unfortunately, we are paying for these costs.

In addition, there is the cost of the public's lost trust in the health care delivery system. As licensed health care providers, this loss of trust impacts our profession and the way the public views mental health professionals and their ability to help.

National patient surveys reveal that 42% of Americans have been affected by a medical error, either personally or through a friend or relative. Another 32% reported that the error had a permanent negative effect on the patient's health.

Another patient survey revealed that 61 % of Americans are very concerned about being given the wrong medicine and 56% worry about complications from a medical procedure.

Although Americans are becoming more aware of these problems, one of the goals of the President's Commission is to provide more education to the public on how they can prevent errors. As mental health professionals workers we can bring this important information to our clients and communities through education and community forums.

ARE PROVIDERS TO BLAME?
Most people believe that medical errors are the result of the failures of individual providers. 75% of Americans surveyed believed that health professionals with “bad track” records should be prohibited from providing care. And 69% believe problem can be solved through "better training of health professionals."

However, the focus of much of the literature on Medical Errors emphasizes the importance of looking at flaws in the system, rather than blaming individual providers, to effectively correct this health crisis. Requiring licensed professionals to take continuing education courses on Medical Errors and developing climates of safety are ways that all health professionals will be better trained and alert to this issue.

HOSPITAL SAFETY?
2.1 million patients each year will contract hospital-acquired infection

One of the first areas impacted by budgetary cutbacks in many health care facilities was custodial staff. Inspection of many hospitals revealed that lack of appropriate custodial services was directly related to high levels of hospital acquired infections.

Nosocomial derived from Latin, means hospital-acquired infection. CDC records show that the term was used to shield hospitals from the "embarrassment" of germ-related deaths and injuries and obscures the true source of germs.

A study of three million state & federal records since 1995 revealed:
- 103,000 deaths from hospital infections (CDC estimates 90,000 per year)
- 75,000 of all infection deaths were preventable

The Chicago Tribune did a three part investigative series on Medical Errors in 2000 http://www.chicagotribune.com/news/specials/chi-000912nursing3side.story and a follow up series in August 2002 http://www.chicagotribune.com/news/specials/chi-0207210272jul21.story that focused on the crisis in nursing.

That study revealed that since 1995 1,720 hospital patients were accidentally killed and 9,584 patients were injured as result of actions or inactions of RN’s. A recent study conducted by the Pennsylvania Nurse’s Association found that for every patient over four on a nurse’s caseload, the chances of patient injury and death increase. Again, this is an indicator of a systems problem. With financial cutbacks many hospitals are increasing their nurses’ caseloads, having longer shifts which contribute to nurse fatigue and error prone situations.

IATROGENIC DISORDERS
Iatrogenic disorders are disorders that are directly traceable to unnecessary and harmful treatments. For example, there have been many instances of individuals developing addictive disorders as a result of medications prescribed for other problems.

The controversy between the Repressed Memory Therapies in relation to childhood sexual abuse and the False Memory Syndrome is an example of Iatrogenic Disorders in behavioral health.

In the example of the Repressed Memories versus False Memory Syndrome, many therapists found themselves facing ethical violations and prosecution for malpractice. According to the malpractice Insurance Trusts, the sixth most frequent malpractice suit against mental health professionals involves using Repressed Memory Therapies.

Failed applications of experimental therapies are another aspect of iatrogenic effect, with often tragic results, of well meaning clinicians using techniques that have not been proved effective in research. It is essential for therapists to keep abreast of the literature and research on therapeutic techniques to avoid harming clients and their own careers.

Other examples of Iatrogenic effects resulted in patients’ exacerbated symptoms or new disorders after the following practice errors:
- Sexual misconduct
- Failure to fully diagnose/assess
- Failure to implement informed consent
- Breaches of therapist/patient privilege

During a recent 20-year period, nearly one in five lawsuits against mental health professionals insured through the malpractice insurance program sponsored by Insurance Trusts alleged some form of sexual impropriety, and more than two-fifths of insurance payments were the result of claims concerning sexual misconduct.

MEDICAL ERROR DEFINITIONS

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 the client who needs stress management techniques, but is contraindicated for actively psychotic patients.

JCAHO differentiates between an "Error of Commission" and "Error of Commission".
An error of commission occurs as a result of an action taken. Errors of commission would include; breeches 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 an individual outside the clinician's area of expertise. 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.

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.

For example, an effective barrier to patient suicide on an in-patient, locked psychiatric unit is periodic bed checks. Patient suicide is associated with a lapse in carrying out frequent patient checks in a psychiatric unit. However, if those checks aren't being done and a patient successfully suicides, that would fall within the definition of an error of omission.

SENTINEL EVENTS

The Florida Agency for Healthcare Administration requires a report of any adverse (Sentinel) event to be made in writing within three business days 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)

JCAHO defines a Sentinel Event as an unexpected occurrence involving death or serious physical or psychological injury, or an occurrence that contains risk for a Sentinel Event, i.e. Near Miss. Serious injury specifically includes loss of limb or function.

The following types of incidents are considered sentinel events and mandate being reported to the state and, if the facility is JCAHO accredited, to JCAHO.

- Death, paralysis, coma, or other major permanent loss of function associated with a medication error.
- Any suicide of a patient in an around-the-clock setting, including suicides following elopement from such a setting.
- Any elopement, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide or homicide) or major permanent loss of function.
- Procedure on the wrong patient/side of the body, or/organ.
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function.
- Patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.
- Hemolytic transfusion reaction involving major blood group incompatibilities.

It is significant that patient suicide is the most reported sentinel event as reflected in the following chart from JCAHO.

Type of Sentinel Event	#	%
Patient suicide	320	16.3%

Op/post-op complication	240	12.3%
Wrong-site surgery	229	11.7%
Medication error	223	11.4%
Delay in treatment	116	5.9%
Patient fall	93	4.7%
Pt. death/injury in restraints	93	4.7%

Settings of Sentinel Events	**#**	**%**
General hospital	1,251	63.9 %
Psychiatric hospital	254	13.0 %
Behavioral health facility	113	5.8%
Psych unit in general hospital	109	5.6%
Emergency department	74	3.8%
Long term care facility	70	3.6%

It becomes apparent how medical errors effect the mental health profession as the highest reported JCAHO sentinel event is patient suicide. The issue of suicide will be covered later in the course.

Events occur most frequently in general hospitals, however, psychiatric hospitals and behavioral health settings have the next greatest occurrence of incidents.

NEAR MISS

A "Near Miss" is a sentinel event that has been averted whether intentionally or unintentionally by competent action or chance.

For example, a depressed patient is evaluated without also assessing for suicide risk and chemical dependency issues. Research shows that many suicidal patients have concurrent issues of depression and substance abuse.

JCAHO defines a "Near Miss" as any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious outcome". Although a near-miss is within scope of definition of Sentinel Event it is outside the scope of those events subject to mandatory review by JCAHO. However, many hospitals and clinics review these events using the same criteria for a Sentinel Event in order to prevent a more serious incident occurring in the future.

The following are events that are not reportable to JCAHO.

- Any "near miss."
- Full return of limb/bodily function
- Any sentinel event that has not affected a recipient of care (patient, client, resident).
- Medication errors that do not result in death or major permanent loss of function.
- Suicide other than in an around-the-clock care setting or following elopement from such a setting.

- A death or loss of function following a discharge "against medical advice (AMA)."
- Unsuccessful suicide attempts.

Included in the types of events not reportable to the JCAHO is suicide other than in an around-the-clock care setting.

ROOT CAUSE ANALYSIS

ROOT CAUSE DEFINITION

The "root cause" is the most fundamental reason for the failure or inefficiency of a process. The term "root cause" may be misleading as there is seldom one root cause for errors. Usually there are several incidents along a time line that contributed to the error or incident.

ROOT CAUSE ANALYSIS

A "Root Cause Analysis" (RCA) is a process for identifying the basic or causal factor(s) that underlies the variation in performance, including the occurrence or possible occurrence of a sentinel event.

The Institute of Medicine reports that the majority of medical errors are due not to individual recklessness but system errors – flaws in the way the system is organized. The paradigm for understanding and avoiding medical errors is to examine the system and not assign blame to individuals.

A thorough RCA objectively explores and identifies all possible root causes without bias. During this process the focus is on system errors. The questions that are asked during this process are "why" and "how" did this event happen, rather than "who" can be blamed.

ROOT CAUSE CATEGORIES

- Human
- Communication
- Environmental
- Supplies
- Equipment
- Policies & Procedures

JCAHO analyzes the root causes of sentinel events in light of the above categories. By thoroughly analyzing these factors and their impact on specific incidents, ways to avoid future errors can be developed. Each of these is investigated in relation as to being contributory or non-contributory to the sentinel event. Even when a category is determined to be non-contributory, it is still included in the final written report.

Each of the above JCAHO categories is then analyzed according to:

- Staffing levels
- Orientation
- Continuing education of staff

Part of the continuing education of staff is keeping abreast of current professional literature and research.

The team that comprises the study includes:

- staff closest to the event,
- staff directly involved in error event
- leadership of system
- members from related technologies
- objective unrelated members of the organization

A successful Root Cause Analysis will identify the following:

- risk points along the continuum of care
- responsible systems – not person
- corrective action plan

- who will implement and follow up effectiveness of corrective actions

BARRIER ANALYSIS

Barrier analysis is the study of the safeguards that can prevent or mitigate (or could have prevented or mitigated) an unwanted event or occurrence. It offers a structured way to visualize the events related to system failure or the creation of a problem.

The productive RCA will identify:

- Absent barriers
- Ineffective barriers
- Preventative measures

An ineffective barrier, using the previous example of bed checks on a locked psychiatric unit, would be if that facility had the policy (a barrier) but the policy was not being carried out (ineffective barrier).

The cost of care is among the most frequently cited barriers to mental health treatment. Rises in co payments of mental health services are associated with lower access. Additional barriers to care for mentally ill lie not in an absence of effective treatments but in the fact that the symptoms and stigma association with severe mental illness may make it difficult for patients to obtain and follow through with appropriate care.

PART II – MEDICAL ERRORS & BEHAVIORAL HEALTH ISSUES

TYPES OF BEHAVIORAL HEALTH ERRORS

In the next section we will cover specific types of errors and how they impact mental health practice.

DIAGNOSTIC

IOM recommends quality assessment in the following areas: mental health, substance abuse and neurological disorders and stresses the need for quality assessments for special populations such as the frail elderly, poor children and ethnic minorities.

The following are potential error prone situations in diagnosing and assessing mental health issues.

- Error or delay in diagnosis
- Failure to use differential diagnosis
- Failure to act on results of monitoring or testing
- Lack of thorough history taking
- Not examining prior diagnosis
- Psychiatric issues that are medical in origin
- Medical issues that have psychiatric components not being addressed

One problem confronting the clinician is having the time to perform a thorough history. Due to time constraints from third-party payers and managed care organizations, therapists frequently do not have the time to adequately assess their clients.

Time constraints also affect the primary physician who may view patients as exhibiting behavioral problems when they are actually displaying symptoms of a medical disorder. Often simple tests can be performed to identify and successfully treat these medical problems. Examples are thyroid problems, brain tumors, and menopause and vitamin deficiencies.

Conversely, clients may have underlying psychiatric issues that are not being addressed. For example, post-partum depression if not diagnosed and treated, can lead to greater problems. Other examples of medical issues that have psychiatric issues often not addressed are diabetes, heart problems and Parkinson's Disease.

TREATMENT

The most significant errors in actual treatment occur with:

- Avoidable delay in treatment
- Inappropriate Care – giving medical/legal advice
- Providing treatment outside one's area of expertise, training and continuing education
- Inadequate record keeping or documentation

Many studies of under use of treatment for psychiatric populations were in chronic care. IOM reports mental health care falls below standards with 78 % of schizophrenics in one study receiving poor symptom management and 79% of them experiencing medication side effects.

PREVENTIVE

Preventive errors include:

- System Failures
- Inadequate staffing
  - Overextended patient/therapist ration
  - Utilization of under qualified or non-credentialed staff
- Security breeches in internet practice
- Inadequate monitoring or follow up of treatment

One example of preventive error is inadequate follow up of treatment. Suicide is more likely to occur in the first month after discharge from psychiatric hospitals and subsequently, low treatment adherence poses major risk for suicidal ideation. Long term follow-up care holds promise for reducing suicide. One study illustrated that an intervention that effectively reduced completed suicides entailed regularly mailing letter to those patients who refused or dropped out of follow up care.

COMMUNICATION

When analyzing contributing factors to medical errors, communication errors are the most significant problem. Some examples of communication errors in mental health include:

- Not explaining informed consent
- Breeches of confidentiality

Asking patients to recall and restate what they have been told during the informed consent process is an effective intervention, insuring valid consent and avoiding possible malpractice issues later.

One of the most reported complaints against therapists, and their office staff, is violation of confidentiality. Workers need to maintain this privilege and provide staff education on the imperatives for assuring patient confidentiality.

SOLUTIONS

In terms of mental health practice, the following interventions can decrease the potential for medical errors.

- Safety Planning
- Competency Issues – Clinicians and Clients
- Obtain Valid Informed Consent
- Educate clients on specific issues
- Special Needs populations

SAFETY PLANNING

By recognizing potential error prone situations, the clinician can insure their own and their clients' safety. Some of the common situations that can produce error in behavioral health are:

- Distraction
- Lack of Knowledge
- Learning errors

- Dependence on technology
- Miscommunication
- Lack of procedural clarity

For examples, distractions can come in many forms, from noise that interferes with our ability to hear clearly what our clients are saying to lack of procedural clarity when working in agencies that do not provide a thorough orientation to policies and procedures.

Another significant aspect of safety issues is that as many as 20% of patients are not literate enough to read, follow, or understand directions. With more patients speaking another language, the chance for misunderstanding becomes greater. The issue of cultural challenges will be addressed later.

COMPETENCY ISSUES

Competent Providers

The Code of Ethics of most mental health professional organizations provides valuable guidelines on competent practice. The Code may state that:

"Practitioners should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience. Practitioners should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm."

http://www.apa.org/ethics/code2002.html

http://www.socialworkers.org/pubs/code/code.asp

http://www.amhca.org/ethics.html

Competent, ethical practice utilizes the Best Practices Model. According to the Insurance Trusts, 27% of malpractice suites again mental health professionals were due to incorrect treatment, often the result of lack of expertise

COMPETENT CLIENTS

Florida law defines incapacitation as a person who is unable to meet at least some of the requirements essential to his health and safety. Section 744 defines the requirements as "those actions necessary to provide the health care, food, shelter, clothing, personal hygiene or other care without which serious and imminent physical illness or injury or illness is more likely than not to occur." Clients who lack capacity to make informed decisions on their behalf may have a guardian appointed for them.

When questions of legal competencies or capacities are raised a clinical assessment process is necessary to supply a cognitive, mental health, and functional evaluation.
Several instruments are available to mental health professionals to assess for client competency. These tools include the Mini Mental Status Examination and the Legal Capacity Questionnaire.

OBTAIN VALID INFORMED CONSENT

Informed consent is defined as a vehicle for expression of patient preferences and/or institutional rules or a policy that conforms to standards.

Florida law mandates a mental health professional must provide enough information for the patient to make a "knowing" decision.

At a minimum the patient must be informed of the following regarding informed consent.

- his/her condition or problem
- the nature and purpose of the treatment or procedures
- any hazards, risks, or potential complication of the therapy
- any feasible alternatives to the treatments
- expected outcome of the treatment
- risks and prognosis if the treatments are NOT done.

Perhaps a more useful term is valid consent. That is consent that is fully informed, non-coerced and from a competent person.

Asking patient to recall and restate what they have been told during the informed consent process reduces risks of non compliance with treatment and ethical violations.

PROBLEMS WITH INFORMED CONSENT

One problem today is that clients often have "too much information" leading to misperceptions about therapy and therapists. This comes from sources ranging from (often faulty) information available on the Internet to the portrayal of therapy in films and television. Often clients come into treatment with erroneous beliefs about therapy and this is where a thorough informed consent process can provide valuable information.

Another problem is due to time constraints. Because of systems that require brief therapy and limited sessions, therapists may not be able to spend the time necessary to provide educated valid consent.

EDUCATION

Assertive communication

Patient safety is essential in avoiding medical errors and educating clients on specific issues like safe medication management decreases the risk for errors. The informed consumer is the most effective way to prevent medical errors. In addition to

providing clients with information on prevention of medical errors, clinicians can assist clients in becoming more assertive communicators. Teaching clients to learn to ask questions and voice their concerns regarding medical treatment and mediations is another effective prevention technique.

The CDC and the U.S. Department of Health and Human Services reports that strict adherence to hand washing policies alone could prevent the deaths of up to 20,000 patients each year. In Australia, researchers found that in their institution's critical care unit male healthcare workers washed their hands one-third less often than female workers did after contact with an invasive instrument or a patient's skin, blood or "excretions." Teaching clients to be empowered to ask their health care workers if they've washed their hands can be a powerful deterrent to the spread of infection.

Although it might feel uncomfortable for many clients, it is important to teach them that it is appropriate and a safety measure to ask their health care workers if they've washed their hands.

Medication Errors

Medication errors are a serious problem. Statistics reveal that more people die from medication errors, around 7,000 annually, than the 6,000 work-related deaths in the U.S. Eleven people die every hour from medication errors in hospitals. In one year, 2.4 million prescriptions were filled improperly in Massachusetts.

Although the mental health clinician is not qualified to discuss specific medications, it is important to educate clients on safe medication practices. Since many mental health clients lack the communication skills to appropriately articulate their concerns, family education on medication issues is an effective and appropriate intervention.

Medication errors can occur due to mistakes in writing, dispensing, administering and failure to recognize and address side effect or interactions of psychiatric medications.

In addition, medication errors occur due to:

- Incomplete patient information
- Unavailable drug information
- Miscommunication of drug orders

Actively psychotic clients or those under the influence of drugs and alcohol, may not be able to communicate correct information to their doctors. The elderly, who may have memory impairment, are also at risk for miscommunication.

Clients should be educated on the following points to assure receiving the right medication.

- Share all medicines with doctor
- Notify physician of all allergies
- Is the prescription legible?
- Read label before taking medications home

HELP CLIENTS SPEAK OUT

One way mental health providers can help clients and the community at large, is to assist in disseminating this valuable information. The Agency for Healthcare Research and Quality has several easy to read pamphlets that explain medical errors, medication issues and patient safety. These pamphlets can be downloaded from the AHRQ website info@ahrq.gov or ordered directly from AHRQ at Agency for Healthcare Research and Quality, 2101 E. Jefferson Street, Suite 501, Rockville, MD 20852, Telephone: (301) 594-1364.

The following documents are available from AHRQ:

Five Steps to Safer Health Care http://www.ahrq.gov/consumer/5steps.htm
20 Tips to Help Prevent Medical Errors: Patient Fact Sheet
http://www.ahrq.gov/consumer/20tips.htm
20 Tips to Help Prevent Medical Errors in Children
http://www.ahrq.gov/consumer/20tipkid.htm
Medical Errors: The Scope of the Problem
http://www.ahrq.gov/qual/errback.htm
Reducing Medical Errors in Health Care: Fact Sheet
http://www.ahrq.gov/research/errors.htm
Ways You Can Help Your Family Prevent Medical Errors!
http://www.ahrq.gov/consumer/5tipseng/5tips.htm

The Five Steps to Safer Health Care is included with this home study course.

SPECIAL NEEDS POPULATIONS

Traditionally, mental health professionals work with populations that are most at risk for medical errors. They include the:

- Aging
- Mentally Ill
- Actively Psychotic
- Children
- Developmentally delayed

About 3% of the adult US population experience severe mental disorders in a one year period. During 1990 these patients, accounted for an estimated $75 billion in national expenditures. As many as half of all individuals with severe mental illness receive no care at all, most commonly because they do not regard themselves as having a problem that requires treatment. Once in treatment only about a third of individuals with serious mental illness receive treatment that is concordant with treatment guidelines.

AGING

Because of physiological changes that effect older American's capacity to adhere to medical treatment, they are an at risk population that deserves special attention. Also, many elderly are "passive" consumers, not questioning healthcare providers or asking for alternative treatments.

MAJOR DEPRESSION

- Approximately one in seven men and one in four women will have an episode of major depression at some point during their lives
- Fewer than half of all individuals with depression are correctly diagnosed
- Fewer than one third receive care that is concordant with clinical treatment guidelines

Depressed patients suffer from levels of disability similar to or greater than those associated with a host of other chronic medical conditions. Major depression contributes to more disability than any other single medical condition. Rates of treatment for depression are substantially lower than for many other chronic conditions

National health expenditures for depression, while substantial, are low relative to the disorder's associated disability.

One study examined how a system change could improve care for depression. It found that patients treated under an enhanced system of care, receiving high-quality depression treatment, including medication supervision and psychotherapy, had a better chance of recovering from the disorder and were more likely to stay in their jobs.

Improving patient education and providing informed consent including risks & benefits of treatment has proven effective in reducing elopement and AMA discharge.

ERROR PRONE BEHAVIORAL HEALTH ISSUES

CULTURE SPECIFIC SYNDROMES

Current U.S. demographics indicate that minority Americans are expected to make up more than 40 percent of the U.S. population by 2035.

There is growing awareness in mental health of the special needs of individuals from other cultures. One barrier these individuals face is the ability and resources to access appropriate health care and treatment.

Through training and education on diverse cultures, the clinician will gain tools to overcome potential barriers to communication. This will lead to improved clinician patient communication, insure valid consent and increase trust

By utilizing appropriate interpreters, therapists will be able to get a more accurate clinical picture of their clients and obtain a thorough psychosocial history. In addition, adequate translation contributes to a reduction in diagnostic errors and unnecessary diagnostic testing.

UNDERSTANDING DIVERSE CULTURES IMPROVES CARE

Harmful interactions between prescribed drugs and folk or home remedies could be avoided by training clinicians to ask patients whether they're using such remedies.
Many cultures utilize home remedies, including herbs and botanicals that may have a negative interaction with prescribed medications. By emphasizing the importance of communicating these practices with their primary physicians, potential

problems may be averted. Health promotion and education materials that reflect culture-specific attitudes and values could result in more successful patient education and increased adherence to treatment regimens.

CULTURE SPECIFIC SYNDROMES

There are many cultural patterns that may present like a psychiatric issue, but are indeed rooted in culture. These syndromes are usually locality-specific patterns of aberrant behavior and may not be linked to DSM-IV category.

An example that is seen with Hispanic patients, especially females, is a phenomenon called "Ataque de Nervios". The symptoms range from uncontrollable shouting, attacks of crying, trembling, verbal or physical aggression, dissociative or seizure like episodes and fainting. Onset is related to stressful family events like death or divorce.

SUICIDE

Magnitude of the problem:

- 30,000 suicide deaths per year in the United States
- 1 million suicides per year worldwide
- During the period of the Vietnam war 4 times the number of Americans died by suicide than died by combat
- Estimated cost to the nation $12 billion/year

There is still a stigma associated with mental illness which is a barrier to treatment and the often greater stigma associated with suicide frequently deters individuals from disclosing their plans with treatment providers.

Suicide statistics reveal that:

- 90% of those who commit suicide have a diagnosed mental illness, most often major depressive disorder.
- About one fourth of all suicides in the US are individuals with alcohol use disorders.
- Alcohol intoxication is indicated in up to 64% of suicide attempts

There are many reasons why individuals attempt suicide. Among these reasons are feelings of powerlessness to change their feelings of sadness or hopelessness or the events occurring in their lives. Other reasons include self-punishment, often to relieve guilt, and punishing others. However, the greatest incidence of suicide is due to mental or physical illness with concurrent substance abuse issues.

There are several risk and protective factors to considering when evaluating a potentially suicidal client and they include:

- Biological Factors
- Psychological Factors
- Substance Abuse and Mental Illness
- Child Abuse
- Social Factors
- Sociopolitical and Cultural Factors

Culture strongly influences how individuals view suicide. Cultural values and social structures largely determine the type and degree of both stressors and support, availability of means and access to treatment and social prescriptions or proscriptions concerning suicidal behavior. Across cultures, family cohesion and support acts as a buffer against suicidality; parenthood protects against suicide. Divorced and never-married status generally increases suicide risk, especially among men. Social support and various types of religious involvement and beliefs are protective against suicide.

Working with suicidal patients presents great challenges for the clinician. The third most reported malpractice charges against mental health professionals involve patient suicide. Seeking out supervision with difficult cases and knowing one's own competency level can decrease suicide risk.

The following are errors commonly made by suicide interventionists:

- Superficial reassurance
- Avoidance of strong feelings
- Professionalism (distance)
- Inadequate assessment of suicidal intent
- Failure to identify precipitating event
- Passivity
- Indirect
- Advice Giving
- Stereotypic Response
- Defensiveness

SUICIDE ASSESSMENT

Studies reveal that assessment tools are inadequate to determine acute suicide risk or to predict when a person will attempt or complete suicide. In addition assessment tools must be validated for various populations since they may not be applicable. Despite their limitations, tools for detection or risk assessment can be an important component of treatment when used appropriately

Anti depressants and lithium maintenance treatment reduces suicide in certain patients. Medicine alone is not sufficient for treatment of suicide nor are treatments equally effective across individuals and diagnoses. Psychotherapy provides a necessary treatment relationship that reduces the risk of suicide. Cognitive behavioral approaches that include problem-solving training seem to reduce suicidal ideation and attempts, and are more effective than treatment as usual or supportive therapy.

Among the assessment instruments available to clinicians are:

- Detection instruments
- Risk assessment instruments
- Assessment of clinical characteristics of suicidal behavior
- Scale for Suicide Ideation (SSI) Beck

IOM RECOMMENDATIONS

In their recommendations to primary care physicians, the IOM claimed that there is insufficient evidence to recommend for or against routine screening for suicide risk. However, the IOM does recommend that the physician should:

- be alert to signs and symptoms of depression and should routinely ask patients about their use of alcohol and other drugs
- utilize tools for recognition & screening
- refer to mental health providers for patients with multiple risk factors
- receive training in suicide risk factors and prevention

Research also reveals that no psychological technique, clinical technique or biological marker is sufficiently sensitive and specific to accurately assess short-term prediction of suicide of in an individual. Assessment instruments can be useful tools but are not a substitute for clinical judgment. Nevertheless, assessment is an important component of psychotherapeutic interventions

Despite the Institute of Medicine's recommendations, research shows that a significant number of suicidal individuals are seen by physicians less than one month before the incident. Statistics indicate that:

  - one half to two thirds of all persons who commit suicide visit physicians less than one month before the incident
  - ten to forty percent see a physician in the week preceding the event.
- These statistics indicate that primary care physicians are on the front line in working with suicidal clients. Providing education on suicide risk and substance abuse issues to primary care physicians is an important intervention mental health professionals can provide on a community level.

ETHICAL ISSUES OF SUICIDE

Mental health professionals have a duty to report, Florida Statute 491.0147 mandates, *"When there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities."*

During the informed consent process, clients need to understand that one of the limits of confidentiality is if they are suicidal and that you, the clinician, will take appropriate measures to protect their safety.

DOMESTIC VIOLENCE

Domestic violence continues to be a significant problem in America and one that clinicians need to be aware of especially during the initial assessment process.

- As many as one fourth of American families experience domestic violence
- Two to four million women are physically abused every year
- Six out of every ten married couples have experienced violence at some time during their marriage.

National crime statistics reveal the following alarming facts.

- About 11% of murder victims were determined to have been killed by an intimate

- Most murder victims were familiar with their assailants.
- Spouses and family members made up about 15% of all victims

Although there are cases of males being victims of domestic violence, this is still largely a crime against women.

- Female murder victims are substantially more likely than male murder victims to have been killed by an intimate
- About one third of female murder victims were killed by an intimate
- About 4% of male murder victims were killed by an intimate

DOMESTIC VIOLENCE IN FLORIDA

Statistics of the 124,016 domestic violence incidents reported in Florida in 2001 reveal that:

- Domestic violence incidents comprised 26.6% of all comparably reported violent offenses
- 23% of state's 867 murders were domestic incidents
- 58.6% murdered by spouse or live-in partner
- 14% of murder victims were children

SCREENING, ASSESSMENT & INTERVENTION

Some of the following are symptoms and signs of domestic violence.

- Depression, anxiety, fear, suicidal ideation
- Feelings of isolation, inability to cope
- Suicide attempts or gestures
- Panic attacks/anxiety symptoms
- Substance abuse
- Symptoms of PTSD
- Lack of independent transportation, access to finances, ability to communicate by phone

INTERVENTIONS WITH SUSPECTED VICTIMS

- Separate patient from partner
- Educate that domestic violence is a serious and common problem
- Express concern for safety of patient and children
- Education on dynamics of DV and effects on children
- Educate about options regarding safety and shelters for battered victims
- Devise and share a safety plan with the patient
- Report any suspected instances of child, elder, or disabled abuse to appropriate agency.

One of the most important interventions is to always separate the client from the potential abuser. Educating the victim on the effects of domestic violence on children can also be a successful intervention.

Florida licensed mental health providers are mandated to report suspected instances of child abuse. The state abuse and tracking system that is reported to is: 1-800-96-ABUSE.

ELDER ABUSE

“GRANNY DUMPING”

In the 1970’s a phenomena was seen in Great Britain where elderly women were abandoned at hospitals and emergency rooms. Because these elders, frequently women, suffered dementia and were unable to identify themselves, this was called “Granny Dumping”. As instances of this began in the U.S., and more reported cases of elder abuse were surfacing, U.S. congressional hearings began to investigate elder abuse, resulting in the Elder Abuse Task Force in the Department of Health and Human Services.

Florida licensed mental health professionals are mandatory reporters of suspected elder abuse.

DEMOGRAPHIC INFLUENCES

- 1900 1 in 25 Americans reached age 65
- 2011, one out of every five Americans will be 65 or over.
- 1900 only 123,000 Americans aged 85 and over.
- 2002 – almost 5 million persons over 85
- By 2050 35 million over age 85.

Because the elderly are the fastest growing population group in the US, our aging clients are particularly at risk for abuse and neglect and often difficult to detect.

SYMPTOMS OF ELDER ABUSE

The symptoms of elder abuse range from physical abuse to neglect and violation of personal rights.

- Physical abuse
- Neglect
- Psychological abuse or neglect
- Financial abuse or neglect
- Violation of personal rights – self-respect, dignity, privacy.

ELDER MISTREATMENT

Abuse is when the caregiver actively harms the senior, such as hitting or pinching.

Neglect is the failure to do something the senior requires, such as getting adequate nutrition.

DIFFICULT TO MEASURE EXTENT OF ELDER ABUSE

However, it is very difficult to measure the actual extent of elder abuse as the victim may be impaired and not able to accurately report or describe the details of the abuse and neglect. Some of the factors making assessment difficult include:

- Mentally impaired patient my not be able to report or describe in detail
- Report might not be believed
- Victims often dependent on abusive caretakers
- Financial exploitation may occur without the victim’s knowledge

ELDER ABUSE STATISTICS

- Annually an average of 36,000 persons age 65 and older are injured by a relative, intimate or close acquaintance.
- Approximately 500 elderly are murdered each year by a relative, intimate or close acquaintance.
- Relatives or intimates committed more than 1 in 4 of the murders and 1 in 10 of the incidents of non lethal violence against persons age 65 or older.
- When faced with violence by a relative, intimate, or close acquaintance, about two—thirds of the elderly were at home, in the day time.
- Victims of murder over ages 64 were 2 times more likely than victims between ages 12 and 64 to have been killed by relatives or intimates.

RISK FACTORS ASSOCIATED WITH ELDER MISTEATMENT

- Dependency/vulnerability issues
- Family member psychopathology
- History of family violence
- Isolation
- Caregiver stress
- Progressive or unstable medical conditions

By recognizing risk factors associated with elder mistreatment, the clinician may be able to effectively intervene with the caregiver and avoid potential abuse incidents.

There are an estimated 54 million caregivers nationwide, the majority of whom are caring for an elderly relative. Surveys indicate that isolation is the number one source of stress for these caregivers.

CONCLUSION

Patient safety is the responsibility of all healthcare providers. Reduction in errors will be achieved through patient and family education and in organizations that emphasize open communication, trust and a learning environment. Mental health professionals can take an active stance in advocating for populations at risk for errors by providing education to and clients and their families and promoting their active involvement in the service delivery area. By following your organization's Code of Ethics and adhering to Best Practices Model, the Florida mental health professionals will be protecting their clients, communities and themselves.

MEDICAL ERRORS POST TEST

1. According to the Institute of Medicine report, which of he following reflect the number of people who die each year in hospitals from medical errors?
   a. About the same number as die of aids.
   b. The number approaches 100,000.
   c. Enough to be categorized as the fifth leading cause of death in our country.
   d. Less than die from vehicle accidents.

2. The primary reason that medical errors must be prevents is because medical errors
   a. are costly
   b. jeopardize patient safety
   c. lead to bad publicity
   d. waste valuable healthcare provider time

3. Most medical errors are in fact preventable.
   a. True
   b. False

4. Factors that impact the occurrence of medical errors include:
   a. Flaws in the way the system is organized.
   b. Limited human resources of time, energy and manpower.
   c. Poor communication
   d. All of the above.

5. Florida licensed health care practitioners must report adverse incidents that result in death, loss of function, or serious injury:
   a. Within three business days
   b. Within one business day
   c. Immediately
   d. Upon the death of a patient

6. Medical errors include:
   a. Errors in diagnosis
   b. Errors in treatment
   c. Errors in giving medication
   d. All of the above.

7. An unintended act, of commission or omission, adverse events, near misses and hazardous conditions that result in an unintended or negative outcome are all inside the confines of the definition of:
   a. Sentinel events
   b. Adverse events
   c. Medical Errors
   d. Root causes

8. Which populations are at greater risk for behavioral health care service delivery errors?
   a. Patients with psychiatric illness
   b. Elderly patients
   c. Patients with coexisting conditions
   d. All of the above

9.JCAHO requires a root cause analysis and corrective plan for every:
   e. patient slip and fall
   f. chart with incorrect date of birth for patient
   g. postponed scheduled surgery
   h. unanticipated loss of function

10. A root cause analysis is considered valid by JCAHO when:
   a. all personnel are involved in the analysis
   b. absent and ineffective barriers are identified
   c. the team videotapes the meeting
   d. all risk points are identified

11. Which of these questions is most relevant to determining the root cause:
   a. Who did it?
   b. When did they do it?
   c. Why did it happen?
   d. When did it happen?

12. The public is very concerned about the medical errors issue. How can you empower your clients to protect their own safety?
   a. Teach them to ask questions and to feel good about asking.
   b. Teach them to discuss their medications with all of their healthcare providers.
   c. Teach them to speak up when something seems amiss.
   d. All of the above.

13. Elder abuse recognition and reporting is so critical because:
    a. Our population of elders is increasing steadily.
    b. Elders typically abuse each other elders in nursing homes.
    c. Older Americans tolerate and accept elder abuse.
    d. The fastest growing populations include those from 50 to 60 years of age.

14. Select the correct example of abuse.
    a. Psychological abuse: failing to provide walking devices.
    b. Physical abuse: pushing, hitting or pinching.
    c. Financial abuse: not applying for Meals on Wheels.
    d. Psychological neglect: failing to provide nutritious meals.

15. Estimates suggest that the number of women physically abused each year in America is:
    a. Between 1 and 3 million
    b. Between 2 and 4 million.
    c. Between 6 and 7 million.
    d. Between 8 and 10 million.

16. In order to provide effective treatment with a victim of domestic violence, the mental health professional should:
    a. Interview the potential perpetrator and the victim together.
    b. Obtain an injunction against the batterer.
    c. Utilize safety plans and community resources with the victim.
    d. Make decisions for the victim.

Michael Freeny Associates

P.O. Box 532021 Orlando, FL 32803

Continuing Education Home Study Evaluation Form

Title of Program: Prevention of Medical Errors

Author: Margot Escott

CE Credit Hours: 2 **Program Recertification:** February 2004

Using the scale indicated below, please place the appropriate number after each statement to indicate the degree to which you agree or disagree to the statement.

1	2	3	4	5
Strongly Disagree				**Strongly Agree**

Content/Format/Learning

1. The program description was accurate ______
2. I acquired new knowledge or skills ______
3. The amount of material presented was appropriate to the allotted credit ______
4. The course content matched the stated learning objectives ______
5. Materials current and useful ______

Instruction

6. The materials were understandable ______
7. The material was well organized ______
8. The concepts were clearly explained ______
9. The teaching style was appropriate for the content ______

Overall Rating

10. I expect this experience will be useful in my professional activities ______
11. The experience was enjoyable ______
12. I would recommend this program to a colleague/associate ______

Logistics

13. This format is conducive to learning ______
14. Registration was smooth and efficient ______
15. Staff were responsive and helpful ______

Additional Comments and Suggestions for Future Programs:

____

____

Your Professional Identification and Degree: ____

Name ______________________________ (Optional:)E-Mail Address__________________________

Michael Freeny Associates

P.O. Box 532021 Orlando, FL 32803

Print the letter of the correct answer on this answer sheet, print and sign the attestation statement, and sent this sheet, along with the evaluation form to the address below.

1.	_____	9.	_____
2.	_____	10.	_____
3.	_____	11.	_____
4.	_____	12.	_____
5.	_____	13.	_____
6.	_____	14.	_____
7.	_____	15.	_____
8.	_____	16.	_____

I attest that I am the individual who has taken and completed this CE At-Home Course.

Name: ______________________________ ________________________________
print signature

Send This Sheet and the Evaluation form to:

Michael Freeny Associates/ClinicalCE.Com
P.O. Box 532021
Orlando, FL 32803
Fax 407-884-6553

A 70% pass rate is required to receive credit. Missed questions can be resubmitted to attain a score of 70%. Your certificate will be sent to you within one week after fulfilling the requirements for this program.