PREVENTION AND REDUCTION OF MEDICAL ERRORS

COURSE OUTLINE

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How can protecting confidentiality reduce errors?
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How can personal characteristics impact practice errors?
What personal qualities impact practice errors?

How can commitment to meeting professionally accepted standards of care reduce medical errors?
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CONCLUSION

What summary point should professionals always keep in mind?

RESOURCES

What references will provide you with more material on medical errors?

INTRODUCTION TO MEDICAL ERROR COURSE

INTRODUCTION NOTE TO PARTICIPANT: This course is presented in a question and answer format. Hopefully each question will focus your attention on critical information, ideas, or concepts to acquire. The questions will help simplify the complexity of the material, as well as, highlight the important issues. The questions and the responses are arranged in a sequential order that allows for a meaningful progression through the course material.

Who can benefit from this course?

This course is intended to provide important concepts and strategies that are crucial to the prevention and reduction of errors within the behavioral healthcare practice of psychologists, counselors, social workers and other behavioral health professionals.

What does the Florida Statute 456.013(7) state?

Medical errors (healthcare provider practice errors) are a source of unnecessary and preventable harm to the public. Government and regulatory agencies at the national and state level are requiring licensed professionals to take steps to reduce medical errors. The Florida Department of Health has stressed the importance of reducing medical errors by requiring a continuing education course on medical errors. It states:

Two (2) hours of the continuing education required in the biennial renewal process must relate to prevention of medical errors, including a study of root-cause analysis, error reduction and prevention, and patient safety. If the course is offered by a facility licensed pursuant to chapter 395 for its employees, the Board will approve up to one (1) hour of the two (2) hour course to be specifically related to error reduction and prevention methods used in that facility.

In addition to including a study of root-cause analysis, error reduction and prevention, and patient safety, course material should discuss areas within mental health practice that carry the potential for "medical" errors. Examples would include improper diagnosis, failure to comply with mandatory abuse reporting laws, inadequate assessment of potential for violence (e.g., suicide, homicide), failure to detect medical conditions presenting as a psychological/psychiatric disorder.

The entire text of Florida Statue 456.013 may be accessed at:

http://www.leg.state.fl.us/STATUTES/

What are the learning objectives for the medical errors course?

- Explain why giving attention to medical errors is important

- Identify major causes of medical errors (practice errors) and barriers to error reduction
- Describe ingredients for improving patient safety, including the Joint Commission's requirements and mandatory goals for patient safety
- Discuss Sentinel Events and the Joint Commission's requirements
- Describe the process for Root Cause Analysis
- Describe the application of Root Cause Analysis to a specific case example
- Provide 5 examples of potential medical errors within behavioral healthcare practice
- Discuss Florida's mandated requirements for error reduction
- Describe steps for preventing and reducing behavioral healthcare practice errors
- Describe how personal qualities impact on practice errors
- Describe principles and practices for overall prevention and reduction of practice errors

MEDICAL ERRORS DEFINITIONS AND RATIONALE FOR REDUCTON AND PREVENTION EFFORTS

What are medical errors?

"Medical and behavioral healthcare errors are the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim. It is mistakes of omission and/or commission made by licensed professionals during the daily activities of their practice."

"People make mistakes. People can have great experience, motivation, or show great care, and still make mistakes. But when the people making mistakes are healthcare practitioners, the consequences of those mistakes can be devastating."

Prevention of errors is effort taken that keeps mistakes from happening or arising. Reduction of errors is effort taken that decrease and minimizes unwanted outcomes. This course is designed to heighten awareness and prompt the development and implementation of processes in clinical practice that both reduces and prevent harmful errors.

What prompted attention on medical errors?

The problem of medical errors gained national attention in 1999 when the Institute of Medicine (IOM) wrote a report entitled To Err is Human: Building a Safer Health System. The report revealed an epidemic of medical errors in the United States. The report identified medical error as injuring 1 in every 25 hospital patients and as being responsible for tens of thousands of deaths each year. Medical errors have been the third leading cause of death in the United States, more deadly than breast cancer, motor vehicle accidents, or AIDS. According to Dr. Leape, the number of deaths from medical errors in hospitals could account for the equivalent to the death toll from three jumbo jet crashes every two days. The IOM report indicated that medical errors cost the economy as much as $29 billion each year.

The report captured the attention of the public, healthcare industry as well as federal and state agencies. In response to the report Congress approved a $50 million annual appropriation for research on patient safety, primarily by the Agency for Healthcare Research and Quality (AHRQ). The Joint Commission now requires that healthcare institutions analyze serious medical errors to determine the root causes and develop an action plan to prevent those errors in the future. In July 2005 President Bush signed into law S.544, the Patient Safety and Quality Improvement Act, which established a voluntary confidential reporting system to create a national database of medical errors for analysis and for development of evidence-based patient safety measures. Twenty-five states, including Florida, have mandatory or voluntary systems for reporting medical errors in hospitals and other healthcare organizations (National Quality Forum, 2007).

What does the APA (2007) report have to say about medical errors?

In response to the legislative efforts occurring at the national level and to ensure that human factors expertise was included in the legislative process, the American Psychological Association published their report Erring on the Side of Human Factors for Patient Safety (APA 2007). The APA and the Federation of Behavioral, Psychological and Cognitive Sciences arranged for patient safety experts to conduct team briefings for both the House and the Senate. They reported that the success of any legislation aimed at reducing medical errors and deaths is dependent upon understanding the complex nature of medical errors.

This may be one reason why the state of Florida included the study of root cause analysis as specific content for medical errors courses (F.S. 456.013). Root cause analysis is a step-by-step process for finding the underlying cause of a specific problem. The cause of an error is typically not simply an individual who is making a mistake, but rather due to various circumstances including system errors. The APA 2007 report stressed that the source of errors must be evaluated systemically, considering administrative policies, conditions within the work environment, as well as individuals who failed to meet standards of care.

Why *Should Behavioral Healthcare Professionals be Concerned about Practice Errors?*

Harm to others

If errors in the medical field can occur at such a high rate, where there has been significant focus at reducing errors, imagine the error rate within the behavioral healthcare field, where relatively little attention has been given to reducing errors. It's very important to remember that behavioral healthcare errors also cause harm to individuals, including relationship conflicts, prolonged emotional distress, and unnecessary suicides.

Economic costs

According to a 2005 Forbes Magazine article, preventable medical errors cost an estimated 500 billion dollars in added health care costs alone or 30% of all health care spending. Total national costs (lost income, lost household production, disability and health care costs) of preventable adverse events (medical errors resulting in injury) are estimated to be between $17 billion and $29 billion, of which health care costs represent over one-half.

Behavioral healthcare practitioners' errors share many of the cost factors found in medicine. In addition, there are opportunity costs. Dollars spent on misdirected sessions, application of ineffective therapy strategies, repeated diagnostic tests and diagnostic interviews are dollars unavailable for other purposes. Purchasers and patients pay for errors when insurance costs and co-payments are inflated by services that would not have been necessary had proper care been provided.

Intangible costs

Not all the costs can be directly measured. Errors are also costly in terms of loss of trust in the system by patients and diminished satisfaction by both patients and health professionals. Patients who experience prolonged intervention as a result of practitioners' judgment errors pay with unnecessary psychological discomfort. Health care professionals pay with loss of morale and frustration at not being able to provide the best care possible. Employers and society, in general, pay in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

Malpractice liability

Errors in professional practice can lead to significant increase in malpractice liability insurance costs, not only for the professional involved in a malpractice activity, but other professionals purchasing malpractice insurance. More seriously, it can lead to a suspension of professional practice, or loss of license, and/or significant financial damages for not meeting standards of care.

CAUSE OF MEDICAL ERRORS AND BARRIERS TO ERROR PREVENTION AND REDUCTION

What are considered primary causes for medical errors?

Experts report that medical errors are seldom due to carelessness or negligence. More commonly, errors are caused by faulty systems and basic flaws in the way healthcare technology and systems are designed and organized. In the behavioral healthcare field, with a lack of carefully designed systems and processes, errors are less due to technology, and more likely due to lack of error awareness, lack of focus on error analysis, and lack of interest in correction and prevention of errors.

What have been barriers to error reduction?

Even with high unnecessary death and injury rates along with the enormous estimated annual cost of health errors to US healthcare system, one major barrier has been the silence that surrounds medical and practice errors. Media coverage has been limited to reporting of anecdotal cases. Consumers generally believe they are protected. Licensure and accreditation suggest, in the eyes of the public, a "Good Housekeeping Seal of Approval." Yet, many licensing and accreditation organizations have focused only limited attention on the prevention of errors. Practitioners also perceive the liability system as a serious threat to applying systematic efforts to uncover and learn from errors. Also, the fragmented nature of the health care delivery system contributes to errors in communication. For example, when patients see multiple service providers in different settings, none of whom have access to complete information, it is easier for something to go wrong than when care is better coordinated. Another barrier to reducing errors has been the lack of effort by third party payment systems to create incentives for health care organizations to improve safety.

REPORTING SENTINEL EVENTS/ERRORS

What does the Joint Commission require accredited organizations to have in place? The Joint Commission requires accredited organizations to have two systems in place for reporting errors…an internal system and an external system. Healthcare organizations must have a process in place to recognize sentinel events. They must conduct thorough Root Cause Analyses that focus on process and system factors, and not on individual blame. (Root Cause Analysis is explained later in this paper). They must document a strategy for reducing risk and establish an internal corrective action plan within 45 days of the organization becoming aware of the sentinel event.

How does the Joint Commission define a sentinel event?

The Joint Commission uses the term "sentinel event" and defines it as follows: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

What are examples of Joint Commission reportable sentinel events?

- Any patient death, paralysis, coma or other major permanent loss of function associated with a medication error.
- Any suicide of a patient in a setting where the patient is housed around-the-clock, including suicides following elopement from such a setting.
- Any elopement, i.e., unauthorized departure, 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.
- Any procedure on the wrong patient, wrong side of the body or wrong organ.
- Any intrapartum (related to the birth process) maternal death.
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2500 grams.
- Assault, homicide or other crime resulting in patient death or major permanent loss of function.
- A 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.

What does the Joint Commission require for each reported sentinel event?

Accredited facilities are to report not only actual but also potential sentinel events, the close calls and near misses. Once sentinel events are reported, the Joint Commission requires facilities to submit the findings of their root cause analyses and corrective action plans. If the submitted root cause analysis or action plan is not acceptable or none is submitted within 45 days, the facility is at risk for being placed on the Accreditation Watch by the Accreditation Committee of the Joint Commissioners. Failure to perform an acceptable root cause analyses and implement appropriate actions can result in a change in accreditation status, including loss of accreditation.

What does the Joint Commission expect accredited organizations to do with the "Sentinel Event Alert"?

The Sentinel Event Alert is an online newsletter published by the Joint Commission. It identifies sentinel events, describes their causes, and suggest actions to prevent these occurrences. Accredited organizations are expected to: (1) review and consider relevant information in the newsletter; (2) consider information in an alert when designing or redesigning relevant processes; (3) evaluate systems in light of information in the alert; (4) consider standard-specific concerns; and (5) implement relevant suggestions or provide a reasonable explanation for not implementing relevant changes. To view examples of Sentinel Event Alerts, click here.

What is the Joint Commission's minimum requirement for sentinel event of suicide?

For the sentinel event of suicide, the Joint Commission requires that at minimum the following areas be evaluated as a possible cause for error. The following areas reflect critical system functions where a breakdown can cause an adverse event. These are:

- Behavioral assessment of patients' risk to self and others
- Physical assessment process and includes search for contraband.
- Patient observation procedures
- Continuum of care
- Staffing levels
- Orientation and training of staff
- Competency assessment/credentialing
- Supervision of staff
- Communication with patient/family
- Communication among staff members
- Availability of information
- Physical environment, including furnishings; and distractions

- Security systems and processes

A mental health clinic or even a practitioner in sole private practice should reflect on each of the above categories and look for incidents of errors or near errors. Practitioners should identify previous feedback from patients and staff, past difficulties or close call errors, or any inconsistencies in the provision of services. Then practitioners should apply an error analysis procedure to discover root cause issues followed by efforts to address needed corrections.

What is Florida's law regarding reporting of adverse event incidents (sentinel events)?

Every licensed healthcare facility in Florida shall, as a part of its administrative functions, establish an internal risk management program that includes all the following components: (a) The investigation and analysis of the frequency and causes of adverse incidents to patients. (b) The development of appropriate measures to minimize the risk of adverse incidents to patients. (c) The risk-management program must also provide risk management and risk prevention 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. (d) Statute 395.0197 mandates reporting of any adverse incident "over which healthcare personnel could exercise control. These include:

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

7. 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;

(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure?

All incident reports must be filed with the risk manager of the healthcare organization or his or her designee within three days after the event occurred. Following receipt of the report, the risk manager in turn must report the event to the Florida Agency for Healthcare Administration (AHCA).

Three types of reports are required by ACHA:

The Annual Report, which includes all adverse incidents that occur in the facility in the course of a calendar year. These reports are due after the first of each year for the previous year.

24-hour Urgent Issue Report, a preliminary report of serious patient injuries of a more complicated nature, within 24 hours of the occurrence of the injury.

Code 15 Reports, which report in detail on each serious patient injury, the facility's investigation of the injury, and whether the factors causing or resulting in the adverse incident represent a potential risk to other patients. The findings must be reported to AHCA within 15 days of an adverse incident. Failure to comply with this mandate may result in fines of as much as $25,000.

PATIENT SAFETY

What ingredients are necessary for improving patient safety?

The ingredients necessary for improving patient safety are attitude, awareness, reporting, analysis of root causes, action plan for correction, and future prevention.

What mandatory goals did the Joint Commission establish to improve patient safety for behavioral healthcare organizations?

Goal 1: Improve the accuracy of client identification.

1A Use at least two client identifiers when providing care, treatment or services.

Goal 2 Improve the effectiveness of communication among caregivers.

2A for verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.

2B Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

2C Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

2E Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

Goal 3 Improve the safety of using medications.

3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization and take action to prevent errors involving the interchange of these drugs.

Goal 7 Reduce the risk of health care-associated infections. 7A Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines when providing services to a high-risk population or administering physical care.

7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goal 8 Accurately and completely reconcile medications across the continuum of care. 8A There is a process for comparing the client's current medications with those ordered for the client while under the care of the organization.

8B A complete list of the client's medications is communicated to the next provider of service when a client is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the client on discharge from the facility.

Goal 13 Encourage clients' active involvement in their own care as a client safety strategy. 13A Define and communicate the means for clients and their families to report concerns about safety and encourage them to do so. A sample of two sources available to clients is listed below:

Goal 15 The organization identifies safety risks inherent in its client population.

15A The organization identifies clients at risk for suicide.

ROOT CAUSE ANALYSIS

What is Root Cause Analysis (RCA)?

Root Cause Analysis (RCA) is a retrospective approach to error analysis. In simpler terms, RCA seeks to find out (1) What happened? (2) Why did it happen? and (3) What do you do to prevent it from happening again.

It has been widely applied to investigate major industrial accidents. With its foundations in industrial psychology and human factors engineering, RCA is now being heavily promoted for the investigation of sentinel events in medicine. In 1997, the Joint Commission mandated the use of RCA in the investigation of sentinel events in accredited hospitals.

What is the purpose of Root Cause Analysis (RCA)?

The use of RCA in medical and clinical practice is intended to uncover errors that underlie sentinel events. RCA provides a structured and process-focused framework with which to approach sentinel event analysis. It stresses identifying system and process errors involved in professional care and seeks to avoid the blame of individuals for errors. By systematically applying RCA with what may appear to be separate instances of accidents, can often lead to finding a common root cause (e.g., a variety of serious adverse events following a particular procedure). Once root causes are identified then system changes are designed to prevent future incidents.

Who is involved in Root Cause Analysis (RCA)?

In large organizations RCA requires the rigorous application of established qualitative techniques. Once a sentinel event has been identified for analysis (e.g., a major chemotherapy dosing error, or in behavioral healthcare an unexpected suicide following a recent termination from services), a team is assembled to investigate the event. The RCA team should be interdisciplinary involving service experts and those who are most familiar with the error situation. The members of this team should be trained in the techniques and goals of RCA.

What steps are involved in Root Cause Analysis (RCA)?

The focus of the root cause analysis is primarily on systems and processes rather than individual performance. If done properly the investigative team must go through important steps. Teams that don't follow the RCA steps often, when faced with an error event, jump prematurely into "thinking they know the problem and what needs to be corrected. The broad steps involve:

Collect Data: establish what happened through structured interviews, document review, and/or field observation. These data are used to generate a sequence or timeline of events preceding and following the event.

Analyze Data: examine the sequence of events generated above repeatedly with the goals of determining the common underlying factors: Look for how the event happened by identification of failures brought on by the activities or lack of activities of people involved in the process.

Identify Root Cause: look for why the event happened through identification of system and procedural failures active or missing in the process. Identifying potential root causes of error is enhanced when teams apply a conceptual framework. For example, Reason proposed the following categories of factors as influencing clinical practice: institutional/regulatory, organizational/management, work environment, team factors, staff factors, task factors, and patient characteristics. For each category the team would brainstorm possible variables impacting on the error that occurred. Root causes in all the categories are considered first before rejecting any factor or category of factors.

Recommend and Implement: At the conclusion of the RCA, the team summarizes the underlying causes and their relative contributions, narrows the list of explanations down to most significant or likely to have contributed to the error, and then begins to identify administrative and systems problems that might be candidates for redesign.

The Joint Commission has developed several comprehensive guidelines on how to conduct a "thorough and credible" root cause analysis and continues to be the leading source of guidance for health care organizations in this area.

What must a thorough Root Cause Analysis (RCA) include? A thorough RCA requires a determination of human and other factors (processes and systems) most directly associated with the error.

It requires an analysis of underlying cause and effect systems through a series of WHY questions to determine where redesigns might reduce error risk.

It requires identification of risks and their potential contributions to error.

It requires a determination of potential improvement in processes or systems that would decrease the likelihood of adverse events in the future.

What must a credible Root Cause Analysis (RCA) include?

A credible RCA requires participation by the leadership of the organization and those most closely involved in the processes and systems under review.

It requires consistency in carrying out a thorough process.

It requires consideration of relevant literature.

It requires corrective outcome measures and top management approval.

It requires that the Joint Commission requirements are met.

How might a Root Cause Analysis (RCA) process look for small behavioral healthcare settings?

Clinical practices are encouraged to put an RCA process in place, to avoid being in the position of crisis functioning. Don't wait for a sentinel event to investigate. Establish your processes now. Clinical practices are also encouraged to practice RCA on nonsentinel events. Clinics could conduct an RCA for training purposes on a situation with no real adverse outcome, such as a lost clinical chart found after an hour of searching for it.

In developing an RCA process in the clinic it's important to educate staff. Be clear in articulating the philosophy of root cause analysis. "Errors must be accepted as system flaws, not character flaws." Root Cause Analyses provides a process that leads to effective problem identification and effective system improvements. Educate staff on the meaning of important terms, such as sentinel event and adverse event. Stress the importance of recognizing adverse events. Explain who and how to report the events. Make the reporting process easy and non-threatening. In addition, it's helpful for a small clinic organization to identify an individual to be "risk manager," someone who understands well the process of conducting an RCA.

Once an adverse event is reported, the risk manager and small member team should determine expeditiously whether an RCA is needed. If an adverse event is identified and considered appropriate for an RCA then it's helpful to identify a facilitator, who understands RCA, and to identify a content expert. The facilitator and content expert would decide what data to review (e.g. clinical records, statements from personnel, policy manuals, etc.), and who should do it, as well as the process of how it

should be accomplished. For smaller organizations or departments, often it is best to involve everyone in the process of RCA. Often those not involved in the event will have good ideas, and involvement communicates a message to everyone that the organization is committed to system improvement and that the organization expects all staff to help play an important role in making the organization as error free as possible.

At the first group RCA meeting, explain the purpose: "We are here to find out all we can about such and such an event; how it happened, how it might be prevented in the future." Emphasize that the purpose is not to find fault, but to prevent future mishaps. Consider posting the National Patient Safety Foundation's philosophy that "...most errors result from faulty systems

rather than human error ... that people are in essence 'set up' to make errors for which they are not truly responsible."

After introductions and opening comments, start by generating the sequence of events. If people start suggesting causes, solutions, jot them down for later use and keep the focus on making the sequence of events detailed and complete. After completing the sequence, identify the immediate corrective actions that were taken at or near the time of the event. Next ask the participants to carefully consider the sequence of events and identify every item, which might in some way have contributed to the adverse event. Mark an event even if it's only one person who thinks it played a role in the adverse event. Next ask the group to brainstorm all the marked items from the event sequence. The group should try to come up with any and all ideas about situations and conditions that may have in some way contributed to (not caused) the adverse event being evaluated. Solutions given, or other interesting thoughts that may be presented should be recorded and set aside for later reflection. Currently the focus is on contributory causes. Consider prompts for brainstorming, such as asking participants to consider barriers or aspects of the system that either failed to function or did not exist. After considering all possible contributory causes, ask the participants to help simplify the suggestions by eliminating duplications, combining items, and forming logical clusters from the brainstorm items.

Many organizations find it helpful to schedule the next meeting one week later. During the week prior to the next meeting, a smaller team including the facilitator and content expert meet and attempt to develop a "Contributory Flowchart " from the material generated by the team participants. The flowchart is layered with contributory issues leading upwards to the adverse event at the top of the flowchart. The team explores and assesses the second layer of contributory cluster names and lower layers of elements making up the cluster name, repeatedly asking the question "WHY?" or "HOW?" Each response to "WHY" or "HOW" helps identify lower-level derivatives to pin-point root causes.

At the second larger group meeting the Contributory Flowchart is presented. Participants are asked to check for omissions, better organization and a more logical flow of events. After exploring the flowchart and generating additional input and modification, the participants aim to reach a consensus on the flowchart. Those elements identified as "Non-Contributory" can be set aside in a special list indicating that they were considered in the analysis. Those identified as "Contributory" become the focus in need of system solutions.

After agreement on the analysis the participants identify corrective action or improvement for each "Contributory Factor." There may be very specific recommendations or more general recommendations, such as, developing a working group to address a specific issue. At this time an RCA reporting table or grid with columns can be introduced, listing: Contributory Factor,

Corrective Action, Person(s) Responsible, Action Due Date, Measurement Technique, Person(s) Responsible, and, Follow-up Date. It's unlikely that this grid could be completed in the meeting. But the small team including the facilitator and content expert can work on the chart prior to the next meeting.

At the third meeting present to the participants the completed Event Sequence, Contributory Flowchart, and, Root Cause Analysis Reporting Grid. Look for feedback from the participants, especially additional opportunities for improvement. The small leadership team now takes on the responsibility to monitor progress made in the corrective actions that where proposed.

Example of Root Cause Analysis (RCA) in Behavioral Healthcare

The case of Gross versus Allen involved a female patient with a history of suicide attempts. The patient, Karen, had a history of depression and attempted suicide. Her psychotherapist referred her to a psychiatrist for medication and medication management. Three years later Karen was still having problems with depression and suicidal ideation. She drove her car into a tree and while in the emergency room told the doctors that she wanted to kill herself. After being admitted to an inpatient program, she attempted to strangle herself. And a few months later, she ingested fifty Halcion tablets, and again survived the overdose.

Two months later she discussed with her psychiatrist, Dr. Allen, her intent to enroll in an in-patient eating disorder program. Doctor Allen forbade her, informing her that her illness was too severe to be handled in a hospital on an open unit. She ignored Dr. Allen's comments, and became admitted to the in-patient eating disorder clinic. During her admission, Karen did not tell her admitting doctor to the eating disorder clinic, Dr. Gross, about her history of suicide attempts. The next day Dr. Gross called Dr. Allen and informed him that Karen had entered the eating disorder program. Although Dr. Gross inquired about her psychiatric history, Dr. Allen did not tell Dr. Gross about her suicide attempts. The next morning Dr. Gross was informed that Karen was drowsy and not responding to directions to get out of bed. Unknown to anyone, Karen had taken an overdose of Nardil. She went into a comatose for five weeks, and because of the overdose she suffered severe neurological damage.

Karen's overdosing and resulting injury would be considered an error event…a sentinel event. Let's consider what a medical/clinical investigative team might do if they were to implement the RCA process. Their activities may look something like the following:

They would carefully review data and records related to the error event. They would do this using a structured interview with Dr. Allen, Dr. Gross, and any other persons who had contact with the chain of information exchange. They would review documents including intake reports, clinical progress notes, special evaluation reports, clinical staffing notes, and discharge summaries. They would systematically step through the sequence of events making

observations of processes involved in the communication of information. They would create a timeline and contributory flowchart sequence of actions and decisions leading up to the event.

They would repeatedly analyze and review the sequence of activities leading to the sentinel event and begin to compare the sequence to best practice activities. Looking for contributory factors, they would study steps involved in the event and identify failures brought on by activities or lack of activities of people involved in the process. They would try to understand why the event happened through system and procedural failures.

In considering institutional contributory reasons, they may list as possible problems: Lack of a clear statement on how to document situations where an individual possesses great risk of harm to self or others. They may suggest there is not a clear policy on how to communicate information to other organizations when a high-risk individual seeks services from other organizations.

In considering management contributory factors, they may list as a possible problem: lack of organizational structure to monitor high risk individuals and guard against breakdowns in communication.

In considering team contributory factors, they may list as a possible problem: lack of a team discussion about high risk patients, monitoring issues, and providing for multiple staff coverage of high-risk individuals.

In brainstorming task contributory factors, the team may list as a problem: lack of a specific evaluation tool to assess risk and monitor changes in risk. They may consider that if there was a special information gathering tool developed on high risk individuals that there would have been a much greater likelihood that critical information on Karen would have been shared.

The RCA team may consider the above and brainstorm many other underlying causes. They would then narrow the list of explanation down to most significant and then begin to identify administrative and system problems that needed to be addressed. They would address those contributory problems by implementing corrective actions and creating reporting grids to monitoring progress.

POTENTIAL FOR MEDICAL ERRORS WITHIN THE BEHAVIORAL HEALTHCARE PRACTICE

What are examples of medical errors involving medications?

Medication errors: Medication errors often involve errors in the use of a drug, administering the wrong drug, adverse drug reactions. Ten common prescribing errors: Sound-alike Drugs; Lack of Drug Knowledge; Dose Calculation Errors; Decimal Point Misplacement; Wrong Dosage Form; Wrong Frequency; Use of Abbreviations; Drug Interactions; Renal Insufficiency; Incomplete Patient History.

Sound-alike drugs: Confusing drug names is a common system failure. Unfortunately, many drug names can look or sound like other drug names, which may lead to potentially harmful medication errors. For example, one name similarity that has resulted in frequent mix-ups is between Zyrtec, an antihistamine, and Zyprexa, an antipsychotic. Patients who receive Zyprexa in error have reported dizziness, sometimes leading to a related injury from a fall. Patients on Zyprexa for a mental illness have relapsed when given Zyrtec in error.

The Joint Commission published a Sentinel Event Alert on look-alike and sound-alike drug names. A list of the more problematic look-alike and sound-alike drug names along with safety strategies specific to each of the problem drug names are provided at the Joint Commission website. Click here to view website.

Handwritten prescriptions: Illegible prescriptions lead to errors. In July 2003 Florida established a law (s.456.42, F.S.) making handwritten prescriptions illegal. The law requires physicians in Florida to either print legibly or type prescriptions and to include the name and strength of the drug prescribed, the quantity of the drug prescribed in both textual and numerical formats, and directions for taking the drug.

Patient name confusion: Sometimes medication is given to the wrong patient. It's not uncommon for several patients seeking services at clinics to share a common last name or even first name. Double checking a patient's charts for at least two identifiers is one way to reduce name confusion errors.

What are examples of medical errors that involve the diagnostic process?

Incorrect diagnoses may lead to incorrect and ineffective treatment or unnecessary testing. Examples of diagnostic errors include misdiagnosis leading to an incorrect choice of therapy, failure to use an indicated diagnostic test, misinterpretation of test results, failure to act on abnormal results.

What are examples of medical errors that occur with treatment?

Examples of treatment errors include errors in administering the wrong treatment to a patient, delay in treatment, not providing best practice treatments, and not providing treatment when intervention is appropriate.

What are examples of medical errors that involve monitoring?

Monitoring errors include inadequate monitoring of progress or follow-up after treatment.

What are examples of organizational procedural errors?

These errors include breach of confidentiality, breakdowns in communicating critical information, poorly implemented policies putting clients at risk.

What are examples of error due to an unsafe working environment?

These errors can include slippery floors, cluttered floors, poor lighting, and unsafe objects not properly secured. Small Lego or puzzle pieces can be swallowed by young children playing with them. Wooden building blocks in a waiting room can be used as a weapon by one child who is angry at another child.

What are examples of medical errors related to personal factors?

Certain personal factors can increase the error rate in healthcare practice (Reason, 1990).

Inattention and distractions: A busy clinic with patients checking in for appointments, other patients scheduling new appointments, along with interruptions for information from colleagues and support staff can make it difficult to concentrate on completing important procedural tasks involved in the care of the patient. Inattention to patient safety can lead to improper death of patient, bodily injury to client, failure to supervise client properly leading to injury, suicide of patient, accidents on premise.

Fatigue: Physical tiredness from lost sleep or excessive workload put clinicians at a high risk for errors.

Emotional states: Anger, anxiety, depression, boredom can all impair work performance and lead to errors. It's not unusual in clinical practices for conflicts to develop with other staff or other persons outside of the clinical practice. This added stress increased internal distractions and the likelihood of errors.

Unfamiliar equipment use: A lack of knowledge and training in the use of clinic computer programs can reduce effective reporting of patient information and impair communication among staff or between providers and patients.

Who's especially vulnerable to medical errors?

The safety of all patients is a major concern for all care providers. However, some patients are especially vulnerable to healthcare errors. For example, the very young and the very old are more vulnerable due to difficulty they have with communication issues and ability to participate in decision-making and monitoring of their care. For older patients there may be some degree of impairment in vision and hearing. Some may have memory or other cognitive impairments. Some with complications of illnesses may be especially at risk for medication interaction errors. Sensory or cognitive problems may lead to misunderstanding of instructions or failure of the very old to raise questions about intervention strategies. It's important when caring for the older patients to communicate with a responsible family member or other patient advocate.

Very young children do not have the communication abilities needed to alert clinicians about adverse experience. This is especially true of medication prescribed to children. Weight-based dosing is required for most pediatric drugs. Errors often occur when physicians or pharmacists convert dosage from pounds (for adults) to kilograms (for children). The USP advises that parents should know their child's weight in kilograms and reconfirm with the doctor that the dosage is correct for that weight.

Patients with limited English and limited health knowledge also have high vulnerability. Some individuals have limited capacity to obtain and understand basic healthcare information and services needed to make appropriate healthcare decisions. Often meeting the needs of culturally and ethnically diverse populations requires bilingual care providers, translators or interpreters. If translation assistance is not available, communicating with family member or other support person is essential. Without these experts available, communication of vital information between patient and provider can lead to misunderstanding and errors.

REDUCING BEHAVIORAL HEALTHCARE PRACTICE ERRORS

What are Florida's mandated requirements for error reduction?

What serious errors are specifically mandated to be addressed by Florida Psychology Board?

The Florida Psychology Board mandates that licensed members receive education on preventing errors related to inadequate assessment of suicide risk, failure to comply with mandatory abuse reporting laws, failure to detect medical conditions presenting as a psychological disorder.

What steps can be taken to reduce errors related to suicidal patients?

During a clinical interview, healthcare providers should always screen for a history and current history of suicidal ideation. Provide a behavioral and emotional assessment of all incidents. This requires a careful clinical history, documenting all instances of potential harm to self. Assess the risk level using clinical criteria and other assessment tools. Consult with another experienced professional. Follow standard of care regarding duty to warn and implement a documented risk management procedure.

What steps can be taken to reduce errors related to homicidal or violent patients?
During a clinical interview, healthcare providers should always screen for a history and current history of aggressive behaviors. Provide a behavioral and emotional assessment of past incidents of aggressive behaviors. Evaluate current threat of harm to others. If a risk is present, seek out consultation from supervisors and other professionals. Apply as appropriate the "duty to warn" standard of care that has been adopted by mental health professionals. In Florida, if necessary to fulfill "duty to protect" obligation, consider the Baker Act (Title XXIX Chapter394). The Baker Act is a legal procedure for the purpose of enforcing an Involuntary Examination for a person who is deemed to be a potential danger to him or herself or others.

Baker's Act Criteria for Involuntary Examination (Florida Law CH 394.463): A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness: The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or The person is unable to determine for himself or herself whether examination is necessary; and without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such 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 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.

What steps are required to reduce errors related to mandatory reporting laws?

Failure to comply with mandatory abuse and neglect reporting laws is a medical error that can have dire consequences. Florida's Chapter 39.201 requires mandatory reporting of child abuse, abandonment, or neglect; and mandatory reports of death to the central abuse hotline. The Adult Protective Services Act (415.101) extends many of these protections to the elderly as well. In Florida mental health professionals are not required to report abuse and neglect in writing, however, written reports that are faxed to the hotline will meet the legal and moral obligation, as well as, providing documentation for the client's clinical chart.

What steps can be taken to reduce errors related to failure to detect medical conditions that present as a psychological disorder?

It's important in the clinical interview for healthcare providers to always check for physical symptoms. When patients present with physical symptoms (i.e., heart palpitation, shortness of breath, sensory changes) proper professional care requires that medical conditions are ruled out before beginning psychological treatment. A referral to a medical specialist or documenting previous contacts with medical specialists can help reduce this type of error.

How can organization systems prevent and reduce practice errors?

How can creating an organizational safety culture prevent and reduce practice errors?

Culture is defined as a system of shared beliefs, values, customs, behaviors, and materials that interact to produce attitudes and behavioral norms that determine how health care providers do things.

Creating an organizational safety culture requires developing a systemic mindfulness, and alertness to safety issues that are happening in the here and now. It involves creating a focused attention at each level of the health care system on how its functions affect patient safety. It involves a wide range of people a in the organization; from those who are farthest removed from individual contact with the patient, such as administrators, members of the board of trustees, and health care leaders to those who are closest to the moment-by moment interactions with the patient and the patient's family.

An organization having a safety culture has written policies, guidelines and procedures that promote a mindful alertness to safety concerns. It establishes regular education and training for its personnel promoting its safety culture. Personnel are made keenly aware of error prone situations, such as equipment safety, infection control, fall prevention, emergency preparedness, and threats of harm to self and others. Personnel are provided with acts and strategies to help prevent practice errors from occurring. Safety culture organizations will then Implement safety surveys, responding and acting on safety recommendations.

When everyone in an organization is aware and alert to safety issues involving equipment safety, infection control, prevention of falls, and many other OSHA and Joint Commission standards, practice errors become reduced.

How can establishing practice guidelines reduce practice errors?

Guidelines are defined as "systematically developed statements that assist practitioner and patient in making decisions about appropriate healthcare." They have traditionally focused on ensuring a perceived standard of care. There has been an increasing emphasis placed on establishing practice guidelines to promote patient outcomes and patient safety. Practice guidelines can be used to effectively guide practitioners' behavior. The implementation of properly developed guidelines can impacts both the process and outcome of care. There has been an increasing emphasis placed on establishing practice guidelines to promote patient outcomes and patient safety.

Practice guidelines have the potential to improve patient safety through carefully designed procedures and practices that effectively reduce practitioner errors. Unfortunately, in the behavioral healthcare field, identified effective healthcare guidelines are not practiced by all despite overwhelming evidence supporting their use. It appears that well-constructed guidelines could play a significant role in ensuring patient safety and reducing errors in the behavioral healthcare field.

***How can empowering patients with informed consent reduce practice error*s?**

Medical and behavioral healthcare ethics and legal principles assert that a competent individual has the right to determine what will or will not be done to him or her. One means of ensuring that patients understand the risks and benefits of a treatment is through the process of obtaining informed consent. The American Psychological Association (APA) Code of Ethics establishes informed consent as an ethical obligation of psychologists. In addition to being an ethical obligation, legislation in all 50 states requires that patients be informed of all important aspects of a treatment and/or procedures. This formal effort of signing a consent form, preceded by an adequate

exchange of information, communicates an empowering message to the patient that they are responsible for making decisions about their own safety and health care. The procedures to obtain informed consent must adequately assist the patient in comprehending the information provided. This may require redrafting the consent forms to reduce complexity, providing written materials to accompany oral conversations, and asking patients to recap their understanding of services and their rights. It's believed that informed patients are less likely to experience medical/clinical errors, thus acting as another layer of protection.

How can protecting confidentiality reduce errors?

Individuals' willingness to seek help is based on their belief that personal revelations of mental distress will not be disclosed without their consent. Violations of their trust not only will reduce use of services by those needing services, but can also create harm through added emotional distress, damage to relationships, risks to employment, and risks to future progress.

The APA's principles for mental health and substance abuse services provides guidelines to help protect patients' confidentiality. These include:

Find out if the information to be disclosed to the payer would be anything other than diagnosis, prognosis, type of treatment, time and length of treatment, and cost. Will the organizations receiving this information keep it as confidential as the mental health professional? How will they protect it? Are there penalties for disclosing information improperly?

If your information is transmitted, stored, or used for any purpose as data, will information that identifies individuals be removed to protect privacy? Will the information be transferred to others or sold?

Individuals have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals.

Individuals shall not be required to disclose confidential, privileged, or other information other than diagnosis, prognosis, type of treatment, time and length of treatment, and cost.

Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the

same rigor and be subject to the same penalties for violation as is the direct provider of care.

Information technology will be used for transmission, storage, or data management only with methodologies that remove individual identifying information and assure the protection of the individual's privacy. Information should not be transferred, sold, or otherwise utilized.

How can providing patient healthcare education materials reduce practice errors?

Healthcare information for patients is easily available from books, web sites and consumer group publications. Behavioral healthcare providers can take this idea a step further by developing and distributing pertinent materials to patients that can alert them of possible problems of error and ways to appropriately intervene should a concern be raised.

In what ways can providing quality documentation reduce practice errors?

Clinical documentation is fundamental to good healthcare linking both clinical (e.g., psychosocial assessment, diagnosis, treatment plans, progress notes, discharge summaries, clinical decisions) and administrative functions (e.g., client demographics, billing, insurance and organizational requirements). Incomplete documentation threatens clinical thoroughness, increasing the chance for practice errors.

Missing or incomplete documentation can lead to frustration for care providers and unbilled or denied charges. Multiple versions of charts and forms for different patient units lead to confusion, inconsistencies and ineffective communication among the professional staff. Poor documentation of complications or severity leads to significant lost revenue.

How can improving discharge summaries reduce practice errors?

Discharge summaries are important for communicating pertinent patient information regarding patient care to other providers. Discharge summaries that lack a structured narrative format invites inaccuracy and can create delays in clarifying summaries of patients' healthcare to other providers. Quality discharge communication can have a significant impact on error reduction by alerting other providers of critical information.

How can supervision reduce practice errors?

There is a growing body of evidence that links lack of supervision and poor teamwork to preventable medical errors. Supervision can reduce practice errors because it allows for addition of new information, different perspectives and judgments. Encouraging

processes for supervision within an organization not only results in the sharing of alternative views, but it also emphasizes to practitioners the organization's commitment to creating a culture of safety, further sensitizing practitioners' awareness of the need to continually look for ways to prevent errors. Planned team meetings that set aside time for clinical discussion of cases, review of high-risk patients, and clinical monitoring of patients transferred to other providers, are promoting reduction of practice errors.

How can personal characteristics impact practice errors?

Up to this point, this article has primarily focused on a category of errors based on system inadequacies, which is the processes and procedures that are defined and implemented within the practice of care. They include leaving clinical charts open for others to view, putting clinical reports into the wrong client's chart, forgetting to send out a discharge summary on a patient who has been hospitalized, and other situations where the behavioral healthcare provider's training is not the primary issue. Many system errors that practitioners make might be easily amenable by simple system changes, such as creating a policy to always file and lock away charts at the end of the day or creating a checklist of dos and don'ts when a client becomes a suicide risk.

This second subsystem category of errors is more complex, often involving errors in judgment that arise from unexpected conditions that are not easily anticipated. Wise judgment depends on habits, attitudes, and personal characteristics, such as self-observation, self-questioning, vigilance, flexibility, and openness.

What personal qualities impact practice errors?

In considering ways to prevent practice errors, it's important to look at personal issues and need for personal changes. Clinicians should be self-observant in all that they do, self-questioning about all feedback they receive, and open to examining personal characteristics and organizational processes, as targets for improving client care.

Thinking errors in making diagnoses

Most errors involved in diagnoses result not from technical foul-ups, but rather mistakes in the mind of the clinician. Making an accurate diagnosis involves gathering information about the patient's symptoms through assessment of mental status, background information, clinical interviews, and administration of clinical inventories. This pattern of information is then superimposed onto a template of typical cases that exists in the clinician's mind and a diagnosis is typically made. However, making diagnoses using pattern recognition doesn't always work well.

One reason for this is that the information collected may be incomplete or misleading. Some patients may not feel comfortable reporting all their symptoms. Sometimes clinicians will cut off a patient who is reciting problems. How the clinician selects the clinical information, weighs its importance, and arranges it in his or her mind can result in several different patterns, leading to several different diagnoses.

Clinician's need to be watchful of cognitive mistakes that can lead to misdiagnosis. One type of cognitive error is called "anchoring", which is the tendency to grab on to the first symptoms that seem to fit a pattern to make a diagnosis.

A second type of cognitive error is termed "availability". This refers to clinicians drawing upon concepts and disorders that they are especially familiar with or comfortable using to make diagnoses. One example of this is when a clinician reads a new book on bipolar disorders and then unconsciously draws upon that information looking for how the patient symptoms fit the pattern of a bipolar disorder as the process for making a diagnosis. Clinician need to be watchful of this tendency to draw upon recent and easily remembered information as a source of influence on their diagnoses.

Another type of mistake in thinking that can result in error is called "attribution". Attribution refers to the tendency to mentally jumping to a stereotype and "attributing" symptoms to it. As an example, a patient may be perceived as complainer, a hypochondriac…leading a clinician to ignore the possibility of other illnesses.

There are a few simple questions clinicians can ask of themselves that can help prevent against these types of errors in thinking. One question, "What else could it be?" A second question, "Could two things or more be going on to explain the symptoms? A third question, "Is there anything in the patient's history, exam information, physical findings, inventory findings, or other information gathered that does not seem to fit with my working diagnosis?"

Disorganization and errors

Clinicians who are disorganized are at greater risk for producing practice errors. Clinicians are encouraged to explore their personal quality of organization/disorganization habits and potential impact on errors by asking themselves the following questions:

To what extent do my habits and personal characteristics impact on how well my workspace is organized? What needs to be examined…personal characteristics, organizational processes and procedures, or perhaps both?

Am I observant enough to see the relationship between disorganization within my environment and likely increase in clinical record errors or errors of not following through on what should be done?

Have my personal characteristics and/or lack of organizational system planning led to phone interruptions during sessions with clients?

What personal characteristics and/or organizational system changes need to be examined in order to manage workload so that it doesn't negatively impact on the management of clinical records and communication of clinical information to appropriate third parties?

Personal fatigue and errors

Clinicians who feel low in energy or feel overwhelmed should explore this personal quality Does my personal fatigue lead to a lack of follow through in providing best practice care activities for clients being seen? What personal or system changes would help protect against this error."

Inaccuracy and errors

What personal characteristics get in the way of improving the accuracy and timeliness of the transmission of clinical information? How might organizational changes assist in habit changes?

What personal characteristics and organizational process need to be considered to improve on the accuracy, clarity, and understandability of information transmitted?

Relationships, communication skills and errors

How might my previous interactions with this other care provider affect my communication now?

What am I assuming in conversations that might not be true?

What interfered with my ability to observe, be attentive or be respectful with the other care provider with whom I am communicating?

How could I be more present and available during communication?

When working with patients, are there any points at which I want to end the communication early?

What do I ignore, when other care providers attempt to transmit client information to me?

How can commitment to meeting professionally accepted standards of care reduce medical errors?

Clinicians help demonstrate commitment to professionally accepted standards through active participation in their professional organization. Attending conferences and reading professional newsletters offered by the organization is a simple way of staying alert to changes in laws, rules, updates to code of ethics, as well as, practice errors made by other professionals. By maintaining awareness and applying professionally accepted standards, clinicians have a guide to decision-making that helps reduce practice errors.

How can reading the Disciplinary Guidelines established by professional boards of regulation help reduce medical errors?

The disciplinary guidelines written into state board regulations exist because professional practitioners have violated them causing serious practice errors and harm to patients. Awareness of these serious violations and its impact on patients, their families, as well as, one's own profession and professional practice, can help prevent future violations.

One destructive violation of the Florida code (F.S. 491.009 and Rule 64B4-5) involves sexual misconduct. The law states: "It is sexual misconduct for a psychotherapist to engage, attempt to engage, or offer to engage a client in sexual behavior, or any behavior, whether verbal or physical which is intended to be sexually arousing including kissing, sexual intercourse, (etc)."

CONCLUSION

What summary point should professionals always keep in mind?

Improving patient safety begins with acknowledging errors, followed by analysis of the root causes and contributing factors and development of a plan of action to prevent similar errors in the future.

Safety has been defined as freedom from accidental injury. This definition recognizes that this is the primary safety goal from the patient's perspective. Error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. According to noted expert James Reason, errors depend on two kinds of failures: either the correct action does not proceed as intended (an error of execution) or the original intended action is not correct (an error of planning). Errors can happen in all stages in the process of care, from diagnosis, to treatment, to preventive care.

Much can be learned from the analysis of organizational system errors and personal judgment errors. All adverse events resulting in serious harm should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future. Errors that do not result in harm also represent an important opportunity to identify system improvements as well as enhance wisdom in trying to prevent adverse events. Preventing errors means designing the health care system at all levels to make it safer. Building safety into processes of care is a more effective way to reduce errors than blaming individuals.

One major force for improving patient safety is promoting intrinsic motivation of health care providers, influenced by professional ethics, norms and expectations. An organizational culture supported by strong leadership can do much to encourage recognition and learning from errors. Other major factors include availability of knowledge and tools to improve safety, strong and visible professional leadership, legislative and regulatory initiatives, and actions of purchasers and consumers to demand safety improvements. Finally, practitioners applying skills of self-observation, self-questioning, vigilance, flexibility, and openness will help in identifying practice errors and promoting patient safety.

In considering ways to prevent practice errors, it’s necessary to explore system changes, as well as personal issues and need for personal changes. Both the development of self-awareness and self-examination by individual clinicians along with the development of organizational systems are likely to be complementary strategies for reducing clinician errors and promoting patient safety.

Behavioral health practice errors are a significant concern in our health care delivery system. Improvement must include a wide range of targets from the narrower focus of a clinician's cognition process and personal characteristics to the broad-based organizational systems interventions. Applying skills of self-observation, self-questioning, vigilance, flexibility, and openness are important activities for identifying practice errors and promoting patient safety. The application of these skills enhances error recognition sensitivity within oneself and within the organizational systems. Overall this can lead to adjustments that promotes doing the right things so that other may not be harmed by errors.

RESOURCES

What references will provide more information on medical errors?

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