Medical Errors Class – Mental Health

Contents

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Course description

Prevention of Medical Errors is a 3-CEUs class approved by the Florida Board of Mental Health, Marriage and Family Therapy and Mental Health Counseling.

The instructional material includes the rationale for teaching this class, definitions of the terms involved, classes of errors that a mental health professional can incur in their practice, a list of factors that can lead to practice errors and some recommendations to avoid them.

The Medical Errors class requirement is the result of governmental agencies wanting to reduce the high incidence of medical errors in the country. The class focuses on general principles that the professionals taking the class need to become aware of in order to prevent errors.

After studying this class, the student should be able to:

∗ Identify ways in which mental health professionals can contribute to patient/client safety

Evaluation:

After reading the material, please return to ceusonlineflorida.com and answer the test online. An 80% score is required to pass the test. You will receive a certificate in the next 48 hrs of passing the test. We will also post the credits to cebroker.com for you.

Selected references:

- Kohn, L., Corrigan JM. & Donaldson M.S. eds. (1999) *To Err Is Human: Building A Safer Health System. IOM, Washington, National Avcademy Press*
- Fritz, S. *(2000) Fundamentals of Therapeutic Massage*, Mosby.
- http://www.Quic.gov/report.htm (Quality interagency Coordination Force report to President Clinton)
- *Medical Errors: The scope of the Problem. Fact Sheet*, Publication No. AHRQ 00-PO37. Agency for healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/errback.htm
- *How safe is our Healthcare System? Understanding Medical error*. Transcript of an audioconference. http://ahrq.gov/news/ulp/trulp518.htm
- *Hippa Information:* Department of Health and Human Services. In http://www.hhs.gov
- *Joint Commission on Accreditation of Health Care Organizations (JCAHO) Sentinel Event Policy and Procedures* - Updated: July 2007 - http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/

SECTION I

1. Background

The 90s was a decade that recognized and studied the issue of medical errors as one of the major challenges the nation faced in improving health care quality. In 1999 the Institute of Medicine (IOM) released "To err is human: Building a safer health system," a comprehensive report stating that medical errors were one of the nation's leading causes of death and injury (8th leading cause of death). They calculated that between 44,000 and 98,000 people die each year because of adverse effects due to medical errors, which led to the conclusion that the rate of health care errors is one of the highest compared to other industries. Preventable errors cost the health care system about $8.8 billions per year.

An independent body that is part of the National Academy of Sciences, the IOM concluded that prevention of medical errors had failed mainly because oversight bodies were focused on individual performance and this fragmented view undermined the function of the HC system. Thus, they recommended taking a systems approach.

The release of the IOM report led to presidential directives that established a quality forum and directed agencies throughout the government to develop meaningful HC quality and patient safety initiatives. The report also contributed to increase public awareness on the issue of medical errors. Since then, government agencies, purchasers of group health care and health care providers have joined efforts to make the United States health care system a safer one. Among these efforts, many states, including Florida, introduced bills related to medical errors, several of which have already become laws.

With more awareness of the problem of medical errors and more precise statistics, now we know that medical errors account for as much as 225,000 deaths per year and that it is no longer the 8th but the 3rd leading cause of death in the United States (*Shi L, Starfield B. Income inequality, primary care, and health indicators. J Fam Pract.1999; 48:275-284).*

In 1999, the Institute of Medicine estimated that the effects of medical errors accounted for $17 billion to $29 billion in domestic health care spending, and as we saw above, the deaths caused by error have not only not declined but increased since then. Reporting adverse events from medical errors is mandatory across the nation but investigators have found that sometimes hospitals modify records and cover up failed operations, deadly accidents, malpractice and other medical errors.

Deaths per year	Cause - 2009
106,000	Non-error, negative effects of drugs
80,000	Infections in hospitals
45,000	Other errors in hospitals
12,000	Unnecessary surgeries
7,000	Medication errors in hospitals
250,000	**Total deaths per year from iatrogenic causes**

(Read more: http://www.nydailynews.com/ny_local/2009/07/26/2009-0726_faked_records_and_fatal_blunders_at_cityrun_medical_centers.html?page=0#ixzz0N8Rc1TVP)

The IOM 4 point tiered strategic approach

In their book (mentioned above), the IOM recommended a tiered strategic approach to avoid errors and prevent adverse events:

1. The creation of a national oversight group.
2. National standardized policies for mandatory and voluntary reporting with the aim of making sure that the system is safe for patients.
3. Organizational level of commitment to patient safety – oversight organizations, group purchasers, and professional groups.
4. Health care deliverers' commitment to patient safety – creating a culture of safety inside HC organizations.

IOM further recommended that states improved their reporting systems and buy HC services from those who are taking steps to improve patient safety. They also recommended that HC establishments used computerized monitoring systems, order entry and bar coding to standardize product, diagnostic and procedure descriptions so that everybody talks the same language.

In 2001, the National Academy for State Health Policy (NASHP) stated the need for a unified state approach regarding patient safety. They also advocated for educational programs for health professions students and public universities and for licensed practitioners through continued education credits for licensure and accreditation. Some progress has been made but there are still states in the Union that have not put mandatory error reporting in place and there is no national oversight group, even though the AHCA is working on it.

A recent report from the National Patient Safety Foundation places the blame on the increasing figures of medical errors on deficiencies in the education doctors receive and a medical establishment that resists change. According to the report, medical schools and teaching hospitals are not efficiently training doctors in safe practices, do not encourage analysis of bad outcomes and have not redesigned the system to make it safer.

Florida Actions

In 2000, the Florida statutes, chapter 256 Section 33, established the *Commission On Excellence In Health Care*. Its mission and duties included:

- To explore how data is collected and used at HC facilities
- Set standards to identify unsafe providers and practitioners and remove them from operation and practice
- Recommend curriculum elements to address the issue of patient safety
- Set guidelines to educate practitioners, providers and consumers regarding patient safety.

The statutes presently include the following item:

Florida Statute 456.013(7)
The boards, or the department when there is no board, shall require the completion of a 2-hour course relating to prevention of medical errors as part of the licensure and renewal process. The 2-hour course shall count towards the total number of continuing education hours required for the profession. The course shall be approved by the board or department, as appropriate, and shall include a study of root-cause analysis, error reduction and prevention, and patient safety.

In 2004, a bill on patient safety passed in the Florida House of Representatives provided that information contained in patient safety data or other records maintained by Fla. Patient Safety Corporation & its subsidiaries, advisory committees, or contractors is confidential and exempt from the Public Records Act.

2. Definitions (based on the IOM report)

a. What is a medical error?

A medical error is a failure of a planned sequence of mental or physical activities to achieve its intended outcome when these failures cannot be attributed to chance. A bad outcome from an appropriate treatment is not considered a medical error. There are two kinds of errors:

- Failure of a planned action to be completed as intended (error of execution) or
- The use of a wrong plan to achieve an aim (error of planning)

b. What is an adverse event?

An adverse event is an injury or death resulting from health care management, not the underlying condition of the patient. It is important to note that not all adverse events happening to patients are the consequence of medical errors. Adverse events related to the mental health professions most often occur when the provider fails to adequately assess observable symptoms. For example, symptoms that could be due to organic or pharmacological causes are considered psychological in origin.

c. What is a Sentinel Event?

A sentinel event is defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as “any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.” The Joint Commission tracks events in a database to ensure events are adequately analyzed and undesirable trends or decreases in performance are caught early and mitigated. It is always important to assess the potential for a sentinel event to occur and take appropriate steps to reduce the risk.

d. What is patient safety?

Patient safety is defined as freedom from accidental injury and comprises preventing errors, reporting errors and attenuating the effects of errors.

e. What is malpractice?

Malpractice is an act or failure to act by a member of the medical profession that results in harm, injury, distress, prolonged physical or mental suffering, or death to a patient while that patient is under the care of that medical professional.

f. What is a system?

A system is a set of interdependent elements interacting to achieve a common aim. The elements may be both human and non-human (equipment, technologies, etc). Medical errors are more likely to occur in vulnerable areas where the system in which a mental health professional works is not well enough designed to accommodate the diversity of clients being served. The IOM reports places emphasis on not blaming the individual, but in understanding that errors are usually the result of a system failure to prevent certain events. Everyone can, at times, have less than favorable outcomes. The focus is on how to identifying potential risks and on designing appropriate assessments that will prevent the errors to occur.

g. What is root cause analysis?

Root case analysis is a set of processes by which the underlying causes of adverse outcomes may be identified, with the goal in mind of preventing the reoccurrence of such events. Sentinel events are studied retrospectively in a specific way.

It is advisable that mental health professionals work in multidisciplinary teams trained in quantitative analysis of data. When an error is made, compiled data can be peer reviewed. The root cause analysis includes studying the sequence of events before and after the sentinel event occurred. It also includes interviewing all persons involved in the events. Once the data is compiled, the team analyzes the data and underlying factors will be identified, including active and latent errors.

Root causes can be found both in the characteristics of the patient and in the system. Among these, it's important to consider the way the team works together, the work environment, the management of the organization, the regulations in place, the educational background and even the hiring process.

JCAHO recommends a "blame-free" analysis as a pre-requisite for change. In their review of 65 cases in which a sentinel event of suicide occurred, JCAHO researchers found that 34 suicides occurred in psychiatric hospitals, 27 in general hospitals with 14 on a psychiatric unit and 12 in a medical surgical unit, and 1 in the Emergency Room. Interestingly, the method of suicide for 75% of these cases, no matter where they occurred, was by hanging in the bathroom or closet while 20% jumped out of the window or off the roof. Using root cause analysis sufficient data was compiled to understand what changes were needed in order to reduce hanging in the bathroom or closet or jumping from the windows or roof.

f. Systems approach

Usually, medical errors and adverse events are treated as isolated incidents or go underreported because of liability concerns. Also, because they usually affect only a patient at a time, it's difficult to identify what failures in the system may have contributed to the occurrence of the error.

A mental health professional is part of the health care system from the personal to the global level. From the individual practice to the local and state legal structure to the national and global evolution of health care. Whatever affects any part of a system will affect the system as a whole. The design of a system affects the outcome of the system and defines the functioning of its parts.

Where do medical errors occur?

The IOM report was focused on medical errors happening in hospitals, but errors happen also in emergency centers, pharmacies and care delivered in the home. It's very difficult to track how many errors are happening outside a hospital. But, for example, a few years ago, the Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions are filled improperly each year in Florida.

The first step to prevent errors is to assume that they can occur and that they can be prevented. To prevent an error to recur it's indispensable to analyze and learn from prior experiences. The IOM report found that claims of privacy, privilege and confidentiality have been misused to cover up errors.

Health care teams need to create a space to conduct discussion of clinical practices. This will contribute to the creation of a culture of patient safety, were consults among members are the norm, no matter how long a professional has been in practice or how well trained she or he is. Taking responsibility for errors helps the team to learn and grow to strengthen the system and prevent adverse events, especially when high risk and vulnerable clients are involved.

Section II

1. Practice errors

Errors that occur mostly in clinics, agencies and hospitals. There are two main classes of errors that a mental health care professional can commit in their practice: cognitive and execution errors. Below is a list of factors contributing to errors:

a. **Cognitive errors:** Failed judgment or assessment or failed treatment planning - decisions not made under optimal conditions by clinicians (including difficult work environments), incomplete appreciation of heuristics (shortcuts that mind uses); heuristics driven by cognitive disposition to respond to particular patients in particular situations in a certain way.

1. **Aggregate bias**: when aggregated data is used to develop clinical guidelines without taking into account individual patient's characteristics or circumstances.
2. **Ascertainment bias:** occur when the clinician has a gender bias or has stereotyped the client.
3. **Anchoring:** Only obvious features in the patient's main complaint are considered.
4. **Blind bias spot:** the tendency not to compensate for one's own cognitive biases
5. **Confirmatory bias:** once the diagnosis is made, the clinician tends to see only the data that confirms it.

6. **Feedback sanctions:** Opinions asked from a team member late in the process of diagnosis may not be taken into account because everybody has already made up an impression of the case.
7. **Framing, labeling**: diagnosis may be influenced by the way the clinician feels towards the patient and even by their approach to diagnosis and therapy.
8. **Overconfidence effect**: The clinician's subjective confidence in their judgments is greater than their objective *accuracy*. Often happens when the team members have assigned one clinician the "know-it-all" role, and he/she might become overconfident, tending to overlook important information in the process of making a diagnosis or a treatment plan.
9. **Outcome bias:** Clinicians or team judge a past decision by its ultimate outcome instead of basing the assessment on the quality of the decision at the time it was made. Given what was known at that time a clinician opts for diagnoses that could lead to a positive outcome, ignoring diagnoses that might involve lengthier treatments. This error is common when clinicians work within the time constraints placed by managed care.

b. **Execution errors:** these are the result of the clinician's or the system's failure to carry out planned actions. Below are some of the factors that contribute to this type of errors.

i. **Knowledge and skills:** Lack of training may lead to committing errors.
ii. **Organizational factors:** inadequate staffing; no follow ups with patients; inadequate supervision; risk-taking behavior; maladaptive group pressures; authority gradients; faulty error detection and tracking; less than optimal communication channels.
iii. **Work-styles:** maladaptive decision styles, lack of feedback from team members.
iv. **Planning fallacy:** tendency to underestimate treatment times (see managed care).
v. **Environment:** overwhelming communication load; overcrowding; production pressures; high noise levels.
vi. Decision-making process:
   a. **Lack of communication** between team members about outcomes and treatment plans
   b. **Premature termination** – might be related to biases described above
   c. **Inadequate diagnosis** – concurrent medical illness overlooked; clinician did not obtain a careful medical history or is unaware of how medical conditions can create psychological distress. Medical conditions diagnosed as a somatic syndrome disorder.

2. What leads to individual practice errors?

From the individual point of view, the following are some of the aspects that can lead to practice errors:

The clinician:

- Steps out of scope of practice
- Is not up to date – poor quality continuing education
- Disregards or misinterprets medical recommendations
- Fails to do a detailed intake interview
- Fails to review patient's data to keep diagnosis and treatment plan updated according to progress and new events or information provided
- Fails to deliver sufficient information to help the client make informed choices
- Selects inappropriate approach or techniques for the condition being treated
- Overlooks patient's signals (body language, body signs, symbolic messages)

Common examples of diagnosis errors made by mental health professionals include people with dissociative identity disorders (they usually come with different diagnosis, different treatment outcomes, past therapy failures), bipolar disorders diagnosed as depression, and schizophrenia.

From the systems point of view, errors need to be considered within the context in which they occur. The IOM reported that most of the medical errors were not produced because of lack of training or out of practitioner's negligence. Rather, errors had occurred due to organizational factors and failures in the systems' design. For example, most doctors and nurses in hospitals work 24 hours shifts. The system had disregarded the negative effects of fatigue on performance. A mental health clinician needs to make sure they don't overload with work; they should consult a colleague is countertransference appears and need to make sure they attend their own physical, emotional and mental needs.

The IOM recommended that systems implemented information technology to prevent errors due to fatigue or illogical reliance on memory. Health care professionals depend on many systems: the educational system in which they were trained, the health system that regulates their practice, the institution that hired them, etc. When the practitioner makes a mistake, it should be analyzed as a system's failure so that they can implement necessary changes and prevent further errors. Blaming an individual rarely contributes to make the system safer.

3. Learning from experience

The IOM recommended that health systems learn from the experience of non-health industries like the aviation industry, which has notably reduced fatalities due to error. Among their recommendations were:

1. To set high standards regarding error rates.
2. To develop a monitoring system to track errors
3. To improve the reporting of errors
4. To investigate errors and adverse events, using root cause analysis
5. To create a culture of safety
6. To use multidisciplinary approaches.

4. The importance of keeping records

It is very important that healthcare professionals keep records of their clients. These records should contain any pertinent facts, observations and treatments or interventions applied. They should also include notes about medical recommendations, individual history and treatment outcomes. These records will facilitate that other health care providers evaluate and plan treatments.

Records need to include any pertinent information of the treatment provided. Chronological progress notes help evaluate progress and are an important element when determining the quality of care. Data might also be used for research and educational purposes.

Basic records should include:

a. Identifying information
b. Contact information
c. Fees and billing information
d. Guardianship

e. Informed consent
f. Waivers of confidentiality
g. HIPAA privacy disclosure
h. Main complaint, relevant history, treatment plan and dated progress notes.
i. Termination notes and summary

Keeping good records allows the therapist to review the patient's progress or lack of it. Reviewing the notes frequently will help the clinician make any adjustment in diagnosis and treatment plans.

SOAP notes (Subjective, Objective, Assessment and Plan) can make a good format to keep progress notes. “Subjective” is defined as resulting from feelings, thoughts or temperament of the subject, whereas “objective” is defined as real, actual, and perceptible to others. These notes are always tied to the treatment goals. In some cases, narrative notes will be required after each session, as well as monthly summaries.

HIPAA, the Health Information Privacy and Accountability Act, implemented a few years ago, allows the clinician to keep two sets of records, one of which is *general progress notes* and another which is called *process notes* or *psychotherapy notes*. This latter set of notes is for the clinician's own use and need not be revealed to insurance companies. However, it is questionable if clinicians who keep such process notes must turn them over should the client be involved in a lawsuit.

Remember: A report should include the information that the patient provided, the observations that you made, your treatment plan, the outcome of the treatment, and the evolution of the client. It should also include any known risk factors.

Section III

1. Preventing errors

Understanding the above common cognitive errors and adhering to appropriate standards of care are the best way to prevent practice errors.

According to the Medical Dictionary, standard of care refers to “a diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance.” In legal terms, standard of care refers to the level at which the average, prudent provider in a given community would practice.” In other words, it refers to the way in which a similarly qualified practitioner would provide care under same or similar circumstances. In malpractice suits, the plaintiff must establish the appropriate standard of care to demonstrate that it has been breached.

Mental health providers follow the Code of Ethics of the discipline of which the clinician is a member. Some states have regulations in place defining expected standards of care.

The clinician has to be careful when adopting techniques that are not evidence based, except when there doesn’t seem to be another option. Extensive assessment to evaluate risks involved is recommended. In cases of post-traumatic stress disorder, it’s advisable to use assessment tools to prevent overlooking patients at risk of injuring themselves or others.

High-risk clients include those with major psychiatric disorders, children and the elderly, individuals with high levels of stress and poor support systems and people with communication impairments.

2. Multicultural perspective

Cultural competence is important, especially for clinicians practicing in states like Florida with a large population of immigrants, to prevent practice errors.

Clinicians need to be especially attentive about his/her own cultural biases. It's common to make assumptions based on personal experiences, common stereotypes, and mistranslations of words and experiences. Symptom expression might be different in different cultures and are likely to be overlooked or misinterpreted even by expert clinicians.

According to *Mental Health: Culture, Race and Ethnicity, A supplement to the report of the Surgeon General on Mental Health*, culture may affect all aspects of mental health and illness, including the types of stresses people confront, whether they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess.

Standardized measure of mental disorders is reliant on at least three types of equivalence: conceptual, scale, and norm.

Conceptual equivalence refers to similarities in the meaning of concepts used in assessment: For example, do all cultures think of well-being, depression, or self-esteem in the same way?

Scale equivalence refers to the use of standard formats in questionnaire items. In the United Stated most people would be familiar with questionnaires having choices such as "strongly agree," "agree," and so on, or a true-false dichotomy. People having a different educational background, may not understand this format. Accordingly, their answers to questions using these response options may not be valid or reliable.

Norm equivalence refers to the application of standard norms developed in one sample and used with another group. It is important to understand if the evaluations instruments or treatments applied, even if considered evidence based have the same validity for clients belonging to a population on which the norms have not being tested.

3. Managed care

Adverse and sentinel events are more like to occur in managed care especially when people who have not being trained as or by clinicians are involved in the decisions made about nature, frequency and length of treatment. Red tape is always a nightmare for a person who is already overwhelmed by life events or has a mental illness. Managed care also avoids providing long and expensive, even if necessary treatments.

4. Special topics on Patient Safety in Mental Health

Suicide

Suicide risks need to be assessed not only at intake but regularly during treatment and not just in patients visibly depressed. If the patient mentions suicidal ideation that happened in the past, this risk has to be continually assessed so that appropriate action can be taken.

Age, beliefs and cultural background need to be taken into account when assessing suicide risk. Suicidal ideation and behavior in adolescents, for example, might not be sufficient to determine risk, but the clinician must be alert to any signals that the adolescent is at risk of committing suicide.

Violent behavior

Recent events involving mass murders, have shown that violent behavior and dangerousness is difficult to predict. The only meaningful factor seems to be that the behavior has occurred several times in the past. The more often people have done something, the more likely they are to do it again. That makes predictions regarding first offenders highly speculative, but it doesn't mean that the clinician should not make their best effort to prevent any violent behavior from their client.

Mandatory reporting

Another serious error that needs to be avoided is related to mandatory reporting. A reasonable suspicion that abuse has occurred is enough for the clinician to report it. On occasion, clinicians believe that therapy might help prevent further abuse. For example, a therapist might think that increasing parenting skills will prevent harsh physical punishment. In other cases, the clinician wants to prevent the possibility of the children being separated from their parents. And even in other cases, the clinician working with undocumented families, fear that reporting abuse will lead to deportation of the non-abusive parent and separation of the family.

Not reporting abuse is a criminal offense. Clinical discretion is no longer accepted in most states. There needs to be a reporting of possible abuse even without a careful clinical assessment. Protection of the child, the elderly person or the disabled individual takes priority.

Patients using psychiatric medication

Often, clinicians treat clients that are under medication for the same symptoms. Mental Health Counselors, Clinical Social Workers and Marriage and Family Therapy are not allowed to prescribe medications in Florida. Not prescribing includes not making the mistake of discussing with the client the primary care practitioner or psychiatrist's criteria for using a particular prescription drug. However, the mental health professional should be aware of possible medication side effects and know about medication doses and interactions with other medication. Adoption of a routine procedure to report, analyze, and learn from common adverse medical events with these medications will help develop a best practices model. These may prevent more serious adverse medical events.

Now that you're finished please take the test online.
Don't forget to fill in the evaluation form and email it back to us.

ANSWER SHEET (practice test)

Please take the test online (www.ceusonlineflorida.com). The test will be scored within 24 hours after it is received. You need a score higher than 80% to pass. A certificate will be issued and emailed to you after you pass the test. If you don't pass the test the first time, you can retake it one more time with no extra charge.

Name: Order No.
Profession:
Email:
FL Professional License Number: Renewal date:
Address:
Street Number
City
State
Zip code

1. What should be included in a client's record?
- a. Personal information, treatment applied, response to treatment
- b. Only their names, dates of visit and procedure
- c. Only patient's notes about how they felt during the treatment or procedure
- d. Phone numbers of all the doctors who have treated the client

2. Why is it important to know the contraindications for a treatment or procedure?
- a. So that the client won't sue me
- b. To pass the Board exam
- c. To avoid committing errors with a client
- d. To get a good job

3. What is the best thing you can do to contribute to empower your client?
- a. Helping them complain about a faulty practitioner
- b. Providing advice to help them improve their personal lives
- c. Providing detailed information about treatment options
- d. Recommending lengthy mental health counseling

4. Clinicians need to be especially attentive about his/her own cultural biases because:
- a. It's common to make assumptions based on personal experiences, common stereotypes, and mistranslations of words and experiences.
- b. Symptom expression might be different in different cultures
- c. Symptoms are likely to be overlooked or misinterpreted even by expert clinicians.
- d. All of the above
- e. None of the above

5. ¿What is the BEST way to stay current and improve your professional skills?
- a. Renewing my license

b. Obtaining a degree from an accredited school
c. Taking quality continuing education classes
d. Receiving feedback from the clients

6. Malpractice is defined as:
a. An act or failure to act by a health provider that harms a patient
b. A lawsuit against a doctor
c. A treatment failure that cannot be attributed to chance
d. A death resulting from a systemic failure

7. Medical errors are one of the nation's leading causes of death
a. True
b. False

8. Aggregate bias refers to:
a. Aggregated data used to develop clinical guidelines without taking into account individual patient's characteristics or circumstances.
b. The clinician's gender bias or stereotype of the client.
c. Cultural misunderstanding of aggregate factors
d. Not taking into account feedback from a team member

9. Adverse event is:
a. An injury or death resulting from health care management
b. Failure to plan an action
c. Using a wrong plan to achieve an aim
d. The same as a medical error

10. What would help you stay within your scope of practice?
a. Knowing the definition of my profession
b. Receiving appropriate training before applying a procedure or technique
c. Staying current with the laws that regulate my profession
d. All of the above

11. HIPAA allows the clinician to keep two sets of records, one of which is *general progress notes* and another which is called *process notes* or *psychotherapy notes*. This latter set of notes is for the clinician's own use and need not be revealed to insurance companies.
a. True
b. False

12. An example of adverse event is when a client makes a suicide attempt if:
a. Clinician never considered it necessary to assess a client for suicide risk because he didn't present symptoms of depression during intake.
b. Clinician disregarded signs because the patient is an adolescent with a dramatic personality
c. Clinician was not keeping track of new events happening in the adolescents life
d. Clinician didn't recommend seeing a psychiatrist because she deemed medication would make things worse
e. All of the above

13. A systemic approach to prevention of clinical errors:

a. Places emphasis on not blaming the individual
b. Uses root cause analysis to prevent further errors
c. Doesn't treat adverse events as isolated incidents
d. All of the above

14. Patient safety refers to:

a. Implementation of safe standards in hospital care
b. Successful root cause analysis
c. Avoidance of adverse events by hospital personnel
d. Freedom from accidental injury

15. Root cause analysis includes the following EXCEPT:

a. Studying the sequence of events before and after a sentinel event occurs
b. Interviewing all persons involved in the events
c. Team analysis of compiled data to identify underlying factors
d. Immediate mandatory reporting of any error
e. None of the above

EVALUATION SHEET
Medical Errors_____
DATE:

Please evaluate the class:

Rate the using numbers from 1 to 5, where 1 is poor and 5 is excellent

The material is clear and easy to read	1	2	3	4	5
The material is relevant for my practice	1	2	3	4	5
The material is well organized	1	2	3	4	5
The website is easy to navigate	1	2	3	4	5

What do you think could be done to improve this class?

Any other observations about the class