- Prevention of Psychological Medical Errors
- *Presenter: David Romano, PhD*

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Prevention OF Psychological Medical Errors

David J. Romano, Ph.D.

Orlando Institute for Psychology & Education, Winter Park

Psychology, College of Arts & Sciences, Barry University

407-628-0504

djromano@barry.edu

Objectives

Identify processes to approach error reduction and prevention.

Recognize error prone situations.

Identify factors that impact the occurrence of errors.

List the management measures designed to reduce error and enhance client/patient safety.

Florida Statute 456.013 (7)

"…The course shall by approved by the board or department, as appropriate, and shall include a *study of root-cause analysis, error reduction and prevention, and patient safety…*"

Quiz: Preventing medical errors in Mental Health is important because…?

a. With ACA there now is more access to Mental Health Care.

b. My family, friends, clients will use the system.

c. Advocates are needed to help work through the system.

d. As a mental health professional, I can provide tools beneficial to users.

e. In mental health, there are opportunities to contribute to and avoid medical and psychological errors.

f. All of the above.

Affordable Care act - Goals

- Use of research and evidence to quickly and effectively improve health care delivery
- The determination, standardization and implementation of "best practices" in health care quality, safety, and value that are scalable to diverse health care settings
- Quality Improvement processes in systems and processes of care to ensure:
  - Intended health outcomes
  - Improvements in patient safety
  - The reduction of medical errors
  - Delivery of high quality, efficient health care services

(ACA, 2010; O'Donohue & Engle, 2013)

Some Definitions

- Error:
  - Planning – use of a wrong plan to achieve the desired goal.
  - Execution – Failure of a planned action to be completed as intended.
- Adverse Event:

  Injury caused by medical management, rather than the underlying disorder/disease/condition of the client.
- Adverse Event as defined by Florida Statute, 395.0197: An event over which health care personnel could exercise control, and which is associated in whole or in part with medical intervention rather than the condition for which such intervention occurred.

Additional Definition

- Sentinel Event
  - Any unexpected occurrence, unrelated to the natural course of the client's illness or underlying condition, involving death, or serious physical or psychological injury, or the risk thereof including:
    - Suicide – where 24 hour care has been received
    - Unanticipated death of full term infant
    - Infant abduction or discharge to the wrong family
    - Rape
    - Surgery with the wrong patient or body part

JCAHO's -Top Sentinel Events List:

Top 10 Leading Reported Sentinel Event Types (CY2024)

Event Types	N	% of Total
Fall	776	49%
Wrong surgery*	127	8%
Delay in Treatment	126	8%
Suicide/death by self-inflicted injurious behavior	122	8%
Unintended retention of a foreign object	119	8%
Assault/rape/sexual assault/homicide	65	4%
Fire/burns	45	3%
Severe maternal morbidity	32	2%
Medication management	29	2%
Self-harm	23	1%
Perinatal Event	22	1%

*Wrong surgery includes wrong site, wrong procedure, wrong patient, and wrong implant.

(Joint Comission, p.5, 2025)

Sentinel Event Settings

Occurrence in Different Settings

- **Hospitals:** The overwhelming majority of sentinel events occur in hospital settings.
- **Behavioral Health:** Suicide/death by self-inflicted behavior, falls, and delays in treatment were prominent.
  - Delay in Treatment: 126 events reported.
  - Suicide/Death by Self-Inflicted Injurious Behavior: 122 events reported.
  - Patient Falls: The most frequent category, representing 49% of all reported events (776).
- **Psychiatric Hospitals:** Falls and suicides were leading causes, along with workplace violence-related events.
  - Patient Workplace Violence-Related Events: 65 events reported.
  - Suicide/Death by Self-Inflicted Injurious Behavior: 122 events reported.
  - Patient Falls: The most frequent category, representing 49% of all reported events (776).

Why This Matters

- By analyzing these events, healthcare organizations can gain deeper insights into the conditions and factors that contribute to serious adverse outcomes. This allows for the development of preventative strategies to improve patient safety and reduce harm across all sectors of the healthcare system.

(Joint Commission, 2025)

Sentinel Event Outcomes

Of the reported sentinel events (1575):

- 21% were associated with the outcome of death
- 49% with severe harm
- 21% with moderate harm
- 5% with mild harm
- 2% with psychological harm
- 2% with no harm

Among the events resulting in patient death, delay in treatment was the second leading category, following patient suicide/death by self-inflicted injurious behavior, with 60% of delays resulting in death.

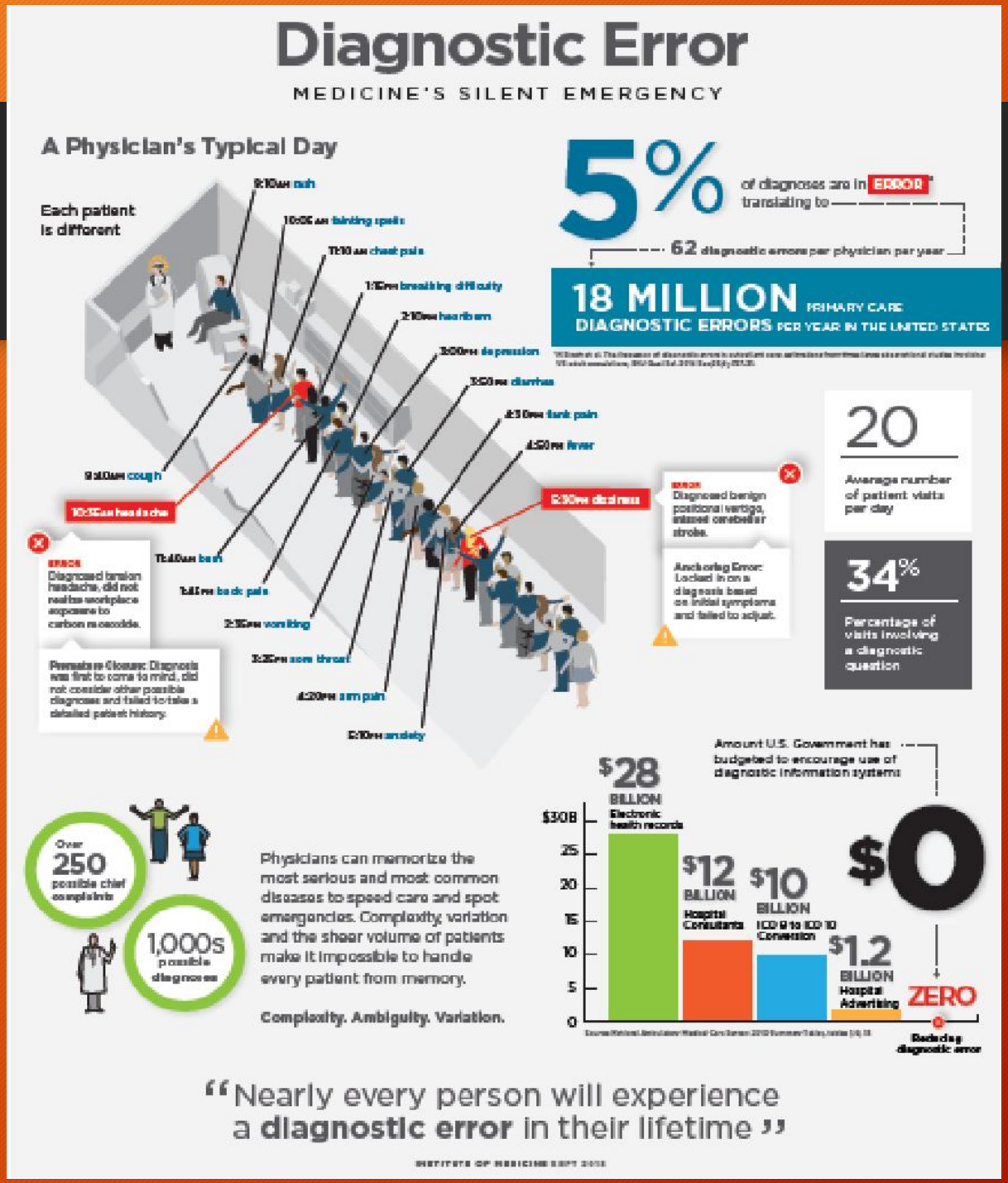
(Joint Commission, p. 2, 2025)

AT A 99.9% PERFORMANCE RATE, WE WOULD EXPERIENCE:

- Is 99.9% good enough???

Magnitude of the problem:

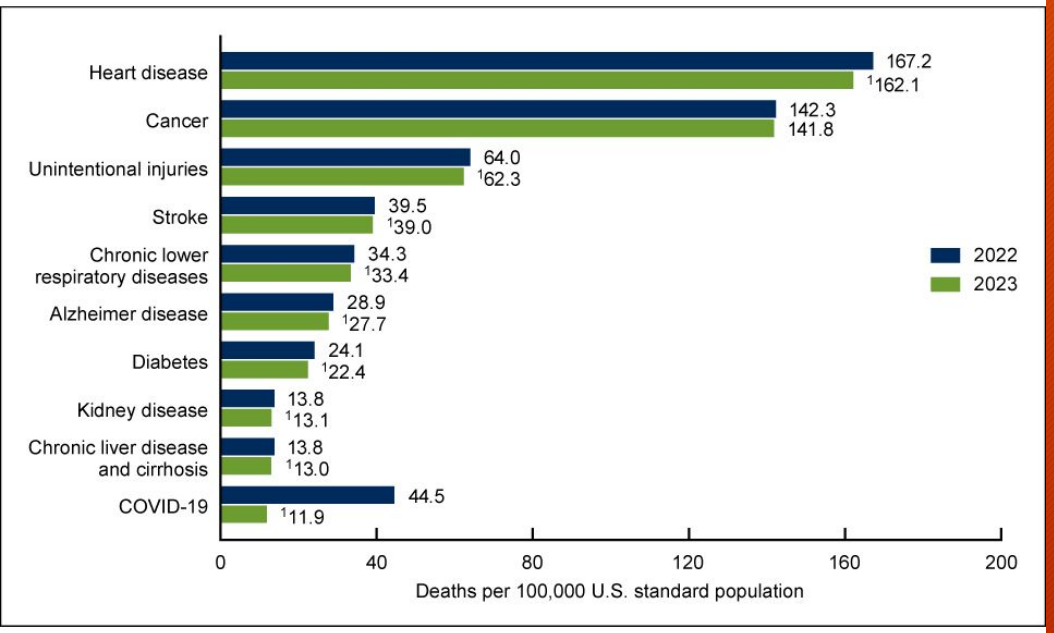
- Study results imply:
  - 1.5 million people are affected by medical errors annually (Ofri, 2010)
  - a lower limit of 250,000 (440 K upper)Americans die each year as a result of medical errors, (Makary & Daniel, 2016)
  - that more people die in a given year as a result of medical errors than from motor vehicle accidents (38,800 (NSC, 2020)), breast cancer (41,760, DeSantis, et al., 2019)), or AIDS (16,350 (cdc, 2020)).



(visual dx, 2018)

Preventable Deaths and Medical Errors

Figure 4. Age-adjusted death rate for the 10 leading causes of death in 2023: United States, 2022 and 2023



[1]Statistically significant decrease from 2022 to 2023 ($p < 0.05$).
NOTES: A total of 3,090,964 resident deaths were registered in the United States in 2023. The 10 leading causes of death accounted for 70.9% of all U.S. deaths in 2023. Causes of death are ranked according to number of deaths in 2023. Rankings for 2022 data are not shown. Data table for Figure 4 includes the number of deaths for leading causes and the percentage of total deaths.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Leading causes of death

Children ages 1-4 years

- Accidents (unintentional injuries)
- Congenital malformations, deformations and chromosomal abnormalities
- Assault (homicide)

Children ages 5-9 years

- Accidents (unintentional injuries)
- Cancer
- Congenital malformations, deformations and chromosomal abnormalities

Children ages 10-14 years

- Accidents (unintentional injuries)
- Intentional self-harm (suicide)
- Cancer

(CDC, 2024; CDC, 2025)

Areas for Potential Medical Errors

Common

- Medication
- Procedural
- Surgery

High Risk

- Psychology/Psychiatry
- Social Services
- Respiratory, Physical, Occupational Therapy
- Radiology/Nuclear Medicine
- Laboratory
- Dietary
- Pharmacy
- Nursing

Some Potential Areas for Psychological Errors

- Suicidal patients
- Mandated reporting
- Custody assessments
- Unreasonable expectations
- Dual relationships
- Practice beyond certification or training
- Failure to appeal a denial of care. (Managed Care)
- Supervision of interns
- Online Therapy

Sanctions and Top 10 Reasons for Disciplinary Action

ASPPB Disciplinary Data System: Historical Discipline Report

Reported Disciplinary Actions for Psychologists: 1974 – 2024

Total Number of Reported Actions in the ASPPB Disciplinary Data System: **7,454**

Disciplinary Actions Taken Per Year (Past 5 Years)

Type of Sanction	2024	2023	2022	2021	2020
Total Reported Actions	123	115	163	107	154
Revocations	4	18	23	9	14
Suspensions	9	16	19	11	18
Probations	13	8	16	23	42
Reprimands	26	8	10	28	36

Note: Each disciplinary action could contain multiple sanctions including other sanctions not listed such as supervision, mandatory continuing education, etc. Therefore, the total number of sanctions reported above does not equal the total number of disciplinary actions reported.

Top 10 Reasons for Disciplinary Action

Historical Information: Data Compiled from All DDS Entries

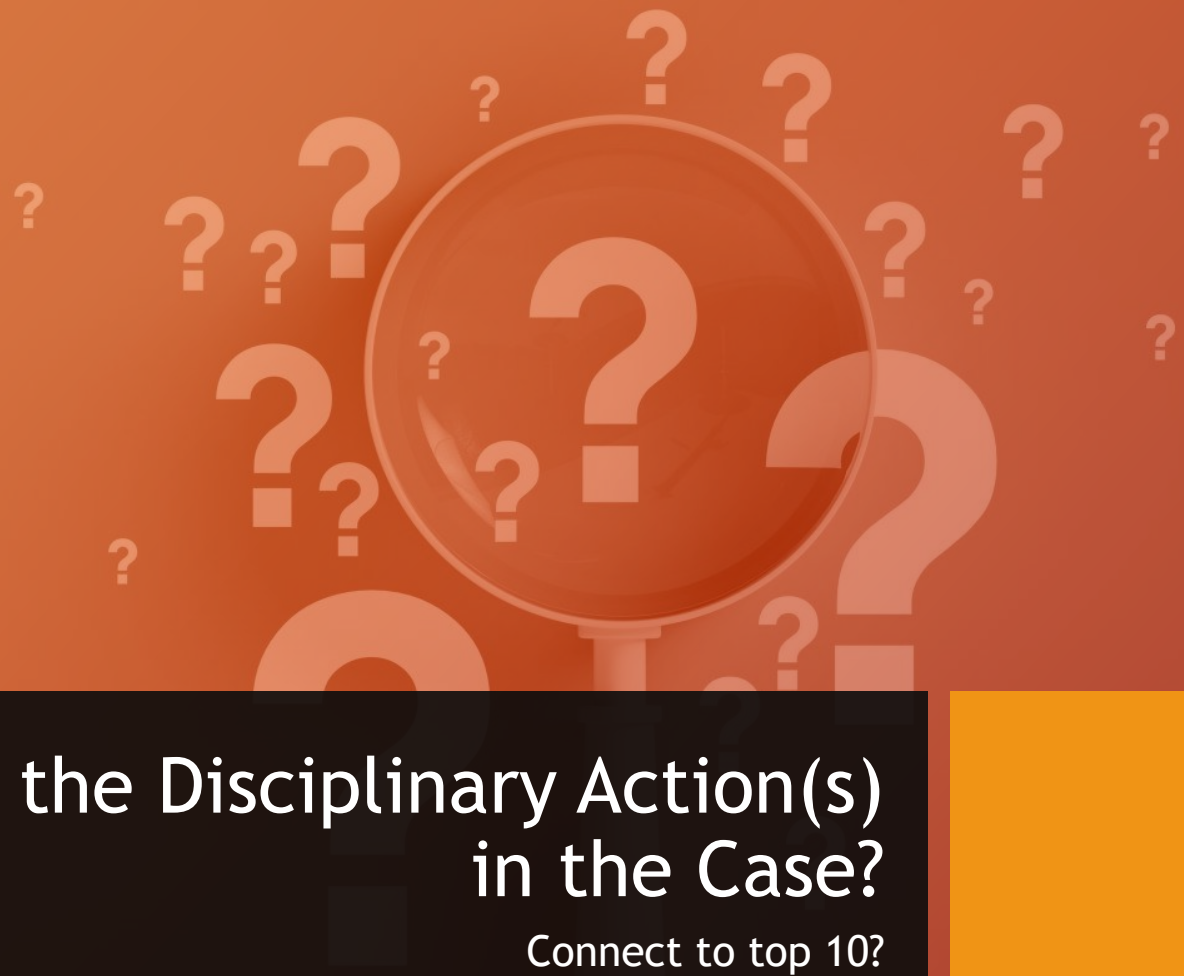
Reason for Disciplinary Action	Number Disciplined
Unprofessional Conduct	1151
Sexual Misconduct	1046
Negligence	841
Non-Sexual Dual Relationship	717
Conviction of Crime	606
Failure to Maintain Adequate or Accurate Records	492
Failure to Comply with Continuing Education or Competency Requirements	445
Incompetence	400
Improper or Inadequate Supervision or Delegation	324
Violation of Federal or State Statutes, Regulations or Rules	337
Other (the combined total of the 76 remaining reasons)	5409

Note: Based on the 7,454 total reports of disciplinary action submitted to the ASPPB Disciplinary Data System. Each action could contain multiple reasons for discipline such that the total number of reasons reported far exceeds the total number of actions.

(ASPPB, 2024)

Case:

- PSYCHOLOGIST DISCIPLINED FOR ACTION AGAINST MOTHER
- William Kale Board of Psychology Disciplinary Hearing



What Was the Disciplinary Action(s) in the Case?

Connect to top 10?

Top 10 BOP Disciplinary Reasons 2022-2024

Top 10 Disciplinary Reasons by Year

Reason for Disciplinary Action	Number Disciplined
2024	
Failure to Comply with Continuing Education or Competency Requirements	13
Negligence	11
Unprofessional Conduct	11
Failure to Maintain Adequate or Accurate Records	7
All Disciplinary Reasons are Alleged in that the Psychologist did not Admit nor Deny Charges in the Agreement/Order/Settlement	7
Substandard Testing/Assessment Procedures	5
Sexual Misconduct	5
Non-Sexual Dual Relationship or Boundary Violation	5
Conduct Evidencing Moral Unfitness	5
Conviction of Crime	5
Reason for Disciplinary Action	**Number Disciplined**
2023	
Non-Sexual Daul Relationship or Boundary Violation	16
Negligence	14
Unprofessional Conduct	12
Unable to Practice Safely by Reason of Alcohol or Other Substance Abuse	9
Conflict of Interest	8
Sexual Misconduct	7
Practicing without a License	7
Failure to Maintain Adequate or Accurate Records	7
Violation of Failure to Comply with Licensing Board Order	7
Incompetence	6
Reason for Disciplinary Action	**Number Disciplined**
2022	
Negligence	24
Non-Sexual Dual Relationship or Boundary Violation	17
Violation of Federal or State Statutes, Regulations or Rules	17
Unprofessional Conduct	16
Conviction of Crime	13
Failure to Maintain Adequate or Accurate Records	12
Breach of Confidentiality	11
Failure to Comply with Continuing Education or Competency Requirements	10
Substandard Testing/Assessment Procedures	9
Faud, Deceit or Material Omission in Obtaining License or Renewal	8
Reason for Disciplinary Action	**Number Disciplined**

ASPPB Disciplinary Data System: Historical Report
January 2025

Errors come from:

- People
  - Fatigue
  - Illegibility
  - Using past solutions
  - Inattention and distraction
  - Communication breakdowns
  - Familiarity
  - New situations and problems
  - Design flaws
  - Poor working conditions
  - Mislabeling
  - Wrong instructions
- Processes
  - Variable input
  - Complexity
  - Inconsistency
  - Human intervention
  - Time constraints
  - System culture

- Developmental factors and ability to cooperate with care
- Clients who need monitoring due to cognitive loss
- Ability for infants, children and elderly to respond to treatment (med issues, follow directions)
- Ill clients who have multiple conditions
- Immune system impairments

Factors that May Contribute to Errors

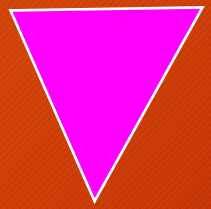
Cultural Factors Contributing to Errors

- Language barriers – understanding & communication
- Expression of health concerns
- Requesting help
- Economic resources
- Use of alternative approaches w/o reporting it
- Religious beliefs/practices

Models to Explain Errors

- Swiss Cheese

- Blunt and Sharp End



- Perceptual Psychological

Error Management

Three Main Ideas:

1. errors will occur,

2. there are positive and negative effects of errors, and

3. efforts should be made to increase positive effects of errors such as learning from errors.

Management Styles

- Positive Error Management - belief that one can successfully cope with errors by openly communicating about errors, feeling competent to deal with errors, belief that one can learn from errors, and acknowledging positive aspects of workplace errors.
- Negative Error Management - consists of avoiding and attempting to cover up errors and thereby usually failing to cope with them.
- NEM > impact on error strain > emotional exhaustion
- PEM < emotional exhaustion

(King & Beehr. 2016)

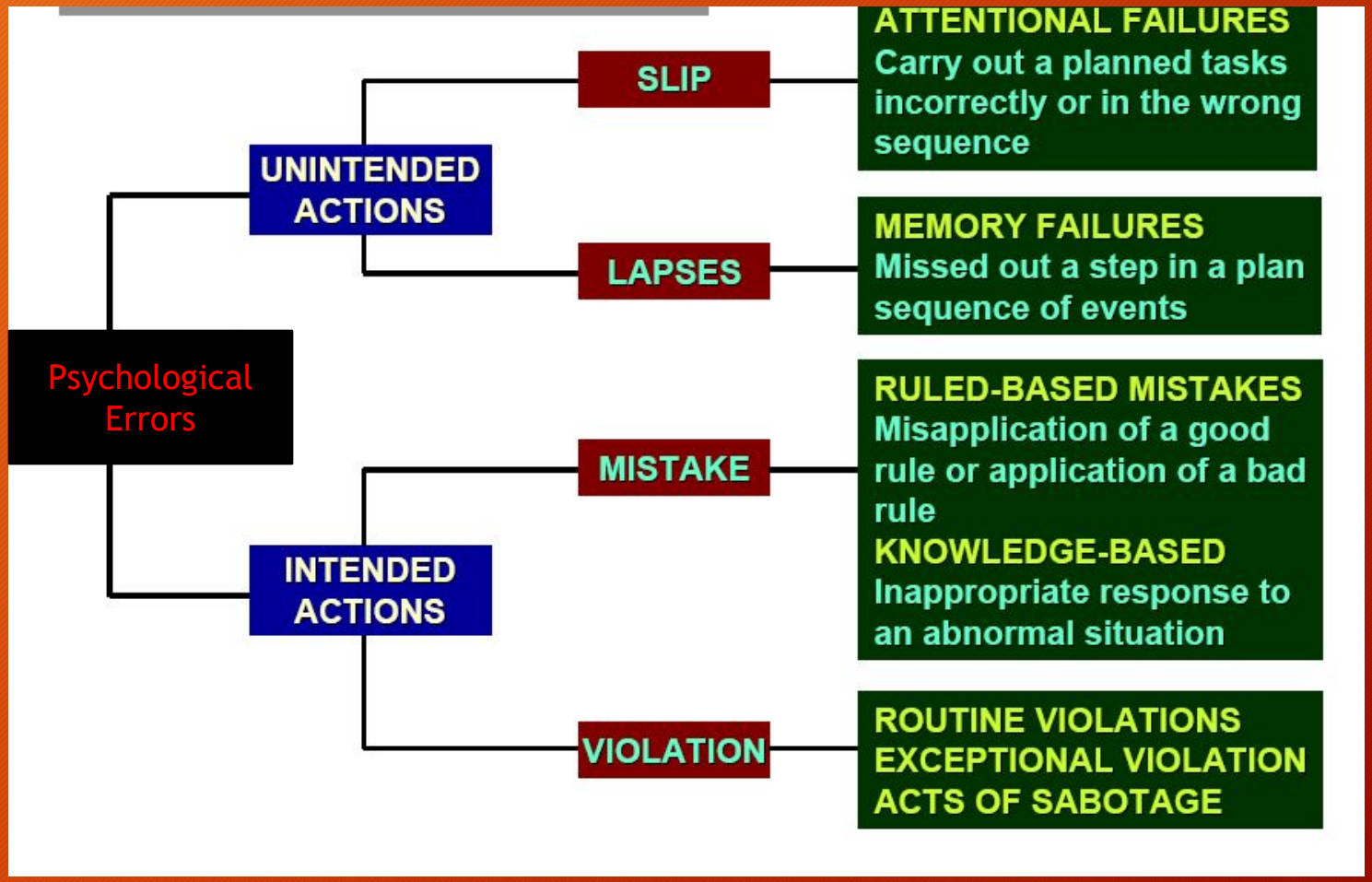
Intended and Unintended Errors

An unintended error occurs when someone does a task which they should be doing but it is done incorrectly.

An intended error occurs when someone deliberately sets out to do something and the action taken is inappropriate or wrong.

Conceptually, unintended errors can be divided into slip and lapses; and intended errors can be divided into mistakes and violations.

Action Error Types (Angeles, 2004)



Fundamental Attribution Error (How we explain others' behaviors)

Overestimate how action reflects individual traits and attitudes

- Own behavior in terms of the situation – environment commands attention
- Others behavior in terms of how person is – person commands attention
- Discount social constraints
- Intelligent and socially competent more likely to make the error
- Social power will lead conversation – have others overestimate knowledge and ability
- Videotape of confession – camera focus changes perspective
- Perspective change over time

We find causes where we look for them

- Self fulfilling prophecy- expectation – influences action – leads to behaviors consistent w/expectation

Look at the impact of situational variables on assessment of the individual

Attribution Bias Errors

- Hindsight bias –predict outcome after knowing it occurred
- Culture bias – related to how we perceive the attributions from personal culture
- In group/out group bias – in group like – build self esteem / out group - more alike than are
- Own race bias – more able to recognize facial distinctions of same race

Psychological Error Messages from Internal Error Message (Therapist)

	IEM	PEM
Perception	No detection	Expectation bias
	Misidentification	Perceptual tunneling
Memory	Forgot to monitor	Similarity interference
	Forgot temporary info	Mislearning
Judgment	Late decision	Failure to consider effects
	Under plan	Risk negation/tolerance
Action Execution	Selection error	Manual variability
	Unclear info given	Perceptual confusion

Client Errors that can lead to PME

(Buetow & Elwyn, 2007)

	Planning	Execution
Pre consultation attendance	Avoid or delay care	Does not show
Consultation Information giving	Does not offer certain info	Fails to state info clearly (preferences)
Manor & attitude	Single focus	Disrespectful
Investigations	Refuses tests or referrals	Forgets to bring items/homework
Diagnosis	Rejects	"Doctor shops"
Treatment	Refuses offered treatment	Forgets to do treatment
Post consultation	Chooses to do none or parts of treatment	Fails to carefully follow devised plan

The Truth About Errors

15% of Errors May be Attributed to People

85% of Errors May be Attributed to Processes

"medical errors most often result from a complex interplay of multiple factors. only rarely are they due to carelessness or misconduct of single individuals".

Lucien L. Leape, M.D., Harvard School Of Public Health

Case:

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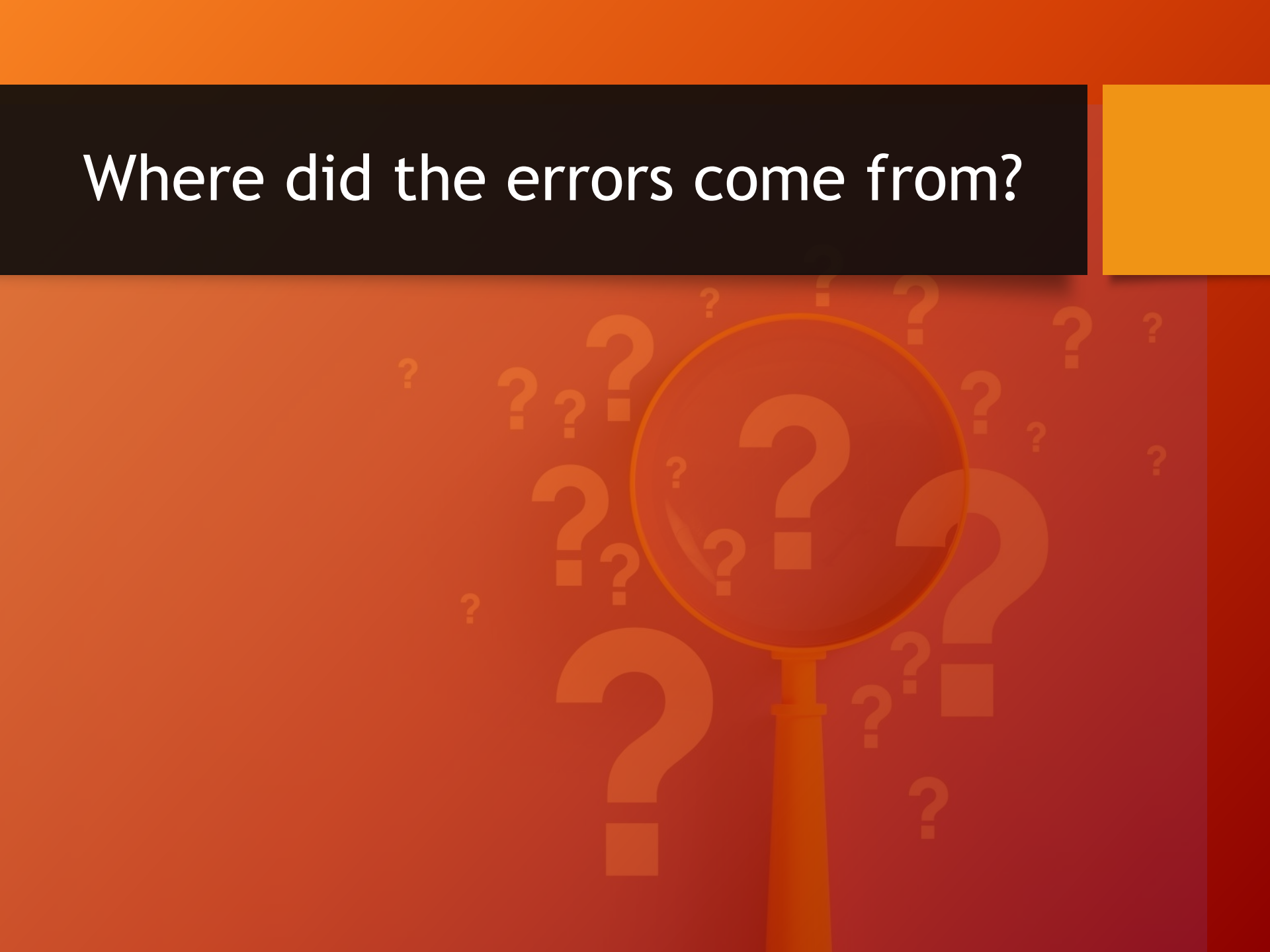
Where did the errors come from?



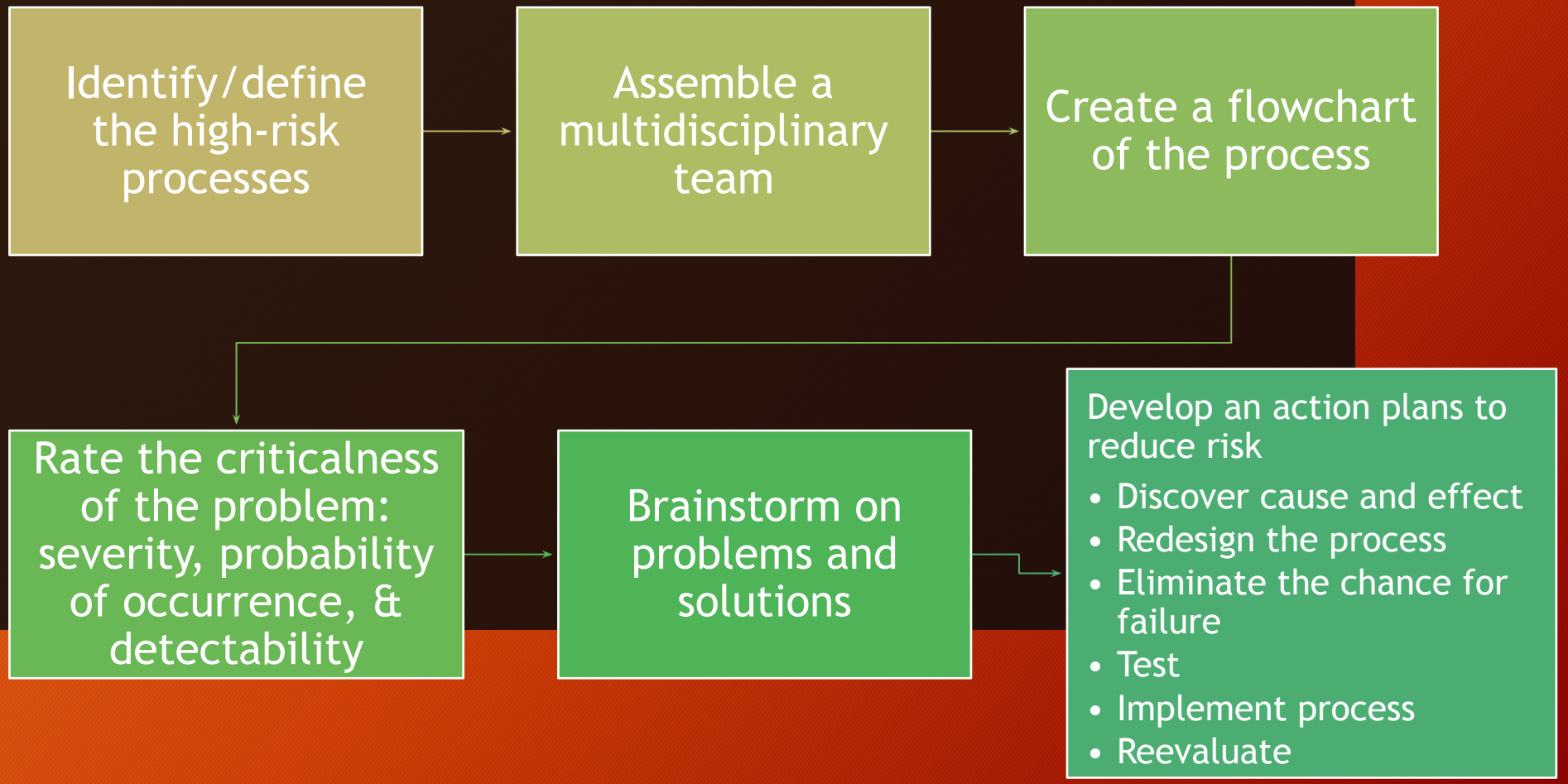
Two Main Tools for Prevention and Analysis

- FMEA
  - Failure mode, effects and analysis
- RCA
  - Root cause analysis

FMEA Keywords

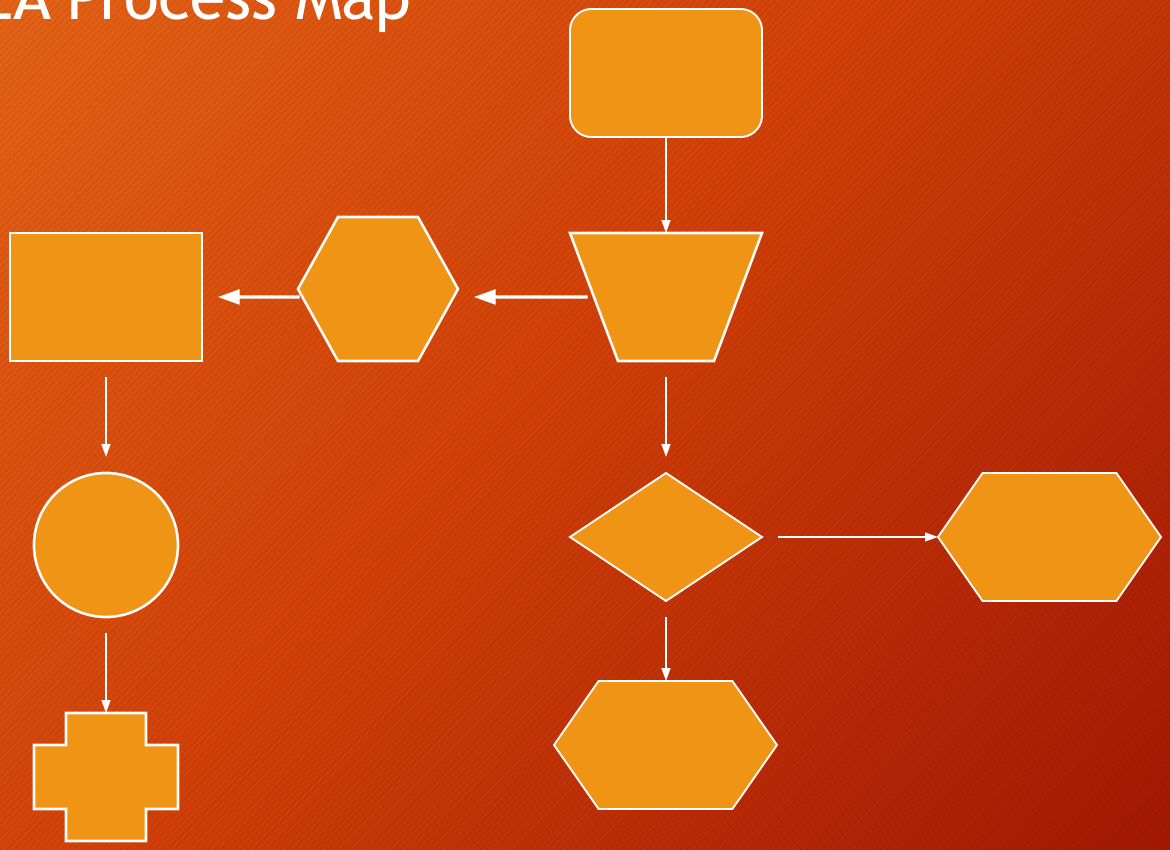
- Failure: When a system or part of a system performs in a way that is not intended or desirable.
- Mode: The way or manner in which something, such as failure, can happen.
- Effects: The results or consequences of a failure mode.
- Analysis: The detailed examination of the elements or structure of a process.

FMEA Process



Simple Flow Chart for Conducting an Analysis

- FMEA Process Map



RCA (Root Cause Analysis)

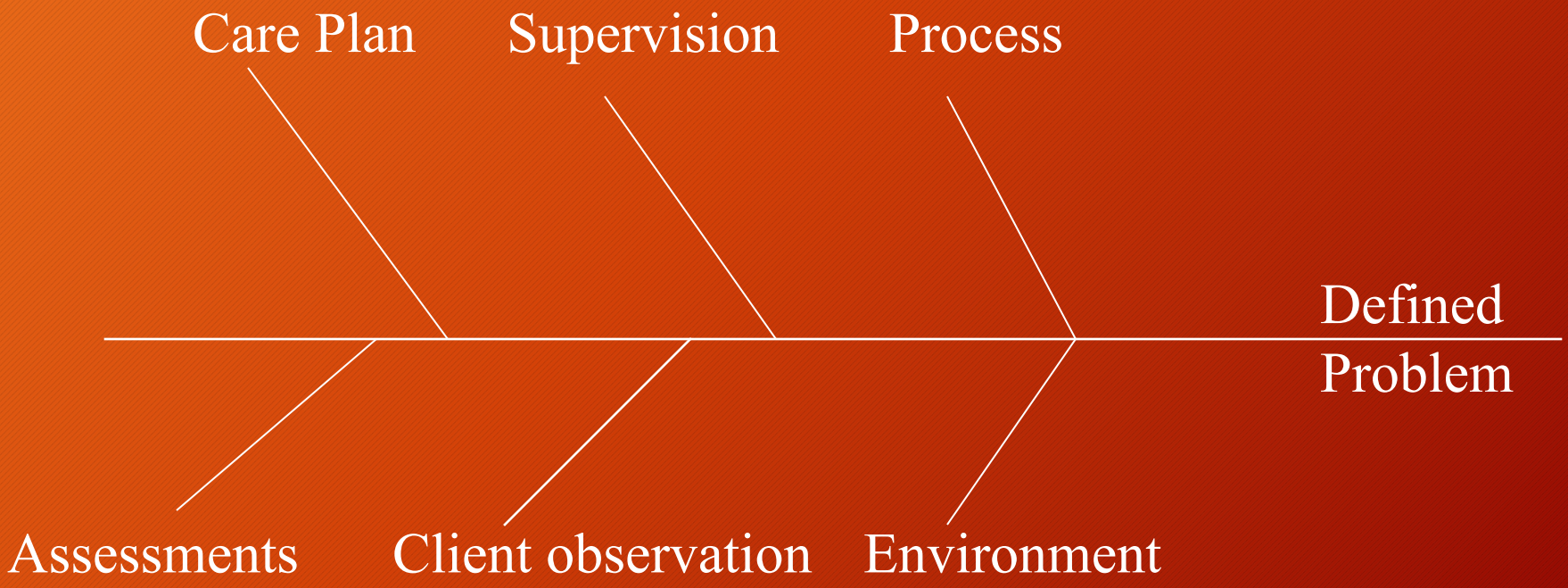
- JCAHO's Definition:

  "Root cause analysis is a **process for identifying the basic or causal factors that underlie variation in performance**, including the occurrence or possible occurrence of a sentinel event. A root cause analysis **focuses primarily on systems and processes, not individual performance**. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist."

“Root” vs. “Proximate” Causes

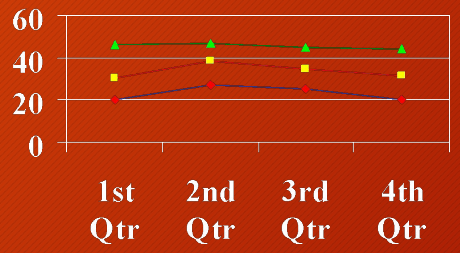
- Root causes are findings related to systems or processes (“common cause” variation) that have potential for redesign to reduce potential risk.
- Proximate causes involve “special cause” variations (things significantly different from standard operating procedure—either controllable or uncontrollable)

Fishbone Method for Conducting an Analysis



Another Method for Conducting an Analysis

- Graphs
  - Show trends in data
  - Verify root causes
  - Statistical Process Control Charts demonstrate common cause & special cause variation



Basic RCA Process

- Defining the problem, what happened & gather facts
- Assemble an interdisciplinary team – include leadership, those directly involved, & any “experts” needed
- Identify the sequence of events
- Recognize contributing factors and brainstorm possibilities
- Select root causes for the problem
- Develop an corrective action and follow-up plan to improve processes

3 Causes of Errors – Root cause

1. Physical causes: Tangible causes such as a lack of an electronic health record. An inappropriately prescribed psychiatric medication would be an example of a root physical cause.

2. Human causes: A practitioner did something wrong or failed to do something that ought to have been done. An example would be to fail to take the appropriate precautions with a suicidal patient.

3. Organizational cause: In this type of cause a system fails to make the proper decisions or fails to create processes in which work is rarely defective. An example of this would be if an organization fails to train workers so that they are competent in reporting child or elder abuse.

(O'Donohue & Engle, 2013)

Root Cause Driving Questions

1. What happened?

2. Why did it happen?

3. What can be done prevent it from happening again?

10 Most frequently identified root causes for Sentinel Events

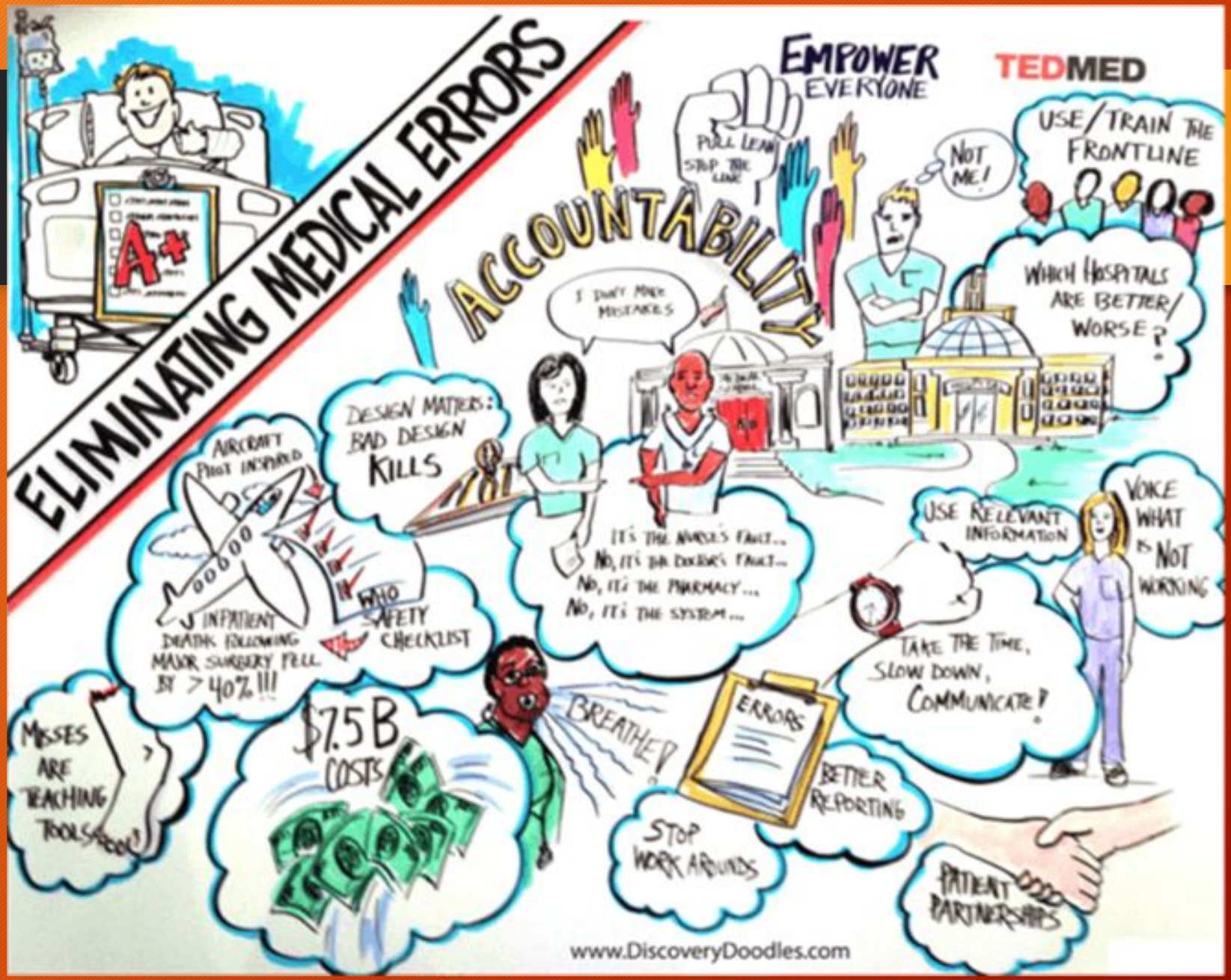
- Human factors (ex: staff supervision issues)
- Leadership (ex: organizational planning)
- Communication (ex: with patients or administration)
- Assessment (includes timing or scope of assessments)
- Physical environment (ex: fire safety)
- Information management (ex: medical records)
- Care planning (planning and/or interdisciplinary collaboration)
- Health information technology-related (ex: incompatibility between devices)
- Operative care (ex: blood use or patient monitoring)
- Continuum of care (includes transfer and/or discharge of patient)

(JCAHO, 2016)

Minimum Scope Checklist for an RCA

Minimum Scope Checklist for an RCA, continued

- Communication with client and families
- Communication among staff members
- Availability of information
- Adequacy of technological support
- Equipment maintenance/ management
- Security systems and processes
- Control of medications (psychological supplies), storage, access
- Physical environment
- Labeling of medication (psychological supplies)



(Lu, 2013; discoverydoodles.com, 2013)

How to Think Better and More Logically - Remove Bias

- 12 Cognitive Biases Explained

- Diagnosis
- Assessment
- Medication use
- Treatment procedures & plans
- Confidentiality
- Timely and appropriate referrals
- Gathering & release of information
- Potential misconstruing of conduct
- Appropriate reporting to authorities

The most common errors in Mental Health

Some Sources of Error in Psychological Practice

Dodo Verdict - controversial belief that all therapies are equally effective – I've been doing

Vaguely Defined Concept of Professional Knowledge – Education vs Competencies as alternative

Emphasis on Cultural Without Individual Consideration

Facilitated Communication – Assisted/Interpreters

Other Harmful Interventions – (e.g. debriefing, boot-camp interventions)

Lack of Consultation

(O'Donohue & Engle, 2013; Pope, 2006; Maheu, 2020)

Failing to Diagnose and Failing to Treat an Addicted Client

Consistently screen and diagnose addictive behaviors during initial assessments.

Offer empirically supported treatments to clients with addictive behaviors, taking clients' readiness to change carefully into consideration (e.g., MI and integrated therapy approaches).

Psychotherapy training programs require at least basic education and training in the diagnosis and treatment of addictive behaviors, so all therapists have relevant addiction-related knowledge and skills.

Education and training programs address prohibitive attitudes about addictive behaviors.

Professional organizations representing psychotherapists pay greater attention to addictive behaviors. These organizations are especially well positioned to raise awareness about addictive behaviors among general psychotherapy practitioners.

Group and Individual Therapists Ignore Multiple Realities

Preparing Patients for Group Work: The Group as a Social Microcosm

- seduced demeanor and failed to examine interpersonal struggles.

When Multiple Realities Cannot Coexist in the Group

- multiple realities where she felt one way and someone else felt differently .

Preparing Individual Therapists for Conjoint Therapy

- discuss therapeutic collaboration.

Splitting: It Has to Be My Reality Because the Problem Cannot Be Me

- denies the existence of other realities that likely exist.

Group Intakes: Not Overly Relying on Individual Therapists' Realities

- imagine the challenges they will face in the group and how they will be able to navigate them.

(Marmarosh. 2016)

Errors In the Treatment of Miscarriages

- **Minimizing or Avoiding Painful Affects Related to Miscarriage** - symptoms of anxiety, as well as psychological intrusion and avoidance that are comparable to posttrauma victims; depressive symptomatology reaches clinical significance 6 months following a miscarriage; 30% of women who experienced a miscarriage reported suicidal thoughts
- **Assuming that Grief is Resolved Upon a Subsequent Pregnancy** - grief is long lasting, often extending beyond the birth of a healthy baby, and in many cases does not follow a "normal" linear decline in symptoms; fear that another loss may follow, leading to chronic hypervigilance and pregnancy-specific anxiety as well as elevated levels of depression
- **Neglecting Early Losses Resurrected by the Pregnancy Loss** - relational conflict in the couple after a miscarriage, a common clinical error is stop there, rather than also exploring the historical aspects underlying each partner's response to the loss.
- **To Avoid** - Better treatment approach is based on the assumptions:
- miscarriage is often a traumatic loss in a woman's life,
- the traumatic affect associated with the event should be approached, rather than avoided, within a safe affect regulating relationship with the therapist.

(Markin. 2016)

4 Main Errors

1. Neglecting to conduct a detailed functional analysis of the presenting problem(s) prevented with significant exposure to the knowledge base of cognitive and behavioral principles.

2. Not adequately engaging the patient in developing a case formulation for the purposes of treatment planning use of a comprehensive case conceptualization compatible with the patient's own understanding of the presenting problem

3. Getting wrapped up in simply examining beliefs without behavioral tests, treatment goals that are observable, measurable, achievable, and that are connected to the patient's presenting problem.

4. Not holding patients accountable for fear of rupturing the therapeutic alliance be curious, interpersonally aware, and flexible while closely monitoring to hold patients accountable.

Clinical Errors in Cognitive-Behavior Therapy

(Kim. Hollon , & Olatunji, 2016)

Reducing Inadvertent Clinical Errors- Functional Analytic Psychotherapy

Functional Analytic Psychotherapy (FAP) harnesses the power of the therapeutic relationship and maximizes the genuineness, intensity, compassion, and effectiveness of the therapist; client as a microculture with complex life stories

Session Bridging Form for Data Collection - session effectiveness, connection to therapist, and other similar variables

Inadvertently Reinforcing a Problematic Behavior or Clinically Relevant Behaviors RB1(daily life)

- Incessant Talking
- Overly Compliant Behavior

Inadvertently Punishing an Improvement Behavior or CRB2 (in session)

- Silence
- Uncooperative Behavior

Therapist awareness of their own problems behaviors (T1s) and target behaviors (T2s) will decrease the likelihood of clinical errors.

(Tsai, et el., 2016)

Some Other Psychological Errors

- Psychological Masquerade - nonmedical mental health practitioners misdiagnosing medically based disorders as psychologically based
  - exercise biological rule outs; working on interdisciplinary treatment teams and regularly reading literature from other practice models, become familiar with the strengths and limitations of informal clinical decision-making
- Responding to Client Questions - respond with too little or too much information or shutting down the discussion prematurely; can damage the therapeutic relationship, the psychotherapy process, or both
  - receive the client's question respectfully; promote curiosity about the question; answer the client sufficiently to keep the client engaged; and explore possible underlying and idiosyncratic meanings
- Information Processing Bias Toward Psychopathology: Interpreting Likert Scales at Intake Assessment - Symptom Check List 90 - Failing to Discuss Individual Outputs of Psychometric Questionnaires
  - Validate Individual Problems, Isolate Individual Problems, Validate Individual Strengths, Break Through Black and White Thinking (DSM-5)

(Spengler, Miller, & Spengler, 2016; Waehler & Grandy, 2016; Fluckiger, Znoj, & Visla, 2016)

Essential Mitigation In Mental Health

Communication with patients and providers is the most potent way to avoid errors

A sense of Powerlessness is a large contributor to medical errors.
E.g. “Doctors and others won’t listen to or respond to my concerns.”

Treatment Decision-Making Process – Error producing

Doctor Knows Best Model

- decision-making power lies primarily with the therapist
- uses knowledge and experience to decide which treatment or treatment format would be best
- stronger allegiance to a single theoretical orientation
- emphasis on the use of empirically supported treatments in the field
- lack of training in multiple treatment approaches
- pull for the therapist to provide solutions and direct the decision making

Independent Choice Model

- all decision-making authority given to the client
- preexisting ideas about what treatment might work best for them
- lack essential knowledge about the various treatment options
- miss contraindications for some of the treatments
- lack critical skills to evaluate the pros and cons of each of the options

(Park, Goode, Tompkins, & Swift, 2016)

Treatment Decision-Making Process – reducing Error

Shared Decision-Making Model

- therapist and the client are actively Involved in decision making
- share information with each other
- discuss the benefits and drawbacks
- collaborative agreement about which option to implement

(Park, Goode, Tompkins, & Swift, 2016)

Deming's Quality Improvement Model – Continuous Improvement

- Appreciation of a system: understanding the overall processes involving suppliers, producers and customers;
- Knowledge of variation: Understanding the range and causes of variation in quality and use of statistic sampling, in measurements;
- Creating constancy of purpose toward improvement;
- Institute leadership to help people do a better job;
- Improve management's orientation toward quality. As Deming said, "a system must be managed";
- Drive out fear;
- Break down barriers;
- Institute a vigorous program of education;
- Providing workers the tools to perform well;
- Measure processes and use plan-do-study-act cycles to constantly minimize errors;
- Create joy in work and pride in work.

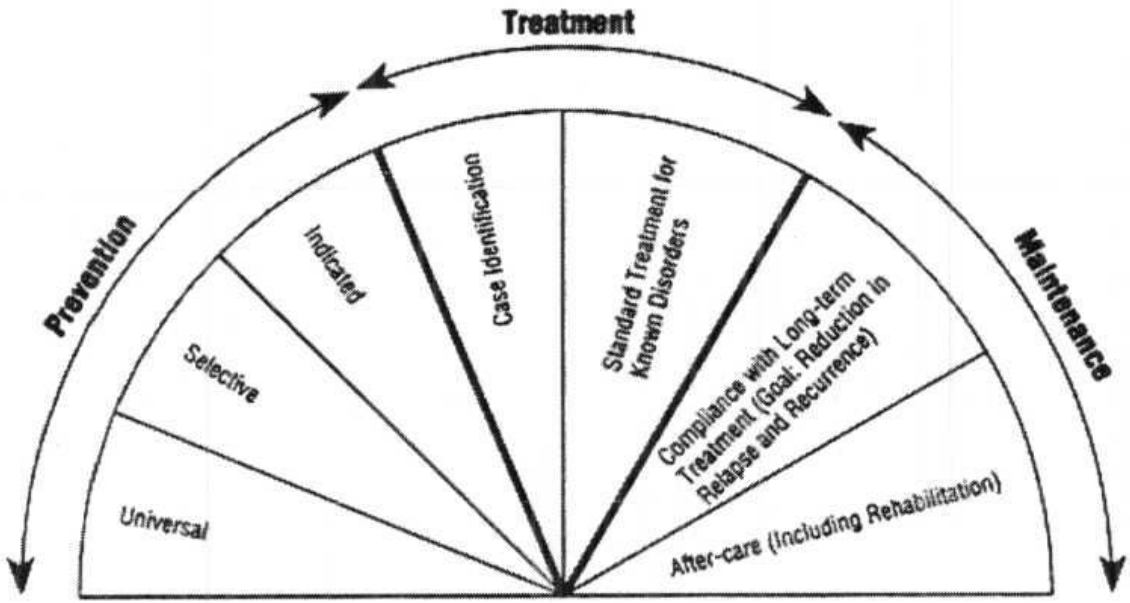
(O'Donohue & Engle, 2013)

Include Clients & Families

- Education
- Continued communication regarding treatment & expectations
- Discuss patient rights & *responsibilities (HIPAA)*
- Encourage taking an active role as health care consumers - ask questions frequently
- Use advocates to help navigate the system

Intervention Conceptualization

FIGURE 1
The mental health intervention spectrum for mental disorders.



(Mrazek & Haggerty, 1994)

Building a Safety Culture

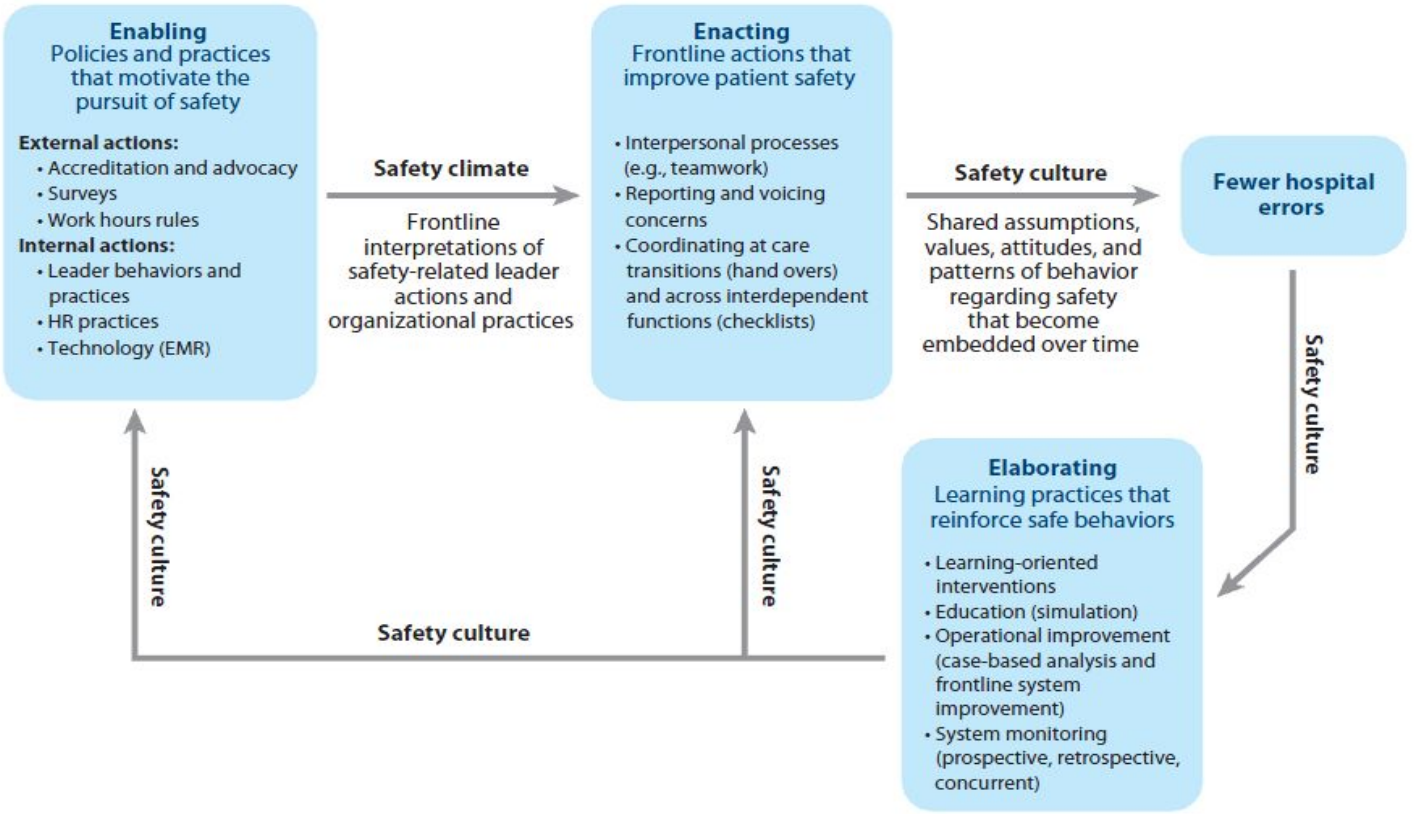


Figure 1

A cultural approach to reducing hospital errors. EMR, electronic medical record; HR, human resources. Adapted from Reference 164.

(Singer & Vogus, 2013)

Error Reporting

- In agencies, create a “Report-Friendly” Environment (don’t let a “small slip” go by and develop into a Sentinel Event)
- Florida Law requires a Licensed Risk Manager in most health/behavioral health care facilities
- Legal consultation/representation
- Reporting adverse outcomes to regulatory or accreditation bodies

Ways to accomplish process changes

- Simplify
- Standardize
- Reduce reliance on memory
- Checklists
- Remove constraints
- Eliminate look and sound alikes
- Training
- Increase communication and feedback
- Teamwork
- Adjust environment
- Shift work schedules

Move Toward an Evidence Based Practice

- Develop a level of knowledge about and commitment to quality improvement
- Understand the consumers
- Develop domain quality indicators
- Use information technologies that track domain quality indicators
- Use process analysis and cycles of learning
- Implement continuing education
- Create benchmarks
- Transparency report card

(Fisher & O'Donohue, 2006)

Data in Mental Health is Essential

Data provides a framework for treatment.

Data reinforces knowledge

Data can identify trends

Data supports continuing a process or making a change

Lack of Context Responsiveness

Client Context responsive markers and evidence-based responsive modules:

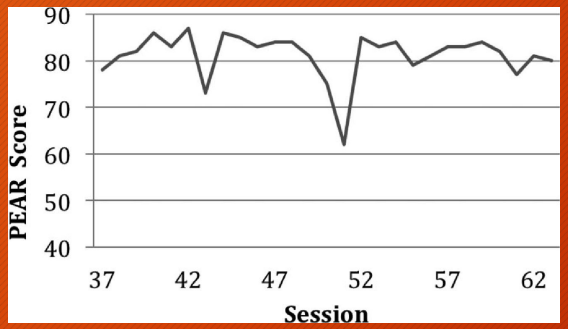
- low outcome expectations - lack of confidence in treatment's efficacy mark the need to address treatment beliefs;
- change ambivalence - not sure about making a change mark the need for clinicians to use interviewing strategies;
- self-strivings - need for self-enhancement, positivity, and self-consistency, which may clash with underlying negative self-views, attended to and affirmed to avoid incongruence in the therapeutic process and subsequent negative relational consequences;
- alliance ruptures and repair – session glitches make adjustments to affirm connections;
- lack of outcomes monitoring – not identify client states emphasize importance of tracking progress and respond to deterioration or lack of expected clinical change

University of Rhode Island Change Assessment Scale (URICA); Working Alliance Inventory—Self-Report Client (WAI-SR); Overall Anxiety Severity and Impairment Scale (OASIS); Overall Depression Severity and Impairment Scale (ODSIS)

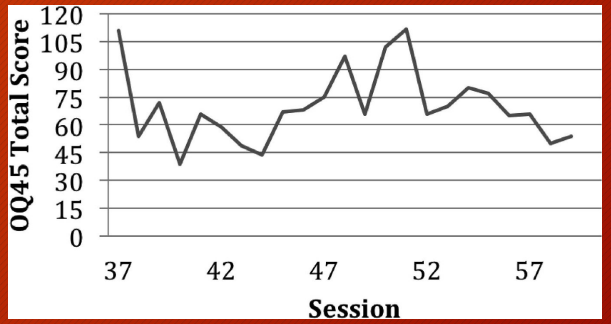
(Bugatti & Boswell, 2016)

Using Measure-Based Feedback to Identify and Repair a Clinical Error

- to overcome our blind spots is by frequently and systematically collecting measure-based feedback from the patient.
- measures that focus on the process of psychotherapy combined with treatment outcome measures to monitor the patient's therapeutic experience and progress.
  - Patient's Experience of Attunement and Responsiveness scale (PEAR)



  - Outcome Questionnaire 45.2 (OQ-45.2)



(Snyder, & Aafjes-van Doorn, 2016)

What Do you DO?

- What is one thing you do well in your practice?
- How do you measure it?
- What do you use to measure it?

Screening Tools

- SAMSHA
- Hazelden
- MENTAL HEALTH SCREENING AND ASSESSMENT TOOLS FOR PRIMARY CARE
- Screening and Assessment Instruments for Young Children

Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

- Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

- Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used

- HIPAA-compliant video communication products and that they will enter into a HIPAA BAA: Skype for Business / Microsoft Teams, Updox, Vsee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet, Cisco Webex Meetings / Webex Teams, Amazon Chime, GoToMeeting

(Severino, 2020)

Assessment in Telehealth Implementation: a Five-Theme Framework

Specific issues in the delivery of assessment via telepractice include, but are not limited to:

- The age and characteristics of the examinee
- The skill, experience, and training level(s) of the examiner
- The assessment task format(s)
- Appropriate modifications of tasks delivered in a telepractice setting
- The data supporting the valid and reliable modification of any use of norm-referenced scores validated on a paper administration in a telepractice environment
- The legal requirements of any use of published test content in a telepractice context

A five-theme framework) for addressing issues of assessment in telepractice may be helpful in identifying key areas of focus or concern for each assessment. The five themes are:

- **Audio/Visual Environment** (e.g., sound quality, video quality, background distractions)
- **Examiner Factors** (e.g., technological competence, familiarity with the test)
- Examinee Factors (e.g., behavior, fatigue level, comfort with technology)
- **Test/Test Materials** (e.g., type of task to be administered, format of stimulus, ease of use)
- **Other/Miscellaneous** (e.g., purpose of the administration, nature of clinical relationship)

(Eichstadt, Castilleja, Jakubowitz, & Wallace, 2013)

- Please note that any change in the currently published formats of any test requires prior permission from Pearson before you begin to manipulate any copyrighted material. See the Legal Policies on their website for additional detail. (Pearson, 2020)

WPS Statement on Telehealth assessment

- …For these tests tele-assessment methods would be considered an adaptation of the standardized administration and should be taken into consideration when reporting and interpreting the results of a remote administration…

(WPS, 2020)

Risk Management Formula

$$\text{Clinical Risk} = \frac{(P \times C \times D)}{TF}$$

P = patient risk characteristics
C = context
D = disciplinary consequences
TF = therapist factors

(Bennett, et. al., 2006)

P = patient risk characteristics

- Serious personality disorders
- DID
- Reported recovered memories of abuse
- Abused as children
- Danger of serious harm to self or others
- Wealthy
- Involved in lawsuits or other legal issues

$$\frac{(P \times C \times D)}{TF}$$

C = context

- Total circumstance of seeing patient/client
- Setting
- Type of service provided
  - Evals with relationship consequences
  - High conflict divorce
  - Under supervision
  - Clinically contraindicated multiple relationships

(P X C X D)

TF

D = disciplinary consequences

- Proactive – training, associations, consultative services, peer assistance programs
- Reactive – licensing boards, ethics committees, malpractice (negligence), civil (breach of contract), criminal (mandatory reports, insurance fraud) courts

$$\frac{(P \times C \times D)}{TF}$$

TF = therapist factors

- Personal skill inventory
  - Knowledge
  - Skills
  - Past experiences
  - Emotional competencies
  - System of assistance (protection)
- Personal database
  - Fund of info about a diagnosis
  - Area of professional practice

$$\frac{(P \times C \times D)}{TF}$$

Mental Health Practitioner's Tools to Prevent Medical Errors

- Use Peer and outside Consultation
- Participate in Professional Associations
- Obtain Legal Counsel when needed
- Keep thorough practice information
- Obtain signed treatment plans
- Communicate accurately with clients.
- Explain limits of confidentiality under State Law and HIPAA

Preventing Psychological Medical Errors

- Documentation
- Treatment Planning
- Continuum of Care Planning
- Know/Follow Policy & Procedure
- Training, Training, Training
- Develop & Maintain Performance Standards
  - Clinical Performance Measures
  - Service Performance Measures
  - Outcomes Measures

Last Thoughts

- You can help prevent Psychological Medical Errors
  - Establish minimum scope process in your practice (RCA)
  - Accomplish process changes
  - Utilize fact sheets to educate clients
  - Practice Risk Management
  - Remain aware of issues and guidelines
    - Agency for Healthcare Research & Quality achpr.gov
    - Medical and Mental Health Procedural Guidelines www.guideline.gov

Prevention OF Psychological Medical Errors

David J. Romano, Ph.D.

Orlando Institute for Psychology & Education, Winter Park

Psychology, College of Arts & Sciences, Barry University

407-628-0504

djromano@barry.edu

Evaluation Forms

You can fill out the evaluation form using the app. Look for the evaluation form link at the bottom of each session. (preferred)

OR

You can fill out the evaluation sheet by hand and give it to a staff member or the moderator of the session.

You need to fill this form out to receive full credit for the session.

Thank you!