

## **Medical Errors for Mental Health Professionals 2022 (2CE)**

Written by:

K McCarthy, Esq., JD, MS, NCC

Sean Chambers, MSW. BA

B. Jones, Esq., JD, BA

Fiona Gain, BA

© 2022 Ace-Classes, Inc.,  
*Adapted with permission for ACEonline, LLC*

## **Medical Errors**

A **Medical Error** is a preventable adverse effect of care, whether or not it is evident or harmful to the patient (Grober, 2005). This might include an inaccurate or incomplete diagnosis or treatment of a disease, injury, syndrome, infection, or other ailment. Globally it is estimated that 142,000 people died in 2013 from adverse effects of medical treatment up from 94,000 in 1990 (Institute of Medicine, 2000).

Medical errors can be further defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities (Carver 2020). High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

Medical errors may occur along the continuum of medical care from diagnosis to treatment; they are not intentional, do not always arise to the level of malpractice or negligence, and do not necessarily result in injury to the patient. Those that do are referred to as adverse or sentinel events and must be subjected to rigorous root cause analysis and a response. Even under circumstances in which a medical error did not rise to the level of an adverse or sentinel event, there is often something to be gained by a thorough analysis of the error, why it occurred and what can be done to prevent a recurrence, and, quite possibly, an adverse or sentinel event.

Beyond their cost in human lives, preventable medical errors exact other significant tolls. Medical errors are estimated to cost between US\$17-billion and US\$29-billion per year in lost income, lost household production, disability and additional health care costs (Grober 2005). Errors also are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort. Health professionals pay with loss of morale and frustration at not being able to provide the best care possible. Society bears the cost of errors as well, in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

## **Definitions**

Multiple similar definitions are available for each of these terms from various sources; the health practitioner should be aware of the general principles and probable meaning. The following are common terms and the varying definitions as found in literature:

**Active Error**

- Active errors are those taking place between a person and an aspect of a larger system at the point of contact.
- Active errors are made by people on the front line such as clinicians and nurses. For example, operating on the wrong eye or amputating the wrong leg are classic examples of an active error.

**Adverse Event**

Adverse events may be preventable when there is a failure to follow accepted practice at a system or individual level.

- An adverse event attributable to an error usually is a preventable adverse event.
- An adverse event is a type of injury that most frequently is due to an error in medical or surgical treatment rather than the underlying medical condition of the patient.
- Not all adverse outcomes are the result of an error; hence, only preventable adverse events are attributed to medical error.

**Unintended Injury**

- An unintended injury is medical or surgical patient management that results in prolonged hospitalization, measurable physical disability, or both.
- An unintended injury or complication is the result of prolonged hospitalization or disability or is caused by factors inherent in the healthcare system rather than a disease.

**Latent Error**

- Errors in system or process design, faulty installation or maintenance of equipment, or ineffective organizational structure, and may go unnoticed for a long time with no ill effect.
- When a latent error occurs in combination with an active human error, some type of event manifests in the patient. The active human error triggers the hidden latent error, resulting in an adverse event.
- Latent errors are basically "accidents waiting to happen."
- A classic example is a hospital with several types of chest drainage sets, all requiring different connections and setups, yet not all frontline clinicians and nurses are familiar with the intricacies of each setup, creating the scenario for potential error.

**Medical Error**

- The failure to complete the intended plan of action or implementing the wrong plan to achieve an aim.
- An unintended act or one that fails to achieve the intended outcome.
- Deviations from the process of care, which may or may not result in harm.
- When planning or executing a procedure, the act of omission or commission that contributes or may contribute to an unintended consequence.

**Negligence**

- Failure to meet the reasonably expected standard of care of an average, qualified healthcare worker looking after a patient in question within similar circumstances.
- For example, the healthcare worker may not check up on the pathology report which led to a missed cancer or the surgeon may have injured a nerve by mistaking it for an artery.

**Negligent Adverse Events**

- A subcategory of preventable, adverse events that satisfy the legal criteria used in determining negligence.
- The injury caused by substandard medical management.

**Near Miss**

- Any event that could have had an adverse patient consequence but did not.
- Potential adverse events that could have caused harm but did not, either by chance or because someone or something intervened.
- Near misses provide opportunities for developing preventive strategies and actions and should receive the same level of scrutiny as adverse events.

**Never Event**

- Never events are errors that should not ever have happened. A classic example of a never event is the development of pressure ulcers or wrong-site surgery. The National Quality Forum has identified the following as Serious Reportable Events:
  - Care Management
  - Device/Product
  - Environmental
  - Patient Protective
  - Surgical
  - Radiological

**Noxious Episode**

- Untoward events, complications, and mishaps that result from acceptable diagnostic or therapeutic measures deliberately instituted.
- For example, sending a hemodynamically unstable trauma patient for prolonged imaging studies instead of the operating room. The result could be a traumatic arrest and death.

**Patient Safety**

- The process of amelioration, avoidance, and prevention of adverse injuries or outcomes that arise as a result of the healthcare process.

**Potentially Compensable Event**

- An error that could potentially lead to malpractice claims.
- An event due to medical management that resulted in disability, and, subsequently, a prolonged hospitalization.

**Root Cause**

- A deficiency or decision that, if corrected or avoided, will eliminate the undesirable consequence.
- Common root causes include:
  - Changes in mental acumen including conducting healthcare in an automatic fashion, not seeking advice from peers, misapplying expertise, not formulating a plan, or not considering the most obvious diagnosis.
  - Communication issues, having no insight into the hierarchy, having no solid leadership, not knowing whom to report the problem, failing to disclose the issues, or having a disjointed system with no problem-solving ability.
  - Deficiencies in education, training, orientation, and experience.
  - Inadequate methods of identifying patients, incomplete assessment on admission, failing to obtain consent, and failing to provide education to patients.
  - Inadequate policies to guide healthcare workers.
  - Lack of consistency in procedures.
  - Inadequate staffing and/or poor supervision.
  - Technical failures associated with medical equipment.
  - No audits in the system.
  - No one prepared to accept blame or change the system.

**Sentinel Event**

- Any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof...The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome (The Joint Commission, 2017).
- Sentinel events are so-called because once discovered, they frequently indicate the need for an immediate investigation, discovery of the cause, and response.

*Definitions retrieved from (Rodziewicz & Hipskind, 2020).*

### **Types of Errors**

A variety of factors have contributed to the nation's epidemic of medical errors. One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system--or "nonsystem," to some observers. When patients see multiple providers in different settings, none of whom has access to complete information, it becomes easier for things to go wrong.

There are **two types of errors: acts of commission and acts of omission**. An act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

For instance, ordering a medication for a patient with a documented allergy to that medication would be an act of commission. Failing to prescribe a proven medication with major benefits for an eligible patient (e.g., low-dose unfractionated heparin as venous thromboembolism prophylaxis for a patient after hip replacement surgery) would represent an error of omission.<sup>3</sup>

According to a report by the Agency for Healthcare Research & Quality, errors of omission are more difficult to recognize than errors of commission but likely represent a larger problem (Kalisch, 2011). In other words, there are likely many more instances in which the provision of additional diagnostic, therapeutic, or preventive modalities would have improved care than there are instances in which the care provided quite literally should not have been provided. In many ways, this point echoes the generally agreed-upon view in the healthcare quality literature that underuse far exceeds overuse, even though the latter historically received greater attention. Clinicians commit acts of **commission** when they make mistakes, such as incorrectly diagnosing someone. Clinicians commit acts of **omission** when they fail to act in some way, such as a failure to report Vulnerable Adult Abuse.

In addition to commission vs. omission, three other dichotomies commonly appear in the literature on errors: active failures vs. latent conditions, errors at the sharp end vs. errors at the blunt end and slips vs. mistakes (AHRQ 2019). Active errors involve frontline personnel and occur at the point of contact between a human and some aspect of a larger system (e.g., a human–machine interface). By contrast, latent errors are accidents waiting to happen—failures of organization or design that allow the inevitable active errors to cause harm. Personnel at the sharp end may literally be holding a scalpel when the error is committed, or figuratively be administering any kind of treatment. The blunt end refers to the many layers of the health care system not in direct contact with patients, but which influence the personnel that come into contact with patients. Slips represent failures of schematic behaviors and occur in the face of competing sensory distractions (i.e. fatigue, stress). Mistakes reflect incorrect choices, and more often reflect lack of experience, insufficient training, or outright negligence (AHRQ 2019).

### **The Joint Commission**

The Joint Commission is a national organization with a mission to, “to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value”(Joint Commission, 2020). Accreditors play an important role in encouraging and supporting actions within healthcare organizations by holding them accountable for ensuring a safe environment for patients. Healthcare organizations should actively engage in a cooperative relationship with the Joint Commission through this accreditation process and participate in the process to reduce risk and facilitate desired outcomes of care.

The Joint Commission defines a sentinel event as "an unexpected occurrence involving the death or serious physical or psychological injury, or the risk thereof" (Joint Commission, 2020). 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.

### **Root Cause Analysis**

Root cause analysis (RCA) is a structured method used to analyze serious adverse events. Initially developed to analyze industrial accidents, RCA is now widely deployed as an error analysis tool in health care. A central tenet of RCA is to identify underlying problems that increase the likelihood of errors while avoiding the trap of focusing on mistakes by individuals (AHRQ 2019). RCA thus uses the systems approach to identify both active errors (errors occurring at the

point of interface between humans and a complex system) and latent errors (the hidden problems within health care systems that contribute to adverse events). It is one of the most widely used retrospective methods for detecting safety hazards.

The Joint Commission defines Root Cause Analysis as "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event" (Joint Commission, 2020).

The sentinel event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition

or

The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge
- Abduction of any patient receiving care, treatment, and services
- Discharge of an infant to the wrong family
- Rape or sexual assault

RCAs should generally follow a prespecified protocol that begins with data collection and reconstruction of the event in question through record review and participant interviews. A multidisciplinary team should then analyze the sequence of events leading to the error, with the goals of identifying how the event occurred (through identification of active errors) and why the event occurred (through systematic identification and analysis of latent errors).

As part of the accreditation standards, the Joint Commission requires that healthcare organizations have a process in place to recognize these sentinel events, conduct thorough and credible root cause analyses that focus on process and system factors, and document a risk-reduction strategy and internal corrective action plan that includes measurement of the effectiveness of process and system improvements to reduce risk. This process must be completed within 45 days of the organization having become aware of the sentinel event. The Joint Commission will consider a root cause analysis acceptable for accreditation purposes if it focuses primarily on systems and processes, not individual performance. In other words, the healthcare organization should minimize the individual blame or retribution for involvement in a medical error.



In addition, the root cause analysis should progress from special causes in clinical processes to common causes in organizational processes, and the analysis should repeatedly dig deeper by asking why, then when answered, why again, and so on. The analysis should also identify changes that can be made in systems and processes, either through redesign or development of new systems or processes, which would reduce the risk of such events occurring in the future (AHRQ, 2019). The Joint Commission requires that the analysis be thorough and credible.<sup>2</sup>

To be considered **thorough**, the root cause analysis must include:

1. Determination of the human and other factors most directly associated with the event and the process(es) and systems related to its occurrence
2. Analysis of the underlying systems and processes through a series of "why" questions to determine where redesign might reduce risk
3. Inquiry into all areas appropriate to the specific type of event
4. Identification of risk points and their potential contributions to this type of event
5. A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future or a determination, after analysis, that no such improvement opportunities exist.

(Oberoi, 2004)

To be considered **credible**, the root cause analysis must meet the following standards:

1. The organization's leadership and the individuals most closely involved in the process and systems under review must participate in the analysis.
2. The analysis must be internally consistent; that is, it must not contradict itself or leave obvious questions unanswered.
3. The analysis must provide an explanation for all findings of "not applicable" or "no problem."
4. The analysis must include consideration of any relevant literature.

(Oberoi, 2004).

-

### **Root Cause Analysis and Action Plan Tool Template**

The Joint Commission Root Cause Analysis and Action Plan tool has 24 analysis questions. The following framework is intended to provide a template for

answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking “root cause(s)” and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the “Root Cause Analysis Findings” field for each question #. For each finding continue to ask “Why?” and drill down further to uncover why parts of the process occurred or didn’t occur when they should have. Significant findings that are not identified as root causes themselves have “roots”.

Sentinel Event Settings 2004 through 2014	#	%
Hospital	5749	66.5%
Psychiatric hospital	880	10.2%
Ambulatory care	324	3.8%
Psych unit in general hospital	443	5.1%
Emergency department	478	5.5%
Behavioral health facility	320	3.7%
Home care	165	1.9%
Long term care facility	97	1.1%
Other***	111	1.3%
Office-based surgery	73	0.8%

As an aid to avoid “loose ends,” the two columns on the right are provided to be checked off for later reference:

- “Root cause” should be answered “Yes” or “No” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a “Why?” question such as “Why did it contribute to the likelihood of the event” or “Why did it contribute to the severity of the event?” Each finding that is identified as a root cause should be considered for an action and addressed in the action plan

- “Plan of action” should be answered “Yes” for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

The Joint Commission Template is Continued on the next page and can be downloaded [by clicking here](#).

**When did the event occur?**

Date:	Day of the	Time:
-------	------------	-------

**Detailed Event Description Including Timeline:**

**Diagnosis:**

**Medications:**

**Autopsy Results:**

**Past Medical/Psychiatric History:**

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
---	-------------------	---------	------------------------------	------------	----------------

Online Continuing Education for Professionals

1	<p>What was the intended process flow?</p>	<p>List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes.</p> <p><b>Note:</b> The process steps as they occurred in the event will be entered in the next question. Examples of defined process steps may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Site verification protocol</li> <li>• Instrument, sponge, sharps count procedures</li> <li>• Patient identificatio</li> </ul>			
---	--	---	--	--	--

*Online Continuing Education for Professionals*

2	Were there any steps in the process that did not occur as intended?	Explain in detail any deviation from the intended processes listed in			
3	What human factors were	Discuss staff-related human performance factors that			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
	relevant to the outcome?	contributed to the event. Examples may include, but are not limited to: <ul style="list-style-type: none"> <li>• Boredom</li> <li>• Failure to follow established policies/ procedures</li> <li>• Fatigue</li> <li>• Inability to focus on task</li> <li>• Inattentional blindness/ confirmation bias</li> <li>• Personal problems</li> <li>• Lack of complex critical thinking skills</li> <li>• Rushing to complete task</li> <li>• Substance abuse</li> <li>• Trust</li> </ul>			

*Online Continuing Education for Professionals*

4	How did the equipment performance affect the outcome?	Consider all medical equipment and devices used in the course of patient care, including AED devices, crash carts, suction, oxygen, instruments, monitors, infusion equipment, etc. In your discussion, provide information on the following, as applicable: <ul style="list-style-type: none"> <li>• Descriptions of biomedical checks</li> <li>• Availability and condition of equipment</li> <li>• Descriptions of equipment with multiple or removable pieces</li> <li>• Location of equipment</li> </ul>			
---	---	---	--	--	--

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
		and its accessibility to staff and patients <ul style="list-style-type: none"> <li>• Staff knowledge of or education on equipment, including applicable competencies</li> <li>• Correct calibration, setting, operation of alarms, displays, and controls</li> </ul>			

## Online Continuing Education for Professionals

5	What controllable environmental factors directly affected this outcome?	<p>What environmental factors within the organization's control affected the outcome?</p> <p>Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Overhead paging that cannot be heard</li> <li>• Safety or security risks</li> <li>• Risks involving activities of visitors</li> <li>• Lighting or space issues</li> </ul> <p>The response to this question may be addressed more globally in Question #17. This response should be specific to this event.</p>			
6	What uncontrollable external factors influenced this	Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
	outcome?	disasters.			
7	Were there any other factors that directly influenced this outcome?	List any other factors not yet discussed.			

## Online Continuing Education for Professionals

8	What are the other areas in the organization where this could happen?	List all other areas in which the potential exists for similar circumstances. For example: <ul style="list-style-type: none"> <li>• Inpatient surgery/ outpatient surgery</li> <li>• Inpatient psychiatric care/outpatient psychiatric care</li> </ul> Identification of other areas within the organization that have the potential to impact patient safety in a similar manner. This information will help drive the scope of your action plan.			
9	Was the staff properly qualified and currently competent for their responsibilities at the time of the event?	Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to: <ul style="list-style-type: none"> <li>• Orientation/ training</li> <li>• Competency assessment (What</li> </ul>			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
---	-------------------	---------	------------------------------	------------	----------------



## Online Continuing Education for Professionals

		competencies do the staff have and how do you evaluate them?) <ul style="list-style-type: none"> <li>• Provider and/or staff scope of practice concerns</li> <li>• Whether the provider was credentialed and privileged for the care and services he or she rendered</li> <li>• The credentialing and privileging policy and procedures</li> <li>• Provider and/or staff performance issues</li> </ul>			
10	How did actual staffing compare with ideal levels?	Include ideal staffing ratios and actual staffing ratios along with unit census at the time of the event. Note any unusual circumstance that occurred at this time. What process is used to determine the care area's staffing ratio, experience level and skill mix?			
11	What is the plan for dealing with staffing contingencies?	Include information on what the organization does a staffing crisis, such as call-ins, bad weather or increased patient acuity. Describe the organization's use of alternative staffing. Examples may include, but are not limited to:			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
---	-------------------	---------	------------------------------	------------	----------------

## Online Continuing Education for Professionals

		<ul style="list-style-type: none"> <li>Agency nurses</li> <li>Cross training</li> <li>Float pool</li> <li>Mandatory overtime</li> <li>PRN pool</li> </ul>			
12	Were such contingencie factor in this event?	If alternative staff were used, describe their orientation to the area, verification of competency and environmental familiarity.			
13	Did staff performance during the event meet expectations ?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at the time.			
14	To what degree was all the necessary information available when needed? Accurate?	Discuss whether patient assessments were completed, shared and accessed by members of the treatment team, to include providers, according to the organizational processes.			

## Online Continuing Education for Professionals

	Complete?	Identify the information			
--	-----------	--------------------------	--	--	--

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
	Unambiguous?	<p>systems used during patient care.</p> <p>Discuss to what extent the available patient information (e.g. radiology studies, lab results or medical record) was clear and sufficient to provide an adequate summary of the patient's condition, treatment and response to treatment. Describe staff utilization and adequacy of policy, procedure, protocol and guidelines specific to the patient care provided.</p>			
15	To what degree was the communication among participants adequate for this situation?	<p>Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate:</p> <ul style="list-style-type: none"> <li>• The timing of communication of key information</li> <li>• Misunderstandings related to language/cultural barriers, abbreviations, terminology, etc.</li> <li>• Proper completion of internal and external hand-off communication</li> <li>• Involvement of patient, family and/or significant</li> </ul>			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
16	Was this the appropriate physical environment for the processes being carried out for this situation?	<p>Consider processes that proactively manage the patient care environment.</p> <p>This response may correlate to the response in question 6 on a more global scale.</p> <p>What evaluation tool or method is in place to evaluate process needs and mitigate physical and patient care environmental risks?</p> <p>How are these process needs addressed organization-wide?</p> <p>Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• alarm audibility testing</li> <li>• evaluation of egress points</li> <li>• patient acuity level and setting of care managed across the continuum,</li> <li>• preparation of medication outside of pharmacy</li> </ul>			
17	What systems are in place to identify environmental risks?	<p>Identify environmental risk assessments.</p> <ul style="list-style-type: none"> <li>• Does the current environment meet codes, specifications, regulations?</li> <li>• Does staff know how to report environmental risks?</li> </ul>			

## Online Continuing Education for Professionals

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
		<ul style="list-style-type: none"> <li>Was there an environmental risk involved in the event that was not previously identified?</li> </ul>			
18	What emergency and failure-mode responses have been planned and tested?	<p>Describe variances in expected process due to an actual emergency or failure mode response in connection to the event.</p> <p>Related to this event, what safety evaluations and drills have been conducted and at what frequency (e.g. mock code blue, rapid response, behavioral emergencies, patient abduction or patient elopement)?</p> <p>Emergency responses may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Fire</li> <li>External disaster</li> <li>Mass casualty</li> </ul> <p>Δ Medical emergency</p> <p>Failure mode responses may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Computer down time</li> <li>Diversion planning</li> <li>Facility construction</li> <li>Power loss</li> <li>Utility issues</li> </ul>			
19	How does the organization's	How does the overall culture encourage change?			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
---	-------------------	---------	------------------------------	------------	----------------

*Online Continuing Education for Professionals*

	culture support risk reduction?	suggestions and warnings from staff regarding risky situations or problematic areas? <ul style="list-style-type: none"> <li>• How does leadership demonstrate the organization's culture and safety values?</li> <li>• How does the organization measure culture and safety?</li> <li>• How does leadership establish methods to identify areas of risk or access employee suggestions for change?</li> <li>• How are changes implemented?</li> </ul>			
20	What are the barriers to communication of potential risk factors?	Describe specific barriers to effective communication among caregivers that have been identified by the organization. For example, residual intimidation or reluctance to report co-worker activity.  Identify the measures being taken to break down barriers (e.g. use of SBAR). If there are no barriers to communication, discuss how this is known.			
21	How is the prevention of	Describe the organization's adverse outcome procedures			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
	adverse outcomes communicated as a high priority?	and how leadership plays a role within those procedures.			

## Online Continuing Education for Professionals

22	How can orientation and in-service training be revised to reduce the risk of such events in the future?	Describe how orientation and ongoing education needs of the staff are evaluated and discuss its relevance to event. (e.g. competencies, critical thinking skills, use of simulation labs, evidence-based practice, etc.)			
23	Was available technology used as intended?	Examples may include, but are not limited to: <ul style="list-style-type: none"> <li>• CT scanning equipment</li> <li>• Electronic charting</li> <li>• Medication delivery system</li> <li>• Tele-radiology services</li> </ul>			
24	How might technology be introduced or redesigned to reduce risk in the future?	Describe any future plans for implementation or redesign.  Describe the ideal technology system that can help mitigate potential adverse events in the future.			

Action Plan	Organization Plan of Action Risk Reduction Strategies	Position/ Title Responsible Party	Method: Policy, Education, Audit, Observation & Implementation
For each of the findings identified in the analysis as needing an	Action Item #1:		
	Action Item #2:		

## Online Continuing Education for Professionals

<p>action, indicate the planned action expected, implementation date and associated measure of effectiveness. OR. ... If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time. Check to be sure that the selected measure will provide data that will permit assessment of the</p>	<p>Action Item #3:</p>		
---	------------------------	--	--

<p>effectiveness of the action. Consider whether pilot testing of a planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	<p>Action Item #4:</p>		
	<p>Action Item #5:</p>		
	<p>Action Item #6:</p>		
	<p>Action Item #7:</p>		
	<p>Action Item #8:</p>		



**Bibliography: Cite all books and journal articles that were considered in developing this root cause analysis and action plan.**

### **Misdiagnosis of Mental Health/ Psychiatric Disorders**

Regarding mental illnesses, sufferers of dissociative identity disorder usually have psychiatric histories that contain three or more separate mental disorders and previous treatment failures. The disbelief of some doctors around the validity of dissociative identity disorder may also add to its misdiagnosis.<sup>5</sup>

Studies have found that bipolar disorder has often been misdiagnosed as major depression. Its early diagnosis necessitates that clinicians pay attention to the features of the patient's depression and also look for present or prior hypomanic or manic symptomatology.

The misdiagnosis of schizophrenia is also a common problem. There may be long delays of patients getting a correct diagnosis of this disorder. The DSM-5 field trials included "test-retest reliability" which involved different clinicians doing independent evaluations of the same patient—a new approach to the study of diagnostic reliability.

### **Patient Suicide**

The Joint Commission issued a Sentinel Event Alert on preventing inpatient suicides; this Alert updates the prevention strategies presented in that Alert with a focus on general hospitals and prevention of suicide in medical/surgical units and the emergency department. The goal of this Alert is to assure that patients outside of psychiatric units are appropriately screened and cared for. In addition to non-psychiatric settings, the Sentinel Event Database includes reports of suicide in psychiatric hospitals, behavioral health units of general hospitals, and residential treatment facilities. While psychiatric settings are designed to be safe for suicidal individuals and have staff with specialized training, typically, medical/surgical units and emergency departments are not designed or assessed for suicide risk and do not have staff with specialized training to deal with suicidal individuals. Not surprisingly, suicidal individuals often are admitted to general hospitals immediately following suicide attempts, or they seek help in hospital emergency departments often at the urging of families or friends – when they are most desperate.

These patients are “known at risk” for suicide. It is noteworthy that many patients who kill themselves in general hospital inpatient units do not have a psychiatric history or a history of suicide attempt – they are “unknown at risk” for suicide. Compared to the psychiatric hospital and unit, the general hospital setting also presents more access to items that can be used to attempt suicide – items that are either already in or may be brought into the facility and more opportunities for the patient to be alone to attempt or re-attempt suicide. This Alert presents strategies that can be used and suggested actions that can be taken by general hospitals to help better prepare their staffs and their facilities for suicidal patients and to care for both their physical and mental needs.

The location of the events included bathroom, bedroom, closet, shower and other locations, or they occurred after discharge or leaving the hospital against medical advice. The methods of suicide included hanging, asphyxiation by other than hanging, gunshot, jumping from a height, drug overdose, laceration, drowning, other methods (e.g., jumping in front of a moving vehicle, ingestion of poison, stabbing or burning).

Risk factors for suicide: The risk factors common across health care settings include having previously attempted suicide; recent suicide attempt; suicidal thoughts or behaviors; a family history of suicide or psychiatric illness; on antidepressants; physical health problems, including central nervous system disorders such as traumatic brain injury; diagnosis of delirium or dementia; chronic pain or intense acute pain; poor prognosis or prospect of certain death; social stressors such as financial strain, unemployment or loss of financial independence; disability; trauma; divorce or other relationship problems; hopelessness; and substance abuse. Substance abuse may also exacerbate psychological symptoms such as depression, and the disinhibitory effects of alcohol may contribute to impulsive suicidal behavior. Older adults are prone to additional suicide risk factors including declining health, loneliness and recent bereavement.

Warning signs that are associated with increased desperation and imminent risk include: irritability, increased anxiety (in addition to panic), agitation, impulsivity, decreased emotional reactivity, complaining of unrelenting pain, refusing visitors, crying spells, declining medications, and requesting early discharge. In addition, the following warning signs are diagnostic criteria for depression: hopelessness or helplessness, decreased interest in treatment or prognosis, feelings of worthlessness, and refusing to eat.

There are numerous medications that are associated with an increased risk of suicidal thoughts and behaviors, including antidepressants, antiepileptic or anticonvulsant medicines, and antipsychotic agents. The risk of suicidal thoughts and behaviors applies to both psychiatric and non-psychiatric uses of these

medications. The American Society of Health-System Pharmacists (ASHP) maintains a list of such medications based on FDA alert. Certain other medicines have also been associated with increased risk of suicide, such as some smoking-cessation drugs, anti-infectives (e.g. Mefloquine, interferons, amantadine), and others (e.g., isotretinoin). The increased risk can be associated with use of the medicine either as an inherent risk of an underlying psychiatric or other illness (e.g., epilepsy) or a side effect of the medication itself.

## Works Cited

Agency for Healthcare Administration, (Florida) Adverse Incident Report Process, Report No. 13-06, February 2014

Agency for Healthcare Research and Quality, Root Cause Analysis (Last Updated August 2014), <http://psnet.ahrq.gov/primer.aspx?primerID=10>

Agency for Healthcare Research and Quality, Glossary (Last accessed July 26, 2015) [http://www.psnet.ahrq.gov/popup\\_glossary.aspx?name=error](http://www.psnet.ahrq.gov/popup_glossary.aspx?name=error)

Bowden, C.L. (2001). "Strategies to Reduce Misdiagnosis of Bipolar Depression". *Psychiatric Serv* **52** (1): 51–55. doi:10.1176/appi.ps.52.1.51. PMID 11141528

Carver, Niki. "Medical Error." *StatPearls [Internet]*., U.S. National Library of Medicine, 10 July 2020, [www.ncbi.nlm.nih.gov/books/NBK430763/](http://www.ncbi.nlm.nih.gov/books/NBK430763/).

Kalisch, Beatrice J., et al. "Hospital Variation in Missed Nursing Care." *American Journal of Medical Quality*, vol. 26, no. 4, 2011, pp. 291–299., doi:10.1177/1062860610395929.

Institute of Medicine (US) Committee on Quality of Health Care in America; Kohn LT, Corrigan JM, Donaldson MS, editors. *To Err is Human: Building a Safer Health System*. Washington (DC): National Academies Press (US); 2000. 2, Errors in Health Care: A Leading Cause of Death and Injury.

Reliability and Prevalence in the DSM-5 Field Trials, January 12, 2012 [http://www.dsm5.org/Documents/Reliability\\_and\\_Prevalence\\_in\\_DSM-5\\_Field\\_Trials\\_1-12-12.pdf](http://www.dsm5.org/Documents/Reliability_and_Prevalence_in_DSM-5_Field_Trials_1-12-12.pdf)

Rodziewicz TL, Hipskind JE. Medical Error Prevention. [Updated 2020 May 5]. In: *StatPearls [Internet]*. Treasure Island (FL): StatPearls Publishing; 2020 Jan-.

"Root Cause Analysis." *Patient Safety Network*, Agency for Healthcare Research and Quality, 2019, [psnet.ahrq.gov/primer/root-cause-analysis](http://psnet.ahrq.gov/primer/root-cause-analysis).

Uberoi, RS, et al. "Root Cause Analysis in Healthcare." *Apollo Medicine*, No Longer Published by Elsevier, 16 Feb. 2012, [www.sciencedirect.com/science/article/abs/pii/S0976001612600441#:~:text=To%20be%20thorough%20a%20Root,contributions%20and%20determination%20of%20potential](http://www.sciencedirect.com/science/article/abs/pii/S0976001612600441#:~:text=To%20be%20thorough%20a%20Root,contributions%20and%20determination%20of%20potential)

## **Contributors**

### **Kathleen Mc Carthy, N.C.C., MS. JD**

K. Mc Carthy has extensive experience in community mental health and law related to social services and civil rights. She practiced civil defense including, but not limited to Chapter 39 Dependency and Termination of Parental Right proceedings, Chapter 415 Adult Protective Services proceedings, Chapter 397 Marchman Act proceedings, Chapter 394 Baker Act proceedings, Chapter 744 Guardianship proceedings, Criminal Mental Health Court, Adoptions, and Institutional Review Boards. She has done extensive training for mental health professionals through Psychiatric Consulting and Counseling and Ace-Classes.com.

### **Sean Chambers, BA.MSW**

S. Chambers has a Bachelors in Psychology, Masters in Social Work (concentration in Elder Affairs), and Associates of Science in Paralegal Studies, (Cum Laude)

### **B. Jones, BA, JD., Esq.**

B. Jones, has a Bachelors in Psychology (Cum Laude) and a Juris Doctor in Law. She is an attorney licensed by the Florida Bar with a focus on healthcare/ mental health law. While in law school she received numerous accolades such as: Pro Bono Honor Program, Gold Level (300+ Pro Bono Hours), ILSA Journal of International & Comparative Law, Junior Staff Editor Dean's List (Fall 2011; Winter 2014). B. Jones was the research assistant to Nova Southeastern, Law Professor, Elena Langan and assisted with nomenclature changes to family law statutes around the country, searched relevant court decisions, statutory changes and journal articles.

### **Fiona Gain, BA, MS**

Fiona Gain has a Bachelors Degree in environmental science from the University of Florida, a Masters. Degree from Johns Hopkins University. She has experience researching policy-based topics and has been working with ACE classes to gain expertise in medical policy and information.