Medical Error Prevention for Mental Health Professionals

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Marjorie Conner Allen, BSN, JD, received her Bachelor of Science in Nursing degree from the University of Florida, Gainesville, in 1984. She began her nursing career at Shands Teaching Hospital and Clinics at the University of Florida, Gainesville. While practicing nursing at Shands, she gave continuing education seminars regarding the nursing implications for dealing with adolescents with terminal illness. In 1988, Ms. Allen moved to Atlanta, Georgia where she worked at Egleston Children's Hospital at Emory University in the bone marrow transplant unit. In the fall of 1989, she began law school at Florida State University. After graduating from law school in 1992, Ms. Allen took a two-year job as law clerk to the Honorable William Terrell Hodges, United States District Judge for the Middle District of Florida. After completing her clerkship, Ms. Allen began her employment with the law firm of Smith, Hulsey & Busey in Jacksonville, Florida where she has worked in the litigation department defending hospitals and nurses in medical malpractice actions. Ms. Allen resides in Jacksonville and is currently in-house counsel to the Mayo Clinic Jacksonville.

Faculty Disclosure

Contributing faculty, Marjorie Conner Allen, BSN, JD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all licensed behavioral and mental health professionals, including social workers, counselors, and therapists, particularly those in Florida.

Accreditations & Approvals

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NetCE designates this continuing education activity for 1 NBCC clock hour.

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Special Approvals
This course fulfills the Florida requirement for 2 hours of education on the Prevention of Medical Errors.

About the Sponsor
The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
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Course Objective
The purpose of this course is to satisfy the requirement of the Florida law and provide all licensed mental health professionals with information regarding the root cause analysis process, error reduction and prevention, and patient safety.

Learning Objectives
Upon completion of this course, you should be able to:

1. Define "medical error."
2. Describe the root cause analysis process, and identify the most common sentinel events.
3. Evaluate the most common errors in psychologic or behavioral settings and strategies to prevent these errors.
4. Identify potential psychologic consequences of medical errors.

INTRODUCTION

The Institute of Medicine's (IOM) 1999 publication *To Err is Human: Building a Safer Health System* illuminated the unfortunate reality of medical errors in the healthcare industry. The report reviewed the prevalence of medical errors in the United States and highlighted measures that should be taken to prevent them. Specifically, the authors of the report noted that at least 44,000 and perhaps as many as 98,000 Americans were dying in hospitals each year as a result of medical errors [1]. They further noted that even when using the lower estimate of 44,000, deaths in hospitals due to medical errors exceeded the annual deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297), or acquired immunodeficiency syndrome (16,516) [1]. A 2013 literature review stated that the average number of annual in-hospital deaths attributable to medical error may actually be much higher, at 210,000 to 400,000, which would make medical errors the third leading cause of death in the United States [2]. This was supported by findings of a 2016 study [45].

As part of an effort to address medical error incidents, Florida law mandates that all healthcare professionals and those working as members of an extended healthcare team in Florida complete a two-hour course on the topic of prevention of medical errors [3]. This continuing education course is designed to satisfy the requirements of the Florida law and provide all licensed behavioral and mental health professionals with information regarding the root cause analysis process, error reduction and prevention, and patient safety.

DEFINING "MEDICAL ERROR"

The IOM Committee on Quality of Healthcare in America defines error as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim" [1]. It is important to note that medical errors are not defined as intentional acts of wrongdoing and that not all medical errors rise to the level of medical malpractice or negligence. Errors depend on two kinds of failures: either the correct action does not proceed as intended, which is described as an "error of execution," or the original intended action is not correct, which is described as an "error of planning" [1]. A medical error can occur at any stage in the process of providing patient care, from diagnosis to treatment, and even while providing preventative care. Not all errors will result in harm to the patient. Medical errors that do result in injury are sometimes called preventable adverse events or sentinel events. These events are considered "sentinel" because they signal the need for immediate investigation and response [4].

Preventable adverse events or sentinel events are defined as events that cause an injury to a patient as a result of inaction on the part of the healthcare provider or as a result of an action/intervention whereby the injury cannot reasonably be attributed to the patient's underlying medical condition [1]. For example, if a patient has a surgical procedure and dies postoperatively from pneumonia, the patient has suffered an adverse event. But was that adverse event preventable? Was it caused by medical intervention or inaction? The specific facts of the case must be analyzed to determine whether the patient acquired pneumonia as a result of poor handwashing techniques of the medical staff (i.e., an error of execution), which would indicate a preventable adverse event, or whether the patient acquired pneumonia because of age and comorbidities, which would indicate a nonpreventable adverse event.

Healthcare professionals can learn much by closely scrutinizing and evaluating adverse events that lead to serious injury or death. The evaluation of such events would also enable healthcare professionals to improve the delivery of health care and reduce future mistakes. In addition, healthcare professionals must have a process in place to evaluate those instances in which a medical error occurred and did not cause harm to the patient. By reviewing these processes, healthcare professionals are afforded the unique opportunity to identify system improvements that have the potential to prevent future adverse events. The Joint Commission, recognizing the importance of analyzing both preventable adverse events and near-misses, has established guidelines for recognizing these events and requires healthcare facilities to conduct a root cause analysis to determine the underlying cause of the event [5].

ROOT CAUSE ANALYSIS PROCESS

The Joint Commission is a national organization with a mission to improve the quality of care provided at healthcare institutions in the United States. It accomplishes this mission by providing accredited status to healthcare facilities. 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. Based on data from The Joint Commission, 84% of sentinel events occur in hospitals, emergency departments, or ambulatory care centers and 13% of sentinel events occur in psychiatric hospitals or behavioral health facilities [46].

The Joint Commission defines a sentinel event as "an unexpected occurrence involving the death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome" [4]. Root cause analysis, as defined by the Joint Commission, 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" [4].

The following subsets of sentinel events are subject to review by the Joint Commission [4]:

- The event has resulted in an unanticipated death, major permanent loss of function, or severe temporary harm and intervention required to sustain life 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
  - Unanticipated death of a full-term infant
  - Abduction of any patient receiving care, treatment, and services
  - Any elopement (i.e., unauthorized departure) of a patient from a staffed around the-clock care setting (including the emergency department), leading to death, permanent harm, or severe temporary harm to the patient
  - Discharge of an infant to the wrong family

- Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services
- Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at a healthcare organization
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient or wrong body part
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Severe neonatal hyperbilirubinemia (bilirubin >30 mg/dL)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy
- Fall resulting in: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological or internal injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

(For further definition of terms, please refer to the Joint Commission's Sentinel Event Policy and Procedures at https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures)

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 [7]. This process must be completed within 45 business days of the organization having become aware of the sentinel event [4].

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 [7]. 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. The Joint Commission requires that the analysis be thorough and credible. To be considered thorough, the root cause analysis must include [4]:

- The analysis repeatedly asks a series of "why" questions, until it identifies the systemic causal factors associated with each step in the sequence that led to the sentinel event
- The analysis focuses on systems and processes, not solely on individual performance
- A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence

- The analysis of the underlying systems and processes through the series of "why" questions determines where redesign might reduce risk
- An inquiry into all areas appropriate to the specific type of event
- An identification of risk points and their potential contributions to this type of event
- 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

To be considered credible, the root cause analysis must meet the following standards [4]:

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

Finally, as previously discussed, after conducting this root cause analysis, the organization must prepare an internal corrective action plan. The Joint Commission will accept this action plan if it identifies changes that can be implemented to reduce risk or formulate a rationale for not undertaking such changes and if, where improvement actions are planned, it identifies who is responsible for implementation, when the action will be implemented, and how the effectiveness of the actions will be evaluated [4].

FLORIDA LAW

Mental health professionals have an obligation to report preventable adverse events to leadership and ensure that employers have processes in place to satisfy the Joint Commission requirement. In Florida, certain serious adverse incidents must also be reported to Florida's Agency for Health Care Administration (AHCA). Florida law requires that licensed facilities, such as hospitals, establish an internal risk management program and, as part of that program, develop and implement an incident reporting system, which imposes an affirmative duty on all healthcare providers and employees of the facility to report adverse incidents to the risk manager or to his or her designee. The risk manager must receive these incident reports within 3 business days of the incident, and depending on the type of incident, the risk manager may have to report the incident to AHCA within 15 days of receipt of the report.

Florida Statute 395.0197 specifically defines an adverse incident as [8]:

An event over which healthcare 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, and which:

a) Results in one of the following injuries:
    - Death
    - Brain or spinal damage
    - Permanent disfigurement
    - Fracture or dislocation of bones or joints
    - A resulting limitation of neurologic, physical, or sensory function that continues after discharge from the facility
    - Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent

- Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident

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

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

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

In 2021, the Florida AHCA reported that a total of 184 deaths occurred as a result of hospital error, 21.4% of 859 adverse incidents reported for the year [9]. The next most common incidents in 2021 were transfer of the patient to a unit providing a more acute level of care due to the adverse incident (18.7%), fracture or dislocation of bones or joints (17.0%), surgical procedures unrelated to the patient's diagnosis or medical needs (10.4%), surgical procedure to remove foreign object from a previous surgical procedure (10.2%), brain or spinal damage (5.0%), and surgical procedure performed on wrong site (4.3%) [9]. The following adverse incidents must be reported to the AHCA within 15 calendar days after their occurrence [8]:

- The death of a patient
- Brain or spinal damage to a patient
- Performance of a surgical procedure on the wrong patient
- Performance of a wrong-site surgical procedure
- Performance of a wrong surgical procedure
- Performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
- Surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- Performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

Each incident will be reviewed by the AHCA, who will then determine the penalty to be imposed upon the responsible party [8]. All Florida healthcare professionals who practice in licensed facilities should familiarize themselves with these requirements and ensure that the facility in which they practice has processes in place to ensure compliance.

Unlike Florida's mandatory reporting of serious adverse incidents, the Joint Commission recommends that healthcare organizations voluntarily report sentinel events, and it encourages the facilities to communicate the results of their root cause analyses and their corrective action plans. As a result of the sentinel events that have been reported, the Joint Commission has compiled Sentinel Event Alerts, which it provides to all accredited organizations. These alerts are intended to provide healthcare organizations with important information regarding reported trends and, by doing so, highlight areas of potential concern so an organization may review its own internal processes to maximize error reduction and prevention with regard to a particular issue [10].

ERROR REDUCTION AND PREVENTION

Between 2005 and 2021, the Joint Commission had reviewed 14,925 reported sentinel events impacting 12,731 patients and resulting in 6,258 patient deaths [46]. (Some events, such as fire, can impact multiple patients.) In 2018, the most common categories of sentinel events were unintended retention of a foreign body (including radiation overdose and severe neonatal hyperbilirubinemia) (16%), patient fall (15%), wrong-site/wrong-patient/wrong-procedure (13%), patient suicide (9%), and delay in treatment (7%) [46]. Of these, patient suicide, delay in treatment, and patient fall are the most pertinent to mental or behavioral health practice.

These are all errors with modifiable risk factors. Error reduction may be accomplished by applying the root cause analysis methodology, through extra diligence by healthcare professionals, and by adopting a willingness to identify personal shortcomings and to evolve. As identified in Florida Administrative Code Rule 64B19-13.003, the most serious potential errors in psychologic or behavioral settings include "inadequate assessment of suicide risk, failure to comply with mandatory abuse reporting laws, and failure to detect medical conditions presenting as a psychological disorder" [12]. Failure to detect medical conditions presenting as a psychologic disorder is akin to delay in treatment. These errors affect pediatric, adolescent, adult, and senior patients alike.

PATIENT SUICIDE

It is possible that the event with the greatest emotional impact on mental health professionals (and patients' families) is patient suicide. In general, the suicide rate is increasing, with a nearly 30% higher rate in 2016 compared with 1999 [43]. According to a 2010 Joint Commission Sentinel Event Alert, 75% of inpatient suicides occurred in psychiatric hospitals or behavioral health units of general hospitals [13]. The next greatest number occurred in surgical, intensive care, telemetry, or oncology units (14.25%); emergency departments (8%); and home care, rehabilitation units, and long-term or residential care facilities (2.5%). General hospitals are inherently less safe for suicidal patients than psychiatric hospitals or units, as they offer the patient more time alone and a number of potential suicide options (e.g., jumping, intentional drug overdose, cutting with a sharp object, hanging, strangulation) and means (e.g., tubing, bandages, plastic bags) that are designed out of psychiatric settings [13]. Another study reported 73.9% of hospital inpatient suicides in 2014–2015 happened during psychiatric treatment [48].

In general, patient suicide is highest among those 65 years of age or older. However, the peak is much younger for American Indian/Alaskan Native individuals (with a peak in men 19 to 24 years of age) and women (with a peak at 35 to 54 years of age) [42]. Of patients 17 to 39 years of age admitted to hospitals for one medical condition, suicidal ideation increases from a baseline of 16.3% in the general population to 25%; the rate increases to 35% for those admitted with two or more conditions [14]. The root causes of patient suicide that have been identified, in order of frequency, are [41]:

- Inadequate patient assessment (80% of cases)
- Poor communication between staff
- Human factors
- Poor leadership
- Dangerous physical environment
- Information-related factors
- Poor continuum of care
- Poor care planning
- Medication use
- Lack of patient education

The reporting healthcare facilities recommended a number of risk reduction strategies, including updating the staffing model, monitoring consistency of the implementation of observation procedures, revising information transfer procedures, engaging family and friends in the process of contraband detection, and implementing education for family and friends regarding suicide risk factors [13]. A simple review of these measures demonstrates that healthcare and mental health providers can avoid the devastating impact of an inpatient suicide by implementing fairly routine preventative strategies, such as removing harmful items and careful screening through the admission process [48].

Suicide Risk Assessment

There are many suicide risk assessment tools for use by health and/or mental health professionals but few have been tested empirically. If and when they are used, all too often an assessment tool is insufficient in preventing suicide. A thorough assessment by a trained mental health professional is often the best choice, but even these professionals are not infallible. Of those who die from suicide, 20% have had contact with a mental health provider in the last month [43]. Many reasons have been identified for inadequate professional assessments or lack thereof [16]:

- Suicide risk assessment training was never provided to the mental health professional, physician, or nurse.
- The risk of suicide is minimized or overlooked by the professional due to personal anxiety related to suicide in general.
- The professional has a fear of documenting thought processes because those actions could come under scrutiny in a malpractice suit.
- Risk assessment is performed but not documented.
- The task of suicide risk assessment is delegated to another professional who is incapable of performing an adequate assessment or who does not complete the task.
- Suicide risk assessment is simply not indicated.
- A systematic suicide risk assessment is never performed.
- The professional is reluctant to assess suicide risk due to excessive false positives.

It is recommended that all patients be screened using a systematic, personalized suicide risk assessment by a trained professional and that the results of the assessment be diligently documented [16]. The assessment should be within the scope of practice and competence of the individual performing the task. When a professional, such as a social worker or counselor, identifies a client who is at risk for suicide, he or she has an obligation to protect the client from self-harm and must consult with a supervisor or other colleague. This can be perceived to be in contradiction to the principle of confidentiality, but preventing harm is an ethical obligation with greater importance and should be taken as seriously as threats made against another person.

Although some professionals are uncomfortable with suicidal clients, it is essential not to ignore or deny the suspicion of suicide risk. The first and most immediate step is to allocate adequate time to the client, even though many others may be scheduled. Showing a willingness to help begins the process of establishing a positive rapport. Closed-ended and direct questions at the beginning of the interview are not very helpful; instead, use open-ended questions such as, "You look very upset; tell me more about it."

A thorough assessment involves not only totaling suicide risk factors (acute and chronic) but should consider other factors, such as the patient's job contentment and their satisfaction from interpersonal relationships, which are considered protective [15]. As noted, suicide ideation increases with the severity of an individual's injuries (e.g., traumatic brain injury with enduring sequelae, amputation or loss of limb, loss of motor function), chronic pain syndromes, and poor prognoses (e.g., Alzheimer disease, cancer, autoimmune diseases) [17]. Warning signs of suicidal thought include threatening self-harm, actively seeking suicide means (e.g., medications, medical instruments or other objects, removing IV lines or life-sustaining apparatus), and expressing thoughts about death, dying, and suicide. These patients should be considered at high risk of suicide. When assessing for suicide, it is important to be cautious of misleading information or false improvement [44]. When an agitated patient suddenly appears calm, he or she may have made the decision to complete suicide and feels calm after making the decision. Denial is another important consideration. Patients may deny harboring very serious intentions of killing themselves.

Reluctance or even outright refusal to implement a systematic suicide risk assessment program has been demonstrated in a study of attending hospital psychiatrists (one of the few studies that exist on the topic) [15]. As an advocate for clients, all mental health professionals, including social workers, counselors, therapists, and psychologists, should ensure that a suicide risk assessment is performed and documented and that follow-up assessments are completed on a regular basis.

MEDICATION ERRORS

Unquestionably, medication errors are one of the most common causes of avoidable harm to patients. These errors may occur at three critical points: when ordered by a physician or psychologist, dispensed by a pharmacist, or administered.

The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling; packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use" [18].

A number of medication errors can be linked to the prescriber who continually uses potentially dangerous abbreviations and dose expressions. Despite repeated warnings by the Institute for Safe Medication Practices about the dangers associated with using certain abbreviations when prescribing medications, this practice continues [19].

Other factors contributing to prescriber errors are illegible or confusing handwriting and, a frequently cited cause of many adverse and sentinel events, the failure of healthcare providers to assess risk and prevent errors. Facilities should implement appropriate guidelines, policies, and procedures to ensure safe medication administration practice. These policies should include [20]:

- Reconciling medications at transition points (e.g., admission, discharge, transfer)
- Keeping an accurate medication list (including over-the-counter and complementary and alternative medications)
- Asking patients to bring their medications in periodically

- Informing the patient of indications for all medications
- Asking regularly whether patients are taking their medications, including as-needed drugs, as nonadherence may signal issues other than knowledge deficits, practical barriers, or attitudinal factors
- Considering that new complaints may represent side effects of medications
- Explaining common or significant side effects
- Asking regularly about side effects or adverse drug events
- Avoiding abbreviations
- Working as a team with pharmacists, physicians, and nurses
- Adhering to Class I clinical indications and guidelines
- Using special caution with high-risk medications
- Exercising particular caution in high-risk situations (e.g., when stressed, sleep-deprived, angry, supervising inexperienced personnel)
- Reporting errors and adverse drug events
- Including medications when transferring patients between providers
- Standardizing communication about prescriptions within the practice
- Actively monitoring the patient for response to medication therapy, using validated instruments when possible
- Minimizing the use of free samples

Finally, facilities should have proper quality assurance measures in place to monitor medication administration practices. Included among these would be protocols and guidelines for use with critical and problem-prone medications to help optimize therapies and minimize the possibility of adverse events and to integrate "triggers" to indicate the need for additional clinical monitoring [21].

FAILURE TO REPORT ABUSE

In Florida, as in other states, workers in many occupations are designated as "professionally mandated reporters of abuse," including teachers, nurses, physicians, and law enforcement officials [22]. Social workers, psychologists, and all mental health professionals are included among those who are required to report abuse, neglect, abandonment, and exploitation of children and adults. Additionally, suspected maltreatment is to be reported.

There were about 674,000 unique cases of child abuse in the United States in 2017 resulting in approximately 1,720 deaths [23]. The vast majority of perpetrators of abuse were parents or legal guardians. More than 65% of the referrals of abuse are generated by a mandated professional, including social services personnel (11.7%), medical personnel (9.6%), and mental health personnel (5.7%); children very seldom report abuse themselves [23]. The percentage of reports generated by professionals remained stable between 2009 and 2017.

Only about 17% of all reports of child abuse or suspected child abuse result in a substantiation or indication of actual maltreatment according to state law [23]. However, this should not discourage the professional from intervening. It is never punishable to submit a report in good faith; furthermore, all reports are confidential (except among protective services personnel) until indicated in a judicial proceeding [22]. In addition to breaching the ethical duty to protect clients from harm (and, subsequently, the professional consequences of this ethics violation), there are legal consequences for those who fail to comply with mandatory abuse reporting requirements. Diligent reporting and documenting of abuse better protects professionals from legal action resulting from inaction.

Adult abuse encompasses self-abuse, domestic abuse, and abuse/exploitation by caregiver(s) of a vulnerable adult [22]. Exploitation refers to the misuse of moneys, taking or selling of property, the inappropriate use of guardianship/power of attorney, and the failure to use the vulnerable adult's funds for their care. A vulnerable adult is defined

in Florida as an individual 18 years of age or older with "mental, emotional, long-term physical or developmental disability/dysfunction, brain damage, or the infirmities of aging" that prevent him or her from performing activities of daily living or providing for his or her own care [22]. Vulnerable adults and children are abused at a rate between 4 and 10 times greater than that of the general population and are themselves less likely to report abuse due to a variety of fears, including not being believed, reprisals, and caretaker abandonment [24]. Mental health professionals are often the individuals to whom the abuse is reported. With the aforementioned statistics and somewhat unique fears in mind, it is reasonable that a slightly higher index of suspicion be employed when working with this cohort.

Emotional changes or suspicious injuries that are noticed in adult clients should be documented and reported. Marks and bruises in various stages of healing should be noted, especially those that resemble objects such as belts or electrical cords or those that reoccur regularly; cigar/cigarette burns; burns in the shape of an object (e.g., clothes iron); missing clumps of hair; marks from being tied down; and other injuries with no reasonable explanation [25]. Other signs of abuse include recurrent poor hygiene among those in the care of others, medical conditions left untreated, food hoarding, age-inappropriate sexual behavior/knowledge of sex, unexplained fear of persons/places, unaccounted for injury or disease of the genitals. Psychologic abuse may be harder to detect, but in some cases there are physical manifestations of psychologic abuse. Studies of the long-term physical effects of intimate partner violence or child abuse have found an increased risk of asthma, chronic pain, sexually transmitted infections, stomach ulcers, liver disease, and high blood pressure among victims [6; 32].

Compliance with abuse reporting laws is not optional, and reporting suspected abuse to a supervisor does not satisfy this requirement [22]. Abuse must be reported to the Florida Abuse Hotline by telephone (1-800-962-2873 or TTY 1-800-955-8771), by fax (1-800-914-0004), or online (https://reportabuse.dcf.state.fl.us) when knowledge of abuse or suspected reasonable cause exists. Telephone is the preferred contact method and should always be used in emergency situations. It is up to the Florida Department of Children and Families counselors to determine if the report meets the legal requirements for further action [22]. If a counselor refuses the report, a supervisor can be requested for further discussion.

FAILURE TO IDENTIFY MEDICAL CONDITIONS PRESENTING AS PSYCHOSIS

A large number of medical conditions can cause acute psychiatric symptoms in patients with no history of mental illness and can exacerbate the severity of or create new psychiatric symptoms in individuals with pre-existing mental illness [26]. These conditions include, but are not limited to, central nervous system (CNS) disorders (e.g., seizure, aneurysm, subdural hematoma, tumor); infections (e.g., urinary tract infection, pneumonia, sepsis); cardiopulmonary disorders (e.g., hypoxia, myocardial infarction); metabolic/endocrine disorders (e.g., thyroid, adrenal, renal, hepatic disorders); adverse reactions to medications (e.g., corticosteroids, dopamine agonists); illicit drug use or withdrawal (e.g., cannabis, amphetamines, heroin); and chemical and plant toxicities (e.g., caffeine, psilocybin, aromatic hydrocarbons) [27].

Patients who solely have medical conditions but who present to emergency departments of general hospitals (or psychiatric hospitals) with psychiatric symptoms without medical complaints should be successfully and expediently differentiated from those with psychosis due to mental illness. This can be challenging considering the number of potential diagnoses that must be ruled out dur-

ing a standard medical clearance at a psychiatric hospital or following a mental status exam at an emergency department. Differentiation is further complicated by comorbid conditions (e.g., a schizophrenic patient with pneumonia) and the grey area between some medical conditions and psychiatric illnesses (e.g., seizure disorders) [26]. Furthermore, the increasing workload of hospital psychiatrists and physicians, administrative bureaucracy, advancing age of the country's population, complex drug regimens, widespread prescription and illicit drug use, and psychiatric evaluations performed by individuals not possessing competency have been identified as causative factors of a missed medical diagnoses or delays in treatment. Morbidity and mortality can be significantly increased for many conditions the longer they remain undiagnosed as a result of focusing on psychiatric aspects of care.

In one study, 3% of psychiatric admissions are actually due to a medical condition; this number is likely higher for older individuals [28]. For example, elderly patients or patients with intellectual disabilities with various infections often present to emergency or urgent care facilities with no other symptoms other than psychosis due to delirium; these infections may be initially overlooked as the healthcare team focuses on the psychologic symptoms [29; 47]. Urinary tract infections and pneumonia are the most frequent causes of sudden change in mental status in elderly patients, but these patients are often initially diagnosed with dementia based on their age [30]. Other possible causes include electrolyte imbalances, thyroid dysfunction, organ failure, and medications.

In addition to standard medical testing and mental status examination, it is important for hospital staff to gain as much relevant history from family members, caregivers, and acquaintances about the patient's usual mental status to aid in diagnosis. Social workers and mental health professionals familiar with patients can be valuable substitutes if family members or other acquaintances are unavailable.

PSYCHOLOGIC CONSEQUENCES OF MEDICAL ERRORS

According to the Institute for Healthcare Improvement, there are approximately 6 million survivors of medical errors each year [33]. As a result of these errors and the way they are handled, patients can lose trust in the healthcare system, and some may never feel a sense of safety in the care of anyone (including mental health professionals) again [31]. These same sentiments can carry over into the psyche of family members and even the general public. Stress reactions, anxiety disorders, worsening of existing mental health conditions, drug dependence, and suicidal ideation may develop in victims of medical errors, even as the result of "less serious" events, such as a breech in confidentiality. Feelings of anger, guilt, loss, and fear may persist long after the event [33].

Many individuals are reluctant to accept the risk of seeking help for mental, social, or medical issues, but certain groups have traditionally been wary of trusting professionals in these occupations. In the United States, black individuals have historically been and continue to remain wary and even suspicious of the medical/mental health care system [34; 35; 46]. For example, 40% of black Americans feel that prescribed medications are a form of undisclosed experimentation (compared to 28% of white Americans), and this demographic tends to underutilize health care, especially preventative care [35]. The cause of this suspicion is partially distrust of institutions in general; however, medical errors and gross ethical violations (e.g., the Tuskegee syphilis study, personal experience with discrimination) may also be to blame [34]. It is important that clients be encouraged to seek preventative care for health issues, especially those that disproportionately affect their gender and race.

As part of the movement to bring greater transparency to the practice of medicine, along with an improved effort to reduce the post-traumatic effects of medical errors, mental health professionals are increasingly being relied upon to assist patients and families with coping following serious errors [33]. A growing number of institutions have put into place support programs for professionals who have committed medical errors as the result of studies showing significant personal impact (e.g., guilt, reduced job satisfaction, burnout, sleep disturbances, loss of confidence, anxiety about committing future errors, depression) and lack of support following these events [33; 36; 37; 40]. However, many victims and perpetrators of medical errors may seek help on their own. Social workers and mental health providers should refer clients to specialists when indicated.

It is important that patients and professionals understand that risk and trust are a part of everyday life. It is necessary for clients to regain trust or self-trust and learn to rethink in a more complex way. Cognitive-behavioral therapy has been shown to be one of the more successful methods of reducing post-traumatic stress or anxiety and may be useful for these clients [38; 39].

Individuals with high levels of anxiety are particularly difficult to engage and may be reluctant to participate in psychologic interventions. Using a Socratic dialogue to prompt basic realizations and then beginning cognitive-behavioral therapy can be very useful as a treatment approach for those with anxiety disorders and post-traumatic stress following a medical error. Maladaptive and negative automatic thoughts, such as, "I can't trust anyone/myself," should be explored and replaced with positives [38]. Other therapy components (e.g., exposure therapy, behavioral family therapy) may be considered on an individual basis.

CONCLUSION

The topic of medical errors is especially disconcerting because, by nature, they are a violation of the primary ethic of the various medical and helping professions—the duty to cause no harm. That being said, medical errors will continue to affect healthcare delivery for years to come, but to say that they are unavoidable is somewhat erroneous. In order to ensure client and patient safety through error reduction, mental health and healthcare professionals should make a conscious effort to maintain and improve their knowledge of their profession, accept criticism, recognize personal limitations, build competencies, work as team members, notice and correct insufficiencies in service delivery, practice self-care, effectively manage workloads, and be proactive in creating solutions that may reduce errors. These are some of the keys to a safer healthcare system.

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