Risk management opportunities for Psychiatry

1. Suicidality

Develop standard screening measures and documentation for suicidality. Identify local resources where you can refer patients for higher acuity care and/or emergent intervention.

2. Noncompliant patients

Address patient noncompliance through good communication, including informed refusal discussions when appropriate, and document those discussions. Screen noncompliant patients for possible need for a different treatment setting or higher level of care, and consider when it may be appropriate to terminate the patient-physician relationship.

3. Informed consent

Develop standard informed consent discussions for psychotropic medications, and consider using patient information/consent forms for certain higher risk or often-used medications. Always document informed consent in the medical chart and do not rely solely on signed consent forms.

4. Confidentiality

Understand HIPAA requirements and state-specific laws around privacy and confidentiality of mental health information, including the differences between psychotherapy notes and other mental health records. Document all treatment; do not rely on lack of documentation to protect patient confidentiality. Obtain patient authorization for all third-party requests for information.

5. Telepsychiatry

Understand the federal and state telehealth laws and regulations pertaining to tele-medicine in the areas of licensure, special telehealth requirements, and controlled substance prescribing. (miec.com/resources/telehealth) Learn the techniques for conducting a successful telepsychiatry visit, and document informed consent by using a telepsychiatry consent form that addresses issues unique to virtual care.

Psychiatry Case Study

A 45-year-old male was admitted to an inpatient psychiatric hospital, on transfer from a local ER where the patient had been placed on a 5150 involuntary hold for suicidality. The patient's history was significant for depression, chronic pain, and alcohol abuse following serious injuries sustained in a motorcycle accident several years prior. The patient was admitted into a high-acuity unit and placed on suicide precautions with 15-minute checks. The patient was evaluated on the following morning by the attending psychiatrist, who noted that he reported suicidal intentions but contracted for his own safety in the hospital. Later, the patient requested to be transferred to a different unit because he didn't want to be surrounded by psychotic patients. He was transferred to another high-acuity unit, but the psychiatrist continued the suicide precautions and 15-minute checks. When he was evaluated the next day, the patient reported feeling better but was somewhat irritable and anxious. He had skipped group therapy and reported ongoing suicidal thoughts. That afternoon, approximately 5 minutes after the last nursing check, the patient was found following a suicide attempt. Despite resuscitation and transfer to an acute care hospital, the patient expired a few days later. The patient's family filed a Wrongful Death lawsuit against the psychiatrist and the hospital, alleging that the patient's suicide risk necessitated a higher level of supervision. The defense was complicated by the attending psychiatrist's failure to review prior records that indicated a possible suicide attempt at the prior hospital, and arguably indicating the need for line-of-sight monitoring. **The lawsuit was settled for $350,000 on behalf of the psychiatrist and the hospital.**

Explore the **MIEC Knowledge Library**, which contains valuable patient safety and risk management content.

Data Driven Risk Management: MIEC partners with independent sources to supply detailed data that allows for analysis and insight. This information is intended to help MIEC members evaluate their practices and procedures across a wide variety of clinical settings and specialties.

miec.com
800.227.4527