Minimizing Risk in Your Psychiatry Practice

The field of psychiatry continues to evolve. The increased demand for psychiatric care coupled with less availability of psychiatrists has resulted in the increased use of other licensed healthcare providers, such as nurse practitioners and physicians assistants. Further, there are differing practice settings, such as collaborative care arrangements or hospital settings as well as solo or group practices. Regardless of the type of practice setting you are in, there are many risk management principles to consider. Following these general principles can help minimize your liability risk.

Be Aware of Applicable Laws in Your State

Laws impacting psychiatrists vary from state to state. It is critical that you are aware of laws and regulations within your state. Issues include:

- **Record retention.** How long should you keep records and do the time frames differ when treating children/adolescents versus adults?
- **Consent laws.** These include: age of consent for mental health treatment and whether records may be released to a particular party.
- **Duty to Warn.** These laws vary depending on the state in which you practice. Most states follow one of three approaches: mandatory duty, permissive duty and no duty to warn. Prior to experiencing an issue, it is important that you are aware of applicable laws within your state.
- **Involuntary Admission.** Again, these laws vary depending on the state in which you practice.

Documentation

If ever faced with a lawsuit or disciplinary action, no matter what kind of claim is brought against you, your documentation (or lack thereof) will likely play a major role in successfully defending yourself and can even prevent a claim from going forward. Whether you document in written or EMR format, good documentation ensures effective communication about the patient, supports the billing of services, and speaks to the quality of care. Establishing office policies and procedures pertaining to documentation may help to increase compliance among all providers and ensure documentation best practices are used.
All patient interactions, including missed appointments, should be documented. The following are additional examples of what could be documented in a psychiatric record:

- Relevant information regarding diagnosis and treatment
- Assessment of risk of suicide or possible violence towards others
- Medications should be charted along with notes regarding monitoring the treatment
- Informed consent
- Compliance (or non-compliance) with treatment
- When and if problems arise with boundary issues
- Thorough documentation of termination

Documentation may include:

- The medical record itself, including consent for treatment
- Telephone notes
- Prescriptions
- Emails

Maintain Positive and Professional Patient Interactions

One of the more frequent complaints when a lawsuit is brought involves how the psychiatrist interacted with the patient. This includes issues such as whether the psychiatrist was attentive, followed up, whether the patient felt the physician had enough time for him or her, and whether the patient perceived the psychiatrist as rude/unavailable. The psychiatrist should acknowledge patient concerns and address them. Additionally, after-hours availability is important. Even if the psychiatrist is not available after hours, his or her voicemail should indicate someone who is covering and including that the patient could seek care at a local emergency department.

It is important that the psychiatrist be mindful of potential boundary violations/crossings and familiar with the APA Ethics Code. Potential boundary violations/crossings include not only physical interactions but also business relationships or social relationships which may increase risk of a potential claim or licensing board issue.

Protect Patient Privacy

Keep in mind, you are the “guardian” of patient privacy and confidentiality. Be aware of what the rules are under HIPAA (if you are subject to the HIPAA purview) and also state regulations concerning privacy and confidentiality. If utilizing an electronic health record, be aware of what is required of you to ensure that the patient’s information remains secure and whether you need a business associate agreement in place with the vendor.

With respect to storing written documentation, as you are storing confidential psychiatric records, ensure they are kept secure in a locked area and that only authorized individuals have access to the area.

Office Policies and Procedures

An important consideration is having office policies and procedures which are consistently applied with all patients. Should you experience a lawsuit or a board disciplinary action, policies and procedures or lack thereof can either be helpful or harmful.
Prescribing/Prescription Drug Monitoring Programs (PDMPs)

Be aware of what your obligations are within your state concerning prescribing. Pre-dating prescriptions is not recommended and your state may have rules prohibiting this practice. In addition, if you are supervising another provider, such as a nurse practitioner or physician assistant, know what the prescribing and oversight requirements are within your state.

Concerning PDMPs, every state with the exception of Missouri has an operational prescription drug monitoring program. It is important to understand your obligations under state PDMP, including federal and state prescribing laws. Also, be aware that there is increased scrutiny of controlled substance prescribing by federal and state authorities.

Risk Management Tips

- Understand psychiatry standard of care
- Understand state/federal privacy regulations
- Use documentation best practices
- Understand record retention requirements
- Should you have questions, it is important to discuss with your risk management professional or attorney.