

# FLEX CEUs



## Medical Errors Prevention: Patient Safety in Physical Therapy



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# Introduction

Patient safety is a fundamental responsibility of all healthcare professionals. Despite ongoing efforts to improve healthcare quality, medical errors continue to occur across healthcare settings and remain a leading cause of preventable patient harm. These events can result in adverse patient outcomes, increased healthcare costs, and reduced trust in the healthcare system. Physical therapists (PTs) and physical therapist assistants (PTAs) play an important role in minimizing risk through effective communication, accurate documentation, sound clinical judgment, and collaboration with patients and interdisciplinary team members. Understanding the causes of medical errors and implementing strategies to prevent them are essential components of safe and effective clinical practice.

## Section 1: Understanding Medical Errors in Healthcare

Understanding medical errors in healthcare requires a foundational grasp of both key terminology and the common pathways through which errors occur in clinical practice. Physical therapists and physical therapist assistants play an essential role in patient safety, and their ability to recognize, classify, and respond to medical errors directly impacts clinical outcomes. This section provides an overview of core patient safety definitions, including medical errors, adverse events, near misses, and sentinel events, with emphasis on their relevance to rehabilitation practice. In addition, this section examines the most common categories of medical errors encountered in physical therapy, including communication errors, documentation errors, medication-related concerns, treatment and procedural errors, and system-based failures. Through the integration of a clinical case study and guided reflection questions, learners will apply these concepts to real-world

scenarios and strengthen their ability to identify risk, improve clinical decision-making, and contribute to a culture of safety in rehabilitation settings.

## **Background and Incidence of Medical Errors**

### **References: 1–3**

Patient safety is a cornerstone of quality healthcare. Despite advances in medical knowledge, technology, and quality improvement initiatives, medical errors continue to occur across all healthcare settings. These errors can affect patients in hospitals, outpatient clinics, rehabilitation facilities, home health settings, and long-term care environments. While many errors do not result in injury, some lead to significant patient harm, prolonged recovery, increased healthcare costs, disability, or death.

Medical errors are not limited to physicians or nurses. Every healthcare professional, including physical therapists (PTs) and physical therapist assistants (PTAs), contributes to patient safety through daily clinical decisions, communication, documentation, and treatment implementation. Because rehabilitation professionals frequently interact with patients over multiple visits, they are uniquely positioned to identify risks, recognize changes in patient status, and prevent adverse events before harm occurs.

Medical errors often result from a combination of human factors and system failures rather than a single individual's mistake. Factors such as communication breakdowns, inadequate staffing, workflow inefficiencies, incomplete information, fatigue, and organizational culture can all contribute to errors. Modern patient safety initiatives emphasize improving systems of care rather than assigning blame to individuals. Healthcare organizations increasingly recognize that creating a culture of safety is essential for reducing medical errors. A culture of safety encourages healthcare professionals to report concerns, identify hazards, and

participate in quality improvement activities without fear of punishment. By learning from mistakes and near misses, organizations can implement changes that reduce future risk.

## **Impact on Patient Outcomes and Healthcare Systems**

### **References: 4**

Medical errors can have profound consequences for patients and healthcare organizations. Depending on the nature of the error, patients may experience temporary discomfort, prolonged recovery, permanent disability, or even death. In rehabilitation settings, errors may delay functional progress, reduce participation in therapy, increase fall risk, or contribute to additional complications. Beyond physical consequences, medical errors can affect a patient's psychological well-being. Patients who experience adverse events may lose trust in healthcare providers, develop anxiety regarding future treatment, or become less engaged in their rehabilitation programs. Family members may also experience emotional distress when preventable harm occurs.

Healthcare organizations face significant financial consequences associated with medical errors. Adverse events often result in longer hospital stays, additional treatments, increased resource utilization, legal expenses, and regulatory scrutiny. Healthcare systems devote substantial resources to preventing errors through staff education, quality improvement initiatives, technology implementation, and risk management programs.

Medical errors can also affect healthcare providers. Clinicians involved in adverse events may experience feelings of guilt, anxiety, self-doubt, and emotional distress. This phenomenon is sometimes referred to as the "second victim" effect. Supporting healthcare professionals following adverse events is an important

component of maintaining a healthy workplace culture and promoting continued patient safety.

## **Current Trends and Statistics**

### **References: 5**

Research on medical errors consistently demonstrates that patient safety events occur across all healthcare settings; however, physical therapy is considered a lower-frequency specialty in terms of malpractice claims when compared to high-acuity medical fields such as surgery, emergency medicine, and obstetrics. Professional liability insurance carrier data for rehabilitation providers indicate that physical therapists represent a small proportion of total malpractice claims filed annually, with most claims related to falls during treatment, failure to properly assess or monitor a patient's medical status, improper application of modalities, or inadequate referral to higher levels of care when red flags are present. Overall, the incidence of malpractice involving physical therapists is reported to be low, estimated at approximately 2.5 events per 10,000 practicing therapists per year. Although exact national incidence rates vary by reporting source and insurance dataset, PT-related malpractice claims are generally described as infrequent, particularly when compared to other healthcare disciplines.

Despite the relatively low frequency of formal claims, near misses and minor adverse events in physical therapy practice are likely underreported. This underreporting is often attributed to variability in documentation practices, uncertainty regarding reportable events, and fear of professional or organizational consequences. As a result, the true frequency of safety-related events in rehabilitation settings may be higher than what is reflected in malpractice databases alone.

Over the past two decades, patient safety initiatives have significantly influenced rehabilitation practice, including the adoption of standardized communication tools, electronic health records, evidence-based clinical guidelines, and improved screening procedures for medical complexity. These system-based improvements have contributed to enhanced recognition of risk factors and earlier identification of patients requiring referral or medical escalation.

However, ongoing challenges continue to contribute to the potential for error, including increased patient complexity in outpatient and post-acute settings, time constraints in high-volume clinics, variability in clinical experience among providers, and documentation burden. In addition, fragmented communication between healthcare providers remains a common contributing factor in rehabilitation-related adverse events.

For physical therapists and physical therapist assistants, awareness of these patterns reinforces the importance of consistent safety behaviors in daily practice. Simple but critical actions such as verifying patient identity, screening for changes in medical status, confirming precautions and contraindications, documenting accurately and in real time, and maintaining clear communication with referring providers can significantly reduce the likelihood of preventable harm. A proactive approach to patient safety remains one of the most effective strategies for minimizing risk in physical therapy practice.

## **Definitions and Terminology**

**References:** 6, 7

A clear understanding of patient safety terminology is essential for physical therapists (PTs) and physical therapist assistants (PTAs) to accurately identify, report, and prevent medical errors in clinical practice. Consistent use of standardized definitions allows healthcare professionals to communicate

effectively, participate in quality improvement initiatives, and support a culture of safety within healthcare systems. While terms such as medical error, adverse event, near miss, and sentinel event are often used interchangeably in informal settings, each carries a distinct meaning within patient safety literature.

### ***Medical Errors***

A medical error is defined as a preventable failure in the planning or execution of a healthcare intervention that may or may not result in patient harm. Medical errors can occur at any stage of the care process, including assessment, diagnosis, treatment planning, intervention delivery, documentation, or communication. Importantly, the presence of a medical error does not automatically mean that harm occurred; rather, it indicates a breakdown in the expected standard or sequence of care.

In physical therapy practice, medical errors may include incorrect patient identification, failure to adhere to established precautions or contraindications, inaccurate exercise prescription, or failure to recognize a change in a patient's medical status that requires referral. Errors may be active, occurring at the point of care, or latent, existing within the system and contributing to future failures.

### ***Adverse Events***

An adverse event is an injury or complication that results from healthcare management rather than the underlying condition of the patient. Adverse events may be preventable or non-preventable, depending on whether an error or system failure contributed to the outcome.

In rehabilitation settings, adverse events may include patient falls during treatment sessions, skin breakdown from positioning or assistive devices, exacerbation of symptoms due to inappropriate exercise progression, or

cardiovascular responses during activity that require emergency intervention. Adverse events are particularly significant in physical therapy because patients are often actively participating in movement-based interventions, increasing the importance of continuous monitoring and clinical decision-making.

### ***Near Misses***

A near miss refers to an event that could have resulted in patient harm but was identified and corrected before injury occurred. Near misses are critical indicators of system vulnerabilities and provide valuable opportunities for proactive improvement.

Examples in physical therapy may include identifying an incorrect patient chart prior to treatment, recognizing that a patient has a contraindication to exercise before initiating activity, or catching an error in documentation that would have led to inappropriate treatment progression. Although no harm occurs, near misses reveal weaknesses in communication, workflow, or verification processes.

Encouraging reporting and analysis of near misses is a key component of a high-reliability healthcare system. Organizations that systematically review near misses are better able to implement corrective actions before serious adverse events occur.

### ***Sentinel Events***

A sentinel event is defined as a serious, unexpected occurrence involving death, permanent harm, or severe temporary harm that requires immediate investigation and response. Sentinel events are rare but represent significant breakdowns in healthcare systems.

Examples include patient death during or immediately following therapy due to failure to recognize medical instability, serious injury resulting from a fall during

rehabilitation, or catastrophic outcomes related to improper treatment application or failure to escalate care appropriately. Sentinel events typically trigger formal root cause analysis (RCA) processes to identify contributing factors and prevent recurrence.

## **Types and Rates of Medical Errors**

References: 8–10

Medical errors in physical therapy practice can arise from multiple sources, often involving a combination of human factors, communication breakdowns, and system-level failures. Understanding common categories of errors allows clinicians to anticipate risk and implement targeted prevention strategies.

### ***Communication Errors***

Communication errors are among the most frequently cited contributors to medical errors in healthcare. In physical therapy, communication may occur between PTs and PTAs, between rehabilitation staff and referring providers, or between clinicians and patients.

Common communication-related issues include unclear verbal orders, incomplete handoffs between providers, failure to communicate changes in patient status, and misinterpretation of physician precautions or restrictions. Inadequate communication can lead to inappropriate treatment progression, delayed referrals, or failure to recognize medical deterioration.

Effective communication strategies such as structured handoff tools (e.g., SBAR: Situation, Background, Assessment, Recommendation), closed-loop communication, and standardized documentation practices significantly reduce the likelihood of communication-related errors.

## ***Documentation Errors***

Documentation errors involve inaccurate, incomplete, delayed, or inconsistent recording of patient information. In physical therapy, documentation serves as both a legal record and a clinical communication tool, making accuracy essential for patient safety.

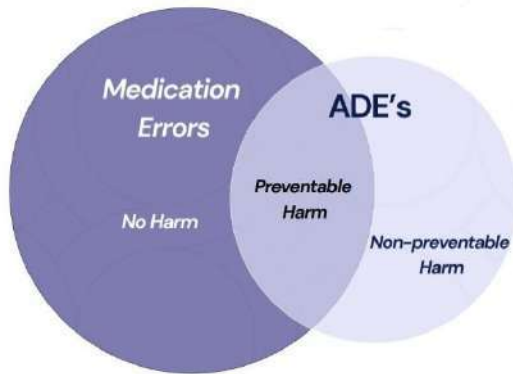
Common documentation errors include incorrect recording of treatment interventions, failure to document changes in patient status, omission of critical safety information (such as fall risk or precautions), and copying forward outdated or incorrect information in electronic health records.

Poor documentation can lead to inappropriate clinical decisions, duplication of services, or failure to recognize important changes in a patient's condition. Timely and accurate documentation is a key safeguard against medical error and supports continuity of care across providers.

## ***Medication-Related Errors***

Although physical therapists do not typically prescribe or administer medications independently, medication-related errors can still occur in rehabilitation settings due to indirect involvement in patient monitoring and communication. Examples include failure to recognize medication side effects that impact therapy participation (such as dizziness, orthostatic hypotension, or fatigue), miscommunication regarding anticoagulant precautions, or lack of awareness of medication changes that affect exercise tolerance.

PTs and PTAs must maintain awareness of common medications and their functional implications, particularly in populations with complex medical histories. Effective collaboration with nursing and medical providers is essential to ensure safe participation in therapy.



<https://soterius.com/blogs/medication-errors-patient-safety-part-i/>

### ***Treatment and Procedural Errors***

Treatment and procedural errors occur when an intervention is applied incorrectly or inappropriately based on patient condition, clinical guidelines, or safety precautions.

Examples include incorrect exercise dosage, inappropriate progression of weight-bearing status, failure to monitor vital signs during high-risk activity, or application of modalities without proper screening or contraindication review. In some cases, errors may involve failure to modify treatment based on changes in patient presentation.

These errors often occur in fast-paced clinical environments where clinicians must balance productivity demands with safety considerations. Structured clinical reasoning and adherence to evidence-based guidelines are essential for minimizing risk.

### ***System-Based Errors***

System-based errors arise from failures within the healthcare environment rather than individual clinician actions alone. These may include staffing shortages, inadequate training, unclear policies, inefficient workflow design, or lack of access to necessary patient information.

In rehabilitation settings, system-based errors may include scheduling pressures that reduce time for proper patient screening, fragmented electronic health record systems that limit access to medical history, or inconsistent protocols across clinicians.

Modern patient safety frameworks emphasize that most errors are system-related rather than purely individual failures. As a result, improving systems of care is considered a primary strategy for reducing harm.

## **Case Study 1**

A 67-year-old patient with a history of congestive heart failure and type 2 diabetes is referred to outpatient physical therapy following a hospitalization for deconditioning. The referral includes general instructions for “gait training and strengthening as tolerated.” During the initial evaluation, the physical therapist performs a basic assessment but does not contact the referring provider for clarification regarding cardiac precautions or activity limitations.

On the second visit, a physical therapist assistant begins treatment based on the established plan of care. During exercise, the patient reports increasing shortness of breath and dizziness. The PTA attributes the symptoms to deconditioning and encourages rest breaks but does not immediately notify the supervising PT. The patient later experiences a significant drop in blood pressure and requires emergency medical evaluation.

Subsequent review reveals that the patient had recently been started on a new beta-blocker medication and had documented activity restrictions that were not communicated in the referral packet. The lack of clarification from the referring provider, combined with incomplete internal communication between the PT and PTA, contributed to a preventable adverse event.

A root cause analysis identifies multiple contributing factors, including unclear referral information, inadequate handoff communication, and insufficient screening of cardiac risk factors prior to treatment initiation. Recommendations include implementation of a standardized referral clarification process, mandatory vital sign monitoring protocols for high-risk patients, and structured PT-PTA communication during treatment progression.

### ***Reflection Questions***

1. What communication failures contributed to the adverse event in this case?
2. At what points in the care process could the medical error have been prevented?
3. What system-level factors increased the risk for this patient?
4. How could the physical therapist have improved initial evaluation procedures to reduce risk?
5. What role should the PTA play when a patient presents with concerning symptoms during treatment?

### ***Responses***

1. Communication failures included lack of clarification with the referring provider regarding cardiac precautions, incomplete transfer of critical medical information, and failure of the PTA to promptly escalate concerning symptoms to the supervising PT.
2. The error could have been prevented during the initial referral review by clarifying activity restrictions, during the evaluation by obtaining complete medical history, and during treatment by implementing appropriate monitoring and escalation protocols.

3. System-level factors included incomplete referral documentation, lack of standardized communication procedures between providers, and insufficient protocols for high-risk patient screening in outpatient rehabilitation.
4. The physical therapist could have improved safety by contacting the referring provider prior to initiating treatment, performing a more detailed cardiovascular risk assessment, and establishing clear monitoring parameters for exercise tolerance.
5. The PTA should immediately report concerning symptoms to the supervising PT, stop or modify treatment as appropriate within scope of practice, and follow clinic emergency protocols when patient status changes indicate potential medical instability.

## **Section 1 Key Words**

Medical Error – A medical error is a preventable failure in the planning or execution of a healthcare intervention that may or may not result in patient harm

Adverse Event – An adverse event is an injury or complication that occurs because of healthcare management rather than the patient's underlying condition, and may be preventable or non-preventable

Near Miss – A near miss is an event that could have resulted in patient harm but was identified and corrected before injury occurred

## **Section 1 Conclusion**

Medical errors in physical therapy are rarely the result of a single action; rather, they emerge from a combination of communication breakdowns, documentation

issues, clinical decision-making challenges, and system-level vulnerabilities. By clearly defining key patient safety terminology and understanding the most common types and sources of error, PTs and PTAs are better equipped to recognize risk early and intervene appropriately. The case study highlights how gaps in communication and incomplete clinical information can quickly escalate into adverse events, reinforcing the importance of structured communication, thorough evaluation, and vigilant monitoring throughout the plan of care. Ultimately, consistent application of patient safety principles, supported by accurate documentation, effective interdisciplinary collaboration, and proactive clinical reasoning, serves as the foundation for reducing medical errors and improving outcomes in rehabilitation practice.

## **Section 2: Risk Factors and Root Cause Analysis**

Medical errors rarely occur in isolation and are most often the result of multiple interacting factors involving patients, clinicians, and healthcare systems.

Understanding who is at increased risk for harm and why errors occur is essential for improving patient safety in physical therapy practice. This section explores vulnerable populations, common clinical consequences of medical errors, and the role of Root Cause Analysis (RCA) in identifying system-level failures. It also reviews strategies for preventing future harm through corrective action, continuous quality improvement, and organizational learning.

### **Vulnerable Populations and Increased Risk**

#### **References: 11**

Certain patient populations are at increased risk for medical errors and adverse events due to age-related changes, medical complexity, cognitive status, or

barriers to communication. In physical therapy practice, these vulnerabilities can directly impact safety during evaluation and intervention, particularly when patients are engaged in movement-based care. Recognizing these risk factors early allows clinicians to adjust decision-making, supervision, and monitoring to reduce the likelihood of harm.

## ***Older Adults***

Older adults represent one of the most vulnerable populations in healthcare due to physiological aging, increased prevalence of chronic disease, and higher rates of functional decline. In physical therapy settings, age-related changes such as decreased balance, reduced strength, slowed reaction time, and impaired sensory function significantly increase the risk of falls and other adverse events.

In addition, older adults often experience transitions between multiple care settings, including hospitals, skilled nursing facilities, outpatient clinics, and home health services. These transitions increase the likelihood of fragmented communication, incomplete documentation, and inconsistent application of precautions. Even minor errors in this population can result in major functional decline or loss of independence.



<https://myphc.com/services/geriatric-care/what-you-need-to-know-about-falls-in-the-elderly/>

### ***Individuals with Multiple Comorbidities***

Patients with multiple chronic conditions present increased clinical complexity due to overlapping physiological limitations and medication interactions. Common comorbidities such as cardiovascular disease, diabetes, respiratory conditions, and renal impairment can significantly influence exercise tolerance and response to rehabilitation interventions.

Medical errors in this population often occur when clinicians fail to integrate the full scope of a patient's medical history into clinical decision-making or do not recognize early signs of intolerance to activity. Without careful monitoring and interdisciplinary communication, inappropriate exercise dosing or progression may lead to adverse cardiovascular or metabolic events.

### ***Patients with Cognitive Impairments***

Patients with cognitive impairments, including dementia, traumatic brain injury, and other neurological conditions, are at increased risk for medical errors due to limitations in memory, attention, judgment, and comprehension. These impairments may reduce a patient's ability to follow instructions, report symptoms accurately, or maintain safety precautions during therapy.

In rehabilitation settings, cognitive deficits can lead to incorrect execution of exercises, reduced safety awareness, and increased fall risk. Clinicians must rely more heavily on observation, caregiver input, and structured safety strategies to ensure appropriate care delivery. Failure to account for cognitive limitations can significantly increase the likelihood of preventable harm.

### ***Patients with Communication Barriers***

Communication barriers, including language differences, hearing impairments, speech difficulties, and low health literacy, can significantly impact patient safety.

Miscommunication may lead to incorrect performance of home exercise programs, misunderstanding of precautions, or failure to report important symptoms.

Without appropriate communication support such as interpreters, visual aids, or teach-back methods, patients may be unable to fully understand or participate in their care. These barriers increase the risk of preventable errors and highlight the importance of clear, patient-centered communication strategies in rehabilitation practice.

## **Clinical Consequences of Medical Errors**

**References:** 5, 12

Medical errors can have wide-ranging consequences that extend beyond the immediate event itself, affecting a patient's physical health, psychological well-being, healthcare utilization, and overall rehabilitation trajectory. In physical therapy practice, where interventions are often movement-based and require active patient participation, the impact of even minor errors can be amplified due to the dynamic nature of treatment and the functional demands placed on patients. Understanding these consequences reinforces the importance of prevention, early recognition, and rapid response to changes in patient status.

### ***Physical Harm***

The most immediate and clinically significant consequence of medical errors is physical harm. In rehabilitation settings, this may present as acute injuries such as falls resulting in contusions, fractures, or head trauma, particularly in older adults or individuals with impaired balance. Errors in exercise dosing, progression, or supervision can also lead to musculoskeletal injuries such as strains, joint

aggravation, or tendon irritation, potentially delaying recovery or worsening the original condition.

Medical errors may also contribute to exacerbation of underlying medical conditions. For example, inappropriate exercise intensity in a patient with cardiovascular disease may lead to abnormal blood pressure responses, dizziness, syncope, or cardiac events. In individuals with respiratory or metabolic conditions, failure to monitor exertion levels appropriately may result in oxygen desaturation or glycemic instability.

Because physical therapy often involves real-time clinical decision-making during movement, therapists and assistants must continuously monitor patient responses. Small lapses in judgment, inadequate supervision, or failure to recognize early warning signs can quickly escalate into significant adverse events. As a result, vigilance and clinical reasoning are critical components of minimizing physical harm.

### ***Psychological Effects***

In addition to physical injury, medical errors can have meaningful psychological consequences for patients. Individuals who experience an adverse event during healthcare often report increased anxiety, fear, and reduced confidence in both the healthcare system and their own ability to recover. In physical therapy, this may manifest as fear of movement (kinesiophobia), decreased willingness to participate in therapeutic exercises, or reluctance to engage in higher-level functional activities.

Loss of trust in the treating clinician or healthcare system can also occur, particularly if the patient perceives that the event was preventable. This breakdown in trust may negatively affect therapeutic alliance, which is a key predictor of rehabilitation adherence and outcomes. Patients may become less

communicative about symptoms or concerns, further increasing safety risks in subsequent sessions.

Psychological distress following medical errors may also contribute to decreased motivation, reduced engagement in home exercise programs, and increased perceived disability. Over time, these factors can significantly impair rehabilitation progress and limit functional recovery.

### ***Increased Healthcare Utilization***

Medical errors frequently result in increased utilization of healthcare resources, which contributes to higher costs for both patients and the healthcare system. Following an adverse event, patients may require additional diagnostic testing such as imaging, laboratory work, or specialist consultations to assess injury severity or rule out complications. In more serious cases, emergency department visits or hospital admissions may be necessary.

Within rehabilitation settings, medical errors may lead to interrupted care plans, regression of treatment progressions, or extended episodes of care. Patients may require additional visits to address complications or restore lost function, increasing the overall duration and intensity of rehabilitation services.

From a systems perspective, these increased resource demands place additional strain on already burdened healthcare environments. They may also contribute to reduced access to care for other patients, longer wait times, and increased administrative workload associated with incident reporting and follow-up.

### ***Impact on Rehabilitation Outcomes***

Perhaps the most clinically relevant long-term consequence of medical errors in physical therapy is their impact on rehabilitation outcomes. Errors can disrupt the

planned progression of care, delay functional improvements, and reduce a patient's ability to achieve established goals within expected timeframes.

For example, a fall or injury during therapy may require temporary cessation of treatment, regression to lower-level interventions, or modification of weight-bearing status. This interruption can slow neuromuscular adaptation, reduce conditioning gains, and negatively affect patient confidence in movement.

In medically complex or older adult populations, the consequences may be even more significant. A single adverse event can result in long-term functional decline, loss of independence, or transition to a higher level of care such as assisted living or skilled nursing facilities. In some cases, patients may never fully regain their pre-event level of function.

Additionally, medical errors can influence patient adherence to therapy programs. Patients who experience adverse events may become hesitant to participate fully in rehabilitation activities, limiting the effectiveness of interventions designed to restore strength, mobility, and function.

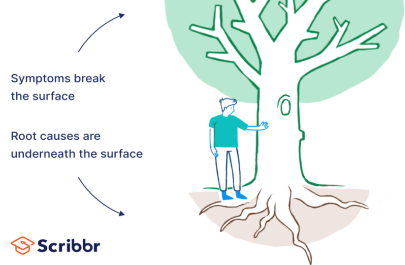
Overall, the impact of medical errors on rehabilitation outcomes underscores the importance of proactive risk identification, continuous monitoring, and timely intervention. Preventing errors not only improves safety but also supports optimal functional recovery and long-term quality of life for patients.

## **Root Cause Analysis (RCA)**

### **References: 13**

Root Cause Analysis is an important safety tool used to better understand why adverse events and near misses occur in healthcare. In physical therapy and other clinical settings, it helps teams look beyond the surface of an error and examine the deeper factors that contributed to it.

## Root Cause Analysis



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### ***Purpose and Principles***

Root Cause Analysis is a structured, systematic process used to identify the underlying causes of adverse events and near misses in healthcare. Its primary purpose is to move beyond simply documenting that an error occurred and instead understand the full sequence of events and conditions that allowed it to happen. Rather than focusing on assigning blame to an individual clinician, RCA emphasizes identifying breakdowns within processes and systems to determine how it influenced the event and whether it represents a modifiable risk. In physical therapy settings, contributing factors may also include incomplete referral information, lack of standardized screening procedures, unclear documentation of precautions, or inconsistent communication between the physical therapist and physical therapist assistant. The goal is to identify patterns or breakdowns that extend beyond the immediate action of one clinician.

### ***System Versus Individual Factors***

A central principle of RCA is distinguishing between system-level issues and individual performance. While individual decision-making may play a role in an

event, most medical errors occur within systems that shape how clinicians work, communicate, and make decisions. These systems include organizational policies, documentation platforms, staffing models, and communication structures.

By identifying system-level contributors, healthcare organizations can implement changes that support safer practice environments, such as standardized protocols, improved communication tools, or redesigned workflows. This approach recognizes that sustainable error prevention is achieved not only by improving individual performance but by strengthening the systems in which clinicians operate.

## **Preventing Future Harm**

### **References: 13**

Once the causes of an error have been identified, the next step is to use that information to reduce the likelihood of recurrence. Preventing future harm requires both immediate corrective action and long-term system improvements that strengthen safety, consistency, and communication across the organization. In physical therapy practice, this process is essential for ensuring that lessons learned from adverse events and near misses are translated into meaningful changes in clinical care.

### ***Corrective Actions***

Corrective actions are specific, targeted interventions implemented after an error or near miss to reduce the likelihood of recurrence. These actions are typically focused on addressing the most immediate breakdowns in the care process and may involve revising clinical protocols, improving communication pathways between team members, enhancing documentation standards, or introducing

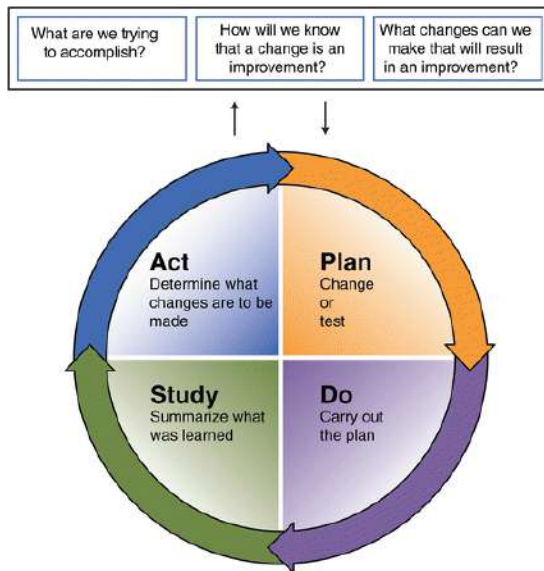
additional safety checks such as required screening tools or clearly defined escalation criteria.

In physical therapy practice, corrective actions may also include reinforcing supervision requirements for physical therapist assistants, updating referral clarification procedures, or implementing mandatory risk assessments for high-risk populations such as older adults or individuals with significant medical comorbidities. In some cases, corrective actions may involve staff re-education or clarification of clinical decision-making pathways to ensure consistency in practice. The overall intent is to directly address identified vulnerabilities in the care process and reduce the likelihood of repeat events.

### ***Continuous Quality Improvement***

Continuous Quality Improvement (CQI) is an ongoing, data-driven process used to monitor, evaluate, and improve healthcare delivery over time. Rather than focusing on isolated events, CQI examines trends and patterns in clinical practice to identify opportunities for system-wide improvement. In rehabilitation settings, CQI often involves tracking key safety indicators such as patient falls, adverse events during treatment, documentation inconsistencies, or incidents requiring medical referral or escalation of care.

Findings from CQI activities are used to guide iterative changes in clinical practice, with the goal of ensuring that improvements are not only implemented but also sustained over time. This process supports evidence-based decision-making and allows clinicians and organizations to adapt to changing patient populations, increasing clinical complexity, and evolving healthcare demands while maintaining a strong emphasis on patient safety.



<https://nursekey.com/tools-and-strategies-for-continuous-quality-improvement-and-patient-safety/>

## Organizational Learning

Organizational learning refers to the ability of healthcare systems to systematically learn from both errors and near misses to improve future performance. This process depends on creating a culture where reporting is encouraged, communication is open, and clinicians feel supported in discussing safety concerns without fear of punitive action or blame.

When organizations effectively learn from adverse events, they are better able to identify recurring patterns, implement system-wide improvements, and reduce the likelihood of similar events occurring in the future. In physical therapy practice, this shared learning environment strengthens interdisciplinary teamwork, improves communication between physical therapists and physical therapist assistants, and supports more consistent application of safety principles across clinical settings. Ultimately, organizational learning contributes to safer, more effective, and more reliable patient care.

## Case Study 2

A 55-year-old patient is referred to outpatient physical therapy following an ischemic stroke with right-sided weakness and mild expressive aphasia. The discharge summary recommends a front-wheeled walker and close supervision for all ambulation. The patient arrives at the clinic using a single-point cane provided by the family.

During the initial evaluation, the physical therapist notes the mismatch in assistive device use but proceeds with gait training using the cane without confirming appropriate equipment or contacting the referring facility. The patient demonstrates balance deficits and difficulty following multi-step commands, but treatment continues with progression of mobility tasks.

During a subsequent session, the patient attempts to ambulate without assistance and experiences a significant loss of balance requiring therapist intervention to prevent a fall. No injury occurs, but the event prompts a safety review.

Root cause analysis identifies failure to verify assistive device recommendations, inadequate reinforcement of supervision level, progression of mobility without confirming safety status, and incomplete transition-of-care communication. System factors include lack of standardized assistive device verification during intake.

Recommendations include implementing a mandatory assistive device reconciliation process, standardized post-stroke mobility safety screening, and improved communication between inpatient and outpatient rehabilitation teams.

### ***Reflection Questions***

1. What breakdown occurred during the transition from hospital to outpatient care?

2. How did assistive device mismatch contribute to safety risk?
3. What clinical signs suggested increased supervision needs?
4. When should progression have been modified?
5. What system change would most prevent this error?

## **Responses**

1. The transition from hospital to outpatient care was incomplete, as the discharge recommendation for a front-wheeled walker and close supervision was not effectively communicated, verified, or implemented. This resulted in a mismatch between the patient's prescribed level of assistance and their actual mobility status upon entering outpatient therapy.
2. The use of a single-point cane instead of a walker significantly reduced the patient's base of support and overall stability. This increased the risk of loss of balance, particularly during turning and transitional movements, and placed the patient at higher risk for falls given their post-stroke impairments.
3. Clinical signs indicating the need for higher supervision included observable balance deficits, impaired motor control on the affected side, and difficulty following multi-step commands due to expressive aphasia. These findings suggest both physical and cognitive limitations that impact safety awareness and independent mobility.
4. Progression of mobility should have been modified immediately during the initial evaluation once instability and assistive device mismatch were identified. At minimum, treatment should have been adjusted to reflect

walker-level support or halted until appropriate equipment and safety parameters were confirmed.

5. A standardized assistive device reconciliation process at intake, requiring verification of discharge recommendations, confirmation of equipment availability, and documentation of appropriate device use, would most directly reduce the likelihood of similar errors. This would ensure consistency across care transitions and improve patient safety during early rehabilitation.

## **Section 2 Key Words**

Root Cause Analysis – A structured, systematic process used to identify underlying system and process factors that contribute to medical errors and adverse events to prevent recurrence

Vulnerable Populations – Patient groups at increased risk for harm due to age, medical complexity, cognitive impairment, or communication barriers

## **Section 2 Conclusion**

Risk factors and root cause analysis help explain why medical errors occur and how to prevent them. Most errors result from system breakdowns rather than isolated actions, making structured analysis essential for prevention. RCA supports identification of system failures and guides corrective action, quality improvement, and organizational learning. For PTs and PTAs, applying these principles improves safety, communication, and patient outcomes across rehabilitation settings.

## **Section 3: The Therapist's Role in Medical Error Prevention**

Physical therapists and physical therapist assistants play an important role in preventing medical errors because they work closely with patients throughout the rehabilitation process. Their frequent contact, ongoing reassessment, and need to adjust treatment based on patient response make safety a constant part of practice. This section examines the responsibilities of PTs and PTAs in reducing error, common sources of mistakes in rehabilitation, and strategies for building a safer, more collaborative care environment. A case study is included to show how small breakdowns in communication and monitoring can lead to preventable harm.

### **Responsibilities of Physical Therapists and Physical Therapist Assistants**

**References:** 12, 14, 15

Preventing medical errors begins with a clear understanding of the distinct but interdependent roles of physical therapists (PTs) and physical therapist assistants (PTAs). While both professionals contribute directly to patient care, their responsibilities differ in scope, level of clinical decision-making authority, and accountability for patient management. Safe rehabilitation practice depends on how effectively these roles are coordinated, communicated, and aligned within the plan of care.

Physical therapists hold primary responsibility for the initial examination and evaluation of the patient. This includes gathering subjective and objective data, identifying impairments and functional limitations, screening for red flags, and determining whether the patient presentation is appropriate for physical therapy

intervention. Based on this assessment, the PT establishes a diagnosis within the scope of physical therapy practice and develops an individualized plan of care that outlines treatment goals, interventions, precautions, contraindications, and expected progression.

Because the PT is responsible for clinical reasoning and diagnostic decision-making, they also carry responsibility for anticipating risk factors that may contribute to medical error. This includes identifying patients with medical complexity, recognizing when referral to another healthcare provider is necessary, and determining appropriate levels of supervision and intervention progression. Clear communication of these expectations to the PTA is essential to ensure safe implementation of care.

Physical therapist assistants play a critical role in the ongoing delivery of care by implementing interventions as directed by the supervising PT. However, their responsibilities extend beyond task execution. PTAs are also responsible for continuous patient monitoring during treatment sessions, including observing changes in functional performance, pain response, tolerance to activity, and overall medical status. When deviations from expected response occur, PTAs are expected to recognize these changes and promptly communicate them to the supervising PT.

This reporting function is a key component of error prevention, as PTAs often spend more direct time with patients during treatment sessions and may be the first to observe subtle but clinically significant changes. Failure to report these changes accurately or in a timely manner can contribute to delayed intervention and increased risk of adverse events.

Although the PT and PTA have distinct responsibilities, patient safety relies on seamless collaboration and shared situational awareness. The PT must ensure that the PTA has a clear understanding of the plan of care, including treatment

parameters, progression criteria, and safety precautions. Likewise, the PTA must consistently communicate patient response and any concerns that arise during treatment sessions.

Breakdowns in communication between PTs and PTAs are a common contributing factor in rehabilitation-related medical errors. These may include unclear treatment instructions, lack of clarity regarding progression criteria, or failure to communicate changes in patient status. Structured communication processes, such as written treatment guidelines, verbal handoffs, and documentation updates, help reduce ambiguity and improve safety.

Ultimately, the effectiveness of the PT-PTA team depends on mutual accountability, shared clinical awareness, and consistent communication. When both roles function cohesively, they create a layered safety system in which evaluation, intervention, monitoring, and response work together to reduce the likelihood of medical errors and support optimal patient outcomes.

## **Clinical Decision Making**

### **References: 16**

Clinical decision-making in physical therapy is a dynamic, ongoing process that evolves with each patient interaction. It requires integration of medical history, functional presentation, psychosocial factors, and real-time response to intervention. Safe decision-making depends not only on initial evaluation accuracy but also on continuous reassessment throughout the episode of care.

Errors in clinical reasoning may occur when patient complexity is underestimated, when assumptions are made based on prior sessions without reassessment, or when subtle changes in status are overlooked. For example, progression of gait training or resistance exercise without recognizing early signs of intolerance, such

as abnormal fatigue, instability, or cardiovascular response, can increase risk of adverse events.

For PTAs, clinical decision-making focuses on recognizing when patient performance deviates from expected outcomes and escalating concerns appropriately. This includes identifying when a patient is no longer responding safely to the current level of intervention and communicating these changes promptly to the supervising PT.

Strong clinical decision-making is grounded in critical thinking, pattern recognition, and a consistent willingness to reassess assumptions in response to patient presentation.

## **Documentation Practices**

### **References: 17**

Documentation is a foundational component of patient safety and serves as the primary mechanism for communication between healthcare providers. In physical therapy, documentation supports continuity of care, legal protection, and clinical decision-making. When documentation is incomplete, outdated, or inaccurate, the risk of medical error increases significantly.

High-quality documentation includes accurate recording of interventions performed, patient response to treatment, changes in functional status, and any safety concerns observed during sessions. It also includes clear communication of precautions, contraindications, and progression guidelines to ensure that all team members are aligned.

Common documentation-related errors include copying forward outdated information, failing to update changes in patient status, or omitting relevant clinical observations such as dizziness, instability, or pain response. These issues

can lead to inappropriate continuation of treatment plans or missed opportunities for intervention adjustment.

In addition, documentation plays a key role during transitions of care. If hospital discharge summaries, referral notes, or prior therapy records are not reviewed thoroughly, important risk factors may be missed, leading to inappropriate clinical decisions early in the episode of care.

## **Patient Monitoring**

### **References: 6**

Patient monitoring is an active, continuous process that is essential for safe rehabilitation practice. Because physical therapy often involves movement, exertion, and functional challenge, clinicians must continuously evaluate how patients respond to activity in real time. Monitoring includes observation of movement quality, balance control, coordination, endurance, pain response, and physiological indicators such as heart rate, blood pressure, and oxygen saturation when appropriate. It also includes attention to behavioral cues such as hesitation, confusion, or decreased safety awareness.

One of the most important aspects of monitoring is distinguishing between expected exertion responses and warning signs of clinical instability. Symptoms such as dizziness, excessive fatigue, loss of balance, or shortness of breath may indicate that intervention intensity is no longer appropriate.

Failure to recognize changes in patient status can result in delayed intervention, progression of symptoms, or preventable adverse events such as falls or medical emergencies. Effective monitoring requires both technical knowledge and consistent attentiveness throughout every patient interaction.

## Communication with Healthcare Teams

### References: 18

Communication is one of the most critical safeguards against medical error in rehabilitation practice. Physical therapists and physical therapist assistants routinely collaborate with physicians, nurses, case managers, discharge planners, and other rehabilitation professionals. Because care is often shared across multiple providers and settings, clear, timely, and structured communication is essential to ensure patient safety and continuity of care.

Communication failures may occur when important clinical information is not shared, is delayed, or is not clearly understood by members of the healthcare team. These breakdowns are especially common during transitions of care, when responsibility shifts between providers or settings and key clinical details may be fragmented across multiple documentation systems.

Structured communication tools such as SBAR (Situation, Background, Assessment, Recommendation) help standardize information exchange, reduce ambiguity, and support clearer clinical escalation when patient status changes. These tools are particularly important when reporting safety concerns, functional decline, or when requesting clarification of precautions or weight-bearing status.

Within the PT-PTA relationship, communication is equally essential. PTAs are responsible for clearly reporting deviations in patient performance or tolerance, while PTs must ensure that the plan of care, precautions, and clinical expectations are clearly defined and documented. Without structured communication, small but clinically significant changes in patient status may go unrecognized until they progress into preventable adverse events.

Communication requirements also vary by clinical setting, and understanding these differences is essential for safe practice.

In acute care hospital settings, communication is typically fast-paced and medically complex. PTs and PTAs must coordinate closely with physicians and nursing staff regarding rapid changes in medical status, vital signs, mobility restrictions, and discharge readiness. Errors in this setting often occur due to incomplete handoffs, rapidly changing orders, or insufficient clarification of precautions in medically unstable patients.

In subacute settings such as skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs), communication focuses heavily on continuity of care, functional progression, and interdisciplinary team meetings. Breakdowns often occur when therapy recommendations are not consistently communicated across shifts or when changes in patient status are not updated in care plans, leading to inconsistent treatment approaches.

In home health environments, communication relies heavily on documentation, phone updates, and coordination with physicians and family caregivers. Because clinicians are often working independently in the field, delayed communication of patient decline, safety concerns in the home environment, or medication-related issues can significantly increase risk.

In outpatient rehabilitation settings, communication is often centered on referral accuracy, progression of exercise programs, and coordination with referring providers. Errors commonly arise when referral information is incomplete, when updates from other providers are not reviewed, or when changes in patient status are not communicated back to the referring physician in a timely manner.

In telehealth physical therapy services, communication is entirely mediated through digital platforms, making clarity, documentation, and patient education even more critical. Limitations in physical examination and direct supervision increase reliance on patient-reported outcomes, requiring clinicians to

communicate instructions with precision and confirm understanding to reduce safety risks.

Across all settings, effective communication serves as a primary safeguard against medical error. When combined with structured tools, clear role delineation, and consistent documentation practices, it strengthens clinical decision-making and supports safer, more coordinated rehabilitation care.

## **Examples of Medical Errors in Physical Therapy Practice**

### **References: 16**

Medical errors in rehabilitation are often subtle and cumulative rather than dramatic or immediately obvious. They frequently result from breakdowns in communication, documentation, monitoring, or clinical judgment.

Patient identification errors may occur when proper verification procedures are not followed prior to treatment, potentially resulting in care being delivered to the wrong individual. While rare, these errors are considered high severity and are entirely preventable through standardized identification protocols.

Documentation inaccuracies include incomplete records, outdated information, or failure to update changes in patient status. These errors can lead to inappropriate treatment progression or failure to recognize clinical deterioration.

Communication failures are among the most common contributors to error in physical therapy. These may involve unclear referral instructions, incomplete handoffs between providers, or lack of communication regarding precautions or changes in patient condition.

Treatment-related errors occur when interventions are applied incorrectly or without adequate consideration of patient status. Examples include inappropriate

progression of exercise intensity, failure to adhere to post-surgical precautions, or inadequate supervision during mobility training.

Failure to recognize changes in patient status represents a particularly high-risk category of error. Subtle signs such as dizziness, increased fatigue, changes in gait stability, or altered cognitive response may indicate underlying instability that requires immediate modification of care.

## **Creating a Collaborative Environment**

### **References: 19**

A strong culture of collaboration is essential for reducing medical errors and improving patient outcomes in rehabilitation settings. Collaborative environments support shared responsibility, open communication, and coordinated decision-making across disciplines.

Interdisciplinary communication ensures that all members of the healthcare team are informed about patient status, treatment plans, and safety concerns. This communication is especially important during transitions of care and when managing medically complex patients.

Team-based care emphasizes that patient safety is not the responsibility of a single provider but rather a shared responsibility among all clinicians involved in care. In physical therapy, this includes coordination between PTs, PTAs, physicians, nurses, and other rehabilitation professionals.

Reporting and learning from errors is a critical component of improving safety systems. When clinicians report near misses and adverse events, healthcare organizations can identify patterns, address system weaknesses, and implement preventative strategies. Without reporting, opportunities for improvement are lost. Promoting a culture of safety requires an environment where clinicians feel

supported in speaking up about concerns without fear of blame. In such environments, communication improves, errors are identified earlier, and system-level improvements are more effectively implemented.

## **Proactive Strategies for Error Prevention**

### **References: 4**

Preventing medical errors requires intentional, proactive strategies that reduce variability and support consistent clinical practice. Standardized procedures are one of the most effective tools for improving safety. These procedures may include structured evaluation templates, standardized intake forms, and clearly defined treatment progression guidelines.

Safety checklists provide an additional layer of protection by ensuring that critical steps are consistently completed. These may include fall risk screening, vital sign monitoring protocols, assistive device verification, and pre-treatment safety checks.

Patient education also plays an essential role in preventing errors. When patients understand their condition, treatment plan, and safety precautions, they are more likely to recognize warning signs and communicate concerns early. Education also improves adherence to home programs and reduces risk of incorrect exercise performance.

Ongoing risk assessment and monitoring are essential throughout the episode of care. Patient status is not static, and clinicians must continuously reassess function, tolerance, and safety. This includes updating fall risk status, monitoring response to exercise progression, and adjusting interventions as needed based on patient presentation.

Together, these proactive strategies create a layered approach to safety that reduces reliance on individual memory or judgment alone.

### **Case Study 3**

A 70-year-old patient is receiving outpatient physical therapy following a total hip arthroplasty. The patient has a history of hypertension and mild balance impairment and is ambulating with a walker under standard post-operative precautions.

During several treatment sessions, the physical therapist assistant observes intermittent unsteadiness and decreased tolerance during gait training. These findings are briefly noted verbally but are not documented in the daily treatment record or formally communicated to the supervising physical therapist. The PT continues the established plan of care without awareness of these changes in status.

In a later session, the patient reports dizziness during ambulation and demonstrates increased instability. The patient nearly falls and requires physical assistance from staff to prevent injury. Although no harm occurs, the event prompts a formal chart review and safety analysis.

Root cause analysis identifies incomplete documentation of changes in patient status, breakdown in PT-PTA communication through the medical record, and lack of clear expectations for documenting deviations from baseline performance. System-level contributors include absence of standardized documentation language for safety concerns and inconsistent chart review procedures.

Recommendations include implementation of standardized documentation templates for change-in-status reporting, mandatory documentation of all safety-

related observations by PTAs, and structured chart review expectations for supervising PTs.

### ***Reflection Questions***

1. What documentation breakdown contributed to the event?
2. How did missing documentation affect PT clinical decision-making?
3. What signs indicated a change in patient status?
4. How could standardized documentation improve safety?
5. What system changes would reduce similar errors?

### ***Responses***

1. The PTA observed unsteadiness and reduced tolerance but did not document these findings in the medical record, limiting accessibility of critical safety information.
2. Because the changes were not documented, the PT continued the established plan of care without recognizing that the patient's functional status had declined, delaying necessary modifications.
3. Signs included intermittent loss of balance, decreased tolerance during gait training, and reported dizziness, all of which indicate declining safety and increased fall risk.
4. Standardized documentation ensures that safety-related observations are consistently recorded, clearly communicated, and accessible to all providers involved in care, improving continuity and reducing oversight.

5. Implementing required documentation fields for change-in-status events, structured PTA-to-PT communication in the EMR, and routine PT chart review protocols would reduce recurrence.

## **Section 3 Key Words**

Clinical Decision Making - The ongoing process by which a physical therapist or physical therapist assistant integrates patient history, examination findings, clinical presentation, and response to intervention to determine appropriate and safe treatment choices throughout the episode of care

Culture of Collaboration - Healthcare environment in which clinicians actively communicate, share responsibility, and work together across disciplines and roles to support patient safety, improve outcomes, and reduce the risk of medical errors through coordinated teamwork and open communication

## **Section 3 Conclusion**

Physical therapists and physical therapist assistants play a key role in preventing medical errors through accurate documentation, consistent clinical decision-making, ongoing patient monitoring, and effective communication. In rehabilitation settings, documentation is not just a record of care, it is a critical safety tool that directly influences clinical decisions and patient outcomes. When documentation is incomplete or inconsistent, important changes in patient status may be missed, increasing the risk of adverse events. Using standardized documentation practices, structured communication, and clear escalation processes helps reduce variability and improves safety across the episode of care. Ultimately, strong documentation habits support safer, more coordinated, and more effective rehabilitation practice while reducing preventable harm across all clinical settings.

## Section 4: Regulations, Policies, and Clinical Application

Preventing medical errors requires more than sound clinical judgment and effective communication; it also requires an understanding of the legal, regulatory, and ethical frameworks that govern physical therapy practice. Physical therapists and physical therapist assistants are expected to provide care that complies with federal and state regulations, adheres to professional standards, and prioritizes patient safety in every clinical decision.

In Florida, laws and administrative rules establish expectations for professional conduct, documentation, supervision, and continuing competence. While these regulations provide legal requirements for practice, they also reinforce broader patient safety principles that apply across all healthcare settings. Understanding these responsibilities enables rehabilitation professionals to make informed clinical decisions, recognize situations that require reporting or referral, and maintain compliance with professional standards. This section reviews Florida statutes and policies related to medical error prevention and discusses practical strategies for applying patient safety principles during everyday clinical practice.

### Florida Statutes and Policies Related to Medical Errors

**References:** 14, 20–22

Healthcare regulations exist to establish minimum standards for safe practice and protect the public from preventable harm. While no regulation can eliminate every medical error, laws and professional standards create a framework that promotes competent clinical care, accountability, and continuous quality improvement. For rehabilitation professionals, understanding these requirements is an essential component of patient safety.

In Florida, physical therapists and physical therapist assistants are regulated through the Florida Physical Therapy Practice Act and the Florida Board of Physical Therapy Practice. Together, these entities establish licensure requirements, define scope of practice, oversee continuing education, investigate complaints, and enforce professional standards. Although these regulations are specific to Florida, many of the underlying patient safety principles are applicable across healthcare systems nationwide.

Rather than viewing regulations solely as legal obligations, clinicians should recognize them as practical tools that support consistent, ethical, and evidence-based care. Many of the activities that reduce medical errors, such as maintaining accurate documentation, communicating effectively with the healthcare team, and practicing within one's competence, are also regulatory expectations.

### ***Regulatory Requirements***

Regulatory requirements establish the legal expectations for physical therapy practice and help ensure that patients receive care from qualified healthcare professionals. These requirements address education, licensure, continuing competence, documentation, supervision, and professional conduct.

Before practicing independently, physical therapists and physical therapist assistants must meet educational requirements, successfully complete licensing examinations, and maintain active licensure through continuing education. These standards ensure that clinicians possess the foundational knowledge and skills necessary to provide safe patient care.

Florida law also requires licensees to complete continuing education related to medical error prevention as part of license renewal. This requirement recognizes that patient safety is not a static competency but rather an ongoing professional responsibility. As healthcare continues to evolve, clinicians must remain informed

about current evidence, emerging safety concerns, and updated clinical recommendations.

Regulations also define the legal scope of practice for PTs and PTAs. Physical therapists are responsible for examining patients, establishing the plan of care, making clinical judgments, and determining when referral to another healthcare provider is necessary. Physical therapist assistants provide treatment under the direction and supervision of the PT while remaining responsible for recognizing changes in patient status and communicating those findings appropriately.

Practicing outside one's legal scope of practice increases the risk of medical errors and may result in disciplinary action. For example, a PTA independently modifying a plan of care without PT involvement or failing to communicate significant changes in patient status may place both the patient and clinician at unnecessary risk.

In addition to professional scope, regulations emphasize accurate documentation, patient confidentiality, informed consent, and maintenance of appropriate clinical records. These requirements serve multiple purposes, including supporting continuity of care, facilitating communication between providers, and creating an accurate legal and clinical record for decision-making.

### ***Key Florida Statutes Supporting Patient Safety and Error Prevention***

Within the Florida Physical Therapy Practice Act, several statutes work together to establish the legal and professional framework that supports patient safety and reduces the risk of medical errors. While each statute addresses a different aspect of regulation, such as licensure, education, or disciplinary action, they collectively function as an interconnected system designed to ensure that only competent, appropriately trained, and ethically practicing clinicians provide physical therapy services. Understanding these statutes in the context of patient safety helps

clinicians recognize that regulatory compliance is not simply administrative, but directly tied to preventing harm and maintaining public trust in the profession.

#### ***486.015 – Legislative Intent***

The Legislative Intent section of the Physical Therapy Practice Act establishes the foundational purpose of regulation in Florida. It clearly states that the intent of the Act is to ensure that physical therapy practitioners meet minimum standards of safe and effective practice and to protect the public from practitioners who may present a risk to patient safety.

From a patient safety perspective, this statute is particularly important because it frames regulation around prevention of harm rather than punishment after an error occurs. It establishes that the primary role of the regulatory system is protective in nature—ensuring that individuals entering practice have the necessary education, skills, and ethical grounding to provide care that does not place patients at unnecessary risk.

In clinical application, this statute reinforces the expectation that all PTs and PTAs must consistently practice within safe boundaries, remain competent, and recognize when patient complexity exceeds their scope or experience. It also supports the broader principle that healthcare systems have a responsibility to proactively prevent unsafe practice rather than respond only after adverse events occur.

#### ***486.028 – License to Practice Physical Therapy Required***

This statute requires that any individual practicing physical therapy in the state of Florida must hold a valid and active license issued by the appropriate regulatory board. This requirement serves as one of the most fundamental patient safety protections in healthcare regulation.

Licensure ensures that all practicing clinicians have completed an accredited educational program, successfully passed required examinations, and met minimum competency standards before providing patient care. In this way, licensure acts as a standardized verification of baseline knowledge and clinical readiness.

From a medical error prevention standpoint, this requirement reduces the likelihood of harm by preventing unqualified individuals from independently providing rehabilitation services. It also reinforces accountability, as licensed professionals are subject to regulatory oversight and must adhere to defined standards of practice.

In clinical environments, this statute underscores the importance of verifying credentials, respecting scope of practice boundaries, and ensuring appropriate supervision structures—particularly when working with physical therapist assistants or students.

#### **486.109 – Continuing Education**

Continuing education requirements within Florida law serve as an ongoing mechanism to ensure professional competence and support safe clinical practice throughout a clinician's career. This statute requires physical therapists and physical therapist assistants to complete continuing education hours as a condition of license renewal, including education specifically related to prevention of medical errors.

This requirement reflects the understanding that healthcare knowledge is constantly evolving. New evidence, updated clinical guidelines, emerging safety risks, and changes in healthcare systems all require clinicians to remain current in their practice. Without ongoing education, clinicians may unknowingly rely on outdated techniques or fail to recognize modern safety standards.

In terms of patient safety, continuing education serves several key functions. It reinforces awareness of common sources of medical error, strengthens clinical reasoning skills, and promotes the use of evidence-based practice. It also ensures that clinicians are regularly exposed to topics such as risk management, communication strategies, documentation standards, and ethical decision-making.

Ultimately, this statute supports a culture of lifelong learning, which is essential for reducing preventable harm in increasingly complex healthcare environments.

### **486.125 – *Disciplinary Actions***

This statute outlines the circumstances under which a physical therapist or physical therapist assistant may face disciplinary action, including suspension, revocation, probation, or other penalties. Grounds for disciplinary action may include unsafe practice, unethical behavior, negligence, impairment, fraud, or failure to comply with professional standards.

From a patient safety perspective, this statute plays a critical role in accountability. It establishes that clinicians are not only responsible for providing safe care but are also subject to consequences when their practice falls below acceptable standards. This reinforces the expectation that patient safety is a continuous professional obligation.

Importantly, disciplinary systems are not solely punitive; they also function as protective mechanisms for the public. When a clinician is unable to practice safely, whether due to incompetence, impairment, or repeated violations of standards, regulatory intervention helps prevent further harm to patients.

In clinical practice, awareness of this statute reinforces the importance of accurate documentation, appropriate clinical decision-making, timely communication of patient status changes, and adherence to ethical standards. It also emphasizes the

need for clinicians to recognize when their own practice may require remediation or additional support.

### **486.151 – Prohibited Acts**

This statute identifies specific actions that are prohibited under Florida law, including practicing physical therapy without a valid license, misrepresenting professional credentials, or engaging in activities outside the defined scope of practice.

This regulation directly supports patient safety by ensuring that only appropriately trained and legally authorized individuals provide rehabilitation services. It also protects patients from misrepresentation, which can occur when individuals falsely claim qualifications, training, or licensure status.

From a medical error prevention perspective, prohibited acts are particularly important because they address high-risk behaviors that can lead to significant patient harm. Practicing without proper licensure or exceeding scope of practice limits bypasses the safeguards built into the regulatory system, increasing the likelihood of inappropriate assessment, incorrect treatment, or failure to recognize medical conditions requiring referral.

In clinical environments, this statute reinforces the importance of maintaining professional transparency, respecting role boundaries between PTs and PTAs, and ensuring that all team members understand and adhere to their defined responsibilities.

Collectively, these statutes establish a comprehensive regulatory framework that supports safe, competent, and ethical physical therapy practice in Florida. The Legislative Intent (486.015) establishes patient protection as the foundation of regulation. Licensure requirements (486.028) ensure baseline competency before practice. Continuing education requirements (486.109) promote ongoing

professional development and awareness of medical error prevention. Disciplinary provisions (486.125) enforce accountability for unsafe or unethical behavior. Finally, prohibited acts (486.151) protect patients from unqualified or misrepresented care. Together, these statutes reinforce the principle that patient safety is not incidental to physical therapy practice, it is a core requirement embedded within the legal and professional structure of the profession.

## **Professional Responsibilities**

### **References: 14**

Professional responsibility in physical therapy refers to the ethical, clinical, and professional obligations that extend beyond minimum regulatory requirements. While laws and licensing boards define what clinicians are legally permitted and required to do, professional responsibility reflects the broader standard of what clinicians should consistently do to ensure safe, effective, and patient-centered care. These expectations are grounded in professional ethical codes, patient safety principles, and evidence-based practice standards that guide day-to-day clinical decision-making.

A core component of professional responsibility is maintaining ongoing clinical competence. Physical therapists and physical therapist assistants are expected to engage in lifelong learning through continuing education, evidence-based practice, and reflective clinical reasoning. Because healthcare knowledge, rehabilitation techniques, and safety standards continuously evolve, maintaining current competence helps reduce the risk of outdated interventions, inappropriate progression of care, and preventable adverse events.

Another key responsibility is recognizing the limits of one's knowledge, skills, and clinical scope. Safe practice requires clinicians to identify when a patient's presentation exceeds their level of experience or competency and respond

appropriately by seeking supervision, consulting with other healthcare professionals, or initiating referral when necessary. Attempting to manage cases beyond one's competence increases the likelihood of delayed diagnosis, inappropriate intervention, and preventable harm.

Patient advocacy is also a fundamental professional responsibility. Physical therapists and physical therapist assistants often serve as frequent points of contact within the healthcare system and are uniquely positioned to observe early changes in patient status, functional decline, or psychosocial concerns. Advocacy may include recommending medical evaluation, communicating concerns about patient safety to the healthcare team, clarifying unclear or potentially unsafe orders, or ensuring that patients understand risks and precautions associated with their care plan.

Accountability is another essential element of professional responsibility. When medical errors or near misses occur, clinicians are expected to document events accurately, report them according to organizational policy, and participate in quality improvement processes aimed at preventing recurrence. Transparency in reporting supports organizational learning and strengthens system-wide patient safety efforts rather than focusing solely on individual blame.

Professional responsibility also varies across clinical settings, but the underlying principles remain consistent. In acute care environments, clinicians must continuously assess medical stability and respond promptly to changes in clinical status. In skilled nursing and inpatient rehabilitation settings, clinicians must coordinate closely with interdisciplinary teams to manage complex medical and functional needs. In home health, therapists must evaluate environmental safety and caregiver support while practicing with greater independence. In outpatient settings, clinicians must recognize when patients are not progressing appropriately and determine when referral back to a physician is necessary. In telehealth

practice, clinicians must ensure safe and effective care delivery despite limited physical contact, relying heavily on communication, patient education, and appropriate patient selection.

Across all practice environments, professional responsibility remains grounded in a shared commitment to patient safety, ethical practice, and evidence-based decision-making. These responsibilities ensure that clinicians not only meet minimum regulatory requirements but also actively contribute to reducing preventable harm and improving the quality of rehabilitation care.

### ***Reporting Considerations***

Despite strong prevention efforts, adverse events and near misses may still occur in clinical practice. When they do, timely and accurate reporting is a critical component of patient safety and continuous system improvement. Reporting is not simply an administrative task; it is a key mechanism through which healthcare organizations identify risks, understand contributing factors, and implement changes that reduce the likelihood of recurrence.

Incident reporting systems provide a structured method for clinicians to document events such as patient falls, unexpected changes in medical or functional status, equipment malfunctions, communication breakdowns, or treatment-related injuries. These reports are used to analyze what happened, why it occurred, and what system-level factors contributed to the event. The goal of reporting is improvement of processes and safety systems, rather than assignment of individual blame.

Near misses are equally important to report because they represent opportunities to identify vulnerabilities before patient harm occurs. Although no injury results, near misses often reveal underlying issues such as unclear communication, inconsistent workflows, documentation gaps, or inadequate safety checks. When

these events are consistently reported and analyzed, organizations can proactively address system weaknesses before they contribute to future adverse outcomes.

Underreporting remains a persistent challenge across healthcare settings. Clinicians may hesitate to report events due to fear of disciplinary action, uncertainty about reporting thresholds, time constraints, or the perception that minor events are not significant enough to document. However, modern patient safety frameworks emphasize a just culture approach, which distinguishes between human error, at-risk behavior, and reckless behavior while prioritizing system improvement over individual punishment. This approach encourages transparency and supports open reporting as a foundational element of safety culture.

Ultimately, effective reporting strengthens organizational learning, enhances communication across disciplines, and supports the development of safer and more reliable healthcare systems. Physical therapists and physical therapist assistants who consistently engage in reporting contribute directly to reducing preventable harm and improving patient outcomes across all rehabilitation settings.

## **Applying Patient Safety Principles in Clinical Practice**

**References:** 14, 16, 18

Knowledge of regulations alone is not sufficient to prevent medical errors; it must be consistently translated into real-time clinical decision-making and daily practice behaviors. Patient safety is achieved when legal requirements, ethical principles, and clinical reasoning are integrated seamlessly across every patient interaction, rather than treated as separate or isolated tasks. In rehabilitation settings, where patients frequently progress, regress, or respond variably to intervention, this integration is essential for identifying risk early and preventing avoidable harm.

## ***Integrating Safety into Daily Workflows***

Integrating safety into daily clinical workflows ensures that essential safety behaviors are consistently performed regardless of clinical setting, patient volume, or time constraints. This begins with foundational safety checks such as verifying patient identity using at least two identifiers prior to each treatment session, reviewing relevant medical history and precautions before initiating care, and confirming physician orders or referral instructions when indicated. These steps create a baseline safeguard that reduces the likelihood of preventable errors related to misidentification, missed precautions, or inappropriate treatment progression.

Safety integration also depends on continuous clinical vigilance during treatment. Clinicians are responsible for monitoring patient response to exercise and functional activity, observing changes in movement quality, endurance, balance, or pain response, and recognizing early signs of physiological or functional decline. Subtle changes, such as increased fatigue, altered coordination, dizziness, or reduced participation, may represent early indicators of medical instability or inappropriate intervention intensity.

Equally important is the clinician's responsibility to respond appropriately when changes in patient status occur. This includes modifying or stopping treatment when safety concerns arise, escalating concerns to the supervising physical therapist when appropriate, and ensuring that clinically significant findings are communicated promptly. These actions should occur as part of routine workflow rather than as exceptions, reinforcing a proactive rather than reactive approach to patient safety.

Standardization further strengthens safety by reducing variability in clinical practice. When workflows are inconsistent, critical safety steps may be missed, particularly in high-volume or fast-paced environments. Standardized tools such as

intake screening checklists, evaluation and re-evaluation templates, fall risk assessment forms, and structured documentation frameworks help ensure that essential safety components are consistently addressed across all patients. These tools support, rather than replace, clinical judgment by providing a structured method for identifying risk factors, contraindications, and changes in patient presentation.

Structured communication tools such as SBAR (Situation, Background, Assessment, Recommendation) further enhance workflow safety by improving clarity and reducing ambiguity when communicating with physicians, nurses, case managers, and other members of the healthcare team. This is especially important during transitions of care, where incomplete or unclear communication can lead to inappropriate treatment progression, delayed medical follow-up, or missed precautions. Standardized communication ensures that critical clinical information is consistently conveyed, even in high-pressure environments.

### ***Documentation and Compliance Considerations***

Documentation serves as both a clinical communication tool and a legal safeguard, making it a central component of patient safety and regulatory compliance. High-quality documentation ensures continuity of care by clearly describing the patient's status, interventions performed, response to treatment, and any changes in functional ability, tolerance, or medical condition over time. It also enables effective interdisciplinary communication by allowing other healthcare providers to understand the patient's clinical trajectory without relying solely on verbal handoffs, which may be incomplete or inconsistently retained.

From a patient safety perspective, documentation is essential for supporting clinical decision-making. When records are accurate and up to date, clinicians can make informed decisions regarding progression, modification, or regression of interventions based on the most current patient presentation. Conversely,

incomplete, delayed, or inaccurate documentation increases the risk of medical error by allowing outdated information to influence ongoing care decisions.

Documentation errors may also contribute to breakdowns in communication between PTs, PTAs, and other members of the healthcare team. If changes in patient status, safety concerns, or response to treatment are not clearly documented, critical information may not be available during future sessions or interdisciplinary discussions. This can result in inappropriate continuation of treatment, missed recognition of clinical deterioration, or failure to escalate care when necessary.

From a compliance standpoint, documentation must align with state regulations, payer requirements, and organizational policies. This includes accurate recording of skilled interventions, appropriate justification of medical necessity, proper documentation of supervision when PTAs are involved, and timely completion of clinical notes. Compliance is not solely administrative; it is directly linked to patient safety because it ensures that care is transparent, traceable, and clinically justified.

### ***Ethical Responsibilities***

Ethical responsibilities further reinforce patient safety by guiding clinicians to consistently prioritize patient well-being, even in situations where external pressures may exist. These pressures may include productivity expectations, time constraints, staffing limitations, or administrative demands. Ethical practice requires that clinical decisions remain grounded in patient needs rather than operational efficiency when the two are in conflict.

A key ethical obligation is maintaining honesty, accountability, and transparency in all aspects of patient care. This includes providing accurate information to patients, documenting care truthfully, and acknowledging errors or near misses

when they occur. Transparency is essential not only for maintaining trust with patients but also for supporting organizational learning and system-wide safety improvement.

Ethical patient care also includes respecting patient autonomy and ensuring informed consent. Patients must be provided with clear, understandable information about their condition, proposed interventions, potential risks, and expected outcomes so they can make informed decisions about participation in care. This process is especially important in rehabilitation, where interventions often involve physical challenge, discomfort, or functional risk.

Patient advocacy is another central ethical responsibility. Clinicians must act in the best interest of the patient, which may include recommending medical referral when symptoms fall outside the scope of rehabilitation, clarifying or questioning unsafe or inappropriate orders, or delaying intervention when clinical presentation suggests potential instability. Advocacy also involves ensuring that patients receive appropriate levels of care based on their medical complexity and functional status.

Finally, ethical responsibility includes participation in error reporting and quality improvement efforts. Reporting adverse events and near misses is not punitive but protective, as it contributes to identifying system weaknesses and preventing future harm. A strong ethical foundation supports a culture of safety in which clinicians actively engage in improving care processes rather than avoiding accountability.

## **Section 4 Key Words**

Standardization – The use of consistent, structured processes, tools, or protocols across clinical practice to reduce variability and improve patient safety and reliability of care

SBAR – A structured communication framework (Situation, Background, Assessment, Recommendation) used to organize and clearly convey critical patient information between healthcare providers

Ethical Responsibility - The professional obligation of clinicians to act in the best interest of the patient by maintaining honesty, accountability, patient advocacy, and safe, evidence-based clinical practice

## **Section 4 Conclusion**

Knowledge of Florida statutes, professional responsibilities, and ethical principles provides the foundation for safe and compliant physical therapy practice. These regulations not only define legal requirements but also reinforce core patient safety principles that guide everyday clinical decision-making. When rehabilitation professionals integrate regulatory knowledge into daily workflows, maintain accurate documentation, communicate effectively, and uphold ethical standards, they significantly reduce the risk of medical errors. Ultimately, applying these principles consistently strengthens patient safety, improves clinical outcomes, and supports higher-quality rehabilitation care across all practice settings.

## **Conclusion**

Medical error prevention requires a proactive and collaborative approach focused on patient safety and continuous quality improvement. By understanding the types and causes of medical errors, recognizing vulnerable patient populations, and applying principles of root cause analysis, physical therapists and physical therapist assistants can help reduce risk and improve patient outcomes. Adherence to applicable regulations, effective communication, thorough documentation, and a commitment to evidence-based practice are critical

components of error prevention. Through ongoing awareness and implementation of patient safety strategies, rehabilitation professionals can contribute to a safer healthcare environment and enhance the quality of care delivered to their patients.



## References

1. Wang Y, Dalwood N, Farlie M, Lee AL. Adverse events related to physiotherapy practice: a scoping review. *Arch Physiother*. 2024;14:138-154. doi:10.33393/aop.2024.3282
2. Humphrey KE, Sundberg M, Milliren CE, Graham DA, Landrigan CP. Frequency and Nature of Communication and Handoff Failures in Medical Malpractice Claims. *J Patient Saf*. 2022;18(2):130-137. doi:10.1097/PTS.0000000000000937
3. Gatto JD, Park HY, Hwang R, et al. Analysis of Medical Malpractice Outcomes for Sports Orthopedic Procedures. *Orthopedics*. 2022;45(1):e47-e52. doi:10.3928/01477447-20211101-06
4. Rodziewicz TL, Houseman B, Vaqar S, Hipkind JE. Medical Error Reduction and Prevention. In: *StatPearls*. StatPearls Publishing; 2026. Accessed June 24, 2026. <http://www.ncbi.nlm.nih.gov/books/NBK499956/>
5. Ottosen MJ, Sedlock EW, Aigbe AO, Bell SK, Gallagher TH, Thomas EJ. Long-term Impacts Faced by Patients and Families after Harmful Healthcare Events. *J Patient Saf*. 2021;17(8):e1145-e1151. doi:10.1097/PTS.0000000000000451
6. Miziara ID, Miziara CSMG. Medical errors, medical negligence and defensive medicine: A narrative review. *Clinics*. 2022;77:100053. doi:10.1016/j.clinsp.2022.100053
7. Berger S, Grzonka P, Amacher SA, Hunziker S, Frei AI, Sutter R. Adverse events related to physical restraint use in intensive care units: A review of the literature. *J Intensive Med*. 2024;4(3):318-325. doi:10.1016/j.jointm.2023.11.005

8. Guttman OT, Lazzara EH, Keebler JR, Webster KLW, Gisick LM, Baker AL. Dissecting Communication Barriers in Healthcare: A Path to Enhancing Communication Resiliency, Reliability, and Patient Safety. *J Patient Saf.* 2021;17(8):e1465-e1471. doi:10.1097/PTS.0000000000000541
9. Lange S, Krüger N, Warm M, et al. Lost in translation: Unveiling medical students' untold errors of medical history documentation. *Clin Teach.* 2024;21(4):e13749. doi:10.1111/tct.13749
10. Saultz J. Mistakes. *Fam Med.* 2021;53(10):833-834. doi:10.22454/FamMed.2021.623606
11. Amboree TL, Montealegre JR, Fujimoto K, Mgbere O, Darkoh C, Wermuth PP. Exploring Preventive Healthcare in a High-Risk Vulnerable Population. *Int J Environ Res Public Health.* 2022;19(8):4502. doi:10.3390/ijerph19084502
12. Madan R, Das N, Patley R, Nagpal N, Malik Y, Math SB. Consequences of medical negligence and litigations on health care providers – A narrative review. *Indian J Psychiatry.* 2024;66(4):317-325. doi:10.4103/indianjpsychiatry.indianjpsychiatry\_799\_23
13. Patel RH, Goldin J. Medical Error Prevention and Root Cause Analysis. In: *StatPearls.* StatPearls Publishing; 2026. Accessed June 24, 2026. <http://www.ncbi.nlm.nih.gov/books/NBK570638/>
14. Code of Ethics for the Physical Therapy Profession. APTA. January 1, 2026. Accessed June 29, 2026. <https://www.apta.org/apta-and-you/leadership-and-governance/policies/code-of-ethics-for-the-physical-therapy-profession>
15. Resource | About Physical Therapists and Physical Therapist Assistants. Choose PT. Accessed June 29, 2026. <https://www.choosept.com/why-physical-therapy/about-physical-therapists-and-physical-therapist-assistants>

16. Wang Y, Dalwood N, Farlie M, Lee AL. Adverse events related to physiotherapy practice: a scoping review. *Arch Physiother*. 2024;14:138-154. doi:10.33393/aop.2024.3282
17. Lorenc T, Khouja C, Harden M, Fulbright H, Thomas J. Defensive healthcare practice: systematic review of qualitative evidence. *BMJ Open*. 2024;14(7):e085673. doi:10.1136/bmjopen-2024-085673
18. McCray S, Gilewicz D. Interdisciplinary Communication to Prevent Toileting-Related Falls. *Rehabil Nurs Off J Assoc Rehabil Nurses*. 2026;51(1):25-33. doi:10.1097/RNJ.0000000000000517
19. Choe AY. Ensuring effective interdisciplinary communication. *J Hosp Med*. 2023;18(2):198-199. doi:10.1002/jhm.13043
20. Statutes & Constitution :View Statutes : Online Sunshine. Accessed June 29, 2026. [https://www.leg.state.fl.us/statutes/index.cfm?App\\_mode=Display\\_Statute&URL=0400-0499/0486/Sections/0486.021.html](https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0486/Sections/0486.021.html)
21. FL Statutes. FPTA. Accessed June 29, 2026. <https://fpta.org/resources/fl-statutes/>
22. Statutes & Constitution :View Statutes : Online Sunshine. Accessed June 29, 2026. [https://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App\\_mode=Display\\_Statute&SearchString=486.125&URL=0400-0499/0486/Sections/0486.125.html](https://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&SearchString=486.125&URL=0400-0499/0486/Sections/0486.125.html)

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