sedgwick®

PROFESSIONAL LIABILITY

RiskResource

SECOND EDITION, 2016

A HEALTHCARE PROFESSIONAL LIABILITY RISK MANAGEMENT NEWSLETTER

In this issue:

Connect With Us

Stay connected to Sedgwick's world of expert resources at sedgwick.com and through our social media channels, including:

linkedin.com/company/Sedgwick

twitter.com/Sedgwick

facebook.com/Sedgwick

http://blog.sedgwick.com

Contact us to find out more about our services or to send editorial correspondence.
HealthcareRM@sedgwick.com | 866-225-9951

Time as an ally: Reexamination in the ED to reduce liability risks

By Robert A. Bitterman, M.D., J.D., FACEP
President & CEO, Bitterman Health Law Consulting Group, Inc.

Many disorders take time to develop and become manifest to the point where physicians can recognize their true nature. In the emergency department (ED), physicians should use time as an ally and frequently reexamine patients during high risk encounters to avoid missed or delayed diagnoses that can result in patient harm and subsequent liability claims.

These situations are well known to emergency physicians, but particularly common are patients with undifferentiated abdominal pain, major trauma victims without initially apparent significant injury and patients with prolonged stays in the ED such as psychiatric patients awaiting disposition. Additional scenarios include patients receiving multiple interventions or consults while in the ED, and patients given parenteral narcotics or other medications with narrow safety margins.

All too often, the value of time is under-recognized as an opportunity to return to the bedside to recheck a patient's condition prior to discharge, admission or transfer. Many professional liability claims involving ED patients are rendered hard to defend due to lack of repeated examinations (or lack of documentation of repeated exams which were, in fact, done) prior to disposition from the ED. Typical cases include:

- A patient with chest injuries from a motor vehicle accident with airbag deployment is handed off at shift change to the oncoming emergency physician while awaiting a chest CT scan. Hours later, the second physician discharges the patient, without reevaluating the patient, because the CT is 'negative.' The patient returns dead-on-arrival, likely the result of bleeding from intraabdominal injuries.

Continued on page 2

- A middle-aged man with vague, diffuse lower right abdominal pain and tenderness is discharged after an hour in the ED with instructions to follow-up with his primary care physician "in a few days" for a recheck. He returns in 24 hours with sepsis from perforated appendicitis.
- A patient given multiple doses of parentaral narcotics in the ED (Dilaudid use is the most frequent cause) over a relatively brief period is discharged only 15 minutes after the last dose. She reportedly dies shortly after leaving the ED from complications related to the administered medications.

Abdominal pain cases, such as 'R/O appendicitis,' and the resulting litigation are particularly frustrating because they are almost entirely preventable with frequent patient reexaminations in the ED and early follow-up with reexamination after discharge.

Patients with undifferentiated abdominal pain who are discharged from the ED should all be rechecked in 8, 12 or 24 hours depending upon the age of the patient, the particular circumstances and the physician's degree of concern.

If the patient has no physician, then the patient should be instructed to return to the ED and it should be on the record that he or she was TOLD to return at a specific time for reexamination. Abdominal pain is notoriously slow to reveal its true nature – the word abdomen itself comes from a Latin derivation meaning 'to hide.'

Robert A. Bitterman, M.D., J.D., FACEP, is a Sedgwick emergency physician consultant.

Risk management recommendations for emergency physicians

1. Frequently reexamine patients who are in the ED for an extended time, such as patients with trauma, abdominal pain or psychiatric conditions, and *always* reassess and recheck vital signs on these patients just prior to discharge.
2. In trauma cases, the mechanism of injury alone may be sufficient to observe and reexamine patients for a prolonged period of time to discover intraabdominal injuries such as liver or spleen lacerations, pulmonary contusions or occult fractures.
3. In undifferentiated abdominal pain cases, particularly in the elderly, not only should the patients be reexamined a number of times during their stay in the ED, but they should *all* be instructed to be reevaluated in 8, 12 or 24 hours after discharge.
4. Psychiatric patients should be reexamined and their vital signs repeated at the time of transfer. Psychiatric patients often remain in the ED for prolonged periods of time after the transfer decision is made but before the transfer is actually effected (often with at least one physician turnover), during which time the patient's condition may (and frequently does) change.
5. Observe and monitor patients awhile after medications or interventions; don't be too quick to discharge them. Utilize the value of time and reexamination to your advantage.
6. *Document* findings of the repeated exams and describe the patient's course in the department and condition at the time of discharge. Tell a story that can be interpreted to come to only one conclusion – yours!

"Did you know?"
Sedgwick knowledge series

Healthcare Risk Management

Strategies for medication safety in the physician office

Kathleen Shostek, RN, ARM, FASHRM, CPHRM, CPPS
Vice President, Healthcare Risk Management

Safely managing medications in the office is an important part of an overall patient safety and risk management program for practice-based physicians and other providers in an outpatient setting. Errors involving medications have been reported in all phases of the drug use process in primary care, including prescribing, dispensing, administering and monitoring.[1] What's more, a 2011 report noted that adverse drug events accounted for nearly 100,000 hospital admissions each year for adults 65 years of age or older.[2] With regard to liability claims, the Doctors Company reports an incidence of 6% of medication-related errors in medical professional liability claims. The classes of drugs most frequently involved in medication-related errors are anticoagulants, antibiotics, opioids and steroids.[3]

When assessing physician practices, Sedgwick consultants find that there are several key areas where medication practices can be problematic. An organized approach to medication management should be taken to reduce patient safety risks and provider liability. The following topics and mitigation strategies are presented for improving the safety of medications.

Drug history and medication reconciliation

A complete drug history should be obtained at the initial patient encounter and updated at each subsequent visit, including prescription drugs, over-the-counter medications, herbal products/nutritional supplements and illicit drugs. Review any available medical records and the medication list with the patient.

- Implement a process for reviewing current medications and updating the patient's medication list each time drugs are ordered, administered, dispensed or discontinued; include any drug samples.
- Maintain all written or electronic prescription orders in the medical record. Document indications for medications and instructions given to the patient, including educational materials. Date and archive any patient education/drug information handouts.
- Obtain and document drug, food and other allergy information prominently in the paper or electronic record, and include name of drug, reaction and severity. Verify and update allergies at each visit.
- The electronic health record (EHR) provides a more robust opportunity for complete documentation of the above processes, as it "forces" standardization and ensures legibility. However, EHRs are not a panacea. Prescribing and dispensing errors occur with electronic systems too.[4]

Office systems to support safe medication management and distribution

It is important to implement office systems that support safe medication use. A designated provider or clinical staff member should oversee intake, distribution and tracking of all medications. This is important in case of a recall or drug alert and to prevent loss, theft and pilferage. Consider the following safety strategies:

- Store all medications, prescription pads, syringes and other medication-related supplies in a secure (locked) cabinet or closet. Drugs should be inventoried and controlled.
- If drug samples are used, control access by pharmaceutical representatives and create and maintain an inventory for each sample medication with the number of doses dispensed and number remaining in inventory. Document lot numbers by patient name or record number and establish a process to identify patients who received drug samples in case of a recall or drug alert. [5]
- Organize stock medications and/or sample drugs by drug class or group and place in labeled storage bins. Separate drugs with similar names and mark storage bins with bright ALERTS to identify high alert medications and avoid mix-ups (see example, figure 1).

Figure 1. Example of a well-organized drug storage cabinet in a physician practice

Label all medications that are dispensed from the office with the following information:[6]

- Patient name
- Medication name
- Dosage
- Frequency or time
- Route
- Form (liquid, tablet, drops) and any storage requirements
- Date dispensed and provider name
- Lot number
- Provider name and telephone number

Medication dispensing, administration and monitoring

Use drug reference and/or prescribing software for decision support, safety alerts and drug-drug interaction information. Ensure that only physicians or providers with prescribing authority dispense medications. Delineate which medications require laboratory monitoring and audit this periodically to be sure blood level checks are performed as indicated.

The ordering provider should discuss with the patient the reason for taking the prescribed drug, how and when to take it, possible side effects, when to notify the office should side effects occur, and any special precautions. Document patient education and level of understanding about his or her medications in the medical record and include instructions in the patient's written encounter summary. Provide information in the patient's language and literacy level. Be sure to provide current Vaccine Information Sheets to patients/parents prior to vaccine administration.

It is important to verify patients' identities (name, date of birth) and drug orders before administration of medications in the office. Use closed loop communication with a standard "write down and read back" protocol for any verbal orders.

Develop a written policy and procedure to support safe use of medications and drug samples in the practice. Establish a means to monitor compliance (i.e., audits) and correct deviances through peer feedback/performance review. Devise internal processes and assign responsibility for reporting, tracking and correcting medication errors. Document annual medication competencies for clinical office staff.

Resources

- Gaffey A., Maximizing EHR functions to improve medication reconciliation. Sedgwick PL Risk Resource. 3rd edition 2013. Page 6: https://www.sedgwick.com/news/Risk%20Resources/Sedgwick_PL_Newsletter-final(2013-3rdEd).pdf
- USP classification system for drug classes: http://aspe.hhs.gov/health/reports/05/drugformularies/ch3.pdf
- Institute for Safe Medication Practices: http://www.ismp.org
- Massachusetts Coalition for the Prevention of Medical Errors: Reducing Medication Errors in Ambulatory Settings: http://www.macoalition.org/reducing_medication_errors.shtml
- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation: http://www.ahrq.gov/qual/match/

References

1. Budnitz DS, et al., Medication errors reported by US family physicians and their office staff. Qual Saf Health Care 2008; 17 (4) 286-90.
2. Budnitz DS, et. al, Emergency hospitalizations for adverse drug events in older Americans. N Engl J Med. 2011;365(21):2002-12.
3. Troxel, D. Medication-related errors and liability: What can you do? The Doctor's Advocate. First Quarter 2012
4. AHRQ Web Morbidity & Mortality on the Web. E-prescribing: E for error? http://webmm.ahrq.gov/case.aspx?caseID=260
5. Sedgwick HCRM. Drug Sample Management Guidance Toolkit. Nov 2014
6. Institute for Safe Medication Practices (ISMP) Principles of Designing a Medication Label. https://www.ismp.org/Tools/guidelines/labelFormats/comments/printerVersion.pdf

10 STRATEGIES FOR SUCCESSFULLY RESOLVING A MEDICAL MALPRACTICE CLAIM

By Jayme T. Vaccaro, J.D., Vice President, Specialty Claims Operations

In a series of ten articles, Jayme T. Vaccaro shares time-tested strategies for resolving a medical malpractice claim. First up, lessons learned in never being afraid to try a case, any case.

Strategy 1: Never be afraid to try a case, any case

From never being afraid to try a case, any case, to knowing what ultimately motivates the plaintiffs, thinking outside the box and utilizing creativity can be a mantra for successfully resolving medical malpractice claims. Getting caught up in rote processes without considering the intangibles of a case can sabotage a good outcome. Missing the elephant in the room and leaving all the power with the plaintiff's attorney without realizing how, when and why we surrendered is unacceptable. Take back that authority and explore ten ways to resolve your medical malpractice claims through the following time-tested strategies.

Ten strategies:

1. **Never be afraid to try a case – any case**
2. **Always be aware of the plaintiff attorney's vulnerabilities – leverage**
3. **Always know where your codefendants lie and wait – friend or foe**
4. **Use your tools – from high/lows to bifurcation**
5. **The courtroom is sometimes not the place – alternative forums**
6. **Know when to hold – and know when to fold**
7. **Know what the plaintiff wants out of the case – the sweet spot, and it may not be money**
8. **Back to basics – know your case inside and out, legal, medical and the like**
9. **Anyone can help you mediate – from the judge to the structured settlement representative**
10. **Understand risk appetites – client/insured/defendant**

Strategy 1: Never be afraid to try a case, any case

You've determined the chance of winning, settlement value and jury verdict value. You've made your best offer. What happens if the case does not settle? In a medical malpractice case, for example, it can be due to the physician not granting consent, the plaintiff having client control problems, the plaintiff wanting too much money or a variety of other obstacles.

Bottom line, you find yourself having to try the case. Equipped with the best trial tactics and trial attorney, you are trying a case that really should have been settled. Trying the case differently becomes essential and creativity is tested.

EXAMPLE #1: NOT THINKING OUTSIDE THE BOX

A plastic surgeon develops a new procedure called liposculpture. He patented the cannula and is the first to do the surgery. Severe scarring is a complication. There are numerous cases pending. Given this is the physician's invention and he is emotionally and financially tied to its success, he refuses to consent and you are forced to try the case. The first case is tried in the traditional way with an expert plastic surgeon, but he has never done the procedure and is, at best, lukewarm in his support of the procedure. No surprise, the case is lost.

EXAMPLE #2: THINKING OUTSIDE THE BOX

You have a second chance and try another of his cases. Do you try it the same way? This time you allow the defendant surgeon to be his own expert. Why? He is the expert as he invented the procedure and even the tools used for the procedure. He is passionate because he believes in the new technique. You can explain this to the jury given medicine is both science and art and without new and forward thinking surgeons like him, medicine would not progress. The traditional reasons defendants in medical malpractice cases are not their own experts, such as the appearance of bias/conflicts, must be ignored. Trying the case this way is your only chance at winning and – guess what? You win.

The above two examples are real. When a case presents that would normally be settled and not tried, you must approach it from a different angle; it may be the best way to try it. Trying cases is one of the ultimate methods of controlling the settlement demands of a plaintiff. Letting the plaintiff and his attorney know you are willing, able and ready to try even the "untriable" case should have him rethinking the demand as he considers the downside of losing.

It is always easiest to panic and pay, but when this is not an option and you must try the case, do not try it like you would a case you expect to win. We are in a field that tries 5% to 15% of our cases. Our win ratio as an industry is almost 80%. In the untriable case, you must change your strategy as the odds are against you and the traditional approach will not carry the day.

Next time, strategy 2: Always know the plaintiff attorney's vulnerabilities – leverage.

Originally published in The SCAHRM Source, September 2014. Vol. 2.

sedgwick

CONNECTION
JOIN THE CONVERSATION

Have you read the Sedgwick Connection blog?

Sedgwick is committed to continuous improvement, being open to new ideas, delivering value and advancing our industry through the sharing of knowledge. Our team of bloggers provides unique insight and commentary on a wide range of issues facing employers today, including healthcare, professional liability, risk management, safety, legislative change and more. Read and join the discussion at http://blog.sedgwick.com. Recent topics have included:

- **The advocacy advantage**: http://blog.sedgwick.com/2016/03/25/the-advocacy-advantage/
- **Dangerous prescribing practices and at-risk patients – a look at best practices**: http://blog.sedgwick.com/2016/04/04/dangerous-prescribing-practices-and-at-risk-patients-a-look-at-best-practices/
- **Caring counts**: http://blog.sedgwick.com/2016/04/07/caring-counts-rims2016/
- **Why mental health?**: http://blog.sedgwick.com/2016/04/11/why-mental-health-why-rims-2016/
- **Risk management maturity**: http://blog.sedgwick.com/2016/04/14/risk-management-maturity-rims2016/
- **Over-the-counter problem no longer under the radar**: http://blog.sedgwick.com/2016/05/12/otc-problem-no-longer-under-radar/

Patient identification: Don't risk it! By Deborah N. Gold, RN, BSN, M.Ed., LNC, Sr Nurse Consultant - PL

Correct identification is critical to the delivery of safe patient care. From the time the patient enters the hospital until the time of discharge, they encounter numerous healthcare workers. The Joint Commission National Patient Safety Goal for Two Patient Identifiers, released on December 9, 2008, specifies that the intent of requiring two patient identifiers is to reliably identify the person for whom treatment or service is intended.

It should be the policy of every healthcare facility to verify the identity of all inpatients, procedural admission patients and emergency department patients by placing a legible identification band on the patient's wrist at the time of registration in the hospital. Information on the ID band should include the patient's name, age, sex, date of admission, patient number, date of birth and medical record number.

All personnel should use two unique identifiers – name and date of birth – to confirm the identity of patients prior to transporting, performing any test, procedure and/or administrating any treatment, blood component or medication.

All healthcare personnel should ask the patient, "What is your name?" and "What is your date of birth?" and verify the accuracy of the information with the patient's ID band. If a patient is non-communicative, healthcare personnel needs to check the ID band against the written order for confirmation of identity and use the medical record number as a third identifier.

Regardless of the healthcare worker and their location, it is necessary to review two patient identifiers with each encounter when a treatment or service should be rendered and not assume the patient's identity.

Same name/similar name patients

The following procedures are recommended to improve patient safety through proper patient identification:

- The Admissions Office should notify the staffing office/shift director and the appropriate nursing unit(s) when patients with the same name or similar name are in the hospital. Additionally, pharmacy, blood bank, clinical labs, radiology, transport and dietary departments should be notified.
- All hospital personnel, prior to transporting, performing any test, procedure and/or administering any treatment, blood component or medication are to verify the patient's full name, date of birth and medical record number, both verbally as well as verifying the accuracy of the information with the patient's ID band. If the patient is non-communicative, check this information on the ID band. Do not perform any tests, procedures and/or administer any treatment, blood component or medication if no ID armband is present.
- Patients with the same or similar last name who are admitted to the hospital should have a "name alert" card posted on the door to the patient room and above the bed. A "name alert" sticker should also be placed on the front of the chart.
- When possible, patients admitted to the same unit with the same or similar last name should be positioned at opposite ends of the unit.
- When possible, the same primary nurse should not care for patients with the same last name.
- "Name alert" considerations should be discussed during unit safety huddles.
- "Name alert" should appear next to the name of those patients affected on the unit-based whiteboards as another means of communication for staff.

Note: a patient's room number is not considered a proper patient identifier as it references their location and not their identity.

A true and alarming scenario: Two years ago, my 88-year-old mother was in the emergency department (ED) of a very well-respected Baltimore hospital on a stretcher waiting for a CT scan, when the nurse came up to another gray-haired elderly lady on a stretcher nearby and asked her if she was Mrs. Gold. The other woman said yes. I thought it was odd that two Mrs. Golds would be in the ED on stretchers at the same time. The nurse asked the other "Mrs. Gold" if she was Harriet Gold to which she replied, "Yes." At that point, I approached the nurse and told her that my mother was definitely Harriet Gold and recommended checking the other lady's ID band. Of course, the other patient was not Harriet Gold, but had I not been there, I can only imagine where they would have taken my mother and what testing she might have undergone, as well as the unnecessary diagnostic study that could have potentially been done for the other woman.

Can patients help?

System changes can make patient identification easier. Patients can help prevent errors if they are educated about the need to identify themselves – even if staff is well-known to them – by holding out their name band, spelling their name, and giving their birth date.

Resources

1. The Joint Commission National Patient Safety Goal for Two Patient Identifiers. [NPSG.01.01.01]
2. Pennsylvania Patient Safety Advisory. Patient identification. http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2004/jun1(2)/Pages/08.aspx
3. Patient Identification SAFER Guide. https://www.healthit.gov/safer/guide/sg006

our world revolves around taking **care** of people

With Sedgwick's national reach and expert resources, we have set the industry standard for customized, performance-based professional liability claims and healthcare risk management solutions. Our innovative services help our customers take better care of their customers. At Sedgwick, **caring counts**.SM

sedgwick

caring counts

www.sedgwick.com | 866.225.9951

Sedgwick supports Healthcare Risk Management Week June 20-24

Sedgwick's healthcare risk management team works alongside healthcare risk managers to reduce risks and improve safety by delivering cost-effective claims, productivity, managed care, patient safety, risk consulting and other services. Taking care of people is at the heart of everything we do. **Caring counts.**SM

Upcoming events

Visit the Sedgwick professional liability team at these upcoming conferences:

- **RL Palooza**
  June 7-10 | Toronto, ON
  Social Media's Impact on Healthcare - The Good and The Bad – speaker: Jackie Lakins
- **Claims and Litigation Management Alliance Medical Legal Conference Midwest Chapter**
  June 23 | Omaha, NE
  Healthcare Mega Breach - Information Security – speaker: Jayme Vaccaro
- **OR Manager Conference**
  September 21-23 | Las Vegas, NV
  – *visit Sedgwick at booth #625*
- **American Society for Healthcare Risk Management Academy (ASHRM) 2016**
  September 25-28 | Orlando, FL
  – *visit Sedgwick at booth #910*
  – *Annual Business Meeting & Recognition Event, President's Address: Ann Gaffey*

About Sedgwick

Sedgwick is a leading global provider of technology-enabled risk and benefits solutions. Our healthcare risk management consultants bring years of risk management and patient safety experience to help clients identify risk and patient safety strategies for success. Our team of national experts addresses both traditional and emerging risks affecting healthcare organizations.

Are you concerned about a lack of teamwork in your perioperative area affecting patient care, possibly leading to retained foreign objects or wrong-site surgery? Our demonstrated success in reducing perioperative risk through assessments, team training, coaching and ongoing education may be the solution for you. Please contact us today for a customized approach to your perioperative risk management and patient safety challenges.

Download a QR code reader from your mobile device's app store, then scan the code to the left to visit our **professional liability** page at www.sedgwick.com.

Or scan the QR code to the left to visit our **healthcare patient safety** page at www.sedgwick.com and learn more about our services and solutions.

PROFESSIONAL LIABILITY
RiskResource
SECOND EDITION, 2016

Professional liability: Claims management, investigations, elder care services, auditing & consulting, healthcare risk management, MMSEA 111 reporting, errors & omissions, Medicare compliance services
HealthcareRM@sedgwick.com | 866-225-9951

sedgwick