

What we have here is: Failure to Communicate

October 29, 2019

Mike Walsh, CPCU, AIC
Liability Claims Manager

Stacie Jenkins, MSN, RN, CPSO
Sr. Director of Quality & Patient Safety



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Learn from
the Past

Think of
the Future



The Stats:

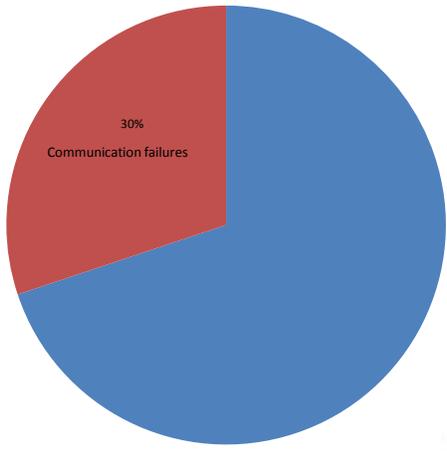
- #3 on the top 10 list of root causes for sentinel events
- TJC states 80% of serious medical events involve miscommunication
- 1/3 of all malpractice claims can be linked to communication breakdowns (CRICO study 2015).
- 55% RMs report poor communication / teamwork = greatest patient safety barrier (AIG study)
- 75% RMs identify communication as their top challenge related to the safety of patients (AIG)



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CRICO Benchmarking Report 2015



| Category | Percentage |
|------------------------|------------|
| Communication failures | 30% |
| Other | 70% |



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Study Details

- 57% Provider-to-Provider
 - Miscommunication
 - Poor documentation
 - Failure to read the medical record
- 55% Provider-to-patient
 - Informed consent
 - Unsympathetic response to complaint
 - Inadequate education or f/u
 - Inaccurate or no test results
 - Language barriers



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Unit-to-Unit Claim Scenario

- 73 y/o old male in ICU was pulling at his CL; nurses obtained a restraint order from the attending physician. A couple of days later one of the ICU nurses removed the restraints for a “trial” period as allowed by the restraint policy. During this trial period the patient was transferred from the ICU to the Med-Surg unit. The patient arrived on the Med-Surg unit with untied restraints on the bed. A couple of hours after transfer to the Med-Surg unit, the patient pulled out the CL. He was found unresponsive on the floor of the room and died from an air embolus.





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Patient Safety Considerations

- **Handoff communication**
 - Policy & Procedure
 - Distractions
 - Ability to ask questions, clarify & confirm





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Key Components in a Handoff

- Patient basic information
 - Including code status/advanced directives
- Diagnosis and chief complaint
- Results from physical exam
- Current condition, including active medications
- **Changes in condition and treatment** (especially the last 24 hours)
- Recent and pending labs – especially any critical results
- **Immediate patient concerns** (during the next 18-24 hours)
- Recommendations



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Structured Tools

| | | |
|--|--|--|
| <p>Situation</p> <p>Background</p> <p>Assessment</p> <p>Recommendation</p> | <p>Introduction</p> <p>Patient</p> <p>Assessment</p> <p>Situation</p> <p>Safety concerns</p> <p>Background</p> <p>Actions</p> <p>Timing</p> <p>Ownership</p> <p>Next</p> | <p>Illness severity</p> <p>Patient summary</p> <p>Action list for next team</p> <p>Situation awareness and contingency plans</p> <p>Synthesis and "read back" of information</p> |
|--|--|--|

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Standardized Structure

SBAR Documentation Form

BEFORE CALLING THE PHYSICIAN

1. Assess the patient. Involve the patient in care recommendations, if possible.
2. Review the chart for recent medication or order changes / changes in condition.
3. Know the primary / pertinent diagnosis.
4. Have the following available when speaking with the physician: Chart, Allergies, Medications, Labs / Results

**FOCUS ON THE PROBLEM
BE CONCISE**

| | | | | | | | | | | | | | |
|---|--|---|----------------|-------------|---------------|-------------|------|---------------|--------------------------|-------|------------------|--------------------|---|
| S B A R | SITUATION State your name and agency I am calling about: (Patient Name) _____ Date _____ The problem I am calling about is: (briefly state problem, when happened/started, and how severe. Code status would be helpful). Notes: _____ | | | | | | | | | | | | |
| | BACKGROUND State the primary and pertinent diagnosis & the date of admission to agency. Relate the complaint given to the patient. Pay special attention to emotional/mental status. List current medications, allergies, most recent vital signs, most recent lab results or treatments. Notes: _____ | | | | | | | | | | | | |
| | ASSESSMENT Give your best guess about this situation. Words like "heighten" or "could be" are helpful. A diagnosis is not necessary. Relate how severe the problem might be. Describe changes from prior assessment. | | | | | | | | | | | | |
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Weight</td> <td>Blood Pressure</td> <td>Blood Sugar</td> </tr> <tr> <td>Mental Status</td> <td>Temperature</td> <td>Pain</td> </tr> <tr> <td>Neuro changes</td> <td>Respiratory rate/quality</td> <td>Wound</td> </tr> <tr> <td>Macrobiochemical</td> <td>Pulse rate/quality</td> <td>GI/GU (Nausea / Vomiting / Diarrhea / Output)</td> </tr> </table> Notes: _____ | Weight | Blood Pressure | Blood Sugar | Mental Status | Temperature | Pain | Neuro changes | Respiratory rate/quality | Wound | Macrobiochemical | Pulse rate/quality | GI/GU (Nausea / Vomiting / Diarrhea / Output) |
| | Weight | Blood Pressure | Blood Sugar | | | | | | | | | | |
| Mental Status | Temperature | Pain | | | | | | | | | | | |
| Neuro changes | Respiratory rate/quality | Wound | | | | | | | | | | | |
| Macrobiochemical | Pulse rate/quality | GI/GU (Nausea / Vomiting / Diarrhea / Output) | | | | | | | | | | | |
| RECOMMENDATION. Say what you think would be helpful or what needs to be done. <input type="checkbox"/> Change treatment to _____ <input type="checkbox"/> Adjust medications for _____ <input type="checkbox"/> Place health/health monitor? _____ <input type="checkbox"/> Obtain consult for discipline (e.g., PT, OT, ST, WOUND, SN, SW, etc.) _____ <input type="checkbox"/> Have the patient come in to see you at your office today or within 24 hrs? _____ <input type="checkbox"/> Transfer the patient to hospital? _____ Increase visit frequency for _____ Any labs / tests needed? _____ Make sure to clarify under what circumstances and when the physician wants us to call again. Notes: _____ | | | | | | | | | | | | | |

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Bedside Briefings

- **Face to face at the bedside**
 - Prompts communication
 - recent care/complications,
 - patient orders
 - Past 24 hours
 - Transfer orders
 - equipment in use
 - lines in place and other treatment in progress

- **Patient involvement**

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ED to Radiology – Claim Scenario #1

- 72 y/o female presented to ED for CP. History includes a couple of recent falls at home r/t dizziness. She was taken back to radiology for a chest x-ray. The tech testified she asked the patient if she was ok to stand for the x-ray and the pt said yes. The pt denied this. There is no documentation or testimony the ED personnel advised radiology personnel of pt's hx of recent falls at home.





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Patient Safety Considerations

- **Handoff communication**
 - Policy & Procedure
 - What junctures constitute a handoff
 - Staff education
 - » Staff competency



- **Structured Tool**
 - Face to face
 - Targeted to risks specific to the ancillary dept.
 - Serves as documentation



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SHARE Tool

- Targeted Solutions Tool (TJC)
 - Hand-off Communications Targeted Solutions Tool
 - Effectiveness of hand-offs





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SHARE Principles

- **S**tandardize critical content
- **H**ard wire within your system
- **A**llow opportunity to ask questions
- **R**einforce quality & measurement
- **E**ducate and coach





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ED to Radiology – Claim Scenario #2

- 81 y/o female fell in ED while she was changing after exam. She had c/o shoulder pain. The ED physician interpreted the x-ray as negative. The over-read by the radiologist was positive for a fracture of the collar bone. The patient was not notified of the discrepancy. She saw her primary care physician about 10 days later and c/o of continued pain. He obtained the x-rays and radiology report where she was first made aware of the fracture.





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Patient Safety Considerations

- **Critical Values/Tests**
 - Policy & Procedure
 - Results other than lab
 - Tests which require reporting
 - STAT
 - Establish a process of reporting & timeframes
 - Include how ED handles reporting after patient discharge





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More Patient Safety Considerations

- **Follow-Up Process from ED**
 - Policy & Procedure
 - Compare ED reading to final interpretation
 - Critical value determined in radiologist final reading
 - Follow same process

Follow UP?

- **On-going Performance Improvement**
 - PI this process



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Physician Order Claim Scenario

- 11 y/o girl undergoes tonsillectomy. The procedure is uneventful. Post-operatively the surgeon orders 600 ml of D5W over an 8 hour period (75 ml/hr). The pharmacist enters the order as 200 ml/hr. The child suffered “water intoxication” resulting in respiratory distress from cerebral edema. She expired about 18 hours after surgery.



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Patient Safety Considerations

- **Patient Advocacy**
 - Questioning orders
 - Intimidation/Disruptive Physicians
 - Team approach to care

- **Staff Education**
 - Age specific care
 - Orientation to department & process
 - Verifying medication “5 Rights”

- **Computerized Physician Order Entry (CPOE)**





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Lab to Physician Claim Scenario #1

- Pt is seen in physician's office late in the day. She was having shortness of breath; suffering from CHF. Physician says she refused admission to hospital. She is sent over to the hospital for some lab work. The physician's fax order form indicates it is not necessary to fax or call in results. K+ level is critical. Lab report is faxed to doctor's office at 5:36 pm. No one could say for sure if the office had already closed for the evening. No documentation that lab personnel attempted to contact physician by phone/pager. Physician admits that he did not call lab for results. Pt returns to ED 6 hours later in critical condition, is admitted but expires the next day.



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Patient Safety Considerations

- **Critical Values**
 - Policy and Procedure
 - Outline how to report critical values
 - How to handle after hours communication to physician offices
 - » Chain of command
 - Critical values are critical values no matter if in-patient or out-patient
 - Verbal reporting
 - The problem with the fax machine
 - Documentation by lab




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Lab to Physician Claim Scenario #2

- 68 y/o nursing home resident admitted to ICU with CHF and PE. Started on heparin drip. Protocol called for an initial bolus according to pt weight followed by a maintenance drip. The drip is decreased according to pt's daily PTT. The PTT's were followed daily and the heparin drip gradually reduced. No further boluses required. She was doing well. A couple of days later a nurse documents that the lab called in the prothrombin time (PT) and subsequently heparin bolus of 2490 units was given and the drip increased. She inadvertently documented the PT in the PTT slot on the heparin protocol flowsheet. No further documentation exists until the family finds the patient unresponsive. A code was unsuccessful.



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Patient Safety Considerations

- **High-risk Medication Management**
 - Condition of Participation §482.25 -The hospital's medical staff must develop policies and procedures to minimize drug error: **Policies and procedures to minimize drug errors should include:**
 - High-alert medications - dosing limits, administration guidelines, packaging, labeling and storage;
 - Double verification of medication
 - Independent verification, including verification of result & physician order
- **Critical Values**
 - Ensure proper reporting per policy
 - Read back of results




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Verbal Order Use

- Pt with kidney disease had abdominal CT with contrast. Ordering physician says verbal order specified PO contrast only. Nurses knew of patient history of kidney disease. Radiology tech says he was called to the ER for the CT. When he got there the paper work was not ready. He got a blank slip, had the nurse stamp it and filled it in for CT of abdomen/pelvis, which routinely means with contrast unless otherwise stated. Nursing never told him patient had history of kidney disease, elevated labs, etc. No nurse could confirm or deny physician's testimony that she specifically verbally ordered PO contrast only.



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Risk Reduction

- **Handoff communication**
 - Policy & Procedure
 - What junctures constitute a handoff
 - Staff education
 - » Staff competency
 - » Simulations

- **Structured Tool**
- Face to face
- Targeted to risks specific to the ancillary dept.
- Serves as documentation
- **Verbal Orders**
- CPOE



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Informed Consent

A one-month old male presented to the pediatrician for circumcision. The following morning the parents brought the child to the local hospital when they found a large amount of blood in the child's diaper. The child was subsequently air-lifted to a major medical center, but unfortunately the child expired the following day. The Death Certificate listed the cause of death as:

“Multi-System organ failure due to hypovolemic shock; complicating circumcision”



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Informed Consent (cont)

- The medical malpractice complaint alleged that the circumcision was performed improperly and that the physician/office failed to obtain proper informed consent. In particular, as to the latter, it was alleged that the informed consent form did not provide a list of material risks of the procedure nor did it list alternatives to a circumcision.



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Informed Consent (cont)

- The Consent For Circumcision of Newborn was signed by the mother. It is documented on the form that the mother answered negatively to the question of whether there was any history of free bleeding in either the mother or father's family. The form also documents that the procedure, precautions and follow-up care were explained to the parent and that the procedure was performed without incident and that bleeding 30 minutes after the procedure was minimal. The form also indicates that a Post-Op instruction sheet was given to the parent and a copy of the form is in the chart. The form stresses that if bleeding occurs that cannot be stopped with 3 minutes of pressure the child should be taken back to the office or to the emergency room.



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Informed Consent (cont)

Finally, the office visit Progress Note reads in part:

Family brings patient into clinic for scheduled circumcision. Reviewed risks, benefits and alternatives of infant male circumcision with family.”



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Informed Consent (cont)

Based upon the panel's review of the charts of the clinic and the two hospitals it ruled:

- There was no evidence that the procedure was performed in a substandard manner. There was no indication of excessive bleeding.
- Post surgical bleeding does sometimes occur; this is a known complication. Based on the records it is noted that the child's diaper was not changed between midnight and 9:30 am. That is unusual. There is no way to know the condition of the child during that time.



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Patient Safety Considerations

- Process of informed consent
 - Relationship vs. the form
- Documentation
 - The consent form
- Discharge Education
 - Appropriate education level
 - Language appropriate
 - Follow up calls



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Contact Information

Mike Walsh, CPCU, AIC

225-368-3815

mikewalsh@hsli.com

Stacie Jenkins, MSN, RN, CPSO

225-368-3823

staciejenkins@hsli.com

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