The Assistant's Role in Risk Reduction

Barbara Bellione, RN, CPHRM, ARM

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Podiatric MPL Claims Closed 6/1/13 – 5/31/15

STATISTICS

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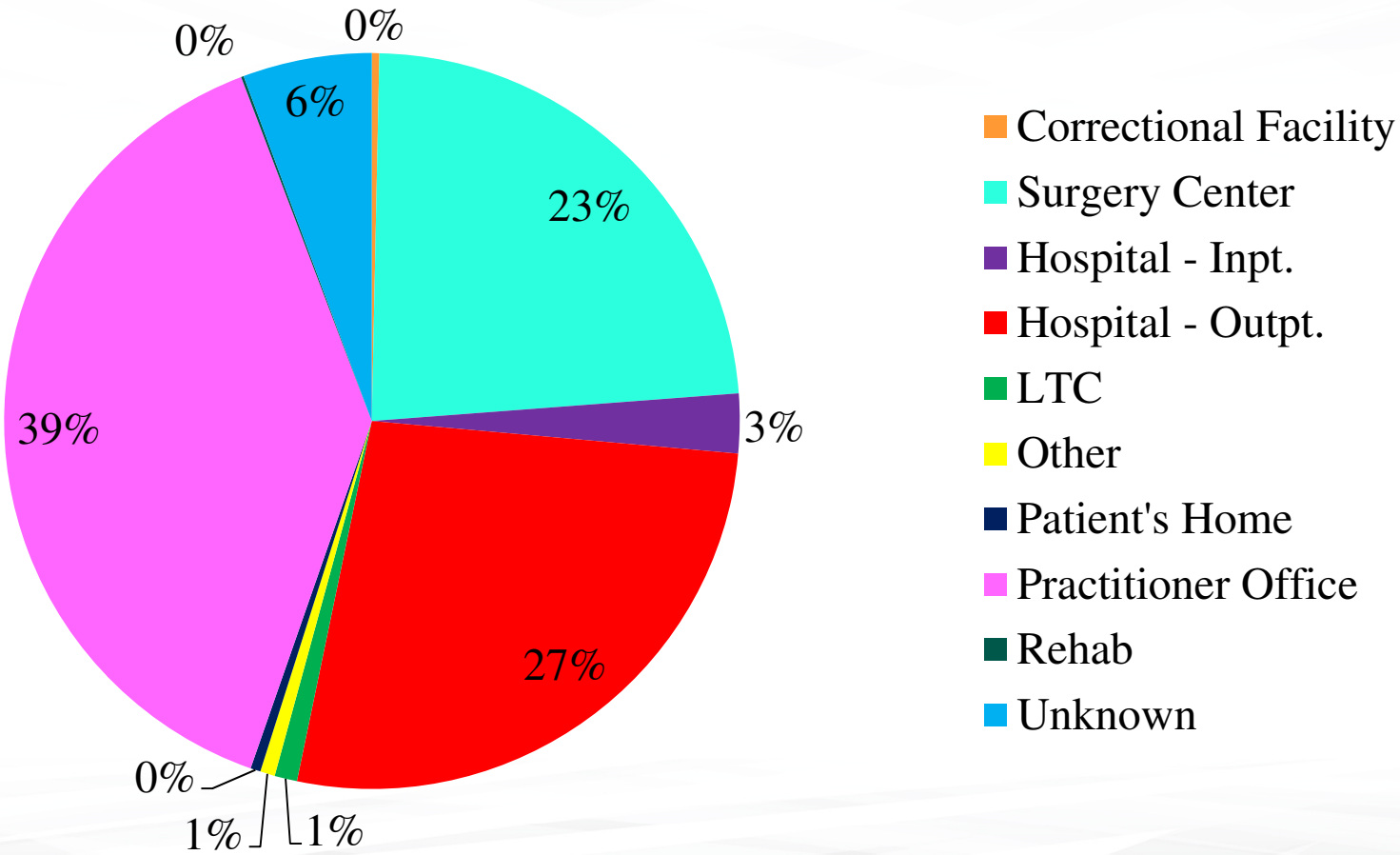
Facility Type



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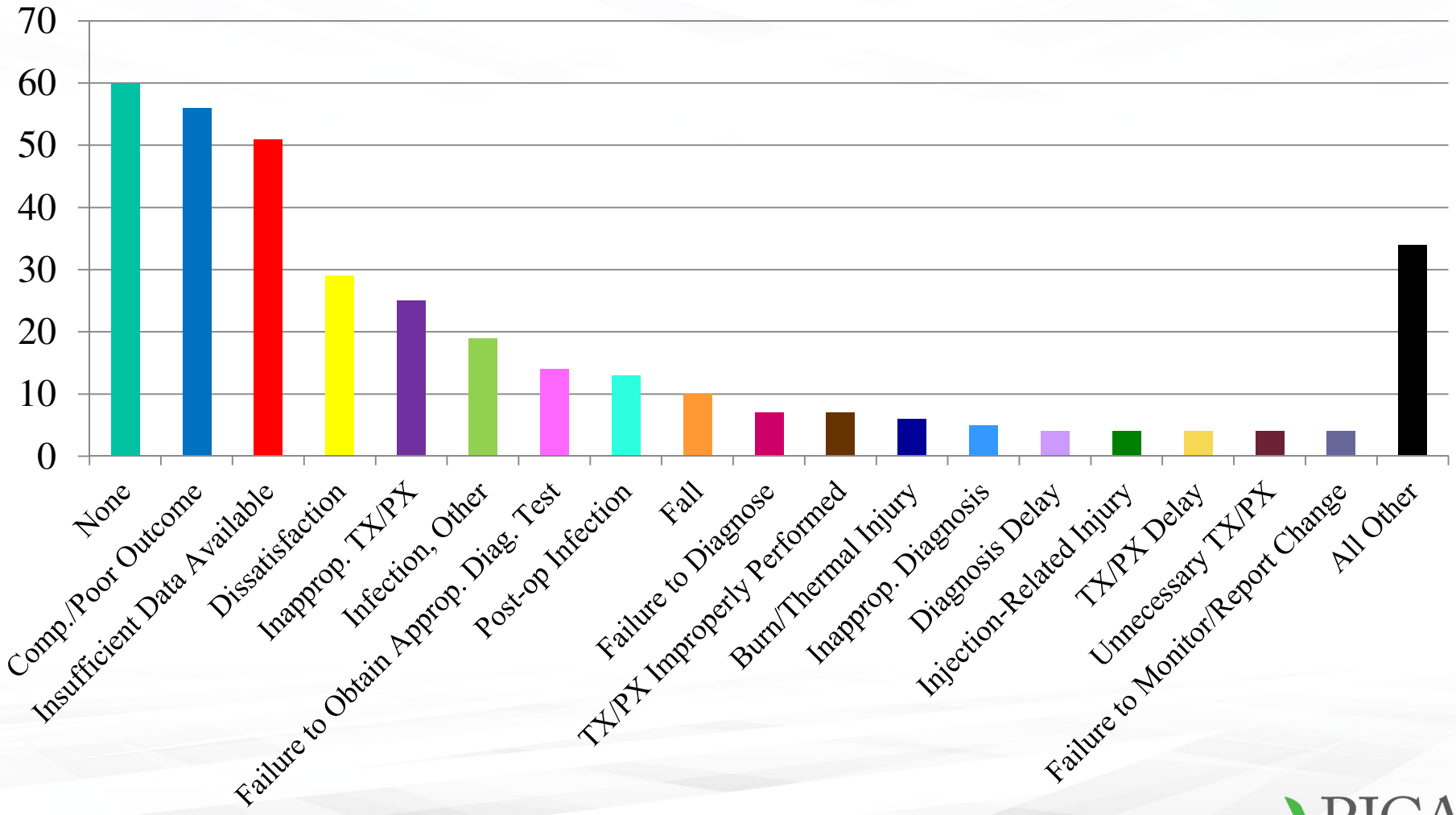
Claims Arising From Practitioner's Office - Primary Risk Issue



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Do you think podiatric assistants are ever involved in the patient's decision to file a lawsuit against the podiatrist?

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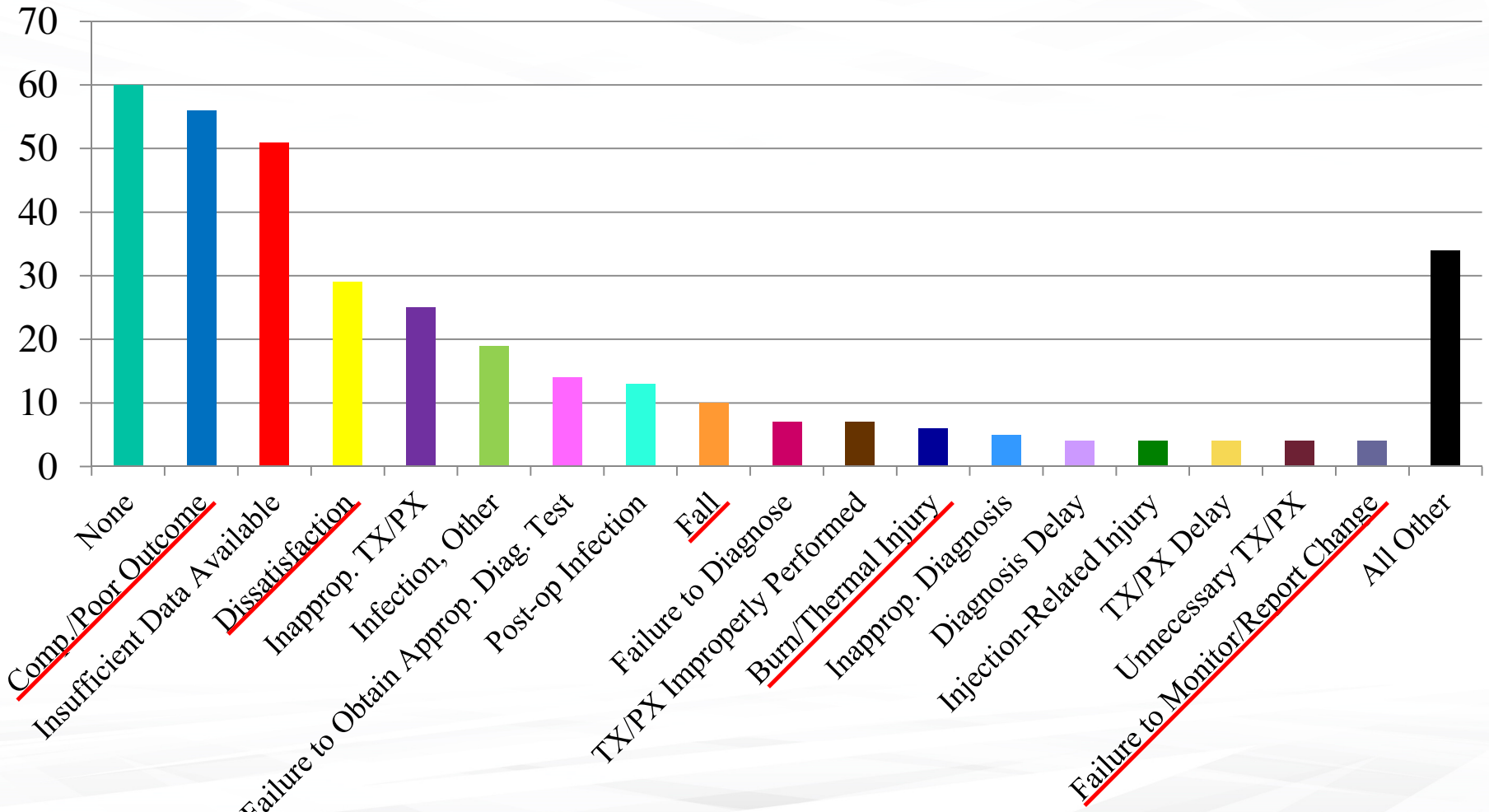
Claims Arising From Practitioner's Office - Primary Risk Issue



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CASE STUDIES

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Case Study #1

- 47 F
  - Plantar fibroma
  - Surgical correction
- Night of surgery
  - Pt. c/o severe pain in foot/ nausea
- Post-op Day 1
  - Pt. called office & asked if she should remove bandage due to pain in foot
  - Staff told pt. not to remove – bandage to remain in place for 3 days

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Case Study #1 (Cont.)

- Post-op Day 2
  - Pt. removed bandage due to severe pain
  - Noted blisters over dorsal aspect of foot w/significant hypersensitivity
- 1st Post-op Visit
  - Blisters resolving
  - C/O pain and numbness dorsal aspect of foot
- 3 mos. Post-op
  - Referred to neurologist – no more visits with podiatrist
  - Entrapment of the deep peroneal and superficial peroneal nerves and common peroneal nerve
- 6 mos. Post-op
  - Surgical decompression of nerves

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Allegations

- Inappropriate advice given by office staff
- Failure to office staff to relay pertinent patient information to the podiatrist

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Case Study #2

- 88 F
- Long-term pt. for treatment of mycotic nails
- After whirlpool, staff escorted pt. to treatment room
- Staff member walked pt. L side of the treatment – However, pt. went to other side of chair, accidently moved a foot pedal which caused chair to close on pt.'s lower leg
- Staff member turned power to chair off
- Insured called 9-1-1 & pt. taken to ED

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Case Study # 2 (Cont.)

- Diagnosed with closed fracture of tibia
- Treated with closed manipulation and casted
- In hospital for 2 days
- Transferred to nursing facility for 1 month
- Subsequently developed DVT & PE

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Allegations

- Negligent supervision of an employee
- Staff member should have monitored patient more closely
- Staff member should not have left the power to the chair on
- Staff member should have provided clear instructions as the pt. was elderly, fragile and hard of hearing
- Doctor failed to properly train the employee to stay with the patient and get her into the chair safely

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Case Study # 3

- 69 F
- To office with c/o "broken left foot"
- Pod. assistant took pt. x-ray via wheelchair
- After X-ray completed, pt. fell while getting off X-ray platform
- Pt. sustained R cuboid fracture as result of fall

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Allegations

- Podiatric assistant left the pt. unattended on platform approx. 1 ft. high, bumped the wheelchair into the platform causing her to fall, did not instruct the pt. to wait before attempting to get off the platform and was inadequately trained on proper techniques in securing a patient's safety

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Case Study # 4

- 60 M
- S/P surgical removal of tibial sesamoid
  - Doctor instructed pt. to come to office for 1st post-op appt. 8 days later.
  - Pt. asked to have his dressing changed prior to that date due to scheduling conflict
  - Doctor told pt. to come to office in 3 days without an appt. and he would work him in

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Case Study # 4 (Cont.)

- Post-op day 3
  - The patient called the office stating he would not be coming in for a dressing change as he felt too ill to drive due to flu-like symptoms (was not on appt. schedule, but that was day doctor told him to come in)
  - Staff member told him to keep his regularly scheduled appt. on post-op day 8

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Case Study # 4 (Cont.)

- 4 days later (Post-op day 7)
  - Pt. called office requesting an appt. because he thought he had foot infection and he did not feel well
  - Doctor saw pt. on emergent basis
  - L foot grossly infected and pre-gangrenous
  - Admitted to hospital
  - Transmet. amputation of L foot due to non-salvageable necrotizing fasciitis
- Subsequent BKA

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Allegations

- Failure of office staff to notify doctor of patient's flu-like symptoms
- Failure to treat the patient's post-op infection which should have been apparent to the doctor by the third post-op day

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Case Study # 5

- 60 M
  - R ankle arthroscopy
  - Placed in below-knee cast
  - Instructed to return in 1 wk. for initial post-op appt.
- Post-op Day 1
  - Podiatric assistant called pt. to check on him – "doing great"

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Case Study # 5 (Cont.)

- Post-op Day 2
  - Pt's wife called office & spoke to staff member
  - Wife reported pt. "felt weird" – foot did not hurt, but his body "felt funny"
  - Wife told staff member she thought husband's symptoms could be related to anesthesia wearing off, but could also be related to a blood clot since her husband's brother died of a blood clot after knee surgery.
  - Staff member told wife that doctor was not in office, but another doctor was present. Could see other doctor or go to ED
  - Pt. opted not to go to the office or the ED

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Case Study # 5 (Cont.)

- Post-op Day 8
  - Pt. passed out at home
  - EMS found pt. in cardiac arrest – CPR instituted
  - To ED
    - Noted to have R lower leg edema
    - Resuscitation unsuccessful
  - Autopsy
    - Cause of death - PE that originated as a DVT in RLE

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Allegations

- Mult. allegations against the podiatrist (summary excluded details about podiatric care – focused on actions of staff member)
- Office staff member failed to instruct the patient to go to the hospital emergency department immediately when wife called to report unusual symptoms.

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All these claims were resolved prior to trail with a payment to the patient.

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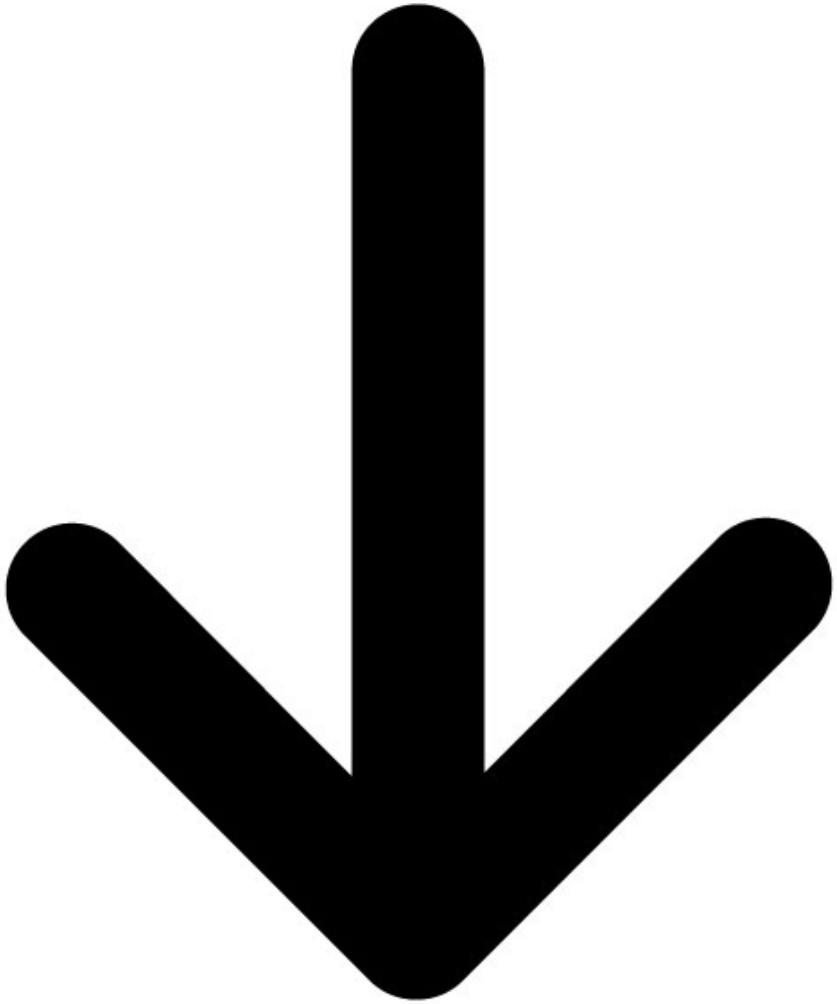
Risk Reduction



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PATIENT RELATIONS AND COMMUNICATION

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Background

- Approximately 40% of podiatric malpractice claims originate from treatment received in the doctor's office.
- A major factor in the patient's decision to sue is his/her relationship with doctor and doctor's office staff
- Patients less likely to sue
  - Caregivers who communicate well with them
  - Caregivers who provide good customer service

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Patient Interaction

- You may represent the first, last and most durable impression the patient has of the office and the doctor!
- Many patients place more weight on interpersonal skills than medical knowledge
- Show patients respect by:
  - Immediately acknowledging upon arrival
  - Addressing them by how they prefer to be addressed (formal title, first name)
  - Introducing yourself
  - Making eye contact
  - Letting them know if there will be extended wait time
    - offer to reschedule or come back later
  - Providing assistance, if needed
  - Knocking before entering exam room
  - Explain what you are doing

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Patient Complaints

- Opportunity to learn important information about the practice
  - May point out a system weakness that can be corrected to prevent an adverse outcome
- Ignored complaints can become foundation for lawsuit
- All complaints should receive courteous response at time presented
  - Acknowledge complaint
  - Research complaint
  - Communicate findings
  - Attempt to resolve

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Communication Skills

- Majority of medical malpractice actions attributed to problems with communication
- Seed of malpractice claims is planted when patient expectations are not met through lack of information or misunderstanding of information
- Many patients who file lawsuits report their healthcare providers
  - Were uncaring
  - Made them feel rushed
  - Did not answer questions

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Communication

- The primary purpose of communication is to send, receive, interpret and respond appropriately and clearly to a message

- The primary goal of communication is a mutual understanding of the meaning of the message

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Telephonic Communication

- Answer phone promptly and in courteous manner
- Limit the use of hold – always ask caller for permission prior to putting on hold
- Triage calls efficiently so caller is transferred to most appropriate person
- Identify yourself and name of practice when answering phone
- Use pleasant tone of voice – smile when you speak
- Return calls promptly

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Automated Phone Systems

- Can be very frustrating to patients
- Avoid long, detailed menu selection options
- Give instructions for emergencies at the beginning of the message
- Give caller option of speaking to a real person

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Assess Your Office Telephone Practices

- Is the automated system easy to understand and use?
- Is receptionist efficient in answering, screening and directing calls?
- Does answering service identify itself as such?
- Is the use of “hold” limited?
- Are people answering phone friendly, courteous and helpful?

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Face-to-Face Communication

- Verbal and non-verbal
- Non-verbal communication includes:
  - Use of gestures
  - Facial expressions
  - Other body language (physical appearance, touch, posture/gait)
- Non-verbal communication constitutes approximately 85% of all communication
- Non-verbal communication should provide same message as verbal communication
- Most important non-verbal communication
  - Smiling
  - Eye contact

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Reinforce Oral Communication with Written Materials

- Unlikely patients will remember all oral instructions
- Allows a patient to review information as often as necessary
- Improves patient compliance

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DOCUMENTATION

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- Good patient relations combined with good patient care go a long way in preventing lawsuits

- However, good documentation can be the best defense in the event a patient decides to sue

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Who Should Document in the Medical Record?

- Develop office P & P defining who within the office is authorized to document in the MR, regardless of media
- The level of record documentation should be defined based on licensure, certification and/or professional experience
- Individuals who document in the MR should be:
  - Trained
  - Competent in fundamental documentation practices
  - Competent in legal documentation standards

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Medical Record Documentation

- Documentation should pertain only to the direct care of the patient.
  - No emotional feelings
  - No statements that blame, accuse or compromise other caregivers, the patient or the patient's family.
- Entries should be made as soon as possible after an event or observation is made
- Each entry should include the complete date and time of entry and the signature or other authentication of person making entry
- All fields of checklists and forms should be completed

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Documentation Principles

- Clinically relevant
- Concurrent
- Chronological
- Objective
- Specific
- Legible
- Complete
- Accurate

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What to Document?

- All Patient Contacts (in person, telephone, e-mail, etc.)
  - Date & time
  - Mode (phone call, visit, electronic)
  - Reason for contact
  - Your actions and/or information/advice given
  - Outcome of contact
  - Plan for future care or follow-up, if applicable

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What to Document?

- Telephone Calls
  - An issue that many times becomes a credibility issue in a lawsuit is whether or not a phone call took place
  - Document all calls to or from the patient and all calls made on behalf of the patient regarding the patient's care and treatment (such as scheduling tests, referrals, etc.) in the MR
  - MR documentation of phone calls should include:
    - Date and time of call
    - Clear indication of whether the call was received or made ("call to" or "call from")
    - Name of person to whom you are speaking
    - Name and title of staff member making/receiving call
    - Reason for call
    - Doctor's orders, if applicable
    - Advice or information given
    - Appointment offered and/or scheduled, if indicated
  - **The doctor should review all telephone messages from patients and advice given by staff members for appropriateness & co-sign to indicate review and approval of the advice**

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What to Document?

- Patient Education/Instructions
  - Review instructions with patient/family and document each session
  - Ensure patient and/or the patient's caregiver comprehends the instructions
    - Ask them to repeat or demonstrate the instructions
    - Ask for and record any questions related to instructions
  - Instructions should be specific and individualized for the patient (wound care, limitation of activity, position or exercise, medication instruction, follow-up appointments, etc.)
  - Supplement oral instructions with written instructions & place copy in the patient's MR
  - Document titles of any supplemental educational materials used (written materials, videotapes, interactive computer instructional programs, etc.)
    - Be sure to maintain a copy of all educational resources used in case they are needed for future reference

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What to Document?

- Follow-up of test results, referrals and missed appointments
  - Document all missed appointments and cancellations
  - Document all attempts (including unsuccessful attempts) to follow up with patient who
    - Missed appointment
    - Failed to have ordered/scheduled diagnostic tests
    - Failed to keep an appt. with a specialist or for a second opinion

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What to Document?

- Medications
  - Eliminate dangerous abbreviations and dose expressions
    - See Institute for Safe Medication Practices (ISMP) website at www.ismp.org/tools/errorproneabbreviations.pdf
  - Pay special attention to decimal points and zeros to prevent overdoses
    - Omit trailing zeros for whole numbers ("5 milligrams" instead of "5.0 milligrams" – 5.0 milligrams could be misinterpreted as 50 milligrams)
    - Utilize leading zeros for fractions of whole numbers ("0.5 milligrams" instead of ".5 milligrams" - .5 milligrams could be misinterpreted as 5 milligrams)
  - At initial visit, document patient's allergies, weight, age, current prescriptions and over-the-counter medications, homeopathic remedies & herbals
    - Update information at each subsequent visit

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Medications (cont.)

- Document any prescriptions or samples dispensed at the direction of the doctor
  - Complete orders
  - Purpose of the medication
  - Specific instructions given to pt.
  - Questions asked and answered
  - Any adverse reaction
- Drug samples dispensed from office
  - Label with:
    - Name of patient
    - Brand and/or generic name of the drug
    - Strength of drug per dosage unit
    - Clear directions for use by the patient
    - Any necessary cautionary statements or use instructions ("may cause drowsiness", "take with food", etc."
  - Document lot number and expiration date of the medication
  - Document when medication has been discontinued

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What to Document?

- Patient Non-adherence
  - A patient may sue his/her doctor following a poor outcome, but many times the reason for the patient's poor outcome is the patient's non adherence
  - These cases are much easier to defend if the patient's non-adherence is documented
  - Document all observations and patient statements of non-adherence
    - Example - "Patient presents for his first post-op visit. Noted the bottom of the dressing on the operative foot to be dirty, worn and loose. When the patient was asked if he walked bearing weight on his operative foot, he stated, "I walked around the house a little without my crutches."

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OFFICE SYSTEMS

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- Effective systems are essential to ensure patients receive appropriate care and treatment and to make the office run more efficiently
- Ineffective systems can lead to medical errors, patient's "falling through the cracks," or patient dissatisfaction which may result in poor outcomes and lawsuits
- Effective systems and processes help reduce adverse events and claims by decreasing reliance on memory or informal mechanisms

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Scheduling Systems

- Schedule reasonable number of patients each day based on:
  - Nature of appointment
  - Number of exam rooms
  - Number of doctors and office staff
- Allow time for
  - Patients who need to be seen urgently
  - Appointments or procedures that require more physician time
  - Patients who need follow-up appointments
- Consider leaving one appointment slot open in the afternoon to allow for an emergency, to catch up from earlier delays or for the doctor to have time to return calls, respond to e-mails, etc.

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Scheduling Systems (Cont.)

- In event of delay, inform patients how long they can expect to wait & give them opportunity to reschedule a routine visit
  - If possible, call patients in advance if long delay is expected.
- Do not turn away a patient with an urgent problem because of scheduling difficulties without offering alternative means of obtaining care (ED or urgent care clinic)

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Tracking Systems

- Should have fail-safe systems to track
  - Diagnostic test results
  - Referrals
  - Missed appointments
  - Patients requiring follow-up
- Documentation of diagnostic tests should include
  - The patient's name
  - The date the test was ordered
  - The name of the referral lab, facility
  - The date the results were received
  - The doctor's initials and date he/she reviewed the results
  - The date of patient notification
  - Any follow-up needed

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Tracking Systems (Cont.)

- Tell patients when they should receive notification of test results & ask them to call the office if they have not heard from you within the specified time
- Patients should be advised of all test results, both positive & negative by person qualified to discuss the results
  - The doctor should personally advise a patient of any results that indicate extensive treatment will be needed or significant condition changes

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Tracking Systems (Cont.)

- Documentation of patient referrals should include
  - Name of the doctor or other practitioner to whom the patient is being referred
  - Date of referral
  - Date of referral appointment
  - Date report from referral provider was received
  - Date the doctor reviewed the report
  - Date of follow-up with patient
- If immediate referral to a specialist is needed, the doctor may need to speak directly to the specialist in order to expedite the referral process

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Tracking Systems (Cont.)

- A "reasonable effort" should be made to follow-up on patient's who miss appointments, tests or referral appointments
  - "Reasonable effort" depends on clinical importance, severity of patient's condition and the risk associated with the missed appointment
  - The doctor should review the records of all patients who miss appointments, tests, referrals to determine the necessity for patient follow-up
  - All efforts to contact the patient should be documented in the patient's medical record
  - As a courtesy to doctors who refer patients to your office, notify referring doctors if a patient that was referred to you fails to keep an appointment so the referring doctor can follow-up with his/her patient

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Telephonic and Electronic Communication Systems

- Policies and procedures should
  - Designate who may:
    - Respond to appointment scheduling requests, clinical issues, billing questions, patient complaints, prescription refills or other medication requests, requests for medical advice
    - Communicate physician orders to patients, family or another healthcare provider
    - Communicate lab or other diagnostic test results to patients
  - Address documentation and privacy and security of phone and other patient communications

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Telephonic and Electronic Communication Systems (Cont.)

- Front office staff should have clear guidelines for when to notify the doctor or designated clinical staff member when the potential for an emergent or urgent situation exists
  - (example-post-op patient calling with complaints of severe pain)
- Telephone triage or advice should only be performed by competent clinical staff
  - In accordance with written doctor-approved protocols
  - In accordance with state law requirements

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Medication Systems

- Office should have doctor-approved policies and procedures for medication refills and prescriptions
  - Who is authorized to call in prescriptions/refills
  - A list of medications that a non-physician is allowed to call in
  - The number of times a prescription can be refilled before the patient must be seen by the doctor
  - Documentation requirements
  - Procedures to be followed
    - Patient's MR pulled/reviewed prior to calling in refill
    - Noting any allergies
    - Obtaining and documenting the doctor's order for the prescription or refill
      - If verbal orders is obtained, the order should be documented as a verbal order & the doctor should review and co-sign
    - Repeating verbal orders or asking pharmacy staff to repeat the call-in order to ensure accuracy
    - Maintaining a medication flowsheet in the patient's medical record

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Medication Systems

- Medication samples and stock medications
  - Should be stored securely in locked, temperature controlled storage area outside exam rooms
  - Should only be dispensed to patient with a doctor's order
  - The doctor's order and documentation that the medication was dispensed should be included in the patient's medical record.
  - Should be properly labeling in accordance with state law
  - Should be logged as they are received, dispensed or discarded
  - Track medication lot numbers and patient identifiers in the event of a recall

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Billing Systems

- Risks of faulty billing system include:
  - Denying treatment to a patient who needs treatment because the patient has an unpaid balance
  - Surprising the patient with unexpected expenses
  - Alienating the patient with overly-aggressive collection techniques
  - Inappropriate billing leading to under- or overpayment by 3rd party payors
    - Overbilling can open the practice up to increased audits from enforcement agencies & potential fraud and abuse allegations
    - Underbilling results in reduced income for the practice

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Billing Systems

- Develop written billing practices and policy and share with patients prior to or at initial visit
- Discuss fees and out-of-pocket expenses such as co-pays and deductibles up front
- If possible, work out alternative payment arrangement if pt. is unable to pay entire bill at once
- Ask doctor to review MR of all delinquent accounts prior to collection attempts
- Develop a billing compliance plan to ensure appropriate billing practices

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Unusual Event Reporting Systems

- Every office should have a system in place to report, identify, analyze, trend and evaluate risk exposure within the practice
- Definition of an unusual event - Any event involving a patient, visitor, staff member, equipment or facilities and grounds which may affect the quality of patient care, safety of the practice or create the potential for a liability claim
- Early identification and investigation of unusual events may prevent similar problems from occurring and prompt corrective action may limit risk exposure

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Unusual Event Reporting Systems (Cont.)

- A good system can:
  - Improve patient care and overall safety through identification & reduction of risk exposures
  - Provide factual information about occurrences
  - Provide risk issue trending information
  - Assist in gathering information to report potential claims to insurance carrier

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Unusual Event Reporting Systems (Cont.)

- Examples of events that warrant investigation, tracking and correction include:
  - Patient complaints
  - Errors in patient care
  - Development of unexpected outcomes
  - Adverse reactions to treatments, procedures or medication
  - Patient or staff injury or potential injury
  - Loss or damage of personal property
  - Equipment failure or malfunction
  - Any other incident that is not consistent with the routine care & treatment of a particular patient or the operation of the practice

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Unusual Event Reporting Systems (Cont.)

- Steps in the investigation process
  - Interview all persons involved
  - Review patient's medical record
  - Test involved equipment and supplies, if applicable
  - Inspect incident area for factors contributing to the event
  - Review applicable practices, policies & procedures to determine if they were followed or if they need to be changed
  - Recreate the circumstances involved via role-playing or re-enactment
  - Determine other contributing factors

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Unusual Event Reporting Systems (Cont.)

- Analyze and trend unusual events to determine if there is a pattern
  - Example – a number of lost lab specimens should prompt a review of office lab tracking system
- Take corrective action to prevent the event from reoccurring
- Evaluate the corrective action plan to determine if it was effective
- All staff members should be give responsibility and encouragement to report unusual events to identify and correct problems

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Analyze the Cause of an Unexpected Event

- Why did event occur?
- Maintain objectivity when analyzing
- Encourage open, objective review so that all options and causes can be identified

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Analysis

- Review incident and events leading up to incident
  - Interview all persons involved
  - Review patient's medical record
  - Test involved equipment and supplies, if applicable
  - Inspect incident area
  - Review applicable practices, policies & procedures
  - Recreate the circumstances involved via role-playing or re-enactment
  - Determine significant contributing factors

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Analysis (Cont.)

- Identify and document trends
  - What area(s) of service was involved?
  - Was normal procedure followed?
  - Was the procedure appropriate for the situation?
  - What factors contributed to the event?
- Once case is identified, take corrective action to prevent the event from reoccurring. Examples of corrective action include:
  - Office systems changes
  - Policy changes
  - Staff training
- Then evaluate corrective action to determine if effective in eliminating potential for problems

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- Good patient care should be primary goal in every office
- In order to provide good patient care, effective systems must be developed, implemented and continually improved
- The input and cooperation of entire office staff is necessary to achieve this goal
- It takes time and effort to develop effective systems, but reward will include
  - Increased patient satisfaction
  - Improved patient outcomes
  - Improved staff satisfaction

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