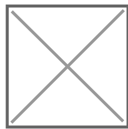
An Analysis of Emergency Medicine Closed Claims

By Carolyn Akland, MBA, RN, CPHQ, LNCC

A review of SVMIC emergency medicine closed claims from 2006 – 2016, where a loss was paid on behalf of an insured, reveals four basic areas that contributed to the indefensibility of the claims as seen in the chart below.



DOCUMENTATION ISSUES: Maintaining a well-documented medical record, from both a patient care and a risk management standpoint, is crucial. As the graph above illustrates, documentation issues were a factor in 49% of claims paid for EMDs (emergency medicine doctors). The majority of the cases involved inadequate documentation, which can negatively influence the ability to defend the care provided to a patient. Most often, there was a failure to document a history, the extent and details of an examination, the main points discussed during phone calls and the specific warning symptoms that should provoke return to the emergency department (ED) immediately.

In one case, a 40-year-old male presented to the ED with sudden complaints of testicular pain and swelling. The EMD diagnosed epididymitis, prescribed Bactrim and Lortab and instructed the patient to follow up with his PCP in 2 days. Within 2 days, the patient returned with testicular torsion requiring an orchiectomy.

Expert review found that the physical exam was insufficient to rule out torsion. Such expert review likewise found fault with the EMD's management in failing to obtain a urology consult or ultrasound. Further complicating the defensibility of the case was the very short length of time from when the EMD first went into the patient's room, completed the exam, wrote out the discharge prescriptions and documented the visit – only 8 minutes. All of this gave the appearance that the EMD performed a perfunctory exam at best and missed the opportunity for timely diagnosis and intervention.

Another case involved a 2-year-old male who was brought to the ED by his parents who reported an unwitnessed ingestion of two oxycodone 10 mg tablets. The EMD sought advice from the poison control center (PCC) and the child was observed for 3 hours. The child appeared playful and exhibited no alarming symptoms during the 3 hour observation so he was discharged home. The parents found him unresponsive 10 minutes after

arriving home. He was resuscitated, but never regained consciousness and eventually expired after transfer to a tertiary care hospital. An autopsy revealed oxycodone intoxication. Defense review was critical of the EMD's failure to administer activated charcoal as a precaution, failure to obtain a urine drug screen and failure to notify the parents of what symptoms to be alert for upon discharge. PCC records were obtained which indicated they had advised the EMD to monitor the child for 12-18 hours; this was difficult to overcome as the EMD failed to document what information was exchanged during his call with them.

COMMUNICATION ISSUES: Communication breakdowns occurred in almost a third of the claims reviewed, with half of these occurring between the EMD and the patient. Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in patients' perception of their quality of care. Small steps taken, such as a warm introduction to the patient as well as the family and asking permission to interview and examine the patient with others present, can place the patient at ease in an otherwise stressful situation. Using open-ended questions and giving them an opportunity to ask additional questions can improve the accuracy of information obtained and increase the likelihood of compliance.

Several of the cases reviewed included the allegation of lack of informed consent. One example involved a 60- year-old man who was administered Imitrex in the ED for a severe headache. Shortly after the injection, he suffered an acute myocardial infarction, requiring emergent cardiac catheterization with stent placement. The plaintiff argued that the EMD was negligent in his superficial examination of the patient and in failing to advise of potential risks and complications associated with the Imitrex. The failure of the EMD to document a cardiac medication (the patient was taking Plavix) and smoking history, along with the failure to document that any risks were discussed, resulted in settlement of the case.

An example of a case involving a communication breakdown between the EMD and a Physician's Assistant (PA) involved a 55-year-old male who underwent a lumbar epidural steroid injection at a pain management center. Eleven days later, he presented to the ED via ambulance complaining of fever off and on since the steroid injection, back pain and a loss of bowel and bladder function. The triage nurse noted leg weakness, 700 cc's urine upon catheterization and a pulse rate of 130. A PA recorded a limited physical exam and failed to note lower extremity strength, reflexes, gait, straight leg raising or sensation. The PA also deferred a rectal exam. A urinalysis was negative, a white blood cell count was 24,000 and the sedimentation rate was elevated. The PA diagnosed a urinary tract infection, prescribed antibiotics and discharged the patient. The patient returned to the ED the next day and underwent an MRI, which revealed an epidural abscess necessitating an emergency laminectomy. Because of the alleged delay in diagnosis, the patient was confined to a wheelchair and incontinent of bowel and bladder function. Among those sued were the PA and EMD. Defense experts were critical of the ED visit, specifically a negative UA that did not support the diagnosis of UTI, an inadequate exam of the patient's extremities, and failure to include spinal epidural abscess in the differential diagnosis.

Plaintiff's experts made the argument that this patient was one that was outside the PA protocol and required either a discussion with, or an exam by, the EMD prior to discharge.

SYSTEMS ISSUES: Systems issues were present in 15% of the claims. Effective systems and processes help reduce adverse events and claims by decreasing reliance on memory or informal mechanisms alone. Failure to follow up on abnormal test results or vital signs were common problems noted in the case review.

This point was illustrated in a case involving a 21-year-old female seen by her PCP with complaints of a cough, shortness of breath and chest tightness for 3 weeks. Her pulse was 108. She was diagnosed with bronchitis and treated with an antibiotic. One week later, she presented to the ED with complaints of hemoptysis, cough and shortness of breath. Her resting pulse was 118. A chest x-ray was performed but was not reviewed by the EMD, and the findings of biventricular cardiac enlargement consistent with cardiomyopathy went unnoticed. The radiologist's call to the ED nurse to communicate unexpected findings was not communicated to the EMD. The patient was diagnosed with persistent bronchitis and sent home. The next day she presented to her PCP's office with worsening symptoms, significantly hypotensive and tachycardic. She was sent to the ED. Upon arrival, she arrested, was resuscitated and admitted to the critical care unit where she developed Acute Respiratory Distress Syndrome (ARDS), multi-organ system failure and expired. The EMD was among those sued. A review of the case revealed two primary system failures by the EMD: failure to follow-up on abnormal vital signs (including tachycardia) and failure to follow up on the abnormal CXR. Multiple indefensibility factors arose which led to settlement; including failure to obtain a CT of the chest and failure to review the CXR, either of which would have led the physician to admit the patient for further evaluation and treatment.

Lessons Learned:

- Personally obtain a complete history and perform a physical exam to include a review of systems, social history and past medical history.
- Document the details of all in person and telephone conversations regarding patient care.
- If medications or other history is not available upon admission and the patient/family are poor historians, document such along with your efforts to obtain that information. Document that you sought old charts and diagnostics for comparison when applicable. Note the actual chart dates reviewed rather than simply stating that you "reviewed the old chart".
- If your observations differ from nursing documentation, verbally communicate with the staff to attempt to reconcile the findings.
- Ensure appropriate oversight of advanced practice providers (APP).
    - Have a clear system that identifies which physician is responsible for supervising each APP shift and have written protocols that address the types of patients who APPs can see independently and which types of patients seen by the APP require EMD consultation prior to discharge.

    - Prior to signing any APP note, the EMD should read it in its entirety to verify accuracy.
- Clearly and timely, communicate/document information about patients with anticipated problems, including your treatment plan, to covering EMD's.If your treatment plan deviates from any local community standard or nationally recognized guidelines for your specialty, document your rationale for doing so.
- Minimize the risks at discharge:
    - Address any abnormal tests and discuss the pertinent follow-up necessary with the patient and with their PCP. Document these discussions to include the physician by name and the essence of the call.
    - Review vital signs prior to discharge and document the rationale for proceeding with discharge if abnormal or not improved.
    - Document the discussion you had with the patient regarding your findings and plan of treatment.
    - Discharge instructions should include:
        - actionable follow-up care instructions that are time-specific (e.g. 2-3 days) and include the doctor's name and phone number,
        - specific warning symptoms that should provoke return to the ED immediately,
        - encouragement to return to the ED if they experience any problems (e.g. follow-up physician will not schedule, etc.), and
        - specific warnings (e.g. dangers of driving or drinking alcohol).
    - Clearly communicate to the patient the importance of keeping a follow-up appointment with the PCP.
    - Have a mechanism in place to track lab tests pending at discharge and to notify discharged patients of discrepancies or the need for a change in the treatment plan.
    - Give the patient a copy of instructions.
    - Arrange for the discharge summary to be sent to the PCP in a timely manner. If the patient has no PCP and follow-up is warranted, work with hospital professionals to arrange follow-up care and communicate the discharge summary to those providers.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.