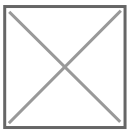
An Analysis of Hospitalist Closed Claims

By Carolyn Akland, MBA, RN, CPHQ, LNCC

A review of SVMIC hospitalist closed claims from 2008 – 2015, where a loss was paid on behalf of an insured, reveals three basic areas that contributed to the indefensibility of the claims. These issues are illustrated in the graph below:



COMMUNICATION ISSUES: Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in a patient's perception of the quality of care received and helps ensure compliance. National data, as well as our data, suggests that patient handoffs between physicians continues to be a significant source of liability for hospitalists. Communication breakdowns occurred in 69% of the reviewed claims, with the majority of these claims being breakdowns between physicians. Case examples include:

In one case, an elderly patient with a non-displaced fracture was transported to an ED without orthopedic services. The hospitalist admitted the patient for pneumonia and stabilized the extremity with a short leg posterior splint including ACE wrap. After discharge, the patient was seen by an orthopedic surgeon who discovered a large pressure blister and ulceration which eventually resulted in osteomyelitis and a below the knee amputation. A lack of documentation as to the nature and extent of the neurovascular examinations of the extremity made it difficult to defend against the plaintiff's allegations that both the hospitalist and hospital nurses failed to properly evaluate the patient's neurovascular condition during the hospitalization.

In another case, a 65-year-old patient became hypotensive following a total abdominal colectomy. The patient continued to deteriorate throughout the night and the nurses notified both the hospitalist and the on call surgeon. The hospitalist remained at the bedside but the surgeon did not come in even though he was notified of the patient's status periodically throughout the night. The patient coded in early morning and was taken to surgery where an arterial bleed was found. The patient suffered an anoxic brain injury. Finger pointing ensued. The surgeon, as the principle target in the suit, said the nurses led him to believe the hospitalist had matters under control and blamed the hospitalist for not communicating with him directly.

MEDICATION ISSUES: Medication errors were present in 38% of the reviewed cases. Medication reconciliation and prescribing at discharge continue to pose significant risk for hospitalists. The case below exemplifies this risk:

After undergoing a total knee replacement, a 46-year-old patient developed a hematoma necessitating additional surgical procedures and antibiotic therapy. The hospitalist ordered Gentamycin and discharged the patient to home health for two more weeks of home infusion therapy with the antibiotics. The orthopedic surgeon continued to refill the Gentamycin; neither physician had ordered any monitoring protocol. Two months later, the patient developed debilitating symptoms of dizziness and imbalance. A referral to the ENT determined the patient had sustained vestibular damage, most likely from the Gentamycin. The hospitalist, having been the one to order the antibiotic initially, bore the brunt of the responsibility for failing to appreciate the risks of aminoglycoside toxicity, inform the patient of those risks and to order monitoring blood tests upon discharge.

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 38% of claims paid for hospitalists. Of those, including the cases cited above, most had inadequate documentation, which can negatively impact the ability to defend the care provided to a patient. Most often there was a failure to completely document the extent and details of an examination; rationale for the diagnosis and treatment plan; and patient education and telephone calls.

Lessons Learned:

- Communicate directly with the surgeon or other consultants treating the patient, to ensure a clear message. Do not assume that telling one nurse is as good as informing all involved in the care of the patient and don't assume vital information will get communicated through your notes alone.
- Understand the risks of accepting and admitting patients who might need the care of a specialist not on staff at your hospital.
- Educate yourself about all hospital by-laws and policies, including how to escalate up the chain of command.
- Clearly and timely, communicate/document information about patients with anticipated problems to covering hospitalists, including information regarding your treatment plans under consideration.
- Utilize a dedicated "hand-off" method between hospitalists.
- Be aware that any written or electronic "hand-off" between hospitalists is potentially discoverable.
- Document only formal consults in the progress notes.
- If your treatment plan deviates from any local community standard or nationally recognized guidelines, document your rationale for doing so.
- Verbal orders require caution. Use sparingly and employ "read-back" for verification and a time for face-to-face questioning.
- Include specific clinical parameters in your orders that instruct not only the frequency but also specifically what should be assessed and when the physician should be

notified.
- Do a thorough physical exam and history of the patient and document the findings. Avoid ambiguous notes such as “doing ok” or “CNS normal”.
- 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.

- Understand potential risks with EHR: Use copy/paste with extreme care. Never copy information in a manner to make it appear that you provided services you did not personally provide. Read the note in its entirety to verify accuracy before signing.
- Document the phone conversations with other physicians to include name, date and time of call as well as the essence of the exchange.
- Minimize the risks at discharge:
    - Make an effort not to order unnecessary tests.
    - The discharge summary should prominently list what test results are still pending and recommended follow-up tests. Make arrangements for the discharge summary to be sent to the primary care physician in a timely manner. If the patient has no primary care physician, work with hospital professionals to arrange follow-up care and communicate the discharge summary to those providers.
    - Ensure tests ordered by yourself (or the previous hospitalist) have been returned. If these test results will not be reviewed by a hospitalist prior to discharge, it is crucial to have a system in place to review these in a timely fashion. Test results that return after discharge should be communicated directly to the primary care physician. If the results are significantly abnormal or urgent, directly call the primary care physician office and document that conversation.
    - Clearly communicate to patients and document the rationale for starting new medications, as well as significant risks, when initiating a new medication.
    - Clearly communicate to the patient the importance of keeping a follow-up appointment with the primary care physician.
    - Notify the patient of tests that are still pending and other incidental findings in need of further outpatient workup. Advise them to contact their attending physician if pending test results are not received.
    - Give the patient a copy of those instructions.