Identifying and Managing Practice Risks

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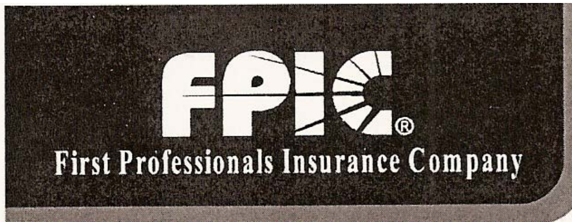

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Physicians are faced with a paradox that the more medicine advances, the greater the error potential. Patients have higher expectations of their physicians given the continuing advancements in technology. While all undesired outcomes cannot be eliminated *even* by extremely well-qualified physicians using the most advanced technology, a number of indefensible cases can be eliminated or reduced by simply utilizing risk reduction strategies and tools.

FPIC's Risk Management Department provides consultations with insured providers to identify liability risks and recommend effective risk management tools in an effort to eliminate or reduce those risks. These comprehensive consultations are an excellent example of the value-added component of FPIC coverage.

The consultations consist of an interview with a key office staff member, a tour of the facility, a patient record review, and are provided at no cost to our Insureds. Consultations are also conducted when Underwriting concerns arise or claim frequency is encountered.

The consultation primarily focuses on:

- General Practice Issues
- Office Observations
- Office Policies and Procedures
- Pharmaceuticals
- Equipment and Supplies
- Diagnostic Functions
- Office Procedures
- Credentials
- Patient Contact and Communications
- Emergency Procedures
- Staffing
- Patient Record Keeping

The practice is assessed with consideration for professional liability exposures and compliance with applicable state and federal regulations. From the assessment, risk management strategies for reducing any identified risk exposures are recommended. The most common liability issues, relative to frequency, discovered during FPIC's risk management consultations are as follows:

Fifty-five percent of all sites evaluated failed to have appropriate emergency response medications and supplies. Problems encountered include a failure to maintain an emergency response kit, inability to locate the kit, lack of staff training in the provision of emergency care, and expiration of emergency medications.

Deficiencies in medication ordering and dispensing of sample medications were *observed* in *over* 50 percent of the practices *surveyed.* Allergies were not prominently noted in a consistent location, medication orders were not documented completely, refills were not consistently documented, and patients were not given administration instructions when samples were dispensed.

One of the most significant deficiencies is tracking and follow-up of diagnostics. *Over* 60 percent of the practices have not implemented an effective mechanism for tracking the completion of ordered diagnostics and referrals. Diagnostic tracking system problems have led to an epidemic of failure to diagnose or timely diagnose claims. Tracking systems should be designed to identify delinquent diagnostic and consult reports and follow-up failures.

It is interesting to note that while operational deficiencies occur in a significant percentage of practices, few other deficiencies occurred with alarming frequency and in virtually all cases the standard of care was rendered.

Most deficiencies identified were related to record keeping. Unfortunately, the patient record is the source of most professional liability claims. Deficiencies in record keeping often prevent nuisance -type claims from being defensible.

Failure to consistently obtain and/or document informed consent for invasive procedures was identified in 50 percent of the practices evaluated. Discussions related to proposed invasive procedures and anticipated risks and complications were not routinely documented.

In nearly 75 percent of all charts reviewed, a plan of care was not sufficiently documented. While diagnostic orders, referral recommendations, and recommendations for procedures were generally documented, continued care recommendations, instructions, cautions, and education efforts often went uncharted.

The patient's chief complaint or reason for the office visit, along with the provider's findings and diagnosis were lacking in nearly 40 percent of the charts reviewed. In some cases, patients were scheduled for an invasive procedure with the preceding office notes indicating no patient complaints, no documentation of abnormal findings, and no diagnosis in the progress notes to indicate rationale for the proposed procedure.

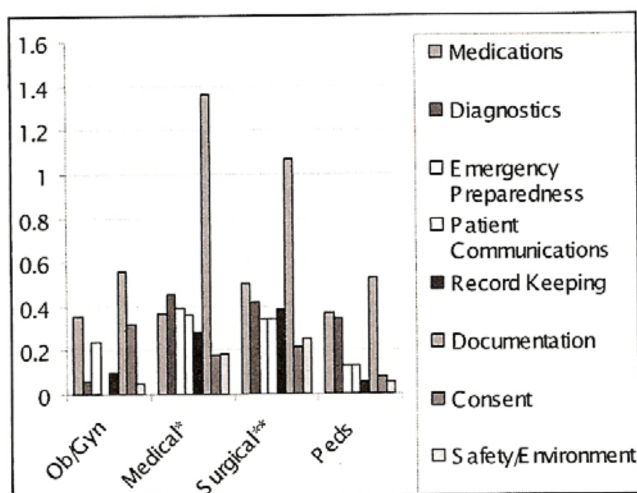
Documentation and follow-up of telephone and after hour's communications with patients were another problem noted in the charts reviewed. Over 40 percent of the practices assessed did not have a procedure for follow up and documentation of phone calls.

Nearly 50 percent of all charts reviewed did not contain a recent patient history and the status of chronic conditions was not appropriately documented.

Surprisingly, handwriting legibility still presents problems. Twenty percent of the charts reviewed contained entries that were illegible. Eighty percent of all paper charts reviewed were organized chronologically, secured with a binder system, and divided according to types of data. Only eight percent of the charts reviewed were stored electronically. Approximately 20 percent of the practices utilized a documentation template and in those cases, documentation was far more detailed and adhered more closely to review criteria.

While operational deficiencies are not always an indication of the level of care provided, they expose the practice to avoidable errors and broaden risk exposure to otherwise medically defensible claims and suits.

RECOMMENDATIONS BY SPECIALTY BASED ON TOTAL IDENTIFIED DEFICIENCIES



• Includes results from Cardiology, Dermatology, Family Practice, Internal Medicine, Pulmonology, and Physical Medicine and Rehabilitation sites.
**Includes results from Gastroenterology, Orthopedics, Ophthalmology, General Surgery, and Urology.

RISK MANAGEMENT CONSULTATION RECOMMENDATIONS:

Rank	RECOMMENDATION
1	Document all patient education efforts: cautions, recommendations for treatment, expectations, follow up recommendations.
2	Document examination findings: characteristics of the chief complaint, history of present illness, status of chronic conditions, review of systems to include normal and abnormal findings.
3	Document plan of care to include treatments, diagnostics, medications, etc.
4	Initial diagnostic and consult reports to indicate review. Document review of results with patient (may simply note on report "Patient notified, date, and initials if no follow up action is indicated"). Notify patients of **all** results.
5	Document a medical, family, social history.
6	Note allergies prominently in chart.
7	Authenticate all transcription by initialing.
8	Document all patient contacts, including office phone calls and after hours calls received, with date.
9	Implement a follow up system to ensure that all diagnostics and consults are completed, reports received, results reviewed and initialed by physician and follow up actions documented
10	Obtain written consent that identifies specific risks inherent with procedure for all invasive procedures performed in the office.
11	Provide written medication administration instructions when dispensing sample medications.
12	Maintain an emergency response kit to include emergency medications (Epinephrine, Steroid, Antihistamine), medication administration supplies, an Ambu bag, oxygen and oxygen delivery system. Ensure that kit is readily accessible, available, and complete and medications are current. Ensure that physician and staff members are trained in emergency response.
13	Organize charts. Secure chart pages to chart cover, use dividers to separate information, arrange chart in chronological order, and avoid the use of "Post It" notes.
14	Make proper error corrections. Avoid the use of "White Out" correction. Avoid obliterating the error.
15	Include the patient's name on every chart page.

Prepared by: **Volusia County Medical Society**
Dated: April, 2009