

Loss Prevention in the Office Practice Setting

—by Patricia Harmon, RN, Consultant, Lifespan Risk Services

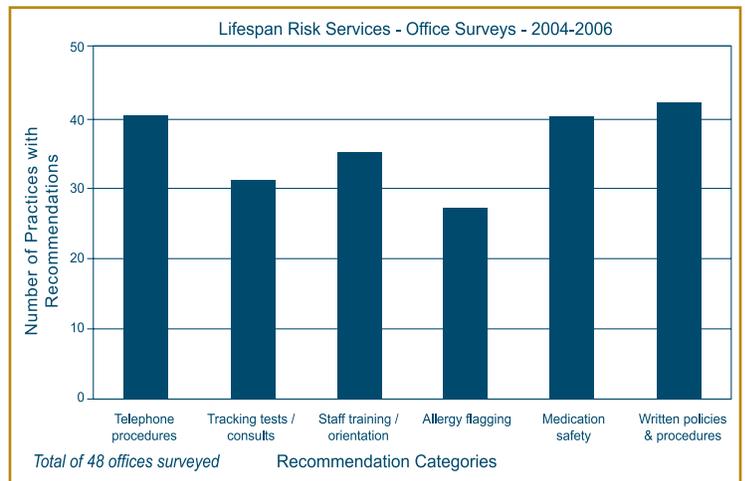
This article describes the Lifespan Risk Services office survey program and summarizes the results of surveys completed to date.

The office survey is an important part of the loss prevention services provided by Lifespan Risk Services for its insured physicians. Loss prevention is an integral component of the risk management process in the inpatient acute care setting, as well as in the ambulatory care/office practice setting. From our claims experience, we have observed that physicians can have professional liability exposure in the absence of negligence due to flaws in systems, communications or documentation. This program was designed to focus on “systems, not people” and to provide recommendations for physicians to improve systems and management practices in their offices that could favorably impact malpractice exposure as well as improve patient care.

As part of the survey we also reviewed existing written policies and procedures and conducted medical record audits. The audits involved a random sampling of medical records to ascertain whether or not established policies regarding documentation translated into actual practice. After the survey was completed, a formal letter was provided to all practices that included recommendations and a summary of the results of the medical record audits. When we found “best practices,” we encouraged and facilitated sharing those among the practices.

The following is a summary of the most frequently made recommendations during our survey process. See graph below.

Over the past two years we have conducted loss prevention office surveys at 48 office sites, including family practice groups and specialty practices. Prior to the on-site visits, a self-assessment tool was provided to the practice managers as a preview of the survey questions. The survey itself included interviews with the office manager and providers about systems and procedures for credentialing, staffing, medication safety, scheduling, telephone management, documentation, confidentiality, informed consent, tracking test results, infection control, equipment safety and emergency procedures.



continued on page 2



**Lifespan
Risk Management**

www.lifespan.org/risk
167 Point Street
Suite 170
Providence, RI 02903
T: (401) 444-8273
F: (401) 444-8963

inside... Page 4 Medical Record Retention Sample Policy
Page 6 Lessons Learned
Insert..... Medical Record Retention and Copying Charges

TRACKING AND FOLLOW UP

One of the most important survey recommendations made to our physicians was related to tracking systems. Current trends in professional liability claims reveal that “failure to diagnose” and “delayed diagnosis” are the most common areas of exposure in the office setting. Creation of tracking and follow-up systems for laboratory, radiologic studies and consultations can help prevent or reduce diagnosis-related errors. Tracking systems can vary from simple written logbooks to sophisticated computer programs.

Physicians often conveyed to us that they felt overwhelmed with the task of tracking ALL patient tests and referrals, especially in busy multiphysician group practices. In these instances, we suggested that physicians prioritize which patients or tests are most critical. Our definition of “the most critical tests” were those that would be associated with a significant delay in diagnosis and treatment, if the result were not reported. For example, a diagnostic chest CT ordered to evaluate a new lung lesion would require tracking. The physician needs to ensure that 1) the patient understands the importance of obtaining the CT and the risks of noncompliance, 2) the test actually gets done and 3) the results are reported in a timely fashion and communicated to the patient along with any follow-up medical instructions.

We believe that all results, including those within normal limits, should be communicated to the patient. This process should be clearly documented in the medical record, including any phone discussions with the patient and a note if the patient has been noncompliant. For non-compliant patients, the expectation is that reasonable attempts be made to contact the patient via phone call or certified letter.

In regard to patient follow-up, we were frequently asked by physicians, “Where do you draw the line?” and “When does it become the patient’s responsibility to follow up?” Patients do need to be involved in their medical care, especially in areas of routine follow-up. However, physicians are obligated

to provide all necessary information about the medical condition, treatment options and risks of failure to follow up to the patient AND to document this.

TELEPHONE CALL MANAGEMENT

Another important area addressed was telephone call management. During our site visits, we identified a wide variety of systems used to handle phone calls ranging from nurse triage system to physician’s taking all calls. A practice in which the physician takes and/or returns all patient calls personally is the gold standard. This should be followed by documentation of all pertinent calls, including after-hours calls. For those offices using nurse triage systems or having messages taken by secretaries, we advise the development of written telephone protocols combined with appropriate training of staff, underscored by the admonition that medical advice should not be given by anyone other than the physician.

DOCUMENTATION

Documentation encompasses a wide range of survey categories, including informed consent, tracking of test results, communications with patients and other health care providers, and missed patient appointments. Responsibility for ongoing care in the case of referrals and consultations requires careful documentation. The results of our medical record audits, in general, revealed appropriate documentation of patient assessments, history and care plans. However, laboratory results, follow up instructions and phone conversations with patients were not consistently documented. We urged physicians and office managers to review these areas and highlighted their importance not only in patient care, but also in malpractice defense. A well-written note regarding a patient discussion can be an invaluable asset at trial.

MEDICATION SAFETY

Our medical record audits revealed a wide variety of methods that physicians use to document medications and new prescriptions. The new JCAHO National Patient Safety Goals

include recommendations for careful medication reconciliation by physicians in both hospital settings and office practices. We encouraged all practices to consider the use of medication flow sheets for the documentation of ongoing medications, new prescriptions, over-the-counter drugs patients are currently using and sample medications given by the office. We advised office staff to be vigilant in documenting allergies and to appropriately flag them on the medical record. We cautioned staff about the practice of having unlicensed personnel renewing prescriptions without documentation of physician authorization.

In practices where medical assistants performed injections, we occasionally noted laxity in technique in both preparation and administration of injectables. We recommended a review of the processes in place, including training and supervision of unlicensed staff and encouraged the development of written policies to reflect standardized nursing practice.

POLICIES AND PROCEDURES

Written policies and procedures standardize patient care and afford staff members a reference for expectations. We encouraged all office managers to begin to draft policy manuals for both general office tasks as well as procedures specific to each site. We provided all offices with the table of contents for a policy manual and an example of a resource manual of standard office policies. Protocols for patient emergencies and the use of interpreters are examples of pertinent medical office policies that should be included in a manual. Each office should have a clear policy on the use of interpreters for the non-English speaking or hearing impaired patients in order to comply with Federal ADA guidelines.

We advised all practice managers to develop a written policy for how patient emergencies are handled. The type of emergency equipment needed in an office setting is dependent upon the specialty of the office, geographic location, patient population and staff education. In general, a physician's office should have basic emergency medications and all staff members with patient contact should have basic CPR training. Everyone who works in the office should be prepared to perform within his/her level

of expertise during a medical emergency. Ongoing educational programs are a key component of any emergency plan and training should be provided annually. Overall, our survey findings revealed that most offices had appropriate protocols in place to handle emergencies, although there were few written policies.

STAFFING

The use of medical assistants is a popular, effective and economic way to provide patient care in the office setting. However, it is important for physicians to be aware of the expectations and regulations associated with this practice. The proposed 2006 Rules and Regulations for licensure/discipline of physicians include new language regarding "the delegation of acts by a physician to an unlicensed medical assistant." Inherent in these regulations is the burden on the physician to provide appropriate training and supervision and to be mindful of the scope of practice and types of acts delegated. The regulations also require documentation of competencies of medical assistants. A physician delegating tasks which require a medical assistant to practice beyond the scope of the regulations may be subject to disciplinary actions. Our survey findings revealed that although excellent training programs for staff were being conducted, there was inconsistent documentation of these programs. In addition to regulatory compliance, documentation of ongoing training is crucial in defending claims involving alleged malpractice of ancillary staff.

MEDICAL RECORDS MANAGEMENT

During our site visits, we found that medical records were stored appropriately. Most practices were storing inactive records on site or in storage facilities. In order to assure compliance with the RI Rules and Regulations for licensure/discipline of physicians, all practices should have a record retention policy. (See an example on pages 4-5.) As practices become more complex, office managers may need to seek storage alternatives in the future. Some offices have contracted with copying services for subpoena requests and patient requests for record copies, as well as permanent electronic record

SAMPLE POLICY

UNIVERSITY MEDICINE FOUNDATION, INC.
ADMINISTRATIVE POLICY AND PROCEDURE

TOPIC: Medical Record Retention
APPLICABILITY: All Divisions Within the University Medicine Foundation, Inc.

Effective Date: Board Approval Date:

A. PURPOSE

Medical records are individually identifiable data, in any medium, collected and directly used in and/or documenting healthcare or health status.
Records are retained for the benefit of patients and providers. Ownership of medical records is assigned to the University Medicine Foundation, Inc. (UMF).
Whenever possible, medical records in paper and electronic form should be kept indefinitely. It is understood that it may not be practical to store paper records indefinitely.
The policy is developed in conformance with state and federal regulations and statutes and ensures an efficient and standardized approach to the retention of medical records

B. POLICY

UMF adopts the following retention periods for medical records in paper or electronic form.

Adults: ten years after the last professional encounter with the practice

Minors: ten years after the patient's eighteenth birthday

Deceased: ten years following the death of the individual

Incompetent: ten years after the last professional encounter with the practice

Civil, criminal or administrative proceedings: records of potential or active litigation or investigation are retained indefinitely.

Immunization records, operative and chemotherapy notes: retain indefinitely

C. PROCEDURE

Office Managers or their designee will be the keeper of records for the individual offices and are responsible for the safe and accessible storage of medical records. The chief billing officer is responsible for records contained at the central billing office.

The practice administrator will designate the off site storage facility for each office and is responsible for ensuring adequate preventive measures are met. The storage areas shall be secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption or damage.

A business associate agreement will be executed by UMF and the facility to ensure compliance with HIPAA. The compliance department is responsible for the business associate agreement.

When a provider terminates from UMF, the practice administrator or his/her designee will be the keeper of records.

Records will be stored in a manner that clearly identifies the contents of materials and the month and year records may be destroyed. The office managers are responsible for maintaining data on records in storage and shall provide such information to the state Medical Board of Licensure and Discipline, upon request, and identifying those records meeting the criteria for disposal.

Paper medical records may be scanned and stored electronically at the directive of the practice administrator. Scanning shall include the entire record and be an accurate reproduction of the record. The scanned record must be readily retrievable and transferable. The compliance department will randomly audit the paper and newly scanned records for accuracy.

Paper and computer and laser disks shall be destroyed in a manner that ensures no possibility of reconstruction of the information. A professional data expert who has signed a business associate agreement will carry out the destruction. A certificate of destruction will be forwarded to the practice administrator.

Providers will be asked to sign an agreement advising them of this policy. Providers will have the opportunity to request their written records not be destroyed after scanning. The agreement would make it clear that unless there is a written objection, their records may be destroyed after scanning or at the designated time period. The practice administrator may assign a fee to those providers for the continued storage of records after scanning or the designated period. The compliance department will inform providers of the policy and forward a list of those requesting their records not be destroyed to the practice administrator.

Number: #05-03

Date: April 25, 2006

Date: _____

Approvals: _____ Date
UMF President

UMF Chief Executive Officer

storage. We strongly suggest that any contracts with copying services be carefully reviewed to ensure that the complete record is preserved in the event of future litigation.

The office survey program has been a valuable tool to help us partner with our insured physicians and their office staff toward our mutual goal of quality care for the patients we serve. Although few of our claims come from the office setting, those that do most often involve a failure to diagnose or a delay in diagnosing a medical condition that subsequently leads to increased morbidity and, sometimes mortality. Investigation of these claims frequently highlights the importance of good office

systems to support the care given by the team of healthcare providers. The successful defense of a case will rest on the timeliness and thoroughness of the documentation in the patient's records, and the extent to which good policies and procedures are written and followed. We believe that a non-punitive, proactive approach to loss prevention, like an office survey, can lessen the risk of liability for our providers and create a safer and more efficient environment for our patients.

We invite any of our insured physicians to call Peggy Martin (444-6491) or email her (pmartin2@lifespan.org) with questions concerning the office survey program.

Lessons Learned

The purpose of this section is to share summaries of closed cases that have occurred in the New England area and represent real life issues that provide proactive risk management educational opportunities. The cases used may come from Lifespan affiliates, or other institutions or practices, or may be composites of several cases with very similar fact patterns. We present these cases because we believe they have some relevance to situations that you may encounter.

THE PATIENT

A 70-year-old male patient was admitted to the hospital by an orthopedic surgeon following a fall. Radiology studies confirmed a complex fracture of the left hip and pelvis. The patient was placed in traction and a pelvic CT was done, confirming the pelvic fracture and associated pelvic hematomas. The admitting surgeon consulted an orthopedic surgeon at another hospital. They planned to transfer the patient to the second hospital to do the surgery but the transfer was delayed because no beds were currently available.

Two days after admission, the patient's PCP (a family practice physician) was consulted for treatment of alcohol withdrawal. He reported that the patient had a known drinking problem, had been without alcohol for more than 36 hours, and was beginning to show signs of withdrawal. The PCP recommended that the appropriate protocol (in this case, Lithium) to control symptoms associated with alcohol withdrawal (specifically, delirium tremens) be given and that the

patient be given Compazine. He also recommended that surgery be delayed until the patient's tachycardia resolved and his alcohol withdrawal was under control.

That same day, a general surgeon was asked to assess the patient for a developing abdominal distention. An x-ray was done, which suggested a possible paralytic ileus.

The next day, three days after his admission to the first hospital, the patient was transferred to the second hospital for surgery. Shortly after arrival in the late afternoon, the patient began to develop respiratory problems and had a pulse oximetry level of 75% on room air. Although the patient denied shortness of breath, radiologic examination (VQ scan) showed a high probability of a pulmonary embolism and the patient was started on Heparin.

The following morning the patient was found on the floor near his bed with no pulse or respirations. He was resuscitated and transferred to the medical intensive care unit. He never regained consciousness and expired later that evening.

LIABILITY

The patient's estate brought a medical malpractice lawsuit against the first hospital and three physicians (the orthopedic surgeon, the family practice physician, and the general surgeon). The plaintiffs alleged that there was a delay in repairing the hip fracture, failure to protect the patient from a pulmonary embolism during the surgical delay, and failure to inform the patient of the increased risk for a pulmonary embolism during the time the patient was awaiting surgery. They further alleged that, as a result of the delay in surgery and the lack of measures to decrease the risk of clotting, the patient developed a fatal pulmonary embolism.

RISK MANAGEMENT ISSUES

The expert reviewers retained to assess the care given by the orthopedic surgeon were clear in their opinion that the standard of care required deep vein thrombosis/pulmonary embolus (DVT/PE) prophylaxis for the patient because of his significant pelvic injury. Most agreed that although there was a risk of increased bleeding with Lovenox (low molecular weight Heparin), it could be monitored and controlled. They felt that a potentially fatal DVT/PE was a far greater risk.

All the experts agreed that there had been no unreasonable delay in performing the surgery, saying that the repair of this type of fracture is not usually considered emergent. The area is highly vascular and associated with risk of increased bleeding. In fact, the CT did show a pelvic hematoma shortly after admission to the hospital. In addition, it was important to optimize the patient's medical condition prior to the surgery. In this case, the family practice physician was consulted to treat the patient's alcohol withdrawal, and a general surgeon was consulted on the patient's intestinal ileus.

The lack of documentation on two key issues made this case hard to defend. There was no evidence in the medical record to indicate that the orthopedic surgeon ever considered DVT prophylaxis. It would have been easier to defend him had he documented that he had considered such prophylaxis treatment options and rejected them based on the patient's other conditions. Without that rationale, the record supported the allegation that the orthopedic surgeon did not even consider this treatment as an option. In addition, there was no evidence in the record that he advised the patient and his family of the benefits or consequences of DVT/PE prophylaxis. The absence of evidence of this type of discussion supported the allegation of "failure to inform of the increased risk."

OUTCOME

The case was settled in the middle range on behalf of the orthopedic surgeon.

Sometimes, in cases involving several medical consultants, the continuity of care becomes one of the critical issues. Although there were several physicians involved in the care of this patient, the orthopedic surgeon had the primary responsibility to prevent this life-threatening complication. The experts that reviewed this case agreed that the delay in surgery was not unreasonable given the patient's medical conditions, but that the delay made it even more crucial to be vigilant in preventing the known and deadly complication of pulmonary embolism in patients with this type of fracture. The medical record did not reflect the orthopedic surgeon's rationale for his treatment decisions, thus making it difficult to defend him in the face of the devastating outcome in an otherwise fairly healthy patient.

Risk Management Activities and Services

The staff:

- Is available to provide risk management educational programs tailored to the schedule and needs of the audience,
- Conducts Risk Management Office Surveys for our affiliated physician groups, for hospital departments, procedure areas, and nursing units,
- Administers the Risk Management Grant Program, and
- Produces this newsletter. Back issues are available in a printable format from our website: www.lifespan.org/risk

For more information, questions, consultations, or suggestions, contact **Peggy Martin** at Lifespan Risk Services, by email at pmartin2@lifespan.org or at **444-6491**.

Insights is published by Lifespan's Risk Management Department. Submissions and ideas are welcome and may be submitted to **Peggy Martin** via e-mail: pmartin2@lifespan.org or fax: **(401) 444-8963**.

editorial committee chairperson: Peggy Martin

committee members: Paul Adler, Joan Flynn, Rick Almeida, and Joseph Melino

Please send address changes to Valerie Till, (401) 444-4595 or vtill@lifespan.org

Nonprofit
U.S. POSTAGE
PAID
Providence, RI
PERMIT NO. 538

Lifespan
Risk Management
167 Point Street
Suite 170
Providence, RI 02903



MEDICAL RECORD RETENTION AND COPYING CHARGES

The following information is based on the 2006 R.I. RULES AND REGULATIONS FOR LICENSURE AND DISCIPLINE OF PHYSICIANS

Q What amount may physicians charge for copying medical records?

A Reimbursement to the physician may not exceed 25 cents per page for the first 100 pages and may not exceed 10 cents per page after 100 pages when the copying is not connected to a subpoena. If the copying is pursuant to a subpoena, then the charge for the copying is limited to \$25. Note that under HIPAA, a covered entity may not charge a retrieval fee to a patient for copying the patient's medical record. A retrieval fee, however, may be imposed if a person other than the patient (or the patient's legal guardian or parent in the case of a minor) makes the request.

Q Are their special fees for attorney requests?

A No. Requests for records made by attorneys should be billed in the same manner described above.

Q Can the fee charged to the attorney and persons other than the patient for the retrieval of records be adjusted according to the time needed to obtain the record?

A No. The most that may be charged for retrieval is \$15.00 regardless of the time necessary to retrieve the record.



**Lifespan
Risk Management**

www.lifespan.org/risk
167 Point Street
Suite 170
Providence, RI 02903
T: (401) 444-8273
F: (401) 444-8963

Q Can physicians charge extra for "rush" requests?

A Yes. A special handling fee of an additional \$10.00 may be charged if the records must be ready within 48 hours of the request. For routine requests, records must be provided within 30 days of the receipt of the written request.

Q Can a physician require that outstanding charges for medical services be paid in full as a condition for obtaining record copies?

A No.

Q Are there any situations in which charges should not be made?

A Yes. There should be no charges for record requests in the following situations:

- Immunization records required for school admissions
- For the purpose of supporting a claim or appeal under the provision of the Social Security Act for any Federal or State needs-based benefit program
- For benefits to applicant in connection with a Civil Court Certification Proceeding
- Workers Compensation Claim

Q How long should physicians store medical records?

A Medical records should be stored by physicians or their authorized agents for a period of at least five years, unless otherwise required by law. See pages 4-5 for a sample Medical Record Retention policy.