MEDICAL LIABILITY AND DOCUMENTATION ERRORS

2014 Office Practicum User Conference, Philadelphia
Learning Objectives

- Understand Scope of Medical Documentation Errors
- Affects on Patient Safety
- Appropriate Medical Documentation
- Paper to Electronic
- Risk Management in Preventing Medical Documentation Errors – Legal Liability
UNDERSTAND

SCOPE OF DOCUMENTATION

ERRORS
Scope of Errors

Medical Errors

- Wrong-site surgeries
- Scrambled Lab Results
- Medication Mishaps
- Misidentification of Patients
- Equipment Failures
- Limited Patient Information
Medical Errors and IOM

- “Do No Harm”
- 44,000-98,000 Deaths annually – 8th
- 7,000 Medication errors alone
- Cost Preventable Medical Adverse Events – 17-29 Billion Dollars/Year
- Costs are often attributable to LOS
- Immeasurable Costs – reputational, physical Pain, frustration
Who is Involved - Defragment

- Hospitals
- Outpatient Surgical Centers
- Physician Offices
- Clinics
- Retail Pharmacy
- Nursing Homes
- Home Based Care
Medical Documentation Error

- Definition: “Medical Documentation Error is the failure of a planned action to be completed as intended or the use of the wrong plan to achieve an aim”
B

Metadate: 10am
#100 (one hundred)

III PD g day
Date: 23/11/190

Dear Mr. A,

Due to the heavy rain today, I am not able to go out.

Yours sincerely,

Don't write like this.
Abbreviations

- ug – mg – Recommend “mcg”
- Trailing zero 1.0 mg easily read to be 10 mg
- Missing zero - .1 mg easily read for 1mg – Recommend 0.1 mg
- Insulin Units 10u - easily read as 100 units of insulin
Medical Documentation Errors

- Illegible Handwriting
- Diagnosing Errors
- Ordering Errors – Verbal Orders
- Medication Administration - Six Rights
- Continued Importance of the Six Rights even in the Digital Age of Medicine
Ease of Errors

- Narcan and Norcuron
- Altocor and Advicor
- Amantidine and Amiodarone
- Brevibloc and Brevital
- Coumadin and Cardura
- Hespan and Heparin
- Neurotin and Motrin
- Viagra and Allegra
Six Rights of Administration

- Right Patient
- Right Medication
- Right Dose
- Right Route
- Right Documentation
- Right Time
PATIENT SAFETY FROM MEDICATION ERRORS

MONITOR
Patient Safety Affects

- Physical Well-being
- Mental Well-being
- Trust in Medical Establishment
- Hidden Costs – Lost Work
- Changed Lives - Permanent Disability
- Death
DETERMINE

APPROPRIATE MEDICAL DOCUMENTATION
ISMP SUGGESTIONS

- ISMP – Institute for Safe Medical Practices
- Targeted Medication Safety Best Practices
- Examples: METHOTREXATE
  - Methotrexate – hard stop daily dose
  - Patient received 10mg x 7 days
  - Immunosuppressive agent
Death Certificate

- Gastrointestinal hemorrhage
- Pancytopenia
- Methotrexate toxicity
- Inquiry found physician, nurse and pharmacist responsible
- GP had disabled medication alerts
- Ensure computer systems do not propagate incorrect information
ISMP SUGGESTIONS

- Measure and express patient weights in metric units only
- Patient scales only measure only in metric units
- The goal of this best practice is to standardize the measurement and communication of patient weight grams and kilograms
- Weight-based dosing
ISMP SUGGESTIONS

- Ensure that all oral liquids that are not commercially available as unit dose product
- Dispensed by the pharmacy in an oral syringe
- Syringes marked “Oral Use Only.”
- Prevent the unintended administration of oral medications via the IV route
ISMP SUGGESTIONS

- Oral medications via IV
- 20% result in harm with one death
- Use of parenteral syringes to prepare and administer oral liquid medications
- Momentary slip - given IV
- niMODipine – through NGT at bedside mistakenly given IV
HMM....WELL, ACCORDING TO THE TERMS OF YOUR HEALTH MANAGEMENT PLAN, YOU HAVE TWO TREATMENT OPTIONS: SICKNESS OR DEATH.
MEDICAL DOCUMENTATION
PAPER TO ELECTRONIC
EMR Patient Advantages

- Improved diagnosis and treatment
- Significantly fewer errors found within personal health records
- Faster care and decision making responses from assigned medical professionals
- Portability
- Readability
- Clarity
EMR Hospital Advantages

- Quick transfer of patient data
- Improved results management and patient care with a reduction in errors
- Reduced operational costs
- Customizable and scalable electronic medical records that can grow with your practice
- Advanced e-Prescribing
Paper to Electronic Helps

- Handwriting
- Lost charts
- Patient Engagement Access
  - Track data over time
  - Identify need preventive visits and screenings
  - Monitor how patients measure up to certain parameters
Patient Involvement

- 100% Rx Prescribed
- 88% Rx Filled
- 76% Rx Taken
- 47% Rx Continued
-12% decrease
-12% decrease
-29% decrease
Electronic “Solutions”

- Computer-based Medical Records
- Pharmacy Integration
- Decision Support Software
- CPOE
- Bar Coding
- Alerts
- Templates
Let’s Talk

- CPOE – “garbage in – garbage out”
- Pharmacy Integration – 🕵️‍♂️
- Decision Support Software – Off?
- Bar Coding – Bracelets Taped
- Alerts – Turned Off, Slow Down Work Flow, Multiple Levels of Stringency
- Templates - “Lawyer’s Delight”
"Guess you didn't get the email. They beefed up the security for remote access to the E.H.R."
Increase Patient Safety
DECREASE LEGAL LIABILITY
Increase Patient Safety?
"The patient in the next bed is highly infectious. Thank God for these curtains."
AHRQ (Agency for Healthcare Quality) - 20 Steps

- Doctor aware all medications
- Bring medications and supplements to appointments
- Advise allergy/adverse reactions
- Read Rx when written
- Ask for medication information
- Check with pharmacist
- Understand labels
AHRQ (Agency for Healthcare Quality) - 20 Steps

- Measuring Device
- Side Effect Profile
- Wash Hands?
- Know Discharge Plan
- Verify Surgery
- Surgery Done Frequently by MD
- Speak Up
- Insure Coordinated Care
AHRQ (Agency for Healthcare Quality) - 20 Steps

- Divulge ALL information
- Take a friend
- More not always better
- Test - Follow Up (Don’t assume no news is good news)
- Review all Treatments Options and have someone with you when doing so
Institute for Safe Medication Practices

- cloNIDine - KlonoPIN
- CeleXA - CeleBREX
- zyYPREXA - ZyrTEC
- EPHINEPHine - ePHEDrine
- oxyCODONE - HYDROcodone
- PriLOSEC - PROzac
Patient Safety Organization

- PSO created by AHRQ – PL 109-41
- Support Implementation of Patient Safety and Quality Improvement Act
- Target Transitions and Handoffs - Huddles
- Create Nonpunitive Repository to Collect De-identified Medical Errors
- Analysis to prevent reoccurrence
PSO Legal Perspective

- No identifiable patient data
- Extends legal privilege and confidentiality protection to health care providers who voluntarily submit patient safety information to PSOs
- Amass data and analyze free from fear of retribution or suit
MEDICAL DOCUMENTATION
LEGAL LIABILITY
Legal Liability

- Federal Rules of Evidence Accept Medical Records as “First Hand Evidence” in a Court of Law As Long As:
  - The record was documented as part of the normal course of business
  - Record was created at or near the time of the delivery of healthcare
  - The person that is documenting in the record had actual knowledge of the events that are being recorded and has the legal ability to document in the chart
Legal Liability - Paper

- Errors in the record should not be obliterated.
- They need to be documented as an error, and the correct information needs to be entered.
- The information still has to be viewable.
- Addendum note that contains the corrected information.
Legal Liability - Paper

- Illegal and unethical – w/o authority to alter chart
- An audit trail – initial correction changes in the medical record, with the date and time of the error correction
- Errors not corrected properly - legality of the medical record in a court of law can be called into question
Legal Liability - Electronic

- Risk for Medical Malpractice Claims
- Permanence of Medical Errors
- Vulnerability to Fraud Claims
- Breaches, Theft and Unauthorized Access to PHI
- Need for Physicians to Accept and Understand Compliance and Legal Risks
EMR Record Ownership

- File Cabinet is Gone
- Where is the Data?
- Paper Rule – Physicians and Insurers owned the “tangible vessel in which they store patient data”
- Paper Rule - Patient’s had “right” to “access and accuracy”
- No “property rights” to paper information
Electronic Data Storage

- Physical Location of the Data becomes an Important Issue
- Two Basic Storage Options:
  - VAR – Value Added Reseller or Computer Based – stored in server within medical locale
  - ASP – Application Service Provider – Internet Based – data in an off site server out of the physical control of the practice
Legal Aspects of ASP

What needs to be included in Service Agreement for an ASP EMR System:

- Ownership of Patient Data
- Contractual Rights of Vendor to Use Data
- Software and Source Code Escrow
- Access to Data Scheme
- Contract Termination
Template Ownership

- Create Own Practice Specific Templates
- Time and Resource Consumption
- Vendor Should Never own Copyright to Your Templates
- Your Intellectual Property
- AND
- Lawyer’s Dream
Templates – Lawyer’s Dream

- Physician tired and fails to check off all the subsections
- Did you not perform a ROS?
- Recitation created with each new patient?
- EMR can be double edged sword
- EMR becomes Standard of Care
- COPY AND PASTE
Suggestions

- Document, Document, Document
- Written Policies and Procedures
- Written Business Associate Agreements
- Increase and Update Data Security
- Understand Breach of Privacy Reporting
- Understand Auditing Access to Electronic Data Files
- Geo-neutral Jurisdiction of Data
• McDonald CJ, Weiner M, Hui, SL. Deaths due to medical errors are exaggerated in Institute of Medicine report. JAMA 2000; 284(1):93-95.
• Leape L. Institute of Medicine’s error figures are not exaggerated. JAMA 2000; 284(1):95-97.
• Extraordinary similarities exist between infection control and medication error prevention. ISMP Medication Alert. November 17, 1999.
THANK YOU FOR YOUR ATTENTION
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