



HEALTHCARE

RISK MANAGER

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Medication Management Issues - A Driver in Professional Liability Lawsuits

By: Georgette Samaritan, Senior Risk Management Consultant

According to the Physician Insurer's Association of America (PIAA), medical liability claims involving prescription medications are the second most frequent and second most expensive type of professional liability claim in this country. Often times, problems patients experience as a result of taking medications are associated more with a monitoring and management issue than with a strict medication-related error.

The following case examples emphasize the importance of establishing a medication management plan at the time the prescription is written, and following that plan until the prescription is discontinued. The type of scenarios illustrated in this article could occur in almost any medical practice and involve good physicians. The challenge to physicians is to carefully examine their medication monitoring practices, and to make adjustments as necessary.

Case Study 1-Patient Monitoring/Medication Management

This case involves a 32 y/o white married male who was initially diagnosed with atopic dermatitis in year 2000. At that time his physician prescribed 40 mgs of prednisone for seven days, followed by 20 mgs for an additional seven days. Two years later the patient presented to a second physician with the same symptoms. At that time he stated, "I can't go on living like this." After a lengthy discussion of the risk and benefits, the patient agreed to proceed with a plan of care that included taking prednisone. This physician instructed the patient to "take 10 mgs daily until clear," then to try to reduce the dose to 10mgs every other day. He scheduled the patient for a two month follow-up in March. The patient did not show up for his March appointment. A week later, the patient called the office requesting a prednisone refill. The physician was not in the office. His physician's assistant gave the patient a prescription for 30 additional prednisone pills. Two months later the patient called again for another refill. The PA gave him 20 pills with no refill. Two weeks after that refill, the patient called for another. He had again missed his scheduled follow-up appointment. The PA gave him just enough pills until he could be seen. The patient did return to the office in mid June and was seen by that PA. The PA provided a three month prescription of prednisone with no refill. The patient was a no-show for his September appointment, but called in October for a

prescription refill. When the physician pulled the record, he wrote a note that the patient was to receive no more prednisone. That same month the patient began experiencing hip pain, and was diagnosed by MRI as having developed avascular necrosis in both of his hips. Subsequently, the patient underwent surgery on both hips and became a candidate for full bilateral hip replacements.

In summary, after having had one initial visit at the beginning of the year, this patient had been prescribed multiple 30 day courses of prednisone, 10 mg /day in February, March, April, May and June. He showed for one follow-up visit in June with the PA, who continued his prednisone prescriptions in July, August and September.

The lawsuit filed two years later alleged the physician failed to monitor prednisone therapy resulting in the patient's development of avascular necrosis.

Defense: Our primary defense in this case was that it is not definitive that prednisone in these low doses was the cause of the plaintiff's avascular necrosis, as opposed to prednisone prescriptions provided by the patient's first physician, and prior to seeing our physician. The patient did not voice complaints of hip pain in his June follow-up visit. The physician's office notes clearly state he went over the risks associated with prednisone. Despite these risks, the patient insisted that prednisone was "the only thing that worked" for his condition. He would accept no alternative or more conservative forms of treatment.

Case Disposition: With the physician's approval, this case settled for a moderate amount.

Risk Management Commentary:

- (1) According to our experts the physician lost credibility for not monitoring this patient more closely.
- (2) The patient was non-compliant, and did not come in for his appointments. During the nine months of treatment, we continued to tell him we were not going to give him additional prednisone unless he kept his appointments. Despite that warning, the physician's PA continued to provide the telephone refills.

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Conclusion:

In addition to monitoring patients receiving certain medications, it is also important to involve the patient in his/her care by providing the patient with practical and relevant information concerning the medications prescribed, and the overall goals of the management plan. Patients should be made aware of serious, well-recognized risks, as well as the potential benefits of taking certain medications. Physicians should consider referring patients to an appropriate specialist if the patient's condition does not improve after months of following a medication treatment plan. Medical offices should have refill policies in place, and supervise staff authorized to provide refills. Physicians should emphasize to patients the importance of following up with scheduled appointments, and taking the medication(s) as prescribed.

Case Study 2-Medication Risk/Benefit Analysis

This case involved the death of a 64 y/o old married male secondary to a massive intracranial hemorrhage following a cardiac catheterization performed by our insured cardiologist.

The plaintiff patient had a history of cerebral hemorrhage and DVT. As a result of the stroke, his vision was affected but he did not suffer from mobility problems. Three years later, the patient suffered a heart attack and was referred to our insured cardiology practice. At that time physicians inserted a pacemaker. The patient continued to be followed by cardiologists in this group.

Two years later while on a camping trip, the patient suffered another heart attack. He was admitted to the care of the same cardiologists. Two days later the patient underwent a cardiac catheterization by one of the group's cardiologists. On the previous day, and at the time of admission, the cardiologist's On-Call partner wrote a progress note stating that the patient was to receive no Integrelin based on his history. There was some question regarding when this entry was made as it was squeezed in between two other lines of notations. The On-Call partner testified that his note was in no way meant to preclude the use of Integrelin. He meant it as an advisory in the event that patient needed catheterization. Our treating cardiologist does not recall seeing this progress note prior to the catheterization. Prior to cardiac catheterization, he gave the patient LovenoX and Plavix even though the record clearly stated that no TPA or other thrombolytic agents were to be used due to the patient's predisposition to intracranial bleed. The cardiologist performed an angioplasty, and observed the area of chronic occlusion. He thought the patient would benefit from opening the occluded coronary vessels, and therefore administered Heparin and Integrelin. Heparin was administered at 70 units/kilogram of body weight. When the cardiologist determined that he would be unable to open the occluded artery, he terminated the procedure. He discontinued the Integrelin at the conclusion of the procedure. Later that evening when the cardiologist made rounds, he learned that the patient had suffered a massive intracranial bleed, was in a comatose state, was not expected to survive, and would not benefit from neurosurgery according to neurology and neurosurgery consults. At the family's request, orders were written for "Do Not Resuscitate;" the patient was not intubated nor placed on a ventilator. He was pronounced dead two days later.

At the post death conference, the patient's wife asked the

New Offering for Policyholders: Free Web-Based Risk Management Training for Office Staff

Practices may now take advantage of a series of free on-line training programs, or Learning Modules, designed specifically for medical office staff. These Learning Modules include important medical office system topics that have professional liability implications for physicians:

- Telephone Communications
- HIPAA Compliance
- Safe Handling of Sample Medications
- Maintaining an Effective Clinical Tracking System
- Documenting Patient Non-Compliance

Locate the Learning Modules at
www.magmutual.com/CME/interactive-modules/index.html

cardiologist why he did not review the chart, and why he gave her husband blood thinners. The cardiologist's response was that no one told him and that he was sorry.

Clinical Risk Management Commentary

The key issue in this case was our treating cardiologist's failure to review the medical record and to communicate with his partner concerning the patient's sensitivity to Integrelin and other blood thinners.

We attempted to mount a defense based upon a theory of "benefit greater than the risk." Defense experts opined that the use of Integrelin on this patient outweighed the risks of hemorrhagic stroke. However, they agreed that substantial defense obstacles included:

- The PDR and package inserts contradicted the cardiologist's decision and treatment plan.
- While the information concerning the use of Integrelin in patients with prior history of stroke may have been somewhat outdated when compared with newer studies, most likely the cause of the patient's stroke was the administration of Heparin.
- There was a question as to whether the intervention to open the patient's right coronary artery blockage, present for years, should have been attempted.
- The patient had not had an MRI or MRA to evaluate his neurological status prior to administering the Integrelin.
- Our insured was poorly prepared for the post death conference with family, making statements which may have implied negligence.

Conclusion

Some lessons to be learned from this classic case scenario are that physicians should implement a standardized approach to "hand off" communications, including allowing an opportunity for the receiving physician to ask and respond to questions. The receiving physician should build in time to conduct a complete review of the patient's history.

Medication Management: What Does Your Medical Record Documentation Reflect?

By: *Georgette Samaritan, Senior Risk Management Consultant*

Here are some suggested components providers might consider when documenting medication management issues. How does your current medical record documentation compare? To download a copy of this tool and other helpful tools, go to the MAG Mutual Risk Management & Patient Safety web page: www.MAGMutual.com/risk/index.html

Documentation Component	Yes	No
Assessment/Problem Definition		
<ul style="list-style-type: none"> Have you correctly identified the problem or condition (onset, frequency, intensity, duration, etc.) for which a medication is being prescribed? 		
<ul style="list-style-type: none"> If needed, have you clearly documented your rationale for the use of the medication(s) as treatment for the problem or condition? 		
<ul style="list-style-type: none"> Have you identified the <u>individual</u> patient's risk factors for the use of the prescribed medications? 		
Diagnosis/Cause Identification		
1. For any <u>new</u> patient event, such as loss of patient appetite, weight loss, fall, change of mental status/behavior, etc., have you reviewed the drug regimen to determine the possibility that one or more medications may have contributed to the change in condition or functional decline?		
2. When a new patient event results in adding another medication to treat the symptom, have you explained why the additional medication is the most appropriate treatment?		
3. Have you considered that the drug order or actual medication administration (transcription error, illegible handwriting, adequate fluid for swallowing, taken with/without food, the amount of medication taken at one time, the interaction of that medication with existing medications) may have contributed to the patient's change in condition?		
Treatment/Problem Management		
<ul style="list-style-type: none"> Have you identified a high-risk medication, medication combinations, doses and other factors that may contribute to a significant change in the patient's condition? 		
<ul style="list-style-type: none"> Have you periodically monitored the patient for significant effects, side effects, and complications by performing appropriate lab tests, monitoring for target symptoms etc.? 		
<ul style="list-style-type: none"> Have you demonstrated a systematic approach for timely response to adverse drug reactions? 		
<ul style="list-style-type: none"> Have you followed a possible adverse drug reaction until the symptoms resolved or another cause for the symptoms was identified? 		
<ul style="list-style-type: none"> Have you educated the patient sufficiently (i.e. Informed Consent) so that he/she might be an active participant in the medication treatment plan? 		
<ul style="list-style-type: none"> Have you documented your patient's understanding of the medication and treatment plan in the medical record? 		
Medication List		
Have you adopted the use of a medication record, listing <u>all</u> of the patient's medications and supplements?		
Is allergy/sensitivity information prominent and easily found in your medical record?		
Does the patient have a current copy of their medication record?		

If you answered "No" to any of these questions, please consider developing a plan to address the identified issues. Please contact us for additional assistance.

Develop Grass-Roots Level Organizational Commitment and Improve Productivity by “Engaging” Your Employees

By: *Joe Deroko, Manager, Training & Development*

What does “engaging your employees” mean? How do you know if your employees are “engaged” in their jobs? How does employee “engagement” improve organizational productivity and decrease loss of time and resources in an organization?

Basically, employees who are engaged believe in their company, love what they do, understand the bigger picture, will most likely show up to work, have a positive attitude, and are less likely to leave for other opportunities. They will provide excellent customer service, improve processes, and be a breath of fresh air for their managers.

According to a recent Gallup study on “employee engagement,” about 54 percent of employees in the United States are not engaged and 17 percent are disengaged. Only 29 percent are engaged. There are real risks associated with a workforce that is not “engaged,”

namely: higher occurrences of absenteeism, poor morale, frequent employee relations issues, higher turnover, and lack of production, EEOC Claims, and even eventual company shut-down.

Managers can work at the gras-roots level to engage the workforce one employee at a time by:

- **Assisting the company in making positive culture changes**
- **Developing consistent & active communication processes**
- **Providing on-going feedback**
- **Providing opportunities for success**

To obtain more information about this topic, or other Human Resources topics of interest, contact **Joe Deroko** at **404-842-5688**.

Problems Documenting Test Result Management- How about this Risk Management Tip?

By: *Teresa McMillan, RN, MSA, CPHRM, LHRM*

Problems with processing and managing test results is a common, but high risk task, often leading to failure to diagnose or delay in diagnosis claims if not properly performed. To protect the patient and your practice, the medical record should reflect that the process of managing patients’ test results is well documented in the medical record, particularly that the patient was notified of the results, and that a follow-up plan is in place, if applicable.

Tip: For those practices that are using paper records, consider applying a stamp (Figure 1) to ensure documentation and tracking has occurred. The stamp may be applied to the test result itself as long as the information contained in the report is not obscured.

Received (Date):	Dr. Reviewed _____ (initial/date)
Results Normal <input type="checkbox"/>	Call/notify patient <input type="checkbox"/> (date)
Results Abnormal <input type="checkbox"/>	Schedule f/u appt <input type="checkbox"/> Date:
Other action s needed:	
Nurse/MA:	Action Taken :

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