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MEDICAL LOSS PREVENTION bulletin

Avoiding the Fumbled Handoff

Healthcare providers often underestimate the risks inherent in transitions of patient care from one provider to the next. Malpractice litigation and regulatory agency investigations against healthcare providers, however, frequently focus on claims of "fumbled" handoffs. In order to deal with this problem effectively, health care providers who are committed to a culture of risk management must start with the realization that making (or receiving) a good handoff is no less important than making a proper diagnosis.

At the outset, healthcare providers with a proper risk management mind set should be attuned to circumstances in their practice that are ripe for handoff problems. Among the more frequently and countered situations in medical malpractice litigation are the following:

- Patient transfers from busy emergency departments to attending physicians on the floor. (Hectic environments are an invitation to poor communication. For example, "wrong site" surgery cases almost always start with inadequate or inaccurate information from initial healthcare providers.)
- Patient transfers to and from PCP's and Hospitalists. (Physicians who specialize in in-patient care provide many benefits to both patients and primary care providers, but proper continuity of care at both admission and discharge is dependent upon proper exchange of relevant information.)
- Hospital discharges where patients have ongoing needs for medication, testing and follow-up. (The period between hospital discharge and resumption of physician office visits is often a stage on which malpractice cases are set. Especially for patients who are older or chronically ill, this time period is often characterized by confusion and uncertainty about ongoing care.)
- Patient transfers from attending physicians to on-call physicians, especially at vacation time. (It is a recurring theme in malpractice litigation that a physician's worst complications are those that arise when he or she leaves for vacation and fails to communicate important information to covering physicians.)
- Consultations that are informal or fail to clearly define the reason for the consultation or the scope of responsibility. (Failure to clearly document the scope of the consultation and demarcate the lines of responsibility, especially for ongoing medical needs such as anti-coagulation, often leads to malpractice litigation. In the world of malpractice litigation, there is no such thing as an informal or limited consultation.)

Case Study I ▶

A 55 year old male presented to his Dermatologist for a lesion on his forehead. A shave biopsy noted fragments of scale crust, solar-altered dermis and dysplastic squamous epithelium extending to the margins of the specimen. The Dermatologist recommended excision of the lesion, but because of its size, referred the patient to a Plastic Surgeon for excision of the lesion. The Dermatologist called the Plastic Surgeon and described his findings, impressions and reason for referral, but sent no documentation. After seeing the patient, the Plastic Surgeon, who was unaware that the biopsy specimen extended to the margins, believed that the lesion was a benign growth that would likely recede in size and he recommended a period of watchful waiting prior to surgical excision so as to reduce the size of the resulting scar. After more than 6 months, the lesion showed no signs of receding and the lesion was excised. Surgical pathology showed the lesion to be squamous cell carcinoma. Within 18 months, there was evidence of metastatic disease and the patient eventually succumbed to cancer. The Plastic Surgeon settled for policy limits. A jury returned a verdict against the Dermatologist for $6 million.

Case Study II ▶

A 37 year old female with thrombocytopenic purpura was admitted for replacement of her dialysis catheter. During the surgery, difficulty was experienced in replacing the catheter and eventually a catheter had to be inserted on the patient's other side. An air embolism apparently occurred during the initial catheter replacement attempt. The patient was brought to the PACU and a routine post operative chest x-ray was requested to confirm position of the catheter. The PACU nurse asked the physician to read the film before leaving the hospital, which is a requirement for patient discharge from the PACU to the hospital floor, but the physician left the hospital before reading the film. He signed out to his partner and asked her to read the film as they were passing in the hospital parking lot. The physician did not mention that he had particular difficulty in placing the catheter and that the guide wire kept coiling, nor did he mention that an air embolism was suspected.

Within 30 minutes of the patient's arrival to the PACU the patient began complaining of the inability to breath. The nurse paged the physician, but received no answer. The nurse then paged the covering physician to read the chest film, but she was already in the Operating Room performing surgery. The patient continued to have respiratory difficulties and was eventually intubated and taken to the ICU. Despite multiple interventions she never recovered and died.

Recommendations ▶

The Joint Commission on Accreditation of Healthcare Organizations identified communication problems as a major cause of nearly 70% of all sentinel events. Whether assuming care from or transferring care to another, therefore, healthcare providers should devote proper time and attention to communication. Beyond the basic patient-specific information such as history of present illness, past medical history, physical findings, medications, test results and the like, providers should also devote proper attention to such matters as purpose of transfer or consultation, lines of responsibility, expectations for the patient's future care and appropriate documentation. Transitions in patient care should not involve guesswork.

The following recommendations address loss prevention issues associated with bowel perforations. These strategies are provided with the intention of improving patient care, optimizing patient outcomes and minimizing physician exposure to litigation.

- Consultation requests and consultation reports should be formally documented. Copies of relevant records should be provided.
- Patients should not leave the hospital without a clear understanding of the plan for their medications and the specifics of the plan for follow up—who, where and when.
- Sign-outs to on-call physicians or other physicians assuming the patient's care should flag any complications or unusual occurrences or ongoing medical issues that may need attention.
- Try to have handoffs in a quiet, private place to minimize the possibility that information will be lost or overheard by those other than the intended recipients.
- Avoid e-mail or voicemail by itself in the handoff process.
- Have a checklist for elements of a safe handout.
- Keep in mind, communication failures can lead to uncertainty in patient care decisions.

This review was conducted for its loss prevention value to assist doctors in recognizing the liability exposure as it relates to the failure to diagnose and treat bowel perforations. **You may address these issues further by contacting Nancy Moody, Medical Loss Prevention Specialist, at 860-633-7788 ext. 283. Please return the attached form to receive CME credit for reviewing this Medical Loss Prevention Bulletin.**

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