MALPRACTICE PREVENTION FOR ALLIED HEALTH PROFESSIONALS

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PRACTICAL OVERVIEW: Why Discuss Malpractice?

- Medical errors occur in 2.9% to 3.7% of hospital admissions
- 8.8% to 13.6% of errors lead to death
- As many as 100,000 hospital deaths may occur each year as a result of medical errors

Institute of Medicine Report

Putting it into perspective…

- 6,000 Americans die each year in work place injuries
- 7,000 Americans die each year from medication errors alone

Putting it into perspective…

- More people die each year as a result of medical errors than from:
  - Vehicle Accidents (43,458)
  - Breast Cancer (42,297)
  - HIV Related Illness (18,987)

WHY PATIENTS SUE PROVIDERS?

Provider Communications Failure to discuss and disclose Failure to respond to requests	35%
Provider Attitudes In a hurry Air of superiority Appearing indifferent	35%
Unrealistic Expectations	5%
Provider Disparagement of Previous Care	7.5%
Media Coverage of Malpractice	7.5%
Patient's Financial Incentive	10%

WHY PATIENTS SUE HEALTH SYSTEMS?

- Poor Documentation
- Failure to Provide Quality Customer Service
- Medication Errors
- Systemic Issues
- Alleged Negligence in Emergency Procedures

The Legal Overview

What is Medical Negligence?

Medical Negligence

- Four Elements of Medical Negligence:
  - Duty
  - Breach of Duty
  - Proximate Cause
  - Injury/Damages

Medical Negligence

- Duty
  - To exercise reasonable care
  - To use best judgment
  - To comply with the standard of care

Medical Negligence

- Breach of Duty
  - Failure to meet one's duty or to conform to a required standard. In a malpractice case, this involves determining the standard of care and whether it was met.

Medical Negligence

- Causation
  - Requires proof that there was a direct relationship between the breach and the injury.

Medical Negligence

- Injury/Damages
  - Actual loss or damage

Medical Negligence – The Specifics

Duty – Not Guarantor of Diagnosis, Analysis, Judgment or Result

A health care provider does not, ordinarily, guarantee the correctness of her diagnosis, analysis or judgment as to the nature of a patient's condition or the success of her health care service rendered. Absent such guarantee, a health care provider is not responsible for a mistake in her diagnosis, analysis or judgment.

Medical Negligence – The Specifics

Duty – Highest Degree of Skill Not Required

The law does not require of a health care provider absolute accuracy, either in her practice or in her judgment. It does not hold her to a standard of infallibility, nor does it require of her the utmost degree of skill and learning known only to a few in her profession. The law simply requires that the care provided fall within the standard of care.

Establishing the Standard of Care

- Requires expert testimony (Rule 9(j))
  - The expert witness cannot simply testify that he or she would not have practiced in that manner.

Establishing the Standard of Care

- Proof is established through expert testimony citing:
  - Standards established by the hospital or health care system involved
  - Standards established by the community of health care providers – what are other health systems doing?
  - Standards established by recognized organizations like the CDC (Centers for Disease Control)
  - National or state associations

Medical Negligence – A Common Defense

- Contributory Negligence
- If the plaintiff's negligence joins with the negligence of the defendant in proximately causing the plaintiff's own injury or damage, it is called contributory negligence, and the plaintiff cannot recover.
  - failure to provide accurate medical history, e.g., allergies
  - failure to follow medical advice, e.g., non-compliance

MOST LITIGATED ISSUES

- Failure to ensure patient safety
- Improper treatment or performance of respiratory procedures
- Failure to follow hospital policies, protocols
- Failure to document accurately or appropriately
  - Not enough documentation
  - Allowing others to document the event
  - Failure to review documentation of others

PREVENTING MALPRACTICE: The First Step

- Put Resources into Orientation and Training
- Focus on Preceptor Programs
- Continuously Update Skills
  - In-service programs
  - Off campus seminars

PREVENTING MALPRACTICE: THREE SIMPLE RULES

- Improve relationships with patient, family and other providers
  - Take the time
- Improve communication with providers
  - Listen and advocate
- Improve medical record documentation
  - Carefully document critical events
  - Read the documentation of others

MEDICAL RECORD DOCUMENTATION

How Records are Used to Prosecute a Claim

- To determine the extent of the injury.
- To show a series of events leading up to the injury.
- To help determine where to place responsibility.
- To show that information was available in the record and staff failed to use it.
- To show failure to write clear medical orders.

MEDICAL RECORD DOCUMENTATION

How Records are Used to Prosecute a Claim

- Document all relevant information.
- Substantiate the rationale for care provided or not provided.
- Show the interaction between disciplines and professionals.
- Create a timeline for the care given.
- Document the psychosocial as well as medical needs and concerns of the patient and relevant others.
- Preserve the medical history of the patient.

WHAT PLAINTIFF ATTORNEYS HOPE TO SEE IN YOUR MEDICAL RECORDS

- Failure to refer, track, and recommend preventative health measures
- Failure to document supervision and monitoring of patients
- Contradictory statements
- Derogatory statements or comments about patients or their family, other providers
- Failure to document telephone calls during and after business hours

WHAT PLAINTIFF ATTORNEYS HOPE TO SEE IN YOUR MEDICAL RECORDS

- Failure to document informed consent
- Failure to instruct patients regarding treatment
- Failure to provide warnings about high-risk medications
- Failure to note allergies, maintain a current list of all medications

What Plaintiff Attorneys Hope to See in Your Medical Records

- Illegible and/or incomplete documentation
- Altered records
- Self-serving late entries
- Failure to acknowledge and properly act on lab and diagnostic test results
- Failure to coordinate care with a consulting physician

Documenting Conversations With Patients/Families

- Document teaching/discharge instructions given to the patient.
- Document evidence of patient non-compliance.
- Document verbatim reports of patients in quotations.
- Document interference of family members.
- Document information supplied by family members if critical to patient's care or relayed to other HCPs.

Medical Record Documentation

Essentials of Documentation

- Document each time a patient refuses treatment and why.
- Document what you did about it and who you notified.
- If your care varies from policy or procedure, your note should reflect the deviation and the reason.

Medical Records Documentation

Tampering With the Medical Record

- Altering the record, whether unintentionally or intentionally, may lead to disputes in the care received.
- Tampering with record may include:
  - Changing inaccurate information
  - Filling in omissions
  - Altering dates and times
  - Adding to someone else's notes
  - Correcting and amending notes

Medical Records Documentation Summary

Be sure to…

- Thoroughly document emergent events
- Thoroughly document critical events
- Review the documentation of others for accuracy
- Record pertinent discussions with patients
- Document non-compliance

ASSISTING IN FUTURE LITIGATION

What to Do to Protect Yourself and the Institution…

Three Rules to Ensure Privilege and Protection

1. Do not document until instructed to do so by Risk Management or counsel.
2. Do not discuss details with peers. Stop talking.
3. Seek out Risk Management personnel if concerns or questions.

The Role of Allied Health Professionals In Preventing Litigation

- **Keeping Information confidential**

(1) In anticipation of litigation

(2) Work product

(3) Attorney-Client privilege

Keeping Information Confidential

To keep information confidential, notify Risk Management early before documenting/investigating outside the medical record.

Attaching Privilege to Your Thoughts and Notes

Keeping Information Confidential

Early notification to attorney

(1) Assures confidentiality

(2) Protects free flow of candid information and analysis

(3) Protects allied health professional and hospital in future litigation

Questions?