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Risks in the Office Setting: Enhancing Patient Safety

AND

Social Media in Litigation

MPL

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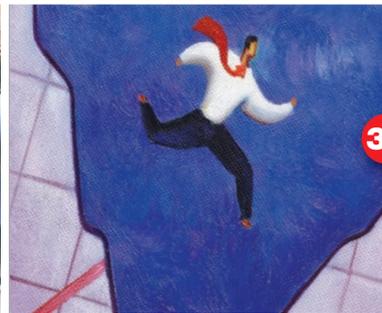
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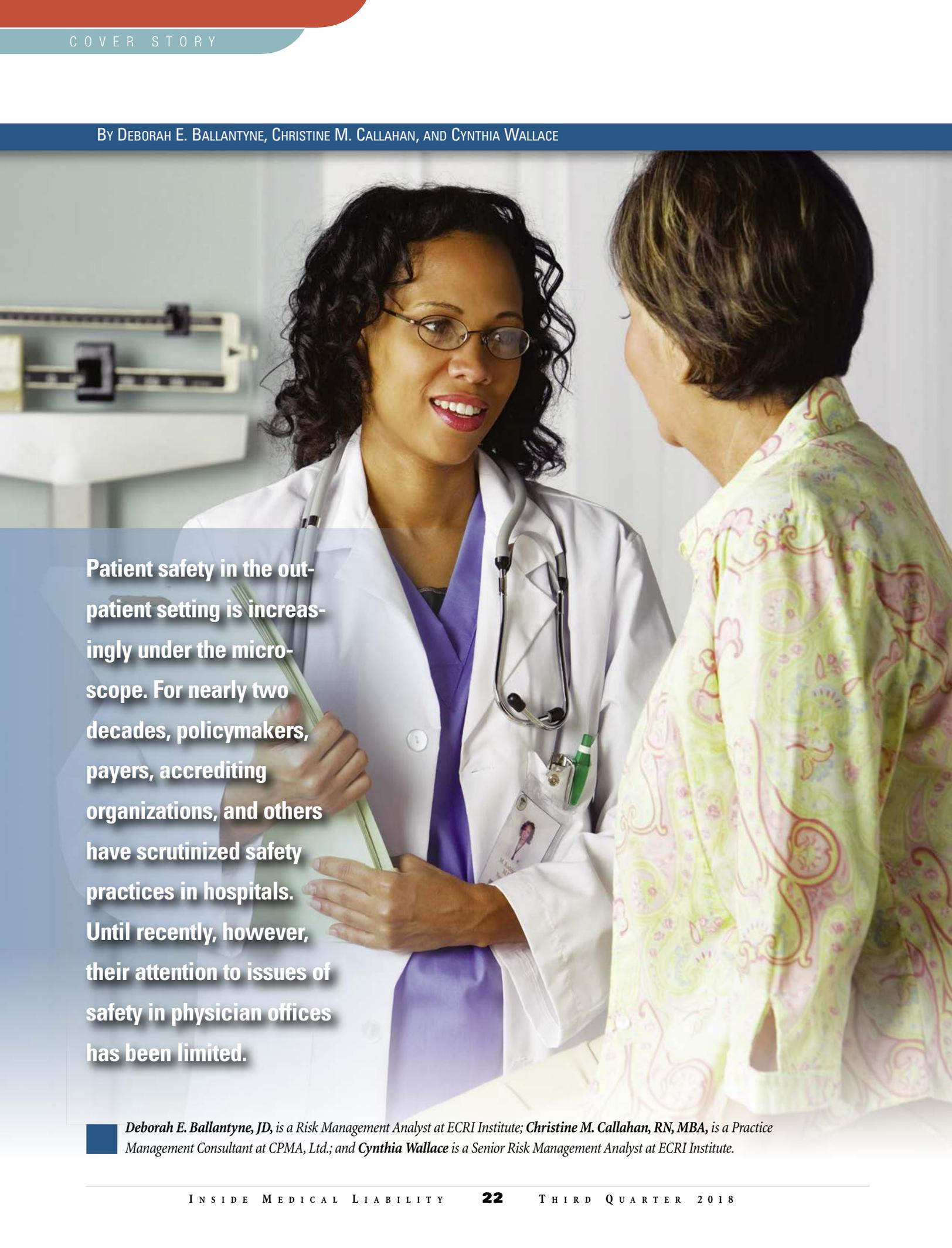
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“Physician practices cannot simply apply the patient safety strategies used in hospitals to outpatient care. Not all hospital safety practices transfer to outpatient settings.”

—Cover story

BY DEBORAH E. BALLANTYNE, CHRISTINE M. CALLAHAN, AND CYNTHIA WALLACE



Patient safety in the outpatient setting is increasingly under the microscope. For nearly two decades, policymakers, payers, accrediting organizations, and others have scrutinized safety practices in hospitals. Until recently, however, their attention to issues of safety in physician offices has been limited.

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Are These Risks on the Office Practice's Patient Safety Radar Screen?

Here's Why Providers Need to Pay Attention

In 2017, the American College of Physicians declared that the focus on patient safety must extend to the outpatient setting, where health-care interactions far outnumber those in hospital visits.¹ The risk of errors is just as high—if not higher—in the outpatient setting, the physicians' group said.

Although much research in patient safety has focused on hospitals, physician practices cannot simply apply the patient safety strategies used in hospitals to outpatient care. Not all hospital safety practices transfer to outpatient settings. For example, avoiding patient identification errors has been a focus in hospital safety, and instituting a protocol to use at least two patient identifiers can prevent patient identification mix-ups in all types of clinical settings; however, strategies emphasizing alarm safety are important in hospitals but have less relevance for physician practices.

Physician practices must develop patient safety programs tailored to their needs, as well as to the needs of their specific patient population. Often, attention is directed to strategies for problem-prone areas, such as tracking of test results, medical record documentation, and communication with patients. Unfortunately, other error-prone areas may fall off physician practices' radar screens for patient safety.

ECRI Institute, a nonprofit organization dedicated to improving patient care, works closely with organizations that focus on outpatient and physician office care to identify and develop processes to overcome gaps in patient safety. We address commonly noted patient safety gaps, but we also tackle the little-noticed patient safety concerns that can lead to errors, as well as costly claims and litigation.

Four patient safety topics that physician practices may overlook are vaccination safety, medication sample management, telephone and in-person triage, and competency assessment of unlicensed nonphysician providers, such as medical assistants.

Vaccination safety



Every year, physician practices vaccinate millions of children and adults in the U.S. to prevent the sickness, disability, and death that can result from infectious diseases and illnesses, such as influenza, polio, measles, mumps, and rubella. Unfortunately, errors can occur,

particularly during vaccine administration.² Examples of errors include the following:

- The wrong vaccine is given.
- The wrong dose is administered.
- An expired vaccine is given.
- A recommended vaccine is missed or omitted.

Although adherence to an organization's medication-safety practices can prevent many vaccine errors, some errors are the result of issues specific to vaccines, such as confusion about adult- and child-specific presentations and mix-ups involving similar vaccine names and packaging. For example, mix-ups are particularly common for the diphtheria, tetanus, and pertussis vaccines, abbreviated as DTaP and Tdap. These vaccines have similar abbreviations but very different uses; DTaP is used to immunize patients six weeks through six years of age, while Tdap is used as a booster shot for older children and adults.

The safe administration of vaccines depends on professional staff who are trained and educated in the proper storage and handling of vaccines, correct techniques for vaccine reconstitution, and appropriate timing of vaccine administration according to evidence-based vaccine schedules issued by the Centers for Disease Control and Prevention. In addition to providing staff with education about vaccines, practices can help staff avoid errors during vaccine administration by using standard-

ized protocols that present information in a clear, consistent, and uniform format. Strategies that practices might use include the following:

- Ensure that staff have access to current patient information (such as immunization records) and the most current immunization schedules.
- Ensure that providers give a Vaccine Information Statement (VIS) to every patient for each vaccine he receives, before administering the vaccine. VIS sheets describe indications, risks, and contraindications. In addition to providing the VIS, they need to engage patients and parents of pediatric patients in discussions about vaccines; patients are the last line of defense in preventing errors.
- Set up task-specific templates (electronic) or order forms (paper) that identify the vaccine name (trade and generic), patient age parameters for the vaccine, dosage, and route of administration.
- Require staff to check vaccine expiration dates before reconstitution or administration.
- Instruct staff to follow the “rights” of vaccine administration with every patient (i.e., right patient, vaccine and diluent, time, dosage, route, site, documentation); require and monitor that all staff verify the patient’s identity by checking two patient identifiers (for example, ask the patient to state his name and date of birth) immediately before administering the vaccine.
- Unless the vaccine is prepared in front of the patient, label all syringes with the name of the vaccine to be administered.

Practices should consult their state statutes to confirm which professionals can administer vaccines. Typically, registered nurses and medical assistants administer vaccines, but a few states prohibit medical assistants from administering injections. If medical assistants are permitted to administer vaccines, practices should consider requiring that they be certified or registered with an accredited medical assistant program to administer vaccines of any type. They should also routinely confirm that their certification is current.

Many physicians provide medication samples to patients, despite safety concerns and ethical issues regarding their use. Frequently cited reasons for handing out samples are to help a patient initiate medication therapy and to reduce prescription costs for low-income patients, although some studies dispute the effectiveness of such efforts. As of 2009, an estimated two-thirds of physicians accepted medication samples from pharmaceutical sales representatives, but that percentage has been declining, with the public increasingly aware that conflicts of interest can influence physician prescribing.³



Some practices reportedly do not have important safeguards in place for the use of medication samples. For example, one spot check of drug samples kept by a group of family-practice and general internal-medicine offices found that 14% of the samples had expired.⁴ Another analysis of 17 urban and rural primary care practices found that no office was following all of the recommended practices for dispensing samples to patients, such as communicating precautions for use.⁵ Physicians could be at risk of litigation if a medication sample is given to a patient by mistake and causes harm.

Short of eliminating medication samples from the practice altogether, important measures for handling samples to ensure patient safety include the following:

- Educate pharmaceutical company representatives regarding the practice’s policy on sample medications, and have representatives sign in and out upon each visit.
- Remove samples from examination rooms, and store them in a secure location that is in sight of office staff and locked during nonpatient hours.
- Keep a log of medication samples that lists the drug name, lot numbers, quantity, and expiration date. Providers and office staff who distribute samples should sign the medications out using the same log.
- Provide written information about the medication to the patient (reason for the medication, dose, special precautions, and side effects, including allergic reactions).
- Track sample medications to their final disposition. Be alert to recalls. In the event of a recall of medications dispensed from the office, the practice must notify the patients to whom the medications were dispensed.
- Separate and clearly identify medications of different strengths. For high-alert medications with the potential to cause serious harm if administered incorrectly, limit the number of doses and forms available.
- Store medications according to class or in some other easily understood order that prevents mix-up of similarly packaged products. Do not store medications in alphabetical order.

- Stock medications with look-alike or sound-alike product names in separate areas. Attach brightly colored warning labels to packages of drugs that might be easily confused.

- Routinely inspect medication samples, promptly removing recalled or expired drugs from the inventory. Discard expired medication samples in accordance with federal, state, and local laws.

- Limit the amounts and types of samples available to medications most often prescribed by the practice’s providers.⁶

Patient triage, either in person or by phone, enables a practice to direct a patient to appropriate services in a safe and timely manner. Triage services are typically offered during regular work hours within a range of practice settings, including general practices, primary care, pediatric practices, and managed care environments.

Triage is not the same as message taking. It is grounded in a clinical skill set sometimes

required of licensed medical professionals that involves the safe, appropriate, and timely evaluation of patient symptoms.

Failure to set protocols in place to guide triage can create confusion and frustration for both staff and patients. ECRI Institute recommends that practices periodically evaluate their triage system, to identify opportunities to tune up their procedures and formalize their protocols. They should start by assembling a team of clinical and administrative staff to discuss the current approach and suggest improvements.

The qualifications of triage staff are an issue that often arises. Most important is to check state scope-of-practice regulations. Many states have clear guidelines related to who is qualified to make an assessment over the phone or in person. Usually, telephone triage is performed by a registered nurse, advanced-practice professional (such as a nurse practitioner), physician assistant, or, in some cases, a physician. Licensure alone is not enough. Triage staff should complete a standardized education program that includes an orientation with a preceptor prior to starting triage duties.

Also, practices need to consider the qualifications of staff performing triage on site. The person who is assigned to do triage may be the first person to encounter a patient experiencing a cardiopulmonary event. Therefore, completion of both basic and advanced cardiac life support courses may be necessary. Depending on the practice's patient population, triage staff may need additional training in areas such as maternal and child health, behavioral health, or geriatrics.

If the office offers telephone triage, staff will need additional training to underscore the responsibilities—and challenges—inherent in taking telephone calls, as opposed to seeing patients face to face. When a practice takes a call, it is liable for any advice given—as well as any advice that is appropriate, based on the patient's chief complaint, but is *not* given. Essential principles of telephone triage



Telephone and in-person triage

include the following:

- Know the “red flag” complaints that should prompt an urgent response.
- Get enough information to give informed advice.
- Give advice based on the worst-case scenario.
- Follow standard written protocols for triage of patient symptoms. Protocols are used to explore patients' symptoms with a preestablished set of questions and then recommend

a course of action.

- Resist being dismissive of a caller's concerns or overinvesting in the patient's self-assessment of his or her condition without asking more questions.
- If the call is about a previous or unresolved problem, revisit the problem until it is resolved.
- Document the history taken and advice given by telephone.

Staff should also be aware of common pitfalls in triage, especially on the telephone. For example, be careful with the use of voicemail. Check messages regularly, to be sure staff return calls promptly.

To identify gaps, the office should periodically assess its triage practices. Sample questions might include the following:

- Is a system in place to monitor triage staff compliance with triage protocols?
- Do nurses and other licensed professionals who give telephone advice have specific training, experience, and documented competence in telephone assessment techniques?
- Are the standard triage protocols reviewed and updated at least every two years to ensure consistency with current standards of care?
- Are triage staff instructed to consult a physician whenever they have doubts about proper instructions or advice?

- Are physicians assigned to back up triage staff to answer questions? Are physicians receptive to questions from triage staff regarding patient calls?



Competency assessment of nonphysician providers

Delivering safe, high-quality care to patients depends on employing a staff of competent healthcare professionals of all levels.

Assessing the competence of unlicensed staff, particularly medical assistants, is another area that requires close study. In one incident, a medical assistant administered an influenza vac-

cine to a newborn during a well-baby check, not realizing that babies under six months of age do not receive these vaccines. No one in the practice had checked the medical assistant's knowledge of flu vaccines. Fortunately, the baby was unharmed, but a similar mistake could lead to serious injury and result in costly litigation.

Outcomes-oriented assessments are essential to enable unlicensed staff to demonstrate effective and practical use of their knowledge and skills, such as placing leads for electrocardiograms and measuring a patient's height and weight. Simply relying on how an employee scored on a test is insufficient.

Practices should develop a step-by-step approach to assess and reassess staff members' competence throughout their periods of employment. Staff should be evaluated at periodic intervals to determine whether their competency meets the standards expected of their position. While the following checklist for assessing a staff member's basic competencies can apply to both licensed and unlicensed clinical staff, its focus is assessment of unlicensed staff members, such as medical assistants.

- Examine the hiring process to make sure that it includes verifying the applicant's training, education, certifications, and experience and checking his or her references.
- Review all job descriptions at least every two years or more often, if position responsibilities or advances in technology necessitate an update. Check the state's scope-of-practice laws before updating any job description.
- Review the staff orientation process to ensure that it includes a general office orientation as well as orientation to responsibilities specifically outlined in the individual's job description. Use an orientation checklist to be sure that all items are covered.
- Review the available training for clinical staff, recognizing the limitations and roles of the position. Use different types of learning methods, such as written information, video, demonstration, and simulation, to ensure that the individual has a comprehensive understanding of the topic.
- Identify staff who can take on training responsibilities, and ensure that they understand their role in training new staff using current policies and best practices. Do not permit training that is based on the shadowing of staff, which can lead to the adoption of ingrained bad habits, such as workarounds and omission of necessary steps in a process.
- Assess staff competencies in all areas, but especially in high-risk or high-volume areas, such as medication administration, weights and measures, and specimen collection.
- If a staff member's skills fall short in a particular area, institute a process to retrain and retest the individual, and document the outcome.
- Develop a performance appraisal form that is consistent with the

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staff person's job description. This will provide guidance on an annual basis to help the individual perform within his or her scope of practice and effectively demonstrate competency.

- Establish an internal committee (or use an existing one) to periodically review the forms used for orientation, competence, and performance evaluations, to be sure that they are up to date and accurate.

Adopting a comprehensive approach to patient safety

Care provided in physician offices represents the largest and most widely used segment of the U.S. healthcare system. Even so, until recently, the physician office setting has not received the attention with regard to patient safety that, for two decades, has been directed at hospitals and other healthcare institutions. But recently, attention to safety in physician practices has been increasing, with emphasis

falling on problem-prone areas, such as tracking of test results, documentation, and more. Unfortunately, other areas known to cause errors have received little attention.

Physician practices must adopt a comprehensive approach to patient safety, devoting their attention not only to the issues that appear on every office's patient safety radar screen, but also to the risk areas that frequently go unnoticed. **MPL**

For related information, see www.ecri.org.



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