



HEALTHCARE

RISK MANAGER

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Closed Claim Abstracts

The following closed claim abstracts vividly illustrate some of the ways in which prescription errors occur.

Antibiotics

A 37-year-old male presented with complaints of swelling of the left lower lid of three days duration. The patient's written history noted that he was not on any medications, but had a known penicillin allergy. The ophthalmologist diagnosed a hordeolum and prescribed warm compresses and ampicillin 250 mg TID for five days. After two doses of ampicillin, the patient called the ophthalmologist's office to complain of skin rash and generalized itching. He was instructed to discontinue the ampicillin and was switched to tetracycline 500 mg TID for five days. Meanwhile, the patient went to an employee health clinic and was treated with Benadryl and a Medrol Dose-Pak.

Five days after seeing the ophthalmologist, the patient was admitted to the hospital with confluent, erythematous rash over his entire trunk and extremities and was treated with intensive IV steroids, H1 and H2 blockers, and topical steroids. He improved rapidly and was discharged three days later on tapering doses of oral steroids, topical steroids and Benadryl with instructions to avoid the sun for one month. Subsequently, the patient developed severe episodes of skin rashes and had a skin biopsy showing nonspecific chronic dermatitis.

The patient sued the insured ophthalmologist, alleging negligence in prescribing ampicillin to a patient with a known penicillin allergy.

Overcoming Prescribing Errors - Not a Bitter Pill

Medication prescribing errors occur all too frequently. A few key items can spell disaster on a prescription pad: a patient's changing or declining kidney function, a patient's documented drug allergy, the wrong drug name or abbreviation, incorrect dosage calculations, and unusual or critical dosage/frequency considerations. These contributing factors are relatively easy to recognize, and most of the time easy and inexpensive to fix.

The Malpractice Experience

The Physician Insurers Association of America (PIAA) Data Sharing Reports identify "prescription of medication" as the second most frequent and second most expensive procedure in claims against physicians insured by PIAA member companies like MAG Mutual.

A recent PIAA report reveals that the medical specialties with the highest number of medication-related claims were Family Practice and Internal Medicine. Family Practice and Internal Medicine also had the highest total indemnities paid of all specialties.

Table 1: PIAA Medication-Related (Closed) Claims by Physician Specialty (Jan. 1, 1985-December 30, 2005)

Specialty Group	Closed Claims	Paid Claims	Total Indemnity
General and Family Practice	1910	610	\$63,916,760
Internal Medicine	1659	517	\$60,495,293
OB/GYN Surgery	287	92	\$14,108,731
Internal Medicine-Subspecialties	280	44	\$7,073,082
Psychiatry	255	62	\$10,039,997
Cardiovascular Disease	236	41	\$7,327,685
General Surgery	210	83	\$14,475,784
Pediatrics	201	68	\$8,354,219
Dermatology	178	63	\$6,220,783
Orthopedic Surgery	176	59	\$8,508,362
Neurology	176	45	\$9,085,552
Gastroenterology	112	19	\$2,509,500
Ophthalmology	88	27	\$2,781,158
Urologic Surgery	79	30	\$3,016,776

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Inadequate Monitoring/Management of Glucocorticoids

A 35-year-old obese male presented to his ophthalmologist with a history of severe chronic uveitis. Initially, the patient's visual acuity was 20/400 OU. The ophthalmologist administered bilateral subtenon's injections of Depo-Medrol and prescribed hourly topical steroids and cycloplegics. Systemic prednisone was added when this regimen failed to control the uveitis. While on systemic steroids, the patient's vision improved. However, attempts to withdraw the systemic prednisone resulted in a worsening of the patient's vision and uveitis.

The patient developed side effects and complications from the prednisone. The ophthalmologist eventually referred the patient to an internist to monitor the steroid's effects because of the patient's obvious weight gain and blood glucose readings. An attempt to switch the patient to chlorambucil failed due to side effects. The patient was unable to achieve further improvements in visual acuity and eventually developed frank diabetes and hypertension. Treatment with systemic steroids continued for two more years when the patient was admitted to the hospital with adult respiratory distress syndrome (ARDS) and died. The cause of death was systemic candidiasis and ARDS, probably caused by steroid therapy. The autopsy also revealed the patient was HIV positive. The patient's family sued the insured ophthalmologist for wrongful death caused by negligent prescription management of steroid therapy. The case was settled prior to trial.

Verbal Order

A 66-year-old female suffering from multiple myeloma of the monoclonal gammopathy variety with an uncertain diagnosis claimed that her oncologist and the personnel at the medical office failed to properly instruct her on dosage and use of Alkeran, a chemotherapy drug, resulting in overdose and damages to the patient's immune system. Subsequently the patient underwent three blood transfusions,

Overcoming Prescribing Errors – Not a Bitter Pill

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A claims analysis conducted by the Harvard Risk Management Foundation (RMF), found that medication-error claims closed with payment more frequently than all claims, and that the payments were substantially higher.

Regarding classes of drugs most frequently involved, the study found that more than 60 percent of alleged errors in liability claims were associated with the following five drug groups:

- Antibiotics
- Anticoagulants
- Steroids
- Narcotics
- Cardiovascular drugs

These findings are similar to those reported by the PIAA in its 1993 Medication Errors Study.

Types and Causes of Errors

According to the PIAA, the greatest risk in prescription errors is for the physician rather than the pharmacist. The predominant root cause of prescribing errors is a lack of knowledge about the drug to be administered, as well as a lack of detailed and timely information about the patient who is to receive the drug. Patients with kidney conditions, liver conditions, or known drug allergies are at great risk.

An Institute of Medicine (IOM) report cites the following factors as causal in medication errors:

- Failure to alter a medication or dosage due to patient's reduced kidney or liver function
- Known allergy to same medication class
- Using the wrong drug name, dosage form or abbreviation
- Incorrect dosage calculation and decimal point misplacements
- Atypical or unusual and critical dosage frequency considerations

FDA Joins the ISMP to Campaign Against Error-Prone Medical Abbreviations

The use of ambiguous medical abbreviations and dose designations has been recognized as one of the most common but preventable sources of medication errors. In an effort to help prevent medication errors, the FDA is partnering with the Institute for Safe Medication Practices (ISMP) to create a comprehensive educational campaign to eliminate potentially harmful abbreviations. The practice of using medical notations that are frequently misinterpreted is a key example of an area where education of healthcare practitioners, the pharmaceutical industry and others involved in medication use could help save lives.

The campaign that began this year, recommends that *ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations* (<http://www.ismp.org/tools/abbreviationslist.pdf>) be referenced whenever and

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wherever medical information is being communicated. Some of those notations are included in the current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goal 2B, a “do not use” list of error-prone abbreviations and dose designations, but ISMP’s listing includes additional abbreviations that have been associated with medication errors reported to the USP-ISMP Medication Errors Reporting Program.

Abbreviations and Mistaken Identity

Abbreviations are a staple of prescription drug administration. But they can also be the root of many medication errors. Following are some common abbreviation mistakes.

Abbreviations	Intended Meaning	Misinterpretation	Correction
ug	Microgram	Mistakes as “mg”	Use “MCG”
BT	Bedtime	Mistaken as “BID” (twice daily)	Use “bedtime”
IN	Intranasal	Mistaken as “IM” or “IV”	Use “intranasal” or “NAS”
OJ	Orange Juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use “orange juice”
Qld	Daily	Mistaken as q.i.d. (four times daily)	Use “daily”
U or u**	Unit	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 4U seen as “40” or 4u seen as “44”); given in volume instead of units (e.g., 4u seen as 4cc)	Use “unit”

SOURCE: Institute for Safe Medication Practices

Low-Cost, Common-Sense Initiatives to Reduce Errors in Prescription Writing

- Prescribers should print prescriptions clearly
- Prescription orders should include a brief notation of purpose (e.g. for cough), unless considered inappropriate by the prescriber
- All prescription orders should be written in the metric system except for therapies that use standard units such as insulin, vitamins, etc.
- Units should be spelled out rather than writing “U”

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sustained ulcerations to her mouth, pneumonia, headaches, a rash and stomach distention.

The oncology office is “paperless.” At the time the drug was prescribed, the computer was down and the physician was unable to print out the prescription. Therefore, the Alkeran prescription was called in to the pharmacy on behalf of the patient. Poor communication resulted in the pharmacy giving the patient an incorrect dosage and improper instructions for taking the drug. The case was settled for a moderate amount.

Anticoagulation

A 36-year-old Caucasian male received a mechanical aortic valve replacement for aortic insufficiency. His post-op course was uneventful, and he was discharged home on 2.5 mg Coumadin per day. However the PA miswrote the Coumadin discharge dose as 10 mg per day. On Monday, the patient returned for an INR check. His INR was 3.49. He was instructed by the nurse to continue his Coumadin at 10 mg per day. The actual discharge dosage of 2.5 mg was never communicated to the office. A week after discharge, the patient was found to have an INR of 18 during a routine outpatient evaluation. He was admitted for observation, his Coumadin was held and Vitamin K was administered.

A head CT was performed for complaint of persistent headache, but showed no evidence of an intra-cranial bleed. The patient remained stable and without complaints until the next day when he became diaphoretic, experienced tachycardia and became pulseless. He failed to respond to resuscitative measures and was pronounced dead. At autopsy the medical examiner concluded that the patient died of cardiac tamponade, resulting from the accumulation of hemorrhagic fluid in the pericardial sac related to anticoagulant usage.

Low-Cost, Common Sense Initiatives to Reduce Errors in Prescription Writing

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- Prescribers should include age and, when appropriate, weight of the patient on the prescription or medication order
- The medication order should include drug name, exact metric weight or concentration and dosage form
- A leading zero should always precede a decimal expression of less than one. A terminal or trailing zero should never be used after a decimal
- Review and post the ISMP's List of Error-Prone Abbreviations, Symbols and Dose Designations: Remind all prescribers to avoid the use of abbreviations including those for drug names, like MOM, HCTZ and Latin directions for use
- Prescribers should not use vague instructions such as "take as directed" or "take/use as needed" as the sole direction for use
- Recognize the need for dose adjustment in children and elderly patients
- Recognize the hazards of polypharmacy, drug/drug interactions and possible adverse effects
- When co-managing patients with other physicians, make sure that the individual areas of responsibility are clearly documented in the patient's record (e.g., who is managing the dosage and monitoring the response or complications)
- Encourage patients with multiple physicians, prescriptions or complicated medication regimens to use **one** pharmacy
- Ensure ongoing physician education on new drugs, new uses, unusual uses, etc. and use guidelines from professional organizations
- Instruct staff to always verify questionable or illegible orders with the prescribing physician and encourage staff to ask questions

Verbal or Telephone Orders

Verbal or telephone orders present special problems. They can easily be misheard or misinterpreted, transcribed incorrectly, or not recorded in a patient's chart. They may also be incomplete and confusing. Ideally, verbal orders should be accepted only in emergency situations. Physician's offices should institute a firm policy for regulating verbal or telephone orders. Include the following:

- Ensuring that a caller is properly identified as the individual's physician or other authorized prescriber. Some facilities may use a password/code system to authorize prescribers
- Identifying the patient
- Ensuring that the prescriber is available by phone or other means to confirm or clarify an order if questions arise
- Ensuring that the order is recorded in the chart immediately and later authenticated by the authorized prescriber within a stated amount of time
- Ensuring that recipients verify the order by reading it back as it is written. The patient's record should document that the order was "repeated and confirmed"
- Spelling out all drug names, however simple, and specifying doses carefully

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National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) c/o U.S. Pharmacopeia NCC MERP Secretariat 12601 Twinbrook Parkway Rockville, MD 208052 (301) 816-8265, www.nccmerp.org

Institute for Safe Medication Practices, Suite 810, 1800 Byberry Road, Huntingdon Valley, PA 19006 (215) 947-7797, www.ismp.org

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