



HEALTHCARE

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Hidden Consequences of Taking Call—Misunderstandings and Miscommunications

By John Antalis, M.D.

This article examines some of the potential problems associated with being “On-Call,” and provides some general risk management recommendations applicable to all specialties, as learned from 20-20 hindsight when examining root causes of patient injuries and lawsuits. Emergency Medical Treatment and Active Labor Act specifics are not discussed in this article.

A 77 year old male was admitted from a living center due to a two day history of vomiting, abdominal pain, confusion, and altered mental status. On admission at 5:00 pm, his family physician, Dr. A, noted the patient to be dry and dehydrated. She ordered labs and intravenous saline, 20 meq/L of potassium chloride at a rate of 100 cc/hr.

Dr. A was not on call that night and her partner, Dr. B, assumed call at 6:00 pm. At 9:35 pm the floor nurse called Dr. B, reporting that the patient's potassium was 5.9 meq/L. (Normal range: 3.5-5.5). Later, Dr. B would claim that he never received this call. The IV was continued and the nurses made no further calls to Dr. B throughout the night. The next morning when making her hospital rounds, Dr. A noted the patient's high potassium from the previous night. However, she did not give any orders to stop the potassium or to treat the elevated potassium. She did write a routine order for a basic metabolic profile. The lab result came back to the floor an hour later showing a potassium level of 7.2 meq/L.

The nurse paged Dr. A, but did not receive a reply. She called again a half hour later, but still received no reply. On her own, the nurse stopped the potassium infusion. Forty minutes later, Dr. A returned the call, after receiving the nurse's message, and ordered the patient a soft diet, Kayexalate, and a repeat potassium level.

Later when asked why she did not respond earlier, Dr. A stated that she thought it was a routine call; it was not a number associated with a stat call. In the meantime, the patient's potassium level increased to 8.3 meq/L. He expired two hours later from a cardiac arrest due to extremely elevated potassium. Both Drs. A & B were sued and were found to be at fault.

All physicians have had to take “the duty” or be “On-Call” during training. Physicians may work all day seeing and treating patients, performing multiple surgeries, or delivering babies. No matter the

daily schedule, nor overdue personal responsibilities, night call for the physician, the practice, and/or the hospital seems to come around all too often, imposing with it a duty to patients until the next morning. When the on-call physician does not respond appropriately to patient events occurring during the on-call period, and a patient injury or death occurs, a claim or lawsuit may result. These claims are often difficult to defend. Again, it's all about “duty,” and the issue raised will be whether the on-call physician “abandoned the patient.”

Receiving phone calls at all hours of the night, and covering for several physicians at a time while not being familiar with their patients, not being familiar with the nursing staff, and having to go into the hospital to examine patients, are not only some of the inconveniences of being on call, but create liability exposures for all on-call physicians.

Some suggestions for decreasing your on-call risks:

- Instituting a sign-off system that ensures physicians are aware of the status of those in the hospital or in the delivery room.
- Being able to reach the hospital in a reasonable amount of time.
- Understanding the high potential for miscommunication when relying upon phone communications with the hospital nursing staff. Many cases of lawsuits are based on misunderstandings and miscommunications between physicians and nurses.
- Knowing the hospital staff and the call system is as important as knowing your on-call patients.
- Once you've given telephone orders, review them with the nurse. Make sure the nurse reads back your orders precisely before hanging up, especially if it is in the middle of the night. Review all on-call orders; yours, your partner's, and/ or your Mid Level Provider's, when making rounds in the morning.
- When you receive a call about a patient with whom you are not familiar, ask multiple questions about the patient, the reason for their hospitalization, their current condition, and any labs before giving an order for that patient. Even aspirin or a stool softener

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may not always be appropriate. Continue to question the nurse until you are comfortable with your decisions.

- If there is a potential life threatening condition, or your inner medical voice tells you that the information you are receiving from the nurse does not make sense, go see the patient. This single effort has saved many an unfortunate outcome. It gives you real time data to make a proper decision. Incidentally, patients and family appreciate your efforts to help in the middle of night.

Simple Caveats:

1. The On-Call physician is the “Captain of the Ship,” with a duty to all patients assigned during the on-call period.
2. Take telephone calls from the nursing staff very seriously; ask

extra questions needed to assure you of a patients’ stability; take quick notes.

3. If there is any doubt in your mind about the information you are receiving by phone, go examine the patient personally.
4. Remember, it is better to lose a few hours one night than to lose hundreds of hours over the resolution of a lawsuit caused by not taking care of a potentially avoidable incident while on-call.

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Employment Practices Services Question of the Month

Question:

As a private company, are we permitted to terminate employees that refuse to sign policies if we make this part of our handbook? What about refusal to sign disciplinary warnings? We have a place for an employee rebuttal but still have employees that refuse to sign.

Answer:

If an employee refuses to sign the acknowledgement for receipt of handbook or policies, which is, in effect, a refusal to review the company’s policies and comply with them, then you would be within your rights to terminate that employee’s employment relationship if compliance with company policies is a condition of employment at your company (and assuming there is no collective bargaining agreement or other employment contract which states otherwise). If an employee refuses to sign a warning or disciplinary action form, the person issuing it should note “refused to sign” in the signature block and then date and initial it and the document should be filed.

Going forward, the signature block on any warning or disciplinary action form should state that the employee’s signature acknowledges only that the warning or disciplinary action was issued and that he or she received it. The signature does not have to signify that the employee agrees with the warning or disciplinary action form (which is often why they refuse to sign it), and there should be a place on the form for the employee to make comments. This might make it easier to obtain signatures from employees going forward if they know that they are not signing an acknowledgement of agreement, rather one only of receipt.

If the employee still refuses to sign the acknowledgment for receipt of the warning or disciplinary actions then absent a governing collective bargaining agreement or employment contract, we are not aware of any law which prohibits an employer from terminating the employee if it is consistent with company policy to do so. If there is no such policy in place, we recommend the changes to the warning form and establishing the policy with reasonable notice to all employees.

The Question of the Month column is being reprinted courtesy of Epstein Becker & Green, P.C. and the MAG Mutual HR HELPLINE. For information on how to utilize this value-added benefit to answer your specific HR and employment law questions, go to: <http://www.hrhelpline.com/magmutual/overview> or call: Chip Goen at 800-282-4882 Ext. 5584.

Just When You Thought Your Narcotics Were Safe..... Implementing a Fail Safe System in the Ambulatory Surgery Center

By Shannon Moulton, RN, Clinical Director

One day our pharmacy consultant reported that all of the pop tops on our facility's Demerol vials had been removed and were loose in the box. The rubber stoppers appeared to have been accessed. In my ten years of managing two Ambulatory Surgical Centers, I've never experienced a narcotics safety concern. With the advent of Propofol use by anesthesia, *narcotics are rarely being used now in our facilities. Narcotics counts are a daily activity in which counts may remain the same for weeks on end. Complacency had set in.*

As required, we investigated every possible aspect of this strange breach, drug tested all personnel, held mandatory policy in-services, installed cameras, changed the Brinks access code, changed the door code, and provided all individuals their own codes. Okay, so we're good, right?

Then the second center was breached. Now, both Fentanyl and Demerol were involved; same scenario, caps off, rubber stopper breached, some other fluid added to the vial. We became panicked. Now we took custody of the keys, and only allowed access to the narcotics when the administrator was present. Since an administrator is not always present at the first center, *two licensed personnel were given access to the administrative office to retrieve keys.*

We notified both the pharmacist, law enforcement and the DEA. The police took statements and advised us to wait on DEA. The DEA interviewed Administration, and advised us to call if another incident occurred. *Everyone knew that we meant business!*

Unbelievably a third infraction occurred back at the first location. Now we purchased a safe for the narcotic keys with finger print access, reviewed the brinks security log for access entries, installed cameras, and unfortunately had to change the entrance door codes again.

The DEA returned to interview staff over the next two days. On the second day of the interviews, the technician who had only been

employed for 6 months finally confessed. She admitted that all it took for her to breach our system was to observe our usual routine, and to return to the facilities when closed. Pre-employment background checks, drug testing and good job references hadn't revealed her as a suspect.

We had learned a lesson about complacency.

In less than a year we had suffered through three incidences of narcotic theft. We believe that the processes and procedures we developed after these events are imperative considerations for every facility handling controlled substances.

1. Check your procedures and build in safeguards against complacency
2. Check staff competencies and compliance frequently
3. Secure access with cameras, limit key access [the finger print safe worked well for us], and observe your staff doing counts
4. Emphasize that staff inspect drugs for tampering, and report any suspicious activity to Administration
5. Change your access system at intervals, and appoint licensed staff to oversee quality management and improvement of medication administration. Hopefully, you can save your facility from a narcotics breach

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New Offering for Policyholders: Free, Online Risk Management Training for Office Staff

Take advantage of a new series of on-line Learning Modules, designed specifically for your medical office staff. Based on our experience and research, the featured Learning Modules include important medical office system topics that could have professional liability implications for your practice.

The Modules are free of charge and include a post-test, making them ideal for training and refresher courses. The topics are:

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

Locate the Learning Modules by going to www.MAGMutual.com, select **Risk Management & Patient Safety** and look under the **Education** header for Learning Modules for Office Staff.

Joint Commission Alert: Preventing Deaths During, After Pregnancy

High blood pressure, diabetes, obesity put women at risk.

Pre-existing medical conditions such as high blood pressure are putting women at greater risk for death during or shortly after pregnancy, according to a Joint Commission *Sentinel Event Alert* issued January 26, 2010.

The Alert comes as federal and state governments are stepping up efforts to identify the causes of maternal deaths in order to prevent them. The most current statistics from the Centers for Disease Control and Prevention (CDC) show that there are 13.3 maternal deaths per 100,000 live births, well over the target of 3.3 maternal deaths per 100,000 live births set as part of the U.S. government's Healthy People 2010 initiative. Common preventable causes that lead to maternal deaths include uncontrolled high blood pressure, undiagnosed fluid build-up in the lungs of women with pre-eclampsia, failure to pay attention to vital signs after a Cesarean section, and hemorrhage following a Cesarean section.

"It is a profound tragedy whenever a mother dies in childbirth. Fortunately, these are rare events," says Mark R. Chassin, M.D., M.P.P., M.P.H., president, The Joint Commission. "Achieving our national goal of reducing their frequency even further requires organizations and caregivers to have a thorough understanding of the underlying causes of maternal deaths and a disciplined focus on assuring consistent excellence in the early recognition and management of complications of delivery."

To prevent pregnancy-related deaths and severe illness, The Joint Commission's Sentinel Event Alert suggests that hospitals take a series of six specific steps, including the following:

- Educate physicians and other caregivers about underlying conditions such as high blood pressure, diabetes or morbid obesity that may put women at risk if they become pregnant.
- Use specific protocols to treat pregnant women who have, for example, experienced a change in vital signs, hemorrhage or pre-eclampsia.
- Train emergency room staff to consider whether female patients may be pregnant or recently pregnant. Pregnancy can affect the

diagnostic process or change a woman's response to treatment. For women who are identified as being at high risk because of existing conditions such as high blood pressure, diabetes or morbid obesity, the Alert calls for referrals to experienced prenatal care providers who can provide specialized services. In order to avoid pulmonary embolism, The Joint Commission urges hospitals to make pneumatic compression devices available to high-risk patients undergoing a Cesarean section. Finally, hospitals are urged to evaluate whether pregnant women who are at high risk for dangerous blood clots (thromboembolism) should receive a special dosage of blood thinner after giving birth.

In addition to the specific recommendations contained in the Alert, the Joint Commission urges hospitals to use its accreditation standards to improve safety for pregnant women. The standards require hospitals to have a process for recognizing and responding as soon as a patient's condition appears to be worsening, and to develop written criteria for early warning signs that a patient's condition is deteriorating. The standards also address staff response to concerns about a patient's condition and educating patients and families about how to get help if they have concerns.

The warning about maternal deaths is part of a series of Alerts issued by the Joint Commission. Much of the information and guidance provided in these Alerts is drawn from the Joint Commission's Sentinel Event Database, one of the nation's most comprehensive voluntary reporting systems for serious adverse events in health care. Previous Alerts have addressed health care technology, anticoagulants, wrong-site surgery, medication mix-ups, health care-associated infections, and patient suicides, among others.

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The complete list and text of past issues of *Sentinel Event Alert* can be found at <http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/>

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