



HEALTHCARE

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From Paper Charts to an EHR: What are the Concerns?

By Ron Sterling

The transition from paper to EHR is a major policy decision that can have repercussions on patient service, your operations, and even your medical professional liability. Unfortunately, many practices are not taking the time to analyze their options and responsibilities from a patient care and compliance standpoint. In order to set the correct framework for your effort, you should think about how you would answer questions about your paper chart transition strategy in order to prove due diligence in maintaining the patient record and/or in the transition from the paper chart to your EHR.

ISSUE: *Disposition of the Paper Chart in the Move to EHR*

Many vendors encourage practices to move from the paper chart directly to the EHR. The vendors (and many doctors) take the position that the contents of the paper chart become obsolete with the EHR. However, the physician and practice will be held accountable for patient care that could be affected by information in the paper chart. As important, a flawed transition from paper to EHR could compromise the designated record set for a patient or even all patients in a practice.

- What were the decision factors that determined your paper record-to-EHR strategy?
- How was the EHR vendor involved in the decision about the paper record-to-EHR move?
- Was your paper record strategy and decision approved by the Chief Medical Officer and Practice Management?
- What are the paper chart contents and other paper items (ex: logs and registers) that you consider part of the patient paper record?
- How do you provide access to information in the paper record that was not entered or scanned into the EHR?
- What information on patient care or history that was not in the EHR was available in the paper chart?
- Is it possible that subsequent information may be recorded into the paper chart that was not recorded in the EHR?

ISSUE: *Selecting Items to Scan into the EHR*

Many practices select specific items from the paper chart to be scanned into the EHR. In some cases, the doctor selects specific items in an

iterative process. In other situations, the practice develops a list of items that should be scanned into the EHR and has various employees select the items to be scanned into the EHR.

- How was the list of items to be scanned into the EHR determined?
- In retrospect, what items were not selected for scanning into the EHR that should have been?
- Are there any items not selected that were needed or missing after the transition?
- When you scanned information, did you ensure that you scanned all pertinent and cross-linked information so data could be understood in context?
- Who selected items from a patient's paper chart to be scanned into the EHR?
- What were the qualifications of the people who selected the items to be scanned?
- How were the people who selected the items to be scanned able to assure themselves of the relative importance of a particular paper chart item?
- What quality assurance activities were undertaken to ensure that all of the items were properly selected?
- What quality assurance procedures were in place to ensure that all of the items to be scanned were scanned and properly placed in the EHR?
- What was the training program to explain the scanning strategy and its limitations in caring for the patient? For example, if the chart contents from the last two years were scanned, how were the staff and doctors trained on gathering or selecting additional information from the paper chart?

ISSUE: *Initially Loading Key Clinical Information into the EHR*

In order to introduce a patient to an EHR, a variety of information may be needed to properly set him or her up and trigger appropriate care guidelines or protocols. For example, surgeons may want to record previous surgeries. Other doctors may want to record previous issues for a patient.

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- What was the basis for the information that was selected for entry into the EHR?
- What information was transferred from the paper record into the EHR?
- What was the source of information that was gathered from the chart? What confidence do you have in the accuracy of the paper chart source?
- What interpretations and/or translations were required to accommodate the EHR structure when entering information from the paper chart?
- What were the qualifications of the staff who located and interpreted the data from the paper chart to be entered into the EHR record?
- What were the quality assurance procedures to verify the currency, accuracy, and interpretation of any information gathered from the paper chart for entry into the EHR?
- What were the quality assurance procedures to verify the entry of information and representation of that information into the EHR?
- When are paper charts accessed for a patient who has already been served through the EHR?
- Why are patient charts still accessed after the patient has been transitioned the EHR?
- Does the paper chart contain information gathered after using the EHR that was not entered into the EHR?
- Does the continued use of the paper chart call into question the completeness of the patient's EHR-based information?
- Based on the use of both the paper chart and the EHR for patient care, where is the patient's designated record?

The transition from the paper chart to the EHR has to be planned, analyzed, designed, and performed in a manner that assures the integrity of the patient chart. Asking the right questions to frame your effort can help to prevent problems and issues going forward. Otherwise, you may have to answer more difficult challenges long after you thought your paper record would become irrelevant.

ISSUE: Use of a Paper Chart After Conversion to EHR

In many cases, patient paper charts that have been used to start the patient's EHR record are still used in the practice. Physicians and staff may use the paper charts to access information that was not scanned into the EHR, or as a convenience.

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Surgical Fires: Reducing the Risk of Patient Injury

By Georgette Samaritan, RN

Surgical fires — fires that occur on or in a surgical patient — can have devastating consequences. The ECRI Institute estimates as many as 550-650 surgical fires occur in operating rooms, physicians' offices, and outpatient facilities annually. It appears that many surgical fires go unreported because, fortunately, 95% of them result in no injury. About 20-30 do result in disfiguring or disabling injuries each year, and one or two of those — typically those occurring in the airway — are fatal. Lawsuits stemming from these injuries can lead to substantial awards for plaintiffs. Although methods for reducing the risk of airway fires have been available for decades, patients are still being seriously injured.

In one case, a jury returned a favorable plaintiff verdict after finding a plastic surgeon and his corporation responsible for causing a fire in the surgeon's ambulatory surgical center.

The young patient was having a mole removed from her right eyebrow. She was sedated for the procedure and was receiving oxygen supplementation via a face mask when the surgeon activated an electrocautery device, causing a fire to erupt. The patient alleged the surgeon was negligent in failing to communicate to the anesthesia assistant controlling the oxygen that he was going to use electrocautery

so that the anesthesia assistant would know to turn off the oxygen. During the trial, the surgeon blamed the anesthesia assistant for not knowing that he was going to use electrocautery. In this case, the jury exonerated the anesthesia assistant, but found the surgeon 100% responsible for the fire.

The jury also found that the surgeon concealed from the patient and her parents the true cause of the fire and, as a result, awarded the patient additional money in punitive damages against the surgeon.

Risk Management Commentary & Recommendations

Nearly all surgical fires can be prevented if the surgical team members are aware of the elements that can lead to a fire and follow practices to minimize risks.

Procedures at high risk for a fire include those involving the head, neck, face or upper chest because they may bring a fire ignition source, an electrosurgical unit, in proximity to an oxidizer-enriched atmosphere. The oxidizer-enriched atmosphere is created by the supplemental delivery of oxygen above room air levels (exceeds 21% oxygen concentration) and/or nitrous oxide.

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- **Preoperative briefing.** Just as time-outs are conducted before surgical procedures to facilitate communication among surgical team members about the procedure, the American Society of Anesthesiologists (ASA) recommends that the surgical team conduct a preoperative briefing to determine whether a high-risk situation exists for a surgical fire to occur. This briefing can be made part of the preoperative time-out protocol. Current time-out protocols do not have a standardized approach for identifying fire risk.
- **Avoid using ignition sources in proximity to an oxidizer-enriched atmosphere; if oxygen must be used, it should probably be in a closed system that would not allow the field to be flooded with oxygen. An example of a closed system is an endotracheal tube connected to a circuit, which would channel any supplemental oxygen away from the face or surgical site. Examples of an open system are nasal prongs or plastic face masks.**
- **Configure surgical drapes to minimize the accumulation of oxidizers.**
- **Allow sufficient drying time for skin-prepping solutions; use non-flammable preps whenever possible.**
- **Although anesthesiologists seldom use petroleum-based eye lubricants, if oxygen will be used, the surgeon should always inquire about the product to be used.**
- **Moisten sponges and gauze liberally when used in proximity to ignition sources.**

Major clinical practice changes being advised for head, face, neck, and upper-chest surgery include the following:

- Use only air for open delivery to the face, provided that a spontaneously breathing, sedated patient can maintain his or her blood oxygen saturation without extra oxygen (ASA; Anesthesia Patient Safety Foundation).
- Secure the airway by using a laryngeal mask airway or tracheal tube if the patient cannot maintain safe blood oxygen saturation without

supplemental oxygen, so that oxygen-enriched gases do not vent under the surgical drapes.

- Discontinue the traditional practice of open delivery of 100% oxygen, with limited exceptions, such as carotid artery surgery, neurosurgery, and some pacemaker implantations. In these cases, the surgical team should seek to deliver the minimum oxygen concentration necessary for adequate oxygenation, starting with an oxygen concentration of 30% and increasing as necessary.

It is important to remember that for surgery in a location not in proximity to an oxygen source, such as the abdomen, groin, legs, and hands, open delivery of oxygen can be used; however, the risk of fire is always present and adequate precautions still need to be included in the process.

Further Reading, Resources, and Tools

The American Society of Anesthesiologists strongly advocates that all anesthesiologists should receive fire safety education specific to surgical fires that focuses on the risks created by an oxidizer-enriched atmosphere. You can find materials and resources on the ASA website, as well as an excellent Operating Room Fire Algorithm. A free electronic copy of the ASA Practice Advisory for the Prevention and Management of Operating Room Fires is available at <http://ecommerce.asahq.org>, as well as the ASA Fire Safety CME program.

Both ECRI and the ASA have good materials to assist providers in developing policies and procedures and physician/staff educational programs dealing with the prevention and control of surgical fires.

References:

ECRI Institute, Healthcare Risk Control, Executive Summary, Surgery & Anesthesia 10, Vol. 4 July 2010.

ECRI Institute, Healthcare Risk Control, Executive Summary, Safety & Security 13.1, Vol. 3, July 2010.

American Society of Anesthesiologists (ASA) Task Force on Operating Room Fires, Practice Advisory for the Prevention and Management of Operating Room Fires; Anesthesiology 2008 May; 108 (5): 786-801.

Conscious Sedation in the Medical Office Setting: Patient Safety Considerations

By Leslie Mattson, RN

When planning to administer conscious sedation in the office setting, you must address several precautionary steps and procedures. Physicians and staff must be prepared to treat and monitor sedated patients effectively, as well as to handle potential problems and emergencies in a timely manner.

The following are suggested guidelines when providing sedation in your facility:

Patient Selection

Patients being considered for sedation in the medical office should be in good general medical health. Prior to procedures requiring sedation, patients should be assessed for health problems. The assessment may include any disease processes, surgical history, medications, and drug allergies and should be documented in the patient's medical record. The patient's history may be obtained by staff, but also should be reviewed by a physician to determine if risk factors may increase the likelihood of an

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adverse event. If risk factors are present, to get appropriate clearance and to determine the need for acute care, consult with the treating physician.

Patient Education

Educating the patient is an important step in the pre-procedure process, as informed patients tend to be more compliant and experience better outcomes. Patients should know what to expect, including NPO restrictions, pain, medications, and activity restrictions post-procedure. Patients should be instructed not to drive immediately after the procedure and to arrange for transportation. Prior to the procedure day, patients should be informed about the risks and benefits of sedation, and should consent to the sedation plan. Informed Consent documentation should be included in the patient's medical record.

Monitoring and Emergency Equipment

Equipment that is appropriate for the size and age of the patient should be available and should be checked prior to the administration of sedation. Recommended equipment includes: oxygen and an oxygen delivery system, including equipment for both regular and emergency delivery; suction equipment; and patient monitoring equipment to measure oxygenation, pulse rate, and blood pressure. An emergency resuscitation cart, including a defibrillator or AED, emergency equipment and supplies, and an immediate source for summoning assistance are recommended and should always be maintained. A baseline assessment, including vital signs and NPO status, should occur prior to the procedure. Vital signs should be monitored and documented consistently at frequent intervals, including respirations, oxygenation, and heart rate.

Staff Training and Preparation

The person monitoring the patient should not have any other responsibilities during the procedure. Minimum qualifications include: Advanced Cardiac Life Support (ACLS) certification, proven competency in all medications used and their effects, managing an airway, variations in homeostasis, and recognition of signs of potential problems and solutions to manage them. There should be a qualified physician to directly supervise the sedated patient's care and immediately manage the patient should any complications arise. Required staff competencies should be documented in the personnel record.

Choosing Medications

All medications, routes, amounts, and safe parameters should be determined by the facility and accurately documented. A safe route for administration, either through IV access or IV fluids, should be established for all patients prior to the procedure. All administered medications should be given as appropriate and documented in the medical record.

Post-Operative Care

Post-procedure assessment and equipment should be the same as during the procedure. Pre-established discharge criteria should be met prior to the patient being released. Written and verbal instructions should be given to the patient prior to discharge to educate the patient on any restrictions, potential complications, what to do if a complication occurred, and how to reach the physician or physician on call after hours. If discharge criteria are not met, the patient should be transported to an acute care facility where the treating physician has privileges.

Summary

By establishing policies and processes with these recommendations, practice staff will provide safer, more effective care to those patients undergoing procedures that require sedation in the medical office setting.

Editor's Note:

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Due to the potential for rapid, profound changes in sedative/anesthetic depth and the lack of antagonist medications, the American Society of Anesthesiology (ASA) states that even if moderate sedation is intended, patients receiving propofol should receive care consistent with that required for deep sedation.

References:

STATEMENT ON SAFE USE OF PROPOFOL Committee of Origin: Ambulatory Surgical Care (Approved by the ASA House of Delegates on Oct. 27, 2004, and amended on Oct. 21, 2009)

GUIDELINES FOR OFFICE-BASED ANESTHESIA Committee of Origin: Ambulatory Surgical Care (Approved by the ASA House of Delegates on Oct. 13, 1999, and last affirmed on Oct. 21, 2009)

All ASA documents can be found at www.asahq.org.

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