Accurate information about a patient’s past history is vital for decision making in every physician-patient interaction. In addition, proper documentation is essential for care that may be provided in the future by yourself or other physicians. Coordination of care is as much of a patient safety challenge as making an accurate diagnosis or ordering the appropriate treatment. The path of care from the initial complaint to completion of treatment is far from seamless. Sometimes it can be full of obstacles — such as the potential to misunderstand or not see important information, including details that could pose serious risks for the patient. Many medical liability cases involve poorly coordinated care that results in harm to a patient.

In one study done by CRICO, coordination of care lawsuits were found to originate from the mismanagement of tests and referrals, all the way through to the mismanagement of handoffs.

The following case studies provide examples of the challenges faced in the coordination of care:

Case Study #1

A 68-year-old female is admitted for Systemic Inflammatory Response Syndrome (SIRS) and her blood cultures reveal Methicillin-Sensitive Staphylococcus Aureus (MSSA). A two-week course of antibiotics is recommended by the Infectious Disease (ID) physician, as no source of infection was found. On the day of discharge, an echocardiogram
shows endocarditis; however, the diagnosis is not noted by the discharging physician. The nursing home physician discontinues the antibiotics after two weeks per the discharge summary. Two weeks later, the patient develops back pain and leg weakness. She eventually develops paralysis from an epidural abscess. The ID physician consults again and states that he would have given the antibiotics for six weeks if he had known of the echocardiogram results. A lawsuit ensues.

In 2009, the *Journal of General Internal Medicine* reviewed the charts of 668 patients and found that even though all patients had some tests pending, only 25 percent of discharge summaries mentioned those pending tests. The study’s conclusion was that discharge summaries are inadequate tools to communicate pending studies to subsequent providers.[1]

A more recent study addresses discharges to sub-acute care. In 2011, the *Journal of General Internal Medicine* published a study where approximately one-third of patients had tests pending at the time of transfer.[2] Only 11 percent of these pending tests were documented in the summaries. Both of these studies reflect not only a lack of coordination of care, but the dangers that arise when tests slip through the cracks at the time of discharge.

Case Study #2

A 43-year-old male is admitted for cellulitis which quickly resolves. Microcytic anemia is incidentally found and the patient admits to recent rectal bleeding. The patient is told to follow up with his primary care physician (PCP) at a later date. No note of the anemia is made in the discharge summary. The patient does not have a PCP and does not see a physician until 18 months later. At that time, the patient presents to the emergency room with an acute abdomen and is found to have metastatic colon cancer at surgery. When asked, the patient mentions that his father had colon cancer at an early age. A lawsuit is filed.

The reality is that younger patients can get colon cancer too: in fact, about 3 percent of all colon cancer occurs in patients under 40 years of age. Risk factors include a positive family history, inflammatory bowel disease or familial polyposis. Anemia without an obvious explanation should be evaluated. Rectal bleeding should be investigated with a test that can visualize the colon.

A 2007 article in the *Archives of Internal Medicine* revealed that in a cohort of 693 hospital discharges, 240 different outpatient workups were suggested.[3] Of these workups, 36 percent were not completed. An available discharge summary at the time of the first follow-up visit increased the chance of these tests being completed. The authors concluded that non-completion of suggested workups, as noted above, is common.

Case Study #3

A 50-year-old female is evaluated for a self-discovered lump in her breast. The physician refers her to a surgery specialist who does not feel the mass. The subsequent mammogram is equivocal. The surgeon suggests that a follow-up visit be performed in one month but does not specify which physician the patient should see. The patient is not seen for another nine months and returns with a worsening mass that is diagnosed as breast cancer. She stated that after her previous visit, she was uncertain whether or not she needed to follow up regarding the mass. She also did not know which physician to follow up with – the PCP or surgeon.

This case demonstrates that providers need full access to information and need to establish a clear plan of care for the follow-up of that information. It is also important to engage patients in their own care so that they are clear as to the next step and next point of contact in their treatment.

Several strategies are useful to prevent poor coordination of care:

- You cannot rely on memory alone to order the right tests, treatment or follow up. Whether one’s system is paper or electronic, tracking systems are critical to avoid preventable adverse outcomes.
- When a significant issue is apparent, you need to discuss it with the patient and, at the very least, explain the ultimate risk if a problem is not evaluated. Documentation of this discussion is critical to your defense should an
adverse outcome occur because it shows that the patient did not adhere to your recommendations.

- Be the patient’s advocate and help arrange that important test, follow-up visit or referral.
- Enhance closed loop communication with other providers and be aware of the multiple places where handoffs occur.
- Always remember that discharge is a high-risk handoff time. Take care with your discharge summaries and make sure worrisome issues are addressed and, if possible, workup is arranged.
- Involve the patient in his or her own care and shared decision making. Enabling patients to access their own information and subsequent care plans is critical to avoiding preventable adverse outcomes.


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