Defective Hand-Off Communication forces Defendant Physician & Hospital to Settle Lawsuit

Abstract:

This claim arose out of the alleged failure of the attending physician to diagnose an allergy to Solu-Medrol and its components in a middle-aged female patient. While hospitalized, the patient suffered an anaphylactic reaction to Solu-Medrol given by a nurse, and subsequently fell into a permanent vegetative state.

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The Case:

The patient complained to her primary care physician (PCP) of itching and hives. She denied exposure to new foods, medications, or other products. Her PCP diagnosed idiopathic urticaria; administered Decadron; and ordered oral prednisone, Benadryl, and Pepcid.

Six days later, the patient's husband called 911. Her condition had worsened; she felt her throat closing. The ED physician ordered Solu-Medrol IV 125 mg, Pepcid IV, and hydroxyzine HCL. Only minutes later the patient became unresponsive, going into cardiac arrest. Resuscitation was successful. She was admitted to the ICU, placed on a ventilator via tracheostomy, and had multiple clinical consults, including one with an allergist.

The allergist was unable to find a specific allergy trigger for the patient’s condition. The patient was transferred to another hospital where she markedly improved over eleven days. At that facility, the patient was seen by a neurologist for the evaluation of her generalized weakness. The neurologist ordered Solu-Medrol IV to be given over the weekend. When the patient’s 3-11 shift nurse attempted to administer the Solu-Medrol, the patient’s husband instructed her that his wife was allergic to steroids, and not to administer it. The nurse noted the reported allergy in the EHR. However, the next morning, the day shift nurse started the 100 mg bag of IV Solu-Medrol. The patient’s husband, who had gone downstairs for breakfast, returned to the room only to find his wife unresponsive, and in agonal breathing. The patient was transferred to the ICU, and placed on a ventilator. She was eventually transferred to a nursing home where she remained in a persistent vegetative state.

Allegations:

It was alleged the allergist failed to consider the anaphylactic reaction the patient sustained in the first hospital’s ED, could have been caused by the IV administration of Solu-Medrol succinate.
It was also alleged the allergist failed to notify subsequent treating physicians, by way of his medical record documentation, and warn them not to order/administer Solu-Medrol to this patient. She was likely allergic to the succinate in the Solu-Medrol.

**Disposition:**

The case was mediated and settled for a large amount of money on behalf of the allergist, although defense experts were supportive of the allergist’s medical treatment. The hospital settled their claim separately, on behalf of its nurses.

**Risk Management Commentary:**

Our case files are replete with serious medical errors caused by miscommunications during hand-offs between medical providers. A review of MagMutual closed claims (2010-2014) revealed that 4% or more of claims were specifically due to provider communication problems.

From a risk management perspective, this patient’s injury may have been prevented by clearer handoff communications by all providers involved in the care of this patient.

It would have been helpful to subsequent providers had the allergist clearly summarized his workup, observations of the patient’s experiences, and that he suspected a problem with Solu-Medrol. Although no allergy test exists for Solu-Medrol or its component, succinate, the allergist did testify he suspected the patient was having a problem with Solu-Medrol, but didn’t document this suspicion for the benefit of the patient and other providers.

Likewise, the admitting nurse at the second hospital only partially completed the first part of communicating the patient’s husband’s allergy concerns. She did document the allergy in the section provided within the medical record, but was found negligent in not completely communicating this allergy report to the nurse who took over the patient’s care at shift change. Consequently, neither she nor her nurse colleague followed-up the allergy concern with the prescribing physician, or the hospital pharmacy, concerning the existing Solu-Medrol order.

The Joint Commission requires all health care providers to "implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions" (2006 National Patient Safety Goal 2E.) The Joint Commission National Patient Safety Goal also contains specific guidelines for the handoff process, many drawn from other high-risk industries:

- interactive communications
- up-to-date and accurate information
- limited interruptions
- a process for verification
- an opportunity to review any relevant historical data
The Accreditation Council for Graduate Medical Education also requires that residency programs maintain formal educational programs in handoffs and care transitions.¹

In 2009, The Joint Commission Center for Transforming Healthcare developed the Targeted Solutions Tool® (TST®) for Hand-off Communications. The TST reports that by fully implementing solutions targeted to the specific cause of an inadequate hand-off, participating and pilot organizations achieved an average of over 50 percent reduction in defective hand-offs. Using the tool and the solutions from the Center’s Hand-off Communications project, health care organizations reported an increase in patient and family satisfaction; staff satisfaction; and successful transfers of patients (reduced bounce backs).²

We encourage both our hospital and physician policyholders to take a close look at the tools provided by the TST®, and/or other tools designed, to help providers deliver effective handoffs³⁴, and to adapt these tools to their individual situations, as necessary.³

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Test Your Patient Safety IQ

From the facts illustrated in this case, briefly describe two key communication failures, among others, that occurred at the time the patient was discharged from the first hospital.

Answer:

(1) The discharging allergist did not document his suspicion that the patient was having a problem with Solu-Medrol, list the drug in the allergy section of the patient’s medical record, and warn future providers against prescribing this drug.

(2) The admitting nurse at hospital number two did not formerly convey the patient’s husband’s statement about her allergy to Solu-Medrol to the next shift of nurses, did not put the Solu-Medrol on HOLD in the nursing medication distribution system, and did not contact the attending neurologist and hospital pharmacist.

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This case is a good illustration of how poor hand-off communication at each internal and external patient transfer of care, works with Reason’s Swiss Cheese model of accident causation. The flaws in each layer of defense lying between the hazard of an allergic reaction, and the allergic reaction accident that occurred, could have been prevented with good handoff, at any one of these transfer points.
MAG Mutual Risk Management and Patient Safety Consultants invite our policyholders’ questions. If you wish to discuss the risk management advice presented, or have other questions please call us at 1-800-282-4882, and ask for Risk Management.

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i AHRQ PSNet, Patient safety network, National Patient Safety Goals, Oakbrook Terrace, IL: The Joint Commission; 2015
iii SBAR Toolkit-Institute for Health Care Improvement; http://www.ihi.org/resources/Pages/Tools/sbartoolkit.aspx
iv TeamSTEPPS®: Strategies and Tools to Enhance Performance and Patient Safety

Image A “Swiss cheese model of accident causation” by Davidmack - Own work. Licensed under CC BY-SA 3.0 via Wikimedia Commons

Published February 16, 2015