A “Watchful Eye” on ROP

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There is no greater liability exposure in ophthalmology than the examination and treatment of premature babies at risk for retinopathy of prematurity (ROP). Unlike most care provided by ophthalmologists, ROP is hospital-centered, multidisciplinary care with a very narrow window in which to provide timely examination, treatment, and follow-up. The challenges include providing ophthalmic care to infants who are often very sick, guaranteeing smooth patient discharge or transfer of care, and ensuring that caregivers understand the importance of compliance with follow-up appointments. This patient safety/liability risk is unlike any other that OMIC has grappled with in its 23-year history. The main obstacle has been developing a multidisciplinary, systematic approach to dealing with this unique liability risk. OMIC believes it has found such a system in the St. Luke’s Hospital and Health Network’s Watchful Eye Program for Retinopathy of Prematurity (©2008 St. Luke’s Hospital of Bethlehem, Pennsylvania).

The Concept

The Watchful Eye program is a fairly simple model of hospital-centered care (see conceptual map on page 4). Its premise is the overall management of ROP care by a Retinopathy of Prematurity Coordinator (ROPC). The ROPC participates in and monitors the ROP care of the infant, both as an inpatient and outpatient, until the infant reaches full retinal vascularization and is no longer at risk. OMIC’s own ROP claims analysis and safety net (see “ROP: Creating a Safety Net” at www.omic.com) has pointed out the importance of an ROPC. Identifying the concept of an ROP tracking system and coordinator is clear-cut; however, the Watchful Eye program demonstrates that the commitment and attention to detail required to develop, implement, and monitor results is a complex process that cannot be underestimated.

An Interdisciplinary Approach

The Watchful Eye program was developed by an interdisciplinary team at St. Luke’s Hospital and Health Network in Bethlehem, Pennsylvania. The team included nursing administration, nursing staff, legal counsel, ophthalmology, neonatology, and social services. This type of collaboration is the essential first step in the creation and implementation of an ROP patient safety program. The St. Luke’s team also underscores the fact that high level leadership within the hospital administration is indispensable to ensuring the success of such a program.

Ten years ago, OMIC emerged from a crowded field of more than 35 malpractice carriers by consistently outperforming the industry in both claims defense and financial results. OMIC had established itself as the nation’s leader in ophthalmic risk management. Moreover, recent trends suggest that OMIC’s financial success can be directly tied, at least in part, to our revolutionary loss prevention program.

Measuring the effectiveness of risk management is difficult because of the complexities involved in determining the extent to which physicians actually put loss prevention principles into practice (as opposed to physicians who do not) and then matching clearly defined groups to claims activity. Furthermore, we know that claims are sometimes filed no matter what processes a physician puts into place and risk management is simply an attempt to lessen the chance, not eliminate it.

Intuitively, we know that our claims experience is improved by studying what worked (and what didn’t) during the course of litigation and then making adjustments to improve our performance. Not unlike our clinical practice, where adjustments we make to our procedures and techniques eventually take the form of changes to our specialty’s preferred practice patterns, OMIC has measured the effectiveness of risk management is difficult because of the complexities involved in determining the extent to which physicians actually put loss prevention principles into practice (as opposed to physicians who do not) and then matching clearly defined groups to claims activity. Furthermore, we know that claims are sometimes filed no matter what processes a physician puts into place and risk management is simply an attempt to lessen the chance, not eliminate it.

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Besides preventing blindness in premature infants, an important goal of the Watchful Eye program is to reduce St. Luke’s exposure to large losses arising from ROP claims. The leadership of St. Luke’s learned in 2006 of the $20 million dollar judgment against a Pennsylvania hospital and neonatologist who were found to be jointly responsible for discharging an at-risk infant and failing to provide adequate follow-up care—just one of several multimillion dollar ROP verdicts passed down in recent years. For St. Luke’s, the decision was straightforward: allocate the requisite time and money to proactively prevent this type of claim or pay untold millions in damages sometime in the future.

The Role of the ROPC Nurse
There are many more facets to the Watchful Eye program than this article can address. (See “Keeping a Watchful Eye on Retinopathy of Prematurity” in Neonatal Network, Sept/Oct 2008; v. 27, n. 5.) However, the heart of the program is the ROPC, a registered nurse with neonatal nursing experience who is responsible for identifying and tracking infants, assisting the ophthalmologist during the screening exam, and caregiver education. At St. Luke’s, the ROPC is a 16-hour-per-week position. The thorough development of this key position is a feature that underscores the innovative aspect of the Watchful Eye program. The patient safety challenge has always been how to ensure that there is someone who will take responsibility for monitoring the infant until the risk has passed. The ROPC nurse takes full responsibility and is dedicated to the inpatient and outpatient tracking of ROP care of premature babies in the program. Until now, inpatient and outpatient tracking and monitoring has been fragmented, leading to tragic injury to the infants and finger-pointing among the healthcare providers and caregivers. In fact, several surveys of ophthalmologists indicate that the liability risk arising from improperly tracking and monitoring ROP care convinces many to simply stop providing ROP services. This exodus of well-qualified, well-trained ophthalmologists creates a public health risk.

Double Check System and Filing
The Watchful Eye program employs a unique and very detailed “double check” strategy and filing system. The double check system ensures that at each step of the process there are two people checking the status of ROP care to be provided. The ROPC is always one of the people involved in the double check system, together with either the neonatologist or ophthalmologist (examining or treating), who follow the infant’s inpatient and outpatient care.

The actual documentation and recording of the double check is carried out through a detailed color coded filing system maintained by the ROPC as an adjunct to St. Luke’s electronic medical record (EMR) system. The ROP filing system is maintained even after the infant is discharged. Only when the infant reaches full retinal vascularization is the ROPC filing closed and scanned into St. Luke’s EMR system. The underpinnings of the double check strategy and filing system again hinges on the ROPC. Without an ROPC, the double check and filing system simply is not viable.

Caregiver Education
In most hospitals, the only healthcare provider who participates at each step of ROP care is the NICU nurse. The ROPC nurse interfaces not only with the neonatologist and ophthalmologist but, most critically, with the parents. The St. Luke’s Watchful Eye program now has an ROPC nurse responsible for the most precarious step in the care continuum: ensuring compliance with the follow-up appointment. The ROPC understands that caregivers are dealing with a needy infant requiring multiple post-discharge appointments and follow-up care. The ROP follow-up appointment is only one of many issues the caregiver must handle. Simply providing a document about the importance of the follow-up appointment is a precarious way to
ensure compliance. The Watchful Eye program addresses the importance of follow-up care even before the infant’s first ROP examination in the NICU. As soon as it is determined that the infant needs to be followed for ROP, the ROPC approaches the parents and provides both oral and written information about ROP. The ROPC informs the family that the infant’s first eye exam will be at four weeks of age. The parents are invited to be present for the examination and are fully informed about the procedure. After the exam, the ROPC nurse assists in educating the family about the results.

Outpatient Coordination
When the infant is ready for discharge, the ROPC makes the follow-up appointment at the ophthalmologist’s office. In scheduling the appointment, the ROPC communicates the family’s needs to the ophthalmologist’s appointment scheduler. The ROPC nurse then records the appointment date on a discharge instruction form. Developed by the ROPC team, the discharge form provides educational information about ROP and contains this disclosure: “If you fail to keep this (follow-up) appointment, the ophthalmologist and/or St. Luke’s Hospital and Health Network may contact the appropriate legal authorities, as required by law, in an effort to locate your baby and provide treatment.” After the parent signs the form, copies are made for the family, the ophthalmologist, and the hospital records. Again, it must be emphasized that this is only one step in the education and orientation process of the parent/caregiver. This step by itself would be too little too late.

Part of the Watchful Eye program is careful outpatient coordination with the ophthalmologist’s office. As noted above and in the conceptual map on page 4, the double-check strategy and filing system continues after the infant’s discharge from the hospital.

Unit-wide Orientation and Monitoring
The Watchful Eye program is not an isolated component of care for the premature infant nor is it static. It is a dynamic process that has to be integrated into the infant’s overall care and updated when necessary. This multidisciplinary approach extends beyond the providers active in treating ROP to the NICU unit responsible for the overall care of the premature infant. The entire NICU unit needs to be oriented to the program, including social services, administrative staff, discharge planners, etc.

The process is dynamic in that the principles of continuous quality improvement are applied. An excellent example is a 2008 revision to the Watchful Eye program placing stronger emphasis on ROP education for parents prior to discharge to help them understand the potential risks and consequences of their infant’s condition. This increased emphasis on caregiver education has resulted in better outcomes while maintaining 100% follow-up compliance. The need for ROPC interventions dropped from 23% to 2% and the number of patients requiring surgery decreased from 6% to 2% in the year following this revision (see graph).

The “Watchful Eye” and OMIC
On behalf of the 325 OMIC insureds and other ophthalmologists who screen and treat for ROP, OMIC has been at the forefront of addressing the unique liability risks of ROP for more than two decades. During this time, it has become evident to us that many hospitals are reluctant to create and implement a comprehensive ROP tracking and monitoring program. This frustrates ophthalmologists who would provide ROP care if hospitals were more involved.

OMIC believes the Watchful Eye program presents an opportunity for hospitals, nurses, neonatologists, and ophthalmologists to work together in a collaborative and innovative way to solve this problem. St. Luke’s Hospital and OMIC are in the process of bringing the Watchful Eye program to OMIC insureds and others interested in a comprehensive ROP tracking system. We anticipate a great deal of interest from the AAO, AAPOS, SOOp, and ASRS as we tackle one of ophthalmology’s greatest challenges: preventing blindness in premature infants.