Ophthalmic Risk Management Digest

OMICDIGEST

MESSAGE FROM THE CHAIRMAN

Assuring Safe Passage Through the Healthcare System

By Anne M. Menke, RN, PhD
OMIC Risk Manager

During our recent OMIC Forum on "Shared Care" at the AAO annual meeting, Dr. Steven Brown presented the following case involving four competent, experienced physicians. A primary care physician (PCP) referred an elderly gentleman to a comprehensive ophthalmologist (CO) for evaluation of a grey spot in his eye. After diagnosing a melanoma, the CO referred the patient to a retina specialist for confirmation and treatment options. The retina specialist offered the patient a choice between radiation and enucleation, and reported back that the patient chose enucleation. The CO then referred the patient to an oculoplastic surgeon for the procedure, which was completed two weeks after the initial ophthalmological evaluation. So far, the patient had received timely, effective, well-coordinated care. Nonetheless, when the patient died from metastatic disease that was diagnosed by his PCP eight months after his eye was removed, his family requested the medical records and concluded that the care was negligent. They reached their conclusion after finding a report from the retina specialist to the CO, advising him of the need for tests to monitor for metastasis. The family proceeded to sue the PCP, CO, and oculoplastic surgeon, alleging failure to follow-up and coordinate care. Investigation revealed that all three physicians knew the patient was at risk for metastatic disease, and knew which tests to order to monitor for it. Yet no one took the responsibility to clarify who was in charge, and none of them ordered the necessary tests. The oculoplastic surgeon testified that he had explained the need for follow-up to the patient but did not provide his recommendations in writing or document them in his record. No doubt the patient was not able to truly hear these care instructions while facing a new diagnosis of cancer and recovering from an enucleation.

Patient "Hand Off" A Critical Moment In Care

The Joint Commission (TJC) receives regular reports of medical errors that occur at the hospitals, ambulatory surgery centers, and other healthcare organizations that it accredits. By analyzing the problems, TJC hopes to understand not only which errors occur but more importantly what causes them. What TJC determined echoes the findings of the OMIC case. The top factor contributing to medical error was not lack of knowledge or technical skills

When the Centers for Medicare & Medicaid Services (CMS) announced earlier this year that Medicare reimbursement for Bevacizumab (Avastin®) would decrease from $35 to $7 a dose, it sent shock waves through the retina community. Although ophthalmologists, like other physicians, have grown accustomed to lower fee reimbursements across the board, this particular action posed such a significant threat to our ability to provide care to our patients that it was imperative it be reversed.

Major ophthalmic societies, including the American Academy of Ophthalmology, the American Society of Retina Specialists, the Macula Society, and the Retina Society, united in a coordinated effort to convince Medicare to reverse the decision. Key members of OMIC's Board, including Dr. David W. Parke II, CEO of the American Academy of Ophthalmology, and Dr. George A. Williams, a leading retina surgeon at William Beaumont Hospital in Royal Oak, MI, contacted Medicare officials to help educate those involved of the unintended consequences of such a fee decrease. Ironically, these included increased cost to Medicare if doctors suddenly switched to

IN THIS ISSUE

or inexperience. Rather, it was problematic communication: the information conveyed during care was incomplete, inaccurate, and/or misinterpreted. Ineffective communication occurred in 70% of "sentinel events," a term TJC uses for incidents that have the most serious outcomes. Just as with the OMIC case, fully half of the time, the harmful communication breakdown occurred during a "patient hand off."[1]

Patient safety experts, aware of the dangers of the hand off, have focused attention on ways to ensure communication and coordination of care during the moments when patients transition from one provider, facility, or unit to another. "Lost in Transition: Challenges and Opportunities for Improving the Quality of Care" points to our fragmented American healthcare system as the cause: decreasing numbers of primary care physicians, increasing numbers of patients with more than one disease who require diagnostic tests and specialists, and a payment system that does not reimburse physicians for the time it takes to communicate with one another and coordinate care.[2]

A literature review of care transitions found that patients referred to a specialist arrived 49% of the time with no information about the patient. The consultants apparently responded in kind, as the referring physicians complained that even four weeks after the consultation, 25% had not received a report back. PCPs said they were not notified that patients had been hospitalized and rarely received discharge summaries. The few that came were inadequate for directing care. Patients received even less information. Those sent for tests said that 17% of the time the physician had not received the results by the time of the office visit scheduled to discuss them. More than 75% of physicians report not informing patients when test results are normal, and 33% do

not even disclose abnormal results. The author concluded that, "Care among multiple providers must be coordinated to avoid wasteful duplication of diagnostic testing, perilous polypharmacy, and confusion about conflicting care plans."[3]

To help ophthalmologists coordinate care and follow up on referrals, test results, and appointments, OMIC developed a tracking system, which is discussed in the **Hotline** article and presented in detail in our document, "Noncompliance: A Frequent Prelude to Malpractice Lawsuits," available in the risk management recommendations section at www.omic.com. A tracking system is only effective, however, if all physicians involved in the care of a patient are clear on who is in charge of ordering, interpreting, communicating, and acting upon the results of tests and consultations. As the OMIC case demonstrates, sending a letter with the proper recommendations does not lead to safe care if the message is not received and acknowledged. A more active process is required. Several new regulations imposed on healthcare facilities have been adopted to force physicians, nurses, and other caregivers to better coordinate care and hand off patients. The first is medication reconciliation, the second is standardized hand-off discussions; each will be addressed in turn.

Reducing Errors from Medication Changes

OMIC claims experience and the studies discussed so far show that patients and providers alike appear to be inadequately prepared for their role in the next phase of care. This is particularly true with changes to medications, which occur regularly when patients undergo diagnostic/surgical procedures, are diagnosed with new conditions, or are hospitalized. Too many times, neither the patient nor the prescribing physician has accurate and complete information about the patient's current medication regime. The stage is thus set for errors and adverse drug

events that result in patient harm, hospitalization, increased costs, and allegations of medical malpractice.

Take anticoagulants, for example, which are among the top three classes of drugs involved in medication errors. Ophthalmologists who are planning procedures with a high risk of bleeding, such as blepharoplasty, routinely inquire about prescription and over-the-counter drugs that influence the clotting cascade, and make changes to the drug regimen preoperatively. OMIC claims studies have shown, however, that patients misremember which medications they are taking, misrepresent—often when faced with financial problems—when they last had clotting studies done by their primary care physician, or do not think to report recent cardiac procedures, such as the placement of stents. Failure to confirm dosages, test results, and the intended change in medication with PCPs and cardiologists, failure to confirm that a patient has indeed stopped medications as directed, and failure to provide comprehensible, written instructions on how and when to restart medications have all led to malpractice lawsuits. Adverse medication events such as these indicate the need for an explicit process of "medication reconciliation" at key transition moments, such as a new diagnosis, admission for surgery, or discharge from a healthcare facility. This step is now a "National Patient Safety Goal" that facilities must meet in order to maintain accreditation by organizations such as TJC and AAAHC.[4] And while time consuming, the process works: studies show that medication reconciliation decreases medication errors by 70% and adverse drug events by 15%.[2]

Tools to Improve the Quality of Hand Offs

One study of hand offs looked at the accuracy of information exchanged by nurses during shift change. Twelve fictitious patients were created, and nurses passed on information during five consecutive hand overs.

Oral communication resulted in the loss of all data. Note taking during hand off reduced data loss to 31%. It was only when a standardized form was combined with oral exchange of information that data loss was minimal.[5] Studies such as this convinced many organizations, including the Institute of Medicine, the Department of Defense Patient Safety Program (DOD), Kaiser Permanente, and AORN (Association of periOperative Registered Nurses) to produce tools to better structure patient hand offs. These teams learned that standardized hand offs shifted the focus from the people involved in the exchange (often hierarchical) to the patient, and led to common expectations about what was going to be communicated, how the communication would be structured, and the required elements. Most importantly, the process requires two-way conversation in which critical information is verified and clear responsibility for ongoing care is established.

The toolkit jointly developed by the DOD and AORN is particularly useful to ophthalmologists as it focuses on

TALK TO ME IN SBAR

SITUATION
Why are you calling this physician?
Identify yourself, unit, patient, etc.
Briefly state the problem: what, when, severity

BACKGROUND
Information related to the situation
Admission diagnosis and date
Most recent vital signs
List of current medications, allergies, IV fluids, test results
Lab results: date and time done, comparison to previous results
Other pertinent clinical information

ASSESSMENT
What is your assessment of the situation you are calling about?

RECOMMENDATIONS
What do you want from the physician?
Test or medication order?
Patient needs to be seen now?
Order change?

I PASS THE BATON

I	Introduction	Introduce yourself and your role/job (include patient)
P	Patient	Name, identifiers, age, sex, location
A	Assessment	Presenting chief complaint, vital signs, symptoms, diagnosis
S	Situation	Current status, medications, circumstances, including code status, level of (un)certainty, recent changes, response to treatment
S	SAFETY Concerns	Critical lab values/reports, socioeconomic factors, allergies, alerts (falls, isolation, etc.)
THE		
B	Background	Comorbidities, previous episodes, past/home medications, family history
A	Actions	What actions were taken or are required AND provide brief rationale
T	Timing	Level of urgency and explicit timing, prioritization of actions
O	Ownership	Who is responsible (nurse/doctor/team) including patient/family responsibilities
N	Next	What will happen next? Anticipated changes? PLAN? Contingency plans?

team building and was developed specifically for perioperative care.[6] It provides information on several standardized hand-off formats (see **TALK TO ME IN SBAR** and **I PASS the BATON**). Ophthalmologists would be well advised to become familiar with these hand-off processes, now that the Joint Commission, in National Patient Safety Goal 2E, requires facilities to implement a standardized approach to hand offs. TJC has clarified its expectations: hand offs must be interactive, allowing for participants to ask and answer questions; they must include accurate, current information; interruptions during hand offs should be minimized; they must include a process for verification of the received information, including read back or repeat back if needed; and other necessary patient information should be available for review.[7] It will no doubt take time to hone the hand-off process, but the effort will clearly result in safer care and less liability.

1. JCAHO. "Improving Hand-off Communications: Meeting National Patient Safety Goal 2E." *Joint Perspectives on Patient Safety* 2006; 6(8): 9-15.
2. Coleman EA and Berenson RA. "Lost in Transition: Challenges and Opportunities for Improving the Quality of Care." *Ann Intern Med* 2004; 140: 533-536.
3. Bodenheimer, Thomas. "Coordinating Care—A Perilous Journey Through The Healthcare System." *New England Journal of Medicine* 2008; 358: 10.
4. Several resources provide medication reconciliation tools. The Agency for Healthcare Research and Quality has a primer available at http://www.psnet.ahrq.gov/primer.aspx?primerID=1. The Institute for Healthcare Improvement has a tool to help review medical records to catch medication errors and develop an effective reconciliation process; this tool is available at http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/Medication+Reconciliation+Review.htm.
5. Pothier D, Monteiro P, Mooktiar M, Shaw A. "Pilot study to show the loss of important data in nursing handover." *British Journal of Nursing* 2005; v.14, n.20.
6. The toolkit, which includes slide presentations, sample tools, and forms developed for perioperative use, is available at http://www.aorn.org/PracticeResources/ToolKits/PatientHand-offToolKit/.
7. The Joint Commission's National Patient Safety Goal on hand-off communication can be found at http://www.jointcommission.org/AccreditationPrograms/LongTermCare/Standards/09_FAQs/NPSG/Communication/NPSG.02.05.01/hand_off_communications.htm. Accessed Dec. 1, 2009.