PROMOTING COLLABORATION AND MANAGING RISKS IN HEALTHCARE TRANSITIONS

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Objectives

• Identify the myriad reasons for communication among health care providers at all stages of care.

• Define where care transitions occur.

• Describe effective care transitions.

• Recognize the correlation between accuracy/completeness of communication and medical error.

• Recognize the limitations of documentation and implications of poor communication.

• Understand how communication and documentation affect liability.
What we will cover...

✓ What is a care transition?
✓ Elements of good documentation
✓ EMR - better or worse?
✓ What about “CBE”? 
✓ Care transition communication and documentation
✓ Care transition challenges
✓ Role of documentation in a medical malpractice case
✓ Lessons learned during the pandemic
✓ Karen’s Top Ten Takeaways
✓ Q&A
• Transfers from outside hospital to ED?
• Transfers from hospital to post-acute provider?
• Transfers within hospital?
• Shift change?
• Change in patient care team?
• Patient discharge to home?

A care transition occurs when all or a part of a patient’s care is transferred from one caregiver to another, whether it involves a change of location or not.
Elements of Good Documentation

• Accurate, relevant and consistent
• Clear and concise
• Comprehensive and complete
• Legible
• Timely, contemporaneous and sequential
• Accessible (i.e. in patient’s chart or provided prior to/at time of care transition)
Why document?

- Safety/quality
- Continuity of care every time a care transition occurs
- Written record of communication between/among caregivers
- Written record of communication between caregivers/patients
- Record of patient condition and changes
- Reimbursement
- Evidence
Case Study #1

How well does a care provider recall the details of care provided to a patient 2 years before? Put yourself in the shoes of the care providers below:

• A patient was admitted for a surgical procedure. He was alert, oriented and capable of self-care. The patient went from the operating room to PACU to a med-surg unit and later was discharged to SNF for additional rehab. He was then discharged home and returned to the ER where he coded and died.

• 2 years later in a deposition, the care providers must recall the details of the care.

• The only point of reference is the documentation they created contemporaneous with the care rendered.
**DOCUMENTATION: HOW?**

<table>
<thead>
<tr>
<th>Appears confused</th>
<th>Patient found in lobby, stated he thought he was at the airport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicated for pain</td>
<td>Patient states incisional pain at a level 7 on 1-10 scale; patient medicated; (1/2 hour later) patient states pain at a level 2</td>
</tr>
<tr>
<td>(1/2 hour later) Reports relief</td>
<td></td>
</tr>
<tr>
<td>Voiding qs</td>
<td>Voided 300 mL clear yellow urine</td>
</tr>
<tr>
<td>Pedal pulses present</td>
<td>Peripheral pulses in both legs 2+/4+</td>
</tr>
<tr>
<td>Taking oral fluids well (1000)</td>
<td>Drank 1,000 mL since 0700</td>
</tr>
<tr>
<td>Nervous</td>
<td>Patient asked several times about length of hospitalization, expected discomfort and time off work.</td>
</tr>
<tr>
<td>Breath sounds normal</td>
<td>Breath sounds clear to auscultation all lobes. Chest expansion symmetrical- no cough. Nail beds pink.</td>
</tr>
</tbody>
</table>
Some research suggests implementation of an EMR may result in improved and more efficient care, care coordination, and patient safety.¹

Other findings indicate that while use of EMRs may decrease the rate of “things falling through the cracks,” it is also associated with more frequent medication errors, fair/poor quality of care, and poor confidence in patients’ readiness for discharge.²

EMR CHALLENGES AND PRECAUTIONS

Consistency and ease of legibility with some risks:

- “Forces’” choices
- Limitations of drop-down options
- “Video Game” mentality
- Work arounds
- What other challenges?
What about “CBE”? 

• In a CBE environment, what is the minimum that must be charted?
  • Comprehensive initial assessment to establish baseline patient condition
  • Periodic reassessment and documentation of any changes in condition
  • Verbal orders/oral communications
  • All treatment provided including:
    • Fall interventions
    • Skin breakdown interventions
    • Medications administered or withheld

So what’s the problem?
What about “CBE”? 

- In general, if it is not documented, it didn’t happen.
- So, is charting by exception effective?
- CBE requires well-defined guidelines and standards of care with consistent execution.
Case Study #2

The nurse on the previous shift documented that the central line dressing had blood visible through the dressing. The nurse changed the dressing but neglected to change the status of the dressing to clean, dry and intact.

The oncoming nurse “carried forward” the previous documentation, reflecting the unchanged/soiled dressing.

• The policy requires that the dressing be changed every 7 days or when soiled, loose or signs of visible blood.
• Can/does this happen in an EMR situation?
• Can/does this happen in a CBE situation?
• Even though the nurse complied with the dressing change policy, the documentation does not validate the care rendered.
Care Transition Communication

• Effective communication at the time of care transition is essential to assure safe and timely patient care.

• All information transferred must be up to date, accurate and reflect the patient’s needs and preferences.

• It is not just the documentation delivered to the new care provider, but also the communication during the care transition that impacts quality/safety of care rendered immediately post-care transition.

• During care transitions, there is increased risk of communication errors.

• Communication errors are often contributing factors in sentinel events.
Considerations re Care Transitions

- Nationally, about 18% of all patients discharged from hospitals to nursing homes are readmitted within 30 days.
- What are the biggest challenges when transferring a patient from hospital to nursing home and vice versa?
- What are the barriers to transitions of care?
  - Medication information
  - Infection prevention challenges
  - Fall risk issues
  - Risk of skin breakdown
  - Others?
Improving Care Transition Communication

- List of key patient information to share
- When/how information is shared
- Standardize “handoff” forms
- Early/frequent communication with post-discharge care providers
- Developing standardized approach to care transitions:
  - Outreach to stakeholders
  - Collaboration as to key elements
  - Periodic evaluation and adjustment
FOCUS: Consider the following...

• Stop and think- what would be the most important thing(s) the next caregiver would need to know about a particular patient?

• How will that information be communicated?

• Does the chart documentation reflect that?

• Is there a “right place” to record that information?
Case Study #3

A patient was transferred to a SNF 3 days post-op (hip replacement). 2 days post-discharge, the patient fractured her femur in a fall and was transferred back to the hospital where she died 16 days later. During initial hospital-SNF transfer, a copy of the EMR was provided which included well documented post-op status with a high risk of falls and the prevention protocols that were in place. A provider-to-provider discussion on key patient concerns was held but not documented.

At the SNF, the admission documentation indicated low risk for falls. No special fall risk protocols were implemented.

- Where is the breakdown?
- What do you think the outcome of litigation would be?

*The importance of documenting critical discussions cannot be overstated.*
DOCUMENTATION AND THE MEDICAL MALPRACTICE CASE

• 20/20 hindsight
• What % of malpractice cases are “won/lost” on documentation?
• How likely is a care provider to remember accurately a particular patient? What happened? How? Who was present?
• How is documentation perceived in the rear-view mirror?
• When/why do patients/families sue healthcare providers?
• What can be done to minimize the likelihood of a claim?
TOP ISSUES IN MALPRACTICE CASES

#1: ABSENCE OF DOCUMENTATION
#2: TIMING OF DOCUMENTATION
#3: FAILURE TO RECORD:
   • Medication administration
   • Discontinued meds
   • Drug reactions
   • Care transition communications

What are the implications in care transitions?
THE MALPRACTICE CASE

Will the documentation testify that the care provider...?

• Conducted and recorded a comprehensive initial assessment and periodic assessments thereafter?
• Formulated, individualized and followed a plan of care?
• Observed, monitored and performed treatments according to accepted standards of care?
• Noted patient’s response to any interventions initiated in response to change in condition?
• Documented/communicated significant changes to other care providers, particularly during care transitions?
Lessons Learned During the Pandemic

• Effective and consistent processes are critical for communicating at any point of care transition.

• Shortage of resources led to risky shortcuts and reduced communication.

• Delays in pending labs created potential exposures during care transitions, making quarantine protocols even more critical.

• Universal precautions, although they’ve been the standard of care for decades, are not consistently followed. More training and rigorous enforcement required.

• It’s easier to manage the obvious.
Karen’s Top 10 Takeaways

1. SAFETY FIRST!
2. Care transitions are risk points in patient care.
3. During care transition, focus on key areas relevant to the patient.
4. Use a standardized care transition form, but also require 1:1 verbal communication.
5. Don’t rely on memory.
Karen’s Top 10 Takeaways

6. Document as soon as possible after providing care or after any communication, including communication related to care transition.

7. Focus on what the next caregiver needs to know—what’s important?

8. Adhere to policies/procedures particularly those designed for safety (even more important in a crisis).

9. Foster/encourage communication between care providers, including physicians, nurses, therapies, patient, and patient family members.

10. TAKE TIME TO THINK AND BREATHE!
RESOURCES

• Communication at Transitions of Care - PubMed (nih.gov)
• Changes in medical errors after implementation of a handoff program - PubMed (nih.gov)
• Handoff Communication between Remote Healthcare Facilities - PubMed (nih.gov)
Questions

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