Risk Rx

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IN THIS ISSUE:

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Managing Behavior and Eliminating Harm:

Moving Toward a Just and Safe Culture

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Patient Safety focuses on protecting patients from harm by learning methods of preventing adverse avoidable events due to latent, often unidentified flaws in complex medical care systems. Clinicians are and should be held accountable for improving care systems, but since 95% of medical harm involves competent, conscientious people working within complex healthcare environments, punishing individuals for their unintended mistakes will not protect future patients from harm -- and does not address the fundamental system issues that typically contribute to a mistake. Fear of prosecution or job loss inhibits reporting of "near misses"; errors that could have resulted in patient harm if not for serendipitous circumstances. It is these reports that have lead to the greatest gains in patient safety.

Employees who work in punitive workplace cultures will be understandably reluctant to come forward and report errors for fear of retribution. Organizations that are recognized for safety and reliability expect imperfection and dedicate a great deal of effort towards identifying and solving problems of latent error. "Just Culture" is a system of management championed by David Marx, Lucian Leape and other leaders within patient safety that focuses on management of human behavioral choices that are an inevitable part of working within a complex workplace where professionals exercise judgment as an expected part of their professional duties and where system design and workflow can result in behaviors that lead to increased risk of error and adverse events.

In a Just Culture, employees know that the constant goal is decreasing harm to the next patient and are comfortable sharing lessons learned from personal errors without fear of retribution. This is not a "blame-free" approach to adverse patient safety events; rather, as David Marx notes, "society rightly requires that some actions warrant disciplinary or enforcement action. Just Culture balances the need to learn from our mistakes and the need to take disciplinary action…." [David Marx, Patient Safety and the "Just Culture:" A Primer for Health Care Executives; April 17, 2001]

There are 3 main behaviors that are predictable within the clinical care environment: human error, defined as "inadvertently doing other than what should have been done" and comprising slips, lapses and mistakes; at-risk behavior, defined as acting without recognizing risk or mistakenly believing that risk is justified under the circumstances; and finally, reckless behavior, consciously acting with no regard for the "substantial and unjustifiable risk" that one is taking. [Outcome Engenuity, The Just Culture Community]

This latter form of behavior is extremely rare in healthcare environments. At-Risk behavior is the most common and problematic phenomenon associated with preventable adverse patient safety events and arises from predictable changes in the way we perceive risk with experience and repetitive exposure to similar situations.

Under production pressure, communication and team work break down while the system continues to strive for efficiency -- to do more with less time. Humans engage in "short cuts" such as multi-tasking, skipping portions of checklists and relying on memory, and overriding safety alerts generated by computerized medication order entry systems because they are perceived as "false alarms." In time, as these short cuts pay off in time saved, humans perceive a fading perception of risk when no negative consequences have occurred. This further reinforces risk taking behavior.

Regardless of whether a serious adverse outcome occurs as a consequence of adverse behavior, Just Culture holds that this type of behavior should be managed through coaching employees in the implications of these practices through creation of greater situational awareness-- and that the management system can help reduce or eliminate these behaviors by removing the hidden incentives to engage in these practices and shift towards healthier behavior choices. Punishing or terminating an employee who had no intention of causing harm will not create a safer clinical environment for patients being cared for by another substitute employee within the same care system.

Ultimately, the promise of Just Culture is that staff and management expectations change to where human imperfection is expected and the focus of the patient care system shifts towards a proactive search for novel risks and hazards in order to refine and continually work towards safer medical care. Through fair and just standards of accountability, medical care personnel are empowered to make safer choices. The reward of a Just Culture is an engaged workforce that discusses adverse events openly and turns them into opportunities to improve healthcare.

Punishing or terminating an employee who had no intention of causing harm will not create a safer clinical environment for patients being cared for by another substitute employee within the same care system.

— Eric I. Rosenberg, M.D.

Correcting Errors in the Electronic Medical Record

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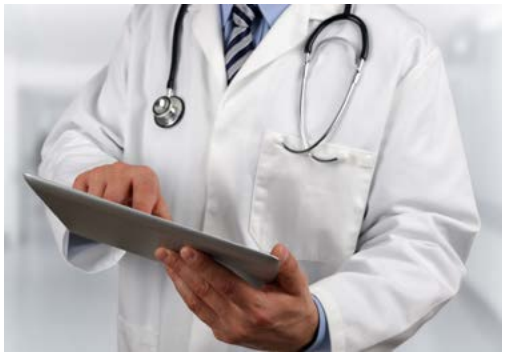

Despite all of the benefits that electronic health records (EHR) offer, there remain opportunities for incorrect data entry due to problems with system design and or user error. Errors caused by system problems (e.g., a confusing screen design, etc.) can be prevented by working with your vendor to reset user preferences as needed. In order to preserve data quality and protect patient safety, it is essential to set a policy to funnel all errors to necessary staff and physicians in a timely manner. The case study below illustrates why establishing a sound system is very important.

Suppose that a physician orders a pregnancy test on a patient before administering a variety of drugs known to cause birth defects in the fetus. An incorrect result is recorded in the patient's record, but subsequently discovered. The patient might well have begun treatment prior to the correction of the lab report. In such a situation, it would be important to the physician to be able to prove that the initial (incorrect) report on which he relied, existed. It is also important that a corrected report be brought to the immediate attention of the physician.

In the case of electronic records, the problem is that the correction of the lab report may potentially eliminate information that the physician relied on for a period of time. Also, the correction might be made without the physician ever being aware that a reporting error was made. State laws vary on how medical records can be amended. Generally the law frowns on erasing relevant information so that it cannot be recovered. That's why opaque correction fluid should not be used in correcting paper records, and why incorrect entries in the written medical record be lined out and rewritten rather than obscured.

The possibility exists that over-writing the initial EHR, even though the information is incorrect, could be construed as improper alteration of the historical medical record. In general, states merely require that electronic records be maintained "to the same standards" as paper copies. Also, the amended EHR should be flagged to indicate that it has been corrected, and some mechanism be put in place to retain and easily access copies of the original, if incorrect. A comment field in the amended report may suffice. In general, a narrative entry in the medical record statement indicating that an error has been made, and is being corrected, is the best procedure. When a lab or diagnostic report is involved, the facility director or pathologist should assume the responsibility for insuring that such an entry is made. Both the original error and the correction should be well documented for future reference.

Personal contact between the laboratory/diagnostic facility and the involved physician is always desirable, and should occur whenever an erroneous report must be corrected. Keep in mind that the report may be critical and time may be of the essence. Most importantly, whenever an error in lab/diagnostic test reporting is made, it is essential for the laboratory/facility to retrace the handling of the specimens, films, etc., and determine how erroneous results were released.
The facility should then institute appropriate policy and procedure changes to prevent recurrence of such errors.

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In summary, correcting errors in EHR systems should follow the same basic principles as correcting paper copies. These specific considerations apply:

- Work with your vendor to confirm that your EHR system allows error correction and determine whether or not the vendor has established a process.
- The system must have the ability to track corrections or changes once the original entry has been entered or authenticated.
- When correcting or making a change to an entry, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted.
- In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.
- The process should permit the author of the error to identify, and time/date stamp, whether it is an error.
- The process should offer the ability to suppress viewing of the actual error but ensure that a flag exists to notify other users of the newly corrected error.
- The location of the error should also point to a correction. The correction may be in a different location from the error if there is narrative data entered, but there must be a mechanism to reflect the correction.
- Develop a practice policy to ensure that your facility corrects and reports errors in a consistent and timely manner.

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Veterinary Medicine and the Law:

How to Provide Good Care and Protect Yourself in the Process.

Part I: Informed Consent

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When providing veterinary care, the healthcare provider is dealing not only with the health and wellbeing of the animal, but with the owner's concerns as well. Regardless of the type of patient, however, there is a minimum standard of care that should be provided by every healthcare provider. Every provision of appropriate and thorough care begins with the examination of the animal and the performance of tests, including radiographic studies and laboratory tests. The veterinarian can then provide the owner with the available treatment options, explaining the risks and benefits of each. It is wisest to provide the owner with all of this information in writing, explaining the type of procedure and a majority of the most likely complications, and to also obtain their consent and understanding in writing. Any procedures involved in the treatment may also require a separate informed consent. Informed consents are one of the critical protections available to all healthcare providers, including not only fully advising the owner of risks and complications, but of documenting these in the medical record and in the informed consent that is acknowledged and signed by the owner. Because legal action can often come to fruition years after the event, the medical records are often the only manner in which the thought process of the veterinarian and the understanding of the owner have been memorialized. We will discuss medical records and how vital they are to the defense of a veterinary malpractice action in the second part of this article.

A key component of meeting the standard of care is being able to provide the owner with a fully informed analysis of the patient's condition, the treatment options and the risks associated with those options, so that the signed consent and authorization is as informative as it reasonably can be. Of course, one cannot inform an owner of all the possible risks and complications, as each of those complications come with their own set of complications. The key is to provide enough information so that the owner may make a reasonably informed decision. Of course, as with any procedure, test or treatment, even the most apparently innocuous have inherent risk and danger. It can be a fine balance between trying to fully inform the owner and not creating additional stress or concern. Part of your mission is also to reassure the owner that the procedure or treatment will go well. Or, in some circumstances, be frank about your concerns that the procedure may be experimental, risky, or not likely to work, but that it may be the only option available. Whenever possible, some owners are encouraged by success rates and percentages within your own practice and in the public at large. Therefore, you may want to have this information available should you need to quantify the success rates, as well as the risk rates.

Part of any informed discussion is to discuss the nature of the animal's condition and the diagnosis. Because animals are considered property, the decision about whether or not to treat a particular ailment is different than it would be for a human patient. For some, the decision whether or not to initiate treatment or perform tests on an animal is a question of money. Part of the informed consent should include the prognosis or risk to the animal

should the owner refuse any treatment at all. Should they elect to proceed with treatment, it is wise to provide a number of treatment options when possible and the purpose or reason for each. A number of complaints and claims are filed when the treatment, that was so desperately requested, has failed and the owner is left with a substantial bill and effectively, nothing to show for it.

As evidenced already by this discussion, communication is at the center of almost all human discourse. This includes both oral and written communications. Many claims are made and lawsuits filed because of a breakdown in communication between the veterinarian and the client. This breakdown can occur at almost any or all points in your interaction with the client, beginning with the examination and diagnosis. This stage can sometimes be one filled with fear about their pet's condition and clients under stress may not always fully assimilate the information provided or remember it accurately. It is also important to convey that results are not guaranteed. As with any healthcare, many factors play a role in the outcome of the animal and many of these are out of your control. Unreasonable expectations will only lead to disappointment, confusion and anger.

Therefore, it is beneficial to discuss a treatment plan, put it in writing, and to provide an estimate of the charges associated with that treatment plan. Ideally, this estimate is signed by the client and you should ensure that you retain a copy of that signed estimate in your file. You or a trained staff member should go over it with them in detail and answer any questions associated with that treatment plan. Remember to keep it simple and use plain English when explaining the animal's condition and the proposed treatment. Otherwise, you may inadvertently contribute to the client's stress and confusion. They may feel intimidated by the words they don't understand and may be less likely to ask questions that would help you allay their fears.

Along with the discussion of the care, it is also helpful to provide the owner with handouts or information about the procedure or treatment. In this increasingly technologically savvy world, clients are very likely to Google and diagnose their pets themselves. Better to control the dissemination of that information yourself to make certain they are receiving reputable information. Once the treatment plan and estimate are accepted, and prior to any treatment or procedure, an informed consent will serve to more thoroughly outline the risks and benefits of the procedures and again will be signed by the owner to evidence their receipt and understanding. In a study by the Institute of Medicine it was found that half of Americans do not understand basic health information. Therefore, written material provided to patients should be written at an eighth-grade level.

If the proposed treatment involves surgery, there should also be a discussion of who will actually be performing the surgery and where it will be performed. It

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— Francys C. Martin, Esq

may be the surgery is to be performed at another facility, and although you cannot advise of all the policies, processes and costs of an outside facility, some effort should be made to at least inform the owner that there will be another party involved with which they should also discuss their concerns. The location and methods of transportation may also be significant depending on how far from the owner's home the treatment is to take place, resulting in additional costs that may also include boarding.

The value of animals as property, and, therefore, the value of their care is quite dependent on the type of animal and some can be quite expensive. For example, the purchase of a horse can be a substantial investment and as a result, pre-purchase examinations of the horse by a veterinarian are quite important and can have serious ramifications on the success of the deal. Horse communities in certain geographic areas can feel quite small and often the same parties are involved. Therefore, it is key to let all parties involved know whether they have worked together in the past and whether the veterinarian has treated the horse in the past. If no conflict of interest exists, or if all parties are aware of conflicts and consent, it would also be beneficial to the veterinarian to have that conflict acknowledged in writing by all parties involved to avoid potentially being accused of any impropriety in the future.

A better informed owner is often a more satisfied owner. When given all available information and provided an opportunity to ask questions, owners will feel that they've been given a true opportunity to participate in the care and assert some control over a situation that can often feel out of their control. Remember that, in a sense, the owner is your patient as well. Taking these steps will assist the owner, but also provide some level of protection to you and your practice should any claims be made in the future. In the next segment of this article, we will discuss the importance of medical records.

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Risk Rx, which has been provided to our Self- Insurance Program participants for the past ten years, gives us an opportunity to communicate with you on a quarterly basis about the many issues impacting health care providers. Its intent is to share and promote useful subject matter and strategies to enhance patient safety, prevent loss, and minimize exposure to liability.

-Jan Rebstock, RHIT, LHRM, CPHRM

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