

28 Items Included in NQF's List of 'Never Events'

Historical Perspective on Identifying and Defining 'Never Events'

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

The National Quality Forum has developed a list of 28 'never events' - health care-related adverse events that are serious, largely preventable, and of concern to both the public and health care providers.

In 1998, the Joint Commission recognized the need to identify serious yet preventable adverse health care-related events which were happening consistently across the United States that were associated with bad patient outcomes. These events were labeled as 'sentinel events.' In 1999, the National Quality Forum (NQF) was created by presidential decree, and its members were given a charge to look at the overall health care system, issues of quality within the health care system, and setting performance standards for patient safety. The NQF is a "think tank" based in Washington, DC. Also in 1999, the report *To Err Is Human: Building a Safer Health System* was published (Kohn LT, Corrigan JM, Donaldson MS, eds. Washington, DC; National Academies Press; 2000), which identified systematic problems across the health care industry that caused harm and sometimes death to both inpatients and outpatients. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Despite Precautions, Wrong-Site Surgeries Still Occur

Never Events: Wrong-Site Surgery and the Universal Protocol.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Despite everyone's best efforts to avoid the 'never event' of wrong-site surgery, this preventable error continues to occur. For example, 1 wrong-site surgery occurs in Pennsylvania every 5 days.

'Never events,' as defined by the National Quality Forum (NQF), include a list of 28 preventable medical errors that result in adverse patient outcomes. Other terminologies may overlap with 'never events.' The term 'never events' may be intermingled with 'sentinel events,' particularly in the State of Pennsylvania where we are currently practicing. Also the term 'serious events' often overlaps with 'never events.' Therefore, something that could be labeled as a 'never event' for billing purposes, for Centers for Medicare and Medicaid Services (CMS) purposes, or for insurance purposes may be considered a sentinel event as defined by the Joint Commission and by the Pennsylvania Patient Safety Authority. These serious recordable events can be classified into 6 different categories. The first of these categories involves surgical or procedural complications, which contains several items. **Wrong-Site Surgery:** The first item is surgery performed on the wrong body part. There has been an enormous amount written on how to prevent this error. Every existing hospital has a procedure or policy on how to prevent wrong-site surgery. However, in the 2009 National Patient Safety Goals, the Joint Commission indicated that this was a continuing problem across the United States and introduced the idea of the "Universal Protocol." *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Verify That Correct Patient Is Present for Surgical Procedure

Never Events: Wrong Surgical Patients and Wrong Surgical Procedures.

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Two items included on the surgical 'never events' list include (1) a surgical procedure performed on the wrong patient and (2) the wrong surgical procedure performed on a patient.

Serious preventable medical errors associated with surgical procedures can occur while caring for inpatients and outpatients. The 'never events' for surgical procedures include a list of reportable errors that include several items. Surgery performed on the wrong patient is one such item. This event occurs less frequently than does surgery being performed on the wrong body part. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Human Error Results in Surgical Foreign Object Retention

Never Events: Postoperative Unintended Retention of Foreign Objects - Part 1.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

One of the most concerning 'never events' associated with surgical procedures is that of the unintended retention of foreign objects in a patient after a procedure, including objects ranging from a Cottonoid® to a malleable retractor.

(Card 1 of 2) Good health care must ensure patient safety. Yet, severe preventable surgical errors occur. The National Quality Forum has developed a list of severe 'never events' associated with surgical procedures as well as other health care-related situations. One of the most concerning or frightening surgical situations is that of unintended retention of foreign objects in a patient after a procedure. The more familiar of the retained foreign bodies range from a Cottonoid®, which is very small (the size of the tip of a Q-tip™), to a malleable retractor, which is 1 foot long and very thin but is also big and metal. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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New Technologies Help Prevent Foreign Object Retention

Never Events: Postoperative Unintended Retention of Foreign Objects - Part 2.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

New technologies being developed to prevent the retention of foreign objects in surgical patients include placing radiofrequency identifiers on sponges or surgical items and trash cans that count items as they are discarded.

(Card 2 of 2) One of the most concerning preventable surgical errors is that of unintended retention of foreign objects in a patient. This error is included on the list of 28 'never events' developed by the National Quality Forum, which defines preventable medical errors resulting in adverse patient outcomes. If surgical team members find that their instrument counts, sponge counts, or needle counts are not correct, then they must proceed through a series of steps to account for all objects, including taking x-rays in the operating room, which often can be a difficult task. However, for cases that we have followed up by interviewing the staff and reviewing the documentation, the counts appear to be correct. Therefore, the unintended retention of a foreign object is a difficult situation, and it is one of the most difficult situations for the patient. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Preop "Time Out" May Prevent Intraoperative Deaths

Never Events: Intraoperative or Immediately Postoperative Death in Normal Healthy Patients.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

A major surgical 'never events' item is the intraoperative or immediate postoperative death in ASA Class 1 patients, who represent patients with the least amount of surgical risk and are the easiest to care for in the operating room.

Most preventable medical errors do not result from individual recklessness. Nonetheless, a list of serious preventable 'never events' has been developed that includes a series of errors associated with the surgical care of inpatients and outpatients. A major item on this list of surgical 'never events' is the intraoperative or immediately postoperative death in an American Society for Anesthesiologists (ASA) Class 1 patient. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Wrong-Site Surgeries Remain Problem Despite Precautions

Surgical 'Never Events': How Common Are Adverse Occurrences?

West JC:

ASHRM Journal 2006; 26 (1): 15-21

In Minnesota, the surgical error of wrong-site surgeries continues to be a problem despite adoption of the Universal Protocol and state reporting requirements for this serious error.

Background: Surgical errors are typically the easiest to understand of the 28 'never events' (serious preventable medical errors) listed by the National Quality Forum (NQF). Many preventive guidelines have been published in an attempt to reduce these surgical 'never events.'

Objective: To describe the Minnesota experience since 2003 with the NQF's 'never events' list.

Results: The Minnesota legislature passed the Adverse Health Care Event Reporting Act, and hospitals were required to report the different 'never events' to the Minnesota authorities. With respect to surgical 'never events,' hospitals had to report surgical errors, including surgery on the wrong patient, surgery on the wrong body part, the wrong procedure, foreign body retention, or the intraoperative or immediately postoperative death of a healthy patient (ASA Class 1). From July 2003 to October 2004, these hospitals reported performing 356,000 surgical procedures during which the following surgical 'never events' occurred: 31 retained foreign bodies, 13 wrong-site procedures, 5 wrong procedures, 2 deaths of healthy individuals, and 1 surgery on the wrong patient. However, from October 2004 to October 2005, the surgical error list included 26 wrong-site procedures. From October 2005 to October 2006, 31 wrong-site procedures were reported.

Reviewer's Comments: Despite the emphasis on preventing these surgical errors, the adoption of the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™, and the reporting requirements, these errors continue to be an issue and a problem. Whenever people are involved in a process, the potential exists for human error. Because people are involved, you must incorporate redundancies and several steps in an attempt to prevent these different surgical 'never events' in your practice. (Reviewer-Richard P. Kidwell, JD).

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Universal Protocol Applies to Many Health Care Situations

Never Events: Applying the Universal Protocol Beyond the Operating Room.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

The Joint Commission's Universal Protocol is designed for more than just the operating room and should be used for all health care situations in which the staff must verify the right patient, the right procedure, and the right body part(s).

In an effort to reduce the incidence of surgical errors, the Joint Commission has published the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™ for use in the operating room. However, the Universal Protocol can and should be used in health care situations beyond the operating room as well. Any time an interventional procedure is scheduled in a radiology department or in any other practice area, and any time a central line is being placed at a bedside, the Universal Protocol should be incorporated. The Universal Protocol applies to all situations in which the staff must verify the right patient, the right procedure, and the right body part(s). As an industry, health care has not done a great job checking all these important points of information when providing care to a patient outside of the operating room. **Resources:** To obtain a copy of the patient safety videos entitled "Doing the Right Thing," please contact Kathleen Hale at halekm@upmc.edu. Episode 1 is entitled "Wrong-Site Surgery." Episode 2 is entitled "I Need Some Clarity." In March 2009, a third episode was in the concept stage. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Complex Process of Medication Orders Vulnerable to Errors

Never Events: Medication Errors Resulting in Patient Death or Disability.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

A nonprofit organization called the Institute for Safe Medication Practices provides objective information and good safety points about how to prevent medication errors.

A list of 28 serious preventable medical errors, termed 'never events,' has been defined by the Joint Commission. One group of 'never events' is contained under the heading of care management events. A few of the categories under this heading are somewhat controversial. However, the first category of care management events is fairly well understood by most clinicians - patient death or serious disability associated with medication errors. These errors involve wrong drug, wrong dose, wrong patient, wrong time of administration, wrong rate, wrong preparation, or wrong route of administration. This is another portion of health care that has been repeatedly evaluated and investigated, and it is probably the most complex portion of health care delivery. The process requires that a medication order from a physician go to a pharmacist who must be able to read the order and then find the appropriate medication, dose, strengths, etc. Then, the pharmacist must get the medication to the nursing unit in a timely fashion. The nursing staff then must administer the medication as the order specifies. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Pharmacy, Nursing Distractions Contribute to Medication Errors

Pharmacy and Nursing Factors Contributing to Medication Errors.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Numerous distractions occur in pharmacies and on nursing floors that contribute to medication errors, which may result in death or severe patient disability.

Medication errors that result in patient death or serious disability are included in one group of 'never events' (serious preventable medical errors) defined by the Joint Commission. The entire process of medication administration begins with a handwritten or computerized medication order from the physician. Next, the order is delivered to the pharmacy, which is responsible for filling the order as it is written. The pharmacist may need to get clarification from the physician. When ready, the pharmacist starts mixing various compounds. Because many of the materials in a pharmacy are clear liquids, the pharmacist must ensure that the correct concentration is used and that the correct clear liquids are mixed together to make the product needed by the patient. The number of distractions that can occur during this process is innumerable. Most pharmacies have a double-check system, but even these systems are not foolproof. Inpatient pharmacies in which only one pharmacist works have many challenges associated with this work environment. Their work is double-checked, but staff members often get distracted or are very busy and they go through only the motions of doing the double-check system. Therefore, medication errors may get missed in the pharmacy. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Participation Helps Avoid Medication Errors

Medication Errors: Encourage Patient Participation to Reduce Errors.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

A factor that appears to make a huge difference in avoiding medical errors is instructing and encouraging patients to be involved in their own health care, whether it be the right site for surgery or the right medication.

Medication errors that result in death or severe patient disability are under intense evaluation for developing good preventive practices. At the bedside, new scanning technologies are now available so that the nurse can scan the patient's identification bracelet and then scan the medication to verify that everything matches correctly. This and other available technologies designed to help the staff have been met with mixed responses. While the technology can make things go much more rapidly, it does not replace the need for the nurse to read and verify that the right medication is being given at the right strength to the right patient. By scanning all that information, errors can still occur. It is very unfortunate when these errors occur, but it all goes back to the really simple things of talking to the patient and verifying that he or she is the correct individual for whom the medication is intended. Often, after an error has occurred, the investigator is told, "Well, I was taking care of both patients in that room and I knew them both." A simple human error can cause a medication error that can result in harm to a patient. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Verification Key to Preventing Transfusion Reactions

Never Events: Hemolytic Transfusion Reactions Due to Administration of Incompatible Blood.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

The most common reason for hemolytic transfusion reactions due to administration of ABO incompatible blood appears to be in the failure to verify that the correct patient is receiving the blood.

Part of the Joint Commission's list of 'never events' includes preventable medical errors that are categorized under the heading of care management events. One of these items is patient death or serious disability associated with hemolytic transfusion reaction due to administration of ABO incompatible blood or blood product. An enormous amount of time and energy has been spent to create a safe system for blood transfusion. An enormous amount of testing must happen in the lab to find out what kind of blood the patient has, whether they have antigens, and whether there is going to be difficulty transfusing a patient. We need to be acutely aware of the complicated nature of this system. Most people deal with only 1 piece of the system and do not look at the overall system. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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No Trends Recognized for Cause of Delivery-Related Maternal Deaths

Never Events: Maternal Death or Disability Associated With Labor or Delivery in a Low-Risk Pregnancy.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Despite investigations and studies, no trends have been identified to help develop measures to avoid maternal deaths or serious disability associated with labor or delivery in a low-risk pregnancy.

The National Quality Forum has compiled a list of 28 serious health care-related errors, or 'never events,' classified into 6 different categories. One of these 6 major categories is care management events, which includes several different issues. One such issue is that of maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility. The expectation today is that women receive prenatal care, regardless of whether they plan to deliver at a birthing center, in a hospital with an obstetrician, with a midwife, or with a family practitioner. Regardless, the expectation is that there will be prenatal care. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Poor Patient Compliance May Cause Hypoglycemia in Hospital

Never Events: Serious Patient Disability Associated With Hypoglycemia.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

One defined 'never event' is serious patient disability associated with hypoglycemia, the onset of which occurs while the patient is being care for in a health care facility. The preventability of this event is somewhat controversial.

'Never events' are serious medical errors made while providing health care to inpatients and outpatients. According to the National Quality Forum, 'never events' are preventable, and one such item is serious patient disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility. The preventability of this event is somewhat controversial because the patient can have a significant impact on this medical error. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Untreated Hyperbilirubinemia in Newborns Rare Error

Never Events: Failure to Identify and Treat Hyperbilirubinemia in Newborns.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Because pediatricians usually identify and treat hyperbilirubinemia immediately, untreated hyperbilirubinemia in newborns is a rare medical error in the United States.

A list of 28 'never events' compiled by the National Quality Forum defines serious but preventable medical errors. This list contains a medical error that deals with a very specific patient population: the death or serious disability associated with failure to identify and treat hyperbilirubinemia in newborns. This is a very rare event in the United States. Most neonatal intensive care units or basic nurseries have bili lights (a phototherapy tool used to treat newborn hyperbilirubinemia) and have access to the technology and the testing needed to keep the baby safe. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Physician Records Critical in Stage III/IV Pressure Ulcers

Never Events: Stage III or IV Pressure Ulcers Acquired After Admission to a Health Care Facility.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Stage III or IV pressure ulcers acquired after admission to a health care facility are incredibly controversial 'never events' items because skin breakdown may still occur despite best efforts to maximize care and protect the skin.

Several items on the 'never events' list developed by the National Quality Forum regarding serious medical errors are considered to be controversial. Perhaps the most controversial item is that of Stage III or IV pressure ulcers acquired after admission to a health care facility. This is an incredibly controversial item because, when a patient comes through the door, we often have an individual with poor nutrition who is immobile or who is so sick or injured that we do not have the ability to turn them, to reposition them, to perform the proper skin care, or to do all the treatments required to keep their skin healthy and intact. Despite best efforts with maximizing nutrition, using specialty beds and overlays, and providing all sorts of other things to protect the skin, breakdown occurs. especially true with elderly or incapacitated patients who are bouncing between nursing homes and hospitals. In these cases, blame for the ulcer is often placed on the other care facility. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Communications Vital to Avoid Spinal Injury, Wrong Donor Sperm

Two 'Never Events' Disability Due to Spinal Manipulative Therapy and Artificial Insemination With the Wrong Donor Sperm or Egg.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

The two separate 'never events' of (1) serious patient disability due to spinal manipulative therapy and (2) artificial insemination with the wrong donor sperm or egg can be prevented with good patient communications.

The National Quality Forum has listed serious patient disability due to spinal manipulative therapy as 1 of the 28 serious but preventable health care-related errors defined as a 'never event.' This is a rare situation, and very few clinicians actually practice this type of procedure. Therefore, the error of patient disability due to spinal manipulative therapy is restricted to a small number of clinicians and to a small patient population. Nonetheless, because the resulting disability is the focus of this 'never event,' the level of care provided to the patient is very important. If you are performing spinal alignments and/or if you are working as a chiropractor, then you must immediately move patients up to the next level of care if they experience tingles and nerve issues. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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HAls Considered Reportable Events in Some States

Never Events: Health-Care Associated Infections - Part 1.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

In some states such as Pennsylvania, health care-associated infections must be reported to state officials, and a letter must be sent to the patient informing him or her about the infection.

(Card 1 of 2) An item that appears on some lists of 'never events' (serious preventable medical errors) developed by the National Quality Forum is health care-associated infections (HAIs). This is a big issue in several states, including Pennsylvania. In 2007, the Pennsylvania legislature passed Act 52, which requires health care facilities to report HAIs to the Pennsylvania Patient Safety Authority. Act 52 amends the Medical Care Availability and Reduction of Error (MCARE) Act by requiring the reporting of these HAIs. *Clostridium difficile*, which is a gastrointestinal infection. Much work has been done with indicators and markers to make sure that patients do not receive excessive amounts of antibiotics, which may have been administered in previous eras. Despite research and new antibiotic treatment regimens, we are still seeing large numbers of *C difficile* cases. Most of these infections are readily treatable, but on occasion, they may result in a patient needing a colectomy. Therefore, we have been focusing on minimizing *C difficile* infections in addition to methicillin-resistant *Staphylococcus aureus* (MRSA) infections. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Discuss Potential for HAIs With Patients on Admission

Never Events: Health-Care Associated Infections - Part 2.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

In some states, urinary tract infections that may have been present at admission and surgical site infections are among the various health care-associated infections that must be reported to state authorities.

(Card 2 of 2) One reason that health-care associated infections (HAIs) may be classified as a 'never event' on some lists but not on others is that the genesis of the infection is not always known. Health care providers are working to identify infections and colonizations that are present in the patient at admission, which allows preemptive treatment and minimizes transmission to other patients. If a patient is admitted with an unknown infection or if we do not suspect that they have an infection, then we do not isolate them and, in turn, risk spreading that infection to other inpatients. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Check Out Medical Equipment When Small Shocks Reported

Two Never Events: Electric Shock and Gas Line Delivery Errors.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Two environmental 'never events' include patient death or serious disability linked to either an electric shock or the switching of lines designated for oxygen with the wrong gas while being cared for in a health care facility.

Six major categories of preventable medical errors are incorporated into the National Quality Forum's list of 28 'never events.' One of these major categories is environmental events, which include items such as electrical shock, fires, and switched gas lines. The first item in the environmental events category is patient death or serious disability associated with an electrical shock while being cared for in a health care facility. This is a very rare event.²). Meters used to deliver oxygen and CO₂ are different colors, and they are not interchangeable. However, the tubing used to deliver these gases can be interchangeable, which is where the error usually occurs. Oxygen is typically delivered off of a green meter and CO₂ is delivered off of a yellow meter, but the equipment that attaches to these meters is comparable. Therefore, it is not unheard of to switch the 2 gases, which can be devastating for the patient. There are also some reported cases of switches with anesthetic gases that can be problematic. On rare occasions, you will have contamination of a tank line, which can be picked up in many ways. With contamination at that level, you are going to be delivering gases to a large number of patients, and the health care team picks up quickly on what is happening. All these types of incidents are considered a 'never event.' *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Preventing OR Fires Requires Anesthesia, Surgeon Coordination

Never Events: OR Fires and Burns Resulting From Inappropriate Use of Bovie.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Flash fires occur in the operating room when there is a pooling of oxygen due to the anesthesia technique and the Bovie (instrument used for electrosurgical dissection and hemostasis) being used simultaneously by the surgical team.

In any health care facility, environmental errors can result in serious patient injury or death. Several environmental errors are listed on the National Quality Forum's list of 28 'never events.' One of these items is that of patient death or disability associated with a burn incurred from any source while being cared for in a health care facility. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Education About Flammability of Oxygen Is Critical

Never Events: Serious Errors Due to Equipment Fires or Patients Smoking While Receiving Oxygen Therapy.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Flash fires that result from a patient lighting a cigarette while receiving low-level oxygen therapy may be a truly devastating event because, when an airway is scorched, recovery may or may not be possible.

Patient death or disability associated with a burn incurred from any source while being cared for in a health care facility is considered an environmental error and is included on the National Quality Forum's list of 28 'never events.' One category of fires in a health care facility involves equipment that suddenly catches fire. However, in truth, equipment generally does not 'suddenly' catch on fire. Instead, it usually smolders for a time, particularly with beds. Most beds used in health care facilities have electronic mechanisms somewhere within them. We place a mattress over these mechanisms, and the equipment will usually smolder before eventually causing a fire. This is a very rare event. When investigating these events, we learn that there is often a telltale shock that hints at the problem in advance of the fire. When these shocks are reported, the health care team needs to begin looking for the cause. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Falls Require Thorough Documentation

Never Events: Falls Occurring at the Health Care Facility - Part 1.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

In the hospital, a patient fall must be carefully documented because the patient may initially blame himself or herself but later change the story after talking with family members and/or a lawyer.

(Card 1 of 2) Patient death or serious disability associated with a fall while being cared for in a health care facility is 1 of the 28 items on the National Quality Forum's list of 'never events.' This is a controversial 'never event' because it involves whether or not patients are compliant with the instructions they were given and whether or not patients understand their own limitations. Fortunately, many falls do not involve death or serious disability, but they could. One example is that of a new mother. She has just given birth, has gone through quite an experience, and feels that the worst is over. She has had an epidural, and she wants to get back to her normal routine. Despite the fact that she cannot feel her feet, she gets up to walk and experiences a fall. Because these types of falls occur in young and healthy individuals, usually there is not a serious injury, but the potential for a serious injury is present. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Not All Patient Falls Are Predictable, Preventable

Never Events: Falls Occurring at the Health Care Facility - Part 2.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Several leadership organizations in the health care industry would like to further explore the applicability and implications of the 'never events' defined by the National Quality Forum, especially regarding the issue of patient falls.

(Card 2 of 2) Despite patient education and good care, patients may fall while being cared for in a health care facility, which may result in death or serious disability. One interesting case study of such a fall was documented by a nurse who was caring for a patient with a cardiac history and atrial fibrillation (A-fib). Because of the patient's A-fib, he was receiving anticoagulation therapy, and as a result, he had an elevated International Normalized Ratio (INR; measure of blood clotting potential). In addition, the patient was experiencing other kinds of arrhythmias at the same time. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Problems With Products, Devices May Cause 'Never Events'

Never Events: Problems With Products or Devices Used in Health Care.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Products or devices used in a health care facility may cause problems when they are contaminated, when they malfunction, or when their use results in an intravascular air embolism.

The National Quality Forum's list of 28 'never events' is classified into 6 different main categories. One of these categories involves products or devices used in health care, which is a fairly short list. The first item on the list is death or serious disability associated with use of contaminated drugs, devices, or biologics provided by the health care facility. The health care facility needs to know where their products and devices are coming from and whether they have been certified by the Food and Drug Administration. If certain products or devices are being reused, then the processes for reusing them must be reliable, and culturing must be performed at every possible point to check for contamination. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Facilities Need Protocols, Personnel for Product Recalls

Recommendations for Response to and Protocols for Managing Product Recalls.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Health care facilities must have a process in place allowing for prompt and appropriate responses to product recall notices and for thorough documentation of each facility's response to the recall.

From time to time, health care facilities must deal with the issue of product recalls. When responding to these recalls, the facility must ensure that they do not rely solely on the representative from the device or drug manufacturer to make sure that all recalled items have been retrieved. Instead, the facility must verify that all recalled products are managed appropriately by relying on their own processes and personnel. The "Dear Doctor" recall letters are very important. We must pay attention to these letters when they announce recalls or issues with drugs or devices. Our health care facilities must also have a process in place allowing for prompt and appropriate responses to these recall notices and for thorough documentation of each facility's response to the recall. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Dementia, Closed Head Injury Patients at Risk for Wandering

Never Events: Patient Protection Errors at Health Care Facilities.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Serious health care errors in patient protection include items such as discharging an infant to the wrong person and patient injury or death related to the patient wandering away from the facility without permission.

Patient protection events are included in one major category of serious medical errors considered to be 'never events' as defined by the National Quality Forum. The first item in this category is discharging an infant to the wrong person. This is a very rare situation and is different than an infant abduction. Typically in these situations, someone arrives to take the infant home and misrepresents themselves (perhaps as a sister or cousin) as having been given the authority to take the child home. Situations like this more commonly occur when a healthy baby is discharged before the mother or when a baby has needed prolonged hospitalization and the mother was discharged earlier. To avoid this problem, health care facilities need to have a system of double checks to verify that the right person is taking the baby home. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patients at Risk for Suicide Need Careful Observation

Never Events: Patient Suicide While at a Health Care Facility.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

When dealing with patients at risk for suicide, the health care team must initially recognize and identify these patients, document their care plan, and carefully follow through with that care plan.

Patient protection errors at health care facilities are 1 of the 6 major categories of items included on the 'never events' list developed by the National Quality Forum. Among the patient protection errors, one very concerning item is that of patient suicide or attempted suicide resulting in serious disability while being cared for in a health care facility. This is always a devastating event, and staff members do a great deal to prevent these situations. The thing that we have found interesting in investigating events like this is that staff members expect the patient to think in the same way that they think in terms of what could be used to cause personal injury or to attempt suicide. In recent investigated situations, we have had patients who have been very creative with their clothing as a means of harming themselves. We have also had patients who have done serious damage to themselves and large blood vessels in their body by somehow removing the sharp edge on a paper towel dispenser and using it as a weapon. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Question Personnel Who Do Not Have Proper ID

Never Events: Criminal Events Occurring at the Health Care Facility.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD -Special Presentation

Criminal events on the list of 'never events' include impersonating a health care provider, abduction of a patient, and sexual or physical assault of a patient within or on the health care facility's grounds.

Patient death or disability resulting from a criminal event occurring while at the health care facility is 1 of the 6 major categories of 'never events' defined by the National Quality Forum. The first item on this list includes any incidents of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider. To prevent impersonation, we must ensure that background checks to verify past employment, education, licensure, and other such items are performed for each new employee. This process is sometimes cut short or done incorrectly. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Communication Errors Cause Most Wrong-Site Surgeries

Doing the "Right" Things to Correct Wrong-Site Surgery.

PA Patient Safety Authority:

PA-PSRS Patient Safety Advisory 2007; 4 (June): 1, 4-17

Causative factors associated with wrong-site surgery include the surgeon specifying a wrong site, not completing a proper "time out" before the surgery, and poor patient positioning thereby concealing the surgical mark.

Background: Between 1987 and 1995, the average payment made to a plaintiff in a wrong-site surgery malpractice claim was \$54,790. Wrong-site surgery is considered a preventable serious medical error that has been listed as a 'never event' by the National Quality Forum.

Objective: To compare the experiences of the Pennsylvania Patient Safety Reporting System (PA-PSRS) with the experiences of others regarding wrong-site surgeries.

Results: The most common sites for wrong-site errors are the lower extremities. The medical specialties most frequently involved in wrong-site surgeries include orthopedic/podiatric surgery (41%), general surgery (20%), neurosurgery (14%), and urology (11%). A survey of orthopedic surgeons found that 25% of surgeons practicing for 35 years reported having at least 1 wrong-site surgery. Factors that may have been responsible for a wrong-site surgery include: (1) surgeon specifying wrong site, (2) not completing a proper "time out" before the surgery to identify the patient and the operative site, (3) not verifying consents or site markings, (4) inaccurate consents/diagnostic reports or images, and (5) poor patient positioning concealing the surgical mark or promoting site confusion. In >70% of wrong-site surgeries, the causative factor was a breakdown in communications between patient and/or family members or surgical team members. A failure to communicate the correct information, a failure to understand the information, or a failure to communicate changes or corrections in information can lead to a wrong-site surgery. The Joint Commission proposed a Universal Protocol in 2003 to help avoid wrong-site surgeries. This protocol has been endorsed by many medical professional societies. In this protocol, time is taken to verify the patient's identity preoperatively, the operative site is marked by the physician using the word "Yes" or the physician's initials, the surgical site is verified preoperatively, and a brief "time out" is taken in the operating room before making the skin incision to verify the patient's identity and the surgical site and procedure. Several organizations have developed additional measures to avoid wrong-site surgeries. For example, in one hospital, the blade is not placed on the scalpel handle until a preoperative "time out" is satisfactorily completed.

Conclusions: The error of wrong-site surgeries indicates a breakdown in communications and teamwork. Punishing these errors will not fix the problem. Studying the psychology behind these errors can help identify causative factors and prevent errors before they occur.

Reviewer's Comments: This article is a "good read," both entertaining as well as informative. Multiple examples of the problem (wrong-site surgery) are given, including analyses of causes and methods for prevention. Unfortunately, there is no perfect formula or set of guidelines that will accomplish elimination of these 'never events.' (Reviewer-W. Murray Yarbrough, MD).

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Top Liability Complaints Include Diagnostic, Medication Errors

Major Categories of Health Care Professional Liability Issues.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

In the field of health care professional liability, the newest area on which lawyers are focusing is under-anticoagulation and over-anticoagulation for atrial fibrillation.

Liability issues are of concern to all health care professionals. To impact liability issues, we must first identify the major categories of existing clinical risks. Some important situations that can result in adverse outcomes include mammogram misses, failure to diagnose cancer, and heparin-induced thrombocytopenia. The newest area on which lawyers are focusing is under-anticoagulation and over-anticoagulation for atrial fibrillation. Other big problems include bad outcomes for spine procedures, bad baby cases, chest pain, acute myocardial ischemia (MI), and failure to identify coronary events. A new liability frontier in Pittsburgh, where I practice, is failure to screen for colon cancer. Failure to diagnose pulmonary emboli and aortic aneurysm rupture are both on our 'hit list' for reducing adverse outcomes. A local insurance company published its own 'hit list' of the top 5 conditions that they have seen with the greatest frequency during the past 15 years. These conditions include coronary disease, acute MI, breast neoplasms, displacement of discs for back patients, and neurologically impaired newborns. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Medical Records Should Be Clear, Unaltered

Consent and Documentation Issues Top Professional Liability Concerns.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Good documentation is 1 of the keys to success in many liability cases. Be clear in your documentation, and write out your thought processes and differential diagnoses. Remember, you do not have to be right 100% of the time.

In the field of health care professional liability, consent and documentation are 2 important issues. The topic of consent involves more than signing a piece of paper before surgery. It also involves the issue of consent to treat people in a medical office. It is important to have discussions in the office with the patient about medications and/or course of treatments being prescribed so that patients have a chance to gather this information, process it, and ask questions. These discussions help establish a rapport between patient and physician, which is going to be very important if there is a bad outcome later. We want that patient to be comfortable enough to return to you and discuss the outcome instead of picking up the phone and calling a lawyer. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Handoff, Discharge Communications Critically Important

Patient and Peer Communications Important Issue in Professional Liability.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

An important topic of concern for professional liability is careful communication with patients, families, and physician peer groups. For physicians, communication with their peers via charts only is an area for disaster.

In the field of health care professional liability, communication is a very important topic. Physicians must communicate with their patients by having an open discussion about treatment plans in such a manner that patients become involved in those plans. In this era of HIPAA (Health Insurance Portability and Accountability Act), we must first get the patient's permission to have a discussion with family members when we believe that they, too, should be involved in the care plan. In addition to patient communications, physicians must communicate with their peer groups. Communication via charts only, without actually talking to another doctor, is an area for disaster. We cannot stress strongly enough how careful communication with patients, families, and physician peer groups is important. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Residents Must Be Encouraged to Ask for Help

Adequate Supervision of Resident Staff Is Area of Risk for Professional Liability.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Attending physicians and surgeons are responsible for supervising their residents and ensuring that patients get adequate care. Attendings are ultimately responsible when a resident makes a mistake.

A major area of risk for health care professional liability issues is supervision of the resident staff at a health care facility. This is a big problem, especially for teaching hospitals. Remember, attending physicians and surgeons are responsible for supervising and ensuring that patients get adequate care. Often, residents have varying degrees of autonomy, and attendings need to make sure that residents receive adequate supervision. Attendings are ultimately responsible when a resident makes a mistake. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Failure to Offer Screening Exams New Malpractice Target

Failure to Screen for Colon Cancer and Other Conditions as a Liability Issue - Part 1.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Many patients have refused screening for colon cancer, but because there is often no documentation of their refusal, primary care physicians may face malpractice claims for failure to screen.

(Card 1 of 2) Providing screening for conditions such as breast cancer and colorectal cancer are new areas of focus for professional liability cases. **Case Report:** This is the case report of a man who was diagnosed with metastatic colon cancer at age 53 years. Before diagnosis, he had presented to his primary care physician on multiple occasions for acute episodic care starting at age 49 years. He had at least 15 visits during a 3-year period. During that time, despite having reminders on the chart, the patient was never offered an option for colorectal cancer screening. At age 52 years, he presented with some rectal bleeding, and this too was ignored. About 6 months later, he presented and was diagnosed with Dukes' stage D carcinoma, a fairly advanced carcinoma. *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Refusal of Screening Exam Must Be Documented

Failure to Screen for Colon Cancer and Other Conditions as a Liability Issue - Part 2.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Primary care physicians must document when they offer screening exams to a patient and the patient's decision regarding the exam. If the patient refuses the exam, the refusal needs careful documentation.

(Card 2 of 2) Primary care physicians (PCPs) must document when they offer screening exams to a patient and the patient's decision regarding the exam. Often, there is no documentation of offering a screening exam that is declined by the patient. As a result, this "failure to screen for disease" is becoming the next frontier of malpractice cases. Physicians must discuss and document screening tests, and they need to clearly have documentation of a patient's refusal. Therefore, make sure you use chart tools or, if you have an electronic record, use health preventative reminders, make sure you go to that section, fill it out, and document (1) if a patient refused and (2) the risk of not screening. In malpractice cases, you must provide adequate documentation that appropriate care was offered and it was the patient's decision to not undergo the procedure. **Case Report:** A 50-year-old woman discussed with her primary care physician (PCP) her desire to undergo a colonoscopy. However, she never underwent the procedure, had colon cancer, and died. Her estate sued the PCP. The PCP's defense was that the woman had said she was going to have the screening procedure done through her obstetrician gynecologist (OBGYN), yet there was no documentation in the PCP's chart about the patient's statement. Her husband specifically denied that testimony at depositions. Because of the lack of documentation regarding the patient's statement, the responsibility for performing the procedure fell back on the PCP, especially since the patient had indicated that she wanted the test. The OBGYN in this case also testified that he did not discuss the screening exam with the woman and that he did not order it nor did he routinely order these exams. Instead, he expected the PCP to take care of colorectal screening. The OBGYN's documentation was consistent with those statements and helped sink the PCP in this case. *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Overdosing, Underdosing Big Problems With Coumadin® Therapy

Professional Liability Issues for Managing Anticoagulation With Coumadin.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Coumadin management is becoming an increasingly problematic area in professional liability. Both overdosing and underdosing are problems, and physicians must provide meticulous tracking of patients.

Case Report: A 45-year-old man had an aortic valve replacement and was started on anticoagulation therapy with Coumadin® (warfarin). For years, his cardiologist regularly monitored his prothrombin time (PT) and International Normalized Ratio (INR), which had been stable for some time. Then, at some point, the cardiologist had some issues in his office, and this patient went 4 months without PT or INR being assessed. The patient then presented to his primary care physician (PCP) with a severe headache. The PCP thought the patient most likely had a sinus headache. Within 24 hours, the patient was admitted with a central nervous system bleed, and his INR was 5.5 (INR goal for anticoagulation: 2 to 3). This malpractice case was settled for 7 figures. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Altering Records Can Make Malpractice Cases Indefensible

Defensible Liability Cases Can Be Made Indefensible If Records Are Altered.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Addendums to medical records can be made safely when done correctly. However, tampering with a record is never appropriate and can turn defensible malpractice cases into indefensible cases.

Case Report: A 32-year-old woman presented to her primary care physician (PCP) with a 3-month history of heartburn. She had many risk factors for coronary disease including a family history, cigarette abuse, and a cholesterol level >250 mg/dL. She reported pain that occurred on bending and lying down. She was treated for reflux esophagitis and was found dead the following day. Autopsy showed significant 3-vessel disease. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Negligence, Injury Required to Win Malpractice Case

Physical Harm Must Be Proved by Plaintiff Lawyer to Win Malpractice Claim.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

In malpractice cases, it is not just enough to show that there was a breach in the standard of care. The plaintiff lawyer also must have expert testimony proving that the negligence caused some harm or injury to the patient.

Case Report: A 38-year-old woman presented with scapular pain in late August. She was a friend of a friend, and the primary care physician (PCP) said, "Let me see your friend." He focused on the evaluation, and the individual never really was a patient of this PCP. In any event, the PCP thought the scapular pain was musculoskeletal in origin, placed the patient on anti-inflammatory medication, and recommended physical therapy. The patient presented about 2 months later for a physical exam. No breast mass was found at that time, but a mammogram was ordered. In November, the patient presented with hypercalcemia and worsening diffuse bone pain. She was found to have metastatic breast cancer. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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PCPs Not Required to Question Specialists' Conclusions

Primary Care Physicians Can Legally Rely on Expertise and Evaluation of Specialists.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Primary care physicians (PCPs) are not required to independently evaluate data received from a specialist to whom they have referred a patient. Instead, from a legal perspective, PCPs can rely on the expertise of the specialist.

Case Report: A 69-year-old woman noted reddening and soreness in her left breast. Her mammogram was negative, but out of an abundance of caution, she was sent to the surgeon who did a skin biopsy and a fine-needle aspiration biopsy (FNAB). The FNAB results showed atypical nuclei. The skin biopsy showed inflammation in the upper dermis and focal hemorrhage in the lower dermis. The pathologist report did not rule out cancer and stated that an excisional biopsy may be indicated. After receiving this pathology report, the surgeon wrote a letter to the primary care physician (PCP) and stated that the patient did not have cancer - instead the patient had an inflammatory process. However, the surgeon enclosed a copy of the pathology report along with the letter to the PCP. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Good Documentation May Prove Appropriate Care to Jury

Documentation Is Bedrock of Physicians Defense in Malpractice Cases.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Even if a physician has excellent documentation of a case, this does not prevent a malpractice claim from being pursued. Nonetheless, this documentation will be the bedrock of a physician's defense in such situations.

Case Report: A 42-year-old woman presented to the emergency department (ED) with acute radicular pain. The ED physician noted that there were no red-flag symptoms associated with back pain and the radicular pain. The following day, an MRI was ordered by the ED doctor and a large herniated disc was found without spinal cord compression. The next day, the patient follows up with the primary care physician (PCP) and is appropriately treated. On day 5, the patient starts complaining of some numbness in the groin area ('saddle anesthesia'). She was seen immediately by the PCP, and within 30 minutes of presentation, she was airlifted to a tertiary care center with a possible diagnosis of cauda equina syndrome. She was operated on 36 hours later. The patient claimed to have persistent pain and was unable to enjoy sex because of her numbness. She sued the PCP for failure to offer an operation because of a huge bulging disc. The case went to trial and the verdict went to the physician. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Care of Headaches, Migraines Major Liability Risk

Care of Migraines and Headaches Puts Physicians at Risk for Liability Claims - Part 1.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Headache is an important area for malpractice claims, especially at the emergency department level. Physicians must closely monitor headache symptoms and any change in those symptoms.

(Card 1 of 2) **Case Report:** A 52-year-old woman with a history of migraine presented with a headache. She was admitted for observation. She had had an MRI and a CT scan in the past year, and both were normal. No imaging was done on admission or during the day because of this reassuring past MRI and CT scan. During the course of the day, the headache changed character. She developed slurred speech and an unrelenting headache that was unresponsive to Dilaudid®. At about 5:00 pm, the patient was handed off to a covering physician, but the change in symptoms was not communicated to the doctor. The woman ultimately had a bleed in her central nervous system (CNS bleed). Her primary care physician (PCP) arrived at about 9:00 pm, and by then the patient had been having symptoms for at least 9 hours as documented by nursing notes. The patient was transferred to a tertiary care facility, and she had a completed stroke with residual sequelae. In cases such as this, we see that handoffs can be a big problem and that communication is a huge problem. This case was settled. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Statements Help Distinguish CNS Bleed From Migraine

Care of Migraines and Headaches Puts Physicians at Risk for Liability Claims - Part 2.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

When a patient presents with severe headache to the emergency department, a normal-appearing CT scan can lull the physician into a false sense that a central nervous system bleed can be ruled out.

(Card 2 of 2) Headache and migraine remain an important area where physicians continue to be at risk for professional liability claims. During a bleed in the central nervous system (CNS bleed), the typical catchphrase reported by the patient is, "This is the worst headache in my life." In medical school, we are taught to immediately think "CNS bleed" when we hear a patient saying this to the health care team. Therefore, this information must be communicated clearly - talk with your nursing staff and other physicians. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Disparaging Comments Can Lead to Malpractice Claims

Disparaging Remarks by Colleague Can Result in Malpractice Claims - Part 1.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Frequently, malpractice defense cases get started because of a comment made by a subsequent treating physician - some other health care provider who criticized the previous care that was rendered.

(Card 1 of 2) When discussing topics in health care liability issues, one important issue is that of malpractice claims being made against one physician based on disparaging remarks made by a second physician. Frequently, when lawyers are doing discovery in a malpractice defense case, they find out that the whole case started because of a comment made by a subsequent treating physician - some other health care provider who criticized the previous care that was rendered. After thinking about these disparaging remarks, the patient gets a lawyer to file a claim. Often, remarks made by the second physician are just gratuitous or even sarcastic or facetious. Nonetheless, the remarks upset the patient and serve as the genesis for some medical malpractice cases. **Case Report:** A 62-year-old woman had a total hip replacement done. Six months later, she had recurrent dislocation of the hip. She became upset with her orthopedic physician and consulted a new doctor. The new doctor said very clearly that the wrong cup component was inserted and that he could fix her problem. She had a good outcome and promptly filed a malpractice case. The second physician's note is very derogatory and inflammatory of the initial orthopedic care. This suit was settled for \$150,000 despite the fact that the defense was able to produce experts who suggested that the appropriate components were inserted during the initial surgery. *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patients Should Take Complaints About Care to Original Provider

Disparaging Remarks by Colleague Can Result in Malpractice Claims - Part 2.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Patients with complaints about previous care should address their complaint directly with the doctor who provided that care. The subsequent physician should not make comments about the care that could engender a lawsuit.

(Card 2 of 2) Malpractice claims against one physician are sometimes based on disparaging remarks made by a second physician. **Case Report:** A pregnant woman presented with headache and hypertension. Her physician ordered a couple of urine collections on her to rule out a pheochromocytoma. All urine tests were normal. The woman eventually had her baby, and everything was fine. About 6 or 7 years later, she presented with headache and palpitations and was found to have a pheochromocytoma. The woman was prepared to bring a malpractice claim against the physician, but her endocrinologist told her, "Your physician did the appropriate workup at the time and the results were negative. You really don't have a case." The endocrinologist called the physician and said, "Just in case you get sued, I want you to know what happened and what I communicated with this patient." Therefore, as physicians, we can help prevent malpractice cases when our colleagues do the right thing, and we can hurt our peer group with our comments as well. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Diligently Track Tests That Have Been Ordered

Follow-Up and Documentation of Follow-Up Important Considerations in Liability Issues.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

If you order a test, you must make sure that the test is performed. If the test is not performed, you must contact the patient, ask why the test was not performed, and document this in the patient's record.

Case Report: A 45-year-old man went to the emergency department (ED) with atypical chest pain and had risk factors for coronary disease. He went to see his primary care physician (PCP) within 1 week, and the PCP ordered a stress test. The stress test was never done. The patient came in for follow-up on 2 other occasions for non-related symptoms. Within 3 months of the chest pain, he underwent spine surgery for spinal stenosis, and he died 2 weeks postoperatively. He was found to have severe coronary disease with acute infarct in the left anterior descending coronary artery distribution. This case was settled out of court. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Carefully Document Patient Compliance Issues

Documenting Care and Reminders Given to Noncompliant Patients Helpful for Malpractice Defense.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

For patients who repeatedly miss follow-up visits to monitor an existing condition, make repeated phone calls to the patient to encourage a follow-up visit, and then document noncompliance issues carefully in the patient's record.

Case Report: A 46-year-old man had a history of alcohol and cigarette abuse. He was followed up for typical symptoms of gastroesophageal reflux disease for at least 5 years in a primary care clinic. His symptoms responded to therapy with proton pump inhibitors, but at times, the patient was not very compliant with his medications and follow-up visits. At that time, he never had any red-flag signs in terms of pain with swallowing or food sticking. After missing 6 months of follow-up visits, he presented with severe anemia. He was then diagnosed with a metastatic gastric carcinoma. Interestingly enough, this case was dismissed because of meticulous documentation of missed appointments. The physician's staff had made repeated phone calls to the patient for outreach to get him to come in for follow-up visits, and this was well documented in the patient's record. *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Good Records, Caring Demeanor Help Avoid Trials

Secrets of Preventing Malpractice Claims: Lessons Taught by Plaintiff Lawyers.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

If the care provided by a physician is deemed to be appropriate and compassionate and if a physician looks kind, caring, and not arrogant in the deposition, then the plaintiff lawyer will be more likely to settle a malpractice claim.

Plaintiff lawyers have taught defense attorneys some very important lessons regarding malpractice cases. For example, if the care provided by a physician is deemed to be appropriate and compassionate and if a physician makes a good appearance in the depositions (looks kind, caring, and not arrogant), then the plaintiff lawyer knows he has a difficult issue and will be more likely to settle. Plaintiff lawyers also tell us that they will not fight the medical record. In other words, the plaintiff lawyer does not want to take a chance on a patient who tells a completely different story than what is documented in the medical record. Instead, these lawyers want those cases for which documentation is either lacking or poor. Therefore, for cases with meticulous documentation, plaintiff lawyers are not going to fight the documentation, and they are not going to take the patient's word that something completely different happened or was not done for them. A critical preventive measure that all physicians can take against malpractice claims is to meticulously document all cases. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Documentation of Evening, Weekend Calls Often Overlooked

Conversations and Care Delivered During Off-Hours Need Careful Documentation.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

A lot of phone conversations with patients and care administered during off-hours do not get documented properly because the physician is not in the office or hospital setting.

After years of managing malpractice cases, we have seen several preventative strategies that help health care professionals avoid litigation. One important area that puts physicians at risk for liability issues is weekend and night coverage. Many phone calls are received, and a lot of care is delivered during off-hours. All of these care events need documentation. We suggest you set up a phone line in your office on which you can dictate into the phone to document the call or the actual care delivered. Remember to include what you did and what you did not do during this off-hours situation. Make sure that the physician for whom you are covering gets a record of what happened. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Several Areas Continue as Common Liability Pitfalls

'Click Errors' for Computerized Orders, Incomplete Medication Discussions, and Patient Referral Issues Can Increase Liability Risks.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Several areas of health care continue to be liability issues for the physician, including errors in ordering medication, incomplete discussions about drug side effects, and patient referrals to specialists.

Several areas of health care continue to put the physician at risk for malpractice claims. These include medication errors, treatment plans, and discussions about drug side effects with patients. Many of our medication errors in the past were due to handwriting errors. Even with electronic prescribing, there are still errors, especially 'click errors' in which a physician selects (or clicks on) the wrong dose or the wrong instructions. The avoidance of 'click errors' is becoming extremely important as our world becomes more computerized. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Honest Conversations About Physician Errors Essential

Expert Tips on Managing Medical Errors by the Physician.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD -Special Presentation

Patients want these 3 things when their physician has made an error: an apology, a clear explanation of what happened, and an assurance that changes will be made so the same mistake does not happen to someone else.

When a physician has made a mistake, the best policy is to disclose the error and to be candid, forthright, and honest with the patient. Do not make a second mistake by ignoring or covering up the first one. Talk to risk management personnel or your legal advisor about the best course of action. Then, sit down with the patient, explain what occurred, and apologize. *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Good Documentation May Sway Lawyer to Drop Case

Risk Management Fundamentals.

Kidwell RP:

Postgrad Obstet Gynecol 2004; 24 (October 15): 1-3

Good documentation contains the following essential elements: each entry made with the date and time recorded, legible writing, entries that are consistent with one another, and all corrections made properly.

Objective: To review the use of documentation and communications as a means to help physicians prevent or help defend themselves against malpractice claims.

Results: When a plaintiff's attorney accepts a case, the attorney will acquire copies of all the physician's documents about the case and will have them reviewed by experienced staff members and expert witnesses. The plaintiff's attorney wants the records to be incomplete, with gaps in the documentation regarding actions taken by the physician. However, thorough documentation of the physician's actions and judgments may sway the attorney to drop the case. Good documentation contains the following essential elements: each entry made with the date and time recorded, legible writing, entries that are consistent with one another, and any corrections to an entry made according to professional and state standards. The date and time noted for each entry helps establish the chronology of events and helps demonstrate the physician's level of responsiveness to various situations encountered with the patient. Clinical judgment is important to document when multiple reasonable diagnoses or treatment plans exist. An adverse patient outcome does not mean that the physician provided substandard care, but the plaintiff's lawyer will comb through the documentation trying to prove that different diagnoses and treatment options were not considered. Good notes are made as soon as possible after an event, as demonstrated by the time/date notation, proving good recall of both the events and decisions made. In addition to good documentation, solid communication skills can also help a physician prevent a malpractice claim. The physician must use good verbal and written communications to convey important information to and from other care providers. Encouraging a sense of teamwork with other doctors and care providers on a case can help keep the lines of communication open. A physician must also have good rapport with his patients, allowing adequate time for discussions about their condition and treatment options. The comfort level of each patient with his or her physician depends largely on the level of open communications between these individuals.

Conclusions: Both good documentation and good communications with the patient and other health care team members can help prevent a malpractice claim.

Reviewer's Comments: How many times have we been told this? And yet because of carelessness, time constraints, inaccuracies both corrected and uncorrected, and/or illegible penmanship, we continue to fall into the traps of the plaintiffs' attorneys. This article should be read by all physicians who see patients and keep records. (Reviewer-W. Murray Yarbrough, MD).

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Knowing Patient's Health Literacy Can Improve Communications

Seven Strategies to Improve Communication With Patients.

Staff Writers:

Inside the Joint Commission 2007; 12 (July 30): 1-8

The language of the medical world can be confusing to patients. Good physician communication skills can help the patient more fully understand their condition and the directions they have been given.

Objective: To review 7 different approaches to help improve the effectiveness and character of communications between physicians and their patients.

Results: During the initial exam of a patient, the physician needs to take time to determine the health literacy level of that patient. An assessment tool called the *Newest Vital Sign* has been created by a team of researchers to help health care providers determine if the patient can read and understand health information. Understanding the health literacy level can help the physician and other staff members know when additional time may be required to assist the patient in understanding new information and new orders. In addition, the physician should encourage patients to ask questions and to admit when the medical terminology is over their head. Perhaps the 3 most important questions a patient can ask are as follows: "What is my main problem?" "What do I need to do?" "Why is it important for me to do this?" When speaking with patients and writing instructions, the language used by physicians and staff members should be simple, easy to understand, and free of technical terms that are often confusing. When helping patients select options in their care, physicians can help by giving patients simple options and clear facts, which should simplify the decision-making process and make final directions easier to remember. Although physicians are often in a hurry to move on to the next patient, they should be reminded to speak slowly to patients so that their words do not become garbled and misunderstood. Finally, asking patients to repeat the directions they have been given can help the physician determine if they understood what they were told.

Conclusions: The language and terminology of the medical world can be confusing to patients. Communication between the physician and patient can forge a trusting bond and can help the patient more fully understand about their condition and the directions they have been given. Therefore, physicians must be aware of each patient's medical literacy level and strive to speak with them using clear, easy to comprehend language.

Reviewer's Comments: How true, this article. As lawyers quite often use "legalese", we physicians too often use "medicalese" and also quite often the patient is reluctant to confess his failure to understand our communications. I doubt if this article contains much information we don't already know, but it certainly points out a rather uniform deficiency in our medical-to-layman communication skills, suggestions for correction, and a brief lexicon of synonyms more easily understood. (Reviewer-W. Murray Yarbrough, MD).

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