physician connection

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Communication Breakdowns Jeopardize Continuity of Care and Patient Safety

It is well-known that poor communication can result in medical errors, cause patient injuries and disrupt the continuity of care—all of which can lead to malpractice claims.

Various studies have shown that communication breakdowns can occur at any point on the care continuum, in any type of healthcare facility and between any of the "players" involved in a patient's care.

Research has also demonstrated that communication breakdowns affect both patient safety and quality of care. In addition, they are more likely to occur at transition points in a patient's care, and in emergency situations. A transition point is one in which the patient is moved from one care setting to another, or from the responsibility of one provider to another.

Because medical errors are more likely to occur at transition points, those involved should be especially mindful of the need for clear and complete communication. Communication (or a lack thereof) between providers has been found to have a significant impact on the success or failure of a transition and the subsequent outcome of care for the patient. If a good exchange of essential clinical information does not occur at the transition point, the following can occur:

- Continuity of care and quality of care may suffer.
- The potential for a medical error may increase.
- The patient's treatment, his or her physical well-being, and the ultimate outcome of the patient's care may be jeopardized.

Multiple Providers Mean More Risk

Communication problems tend to intensify when there are more providers and care settings involved in a patient's care, and there is an increase in the complexity and variety of systems in use.

Today, very few people receive care from only one physician. Patients may also receive medical care in more than one venue. These include: PCP offices, specialist offices, diagnostic imaging centers, hospital emergency departments, ambulatory surgery centers, in-patient facilities, rehabilitation facilities and patient homes.

The need for good communication between physicians, hospitalized patients and their families is even more critical today.

The more complex a patient's clinical picture, the more likely it is that specialists and ancillary care providers will be involved in that patient's care. This may result in more transition points, and, unfortunately, more opportunities for communication breakdown, medical errors and patient harm.

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What to Do When a Patient Might Sue

The first step you should take if you suspect a patient is considering a lawsuit or a complaint against you before your state board (and certainly any time you get a letter from an attorney, a summons or complaint) is to contact PSIC at 1-800-640-6504.

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Physicians must communicate with all providers to coordinate care.

Consider the following examples:

Who's on the Team?

Marla Gregg, age 50, was in generally good health. She did not have a family physician, but she routinely saw a gastroenterologist for chronic GERD, a cardiologist for mild hypertension and a GYN for routine care.

After having recurring lower back pain, the patient self-referred to an orthopedic surgeon. The orthopod diagnosed a partially herniated disk at L5-S1 and prescribed NSAIDs and a course of physical therapy.

Communication breakdowns that affect patient safety and quality of care are more likely to occur at transition points in a patient's care.

After several months on the NSAIDs, Marla had a severe episode of gastric bleeding and was admitted to the local ED. Lab work on admission showed anemia and an abnormally high creatinine level. It was only as a result of the admission that her gastroenterologist learned that she was seeing an orthopedic surgeon who had prescribed the NSAIDs, the cause of her gastric bleeding and rising creatinine level.

Discussion: Physicians involved in a patient's care must be aware of all other providers seeing the patient, as well as drugs or other medical treatments being prescribed. In this case, because all the physicians seeing the patient were specialists, no one was coordinating her care. The orthopedic surgeon's new patient information form asked only for "Family Physician," and Marla wrote "None."

When Marla was seen at the gastroenterologist's office, the clinical staff did not routinely update the patient history or the drug history (it was the practice's procedure to do so annually). Obviously, the patient contributed to this outcome by not providing information about all the physicians she was seeing. However, the involved physicians did not elicit critical clinical information that could have prevented her hospitalization and adverse outcome.

Who's in Charge?

Tom Lewis, age 66, arrived at the ED via ambulance after he was found on the floor by his wife. She reported he was mumbling, confused and unable to move his left side. The ED physician examined the patient and diagnosed a CVA with left-sided hemiparesis. The patient was admitted to the service of the on-call internist.

The internist called the family physician and learned that the patient had a history of several "mini-strokes" and was on low-dose anticoagulants in addition to other medications. The internist told the FP that he would order a STAT Pro time, so a therapeutic anticoagulant dose could be determined.

The internist was going off-call and told the nurse on Mr. Lewis' floor that the FP was going to be coming in to see his patient and would make the necessary adjustment to the patient's warfarin based on the pending lab results. When the lab results came back, the nurse put them on top of Mr. Lewis' chart at the nurses' station. When the next nursing shift came on, the results

were still at the nurses' station. No physician had been in to see Mr. Lewis, review the lab work or order anticoagulation for the patient.

Several hours into her shift, the nurse in charge realized the patient's chart was still on the desk and that no physician had been notified of the results. She attempted to get in touch with the admitting physician on the record. By now it was after office hours, and the nurse had to contact the internist through his answering service.

When he finally called back, he said it was his understanding that the FP was coming in to see the patient and would be following Mr. Lewis while hospitalized.

Physicians must be aware of all other providers seeing the patient, as well as the drugs and medical treatments they prescribe.

The FP was contacted, and said he was under the impression that Mr. Lewis was being taken care of by the internist and his group.

Before any anticoagulation was reinstituted, Mr. Lewis experienced a

more much serious CVA, became permanently disabled and died six months later in a long-term care facility.

Discussion: In this case, there was obvious confusion regarding who was in charge of the patient's care:

- The internist thought the wife wanted the FP to take care of her husband. As a result, the internist believed he signed off to the FP when he called to discuss the patient's care.
- The nurse thought the FP was coming to the hospital to assume the patient's care, and she passed on this misinformation at shift change.
- The FP thought the internist, as the admitting physician, would be coordinating the care of his patient while hospitalized.
- This situation was allowed to continue over a shift change, and the delay resulted in serious consequences for the patient.

A subsequent malpractice action was filed against the internist and the FP, the two charge nurses and the hospital. The case was settled before trial.

Hospitalist/PCP Communication

Steven Ellis, a 64-year-old grossly obese male, was admitted to the hospitalist service of a community hospital for control and stabilization of his Type I Diabetes. After successful in-hospital management and patient education about self-management and nutrition, Mr. Ellis was discharged back to the care of his PCP.

At discharge, the results of a potassium level ordered earlier that day were outstanding, but this went unnoticed. The lab value of 5.8 mEq/LL was entered into the patient's hospital e-record after discharge.

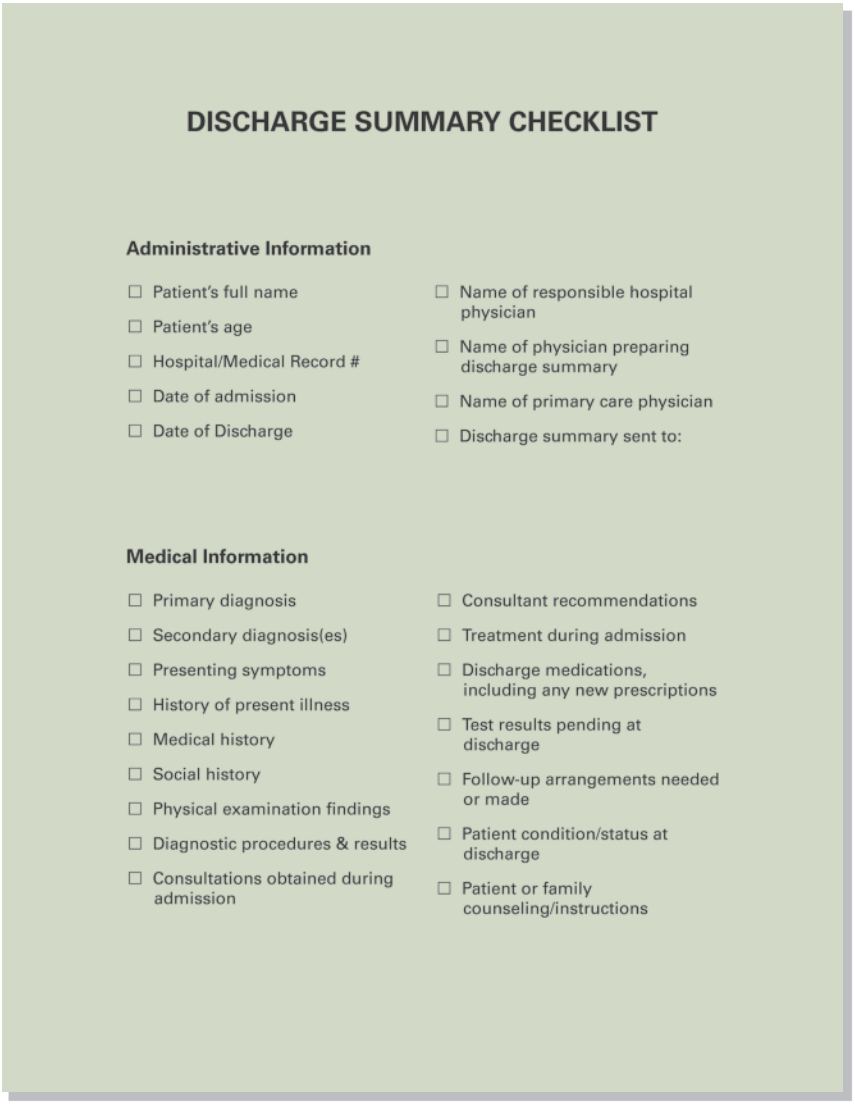
The patient's previous recorded potassium level had been 4.6 mEq/LL. By the time this information was discovered and sent to the PCP in the discharge summary, the patient had been re-admitted to the hospital's ICU with cardiac arrhythmia, attributed to his hyperkalemia.

Discussion: With more and more hospitals using hospitalists and intensivists, the need for good communication between physicians, hospitalized patients and their families is even more critical. A PCP using the hospitalist service must serve as the patient information provider pre-admission.

From admission through discharge, it is the hospitalist who takes on the role and responsibility of patient care provider, coordinator of care and chief communicator. At discharge, the hospitalist must communicate with the PCP the details of the patient's hospital stay, condition at discharge, any outstanding test results and discharge instructions given to the patient.

Inserting hospitalists into the care continuum adds importance to the discharge summary because it becomes the principal communication tool between the hospitalist and the PCP who will be providing ongoing patient care.

SAMPLE DISCHARGE SUMMARY CHECKLIST



DISCHARGE SUMMARY CHECKLIST

Administrative Information

- ☐ Patient's full name
- ☐ Patient's age
- ☐ Hospital/Medical Record #
- ☐ Date of admission
- ☐ Date of Discharge
- ☐ Name of responsible hospital physician
- ☐ Name of physician preparing discharge summary
- ☐ Name of primary care physician
- ☐ Discharge summary sent to:

Medical Information

- ☐ Primary diagnosis
- ☐ Secondary diagnosis(es)
- ☐ Presenting symptoms
- ☐ History of present illness
- ☐ Medical history
- ☐ Social history
- ☐ Physical examination findings
- ☐ Diagnostic procedures & results
- ☐ Consultations obtained during admission
- ☐ Consultant recommendations
- ☐ Treatment during admission
- ☐ Discharge medications, including any new prescriptions
- ☐ Test results pending at discharge
- ☐ Follow-up arrangements needed or made
- ☐ Patient condition/status at discharge
- ☐ Patient or family counseling/instructions

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The patient's continuity and quality of care requires that the hospitalist transfers the discharge summary to the PCP in a timely manner after discharge.

Risk Management Strategies for Improved Communication

- The communication between the referring physician and the consultant should include the purpose of the consultation and the consultant's expectations.
- The referring physician must clearly state if he or she expects the consultant to assume care of the patient on an ongoing basis.
- Physicians should follow a consistent procedure when referring a patient.
- All providers involved must transmit and document any essential information in the patient's record.
- Consultants must ensure that communication of consultation findings and recommendations occurs in a timely manner.
- Physicians should complete hospital discharge summaries in a timely manner.
- The admitting physician or hospitalist should provide relevant clinical information about the patient's hospital stay to a patient's PCP promptly.
- Discharge summaries should include: diagnostic findings, treatment, complications, condition on discharge, tests or other issues pending at discharge, discharge instructions given to patient, post-discharge, and follow-up plans.

Resources for Effective Communication

Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. Snow V, Beck D, Budnitz T, et al. J Gen Intern Med. 2009;24:971-976. www.ncbi.nlm.nih.gov/pmc/articles/PMC2710485/

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Electronic Medical Records and Communication with Patients and Other Clinicians: Are We Talking Less? Ann S. O'Malley, Genna R. Cohen, & Joy M. Grossman. Center for Studying Health System Change, Issue Brief: *Findings from HSC*, No. 131, April 2010. www.hschange.org/CONTENT/1125/1125.pdf

AAFP Guidelines for Interaction in "Hospitalist" Models. www.aafp.org/online/en/home/practicemgt/mgmt/hospitalists/guidelines.html

Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. JAMA. 2007;297:831-841. http://jama.ama-assn.org/content/297/8/831.full.pdf

Questions?

If you have any questions you'd like our **Connection** *experts to answer, please e-mail them to riskmanagement@psicinsurance.com*

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