For Twenty-Five Years
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MEDICAL LOSS PREVENTION bulletin

Reducing Medical Malpractice Exposure in the Office Setting

Expensive claims and lawsuits can arise from patient harm as the result of failures in a medical practice's process or system. Effective risk management principles are critical to reduce medical malpractice exposure in the office setting. These principles include compliance with federal and state regulations, HIPAA requirements and licensure standards. In addition to these principles, health care practitioners should ensure their office staff is following proper guidelines; i.e. timely completion of forms, dictation, and record filing and proper follow-up with patients.

Onsite Assessments

CMIC provides on-site office practice assessments to minimize risk and exposure. Our assessment process is designed to help the practitioner control the risk inherent in the process of delivering care thereby improving patient safety while mitigating risk and potential claims.

The two hour assessment includes a tour of the facility, doctor and staff interviews and a review of medical records, policies and procedures. A report of the findings and recommendations is then sent to the practice.

In 2009, CMIC completed numerous assessments in several different specialties including family/general medicine, surgery, plastic surgery, dermatology, nephrology and pulmonary medicine. Based on data collected during the assessments, we were able to draw important conclusions regarding areas of significant exposure within the medical practice and recommend the necessary best practices.

Assessment Findings

According to findings based on our assessments, the three top risk exposures are: ineffective tracking processes for diagnostic test/consults, incomplete or poor documentation and failure to follow scope-of-practice requirements for office staff, including non licensed and licensed personnel.

Lack of an effective test result tracking system tops the list as the most frequent risk exposure in the office setting. Cases involving lack of notification and follow up on abnormal test results are difficult to defend and expensive to settle. The goal is for the correct test to be performed on the correct patient with the results being returned to the doctor, who then communicates them to the patient, in a timely manner, with a plan for follow-up care. The most frequent failure within this process occurs when the test/report is returned to the practice without a consistent system to verify the doctor reviewed and communicated the results to the patient. Another common scenario transpires when a patient does not complete an ordered test and a formal process to track or follow up is not present. (Visit our website for a sample tracking document. See box on other side.)

Incomplete or poor documentation in the medical record is the second most frequent exposure. Cases involving the medical record may be the final piece of definitive evidence. The importance of good record keeping cannot be overemphasized.

Failure to follow scope of practice requirements rounds out the top three exposures. Most practices hire unlicensed personnel, such as medical assistants or technicians. It is imperative to have job descriptions in place that describe the responsibilities of all positions and reflect the laws and regulation in the state which the doctor practices. We found some practices allow medical assistants to perform duties outside their scope of practice, for instance, triaging patients who call the practice with a problem and calling-in prescriptions to the pharmacy. No matter how competent the medical assistant/technician may be he/she is an unlicensed professional and therefore should not be assigned the roles of licensed healthcare professionals.

Top Three Exposures ▶

1. Ineffective tracking process.
2. Poor documentation.
3. Failure to follow scope of practice requirements for office staff.

Top Five Medical Record Issues ▶

1. Failure to document allergies in a consistent location.
2. Illegibility of paper records.
3. Inadequate or incomplete documentation of informed consent with little or no involvement by the physician.
4. Failure to maintain and update a patient problem list.
5. Failure to date and sign each entry in the medical record.

Recommendations

The following reminders may improve patient care and minimize physician exposure to litigation:

Tracking & Following

- Implement a formal test-tracking system.
- Make a policy of notifying every patient of every result.
- Empower patients to serve as safety double-checks.
- Only file signed reports, letters, dictations, and results.
- Follow-up with the patient if needed.

Tracking and follow-up systems may consist of a log book containing entries for each ordered test, with a space to track and document returned test results; index cards sorted by day, month or patient; tickler and reminder system; or computer programs.

A follow-up system may prevent a patient from being harmed because of his/her failure to make return office visits or recommended testing. An effective follow-up system should track recommended diagnostic tests. It is necessary to have a system to identify if the patient followed through with the testing. This could be a log in which ordered tests are recorded then marked off when results are received. If a patient refuses a test then this is documented in the patient's medical record.

Remember: *Cases involving lack of notification and lack of follow-up of abnormal test results are difficult to defend and expensive to settle.*

Medical Records

- Medical records should be complete and legible.
- All entries should be dated and authenticated.
- Document the informed consent dialogue in the patient's medical record.
- During the informed consent discussion, explain risks, benefits and possible complications as well as alternative treatments. Make certain all questions and concerns are addressed.

Remember: *Cases involving the medical record may be the final piece of definitive evidence. Therefore, "If it's not documented, it is not done."*

Scope of Practice

- Provide a detailed "position description" with clearly defined duties, responsibilities and performance review criteria which establishes measurable goals.
- Comply with any statutory responsibilities you may have as an employer, "collaborating" or "supervising" physician.
- Check state law requirements regarding unlicensed personnel.

Remember: *No matter how competent the medical assistant/technician may be he/she is an unlicensed professional and therefore should not be assigned the roles of licensed healthcare professionals.*

Resources ▶

Sample tracking forms can be found in the "For Members" section of our website www.cmic.biz. Instructions to access this area are outlined below. Access requires your policy number and name as shown on your policy. Upon first access to the system, you will be required to complete a short user verification process. Future visits will only require your policy number and password.

1. Go to www.cmic.biz.
2. Click "For Members" at the top of the screen.
3. Enter your six digit policy number.
4. Click "Proceed."
5. Enter your name **exactly** as it appears on your premium invoice.
6. Click "Proceed."
7. Choose a password following the parameters on the screen.
8. Choose a secret question and provide the answer.
9. Click "Proceed."
10. You have now entered the secure portion of CMIC's website.
11. Click "Resources" on the menu to the left.

This review was conducted for its loss prevention value to assist doctors in recognizing the liability exposure as it relates to exposure in the office setting. **You may address these issues further by contacting Susan Sperzel, director of loss prevention, at 860-633-7788 ext. 280. Please return the attached form to receive CME credit for reviewing this Medical Loss Prevention Bulletin.**

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