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PREFACE

This Guide is for Hospitalist Physicians and Hospitalist Companies. Faced with ever-increasing risk complexity in their work, this guide provides a practical framework for risk identification, management and mitigation.

The Guide provides information on a variety of risk issues. Each topic or section includes a brief summary followed by a list of potential risk exposures, risk management strategies and a case example, allowing Hospitalists and staff educators to apply key risk management concepts. Each section includes a brief description of the applied risk management strategies.

The appendix to this Guide includes a list of acronyms often found in healthcare and a set of tools.

Questions about this Guide should be directed to Patricia Hughes, Vice President, Risk Management, OneBeacon Professional Insurance

OneBeacon Professional Insurance carefully selected the authors of this Guide based on their expertise, experience and wisdom. All expressed great interest and enthusiasm for the opportunity to assist colleagues in becoming safer, more effective clinicians. We are grateful for their participation.

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HOSPITALIST RISK MANAGEMENT GUIDE

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Introduction

Risk Management Role and Responsibility of Hospitalists

Delivering care to patients is the core business of a healthcare organization and the professional medical staff. The majority of the direct patient care is provided by employees as directed by the physicians and surgeons who make up the medical staff. The equipment, supplies, and buildings make up the property of the organization that must be kept in working order. No one wants to go to a facility that has a reputation of frequent or severe untoward outcomes or for giving “bad” care. All of these components are intertwined to make the whole of the healthcare organization.

Risk management’s focus is to protect those assets of a healthcare organization. Prevention of errors, with a particular emphasis on medical errors, is a major component of loss prevention, a significant activity of risk management. All staff members are accountable for their own actions. Prevention of risks, loss prevention, is everyone’s responsibility, including the hospitalists’. Errors have direct and indirect costs and have emotional and efficiency costs. The costs, direct and indirect, to prevent a medical error or a preventable untoward outcome are less than those costs incurred to handle an asserted potentially compensable event (PCE) with all its attendant activities and potential monetary payout. Loss prevention addresses the frequency and loss control addresses the severity. Both are important components.

The Hospitalist plays a significant and active role in risk management. A positive working relationship with the facility Risk Manager should be cultivated. The patient is the responsibility of the facility/hospital and of the Hospitalist, and each has a responsibility to render safe and ethical care. Reporting events and identified risks to the facility risk manager does not compromise the relationship between the Hospitalist, the Risk Manager or the companies they represent, as each has a stake in providing safe care.

The following topics are laid out to assist the Hospitalist to understand risk management and the risks facing you in your day-to-day patient care activities. We have endeavored to not only examine the risks, but to give you guidance on how and why they need to be addressed for your protection and that of your patients.

1. RISK IDENTIFICATION

Risk Managers utilize the information regarding the risks identified by employees, medical staff and other staff members and reported using the incident reporting system. Some organizations utilize an electronic reporting system while others who have not yet converted still utilize the paper forms to report directly to the risk manager. Reports of significant events are made by phone or in person to the risk manager. All staff members, including physicians, are responsible for and have an obligation for reporting “anything out of the ordinary.” “Near misses”, those events or situations that might have become an event or caused an untoward outcome, but for the intervention or recognition of a staff member, should be reported as well. Physicians play a role in identifying errors, omissions, commissions and “near misses,” regardless if it were a nursing, medical, pharmacy or other ancillary or paraprofessional incident. Risk management uses the information and data from these reports to identify trends and patterns with the goal to intervene and prevent future occurrences. In those events where warranted, an investigation may be initiated and a root cause analysis begun.
RISK EXPOSURES:

- Omission
- Commission
- “Near Misses”
- Medical Errors
- Anything out of the ordinary
- Untoward outcomes
- Unhappy patient or family

RISK MANAGEMENT STRATEGIES:

The first goal of risk identification is to protect the patient. Unsafe practices, hazards, or an unsafe work area should be brought to the attention of the unit or departmental manager and reported to Risk Management using the organization’s reporting system. Depending on the severity of the risk or hazard, a phone call may be in order.

When an order has been given and not carried out, it should be brought to the attention of the Unit Manager. An incident report should be completed by the physician and sent directly to the Risk Manager. While it may seem like unnecessary work to complete the report form, it is an important method to get the issue to the attention of Risk Management. When reporting to the Unit Manager, the Hospitalist should ask to be kept in the loop with feedback on corrective action taken. When relating to corrective action, one should not focus on persons, but on processes.

“Near misses,” untoward outcomes, situations out of the ordinary and medical errors should be reported as soon as possible directly to the Risk Manager. As warranted by the severity of the situation, Risk Management should be contacted immediately (“24/7” if there is a method to do that).

- In serious situations, the Risk Manager should be called immediately.
- Risk Management is also available to assist in managing adverse events and difficult situations.
- Reporting should be factual, identifying comments of the patient or family members in quotes.
- Each organization has a reporting form, whether electronic or hard copy/paper, that should be completed.
- No copies of the completed form should be made, and no notation regarding the report or contact with Risk Management should be made in the medical record. Confidentiality of the report is governed by state law.
- Following the Hospitalists’ company procedures, an incident report should be submitted to its Risk Manager when a serious event has occurred or a patient has been injured.

CASE EXAMPLE:

After a volunteer fell in the hospital lobby and broke her hip, risk management investigated the incident. The head of volunteer services had pointed out to the risk manager that this was not the first volunteer to fall at that exact location. The risk management investigation found that: the
hospital lobby floor is carpeted; the gift shop is in the middle of the lobby; volunteers staff the gift shop, the majority of whom are retired and over 60 years-old; this was the sixth incident report of a fall in the area of the gift shop in 18 months, four involving volunteers and two involving visitors. Upon further investigation, it was determined that the floor was not even in this particular area of the lobby, which caused the elderly volunteers, the majority of whom wore rubber-soled shoes, to fall. The risk manager learned that many staff members had caught their feet on the rug, but hadn’t fallen and hadn’t made the report of a hazardous “near miss” to risk management or to physical plant operations. As a result of the investigation precipitated by the falls that resulted in injury, steps were taken to change the traffic pattern to prevent walking in the area with the uneven floor.

APPLYING RISK MANAGEMENT STRATEGIES:

Physicians have the opportunity to identify hazards as they make rounds or traverse the halls of the facility. Lights that don’t turn on, call bells that don’t work, rugs with ripples, loose or missing walkway bricks, loose floor tiles, bedside curtains that are soiled, patients who complain of back pain who are lying on mattresses that are obviously concave, beds of patients who have no ambulation restrictions always found in the high position when making rounds are examples of hazards that could lead to patient injury, some are hazards to the general public, including the physician. While these examples may seem trivial and time consuming to address, it is the responsibility of all who work in any facility to report hazards and to take steps to prevent an accident when recognized.

Observation or recognition of a hazard, risk, or unusual situation should be brought to the attention of the department head or Unit Manager as the first line of communication, while concurrently notifying the Facility Risk Manager.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Facility Risk Management Department
- The nursing manager or department head
- The nursing or house supervisor if on the weekend or 3-11 or 11-7 shift.
- Hospitalist’s facility based medical director
- Hospitalist’s Company
2. RISK MITIGATION

Mitigation occurs when actions are taken to control or reduce the severity or contain the damages of a situation or the outcome of an untoward event. For example, a patient on a medical-surgical unit may experience a severe allergic reaction to penicillin. The Hospitalist responds, evaluates the situation promptly, orders antihistamines and injects epinephrine to contain the evolving, systemic reaction. The patient is monitored closely to make certain that the reaction subsides. The Hospitalist documents the urgent care situation, noting that the patient had denied a history of penicillin allergy or sensitivity in the past. On the EMR, the Hospitalist checks off the tab “Allergies” and completes the sub tab for “penicillin.” He also revises the patient medication order list, removing penicillin and replacing it with another antibiotic. Once the document is saved, the allergy alert is noted on the patient’s EMR. The actions taken to control the allergic response demonstrate good clinical risk mitigation practice. Since the patient was scheduled for another dose of the same drug several hours later, updating the EMR record, and changing the medication order helped to eliminate a known clinical risk. This latter step is different from risk mitigation, an approach that helps to minimize the extent of an adverse outcome or the scope of potential damage.

RISK EXPOSURES:

- Breach of a standard of care
- Breach of hospitalist contract with the acute care facility

RISK MANAGEMENT STRATEGIES:

Hospitalists are often asked to respond to patients exhibiting complications or evolving health-threatening situations. As noted above, sometimes such events involve adverse drug reactions. At other times it may be a significant change in status that triggers a request for prompt assistance to mitigate or contain the potential for a serious adverse outcome. The timeliness of the response and effective communication with other care providers are important factors that can influence the success of mitigation efforts. Risk management strategies to consider include:

- Participate in team crew training for clinical rapid response teams.
- Participate in regular simulation training for responding to patients who experience serious adverse events or significant change in status.
- Become familiar with the codes and code protocols in the hospital.
- Utilize a shared or common taxonomy of terms when responding to requests for assistance with patients who experience serious adverse events or significant changes of status.
- Follow good clinical practices to contain the severity of adverse events, including calling appropriate treatment codes or summoning rapid response teams.
- Follow good clinical practices to contain the severity of adverse events, including stabilization and prompt transfer of patients to higher acuity care levels such as the ICU.
CASE EXAMPLE:

At 0740 hours, Sarah Starr had delivered a healthy 7.5 pound baby girl. The patient had a history of gestational diabetes and a longstanding history of hypertension. She also was a two pack-per-day smoker. At 1500 hours, the OB Hospitalist responded to a page from a nurse. As he walked into the room, Mrs. Starr was telling the nurse that she was short of breath. The patient said, “Hello doctor. I think I am getting a chest cold. I have a temperature and golly, my leg calf really hurts.” The patient’s heartbeat was rapid. The Hospitalist examined the patient and facilitated a stat transfer to the ICU. Accompanying the patient to the ICU, he told her, “Mrs. Starr, you may have a blood clot in your lung. You are being moved to the Intensive Care Unit so that the doctors and nurses in that area of the hospital can complete appropriate treatment for you. The OB Hospitalist spoke with the Intensivist. The response was rapid, including placement of an inferior vena cava filter and medication. Although Mrs. Starr remained hospitalized for several days, she had a successful outcome. The Intensivist told the patient, “The OB Hospitalist made a good call. His swift action helped to save your life.”

APPLYING RISK MANAGEMENT STRATEGIES:

- Respond rapidly to requests from clinical personnel, patients, and/or family members about significant change in patient status or adverse clinical situations.
- Utilize good critical thinking and situational analysis to identify evolving adverse clinical situations.
- Communicate effectively with other care providers to facilitate prompt clinical interventions that are designed to contain the scope of adverse clinical events or significant change in status of patients.
- Follow hospital protocol for documenting the response to adverse clinical events or significant change in status of patients.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Hospitalist’s Company
- Hospital Risk Manager

3. RISK ELIMINATION/RISK RESOLUTION

Risk resolution occurs when a recognized risk is contained or corrected so it no longer exists. This can be the result of a physical change, a change in process, a change in malfunctioning equipment, change in personnel, or a change in the culture. For example, a hospitalist notices that an electrocardiogram machine has two defective leads. Someone had tried to do a work-around to fix the leads using electric masking tape. Rather than using faulty equipment, the Hospitalist requests a replacement twelve lead EKG machine. Not only did this decision eliminate a risk involving faulty equipment, it helped to resolve a potential liability exposure involving a sensitive device used in clinical care.
RISK EXPOSURES:

- Physical hazard to patients and staff from faulty equipment
- Inaccurate clinical information stemming from faulty equipment
- Clinical hazard from healthcare personnel
- Substandard care and liability exposure

RISK MANAGEMENT STRATEGIES:

Exercising good situational awareness and critical thinking are key attributes in clinical risk elimination and resolution. Hospitalists play an active role in this regard whether the risk-prone situation involves personnel, equipment, or the environment of care. Success turns on prompt intervention and effective communication. Some risk management strategies to consider include:

- Identify equipment or device irregularities.
- Do not use any equipment that appears to be faulty or packaging that appears to have been opened or compromised and is no longer sterile.
- Speak up when staff appear ill and should not be in close proximity to patients.
- Speak up when other care providers fail to follow clinical policies, procedures, and practice routines (for example, no gloving, no hand washing, etc.).
- Speak up when clinical personnel are unfamiliar with practice routines (for example, an agency nurse does not know how to use a type of smart pump).
- Use chain of command when warranted to facilitate risk elimination and risk resolution.

CASE EXAMPLE:

Jane Thomas, D.O. was rounding on the medical-surgical unit when she noticed that a CNA appeared ill. “Are you okay, Ms. Martin? You do not look very well,” said Dr. Thomas. The CNA replied, “Oh, I will be okay. No need to worry, just a little cold.” Dr. Thomas also noticed that Ms. Martin had a deep cut on her right hand. “How did you manage to do that to yourself? It looks painful,” said Dr. Thomas. The CNA smiled and said, “Cutting some bushes in the backyard. It does hurt a little.” Dr. Thomas noted that Ms. Martin was about to enter the room of a patient who was immuno-suppressed. “Ms. Martin. I need you here. Please come here now,” said Dr. Thomas. Ms. Martin turned and came back to the nurses’ station. “What is it, Dr. Thomas? What do you need?” asked Ms. Martin. The doctor replied, “I need you, Ms. Martin. I need you NOT to go into that patient’s room. You have an open wound, and you were going in to care for a patient who is immuno-suppressed. You are coughing up a storm and by your own admission you have a cold. I cannot permit you to care for patients in your condition. I think it is best that you go home and get some rest. If that chest cold gets worse or that cut continues to ooze, get some help, please.” Ms. Martin shook her head and said, “Well, maybe you are right, Dr. Thomas. I will let the unit manager know.”

APPLYING RISK MANAGEMENT STRATEGIES:

- Identify unsafe practices and facilitate risk resolution.
- Take appropriate action to eliminate or resolve a clinical risk situation.
Use effective communication skills to help promote risk elimination and risk resolution.
Communicate findings and actions to appropriate clinical leadership with a view to using risk elimination and risk resolution activities to reinforce good practices among all clinical personnel.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:
- Hospitalist’s Company
- Hospital Risk Manager

4. PATIENT ADMISSIONS
When admitting a patient to an acute care facility, the Hospitalist is responsible for completing a number of steps for the delivery of quality, safe and effective medical care. Admission requirements are often found in state laws and regulations. Additionally, the Centers for Medicare and Medicaid Services (CMS), have established specific admission standards for hospital patients. Other federal requirements dealing with coding and billing insist upon effective documentation of conditions that are present on admission or “POA.” The failure to document present on admission information may result in an acute care hospital receiving less payment for services than would otherwise be applicable for properly documented and coded Medicare Severity Diagnosis Related Group (MS-DRG) data under the In-Patient Prospective Payment System (IPPS) for Hospitals. Recognize that some hospitals are exempt from the present on admission requirement. Reimbursement issues aside, substandard admission information, clinical orders, and medication orders may also trigger adverse patient care outcomes and litigation against the Hospitalist, his or her employer, and the hospital.

RISK EXPOSURES:
- Negligence claims
- Professional disciplinary action through the medical staff bylaws
- Decreased revenue
- Breach of contract

RISK MANAGEMENT STRATEGIES:
Generally speaking, effective patient admissions involve a number of elements that can help reduce risk exposure, including the following:

- Become familiar with standards for admission at the acute care facility, including applicable state legislative and regulatory requirements for this purpose.
- Develop an understanding the CMS Hospital Conditions of Participation standard for patient admissions.
- Complete training on documenting present on admission information.
Follow good clinical practices for completing the admissions process, including:

- Obtaining and reviewing the patient’s medical and medication history.
- Reviewing available patient medical record data supplied by the primary care provider, skilled nursing, assisted living, or rehabilitation facility, or the patient.
- Completing a documented “present on admission” evaluation.

Develop a set of patient-specific admissions orders for:

- Diet
- Medication
- Diagnostic testing
- Treatment

CASE EXAMPLE:

Louise Young, an 83-year-old resident of a skilled nursing facility was brought to the hospital after a fainting spell and fall. The patient had a history of coronary artery disease, peripheral vascular disease, and mild dementia. She suffered from visual impairment. Preliminary diagnostic imaging completed in the Emergency Department (ED) revealed no evidence of fractures. Because Mrs. Young had been unconscious for five minutes after the fall, and because of her underlying condition, she was admitted by Dr. Stein, the Hospitalist on duty, for testing to rule out any neurological or undiagnosed cardiac problems. A nurse completed a “head-to-toe” examination of the patient and found no evidence of bed sores on admission. A urine sample taken in the ED was sent to the lab for analysis along with blood samples. There had been a five-hour delay in getting a bed for Mrs. Young. During that time, the lab results came back positive for a urinary tract infection. A sticky note was placed on page 5 of the medical record. The note read: “2015. UTI test positive.” The Hospitalist did not review the entire medical record and therefore did not see the lab result. Instead, he quickly looked for what he considered key information, thinking that his colleague taking over in a few hours would do a more thorough work-up once the patient was assigned to a room. The Hospitalist wrote up what he considered a routine set of orders and left after his shift. It was 12 hours later when a nurse saw the note and questioned the Hospitalist then on duty about the UTI. By this time, the urinary tract infection had become much more serious. The patient subsequently developed bed sores, and she had a mild stroke. Once she was stabilized some seven days later, she was transferred to the rehabilitation unit of the skilled nursing facility. A coder raised a concern with the hospital’s billing office, “I do not think that we can use the usual MS-DRG. The UTI was not documented upon admission.” The billing office agreed, and the Chief Medical Officer (CMO) was asked to meet with Dr. Stein about the incomplete documentation. The CMO said, “This type of clinical practice must stop! It could lead to serious patient harm, litigation, and in this case, it cost the hospital money. I am going to speak with your company. For now, your documentation practices will be scrutinized for all your cases.”

APPLYING RISK MANAGEMENT STRATEGIES:

- Review patient medical records thoroughly during the admissions process.
- Be certain to document carefully all present-on-admission clinical data.
- Recommend good practices to help highlight clinical data, laboratory results, and nursing “head-to-toe” patient evaluations for patient admissions.
□ Confirm receipt and action on outstanding laboratory and diagnostic imaging results ordered in the Emergency Department prior to patient admissions.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

□ Hospitalist’s Company
□ Hospital Risk Manager

5. INFORMED CONSENT

A patient or a duly authorized legal representative should make informed choices regarding various tests, surgical or invasive procedures, and medication therapy. Consent requirements are found in state laws and regulations and hospital policies and procedures. Federal laws and regulations set informed consent requirements for participation in clinical research. Some states (for example, California, New York, and Virginia) have detailed clinical research consent requirements. Additionally, the Centers for Medicare and Medicaid Services (CMS) have issued guidance on informed consent for surgical procedures and specific standards for hospitals that participate in Medicare and Medicaid.

RISK EXPOSURES:

□ Negligent consent litigation
□ Claims of assault or battery
□ Claims of misrepresentation, deceit or fraud
□ Complaints to licensing board of unprofessional conduct.

RISK MANAGEMENT STRATEGIES:

Generally speaking, an effective informed consent process involves a number of elements. Completing the following components can help reduce the risk of successful consent claims:

□ An understandable explanation of the patient’s condition that requires treatment.
□ A description of the proposed test, surgical or invasive procedure, or medication regimen.
□ An explanation of the probable benefits and probable risks of proposed tests, surgical or invasive procedures, or medication regimen.
□ An explanation of treatment alternatives, including associated probable benefits and probable risks of these optional tests, surgical or invasive procedures, or medication regimen.
□ An explanation of the probable consequences of refusing either recommended or alternative forms of testing, surgical or invasive treatment or medication regimen.
□ Make certain that the patient is mentally capable of making treatment choices and that the patient who has the legal capacity to make treatment decisions. NOTE: A patient under a guardianship of the person for health care decisions cannot give or refuse
consent to treatment. However, the patient may provide useful information to consider in the care plan.

☐ Use terms that are understandable to the patient or surrogate.

☐ Pace the discussion to meet the cognitive needs of the patient or surrogate. NOTE: The fact that the patient has received pain management or has consumed alcoholic beverages or used recreational drugs does not eliminate the need to determine if the person can make a treatment choice (mental capability).

☐ Use a translator or sign interpreter for patients who require language assistance.

☐ Encourage the patient or surrogate to ask questions and provide understandable responses.

☐ Provide sufficient time for the patient or surrogate to absorb information.

☐ Complete a consent “teach back” to confirm patient or surrogate understanding.

☐ Never use intimidation or coercion to obtain a “consent” to treatment.

☐ Respect a decision to refuse tests, surgical or invasive procedures, or medication management. However, make certain that the decision is an informed choice by following the consent process as outlined here.

☐ Document the patient’s decision in compliance with applicable hospital policy and procedure.

**CASE EXAMPLE:**

The patient, Michael Brown, was admitted to a hospital medical-surgical unit following a fall at home. The patient provided a detailed medical history and a list of his medications. He had a history of TIs, diabetes, and what he called “fainting spells.” Upon admission, the patient’s blood sugar was normal, and the EMTs who brought him to the hospital had found a normal blood sugar at his residence. However, he seemed disoriented and complained of some weakness in his left arm and hand. He had a deep 12 mm. cut over his right ear and pain and impaired movement in his right elbow suggestive of a possible fracture. The Hospitalist, Dr. Hanes, wanted to order a CT scan with contrast dye of the brain to rule out a stroke. She also wanted to order a diagnostic image of the elbow. The patient agreed to the diagnostic image of the elbow but refused the brain scan. Dr. Hanes did not explain other alternatives to the latter test nor did she inform the patient of the possible risks associated with refusing the brain scan. Without discussing with the patient whether or not he had a recent pneumonia vaccination, the doctor ordered Pneumovax for the patient. Later, when Mr. Brown objected to the vaccine’s administration by a nurse, he was told he “must take it” as it was the doctor’s order. Twelve hours later the patient suffered a massive stroke. Despite treatment, he had residual left-side weakness, diminished vision in his left eye, and slurred speech.

In a lawsuit for lack of informed consent, the plaintiff might have a viable claim since the Hospitalist failed to explain diagnostic testing options and the consequences of refusing the CT scan. Administering the vaccine over the patient’s objection might constitute battery for unauthorized treatment.
APPLYING RISK MANAGEMENT STRATEGIES:

- Follow state laws, regulations, and hospital requirements for informed consent for diagnostic testing, surgical and invasive procedures and medication management.
- Provide patients with information about alternatives and the related benefits and risks of such options.
- Provide information for an informed refusal of care.
- When a patient refuses a vaccine do not proceed to administer it.
- Document the patient’s treatment choice and, in the case of a decision not to receive a prescribed treatment, his or her informed refusal.

See also, APPENDIX B, Hospitalist Consent Checklist

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Hospitalist’s Company
- Hospital Risk Manager

6. MEDICATION RISK REDUCTION

Medications are a major component of the medical therapies. However, with the healing powers of medications come potential complications such as overdoses, adverse reactions, allergies, and administration errors. Medication errors and adverse drug events (ADE) are a significant patient safety issue, resulting in frequent and significant patient morbidity and mortality. In addition, negligent medication management is a frequently seen allegation in medical malpractice litigation against physicians of all specialties. Hospitalists can play a significant role in the safe utilization of medications for their hospitalized patients.

RISK EXPOSURES:

- Medication-related injuries or death
- Adverse drug reaction
- Substandard care

RISK MANAGEMENT STRATEGIES:

The risks associated with medication management are many, as are the number of available prescription medications available to the Hospitalist today. Before a medication is prescribed, any physician has to take into consideration multiple components of the patient’s medical history, including chronic and acute conditions and diagnoses for which he or she is being treated, his or her medication history, any known allergies or adverse reactions to medications, and all the medications (prescribed and OTC) that the patient is currently taken. In addition, new side effects and adverse reactions are being discovered and reported by the FDA and pharmaceutical companies on a regular
basis. All this data has to be considered and will have an impact on the Hospitalist’s medication choice. It is not uncommon for a single patient to present on admission with a long list of current medications prescribed by various specialists in the community for a variety of conditions (See also, 7. Medication Reconciliation). The hospitalist faces the challenge of having to sort through all the data available to choose the drug that will best meet each patient's specific medical needs in the safest and most effective way.

CASE EXAMPLE:
Nancy George, a 52-year-old female, was admitted to the Hospitalist service for complications of systemic lupus erythematosus (SLE) that included acute renal failure. She was started on corticosteroids for her SLE. After the first week of her three-week hospitalization, she developed cerebritis and thrombocytopenia, also recognized SLE-related complications. The Hospitalist, Dr. Stoner, prescribed Vancomycin for her altered mental status and leukocytosis of 19,000. A few days later, he added Levofoxacin because of continued low-grade fever and leukocytosis. Dr. Stoner was puzzled when repeated multiple cultures (urine, blood, and sputum) yielded no organisms, but continued both antibiotics for another ten days because of Ms. George’s persistent, but low-grade fever. When the patient’s fever suddenly went up to 39.6°C, Dr. Stoner called in an Infectious Disease specialist. A blood culture ordered at that time grew Vancomycin-resistant Enterococcus faecium (VRE), as did a central line catheter tip. The ID specialist and Dr. Stoner decided that the appropriate course of action at this time was to stop all antibiotics. Within 36 hours, the patient’s temperature normalized, her condition was stable, and Dr. Stoner was able to resume treatment of her SLE. The patient’s SLE made this case especially challenging to manage because it put her at increased risk of infection. However, after continuing the antibiotic therapy for two weeks without demonstrable evidence of a bacterial infection, Dr. Stoner should have considered an etiology other than infection; his failure to do so contributed to the antibiotic resistance.

APPLYING RISK MANAGEMENT STRATEGIES:

- Follow the read-back, spell-back, and indication process to ensure the correct drug was ordered and administered.
- Comply with the facility’s DO NOT USE medication symbols and abbreviations when ordering medications for your patients.
- Keep verbal and telephone orders to a minimum. Computerized Physician Order Entry (CPOE) has been shown to considerably reduce serious medication errors and adverse drug events (ADEs).
- Maintain a high level of sensitivity to the significant risk potential for error and patient injury posed by look-alike, sound-alike medications or classes of drugs known to be high risk of patient harm when errors occur or even when used correctly (e.g., antithrombolytic agents, antibiotics, antiarrhythmics, anesthetic agents, sedation agents, narcotics and opiates, total parenteral nutrition solutions, etc.).
- Be aware that certain medications have heightened risk of patient harm in certain patient populations, e.g., pediatric or geriatric patients, and be extra vigilant in monitoring these patients when these drugs have been prescribed.
Use available resources, references, and clinical-decision support tools (hard-copy or electronic) for prescribing. When linked into EMRs, these tools have been very effective in reducing medication prescribing errors and ADEs.

- Routinely use and update the facility’s medication reconciliation form and process on admission and discharge.
- Provide information to the patient regarding all medications ordered, including indication, intended outcome/effect, complications, and contraindications. This discussion should be documented.
- Educate patients and families about the medications, dosage, frequency, and potential side effects of all medications ordered. This empowers the patients to participate in their own treatment.
- Respond to and resolve any patient or a family member questions or concerns about a medication. Many a “near miss” medication error has been prevented by a nurse or physician heeding the patient’s question or concern and verifying a dose or the actual medication prior to administration.
- Consider developing standardized medication protocols for management of frequently seen clinical situations, e.g., prophylaxis for thromboembolism, to improve management and increase patient safety.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Pharmacist
- Nurse manager
- Facility Risk manager
- Facility Medical Director
- Hospitalist’s facility-based Medical Director

7. MEDICATION RECONCILIATION

Medication reconciliation is an important risk management approach to prevent errors in clinical care. For Hospitalists, medical reconciliation involves both new patients and those being discharged. Medication reconciliation risks can also occur with patients being transferred within an acute care facility. Medication reconciliation involves the names of and indications for pharmaceutical preparations, the dose, and frequency of use. If the hospital formulary does not include medications used by the patient in the community or in long-term care, the reconciliation process will entail additional work in identifying suitable substitutes that will not provoke drug-drug interactions, allergies, or sensitivities. Sometimes, hospital policy and procedure will permit the patient to bring in non-formulary preparations to avoid substitutions. For the hospitalist, the key is to reconcile both formulary and non-formulary preparations and properly document this information on the medication order list at admission and at discharge. Essential to this process is effective medication history-taking of the patient.
RISK EXPOSURES:

- Medication error
- Adverse drug events
- Medication-related injuries or death
- Substandard care
- Breach of the hospitalist contract

RISK MANAGEMENT STRATEGIES:

Medication reconciliation plays several roles in the safe administration of medications:

- Complete a medication history of the patient, including information about prescription medication, over-the-counter (OTC) preparations, herbal remedies, supplements and other substances.
- Inquire about the use of recreational drugs.
- Ask the patient questions to determine medication adherence, especially among patient populations at-risk for skipping doses or attenuating expensive medication through pill-splitting.
- Inquire about allergies and sensitivities, including wheat and dyes that may explain why certain drugs are on the medication list and not less expensive equivalents or generics.
- Inquire about lactose intolerance as this could be a “rule out” for patients who cannot take certain types of medication.
- For cognitively challenged or incapacitated patients, make appropriate inquiries of family care givers to document the intake medication list.
- Contact the primary care provider and/or community pharmacist to complete the intake medication reconciliation process.
- Follow-up with community-based specialists if the primary care provider does not have a complete list of medications prescribed for the patient.
- Reconcile medication lists supplied by the patient, EMS, and transferring facilities.
- Reconcile medication lists supplied by other units in the acute care facility.
- As part of the discharge plan, complete a medication reconciliation process, utilizing appropriate forms or computerized order entry in the Electronic Medication Administration Record (eMAR).

CASE EXAMPLE:

Veronica Swift, a 67-year-old retired bank teller, was brought to the hospital by EMS after collapsing at a local restaurant. Ms. Swift suffered a concussion. In the emergency department, Ms. Swift had a sustained heartbeat of 150 and a blood pressure of 90/59. There were also anomalies on her electrocardiogram. She was admitted to the medical-surgical unit. Dr. Herrington, a Hospitalist, was on duty when Ms. Swift came up to the unit. He reviewed the medication list obtained by EMS. He also spoke with Ms. Swift and her husband. Because there were two or three medications on the EMS list that Ms. Swift said she no longer used, Dr. Herrington contacted her primary care provider.
“I have her list here that we downloaded from her personal health record. It is terrific. Just updated four days ago. The list includes meds prescribed by her cardiologist and her rheumatologist. Our practice has access through the secure portal. I will send it to you now,” said the primary care provider. Dr. Herrington reviewed the PHR list with Ms. Swift. “Does it contain the new medication ordered by the rheumatologist? The one she gave me the other day? She gave me a ten-day starter pack. Is it on the list?” asked Ms. Swift. As it turned out, the “starter pack” medication was not on the list. When Dr. Herrington reviewed the new medication with the hospital pharmacist he learned that the drug could have a synergistic effect with some of Ms. Swift’s other prescription preparations. Also, it was known to cause cardiac changes and low blood pressure. Dr. Herrington called the rheumatologist, and they both agreed to stop the new drug to see if it was causing the cardiac and blood pressure problems. Within 24 hours of discontinuing the new medication, the cardiac and blood pressure symptoms were resolved. “I think we found the problem, Ms. Swift,” said Dr. Herrington. She smiled and said, “Well, it was a good thing you asked about the medications on my PHR key fob. I guess I have to remember to ask my specialists to upload sample drugs next time.”

APPLYING RISK MANAGEMENT STRATEGIES:

☐ Complete thorough medication reconciliation procedures at intake and at discharge.
☐ Make certain to confirm that the content of PHR and written medication lists are up-to-date.
☐ Ask good drill-down questions that may reveal the names of medications not on the patient’s PHR or written medication list.
☐ Communicate with hospital pharmacy and physicians in the community as indicated to complete thorough medication reconciliation procedures.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

☐ Hospitalist’s Company
☐ Hospital Risk Manager

8. DOCUMENTATION PRACTICES AND CONTINUITY OF CARE

A patient’s medical record plays an extremely important and multifaceted role:

- it presents a chronological account of the patient’s medical story – history, diagnosis, the clinical decision process and treatment rationale, treatment, and the outcome of that treatment;
- it is the primary communication tool between providers and other members of the healthcare team involved in a patient’s care and therefore is critical to continuity of care;
- it serves as evidence of a provider’s / hospital’s compliance (or lack of compliance) with established standards of care, laws, regulations, and accreditation requirements;
it can demonstrate a measure or lack of quality or performance when assessed by quality assurance or utilization review personnel, peer review committees, and even state licensing bodies
it is the foundation of all third-party reimbursement and, as such, must support all third-party claims filed for care rendered; and
it is the legal record of the patient’s care.

Under the Medicare Conditions of Participation (CoPs) on Medical Record Services, a hospital is required to maintain a medical record for every individual evaluated or treated in the hospital. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services. The hospital’s medical record system – whether paper-based, electronic, or a hybrid of both – will be set up in a way that complies with the CoPs and other laws, regulations, and accreditation standards. As a member of the Hospitalist team at a hospital, you will be required to follow that hospital’s policies and procedures with regard to medical recordkeeping to assure compliance on both a facility- and personal level.

Nationwide, healthcare systems and providers are increasingly moving from traditional paper-based medical records to electronic health records (EHRs). EHRs have associated benefits as well as challenges for the hospitalist. Many hospitals are in transition – somewhere between 100% paper and 100% electronic – which itself can present problems when some patient data is stored electronically and other information is maintained in hard-copy files. Wherever your facility is along that continuum, the basic elements of good documentation apply and are essential to the provision of high-quality, safe patient care. An EHR, in and of itself, is not a guarantee of “good documentation” or an automatic improvement over paper records; rather, if documentation bad habits were present in a traditional paper medical record system, it is likely that they will be carried over to an electronic system. For example, while an EHR system removes the issue of illegible record entries due to poor physician handwriting, it has new potential risks that arise when poor typing skills or hasty data entry result in a physician’s hitting the wrong key on the keyboard. In an EHR, a “typo” can have serious patient safety ramifications. However, an EHR system with a basic computerized physician order entry (CPOE) feature can eliminate the majority of legibility issues and standardize order formats. In addition, EHR systems that incorporate clinical decision-support features such as automatic “alerts” about drug-drug interactions, patient allergies, outstanding test results, or test results that require a change in treatment have obvious risk management and patient safety potential.

Common documentation problems include incomplete, sparse, or illegible records due to poor handwriting; documented “jousting” between physicians or between physicians and nursing staff; the inclusion of inappropriate, derogatory, or subjective information in the record; alteration of a medical record after litigation has been filed; use of abbreviations, acronyms, and symbols that can jeopardize patient safety; delayed documentation or dictation of reports for inclusion in a patient’s record, and the like. In addition, when claims filed for services rendered don’t match the documented patient care, serious consequences are possible for the facility and physician from a fraud and abuse perspective.

While EHRs can eliminate some of the more common risks, errors, and liability associated with documentation, they bring their own associated problems to the table: data entry errors (e.g., decimal point placement when typing in medication doses or clicking / checking off the wrong box in
a list of existing conditions, etc.); auto-completion of fields left blank by a clinician; potential perils of “copy and paste” documentation by physicians; lack of clear physician sign off and signature verification or auto-authentication that eliminates the need for physician review of an entry, problems with patient identification when patients have similar or the same names; after-the-fact alternations or deletions of electronic entries, etc. A potentially serious problem can arise when a physician fails to heed built-in system prompts regarding drug-drug interactions, known allergies, outstanding test results, etc., and/or attempts to bypass or work-around the system’s warnings.

Then there are the risks of non-compatibility and system failures that arise when several different electronic systems co-exist in one facility, e.g., between departments, preventing interoperability and smooth transmission of patient data. Even more problems can occur in facilities where some patient information is stored or transmitted on paper and some electronically – these situations can be extremely frustrating for physicians and staff looking for specific patient information and can be potentially dangerous from a patient safety perspective.

**RISK EXPOSURES:**

- Medication Errors
- Disruption in Continuity of Care
- Communication Breakdown between providers
- Delayed Diagnosis or Treatment / Misdiagnosis
- Patient Injury / Death
- Fraud and Abuse Issues when Records don’t support claims for reimbursement

**RISK MANAGEMENT STRATEGIES:**

From a risk management perspective, good documentation practices include the following:

- Document the patient’s complete medical history and the findings – both positive and negative – of the systems physical evaluation at admission [See also 4. Patient Admission for discussion of Present on Admission findings]
- Maintain and update a medication list in a consistent and prominent place in the patient’s chart – whether paper or electronic – with medication allergies or an absence of allergies noted prominently.
- Document to demonstrate continuity of care and coordination of care between the hospitalist and all physician consultants and all ancillary care providers involved in the patient’s care and treatment.
- Document legibly (if done manually). If electronic records are used, record entries should be reviewed prior to sign-off for accuracy and correctness.
- Develop a working knowledge of the CMS Hospital Conditions of Participation standard for Medical Record Services.
- Make any necessary record additions or corrections in accordance with the facility’s policy, again, depending on whether a paper-based or electronic system is used. If paper, the recognized correction method is to cross out the error with a single line; note “Error,” initial and date, and add the correct notation. An EHR will have a specified error correction method (may vary from system to system) that should be followed exactly.
Use ONLY facility-accepted abbreviations and symbols when documenting. Best practice is to completely avoid the use of abbreviations and symbols to prevent interpretation errors, particularly if records are handwritten.

Complete each blank on record forms to indicate that the category or question was addressed. If completion of all fields is not required or not applicable to the patient, then a N/A (or whatever is customary procedure at the facility) should be entered. No block or field (in an EHR) should be left blank!

Review and authenticate any transcribed records to verify that what you dictated was accurately transcribed. Don’t skip the reviewing step! When you sign off on a transcribed report or record, your signature or initials indicate that what was transcribed is indeed what you dictated and correct.

Make sure to always sign off on all orders and patient encounter notes when using an EHR system and signing off in a way that will be evident to others viewing the record. Again, review before signing off.

Always respond promptly to any system prompt or alerts and take the appropriate action to address the problem and resolve it. These alerts are in the system for the patient’s protection as well as the benefit of the healthcare providers involved in the patient’s care. They should never be ignored or bypassed! Keep in mind that the system’s audit trail will demonstrate exactly when you were “in” the record, when you logged out, and that such an alert was active during your time in the patient’s e-record – even if you figure out how to bypass it.

CASE EXAMPLE:
A Hospitalist, Dr. Mehti, was finishing up his shift and about to leave when he remember he wanted to order a portable chest x-ray on Mr. Rawlings, an elderly male patient. When he logged into the patient’s e-record, an alert came up on the screen that the patient’s recent lab work had a “panic value” that had to be addressed. The system had been set up to require the such automatic “alerts” be addressed by the next physician logging on to the patient’s e-chart, and precluding any further activity in the chart until the alert was read and appropriate action taken. However, Dr. Mehti had figured out a work-around for such alerts (with the help of his computer-savvy teenager). Because he was already running late, he did his workaround maneuver, ordered the x-ray, and logged out – figuring someone on the next shift would review of the lab work. The alert was triggered by panic values in both serum creatinine and BUN, indicating severe renal dysfunction. By the time this was addressed by the next Hospitalist on duty, there was significant and permanent damage to the patient’s kidneys. Mr. Rawlings filed a malpractice action against the hospital and the Hospitalist who ignored the alert, alleging that the delay resulted in permanent renal damage that might have been prevented by an immediate response.

APPLYING RISK MANAGEMENT STRATEGIES:
Good documentation practices apply to all members of the healthcare team in all clinical settings – without exception. The importance of a well-documented record to a patient’s diagnosis, treatment, treatment outcome, and overall well-being cannot be overemphasized. It is common knowledge that the medical record takes on yet another vitally important role should a medical malpractice action be brought against a physician or hospital. Documentation can be the deciding factor in the
determination of whether a case is defensible or not. As the old adage says, “If it’s not in the record, it didn’t happen.” Make sure your documentation completely, objectively, and accurately reflects the care you rendered.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

☐ Hospital Risk Management Department
☐ Hospitalist’s company
☐ Hospital Information Management (if an IT system-related issue)

9. HIPAA AND HITECH PRIVACY REQUIREMENTS

HIPAA

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, as it is commonly known was enacted with the goal of improving and standardizing electronic healthcare records; its key components addressed e-record transactions, unique identifiers for providers, patients, insurers, and employers, privacy, and security. It is the privacy and security components that have the most far-reaching effects on all levels of the healthcare industry – particularly how patient health information (PHI) in any form is created, maintained, and disseminated.

HIPAA applies to all healthcare providers – hospitals, clinics, physicians, physician offices – grouping them all under the “official” name of “covered entities.”

As a Hospitalist, you will be most affected by HIPAA’s Security and Privacy provisions. The Security provisions provide guidance to organizations and providers on how to protect the integrity and confidentiality of medical information collected from patients through risk identification and assessment and subsequent implementation of security measures to reduce those risks. The four areas that are addressed in the Security section are:

- Administrative safeguards – e.g., formal security policies and procedures, data back-up and recovery plans, staff training, gap analysis (comparison of existing security standards to the HIPAA standards to identify “gaps” and develop an action plan to close those gaps)
- Physical safeguards – e.g., limiting physical access to the facility’s record storage areas and IT department, protecting data and data back-up, and other physical safeguards PHI from unauthorized access
- Technical security measures – e.g., measures that limit access to PHI, system audit controls, individual user password protection, data protection from alteration or destruction, PHI disclosure consents
- Technical security mechanisms – e.g., protection for data transmitted or communicated over networks, such as alarm systems, audit trails, encryption mechanisms, user identity verification.
In the hospital setting, the facility and/or health system must have appropriate security measures and systems in place for HIPAA compliance in this regard. Any employee or contracted physician working in the facility will be expected to abide by the facility’s policies and procedures in this regard so as not to jeopardize the privacy and protection of patient information or the facility’s compliance.

The Privacy Rule has the largest impact on healthcare facilities and providers. It protects individually identifiable health information by defining and limiting the circumstances under which PHI may be used or disclosed by a covered entity; i.e., PHI may be used or disclosed for treatment, payment, or other healthcare-related purposes as allowed under the Privacy Rule, or with the expressed written consent of the patient (or his/her personal representative). As defined by HIPAA, treatment is “the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.”

HIPAA Privacy protection extends to all forms of individually identifiable health information that has been maintained or transmitted by a covered entity, whether communicated electronically, on paper, or orally. Individually identifiable health information is further defined as information, including demographic data that relates to:

- the individual's past, present, or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and
- identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual (e.g., name, address, birth date, and Social Security number).

All covered entities are required to provide and display a Notice of Privacy Practices (NPP). The notice must be in plain language, prominently posted in the facility and on the facility's Web site. It also must be made available to any person who requests it and must describe:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

Any disclosures of PHI must be consistent with the covered entity’s practices as outlined on its Notice of Privacy Practices.

HHS’ Office for Civil Rights is responsible for enforcing the Privacy and Security Rules. Enforcement of the Privacy Rule for most HIPAA covered entities.

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HITECH

The Health Information Technology for Economic and Clinical Health (HITECH) Act (Title XIII) is a section of the American Recovery and Reinvestment Act (ARRA) of 2009 that was signed into law on February 17, 2009. Among other things, ARRA earmarked $19 billion in financial incentives to stimulate the adoption of EHRs by healthcare providers, with the ultimate goal being interoperability to improve health information transfer and exchange, thereby facilitating medical treatment and improving the quality of care.

HITECH addresses the privacy and security risks associated with the electronic transmission of health information, calling for strengthened civil and criminal enforcement and harsher penalties for privacy and security breaches — the first significant amendments to HIPAA’s Privacy and Security sections since its enactment. These include but are not limited to:

- Expanded security breach notification requirements that include notification of the affected patients and HHS notification in certain situations
- Penalties for HIPAA violations have been increased, are tiered, and can range anywhere from $100 to $50,000 per violation, depending on the nature and extent of the violation and the nature and extent of the harm resulting from the breach.
- Expanded requirements for Business Associates
- Expanded requirements regarding disclosure accounting
- Patients may now request electronic copies of their PHI if the covered entity uses or maintains the PHI in electronic form (i.e., EHR). The patient may direct the electronic copy to be sent to him- or herself or to another entity or person.
- Increased restrictions on use of PHI for marketing and fundraising
- Requires covered entities to comply with patient-directed restrictions on disclosure of his or her health operations-related PHI if:
  - the patient restricts disclosure to a health plan for payment or health operation purposes;
  - the restriction is not related to information needed to carry out treatment; and
  - if the restriction deals with information related to a treatment or service that has already been paid for by the patient (i.e., “out-of-pocket”).
- All covered providers must continue to comply with the HIPAA requirements as amended by ARRA or their specific state law – whichever is more restrictive.

[NOTE that the above information is based on the HITECH Interim Final Rule that became effective on September 23, 2009, and remains in effect as of November 1, 2010, or until the effective date of the breach notification final rule, which has not yet been released.]

RISK EXPOSURES:

- Breach in Patient Confidentiality
- HIPAA / HITECH non-compliance
- Reputation of Hospitalist and Facility
- Financial penalties to all providers involved in breach
RISK MANAGEMENT STRATEGIES:

Physicians have always had a professional and ethical duty to protect their patients’ information, and that means any data or information accumulated during the physician-patient relationship. With that duty now also regulated on federal and state levels, a physician has to be extremely careful that the information entrusted to him or her is not inadvertently disclosed without the patient’s permission. Such breaches of patient information can result in hefty fines for the Hospitalist and hospital plus loss of a patient’s trust.

In some respects, Hospitalists are better prepared for and equipped to protect PHI by virtue of practicing in a facility that is also a covered entity under HIPAA. Physicians in a private office or clinic practice have to build their own security systems and programs and develop and implement privacy policies and procedures for their practices. What is important, then, is that the Hospitalist knows the facility’s privacy policies and procedures, knows the patient’s wishes in this regard, and is ever-vigilant about protecting his patients’ health information from inadvertent disclosure.

See also APPENDIX C, A Guide to Communicating with a Patient’s Family and Friends or Others Involved in the Patient’s Care under HIPAA

CASE EXAMPLE:

An on-duty Hospitalist passing by the nurses’ station was asked by an LPN to take a call “from Mr. Fowler’s son. He’s the diabetic patient in Room 445 with the gangrenous foot.” The Hospitalist, Dr. Ruzik knew the patient well, as he had been the admitting Hospitalist and been involved in the patient’s care for the entire week of his admission. He took the call right there and in response to direct questioning, told the caller that the time had come where the foot could no longer be saved and that a surgical consult had been ordered to discuss amputation. Dr. Ruzik told the son, “I haven’t even had a chance to talk to your father and mother about this. Your mom should be coming in for visiting hours shortly, and I was going to tell them both then.”

The caller thanked the Hospitalist for his candor and hung up. Later, when Mr. Fowler’s wife and daughter came to visit, they sought out the Hospitalist before he came to see them. They were visibly distraught and angry, and advised Dr. Ruzik that the patient would be filing a suit against him and the hospital for breach in confidentiality and would be making a formal HIPAA complaint for unauthorized disclosure of PHI. The physician was shocked and told the family he had no idea what their allegations were all about. They informed him that on admission the patient had given specific instructions that no information was to be given to his son – with whom he had “cut all ties.” The son had apparently contacted the family and the patient after talking to Dr. Ruzik. Not only did he tell his father and mother that he talked to the Hospitalist, but he also broke the bad news about the amputation. Dr. Ruzik apologized profusely, but that did not appease the patient or his family. On later checking the patient’s chart, Dr. Ruzik saw that the patient had indeed authorized disclosure of his PHI only to his wife and daughter.

APPLYING RISK MANAGEMENT STRATEGIES:

There are some lessons to learn from the case study presented with regard to protecting a patient’s privacy: First, be wary of talking about PHI to “strangers” on the phone. The LPN and Hospitalist in the case really had no way of knowing whether or not the “prodigal son” really was who he said he
was. There had been no prior contact with a son during the patient’s weeklong hospital stay. He hadn’t been in to visit his father. No mention of a son by any family member. Obviously, a Hospitalist is not expected to know all the family members of every patient under his or her care, much less be able to recognize them by sight or sound. However, this breach could have been prevented if the LPN had asked for the caller’s number and offer to have the Hospitalist call back when convenient. Most facilities will have a policy or procedure that speaks to this and provides guidance on how to handle such calls correctly.

Be wary of such calls – there is no way to verify the identity of someone over the phone. There have been cases where PHI is breached after being disclosed over the phone by an unsuspecting member of the healthcare team. When the patient is a celebrity or person of local interest, this ruse is frequently attempted by press or “fans.” A physician finds out that the “patient’s daughter” he talked to on the phone was actually a reported from the Daily News when he finds he is quoted in the morning paper talking about the patient’s condition or treatment. Most facilities will have a policy or procedure in place that speaks to calls and queries about patients and provides guidance on how to handle such calls correctly. Special procedures are usually in place to address those “celebrity” patients. Generally, asking callers to give a number for physician callback will usually be enough to weed out any “imposters,” as they will be reluctant to provide information that could reveal their true identity.

In addition, healthcare providers have to be aware of their patients’ wishes with regard to release of their medical information. With the passage of HIPAA, it is routine to have a patient complete a form or otherwise provide information about disclosure of PHI in all healthcare settings. The patient provides names and contact information of those family members or friends to whom information about his or her condition and treatment may be given. Release of the patient’s information to anyone NOT specifically listed is a breach of the patient’s confidentiality, unauthorized disclosure of PHI and a violation of HIPAA. In any healthcare setting, the members of the healthcare team have to be aware of the patient’s instructions in this regard and follow them; every member of the healthcare team has a professional and ethical duty to protect the patient’s confidentiality.

Patients may also request that release of specific medical information be restricted beyond their normal authorization. For example, a patient who receives a diagnosis of pancreatic cancer from his Hospitalist may request that his adult children not be told his diagnosis – even though he would normally allow his physician to include them in discussions about his care and had allowed his medical information to be disclosed to them in the past. The patient’s wishes have to be respected and honored. In such cases, this special restriction of PHI disclosure should be communicated to all involved in the patient’s care and the patient’s chart should be prominently “flagged” with this information to avoid inadvertent disclosure.

Some risk management recommendations with regard to protecting PHI:

- Know and follow your facility’s policies and procedures on PHI security and protection and release. Non-compliance can result in serious ramifications for you and the facility.
- Know your patients’ wishes on release of PHI. Check the authorization to release information to make sure you can take that telephone call from “Aunt Mary” who wants to discuss your patient’s condition or treatment.
- Asking your patient and/or the patient’s family to provide a communication designee or designees – one or, at the most, two family members with whom you will communicate
regularly about the patient’s condition and treatment – can be very beneficial to the hospitalists in several ways. It can eliminate the need to have the same conversation with multiple family members concerned about their loved one’s care. It can reduce your risk of inadvertently giving patient information to someone to whom you are not authorized to disclose PHI. It will eliminate the need to check whether you can talk to “Aunt Mary” when she calls; instead, Aunt Mary can be advised that “Cousin Bob” is the designated contact who has received the appropriate information on the patient’s condition and treatment and who is then passing on that information to the rest of the family. Many physicians in various specialties routinely use this method to communicate with their hospitalized patient’s family and find it to be very efficient, time-saving and well-received by the patient’s family. Be sure to document the name and contact information for the family designee(s) prominently and consistently in the patient’s record so it can be used by hospitalists on all shifts throughout the patient’s hospital stay.

☐ If possible, have conversations with a patient’s family in non-public areas that are as quiet and private as possible in a busy hospital. This demonstrates your respect for the privacy of their loved ones. Avoid discussing a patient’s condition and treatment with family members in public waiting rooms, lounges, hallways or at the nurses’ station.

☐ Be very careful discussing any patient’s case or information with anyone within the hearing range of other visitors and even other healthcare providers not involved in the patient’s care. Keep in mind that you never know who is standing behind you in the elevator, in the cafeteria line, or who just passed by in the hall while you are discussing a patient’s case. Even if the person overhearing the PHI is another healthcare provider or hospital employee, if he or she is not involved in the care of the patient and the information heard specifically identified your patient by name, that disclosure was unauthorized. While these are not malicious or criminal releases of PHI, they are breaches in patient confidentiality and can result in litigation and HIPAA penalties.

☐ Consider PHI security when using portable electronic devices such as cell phones, PDAs, smart phones, e-notebooks, laptops, and the like to discuss or transmit PHI. These bring with them their own set of risks with regard to inadvertent release if these devices are not used securely. If your facility does not have a security policy regarding use of such devices, your IT experts may want to develop one or provide guidance on how to use these devices securely so as not to compromise your patients’ privacy.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

☐ Hospital Risk Manager
☐ Hospital Privacy Officer
☐ Hospitalist’s company

10. INCIDENT REPORTING RESPONSIBILITIES

All employees and agents, including physicians and surgeons, have a moral, ethical, and legal responsibility to report situations or risks that could or did cause injury to patients, employees, visitors or property. The first line to report is to the immediate front line management, the unit
manager or department head. The front line staff, including the physicians and surgeons, is in the best position to recognize untoward outcomes and potential issues/“near misses.” It is important and expected that untoward outcomes, medical errors, and “near misses” are reported promptly. The swifter the information is received and reviewed the more promptly intervention activities can be implemented.

As an employee or agent of the Hospitalist company, you have two masters to serve in the area of reporting incidents. Incidents relating to patients should be reported through the facility process/system as mentioned above, but you also have a responsibility to report the same information to your Hospitalist Medical Director and to the Hospitalist Company Risk Manager following the company’s policy and procedure and using its designated form and format. The same principles apply, i.e., facts only, comments in quotes attributed to the person, complete the form, make no copies, and no reference in the medical record to the incident report or contact with risk management on any level, facility or Hospitalist company.

**RISK EXPOSURES:**

- Loss of confidentiality of a completed incident report form due to improper handling.
- Failure to note event in medical record as would be documented in any patient related event or situation with medical assessment, provisional or determined diagnosis and treatment ordered.
- Failure to report to both facility and hospitalist risk manager.

**RISK MANAGEMENT STRATEGIES:**

When an incident involving a patient occurs, it should be factually documented in the medical record with your medical assessment of the patient and provisional diagnosis and/or recommended treatment, as ordered.

Never give a copy of the incident report to anyone, not matter how they may whine or threaten you. The original goes directly to the respective risk manager, no one else.

Never keep a personal diary or other record of incidents. One might think keeping such a record will be helpful if an incident report comes up “missing.” However, such a diary or record can be subpoenaed and break the confidentiality and protection of the incident report form still enjoyed in many states. To assist in the prevention of an incident report from being “lost” or going astray, it should be sent, by you, directly to the facility and/or Hospitalist company risk manager. This also assists in maintaining the concept that the incident report is a risk management tool, not a management tool.

Many times a physician/surgeon will call the risk manager to directly report the incident. Many facilities still want the written report completed and sent, but a call for serious events or outcomes is urged. Do not rely on your assumption that someone else has already completed the incident report or made the call. Risk managers would rather get more than one incident report on the same incident than none because everyone decided someone else was going to make the report, and ultimately, no one reported the incident.
The truth is a protection. Understand that in some states certain types of events or outcomes are required by law to be reported to the state department of health or another specified unit. These same reports may be referred to the state Board of Medicine for evaluation and, depending on its decision, further investigation. Do not blame the risk manager for making these reports that might subsequently involve you in an investigation, whether as the point person or as a witness, as the reports are made as required by the law. Many states have a cross reference with claims asserted or certain diagnosis codes that must be reported to other state agencies. Should it find a certain outcome or event was not reported as an incident, it may result in another type of investigation.

CASE EXAMPLE:
On a Sunday afternoon Ruth Long was visiting her mother who was a patient admitted to the Hospitalist service for stabilization of her hypertension. On the way out of the nursing unit Ms. Long slipped on the tile floor and fell to the floor. Dr. Zolt, the Hospitalist, was on the unit at the time and was called to check out Ms. Long, who refused any assistance or medical attention and said she was fine. The nurse began to complete an incident report asking Ms. Long to share what happened and for her contact and other personal information. When the report was complete, Ms. Long asked for a copy of the incident report. When the nurse refused, based on hospital policy, Ms. Long became quite upset and very loud. Dr. Zolt told the nurse he saw no harm in giving a copy of the report to Ms. Long, especially since the report seemed to be innocuous. Six months later, Ruth Long initiated a claim against the hospital, claiming she suffered ankle and wrist injuries when she fell. No incident report could be found in the risk management files or on the unit. The only copy of the incident report was in the hands of the plaintiff.

APPLYING RISK MANAGEMENT STRATEGIES:

- Never make a copy of an incident report
- Never keep a diary or other personal documentation of an incident or incident report
- Never think someone else will make the report if you are involved or a direct witness, or if you are the one that finds/recognizes the untoward outcome of the event.
- Never give anyone a copy of an incident report, regardless of how harmless you think it is. Refer the requesting party to the facility or hospitalist risk manager to handle.
- The truth is a protection.

Understand that in some states certain types of events or outcomes are required by law to be reported to the state department of health or another specified unit. These same reports may be referred to the state Board of Medicine for evaluation and, depending on its decision, further investigation. Do not blame the risk manager for making these reports that might subsequently involve you in an investigation, whether as the point person or as a witness, as the reports are made as required by the law. Many states have a cross reference with claims asserted or certain diagnosis codes that must be reported to other state agencies. Should it find a certain outcome or event was not reported as an incident, it may result in another type of investigation.
WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

☐ Facility Risk Manager
☐ Hospitalist’s Company
☐ Hospitalist facility based medical director

11. COMMUNICATION WITH PATIENTS AND THEIR FAMILIES

The Hospitalist has a unique physician-patient experience in that, usually, each patient admitted to his or her service is a “new” patient. The patient has never met the physician before. The physician has never seen the patient before. The patient’s family has never met the physician before – this stranger who will now be in charge of their loved one’s care and well-being. There is no existing physician-patient relationship, but rather a brand new one that begins upon each patient’s admission. There is no rapport built on years of interaction as physician and patient. The physician has limited data on which to base an assessment of the patient’s level of understanding. From a communication perspective, the scenario couldn’t get much worse... strangers in a strange environment, thrown together in the face of some of the most emotional, stressful conditions that a human being can face – illness, pain, hospitalization, possible surgery, and many, many unknowns. And it is a scenario that repeats itself for the hospitalist every day, with every admission.

Studies have shown that effective communication between physician and patient not only builds trust and rapport – the foundation for a good physician-patient relationship – but can also improve patient compliance, increase patient and physician satisfaction, lead to better treatment outcomes, and reduce a physician’s risk of being sued for medical malpractice. But, truly effective communication is difficult in any relationship and in any setting. And, as might be expected, studies on physician-patient relationships and rapport all agree that the amount of patient trust and communication effectiveness is directly proportional to the length of the physician-patient relationship – the longer the relationship, the better the rapport between physician and patient. The Hospitalist, therefore, is at a definite disadvantage in that there is little enough time to adequately gather relevant clinical information on which to base the patient’s care, much less use up some of that limited time to build this foundation of trust and rapport with patients and their family.

For this reason, it is necessary to make the most of any initial interactions. As the old saying goes, “You only get one chance to make a good first impression.” And for the Hospitalist, this first chance to communicate with a new patient and the patient’s family is inherently fraught with challenges and barriers to effective communication. So how does a Hospitalist get the information he or she needs, quickly; and still end up being perceived as a caring and competent physician who the patient trusts to help him and who the family members believe will “take good care of Dad”? There is no question that this is a challenging task, but the positive overall effects of good physician-patient communication make it worth the effort.

There are many barriers to good two-way communication between patient and Hospitalist, any one of which can lead to a mere misunderstanding or all the way to a complete communication breakdown: language barriers, patient’s level of understanding, cultural and language differences, gender differences, communication style differences, the patient’s altered mentation from his or her illness, condition, or medications, time constraints, anxiety or emotional stress. The resultant poor
communication can seriously jeopardize the patient’s care and well-being. These barriers can result in misdiagnosis or mistreatment, adverse drug events, medical errors, patient injuries, unanticipated results, patient dissatisfaction, poor patient compliance, and ultimately, poor outcome of care. When there is no rapport and poor communication between patient and Hospitalist or between the patient’s family members and the Hospitalist and something does go wrong or there is an unexpected outcome, there is a much higher likelihood that the patient and family will think “SUE!”

An article entitled, Physician-Patient Communication: Enhancing Skills to Improve Patient Satisfaction,\(^1\) presented the result of a study of physician behavior to determine how different behaviors during physician-patient interaction related to clinical outcomes and either promoted or hindered patient satisfaction with the interaction. The following outlines the identified verbal and nonverbal behaviors shown to influence patient responses.

**Physicians' Verbal Behaviors Promoting Positive Interpersonal Relations**
- Empathy
- Courtesy/friendliness
- Attentiveness during history taking
- Support/reassurance/positive reinforcement regarding patient actions
- Encouragement of patient questions
- Laughter as a tension release

**Physicians' Verbal Behaviors Enhancing Information Exchange**
- Listening
- Giving health education
- Clarifying statements
- Summarizing patient statements
- Talking at patients' level
- Addressing patients' daily lives, problems, social relations, and emotions

**Physicians' Nonverbal Behaviors Associated With Patient Satisfaction**
- Head nodding
- Leaning forward
- More direct body orientation
- Uncrossed arms and legs
- Less mutual gaze

**Physicians' Behaviors Associated With Reduced Patient Satisfaction**
- Excessive focus on medical questions
- Showing tension, anger, or nervousness
- Allowing interruptions

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Withholding information or explanations
Leaning back or angled away from patient
Frequent touching
Unduly dominant approach
Directive behaviors

Reviewing the elements identified by the research can be a useful reminder of what works and what does not work in physician-patient communication.

**RISK EXPOSURES:**

- Negligent or Delayed Treatment or Diagnosis
- Medication Errors
- Patient non-compliance
- Patient injury or death
- Increased length of stay
- Increased likelihood of litigation if all does not go as planned

**RISK MANAGEMENT STRATEGIES:**

The topic of effective physician-patient communication can and has filled volumes of journals and books. There are many, many experts on the subject who have many, many recommendations and strategies for improvement. There seem to be two things the experts do agree on: (1) a person isn’t born a good communicator; and (2) effective communication skills can be developed and learned. That’s good news for the physician who wants to be a better communicator. Once equipped with the knowledge, tools, and skills that enhance communication, a physician will feel more confident about his or her ability to deal with a patient or patient’s family member – no matter how many barriers are present, no matter how emotion-charged the situation. Medical schools and teaching institutions obviously agree, because patient-centered communication is appearing on an increasing number of curricula as mandatory for medical students and/or residents.

Of particular interest are the results of a recent survey of hospitalized patients and their physicians to determine the effectiveness of physician-patient communication. The findings demonstrated considerable, fundamental gaps in patients’ knowledge of their illnesses. Despite the fact that this information was indeed communicated by their physicians, nearly 40% of patients surveyed were unaware of their diagnosis and 90% were unaware of potential side effects of medications they were taking. On the other side of the physician-patient relationship, the physicians surveyed tended to overestimate patients’ understanding of their diagnosis and care. Obviously, there exists quite a difference between patient and physician perception when it comes to assessing a physician’s ability to communicate effectively.

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CASE EXAMPLE:

A 67-year-old Asian woman, Kye Chin, was first seen by Dr. Deiter, a Hospitalist, soon after her admission from the ED around 6PM. At that time, she was alone and in soft restraints, somewhat agitated and anxious and having some respiratory distress. She had been brought to the hospital via ambulance after a neighbor found her lying at the bottom of her front steps, obviously very confused and agitated, and unable to stand, and called 9-1-1. In the ED, a left femoral neck fracture was diagnosed, and she was admitted for open reduction/internal fixation by an orthopedic surgeon. The Hospitalist and orthopedic groups had a co-management agreement where the orthopedic group’s surgical patients were medically managed during admission by the hospitalists. The ED resident had also listed “Dementia” as a secondary diagnosis. Dr. Deiter tried to talk to the patient but her speech was garbled, and it was obviously to him that she was speaking a language other than English. He asked an RN to have Social Services attempt to locate an Asian language translator and to determine if the woman had any family who could consent to the surgical repair.

A translator arrived around 8PM but was unable to really communicate with the woman. She said the woman’s dialect was unfamiliar to her and although they could make out some of each other’s words, true communication failed. The translator said she thought the patient said, “fell” or “fall” and “daughter,” but she couldn’t be 100% sure. The Hospitalist and translator attributed the woman’s inability to communicate clearly to her dementia.

Several hours later, just before midnight, Social Services provided Dr. Deiter with a phone number for the patient’s daughter who was out of town on business. He called the daughter immediately and explained the situation. He informed the daughter that because of her mother’s dementia, the surgeon would like to explain the planned procedure to the daughter and get her consent to operate. The daughter was very upset and said she would cut her business trip short, head home immediately and would probably be at the hospital around 5AM. Dr. Deiter contacted the orthopedic surgeon who said he would be in the hospital by 6AM to speak with the daughter and schedule Mrs. Chin’s surgery for later that morning.

At 5:30AM, the Hospitalist was paged and told that Mrs. Chin’s daughter had arrived, and he met her in the visitor lounge. While they waited for the orthopedic surgeon to arrive, he explained how her mother got to the hospital, what had transpired since admission, and what was planned to repair the hip fracture. He asked her if she had any questions. She said, “Why do you keep talking about dementia . . . saying that my mother couldn’t consent to the surgery herself because she’s DEMENTED?? You said that on the phone to me last night too. My mother doesn’t have dementia! She never had dementia! She was perfectly fine when I spoke with her at lunchtime yesterday.” On further questioning, Dr. Deiter was able put together a more complete medical history and learned that Mrs. Chin was taking a blood thinner because of a cardiac stent placement three years earlier.

By the time the physician got back to Mrs. Chin’s room, she was being attended to by an RN who said the patient just had a seizure and lost consciousness. Dr. Deiter ordered a STAT CT of the head. The CT scan demonstrated a non-displaced skull fracture and subdural hematoma caused by an intracranial bleed. Neurosurgery was called and the patient was taken to the OR for stereotactic aspiration and thrombolytic therapy. She made a good recovery but was left with some minimal, but permanent neurologic deficits. She had a good result from the surgical repair of the hip fracture, but she was never able to live independently again and was discharged to an assisted-living facility.
APPLYING RISK MANAGEMENT STRATEGIES:

The case study was a difficult case with many issues beyond physician-patient or physician-patient family communication problems. However, it does have some good teaching points. The ED resident’s failure to diagnose the patient’s head trauma got the ball rolling. He diagnosed her confusion and garbled speech as “dementia” without ruling out any physical cause, and focused on her more obvious hip injury. But keep in mind that this patient arrived at the hospital alone, agitated, and seemingly confused – a very difficult, vague presentation. Whether or not he recognized that she was speaking a language other than English was unclear, but no translator was called prior to admission. [See also 12. Cultural Competency and Language Services]. The “dementia” diagnosis went with her to the floor and helped to mislead the Hospitalist’s initial evaluation of the patient. He did, however, get a translator and did eventually get to speak to the patient’s daughter. The translator was of minimal help. It could be argued that if this translator was not fluent in the patient’s dialect, additional efforts should have been made to find one who was. Again, the incorrect diagnosis of “dementia” led everyone astray again.

There are simple things a Hospitalist can do to enhance the level of communication during that initial meeting with the patient and / or the patient’s family and throughout the patient’s hospitalization – things that will be perceived as more patient-centered, caring, and empathetic. These include:

- Introduce yourself to the patient and family members present, explain who you are and what you, as a Hospitalist, will be doing for the patient during his or her admission.
- If possible, sit down when you’re talking to the patient or family. This will make the situation seem more relaxed and less rushed. If there are no available chairs, perching on the edge of the patient’s bed is an option.
- Avoid medical jargon or technical terms that will distance you from the patient. Keep it simple and provide explanations when necessary. Information conveyed at or near the patient’s level of understanding will be better received and can help reduce stress and anxiety.
- Solicit the medical information you need from the patient. Open-ended questions work best. But then allow the patient or family to ask you questions too, without interruption.
- Always, always, be honest and open with your patients. Let them know this is your policy and, in return, you ask that they will always be honest with you.
- Confirm understanding. Ask the patient, “Do you understand the procedure? Do you or your family have any questions for me?”
- While the patient or a family member is speaking, listen quietly and make eye contact, providing non-verbal feedback such as nodding, to demonstrate attentiveness.
- Once more – LISTEN to what the patient is telling you. He is providing the building blocks for your diagnosis, he’s telling you his symptoms, and he’s building his relationship with you. Don’t be thinking about your response or the next question you have for the patient, or the many other patients you have to see while the patient is talking to you. Half of being a good communicator is being a good listener.
- “Listen” with your eyes as well. Be attentive to the patient’s body language and facial expressions. Non-verbal cues can be very telling. Does the patient avoid eye contact? Does the patient always look at her husband before answering your question? Your
recognition of and appropriate response to these non-verbal cues will convey your empathy and concern. “I see you are very anxious about your surgery.”

☐ Explain exactly what you intend to do, what your treatment plan is, the rationale for that plan, and what you hope will be the outcome of that plan. That will result in better understanding and reasonable expectations on the part of the patient and family.

☐ Ask the patient and family to designate one or two family members to serve as the physician’s point of contact – with the patient’s permission / authorization, of course. Offer to regularly contact this person or persons during the patient’s admission to provide updates on condition and treatment. This can be a win-win for physician and family. It can eliminate the number of phone calls from multiple family members so the physician will not have to repeat the same information multiple times. It will help protect the patient’s privacy and prevent inadvertent unauthorized release of PHI – a HIPAA violation. It will keep the patient and patient family informed. And it will strengthen the Hospitalist’s relationships with this patient and family and build that important rapport by showing that the physician understands what the family is going through while “Mom” is in the hospital and how important it is to keep the informed about her while she’s there.

NOTE: There will always be situations where a patient’s family is non-cooperative with the Hospitalist and repeated efforts to communicate just fail miserably. The Hospitalist is in a situation where he or she will often be the bearer of bad news – delivering devastating test results, poor prognoses, unanticipated outcomes, or even patient death. These are difficult, stressful, and emotional situations for all concerned and reactions are impossible to predict. If a Hospitalist is faced with situations where he is concerned about the family’s reaction or if a dysfunctional family member is disruptive, disturbing to the patient, or in any threatens the well-being of the patient, the physician, or any member of the healthcare team, the hospital risk management department should be contacted immediately. In some cases, the risk manager may be able to facilitate a discussion between the patient, family members, Hospitalist and other members of the care team. In others, doing what is best for the patient may necessitate transfer of the patient’s care to another facility or another provider. [See also 15. Disclosure and Apology and 17. Terminating the Physician-Patient Relationship]

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

☐ Hospital Risk Management Department
☐ Hospitalist’s Company

12. PATIENT AND FAMILY COMPLAINT MANAGEMENT

Patients and families unfamiliar with Hospitalist care may be unsettled or upset by the prospect that a “stranger” is managing patient care. Because they have an element of concern about this unknown care provider, patients and families may question every test, every medication or treatment. They may also complain when Hospitalists do not heed their requests for certain tests or contacting a specialist in the community. When questioning turns to distrust, patients and families may complain
to nurses or to hospital administration. Although some complaints may be legitimate, many situations can be avoided by establishing rapport with patients and family members and setting reasonable expectations about the Hospitalist-patient relationship.

**RISK EXPOSURES:**

- Negligence treatment
- Negligent Consent
- Unauthorized treatment
- Formal patient complaints and grievances with the hospital
- Adverse publicity for facility and physicians
- Breach of contract between the hospitalist group and the hospital for substandard practice

**RISK MANAGEMENT STRATEGIES:**

Generally speaking, patient and family complaints can be avoided by utilizing good communication skills and setting reasonable expectations of care from the hospitalist system. No doubt, some patients and families may have read or heard negative stories about care that others have received from a Hospitalist. To avoid such situations, the Hospitalist group and the hospital should consider developing patient and family-focused information about the Hospitalist system. Such a document might include frequently asked questions or FAQs and who to contact if patients or families have concerns or complaints. This information might be made available as a flyer or brochure in local primary care practitioner’s offices or in the admissions and emergency departments. Similar text could be included on the hospital’s website or internal hospital television system. Additionally, Hospitalists should consider spending a few moments speaking with patients and family members about themselves and their role and responsibilities. Anticipating questions about contact with primary care providers and specialists in the community, Hospitalists may help ease uncertainty for patients and family members.

Specific risk management strategies include:

- During the first meeting with the patient and family introduce yourself and your role and responsibility.
- Explain the hospitalist system and how such physicians communicate with specialists and primary care providers in the community.
- Ask if they have any questions about the hospitalists’ care system.
- Provide patients and family members with information about hospitalists who may be coordinating care during the hospitalization.
- Work with hospital leadership to develop brochures, website information, and hospital television content about the hospitalist program.
- Recognize that information about the hospitalist program should include information for patients and families who wish to make complaints.
- Address patients and family concerns and complaints during the care giving process.
Notify the hospitalist company when formal patient grievances or complaints have been made regarding care you provided during the hospitalization.

Follow applicable state law and hospital policy and procedure for declaration of death.

CASE EXAMPLE:

Rick Property, MD was on the medical-surgical unit when Don Vivian was admitted with severe pain and cramping in his right calf. Mr. Vivian, a long-distance runner and skiing coach, had collapsed at mile 20 during a marathon run in town. Seven years earlier, Mr. Vivian had fallen while training for a long-distance run and sustained a torn ACL. He had also experienced cramping during a sprint series during a heat wave. Each time, Mr. Vivian had been treated by a physician well-known as a Sports Medicine expert. “So what type of experience do you have in Sports Medicine, doctor?” asked Mr. Vivian. He continued, “You know that I am in training for the New York City Marathon. I do not want to do anything to mess up my training schedule.” Dr. Property responded, “I am not a Sports Medicine specialist. I am a Hospitalist. I will be responsible for your medical care while in the hospital. If you need a Sports Medicine or Orthopedic specialist, certainly I can request such a consultation. With your permission, I would like to contact your primary care provider and your Sports Medicine specialist in the community. I would like to talk with them about my findings.” Don Vivian did not like the response. “No doctor, I don’t want you doing anything with my care. I want my own doctor. I do not need anyone I don’t know or trust messing up my care,” he said. Dr. Property replied in a stern manner, “Mr. Vivian, this hospital uses a Hospitalist system. That means that hospital-based physicians manage your treatment as an in-patient. In this instance, I am one of six doctors who rotate in the delivery of hospitalist care. I will be treating you, not your doctor in the community.” Mr. Vivian stood up and said, “Well, if that is the case, I am leaving right now. I will take my chances with my own doctor in the community.” Dr. Vivian called a friend who helped him leave the hospital. Dr. Property wrote a short note in the patient record, “Pt. left against advice.” Two days later, Mr. Vivian submitted a formal complaint to the hospital about the attitude and demeanor of Dr. Property.

APPLYING RISK MANAGEMENT STRATEGIES:

- Do not assume a patient understands the Hospitalist care system.
- Take the time to explain to the patient the role and responsibility of the Hospitalist during the admission.
- Provide written information about the hospitalists involved in the system.
- Establish a rapport with the patient.
- Address any concerns or reservations about Hospitalist care with the patient.
- Avoid use of terminology, demeanor or tone of voice that could cut short effective communication with the patient.
- Follow hospital policy and procedure for documenting a patient’s decision to leave against advice.
- Report to the Hospitalist company any formal patient complaints or grievances that have been filed with the hospitalist.
Follow Hospitalist company guidance in working with the hospital to respond to formal patient complaints or grievances.

Follow a similar approach to complaints or grievances filed by patient families with the hospital.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Hospitalist’s Company
- Hospital Risk Manager

13. CULTURAL COMPETENCY AND LANGUAGE SERVICES

Understanding the cultural beliefs and values of a patient is important in the delivery of quality, safe patient care. Cultural issues are often present when a patient presents with limited English proficiency. The inability to appreciate cultural barriers to healthcare and language challenges can interfere with patient treatment. The issue was recognized at the level of federal law a decade ago when 14 standards were issued on cultural and language services in the healthcare setting. Some states have enacted laws requiring cultural competency or language interpretation. For example, in New Jersey as a condition of licensure for physicians they must complete education on the subject of cultural competency. Like other healthcare professionals, Hospitalists should not impose their cultural beliefs on a patient. When treating a patient for whom English proficiency is in doubt, it is prudent to obtain the services of a qualified interpreter unless the Hospitalist is linguistically capable in the patient’s language. In those situations in which a surrogate is responsible for making treatment decisions on behalf of a patient, similar concepts apply with regard to language interpretation. Most hospitals have some process in place for language services. Staff members who have demonstrated proficiency in language services may be called upon to facilitate a discussion with a patient or surrogate. In other instances, “Language Line” services may be used for this purpose. The failure to understand and address cultural and language differences can lead to lack of treatment adherence or inappropriate care. The absence of language accommodation may also trigger violations of federal law.

RISK EXPOSURES:

- Negligence treatment
- Complaints to relevant federal agencies responsible for enforcement of cultural and language service standards.
- Litigation involving violations of federal laws directed toward patients’ rights.

RISK MANAGEMENT STRATEGIES:

Generally speaking, an effective approach to cultural and language accommodation involves an understanding of the patients’ cultural and language needs. Such information may have been collected as part of patient demographic information during the admission process. In other
situations, it may not be clear until the Hospitalist engages the patient or surrogate in a conversation. Some strategies to consider include:

- Review the patient’s demographic information in the medical record to determine if cultural or language needs have been identified.
- In the absence of information in the medical record on culture and language needs, ask a series of questions that may help identify such requirements.
- Obtain suitable language interpretation services when requested to do so by the patient or family.
- Obtain suitable language interpretation services when as a care provider you believe such assistance is needed.
- Request with management of cultural accommodation in the care of the patient from social services or clergy.
- Use chain of command if requests for language accommodation are denied.

CASE EXAMPLE:
Juanita Quellar came to the United States from Peru five years ago. She had obtained a green card through the lottery system and since her arrival; she had worked as a seamstress. Juanita had taken courses in conversational English, but her heavy accent made it difficult to understand her. Juanita was admitted to the hospital after she was injured at a local grocery store by a shelf of heavy cans falling on her right shoulder. Juanita was found to have a dislocated shoulder and in falling, she fractured her right wrist. Diagnostic imaging revealed that she needed surgery to repair the wrist fracture. A Hospitalist was responsible for the patient’s medical management. Although the Hospitalist had a working knowledge of Spanish, his ability to communicate medical information was of concern to him. He asked the nurse manager to arrange for a language interpreter. A person from Dietary was sent to the patient’s room to serve as interpreter. After a few minutes, it became clear to the Hospitalist that the well-intentioned dietary aid was not proficient as a medical interpreter. He took her outside the patient’s room and said, “Thank you, but I need a real language interpreter.” He discussed the matter with the nurse manager who said, “Sorry, doctor. That is the best that I can do.” The Hospitalist indicated that he would “take it from here.” The Hospitalist contacted the Director of Nursing (DON) and explained the situation. The DON replied, “Doctor, you took the right approach. Thank you for letting me know about this situation. I will come to the patient’s room and initiate the web-based service for you.” On questioning the patient, the interpreter learned that, as part of her native culture, Ms. Quellar had some specific requests, which were easily accommodated. As it turned out, Juanita Quellar was also illiterate in both Spanish and English. The qualified interpreter also read the consent form to Ms. Quellar in Spanish. The patient was relieved and thanked the Hospitalist and the DON. The use of a language interpreter was documented in the progress notes and on the consent document. Ms. Quellar underwent successful surgery. At discharge, the web-based language interpreter service facilitated the discussion between the patient and a member of the nursing staff.

APPLYING RISK MANAGEMENT STRATEGIES:

- Become familiar with the policy and procedure of the hospital on language interpretation services and assistance with patient cultural needs.
- Verify language and cultural needs of the patient.
- Make certain that the individual serving as a language interpreter assists in identifying cultural needs.
- Determine what can be done to recognize the patient’s cultural needs, once again, using the qualified language interpreter.
- Utilize chain of command when the level of service is not consistent with the needs of the patient in terms of language and cultural requirements.
- Include in the consent documentation when a language interpreter reads the content to the patient. Identify the name of the language interpreter and the language and dialect used in the patient’s case.
- Include in the discharge summary instruction documentation when a language interpreter reads the content to the patient. Identify the name of the language interpreter and the language and dialect used in the patient’s case.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:
- Hospitalist’s Company
- Hospital Risk Manager

14. COMMUNICATION WITH PRIMARY CARE PROVIDERS

Research has shown that patient safety and quality of care are more likely to be less than optimal at transition points in a patient’s care – that is, when the patient is moved from one care setting to another. Transitions can be out-patient to in-patient (e.g., a hospital admission) or vice versa (e.g., hospital discharge); from one in-patient setting to another (e.g., medical floor to ICU); or from one in-patient facility to another (e.g., hospital to skilled nursing facility). The Hospitalist’s course of involvement in the care continuum involves, at least, two major transition points: admission, the point where the hospitalist takes over the patient’s care, and discharge, where the patient’s care is transferred back to his or her primary care provider (PCP) by the hospitalist. Other significant transition points could occur in between, depending upon the patient’s condition and hospital stay.

Studies have also shown that communication (or a lack thereof) between PCP and Hospitalists can have a significant impact on the success or failure of a transition and the outcome of care. At any transition of care point, there is a need for transmission of information from one provider to another. If a PCP refers a patient for admission, it is the PCP who is the information provider to the hospitalist before or at admission. Once the patient is admitted, however, it is the Hospitalist who takes over as communicator – to the patient, the patient’s family, and other providers involved in the patient’s in-hospital care and, at discharge, the patient’s PCP. If the patient was admitted through the ED, then it is up to the ED physician to provide essential pre-admission information. In addition, it is prudent for the Hospitalist to contact the patient’s PCP to make sure there he or she has a complete and accurate medical history and medication list on which to base the patient’s medical management while hospitalized. If a good exchange of critical clinical information does not occur, patient safety and quality of care will be adversely affected, with the patient’s treatment and physical well-being jeopardized.
RISK EXPOSURES:
- Disruption in Continuity of Care
- Delayed treatment or diagnosis due to lack of essential information
- Unnecessary duplication of medical or diagnostic tests / efforts
- Drug-drug interactions or other medication errors
- Patient “lost” to follow-up or delayed follow-up post-discharge

RISK MANAGEMENT STRATEGIES:
A majority of the risks exposures listed can be mitigated by the development of good professional relationships between Hospitalists and the Primary Care Providers in the community who may refer patients for admission to the Hospital Medicine service. Good working relationships will result in good two-way communication of clinical information before and after hospitalization of the PCPs’ patients. Ideally, the Hospitalist and referring PCP will agree on what information is required for optimal patient care.

Remember that good communication between Hospitalist and PCP is in the patients’ best interest and vital to their safety. In addition, this two-way exchange of information is critical to both Hospitalist and PCP as the foundation from which differential diagnoses and subsequent treatment decisions are built. A hospital will have its own policies and procedures with regard to the accumulation and exchange of patient information exchange, and compliance on the part of all physicians on staff will be expected. Failure to do so can have serious adverse effects on patient care and negative repercussions professionally.

The following are some risk management strategies that will help ensure that the needs of all parties involved in the care of a patient are met throughout the in-patient episode of care:
- Consistently follow a mutually agreed-upon communication method with the PCPs in the community; e.g., phone, fax, secure e-mail, or, if absolutely necessary, “snail mail.”
- Adhere to defined communication contact points during a patient’s hospital stay (i.e., when the hospitalist will ALWAYS contact the patient’s PCP and vice versa): e.g., within x hours of admission, within x hours / x days of discharge, or when patient status / diagnosis changes, etc.
- Define deliverables: e.g., a PCP referring a patient for admission will provide the Hospitalist with the patient’s medical history, medication list (including allergies), advance directives, and any other information pertinent to the present need for admission; in return, the Hospitalist will send the PCP a preliminary discharge summary at the time of patient discharge and/or a copy of the actual discharge summary as dictated for the patient’s hospital record within x days of patient discharge.
- When a patient’s PCP is not local, that physician’s contact information should be routinely collected from the patient or the patient’s representative on admission so that the Hospitalist may contact him or her if necessary during the patient’s hospitalization, discuss discharge plans and recommended post-discharge care, and / or send a discharge summary / report upon the patient’s discharge.
CASE EXAMPLE:

An elderly woman, Tillie Wilson, was brought to the hospital by ambulance after a friend found her confused and complaining of chest pain and shortness of breath. She was admitted through the ED for EKG evidence of an acute myocardial infarction (AMI). Mrs. Wilson was visiting from out-of-town. The Hospitalist, Dr. Newton, attempted to put together a history from the patient, who was clearly confused. Mrs. Wilson’s friend was not aware of her medical history other than knowing she had “high blood pressure,” may have had a heart attack in the past, and that her only relatives were a niece and nephew somewhere in California. The friend had found several pill bottles in the patient’s purse, and, from those, Dr. Newton was able to confirm that the patient was diabetic and was on a beta-blocker and diuretic. The prescribing physician was tracked down by the Hospitalist for other pertinent clinical information. Mrs. Wilson had a stent inserted to alleviate the blockage. While in the hospital, Plavix was added to her medication regimen. On discharge, she was given a prescription for a two-week supply of Plavix and was told to follow-up with her PCP for cardiac rehab and ongoing medical management. Since she was from out-of-town, Dr. Newton gave her two copies of the discharge instructions, one for her and one to take to her PCP back home.

Unfortunately, the patient did not go straight home, but continued her planned vacation. By the time she returned home, she had exhausted the two-week supply of Plavix five days earlier. She called her PCP’s office, telling the receptionist that she was supposed to make a follow-up appointment after her recent hospitalization elsewhere, and she was given an appointment in three weeks. Prior to that appointment, the patient suffered another MI that proved to be fatal.

Mrs. Wilson’s relatives brought suit against Dr. Newton for failing to adequately communicate with the patient and her PCP. The Hospitalist’s discharge instructions -- verbal and written on the discharge summary -- allegedly did not convey to the patient the importance and urgency of following up with her PCP, and the hospitalist did not take the time to determine that the patient was not going directly home upon discharge. It was further alleged that Dr. Newton had not adequately educated Mrs. Wilson about why she needed to be taking a blood-thinner and the need for close monitoring. In addition, the Hospitalist did not contact the PCP at the time of discharge, did not send the discharge summary or the subsequent discharge report to the patient’s PCP, so critical information was not conveyed.

APPLYING RISK MANAGEMENT STRATEGIES:

The best way to prevent breakdowns in communication that jeopardize patient care and patient safety is to be proactive in your communicating with referring PCPs or PCPs who will assume care of a patient post-discharge.

Obviously, in the case presented, the patient and her PCP were from out-of-town and were unknown to the Hospitalist. In such cases, communication with the PCP is more difficult but can be even more critical since there was no existing PCP-hospitalist relationship; both physicians were complete unknowns to each other in terms of patient care and communication styles. The discharge summary and report should have been sent directly to the physician as required by hospital policy rather than having the patient hand carry the summary. Ideally, the Hospitalist should have spoken to the patient’s PCP informing him of the specific discharge plans, the addition of an anticoagulant to her medications, the need for cardiac rehab, and any other follow up that the Hospitalist believed the patient would need based on her in-patient experience and her condition at discharge.

See also APPENDIX D, Handoffs and Sign - Outs Resources
WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Hospitalist’s Company
- Hospital Risk Manager

15. COMMUNICATION WITH SPECIALISTS AND OTHER PROVIDERS

During any patient’s hospitalization, the Hospitalist serves as the “traffic controller” – directing and coordinating the many physicians and other healthcare providers involved in a patient’s care between admission and discharge. How many and what particular specialists are involved will depend on a particular patient’s needs. The role of the Hospitalist in a patient’s care will also vary. If a patient was admitted for surgery, for example, the Hospitalist would provide general medical oversight during the patient’s admission, i.e., co-management. In a complex medical case, the Hospitalist may consult with several medical specialists who may all play a significant role in the care of a patient, but the Hospitalist will usually be the one making the major decisions regarding care, consultations, transfer, and discharge.

In this role, a major portion of a Hospitalist’s day is spent communicating with the various key members of each patient’s care team to exchange important clinical information. But too often, communications in the healthcare setting are less than optimal. Orders are lost; lab results don’t get put on the patient’s chart; an illegible order results in an incorrect dosage and subsequent adverse drug event; a consultant write the post-discharge orders he said he would; the Hospitalist thinks the surgeon is ordering the patient’s post-op chest x-ray and the surgeon thinks the Hospitalist is taking care of that; and on and on. Good team communication – verbal and written – is absolutely essential to the delivery of optimal patient care and patient safety and, based on the number of Sentinel Events and malpractice claims attributable to miscommunication, good and timely information exchange among the care team members is obviously lacking.

Coordination of care is important in any healthcare venue when more than one physician is involved in a patient’s care, and that coordination becomes more difficult with any addition to the care team. All members of a patient’s care team have to be clear on what is expected of them, what their role is in that patient’s care – not only in their own eyes, but in the eyes of the patient, the patient’s family, and their fellow team members. This is where the Hospitalist assumes the role of “traffic controller” – in charge of coordinating care to make sure the care process flows smoothly, making sure the necessary team has been assembled to meet the patient’s needs, and directing each member of the team so that those needs are met efficiently and safely and in a timely manner. Having standard policies and procedures in place that speak to “who’s in charge” under various circumstances and specialty situations and the responsibilities associated with being in charge will improve continuity of care, the quality of care, patient safety, and treatment outcomes while reducing liability risk for the hospitalist and the facility.
RISK EXPOSURES:
- Disruption in Continuity of Care
- Delayed diagnosis or treatment due to poor communications
- Poor hand-offs resulting in patient harm / injury
- Claims of abandonment
- Hospital liability in on-call physician refusal to see patient

RISK MANAGEMENT STRATEGIES:
Communication breakdown has been found to be a major contributing factor in a significant number of medical malpractice cases. It has resulted in delayed treatment or diagnosis, misdiagnosis, unnecessary or incorrect treatment and can have serious patient safety ramifications. Unfortunately, despite its identification as a significant risk and the widespread dissemination of this fact by specialty organizations, accreditation organizations, professional liability insurers, and risk management professionals, the problem persists. With the myriad communication devices and tools available to facilitate and improve information exchange, the problem has not improved. The Joint Commission specifically requires an accredited facility to have systems in place to reduce communication breakdowns, particularly targeting hand-offs in patient care, but yet this issue has been identified as a leading factor in Sentinel Events reported to the Joint Commission.

Time constraints, environmental distractions, stress, interruptions, volume of information to be communicated, fatigue, language, culture, communication styles, and hierarchy are some of the more commonly cited factors leading to miscommunication or complete communication breakdown. Putting any safeguards, standards, policies or procedures in place that reduce or mitigate these factors will help to ensure that the providers involved in a patient’s care are exchanging information vital to the patient’s safe and successful care and that all are aware of his or her particular role in the patient’s care.

A potentially serious medical-legal issue involving Hospitalist-specialist relations has been reported with some frequency, particularly when the specialist involved knows that a Hospitalist is “in the house.” When the on-call specialist is called and asked to come in to see a patient by nursing personnel or the Hospitalist on duty, he or she refuses to come to the hospital -- deferring to the in-house Hospitalist or advising nursing personnel to contact the Hospitalist rather than coming in himself or herself. Regardless of the presence of a Hospitalist, if the on-call specialist is asked to come in the hospital to see a patient, he or she has a duty to come in. Obviously, if the situation could be handled by the Hospitalist, the specialist would not have been called. Therefore, refusing to come in to see the patient under such circumstances could result in charges of abandonment against the on-call specialist and potential liability for the facility. Hospitalists who experience this problem should report the specialist’s unacceptable behavior to the appropriate department chairman.

CASE EXAMPLE:
A 66-year-old patient, Joanna Line, was admitted to the Hospitalist service via the ED after her daughter found her weak, semi-conscious, and disoriented and called 9-1-1. On admission, the Hospitalist, Dr. Amir, also noted shortness of breath, dehydration, and tachycardia despite the presence of an implantable cardiac defibrillator (ICD). Mrs. Line’s daughter recalled that this had
been put in “at least 5 years ago” by a cardiac surgeon in another state because of her mother’s “irregular heart beat.” Dr. Amir suspected a mechanical failure of the defibrillator and told a nurse to get someone from Cardiac Surgery to see the patient in consultation, figuring surgery would be needed to replace the malfunctioning ICD. The following day, some 18 hours post-admission, another Hospitalist noted that the patient had not yet been seen by Cardiac Surgery, and this time personally called one of the Cardiac Surgeons requesting that the patient be seen “as soon as possible.” Apparently, the prior day’s consult written by Dr. Amir had “slipped through the cracks.” However, before a physician from the Cardiac Surgery service saw Mrs. Line, she went into cardiac arrest. Despite prompt resuscitative efforts, the patient died. Mrs. Line’s daughter brought suit against the hospital and Dr. Amir for delayed treatment that resulted in her mother’s death.

APPLYING RISK MANAGEMENT STRATEGIES:

As discussed above, there must be a infrastructure or system in place and routinely used for critical clinical information to be communicated routinely between all providers involved in a patient’s care, both verbally and through documentation of key information in the patient’s chart. All members of the team must be committed to the system and consistently follow the procedures in place for communication pertinent clinical information about their shared patient. Communications policies and procedures should be in place that speak to high-risk points for miscommunications or communication failures during the patient’s hospital stay, such as hand-offs, transfers, and discharge. And, again, everyone has to be onboard to prevent system failures that can jeopardize patient safety.

Some procedures / tools that facilities have found to be successful in assuring optimal communication between the members of a patient’s care team are:

- Always identify who’s in charge for every patient. Is the Hospitalist heading up the team and coordinating care? If a surgical patient, is the surgeon “in charge” with the Hospitalist serving to oversee the patient’s general medical management during admission for surgery? Is a specialist who is consulted expected to assume the primary care giver role? This should be communicated to every member of the patient’s team, upon admission and if any circumstances during admission warrant a change in this regard to avoid any confusion or misunderstandings that could lead to any disruptions in the continuity of care and patient harm. The physician in charge should routinely review the patient’s medical record to ensure that all orders have been carried out in a timely manner and follow-up on any that have not.

- Make sure you familiarize yourself with the existing policies of the hospital with regard to established duties and responsibilities of physicians involved in patient care, including specialists, consultants, and Hospitalists.

- If the Hospitalists and surgical specialties co-manage surgical admissions, i.e., the Hospitalist manages the surgical patients’ medical conditions while their surgery and related issues are handled by the surgeon, it is best to have these arrangements worked out beforehand so that all parties involved agree upon their specific roles and responsibilities. Potential “gray” areas of management should be discussed (e.g., prophylactic antibiotics or anticoagulation management, discharge orders, pre-op assessments, etc.) and resolved. These arrangement terms should also be communicated to the medical and nursing staffs for optimal patient care and safety and efficient delivery of care.
Consistently follow mutually agreed-upon communication methods with specialists with whom you regularly consult, whether by phone, email, texting, or in the patient’s record. Consistency is extremely important in preventing communication breakdowns.

Briefings or “Report” – pulling together the various members of the patient’s care team for a few minutes on a daily basis, e.g., at the beginning of each shift to review the patient’s current status, care plan, etc.

Use Situation-Background-Assessment-Recommendation (SBAR) or another similar communication tool throughout the facility so that everyone is communicating patient information in a consistent and succinct way. SBAR stands for:

- **Situation** -- what is going on with the patient?
- **Background** -- what is the clinical background or context?
- **Assessment** -- what do I think the problem is? and
- **Recommendation** -- what would I do to correct it?

SBAR can be the basis for verbal communication, chart documentation, and even used to communicate patient information at a team briefing as described above.

If the facility opts not to use SBAR, it would be prudent to develop a list of the specific information that should always be transmitted during hospitalist-specialist or hospitalist-hospitalist communication or at a hand-off in a patient’s care. For example: patient diagnosis, condition / status, any recent changes in the patient’s condition or treatment plan, signs that may indicate an impending problem or change in condition, outstanding test results, etc.

Communication failures between a patient’s various physicians and care givers as a patient safety issue were recently addressed by the Joint Commission’s Center for Transforming Healthcare in its Hand-off Communications Project. This issue was targeted after being repeatedly identified as a leading factor in Sentinel Events reported to the Joint Commission. The Center for Transforming Healthcare reported that defective handoffs were reduced by 52% in the ten hospitals and health systems who voluntarily participated in the project when unsuccessful hand-offs were targeted by the Center’s SHARE solutions. While the Center’s project focused on communication breakdown at the time of patient “hand-off” – the point when responsibility for a patient is transferred or handed-off – its recommendations can be applied generally to any communication among the various members of a patient’s care team:

- **Standardize** critical content, including patient’s history with an emphasis on key information
- **Hardwire** within your system by using standardized forms, methods, and checklists
- **Allow** opportunity to ask questions
- **Reinforce** quality and measurement by holding staff members accountable and using appropriate data
- **Educate** and coach by training staff about what a successful handoff is

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WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Hospital Risk Management Department
- Hospitalist’s Company

16. DISCLOSURE AND APOLOGY

After an unanticipated or adverse event, the Hospitalist should have a conversation with the patient and/or family or patient surrogate. The initial conversation should focus on the patient’s condition, and, when applicable, what to do alleviate the effects of the unanticipated or adverse outcome. It is acceptable to say to the patient, family or surrogate that you are sorry that the unanticipated or adverse outcome took place. Additionally, it is acceptable to discuss specific needs for the patient or family or surrogate. This may involve hotel arrangements for an immediate family member, or, in the case of a patient’s death, assistance in contacting clergy or funeral directors. Once details emerge about the likely cause of an unanticipated or adverse event, it is prudent to have a follow-up meeting with the patient and family or surrogate. At this stage, a more detailed explanation would be provided to them. During each encounter with the patient and family or surrogate, it is useful to establish specific goals for the disclosure discussion and to answer any questions they may have about the event. Each disclosure discussion should be documented in accordance with hospital policy and procedure and the terms of the contract between your hospitalist group and the acute care facility. Disclosure discussions can be filled with emotional dialogue, tears, and anger. For the hospitalist involved in such situations, the prudent approach is to remain calm, demonstrate empathy, and to provide factual information. Rather than guessing or speculating, the role of the hospitalist is to provide fact-based information. After the disclosure discussion, many hospitals encourage participants to take part in a debriefing discussion and to take some time to relax before resuming a hectic schedule. Some may also benefit from discussion with a peer or a counselor to bring closure to the situation.

NOTE: Many hospitals have developed detailed disclosure policies and procedures that reflect the requirements of state law. For Hospitalists, it is important to become familiar with the requirements of state law as well as hospital policy and procedure on apology and disclosure.

RISK EXPOSURES:

- Negligence litigation
- Complaints to licensing board of unprofessional conduct.
- Breach of contract actions between the hospitalist group and the hospital.
RISK MANAGEMENT STRATEGIES:

Generally speaking, an effective apology and disclosure process involves a number of elements. Hospitalists have dual accountabilities to their companies and the hospitals in which they practice. As such, it is important to have one guidance document regarding responsibilities in the apology and disclosure process. Some strategies to consider include:

- Obtain guidance from Hospitalist company area medical directors or corporate risk management when a hospital requests your participation in an apology or disclosure communication with a patient or family or surrogate.
- Become familiar with applicable state laws and hospital policies and procedures on apology and disclosure.
- Understand responsibilities for apology and disclosure as stated in the Hospitalist agreement with the hospital.
- Follow established protocol for patient and family or surrogate communication for purposes of apology and disclosure.
- Document the apology and disclosure discussion in accordance with hospital policy and procedure.
- Follow Hospitalist company documentation requirements for apology and disclosure communication.

CASE EXAMPLE:

A 72-year-old patient, Joseph Stevens, was admitted to a medical-surgical unit after a fall at a local restaurant. The patient lost consciousness for approximately five minutes following the fall. A decision was made to admit Mr. Stevens for observation. He had experienced a similar fall three months earlier. In each instance, the patient sustained no head injuries.

Mr. Stevens had a history of diabetes and hypertension. Upon admission, his blood pressure was 165/103. However, when EMTs provided care to the patient at the restaurant, his blood pressure was 98/52. Because the patient’s blood pressure continued to fluctuate throughout the first few hours on the unit, the hospitalist, Dr. Shore, decided to order medication to stabilize the situation.

Dr. Shore’s attempt to reach the patient’s primary care physician was unsuccessful and the patient’s endocrinologist was on vacation. He was reviewing the patient’s record from the previous hospitalization when he was summoned to a cardiac arrest. Because there was a lot of activity on the unit, Dr. Shore did not have time to continue reading through the patient record. He decided to order medication considered appropriate for stabilizing the patient’s blood pressure.

Within 15 minutes of Mr. Stevens receiving the medication, a nurse paged Dr. Shore. The patient was experiencing asthma-like symptoms. Shortly thereafter, he stopped breathing. The code team responded and helped resuscitate the patient. Mr. Stevens regained consciousness and overheard someone in the room say, “Now that was stupid! Why didn’t anyone ask if this guy was allergic to any medication? There was no excuse for this event. This was an obvious allergic reaction. He is lucky to be alive.”
The episode was considered a serious event that triggered notification of the on-call administrator and risk manager. Mr. Stevens was moved to ICU. A preliminary review of the situation revealed that he had a documented allergy to the prescribed medication, but the Hospitalist had skipped the page with that information when he responded to the cardiac arrest.

The next morning, Dr. Shore was informed that he had to apologize to the patient and his family. “Doctor, they are really very angry, and they want answers. It is your responsibility to talk with them, to apologize, and to explain the situation. Just follow the hospital protocol,” said a representative from risk management. In this instance, the protocol required the Hospitalist and the Chief Medical Officer to participate in the discussion. It was agreed that the Hospitalist would review the facts and that the Chief Medical Officer would discuss the hospital’s response.

**APPLYING RISK MANAGEMENT STRATEGIES:**

- Notify the Hospitalist company of the adverse drug reaction and the facility’s order to complete an apology and disclosure communication with the patient and family.
- Obtain relevant factual information available at this stage of the adverse event review process. Utilize only this factual information in the apology and disclosure process. Do not speculate.
- Discuss role and responsibility for the communication process with the hospital representative who will participate in the discussion.
- Offer a sincere, empathetic apology and factually based explanation to the patient and family.
- Response to questions posed by the patient and family. Recognize that if they ask questions regarding the hospital’s role and responsibility, it is prudent for a hospital representative to respond to such queries.
- Follow both applicable hospital policy and state laws and regulations for apology and disclosure.
- Follow Hospitalist company guidelines or protocols for the apology and disclosure communication.
- Document the communication in accordance with hospital policy and procedure and the direction provided by the hospitalist company.
- If there is any disagreement about role and responsibility in the apology or disclosure process, contact the Hospitalist company area medical director or the corporate risk manager.
- Take advantage of debriefing opportunities and counseling following the adverse event and disclosure process.

See also **APPENDIX E, Checklist for Managing a Disclosure of Adverse Outcome**

**WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:**

- Hospitalist’s Company
- Hospital Risk Manager
17. CHAIN OF COMMAND – FACILITY / HOSPITAL AND HOSPITALIST’S COMPANY

A Hospitalist finds that a nurse is not carrying out his orders for care. In another situation, the hospitalist believes that the post-operative orders written by the surgeon are inappropriate yet the surgeon is adamant about his orders for treatment. What should the Hospitalist do in such situations? The answer can be found in a well-known process called “chain of command.” Most often associated with nurses who question medical orders, medication, or the actions of fellow nurses, chain of command is a clinical communication process that is available to physicians, nurses, pharmacists, and other members of the hospital care team. Although the specific steps may vary from one acute care facility to another, the process usually involves a discussion with the person who is either doing or not doing a specific task or whose order or lack thereof is a subject of concern. If the matter cannot be resolved at that level, the Hospitalist can escalate the issue to a higher level of authority in clinical supervision. This involves going up the “chain of command.” Parallel to this process, for Hospitalists, the Hospitalist company may also have a chain of command approach for escalating clinical issues above the level of the regional medical director. The failure to utilize the chain of command process can involve a number of risk exposures.

RISK EXPOSURES:

- Adverse outcomes
- Negligence litigation
- Corrective action under the medical staff bylaws
- Disciplinary action for unprofessional conduct
- State agency surveys and action for “immediate jeopardy”
- Accreditation body action for quality of care issues
- Breach of hospitalist contract

RISK MANAGEMENT STRATEGIES:

Chain of command provides a step-wise communication process to resolve disputes involving patient care and clinical services. The person who wishes to challenge or question treatment orders or clinical care should do so quickly, using good communication skills. The discussion should be free of personal attacks, threats, or intimidation. It should be focused on the issue, the question, and discussion of clinical care options. If the other person disagrees, the one challenging treatment or clinical orders has the option of escalating the matter to a higher level of authority. In the case of a nurse who disputes a Hospitalist’s order, the next few steps may progress from the unit manager, to the director of nursing or chief of clinical services, up to the chief medical officer. Similarly, a Hospitalist may use the chain of command process to address unresolved concerns in the nursing care provided to a patient. Risk management strategies for using chain of command include the following:

- Complete a timely communication with the care provider with whom there is a disagreement about treatment or clinical orders.
- Explain the rationale for the disagreement.
- Provide options for treatment or clinical care orders.
- Listen to the other party’s explanation.
☐ Use good communication skills.
☐ Do not use personal attacks, threats, or intimidation tactics.
☐ If the parties “agree to disagree,” use the chain of command process set forth in hospital policy and procedure.
☐ Follow the chain of command to the appropriate level of authority. Should the situation not be resolved within the structure of the hospital’s chain of command, contact the Hospitalist company regional medical director for assistance.
☐ Recognize that continuity of care should be maintained for the patient.

CASE EXAMPLE:
Dr. Rivers was very concerned about the way in which Tom Ryan, RN, was taking care of Mr. Nolan, a recent admission to the medical unit. Mr. Nolan, an 85 year-old with a history of low blood pressure and osteoporosis, was frail. He had slipped on a wet floor at the assisted living center and fractured his right wrist. Although the fracture did not require surgical repair, the patient had experienced some cardiac changes, and a decision was made to admit him for observation. Mr. Nolan was on medical unit because the cardiac telemetry wing was full. He was placed on remote monitoring. Dr. Rivers loved to care for elderly patients. He had gained a reputation of being very kindly and respectful; taking the time he needed to make his elderly patients comfortable with having a Hospitalist looking after them. Indeed, Dr. Rivers hoped one day to pursue a residency in Geriatric Medicine. He thought that Nurse Ryan was rather rough with the older patients. He had mentioned it to Nurse Ryan on more than one occasion. While walking past Mr. Nolan’s room, he observed Nurse Ryan repositioning the elderly man. Mr. Nolan winced with pain and said, “Easy son, easy. I have broken wrist. Just take it easy, will you?” When Nurse Ryan came out of the patient’s room, Dr. Rivers asked to speak with him in the staff office. Dr. Rivers said, “I know you mean well and that you have good technical skills. But you have got to be gentler with these frail patients. That man was correct when he told you to take it easy. He has osteoporosis. You could injure him with the wrong move in repositioning him.” Looking exasperated Nurse Ryan replied, “When did you start practicing nursing, doctor? You do not have a clue about our techniques. They do not teach it in medical school. I know what I am doing, thank you.” Remaining calm, Dr. Rivers said, “Nurse Ryan, I respectfully disagree. I am going to let someone above the two of us decide what to do.” Dr. Rivers then called the nurse manager for the unit. She agreed with Dr. Rivers. “Thank you for bringing the matter to my attention. This is not the first time someone has raised the issue. I will look after it, doctor.” Nurse Ryan was counseled by his supervisor. Since he was not receptive to constructive suggestions, he was given a formal warning and required to complete six hours of training on geriatric nursing. He was also required to demonstrate competencies on positioning patients with osteoporosis. Further, he was required to complete a course on anger management.

APPLYING RISK MANAGEMENT STRATEGIES:
☐ Follow the chain of command protocol.
☐ Address the issue with the individual with whom there is a disagreement about treatment or clinical orders.
☐ Escalate the matter to a person in authority if the disagreement cannot be resolved with the other party.
Invoke the chain of command promptly with a view toward maintaining continuity of care.
Never resort to personal attacks, threats or intimidation in the chain of command process.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:
- Hospitalist’s Company
- Hospital Risk Manager

18. TERMINATING PHYSICIAN – PATIENT RELATIONS
As is true for other physicians, situations may arise in which Hospitalists may decide to terminate the care provider-patient relationship. The same may also be true on the part of the patient who does not want a particular Hospitalist to provide him or her with treatment. Terminating the Hospitalist-patient relationship is a decision that merits careful thought and planning. Sometimes it may be a lack of understanding or something that someone else said that triggers anger, distrust or disagreement. At other times, patients who disagree with diagnostic testing and treatments ordered by a Hospitalist may questioned the doctor’s ability and want someone else to manage his or her case. Xenophobic or racially biased attitudes on the part of patients or their families may also trigger requests to remove or terminate a Hospitalist’s involvement in their case. Hospitals often have policies and procedures in place to address termination of physician-patient relations. Following such policies and procedures is important, as is having a process in place for the continuity of patient care.

RISK EXPOSURES:
- Negligence treatment.
- Patient complaints and grievance.
- Adverse publicity.
- Security concerns.

RISK MANAGEMENT STRATEGIES:
Generally speaking, termination of physician-patient relations occurs when other steps have failed to maintain the Hospitalist-patient relationship. Patient or family non-adherence to a care plan or refusal of care by a specific hospitalist may necessitate termination of the patient-hospitalist relationship. In some situations, behavior by the patient or family may make it impossible for the Hospitalist to carry out care for the patient. Threats, physical assaults, or menacing behavior may bring an abrupt halt to the care giving relationship. Indeed, in some instances, family members may be barred from entry to the hospital or the patient may be removed from the healthcare facility. Prior to terminating the Hospitalist-patient relationship, it is good practice to follow hospital policy and procedure. Communication with relevant personnel is warranted to provide for continuity of patient care.
care while in the hospital setting. In situations of actual or threatened violence, hospital security should be notified. Risk management strategies to consider include:

- Become familiar with hospital policy and procedure for terminating the Hospitalist-patient relationship.
- Follow suggested methods for resolving disputes with patients or their families that would obviate the need to terminate the hospitalist-patient relationship.
- Provide for continuity of care when a decision is made that it is impossible or impractical for the hospitalist to continue to care for the patient.
- Provide for continuity of care when the patient terminates the care giving relationship with a specific hospitalist.
- Follow hospital protocol to terminate the Hospitalist-patient relationship when threatened with violence or when physically assaulted.
- Document termination of the Hospitalist-patient relationship in a way that is consistent with hospital policy and procedure and the Hospitalist contract with the hospital.
- Notify the Hospitalist company of situations in which the care giving relationship was terminated by the patient or when the Hospitalist was threatened or assaulted by a patient or family member.

**CASE EXAMPLE:**

Tamara Rhones, DO had served as a Hospitalist for several years. She had an excellent reputation. Dr. Rhones was born in Liberia and spent several years in France and Switzerland after medical school. She spoke with a distinct accent. On Monday, a 61-year-old man, Brian Johnson, was admitted to the hospital with complaints of abdominal pain and constipation. The patient had stopped smoking ten years earlier. He had diabetes, coronary artery disease, and hypertension. Dr. Rhones introduced herself to the patient. After explaining her role and responsibility for his care, the patient said, “You must be joking, lady! You cannot be a doctor. Besides, you are not my real doctor. I want him to take care of me.” Dr. Rhones replied, “Sir, I am a physician, and I am happy to take care of you. I shall be in communication with your doctor in the community, but while you are a patient in the hospital, I will take care of you.” Dr. Rhones ordered some tests. After discussing Mr. Johnson’s history with his primary care provider, Dr. Rhones also scheduled him for a colonoscopy. The next day, Dr. Rhones was surprised to learn that the colonoscopy had been postponed. Although she had explained to the patient the reason for the test and what was involved in the preparation for it, Mr. Johnson and his family thwarted her efforts. Instead of drinking only liquids, he dined on fast foods brought in by family members from a local restaurant. This happened again the next day. Frustrated, Dr. Rhones asked for assistance from a nurse manager who seemed to be able to speak with the patient. Although the nurse manager thought the misunderstanding had been cleared up, when Dr. Rhones spoke with Mr. Johnson she was greeted with an agitated conversation. “Who the hell do you think you are, anyway?” I know what I want, and it sure as hell is not what you think is best for me. I don’t want your kind taking care of me. Now get out of here and let them send a real doctor in to take care of me!” When Dr. Rhones tried to respond, Mr. Johnson stood up and pushed her out the door of his room. Dr. Rhones reported the situation to hospital administration. She was visibly upset by the encounter. Not wanting the situation to escalate, the CEO and the Chief Medical Officer went to see Mr. Johnson. They wanted to be certain that he was able to understand the nature and consequences of his actions. After their conversation with the patient, the CEO and the
CMO were satisfied that he was lucid and understood the consequences of his actions. The discussion confirmed for the CEO and CMO that it was not simply a matter of not wanting Dr. Rhones to provide treatment; Mr. Johnson did not want the colonoscopy. “Sir, given your actions and your persistent refusal to follow appropriate medical advice, it is clear that we cannot provide you with the care you require. Therefore, we are terminating your treatment at this facility. You are being discharged immediately. You are free to go home and follow-up with your primary care provider.” A short time later, the patient left the hospital. The CEO and the CMO spoke with Dr. Rhones and offered her access to the Employee Assistance Program. The Hospitalist company was notified of the situation. On behalf of the hospital, the CEO followed up with a letter to Mr. Johnson confirming the termination of treatment at the facility and the suggestion that he seek further care from this primary care provider. The letter was sent with return confirmation.

APPLYING RISK MANAGEMENT STRATEGIES:

- Use good communication skills to address patient non-adherence to diagnostic or treatment regimens, emphasizing the indications for ordered tests or treatment.
- Utilize the assistance of nursing, social service, or other providers to overcome patient non-adherence to preparation for or undergoing medically necessary tests or treatment.
- Use teach-back style strategies if possible to confirm that the patient realizes that the recommended diagnostic or therapeutic regimen is the most prudent for his or her condition and that other forms of testing or treatment are not warranted.
- Use communication techniques to defuse confrontations with non-adherent patients.
- Report any threats or physical assaults.
- Work with hospital leadership to terminate the care provider-physician relationship when the patient manifests persistent non-adherence or physically menaces a care provider.
- Do consider counseling following verbal altercations.
- Do consider medical assistance if patient altercations involve physical violence.
- Document the physician-patient relationship termination in accordance with hospital policy and procedure.
- Notify the hospitalist company of hospitalist-patient termination situations, including those in which physical assault was a factor.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Hospitalist’s Company
- Hospital Risk Manager

19. END OF LIFE CARE AND ORGAN PROCUREMENT

Hospitalists have specific responsibilities in dealing with end-of-life care for patients. It is important to determine if the patient completed any advance directives while capable of individual decision-making. Equally important is determining if the patient appointed anyone to serve as a surrogate
decision-maker or healthcare proxy in the event of incapacity to make individual treatment choices. Even in the absence of an advance directive, state law may give relatives – in a certain order of relationship to the patient – the authority to make decisions on behalf of an incapable person. Situations may arise involving a choice of withholding or withdrawing life-support, artificial nutrition, or hydration. Determinations will be required for orders not to resuscitate. In other instances, patients may be good candidates for organ donation. Some may be brain dead. Other individuals may be on the verge of cardiac death. Although many individuals may have indicated their desire to be organ donors in the past, others may not have made such a declaration. In such cases, the family may be legally authorized to make such a determination or the choice may be made by a duly authorized legal representative. State legislation and regulation set forth the requirements for a variety of advance directives and the measures to follow for declaration of death. Both federal and state law identifies requirements for organ procurement. Hospital policies and procedures should reflect applicable requirements for hospitalists to follow.

RISK EXPOSURES:

- Negligence treatment.
- Unauthorized procurement of donor organs and tissue.
- Adverse publicity.
- Breach of contract between the hospitalist group and the hospital for substandard practice.

RISK MANAGEMENT STRATEGIES:

Generally speaking, end-of-life care and organ procurement is part of a well-defined process in hospital policy and procedure. Although discussing end-of-life planning with a patient may be difficult, the conversation can be completed in a compassionate and empathetic manner. Notwithstanding what the patient has written in an advance directive, it is prudent for the Hospitalist to confirm the patient’s wishes. The presence of a trusted member of the family or a designated surrogate decision-maker may prove useful, especially if difficult treatment choices must be made after the patient is unable to take part in the decision-making process. For those patients who present in an incapacitated state, it is useful to request and review relevant advance directive information. Surrogate decision-makers should be contacted by the Hospitalist to discuss end-of-life care plans for the patient. When no one has been designated for this purpose, a good practice is to follow state law and hospital policies and procedures for contacting relatives authorized to make decisions on behalf of the patient. If the patient is without a relative, appointment of a guardian may be necessary. Hospital counsel will work with the Hospitalist to complete this process. Should disputes arise among family members responsible for making treatment choices for the patient, it is a good idea to enlist the assistance of clergy or to refer the matter to an ethics committee for prompt review and recommendations. For those patients near death who are good candidates for organ procurement, the Hospitalist should follow hospital protocol and request a meeting by the organ procurement coordinator with the patient’s surrogate or family. Specific risk management strategies include:

- Communicate with the capable patient about end-of-life care plans, including pain management, intubation, hydration and nutrition, as well as orders not to resuscitate. Be certain to refer to available advance directives provided by the patient.
- Document the conversation with the capable patient regarding end-of-life care.
☐ Communicate with identified surrogate decision-makers for incapable patients regarding an end-of-life plan.

☐ Document the relationship, if any, of the surrogate decision-maker to the patient. Record any letter of appointment or advance directive identifying the individual as the surrogate decision-maker.

☐ In cases in which a family member is identified as the surrogate decision-maker on behalf of an incapacitated patient, communicate with him or her regarding an appropriate end-of-life plan for the patient.

☐ Document the relationship of the relative who will serve as the surrogate decision-maker for the patient and the end-of-life care plan.

☐ Contact hospital chaplains or clergy for guidance when there are questions about proposed care plans or organ procurement requests that may be contrary to the patient’s religion, beliefs, or culture.

☐ Make timely referrals for family disagreements on the propriety of end-of-life care decisions such as do not resuscitate orders, withholding or withdrawing life support, and the use of artificial hydration and nutrition.

☐ Follow hospital policy, procedure, and protocols for contacting the organ procurement coordinator.

☐ Follow applicable state law and hospital policy and procedure for declaration of death.

CASE EXAMPLE:

Susannah Tartent had metastatic lung cancer. She had been hospitalized after complications from her last chemotherapy treatment and she had significant bone pain. “I know I am going to die soon, doctor,” said Ms. Tartent. She continued, “The oncologist meant well, but this last treatment reaction convinced me I am near the end. I have an advance directive. The only thing I ask is that I be kept comfortable. I do not want any tubes shoved down my throat. Just let me go in dignity. My sister, Joan, is my chosen decision-maker. I do not want my brothers to have any say in the matter. They will want everything done. I just want to go in peace. Please make certain that happens. Here is the paperwork.” Two days later, Ms. Tartent developed a high temperature and an infection that did not respond to antibiotic therapy. She lapsed into a comatose state. Over the course of a few hours, she experienced multiple organ failure. Ms. Tartent’s family was summoned to the hospital and the Hospitalist explained to Joan Tartent and the patient’s brothers what was happening. “You are going to do everything for her, right? You know, resuscitation, whatever it takes,” said the older brother. “No,” responded the hospitalist. He continued, “I discussed with your sister what she wanted. It is all here in her advance directive. She asked Joan to make choices for her when she became unable to do so. I am going to respect what your sister told me and directed Joan to do: to keep her comfortable at the end. I regret to say, she is at the end-stage now. It is only a matter of time.” Six hours later, Susannah Tartent passed away surrounded by her family. Given the extensive nature of the cancer, the organ procurement coordinator had agreed in telephone conversation earlier that day with the Hospitalist that Ms. Tartent was not a suitable candidate for organ procurement.
APPLYING RISK MANAGEMENT STRATEGIES:

- Discuss preferences for end-of-life care with the capable patient.
- Confirm care plan items documented in the patient’s advance directive.
- Document in the patient record the end-of-life care plan and reference the available advance directive.
- Anticipate that some family members may dispute the end-of-life plan. Utilize the conversation with the patient and the advance directive to help resolve the possibility of a family dispute regarding the end-of-life plan.
- Issue appropriate orders that are consistent with the patient’s wish for end-of-life care.
- Communicate with the surrogate decision-maker.
- Complete the communication process with the organ procurement coordinator, recognizing that this individual will follow a specific protocol for determining when it is feasible to consider organ procurement.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

- Hospitalist’s Company
- Hospital Risk Manager

20. DISCHARGE PLANNING

Discharge from a hospital can be a very risk-prone process for patients and their family members. In some instances the patient may be weak or tired and his or her recall of instructions may be less than clear. Sometimes too, nursing personnel are rushed, processing many patients in a short period of time. Medical orders or prescriptions may be incomplete, requiring the nurse to stop the discharge process with the patient and retrieve necessary information. It may well be that the patient was on medications obtained from a community pharmacy that were not on the hospital’s formulary. A Hospitalist may have substituted a similar medication. At other times, the Hospitalist may prescribe a new preparation for the patient. For one reason or another, a medication that should be on the discharge summary list is missing. Unless the discharge summary process includes a pre-hospitalization and discharge medication reconciliation process, a patient may not have an order for a vital pharmaceutical. Hospitalists have an important responsibility to make certain that medication orders and follow-up instructions are complete and ready for the nurse to explain in the discharge process. It is important to note that this responsibility extends beyond situations involving patients returning home and timely communication with the patient’s primary care provider. Communication regarding discharge plans may include telephone or electronic communication with the patient’s primary care provider. Discharge plan coordination extends to patients being sent to rehabilitation facilities, assisted living centers, skilled nursing facilities, and home health services. If anything is incomplete, hospital policy and procedure should include a communication process to rectify such matters between the nurse managing the patients discharge and the hospitalist.
RISK EXPOSURES:

- Negligence treatment
- Patient grievance and complaint
- Readmissions due to lack of proper discharge instructions or planning

RISK MANAGEMENT STRATEGIES:

Generally speaking, effective discharge planning for the Hospitalist involves a review of the current medication regimen and what the patient was taking prior to being hospitalized. It requires too, an evaluation of patient needs and abilities. For example, if a patient who lives alone underwent surgery using his dominant hand, it would not be reasonable to prescribe a medication that required him to split a tablet. If the patient complains that the recommended care is too expensive or too complicated, the Hospitalist may be compelled to refine follow-up care instructions. The point is that hospital discharge planning involves more than a review of the medical record; it also includes a discussion with the patient and family care givers to design a plan that can work in the patient’s home setting. Some strategies to consider include:

- Work with colleagues and nursing administration to develop a medical discharge planning checklist.
- Consider including on the checklist:
  - Patient medication reconciliation of pre-hospitalization and post-hospitalization requirements
  - Patient care plan information
  - Follow-up appointment requirements
  - Discussion with patient and family care giver
  - Patient/family agreement to plan
  - Patient/family require assistance – referral for social worker assistance
  - Timely communication with specialists and the patient’s primary care provider
  - Timely completion of medical and medication orders for patient discharge
  - Documentation of date, time, and signature on the medical discharge plan
- A process for nurses managing the discharge planning process to communicate with the Hospitalist.

CASE EXAMPLE:

James Tatten had suffered a crippling stroke four years ago. He was left with right-side weakness and impaired vision in his dominant eye. Although he made good progress with aggressive rehabilitation, Mr. Tatten never regained full use of his dominant hand. He used a reading “enlarger” device to view print smaller than 18 font. More recently, Mr. Tatten had been hospitalized with pneumonia following a serious bout of bronchitis. Mr. Tatten refused a short-term stay in a rehabilitation facility. “I want to go home now,” he said. The Hospitalist, Dr. Janus, completed the medical discharge component of the plan. Later that day when Mr. Tatten was discussing his discharge plan with a nurse, he said, “Read that list of medications again, will you?” The nurse did as Mr. Tatten requested. Shaking his head, he said, “Young lady, something is wrong. I did not hear
you mention aspirin or Plavix. I was told three months ago when I had my cardiac stent that I had to take both those medications for a long time. I think there is something wrong.” The nurse said that she would check the discharge information. Sure enough, Mr. Tatten was correct. When Dr. Janus was preparing the medical aspects of the discharge plan, he had read only one page of the patient’s medication list and that was very quickly. “You were quite right, Mr. Tatten,” said the nurse. She continued, “I am sorry for the misunderstanding. The discharge instruction plan has been corrected. I want you to be clear about it, too. I am going to go over the discharge plan and medications again. If you have any questions, please let me know.”

**APPLYING RISK MANAGEMENT STRATEGIES:**

- Develop and implement a discharge planning process reconciliation checklist.
- Complete a pre-hospital and pre-discharge medication reconciliation process, making certain that any continuing medications are on the list.
- Discuss with the patient and family care giver information on the discharge plan, including medications.
- Address any concerns expressed by the patient or family in terms of the discharge plan, including medication.
- Respond to inquiries from nursing quickly regarding medication discharge plans.

**WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:**

- Hospitality’s Company
- Hospital Risk Manager

**21. PARTICIPATION IN FACILITY-BASED COMMITTEES AND ACTIVITIES**

Facilities have standing committees, task forces and ad hoc committees. Examples of standing committees are the Infection Prevention, Patient Safety, Pharmacy and Therapeutics, Code Blue, Product Evaluation, Quality Improvement, and Compliance Committees, to name just a few. As members of the medical staff, Hospitalists may be asked to serve on these committees. Similarly, Hospitalists may be asked to take part in root cause analysis groups. Such activities are expected of physicians with full staff memberships. The degree to which Hospitalists may participate in such activities turns on the contractual agreement between their Hospitalist organizations and the hospitals. Issues related to dual reporting on some matters should be addressed in either the contract between the Hospitalist group and the hospital or through a memorandum of understanding (MOU). The failure of Hospitalists to fulfill these contractually based obligations could jeopardize the relationship between the Hospitalist group and the acute care facilities and trigger review of the staff appointments of those who fail to abide by the terms and conditions of the medical staff bylaws in terms of committee responsibilities.
RISK EXPOSURES:
- Breach of Contract
- Termination of hospitalist contract.
- Failure to abide by terms and conditions of the medical staff bylaws.

RISK MANAGEMENT STRATEGIES:
At the outset of the staff appointment, it is prudent for the Hospitalist to identify his or her role and responsibility on medical staff committees and related activities. Mindful of the underlying contractual between the Hospitalist group and the hospital, the Hospitalist should confirm the terms and conditions under this agreement relative to committee service. Should there be any doubt about role and responsibility on medical staff committees, Hospitalists should obtain clarification from the regional medical director or the person responsible for hospital relations within the Hospitalist company.

CASE EXAMPLE:
As a new member of the hospital medical staff, Dr. Wiley, a Hospitalist with Welton Hospital Group, was assigned to the institutional review board (IRB). In previous years, Dr. Wiley had served on the IRB of a community hospital. Because of that experience, the CMO of the hospital was delighted to have such an experienced individual available to serve on the IRB. The contract between the Hospitalist group and the hospital provided that Hospitalists could serve on no more than three medical staff committees and that the estimated monthly time allocation for such committee work could not exceed six hours. Dr. Wiley was assigned to the IRB, as well as the Utilization Review and Pharmacy and Therapeutics Committee. Additionally, Dr. Wiley was assigned to a task force exploring process improvement in the admission-to-Hospitalist orders through put. The goal was to reduce the length of time for the entire process by 25%. The projected time per month for the three committees and the task force was 15 hours. The IRB met twice monthly and with the preparation for the committee meeting, the total for that one function was projected to be nine hours. If Dr. Wiley did not participate in the IRB, he would be able to fulfill the other assignments. Dr. Wiley notified the Hospitalist company’s regional medical director of the matter and, after a telephone discussion, the CMO of the hospital agreed with the regional medical director that the most practical solution was to remove Dr. Wiley from the full-time roster of the IRB.

APPLYING RISK MANAGEMENT STRATEGIES:
- Determine the scope of responsibilities for committee, task force and other assignments under the Hospitalist contract with the hospital.
- Do not exceed the terms of the contract for participation on committees, task forces and related activities.
- Refer questioned committee and task force assignments to the regional medical director.
- Make certain that refinements are made to committee and ad hoc task force workgroup assignments.
Should questions arise about committee assignment or task force activities that are not resolved by the regional medical director for the hospitalist group, utilize corporate chain of command to obtain a resolution.

**WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:**
- Hospitalist’s Company
- Hospital Risk Manager

### 22. PARTICIPATION IN FACILITY PEER REVIEW COMMITTEES AND ACTIVITIES

As a member of the medical staff, Hospitalists are apt to have a role in hospital-based peer review committees and activities. Such work is important in terms of identifying opportunities for improvement in patient care and patient safety. Additionally, by participating in hospital peer review work, Hospitalists can help to solidify the relationship between the hospital and themselves as active members of the hospital medical staff. Hospitalists, however, are contractual employees of the Hospitalist company. As such, they are obliged to fulfill the specific role and responsibility as employees of the Hospitalist company. Situations may occur during the hospital-based peer review process in which the Hospitalist sees quality of care issues impacting the Hospitalist company. Due to the confidential and privileged nature of the peer review process, Hospitalists are not at liberty to share such information with the Hospitalist company. The tension created by this dual responsibility goes well beyond political considerations; it may be that Hospitalists engaged in peer review activities identify the need for improvements at the level of the Hospitalist company. From a practical risk management perspective, the key is to be familiar with the process in place for communicating information that does not violate either hospital peer review requirements or the terms of the Hospitalist contract with the healthcare facility.

**RISK EXPOSURES:**
- Breach of evidentiary protection under applicable law.
- Breach of confidentiality under applicable law.
- Breach of medical staff bylaws, rules and regulations of the medical staff.
- Breach of contract between the healthcare organization and the hospitalist company.

**RISK MANAGEMENT STRATEGIES:**
The prudent approach is to follow applicable requirements for participating on peer review committees and similar activities. This means following medical staff bylaws and the rules and regulations of the medical staff on peer review. Since state law establishes a framework for evidentiary requirements safeguarding information review or discussed in peer review committees, it is important to comply with such requirements. This means that if a representative of the Hospitalist company or a person not involved in the peer review process asks for details about such matters, the Hospitalist should refrain from sharing such information. For the Hospitalist company, relevant
quality of care data can be made available through a contractual process. In other words, the Hospitalist member of the hospital peer review committee is not a conduit for protected information. Suggested risk management strategies for this purpose include:

☐ Become familiar with the requirements for the peer review process at the hospital.
☐ Become acquainted with applicable state law requirements for maintaining evidentiary protection and peer review.
☐ Do not share any information outside the peer review process unless specifically authorized to do so in accordance with the medical staff bylaws and applicable state law.
☐ Refer all requests for sharing confidential or privileged peer review information to hospital legal counsel and notify the regional medical director of the Hospitalist company of such requests.
☐ Use of chain-of-command procedures to escalate unauthorized requests for peer review information.

CASE EXAMPLE:
Dr. Norton, an OB Hospitalist, served on the Department of Obstetrics and Gynecology Peer Review Committee. Among the case records under review were three involving Peg Thinne, D.O., another OB Hospitalist employed by the same Hospitalist company. The cases raised serious concerns about quality of care, since the patients in each experienced serious tears during the delivery process. The committee reviewed all the data very carefully. Ultimately, the committee recommended serious options, including curtailing privileges, a focused review, and having a peer participate in the next 10 cases for which Dr. Thinne was responsible. After the peer review committee meeting, Dr. Norton received a telephone message from Bob Feeson, the hospital relations officer at the Hospitalist company. Mr. Feeson said, “Do me a big favor and give me the low down on Dr. Thinne. What did you folks decide to do in peer review? It would save me a huge amount of time trying to get this data from the hospital.” Dr. Norton declined the request saying, “I cannot help you. It is privileged information. You should go through proper channels.” Mr. Feeson responded, “Let me remind you who your employer is, doctor.” Dr. Norton said, “I am aware of my employment relationship and the fact that you have to follow established protocol. Good day, Mr. Feeson.” After he ended the call, Dr. Thinne reported the situation to the regional medical director. Later that day Mr. Feeson was counseled by his supervisor to never ask a Hospitalist employee to do anything that was at variance with the Hospitalist company contract.

APPLYING RISK MANAGEMENT STRATEGIES:
☐ Comply with medical staff peer review policies and procedures.
☐ Follow state law requirements on evidentiary peer review protection.
☐ Do not accede to granting anyone unauthorized access to peer review information either verbally or in writing.
☐ Report requests for unauthorized access to peer review information to the Hospitalist company.
☐ Utilize chain of command within the hospitalist company when necessary.
WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:
- Hospitalist’s Company
- Hospital Risk Manager

23. SCOPE OF PRACTICE
Hospitalists are expected to conduct themselves within the framework of a set of practice parameters or scope of practice requirements. The framework for the scope of practice can be found in the contract between the Hospitalist group and the hospital. Additionally, the delineated privileges granted to the Hospitalist set forth specific clinical criteria for the delivery of patient services. Contemporary Hospitalist practitioners find themselves often asked to complete tasks that go well beyond their scope of practice. These requests may include providing clinical services in the outpatient units or supervising nurses and physicians’ assistants, functions that exceed their contractual and staff privilege responsibilities. The lack of clarity from Hospitalist group leadership on this “mission creep” phenomenon could lead to unwelcome risk exposures. The prudent risk management approach is to act within the scope of delineated privileges. Requests that exceed such practice parameters should be referred to the regional medical director or further up the chain of command of the hospitalist group.

RISK EXPOSURES:
- Unauthorized services
- Breach of contract
- Ostensible or apparent agency liability for the hospitalist group through the actions of the hospitalist acting as a supervisor on behalf of the hospital
- Adverse publicity
- Breach of contract between the hospitalist group and the hospital for substandard practice of care

RISK MANAGEMENT STRATEGIES:
Generally speaking, scope of practice is part of a well-defined term in Hospitalist contracts and in hospital policy and procedure. Any requests to extend the scope of service beyond that defined in the contract should be discussed between the Hospitalist group leadership and the hospital. Should the practice parameter be extended to include administrative oversight or additional clinical responsibilities, it is important that this determination is made clear to all relevant parties, including the Hospitalists whose duties will be increased by such a decision. Additionally, consideration should be given to revision of delineated privileges, an issue that will require input from those involved in the credentialing and privileging process. Training, orientation, and demonstrated competencies for extended duties should be considered along with staffing requirements for the Hospitalist organization in the hospital setting. If the scope of practice extends beyond the limits of professional
liability insurance for the Hospitalist, this matter should be discussed with the insurance agent or broker for the Hospitalist organization. Specific strategies include:

- Decide if the scope of practice for the Hospitalist group will be extended beyond existing practice parameters.
- Revise the terms and conditions of the Hospitalist group-hospital agreement to reflect this change in scope of practice.
- Make certain the revised scope of practice takes into consideration:
  - Remuneration.
  - Work hours.
  - Clinical coverage
  - Training for Hospitalist involved in the expanded scope of practice.
- Chain of command for the Hospitalist involved in scope of practice revisions – with relevant Hospitalist leadership and the regional medical director of the Hospitalist organization.

CASE EXAMPLE:

At 11:35 PM, Dr. Martin, a Hospitalist on the 7 AM to 4 PM shift, received a call from the Director of the Emergency Department requesting that he do a “telephone admission” for a patient with CHF and pneumonia. The hospital had a contract with the Hospitalist group to cover 7 AM to 4 PM. The other shifts did not have a Hospitalist on duty. The contract with the Hospitalist organization and the Medical Staff Bylaws prohibited telephone admissions for any “high risk” patients, including those with presenting symptoms of chest pain, congestive heart failure, stroke, and myocardial infarction. Dr. Martin refused to accede to the request. “Look, this is an unsafe practice. The patient needs a physician to do the admission. It is right in the bylaws that I cannot do it,” he said. The Director of the Emergency Service was insistent stating, “A PA can do the initial work-up, Dr. Martin. I mean . . . you know we are only talking about a few more hours here and your colleague Dr. Vincent will be here to complete the work.” Dr. Martin refused, and the ED Director’s tone became somewhat threatening. “I am telling you to do the telephone admission, doctor. There could be repercussions for the contract with your group.” Dr. Martin replied, “As I said, the answer is no. Good night.” He hung up the telephone and paged the regional medical director of the Hospitalist group. It turned out this was the third such “request” in a month. The hospital did not want to pay for an overnight shift. Fearing the potential for poor patient care, the Hospitalist group had declined the telephone admission requests. The day after the call, Dr. Martin, the Hospitalist regional medical director, and the CMO of the hospital met for a candid review of the situation. In the end, the hospital agreed to an extension of the agreement to include a new overnight shift staffed by Hospitalists.

APPLYING RISK MANAGEMENT STRATEGIES:

- Follow contractual requirements related to scope of practice.
- Follow hospital policies and procedures regarding scope of practice.
- Follow medical staff bylaws, rules and regulations of the medical staff, and clinical protocols when dealing with requests for clinical services that may not be within the scope of practice of Hospitalists.
Utilize chain of command to address requests for service that exceed the scope of practice of the Hospitalists group or individual hospitalist practitioners.

**WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:**
- Hospitalist’s Company
- Hospital Risk Manager

24. **WHO TO CONTACT ABOUT RISK MANAGEMENT ISSUES AND OTHER MANDATORY REPORTING ISSUES**

The Hospitalist, like other healthcare professionals, works to prevent errors and untoward outcomes. When a Hospitalist observes activities that may lead to adverse patient outcomes, he or should report such concerns to the nurse manager on the unit or utilize the Chain of Command Process (See Section 17). Sometimes, there will be no time to request a change in practice or to utilize the chain of command. In such instances the Hospitalist becomes a “front line” risk manager, helping to prevent or contain error prone situations. On other occasions, the Hospitalist will be responsible for reporting untoward outcomes. Such notifications may be through the incident or occurrence reporting system. Concomitant with completing incident reports, most hospitals provide care providers with a telephone notification process. Such calls typically go to the hospital risk manager. The notification process will involve mandatory reporting too, especially in situations involving unexplained death, death in restraints or while under the influence of chemical restraints. Cases involving abuse, elopement, or abduction are likely to serve as the basis for other types of mandatory reports. The failure to complete internal notification can delay the investigation of a potential compensatory event or reviewable sentinel event. Important data can be lost too, including details about the location of the occurrence, the position of equipment, the patient, etc. With regard to external notification, the failure to follow mandatory reporting requirements may trigger unwanted regulatory scrutiny and fines.

**RISK EXPOSURES:**
- Breach of a standard of care
- Untoward outcome
- Fines, citations, investigations, disciplinary actions, patient or staff injury, property damage for failure to report properly or timely as required
- Breach of the hospitalist company contract with the hospital

**RISK MANAGEMENT STRATEGIES:**

As part of the orientation process, Hospitalists should become familiar with the risk management system for reporting known or suspected compensable events. From a quality and patient safety perspective, orientation programs should acquaint hospitals with the process to follow when trying to address risk-prone practices that could lead to injury. Such training would encompass chain of
command procedures as well as how to serve as a “front line” risk manager. For situations in which harm has occurred, Hospitalists should be familiar with the notification system, when to complete incident or occurrence reports, and who to call regarding potential compensatory events and reviewable sentinel events. Working in concert with the hospital risk management professional, Hospitalists can also fulfill external reporting requirements. Similarly, in the event of potential compensatory events and reviewable sentinel events, Hospitalists should be aware of reporting obligations to the regional medical director or company risk management professional. Risk management strategies to consider include the following:

- Be prepared to serve as a front line risk manager to address an evolving risk situation.
- Become familiar with reporting requirements for potential compensatory events and reviewable sentinel events.
- Complete both internal and external reporting requirements on a timely basis.
- Provide the Hospitalist company regional medical director or the corporate risk management professional in accordance with established policy and procedure.

**CASE EXAMPLE:**

Nancy Mendez underwent an operation to repair abdominal adhesions from an earlier surgery. The surgery went well. However, after she was moved to a medical-surgical unit, Ms. Mendez experienced hallucinations. She kept trying to remove drains and dressings. At one point, a nurse found Ms. Mendez leaning against the window near her bed. “I have to go home now,” she kept repeating. Fearing that she could injure herself, Dr. Jackton, the Hospitalist on duty, decided that Ms. Mendez should be placed in soft physical restraints. Ms. Mendez fought the restraints and screamed for assistance. It was at this point that, in addition to the continued use of the restraints, Dr. Jackton ordered medication for Ms. Mendez. “This lady is having a terrible reaction to the anesthetic. She needs help so I hope that this chemical restraint will help her,” Dr. Jackton told the nurse manager on the unit. Dr. Jackton followed the clinical protocol for documenting the physical and chemical restraints. Nursing personnel followed the treatment protocol and checked Ms. Mendez on a consistent basis. Toward the end of the order period for the chemical restraint, Bobbi Dutrie, RN went into the room to check Ms. Mendez. She found her unresponsive. A code was called. Ms. Mendez could not be resuscitated. The nurse manager notified the risk management department and the office of clinical affairs. The room was secured along with the medical record. Dr. Jackton called the patient’s family and asked them to come to the hospital. Dr. Jackton, a nursing supervisor, and the chief medical officer met with the family. After disclosing the unanticipated death and expressing sincere regrets for the patient’s demise, the two physicians explained that the medical examiner’s office would be notified along with the Centers for Medicare and Medicaid Services (CMS). The chief medical officer went further, explaining that an internal review would be completed. The family members were asked if they had any questions or if they needed anything. After the discussion, the disclosure process was documented by Dr. Jackton. Thereafter, Dr. Jackton met with the risk manager and compliance officer. They discussed the process for notifying CMS about the patient’s death. The process was completed in accordance with federal requirements. A few days later, the medical examiner reported his findings. Ms. Mendez died of congenital cardiac problem. The use of physical and chemical restraints was ruled out as causes or as even contributing reasons for the patient’s death. A follow-up meeting was held with the family to explain the medical examiner’s findings. However, in the rush to complete all the internal and mandatory reporting, Dr. Jackton failed to notify the regional medical director (RMD) of the Hospitalist company. Two weeks later Dr.
Jackton received an urgent call from the Hospitalist company risk manager asking about the event. “Oh, I forgot to call the RMD or you,” said Dr. Jackton.

**APPLYING RISK MANAGEMENT STRATEGIES:**
- Comply with hospital policy and procedure for internal and external notification following a potentially compensable event or reviewable sentinel event.
- Complete all necessary documentation in a timely manner.
- Make required notifications to the hospitalist company.

**WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:**
- Hospitalist’s Company
- Hospital Risk Manager

See also, APPENDIX F - Reporting Matrix Tool.

**25. COMPLEX RISK SITUATIONS**
Clinical care encounters can sometimes become the basis for complex legal-regulatory developments. Medical malpractice liability is only one concern. Alleged violations of state and federal law and accreditation requirements may follow from the same event. Because the Hospitalist works at the acute care facility as a consequence of a contractual arrangement there may litigation involving an alleged breach of that agreement. Staff privileges may also be subject to review. That a single, clinical encounter may generate such disparate legal and regulatory action speaks to the fact that liability risk exposures can be quite complex. For Hospitalists, it is important to know how to respond to such situations.

**RISK EXPOSURES:**
- Adverse outcomes
- Negligence litigation
- Corrective action under the medical staff bylaws
- Disciplinary action for unprofessional conduct
- State agency surveys and action for “immediate jeopardy”
- Accreditation body action for quality of care issues
- Breach of hospitalist contract

**RISK MANAGEMENT STRATEGIES:**
When an event triggers a number of legal-regulatory and accreditation risk issues, Hospitalists should be poised to respond quickly and effectively. The response will include effective communication with
representatives of the hospital and the Hospitalist company. Additionally, documentation should be completed in accordance with applicable law and hospital policies and procedures, and Hospitalist company requirements. Risk management strategies include the following:

- Become familiar with hospital policies and procedures for documenting complaints or potential compensatory events.
- Understand how to document complaints or potential compensatory events in accordance with hospital policies and procedures.
- Know when to contact the Hospitalist company about complaints or potential compensatory events.
- Know when to contact the Hospitalist company about allegations involving violations of applicable state and federal law.
- Know who the contact person at the Hospitalist company is when the hospital requests information about allegations involving medical malpractice, breach of state and federal law requirements, or failure to comply with accreditation standards.

**CASE EXAMPLE:**
Five-year-old Bobby Johnson had fallen off a slide during recess at his kindergarten. Scratched and bruised on his left knee and shin, he complained that his head hurt. Concerned that the child might have experienced a concussion, the school administrator called EMS. The child was transported to the emergency department of the local community hospital. Vomiting and complaining that his head continued to hurt, the child underwent diagnostic imaging of his head. Because the left shin had become swollen and very tender during attempts to manipulate the leg, a decision was made to complete x-rays of the limb. Bobby’s parents were divorced, with the child’s mother having custody and the father visitation rights. Several calls to the mother’s office went unanswered. There was evidence of a concussion; however, it did not appear that Bobby had any cranial bleeding. He was admitted to the pediatric unit for observation. As Dr. Raines, the Pediatric Hospitalist completed his examination of Bobby he received a call to come to the nurse’s station. “Doctor, the radiologist wants to talk with you stat about that youngster. I thought it was best that you speak with him here,” said the ward clerk, and handed him the phone. “This is Dr. Raines. I believe Dr. Stratton wanted to speak with me,” he said to the radiology department assistant. “Dr. Raines? This is Mike Stratton. Please pull up the images on that new admission from the playground. I want to walk you through some things that do not make sense. He was supposed to have fallen off a slide. Well look at the limb. He has at least three spiral twist fractures in that leg. These fractures have healed, but these fractures are not that old. Also, he does have a hairline fracture from this fall. I reviewed the CT scan of his head. This kid looks like he has experienced fairly recent head trauma. This is more than a kid falling off a slide. It is your call, but I think you need to alert the Department of Children’s Services,” said the radiologist. Dr. Raines contacted the Director of Social Services. The “Child X” team came up to start a review for abuse. When the child’s mother arrived to see her son, the youngster’s affect changed. He became very quiet and withdrawn. He refused to look at Dr. Raines. Ms. Johnson thanked Dr. Raines for his help, but said that she was going to take her son to his own pediatrician for further care. “I do not think that is advisable. Bobby has sustained a concussion. We are trying to determine the extent of his head trauma. He also needs treatment for his leg fracture. It is ill advised to move him in his current condition,” said Dr. Raines. “Look doctor, I know my kid. Bobby is always falling. He is clumsy and like all boys his age, he always has some cuts and bruises. He will be fine.
He is going home with me now,” said the child’s mother. “May we speak outside?” said the Director of Social Services. The woman followed the Director of Social Services to a private room. In the room was Marcy Oliver from the Department of Children’s Services. “Why are you here? What is going on?” said Ms. Johnson. “Your child is going to remain in the hospital for treatment. Based on x-rays and CT scans completed earlier, we have reason to believe that your son is the victim of repeated child abuse. Here is some documentation for you to review,” said Ms. Oliver. The woman became enraged. “Are you crazy? Do you know what you are doing? I am the press secretary for the attorney general of this state. Did anyone bother to call my son’s pediatrician? She would tell you exactly what I told that doctor. My son has a documented condition that leads to repeated falls. He has been under treatment for his condition. I suspect that my sitter forgot to give him his medication while I have been out of town. Up to now, since he has been receiving this medication, he has not experienced any falls. He is coming home with me now, she said. Ms. Oliver said, “Like I said. Your child will remain here. There will be a court hearing within seventy-two hours. You are at liberty to present what information you wish to the juvenile court judge. Let me caution you that if you attempt to remove your son from the hospital prior to the hearing, you will be subject to the criminal laws of this state.” As it turned out, Mrs. Johnson had told the truth. The young boy did have a rare condition that explained his frequent falls. He was not the victim of child abuse. Because the press had gotten hold of the story, the local newspaper had a field day with the situation. “AG’s Press Secretary a Suspected Child Abuser?” read the headlines. In the middle of a tight race, the child’s mother was forced to resign from the AG’s office. The attorney general could ill afford this sort of distraction adversely affecting his campaign. Ms. Johnson sued the hospital, the Hospitalist, and the Hospitalist’s company for negligence and defamation. She pursued a formal complaint with the state medical board against the hospitalist alleging unprofessional conduct and substandard competencies in the practice of medicine. The hospital received an unannounced visit from the state agency and the Joint Commission looking at quality of care issues. As a result of the state agency visit, a recommendation was made to revoke the hospital’s certification for Medicare and Medicaid unless several “critical” issues were resolved within thirty days.” Four private health plans notified the hospital that unless these critical issues were resolved, their contracts with the facility would be terminated. The hospital, in turn, launched a focused review of Dr. Raines, and it notified the Hospitalist company that it was invoking clause 14.5 to terminate the agreement within two business weeks. The termination was due to substandard performance on the part of the Pediatric Hospitalists supplied to the hospital. Dr. Raines notified the risk manager of the hospitalist company about the situation. The Hospitalist company risk manager, in turn, notified legal counsel and the insurers. Legal counsel was assigned to work with Dr. Raines and a response team was established to discuss the complex event with the hospital. Following further review, it was clear that Dr. Raines had acted in good faith and that he had fulfilled his responsibilities under hospital policy and procedure for reporting a “suspected” child abuse case. Although the root cause analysis completed by the hospital would reinforce the importance of communicating with the patient’s primary care provider in the community, the hospital reversed itself and decided not to pursue termination of the agreement or corrective action against Dr. Raines. Further, the state agency and the health plans decided to withdraw their proposed action. As for the patient’s mother, she issued a letter of apology to the hospital.
APPLYING RISK MANAGEMENT STRATEGIES:

☐ Follow the hospital policies and procedures for dealing with complex risk situations.

☐ Communicate promptly with Hospitalist risk management or other identified individuals in the company when notified of a complex risk situation involving the hospitalists assigned to the hospital.

☐ Adhere to hospitalist company policies and procedure dealing with complex risk situations.

WHO TO CONTACT IF THERE IS A RISK MANAGEMENT ISSUE:

☐ Hospitalist’s Company

☐ Hospital Risk Manager
<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ADE</td>
<td>Adverse Drug Event</td>
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<td>AMI</td>
<td>Acute Myocardial Infarction</td>
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<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>CNA</td>
<td>Certified Nurse Assistant</td>
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<tr>
<td>CoPs</td>
<td>Conditions of Participation in Medicare and Medicaid Programs</td>
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<tr>
<td>CPOE</td>
<td>Computerized Physician Order Entry</td>
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<tr>
<td>CT</td>
<td>Computed Tomography</td>
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<tr>
<td>DON</td>
<td>Director of Nursing</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>eMAR</td>
<td>Electronic Medication Administration Record</td>
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<td>EMR</td>
<td>Electronic Medical Record</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>EMT</td>
<td>Emergency Medical Technician</td>
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<td>EMTALA</td>
<td>Emergency Medical Treatment and Active Labor Act</td>
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<td>HAC</td>
<td>Hospital-Acquired Conditions</td>
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<td>HAI</td>
<td>Healthcare-Associated Infections</td>
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<td>HIPPA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
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<tr>
<td>HITECH</td>
<td>Health Information Technology for Economic and Clinical Health Act</td>
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<tr>
<td>ICD</td>
<td>Implantable Cardiac Defibrillator</td>
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<tr>
<td>IPPS</td>
<td>In-Patient Prospective Payment System</td>
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<tr>
<td>LASA</td>
<td>Look-Alike / Sound - Alike Medications</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MS-DRG</td>
<td>Medicare Severity Diagnosis Related Group</td>
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<tr>
<td>NPP</td>
<td>Notice of Privacy Practices under HIPAA</td>
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<tr>
<td>OTC</td>
<td>Over-the-Counter</td>
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<tr>
<td>PCE</td>
<td>Potentially Compensable Event</td>
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<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
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<tr>
<td>PHI</td>
<td>Patient Health Information or Protected Health Information</td>
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<tr>
<td>PHR</td>
<td>Personal Health Record</td>
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<tr>
<td>POA</td>
<td>Present on Admission</td>
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<tr>
<td>TIA</td>
<td>Transient Ischemic Attack</td>
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</table>
APPENDIX B
Hospitalist Consent Checklist

Determine patient communication needs:
- Language interpreter
- Visual impairment – careful verbal explanation
- Hearing impairment – use of TTY or sign interpreter
- Cognitive ability – slower pace of information
- Pain management – ability to understand and make decisions not impaired
- Health Literacy – ability to comprehend information

Consent Process
- Provide an explanation of the indications for a test, treatment or medication
- Provide a description of what is involved in the recommended test, treatment or medication
- Describe the probable benefits and probable risks
- Describe the alternatives and the related probable benefits and probable risks
- Provide details on frequently asked questions, including the likelihood of pain, time away from work and the need for lifestyle changes
- Describe the probable consequences of declining recommended or alternate test, treatment or medication
- Answer patient questions
- Information provided is gauged at the level of patient understanding
- Conversation is free of undue influence or coercion
- Patients provide appropriate answers to questions posed to test understanding of information discussed during the consent process

Consent Documentation
- Brochures or information sheets provided – copy retained for the medical record
- Use of website, DVD or interactive computer based education – documented in the medical record
- Use of an interpreter – name and language used
- Date and time of the conversation
- Signature of the care provider and patient
- Exceptions – document per hospital policy and procedure:
  - Emergency
  - Impracticality of consent
  - Compulsory care
  - Therapeutic Privilege
Consult hospital policy and procedure:

- Minors
- Mentally incapacitated patients
- Legally incapable patients
- Patient with a guardian of the person
- Prisoners
- Clinical trials
A HEALTH CARE PROVIDER’S GUIDE TO THE HIPAA PRIVACY RULE:

Communicating with a Patient’s Family, Friends, or Others Involved in the Patient’s Care

This guide explains when a health care provider is allowed to share a patient’s health information with the patient’s family members, friends, or others identified by the patient as involved in the patient’s care under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. HIPAA is a Federal law that sets national standards for how health plans, health care clearinghouses, and most health care providers are to protect the privacy of a patient’s health information.1

Even though HIPAA requires health care providers to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient’s family, friends, or others involved in their care or payment for care. This guide is intended to clarify these HIPAA requirements so that health care providers do not unnecessarily withhold a patient’s health information from these persons. This guide includes common questions and a table that summarizes the relevant requirements.2

COMMON QUESTIONS ABOUT HIPAA

1. If the patient is present and has the capacity to make health care decisions, when does HIPAA allow a health care provider to discuss the patient’s health information with the patient’s family, friends, or others involved in the patient’s care or payment for care?

If the patient is present and has the capacity to make health care decisions, a health care provider may discuss the patient’s health information with a family member, friend, or other person if the patient agrees or, when given the opportunity, does not object. A health care provider also may share information with these persons if, using professional judgment, he or she decides that the patient does not object. In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient’s care or payment for care.

Here are some examples:

- An emergency room doctor may discuss a patient’s treatment in front of the patient’s friend if the patient asks that her friend come into the treatment room.
- A doctor’s office may discuss a patient’s bill with the patient’s adult daughter who is with the patient at the patient’s medical appointment and has questions about the charges.
- A doctor may discuss the drugs a patient needs to take with the patient’s health aide who has accompanied the patient to a medical appointment.
- A doctor may give information about a patient’s mobility limitations to the patient’s sister who is driving the patient home from the hospital.

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1 The HIPAA Privacy Rule applies to those health care providers that transmit any health information in electronic form in connection with certain standard transactions, such as health care claims. See the definitions of “covered entity,” “health care provider,” and “transaction” at 45 C.F.R. § 160.103.

2 The full text of these requirements can be found at 45 C.F.R. § 164.510(b). Note that this guide does not apply to a health care provider’s disclosure of psychotherapy notes, which generally requires a patient’s written authorization. See 45 C.F.R. § 164.508(a)(2).
APPENDIX D
Handoffs and Sign outs Resource

Background
Discontinuity is an unfortunate but necessary reality of hospital care. No provider can stay in the hospital around the clock, so patients will inevitably be cared for by many different providers during hospitalization. Nurses change shifts every 8 to 12 hours, and, particularly at teaching institutions, multiple physicians may be responsible for a patient's care at different times of the day. This discontinuity creates opportunities for error when clinical information is not accurately transferred between providers. As one author put it, "for anyone who has watched children playing 'Telephone'...the inherent potential for error in sign outs is obvious." The problems posed by handoffs of care have gained more attention since the 2003 implementation of regulations limiting house staff duty hours, which has led to greater discontinuity among resident physicians.


The process of transferring responsibility for care is referred to as the "handoff," with the term "sign-out" used to refer to the act of transmitting information about the patient. (This Primer will discuss handoffs and sign outs in the context of transfers of care during hospitalization.) For information about safety issues at the time of hospital discharge, please see the related Patient Safety Primer Adverse Events after Hospital Discharge.

Handoffs and sign outs have been linked to adverse clinical events in settings ranging from the emergency department to the intensive care unit. One study found that being cared for by a covering resident was a risk factor for preventable adverse events; more recently, communication failures between providers have been found to be a leading cause of preventable error in studies of closed malpractice claims affecting emergency physicians and trainees. The seemingly
straightforward act of communicating an accurate medication list is a well-recognized source of error. To avert this problem, hospitals are required to "reconcile" medications across the continuum of care. (For more information, see the related Primer "Medication Reconciliation.")

Implementing Structured Handoff and Sign-out Protocols

Current sign-out mechanisms are generally ad-hoc, varying from hospital to hospital and unit to unit. Guidelines for safe handoffs focus on standardizing the sign-out mechanism. The components of a safe and effective sign-out can be summarized using the acronym ANTICipate:

- **A**dministrative data (e.g., patient's name, medical record number, and location) must be accurate.
- **N**ew clinical information must be updated.
- **T**asks to be performed by the covering provider must be clearly explained.
- **I**llness severity must be communicated.
- **C**ontingency plans for changes in clinical status must be outlined, to assist cross-coverage in managing the patient overnight.

Several guidelines have been developed for implementing standardized sign outs. One trial of a computerized and structured sign-out system in an academic medical center demonstrated improved efficiency and more time spent in direct patient care after implementation. Innovative sign-out strategies have incorporated practices from other industries, such as the adaptation of a sign-out strategy from Formula One auto racing to the handoff from operating room to intensive care unit. In nursing, the SBAR method (Situation-Background-Assessment-Recommendation) has become widely accepted not only as a sign-out tool but as a structured method for all communications between providers.

Current Context

The Joint Commission requires all health care providers to "implement a standardized approach to handoff communications including an opportunity to ask and respond to questions" (2006 National Patient Safety Goal 2E). The Joint Commission National Patient Safety Goal also contains specific guidelines for the handoff process, many drawn from other high-risk industries:

- interactive communications
- up-to-date and accurate information
- limited interruptions
- a process for verification
- an opportunity to review any relevant historical data

Additionally, medication reconciliation was a 2005 National Patient Safety Goal.

FOR ADDITIONAL RESOURCES ON HANDOFFS AND SIGNOUTS, see: [http://psnet.ahrq.gov/ primer.aspx?primerID=9](http://psnet.ahrq.gov/primer.aspx?primerID=9)

APPENDIX E

Disclosure Process Checklist for Hospitalists

When notified of an adverse or unanticipated event that may involve the Hospitalist, notify the area medical director or the corporate risk manager immediately.

When asked to participate in a communication of apology or disclosure with the patient or family, consider the following strategies:

**Relevant FACTUAL information obtained about the event**
- Reviewed documentation
- Obtained current patient status report
- Note: if the patient is deceased, determine if the family has had private time. Check demographics for religious/cultural affiliation to determine possible traditions or prohibitions on viewing the body

**Prepare for INITIAL COMMUNICATION session***
- Decide who will lead the discussion
- Decide who will take notes
- Develop an agenda – include needs of patient and family, requirements for clergy or social services, baby-sitting, etc.
- Script out what to say – do not use a script in the actual discussion
- Practice
- Determine who will be present from the patient and family
- Determine where to hold the discussion
- Determine when to hold initial discussion

*NOTE: If there is any concern about a propensity for acting out or violence on the part of the patient or family, consult with security about room set-up and safety requirements

**INITIAL COMMUNICATION SESSION**
- Introductions of those present
- Reason for note-taking for follow-up purposes
- Expression of sympathy and of empathy
- Factual information
- Inquire if the patient and/or the family have any questions
- Provide responsive answers
- Document the conversation per policy and procedure
- Create a “follow-up” list of items based on the discussion with the patient and family.
Follow-up COMMUNICATION

- Decide who will lead the discussion
- Decide who will take notes
- Develop an agenda
- Script out what to say – do not use a script in the actual discussion
- Practice
- Determine who will be present from the patient and family
- Determine where to hold the discussion
- Provide information to patient and/or the patient
- Answer questions
- Document the conversation per policy and procedure

Managing COMPLEX SITUATIONS**

Contact the hospital risk manager, general counsel to analyze disclosure situations that come within the category of complex communication cases, including the following:

- Abuse or neglect events
- Self-abuse cases
- Law enforcement investigations still pending
- Family and protective service investigations still pending
- Cultural issues
- Language or interpreter needs
- Potential violence towards the Hospitalist or hospital staff
- Non-compliance with treatment as a precipitating cause of the adverse or unanticipated event
- Third party has raised doubts about initial disclosure
- Event triggers compliance inquiry, patient grievance, or other action, including complaint-based surveys by a state agency, CMS, or an accreditation body such as The Joint Commission.

**Note: in some instances Hospitalists or their companies may collaborate in discussion on the management of such complex situations.

Disclosure DOCUMENTATION

- Names and relationships of those present
- Location, date, and time of the discussion
- Use of telecommunications discussion (describe: telephone or computer-based audiovisual conferencing) the date and time of the call and the names and relationships of participants
- Summary of FACTS presented
- Summary of QUESTIONS posed by patient and family
- Summary of RESPONSES to questions
- Information VOLUNTEERED by patient and family
- Communication challenges identified and addressed (for example, American Sign Language interpreter, use of the Language Line, etc.)
- Follow-up items
- Signed, timed and dated by the person writing the note
## APPENDIX F

### Hospitalist Reporting Matrix Tool - Potential Compensatory Events and Serious Reviewable Events

<table>
<thead>
<tr>
<th>Event</th>
<th>RM</th>
<th>Compliance</th>
<th>General Counsel</th>
<th>CMO</th>
<th>Performance Improvement</th>
<th>RMD</th>
<th>Hospitalist RM</th>
<th>Medical Examiner Coroner</th>
<th>State Agency</th>
<th>Public Health</th>
<th>CMS</th>
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<td>Unanticipated Death</td>
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<td>Adverse Drug Reaction - injury</td>
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<td>Medication Error - injury</td>
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<td>Return to OR</td>
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<td>Admission to ICU</td>
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<td>Leave Against Advice</td>
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<td>Rapid Response Team Called</td>
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<td>Hospitalist Termination by Pt.</td>
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</table>

**Legend:**

**Priority Reporting**  (1) By Phone  (2) By Occurrence Report  (3) By Phone and Occurrence Report

**Timeframe:**  (A) Immediately;  (B) Within 1 hour of event;  (C) Within 12 hours;  (D) Within 24 hours;  (E) Within 48 hours.