"Safer care in a lower risk environment"

Learning from the unexpected:

Using malpractice claims data to focus and guide improvements

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Malpractice Case Example – *Obstetrics*

Patient

28-yo non-English speaking woman, G1P0, late third trimester

Pre-episode

6/18 seen by OB, told to return in one week. Scheduled visit 7/12

Episode (7/7)

1800 presents to ER with back pain+ decreased fetal movement (2days)

2050 admitted to busy L&D – cervix long, closed, occasional decels

2330 seen by MD (med student)

0000 emergency C-section

0015 surgery begins w/o airway, unable to intubate (class II)

0020 mother codes d/t anoxia

0022 viable infant delivered; mother comatose

Post episode

8/15 mother expires

Case involves an emergency C-section that ends with anoxia, coma and death. Why was it an emergency? Why did she present to ER? Is it an anesthesia issue?

Allegations

- Delay in treatment of fetal distress (minor)
- Delay in delivery (minor)
- Anesthesia-related (Major)

Severity

- Death (9)

Diagnosis

- Post-term pregnancy (initial)
- CNS CC's of anesthesia (final)

Procedures

- Insertion of endotracheal tube

Injuries

- Organ damage - brain (initial)
- Coma - CNS (final)
- Death (major)

Services

- Obstetrics (admitting)
- Anesthesia (responsible)
- Obstetrics (secondary)

Risk management issues

- Access/scheduling/waiting issues
- Selection and management of therapy-Labor and delivery
- Communication among providers- Poor professional relationship
- Failure to identify provider coordinating care
- Lack of/Failure in system for Patient Care,other
- Communication between patient / family and provider-language barrier
- Patient not informed of adverse event
- Patient assessment issues-Lack of /inadequate patient assessment- failure to note clinical information

A core question

Is all malpractice unexpected?

Yes, in each particular setting

No, there are trends and patterns

- **(Why) are there patterns of loss?**
  Practice patterns, provider patterns, patient patterns, organization patterns

- **(How) do organizations differ?**
  Claims, losses, exposures, activities, jurisdiction, clinical drivers, trends

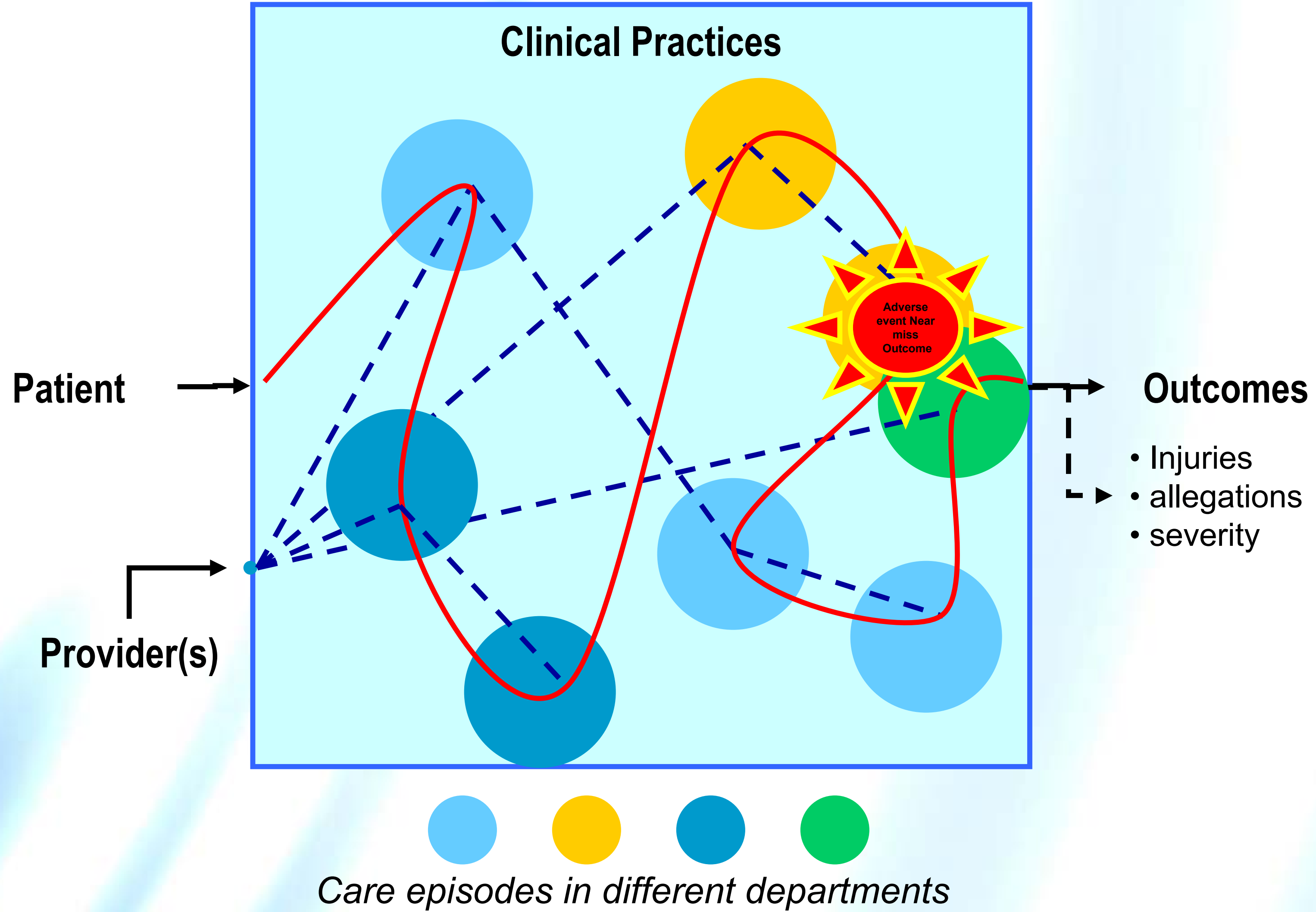
- **(How) can you reduce losses?**
  Reduce susceptibility to errors, reduce vulnerability to damage, improve situation awareness, improve mindfulness and resilience

Getting started on improvements

<u>Leverage experiences from surprises to find vulnerabilities</u>

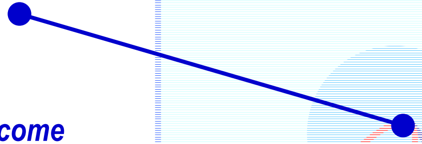
- Gather information on organization, processes, activities, exposures and culture
- Acquire data on unexpected occurrences, on malpractice claims, on patient experiences
- Analyze for patterns and trends, against a model for risk and in comparison with other organizations
- Drill into areas of opportunity
- Engage clinicians in improvement
- Address systems issues
- Focus on the patient experience

Understanding Risk – *clinical system dynamics*



Understanding Risk – *improvements*

<u>Care episodes</u>
Point of care information
Point of care tools
Qualified personnel
Communication
<u>Outcome</u>



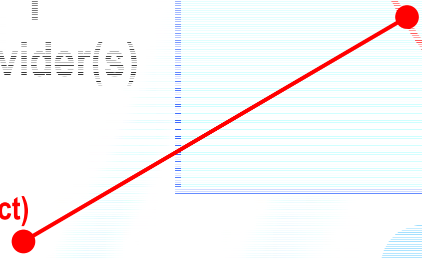
<u>Operational infrastructures</u>
Leadership and teamwork
Training and education
Standards and procedures
Tools and documentation
<u>Compliance</u>

Clinical Practices

Patient

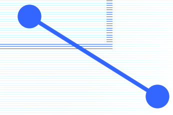
Outcomes
- Injuries
- allegations
- severity

Provider(s)



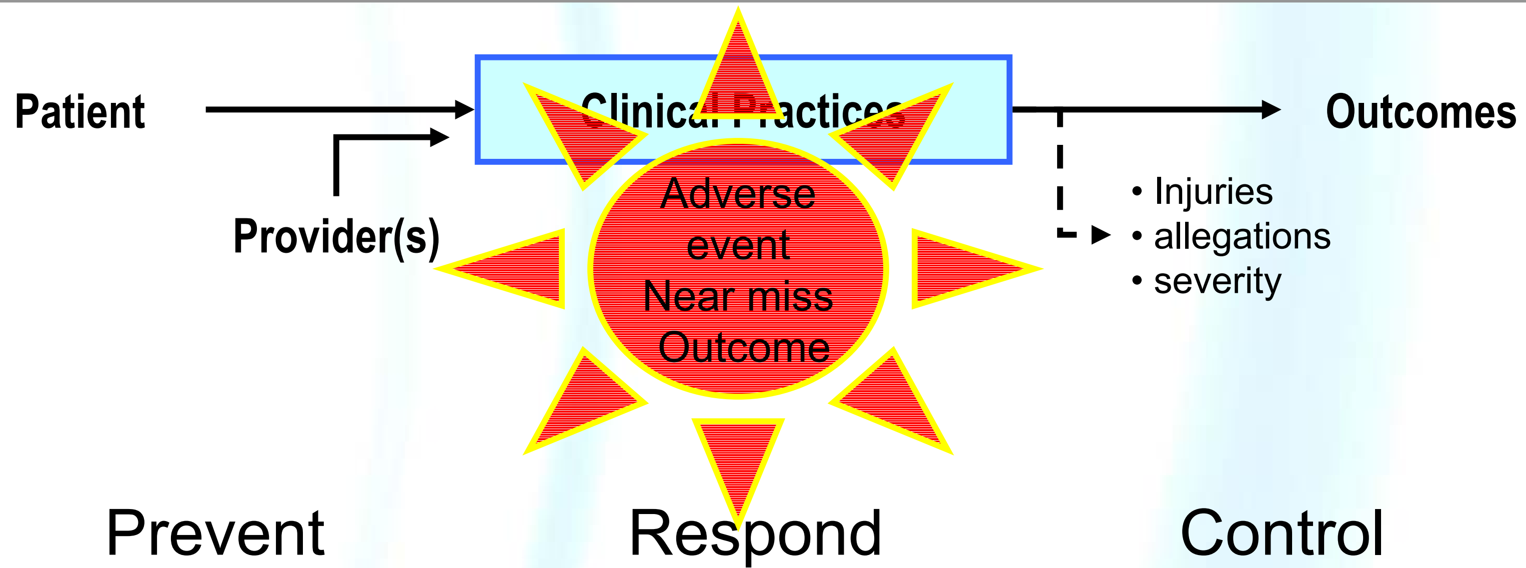
<u>Patient experience</u>
Communication (expect)
Partnership (respect)
Follow-up & coordination
Information
<u>Well-being</u>

Care episodes in different departments



<u>Systems infrastructure</u>
Organization and staffing
Policies
Resources
Systems and coordination
<u>Productivity</u>

Understanding Risk – *manage the unexpected*



Prevent

Reduce errors
- *learn from mistakes*
- *mindful of error*
- *aware of situation*

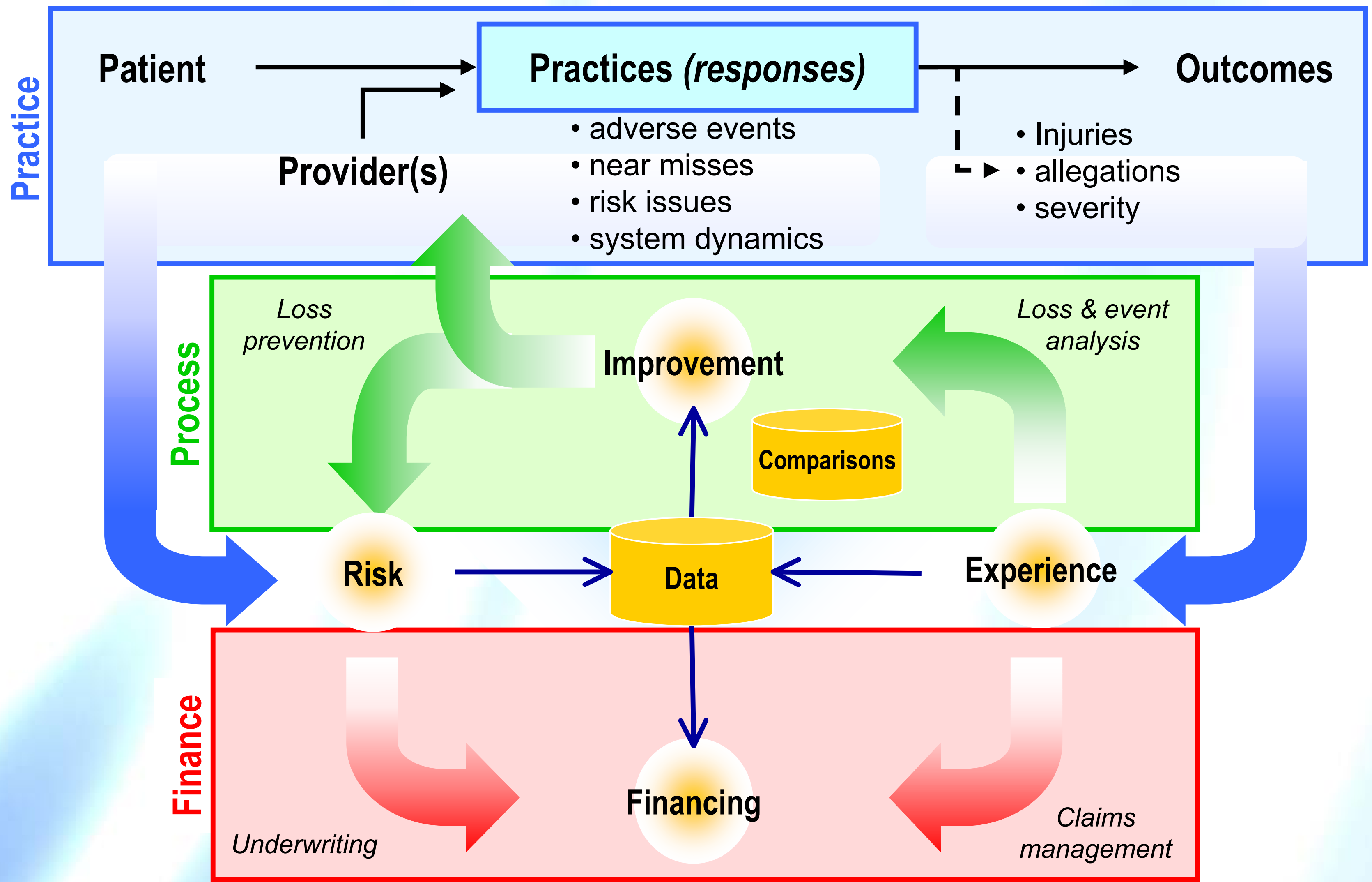
Respond

Manage unexpected
- *early detection*
- *situation awareness*
- *practiced response*

Control

Contain loss
- *investigation*
- *evaluation*
- *resolution*

Understanding Risk – *integration with process*



Malpractice Case abstracting and coding

Objectives

- **Develop case abstracts with clinical occurrence information**
- **Validate information**
- **Code key information**

  Specific Clinical Allegation,

  Diagnosis,

  Procedure,

  Specific Injuries,

  Severity,

  Risk Management Issues
- **Interrelate with other data**

Initial report by risk manager –

Loss and other dates, names and titles of people involved, brief description of incident, location, time and site.

Initial investigation by adjuster –

Background on the event and opinion of persons involved – what contributed to the event or what might have been done differently.

Summons and complaint (if applicable) –

Confirm loss date, develop allegations, why plaintiff brought the action.

Appropriate medical records –

Derive the clinical description from documents leading up to and immediately following the event such as; history and physical, test results, pre / post op reports, op notes, medication records, autopsy etc.

Medical expert reviews –

Opinion of professional in same specialty/position as to the care rendered helps to clarify the issues in the medical record.

Attorney correspondence –

Summary of events to date, results of depositions and expert reviews

Adjuster status reports –

Periodic updates as investigation continues. Convenient summaries of expert meetings, depositions, interviews etc.

Depositions taken by plaintiff and defense counsel –

arrive late in the process but can provide insight into both sides of the story, and how the event has affected the patient/family.

Closing Reports

Summarize the final results and issues on the case.

Coded data: demographics, financial, litigation and clinical information

LOSS ABSTRACT

CASE NUMBER: 1996-MH-00017890 CLAIMANT: Romanoff, Ariana

CASE INFORMATION

Reporting Entity : MEMORI
Status : CLOSED
Coverage : PL
Case Adjuster : Fred White
Supervisor : George Wi
Team : Team 1

DESCRIPTION / ALLEGATION

Mother brought to OR for emerge management, she coded and sustained

FINANCIAL INFORMATION

Date
Jul 24, 1996
Sep 20, 1998
Feb 10, 2001
Oct 01, 2001
Dec 01, 2002
CURRENT
Dec 01, 2001
Dec 15, 2001
CURRENT
Apr 05, 2002
DISPOSITION

INSURED INFORMATION

INSURED	Type
Feldman, Douglas	PH
O'Leary, Michael	PH
Becket, Arthur	PH
Memorial Hospital	O
Jones, Betty	E

LITIGATION INFORMATION

Plaintiff Firm : Smith & Car
Plaintiff Attorney : Ogden, John

Filing Date : Sep 20, 1998
Trial Date :
Trial Result : SETTLED

INSURED	D
Feldman, Douglas	
O'Leary, Michael	
Becket, Arthur	
Memorial Hospital	
Jones, Betty	

HM *Harris & Mathis*
LCT *Lewis, Charles & Taylor*

CASE NUMBER: 1996-MH-00017890

CLAIMANT / PATIENT DEMOGRAPHICS

Date of Birth : Jan 01, 1963
Sex : Female
Medical Record No: 123456
Address : 56 Main St, C
Insurance : COMMERC
Occupation : HOME
Type : INPATIENT

DESCRIPTION

On 6/18/96, mother, G1P0, non English gestation. Pt instructed by OB to return

On 7/7, 6:00PM, ? post dates, pt prese 8:50PM. Cervix long, closed. Occas de student) 11:30PM.

OB ordered Emerg C/S for fetal distr Code team delayed d/t problem finding infant deliv'd. Husband not informed of

Pt expired 8/15/96. Of note, Infant error

LOCATION & SERVICE

Occurrence Location : 0
Site Location : 6
Admitting Service : 4
Responsible Service : 4
Secondary Service : 4

DIAGNOSIS & PROCEDURES

Severity : 9 DEATH
Initial Diagnosis : 645.12 Post term pregnancy
Final Diagnosis : V58.1 CNS CC's of anethesia
Procedure : 94.02 Insertion of endotracheal tube
Device : Endotracheal tube
Medication :

ALLEGATIONS

	Allegation	Type
0216	Delay in delivery	Minor
0215	Delay in treatment of fetal distress	Minor
0414	Anesthesia- related, other	Major

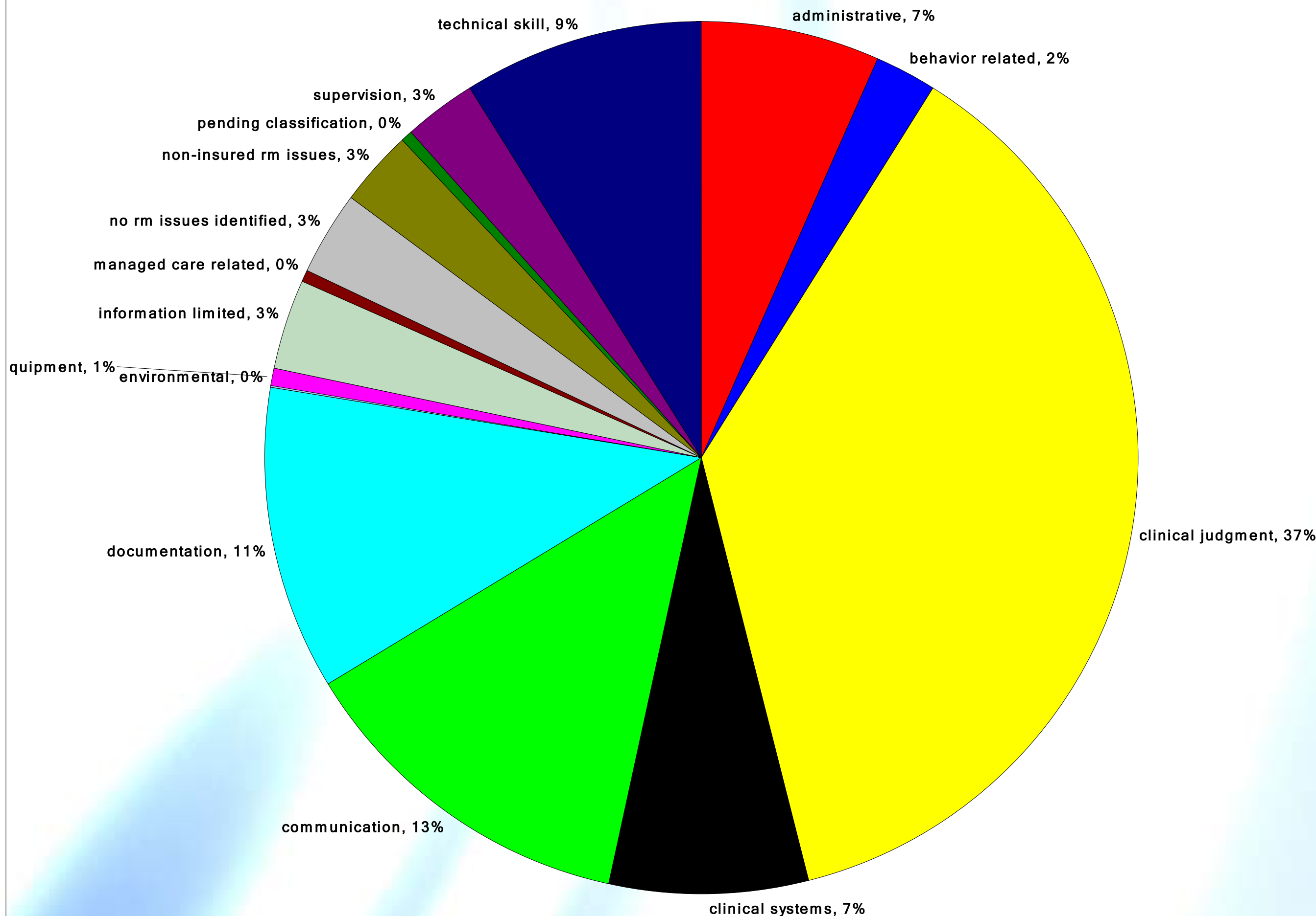
INJURIES

	Injury / Condition	Body Part / System	Type
140	Death	146 N/A	Major
042	Organ damage	054 Brain	Initial
120	Coma	009 CNS	Final

RISK MANAGEMENT ISSUES

AD1014	Access/scheduling/waiting issues
CJ2011	Selection and management of therapy-Labor and delivery
CO1003	Communication among providers-Poor professional relationship/rapport
CS1001	Failure to identify provider coordinating care
CS9009	Lack of/Failure in system for Patient Care, other
CO2017	Communication between patient/family and provider-language barrier
CO2013	Patient not informed of adverse event
CJ1011	Patient assessment issues-Lack of /inadequate patient assessment-failure to note clinical info (lab values, diagnostic tests, symptoms)

Risk management issues



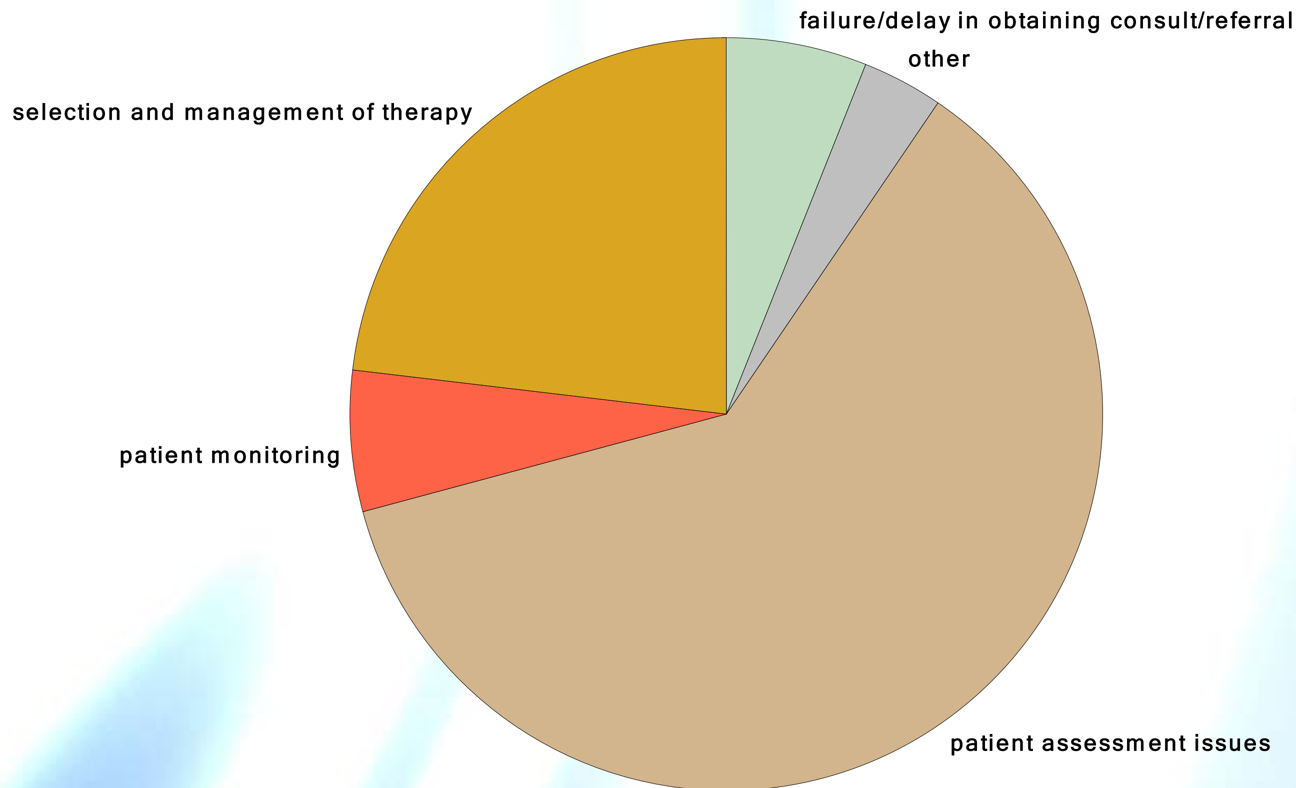
Risk management categories

Issues are identified from the case files – medical records, investigations, depositions, expert testimony, and so on.

Chart shows proportion of issues, by category, for the number of cases in an example healthcare system.

Risk management issues are categorized further by sub-category and detailed issue.

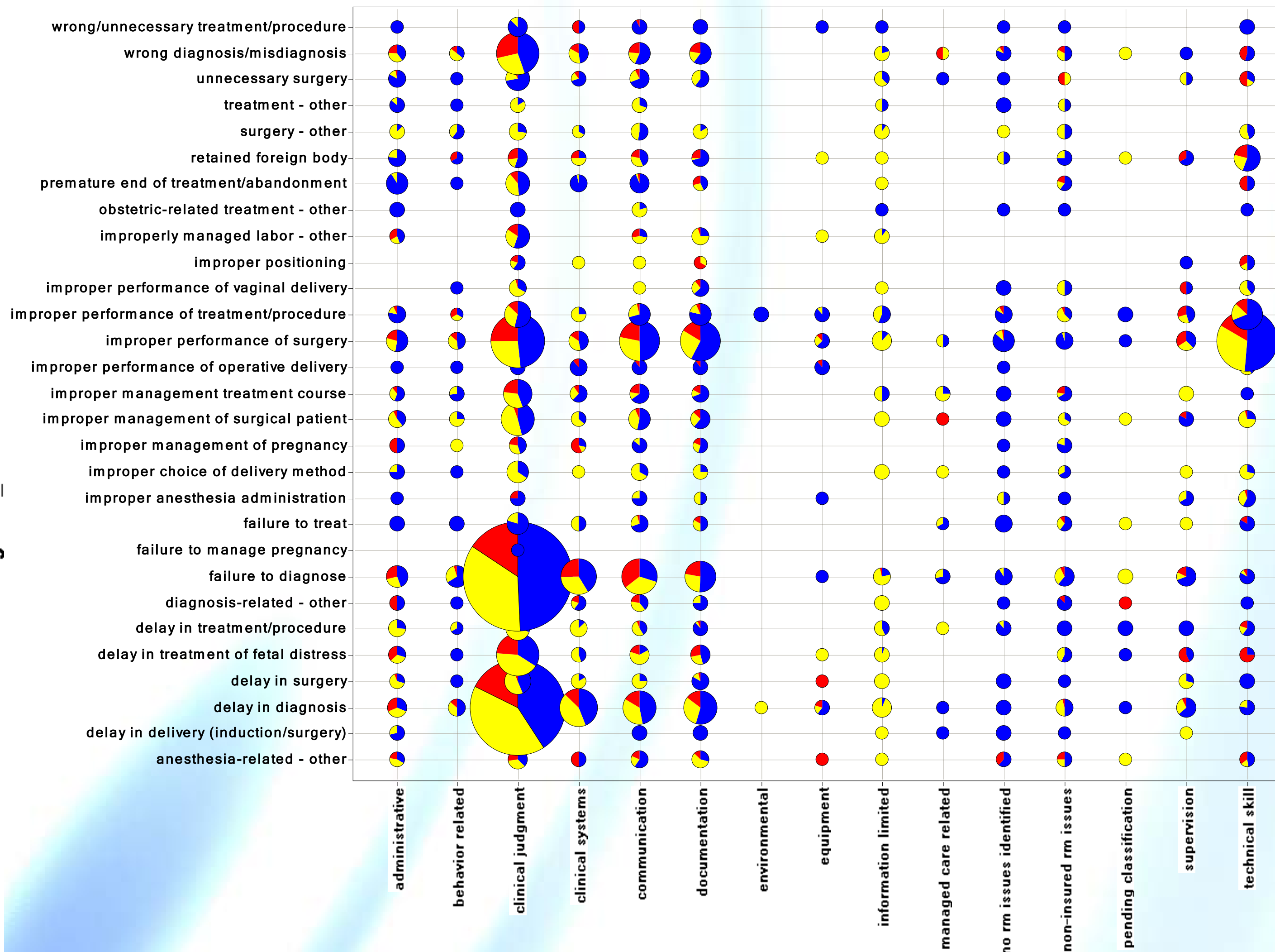
Clinical judgment breakdown



<u>Clinical judgment sub-categories</u>

Chart shows the financial value of cases for various sub-categories of clinical judgment risk management issues, for an example healthcare system.

Allegations by risk management categories



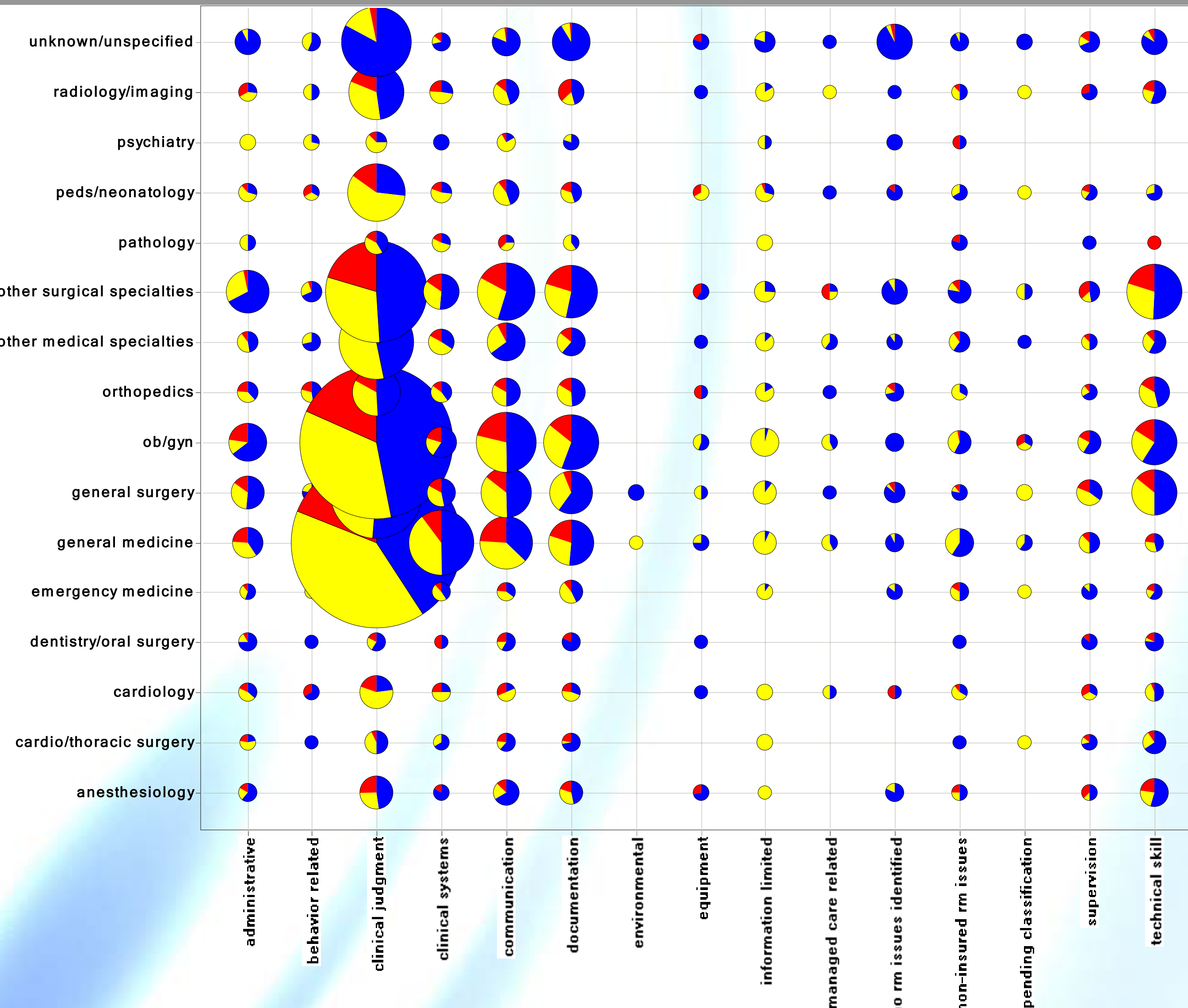
Allegations and risk management categories

Allegations are asserted by the plaintiff. Issues are identified from the case files – medical records, investigations, depositions, expert testimony, and so on.

Chart shows the number of cases for allegation in a specialty category, for an example healthcare system.

The size indicates number of cases, red indicates cases with payment, blue cases without payment, and yellow cases still open.

Specialties by risk management category



Specialties and risk management categories

Defendant specialties and issues from the case files – medical records, investigations, depositions, expert testimony, and so on.

Chart shows the number of cases for risk management issues in a specialty category, for an example healthcare system.

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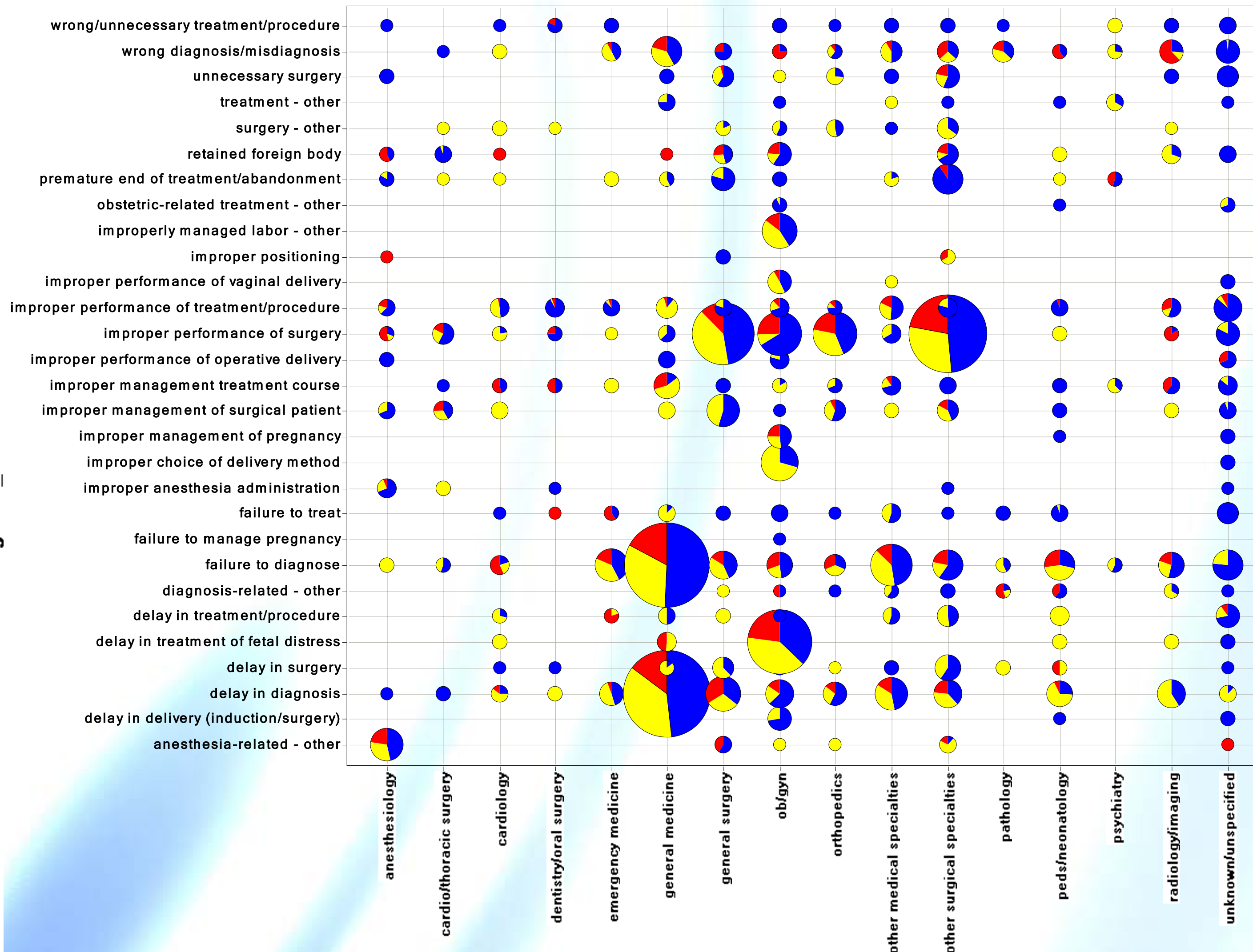
Allegations by specialty



<u>Allegations and defendant specialties</u>

Allegations are asserted by the plaintiff.

Chart shows the number of cases for allegation in a specialty category, for an example healthcare system.

The size indicates number of cases, red indicates cases with payment, blue cases without payment, and yellow cases still open.

OB Case Example Learning

Questions to Ask	Recommendations	Interventions
Is there a teamwork issue in the OR?	Differentiate/eliminate look-alike and sound-alike packaging and products	Standardized shift reports
Are there staffing issues in L&D?	Drive out fear	Teamwork training
Are interpreters available when needed?	Improve access to information	Clarification of policies
Are there checklists for class II airways?	Improve direct communications	Improved availability of code teams
Is stress common?	Increase immediate feedback	Redesign of waiting areas to make patients visible to staff
How can scheduling be improved?	Obtain leadership commitment	Redesign of workflow for high-activity periods
Are nurses able to speak frankly with physicians?	Optimize the work environment for safety	Checklists for triage nurses
Are staff trained with the technology?	Reduce handoffs	
Are staff trained to deal with family?	Reduce multiple entry	
Are handoffs standardized?	Reduce reliance on memory	
	Reduce reliance on vigilance	
	Simplify the process	