FEATURE: MEDICAL PRACTICE  TRANSPARENCY OF PHYSICIAN INFORMATION: what physicians need to know

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from the CEO   The CMPA is preparing for our major member event of the year, the 2016 annual meeting and information session, which will be held on August 24th in Vancouver. If you have ever been interested in understanding how the CMPA determines and optimizes your fees to deliver cost-effective medical liability protection, I would urge you to attend. Learning how the modern CMPA functions as an essential component of the healthcare system is both important and interesting.

The year’s topic of the information session is “Opioid prescribing: Conversations. Collaboration. Solutions.” I’m sure you will agree that opioid prescribing for chronic pain is a serious and complex issue. To put the problem in perspective, Canada ranks second only to the United States in per capita consumption of prescription opioids. Also, the use of prescription opioids in North America is more than double that of the European Union, Australia, and New Zealand.¹

Clearly, the increasing use and abuse of opioids is a phenomenon that requires urgent attention. The CMPA believes we need a better understanding of the underlying reasons for over-prescription and over-utilization of opioids and what can be done about it.

In Vancouver we intend to share meaningful information about the CMPA’s experience with medical-legal difficulties associated with opioid prescribing and look at specific approaches that have worked for some physicians, so that other physicians may improve their opioid prescribing practices.

Educating physicians about prescribing appropriately is just one means of addressing the problem. As a society, we also need to come to grips with the multitude of existing system issues, and develop system-level improvements aimed at preventing harm from opioids. For example, better controls and systems to track opioid prescriptions would help physicians to know when a patient is seeking opioids from more than one doctor. Supports for physicians practising in regions of high drug use and who may be challenged or threatened by patients to provide prescription opioids may also help.

The CMPA’s information session will include a panel of experts from Canada and the United States who will discuss and answer questions on many aspects of opioid prescribing. I believe the session will be highly valuable for attendees, and for those of you who cannot be there in person, a webcast of the session will be available on our website.

So, welcome everybody! I invite you to attend what will undoubtedly be a thought-provoking session, and look forward to seeing many of you in Vancouver.

Hartley Stern, MD, FRCSC, FACS

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The newborn with jaundice: we can do better

Learn what two recurring risk themes were found in the CMPA’s medical-legal cases involving newborns with severe hyperbilirubinemia and how you can reduce these risks in your practice.

“Dictated but not read”: unreviewed clinical record entries may pose risks

Do you use the phrase “dictated but not read” in your transcribed reports or entries into medical records? Find out how to use the phrase appropriately.

Improving teamwork and communication in an emergency

Two recurring areas of risk in CMPA’s medical-legal cases involving obstetrical emergencies are communication and teamwork. Read how to avoid these in your practice.

Who is the most responsible physician? Check your knowledge

Identifying the “most responsible physician” is not always straightforward, particularly in hospitals and other institutional settings.

Transparency of physician information: what members need to know

As medical regulatory authorities (Colleges) make more information about physicians available to the public, the CMPA is working to ensure that information is necessary.

Coordinating critical care: Communication challenges for providers and patients

Discover how effective communication can help keep critical care well coordinated.
The newborn with jaundice: we can do better

Severe hyperbilirubinemia — defined as a total serum bilirubin of greater than 340 μmol/L in the first 28 days of life — can lead to serious complications such as encephalopathy and kernicterus. Despite the condition being largely preventable with the proper testing and diagnosis, infants today continue to suffer debilitating complications.¹,²

Almost 10 years ago clinical practice guidelines were published to assist healthcare providers and hospitals manage the condition and lower the number of incidents.³ and, while overall numbers have fallen since that publication,⁴ potentially preventable cases are still occurring.

In an analysis of its medical-legal files involving jaundice in newborns, the CMPA has identified two recurring risk themes and, based on the peer experts’ opinions, has also identified actions hospitals and providers can take to reduce these risks to susceptible newborns.

CASE EXAMPLE

The baby at risk for hyperbilirubinemia

A woman prepares to leave the hospital with her newborn after a two-day stay post-delivery. The baby, born late pre-term, appears healthy with mild jaundice and a bilirubin level of 168 μmol/L at 42 hours. The mother is a glucose-6-phosphate dehydrogenase (G6PD) deficiency carrier and the baby’s brother has the condition. At discharge, the pediatrician advises the mother to watch for increased jaundice and signs that the baby is unwell.

Two days later the mother brings her baby to a follow-up appointment. Her regular physician is away, so she sees a second pediatrician who is covering for her regular physician. The second pediatrician notes that the baby is slightly jaundiced but that the mother reports the infant is breastfeeding well and voiding adequately. He instructs the mother to watch for increased jaundice and signs that the baby is unwell.

Three days later, the mother is concerned that her baby is lethargic and not feeding well. She takes him to her regular pediatrician. The
Hyperbilirubinemia (jaundice) is common in newborns and usually does no harm. But failure to identify and monitor severe hyperbilirubinemia ranks in the top 15 risks in healthcare based on total claims costs compiled by the Healthcare Insurance Reciprocal of Canada (HIROC).1 Canada has previously reported the highest incidence of severe hyperbilirubinemia (1 in 2480 live births) in the developed world.2

In 2007, the Canadian Paediatric Society (CPS) published guidelines for the detection, management, and prevention of hyperbilirubinemia.3 However, not all Canadian hospitals or physicians have adopted them. By 2012, about 79% of Ontario hospitals reported having implemented the guidelines.5 And a national survey found that only about 75% of pediatricians, 69% of midwives, and 40% of family physicians were using them.6

During the years from 2000–2014, the CMPA identified 16 medical-legal cases (11 legal actions and 5 complaints to a regulatory authority [College]) involving hyperbilirubinemia or kernicterus. While recent surveillance data demonstrate a decrease in the minimum estimated incidence of severe neonatal hyperbilirubinemia,4 six of these cases occurred after publication of the national guidelines. Ten cases had major or catastrophic injuries, such as severe hearing loss and cerebral palsy. Six cases involved peer expert criticism of a physician’s clinical care.

physician remarks that the baby is very jaundiced and orders a serum bilirubin test. The level is over 500 μmol/L. He immediately admits the baby to the hospital for phototherapy and IV fluids, and arranges for transfer to a tertiary care hospital for exchange transfusion. The infant is diagnosed with severe hyperbilirubinemia with related encephalopathy. Screening reveals G6PD deficiency and an MRI is consistent with kernicterus. Despite aggressive treatment, the child is left with profound hearing loss and cerebral palsy.

The CMPA pays a settlement in response to a legal action, on behalf of the second pediatrician. Experts are critical of this doctor for failing to order a serum bilirubin test at the initial follow-up appointment; knowing the baby’s bilirubin level would have been helpful in the management of his jaundice. Furthermore, a peer expert states that the baby’s risk factors, namely late preterm birth and family history of G6PD deficiency, required that he be followed very closely for a potential increase in serum bilirubin.
Themes found in CMPA files point to either a poor understanding of newborn jaundice or poor adherence to the published guidelines. These included:

- failure to consider patient risk factors, including prematurity, Rh incompatibility, ethnicity, and G6PD carrier status
- inadequate monitoring or follow-up of bilirubin levels, including inadequate discharge instructions for follow-up blood work
- delay in transfer of the patient to a tertiary care hospital for treatment or assessment by a specialist
- delay in treating the patient with phototherapy or an exchange transfusion
- early discharge of a premature infant

Some of these themes were highlighted in a report on the U.S.A. Kernicterus Registry, which also found that a lack of understanding of the potential neurotoxicity from hyperbilirubinemia contributed to cases of kernicterus. Additionally, several system issues were identified such as multiple providers providing services at multiple sites; early discharge (<72 h of age) associated with lack of pre-discharge screening and/or failure to have the bilirubin level checked post-discharge; and inadequate breastfeeding support.

**Using the guidelines, identifying babies at risk**

Although rare, kernicterus is a serious complication that can be prevented in most cases by using organizational checks and balances such as plotting bilirubin values on the hourly nomogram available with the Canadian guidelines.

Importantly, all providers who care for mothers and newborns should be aware that the Canadian guidelines were written for the prevention, detection, and management of jaundice in otherwise healthy term and near-term infants. Babies who have significant risk factors for pathologic hyperbilirubinemia need more focused care. Providers must carefully interpret the prenatal history of these at-risk infants and take appropriate action.

To determine their readiness for care for newborns with jaundice, providers and hospitals may ask themselves:

- Are we aware of the risk factors for jaundice?
- Are we aware that some babies are at greater risk for pathologic jaundice and should be identified as needing an even more focused approach to their care?

**Risk reduction considerations based on experts’ opinions in the CMPA cases**

- Keep up-to-date on current guidelines for the detection, management, and prevention of hyperbilirubinemia.
- Complete an appropriate history, noting relevant risk factors for hyperbilirubinemia, including comorbidities and family history.
- Be aware of the delivery and neonatal characteristics (e.g. prematurity [< 38 weeks], higher birth weight, exclusive breastfeeding) that can place an infant at higher risk of hyperbilirubinemia.
- Consider whether additional diagnostic tests or consultations are necessary to establish or confirm the diagnosis.
- Have a systematic approach for the detection and timely follow-up of hyperbilirubinemia and consider whether further investigation or referral is indicated.
- Provide clear discharge instructions including follow-up instructions and when to seek further medical attention.

**Use of the Canadian Paediatric Society’s hyperbilirubinemia guidelines:**

- **79%** Ontario hospitals
- **75%** pediatricians
- **69%** midwives
- **40%** family physicians
How strong are your systems, what are your vulnerabilities?

- Have you or your hospital implemented the CPS’s Guidelines for the detection, management and prevention of hyperbilirubinemia in term and late preterm newborn infants?
- Do you have access to maternal prenatal records so you can identify risk factors?
- Does your hospital use appropriate hour-specific bilirubin nomograms?
- Is there a process to ensure that bilirubin results are reported in a timely fashion to the most responsible physician?
- Can you and your hospital identify and treat babies in need of intervention in a timely fashion, including having systems for the transfer of babies who require exchange transfusions and tertiary care?
- Do you or your hospital review discharge instructions with the parent(s) and then provide them with supporting written material?
- What resources are available to breastfeeding mothers? How do they find out about these resources?
- Are adequate post-discharge processes in place to ensure appropriate follow-up and testing of newborns, including contact information for the parent in need of advice?
- How do you communicate with other healthcare professionals who will be providing follow-up?

“dictated but not read” unreviewed clinical record entries may pose risks

Many physicians dictate reports or chart entries in the course of providing medical services. In some cases, the transcribed reports or entries are marked “dictated but not read” and entered into the medical record or forwarded to the referring physician without prior review by the dictating physician. The report or entry may be reviewed and authenticated several days later or not at all, in which case the “dictated but not read” notice remains on the clinical record.

Marking transcribed reports or entries “dictated but not read” alerts readers that the author has not yet reviewed the transcription for accuracy. It prevents delays in the report or entry being included on the patient’s chart, thereby facilitating ongoing patient care. However, the practice also gives rise to some medical-legal risks for the author and can create uncertainty for those relying on the transcribed information when providing patient care. These concerns apply both when dictation is transcribed manually and when using speech recognition software.

**Medical-legal risks**
A significant risk associated with the practice of marking reports or entries “dictated but not read” is the possibility that incorrect information becomes part of the patient’s medical record indefinitely. The incorrect information could be relied upon by other physicians when making treatment decisions, increasing the risk of a patient safety incident. This could lead to a legal action involving the dictating physician and possibly the subsequent treating physician.

A patient who is injured as a result of an error in a dictated and unreviewed report may launch a legal action claiming that the physician who made the dictation was negligent. In this situation, the patient would have to establish that the error in the report was a breach of the standard of care on the part of the dictating physician. When a physician knows that their unreviewed notes will be relied on by other practitioners, a court could expect the physician to meet a high standard of care with respect to those notes. This might include an expectation that the initial dictation was error free or that the notes were promptly reviewed.

The time the report remained unreviewed, and the reason it was unreviewed for that period, will likely be important in determining a physician’s exposure to liability. In most cases it is unlikely that administrative convenience or efficiency will be accepted as a legitimate rationale for failing to ensure that a transcribed report is reviewed for accuracy and finalized within a reasonable time.

The transcriptionist will also likely bear some responsibility for the patient’s injury resulting from a negligently transcribed dictation. As well, the physician who relied on a report that she or he knew had not been reviewed by the dictating physician might also be named in the legal action. The court will determine whether it was negligent for that physician to rely on the unreviewed report based on the specific facts and circumstances of the case.

**Record-keeping requirements**
Physicians should maintain medical records in accordance with applicable legislation and institutional and regulatory authority (College) policies. Those policies and legislation may require physicians to review and sign dictations within a specified period of time. Some hospital policies may include guidance or limitations on the use of the “dictated but not read” notation. Physicians who fail to comply with applicable record-keeping requirements may be subject to disciplinary action by their hospital, health authority, or College.
MEDICAL RECORDS IN LEGAL PROCEEDINGS

Proceedings are often brought many years after the advice or treatment was provided and a physician may not have an independent recollection of the patient. For that reason, accurate medical records are often a physician’s best defence. Conversely, inaccurate or incomplete records can be highly detrimental to a physician’s defence.

The practice of using “dictated but not read” notations may result in a physician being confronted with a record in the course of legal proceedings and recognizing only then that it does not accurately reflect the care provided or the patient’s condition. A court may draw an adverse inference against a physician for any attempt to challenge the accuracy of the record.

RISK MANAGEMENT CONSIDERATIONS

- Avoid including unreviewed dictated reports or entries in medical records.
- In circumstances where it is necessary for a transcribed but unreviewed report to be included in the record, ensure that the report indicates that it has been “dictated but not read” and, at the first opportunity and within the timeframe required by hospital or health authority rules and applicable legislation, review the transcribed report to ensure its accuracy.
- Contact the author for clarification if you are relying on a record marked “dictated but not read” and where serious consequences could result from an error in that report or where there is ambiguity in the entry.
- If you find an error in an entry or report you dictated, notify any practitioners you can reasonably assume have relied on that entry or report, and sign and date an addendum that preserves the original record but clearly shows the corrections made.
transparency of physician information: what members need to know

The Medical Post’s 2015 Canadian Physician Trends Survey found 69% of doctors believe their provincial medical regulatory authority (College) will become more involved in their practices over the next five years. The survey also revealed physicians are almost evenly divided as to whether or not they believe their provincial College is supportive of the medical profession.¹

These findings are not surprising. In the last few years, medical regulatory authorities have taken some well-publicized steps to ensure public safety and enhance their own public accountability. These steps have included increasing the amount of information about doctors that they make available to the public in registries, including those posted online. While each College maintains a public register that includes specific information about each doctor practising in their jurisdiction, the information being made available by Colleges varies. The CMPA’s focus is to ensure the information publicly available is necessary to fulfill the College’s statutory mandate to protect the public.

COLLEGE ACTIVITIES
All Colleges are feeling the pressure of public accountability and are taking a variety of steps to address this. For example, the College of Physicians and Surgeons of Ontario (CPSO) was among the first to use a multi-phase approach. The CPSO approved new bylaws in 2015 to post a range of additional information on its public register.² The information includes criminal charges, cautions in-person, specified continuing education or remediation program (SCERP) orders, discipline findings, and licences in other jurisdictions. The CPSO makes public any undertakings against a physician, as these are generally seen to be tied to issues that are either moderate or high risk to the public. Most recently, the College implemented a policy whereby disciplinary decisions involving criminal activities will be forwarded to the police.³

In September 2015, the College of Physicians and Surgeons of Newfoundland and Labrador announced that it will make more information about physicians available on its website including licence or practice restrictions.⁴ The College of Physicians and Surgeons of Saskatchewan allows the public to access a variety of information about physicians in that province, including medical education, qualifications, licence history, and discipline history.⁵

MEMBER ASSISTANCE
CMPA members requiring support when their personal information is available to the public are encouraged to contact the Association. A physician advisor can offer confidential support, assistance, and advice on Colleges’ processes.

Physicians are reminded to remain professional and objective when their personal information is placed on the public register. Focusing on appropriate continued medical practice, knowledge, and clinical skills is recommended. It is also important to remember that most patients will continue to seek care from the physician they know and trust, even when an online registry lists an adverse ruling. Physicians should seek personal support or professional help if a College-related matter results in excessive anxiety or distress.
WHAT IT MEANS FOR PHYSICIANS

The CMPA estimates more than 75% of the complaints made to the Colleges about doctors are dismissed outright or dismissed with some concern, yet doctors experience stress and anxiety when dealing with a College complaint or proceeding. This anxiety may have negative effects on a physician’s personal life or medical practice, and some physicians even consider leaving medicine or changing the scope of their practice to minimize the risk of future complaints. With Colleges making more physician information available to the public, the CMPA believes a balanced approach must be struck that includes reasonable precautions to protect public safety and respect for the privacy rights of individual physicians.

When information about a physician is placed in a College registry, particularly online, doctors’ anxieties normally revolve around how much will be made public, especially frivolous or unproven allegations. Physicians are also concerned about what information they must disclose to their hospital or regional health authority, as many of these organizations are requiring physicians to disclose information about a variety of topics. Additionally, in considering whether to accept disposition of a College complaint, many physicians worry about the outcome being made public.

CMPA ADVOCACY EFFORTS

The Association regularly communicates with medical regulatory authorities about protecting physician information. The CMPA generally encourages the Colleges to consider whether the information is necessary to protect the public and to balance this against the physician’s right to privacy. In specific cases, the CMPA may ask the College not to publicly distribute information about a physician on the basis that it is not relevant to the protection of the public. In other cases, the Association might suggest the College provide written notification to the affected physician in advance of publicly posting the information.

Improving teamwork and communication in an emergency

Obstetrical emergencies can be catastrophic and require immediate and capable management from the healthcare team. Although rare, these emergencies can occur at any time and often without much warning. Optimizing teamwork and communication will improve the team’s response to obstetrical emergencies and, as a result, enhance the safety of care for mother and baby.

An analysis of 169 CMPA closed medical-legal cases involving obstetrical emergencies over the past 10 years focused on the recurring themes of teamwork and communication. The main problem for all members of the care team was not clearly communicating in these situations. Emergencies included shoulder dystocia, placental abruption, cord prolapse, and maternal hemorrhage. Nearly three-quarters of patients in these cases experienced harm.

PROBLEMATIC TEAMWORK

Several factors were identified as impediments to teamwork in the reviewed cases, and involved all team members including physicians, nurses, and residents. These factors included lack of verbally articulated team situational awareness, intimidation felt by some team members, unclear roles and responsibilities, and non-adherence to policies and clinical practice guidelines.

Nurses and residents in the analyzed cases were found to not be informing the attending physician of changes in fetal or maternal status, and to be omitting critical information in their updates, both verbally and in the medical record. The most commonly overlooked information was the presence of atypical or abnormal fetal heart rate (FHR) tracings. Physicians, meanwhile, were found not to be seeking out sufficient clinical information on the patient’s condition when discussing the case with team members, or failing to recognize the significance of the information communicated to them.

Studies show that communication breakdowns are leading contributors to serious obstetrical patient safety incidents.1,2
**CASE EXAMPLE**  **COMMUNICATION BREAKDOWN BETWEEN HEALTHCARE TEAM MEMBERS**

A multiparous woman with gestational diabetes is induced at term due to new onset of gestational hypertension. She is given prostaglandin and IV oxytocin. Several hours later, the patient receives an epidural, the obstetrician ruptures her membranes, and meconium is noted. During this time, the FHR tracing is normal. Three hours later, the obstetrician notes the patient’s cervix is 5 cm dilated. Over the next 30 minutes, while the patient is observed by the nurse and resident, the external fetal monitor records significant decelerations, absent variability, slow recovery barely to baseline, and episodes of compensatory tachycardia. The resident re-examines the patient, notes that the cervix is 9 cm dilated, and calls the obstetrician about the dilatation and the decelerations. The obstetrician instructs the resident that the decelerations can be attributed to rapid dilatation, and to continue monitoring. He instructs the resident to inform him of any further decelerations.

Fifteen minutes later, the nurse asks the obstetrician to attend in person to review the persistent decelerations. Upon arrival, the obstetrician concludes that the tracing has been abnormal for the last 45 minutes, and he decides to perform a vacuum-assisted delivery. After two contractions, a limp baby is delivered in need of aggressive resuscitation.

The resident and nurse are questioned by the hospital review committee as to why they did not notify the obstetrician sooner about the changes in the FHR tracing. They explain that they did not think at the time that the situation was worrisome, and that they felt intimidated by the obstetrician’s gruff manner. The committee reviews the documentation made by the nurse, resident, and obstetrician, and finds that their sparse notes are contradictory and do not adequately convey the situation and clinical thinking. The committee concludes that the patient’s care was mismanaged, that there was delay when delivery should have been expedited, and that crucial information was not properly communicated between members of the team.

**INEFFECTIVE COMMUNICATION**

Ineffective communication hindered a response in many situations in the reviewed cases. Factors that contributed to miscommunication included chaotic workplace environments, ineffective hospital paging protocols, inadequate handovers, and poor communications skills. Where communication breakdown was identified in the reviewed cases, hospitals often responded with changes to processes and protocols. These changes included the creation of contingency plans when physicians do not respond to pages or cannot attend, and the development of structured tools for sharing information at shift change or during handovers. The following case illustrates how failing to communicate clearly during an emergency can contribute to a serious outcome.

**CASE EXAMPLE**  **MISCOMMUNICATION OF URGENCY**

A family physician is attempting a vacuum extraction to deliver a baby whose FHR tracings show profound decelerations. The unit has been very busy overnight, and the incoming team has many patients to discuss at handover. The physician asks the outgoing nurse to page the on-call obstetrician for assistance. His request is not passed on to her replacement. The physician leaves the patient’s bedside to seek out the obstetrician, who upon arriving reviews the FHR tracing and determines that an urgent caesarean section is needed. As the urgency is not well communicated to the operating room (OR) personnel, there is a delay in the transfer of the patient. The anaesthesiologist does not attend urgently because he is under the impression that the indication is elective and not urgent. Forty-seven minutes later, a stillborn infant is delivered.

The patient files a legal action. Peer experts reviewing the case are critical of several aspects of care, including the unreasonable delay in performing an urgent procedure. Following this event, the hospital implements an improved process to prioritize caesarean section bookings.
IMPROVING COMMUNICATION IN OBSTETRICAL EMERGENCIES

The following suggestions, aimed at fostering a culture of safety with open and respectful communication in obstetrical units, are based on expert opinions in the reviewed CMPA cases.

For physicians in practice:

▪ Obtain informed consent, and keep the patient informed of changes in the treatment plan as they develop.
▪ Clearly verbalize concerns with team members about the patient’s condition to enhance the team members’ situational awareness, and confirm that the team recognizes the urgency.
▪ Use a structured communication tool for sharing information at handover and when providing progress reports, regardless of whether these exchanges are verbal or via the medical record.
▪ Consider using a standardized documentation template for situations in which timelines are important (e.g. shoulder dystocia, assisted vaginal deliveries).
▪ Debrief with the team following an urgent delivery or patient safety incident to review the sequence and timing of events and the effectiveness of team communication. All team members should document the care provided and the information should be consistent.
▪ Following an obstetrical emergency, discuss the circumstances and outcomes with the patient and her family. Consult the CMPA handbook Disclosing harm from healthcare delivery, or contact the Association for individual advice on disclosure.

For physicians in leadership roles:

▪ Develop and encourage use of strategies to escalate clinical concerns within a team environment.
▪ Facilitate and encourage simulation training and drills to practise team shared situational awareness, effective communication, and crisis response.
▪ Clearly define the roles and responsibilities of each team member to optimize care coverage and responsiveness.
▪ Encourage regular reviews and updates of communication policies and training. Periodically evaluate adherence to such policies and quality improvement activities.

Lack of communication with patients is frequently the basis for hospital and medical regulatory authority (College) complaints in which patients allege they were not fully informed about their care, such as the reasons for necessary treatment or the risks associated with anticipated procedures.

More information

The CMPA Good Practices Guide, at www.cmpa-acpm.ca/gpg, has more information on team communication, including structured communication methods, situational awareness, and approaches for speaking up.

spotlight on essential medical-legal concepts for physicians

who is the most responsible physician?

identifying the individual who is the “most responsible physician” is not always straightforward, particularly in hospitals and other institutional settings. but knowing who that person is at any given time is important for ensuring the delivery of safe and effective care.

the term most responsible physician (mrp), or most responsible practitioner, generally refers to the physician, or other regulated healthcare professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time. while typically the attending or admitting physician will be the mrp, this may not always be the case.

generally, a healthcare professional is not responsible for the care provided by another healthcare professional. often, more than one healthcare professional will owe a duty of care to a patient. when a referral is made to a specialist, the referring mrp is generally not responsible for the care provided by the consultant, even though that mrp continues to be responsible for coordinating the patient’s ongoing care — at least until a new treating physician can assume such care.

misunderstandings about who is responsible for a patient’s care during handovers can be avoided when there is open communication among the healthcare team and when systems are in place, such as the use of structured communications tools. this includes documenting the handover and communicating to patients and families on who is most responsible for care at particular points in time. hospital or institution policies and procedures that outline what is expected of the mrp may provide valuable guidance.

for more information on this topic, see “the most responsible physician: a key link in the coordination of care,” and “improving patient handovers,” available on the cmpa website at www.cmpa-acpm.ca.
Effective coordination of care is central to ensuring patient safety in the hospital. But, healthcare transitions or handovers are particularly challenging for patients requiring critical care. Factors such as frequent interruptions,1 the complexity of patients’ conditions and the required constant monitoring,2 and the need for full and frequent involvement of families or substitute decision-makers3 place added demands on the transfer of care in hospital.

The CMPA analyzed its medical-legal cases that involved patients in the intensive care unit (ICU) to identify issues with the coordination of care. Particular emphasis was placed on communication breakdowns that occur between departments or healthcare facilities. This analysis of 47 cases, closed between 2010 and 2014, found that these breakdowns occurred not just between healthcare professionals, but also between the care team and patients and their families.

A recurring theme was identified in the cases reviewed. Important clinical information was not being communicated during handovers, as evident in more than a quarter of cases. The missed information was most commonly about the patient’s acuity level; care plans, including tests performed and requiring follow-up; and medications, either received before transfer, or to be discontinued or resumed after transfer. These knowledge gaps often led to the receiving care team giving inappropriate care. Information was often missing because of non-structured handovers that lacked direct or face-to-face communication or the involvement of all members of the care team, as well as inadequate documentation.

More than a third of cases involved poor communication with families. Information not adequately shared or explained to families mainly related to the care plan including end-of-life decisions, consent discussions, the roles and responsibilities of the physicians involved in the patient’s care, and plans to transfer the patient. In their complaints families sometimes reported receiving mixed messages from different care providers.

System issues also played a role. In these cases, peer expert criticism focused on inadequate systems for tracking test results, lack of structured communication protocols for handovers, no reconciliation of medications, delays in the receipt of test results, and issues with access to critical information within an electronic health records system.
OPTIMIZE HANDOVER
Suggested approaches based on experts’ opinions in the cases reviewed:

- Consider using a structured communication tool for sharing information during handovers.
- Take a structured approach to reconciling key information from the patient profile (e.g. medications, allergies, and patient wishes including advance directives and special exemptions) at every transition of care. Ensure that important information is flagged for all members of the healthcare team. For example, communicate via signage, patient bracelets, verbally, or in writing.
- Verify the availability of advance directives and ensure that this information is communicated at handovers so that patients’ wishes are respected in the event they are unable to communicate.

INFORMATION BREAKDOWN

CASE EXAMPLE

Late in the afternoon, a stable, elderly male with heart disease is transferred to the ICU for monitoring of post-operative bleeding after endovascular aortic aneurysm repair. The resident on call accepts the handover from a nurse.

The patient is assessed several times that evening. During that time his hemoglobin drops to 81 g/L. The resident orders one unit of packed red cells. Two nurses administer the transfusion in the middle of the night while the patient is sleeping.

The next morning, while reviewing the patient’s record, the resident discovers a “Refusal of consent to blood and blood products” form indicating that the patient objects to these interventions on religious grounds. The resident advises the attending of this error, and a disclosure meeting is held later that day between the patient, his family, and several members of the healthcare team. The patient later files a legal action.

The CMPA, on behalf of the resident, and the hospital, on behalf of the nurses, pay a settlement to the patient. Hospital handover protocols requiring physician-to-physician transfer of information were not followed, appropriate precautions were not taken to identify a patient who had refused blood products, and nurses did not check with the patient before administering the transfusion. There was no expert support for the care provided by the resident as he did not read all relevant parts of the medical record before ordering a blood product.
LACK OF CARE COORDINATION

CASE EXAMPLE

A young person with multiple injuries from a motor vehicle collision is being cared for in the ICU. The orthopaedic surgeon (surgeon A) on call that evening orders a series of X-rays to evaluate the extent of the patient’s injuries, which include multiple fractures to the spine and ribs.

The X-rays are read the following day by the next orthopaedic surgeon on call (surgeon B). Surgeon B decides to perform a reduction under sedation to correct a dislocated elbow, after obtaining consent. Post-reduction, surgeon B notes some instability in the joint. He orders a follow-up X-ray and, at the end of his shift, informs the nursing staff that the orthopaedic surgeon coming on call the next day (surgeon A) will be assuming the patient’s care and asks them to inform the surgeon of the need to review the X-ray.

Three weeks later, surgeon A, who cared for the patient post-reduction, evaluates the patient again to assess the mobility in the arm. He notes instability and orders an X-ray of the elbow. When the X-ray, which shows persistent dislocation, is read, the initial post-reduction X-ray, which shows the same result, is discovered.

The patient files a legal action alleging that the delay to diagnose persistent dislocation contributed to ongoing pain and the need for additional surgery. A peer expert criticizes the handover, stating that surgeon B should have communicated directly with the next physician, surgeon A, about the post-reduction X-ray. Furthermore, the expert notes, both surgeons met several times over the month and therefore had opportunity to discuss this patient’s case. The longer than acceptable wait for imaging results was also criticized — this caused the report to be missed over a shift change. The CMPA, on behalf of both surgeons, and the hospital, on behalf of the nurses, pays a settlement to the patient for the miscommunication and for the inadequate imaging protocols.

Establish the plan

Suggested approaches based on experts’ opinions in the cases reviewed:

- Verbally communicate information relevant to the patient’s care directly to the most responsible physician at handover. (See the article, “Did you know...Who is the most responsible physician?” on page 15 of this issue.)
- Ensure a reliable system is in place to facilitate the timely receipt, effective review, and appropriate follow-up of imaging reports.
- Consider scheduling periodic briefings or “huddles” to review patient needs and care plans with all staff in the department involved in the care of the patient.

Issues within the ICU

Patient monitoring was the most frequently identified issue with coordination of care within the ICU. Specifically, healthcare professionals did not fully appreciate and communicate the significance of a patient’s deteriorating condition. Occasionally, cases involved members of the care team having difficulty reaching the required physician in an emergency. Other issues within the ICU were the same as with intra-hospital transfers. The most responsible physician for the patient’s care was not clearly identified, communication with patients or their families was inadequate, and (intra-shift) handovers were poor.
POOR COMMUNICATION WITH THE PATIENT OR FAMILY

CASE EXAMPLE

A regulatory authority (College) complaint is filed by the family of a middle-aged woman who died of a pulmonary embolism a day after being discharged from the hospital following complications from surgery. They allege that poor communication within the ICU led to her death.

The patient had experienced an anastomotic leak and abscess following a hemicolectomy to remove a suspicious lesion. These complications required she undergo additional surgery and admission to the ICU for monitoring. The family felt the patient was discharged too soon from the ICU and that her condition was not being taken seriously — the ICU physician decided to discharge the patient much sooner than the family expected based on what they had been told on the patient’s admission to the ICU. They also claim that at several points they were unaware of which physician was responsible for the patient’s care.

The College committee investigates the family’s complaints and determines that care was appropriate. Transfers of care were well documented, the decision to discharge from ICU was appropriate given the patient’s clinical picture at the time, and protocols for VTE prophylaxis were followed. The committee acknowledged, however, that communication with the family could have been improved as it was clear that the family members did not understand how and why care decisions were being made.

Foster open communication

Suggested approaches based on experts’ opinions in the cases reviewed:

- When multiple physicians are involved, confirm that the reason for the transfer of care is clear to the patient, family, or substitute decision-maker.
- Tailor your communication style to the individual’s needs.
- Document the information shared with the patient, family, or substitute decision-maker in the medical record, including the rationale supporting decisions about tests, treatments, discharge, and plans for follow-up.

The bottom line

This analysis highlights the importance of effective communication in the critical care context — not just between professionals, but also with patients, their families, or their substitute decision-makers. Reliable communication protocols, developed within a quality improvement framework, can help prevent the most common problems associated with poorly coordinated care.

CMPA Annual Meeting and Information Session

1:30 p.m. Annual Meeting
- President’s report
- 2015 Report of the Audit Committee
- 2015 Financial report
- 2017 Aggregate fees by region
- 2016 Council election results
- Q&A for members
- CEO’s remarks

Members who wish to initiate a motion for consideration during the annual meeting should complete a Notice of Motion form and Support for Notice of Motion form, and submit these to the CMPA at least 60 days prior to the meeting.

More information about the 2016 annual meeting and draft minutes of the 2015 annual meeting are available on the CMPA website at www.cmpa-acpm.ca.

3:00 p.m. Information Session
The CMPA has assembled a distinguished group of panelists to discuss an important and timely topic: Opioid prescribing: Conversations. Collaboration. Solutions.

Ms. Pamela Fayerman
Moderator
Medical/health issues reporter, Vancouver Sun

Mr. Phil Emberley
Director of Professional Affairs, Canadian Pharmacists Association

Dr. Benedikt Fischer
Senior scientist, Centre for Addiction and Mental Health
Professor, Department of Psychiatry, University of Toronto

Dr. Gary Franklin
Research professor, Departments of Environmental Health, Neurology, and Health Services, University of Washington
Medical director, Washington State Department of Labor and Industries

Dr. Heidi Oetter
Registrar, College of Physicians and Surgeons of British Columbia

Dr. Gordon Wallace
Managing director, Safe Medical Care, Canadian Medical Protective Association

4:30 – 5:30 p.m. Reception

Join us in Vancouver
The Fairmont Waterfront, August 24, 2016

More information: 1-800-267-6522 or executive@cmpa.org
Contact us if you have accessibility requirements.

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