• If you are viewing this course as a recorded course after the live webinar, you can use the scroll bar at the bottom of the player window to pause and navigate the course.

• This handout is for reference only. It may not include content identical to the PowerPoint. Any links included in the handout are current at the time of the live webinar, but are subject to change and may not be current at a later date.

© continued.com, LLC 2017. No part of the materials available through the continued.com site may be copied, photocopied, reproduced, translated or reduced to any electronic medium or machine-readable form, in whole or in part, without prior written consent of continued.com, LLC. Any other reproduction in any form without the permission of continued.com, LLC is prohibited. All materials contained on this site are protected by United States copyright law and may not be reproduced, distributed, transmitted, displayed, published or broadcast without the prior written permission of continued.com, LLC. Users must not access or use for any commercial purposes any part of the site or any services or materials available through the site.
Medical Errors: An Ounce of Prevention Is Worth A Pound of Cure

Brigette Cuffia PT, JD

Welcome and Thank you!

› 2 hour Webinar
› Topic is Medical Errors
› Goal: Introduce PTs/PTAs to their role in the prevention and reduction of medical errors as well as to appropriately manage the errors that do occur

Objectives

› Describe the phenomenon of medical errors in our current health care climate
› Identify areas of risk in daily PT practice
› Relate precautions and contraindications to medical errors in daily PT practice
Objectives

- Apply concepts of scope of practice, specifically related to pharmacologic intervention, to medical errors in PT practice
- Relate medical errors information to quality of care initiatives and practice management strategies
- Understand the relationship between ethical principles and medical error prevention

Objectives

- Develop a personal plan for prevention of medical errors that relates to your clinical practice
- Explore resources for error prevention and promoting a culture of safety

“Disclaimer”

The information provided in this webinar/online course is intended for educational purposes only. This information is in no way an advisory interpretation of any state practice act or legal advice. A good faith effort has been made to correctly reference and acknowledge all sources of information.
Overview of Issue
- Economic Impact
- Ethical Impact
- Legal/Regulatory Issues
- Risk Management Claims Data
- Daily Practice Applications – Development of a plan for Error Prevention
- Creating a Culture of Safety
- Patient Perspective
- Resources
- Questions and Answers

Where it all began...
- In 1999 the Institute of Medicine released a report entitled
  "To Err is Human: Building a Safer Health System"
  Report brief available at
  http://www.iom.edu/~/media/Files/Report%20Files/1999/To-Err-is-
  Human/To%20Err%20Is%20Human%201999%20Report%20Brief.pdf
  Medical errors are pervasive throughout our healthcare system: costly and deadly
  Errors are the result of major systems failures, not isolated individual actions
  Emotional response to report by multiple stakeholders

“Infamous” analogies
- Estimates of “at least 44,000 and up to 98,000” people dying per year due to preventable medical error” drew the comparison of a jumbo jet crashing every other day for a year
- Another almost inconceivable analogy is that more Americans die in the hospital due to preventable medical errors in a 6 month period than the total amount of American deaths in the Vietnam war
- *** neither of these quotes was in the actual report!
Numbers are shocking

- IOM Report indicated that these errors cost $17-$29 billion per year (more on costs later)
- Even more shocking these initial numbers estimated only INPATIENT errors – the IOM report did not include data on ambulatory/outpatient care
- Data was mined from medical records – so only errors reported in the medical record were counted

(Medscape General Medicine, 2000)

Important points from IOM report

- Serious errors are most likely to occur in EDs, ICUs and operating rooms
- Errors are multifactorial:
  - Decentralized and fragmented delivery system
  - Health care workers with minimal knowledge or training in error prevention
  - Systems failures within organizations

Important points from IOM report

- Common problems or errors:
  - Adverse drug events
  - Surgical injuries or wrong site surgeries
  - Suicides
  - Restraint related injuries or deaths
  - Falls
  - Burns
  - Pressure ulcers
  - Mistaken patient identities
4 pronged approach to improvement

Prong 1:
“Establishing a national focus to create leadership, research, tools and protocols to enhance the knowledge base about safety”

Specifically asking Congress to form and fund a “Center for Patient Safety” within the Agency for Healthcare Research and Quality

Prong 2:
“Identifying and learning from errors by developing a nationwide mandatory reporting system and by encouraging health care organizations and practitioners to develop and participate in voluntary reporting systems”

States to run mandatory reporting practices
Voluntary reporting should be confidential

Prong 3:
“Raising performance standards and expectations for improvement in safety through the actions of oversight organizations, professional groups and group purchasers of healthcare”

Regulation, accreditation, licensing, certification
Purchasers should create financial incentives for safe practices

CONTINUED
4 pronged approach to improvement

Prong 4:
“Implementing safety systems in health care organizations to ensure safe practices at the delivery level”

» Cultivate a culture of safety

Important Definitions / Key Terms

IOM Report definition of **medical error**
“the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim”

» Does not address harm in the definition
» Even something as simple as this broad definition caused controversy

Definitions of medical error

» Should distinguish from a medical complication (acknowledged risks of medical care)
» Can have an error without harm
  (Shanafelt, 2009)
» Error means always preventable
» Errors do not result from omissions
  (De Bos, 2011)
» Errors can result from omissions
  (Chamberlain, 2012)
Definitions of medical error

Describe by outcome:
"Near miss"
"Non-harmful event"
"Harmful Event"
"Death"

(Chamberlain, 2012)

Vs.
"Adverse Event" and "Preventable Adverse Event"

(Woods, 2007)

Led to key term: "sentinel event"
Used by the Joint Commission
Sentinel events require an immediate investigation
Sentinel event is NOT necessarily a medical error—can have an error that does not result in serious harm, can have a sentinel event that does not stem from an error

JointCommission.org/Sentinel Event

Key Term

Definition of Sentinel Event:

"An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome"

From the report: Sentinel Event Data: Event Type by Year 1995–2013 JointCommission.org
Key Term

Root Cause Analysis:
“Fundamental reasons for the failure or inefficiency of one or more processes. Points in the process where an intervention could reasonably be implemented to change performance and prevent an undesirable outcome. The majority of events have multiple root causes.”
From the Report: Sentinel Event Data: Root Causes by Event Type 2004–2013 JointCommission.org

The Joint Commission
› Independent Accrediting Body for Hospitals
› Does many different things to improve safety in hospitals including
    Collects voluntary reports of sentinel events
    Collects complaints about sentinel events
    Publishes information on sentinel event data—by year and by type
› Trend setter for significant amount of research into these 2 key terms

The IOM Report
› Consolidated 10plus years of research and data into a report that resulted in
› Public outcry
› Congressional hearings
› A Joint Commission response
› the Center for Patient Safety within AHQR
› Lots of op eds, rebuttals, conspiracy theories about reporting, anger, tears etc.
    And then what happened?

continued
5+ years later

› In 2006 a group of researchers searched Medline to review published data about patient safety
› Found that there was increased interest in the subject as evidenced by publications about patient safety including policy considerations and research awards
› Did not find information on improved clinical care

(Stelfox, 2006)

7+ years later

› Comprehensive study published on adverse events in ambulatory care leading to admission to the hospital resulted in over 2500 deaths as well as 4839 serious and permanent injuries

(Woods, 2007)

10+ years later

› Dec. 2010 Office of the Inspector General releases a report that states that 1 in 4 Medicare beneficiaries are “victims of medical harm”
› Estimates 180,000 deaths a year among Medicare beneficiaries alone

(Andel, 2012)
10+ years later

- Study in Health Affairs uses a “global trigger tool” to measure adverse events
- Finds that the methodology in the IOM report potentially grossly underestimated the number of preventable adverse events in hospitals
- The real number of inpatient adverse events is 10X what the IOM report suggests
  - (Classen, 2011)

10+ years later

- Study in NEJM Nov. 2010
- 10 acute care hospitals in NC
- Used this same “trigger tool”
- Found “little evidence” of decrease in the rate of harm from medical care between 2002-2007
- Used both internal and external reviews
  - (Landrigan, 2010)

10+ years later

- Concern among consumer patient safety groups remains high
- Example: SafePatientProject.org
- Gives our American healthcare system the grade of F secondary to minimal mandatory reporting, lack of transparency with errors, inadequate oversight of healthcare systems, and a weakened tort system that once helped to protect patients
  - (Consumers Union Report, 2009)

(continued)
Scope of the Problem

- Was extensive
- Remains extensive
- We know much more today than we did in 1999.
- Many goals in the 4 prongs of the original IOM report have been partially or fully met
- System change is being implemented in big and small ways

Scope of the Problem

- Where is PT in the patient safety discussion?
- Very little is known about medical errors or adverse events in physical therapy
- Ebsco Host, PubMed and Google scholar searches resulted in NOT ONE scholarly article about PT and Medical Errors
- 2 magazine articles in PT in Motion magazine as well as 2 APTA position statements were found… that’s it!

Scope of the Problem

- Medical Errors and Patient Safety are broad health policy topics
- We will organize our approach by looking at
  - Economic Factors
  - Ethical Imperatives
  - Legal Aspects including Risk Management
  - Practice Expectations/ Safety Culture
**Scope of Problem**

Explore the topic through different perspectives
An organizational strategy
Considering the title
*“An Ounce of Prevention is Worth a Pound of Cure”*
As PT’s how can we prevent errors?
How can we “fix” the errors that inevitably will occur?

**Economic Impact**

- Actual numbers are hard to determine
- Estimated $19.5 billion in costs in 2008
- Compare to a factoid from 2012 article citing a New England Healthcare Institute brief that suggests medication errors alone cost $21 billion dollars
- Different calculations on different definitions
- Many studies are old
  (Andel, 2012)

- Article published in 2011 which used data from 2008 found that the most frequent medical errors were
  - Pressure ulcers
  - Postoperative infections
  - Post laminectomy syndrome
  - The top ten problems identified cost more than 2/3rds of all errors
  (Van De Bos, 2011)
The article’s methods were actuarial; addressed groupings of claims data. Did not include injuries without claims such as errors of omission or costs beyond claims such as legal costs, over the counter medications etc. Lead author Van Den Bos states that their study is the first to subtract out the costs of care that would have occurred regardless of the error leaving only the costs borne from the error: An estimated $17.1 billion problem.

Impact of the economy: recession and post recession:
- Staffing shortages: nursing and pharmacy
- Elimination of FT staff for PRN or per diem staff
- Facility maintenance
- Equipment life span
  (Andel, 2012)

Historically costs of medical errors may have benefited the hospitals that caused the error in the first place through readmissions. PPACA prevents this phenomenon through new CMS regulations. CMS will no longer reimburse hospitals for:
- Preventable readmissions
- Health care facility acquired conditions

Continued
Economic Impact

If hospitals aren’t bearing the costs of medical errors, who is?
- Patients and families
- Insurance companies

Costs associated with medical error are economic but also physical, mental, social, emotional and impact quality of life

(Mello, 2007)

Economic impact

- What is the impact on PT of this economic information?
- Hospital based PTs will be integral personnel in identifying and preventing factors that would lead to hospital acquired problems: infections, falls, medication errors, pressure ulcers and readmissions
- Home care therapists are key in prevention of transitional incidents (more on that later)
- SNF/LTC therapists have similar concerns to hospital therapists
- Outpatient therapists: postlaminectomy syndrome!

Ethical Imperatives

Ethics for Physical Therapists: 2 prongs
1) Bioethical Principles:
   - Beneficence
   - Nonmaleficence
   - Autonomy
   - Justice
2) APTA Code of Ethics
   - 8 Principles related to core Values
Nonmaleficence “Do no Harm”

Acts and Omissions
Precautions and Contraindications

4 Principles of Bioethics are the life work of 2 bioethicists Beauchamp and Childress

Justice is also related

Errors occur more frequently in the elderly (Camargo, 2012)

Errors occur more frequently in the care of the very ill (Tamang, 2005)

Errors are more frequent in people who primarily speak a language other than English (Wasserman, 2014)

Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals.
(Core Values: Compassion, Integrity)
Principle 1

› "Equality" principle
› Relates to justice as discussed
› In 2007 Divi et al found that persons with LEP who experienced an adverse event were more likely to be harmed.
› Adverse event more likely to be a communication error.
› Harm was more likely to be serious.
(Wasserman, 2014)

Principle 1

› 3 common reasons for errors with patients with LEP:
• Use of non-qualified translators: family, friends, clinic staff
• Provider using a "get by" approach and translating for patients
• Lack of cultural competence understanding
(Wasserman, 2014)

Ethical Imperatives

Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.
(Core Values: Altruism, Compassion, Professional Duty)
“Fiduciary Duty”
Principle 2: A Duty is created

- A fiduciary relationship is holding another in your trust
- Hierarchical – PT has education, knowledge, resources/research, license
- Patient is in their care
- Patient does not have a corresponding duty to the PT
- Basis of “malpractice”

Ethical Imperatives

Principle #3: Physical therapists shall be accountable for making sound professional judgments.
(Core Values: Excellence, Integrity)

Scope of Practice issues

Principle 3

- Current practice related to pharmaceuticals
- We Do NOT prescribe: “take this”...
- We do Question, Analyze and Educate
- “Best practices”/standards of practice require us to relate what we know about the patient’s medications to their exam, interventions and overall plan of care
- Contribute to the team, work with the family physician, advise the specialist… will play different roles in varied settings
Many studies have found medication errors to be a leading cause of medical errors or adverse events.

Medication errors are so prevalent that in 2006 the IOM released a full report on the problem entitled Preventing Medication Errors.

From pharmacy to patient, medication errors occur at every link in the chain.

Recommendations from the report:
1. Educate and encourage patients to take a more active role in understanding the medicines they are using.
2. Act as a consultant to assist patients with their medication regime.
3. Expect each patient to catalog all medicines they are using as well as all doctors who are prescribing medications for them.
4. Ask specific questions related to patient response to medications and potential side effects or drug interactions.
5. Help patients to understand the risks associated with their medications.

Cultural change for many PTs:

New grad DPTs are comfortable with this practice.

We all need to be comfortable with this practice.

In resources section will have a link to “my medications” to help start the process with your patients.
Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

(Core Value: Integrity)

“Integrity” leads us to another big topic in medical errors… disclosure

- Should a patient be told of an error that occurred? If yes, how? When?
- If no, why not?
- Ethically, disclosure is an imperative
- Strong evidence does not exist to support the idea that disclosure creates lawsuits

Gallagher et al (2004) advocated for the disclosure of medical errors stating:
- Respects patient autonomy
- Endorses honesty
- Desired by patients
- Is required by accrediting bodies
- Many states of statutes related to apology
Principle 4

Disclosure does not occur because of:
- Fear of a malpractice suit
- Awkwardness/discomfort
- Fear of damage to his/her reputation

(Gallagher, 2004)

Principle 4

- Gallagher et al conducted focus groups with physicians and patients
- Found that physicians and patients had different concerns related to medical errors
- Patients looked at "errors" in a broad sense, physicians in a more narrow way
- Patients desired "all" information about an error, physicians "chose words carefully"

Principle 4

- Patients wanted a sincere apology
- Physicians are fearful to admit wrong doing even if the error was out of their control
- Both patients and physicians had an emotional reaction to an error
- Study concludes physicians may not be providing the communication and emotional support that patients need in regards to errors

(Gallagher, 2004)
Principle 4

- A 2010 article found discrepancies in attitudes towards disclosure of medical errors between physicians and risk managers.
- Risk managers knew more about hospital disclosure policies and procedures and were comfortable with disclosure *however* risk managers were not comfortable with physicians offering a full apology.
  
  (Loren, 2010)

---

Principle 4

- In contrast, physicians were not as knowledgeable or comfortable with disclosure but wanted to fully apologize to patients who were harmed.
- Conflict is inevitable with these differing attitudes and perceptions.
- Hospitals must work to improve collaboration between risk managers and physicians.
  
  (Loren, 2010)

---

Principle 4

- A 2012 article on disclosure stated that:
  - Patients are less likely to sue if disclosure is immediate, an apology is given, education is provided as to how future errors will be avoided and some sort of settlement or compensation is given.
  - Patients are more likely to sue if they think the physician or hospital is dishonest or misleading, or delaying disclosure.
  
  (Chamberlain, 2012)
Principle 4

- Chamberlain et al suggests:
  - Disclose in a timely manner
  - Be clear and concise in communicating the error
  - Explain potential outcomes
  - Apologize
  - Explain how error will be reported
  - Explain how similar errors may be prevented

Ethical Imperatives

Principle #5: Physical therapists shall fulfill their legal and professional obligations.
(Core Values: Professional Duty, Accountability)

Principle 5

- PT has many legal obligations:
  - Follow federal laws
  - Follow state laws
  - Practice within State Practice Act
  - Practice within an acceptable standard of care
  - Including do no harm!
Principle 5

- In legal section will cover more thoroughly what types of harm PTs have been shown to cause (as determined by insurance claim data)
- Under legal duties in ethics section will emphasize supervision
- PTs have a duty to properly supervise PTAs, aides/techs and patients themselves
- Legal/ethical duty to ensure that harm does not come to patients because of failure to supervise

Principle 5

- Examples of failure to supervise:
  1) Allowing a PTA to function outside of their scope of practice (varies state to state) i.e. allowing a PTA to perform some tests for the IE
  2) allowing a PTA to re-eval the patient
  3) allowing the PTA to identify and establish plans of care including goals outside the initial plan of care as established by the PT

Principle 5

- Examples of failure to supervise
  Expecting a PT aide/tech to teach exercises to progress exercises including the addition of weight to work 1 on 1 with a patient in a skilled activity
Principle 5

- Failure to supervise a patient
  - Falls in a patient who is a known fall risk
  - Falls or loss of a patient who requires restraints
  - Inappropriate restraint of a patient due to inattention
  - Pressure sores or ulcers due to inattention to position, equipment, seating, etc.
  - Miscommunication leading to injury

Ethical Imperatives

**Principle #6:** Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.

*(Core Value: Excellence)*

Principle 6

- Medical Errors can be reduced through clinical knowledge and through process knowledge
- Ex of clinical knowledge:
  - drug side effects and interactions
  - signs and symptoms of specific infections
  - outcomes and prognoses for various impairments/disabilities that establish a standard of care
Examples of process knowledge for the PT:
- knowledge of commonality of errors in specific practice setting or patient setting
- familiarity with root cause analysis
- communication imperatives
- reporting requirements
- disclosure requirements

Root Cause Analysis:
- Started in the auto industry
- Has been a Joint Commission requirement for 10+ years
- Looks at the system, not at individuals
- Is a management tool, not a patient care tool
- RCA is a series of questions used to determine why the medical error happened
  - (Sherwin, 2011)

Article in PT in Motion Magazine in 2011 about applying RCA to PT practice settings
- Asking questions to get to the “root” of the problem
- Recommends 5 layers of “Why?”
Principle 6

- Incident reports are not enough
- When an adverse event or medical error occurs gather everyone involved ASAP (even family members!)
- Ask everyone to contribute what they know whether it initially seems relevant or not
- Use the 5 whys technique to get to the root (Sherwin, 2011)

Principle 6

- Can use a root cause analysis for a suspected area of concern/error
- Can use a root cause analysis for a near miss event
- Once RCA is used to determine the origin or root of the problem systems can be changed to address it
- PT managers should be ready to conduct a RCA before an error occurs (Sherwin, 2011)

Ethical Imperatives

**Principle #7:** Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

*(Core Values: Integrity, Accountability)*
Principle 7

- Organizational behaviors that help to prevent medical errors:
  - General knowledge of what errors might occur in that setting or with a particular population
  - Endorsement of error prevention practices to address those common errors i.e. Hand washing to prevent infection
  - Process for communicating, documenting and reporting errors

Principle 7 (cont.)

- Organizational behaviors (cont.)
  - Plan to conduct a RCA
  - Plan to address error with patient/family
  - Plan to address “root” by systems change
  - Focus on systems, not isolated human error
  - Focus on integrity, don’t allow a cover-up

Ethical Imperatives

**Principle #8**: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.

*(Core Value: Social Responsibility)*
Principle 8

- Prevalence of medical errors suggests that every person that engages the health system in any setting has a decent chance of having an adverse event or outcome
- Think locally, think nationally, think globally: what are the risks of medical errors or adverse events and how can I work to prevent them?

Legal Issues

- Federal Statutes/State Statutes: Legislative
- Federal Administrative Bodies/State Administrative Bodies: Executive
- Case Law/Common Law: Judicial Branch
  - More common in a medical error situation to have information on insurance claims data rather than the outcome of a lawsuit

Legal Issues

- Policies that when enacted help to create "law" through standards of practice are created by independent bodies such as the Joint Commission
- For ex. Joint Commission requires frequent hand washing therefore this is an expected standard of care
### Legal Issues

- PTs have State Practice Acts which establish “law”: rules and regulations, scope of practice in that state
- PTs have body of research, information from professional groups (Ex. APTA) that also establish standards of care

### Legal Issues: Federal Laws

- IOM report spurred Congressional hearings, interest of the President and a move to create legal structures for reporting and accountability
- Patient Safety and Quality Improvement Act of 2005: primary goal is voluntary and confidential reporting

### Legal Issues: Federal Laws

- NEJM 2010 stated primary reason for continuous pervasive medical errors was lack of electronic record keeping
- Reported figures: at that time only 1.5% of hospitals had implemented “comprehensive” EMR, 9% had basic EMR, 17% had computerized order entry

(Landrigan, 2010)
Legal Issues: Federal Laws

Health Information Technology for Economic and Clinical Health Act:

Part of the American Recovery and Reinvestment Act of 2009
Over 20 BILLION dollars to promote the “meaningful” use of EHR
Effective Date: September 27, 2010
HealthIT.gov

Legal Issues: Federal Laws

- Not created to address medical errors but will have a significant impact
- “Meaningful use” provisions through 2014
- Goal: better communication, timely information, accessible data
- Allows for a major impact on patient safety using EMR
- The Health IT Patient Safety Action and Surveillance Plan: “Use health IT to make care safer, and continuously improve the safety of health IT”
  (HealthIT.gov)

Legal issues: PPACA

- PPACA had specific provisions related to patient safety AND further strengthened CMS’s role in preventing medical errors
- Requires a medical error “track record” from Medicare participating hospitals
- Create Patient Centered Outcomes Research Institute: http://www.pcori.org
- Establish Center for Quality Improvement and Patient Safety (within AHRQ)
Even before PPACA, Medicare was working to make errors costly:
- 2008: "reasonably preventable" errors will not be reimbursed (HAC: hospital acquired conditions)
- 2010 PPACA added: penalties or no reimbursement for readmissions related to HCA
Hospitals with better outcomes will receive better payments by 2014: hospitals with poor safety records face monetary penalties

Administrative Bodies within Department of Health and Human Services:
- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Services
- Centers for Disease Control and Prevention
- National Institute of Health
- HHS.gov

Joint Commission: independent not government agency
- Maintains Sentinel Event Database
- Establishes National Safety Goals
Legal Issues: State Laws

- State laws often mimic and reinforce federal law
- 50 different sets of state laws
- States may have reporting laws
- States may have protection for disclosure/apology
- States have their own administrative bodies—can act as regulatory or accrediting bodies
  - Ex. DPW in state oversees SNFs

Legal Issues: State PT Practice Acts

- 50 different Physical Therapy Practice Acts
- Rules and regs for PT practice
- Explicit on supervision, particular types of practice, mandatory reporting
- May be broad/implicit as to “following state laws”, “ensuring standards of practice”
- Absolutely must know and understand your State Practice Act

Legal Issues: Case Law/Common Law

- Learn more from analysis of malpractice data broadly than from individual cases
- Filed claims result in insurance company payouts
- Malpractice claim information is rich, documentation is extensive and has been examined thoroughly
  - In addition to medical record often includes depositions, expert opinion, possibly internal investigation information

(Gandi, 2006)
Legal Issues: Malpractice Data
Focus has been on hospitals and inpatient medical errors.
Study published in 2011 "Paid Malpractice Claims for Adverse Events in Inpatient and Outpatient Settings" found that inpatient and outpatient claims were similar using 2009 malpractice data.
Study authors warn that increasing outpatient safety from medical errors is more difficult than in inpatient care: more outpatient clinics, less oversight, less communication, often small, less training opportunities for staff etc. (Bishop, 2011)

Legal Issues: Malpractice Data
- 2006 Study "Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims" Gandhi et al.
- Data is important because "negligent misdiagnosis" is most common claim in ambulatory setting.

Legal Issues: Malpractice Data
- Of errors identified 59% were related to a serious adverse outcome, 30% resulted in death.
- Cancer was the diagnosis most often missed followed by infections, fractures, MI and embolisms.
- Errors were systematic and multifactorial.
  (Gandhi, 2011)
Legal Issues: Malpractice Data

- Errors included:
  - Failure to order an appropriate diagnostic test
  - Failure to create a proper follow-up plan
  - Failure to obtain an adequate history
  - Failure to perform an adequate physical examination

  (Gandi, 2006)

- Contributing factors were
  - Failures in judgment
  - Failures in vigilance or memory
  - Failures in knowledge
  - Patient related factors such as time in between appointments
  - Patient handoffs

  (Gandi, 2006)

- PTs practicing in outpatient this information sends a strong message:
  - Do a thorough patient history
  - Ask the right questions
  - Do a thorough patient exam
  - Inquire as to patient diagnostics, blood work, follow up, plan of care from patients perspective
  - Communicate with the referring physician or if direct access reach out to the PCP
Legal Issues: Malpractice Data

- HPSO-CNA studied Physical Therapy claims data available from 2001–2010
- In order of prevalence allegations were:
  - Improper performance using TE
  - Improper performance with physical agents
  - Failure to supervise or monitor
  - Improper performance of manual therapy
  - Improper management over the course of treatment


- In order of prevalence the injuries patients suffered most commonly were:
  - Fractures
  - Burns
  - Increase or exacerbation of injury/symptoms:
    - 34% shoulder
    - 22% low back
    - 19% knee


- What can we learn from this information?
- What systems and processes can we implement to prevent injury?
- How can we improve as individual practitioners and also in our clinics as a team, in our organizations as a unit?
Legal Issues: Malpractice Data

- Subject is controversial by nature.
- Right to sue, right to be made whole vs. need for tort caps, protection of individual providers, access to high risk specialties easily.
- What is impact of malpractice law on medical errors?
- Does the threat of being sued prevent transparency?

Legal Issues: Malpractice Data

- 2013 NY Times article “How Healthcare is Learning from Lawsuits"
  - Accessed at: http://www.nytimes.com/2013/05/17/opinion/how-healthcare-is-learning-from-lawsuits.html?_r=0

Legal Issues: Malpractice Data

- Study findings:
  - Transparency is increasing due to federal laws and accrediting body requirements as well as confidentiality protections for internally discussing error.
  - 80% of hospitals surveyed had an “apology policy.”
  - Malpractice data is a valuable source of info about medical error.
Legal Issues: Malpractice Data

- 95% of hospitals in the study use malpractice data in medical errors prevention
- Can find useful info for RCA in depositions, internal investigations etc.
- Hospitals typically underreport in incidences of error, med mal data is more detailed
- Lawsuits find errors that were not reported at all
- Closed litigation files can be used for teaching

Practice Applications: Creating a Safety Culture

- As PTs in daily practice, How can we use this information?
- Often setting specific: Hospital PTs:
  - What policies and procedures are in place at your institution to protect patient safety?
  - What initiatives are ongoing to prevent medical errors?
  - Do you know what to do in case of an error or incident? How to report?
  - Do you have an apology policy?

- Hospital PTs:
  - What are you doing individually to prevent the spread of infection, to prevent falls, to increase communication among disciplines?

- PTs who work in rehab or SNFs have similar concerns:
  - How are pressure ulcers prevented?
  - Is restraint use appropriate?
Practice Applications: Creating a Culture of Safety

- Home Care PTs have the great responsibility of monitoring the patient’s “recently resolved” acute medical condition:
  - Are vitals stable?
  - Any signs of infection?
  - What is the follow up plan?
  - Does the patient understand their new medications? Are they taking them appropriately?

2003 Study by Moore et al found that 49% of patients encountered at least 1 medical error related to discharge from inpatient to an outpatient setting.

Study found that discharge information is incomplete, inconsistent and not readily understood by the patient/family.

Practice Applications: Creating a Culture of Safety

- Outpatient Setting
  - *Differential Diagnosis* skills essential
  - Take a thorough history
  - Include medications list and education as necessary
  - Supervise staff appropriately
  - Administer modalities carefully
  - Monitor course of care closely
Across settings: Important issue: “Patient Handoff”

APTA BOD Position statement 2008

PHYSICAL THERAPIST OF RECORD AND “HAND OFF” COMMUNICATION HOD P06-08-16-16

Establish a “PT of record”

Ensure a strategy is in place for effective communication

Accessed at apta.org

---

Physical Therapist of Record is defined as:

*The physical therapist of record is the therapist who assumes primary responsibility for patient/client management and as such is held accountable for the coordination, continuation, and progression of the plan of care;*

PHYSICAL THERAPIST OF RECORD AND “HAND OFF” COMMUNICATION HOD P06-08-16-16

---

PT in Motion Magazine Article

“PT of Record” helps to identify PT/PTA in charge of patient’s course of care

May not be the PT who did the IE

“Hand off” between PT who performs IE and PT of Record should be a known and used policy and procedure

Encourages all clinical practice settings to make this distinction

Improve communication about the patient across their course of PT care

(Nicholson, 2010)
Practical Applications: Creating a Culture of Safety

- Clinics should also have P and P for changing the "PT of Record", detailing how the change will occur and how communication will be preserved.
- Practice management must consider the role of the per diem PT or coverage PT, the role of team based treatments and the use of PTAs when creating P and P for "PT of Record" (Nicholson, 2010)

Practical Applications: Creating a Culture of Safety

- Across settings PTs can:
  - Focus on known problem areas:
    - Examples: Initiatives to prevent falls
    - Education on back surgery outcomes
    - Strategies to improve care for persons with LEP
    - Enforce safe modality usage
    - Demand proper supervision of patient care

Practical Applications: Creating a Culture of Safety

- Across settings PTs can:
  - Establish means to address potential errors or near misses
  - Examples: Develop a medical errors reporting policy
    - Train managers in RCA
    - Track data regarding errors
    - Implement outcome measures to further analyze data
Practical Applications: Creating a Culture of Safety

- Across settings PTs can:
  - "Prevent" rather than "Cure" errors by:
    - Identifying leaders to initiate change
    - Training staff in communication and team work techniques
    - Initiating "rounding" on patient safety
    - Promoting projects specific to safety culture

  (Harden, 2008)

Practical Applications: Creating a Culture of Safety

- Comprehensive resource for initiatives to create a culture of safety:


  “Enabling, enacting and elaborating” model
  (Singer, 2013)

Patient Perspective

- Over 120 slides and have yet to hear from the most important source related to medical errors... the patient
- Many heartbreaking stories from patients and family members
- Limited data about patient experiences
Patient Perspectives

- Qualitative piece of a mixed methods study conducted by telephone of 30 community members identified as having suffered a medical error
- Patients’ experiences focused on
  - Poor communication
  - Poor interpersonal skills
  - Perceived negative attitudes towards them and their families
  - Need to understand the error
  - Need to be seen as a patient, patient identity
  (Kooienga and Stewart, 2011)

Patient Perspectives

- Survey of 80 medical or surgery patients post discharge found
  - 3.2 “undesirable” events per person
  - 136 interpersonal problems
  - 90 medical complications
  - 32 health care process problems
  - Reinforces that patient perception of medical errors and how healthcare professionals define errors is very different
  (Kooienga and Stewart, 2011)

Patient Perspectives

- Also found that
  - Patients report more incidences than are found in their records
  - Patients are more willing to report for research purposes than for compliance with national reporting
  - Role of patient in detecting and reporting errors is a novel area rich for research and development
  (Davis, 2012)
Patient Perspectives

- Public Perspectives are relatively unknown

*Perceptions of Medical Errors in Cancer Care: An Analysis of How the News Media Describe Sentinel Events*

Analysis of media reporting of cancer related adverse events over a 10 year period

Findings: the media typically and inaccurately blame an individual provider when the error is really a complicated systems problem

(Li, 2013)

Resources

- To learn about specific topics:
  - AHRQ Patient Safety Primers by Topic (find specific resources)
  - [http://psnet.ahrq.gov/primerHome.aspx](http://psnet.ahrq.gov/primerHome.aspx)
    - great example of a comprehensive source
  - "Diagnostic Errors" of special interest to clinicians using Direct Access

Resources

- To see a comprehensive plan on preventing medical errors:
  - Health Partners Ambulatory Patient Safety Tool Kit

  - *mentions the APTA as a resource for falls prevention*
Resources

Joint Commission: National Safety Standards
http://www.jointcommission.org/standards_information/npsgs.aspx

Speak Up Program:
http://www.jointcommission.org/speakup.aspx

Promote patient involvement

Lots of other information on Joint Commission site

Resources

› Numerous resources for PTs in a variety of practice settings to begin to create a safer clinic environment and prevent errors
› For example: Limiting Medication Errors
   › IOM Medication Errors Fact Sheet:

Resources

› "My medication list" to use with patients:
  http://www.safemedication.com/safemed/MyMedicineList.aspx
› English and Spanish versions
› Spring board for necessary medication discussions
Resources

- SorryWorks.net
- Brain child of family that lost a son to medical error
- Trains physicians, providers, and lawyers in disclosure

The Future: New Initiatives

- Partnership for Patients:
  - Public–Private Partnership
  - 2 goals: keep patients from getting sick or injured and help patients heal without complications
  - More info: healthcare.gov

The Future: Better Outcomes

- CMS reported on May 7 that data from 2010–2012 shows marked improvements in the safety of Medicare patients
- 9% decrease in errors overall
- Prevented 15,000 hospital deaths
- Saved over $4 billion

Thank you!

Questions and Answers