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PTs and Patient Non-Compliance

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PTs and Patient Non-Compliance Learning Objectives

- List the leading techniques for dealing with non-compliant patients
- List the leading techniques for developing, reviewing and implementing written protocols
- Identify key risk management tools that PTs, PTAs, and PT Practices can incorporate into their practice

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Key Terms

- **Indemnity** - monies paid on behalf on a HPSO/CNA insured PT, PTA or PT Practice in the settlement or judgment of a claim.
- **Expenses** are monies paid in the investigation, management or defense of a claim – this may include but not limited to expert witness fees, court costs, etc.
- **Defendant** - the party against whom a claim or charge is brought in a court.
- **Plaintiff** - the party who brings suit in a court.
- **Malpractice** - is a type of negligence; it is often called "professional negligence". It occurs when a licensed professional (like a PT) fails to provide services as per the standards set by the governing body ("standard of care"), subsequently causing harm to the plaintiff.

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Case Study

- A 45 year-old woman suffered a fall at work. Immediately after the fall, she was taken to an emergency department (ED).
- The ED practitioner diagnosed her with a Grade three lateral right ankle sprain injury and referred her to an orthopedic practitioner.
- The orthopedic practitioner fitted her for a controlled ankle movement (CAM) boot and instructed her to be non-weight bearing until she returned to for her follow-up appointment in three weeks.

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Case Study

- The patient was prescribed pain medication and physical therapy.
- Two days after her orthopedic appointment, the patient was seen by our insured physical therapist (PT) for her initial therapy assessment.
- The PT (co-defendant) noted the patient was wearing a CAM walker boot. The patient reported to be relatively healthy without any chronic or acute illness. She admitted to be a one-pack a day smoker for the past 30 years and had recently begun oral contraceptive medication to treat abnormal premenopausal menstrual bleeding.
- The patient complained of right calf pain, so the PT performed a Pratt Test to the right calf which was negative for increased symptoms. The patient indicated the pain could be from the walking boot, because it felt like a pulled muscle.
- The insured documented that the patient was going on a cruise in the near future and her goal was to ambulate without a walking cast for the cruise, but did not note the calf pain or negative Pratt Test results in the patient's healthcare record.

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Case Study

- On first day of physical therapy, the patient complained of continued right calf pain; however, she used her foot during therapy.
- The PT continued to believe that the walking boot was likely the cause of the patient's calf pain.
- The insured examined the patient's calf and it did not exhibit clinical signs of a deep vein thrombosis (DVT). Moreover, she could not elicit any pain upon performing a Pratt Test.
- The PT again failed to document the examination of the patient or her assessment of the calf.

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Case Study

- On second day of therapy, the PT was concerned about patient's presentation and comments while in the waiting room.
- The patient informed the PT that she had taken off her walking boot off at work. She ambulated most of the day without any support in order to try and speed up her recovery.
- During the short walk back to the exercise room, the patient became short of breath and had to stop to rest. The patient mentioned to the PT, "I don't know what's wrong with me today, I feel so tired."
- The PT assessed the patient's right calf area and found that it was softer than it had been the two prior examinations.
- The PT performed the Pratt test and again it did not elicit any signs of pain. As a result of the negative clinical evaluation, the insured continued with the patient's therapy.

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CONTINUED

Case Study

- During the session, the patient performed three active range of motion exercises using her ankle. There were two exercises, grasping marbles with her toes and ambulating upstairs, that she was unable to perform.
- Upon completion of the therapy, the patient again became out of breath during the walk back to the waiting room.
- While in the waiting room, the insured explained to the patient that she was very concerned about her condition and felt that she needed to be examined by a practitioner prior to her cruise.
- The patient response was that there was no reason for her to go to the doctor as they had not been listening to her.
- However, the PT insisted that she be seen by a physician because she was concerned about her shortness of breath, fatigue and complaints of calf pain.

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CONTINUED

Case Study

- Although the PT had this conversation with the patient, she failed to document her recommendations and patient's response in the patient's healthcare records.
- The only conversation documented in the patient's healthcare record was, "The patient stated she will be on cruise for 14 days and would return to therapy after her vacation".
- Unfortunately, two days later the patient was found dead in her home. An autopsy revealed her cause of death to be an "acute pulmonary thromboembolism" with deep vein thrombosis of the right leg and a history of right ankle sprain.
- Six months after the patient's death, both the PT and the physical therapy business owner (co-defendant) received a pre-suit notice of intent to sue from the patient's son (plaintiff).

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Case Study

- **Do you believe this PT was negligent?**
- **Do you believe any other practitioners/parties were negligent?**
- **Do you believe that an indemnity and/or expense payment was made on behalf of the PT?**
- **If yes, how much?**

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Allegations

- **For the Physical Therapist**:
  - Failure to perform an adequate patient assessment
  - Failure to report a patient's condition to the referring practitioner
  - Failure to cease treatment with excessive/unexpected pains
  - Failure to recognize a medical emergency, Inaccurate and incomplete healthcare documentation
  - Failure to document according to standards promulgated by physical therapy professional associations, state practice acts and facility protocols
- **For the Physical Therapy Owner:**
  - Failure to provide appropriate education for clinical staff
  - Failure to maintain a safe environment
  - Failure to assure that clinical staff are qualified

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Additional Information

- After the PT learned of the patient's death, she documented the events that had occurred at the facility on the last day of the patient's visit. This document was undated and unsigned. It stated that the PT was concerned about a possible DVT at the last visit and that she had urged the patient to be seen by a practitioner.
- During her deposition, the PT explained that she created the documentation in an effort to clarify and add information that was missing after learning that the patient had passed away.

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What the Experts Said

- Several PT defense experts were asked to review the claim and most were not supportive of the insured's care. One expert criticized the PT for failing to document concurrently the patient's need to be seen urgently by a medical practitioner.
- More problematically, the expert indicated that the patient's complaints of increased pain in her calf, shortness of breath and increased fatigue with walking should have triggered the PT to halt all physical therapy treatment until the patient's leg could be examined. The PT's action of continuing with therapy put the patient at risk for dislodging the clot.
- A cardiovascular expert noted with the patient's long history of smoking and taking birth control elevated her risk for DVT. Additionally, her risk was also increased with the use of a CAM walker boot. This immobility by the boot increased the likelihood of the blood pooling in the leg.
- The expert also indicated that the Pratt test to examine whether the patient had a DVT was appropriate. However, the current research indicates that the test has a high false positive rate resulting in poor reliability.

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What the Experts Said

- Even though the physical therapy business owner had never participated in the patient's care, he was being sued due to the actions of the employed treating PT. Because the owner had few employees (less than 10), he had very few policies and procedures and had not provided any continuing education for his employees.
- He had known his employees prior to hiring them and believed annual performance or competency reviews was unnecessary. The owner never received complaints from current or former patients.
- Prior to this claim, his business had positive remarks on all social media sites. However, despite having essential current healthcare business documentation, the defense of the PT practice owner was difficult.

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The Resolution

- Indemnity payment: Greater than $475,000
- Expense payment: Greater than $125,000

- The possibility of a defense verdict was deemed to be less than 10 percent.
- Defense counsel assessed the potential exposure/claim value of the case for all defendants as being between $500,000 and $750,000 with our insured PT identified as having all of the liability.

Figures represent only the payments made on behalf of our physical therapist and physical therapy firm and do not include any payments that may have been made from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

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Risk Control Recommendations for the Treating PT

- ***Recognize patients' medical conditions, co-morbidities and any additional specific risk factors that may affect therapy.***
- ***Notify the appropriate practitioner(s) of the patient's clinical responses to therapy,*** and swiftly convey any signs or symptoms of physiological or psychological changes that could indicate a new pathological condition or a change in an existing condition.
- ***Document your patient care assessments, observations, communications and actions in an objective, timely, accurate, complete, appropriate and legible manner.***
- ***Never alter a record for any reason or add anything to a healthcare record after the fact*** unless it is necessary for the patient's care. If information must be added to the record, accurately label the late entry. However, never add anything to a record for any reason after a claim has been made. If additional information related to the patient's care emerges after becoming aware of pending legal action, discuss the need for additional documentation with your manager, the organization's risk manager and/or legal counsel.

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Risk Control Recommendations for PT Practice Owners

- ***Perform at least annual performance reviews for each employee, including a review of errors, "near misses", document requirements compliance, existing skills and directly observed competencies.*** Provide physical therapy staff with coaching, mentoring, and clinical and system education as needed to ensure that patient safety requirements are satisfied.
- ***Ensure that clinical practices comply with standards endorsed by physical therapy professional associations***, state practice acts and facility protocols.
- ***Provide appropriate clinical support for physical therapists, in compliance with supervisory or employment agreements.*** Encourage compliance with relevant legal, ethical and professional standards for clinical practice.

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CONTINUED

Healthcare Perspective

Patient Noncompliance: Reduce Risk by Strengthening Communication


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Patient Noncompliance: Reduce Risk by Strengthening Communication

Patient noncompliance can come in many forms: unwillingness to follow a course of therapy, repeated missed appointments, rejecting treatment recommendations, reluctance to take medications, refusal to provide information or chronic late payments. If left unchecked, such conduct may result in litigation. In this issue, you'll find several sound business techniques for dealing with noncompliant patients, including:

- **Sound documentation:** how it helps defend against allegations of negligence or abandonment
- **Missed appointments:** formulating a written policy and putting procedures in place behavior
- **Communications:** risk management recommendations for written communications
- **Refusal-to-consent form:** having the client acknowledge in writing the dangers of noncompliance
- **Terminating the client-provider relationship:** suggested steps to follow to protect your practice

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Sound Documentation

- Sound documentation and timely intervention are critical to limiting the consequences of defiant, recalcitrant or passive-aggressive client behavior. A carefully documented record may prove invaluable in defending against allegations of negligence or abandonment.
- Early identification of the signs of noncompliance is critical to reducing risk, permitting healthcare business owners to take action before the situation worsens.

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Documenting Missed Appointments

- Too often, healthcare practices treat a missed appointment merely as an annoyance and fail to note the occurrence in the patient healthcare information record.
- However, as missed appointments may indicate potential noncompliance, they require thorough follow-up and documentation. Healthcare businesses should have a formal written policy for managing missed appointments, which includes the following procedures, among others:
  - *Prepare a daily list of missed appointments* by patient name and medical identification number.
  - *Document the occurrence of missed appointments* in the progress notation of the patient healthcare information record.

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Documenting Missed Appointments

- *Utilize a special template for electronic record systems or preprinted stickers for paper records*. Ready-made formats or notes facilitate documentation of missed appointments and prompt appropriate follow-up orders, such as:
  - Call patient today to reschedule.
  - Send reminder card to reschedule.
  - Send certified/return receipt letter regarding the need to reschedule.
  - Document all patient follow-up efforts and place a copy of any written correspondence to or from the client in the patient healthcare information record.

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Communicating with Non-compliant Patients

- When treating uncooperative patients, even basic expectations must be spelled out. Standardized educational materials, appointment reminders, and other teaching and memory aids can help foster a better rapport with such patients.
- If written reminders fail to improve compliance, schedule a face to-face discussion with the patient regarding mutual concerns and expectations, and document this meeting in the healthcare record.

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Communicating with Non-compliant Clients

- Follow up with a letter to the patient, explaining that the primary goal of the practice is to deliver quality care and emphasizing that noncompliance with recommended treatment precludes optimal results. Both spoken and written messages to the patient should be clear, direct, polite and sympathetic.

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Communicating with Non-compliant Patients

- When communicating with noncompliant patients by letter, consider the following risk management recommendations:
  - *Send the letter by certified mail* and place a copy in the patient's healthcare information record.
  - *In the letter, instruct the patient on how to contact the office,* in order to reschedule missed appointments or otherwise rectify the situation. Emphasize that one wishes to improve the relationship and continue to provide treatment.

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Informed Refusal

- Persistent failure to heed medical advice can lead to less than desirable results for the patient, as well as potential liability exposure for providers.
- Business owners can counter this risk by adopting a standardized refusal-to-consent form, which serves to confirm in writing that the provider fully disclosed to the patient the risks of forgoing the proposed test, treatment or procedure. By signing the form, patients acknowledge that they have discussed the proposed course of care with their practitioner and understand that failure to follow medical recommendations can have serious or even life-threatening consequences.
- The completed refusal-to-consent form should be placed in the healthcare information record. If the patient subsequently experiences a downturn, the documentation can help protect the provider, as well as the practice or business, by demonstrating that the patient's own behavior and actions contributed significantly to the negative outcome.

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Informed Refusal – Sample Form

HEALTHCARE PERSPECTIVE
SUPPLEMENT 2015 ISSUE 7
CNA · NSO · HPSO

A Sample Informed Refusal of Care Form for Healthcare Business Owners

Patient name: _____ ID#: _____ Date: _____
This is to certify that I, *Patient Name*, a patient at *Healthcare Business*, am knowingly refusing treatment against the medical advice of *Provider Name*.

I am refusing the following:

☐ **Medical Examination**
I have made the decision to leave prior to being examined by a physician.

☐ **Continuation of Care After Medical Screen**
I understand that I do not have an emergency medical condition and acknowledge that I have not been refused treatment.

☐ **Test or Treatment**
I am refusing to undergo the following tests and/or treatments: _____
and the risks of doing so have been explained to me.

☐ **Remaining in the Facility**
I refuse further care and am leaving the facility against the advice of my provider.

☐ **Other** _____

I understand that my refusal of treatment and care has been documented in my medical record. I have been informed of the risks involved, including a possible worsening of my medical condition. I assume all risks of this refusal and release my treating providers from all responsibility and liability for any ill effects that may result from such refusal of treatment and care.

Patient signature: _____ Date: _____
Witness: _____ Date: _____
Witness: _____ Date: _____

I declare that I have personally explained to the patient the risks and potential consequences of his/her decision, described the benefits of treatment and presented alternative therapeutic possibilities, if any exist.

Provider: _____ Date: _____

Terminating the Patient-Provider Relationship

- If compliance remains an issue despite a determined effort to educate and communicate with the patient, it may become necessary to take decisive action.
- The decision to unilaterally end a patient-provider relationship can have legal repercussions and should not be made without proper deliberation.
- Irrespective of the circumstances preceding termination, providers must ensure that the patient's health status is not compromised. Treatment should continue until procedures already begun are completed and the patient is medically stable.

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Terminating the Patient-Provider Relationship

- If the provider ends the relationship without providing reasonable notice, the patient may sue on grounds of abandonment. To prevent such allegations and satisfy ethical and professional obligations, the treating provider should observe the following safeguards:
  - *Check the termination policies of the patient's health plan* prior to initiating any action.
  - *Send the termination letter by certified mail* after communicating the reasons for the decision via face-to-face discussion.
  - *Indicate the patient's current health status* and include any recommendations for immediate medical care.
  - *Note the date the relationship will end*. Thirty days from receipt of the letter is customary.
  - *Agree to provide emergency care* until the stated date of termination.
  - *Suggest the patient locate another provider* by contacting the health plan's member services department or the local medical society.
  - Provide telephone numbers or other contact information, as necessary.

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Terminating the Patient-Provider Relationship

- *Offer to send a copy of the patient healthcare information record to the subsequent treating provider* after the patient has executed a form authorizing release of information. Enclose such a form with the termination letter, along with a self-addressed stamped envelope.
- *Retain a copy of the termination letter in the patient healthcare information record* and carefully document any subsequent correspondence with the patient.

- Patient noncompliance is too serious a risk to ignore. Healthcare business owners can help minimize liability exposure by ensuring that providers and staff respond promptly to missed appointments, communicate expectations clearly and document patients' refusal of recommended treatment. If it eventually becomes necessary to terminate a chronically noncompliant patient, the measures indicated herein can help prevent disruption of care and subsequent allegations of abandonment.

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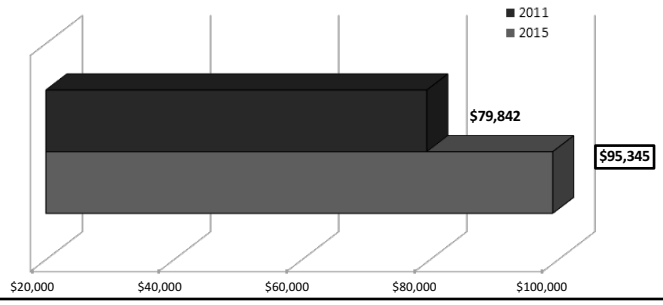
CONTINUED

Closed Claims by Type of Coverage

Licensure type	Percentage of closed claims	Total paid indemnity	Total paid expense	Average paid indemnity	Average paid expense	Average total incurred
Individually Insured PTA	2.0%	$1,186,750	$152,685	$131,861	$16,965	$148,826
PT practice	75.4%	$32,263,702	$8,200,411	$96,598	$24,552	$121,150
Physical therapist	22.6%	$8,787,456	$2,521,782	$87,875	$25,218	$113,092
Overall	**100.0%**	**$42,237,908**	**$10,874,878**	**$95,345**	**$24,548**	**$119,893**



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Closed Claims by Location

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Long term acute care (LTAC)	0.3%	$450,000	$450,000
School	0.8%	$1,140,443	$380,148
Acute medical-surgical hospital (inpatient)	1.9%	$1,905,496	$272,214
Aging services facility	2.2%	$840,000	$105,000
Patient home	7.5%	$2,766,821	$102,475
Physical therapy office/clinic (non-hospital)	84.8%	$28,425,925	$92,895
Golf course	0.3%	$50,000	$50,000
Fitness center	0.3%	$35,000	$35,000
Practitioner office or private clinic	1.7%	$156,349	$26,058
Spa	0.3%	$13,000	$13,000
Overall	**100.0%**	**$35,783,034**	**$99,122**

Closed Claims by Allegation: PTs

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to properly test/treat	1.9%	$2,047,500	$292,500
Equipment-related	4.7%	$2,166,624	$127,448
Improper performance of manual therapy	8.6%	$3,925,490	$126,629
Failure to supervise or monitor	19.4%	$7,677,447	$109,678
Improper management over the course of treatment	22.2%	$8,370,914	$104,636
Improper performance using therapeutic exercise	20.2%	$6,806,382	$93,238
Environment of care	3.9%	$1,268,942	$90,639
Improper behavior by practitioner	1.7%	$479,000	$79,833
Improper performance using a biophysical agent	17.5%	$3,040,735	$48,266
Overall	**100.0%**	**$35,783,034**	**$99,122**

Severity by Allegation: PTAs

Allegation classification	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Improper management over the course of treatment	23.3%	$1,808,749	$129,196
Improper behavior by practitioner	8.3%	$600,000	$120,000
Improper performance using therapeutic exercise	18.3%	$971,953	$88,359
Equipment-related	8.3%	$374,000	$74,800
Failure to monitor	11.7%	$494,849	$70,693
Improper performance of manual therapy	5.0%	$208,450	$69,483
Environment of care	3.3%	$75,000	$37,500
Improper performance using a biophysical agent	21.7%	$478,288	$36,791
Overall	**100.0%**	**$5,011,289**	**$83,521**

Severity by Allegation: Private Practice

Allegation classification	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to test/treat	1.8%	$2,037,500	$339,583
Improper behavior by practitioner	2.7%	$1,084,000	$120,444
Equipment-related	6.0%	$2,387,124	$119,356
Improper management over the course of treatment	20.7%	$8,199,772	$118,837
Failure to monitor	19.2%	$6,206,307	$96,974
Improper performance using therapeutic exercise	18.9%	$5,995,188	$95,162
Improper performance of manual therapy	7.5%	$2,216,341	$88,654
Environment of care	3.6%	$940,192	$78,349
Improper performance using a biophysical agent	19.8%	$3,197,278	$48,444
Overall	**100.0%**	**$32,263,702**	**$96,598**

Case Study

- A 52 year-old female marathon runner (plaintiff) was prescribed physical therapy for treatment of iliotibial band syndrome.
- The patient reported that her pain began after she ran a 50k race two weeks prior. She stated that since that time she has not been able to run due to the pain, but has been able to use an elliptical machine without any problems.
- Her hope was that our insured physical therapist, which has a specialty in treating athletes, would be able to explain and help the source of her pain.
- During the evaluation, the patient suddenly complained of excruciating pain after the physical therapist performed a piriformis stretch maneuver.

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Case Study

- The physical therapist was so concerned over the patient's complaints of pain that he drove her in his personal vehicle to an urgent care facility.
- He stayed with her while she was at the facility in order to explain to the treating practitioner what had occurred.
- An x-ray of the hip was done and was interpreted as negative for any fractures. The treating practitioner instructed the patient to be non-weight bearing and follow-up with her treating orthopedist.
- The patient did not return to our physical therapist, but two weeks after the incident the patient ran a race (15k). She completed the race, but complained of excruciating pain afterwards and was unable to bear weight.

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Case Study

- A few days later, the patient was seen by her orthopedist. A magnetic resonance imaging was performed and showed a hairline fracture of the femur.
- The patient was instructed to be non-weight bearing until there was no pain which could be up to six months. The patient began running six months later and has since completed several races with excellent times.
- The patient filed a claim against our insured physical therapist for medical negligence and negligence and lack of informed consent.
- The allegations essentially are that during the course of an initial evaluation and piriformis stretch by the physical therapist, the patient suffered a compression fracture of her femur without being completely informed of the risks of physical therapy.

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Case Study

- **Do you believe this PT was negligent?**
- **Do you believe any other practitioners/parties were negligent?**
- **Do you believe that an indemnity and/or expense payment was made on behalf of the PT?**
- **If yes, how much?**

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Allegations

- Failure to complete intake forms prior to performing therapy
- Failure to complete a proper informed consent process prior to performing therapy
- Failure to refer patient to physician after injury

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What the Experts Said

- The patient's/plaintiff's physical therapist expert was critical of our insured for: (1) failure to complete a thorough intake; (2) not obtaining informed consent document; (3) doing a piriformis stretch maneuver before a full evaluation by the physical therapist.
- The cause of the injury is somewhat questionable, because the physical therapist only saw the patient once.
- One of the key witnesses in defense of the case was the patient's treating orthopedist. The orthopedist testified that he had never seen this type of injury specifically from any kind of physical therapy maneuver and felt it was a stress fracture due to running. In addition, he noted that the patient was non-compliant; however, it does not appear as though that was a cause of any delay in healing.
- A defense expert physical therapist reviewed the case and was supportive of the treatment plan.
- Although the expert was supportive of the plan and the overall care provided to the patient he found the medical documentation to be poor. His concerns were that the physical therapist did not have the patient complete the intake forms or the informed consent process prior to performing the stretches.
- He also stated that there was a lack of follow up to ascertain about the patient's status and notifying the referring orthopedist.
- Defense expert's estimated the probability of a defense verdict if this case went to a jury trial as 60 percent and the probable exposure as less than $50,000.

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The Resolution

- Indemnity payment: less than $8,000
- Expense payment: greater than $37,000

Plaintiff's counsel made a demand for $38,000; however, the insured physical therapist did not want to settle the case and wished to peruse a jury trial as he felt he did nothing wrong.

Figures represent only the payments made on behalf of our physical therapist and do not include any payments that may have been made from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

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Risk Control Recommendations for the Treating PT

- ***Before engaging in treatments or interventions, the physical therapist must obtain the patient's informed consent,*** with all discussions carefully documented. At a minimum, informed consent discussions should include:
  - Known risks and benefits of the treatment plan, alternative treatment options and the likely consequences of declining the suggested therapy
  - Disclosure of clinically indicated touching and/or potential discomfort during treatment
  - Answers to patient and/or family questions
  - Repetition of important information by the patient to ensure understanding
  - Written confirmation that the patient agrees to the proposed treatment
  - Provision of pertinent patient education materials and corresponding documentation

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Risk Control Recommendations for the Treating PT

- ***Ensure that clinical documentation practices comply with standards*** promulgated by physical therapy professional associations, state practice acts and facility protocols.
- ***Document objective facts related to patient care*** and refrain from using subjective opinions or conclusions.
- ***Respond immediately to any signs or symptoms of a possible fracture by*** determining the need for additional medical evaluation.
- ***Contact the referring practitioner*** for any consistent patient complaints, such as pain or swelling.
- ***Cease treatment immediately if a patient had an adverse response to treatment or another adverse event/emergency situation occurs.***
- ***Arrange emergency transportation to the nearest emergency department following any suspected injury.*** Transporting patients by staff-owned or personal-owned vehicles in not recommended.

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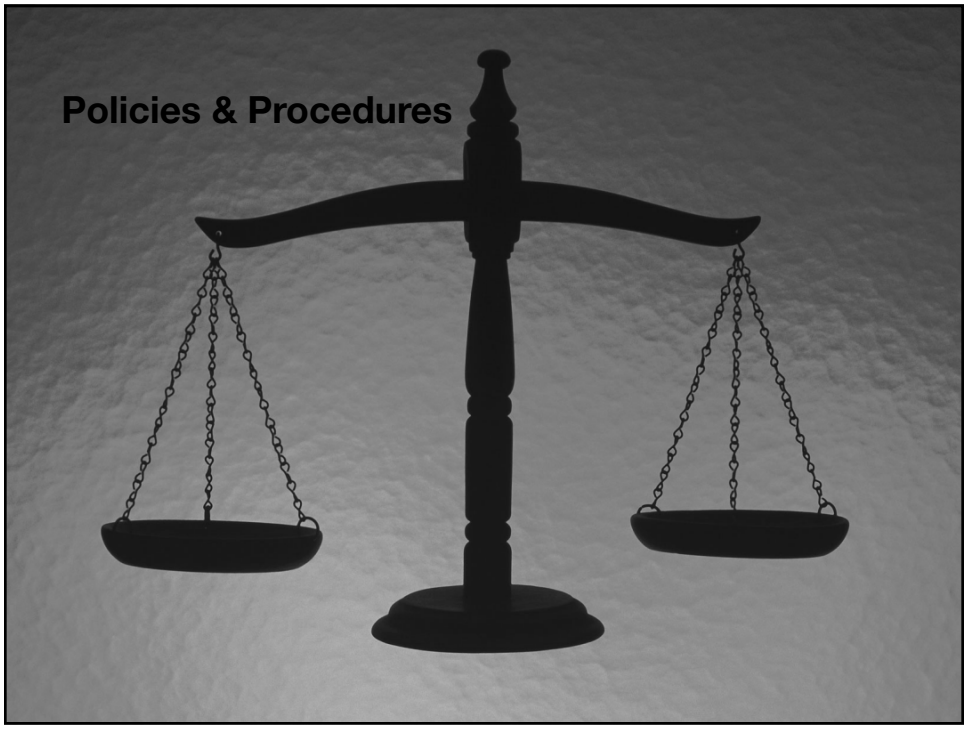

Healthcare Perspective

Policy and Procedure: A Healthcare Business Owner's Guide to Developing, Reviewing and Implementing Written Protocols

- Written policies and procedures primarily seek to improve patient outcomes. Organizations that lack formal protocols or diverge from written policy may find themselves at a disadvantage when it comes to providing a legal defense. In this issue, business owners will find a range of guidelines designed to support policy and procedure development and review, including:


HEALTHCARE PERSPECTIVE

Policy and Procedure: A Healthcare Business Owner's Guide to Developing, Reviewing and Implementing Written Protocols

- **The mechanics of policy development:** research, writing, review/approval and maintenance
- **Policy-drafting guidelines:** tips for drafting practical, user-friendly policy statements
- **The role of policy in litigation:** allegations of noncompliance with written policies & procedures

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Policy and Procedure

- Written policies and procedures serve as an operating framework within which healthcare business owners can accomplish essential clinical and administrative tasks in a systematic and consistent manner.
- The term *policy* refers to the governing principles that reflect an organization's mission, philosophy and goals, while *procedure* denotes the measures required to implement the policy. Every policy statement should include an accompanying procedure.
- Organizations that lack formal practice parameters or that diverge from written policy may find themselves at a disadvantage in the areas of legal defense, accreditation and/or regulatory compliance.

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Policy and Procedure

- Not only do sound policies aid in reducing practice variation and errors, but they also serve the following vital purposes:
  - *Enhancing continuity of care* by promoting a consistent, sequential approach.
  - *Serving as a written reference* for regulatory agencies and accrediting bodies.
  - *Establishing clear lines of authority* and facilitating delegation of responsibility.
  - *Instituting defined, objective parameters* for evaluating employee performance.
  - *Facilitating orientation of new employees* and education of veteran staff about changes.
  - *Strengthening leadership* by fostering compliance with directives.
  - *Supporting defense efforts* in lawsuits involving standard of care issues.

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Policy and Procedure

- Written policies and procedures primarily seek to improve patient outcomes. Thus, most organizations focus initially on clinical practices associated with the delivery of client care and gradually move toward standardization of administrative functions.
- Sound policies and procedures result from a thorough process of **research, drafting/writing, review and maintenance.**

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Research

- The following guidelines address the mechanics of policy development:
  - **Research**. Policy development begins with an assessment of the strengths and weaknesses of existing processes in light of changing conditions and organizational goals. By assembling a policy and procedure working group that includes department managers, senior leaders and clinical staff, business owners can ensure that written policy is aligned with the organizational structure and that affected areas are not taken by surprise.
  - The working group or committee should view policy development as a means of analyzing and responding to an evolving legal and regulatory environment, as well as ensuring that clinical and administrative processes embody industry-wide best practices.

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Research

- The working group is responsible for examining both changing external factors and the organization's own capabilities, resources, liability experience and performance survey findings. The following questions can help initiate the policy development discussion:
  - *Would the organization as a whole benefit* from the proposed policy?
  - *Who should be consulted* when framing policy in this specific area?
  - *Does the proposed policy raise legal or regulatory issues,* and would it potentially affect accreditation or certification status?
  - *Can the policy be implemented with minimal disruption to current practices* and without hindering client safety and operational efficiency?

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Influencing Factors

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- Written policies and accompanying procedures are *teaching documents* designed to help staff members better understand and perform their duties. Therefore, those involved in the drafting process should focus on creating policy statements that are:
  - *Informative* and self-explanatory.
  - *Authoritative* and unambiguous.
  - *Practical*, useful and realistic.
  - *Clear* and understandable even by non-experts.
  - *Quality-focused* and aligned with risk-reduction goals.
  - *Compliant* with federal and state laws, regulations and accreditation requirements.
- Both new and revised policy statements should utilize a template to streamline the drafting process and enhance consistency.

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Review and Approval

- Ask reviewers to verify that the policy:
  - *Is aligned with the organization's mission*, vision, values and goals.
  - *Complies with federal and state laws*, as well as applicable regulations.
  - *Satisfies state survey requirements* and accreditation standards.
  - *Conforms to organizational expectations* regarding format and style.
- Leadership – including the medical and clinical director when appropriate – must approve all policies and procedures prior to implementation. This final executive-level review typically follows several rounds of revision by the working group.

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Maintenance

- Federal and state regulations may require review of policies and procedures on an annual basis. When a policy statement undergoes review, the date of the review and any alterations should be noted in a centralized database. Revisions also may occur in response to external legal or regulatory changes. In such cases, the revision date should be noted, but the regular policy review cycle should not be altered.
- For ease of access, new and revised policies and procedures should be filed in a central location or computerized database. Note that when a policy is modified or retired from practice, the original policy must be secured, in the event that the organization is sued and must establish the standard of care in effect at the time of the occurrence.
- The statute of limitations for professional liability claims typically dictates the minimum length of time that a modified or retired policy and procedure should be retained. Generally, the statute of limitations is two to three years, but it may be much longer when the litigation involves care provided to children. In addition, internal document retention guidelines, based upon relevant state statutory and/or regulatory requirements, should be followed.

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The Role of Policies in Litigation

- Many professional liability lawsuits – especially those involving issues of inadequate training and/or substandard care – include allegations of noncompliance with written policies and procedures.
- Policy statements are often requested during the discovery phase of a trial, where they may be used to establish whether an organization has instituted and adhered to appropriate guidelines. In this situation, an organization's best defense is to prove that the care in question was undertaken in good-faith compliance with established procedures.
- Producing the written policies in force at the time of the adverse event and showing that staff were instructed and trained to follow these established practices can significantly enhance legal defense.

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The Role of Policies in Litigation

- At a minimum, organizations should be prepared to produce evidence that the relevant policies were:
  - *Approved by* leadership.
  - *In effect* at the time of the incident.
  - *Incorporated into staff orientation* and professional development programs.
  - *Included in staff handbooks* and organizational manuals.
  - *Reviewed and revised* on a scheduled basis.
- The defendant organization bears the burden of proving that a request for written policies and procedures is unreasonable. Responding that an obsolete policy cannot be accessed weakens the defense position. To prevent such situations from occurring, properly archive outdated or modified policies, preferably in a computerized system that complies with retention guidelines and timelines.

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The Role of Policies in Litigation

- Organizations should be able to retrieve the following information in a timely manner:
  - *Dates* when the relevant policies and procedures were created, revised and/or canceled.
  - *Location* of outdated policies, in compliance with jurisdictional requirements.
  - *Names* of those requesting policy revision or elimination.
  - *Reasons* for policy revision or elimination.
- Useful, well-drafted, regularly reviewed policies and procedures are an essential component of any risk control program. By formalizing organizational standards and expectations, written policy statements can help promote quality of care, clarify staff roles and responsibilities, and shield the assets and reputation of a healthcare business in the event of litigation.

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Case Study

- A 35-year-old patient was injured in an on-the-job accident when an object struck his left foot causing fractures to the second, third and fourth metatarsals.
- The injury required surgical implants to secure the fractures including pins, wires, screws and plates.
- Following surgery, the patient began physical therapy with a CNA-insured physical therapist (PT).
- During the evaluation, the patient complained of minimal feeling in his foot, perhaps due to the injury and surgery.
- A treatment plan was established, which included heat therapy, a splint for the affected foot and three-day- a-week therapy for six months.

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Case Study

- During the third week of therapy, the PT placed a hot pack on the patient's affected foot and left the room.
- After 10 minutes, the insured returned to the treatment room and removed the hot pack. Noticing that the tip of the patient's left third toe was red, she placed a cold compress on the toe.
- According to the insured, the patient did not complain of pain at the time and refused any additional treatment.
- During the therapy session, the PT witnessed the patient picking at the burn with a paper clip, which he continued to do despite her pleas for him to leave the burn alone.
- At the end of the session, the PT told the patient how to take care of the burn and directed him to seek medical treatment if it showed any signs of infection.
- These instructions, as well as the incident itself and her related observations, were documented in the patient's healthcare record.

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Case Study

- After the patient's therapy appointment, the PT contacted the referring surgeon to notify him of the burn.
- The surgeon stated that he was satisfied with the burn care instructions provided to the patient and that he wished to assess the burn himself.
- He also requested that the patient temporarily stop therapy until he could be evaluated.
- The PT conveyed this information to the patient and reiterated the need to keep the area covered, clean and dry.
- Over the next two weeks, the surgeon's office made several attempts to contact the patient. The patient finally made an appointment and was seen by the surgeon, who noticed that his third toe was swollen, warm to the touch and streaked with red.
- The surgeon's nurse cleaned the burned area and bandaged the toe. The patient was given a prescription for an oral antibiotic and instructed to keep the dressings on for the next 24 hours.
- The surgeon instructed the patient to continue with physical therapy and to keep the toe clean and dry.

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Case Study

- The patient returned to therapy the following day. When the PT removed the bandages per the surgeon's order, she documented that the toe was red and swollen.
- Over the next few days, she noted that while the toe had appeared to heal, necrotic skin had developed at the site of the original burn. She then asked the surgeon to reexamine the toe.
- The surgeon agreed that necrotic skin was present at the site of the burn but noted that the patient would suffer only when the dead skin sloughed off. The necrotic skin fell off eight weeks later, as documented by both the PT and surgeon. The patient never complained of pain at the burned area but did state that his entire foot felt numb after the injury and surgery.
- The patient underwent a subsequent surgery on his left foot, but it was not related to the burn and the burn did not appear to interfere with the procedure.
- The patient's physical therapy continued after the second surgery without complications. The patient was always complimentary of the PT and never mentioned the burn, so when she received a letter from the patient's attorney stating his intention to file a lawsuit, it came as a surprise.

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CONTINUED

Case Study

- Do you believe this PT was negligent?
- Do you believe any other practitioners/parties were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the PT?
- If yes, how much?

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CONTINUED

Allegations

- Improper performance using therapeutic exercise
- Improper technique used during strengthening exercise
- Failure document pertinent patient information in the healthcare record
- Failure to properly reassess patient after change in condition
- Failure to contact referring practitioner after patient suffered a change in condition

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What the Experts Said

- The insured's documentation was very thorough and supported her deposition testimony. The surgeon praised the PT's treatment of the burn and related documentation. He testified that the patient did suffer a mild burn, but that in his opinion the patient contributed to the infection and necrosis by picking at the burn and delaying any medical treatment for two weeks.
- Several PT experts reviewed the claim and found that the PT had properly documented her treatment of the patient. They also observed that the burn did not appear to cause any pain to the patient as it occurred in an area with little or no sensation, due to the preexisting injury. Finally, they noted that the patient did not follow the advice of the insured and did not seek any additional medical treatment for two weeks after the burn.
- The insured PT and treating surgeon acknowledged that the patient's burn occurred while he was being treated with hot packs, resulting in some scarring and decrease of mass of the toe. Defense counsel believed the claim should be resolved for less than $10,000, but the patient refused any amount less than $200,000.
- Since the patient and his attorney were unwilling to negotiate a settlement, the claim went to a jury trial. The trial lasted seven days and ended with a verdict of no liability on the part of the physical therapist.
- The PT's careful documentation assisted in the successful defense of the claim, which lasted over three years and cost more than $35,000.

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The Resolution

- Indemnity payment: $0.00
- Expense payment: greater than $35,000

Figures represent only the payments made on behalf of our physical therapist and do not include any payments that may have been made from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

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Risk Control Recommendations for the Treating PT

- ***Ensure that clinical documentation practices comply with standards*** promulgated by physical therapy professional associations, state practice acts and facility protocols.
- ***Document objective facts related to patient care*** and refrain from using subjective opinions or conclusions.
- ***Respond immediately to any signs or symptoms of a possible fracture by*** determining the need for additional medical evaluation.
- ***Contact the referring practitioner*** for any consistent patient complaints, such as pain or swelling.

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License Defense

An action taken against a license to practice differs from a professional liability claim in that it may extend beyond matters of professional negligence and involve allegations of a personal, nonclinical nature, such as substance abuse. License protection claims represent only the cost of providing legal defense, rather than indemnity or settlement payments to a plaintiff.

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License Defense Paid Claim by Insured Type

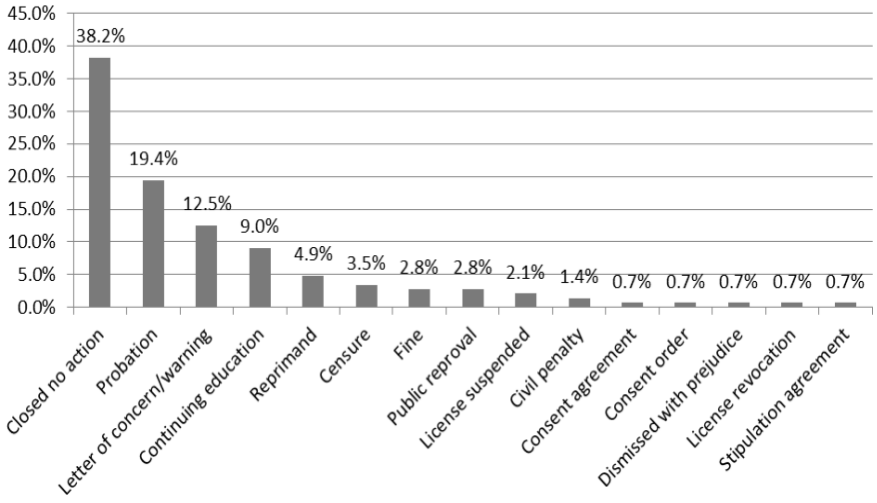
Insured type	Total paid claims	Percentage of paid claims	Total paid	Average paid
Physical therapy practice	48	33.3%	$223,926	$4,665
Individually insured Physical therapist or Physical therapist assistant	96	66.7%	$471,239	$4,909
Total	**144**	**100.0%**	**$695,165**	**$4,828**

License Defense Paid Claim by Allegation Class

	Percentage of paid claims	Total paid	Average paid
Improper management over the course of treatment	38.2%	$204,645	$3,721
Inappropriate behavior	36.1%	$305,962	$5,884
Fraudulent billing	9.0%	$76,495	$5,884
Failure to supervise	9.0%	$70,753	$5,443
Improper performance using a biophysical agent	3.5%	$19,019	$3,804
Failure to test/treat	2.1%	$12,628	$4,209
Improper performance using therapeutic exercise	2.1%	$5,663	$1,888
Total	**100.0%**	**695,165**	**$4,828**

CONTINUED

Board Outcomes



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CONTINUED

Case Study

- From 2010 through 2014 our insured PT was employed by a home health agency.
- During his employment he received several corrective disciplinary actions from his supervisors and most were due to poor work ethics and inappropriate statements regarding patients.
- During the last year of his employment he began a habit of being late to work and failing to complete patient healthcare records and billing documentation.
- His employment ended in a termination and the cause was documented as substandard care provided to patients. Supportive documentation for the termination included statements from patients' family members and co-workers.

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Case Study

- In June 2015 while working for another home health agency, our insured PT received a notice of an administrative hearing from the state board of physical therapy.
- The notice ordered the PT to appear and defend his professional license against two allegations which occurred in 2010 and 2014.
- The allegations involved incidents were the PT violated state professional laws and regulations by engaging in fraud or material deception in the delivery of professional services.
- The complaint was made by his former employer and based on the information provided; the board found probable cause to believe the PT had falsified patient care documentation.
- This documentation indicated that the insured provided therapy services on June 17, 2010 and March 18, 2014 when in fact he did not.
- The board requested a written response to the allegations 20 days prior to the scheduled hearing. The notice also indicated that if the PT failed to provide a written response to the board within the 20 days, this failure was taken as an admission of the charges.

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Case Study

- During the investigation of the allegations, the PT admitted to falsify his documentation regarding physical therapy services for 2010 and 2014.
- After reviewing his documentation for the 2010 incident he confessed that he had falsified his documentation and billing for services. He recalled that he was in a minor motor vehicle accident the morning of incident and was unable to see his afternoon patients due to inability to use his car.
- He also conceded that he had purposively documented and billed for services for the 2014 incident when in fact had not provided any services.
- He recalled not being able to go to work that day due to partying the previous night and not feeling well the next day.
- He knew that if he had called out of work again he would risk being fired, so he thought he would just document he saw the patients instead of risking potential termination.
- The PT knew falsifying his documentation was wrong and agreed to plead guilty to the allegations.

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Allegations

- Gross negligence or gross incompetence in his practice of physical therapy
- Substandard patient care by himself or by persons working under his supervision due to a deliberate or negligent act

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The Resolution

- The PT admitted to both counts of engaging in fraud or material deceptions in the delivery of professional services, including reimbursement. As part of the board settlement the following disciplinary actions were specified:
- The PT's license to practice physical therapy in the state was reprimanded.
- The PT's license was placed on probation for three years from the date of the settlement.
- The PT reimbursed the board $2,500 for the of investigation and legal costs associated with the complaint and $1,000 for violating state law.
- The PT's practice of physical therapy, including documentation regarding any patient care were monitored by a board approved licensed physical therapist. The board approved physical therapist reviewed the first 60 days of documentation after the settlement date, then approximately once every 90 days for the remaining three year probation period.
- The PT was responsible for all costs associated with each monitoring visit.
- The PT was prohibited from working in a home health setting during the probationary period.
- The PT provides all current employers with a copy of the board's settlement agreement.
- The PT completes a compliance and professional integrity course and provides proof of completion to the board.
- The settlement agreement is also considered a public document, available for inspection at any time by any member of the public under the state open records act. The board may share the settlement agreement with any governmental or professional board or organization, publication of a board newsletter and available on the board's website. The board also specified that if the PT practices or resides in another state, then he must notify the board within ten days of his departure.

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Risk Control Recommendations

- ***Annually review the physical therapy practice*** act to ensure an understanding of the legal and ethical requirements associated with a professional licensure.
- ***Be cognizant of how personal, legal and ethical hardships*** can affect ones professional career/employment.
- ***Develop effective communication and interpersonal skills*** and utilize them when interacting with colleagues, patients and family members.
- ***Refrain from making inappropriate*** subjective opinions, conclusions or derogatory statements about patients, colleagues or other members of the patient care team.
- ***Accurately and contemporaneously document*** care given in the patient health record.
- ***Adhere to organizational policies and procedures***, and document compliance.

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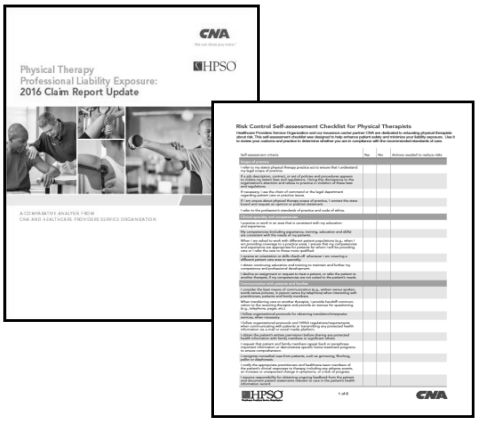
Self-Assessment Checklist

PT Self-assessment Checklist & Claim Tips

hpso.com/PTclaimreport2016



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