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## Ethics in Practice: Examining Medical Errors: An Ounce of Prevention is Worth a Pound of Cure

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## Outline

1. The Beginning: To Err is Human 1999
2. Historical Context
3. Defining Medical Error
4. Economic Impact
5. APTA Code of Ethics analysis
6. Legal Issues
7. Creating a Culture of Safety
8. Patient Perspectives
9. Resources

## continued<sup>®</sup> Learner Outcomes

After this course, participants will be able to:

- Describe the phenomenon of medical errors in our current health care climate.
- Identify at least two areas of risk for error in daily physical therapy practice.
- Explain the scope of practice, specifically related to pharmacologic intervention, in physical therapy.
- List at least three tools to assist patients with medication compliance.
- Recommend at least two communication pathways for patient movement between delivery settings.
- Describe the benefits of patient handoffs in clinical practice.
- Develop a quality care initiative and practice management strategy plan using medical error information.
- Develop a personal plan for prevention of medical errors related to their clinical practice.
- Recommend at least three resources for error prevention and promoting a culture of safety.

continued<sup>®</sup>

### “Disclaimer”

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*A good faith effort has been made to correctly reference and acknowledge all sources of information.*

## Where it all began...

- In 1999 the Institute of Medicine released a report entitled

*"To Err is Human: Building a Safer Health System"*

- Medical errors are pervasive, costly, deadly
- Errors are the result of major systems failures, not isolated individual actions
- Emotional response to report by multiple stakeholders

## Numbers are shocking

- IOM Report estimated errors cost \$17-\$29 billion annually
- 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)

## “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!

## Important points from IOM report

- 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
  - Serious errors are most likely to occur in EDs, ICUs and operating rooms

## 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

## 4 pronged approach to improvement

### 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

## 4 pronged approach to improvement

### 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



## 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

## Definition controversy

- Controversy around definition of medical error, key issues
- IOM Report defines *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
- Does not consider unplanned actions

continued

## Defining medical error

- Should distinguish error from a medical complication- acknowledge risks of medical care
- Error means ***always*** preventable OR  
“Adverse Event” and “Preventable Adverse Event”  
(Woods, 2007)

continued

## Defining medical error

- Errors do not result from omissions  
(De Bos, 2011)
- Errors can result from omissions  
(Chamberlain, 2012)

continued

## Defining medical error

- Is harm all that matters? Can have an error without harm

(Shanafelt, 2009)

- “Near miss”, “Non-harmful event”  
“Harmful Event”, “Death”

(Chamberlain, 2012)

## Medical Error v Adverse Event

- “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](https://www.jointcommission.org/Sentinel-Event)

## 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”
- Reporting is voluntary

## Root Cause Analysis

### 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.”

## The IOM Report in 1999

- Consolidated 10 plus years of research and data into a report that resulted in:
- Public outcry
- A Joint Commission response
- Congressional hearings
- a federal Center for Patient Safety within AHQR

*And then what happened?*

## 5+ years later

- IOM released a 2<sup>nd</sup> report focusing specifically on medication errors:
- “Preventing Medication Errors”
- Errors at every “Step”:
  - Procuring
  - Prescribing
  - Dispensing
  - Administering
  - Monitoring \* role of the homecare PT

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)

continued

## 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)

continued

## 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)

continued

## 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)

continued

## 10+ years later

- Study in NEJM Nov. 2010
- 10 acute care hospitals in NC
- Used the same “trigger tool” as the Health Affairs study
- Found “little evidence” of decrease in the rate of harm from medical care between 2002-2007

(Landrigan, 2010)

continued

## Almost 20 years later!!!!

- In 2016 Johns Hopkins researchers write an open letter to the CDC stating that medical errors are the 3<sup>rd</sup> leading cause of death in the US and should be included on death certificates (related BMJ article Makary, 2016)
- Current regulations allow for diagnoses associated with ICD billing codes
- Important because research emphasis and funding is based on cause of death
- (#1 heart disease, #2 cancer)

continued



## 20 years later...

- More controversy
- Problems with measuring medical error
  - 1) Interrater variability on what is an error
  - 2) Estimates of population toll are extrapolations of studies whose results are far fewer
  - 3) Studies whose results are extrapolated were not designed to determine if deaths were caused by preventable adverse events- they were designed to estimate the prevalence of adverse events in specific patient populations
  - (Ranji, 2016)
- #alternative news- JUST KIDDING

## Scope of the Problem

- Bottom line: Problem was extensive
- Problem remains extensive 20 years later
- Continued attention to the problem is important
- Bright side:

We know much more today than we did in 1999.

Original goals of 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
- Common literature searches come up empty for research
- Continuing education courses are available

## Economic Impact

- Actual economic numbers are hard to determine
- Estimated \$19.5- \$20 billion in costs per year in a model focusing on costs associated with the medical error: extra care, additional surgeries, medications etc. (consistent over time)
- In 2016 group of Loyola Chicago Business school researchers looked at medical errors from a quality standpoint (quality care is less expensive care) and determined costs are closer to 1 TRILLION dollars using Quality -Adjusted Life Years (QALY)

(Andel, 2016)

## Economic Impact

The top ten medical errors identified cost more than 2/3rds of all errors

Using 2008 data authors found top 3 medical errors:

- Pressure ulcers
- Postoperative infections
- Post laminectomy syndrome

(Van De Bos, 2011)

## Economic impact

- 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)

## Economic Impact

- 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

## 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)

## Initial key points for PTs

- Hospital based PTs can help to prevent or reduce 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:

1) Bioethical Principles:

Beneficence

Nonmaleficence

Autonomy

Justice

2) APTA Code of Ethics

8 Principles related to Core Values

## Ethical Imperatives

- Nonmaleficence “Do no Harm”

Acts *and* Omissions

Precautions and Contraindications

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

## Ethical Imperatives

- 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)

## Ethical Imperatives

**Principle #1:** Physical therapists shall respect the inherent dignity and rights of all individuals.

*(Core Values: Compassion, Integrity)*

## “Morality” consideration

- “Any insinuation from the medical community that preventable medical errors should be discounted due to patient age, health or life choices are baseless. If a terminal patient dies prematurely due to a medical error, this is still an unacceptable occurrence.”
- “Medicine does not have the moral authority to discount or disregard days, weeks, or months of life.”

(Kavanagh, 2017)

## 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)*

## Principle 3

- Scope of 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

## Principle 3

- Role may vary by setting
- Hospital- smaller role- more physician support
- Other settings, larger role:
- Ex. Home Care or Outpatient:
  - Medication reconciliation
  - Education
  - Advisement

## Principle 3

- 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

## Principle 3

- 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

## Ethical Imperatives

***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)*

CONTINUED

## Principle 4

- “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?

CONTINUED

## Disclosing medical errors

- Ethically disclosure to patients is an imperative
- Legally may be required
- Strong evidence does not exist to support the idea that disclosure creates lawsuits

CONTINUED

## Pennsylvania law

- Medical Care Availability and Reduction of Error (MCARE) Act of 2002
- Establishes duty to report, patient safety officer, patient safety committee
- Disclosure requirements: ***Duty to notify patient.*** – *A medical facility through an appropriate designee shall provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee, within seven days of the occurrence or discovery of a serious event.*

## Principle 4

- 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 have statutes related to apology

continued

## Principle 4

- Recognized that disclosure does not occur because of:
    - Fear of a malpractice suit
    - Awkwardness/discomfort
    - Fear of damage to his/her reputation
- (Gallagher, 2004)

continued

## 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”

continued

## Principle 4

- Patients wanted a sincere **apology (not just disclosure)**
- 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
  - 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)

CONTINUED

## 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

CONTINUED

## Ethical Imperatives

***Principle #5:*** Physical therapists shall fulfill their legal and professional obligations.

*(Core Values: Professional Duty,  
Accountability)*

CONTINUED

## 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 upcoming 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 (HERE) 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
  - 4) Expecting a PT aide/tech to teach exercises
  - 5) to progress exercises including the addition of weight
  - 6) 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

## Principle 6

Examples of *process* knowledge for the PT:

- knowledge of commonality of errors in specific practice setting or patient diagnoses
- familiarity with ***root cause analysis***
- communication processes
- reporting requirements
- disclosure requirements

## Principle 6

- 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)

## Principle 6

- 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

CONTINUED

## Principle 7

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

CONTINUED

## 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)*

CONTINUED

## 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

continued

## 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

continued

## 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
- Federal law: **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

Federal law: **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 specifically to address medical errors but will have a significant impact
- “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: Federal Laws

- Have EHR been successful in reducing medical errors? (Rajasekar, 2015)

### 1) Diagnostic errors: mixed results

- Pros: alerts, cues to decrease cognitive bias
- Cons: alert fatigue, limited operability to share data- not the full picture
- No clear advantage of EMR

## Legal Issues: Federal Laws

### 2) Medication errors:

- Pros: E- prescribing increases accuracy, decreases legibility errors, increases medication adherence and facilitates less follow up calls
- Cons: human error: miskeys, skipping drop down menus, disconnect between prescriber and pharmacy
- Benefit of EMR is clear

## Legal Issues: Federal Laws

- 3) miscommunication errors
  - Pros: computerized handoff intervention programs, increases physician time at bedside
  - Cons: no
  - Benefit of EMR is clear

## 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)



continued

## Legal Issues: Federal Administrative Bodies

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
- 2014-2015 1% decrease in reimbursement for over 700 hospitals

continued

## Legal Issues: Federal Administrative Bodies

- 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

continued

## Legal Issues: Administrative Bodies

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

continued

## 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
  - Study authors warn that increasing outpatient safety from medical errors is more difficult than in inpatient care:
    - more outpatient clinics
    - less oversight
    - less training opportunities for staff
- (Bishop, 2011)

## Legal Issues: Malpractice Data

- 2006 Study “Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims” Gandi 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
- Differential diagnosis in PT could have an impact  
\*IMO, not Gandhi's

(Gandhi, 2011)

## Legal Issues: Malpractice Data

- Diagnostic 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

(Gandhi, 2006)

## Legal Issues: Malpractice Data

- 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)

## Legal Issues: Malpractice Data

- As PTs: What can we learn from malpractice data?  
HPSO- CNA data report 2010-2014

Fast facts:

- 85% of the incidents occurred in a non hospital based outpatient clinic
- 30% increase in claims for case management- improper management through course of care

example:

SIXTY visits for a 35 y.o. marathon runner with hip weakness, pain and increasing falls- underlying problem was a benign giant cell tumor- claim was for delay of diagnosis

## Legal Issues: Malpractice Data

Malpractice data fast facts:

Common claims:

- Improper performance of manual therapy
  - Ex. Manual traction resulting in lumbar disc herniation
  - Cervical adjustment damaged the carotid artery
- Failure to supervise or monitor (highest average paid claims- PTs leave PTAs/aides alone)
- Improper performance of TE

## Legal issues: Malpractice Data

- Improper performance of a biophysical agent
  - 98% heat, 2% cold
  - Of the burn claims: 54% hot packs, 44% estim burns
- Failure to properly test or treat a patient – only 2% of claims, but the highest payouts:
  - 3 weeks post op rotator cuff repair, MMT resulted in a biceps tear
  - PT had a PTA student do the MMT portion of an initial exam and the PTA student injured the patient

continued

## Practice Applications: Creating a Culture of Safety

- **Timing** may be an issue
  - 1) “the Weekend Effect”
- A 2017 study found that inpatients admitted to the hospital on the weekend had a higher mortality rate than inpatients admitted during the week (Pauls, 2017)
- What are the consequences of a weekend discharge rather than admission?
  - 2) July is the most dangerous month of the year

continued

## 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?



continued

## Practice Applications: Creating a Safety Culture

- 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?

continued

## 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?

continued

## Practice Applications: Creating a Culture of Safety

- 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
- 15 years later: is required discharge information making this better or worse?

continued

## Practical 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

continued

## 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

continued

## 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

continued

## 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)

continued

## Practical Applications: Creating a Culture of Safety

- 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](http://apta.org)

## Practical Applications: Creating a Culture of Safety

- 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

## Practical Applications: Creating a Culture of Safety

- 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 established by 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)

## 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

## 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)

## Patient Perspectives

- It can happen to anyone
- Modern Healthcare series: No One is Free from Harm
- Reflect on personal experiences, experiences of family and friends
- Almost every encounter- room for improvement
- Process- commit to improvement



## Resources

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

*“Reducing Hospital Errors: Interventions that Build Safety Culture”* Singer and Vogus in the Annual Review of Public Health 2013.

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

## Resources

- To learn about specific topics:  
AHRQ Patient Safety Primers by Topic (find specific resources)

<http://psnet.ahrq.gov/primerHome.aspx>

Examples:

- “alert fatigue”
- disruptive doctors
- debriefing for clinical learning
- Checklists
- EHR

## Resources

Joint Commission: National Safety Standards

[http://www.jointcommission.org/standards\\_information/npsgs.aspx](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

- “ My medication list” to use with patients:

<http://www.safemedication.com/safemed/MyMedicineList.aspx>

- English and Spanish versions

- To create a “pill card”:

<https://www.ahrq.gov/patients-consumers/diagnosis-treatment/treatments/pillcard/index.html>

Email or text reminders: <http://www.mymedschedule.com>

continued

Thank you!

*Questions and Answers*