

Reduce Your Risks in the Emergency Department

Protective Policies and Procedures

Interdepartmental Risk Reduction

Clear Communication

Optimal Documentation

Further Decreasing Liability Risks



Medical Insurance Exchange of California
Claremont Liability Insurance Company

Medical Underwriters of California
management company

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Reduce Your Risks in the Emergency Department is a publication of MIEC's Loss Prevention Department. The authors have conducted numerous emergency department (ED) surveys and have reviewed thousands of ED records. Each of the authors has extensive experience in medical malpractice claims management and loss prevention activities on behalf of physicians and other health professionals. Recommendations to reduce emergency department risk are based on the authors' analysis of emergency department policies, discussions with ED physicians and nurses, review of ED records and malpractice litigation files. They include advice from malpractice defense attorneys, claims experts and physicians whose involvement in peer review activities gives them a unique understanding of emergency departments.

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REDUCE YOUR RISKS IN THE EMERGENCY DEPARTMENT

Emergency physicians face daily challenges that few other specialties encounter: They must establish rapport with patients they may never see again, diagnose and treat urgent and emergent conditions that require immediate care, and accomplish both under circumstances that range from unpredictable and uncomfortable, at best, to life-threatening. Patients, especially those disenfranchised from optimal access to health care, use the Emergency Department (ED) for primary care with increasing frequency. In addition, emergency personnel must contend with victims of violence who may bring a measure of that violence with them to the ED. When things go awry, when emergency care can't solve all the patient's problems, when a patient is injured or perceives that he/she has been injured, emergency physicians often become a target of blame.

This booklet highlights the basic tenets of loss prevention, which, if applied, will help emergency physicians protect their patients and themselves. These recommendations will help physicians prevent patient injuries and subsequent lawsuits, contribute to establishing and maintaining patient relations that protect both physicians and patients, and ensure that ED documentation will assist, rather than impede, the ED physician's defense in a medical malpractice lawsuit.

RECOMMENDATIONS FOR PROTECTIVE POLICIES AND PROCEDURES:

1. Establish a comprehensive physician and nurse orientation.

Emergency group physicians have the obligation to ensure that newly hired physicians and nurses have read, and also understand and agree to abide by group, departmental, and hospital policies and procedures. Periodic re-orientation for physicians and nurses is also essential to refresh their comprehension of policies and to alert them to revisions they may not have noted.

In addition to the day-to-day tasks that govern the emergency department, topics that should be considered in a new employee orientation include:

- Availability, accessibility, special needs and/or requirements of other departments, such as radiology, laboratory, specialty units, ob/gyn, psychiatry, transportation, respiratory therapy, social services, and clergy;
- How patients will be admitted to various hospital services;
- Procedures for contacting consultants and specialists, what to do in the event of a conflict between the ED and other physicians, and how to document inter-professional and inter-departmental interactions;
- How to handle in-department crises, such as fires, natural disasters, equipment failures, and violence;

- What the hospital's media policy is, and who will respond to media in the event of celebrity care, disaster response, sensationalistic event, or other media interests;
- A review of reporting requirements, to whom these reports must be made, and within what time frame (abuse, acts of violence, gunshot wounds, threats of harm, recurrent lapses of consciousness, contagious disease, dog bites, etc.);
- Resources for referral of patients to social services, both within the hospital and externally (battered spouses, abused children or elders, indigent patients, rape survivors, psychiatric referrals, etc.);
- How to report and resolve problems and complaints within the department and within the hospital;
- OSHA, HIPAA, and EMTALA regulations;
- Hospital policies related to the Americans with Disabilities Act and patients with limited English proficiency;
- Resources for staff (e.g., inservice programs for licensure, impaired physician resources, etc.);
- How and who will manage Codes within the hospital, where codes will be documented and by whom; and
- Other policies and procedures necessary to safely and competently provide care in the ED.

A good orientation program is completed by evidence of: (1) the process by which policies and procedures are distributed to employees, and (2) employee acknowledgment of their receipt of the information, confirmation that they have read it and understand it, and certification of the fact that they agree to follow it. It is incumbent upon physician and nurse ED directors to participate in periodic reviews of policies and procedures. This serves a twofold purpose. It ensures that policies and procedures reflect the reality of the department. It should lead to regular in-service education programs to ensure that all individuals working in the ED understand the policies and why they exist, and to re-emphasize the need to comply with department requirements. It also provides an opportunity for ED staff to provide feedback to their supervisors.

2. Ensure that all emergency department personnel know how to prevent and handle patient complaints.

Policies that make sense, that are agreed upon by staff and risk management, and that clearly describe what to do to prevent complaints and what to do if a patient makes a complaint, help ensure fewer patient complaints and consistency in how complaints are resolved.

First, avoid patient complaints:

- Treat patients with respect.
- Communicate clearly what you are doing and why.
- Avoid surprises; tell patients what to expect, both with the patient information brochure (*Figure 1*) and by careful communication by all ED staff.
- Apologize for delays and excessive waiting times without placing blame on any particular component of the ED experience (e.g., "The doctor is so slow," "We're understaffed," "Those

Emergency Department Patient Information Brochure

Patients often come to the emergency department (ED) in pain, fearful, intimidated by unfamiliar surroundings, confused, angry, or experiencing a combination of these and other emotions. Any of these reactions can interfere with communication between the ED staff and the patient and inhibit the establishment of a cooperative relationship. A well-designed patient information brochure helps avoid misunderstanding, confusion, and errors that contribute to patient injury or complaints. A patient information brochure tells patients what to expect and what they can do to make the most of their emergency care and treatment. It can also be used to encourage a spirit of cooperation and mutual trust between the ED physicians and ED staff and their patients.

A well-designed patient information brochure includes the following:

- A brief explanation of emergency services, relevant emergency department and hospital policies, and other general information (*such as a map of the facility, description of support services, list of the on-call physician panel, etc.*);
- An explanation about how the ED prioritizes care. (*Many patients do not understand the triage process or why they have been kept waiting while later arrivals were seen. Tell patients what to expect; explain how some emergencies and ambulance arrivals take precedence. Express regret that these types of unpreventable delays may occur during their stay.*);
- An introduction to ED personnel with a brief explanation of how they interact with patients (*Describe the role of registration clerks, triage nurses and others.*);
- A statement about the ED's policy on admitting visitors to treatment areas;
- Answers to Frequently Asked Questions about ED charges, billing, and other administrative and financial concerns. Advise patients if they can expect to receive a separate statement from the laboratory or radiology departments. Include the business office phone number patients can call if they have questions about their statement;

- ❑ A reminder that patients will receive written aftercare instructions at discharge. Tell them why it is important to follow these instructions;
- ❑ A brief statement about patients' responsibilities when they visit the ED. Tell patients it is important that they: (1) provide complete and accurate medical and social information; (2) ask questions whenever clarification is needed; (3) alert the staff to problems encountered in the ED; (4) comply with medical advice; and (5) report adverse reactions to medication or other treatment.

Distribute a patient information brochure to each patient and ensure that copies are available in ED and hospital lobbies, reception and waiting areas.

Follow these suggestions for **all** patient educational and informational materials:

- Choose a format that is readable, uncrowded, and aesthetically pleasing;
- Organize the material in logical sequence;
- Use simple language and short paragraphs;
- Avoid medical jargon;
- Use clear illustrations and/or diagrams when appropriate;
- Double-check for grammar, punctuation, and spelling accuracy;
- Include the ED's address and phone number, so patients know where to call if they have questions;
- Ask several lay people to pre-test material for readability and clarity;
- Reevaluate the content annually and update the brochure as needed; and
- Consider translating brochure into the languages other than English that are spoken most frequently by patients the ED serves.

laboratory people are always late.”) Most patients and their families will readily accept delays if they understand that the ED has to accept more critically injured patients and deal with them first. Train staff to effectively verbalize to patients that a number of events have probably occurred which prolonged evaluation for the particular patient.

- Report test results as soon as they arrive.
- Treat patients the way you want doctors and their staff to treat you, your parents, or your child.

When patients make complaints:

- Develop a clear policy about how complaints will be handled.
- Consider designating a nurse to discuss patients’ nonmedical complaints.
- Only qualified clinicians should discuss complaints about medical care.
- Get advice from MIEC’s Claims Department before responding to significant quality-of-care complaints.
- Discuss complaints calmly and professionally, even in the face of patient anger, which is rarely personal. Be patient and considerate, but end the discussion if the patient becomes abusive. Know what to do and who to call if the patient becomes physically violent.
- In complex situations, ask patients to put their complaints in writing.
- Respect the laws of confidentiality that prohibit discussing a patient’s medical care with others (including patient’s spouse) without the patient’s consent.
- Establish a policy for responding to requests for reducing or waiving fees in conjunction with a complaint. Waiving a fee may be perceived as admitting liability. Fees should be adjusted only with physician approval and after consultation with an MIEC Claims Representative.
- Do not admit liability or negligence when discussing a complaint before you have discussed it with MIEC’s Claims Department. Do not promise the patient or the patient’s family compensation for an injury or adverse reaction. MIEC is not obligated to honor such promises in the absence of prior approval. You may, at some point, be able to freely discuss liability or compensation with a patient with MIEC’s advice and approval, but until then, offer sympathy (not a *mea culpa*) and a promise to look into the complaint.
- Do not discuss complaints or respond to letters or telephone requests from patients’ attorneys without advice from MIEC.
- When patients complain, document those complaints and their resolution in patients’ charts. The documentation establishes a date on which the patient was aware of an alleged injury. The statute of limitations begins from that date if the patient later decides to file a malpractice action related to the complaint.

3. Ensure that policies for transfers-in and transfers-out of the ED satisfy EMTALA criteria.

4. Establish, test, and maintain an ED disaster plan compatible with that of the hospital.

5. Establish and maintain an internal equipment and supply inventory.

6. Establish policies for equipment maintenance and operation, including:

- Training and certification protocols for all levels of emergency department staff, for all equipment they will manage, monitor, or operate.
- Timeframes for equipment testing, inspection, maintenance, and chargeable battery replacement.
- Procedures to respond to equipment malfunction, including obtaining back-up equipment and safeguards and steps for equipment removal and security. (In the event of a personal injury, sequester devices, accessories, and packaging, save recorder strips, and leave the device settings intact.)
- Protocols for contacting risk management personnel, in the event that a patient is injured as a result of an equipment malfunction.

RECOMMENDATIONS FOR INTERDEPARTMENTAL RISK REDUCTION:

7. Establish clear guidelines for interactions with the Radiology Department.

- Establish with the Radiology Department what clinical information is necessary to assist the technologists to take the most appropriate views and for the radiologists to best interpret the results.
- Establish a quality assurance program to monitor discrepancies between ED physicians' first interpretations and radiologists' second interpretations of films. (*Figure 2*)
- In the event of significant discrepancies between the ED physician's and the radiologist's reading of a film, implement a formal plan by which an ED physician takes responsibility for calling the patient or the patient's private medical doctor (PMD) to change the course of treatment. It is prudent to document these calls in patients' charts.
- Agree: (1) that female patients in childbearing years will be asked the date of their last normal menstrual period before abdominal films are taken (remember to document the patient's response); (2) upon the means by which a safe margin (the 10-day-rule, for example) is established for abdominal films; and (3) upon the criteria by which a film will be taken even if there is a pregnancy or suspicion of one.
- Document all telephone calls to and from the Radiology Department when they include diagnostic or clinical information, oral reports of completed studies, problems between the two departments, or if the conversation includes medical decision-making.

8. Establish clear guidelines for interactions with the Laboratory.

- Establish and maintain policies that ensure timely results.
- Create a follow-up system for cultures completed after patient discharge to ensure that a physician reviews the result and initials it as evidence of his/her review. The result then should

Anytown Medical Center
Emergency Department / Radiology Communication

INITIAL IMPRESSION BY E.D. PHYSICIAN

- Essentially Normal
- Other Findings: _____

Date: _____
X-ray Ordered: _____

Chief Complaint: _____

Time: _____
Emergency Physician: _____, MD

RADIOLOGIST'S REVIEW

- Agree, No Significant Discrepancy
- Disagree with ED physician's impression
- Diagnosis: _____

If radiologist disagrees with ED physician's impression:
Notified
in ED at _____ on _____
(Time) (Date)

- Final report dictated.

Radiologist: _____, MD
Date: _____ Time: _____

EMERGENCY DEPARTMENT REVIEW AND FOLLOW-UP

Date: _____

- No Significant Discrepancy
- Discrepancy, No change in therapy required
- Discrepancy, Actions taken: _____

Patient notified at _____ on _____ and advised
(Time) (Date)

Dr. _____ was called at _____ on _____
(Time) (Date)

Patient's private physician, Dr. _____ agreed to notify patient.

Completion, Review and Follow-up by: _____, MD
Emergency Department

Anytown Medical Center
Emergency Department/ Radiology
Communication Form



become part of the patient's chart, and, when appropriate, the patient is contacted. Follow-up contact and advice must also be documented in the chart.

- Document all telephone calls to and from the Lab when they include diagnostic or clinical information; oral reports of completed studies, including critical results; problems between the two departments; or if the conversation includes medical decision-making.

9. Establish clear guidelines for interactions with non-ED physicians.

Private Medical Doctors (PMDs)

Emergency physicians have an independent duty to patients that is not superseded by prior physician-patient relationships. "We've all heard private attending physicians say, 'That's my patient.' This is a definitional problem. Physicians do not own patients. Patients are the responsibility of whatever physician they are seeing at that moment."¹

The following policies will encourage productive interactions with PMDs:

- If PMDs see patients in the ED, establish criteria for their documentation commensurate with that required of ED staff.
- Establish a policy regarding the conditions under which a PMD may send a patient to the ED for medications to be administered by the ED staff. (The policy may be that there are no conditions under which this practice is acceptable.)
- Establish specific policies for PMDs and ED physicians and staff to follow if it is an accepted practice for ED physicians to admit PMDs' patients to the hospital; if it is acceptable for PMDs to schedule procedures in the ED; and if the ED staff is expected to work with PMDs when they see their patients. (Policies may reflect that none of these practices are acceptable.) Ensure that PMDs know how long they have to arrive to examine "their" patient in the ED before the ED staff assumes care of the patient.
- Establish a policy to govern what must be done when patients come to the ED and ask for their PMD.
- Establish a policy to resolve conflicts between ED physicians and PMDs.
- Establish a policy to ensure that PMDs (and specialists, when patients are referred for follow-up care) routinely receive documentation of their patients' treatment and aftercare instructions following their patients' ED visit.

On-Call Specialists

Cooperate with the hospital to assure that ED physicians and staff are familiar with the policies of the hospital with respect to on-call coverage. Policies and procedures should include:

¹ *Emergency Medicine Risk Management: A Comprehensive Overview*, 2nd Edition, American College of Emergency Medicine. Gregory L. Henry, MD, Editor-in-Chief and Daniel J. Sullivan, Associate Editor. 1997. "Patient Expectations," by Gregory L. Henry. Page 7.

- Assurance of current schedules for on-call specialists and a plan of action in the event that a particular specialty is not available. (Document efforts to obtain specialty care if it is not immediately available.)
- A plan of action in the event that there is a conflict between the on-call specialist and the ED physician.

ED physicians should also be aware that on-call physicians who provide care in the emergency department may not have an obligation under EMTALA to provide follow-up care to the patient in a non-emergent setting, unless required by the medical staff by-laws to do so. For a better understanding of ED on-call requirements under EMTALA, see *We Get Letters* #10, #11, and #12.

A word about EKGs—

Policies mandating an over-read of EKGs by cardiologists can be a potential liability unless clinical information about the patient's condition accompanies the EKG strip, and the cardiologist's review results in timely feedback to the ED.

10. Develop effective working relationships with ancillary and support services available to the ED and its patients.

Make certain that ED physicians and staff have access to and know the availability of ombudsmen or other patient representatives, social services, clergy, psychiatric support services, and any other services available to assist the ED and augment patients' ED experiences.

Psychiatric Services

ED physicians should be prepared to conduct a basic psychiatric evaluation and document their findings prior to (or in collaboration with) psychiatric intervention by mental health professionals. Documentation of this kind is crucial to implementation of a psychiatric hold. Physicians must take particular care to document that suicidal or threatening patients agreed to keep an appointment with a mental health practitioner and are no longer a danger to themselves or others when they are discharged from the ED.

RECOMMENDATIONS FOR CLEAR COMMUNICATION:

The number one problem with communication is the illusion that it has been achieved.

Communicating with patients

11. Employ active listening when gathering information from patients.

When patients arrive at an emergency department, they are usually in pain, frightened, and/or disoriented. Unless they are familiar with medical terminology, patients may fail to meaningfully describe their symptoms and mechanisms of injury to hospital personnel. In order to elicit important information from patients, nurses and physicians have to become skilled at reading between the lines, allowing patients to finish what they are saying without interruption, and repeating what they heard the patient say to ensure that the information is accurate. “Real listening is the highest compliment you can pay another person.”²

Identify by name, and relationship to the patient those individuals who accompany a patient, especially if they add anything of significance to the patient’s presentation, history or complaints.

12. Design and distribute an emergency department patient information brochure.

Many emergency departments begin their doctor-patient relationships with clear communication in the form of a patient information brochure to introduce patients to the facility, the emergency department, its policies, the physicians, what to expect while seeking care, and how patients can participate to their advantage in the process. (*Figure 1, pages 5-6*) A patient information brochure serves to inform patients about the “basics” of emergency care, pre-empt the most frequently asked questions, and encourage a cooperative relationship between patient, physicians and staff. (For example, explain that patients are seen according to medical need and that delays may occur.)

As with any written patient information, the brochure should be well-organized, formatted for readability, and written in simple language. Because the average literacy rate for patients ranges from a fifth to seventh grade reading level, illustrations may further aid understanding. Doctors who work in emergency departments that serve large numbers of non-English-speaking patients would be wise to enlist the aid of a local college or a charitable group to help translate the brochure into the most frequently spoken community languages. Authors of patient information brochures should consider cultural nuances, taboos and sensitivities for the communities who will receive and read the brochure. These brochures may also be used to begin educating patients about what constitutes an emergency, the importance of obtaining follow-up care, and other information emergency physicians want to convey to their patients.

Patient information brochures can be made available in the lobby of the hospital or emergency department, and can be given directly to patients when they are triaged for emergency care.

13. Establish a call-back program.

Many injuries alleged to have been the fault of emergency department physicians or nursing staff could have been prevented if emergency personnel had been aware of problems that arose within twenty-four hours of the patient’s discharge from the emergency department. As a proactive measure, many emergency departments have implemented a plan to prevent further medical crises in the aftermath of emergency care. When patients are discharged from the department, they receive a telephone call from a nurse or well-trained ancillary employee within 24-hours of their discharge. Optimally, every patient is called. If this is not possible, criteria may be established for follow-up calls, such as:

² *Emergency Medicine Risk Management: A Comprehensive Overview*, 2nd Edition, American College of Emergency Medicine. Gregory L. Henry, MD, Editor-in-Chief and Daniel J. Sullivan, Associate Editor. 1997. “Patient Expectations,” by Gregory L. Henry. Page 5.

- patients who were excessively and disproportionately anxious about their medical condition or care;
- patients whose discharge was a judgment call and who might require additional care;
- patients the doctor or staff believe might need additional encouragement to follow-up with another physician as directed;
- patients the doctor or staff believe might need additional encouragement to take their medication as directed; and
- patients who demonstrate questionable understanding of aftercare instructions.

During the call, the nurse or well-trained ancillary employee asks the following questions:

How are you doing today?

Is there anything the doctor should know about your condition?

Are you following the doctor's advice?

Are you taking your medications as directed?

Do you have any questions about your condition or care?

What arrangements have you made for your follow-up care?

A call-back program provides the opportunity to correct misperceptions of advice or to reinforce aftercare instructions, and gives emergency physicians a "heads up" if a related medical problem is brewing that should be addressed. Perhaps most importantly, patients are thrilled by the fact that someone from the emergency department called them, so the doctor-patient relationship, and the relationship between the department and the patient are strengthened. Thorough documentation is evidence that the call was made.

Communicating with providers

14. Document significant telephone communication.

The lack of documented telephone communiques has sunk the defense of many a medical malpractice lawsuit. Too frequently, when an emergency department nurse calls a doctor, an emergency physician calls the hospital floor, someone from the radiology department calls the emergency department with a result, the lab calls with a late reading, an emergency physician consults with a specialist, or a private medical doctor calls the emergency department with pertinent information about a patient, SOMETHING is mis-communicated. Someone fails to take advice and forgets it was given. Someone forgets to pass on a message. Someone delays the message. Someone inadvertently reverses numbers. The result? A patient is injured; and then, most inconveniently, the patient blames everyone, and there is no documentation to accurately represent what was said in that critical telephone conversation. This disaster can be avoided by implementing a documentation system that everyone agrees to follow.

Each and every significant telephone conversation should be documented. A significant telephone conversation is one in which new symptoms are conveyed, medical advice is dispensed, or medical decisions are made. Documentation should include the names and titles of participants, what was said, when the conversation took place, and enough substantive detail to make clear what transpired.

15. Schedule regular physician-nurse staff meetings and inservice programs to maximize the relationship between the two groups.

It is a fact that effective teams listen to one another, respect one another, and focus consistently on the common goal rather than becoming mired down by individual differences. To that end, regular and open communication between doctors and nurses can be fostered by meeting regularly to encourage *esprit de corps*. Doctors who share their knowledge to enhance nurses' skills and informational bases also enhance their standing among their nursing colleagues.

RECOMMENDATIONS FOR OPTIMAL DOCUMENTATION

16. Require physicians and nurses to document for patient safety and personnel defensibility. Ensure that:

- General consent forms are signed.
- Admit time is documented: hour, day, month, and year.
- Triage notes are complete and the chart includes evidence that the physician reviewed the triage notes.
- Discrepancies between nurses' notes and doctors' notes are resolved in the chart.
- Vital signs are complete.
- Allergies (or NKDA) are listed consistently and prominently.
- Current medications (including OTC, complementary and alternative, and "recreational") are listed, or "patient denies."
- Names of other physicians the patient sees are listed.
- The LNMP is noted for females of childbearing years (ages 12 to 60).
- X-ray and other radiological results are noted in the progress note or the radiology report is initialed and filed in the chart.
- The name of the ED physician who read the x-ray is in the chart.
- EKG results are noted.
- Patient history is complete.
- Treatment details are complete.
- Time, route, dose, amount, etc., of medication orders administered are clearly documented.
- Significant telephone calls are appropriately and completely documented. (*See item 14. above.*)
- The diagnosis is clearly documented.
- The disposition of the patient is clearly noted.
- The discharge time is documented.
- The patient's condition at the time of discharge is noted.
- Diagrams are used to enhance or supplement the narrative notes.

- Aftercare instructions are complete. They include the diagnosis, they are clearly written and jargon-free, and they are time and action specific. **(See Item #18)**
- Progress notes include adequate detail regarding symptoms, physical findings, physician assessment, and treatment provided and recommended.
- The chart is devoid of strikeovers, writeovers, crossouts, and other improper error corrections.
- Amendments and additions are appropriately entered.
- **All handwritten entries are legible!**
- Transfer documentation, pertaining to both transfers in and transfers out of the ED, is complete and EMTALA-compliant.
- Progress notes justify care and treatment, justify the fee that will be charged, and distinguish between physicians' responsibilities and those of the patient (aftercare instructions).
- The chart is devoid of interprofessional criticism and subjective comments about patients.
- The chart is devoid of squeezed-in notes.
- Interpreters' names and their relationship to the patient are documented.
- All chart entries are initialed or signed.
- Return-to-work (or school) advice is patient-specific and appropriately detailed. *(Figure 3)*
- Patient education, written and oral, is documented.
- Chart includes evidence of physician review of lab reports either because physician signed off on them or included results in the progress note.
- Informed consent and informed refusal discussions are documented. **(See Item #21)**
- Charts comply with the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) required elements.

17. Provide clear aftercare instructions.

According to Greg Henry, MD, past president of the American College of Emergency Physicians (ACEP), "Between one-third and one-half of all emergency medicine legal cases are associated with the discharge instructions or the discharge program constructed for the patient."

Particular care must be taken with the instructions given to patients, orally and in writing, upon discharge from the ED. Regardless of who gives the instructions to the patient, the treating physician is always responsible for their content. Oral and written aftercare instructions should:

- Ensure that recommended follow-up is clearly defined and time- and action- specific.
- Make certain that "as needed" follow-up is clear as to circumstance and where to seek care.

WORK STATUS REPORT

Name: _____ Date: _____
 Employer: _____ Contact Person: _____
 Date of Injury: _____ Date First Seen: _____
 Diagnosis: _____

Nature of Injury/Illness: First injury/Illness Recurrence Cumulative Non-industrial Injury

Work Disposition:

- Unable to return to work from: _____ to: _____
 Can return to **FULL WORK** with **NO RESTRICTIONS** on _____
 Can be in **MODIFIED** work program starting _____ and continuing to _____
(Date) (Date)

IF MODIFIED WORK IS NOT AVAILABLE, EMPLOYEE IS THEN OFF WORK FOR SAME TIME PERIOD.

WORK RESTRICTIONS:

TIME LIMITS: No more than _____ hours per day and _____ hours per week.

LIFT/CARRY:	<u>Not at all</u>	<u>Occasionally*</u>	<u>Frequently**</u>	<u>No Restrictions</u>
0-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-40 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over 40 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABLE TO DO:				
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive hand motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand/walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Occasionally** means up to 2 hours per 8 -hour day. *Frequently** means up to 4 hours per 8-hour day.

OTHER RESTRICTIONS:

- Keep wound/dressing clean & dry Use assistive devices: sling brace crutches
 Avoid contact with chemicals Can do data entry _____ hours at a time
 _____ with _____ hours break for _____ total hours.

FOLLOW UP CARE:

- Final visit, discharge from care for this injury/illness
 Re-evaluation on: _____
 Physical Therapy prescribed: **Frequency** _____ **Duration** _____
 Consultation requested from Dr. _____ **Specialty** _____
Address: _____ **Phone:** _____
 Appointment Date: _____ Time: _____
 Special tests/procedure: _____ Date: _____ Time: _____
Address: _____ **Phone:** _____

(PRINT PHYSICIAN'S name)

Physician's Signature

Physician's Address

Phone: _____

Fax: _____

Figure 3

- Include the working diagnosis on the aftercare instructions.
- Indicate what treatment was rendered in the ED.
- Use patient-friendly language rather than medical jargon.
- Encourage patients to ask questions and repeat the instructions as they understand them. Document that the patient indicates he/she understands.
- If written patient education materials are provided, document this in the chart.

18. To avoid contradictions in the medical record, physicians should read nurses' notes. Conflicts between doctors' and nurses' notes should be resolved in the chart before it returns to medical records for filing.

19. Under no circumstances should medical records be altered because a patient's attorney requests a copy of the records, or upon the threat of litigation by a patient.

Alterations should only be made in a timely manner. Amendments should be referred to in the original note (i.e., "see amendment below"), and corrections should be made by making a single line through the error, then correcting, initialing and dating the correction. If appropriate to the situation, an explanation of the reason for the amendment or correction may be added. If in doubt, call MIEC's Claims Department for advice.

RECOMMENDATIONS FOR FURTHER DECREASING LIABILITY RISKS

"How the patient experience is managed is the ultimate risk management tool."

Greg L. Henry, MD

20. Be aware of the particularly high risks related to:

- errors that commonly occur during shift changes;
- pain management;
- excessive patient waiting times;
- return visits from patients recently seen;
- the treatment of "private" patients sent by their PMDs;
- intoxicated patients;
- behavioral or mental health patients; and
- drug-seeking patients.

Obtain consultations or advice accordingly; document thoroughly.

EMERGENCY DEPARTMENT PATIENT SURVEY

We Want to Hear From You!

Your health care is important to us; so is your opinion. Please tell us what you think about our emergency department and the care you received by answering the following questions. Your answers will help us serve our patients better. Thank you for your response.

What three things did you like best about our emergency department and the services you received?

1

2

3

What three things did you like least about our emergency department and the services you received?

1

2

3

Suggestions, complaints, or additional comments:

Name (Optional): _____

**ABC Emergency Medicine Physicians Group
Anytown Medical Center
1234 Main Street
Anytown, USA
555/123-4444**

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

21. Make certain that all physicians and staff understand the process of obtaining informed consent AND the concept of informed refusal.

When patients refuse care that is essential to their well-being, physicians are obligated to inform those patients of the potential consequences of their refusal. Once informed, patients have the right to continue to refuse the recommended care, but physicians should then accurately document that every effort was made to inform the patient of the negative effect this may have on his or her well-being. In the event the negative outcome occurs in the absence of recommended treatment and the patient blames the physician, it would be difficult for the patient to refute the documentation of his or her informed refusal.

22. Assure that all physicians are aware of the hospital's policy for disclosing unexpected outcomes, as mandated by JCAHO (See Special Report #33).

23. Introduce physicians and ED staff to the hospital's and the ED's disaster plans. Regular disaster drills are a prudent practice.

24. Preserve and protect patient privacy and confidentiality according to federal and state laws, and community standards. All physicians and ED personnel should be familiar with the laws that govern confidentiality, and the reporting laws that supercede the laws of confidentiality.

25. Insist that all physicians are familiar with and follow the hospital's and the department's safety and security precautions.

26. Consider a simple patient satisfaction survey to find out what patients really think of the ED. Often, patients are reluctant to fill out surveys that take page after page of multiple-choice questions and appear officious and formal, rather than patient-friendly. MIEC's sample survey is designed to elicit useful information with minimum "hassle-factor" for either patients or the staff who will gather the data from it. (Figure 4)

27. Establish and maintain a departmental quality assurance or quality improvement program. An effective QA/QI program includes on-going self-assessment among physicians of the group to maintain maximum competence among group members and to assure a group standard that protects patients and the group. The program should also include regular audits of both physician and nursing documentation.

HOW TO REACH MIEC

MIEC Home Office

Underwriting Department
Claims Department
Loss Prevention Department
Oakland, CA
510/428-9411 (Bay Area) Outside 510—800/227-4527

Hawaii Claims Office

Honolulu, HI
Phone: 808/545-7231

Idaho Claims Office

Boise, ID
Phone: 208/344-6378

INTERNET: www.miec.com

Your relationship with your liability carrier

The Medical Insurance Exchange of California staff wants to be of assistance to you. Please feel free to call us when you have questions or concerns related to your policy, your liability risks, individual patients, or practice management issues that impact your risks and/or your defensibility.

Call the Underwriting Department

- When you have a question about your policy
- When you have a question about coverage

Call the Claims Department

- When you receive legal papers related to a patient, such as
 - A request for records
 - A notice of intent to sue
 - A letter threatening a suit
 - A subpoena for records
 - An attorney's request for a meeting or report
 - A deposition notice
 - A Summons and Complaint
- When you want to know the status of a claim
- When you want to report a claim, a potential claim, an incident or an untoward result

Call the Loss Prevention Department

- When you have a question about
 - Informed consent or refusal
 - Patient education
 - Forms and brochures for the department
 - Patient satisfaction surveys
- When you want to know how to properly withdraw from a patient's care

RESOURCES

Patient Communication

Office for Civil Rights

<http://www.hhs.gov/ocr/lep/revisedlep.html>

“Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons”

Medline Plus, a service of the U.S. National Library of Medicine and the National Institute of Health

<http://www.nlm.nih.gov/medlineplus/healthtopics.html>

Click on the “Easy to Read” icon to access easy-to-read health materials in English and Spanish listed alphabetically by topic.

The National Center for Cultural Competence

<http://gucchd.georgetown.edu/nccc/>

Includes information on provider self-assessments in cultural competence; planning guidelines for cultural and linguistic competence; and a guide to choosing culturally and linguistically competent health promotion materials.

The Partnership for Clear Health Communication

<http://www.askme3.org>

Provides printable brochures, fact sheets, and worksheets to facilitate communication between patients and providers. Materials are available in English and Spanish.

Web-book: Debra L. Roter, DrPH, Chapter 2, “How Effective is Your Nonverbal Communication?”

http://www.conversationsincare.org/web_book/chapter02.html

Understand how unspoken messages may be projected through nonverbal communication clues.

World Education Health & Literacy Special Collection

<http://www.worlded.org/us/health/lincs/provider.htm>

Affiliated with the National Institute for Literacy, this Web site contains links to health care provider resources for cultural and linguistic competency. Includes indices by subject and language.

California Healthcare Interpreting Association

<http://www.chia.ws/>

Professional association of California healthcare interpreters. Search function allows you to find an interpreter by city and language, and displays education and training information.

Additional Resources

The American College of Emergency Physicians

<http://www.acep.org>

Contains a medical liability section including resources for litigation stress programs.

Occupational Safety and Health Administration (OSHA)

<http://www.osha.gov/SLTC/bloodbornepathogens/index.html>

This site provides links to the Needlestick Safety and Prevention Act and Bloodborne Pathogens Standard 1910.1030, as well as tools to recognize and minimize hazards in the workplace.

Joint Commission International Center for Patient Safety

<http://www.jcipatientsafety.org>

Patient safety materials and practices are provided through this JCAHO website.

BIBLIOGRAPHY

Emergency Medicine Risk Management: A Comprehensive Overview, 2nd Edition. American College of Emergency Medicine. Gregory L. Henry, MD, Editor-in-Chief and Daniel J. Sullivan, Associate Editor. 1997.

To obtain the following MIEC Publications, please call the Loss Prevention Department:

We Get Letters No. 10, "I'm on the ED's on-call panel...Help!"

We Get Letters No. 11, "EMTALA Changes"

We Get Letters No. 12, "Clarification re EMTALA"

MIEC Claims Alert No. 33, "Disclosure of unanticipated outcomes"

Managing Your Practice No. 14, "Patient education improves care and reduces liability"

6250 Claremont Avenue, Oakland, California 94618
Telephone 800/227-4527 or 510/428-9411
Fax 510/420-7066
email: loss_prevention@miec.com

Medical Insurance Exchange of California
Claremont Liability Insurance Company
Medical Underwriters of California
management company

