Risk management opportunities for hospitalists

1. Communication among providers during transfers.

A common issue reported by hospitalists is that reports issued by the sending hospital do not always provide a true representation of the patient received. Hospitalist groups should try to minimize variation with respect to patient transfers by creating standardized transfer guidelines based on patient diagnosis, such as stroke patient transfers, burn patient transfers, neurotrauma transfers, etc.

2. Communication during hand-off process.

Effective and efficient internal hand-off processes for both change of shift and change of responsible provider. Consider I-PASS or Warm Handoffs to help make this process more consistent among providers.

3. Communication among providers during discharge.

Hospitalists should have a consistent method to identify high-risk patients. When a high-risk patient is identified, it may be necessary for the hospitalist to communicate important information via phone with the ambulatory physician. Additionally, when a patient is being discharged to a post-acute care facility, prompt discharge summaries are vital to continuity of care.

4. Unreconciled test result.

Missed or unreconciled lab results can occur when there is ambiguity as to whether the ordering clinician, the radiologist or even the patient's primary care provider holds ultimate responsibility for follow-up. Greater clarity and transparency of roles and responsibility for practitioners is crucial to reducing unreconciled lab results. A recent study* from BMC Health Services Research also indicated that patients feel it is important for them to have access to their results through online portals, and to use plain language when communicating results verbally to avoid a misunderstanding.

* Alexander et al., Patient preferences for using technology in communication about symptoms post hospital discharge, *https://tinyurl.com/2x67y5ve*

Hospitalist Case Study

Patient background: A 40-year-old patient presented to the Emergency Department (ED) with complaints of severe low back pain after lifting weights. The patient was admitted to the hospital for urosepsis and a kidney stone. However, the urologist noted that the kidney stone did not explain the back pain. At 7pm, the Hospitalist saw the patient, who was febrile and had no urine output for six hours. The Hospitalist ordered a bolus of normal saline, CBC, and Chem 7 to be drawn in the morning. By 9pm, the patient was unable to void and had bilateral lower extremity numbness. The Hospitalist was paged and ordered a Foley catheter. At 1:05am, the patient was unable to move his legs and had tingling in his feet. The nurse paged the Hospitalist, who reviewed the patient's chart and briefly examined the patient. At 3am, the patient woke up complaining of lack of movement in his legs. The Hospitalist saw the patient at 3:20am, suspected an acute spinal abscess causing cord compression, and ordered a CT scan. At 5am, a neurologist evaluated the patient and ordered an MRI. The CT scan was negative, but the MRI revealed an elongated extradural mass located in the posterior aspect of the spinal canal from T3 to T8. At 12:10pm, the patient underwent multi-level thoracic laminectomy and excision of the epidural mass. The patient was diagnosed with T8 paraplegia, with neurogenic bowel and bladder. The plaintiff claimed a delay in the diagnosis of the epidural abscess and sought $4.5 million in damages. **The claim was settled against the Hospitalist for $1.8 million.**