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RISK MANAGEMENT ISSUES FOR COUNTY HEALTHCARE PROVIDERS

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER
HOSPITAL-WIDE GRAND ROUNDS

WEDNESDAY, JUNE 11, 2008 12 NOON - 1:00 P.M.

Topics

- Informed Consent
Adding Procedures Not Listed on Form
- Patients Who Leave "AMA"
What Should Providers Do?
- "No Shows" at the Clinic
When Does Provider's Responsibility End?

What would you do?

- The patient's girl-friend has driven him to the hospital emergency room after he hit his head on the edge of a swimming pool when he attempted to dive into the pool from the roof of his house. He is so drunk he can hardly stand on his own two feet and the beach towel that is wrapped around his head is saturated in blood. When you approach to remove the towel, he raises a fist at you and tells you to stay the @*G!% away from his girlfriend and then turns to walk out the door and leave the hospital.

Consent: Legal Principles

- "Every competent adult has the fundamental right of self-determination over his or her body and property. Individuals who are unable to exercise this right, such as minors or incompetent adults, have the right to be represented by another who will protect their interests and preserve their basic rights." [California Hospital Association Consent Manual](#).

"Informed consent"

- People have a right to know what is going on and may require information from their provider in order to provide "informed" consent. Only the healthcare provider can know what information is "material" to the decision making of the patient.
[Cobbs v. Grant](#), (1972) 8 Cal 3d.

- Provider explains in language, and at level, that patient can easily understand:
 - Patient's medical condition
 - Risks, including potential side effects, of proposed treatment
 - Benefits of proposed treatment
 - Alternatives, including "doing nothing"
 - Risks and benefits of alternatives...
 - Identity of provider who will do procedure

Charting Consent/Informed Consent

- Always chart consent and informed consent; failure to get consent = possible liability for *battery*
- Battery lawsuits: no "cap" on non-economic damages that is available in malpractice cases

- Healthcare providers should use "informed consent" written forms when procedure is risky, or when required by law
- Law requires written forms for things such as blood transfusions, elective sterilizations, hysterectomies, etc.

What would you do?

- 911 has been called to a state-wide high school cross-country meet and a young incoherent runner, accompanied by his coach, is brought to the hospital ED by ambulance apparently suffering from heat stroke -- his parents names are known by the coach, but the parent who has the roster with contact information left the information in her hotel room and hasn't called the coach yet with the parent's phone numbers. The coach is "uncomfortable" signing consent forms to proceed with treatment.....

In an emergency ...

- if patient is unable to consent (e.g is unconscious or is a minor and the parents haven't been located yet) and
- there is no evidence to indicate that the patient/parents would refuse the necessary treatment, i.e., it is reasonable to assume that patient WOULD consent if patient COULD...
- Consent is "implied"

- Provider should document that emergency exists, describe the emergency, and limit care to treating the emergency condition
- By policy, most hospitals ask that two doctors write note in record attesting to emergency condition
- Physicians should not sign the consent form "on behalf of the patient"

Emergency defined: Business and Professions Code 2367

2397. (a) A licensee shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the licensee's office or in a hospital on account of a failure to inform a patient of the possible consequences of a medical procedure where the failure to inform is caused by any of the following:

- (1) The patient was unconscious.
- (2) The medical procedure was undertaken without the consent of the patient because the licensee reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient. ...

(b) This section is applicable only to actions for damages for injuries or death arising because of a licensee's failure to inform, and not to actions for damages arising because of a licensee's negligence in rendering or failing to render treatment.

- (c) As used in this section:
 - ... (3) "Emergency situation occurring in a hospital" means a situation occurring in a hospital, whether or not it occurs in an emergency room, requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

What would you do?

⚡ During surgery to remove a benign ovarian cyst, you discover that massive fibroids on the uterus are causing pressure on vital arteries and will likely cause serious disability at some future time if not removed. Given the size of the fibroids, it appears that a hysterectomy will have to be performed.

⚡ Should you wake the patient up to get consent, and then proceed?
⚡ Ask a family member for consent so that another surgical procedure (with a second anesthesia) can be avoided?
⚡ Or, must you wait until the patient has capacity again, and then get informed consent and schedule a second surgery?

⚡ Unless it is an "emergency" you should not go forward with the procedure until you get permission directly from the patient.

⚡ See excellent discussion in:
[CMA On-Call Document #0417](#)
Informed Consent Exceptions: Emergencies, Therapeutic Privilege, and Patient Requests Not to Be Informed (p.2)

⚡ www.cmanet.org
➤ Click on CMA On-Call, then Consent, then #0417

⚡ In an emergency where the additional surgical procedure was not contemplated, or consented to (e.g., a nicked spleen or lacerated bladder) we can use emergency "implied consent" and go ahead with the necessary repair

⚡ But, if not an emergency, you should not do an elective or non-emergency procedure until a later date, when you can get proper informed consent or you run the risk of being sued for battery.

⚡ And, if it is a hysterectomy, special consent rules and issues apply.

Best practice

⚡ When you can reasonably anticipate need for additional procedure, specifically include it on consent form, e.g.,

⚡ "laparoscopy, possible laparotomy ..."

⚡ "biopsy, possibly mastectomy ..."

What would you do?

⚡ After 4 days in the hospital following major GI surgery, Mr. Smith is getting more and more annoyed with staff, his "roommates," the "service" and his liquid meals. He will need to remain in the hospital at least 3 more days in your opinion before being transferred to a skilled nursing facility. Your cellphone rings and it is his nurse telling you that he has just rolled his wheelchair into the elevator, dragging his I.V. pole along with him after telling her "I'm getting the hell out of here- I'd rather take my chances on the street"

Leaving the Hospital Against Medical Advice or "AMA"

⚡ Basic truth:

Patients have the right to

Leave the hospital even against the advice of physicians

Recommended procedure

⚡ Staff should notify physician immediately

⚡ Try to delay patient until he/she can speak with physician

If patient leaves before MD has an opportunity to discuss situation:

- attempt to get patient to sign AMA form (see CHA Consent Manual, form 5-3) and when appropriate,
- notify Administration, Risk Manager and/or other staff physician

If physician talks to patient...

- Physician should discuss the request with the patient either by phone or in person, if possible, and try to dissuade patient from leaving
- Information provided should include potential consequences of leaving, benefits of staying, and alternatives

If patient insists on leaving...

- Use "AMA form" (CHA form 5-3)
- Form documents that patient was given info regarding possible risks that might result from leaving the hospital against medical advice, and the benefits of continued hospitalization, and any alternatives, and the patient's choice to leave anyway
- If patient refuses to sign form, staff should sign it and indicate that information was provided to patient, but that patient stated "I'm not signing that thing" (or whatever was said)

If patient has capacity...

- Ask patient if you can involve other family members in discussing patient's decision to leave against medical advice
- Sometimes, family can persuade patient to stay, or help provider come up with alternatives that will at least provide for a safer discharge

Other issues

- If patient lacks capacity, a surrogate decision maker should be contacted
- Get help from ethics committee when leaving means withdrawing life-sustaining treatment or other life-threatening event

⚡ If leaving will have serious consequences to patient always notify administration and risk management

Discharge note in chart

Carefully chart "informed refusal"

"patient warned of consequences of leaving hospital in unstable condition) and information provided to patient: patient advised to call physician immediately if _____ (state complications or symptoms), and to return to nearest hospital Emergency Department if _____ (state life threatening or other serious symptoms)

⚡ Make a copy of discharge instructions - one for patient, one for chart

Ensure safe discharge

⚡ Take steps to ensure that the patient leaves in a safe manner, e.g.,

- escort to the exit in a wheel chair,
- make arrangements so patient doesn't drive or endanger third parties (e.g., call a taxi or family member) -- if patient in unsafe condition insists on driving, call 911
- send home medications and Rx for refill

Homeless patients

⚡ Avoid charges of "homeless dumping" by taking additional precautions

⚡ Call social services so that efforts can be made to find safe residential treatment or other appropriate place for patient to go (you don't want to be on the 6 o'clock news!)

May 2007 Kaiser Agreement
(SB 275 vetoed by Governor S. in Oct 07)

⚡ Train staff and implement "discharge protocol"

- ⚡ Record homeless patients on homeless log
- ⚡ Provide appropriate clothing at time of discharge
- ⚡ Assess patients "cognitive intactness"
- ⚡ Perform needs assessment

Establish discharge plans that meet patient's medical and social needs (e.g., help with eligibility for financial assistance)

If discharge to shelter, make sure patient meets shelter's criteria for placement, and document shelter's and patient's consent to the placement

If patient seeks transport to a skid row shelter, hospital administrator or designee must approve discharge plan

EMTALA Patient - CHA Forms

"Patient Request for Transfer or Discharge"
CHA Form 9-8

"Patient Refusal of Transfer"
CHA Form 9-1

"Patient Refusal of Further Medical Tx"
CHA Form 9-6

If patient refuses to sign AMA forms, fill out form and note on form that patient has been warned of consequences but refuses to sign form; have witness sign form

If patient has left without telling nurse, chart last time seen, and circumstances; notify physician immediately

Other issues that you may have to consider

Call APS for help in getting conservator appointed if appropriate

If patient is a child, and parents insist on removing child from hospital, you may have to call CPS for intervention (medical neglect)

What would you do?

It is 12 noon and your 11:15 appointment still hasn't shown up - you'd like to go to lunch but aren't sure if you should wait to see this patient. To make matters worse, this patient has a long history of no shows, or late shows...but, she has a very complex case and suffers from several severe chronic conditions, and when she does show up she is very compliant with her medications and treatment plan. You had hoped today to see how a new medication for her diabetes has been working for her, and have concerns about whether her chronic hypertension has been negatively impacted by the new RX.

"no shows" and "late shows"

Basic truths:

- Patients who are "no shows" or "late shows" are annoying because they cause havoc with our schedule
- Patients who have good outcomes do not sue for malpractice; patients who have bad outcomes sometimes do

- "no shows" and "late shows" tend to have more bad outcomes than patients who are responsible about keeping their appointments (and being compliant, and following our advice)
- "no shows" and "late shows" tend to blame others (us) when things go wrong
- anything we can do to reduce bad outcomes (and lawsuits) is going to be good in the long run

"no shows" at the clinic

Tips to Reduce the "no show" problem

- Inform patients that THEY are responsible for calling to reschedule a missed appointment
- Signs should remind patients to call if they are going to be late or want to cancel
- Inform patients what will happen if they are a "no-show" or a "late show" and haven't had the courtesy to call

"late shows" - sample policy

- Stated policy:** If patient arrives more than 30 minutes late, their appointment will be cancelled
- Actual policy:** Before front desk staff advises patient that their appt has been canceled, nurse or MD should be notified that they have arrived, and "mini triage" will be done to determine whether there is an overriding clinical concern that trumps "late" policy

If patient calls to say he/she will be late (a behavior we want to encourage)...

- Front desk staff can put them on regular appointment schedule later in the day if there is an opening
- If there is no opening, front desk staff should notify nurse or MD that patient is on the phone, wants to be seen, and determine whether there is an overriding clinical reason to try to "squeeze them in" - if not, they will be given next available appointment on the regular schedule

In determining what your "late show" policy will be...

- Some argue that it "teaches patients responsibility" to maintain strict schedules
- Others don't want to "punish" patients who have psycho/social issues that make it hard to get to clinic on time (late buses, can't get off work exactly when they need to, etc.); this is especially true for pediatric patients where the person being punished is the parent and the one suffering is the kid!
- Finally, it is hard to hold patients to a schedule we might not be able to keep ourselves!

"No shows"

- staff may call or send a "**did you forget your appointment?**" letter asking patient to call to reschedule:
 - this can be automatic where all "no shows" get a letter
 - or it can be selective, where only "current" patients with a clinical need to be seen will get the letter

Charting "no shows"

- Dated entry in chart indicating missed appointment
- Patient-initiated appointments – no f/up is necessary

"No show" patient w/medical issues

- Provider-recommended appointment – front desk should return chart to provider for instructions re: rescheduling if medically indicated (see slides below for patient in peril); progress note should indicate plan of action
- If provider wants follow-up appointment, front desk staff should call patient and try to reschedule or determine reason for no-show

Patient contacted, but does not want to reschedule....

- If patient says they do not wish to be seen, provider should be notified so that "informed refusal" information can be provided if appropriate

Non-compliant patients tend to...

- have more bad outcomes (bad outcomes = possible lawsuits)
- blame us for bad outcomes ("you should have told me")
- need the best charting since we know this pattern exists

Always chart:

"patient informed of consequences of (not coming in for follow-up appointment)"

What if patient doesn't return our calls?

- What is our duty to find patient who is not returning our calls?
- *It depends on patient's condition !!*

Key is having current contact info (so we know they got the message!)

- Front desk: each visit confirm contact info and confirm that it is ok to leave info on voice mail; if not, list some other way to reach patient;
note: some patients, especially teens, may prefer email, or text message to their cell phone
- Clinical staff: each visit confirm that info is up to date

If patient is in serious peril:

- Patient who has condition that needs immediate follow-up or other medical attention, but patient does not know it, or fails to appreciate how serious it is (e.g., recent lab work or x-ray revealed serious problem)
- If we get voice mail, message should be detailed enough for person to understand seriousness of situation

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- ✦ If patient doesn't return 2-3 of our calls, send them a "Letter of Importance"
- ✦ "Dear _____,

Recently you had tests done at our clinic to determine the cause of your lower back pain. Your sonogram has revealed a lesion on your left kidney that may be cancer. Please call us as soon as possible so that we can follow-up with you on this..."

Final letter

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Dear _____

We have called you three times and left messages, and have also sent a prior "Letter of Importance" on (date) advising you that you may have a serious (potentially life-threatening) medical condition that needs immediate attention. (Additional details: _____) Since we have not heard back from you we will assume that you have sought medical care elsewhere. Please let us know if you would like your medical chart forwarded to your new health care provider....

Dealing with chronic "no shows" where patient is not in peril

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- ✦ If patient has failed 2 appointments in a row, staff may send "Please call for an Appointment if you Need Medical Care" and put chart in "inactive file" if there is no call within six months

- ✦ Some counties don't give appointments if patient has been a "no show" for 2 consecutive scheduled appointments
- ✦ Instead they give them "double booked" appointments, or offer them a "drop in clinic" on one afternoon a week where they receive services on a "first come, first served" basis

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- ✦ Double booking: schedule at 8 a.m. or 1 p.m. and advise them that provider will see them when break in schedule occurs
- ✦ No more than one "double booked" slot is booked each morning and each afternoon
- ✦ Once patient keeps 2 "double booked" appointments, ok to return to normal scheduling

Questions?
