

TOP TEN RISK MANAGEMENT ISSUES FOR MEDICAL OFFICE PRACTICES

1. FOLLOW UP OF TEST RESULTS

Allegations of a failure to diagnose and/or delay in diagnosis can be found in approximately 25% of all medical malpractice claims. Many of these failures/delays in diagnosis can be directly tied to the fact that a patient's lab or test results have been unread or unreported. If a test is important enough for the physician to order, it is important enough to track the results!

Double checking for a patient's results at the time of their next appointment is certainly helpful, but may not be an efficient practice as not all patients return as requested. Merely asking patients to call if they have not heard from you regarding their results is also not sufficient. For many patients, no news is good news; or, if it was truly important, the physician would have called. Waiting on the patient is no longer considered good practice. What is?

Having a good follow up system in place prevents the following from occurring:

- Not knowing when test results are missing
- Vital clinical information being filed or scanned without a physician's review and initials
- Delay in diagnosis and/or treatment

To avoid these consequences, it is important to establish policies and procedures to track test results and ensure that:

- All ordered tests are returned to the ordering physician's office
- The results are verified and reviewed in a timely manner
- The patient is notified of **all** results – normal and abnormal
- The patient's medical record is documented to show that the results were received, the patient notified and follow up (if any) recommended
- The results are filed
- Necessary follow up is accomplished

The particular format used by the practice is not what's important. What is important is that the system meets the needs of the practice and is followed consistently by staff.

2. MISSED APPOINTMENTS

Every practice should have a tracking system for missed appointments. Staff should contact the patient to determine why the patient failed to show and to reschedule. All missed appointments should be documented in the patient record. Letters should be sent to patients who repeatedly miss appointments explaining the importance of follow up care to their overall health. Consider terminating the doctor-patient relationship according to practice policy.

3. MEDICAL RECORD DOCUMENTATION (IF IT'S NOT DOCUMENTED, IT WASN'T DONE!)

Documentation is primary defense in the event of a lawsuit. Additionally, the medical record is the means by which health care providers communicate about a patient's plan of treatment. Always document the record objectively. Never point fingers at other physicians or clinicians. Use approved abbreviations and write legibly. If you use an electronic medical record system, make sure that the system has a reliable backup and an appropriate disaster recovery plan. NEVER, NEVER, NEVER ALTER THE RECORDS!

4. COMMUNICATION (ASK ME 3)

Health literacy is an increasing risk issue for providers and patients. A patient's limited understanding of medical and prescription instructions results in increased risks for the provider and the patient. Document the name and relationship of anyone acting as a patient's translator. Consider using the Ask Me 3 communication tool for your patients. Ask Me 3 is a free educational program sponsored by the National Patient Safety Foundation and is available at www.askme3.org.

5. MEDICATION MANAGEMENT

At each visit, review the patient's medication list with them (including all over-the-counter meds) and update as needed. Provide the patient with a written medication list that includes dosage, directions for use, and side effects. There are many drug-drug and food-drug incompatibilities. Review a drug's side effects and interactions with the patient. If the practice provides medication samples, record the medication lot number in the medical record. In the event of a medication recall, the practice must have a system in place for identifying samples that have been distributed.

6. MEDICAL RECORD RETENTION

While we recommend that medical records be kept indefinitely, Maryland law provides that records be retained for 5 years after the record is made for an adult patient. We believe that if records cannot be kept indefinitely, that they at least be kept for 10 years. An appropriate means of destroying medical records is through burning or shredding.

7. PATIENT SATISFACTION

Listen to your patients and obtain their input in learning about potential opportunities to improve your office. Review and evaluate all complaints with staff and use them as learning opportunities for the future.

8. SCOPE OF PRACTICE ISSUES

No staff member should do anything that they are not licensed or trained to do. Do not refer to medical assistants as “nurses” or imply that someone is licensed or certified when they are not.

9. DISRUPTIVE PATIENTS

Do not allow a disruptive patient to disturb your practice, to abuse office staff, or to threaten the safety of staff or other patients. If a patient becomes violent, call 911. Do not hesitate to terminate a disruptive patient from your practice.

10. PATIENT TERMINATION

There are a variety of reasons why a practice might want to terminate a patient. Before terminating **any** patient, the physician (or physicians) must be advised and give the ok. Give notice of termination in writing and include the termination date in the letter. Send the letter by registered mail (return receipt requested) as well as by regular mail. Provide at least 30 days of emergency care and include the termination date in the letter to avoid confusion. Notify the patient’s HMO of the termination if required to do so by policy.