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

A 40-year-old patient presented to the ED with complaints of severe low back pain after lifting weights. He was admitted to the hospital for urosepsis and kidney stone. A urologist noted that the patient's kidney stone did not explain the back pain. The Hospitalist saw patient at 7pm. The patient was febrile with no urine output over the prior six hours. The Hospitalist ordered a bolus of normal saline, CBC, and Chem 7 to be drawn in the morning. At 9pm, the patient was unable to void with bilateral lower extremity numbness. The Hospitalist was paged and ordered a Foley catheter. At 1:05am, the patient was unable to move his legs with tingling of his feet. The nurse paged the Hospitalist who claimed he reviewed the patient's chart and briefly examined the patient. At 3am the patient woke complaining of lack of movement in his legs. Hospitalist saw patient at 3:20am, suspecting an acute spinal abscess causing cord compression and ordered a CT scan. A neurologist evaluated at 5am and ordered a MRI. The CT was negative but MRI revealed an elongated extradural mass located in the posterior aspect of the spinal canal from T3 – 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.

— Plaintiff claimed delay in diagnosis of epidural abscess and $4.5M in damages. Claim settled against Hospitalist for $1.8M.

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