# An Analysis of Nephrology Closed Claims

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As the graph below illustrates, medication errors was a common theme in SVMIC paid nephrology claims over the past 5 years. Additionally, failure to diagnose was a primary allegation asserted in the claims. Most typically, the diagnostic errors were not the result of a lack of knowledge or diagnostic ability on the part of the physician, but rather, as the graph below illustrates, were a product of poor documentation, communication breakdowns and poorly designed or ineffective systems.

**MEDICATION ISSUES:** Wrong dose and contraindicated medications were the main issues noted in the reviewed claims. A classic example of a wrong dose event is illustrated in the case of a physician who intended to order 2 mEq potassium chloride to peritoneal dialysis fluid, but mistakenly wrote 20 mEq. The patient arrested and died. To compound the problem, the physician went back after the event, crossed out the "20" and replaced it with a "2". Contraindicated medications were a problem in a case where the physician failed to discontinue Heparin in the face of Heparin-induced thrombocytopenia, and in another case where there was a failure to discontinue Lovenox in a patient scheduled for an invasive biopsy on the kidney. In both cases, the patients suffered bleeding complications and died.

**COMMUNICATION ISSUES:** Effective communication is essential in establishing trust, building good patient rapport and helping to achieve treatment compliance. It is important to communicate information and instructions to patients in terms understandable to non-medically trained individuals. The majority of the cases involving physician to patient communication breakdowns involved the physician failing to provide clear information related to the risks or instructions associated with medications.

There were also communication breakdowns between providers in the reviewed cases. An example involved a patient hospitalized for angina and a subacute MI with congestive heart failure. Treatment included Lovenox and Digoxin. During the hospitalization, the patient was determined to have chronic renal insufficiency requiring acute hemodialysis. The Nephrologist failed to adjust the Lovenox dose, assuming the cardiologist would do so. The patient developed a thoracic hematoma and died.

**DOCUMENTATION ISSUES:** The importance of maintaining a well-documented medical record, from both a patient care and a risk management standpoint, cannot be overstated. As the graph above illustrates, documentation issues were a factor in 38% of claims paid

in Nephrology. The majority of these cases involved inadequate documentation. Most often, there was a failure to document completely the patient and/or family history, details of the physical exam, rationale for the diagnosis and treatment plan, patient education, and conversations with the patient and family regarding treatment recommendations.

**SYSTEMS ISSUES:** The failure to track and act on test results was a common problem in the cases involving systems issues. One case involved a hospitalized patient who was administered IV morphine following the onset of severe flank pain six hours post-renal biopsy. The on-call nephrologist ordered a CT scan and labs. The CT scan revealed a large perirenal hematoma. The on-call doctor did not receive notification of the CT scan results, nor went to the hospital to evaluate the patient. The next morning, the patient's hematocrit dropped significantly. The physician then reviewed the results of the CT scan and noted the hematoma. Transfusions and other measures were unsuccessful and the patient died. The failure of the on-call physician to follow up on the results of the tests he ordered and his delay in going in to evaluate a patient in clear distress caused problems for the defense that led to a settlement of the case.

**LESSONS LEARNED:**

- To help prevent medication errors: Update the medication history at each visit; review and update allergies at every visit and whenever new medications are prescribed; prescribe medications only after reviewing the record; discuss risks, side effects, benefits of, and alternatives to prescribed medications; closely monitor medications with a known toxic effect; train staff who are allowed to administer medications to adhere to the "Five Rights" (right patient, right drug, right dose, right route, right time) and appropriate injection techniques.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, alternatives, and expected outcome. Be careful not to educate above a patient's comprehension level. Be sure the details of all discussions with patients are documented in office records rather than relying on hospital consent forms, which are not procedure-specific and may not capture all details of a conversation.
- Communicate relevant patient information to the covering physician in a timely and clear manner, especially information on patients with anticipated problems.
- When other providers are involved in the care of a patient, make sure there is a clear understanding as to everyone's role and responsibility.
- Clearly communicate and document telephonic advice – use teach back to ensure the patient understands advice given.
- Document clearly, completely, and accurately, and include the following: a comprehensive medical and family history; the chief complaint or purpose for the visit; all relevant positive and negative clinical findings; your diagnosis or medical

impression; the decision-making process for the clearly defined treatment plan; and all relevant instructions and information given to the patient regarding the treatment plan.

- In order to ensure proper follow-up for patients who require a return office visit, schedule such patients before they leave the office or the hospital and provide a reminder card with date and time.
- Be sure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it is important enough to track and personally review.
- To promote continuity of care, implement a system to ensure abnormal test results receive proper follow-up.
- There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected time frame.
- Implement a tracking system for patients who miss or cancel scheduled appointments and have office staff contact the patient and reschedule the appointment in situations where the patient may suffer if there is a delay in treatment, or where ongoing monitoring of the treatment or medication is necessary.

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