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Risk Management Review

Miscommunication Contributes to Death of Home Healthcare Patient

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Introduction

As healthcare delivery evolves, an increasingly common approach to treatment is home care. When appropriate, this approach offers many advantages but also presents risks. Miscommunication is a serious and common issue that occurs across the spectrum of care. This case study illustrates one example of how it can occur during the transfer of inpatient care to the home healthcare setting.

Facts

The patient was a 40-year-old male whose medical history was unremarkable except for nonacid gastric reflux disease. This condition is relatively rare, but it is much more problematic than traditional gastroesophageal reflux disease because it exposes the esophagus to alkaline bile, which is very corrosive.

The patient had experienced this condition for about 15 years, had seen numerous physicians, and was on several medications to treat it. Nevertheless, he was in discomfort a significant amount of time. He eventually was referred to Dr. R, a very experienced MedPro-insured general surgeon.

After thoroughly evaluating the patient, Dr. R proposed a Nissen fundoplication — a procedure he had performed hundreds of times. The patient agreed, and Dr. R performed the procedure at a hospital on June 24. No issues occurred with the initial surgery, but the patient was still having some violent retching and vomiting afterward (which was not unexpected).

The patient was readmitted to the hospital 3 days after the initial discharge with a low-grade fever. A CT scan showed a probable leak at the gastroesophageal junction (a recognized risk of the procedure) with some drainage of fluid. He was taken back to surgery the following day and a 2 cm perforation was

located, which was repaired with good closure. The patient remained hospitalized.

Dr. R was not completely satisfied with the patient's recovery, so he asked Dr. B (another MedPro-insured surgeon in the same practice), who specialized in bariatric surgery, to consult. Dr. B identified a very small fistula adjacent to the repair. Because the esophagus is typically very slow and difficult to heal, Dr. B utilized a stent to allow the fistula to heal without the necessity of another open procedure. The intention was for the stent to remain in place for about 6 weeks. A peripherally inserted central catheter (PICC) line also was placed to facilitate the administration of antibiotics.

Subsequent testing demonstrated no further leaks, and the patient remained hospitalized until July 21. Prior to the patient's discharge, Dr. B wrote an order for home healthcare providers to perform "routine PICC line care; labs (CBC, CMP, magnesium, and phosphorus) and vitals to be faxed to my office each Monday."

The patient was readmitted on July 24 with nausea and intolerance of the stent (which can be very uncomfortable). Dr. B removed the stent on August 4, and the patient was discharged again on August 7. Prior to this discharge, Dr. B wrote an order for home healthcare providers to perform "routine PICC line care; continue labs and vitals to be faxed to my office each Monday." The patient was receiving total parenteral nutrition (TPN), with oral liquids as tolerated. An independent compounding pharmacy provided the TPN.

Dr. B saw the patient in his office the following day (August 8); nothing indicated a continuing infection, but the patient still had severe nausea and vomiting. Because Dr. B was going out of town for a few days, he scheduled the patient to see Dr. R a week later (August 15). The patient failed to keep that appointment, and he was rescheduled for August 19.

The patient also failed to keep the August 19 appointment. Evidence shows that the patient's wife called the practice that day, but she did not leave a message. Dr. R's nurse called the patient's wife after the missed August 19 appointment, but she got voicemail. The nurse left a message to please call the office. No one from the practice reviewed the patient's chart on either August 15 or 19.

Dr. R's nurse did speak to the patient's wife on August 20. The wife explained that she did not bring the patient to his appointment because he was too weak. She also indicated that the patient was "loopy, hallucinating, and talking in his sleep." She attributed this behavior to the diazepam and tramadol he was taking and

indicated that she had cut back on both medications. The nurse reported this to Dr. R, who agreed with cutting back on the medications and urged a follow-up appointment with Dr. B (who was now back).

The following evening, the patient continued to get weaker, and emergency medical services took him to the local emergency department. Tests showed he was extremely hyponatremic, and he died in the early morning hours of August 22. Although some disagreement occurred regarding the cause of death, it was most likely extreme hyponatremia (low blood sodium) leading to sudden cardiac arrest.

A medical malpractice lawsuit was brought against Drs. R and B, the doctors' practice, the home healthcare agency, and the compounding pharmacy. The case was settled following a minimal payment by the practice and no payment by either physician. The other two parties each made payments in the high range. Defense costs for the doctors and the practice were in the high range.

Discussion

Medical risk management professionals are very familiar with the elevated risk associated with care transitions or "handoffs." Handoffs refer to any transfer of patient care from one provider to another. They can be as simple as shift changes but also include scenarios such as a new provider assuming care of a patient or, as in this case, the transfer of a patient from inpatient to home care. The biggest concern with handoffs is the potential for misunderstanding resulting from miscommunication. Elements of miscommunication certainly occurred in this case.

When the patient transferred to the first episode of home care, Dr. B wrote a clear note indicating what he wanted the home healthcare provider to do, including instructions that they should update him weekly regarding the results of the testing he ordered. Because the patient was readmitted after only 3 days, it's likely that the ordered testing was not done in the outpatient setting.

However, when the patient was transferred to home care the second time, Dr. B wrote an abbreviated note referencing his earlier one. He either assumed that the same nurse would provide home care or that a new nurse would review the earlier note.

The same nurse did provide the patient's care, but she did not comply with the instructions. Presumably, she never read the original note or she forgot what it said. When she reassumed care on August 8, she wrote the

following note: “Order clarification needed: Pt. receiving TPN, Phys order reads ‘labs.’ What labs and how often?” However, she never sought clarification. This behavior is completely indefensible, and her attorney did not even attempt to justify her actions.

The compounding pharmacy (which was providing the TPN) also had an opportunity to recognize that the testing was not done. The pharmacy’s normal protocol would result in frequent revision of the TPN as a result of any nutritional deficiencies that the testing identified. However, the original recipe was simply refilled and administered daily.

The patient’s sodium level did not suddenly drop; it was a slow, steady change that the nurse or pharmacy technician could have identified if the required tests had been conducted and reported. The pharmacy technician’s actions also were indefensible, especially considering the pharmacy’s protocols.

The surgical practice also had the opportunity to identify the sodium deficiency before it reached a crisis level. If the patient’s chart had been reviewed on August 19 (the second missed appointment) or any time prior, the missing test results would have been apparent and could have been addressed before the patient’s death. This was the essence of the criticism of Drs. R and B by the plaintiff’s general surgery expert. Although reviewing a chart following a missed appointment is not necessarily the standard of care, it is likely that a review could have helped avert a catastrophe in this case.

Summary Suggestions

The following suggestions may be helpful when coordinating patient care between care settings:

- Develop comprehensive policies and procedures for patient handoffs, including what information to transfer, roles and responsibilities, expectations for verbal and written communication, and the appropriate use of tools, forms, and checklists.
- Consider developing a “tiered” system for follow-up appointments. Although many follow-up appointments are not critical, some patients require prompt evaluation. Designate these appointments as “priority” status; if they are missed, consult the provider so he/she can review the patient’s record and take appropriate action.
- In both the outpatient and home healthcare settings, make sure a reliable

system is in place to ensure that testing and consultation is carried out as ordered.

- Make sure that staff members who are responsible for phone contact with patients and caregivers have adequate knowledge and training to recognize high-risk clinical circumstances and seek appropriate consultation.
- Verify that home healthcare agencies have robust oversight and review processes to ensure that patient care reflects provider orders and complies with policies and procedures.

Conclusion

The surgeons in this case were both excellent from a technical standpoint and were known for their warm and attentive care. Nevertheless, a complex system — over which they had little control — failed them and the patient, resulting in a very disappointing outcome. Implementing the aforementioned summary suggestions likely would have prevented this outcome, and clinicians should consider these risk strategies in appropriate circumstances.