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Avoiding Lawsuits

The Role Your Staff Can Play

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Introduction

There is no question that the care a physician provides a patient can influence whether that patient will file a malpractice claim for a real or perceived grievance.

The manner in which office staff treat patients can also have a profound impact. Front and back office employees play an important role not only in helping to keep patients safe, but also in making them feel comfortable and welcome.

In this booklet, we will highlight a number of policies and procedures you can easily implement in your practice to help minimize risk and promote lasting doctor-patient relationships. These steps can go a long way in helping to ensure that you are meeting – and even exceeding – patient expectations.

Types of claims that office staff can help avoid include:

- Delay in Diagnosis
- Failure to Monitor Care
- Medication Errors

Front Office

The Reception Area

One can never underestimate how stressful a doctor's visit can be for a patient, even for the most routine check-up. To help put patients at ease, front office staff should greet the patient in a warm, friendly manner.

Patients should never have to wait long to check in or feel like they have been forgotten in the waiting area. To minimize frustrations, staff should keep track of the patient's arrival time and explain any reason for a delay, updating the patient as often as needed. Kindness and respect at the front desk go a long way in setting the tone for the rest of the visit.

> Staff who greet patients should recognize that these small interactions can have a huge impact on a patient's feelings about the overall quality of the care he or she receives.

Staff should also recognize the role they play in protecting patient privacy. They should talk with incoming patients in a confidential tone to prevent others from hearing their conversation. Likewise, staff computers should be directed away from visitors standing at the front desk. These seemingly minor considerations will help reassure patients that the medical practice takes patient privacy seriously.

Medical History

Front office staff should ask patients to update their medical history regularly. New information can help physicians make better decisions on changing the course of a patient's treatments and/or medications. Similarly, allergy alerts must be updated and prominently displayed in a patient's record before being given to a physician.

Medication: Get It On the Record

Poor documentation of a patient's medications significantly increases the likelihood of an adverse outcome and a subsequent malpractice claim. Having well-defined procedures for documenting medications and risks in the patient's medical record is a simple, effective solution to this problem. With proper education and training of office staff about medication, a practice can reduce the possibility of related claims while improving its level of care.

> Everyone who opens a medical record should be able to quickly locate any medication a patient is taking.

Missed Appointments

Staff members should carefully document all missed appointments and immediately attempt to reschedule the appointment. If the patient does not respond to phone calls, the situation should be escalated to the physician. At that point, the practice should send the patient a notification via USPS Certified Mail® outlining the risks of not complying with recommended care.

Patient Billing

A frustrating billing experience can overshadow an otherwise positive relationship, so staff should be thorough in attending to billing complaints. There should also be a system in place to inform the physician whenever a patient disputes a bill. The front office staff and physicians should develop a plan for dealing with patients with unpaid bills. For example, if a physician decides to discontinue a patient from his or her practice based on a history of past-due bills, the patient must be given adequate time to find a new provider to prevent gaps in his or her treatment. Taking steps like this can help a practice insulate itself against claims of abandonment.

A frustrating billing experience can overshadow an otherwise positive relationship.

Back Office

The Examination Room

Staff members who accompany patients to examination rooms should listen carefully to any health concerns the patient has and record them for the physician. Treating patients with empathy and respect is an important factor in putting them at ease during the transition from the front office to the back office.

If the physician is delayed in getting to the examination room, someone should visit periodically and keep the patient informed. Staff members should also protect the patient's privacy by closing examination room doors and knocking before entering.

> When a patient moves into the examination room, he or she should receive the same attentive, professional care that was evident in the waiting area.

Strengthening Communication Among Staff

Careful documentation can prevent liability claims that may arise from communication gaps between front and back office staff and the physician.

The practice leader should establish a detailed protocol to ensure that those who work in the front office know what the physician did, what tests were administered, and when a patient is to return. Using a checklist like the one below can be useful when implementing this type of protocol.

Checklist for communicating between front and back office staff:

- ✓ When/how will the patient receive test results?
- ✓ When is the patient to return?
- ✓ Was the diagnosis presented so the patient understood?
- ✓ What is the treatment plan?
- ✓ Was the patient prescribed any medication?
- ✓ Was the patient given any return-to-work notes?

Medical Records: The Best Defense

No risk management program is complete without a system to ensure proper maintenance of medical records. These records are a physician's best defense when a claim is made. They should include every interaction with the patient, along with post-visit follow-ups and test results.

If a practice has multiple office locations, there should also be a system for the timely and confidential transference of records. Practices should have a clear policy for storing medical records.

There is no general law in California requiring physicians to retain records for a certain number of years. The following is a recommendation by the California Medical Association and liability carriers:

> The suggested minimum medical record retention period for adults is ten years after the last date the patient is seen. Minors' records should be kept longer in those cases where the ten years elapses before the minor has reached the age of 18. It is recommended that minors' records be kept until the age of 28. However, if this is not feasible, in no event should a minor's records be destroyed until at least one year after the minor has reached the age of 18.

Maintaining the confidentiality of patient records is equally important. Practices should have a clear policy on releasing medical records to safeguard patients' privacy, while also guaranteeing their right to access the record.

"No News Is Good News" Is Bad News

If your practice has not done so already, eliminate the policy of only reporting abnormal test results to patients. Patients should always be kept up-to-date on test results, regardless of whether they are normal, abnormal, inconclusive, or even lost. When a test result is incomplete or lost and the patient is not notified, he or she could wrongly assume the result was normal. This could delay a potentially serious diagnosis and trigger a liability claim down the road.

While it is permissible for staff to relay normal test results to the patient under the direction of a physician, **all abnormal results must be communicated directly by the physician**.

Tracking Test Results

Practices should also create and maintain a system for logging all test results. Once this is in place, staff members should confirm that a physician has reviewed the result and ordered any necessary follow-up tests before making final updates to a patient's record. Staff members should also develop a system to track all tests that have been ordered.

Prescriptions: Cover the Bases

Documentation and careful note taking are especially important when it comes to prescriptions. Prescribing errors, such as writing down the wrong medication that sounds similar but produces drastically different effects, are among the most common mistakes that can lead to adverse outcomes and liability claims.

To prevent errors when refilling prescriptions, follow these guidelines:

- Document all refills
- Identify refill guidelines for staff:
  - Limits by type of medication
  - Symptoms that require evaluation
  - Medication that may not be renewed

Both staff and physicians should always double-check the prescription information because of the increased potential for tiny errors that can result in severely negative complications.

A simple oversight like forgetting to write a zero before a decimal point (".4 mg" instead of "0.4 mg") can lead to a pharmacist delivering a medication ten times more powerful than prescribed, a potentially fatal error.

It is important to note that staff can only submit prescription refills for medications with no changes. Your practice should have a policy in place stating that **all new prescriptions or changes to existing prescriptions can only be submitted to the pharmacy by physician providers**.

Common errors with prescriptions:

- Prescription illegible/unclear
- Prescription incomplete
- Misspelled name of drug
- Zero or decimal point misplaced or missing (".4 mg" instead of "0.4 mg")

Mastering Complaint Resolution

Many medical liability lawsuits can be prevented by addressing patients' complaints promptly and with empathy. Practices should have a process in place to identify and respond to patient complaints.

The system should follow these guidelines:

- Strongly encourage staff to report all problems and negative patient comments they observe and receive – even seemingly trivial ones.
- Discourage staff from attempting to screen unnecessary phone calls or bothersome patients.
- Ensure that both new and existing office staff have outstanding social skills and complaint resolution experience (through training if necessary).
- Consider using patient satisfaction surveys to improve what you do and how you do it.

> Developing a culture of patient safety can help reduce the chances of being sued.

Front Office Checklist

- ✓ Warmly greet patients upon their arrival.
- ✓ Introduce yourself and give your title.
- ✓ Preemptively explain any delays.
- ✓ Speak with incoming patients in a confidential tone.
- ✓ Keep computer screen out of view.
- ✓ Ask patients to regularly update medical history.
- ✓ Properly document patient medications in the medical record.
- ✓ Note missed appointments and immediately follow up with patient.
- ✓ Thoroughly review patient billing complaints.
- ✓ Develop a system to handle unpaid bills.

Back Office Checklist

- ✓ Carefully note patient's health concerns for the physician. If running behind, periodically inform the patient of expected wait time.
- ✓ Ensure that the patient is informed of test results, whether normal, abnormal, inconclusive, or lost. If the results are abnormal, the physician – not staff – must communicate them to the patient.
- ✓ Record every doctor-patient interaction in the patient's record.

  Establish a system for transferring records between office locations.
- ✓ Store all health records for the recommended period of time.
- ✓ Create a clear policy for releasing records.
- ✓ Double-check all prescription information and carefully document it in the patient record.

Conclusion

Remember that a culture of patient respect and practice safety goes a long way toward preventing adverse outcomes and lawsuits. Everyone working at a medical practice has a vital role in these efforts. Even the smallest decisions or interactions can have a huge impact. Always imagine that the world is watching. If any of your planned actions could be perceived as unprofessional or unsafe, stop what you are doing, reevaluate, and find a better approach.

Experience has shown that taking simple, precautionary steps like those in this booklet can have a remarkable effect on decreasing the likelihood of adverse outcomes and filed claims. Both new and experienced staff members should regularly be reminded of their instrumental role in reducing risk around the practice. Practice leaders should also encourage their staff's continued education and active participation in improving patient care.

When in doubt, CAP physicians can speak with their dedicated member services representative by calling 800-252-7706. They can also call CAP's 24-hour Risk Management Hotline at 800-252-0555. CAP physicians also have access to a human resources expert who can assist with developing and implementing employee policies. Additionally, every CAP physician has a dedicated risk management professional available for visits to the practice for a risk assessment and for support in creating a culture of patient safety.

About CAPAssurance

CAPAssurance, a Risk Purchasing Group, provides large medical groups, hospitals, and healthcare facilities access to superior professional liability insurance and flexible coverage options.

As a program of the Cooperative of American Physicians, Inc. (CAP), CAPAssurance provides exceptional claims defense, and risk and practice management programs designed to help you mitigate risk, improve patient satisfaction, and run a financially successful organization.

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333 S. Hope Street, 8th Floor Los Angeles, CA 90071