Components of a Family Planning Chart Review: Would Your Chart Stand Up To Scrutiny?

Satellite Conference
Thursday, November 10, 2005
2:00-4:00 p.m. (Central Time)

Produced by the Alabama Department of Public Health
Video Communications & Distance Learning Division

Faculty

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Program Objectives

1. Emphasize the importance of chart review in quality assurance.
2. Discuss benefits of the chart review process.
3. Identify components of a chart review.
4. Discuss how to develop an auditing system that will identify your documentation strengths and weaknesses.
5. Review a sample chart review form.
6. Demonstrate through written example exercises the chart review process.

" . . . the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional qualities."

A Strategy for Quality Assurance:
IOM, 1990 *Medicare*

". . . demonstrate that the quality of patient care was consistently optimal by continually evaluating care through reliable and valid measures."

Quality of Professional Services Std
JACHO 1975

Quality Assurance

- Championed by JACHO
- Measure of institutional function
  - Designed to detect variations
  - Is variation acceptable or unacceptable?
- Establish clinical indicators
- Identify situations needing peer reviews
  - Deficiencies
  - Remedial action/outcomes

Quality Assurance

- There can always be improvement
- Quality cannot be determined by one case
- No further action
- Corrective action

Format

- Identify
  - Variation
  - Specific problem
  - Opportunity to improve care/performance
- Formulate a plan
- Record of actions taken

Format

- Documentation
  - Expectations for change
  - Measurement
  - Follow-up
  - Institutional reporting
- Legal consultation

Applying Risk Prevention Documentation to Everyday Practice

Documentation

- Good medical care
- Minimizes chance for miscommunication
- Legal defense
  - Standard of care
  - Careful, thorough care
  - Poor documentation
    - Careless
    - Force settlement
    - Serious harm

Major Principles

- Accuracy
- Comprehensiveness
- Legibility
- Objectivity
- Timeliness

Accuracy

- Use standard method
- Special circumstances
- Consistent in word usage
- Accepted and agreed upon abbreviations
- Time, date and legible signature

Comprehensiveness

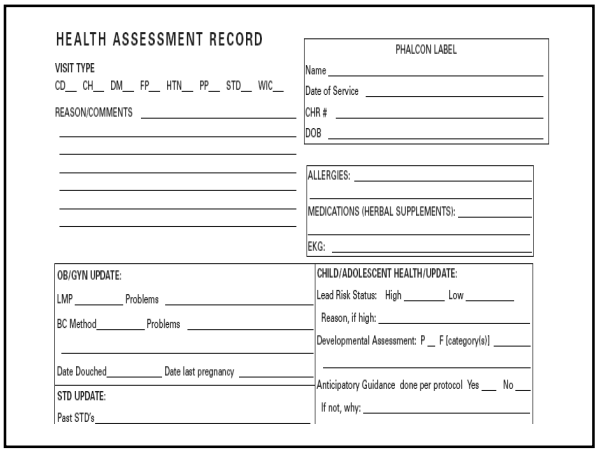
- Identification
- Current condition
- Past medical history
- Past surgical history
- Family history
- Social history
- Medications
- Physical examination

Comprehensiveness

- Initial assessment and reassessment
- Results
- Operative reports
- Procedure notes
- Consultant reports
- Informed consent

Comprehensiveness

- Counseling and education
- Disposition
- Patient correspondence
- Advanced directives



HEALTH ASSESSMENT RECORD

VISIT TYPE
CD__ CH__ DM__ FP__ HTN__ PP__ STD__ WIC__

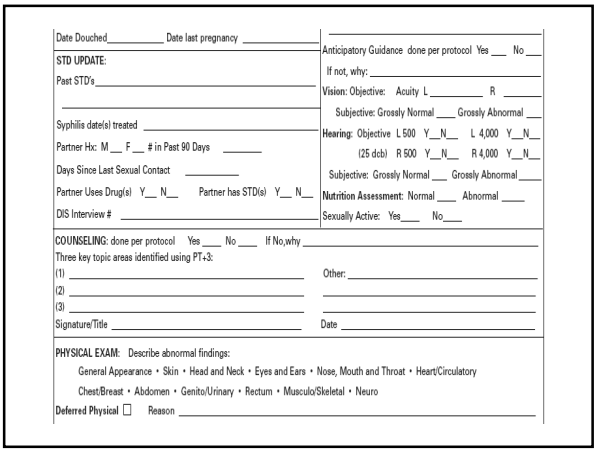
REASON/COMMENTS _____

PHALCON LABEL
Name _____
Date of Service _____
CHR # _____
DOB _____

ALLERGIES: _____
MEDICATIONS (HERBAL SUPPLEMENTS): _____
EKG: _____

OB/GYN UPDATE:
LMP _____ Problems _____
BC Method_____ Problems _____
Date Douched_____ Date last pregnancy _____
STD UPDATE:
Past STD's_____

CHILD/ADOLESCENT HEALTH/UPDATE:
Lead Risk Status: High _____ Low _____
Reason, if high: _____
Developmental Assessment: P __ F (category(s)) _____
Anticipatory Guidance done per protocol Yes ___ No ___
If not, why: _____

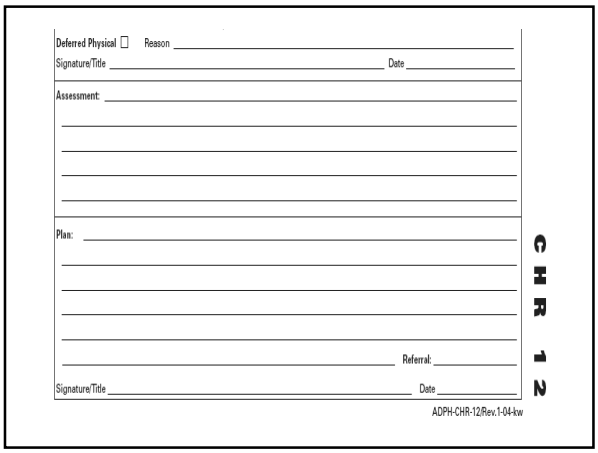


Date Douched_____ Date last pregnancy _____
STD UPDATE:
Past STD's_____
Syphilis date(s) treated _____
Partner Hx: M ___ F___ # in Past 90 Days _____
Days Since Last Sexual Contact _____
Partner Uses Drug(s) Y__ N__ Partner has STD(s) Y__ N__
DIS Interview # _____

Anticipatory Guidance done per protocol Yes ___ No ___
If not, why: _____
Vision: Objective: Acuity L _____ R _____
Subjective: Grossly Normal ___ Grossly Abnormal ___
Hearing: Objective L 500 Y__N__ L 4,000 Y__N__
(25 dcb) R 500 Y__N__ R 4,000 Y__N__
Subjective: Grossly Normal ___ Grossly Abnormal ____
Nutrition Assessment: Normal ___ Abnormal ____
Sexually Active: Yes____ No____

COUNSELING: done per protocol Yes ____ No ____ If No,why _____
Three key topic areas identified using PT+3:
(1) _____
(2) _____
(3) _____
Signature/Title _____
Other: _____
Date _____

PHYSICAL EXAM: Describe abnormal findings:
General Appearance • Skin • Head and Neck • Eyes and Ears • Nose, Mouth and Throat • Heart/Circulatory
Chest/Breast • Abdomen • Genito/Urinary • Rectum • Musculo/Skeletal • Neuro
Deferred Physical ☐ Reason _____


Deferred Physical ☐ Reason _____
Signature/Title _____ Date _____
Assessment: _____
Plan: _____
Referral: _____
Signature/Title _____ Date _____
ADPH-CHR-12/Rev.1-04-kw
CHR 12

Patient Response

- Compliance with recommendations
- Missed appointments
- Patient concerns
- Informed consent
- Informed refusal

Legibility

- Wastes valuable time
- May reflect sloppy/inadequate care
- Misinterpretations

Objectivity

- Relevant facts
- Do not criticize
- Do not resolve differences
- Avoid judgmental words

Timeliness

- Record events when they occur
- Review results in timely fashion
- Develop policy

Quality Assurance

- Information evaluated
- Alternatives considered
- Recommended treatment
- Reasoning
  - Diagnosis
  - Choosing treatment
  - Deviating from the standard of care
  - Deviating from consultant's recommendations

IF IT'S NOT WRITTEN,
IT DID NOT HAPPEN!!!

Exam Documentation:
Adopting A Risk-Management Mindset

Patient Satisfaction Problems

Effective Communication

- Accept patient's perspective
- Respond to concerns
- Use verbal/nonverbal communication
- Be nonjudgmental
- Engage patient in discussion
- Convey comfort
- Abandon stereotypes

SOAP

- Subjective
  - "Quotes"
  - Capacity
- Objective
  - Chaperones
  - Avoid judgments
- Assessment/Opinion
  - Rule out or likely
- Plan
  - Follow-up
  - Referral
  - Access
  - Agreement

Subjective:

41-year-old white female states, "I felt a lump on my right breast yesterday." Lump is nontender without pruritus, bleeding or nipple discharge. No associated fevers, chills, fatigue, weight change, hot flashes, back or joint pains. No personal or family history of breast cancer.

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Implementing and maintaining effective patient tracking and follow-up systems.
- Establishing and following clinic polices and procedures.
- Improving patient relationships.

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Establishing effective communication with patients and families.
- Improving medical record documentation.
- Avoiding disagreement among health care providers.

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Following applicable practice guidelines.
- Hiring qualified staff and supervising them.
- Maintaining patient confidentiality.
- Avoiding medication errors.

Components of a Family Planning Chart Review

Objectives

- Evolution of quality assurance.
- Discuss program development.
- Review screening tools.

- <u>Accessibility of care:</u> The ease with which patients can obtain the care they need when they need it
- <u>Appropriateness of care:</u> The degree to which the correct care is provided, given the current state of knowledge
- <u>Continuity of care:</u> The degree to which the care needed by the patients is coordinated among practitioners and across organizations and time

- **Effectiveness of care:** The degree to which care is provided in the correct manner - i.e., with error, given the current state of knowledge
- **Efficacy of care:** The degree to which a service has the potential to meet the need for which it is used
- **Efficiency of care:** The degree in which the care received has the desired effect with a minimum of effort, expense, or waste

- **Patient-perspective issues:** The degree to which patients and their families are involved in the decision-making processes in matters pertaining to their health, and the degree to which they judge care to be acceptable
- **Safety of the care environment:** The degree to which the environment is free from hazard or danger
- **Timeliness of care:** The degree to which care is provided to patients when they need it

- **Clinical practice guideline recommendations:** Pain should be assessed and documented routinely at regular intervals postoperatively, as determined by the operation and the severity of pain (eg, every 2 hours while awake for 24 hours after surgery).
- **Medical review criterion:** For the patient recovering from surgery, the patient's pain was assessed and documented every 2 hours while awake for the first 24 hours following surgery.

- **Performance measure:** Calculate the following for consecutive surgical patients seen over a 6-month period; the number of patients whose pain was assess and documented every 2 hours while awake. The performance measure is:

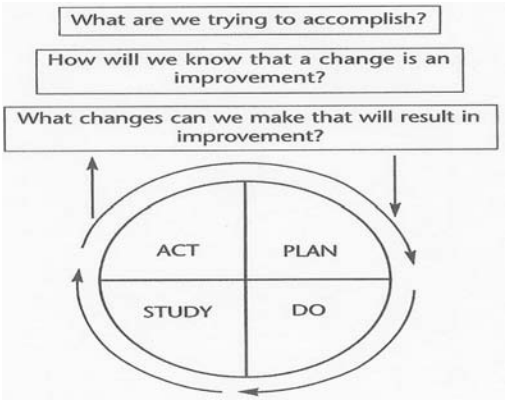
$$\frac{\text{number of cases with criterion met}}{\text{number of surgery cases}} \times 100\%$$

- **Standard of quality:** A performance rate of 95% or less triggers a review to determine how to improve assessing and documenting the patient's pain status every 2 hours while awake for the first 24 hours postoperatively

Avedis Donabedian, MD

- Structure
  - Staffing
  - Equipment
  - Space
- Process
  - Direct observation
  - Medical record
- Outcomes
  - Results/intervention

	Outcomes	Processes
Clinical	Adverse drug reactions	Patient examination
	Patient satisfaction	Medication administration
	Readmission within 72 hours of discharge for same problem	Meal tray preparation and delivery
	Maternal mortality	Patient/family education
Organizational	Regulatory body citation	Product selection
	Delayed discharge	Preventive maintenance
	Procedure delay	Results reporting
	Staff turnover rate/vacancies	Patient registration
		Sequence of test scheduling
		Recruitment procedures



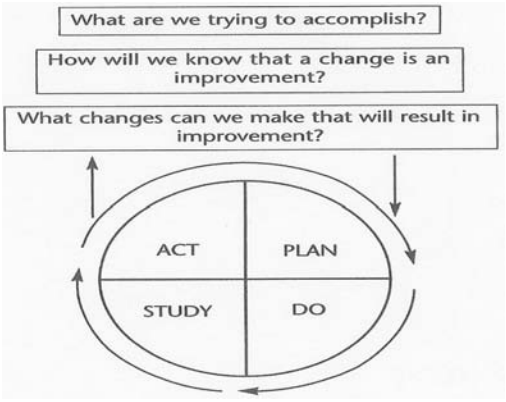
- **Plan:**
  - **State the objectives of the cycle.**
  - **Make predictions about what will happen and why.**
  - **Develop a plan to carry out the change (Who? What? Where? What data need to be collected?)**
- **Do:**
  - **Carry out the test.**
  - **Document problems and unexpected observations.**
  - **Begin analysis of the data.**

- **Study:**
  - **Complete the analysis of the data.**
  - **Summarize what was learned.**
- **Act:**
  - **What modifications should be made?**
  - **What will happen in the next cycle?**

Abbreviations

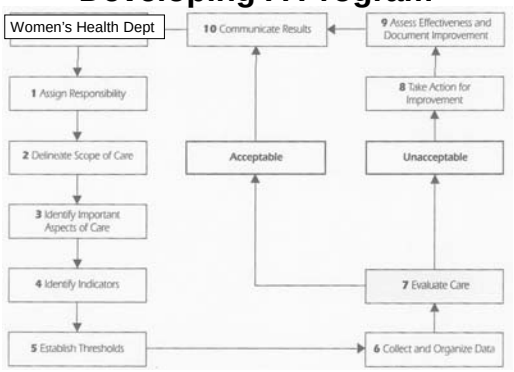
A progress note read, the AAFP patient in with mother for Depo Provera. This was not a recognized medical abbreviation nor was it approved for use according to the facility policy.

Best Practices –
Use medical terminology and only abbreviations approved by your facility.



Quality Improvement	Traditional Risk Management
Ensure that quality of care is optimal; evaluate practitioner performance and protect patients	Minimize the hospital's losses; protect hospital
Educational/remedial	Crisis intervention
Measure actual care against guidelines; when care does not meet guidelines, take remedial action	Detect risks to the hospital, then prevent the recurrence or minimize their effect when they do occur
Single patient or group of patients, discharged or still hospitalized; patterns or recurrent problems in patient care are assessed	Single patient, discharged or hospitalized; isolated events are assessed
Usually retrospective or concurrent with patient stay	May be concurrent or retrospective but usually coincides with awareness of potential loss
Written, explicit, clinically based criteria	Unwritten, implicit criteria (what people think is an "incident")

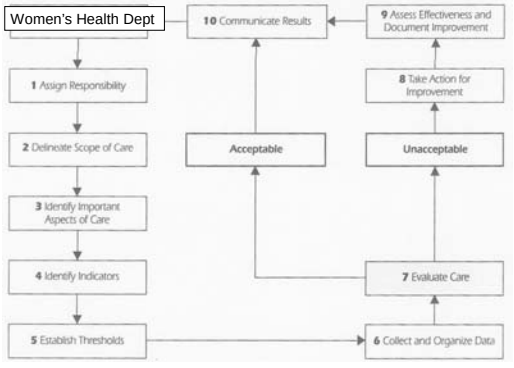
Developing A Program



1) Assign Responsibility

- **Identifies/assigns monitoring responsibilities**
- **Formation of committee**
- **Appointment of members**
- **Consultations**
- **Reporting mechanism**
- **Written plan**

Developing A Program



2) Delineate Scope of Care

- **Who are the patients?**
  - **What is their age range?**
  - **What are their socioeconomic traits (geo-graphic locale; economic resources; cultural groups, etc.)?**
  - **Are there other demographics to consider?**

2) Delineate Scope of Care

- What diagnoses are made and conditions treated?
  - What are the common diagnosis related groups (DRGs) and what is each group's average length of stay, Medicare mean length of stay, and payer mix?
  - What conditions occur most frequently?

2) Delineate Scope of Care

- What diagnostic and treatment modalities are comonly required?
  - What diagnostic testing is routinely performed?
  - What are the most frequent surgical procesdures?
  - What pharmacologic agents are frequently prescribed?

3) Important Aspects of Care

- High volume
  - Occur frequently
  - Affect large number of patients
- High risk
  - Involve significant risks
  - Sentinel events
  - Limitation of services

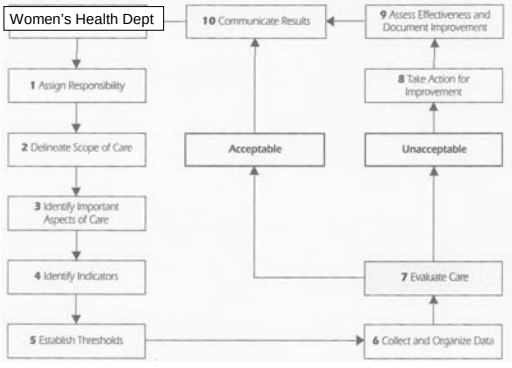
3) Important Aspects of Care

- Problem prone
  - Logistics
  - Implementation
  - Technical support
  - Complex technology

Possible Target Areas

- History/assessment
- STD management
- Medication management
- Plan/treatment
- Progress notes
- Pap smear follow-up
- Method management
- Patient education

Developing A Program



4) Identify Indicators

- Sentinel events
- Specific rates
- Positive/desirable
- Negative
- Address process/outcome
- Considerations
  - Approval by staff
  - Realistic

QA/QI In The Office

- Well suited
- Written plan
- Meet periodically
- Suggested items to monitor
- Concentrate on one system
- Monitor system
- Risk management

Suggested Items to Monitor for Quality Improvement in the Office

- Medical Records/Information System
  - Legibility
  - Organization
  - Documentation-general (including problem list)
  - Documentation of drug allergy
  - Lost medical records
  - Misfiled medical records
  - Breach of confidentiality
  - List of current medications

Suggested Items to Monitor for Quality Improvement in the Office

- Appointments and Scheduling-Patient Flow
  - Acceptable waiting time for appointments
  - Appropriate waiting time in office to see clinician
  - Follow-up on missed or canceled appointments, tests, and procedures

Suggested Items to Monitor for Quality Improvement in the Office

- Patient Relations
  - Periodic patient survey on perceived quality
  - Patient exit evaluation forms
  - Evaluation of patient complaints
  - Periodic assessment of waiting room reading materials and patient information material for timeliness and appropriateness

Suggested Items to Monitor for Quality Improvement in the Office

- Patient Communications
  - Compliance with established protocol for informing patient of the results of laboratory studies and procedures
  - Method of informing patients of a delayed or rescheduled appointment
  - Monitoring appropriateness of method of terminating practitioner-patient relationship

Suggested Items to Monitor for Quality Improvement in the Office

- Telephone Communications
  - Excessive busy signals (data are available fro the telephone company)
  - Excessive holding time
  - Documentation of telephone contact in medical records with disposition documented

Suggested Items to Monitor for Quality Improvement in the Office

- Monitoring of telephone prescription refills for doctor approval
- Monitoring amount of "dropped" of lost calls

Suggested Items to Monitor for Quality Improvement in the Office

- Personnel Management
  - Employee morale
  - Absenteeism
  - Periodic employee performance assessment
  - Maintenance of patient confidentiality

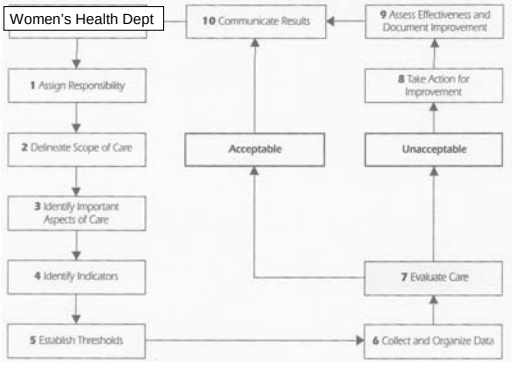
Suggested Items to Monitor for Quality Improvement in the Office

- Equipment and Drugs
  - Periodic equipment check for proper function
  - Maintenance logs of equipment repair
  - Security system to controlled drugs
  - Security system to syringes and needles
  - Method of monitoring drugs for expiration dates (including samples)

Suggested Items to Monitor for Quality Improvement in the Office

- Complications and Adverse Outcomes of Medical Activities and Procedures
  - Drug reactions
  - Wound infections
  - Delayed complications form hospitalized patients (e.g., episiotomy infections, postpartum endometritis)
  - Equipment failure

Developing A Program



5) Establish Thresholds

- **Signals needed for further investigation**
- **Determine when issue is addressed**
- **Based on**
  - **Literature**
  - **National averages**
  - **Local statistical control charts**

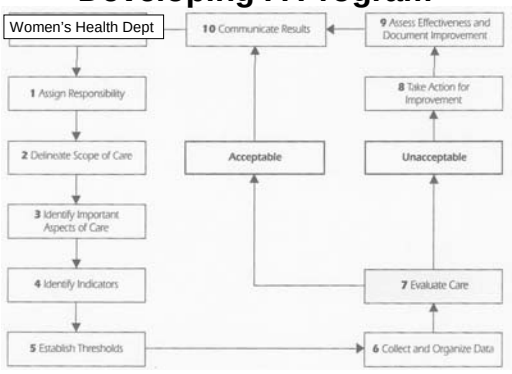
Patient Complaint - Breast

- **A medical record revealed this documentation:**
  - **Patient complained of breast mass before menstruation. Patient counseled to return one week after beginning of next menstrual period for re-examination.**
  - **No other assessment or intervention was included in the documentation regarding this patient's status.**

Best Practices

Do not document a problem or patient symptom without also documenting your assessment and what you did about it.

Developing A Program



Date or Time					
Time Frame	Preadmission Test	Day of or Preoperative	Postoperative 0–12 hours	12–24 hours	24 hours +
Assessments and evaluations		Nsg. database completed Nsg. assessment Vital signs	Routine vital signs every 1/2 h for 2 h, then every 1 h for 4 h, then every 4 h Nsg. assessment	Vital signs every 4 h Nsg. assessment	Nsg. assessment Vital signs every 4 h
Consults		Anesthesiology			
Diagnostics	Lab per MD CXR per MD ECG per MD	All results on chart		CBC	
Diet/fluid balance		NPO IV started	IV fluids as ordered Clear liquids Catheter output I&O	I&O Saline lock IV Regular diet	I&O Regular diet
Activity/safety		Bed rails up	Bed rails up Ambulatory with assist when FC removed, then 4 times daily	Ambulatory with assistance as desired	Up as desired

Activity/safety		Bed rails up	Bed rails up Ambulatory with assist when FC removed, then 4 times daily	Ambulatory with assistance as desired	Up as desired
Education	Hysterectomy book Self-catheterization instruction	Preop/Postop teaching Obtain permits Preop meds	TCDB Postop Care Reinforce pathway with patient/family *Address psychosocial needs (*Document IPR Form)	Activity levels Nutrition Hygiene Hysterectomy booklet given if not provided preoperatively	
Medication		Preop meds if ordered	PCA pump IM meds Oral pain meds Antiemetics	Oral pain meds Stool softeners Home meds	Stool softeners Oral pain meds Home meds
Treatment modalities			TCDB every 2 h Remove vaginal pack Remove catheter 8 h postop		
Discharge planning		Initiate D/C planning	Home health consult if ordered	D/C sheets completed and signed by MD	D/C sheets completed and signed per patient

Polypharmacy

- A chart audit revealed this information
  - A 30-year-old family planning patient with past medical history of diabetes, hypertension, hypothyroidism, seizures and asthma is seen in the family planning clinic.

Polypharmacy

- Drug count included diabetes (three drugs), epilepsy (two drugs), asthma (two inhalers), hypertension (one drug) and hypothyroidism (one drug).
- Records indicated last family planning annual visit was 1 year ago to date, when the patient was started on a combined oral contraceptive with physician order.

Polypharmacy

- Patient denied any current concerns and all conditions are under fair control.
- The medication history was not updated. Patient was issued a year supply of a combined oral contraceptive. No physician order was noted in the chart.

Review

- Patient presents with multiple medical problems.
- Prior documented medication (9).
- Prior physician order for contraceptives.
- Documentation approx. 3 lines, indicates patient provided with one year of COCs.

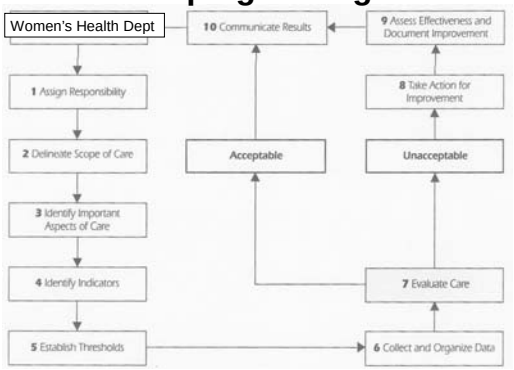
Documentation Problems

- Medical history update noted in chart? NO
- Medication history updated in chart? NO
- Annual physician order required to initiate or continue hormonal contraceptive in chart - NO

Best Practices

- Update information - medication history, medical history, allergies and any changes at every patient visit.

Developing A Program



7) Evaluate Care

- **Quality/appropriateness of care**
- **Allows review by non-medical personnel**
- **Generally accepted**
  - **Below - Substandard**
  - **Above - Levels of acceptable care**
  - **Equally acceptable approaches**

Indication: Acute pelvic pain (625.9)

Confirmation of Indication:

Recent onset of pelvic pain of uncertain etiology

Actions Prior to Procedure:†

1. Document complete history concerning pain‡
2. Confirm by physical exam the presence of abdominal or pelvic tenderness
3. Obtain urinalysis, including microscopic exam
4. Perform pregnancy test for patients of reproductive age
5. Obtain CBC with differential

Were the following documented in the medical record before the procedure?	Yes	No
1. Patient request for permanent sterilization	☐	☐
2. Informed consent in compliance with appropriate state and federal regulations, including the following:		
a. Alternate forms of contraception	☐	☐
b. Specific procedure to be performed, including failure rate	☐	☐
c. Potential for ectopic as well as intrauterine pregnancy	☐	☐
d. Permanence of procedure	☐	☐
3. Last menstrual period*	☐	☐
4. Negative preoperative pregnancy test*	☐	☐

Indication: Cervical intraepithelial neoplasia (233.1, 622.1)

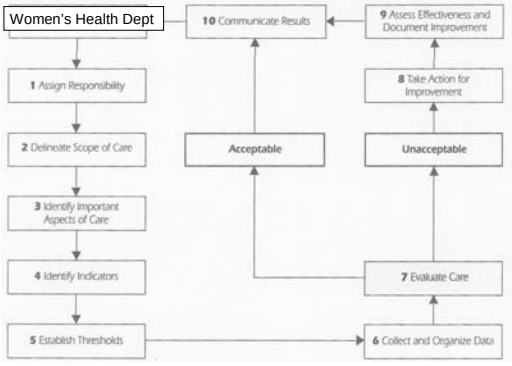
Confirmation of Indication:

Demonstration (by exocervical or endocervical biopsies) of cervical intraepithelial neoplasia without invasion

Actions Prior to Procedure:

1. Perform colposcopy with multiple directed biopsies of the cervix
2. Perform vaginal inspection and biopsy if indicated

Developing A Program



Preventive Measures

- **Education/training**
  - **Morbidity and mortality conferences**
  - **Seminars**
  - **Case studies**
  - **Equipment demonstrations**
- **Clinical protocols**
  - **Complexity of medicine**
  - **Orient/instruct personnel**
  - **Control costs**
  - **Support staff**

Preparation of protocol in a department usually proceeds as follows:

- Recognition of a need
- Review of readily available literature
- Preparation of an initial draft
- Review, revision, and approval by a committee of the department
- Review by nursing staff and any others affected
- Discussion and approval by the department at a full meeting
- Widespread distribution, including members of the risk management and quality assessment programs
- Annual or biennial review with updating as required

Preventive Measures

- **Acquisition of equipment**
  - **Proper indications**
  - **Properly trained**
- **Policy statements**

Abnormal Finding Not Covered In Protocol

- **In one medical record, the nurse documented positive urine dipstick for nitrites and leukocyte esterase on a symptomatic patients and 2+ proteinuria. The progress notes stated "no treatment provided, protocol does no allow for management of 2+ proteinuria".**

Best Practices

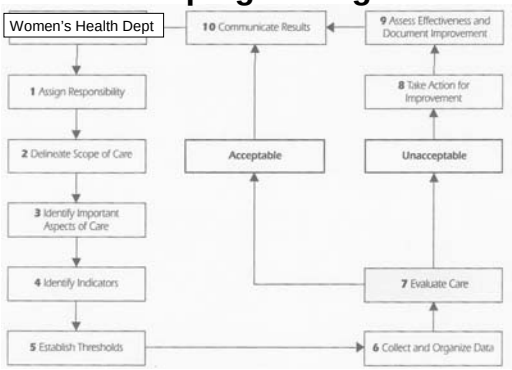
Do not write excuses such as "treatment not provided due to…" in the medical record.

A. No deficiencies found—care appropriate. Morbidity occurred despite appropriate and timely therapy.
B. Opportunity for improvement
   1. Insufficient documentation of care
   2. Incomplete preoperative evaluation or prenatal care
   3. Inappropriate care
      a. Attending physician
      b. House staff
   4. System deficiencies
      a. Nursing
      b. Ancillary services
      c. Other departments (eg, pathology, anesthesiology)
      d. Administration

Corrective Action

- **Discussion/counseling**
- **Observation of practitioner's skills**
- **Focused education**
- **Proctoring**
- **External peer review**
- **Remedial education**

Developing A Program



Corrective Action

- **Reassess problem**
- **Document results**
- **Discuss with legal counsel**


QUALITY IMPROVEMENT COMMITTEE ACTIVITY SHEET: INDIVIDUAL CASE REVIEW

Committee: QA Date reviewed: 8/8/93 Chart #: 123456
Admitting date: 7/3/93 Discharge date: 7/8/93

1. Clinical Indicator Identified:

1. Unplanned return to operating room for surgery-same admission (Dyn 6)
2. Gynecologic surgery requiring more than 2 units of blood (Dyn 8)

2. Brief Clinical Summary:

44-year-old, had TAH BSO for uterine myomata. Developed hemoperitoneum 3 hours postop with hypovolemic shock. Returned to operating room. Arterial bleeding noted from laceration in a small mesenteric artery secondary to retractor. Required 3 units packed cells. Did well. Discharged on 5th postop day.

3. Severity of Injury:

_____ None
__8__ Short-term morbidity
_____ Long-term morbidity
_____ Mortality

4. Reviewers' Comments:

Complication managed well when diagnosed, but complication might have been avoided if bowel examined after removal of retractor and packing.

5. Conclusions:

_____ Deficiency in care

Event involving major error in diagnosis, management, judgment, or technique.

__8__ Opportunity for improvement

Event resulting from clinical situation in which management, when ideal, might have avoided the outcome.

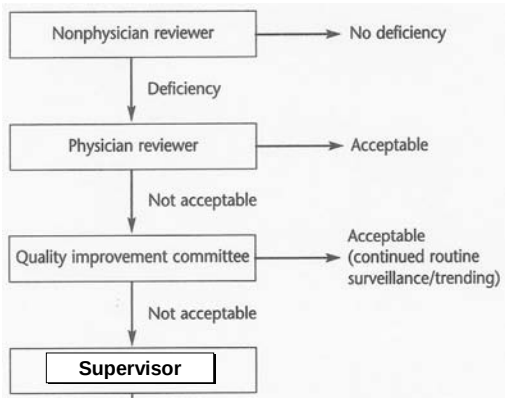
_____ No deficiency identified

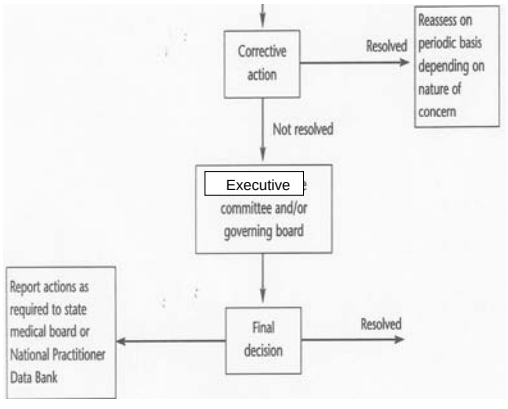
Management appropriate; event due to patient's illness or unavoidable outcome.

6. Committee Action:

No trend in practitioner's performance profile noted. This incident filed in practitioner's confidential QA file for reappraisal process.

Items 1 and 2 are completed by data abstractor; items 3–5 are completed by peer review practitioner; item 6 is completed by committee.





Suggestions

- Develop guidelines
- Training
- Review individual components
- Do not review your own charts
- Allow time for group discussion
- Provide summary report

Common Deficiencies In QA Review

Correcting Medical Records

- Notification
- Place below last entry
- Explain
- Draw a single line
- Do not out
  - Scratch out
  - White out
  - Write out

Correcting Medical Records

- Timely
- Identify late entry
- Spoilation of evidence
  - Document examination
  - Sanctions
- HIPAA
  - Patient may request correction
  - If disagree must notify and offer Statement of Disagreement
  - Civil and criminal penalties may be assessed
    - Pierce v. Penman, 515 A.2d 948

Correcting Medical Records

- No medical record should be altered or back dated

Informed Refusal

- 27 Ca. 3d 285, 1980.
- Repeatedly advised routine pap smear.
- No documentation of explanations/ potential risks.
- Died from advanced cervical cancer.

Informed Refusal

- Risks and benefits of examination or treatment or both.
- Reasons for recommendations.
- Documentation of description of exam.
- Clarify any misunderstandings/allay fears.

Informed Refusal

- Assure understanding of consequences.
- Document above discussion/informed consent.
- Include reasons for refusal.
- Must take all reasonable steps to secure patients written informed refusal.

Legal and Ethical Conflicts

Peer Review Privilege

- State statues vary in reach and strength
  - Information protected
  - Collaborations protected
  - Absolute versus partial privilege
  - Statutory revocation

Legal Protections

- General evidentiary rules
  - Remedial measures
  - Attorney-client privilege
    - Typically only includes senior management
    - Protection lost if sent to non-party
  - Work product doctrine
    - Jurisdictions differ
    - Protection not absolute

Legal Protections

- Specific Statutes
  - Promise confidentiality
  - Anonymous reporting
  - De-identification of data

Standards

- Create discussion between leadership/staff
  - Blameless and non-punitive atmosphere
  - Detrimental effect on error reporting/disclosure
  - Provide emotional support

Standards

- Culture of safety
  - Culture of non-tolerance for high error rates
  - Commitment to reducing error
    - Mechanisms to identify and track errors
    - Setting of norms for training and equipment
    - Adoption of practice parameters
- Mandatory disclosure

Final Thoughts

- It's not fun
- Time consuming
- Diligence will pay off

"A life is not important except in the impact it has on other lives."

Jackie Robinson

Thanks to

John Banja

Larry Wagner

Laura Dean

Department of Ethics in the Health Professions

ACOG QA/QI in OB/GYN

Emory Risk Management Department

For a complete list of upcoming programs, go to the

Alabama **P**ublic **H**ealth **T**raining **N**etwork web site at

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