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MD LEARNING

SYMPOSIUM

# ABSTRACT

## Risk Management at Emergency Room

By: Zedided Ortiz Martínez, Esq.

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# Definitions of RISK

- **GOOGLE:**
  - a situation involving exposure to danger, harm or loss.
  - is the potential of gaining or losing something of value. (life, health, money, material loss)
- **Business Dictionary:**
  A probability or threat of damage, injury, liability, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through preemptive action. (Insurance companies)

# The DUTY of preventing risk
## under the law of Puerto rico

- **The Duty:**
  - To act as prudent and reasonable person not to cause harm neither by action or omission
  - To avoid damages through Preventive actions or measurements
  - Preventive actions should be taken in accordance to the circumstances of:
    - Time, place and person
- **Art. 1802 of the Civil Code of P.R.:**
  El que por acción u omisión causa daño a otro, interviniendo culpa o negligencia está obligado a reparar el daño causado.
- **Art. 1057 of the Civil Code of P.R.:**
  La culpa o negligencia del deudor consiste en la omisión de aquella diligencia que exija la naturaleza de la obligación y corresponda a las circunstancias de las personas, del tiempo y del lugar.

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# DUTY to prevent risk
## (P.R. Case Law)

- ***Ginés vs. Autoridad de Acueductos*, 86 D.P.R. 518 (1962):**
  El deber de cuidado incluye, tanto la obligación de *anticipar*, como la de *evitar* la ocuerrencia de *daños*, cuya probabilidad es razonablemente *previsible*.

- ***Hernández vs. La Capital*, 81 D.P.R. 1031 (1960):**
  El *deber de previsión* no se extiende a todo peligro imaginable que concebiblemente pueda amenazar la seguridad, sino a aquél que llevaría a una *persona prudente a anticiparlo*.

# Liabality for Medical Malpractice
## (Case Law Doctrine)

- ***Oliveros vs. Abreu*, 101 D.P.R. 209 (1973), is the case that states the standard of care for physicians in Puerto Rico:**
  - Aquél que, reconociendo los modernos medios de comunicación y enseñanza, establece que el nivel o calidad de esa atención debe ser la que llena las exigencias profesionales generalmente reconocidas por la profesión médica.
  - The physician should be able to show that he/she has that degree of learning and skill possessed by other physicians.

- ***Oliveros,* also states the *defense of clinical Judgement* ("Error de Juicio clínico"):**
  - This doctrine confers immunity from liability since "judgment" decisions are thought to be acceptable by the peer medical community.
  - Therefore, the physician will not be responsible for the mistake in judgement.

# Clinical Error of Judgement

**Required elements to raise the defense of clinical Error of judgement:**

## DIAGNOSIS:

1. Exists reasonable doubt regarding the illness of the patient.
2. Authorities in medicine are divided with regards to diagnostic procedures; or
3. The diagnoses was made after a good faith effort and study of the condition of the patient.

## TREATMENT:

1. Authorities in medicine are divided or disagree with regards to the appropriate treatment.

**The defense of clinical Error of judgement is based in the following premises:**

- The Judgement must be bona fide (In Good Faith)
- Requires Good communication with the patient

# How to define risk in a HealthCare Facility?

- **Risk:**
  Is an uncertainty arising from the possible occurrence of a given event.

- **Risk Exposure:**
  A state of being subject to a loss because of some hazard or contingency.

# How to identify and classify risk events in the HealthCare Facility?

**Three (3) main categories:**

- **An EVENT is defined as:**
  - Any occurrence out of the routine that affects patient's care or the business operation.

  ***Example:***
  - Shut down of electricity
  - Computer shut down (Electronic Medical Record)
  - Breach of information (hacker breaking the network)

***Reference:** American Society for Healthcare Risk Management (ASHRM)

- **An ADVERSE EVENT is defined as:**
  - Any event that causes *harm* to the patient that is *related to the health care* but is not related with the natural course of the patient's illness.

  - The Harm can be temporal or permanent

  ***Example:***
  - Hospital acquired infections (HAI)
  - Patients' falls
  - Wrongful medication Administration

- **A SENTINEL EVENT is defined as:**
  - Any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient, not related to the natural course of the patient's illness.

  - The harm is of high impact or permanent.

  ***Examples:***
  - Misdiagnosis
  - NO reading of x-ray or misinterpretation of x-ray
  - Blood Transfusion Error
  - Foreign objects for lack of instrument counting
  - Wrong site surgery (lack of Time Out)
  - Burns at E.R.  (Pads, cautery)

## How to identify risk events at the ER?

**There is a NEED to understand the *environment* of the emergency room to asses the risk exposure.**

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# Risk Factors of the Emergency Room

- Type of population (Adults, minors, pregnant,
- cardiac, DIABETES MELLITUS)
- Number of patients (census)
- Medical equipment (MRI, CT Scan, x-rAY)
- Specialist (consulting physicians)
- Amount of Medical staff
- Amount of Nursing staff
- Experience and training of medical and nursing staff
- Capacity for treatment (admission vs. transfer)
- location (rural vs. city)
- Social and economic factors

# Frequent Emergency Room Risk Exposure...

### 1. Minors (Ages 0-21)

- Availability of pediatrician 24/7
- Special equipment for minors (Intravenous catheters, Foley catheters)
- Specialized nursing staff (Intravenous canalization is complicated)
- Specialized x-ray equipment (vital signs monitoring)
- Specialized surgeons (in case of Emergency surgery)
- PICU Facilities (Pediatric Intensive care unit)
- Good Communication with other children hospitals in case of transfer
- Informed consent forms: **General rule:** Both parents must consent to the treatment
  **Exception:** in case of emergency or life threatening condition, one parent can consent to the treatment.
  **Pregnant minor:** can consent only to the care or treatment for the pregnancy.

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## 2. Pregnant Women

- Prompt OB Gyn evaluation
  (Delays in OB Gyn Evaluation is cause of complications)
- Fetal heart rate monitoring to identify fetal distress (correas/trazados)
- APGAR documentation
- Specialized consents (c/s Delivery; Vaginal delivery, vbac)
- Specialized Nursing staff for labor
- Labor room with equipment
- Nursery facilities and equipment

## 3. Diabetes Mellitus

- Laboratories (cbc + Diff)
  - Glucose
  - Bun
  - Creatinine
  - Amylase and Lipase levels
  - ABG (arterial blood gases) (PH, CO2, O2)
  - Blood cultures (infectious disease)
  - Awareness of essential diagnosis:
    - DKTA (Diabetic Keto Acidosis)
    - Metabolic Acidosis vs. Metabolic Alkalosis
    - Dehydration
    - Infected foot abscess
    - UDM (Uncontrolled Diabetes Mellitus

## 4. Dyalisis

- Awareness of some DX:
  - Renal Failure
  - ESRD (End Stage Renal Disease)
  - MRSA (methicillin resistant staphylococcus aureus)
  - Osteomyelitis
  - Infected abscess
  - Dkta (Diabetic Keto acidosis)
  - Metabolic disorders

- Nephrologist specialist
- Infectious disease specialist
- Podiatric specialist
- Hemodialysis services (at room)
- Dialysis Center

## 5. Dyalisis

- Cardiac disease/ hypertension /chest pain

  • Patients with symptoms of:
    - Chest pain
    - HBP (High Blood Pressure)
    - Tachycardia

    } ***Require inmediate attention***

  • Patients with Past history of:
    - CHF (Congestive Heart Failure)
    - CAD (Coronary artery disease)
    - Stroke (CVA or Hemorrhagic)
    - MI (Myocardial Infarction)
    - Bypass surgery

    } ***Require inmediate attention***

  • Awareness of:
    - Perform an EKG in a Timely Manner
    - Anticoagulants and Anti thrombosis medicine in a timely Manner
    - DVT Prophylaxis in a timely fashion
    - Perform studies in a timely fashion (Troponins, CT Scan, MRI)

## 6. Abdominal Pain (frequent misdiagnosis):

- Appendicitis

  • Lack of evaluation for:
    - Rebound effect
    - PSOAS sign
    - Obturator sign
    - Rovsing Sign

    } ***If done, not documented in the medical records***

  • Diverticulitis (perforated diverticular disease)
    - Confusion with UTI (Urinary Track Infection)
    - Confusion with Urethritis (Ureter Stones)
    - Confusion with Colitis

  • Intestinal perforation secondary to trauma (Ex. car accident)

• Gynecological conditions
  - Ovarian Cyst vs. Abnormal Uterine Bleeding or Menorrhagia
  - Appendicitis vs. Endometriosis

**7. Triage Errors:**

- Delay in Triage Evaluation (1 hr; 1.5 hrs.)
- Wrongful classification
  - **Emergency:** requires immediate evaluation, stabilization and treatment; is a life threatening condition
  - **Urgency:** Requires prompt evaluation and treatment in a near future; If not treated can become an emergency
  - **Others / OPD:** does not require immediate treatment

- **EMTALA Violations:** (Emergency Medical Treatment and Labor Act)
  - Proper Screening ⟶ **In a timely fashion (around 30 mins.)**
  - Proper Stabilization ⟶ **In case of an Emergency condition**
  - Admition vs. Transfer
  - Transfer:
    - Lack of Capability
    - Lack of Service

## EMTALA Doctrine

A hospital must perform an appropriate **screening**, within the capabilities of the hospital emergency department, of any individual who arrives at its emergency room requesting treatment to determine whether he or she has an emergency medical condition.

if the hospital makes the determination that the patient is suffering from an emergency condition, the hospital must provide treatment to stabilize the patient's emergency situation before discharging or transferring the patient. (Discharge is appropriate when the emergency is resolved.)

If the hospital does not have the **capability** to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done.

Lack of Capabilities by the Hospital or Emergency Room **does not mean** that the patient has no insurance coverage, because it constitutes **Dumping**.

Hospitals with specialized capabilities are **obligated** to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

A hospital must **report** to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

A patient is considered stable for transfer if the treating physician determines that **no material deterioration will occur during the transfer** between facilities.

If the patient is **unstable**, the hospital may not transfer the patient unless:

- A physician certifies the medical benefits expected from the transfer outweigh the risks; or
- A patient makes a transfer request **in writing** after being informed of the hospital's obligations under EMTALA and the risks of transfer.
  - Patient requests for transfer must be **Documented.**

The transfer of unstable patients must be **appropriate:**

1. The transferring hospital must provide ongoing care within it capability until transfer to minimize transfer risks;
2. Provide copies of medical records;
   - Example: CT Scan; MRI
3. Must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer;
4. The transfer must be made with qualified personnel and appropriate medical equipment. **(Including the Ambulance)**
   - MD on Board increases the categorie of the ambulance

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**An *emergency medical condition* is defined as:**

*"A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health or the health of an **unborn child** in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."*

**Example:**
A *pregnant woman* with an emergency condition must be treated until delivery is *complete*, unless a transfer under the statute is appropriate.

***Emergency Department* is defined as:**

*A specially equipped and staffed area of the hospital That uses a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions.*

Hospital-based **outpatient clinics** not equipped to handle medical emergencies are not obligated under EMTALA and can simply refer patients to a nearby emergency department for care.

# Frequent Emergency Room Risk Exposure... (continued)

### 8. Elderly Patients:

- Risk of fall
- Disorientation

### 9. Number of patients that visit the ER (census)

- Affects ER Capability to give proper and timely treatment

### 10. Facilities, personnel and Specialists

- Determines the Kind of treatment to offer vs. transfer of the patient:
  - Labs
  - X-Rays (CT Scan, MRI)
  - Consultations/Specialists (Ex. Stroke – Neurosurgeon)

## 11. Equipment

- Determines the Quality of Treatment to OFFER and promotes prompt and accurate diagnosis:
  - X-Ray, CT Scan, MRI
  - CPR Equipment
  - Vital Signs Monitors
  - Number of beds at er
  - Number of Cardiac Monitor At ER

- X-Rays Departments
  - Clear Communication with X-Ray Department should be encouraged
  - Contradiction of X-Ray Evaluation between ER physician and radiologist must be discussed
  - Misinterpretation of X-Ray by ER physician requires immediate action
  - Misinterpretations of **Positive** X-Rays of Discharged Patients should be notified **ASAP**
  - **ER Physician:** In case of doubt with a Preliminary X-Ray Interpretation, call Radiologist

## 12. Staff experience and training

- Nursing Staff:
  - Triage Nurse Should be a Registered Nurse (RN) with experience and common sense
  - Nursing Staff should be sufficient according to the census
  - ER Nurses must have appropriate CPR Training (Cardio Pulmonary Resuscitation)
  - Security officials must be trained about emergencies, CPR and ACLS

- Medical Staff:
  - Must be responsible for maintenance of proper credentials
    - Medical mal practice insurance (Tail, Nose)
  - ER physicians should be trained in:
    - ACLS (Advanced Cardiac Life Support)
    - CPR (Cardio Respiratory Resuscitation)

## 13. Telephone Consultations and Orders

- Communication with consulting physicians should be **MD to MD**
- Case Presentation must be Accurate and **documented**
- Telephone orders must be clear and **read back**
- Lab Results must be given in **numbers** (Not Subject of Misinterpretation)
- Panic levels labs must be notified **promptly**
- Clarify **STAT Orders vs. Chart**

- Misunderstandings created by Telephone orders and consultations are the cause of multiple claims and lawsuits.
- Lack of documentation in telephone communication has sunk the defense of many medical malpractice lawsuits.
- **Each and every** significant telephone conversation should be documented.
- A significant telephone conversation is one in which symptoms are discussed, medical advice is dispensed or medical decisions and orders are made.
- Consulting Physicians: If a Consultation is requested within an Emergency scenario, try to evaluate the patient **ASAP.** (30 mins.)

## 15. Re-evaluation

- It is highly recommended to:
  - Re-evaluate the Patient
  - Re-Evaluations should be Documented
  - Verify execution of orders (Status of Lab Tests, X-Rays, ETC.)
  - Verify administration of medications

***Case: *Nuñez vs. Cintrón*, 115 DPR 598 (1984):**
Establece que Un médico tiene el deber de estar accesible y supervisar el cumplimiento de sus órdenes y aplicar el tratamiento rápido, adecuado y recomendado.

## 16. Execution of Orders

- Orders Should be Executed in Accordance to Patient's Condition (ER – ASAP)
- IF Given at ER, should be Executed at ER
- Must be executed by the Personnel in which Area the Patient is Physically located
  *Avoid the twilight zone or blackhole*

## 17. Shifts and Patient Presentation

- Always present your case and document it in the medical record, if possible.
- Avoid errors that commonly occur during shift changes, such as excessive patient waiting times for labs or studies results.
- Avoid to work extra hours (tiredness causes mistakes)

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## 18. Special Dates or Holidays

- Take into consideration that many of the adverse or sentinel events occur in Holidays:
  - Christmas, Thanksgiving, New Years Eve, Good Friday, July 25th, July 4th

## 19. Informed Consent

- Between **MD and Patient** (Is A Physician Responsibility)
- Diagnosis or condition must be informed to the patient
- Offer orientation ABOUT Recommended Treatment
- Explain the Risk and Benefits of recommended treatment
  - Discussed with the patient and Documented in the medical record
- **Alternative treatments** should be discussed and documented
- Refusal: Must Be Documented and Signed by the Patient
- Refusal: Consequences of Refusing treatment must be disclosed
- Written **Consent Forms** should be signed and Dated by The patient and MD
  - Exception:
    - Emergency
    - Impracticability (Tutor)

# Consent Forms

- **Minors** (<21 years) (0-20)
  - **General Rule:** Both Parents Must Consent
    - Patria Potestad vs. Custody
  - **Exception:** Emergency case - one parent is enough, or tutor
    - Consent Given by Telephone Communication Must Be Documented in The Medical Record.
      *Example:* Grandparents
- **Pregnant**
  - Can Consent for her treatment and for the baby
  - Minor
    - Can only consent for the treatment related to the pregnancy.
    - Parents of the pregnant must consent to her treatment, not related to the pregnancy.

- **Treatments' Refusals Must be Documented in the medical records.**

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- **Refusals for Religious Believe Are Allowed and Must be Documented, but should be without coercion.**

  *Example:* Testigos de Jehová Reject Blood Transfusions

## 20. Medication Side Effects

- Avoid Medication Side effects such as:
  - Patients' fall secondary to medication side effects
  - Strong Pain Medication that cause Patients' drowsiness

    *Example:* Demerol
- Avoid medication side effects for past history of Allergies

  *Example:* Allergy to ASA (Aspirin) and Toradol
- Specify doses and Trough levels for special antibiotics

  *Example:* Vancomycin

## 20. Documentation

- General Consent Forms are signed
- Document hour, day, month and year in each note or order
- Review the Triage Note
- Review the Medical Chart
- Review the Vital Signs and check are complete
- Review History of Allergies and document it again
- Review Current Medication in use
- Positive Findings
- Negative Findings
- Names of other physicians the patient sees
- Document Past History of medical conditions or illness
- Document X-Rays Results (Including Preliminary readings)
- Document X-Rays Discussion with the Radiologist
- Document Labs Results and Evaluation (Relevant Findings)
- Document differential diagnosis or rule outs (R/O)
- Document EKG Results
- Medications: Specify Route, Dose, Amount, Etc.
- Telephone Calls and orders should be documented
- Diagnosis: clearly Documented in Admission Note
- Disposition: Clearly Documented with Instructions of Follow Up treatment and Medications
- Document Patient's Condition at Discharge (Discharge Note)
- Diagrams or draws are used to enhance or supplement narratives.
- Always document aftercare instructions (Follow up with PCP)
- Progress notes should include:
  - Symptoms and past medical history
  - Important Physical findings
  - Systems Evaluation
  - Physician assessment, R/O
  - Treatment Provided (Orders, Medications)
- Amendments and additions should be appropriately entered

- Under **NO** circumstances should medical records be altered
- Remember: Patients' attorney requests a copy of the records before filing the claim
- Handwritten entries must be legible (Avoid Squeezed-in notes)
- Transfers In and Out of E.R. should be documented, in compliance with EMTALA
- Progress Notes:
  - Justify care and treatment
  - Document Follow Up Treatment
  - Justify the Fee that will be charged
  - Document Patients collaboration with Treatment or Lack of it
- Avoid to write inter-professional criticism or subjective comments
- All Notes and Entries should be signed or initialized
- Informed consents for specific procedures must be full documented (Risk and Benefits; Alternatives in Treatment, Etc.)
- Refusal to treatment should be documented, including the consequences of the Refusal and alternatives in treatment (Document Discussion with patient).
- Include important labs or tests results in the progress notes
- Avoid Contradictions in medical records (Between Nurses and Physicians notes)
- Deletions, error corrections or Amendments should be properly done:
  - Strike line
  - Initials
  - Date
  - Addendum/amendment – with date, hour and signature
- Practice Defensive Medicine
  - Request Patient Signatures in Refusals to Treatment
  - Document Patient's lack of collaboration with treatment
  - Document if Patient does not follow instructions (Medication Intake)
  - Document the Presence or Absence of Relatives
  - Document Patient's important manifestations with regards to Past medical History or Future Instructions.

# Events that affect patient's safety
## Identified by Centers For Medicare (CMS)

**1.** Bloodstream infections associated to Central Lines

**2.** Urinary Track Infections Associated to Catheters (CAUTI)

**3.** Surgical Site Infections
- Colon Surgery
- Abdominal Hysterectomy
- Call the surgeon

} ***More frequent***

**4.** Methicillin Resistant Staphylococcus Aureus (MRSA)

**5.** Patients' fall
- The Infections mentioned above are Also known as
  - Hospital Acquired Conditions (HAC)

# Emergency Room ERRORS Identified by Plaintiffs' Attorneys

- **Ford, Dean And Rotundo, Law Firm**
  (40 years of Med Mal Practice)
  - Errors in Diagnosis, delays or misdiagnoses: 57% of the Claims
  - Errors in Treatment: 13% of the claims
    *Example:* Failure to stabilize a trauma patient's neck causing paralysis
  - Wrong or inappropriate Treatment: 5% of the Claims
  - Failure to order Necessary Medication: 3% of the Claims
    *Example:* Antibiotics for an infection
  - Patient's failure to follow treatment plan or appointments: 21 % of the Claims
- Also, **17%** of the errors were associated to poor communication among healthcare providers.
- **14%** were associated to patient-provider miscommunication.
- **13%** presented documentation errors (Failure to record information)
- **12%** was related to overwork (Insufficient staffing)

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# Emergency Room ERRORS Identified by Plaintiffs' Attorneys

- **The Becker Law Firm:**
  - Misdiagnosis: is the most common at E.R. (37% - 55%)
  - Heart Attacks and Strokes
    - Infections
    - Meningitis
  - Mistakes with medications
  - Misinterpreting Test Results
  - Delay in Treatment
  - Failure to Order Tests
  - Triage Errors
  - Failure to obtain Medical History
  - Misreading of Tests
  - Failure to notify patients of test findings
  - Failure to provide follow up instructions

- The Causes Identified for the Emergency Room Errors:
  - Lack of Equipment or Resources
  - Overcrowding
  - Staff Stressed or Fatigued
  - Low Staffing
  - Inexperience or lack of training
  - Deviating from Standard Protocols
  - Rush from one patient to another
  - Not obtaining medical history

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# Seven Pillars of Emergency Medicine Excellence

1. **Safety:**
   Quality of Care, Patient outcome and Staff commitment
2. **Satisfaction:**
   Patients' perception and E.R.D. Reputation
3. **Solvency:** $$$ (Utilization)
4. **Space:**
   Functionality of the facility and equipment
5. **Staff:**
   Physicians and nursing credentials and level of retention
6. **Support:**
   Relationship between Administration and clinical Staff; on call coverage and development of committees. *
7. **Systems:**
   Work Flow Processes, Protocols implementation and Technologic advances as electronic Health Record (EHR)

# Risk Events REPORTING

- Most of the Risk Events or Errors are not reported or documented.

- In 2006, The ASHRM Reported that:
  - **86%** of the adverse events are *not reported* by the clinical staff (Nurses and Physicians); even though an incident reporting system exist.
  - **98%** of the providers (Nurses and physicians) are *aware* of incident reporting system; but nurses use it more than doctors.
  - **89.2%** of the nurses have completed an incident report.
  - **64.6%** of the Physicians have Completed an Incident Report.
  - **88.3%** of the nurses know how to locate or access an incident form.
  - **43.0%** of the Physicians know how to Locate or Access an incident form.
  - **81.9%** of the nurses know what to do with a completed incident form.
  - **49.7%** of the Physicians know what to do with a completed incident form.

# Importance of error reporting

- Discussion of errors, such as root-cause analysis, promotes a preventive approach and a safety culture between the staff of the Emergency Room.
- Promotes corrective actions
- Promotes the development of new protocols and procedures
- Promotes patient's safety
- Increases the quality of services
- Decreases the repetition of old mistakes
- Increases reputation
- Reduces medical malpractices claims or lawsuits
- Promotes a safety work environment

# How to handle risk events in the ER

- Stay calm and focused
- Make an assessment of the adverse consequences (For the patient and clinical staff)
- Evaluate the situation and the alternatives to provide a prompt solution
- Select the best solution and apply it
- Act quickly to avoid, stop or reduce the impact of damages

At the end, document the event in the reporting system available

Maintain the "Patient Centered approach". You must focus the attention in the patient.

- Patient safety comes first
- Staff safety is also important
- Communication is key and essential
- Make an estimation of the damages at the conclusion of the event
- Use the ROOT-CAUSE analysis to Discuss weaknesses with the Emergency room team

# Final Recommendations

- Promote a Safety environment to increase quality of services.

- Create Committees to discuss Emergency Room Department Operations:

  - Comite de Caidas
  - Comite de Mortalidad
  - Comite de Incidentes Adversos
  - Comite de Fugas

  } ***promotes discussion of incidents and correction of procedures at E.R.***

- Practice Defensive Medicine: Document in the Medical Record As much as you can. *Is your best defense in a claim.*

- Encourage active participation of the patient in his/her health care.

- Remember the usual Plaintiff Characteristics:

  - The Patient who feels abandonment (Delay)
  - The patient who didn't understand the health care given or administered
  - The Patient who was not oriented or to whom important information was not given or notified
  - Bad outcomes never explained.

- Adverse Events can not be fully avoided, but can be minimized if proper action is taken.

- Frequent Errors can be identified, and therefore, prompt attention can be given to avoid further consequences.

- Embrace a Preemptive approach to create a safety culture in your work.

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# Case Study #1

María Cruz, a single 19 years old female Patient visits the Emergency room with symptoms of abortion. She has a 3 months pregnancy without any treatment. After initial Evaluation of the Emergency Room Physician, the patient is oriented about: (a) the necessity of an OB-Gyn Evaluation, and (b) the possibility to undergo a Dilation and Curettage procedure. The patient expressed that it is her preference to avoid the D&C and questioned if the procedure was a mayor surgery that required her parents' consent or authorization, or if Her consent was sufficient to proceed because her parents are not aware of her pregnancy?

**The Emergency room physician should:**

**A)** Explain to the patient that the dilation and curettage is a procedure performed to Remove tissue in the uterus during or after a miscarriage or abortion To prevent infection or heavy bleeding; and that authorization of her parents is required because she is a minor.

**B)** Informed to the patient that OB Gyn will give her the orientation about the D&C procedure and that no consent of her parents is required, because although she is a minor, the treatment is related to her pregnancy.

**C)** Explain to the Patient that she has the right to reject Medical Treatment and give her the form to reject medical treatment, against medical advise.

# Case Study #2

José Morales is an active member of the church "Testigos de Jehová". While visiting homes in the community, José was shot by Carlos, a known Atheist, who is angry and tired of the harassment of the congregation. José was brought to the Emergency Room Department, were the physician informed him about the necessity to provide him a blood transfusion to safe his life or he will die. Brothers and sisters of the congregation aware José about the sin of receiving a blood transfusion, against Jehovah's will. José refuses the transfusion signing the form to reject medical treatment. At midnight, while josé is at The "ICU", he requested to speak with the Doctor and expresses that he wants the blood transfusion, in strict confidentiality.

**The Doctor should:**

**A)** Order the Type and Cross match and start the Blood transfusion STAT.

**B)** Order The Type and Cross Match, to start with the Blood Transfusion as soon as possible, document in the medical record the revocation of the refusal, assure the patient signature of the Blood Transfusion consent and Provide orientation to nursing and clinical staff about the patient's right to the privacy and confidentiality of his medical treatment (HIPAA).

**C)** Inform to the patient that he needs to Call the legal department of the hospital because to revoke the previously signed refusal it is necessary the presence of a notary public and 2 witnesses.

# Case Study #3

Antonio Pérez is a 62 years old male patient who visits the emergency room with symptoms of abdominal pain in the left lower quadrant. Antonio has Past Medical History of Diverticular Disease. Due to the intensity of the pain and the fact that lab tests revealed an increase in the "WBC" count, The Emergency room physician suspects the possibility of a diverticulitis with perforation. X-Rays studies were ordered stat and consultation with surgery service was requested. To relieve the pain, an order of 80 mg of intravenous Demerol was ordered. The Emergency room is very crowded and there is no bed available. Therefore, the patient was seated at the waiting room area, before being transfer to Radiology Department for a CT Scan.

**In your opinion the treatment given was:**

**A)** ***Correct, because the patient had a past history of diverticular disease and the laboratories showed an elevation of the "WBC" suggestive of perforation or abscess.***

**B)** Correct, Because the CT Study is an accepted method to diagnose a diverticular perforation.

**C)** Incorrect, because although the diagnosis and treatment ordered is within the standard of care, Demerol is a Strong Medication that causes dizziness and drowsiness, and may cause the patient's fall and harm. he should be located in a bed for further observation.

**D)** Incorrect, because Demerol Medication is Prohibited in elderly patients over 60 years old.

# About the Author:

***Zedided Ortiz martínez, Esq.***
Lawyer; Private Law Practice
Active litigation in the areas of medical malpractice, providing legal representation to Hospitals and physicians on trial proceedings at state courts.
**Email:** zedidedortiz@gmail.com

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