Documentation Errors Lead to Missed Diagnosis and Suboptimal Outcome

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

As healthcare practices become larger and their processes become more complex, the days of relying on memory and "sticky notes" to keep track of patients are long gone. Documentation processes are more critical than ever, yet many physicians feel as though they are being crushed under an avalanche of information and performance requirements. This interesting case from the Southeast illustrates what can happen when information management processes break down.

Facts

A 54-year-old male became a patient of a large primary care practice with multiple physicians and physician assistants (PAs). At the patient's first visit, in May of Year 1, a PA conducted a complete physical, including a digital prostate exam, and found the patient

in good health. While the patient was seen at the practice regularly over the next several years, no additional prostate-specific antigen (PSA) testing or digital examination of the prostate was performed.

In May of Year 6, the patient was admitted to the hospital for cardiac evaluation; various blood studies were ordered, including a PSA test. The PSA indicated 4.64, an abnormal result. This result was noted in the hospital health record, including an order to repeat the test in 6 months. However, nobody told the patient about the abnormal result. When the patient was discharged a few days later, per normal protocol, a copy of the hospital discharge summary — including the recommendation to repeat the PSA test — was sent to the primary care practice for inclusion in the patient's health record.

In June of Year 6, the practice converted its recordkeeping to an electronic health record (EHR) system; however, paper health records were not scanned into the EHR, so patients' historical health information was stored separately.

In January of Year 7, the practice was reorganized, and the patient was reassigned to Dr. P, whom he had never met. Unfortunately, Dr. P did not review the patient's paper health record before the appointment that month, so he was unaware that the patient needed a repeat PSA test. In June of Year 7, the patient returned for another check-up, and Dr. P ordered a PSA test as part of the routine bloodwork.

The practice's process for routine bloodwork involved the physician verbally directing the medical technician to order the necessary tests, and then the medical technician drawing the blood and submitting it with a requisition form to the lab. For some reason, the medical technician failed to order the PSA test on the requisition form, so it was not performed.

At that time, the practice was not using the "test tracking" function of the EHR; so when the PSA test result was not received, it did not show up as an "alert" in the system. Because the patient appeared to be doing well, he was put on a 1-year recall schedule.

The patient returned in May of Year 8, and PSA testing was again ordered. The test reported a level of 43.22. When this test result was received, the patient was contacted and immediately referred to a urologist.

A digital examination of the patient's prostate demonstrated that the right lobes were "very hard and nodular," and an ultrasound showed "diffuse hypoechoic appearance" of the prostate. Pathologic analysis confirmed moderately differentiated adenocarcinoma (Gleason score of 7), which had metastasized to the pubic bone.

Because of the advanced stage of the disease, neither surgery nor radiation therapy was an option, so chemotherapy was commenced. The patient's prognosis was poor, and he ultimately died from the cancer.

A medical malpractice lawsuit was filed against Dr. P and the practice. At the insureds' request, the case was resolved with a payment in the high range. Defense costs were in the midrange.

Discussion

In medical cases that result in catastrophic injuries, risk factors in the information management process frequently combine with human errors to produce poor outcomes.

In this case, the first risk factor was the practice's decision not to scan paper health records into the EHR system when the transition was made. Therefore, important historical health information was not available to the physician unless he intentionally retrieved and reviewed the paper health record, which was unlikely for a typical 15-minute visit.

While scanning the paper health record into the EHR is admittedly time-consuming and expensive, the value of having all of the information immediately available in one place cannot be overstated. It may also allow the practice to dispose of some paper health records once all of the information has been archived in the EHR.[1]

If the paper health records are not scanned into the EHR, it is imperative that physicians review both information sources to ensure that they have an adequate understanding of each patient's health history. In this case, if Dr. P had reviewed the paper health record, it seems likely that he would have reviewed the hospital discharge summary, as it would be one of the most recent documents. He then would be aware of the abnormal PSA test result and recognize the need for appropriate follow-up. One can speculate that, if he had, this poor outcome may not have happened.

The second risk factor was that the medical technician did not order the PSA test when Dr. P requested it. It's possible that the medical technician may have been interrupted while completing the requisition form. However, if Dr. P had ordered the PSA test via the EHR system, then it would have automatically ordered the test, "watched" for the resulting report, and alerted him if the report was not received.[2]

Unfortunately, the third risk factor, which was not used as a fail-safe mechanism in this case, was the patient. It is excellent practice

---

[1] Please check with your MedPro Patient Safety and Risk Consultant before disposing of any paper health records.

[2] Use MedPro's guideline, *Using an EHR System as a Quality Improvement Tool in Your Healthcare Practice*, as a helpful resource to understand more about using EHR systems to improve the quality of patient care.

for the healthcare provider to advise the patient: "We have ordered these tests for you and you can expect to hear from us within 2 weeks regarding the test results. If you do not hear from us within that time, please contact our office." This technique, which has been used for many years, is still valuable. Additionally, when the patient was being discharged from the hospital in May of Year 6, he could have easily been instructed to repeat the PSA test in 6 months.

Summary Suggestions

The following suggestions may help healthcare providers and staff document and track patient care:

- Store all patient information in one place. "Shadow records," including paper/EHR records in storage, are not recommended.

- If, by necessity, patient information must be stored in more than one location, physicians should review all sources at appropriate times.

- Track test results, referrals, and follow-up activities to verify that the action occurred and the physician is aware of the results.

- Engage the patient as a "fail-safe" technique. Inform the patient of what to expect, and also remind the patient to contact the practice if he/she doesn't receive test results or other information as expected.

Conclusion

In our imperfect world of complex processes and human error, failures will occur. Good process design and attention to detail will minimize the risk of error, but, if it does occur, hopefully it will minimize the likelihood of harm to a patient.

This document should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

MedPro Group is the marketing name used to refer to the insurance operations of The Medical Protective Company, Princeton Insurance Company, PLICO, Inc. and MedPro RRG Risk Retention Group. All insurance products are underwritten and administered by these and other Berkshire Hathaway affiliates, including National Fire & Marine Insurance Company. Product availability is based upon business and/or regulatory approval and/or may differ among companies.