Tales from the Inpatient World:

Ways to Improve your Inpatient Care, Avoid Harming Patients, and Stay out of the Courtroom.

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DISCLOSURES

- My Father was a P.A.
- No other disclosures to report

What we are covering today

- Patient Case Reviews
- Few Bedside Pearls/Zebras
- Intangibles of Patient Care
- Tips to help you take care of patients and keep you out of the courtroom.

Case #1

Trust, but Verify

MEDICAL ERRORS

- It’s difficult to make one decision that leads to a patient’s mortality, while in the hospital.
  - Pharmacy support
  - Nursing support
  - Multiple support services cross-checking your work
  - What we often see is harm to a patient **by not identifying a potential issue**

Frellick, Marcia (3 May 2016). "Medical Error Is Third Leading Cause of Death in US Marcia Frellick". Medscape. Retrieved 7 May 2016.

GOLD ENCRUSTED PEARL #1

Be faithful in small things because it is in them that your strength lies.

Mother Teresa

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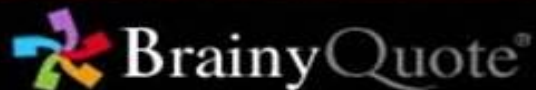

Case #1

- 89-year-old female with mild Dementia, Afib, CAD, Hypertension and Systolic CHF
  - Originally lived at home but now in an assisted living facility.
  - The patient is a fair historian but has a son who is involved in her care.
  - Son notes her energy is gradually declining and she has episodic dyspnea.

February 2018

- Patient with CHF, Afib, CAD, Mild Dementia, and HTN presents to ED with exertional dyspnea times 3 weeks, decreased energy and intermittent chronic chest pain.
- ROS: Cough, Palpitations, Mild leg swelling (worse over the last week), takes meds but does not fluid restrict.
- Meds: ASA, ACE inhibitor, B-Blocker, Coumadin, Gabapentin, PRN Lasix
- Physical Exam: 1+ pitting edema in legs, Positive wheezes, No crackles
- Vitals: Afebrile, P = 82, R =23, BP = 132/76, Sats = 98% on RA
- Labs: CBC, BMP, Troponin unremarkable. BNP = 240 PG/ML (235 in 2015).

February 2018

- Patient with HFpEF, Afib, CAD presents to ED with exertional dyspnea, decreased energy, and intermittent chest pain.

- Conclusion on CXR
    - *Increased bibasilar atelectasis compared to prior may reflect atelectasis, aspiration pneumonitis or pneumonia in the appropriate clinical setting.*
    - *Prominent pulmonary vasculature with a mild component of interstitial edema.*
    - *Trace bilateral pleural effusions. No pneumothorax.*
    - *Enlarged cardiopericardial silhouette stable compared to prior. Aortic atherosclerosis.*
    - *Unchanged deviation of the trachea to the right at the level of the thoracic inlet, suggesting enlargement of the left lobe of the thyroid gland.*
    - *Visualized abdomen unremarkable.*
    - *No acute osseous abnormalities. Diffuse idiopathic skeletal hyperostosis of the thoracic spine. There is degenerative changes of the shoulders.*

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AP Portable

R

DLH

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Anchoring Bias

- Enamored with the first diagnosis
- **Providers “anchored”** on CHF as the source of the patient’s dyspnea, even when the CXR showed mild or no edema.

June 2018

- Presents to ED with dyspnea
- Slight BLE edema. BNP = 282
- CXR conclusions again mention the trachea deviation. No edema.
- ED note describes CXR as “normal”. No mention of tracheal deviation.
- Diagnosed with CHF, given Lasix and discharged

July 2018

- ED visit for fall
- All labs and CXR described as "consistent with baseline."
- Noted to be dyspneic with ambulation
- CXR read: ***Similar rightward deviation of the trachea suggestive of thyroid enlargement.***
- Discharged

August 2018

- ED visit for dyspnea. BNP = 161
- 1+ Lower extremity edema, Lungs clear
- Diagnosed w/ CHF. Treated and released.
- Tracheal deviation again reported on CXR but no mention in ED documentation.

<u>TOTAL SO FAR: Five Chest x-ray's, Five BNP's and Ten providers involved since 2/18.</u>

September 2018

- ED visit for dyspnea
- Tachypnea, few wheezes
- CXR reports tracheal deviation. No edema.
- No mention of Thyroid in ED notes
- Discharged from ED

October 2018

- Presents again with dyspnea and intermittent chest pain
- Hospitalist team admits!!! Concern for P.E.
- INR= 2.5
- Has CT PA study in E.D.

No Pulmonary embolism Large Goiter. The left thyroid lobe is markedly enlarged and heterogeneous with scattered calcifications and retrosternal extension. The left thyroid lobe measures 9.4 x 5.8 cm at the level of the thoracic inlet. It displaces and compresses the trachea, great vessels, and esophagus.

MASS

Trachea

October 2018

- CT PA study

  No Pulmonary Embolism. Large Goiter. The left thyroid lobe is markedly enlarged and heterogeneous with scattered calcifications and retrosternal extension. The left thyroid lobe measures 9.4 x 5.8 cm at the level of the thoracic inlet. It displaces and compresses the trachea, great vessels, and esophagus.

  Recommend evaluation of mass with thyroid ultrasound.

October 2018

- Admitted to hospital for CHF
- No mention of the Thyroid mass for the entire hospitalization
- Results of CT are imported into ED note, Admission H&P, and progress notes
- Four day hospitalization, Five providers involved, No mention of Thyroid Mass in DC Summary

Yes or No?

- If CT results are in your signed note but you never actually read the results, are you responsible for those results?
- Would a jury of your peers give you “a pass” when you explain that you didn’t actually read the CT results?
- Do EMR’s document and timestamp when you look at a report?

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  Come on Erik, you know the answer. Why are you bothering me?

November 2018

- Presented with dyspnea and a fall. Found to have sepsis (E. Coli and Klebsiella)
- Admitted by a Medicine Resident Service!!
- CXR performed: "*Markedly enlarged thyroid gland significantly compressing and displacing trachea to right*."
- A provider acknowledges the Thyroid in a note (resident)!!!!

November 2018

"Problem #9: Enlarged Thyroid Gland compressing and displacing trachea.

Plan: Get TSH and Free T4

Results: Normal TSH and Free T4."

- **Above "copied and pasted" for 5 days in a row.**
- No other documentation about Thyroid

Thyroid Goiter/Nodule Work-up

- History and Physical Exam
  - HISTORY & PHYSICAL IS KEY!!!!
- Serum TSH
- Thyroid Ultrasound

Zebra #1
Pemberton's sign

December 2018

- ED visit for facial droop and slurred speech
- CT Head and MRI done
- *No acute stroke but noted a mass in the right parotid gland*
- Patient placed in ED OBS for TIA and discharged with ENT follow-up

January 2019

- ENT does a fine needle aspiration of Parotid gland
- Biopsy results: Malignancy of unknown etiology. Recommend excision for precise classification.
- No mention of the Thyroid Enlargement in the notes

February 2019

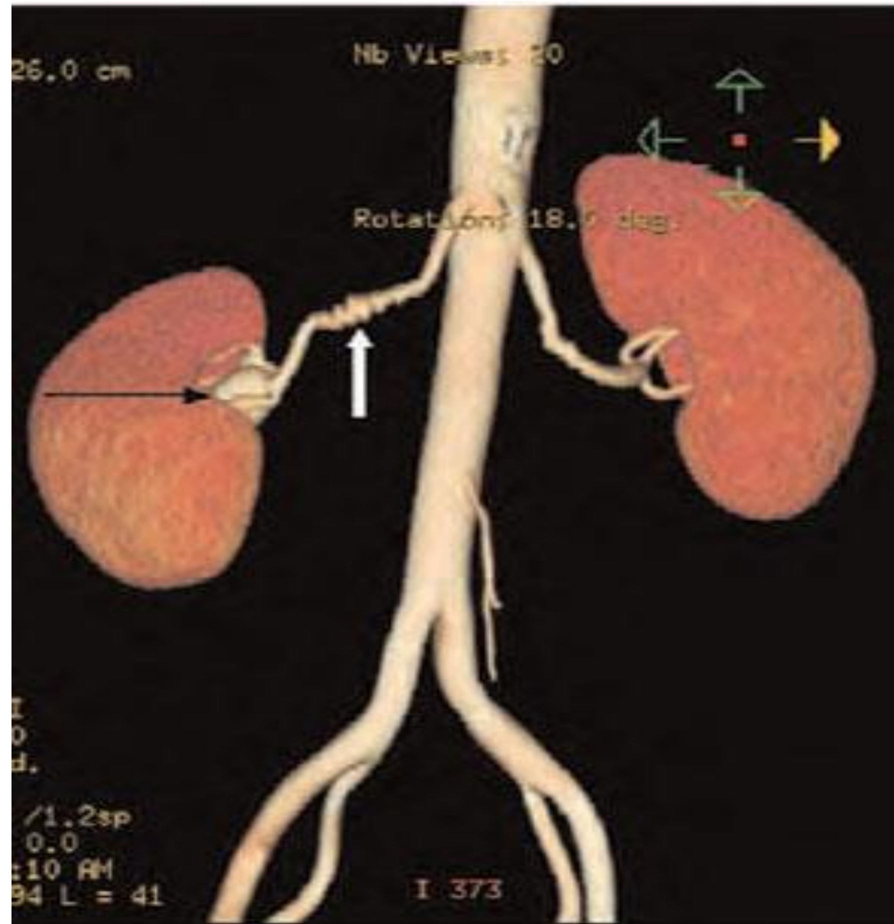
- Presents to ED with left arm swelling
- CT Chest and Upper Extremity Dopplers obtained
- Diagnosis: Left Subclavian DVT due to compression from thyroid mass. Thoracic Outlet Syndrome
- Went to Surgery for a Thyroid Lobectomy.

Follow-Up Points

- Patient died 2 months later in April.
- 34 Medical Providers cared for this patient in the hospital over one year.
- “Could you have been one of the 34?”
- What we often see is harm to a patient **by not identifying a potential issue.**
- **Trust, but Verify**

Frellick, Marcia (3 May 2016). "Medical Error Is Third Leading Cause of Death in US Marcia Frellick". Medscape. Retrieved 7 May 2016

Zebra Alert!!



Case #2

Trust, but Verify

The Sequel!!

Case #2

- Take a patient case and break it down piece by piece.
- Review the opportunities for error, and how to avoid them.
- Discussion of how a provider can get to this point.

Framing

- Framing effect: a different conclusion drawn from the same set of facts, depending on how the facts are presented

- “Frames” provide people a quick way to process information

Framing

- The ED doc calls you with an admission:

"80-year-old anxious female with hypertension and diabetes brought to the ED with a blood pressure a little elevated (200/95)…."

VS

"80-year-old female with dysarthria, left arm numbness and elevated blood pressure who is being ruled out for stroke…"

Potential Hole #1

- **The ED doctor calls you with an admission.**

"*80-year-old female with hypertension and diabetes brought to the ED with anxiety whose blood pressure is a little elevated (220/95). IV Labetalol is bringing it down. Might be a good idea to watch her overnight.* "

You have patients still to see and 2 other admissions.

You tell the ED doctor: "Send her up."

ED puts in some initial admit orders.

Potential Hole #1

- **The ED doctor calls you with an admission.**

"*80-year-old female with hypertension and diabetes brought to the ED with anxiety whose blood pressure is a little elevated (220/95). IV Labetalol is bringing it down. Might be a good idea to watch her overnight.* "

- Is the ED doctor always correct? No

- Do you feel comfortable putting your license and your reputation on the line based on another provider's opinion?

  I don't.

Inpatient Workflow- Starting out

FAST

SLOW

Inpatient Workflow - Career

HOLES

COMPLETE

Potential Hole #2

- **Patient is placed in the ICU and nurse calls you.**

“*Patient’s blood pressure is 218/107 and she’s maxed out on IV Labetalol. She’s anxious and has a headache*”

It’s 5:30 pm and your shift ends at 7. You still have 2 admissions left. You saw 20 patients and did 3 admissions already today.

You review the vital signs in the computer and everything looks good except the blood pressure.

What should be your first thought at this moment?

Answer: I need to go see this patient

Case #2

- Evaluating a patient is more than just going to the computer and looking at numbers.

- History
- Physical
- Labs, Vital Signs, Radiologic studies
- Notes in the chart

Breakdown of the Process

"Listening and asking pertinent questions followed by a thorough examination works."

"Imaging and complex testing should support or refute your hypothesis or differential diagnosis. Testing should not be used to replace listening , a thorough history session and physical examination."

Rutecki, GW, Is the history and physical examination worth performing anymore. Medpage Today; February 2013

TINSLEY HARRISON, M.D.
TEACHER OF MEDICINE

History is The Key

- 7 decades ago: the correct diagnosis can be made after history-taking alone in 74% of patients
  (Platt R. Manchester University Medical School Gazette 1947; 27:139-145)

- Comparing the relative value of history, exam, and labs in making medical diagnoses: correct diagnosis determined after only history in 82% of patients
  (Hampton JR, Br Med J 1975;2:486-489)

- In 1992, Petersen reproduced the above study: found that the history led to the correct diagnosis 76% of the time
  (Peterson MC, West J Med 1992;156:163-165)

Potential Hole #3

- **<u>You give an order over the phone.</u>**

"*How about Nitroprusside? Does that sound okay?"*

Nurse replies: "That sounds good. That should work."

You decide to finish up for the day, and pass off this admission to the night team.

You checkout the patient to the night team ("Hypertensive urgency, needs H&P,Orders") and leave for the day.

Potential Hole #3

Nit*roprusside*

- When administered by IV infusion, begins to act within one minute or less.

- Vasodilator (arterioles and veins)

- This drug can produce a sudden and drastic drop in blood in blood pressure.

- Cherney D, Straus S. Management of patients with hypertensive urgencies and emergencies: a systematic review of the literature. J Gen Intern Med 2002; 17: 937

- Jauch EC, Saver JL, Adams HP Jr, et al, “Guidelines for the Early Management of Patients With Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association,” Stroke, 2013, 44(3):870-947.

Result

- **Patient suffers a massive left-sided stroke and is debilitated in a nursing home to this day.**

What Happened?

Result

- **Patient suffers a massive left-sided stroke and is debilitated in a nursing home to this day.**

- Patient presented to ED with dysarthria and left arm numbness that was resolving.

- Neurology was consulted in the ED to evaluate for tPA. Their note stated "Concern for acute ischemic event."

- ED placed on stroke order set.

- Blood pressure dropped from 218/107 to 105/60 with 2 minutes on IV Nitroprusside.

Plan of Attack for Admissions

Establish your routine:

1. Review all the vital signs
2. **Confirm home meds**
3. What meds were used the ED, especially **Pain Medications**
4. Labs and studies (Know all Radiologic studies, EKG, etc..).
5. Foley's, Telemetry, IVF's
6. DVT prophylaxis, Code status
7. Look at all the ED notes
8. Primary Communication Contact

Plan of Attack for Admissions

Establish your routine:

9. Talk to the patient or individual who can give history.
10. Exam the patient
11. Good documentation of my assessment
12. When is patient going home?

Develop a Plan for how you see a patient

Dr. Summers Plan

1. Knock on the door, count to 3, and then walk in.
2. Treat the patient's room as their "home."
3. Ask permission to speak freely if visitors are in the room.
4. Don't sit on the bed unless you have permission.
5. Don't use the word "Understand."
6. Sit down if you can.
7. Limit computer use in the room.

Develop a Plan for Inpatient Care

8. Be a great listener!
9. Learn how to speak to patients simply.
10. Involve the patient in decisions about their care
11. Write down key information while in the room.
12. Set the tone of the conversation through your mannerisms and eyes.
13. Treat the patient as a person and not a disease.

The Schwartz Center for compassionate healthcare, 2014

GOLD ENCRUSTED PEARL #2

Discharge Pearls

- Call after discharge
- Dismissal summary should be a story.
  - What happened? (Short, concise story)
  - Major tests, labs and procedures
  - Discharge medicines with any changes
- Make sure primary MD gets summary
- Simple way to reduce readmissions

Case #3

Your Professionalism is critical, and negative communication behaviors can impact the care of your patients.

Case #3

- 16 month old admitted to the hospital secondary to complications from prior gastroschisis repair
- Nurse called to inform Surgery resident that Potassium was low
- Surgery resident informed the nurse to give 60 mEq of IV Potassium

Case #3

- Nurse questions the dose as being high. (Patient actually needed only 6 mEq).
- Surgeon berates nurse over the phone. Tells her "I'm the doctor. Do what I say."
- Nurse gives 60 mEq IV Potassium
- RESULT: Patient codes and dies

Case #3

THREE THINGS I LOOK AT CLOSELY WHEN EVALUATING STUDENTS

1. Do they estimate the discharge date daily?

2. What do their progress notes look like and do they put the whole plan together in the note?

3. **What do the nurses/staff say about the student?**

SUMMARY

1. Be thorough, then be efficient
2. Treat staff with respect
3. You are the key to preventing inpatient errors
4. Advocate for your patient and put them first
5. Listen to your patient and communicate
6. It is the little things that will define you.

Questions?

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