Wake Forest®
Baptist Health

Tales from the Inpatient World:

Ways to be a Better Inpatient Provider, Avoid Harming Patients,and Stay out of the Courtroom.

Erik Summers, M.D., Chief Medical Officer
Vice-Chair, Department of Internal Medicine
Associate Professor, Section on Hospital Medicine

DISCLOSURES

- My Father was a P.A.
- Huge Alabama Football fan!

  Google: “Notre Dame eric summers NPR”
- No other disclosures to report

Learning Objectives

- Identify common causes of medical errors in the inpatient setting
- Name attributes of successful inpatient providers who give excellent patient care
- Note cases where medical errors occurred in the hospital
- Identify side effects of IV blood pressure medications that could lead to patient harm

THREE ATTRIBUTES OF INPATIENT PROVIDERS WHO GIVE EXCELLENT PATIENT CARE

1. COMPREHENSIVE
2. COMMUNICATION
3. CARING

Evaluating Providers

1. Comprehensive care of the patient

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

2. Communication

Can the patient or nurse tell me what the plan is?

How well does the provider listen to patients?

3. Caring

What do the nurses/staff say about the provider?

What is your "sentence"?

Bedside Pearls

1. Comprehensive care of the patient

Last issue in your assessment/plan should be explanation of discharge plan

2. Communication

Use “Imagine” and not “Understand.”

3. Caring

Call the patient after discharge

QUOTE OF THE DAY

MEDICAL ERRORS

- It's difficult to make a 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.

Case #1

Trust, but Verify

A Comprehensive Story

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 and gives good history.
  - Son notes her energy is gradually declining and she has episodic dyspnea.

February

- 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

- 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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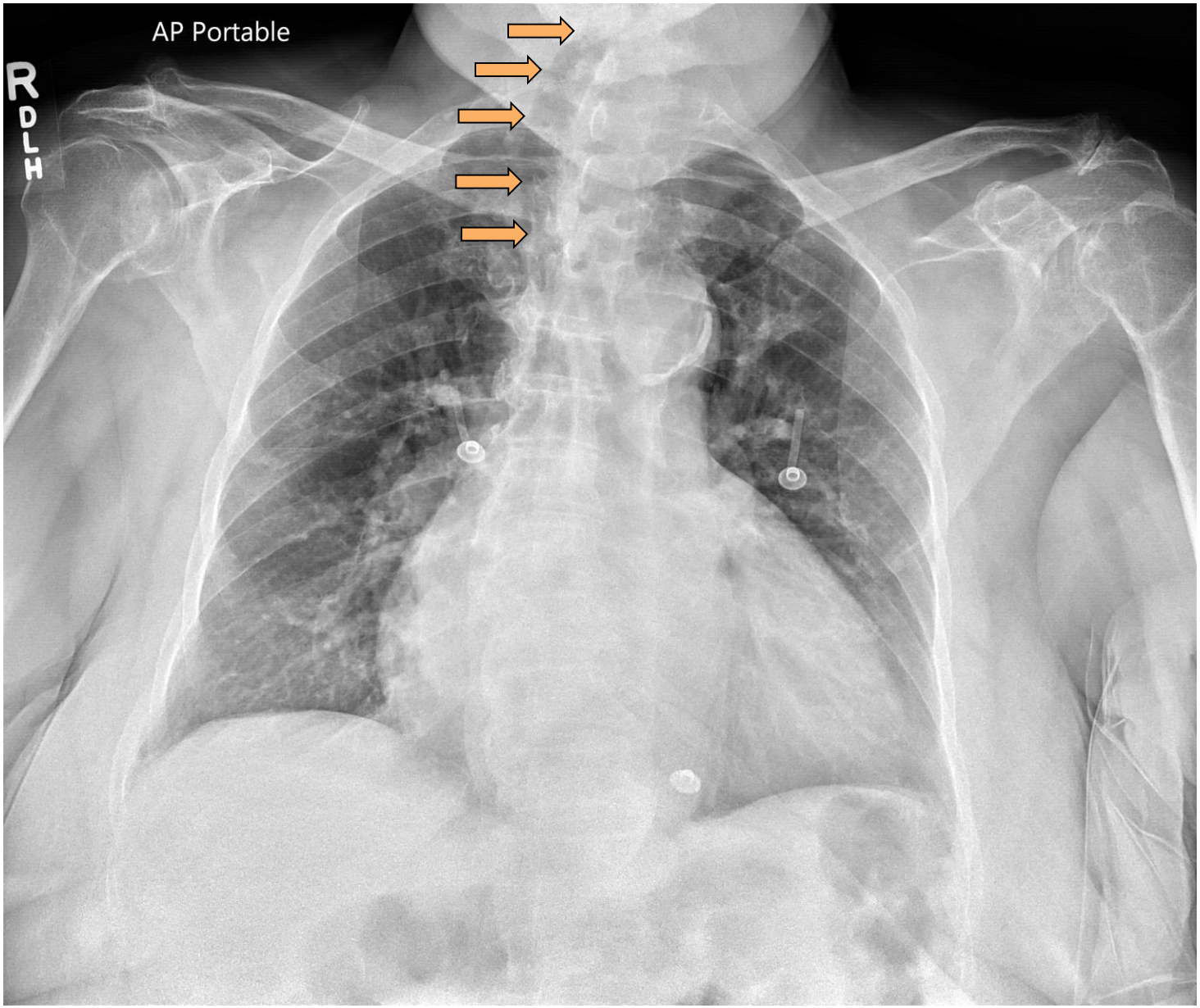
AP Portable
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June

- 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

- 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

- 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.

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

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.

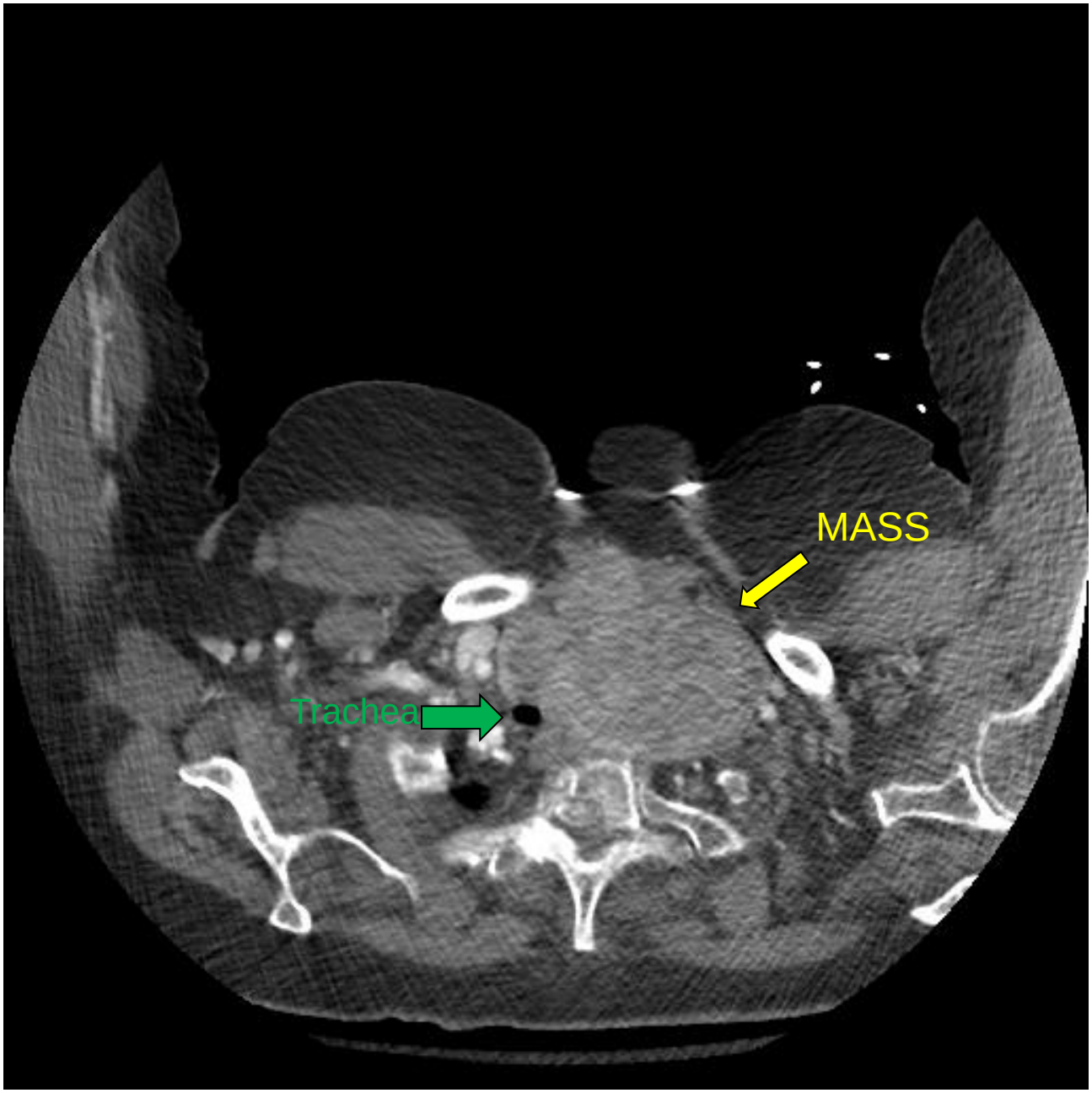
September

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

October

- 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

- 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

- 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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  Quit asking me easy questions.

November

- 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

"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

Pemberton’s sign

December

- 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

- 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 (12 months after all this started)

- 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?”
- While the majority of Medical Errors in the hospital are **Medication-related**, what we also 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

Case #2

Lost time is never found again

A Communication Caring Story

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…"

Swiss Cheese 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.

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- Is the ED doctor always correct?

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

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I don't.

Swiss Cheese Hole #2

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

"*Patient's blood pressure is 218/107 and she is maxed out on IV Labetalol. The patient is anxious and has a headache"*

It's 5:30 pm and your shift ends at 7. You still have 2 admissions left. You finished seeing 20 patients and did 3 admissions 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

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)

Swiss Cheese Hole #3

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

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

Nurse replies: "That sounds good. That worked in a patient I took care of last week."

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.

Swiss Cheese 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 to this day.**

What Happened?

Result

- **<u>Patient suffers a massive left-sided stroke and is debilitated to this day.</u>**

- 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.

Case #3

Be professional and treat everyone with respect. Your patient's life may depend on it.

A very sad story

Case #3

- 16 month old admitted to the hospital secondary to complications from prior gastroschisis repair
- Nurse called to inform physician that Potassium was low
- Physician gives verbal order to nurse to give 60 mEq of IV Potassium

Case #3

- Nurse questions the dose as being high. (Patient actually needed only 6 mEq).
- Physician 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

SUMMARY

1. Trust, but Verify
2. Put your patient’s first
3. You are critical to preventing inpatient errors
4. Treat staff with respect
5. COMPREHENSIVE, COMMUNICATE, CARE

SUMMARY


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