the REPORTER

CME

PATIENT HANDOFFS:
HOW TO INCREASE PATIENT SAFETY DURING CARE TRANSITIONS

CLOSED CLAIM STUDY: SPINAL CORD HEMORRHAGE FOLLOWING EPIDURAL STEROID INJECTION (ESI)

CLOSED CLAIM STUDY: FAILURE TO OBTAIN TIMELY CONSULTS AND TESTS

LONE STAR ALLIANCE
A RISK RETENTION GROUP

Quarter 2, 2026

CONTINUING
MEDICAL
EDUCATION

CME:
PATIENT HANDOFFS:
HOW TO INCREASE PATIENT SAFETY DURING CARE TRANSITIONS

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OBJECTIVES

Upon completion of this educational activity, the learner should be able to:

1. identify and correct common errors that may occur during a patient handoff;
2. recognize and use different documentation frameworks, such as SBAR and I-PASS, to ensure a patient handoff is effectively documented and communicated with colleagues; and
3. integrate practical communication and documentation methods to ensure a safe patient handoff.

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DISCLOSURE

Wayne Wenske, Laura Brockway, and Tanya Babitch have no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in learning more about improving patient transfers and handoffs to enhance patient safety and reduce the potential for medical liability exposure.

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CLOSED CLAIMS

The closed claim studies included in this article illustrate how action or inaction on the part of the physicians during patient handoffs led to allegations of professional liability. These studies are based on actual closed claims from TMLT and have been modified to protect the privacy of the physicians and patients.

RELEASE/REVIEW DATE

This activity is released on June 1, 2026 and will expire on June 1, 2029. Please note that this CME activity does not meet LSA's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

A "patient handoff" (or "patient handover") refers to a physician transferring care of their patients to colleagues — at the end of a shift, before a procedure, during or after a hospitalization, or upon referral to a specialist. These transitions are some of the most routine acts in a health care environment, yet they carry significant risk for patients.

The dangers often lie in miscommunication — usually in the form of omitting critical information or providing incorrect information. Studies have shown that communication failures, including during patient handoffs, are a contributing factor in more than 60 percent of all adverse events in U.S. hospitals. Additional reports have suggested that poor patient handoffs have caused up to two-thirds of preventable sentinel events. [1, 2]

Studies of malpractice claims have found that poor patient handoffs may contribute to delayed diagnoses, missed follow-up on critical test results, medication errors, and failures to treat a patient's condition. [3]

Despite this risk, patient handoffs are often not standardized in hospitals, medical practices, or other organizations. However, several resources are readily available to address patient handoffs in a more standard, systemic way.

For example, the Accreditation Council for Graduate Medical Education now requires residency programs to provide handoff training, including a structured method for patient handoffs. The method used (I-PASS, discussed later in this article) requires providers to rate a patient's condition or illness based on severity and create a corresponding treatment plan.

According to an independent study of nine pediatric programs, this training "decreased preventable adverse events by 30%." Unfortunately, the use of these tools remains inconsistent across different health care environments and hospital systems. [4]

This article will help physicians understand and identify the inherent risks associated with patient handoffs; recognize when and how errors may occur; and consider practical strategies to help make patient handoffs safer.

CLOSED CLAIM STUDY: FAILURE TO DIAGNOSE AND TREAT DIABETIC KETOACIDOSIS

Presentation

On May 19, a 40-year-old woman came to the emergency department (ED) with fever, chills, right flank pain, and dysuria. Her symptoms began on May 15 and had become worse. She also described the right flank pain as constant, sharp, moderate in intensity, and radiating to her right groin. The patient had a history of gestational diabetes with her last pregnancy four years earlier. She reported that she had not received any treatment for her gestational diabetes since giving birth.

Physician action

Emergency Medicine (EM) Physician A examined the patient and documented that she was tachycardic and tachypneic. A CT scan of her pelvis and abdomen showed "multiple wedgelike regions of reduced enhancement in the left kidney." EM Physician A diagnosed the patient with pyelonephritis and started treatment for urosepsis.

Family Physician A admitted the patient to the hospital due to continued, significant tachycardia. Family Physician A also examined the patient, and the admitting diagnosis was sepsis, pyelonephritis, diabetes mellitus, and hyperkalemia.

During investigation of this case, it was discovered that neither EM Physician A nor Family Physician A recognized that various lab results showed the patient was in metabolic acidosis.

Family Physician B examined the patient the following morning, May 20, during rounds. He noted the patient's tachycardia and tachypnea were present, and that she was becoming severely somnolent with Kussmaul breathing, often seen with diabetic ketoacidosis. Family Physician B ordered a stat arterial blood gas test and an insulin drip at a high rate. He transferred the patient to the ICU under the care of Critical Care Physician A.

In the ICU, the patient's pH level was 6.77 and profoundly acidotic. She was given insulin and her pH level fluctuated from 6.77 to 6.98. The patient's PC02 had dropped to 30 mmHg (normal range is 35-45 mmHg). She was hyperventilating, losing consciousness, and demonstrating very deep and fast Kussmaul breathing.

The patient was intubated, but her acidosis increased. She went into cardiac arrest and was resuscitated after 20 minutes. However, the patient experienced an anoxic brain injury that led to unresponsive wakefulness syndrome (UWS).

Family Physician C reviewed the patient's chart on May 21 and noted that the patient's blood bicarbonate levels were undetectable since her admission, indicating metabolic acidosis.

Allegations

A lawsuit was filed against EM Physician A, Family Physician A, Critical Care Physician A, and the hospital. Allegations included failure to timely diagnose and treat diabetic ketoacidosis, leading to irreversible brain damage and permanent UWS.

Legal implications

Expert consultants who reviewed this case for the defense agreed that EM Physician A and Family Physician A missed the diagnosis of diabetic ketoacidosis in the ED. The physicians did not question the working diagnosis of pyelonephritis and did not evaluate the patient's lab results that indicated diabetic ketoacidosis.

At shift change, Family Physician A orally described the patient's condition as severe UTI/kidney infection with sepsis when handing off the patient to Family Physician B. Only when Family Physician B saw the patient during rounds and reviewed the lab results was the patient's diabetic ketoacidosis diagnosed.

If the defendants had conducted a more thorough patient handoff — including a face-to-face encounter where test results and lab work were corroborated — the patient's diabetic ketoacidosis may have been found earlier.

Disposition

The case was settled on behalf of the physicians. The outcome of the case against the hospital is unknown.

Risk management considerations

In this case, critical information about the patient's lab results was not given more emergent attention by the treating physicians during handoff. This resulted in delayed treatment and an adverse outcome for the patient.

If protocols had been in place to check and re-check test results and review alerts for abnormal test results in the electronic health record (EHR), this case may have had a different outcome. Protocols for a more structured handoff may also have prevented the outcome.

PATIENT HANDOFFS: MISCOMMUNICATION

As this case study illustrates, patient handoffs are often subject to a variety of circumstances that can lead to miscommunication. In a busy, distracting, and stressful environment, the patient information provided during a handoff may be condensed, rushed, or given out of context.

Physicians and nursing staff may get interrupted or be multi-tasking during a patient handoff. Important details may inadvertently be omitted that could later become critical as the patient's condition develops.

Any care transition increases the risk of communication lapses and adverse events. [5]

Some of the most common errors that can occur in patient handoffs include:

- missed test results: a critical lab or imaging result not being communicated or being misinterpreted;
- treatment delay: usually because of overwhelmed staff; a missed, lost, or delayed test result; or lack of coordination between departments;
- medication errors, including overlooked dosages during a shift change;
- surgical complications, including transferring post-surgical patients without clear instructions or pain management; and
- hospital discharges without clear or full patient instructions or with lab results still pending that later indicate a serious condition or illness. [3]

In addition to communication lapses, patient handoffs may be compromised by a lack of training in a specific specialty; language barriers or cultural considerations with a patient or between providers; or an over-reliance on written notes that may be incomplete, vague, or erroneous. [6]

Regarding specialists, miscommunications can occur when giving too much weight to a specific aspect of the patient's condition or care. "As such, they may experience cognitive bias . . . The tendency to rely too heavily on one piece of information or trait could lead to breakdowns in communication and possible adverse outcomes." [7]

Different levels of authority or hierarchy among hospital team members can also be a factor that can prevent crucial information from being communicated accurately and in a timely manner. For example, a nurse or technician may be less likely to fully and openly communicate with a person in a more senior position due to fear of being wrong; being considered insubordinate; potentially damaging their own professional reputation; and/or damaging their relationships with individual physicians or within the organization. [8]

Another circumstance is the sheer number of handoffs that happen in a typical day. According to the Joint Commission, a typical teaching hospital may experience more than 4,000 handoffs daily. "A study released in 2016 estimated that communication failures in U.S. hospitals and medical practices were responsible at least in part for 30% of all malpractice claims, resulting in 1,744 deaths and $1.7 billion in malpractice costs over five years." [7]

TOOLS TO HELP REDUCE RISKS INVOLVED WITH PATIENT HANDOFFS

Documentation

As many risk managers will tell you, complete, accurate, and contemporaneous documentation is an essential component of quality patient care. It is also a physician's first line of defense in the event of a claim of medical liability.

At a minimum, the medical record should include patient identification; a clinical summary including the patient's history and current condition; medications; a plan of care including a prioritized list of next steps; and a plan for any potential adverse events. The record should be updated at every transition during the patient's care.

According to the National Committee for Quality Assurance (NCQA), the following items are among the most accepted and consistently found in quality medical record documentation:

- the patient's name or ID number on each page;
- the patient's personal identifiers, such as address, employer, phone numbers, marital status, and email address;
- patient's diagnosis and current condition;
- medications and allergies;
- potential complications or points being watched;
- results of recent imaging, labs, or procedures; and
- outstanding or pending test results. [9]

If any uncertainties exist, the physician who is transferring responsibility is accountable for clearing up ambiguities before the handoff is complete. The receiving physician, specialist, or team member must have a clear understanding of the patient's current condition, what testing is in process, and what results are outstanding. Pending lab tests, consult requests, and imaging results should be identified, along with "next steps" on how to address them.

Providing documented next steps, or a contingency plan, based on possible outcomes demonstrates a thoughtful, proactive approach to the patient's care; helps to support the incoming physician; and provides a level of protection in the event of a claim or board action.

It is also important to name the responsible physician or provider for each outstanding item in the record and how to contact them. This way, roles and responsibilities are clearly assigned and patient safety is enhanced.

Medication reconciliation is also a standard expectation during a patient handoff. At each transition, it is important to note high-risk medications and any changes to the medications that the incoming physician should know.

Face-to-face dialogue

In addition to keeping clear records, it is also important to have a face-to-face dialogue with incoming providers when possible. A face-to-face handoff allows the receiving physician or provider to ask questions; verify their clear understanding of the patient's condition, outstanding issues, and treatment plan; and confirm they have accepted responsibility for the patient's care.

When possible, hold the face-to-face handoff at a preset time in a consistent location that is "conducive for sharing information about a patient, such as a zone of silence, free of non-emergency interruptions."[6]

If a face-to-face meeting is not possible, communicate in real time via telephone or video conference.[6]

Effective handoffs also create opportunities for identifying and correcting any errors or misunderstandings in real time. These brief conversations may help establish greater understanding between the care team members of the patient's condition and its context; the care goals and tasks; and potential threats to the patient during treatment.[10]

Standardized documentation frameworks

To help reduce risks, several standardized protocols have been developed that use acronyms to help providers focus on what information is important to document and communicate effectively with colleagues.

SBAR

One of the first of these methods developed was the **SBAR** tool. SBAR stands for **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation (or **R**equest). It was originally developed in 2006 within a military context and has been widely adopted for use in a health care environment.

Using SBAR, physicians and other providers should consider the following four steps.

- **Situation:** *What is going on with the patient?* Including the name of the person communicating and the patient's name, age, gender, and a brief description of the current problem or situation. "My name is Dr. Jones, and this patient's name is Mr. Smith. He is an 80-year-old man and reports being in substantial discomfort; there is little urine in his catheter bag."
- **Background:** *What is the patient's clinical background or context?* This would include patient history related to the current situation; symptoms; and any test results. "Mr. Smith has a catheter in place from bladder cancer treatment. His temperature is 100.2."
- **Assessment:** *What do I think the problem is?* The assessment is the initial working diagnosis, made with consideration of the patient's history and observations made by other providers who have seen the patient. The assessment should also include possible alternatives; the provider's rationale for making the working diagnosis; any sources to support or provide clarity to the assessment; and any potential consequences to treatment.

- **Recommendation or request:** *What are we going to do to fix it — and when?* It states the recommended treatment, including what is required of the other providers and the patient. It also includes a statement of when the recommendation should happen — including whether it is emergent. "I would recommend we get labs, including blood cultures, this morning to check for infection." [11]

SBAR is often considered more effective when time is limited and a quick decision is needed, as "this tool is suited to situations when a brief summary is sufficient and fewer than 5 key points need to be communicated." Therefore, SBAR may be less effective in situations involving complex scenarios or patients with a complicated history or condition. [12]

I-PASS

To expand on the SBAR model, the **I-PASS** tool was developed in 2010 with a focus on end-of-shift handoffs. After implementing this program in nine pediatric hospitals, a study showed that preventable adverse events were reduced by 30 percent and medical errors were reduced by 23 percent. Another study showed that the use of I-PASS at 32 hospitals led to major improvements in handoff communications and a 47 percent reduction in handoff-related adverse events. [13]

I-PASS has become a preferred method in many organizations. The steps of this method are as follows.

- **I**llness severity: Such as "stable, 'watcher,' unstable."
- **P**atient summary: Including:
  - an overall "situation" statement;
  - events leading up to admission or care transition;
  - hospital course or treatment plan;
  - ongoing assessment; and
  - contingency plan.
- **A**ction list: A to-do list with timelines and ownership of duties.
- **S**ituation awareness and contingency planning: Know what's going on, and plan for what might happen.
- **S**ynthesis by receiver: This step involves the receiver of the communication/handoff being asked to:
  - summarize what they heard;
  - ask any pertinent questions; and
  - restate key to-do/action items. [14]

The "synthesis by receiver" step in I-PASS attempts to "close the loop" with a face-to-face, oral confirmation that the receiving provider has a full understanding of the patient's condition.

Other systems such as **SIGNOUT** (**s**everity, **i**dentification, **g**eneral information, **n**otable changes, **o**ngoing/pending items, **u**nder consideration (plan), and **t**o-do list/action plan) and **HAND IT** (**h**andover of responsibility, **a**ctively discuss the patient's condition, **n**ecessary information, **d**iscuss intent and contingencies, **i**nteraction (two-way communication), and **t**aking time for verification) have been developed for use in specific settings or contexts.

Whatever protocol chosen, it is important that it be used consistently by all staff members across departments and services. Inconsistent use of a standardized protocol can undermine its value and create risk of patient harm.

ELECTRONIC HANDOFF TOOLS

Electronic handoff tools can offer a higher level of consistency. These tools and systems are designed to document patient and treatment information in a standardized way that can be updated, accessed, shared, and tracked throughout a patient's care. Specifically, EHR handoff tools may also be used to extract pertinent patient data from the record — such as current vital signs, laboratory results, active medication lists, and recent notes — and organized into a comprehensive, structured report for incoming providers during a patient handoff. [15]

Some tools/templates are integrated directly into EHR and electronic medical record (EMR) platforms. These tools typically combine two elements of a patient record in the EHR:

1. data fields that pull in vital signs, lab results, and medications directly from a patient's chart, and
2. open text fields where a provider can document a patient summary, active issues, pending lab work, contingency plans, and more. [16]

Many hospitals and practices have developed their own customized handoff templates within their EHR systems. For example, a recent quality improvement project at the Texas Medical Center in Houston involved the addition of a customized EHR handoff template in their dialysis unit to improve patient safety outcomes.

The template included a "dialysis handoff" section that captured diagnosis, dialysis access, lab results, vital signs, and a safety checklist. The results of the project saw a 75 percent decline in clinical emergencies, and the staff's adherence to the handoff process increased from 60 to 90 percent. [17]

Another major category of electronic tools is HIPAA-compliant secure messaging applications. These apps and platforms allow physicians to send and receive detailed clinical messages and attachments and maintain a timestamped, searchable record of communications.

During patient handoffs, these apps have been used when the outgoing and incoming physicians cannot be in the same place at the same time, and for sending updates on a patient's condition among the entire care team.

It is essential that any electronic handoff tools be used in tandem with direct face-to-face communication. As stated, if relying on written transfers or electronic tools, misunderstandings or oversights may occur. Therefore, a patient handoff that incorporates electronic documentation as a reinforcement to in-person communication is most effective. Technology tools should support the face-to-face patient handoff, not replace it.

HOSPITAL TO HOME

In addition to handoff during a hospitalization, discharging patients back to their outpatient physicians also requires careful management. Critical information and timely follow-up may fall through the cracks if processes are not in place to manage the patient's discharge from the facility. Ensure protocols are in place for prompt communication of the patient's history, status, follow-up needs, and medications to physicians who will be treating the patient. This may be communicated electronically via transfer of records, but physicians should consider when the process would benefit from additional communication by telephone or secure messaging apps. If test results or other information is "pending" upon discharge, there should be consistent methods to get this information to outpatient providers.

CLOSED CLAIM STUDY: FAILURE TO REMOVE PATIENT'S FENTANYL PATCH AND NOTIFY PATIENT OF ERROR

Presentation

On October 13, a 39-year-old man was brought to the emergency department (ED) of a local hospital after he fell from a motorcycle.

Physician action

The ED record indicated that the patient had lost consciousness, but he was alert and neurologically intact when he was examined. The results from CT scans of the head, chest, abdomen, and pelvis were normal. An X-ray of the left shoulder showed a small fracture/dislocation of the acromioclavicular joint.

The patient was given injections of hydromorphone and ondansetron, and an IV line was placed. General Surgeon A admitted the patient for observation at 10 p.m. He ordered hydromorphone and ondansetron as needed.

At 9:29 a.m. on October 14, General Surgeon A discontinued hydromorphone and prescribed hydrocodone as needed. At 10:20 p.m., he added a 50 mcg fentanyl patch to be placed on the back of the patient's left shoulder and 1-2 mg of morphine as needed. He also prescribed 30 mg of ketorolac by IV.

At 10 a.m. on October 15, General Surgeon B examined the patient and noted normal vital signs. The patient offered no complaints. General Surgeon B stated that the patient could be discharged when he was walking, voiding, tolerating food, drinking water, and when his pain was under control with oral medication. His plan was to prescribe an oral pain medication and a muscle relaxant at discharge. The patient was instructed to follow up with his primary care physician (PCP).

The patient was discharged between 1 and 2 p.m. According to General Surgeon B's instructions, all hospital-prescribed pain medications — including the fentanyl patch — were to be discontinued. Discharge notes indicated the medications were discontinued.

Once the patient left the hospital, the discharge nurse realized she had not removed the fentanyl patch. She immediately contacted the charge nurse and General Surgeon A. Because the patient was supposed to follow up with his PCP, General Surgeon A did not call the patient about the patch.

Shortly after his discharge, the patient called his PCP and reported that he had not been given any pain medication. The PCP called General Surgeon A, who said he would see the patient before he went home. However, the patient had already been released, and General Surgeon A did not see him.

That afternoon, the PCP examined the patient and noted that he was pale but seemed stable otherwise. He referred him to an orthopedic surgeon for follow up on the shoulder injury. The PCP also prescribed hydrocodone-acetaminophen 10/500.

The patient's wife stated that she slept on the couch that evening because her husband was snoring heavily. At 2 a.m. on October 16, she found him not breathing. She called EMS and the patient was taken to the ED. He could not be resuscitated and died.

An autopsy was performed and the medical examiner described the presence of a fentanyl patch with a serial number on the patient's posterior shoulder area. The patient had an elevated level of fentanyl and hydrocodone in his blood. He also had diffuse pneumonia consistent with a hypoventilation state. The cause of death was listed as narcotic overdose and pneumonia.

Allegations

A lawsuit was filed against General Surgeon A, alleging negligence in prescribing a fentanyl patch for acute pain in a non-opiate tolerant patient. It was also alleged that the patient should have been contacted once it became clear that he left the hospital with the patch. The hospital and the patch manufacturer were also sued.

Legal implications

Two general surgeons reviewed this case for the defense. Both stated that the patient should not have been given the patch. Its use was contraindicated in a patient with acute pain unless the patient is opiate tolerant. The reviewers concluded that the order for the patch was below the standard of care.

Of additional concern to the defense was that General Surgeon A did not take any action when he was told that the patch had not been removed. The plaintiffs argued that he should have called the patient and told him to remove the patch. Lastly, reviewers were critical of General Surgeon A's poor documentation. It was illegible in many places and he did not document the patient's history and physical exam.

Disposition

This case was settled on behalf of General Surgeon A. The hospital and patch manufacturer also settled their cases.

Risk management considerations

While the primary allegation was that the prescribing of the opioid patch fell outside of the standard of care, many other factors made the case difficult to defend. General Surgeon B ordered all medications, including the opioid patch, be discontinued upon discharge. While the nursing record reflected that all hospital prescribed medications were discontinued, the patch was never actually removed by the nurse.

Each medication should be reconciled and reviewed to ensure that "discontinuation" actually occurs before the patient leaves the facility. A patch left on a patient's body offers a particular challenge, as there is no way to ensure "discontinuation" unless the patient is actually observed during removal of the patch.

When the nurse realized the error, General Surgeon A was notified but did not take action. A safer course would have been to promptly notify the patient and the patient's PCP of the error, advise removal of the patch, and give appropriate warnings.

This action, had it been taken and documented, could have changed the outcome of the case. Without knowledge of the patient's opioid patch, the PCP prescribed the patient additional opioid pain medications.

Patients may be more susceptible to medical errors during the transition of care between inpatient and outpatient settings. Physicians are encouraged to consistently communicate with the outpatient provider, particularly if there is critical information that could affect the patient's care.

RISK MANAGEMENT CONSIDERATIONS

Effective patient handoffs are often the result of maintaining a consistent, standardized approach to every patient transition. The following risk management considerations describe the handoff components to keep "front of mind" when either providing or receiving details of a patient's care.

- **Maintain clear policies and procedures on patient handoffs.** It is critical for physician practices and hospitals to maintain clear policies that instruct staff on how patient handoffs should be carried out. This should include any requirements for face-to-face communications (what to discuss and in what order), documentation, and electronic handoff tools. Clearly provide instructions on how written records and electronic tools are to be used, updated, and reviewed.
- **Know your institution's handoff policies and follow them.** If working in a hospital or system setting, make sure you fully understand the handoff protocols and follow them.
- **Encourage all providers, nurses, and support staff to speak up and raise concerns** if they see lapses in care, miscommunications, or errors in care provided (or not provided) to a patient. "Leadership should encourage open communication, where staff feel comfortable discussing concerns related to patient handoffs without fear of reprimand. Promoting a blame-free environment can foster collaboration and continuous improvement in the handoff process." [19]
- **Update documentation at the time of handoff.** Review the record for pending test results, outstanding tasks, and any changes in the patient's condition just before the handoff. This way, you are handing off a patient with the most up-to-date information possible. If you transfer care of a patient without taking this step or taking it hours earlier, there is risk of tests and actions being repeated and changes in the patient not being acknowledged.
- **Reconcile medications at every handoff or transfer.** Taking this step proactively helps flag any medication changes or high-risk medications being used, including dosage, frequency, and status of medication schedule.
- **Ensure a process is in place for tracking pending tests at handoff or discharge.** Include instructions for sharing results with other providers and the names and contacts for those responsible for obtaining and communicating the results.
- **Patient handoffs should incorporate face-to-face communication, when possible**, to promote greater problem-solving, questioning, collaborating, and clarity. Written records or electronic tools can be used to support in-person, oral communications.
- **If feasible, conduct the handoff in a quiet/secure location, such as a designated conference room or office.** This helps to reduce distractions and interruptions and bring better focus to the discussion.
- **Clearly provide contingency plans for unstable patients.** Include the identity of the responsible receiving physician(s) and their contact information.
- For unstable or patients with deteriorating conditions, **require an oral confirmation from the receiving physician** that they fully understand the patient's condition; next steps; and contingency planning.
- **Use a standardized documentation framework, such as I-PASS or SBAR.** Use it consistently as described in your organization's policies and procedures. Inconsistent use of a standardized framework may undermine its value and introduce risks.
- **Avoid "copying and pasting" in the EHR.** Actively review and revise the data fields in a patient's record rather than copying previous notes. This reduces the risk of using outdated information to make treatment decisions or actions based on false data. Copying and pasting can also lead to redundant or irrelevant information being carried over, and a patient record becoming so long and "bloated" that new important information may be challenging to identify. [20]

- **Use only HIPAA-compliant electronic platforms for communicating with patients or colleagues.** Never transmit protected health information (PHI) via standard text messaging platforms.
- **When transferring or handing off a patient to a different facility or to outpatient care by their physician, be prepared for incompatible EHRs.** Electronic data from one physician or institution's EHR may not transfer to another that uses a different EHR platform. Be prepared and available to offer or receive a handoff either in person, over the phone, or over video conference. Providing or requesting paper, written records may also be required depending on the capability of the other facility or physician.

Effective patient handoffs are essential for ensuring patient safety and quality of care. When using standardized documentation tools, face-to-face communications, and HIPAA-compliant technology, physicians can make great strides toward improving the handoff process and patient outcomes.

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CLOSED
CLAIM
STUDY

SPINAL CORD HEMORRHAGE FOLLOWING EPIDURAL STEROID INJECTION (ESI)

by Laura Hale Brockway, ELS, Vice President, Marketing

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

A 49-year-old woman came to see a physical medicine and rehabilitation physician (PMR Physician A) reporting a three-year history of neck pain. An MRI revealed the following:

- disc degeneration with a 4-mm herniation at C3-C4 with moderate central stenosis compressing the cord with severe left foraminal compression of the C4 nerve root;
- C5-C6 degenerative disc disease with moderate central and severe foraminal stenosis compressing the cord in the C6 nerve roots; and
- mild central disc bulge at C6-C7.

PHYSICIAN ACTION

PMR Physician B performed two cervical ESIs at C6-7 on June 10 and July 15 at the practice's surgical center. At a follow-up appointment, the patient reported that the injections did not relieve her pain. PMR Physician A told the patient that her health insurance required her to have three cervical ESIs before she would be approved for surgical intervention. PMR Physician A scheduled the patient for a third cervical ESI on September 2.

PMR Physician A performed the ESI at C6-7 with loss-of-resistance and fluoroscopic technique. According to the medical records, the patient was under "light" sedation and flinched during the procedure. ("Light" sedation was later determined to be conscious sedation.) PMR Physician A reported that he then pulled back slightly and injected the steroid.

In the recovery room at the surgical center, the patient reported weakness in her left hand. PMR Physician A ordered dexamethasone 80 mg IV. EMS was called and the patient was taken to a local emergency department.

An MRI found "multiple foci of susceptibility in the cord, likely representing cord hemorrhage, worst at C6-7, associated cord edema that extends from cervicomedullary junction C7-T1."

A CT scan revealed "extensive hyper attenuation throughout the left greater than right subarachnoid spaces." The patient was admitted and treated for a "cord hemorrhage post cervical ESI and acute subarachnoid hemorrhage."

After her discharge from the hospital, the patient began treatment with a pain management physician for persistent axial neck pain, left arm and bilateral hand pain, and numbness and tingling consistent with complex regional pain syndrome. The patient received a spinal cord stimulator implant with some resolution of her symptoms.

ALLEGATIONS

A lawsuit was filed against PMR Physician A. The allegations were:

- failure to adequately document fluoroscopic guidance and confirmation of injection location;
- negligent use of sedation which caused a delayed reflex response; and
- negligence in puncturing the spinal canal due to poor technique.

The plaintiffs also alleged the procedure was unnecessary because the first two ESI did not relieve the patient's pain.

LEGAL IMPLICATIONS

While defense experts agreed that the "cervical epidural steroid injection procedure description was appropriate and met the standard of care," several documentation issues made this case difficult to defend. PMR Physician A's documentation was described as poor with the use of copy-and-paste templates. Copy-and-paste templates should be avoided, as they can create records that appear generic and incomplete. Documentation should clearly reflect the specific clinical circumstances of each encounter.

In addition, documentation for procedures such as ESI should include the clinical indication for the procedure, a description of the technique used, the number and placement of fluoroscopic images obtained, the patient's response during and after the procedure, and any intraoperative events — such as patient movement or flinching — and how they were managed.

However, only one fluoroscopic image showing the final placement was included in the medical record. Had images been captured and retained at multiple steps of the procedure — including needle advancement, contrast injection, and steroid injection — they would have provided contemporaneous evidence of the physician's technique.

There was also no documentation of the indication for the third ESI, which was consistent with the plaintiff's claims that the procedure was unnecessary. Whenever a procedure is performed — particularly one in a series where prior attempts have not produced relief — document the rationale for proceeding.

Among defense experts, PMR Physician A's decision to use "light" sedation was considered controversial due to the pros and cons of deep and light sedation with ESI. There was no documentation about the use of conscious sedation or why it was employed during this procedure. PMR Physician's A defense would have been strengthened by documenting his rationale for deciding on the sedation used, the type and level of sedation employed, and how patient responsiveness was monitored.

DISPOSITION

This case was settled on behalf of PMR Physician A.

More on documentation errors at https://www.tmlt.org/resource/about-documentation-errors.

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CLOSED
CLAIM
STUDY

FAILURE TO OBTAIN TIMELY CONSULTS AND TESTS

by Wayne Wenske, Senior Marketing Strategist

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION AND PHYSICIAN ACTION

On August 26 at 8:40 a.m., a 45-year-old man was transported from his home by EMS to Hospital A for severe, sudden onset back pain. The patient's history included diabetes, hypertension, and obesity.

Emergency Medicine (EM) Physician A saw the patient at 8:50 a.m. and noted significant tachycardia, blood pressure of 200/100 mmHg, and elevated white blood count (WBC). The patient rated his pain as 10/10.

Efforts to lower his blood pressure with IV medication were not successful. A CT scan of the abdomen and pelvis did not reveal any acute findings but did show an enlarged bladder. The patient was given several IV pain medications. Antibiotics were also ordered to address the elevated WBC and possible infection.

At 4 p.m., EM Physician A arranged to transfer the patient to a different facility where he could receive a higher level of care. Around this time, the patient reported that his lower left leg was numb.

The patient was taken to Hospital B at 6 p.m. The trip took about 90 minutes to complete. Upon the patient's admission to the hospital under Hospitalist A, several tests were ordered, including a neurologic exam, musculoskeletal exam, and pelvic x-ray. The findings were mostly normal. The one exception was a lumbar CT scan that showed mild degenerative changes, which Hospitalist A noted did not explain the patient's pain level.

Hospitalist A noted that her primary concern was the patient's malignant hypertensive urgency. She ordered a D-Dimer to rule out aortic dissection and a head CT to rule out acute pathology. Additional notes included that the patient had numbness in both legs; 2+ pulses bilaterally, and bowel and urinary incontinence.

On August 27 at 4:10 a.m., Hospitalist A ordered an MRI of the lumbar spine to rule out acute pathology with an orthopedic evaluation indicated, pending the result of the lumbar MRI. The MRI was ordered as "routine."

Hospitalist A's shift ended at 7 a.m. and she was relieved by Hospitalist B.

At 10 a.m., Hospitalist B saw the patient, still in the ED waiting for an available inpatient bed. The patient was unable to move his legs. Upon examination, Hospitalist B documented that the patient was suffering from acute to chronic low back pain with bilateral leg numbness/weakness. Hospitalist B rated the patient's bilaterial leg strength as zero out of five (0/5).

Hospitalist B ordered a neurosurgery consult and upgraded Hospitalist A's "routine" order for a lumbar MRI to "stat." The stat MRI was completed almost six and a half hours later at 3:25 p.m.

The lumbar MRI showed disc protrusion and at least mild stenosis at T11/12 and T10/11. The radiologist recommended MRI of the thoracic spine.

At 8 p.m., a nurse placed a call requesting the neurosurgery consult originally ordered by Hospitalist B at 10 a.m. that morning. At 8:45 p.m., Neurosurgeon A examined the patient who he was unable to move or feel his legs. Neurosurgeon A documented that the patient's condition had worsened since his arrival at Hospital A. Neurosurgeon A also noted that the previous test results did not explain the patient's acute paraplegia.

A stat thoracic MRI was ordered, as recommended by the radiologist, and showed disc herniations at multiple levels in the thoracic spine level compressing the spinal cord on the left side.

The next morning, August 28, Neurosurgeon A took the patient to surgery for an emergent thoracic laminectomy at T9-10, T10-11, and T11-12. He documented that he removed an epidural mass consistent with disc material and osteophyte that was compressing the thoracic spinal canal.

The patient remained in Hospital B for three weeks. He had a complete loss of sensory and motor function below T9-10. The patient reported no feeling below the waist and was unable to move his legs. The patient was discharged to a rehabilitation hospital and now uses a wheelchair.

ALLEGATIONS

A lawsuit was filed against EM Physician A, Hospitalist A, Hospitalist B, Hospital A, and Hospital B alleging numerous delays that resulted in the patient's permanent paraplegia. Delays included ordering appropriate diagnostic testing and a timely neurosurgery consult.

LEGAL IMPLICATIONS

Expert consultants for both the defense and the plaintiff were critical of the physicians in this case, specifically for failing to recognize the patient's neurological symptoms and the lack of follow up on ordered imaging tests and a neurosurgery consult. While there was support for Hospitalist B in changing the MRI order from routine to stat to ensure its completion before a neurosurgery consult, the consultants felt that Hospitalists A and B did not fully appreciate the patient's condition and should have taken more urgent action to get the patient's MRI completed and the patient seen immediately after by a neurosurgeon.

However, another consultant stated that by the time Hospitalist B saw the patient, he had been reporting leg weakness and numbness for approximately 14 hours and was likely already paraplegic.

The hospital and nursing staff were also criticized for the communication breakdowns that caused delays throughout this patient's care, from transfer and admission to testing and consults. The events in this case took place during the height of the COVID-19 pandemic, which legal counsel for the hospital pointed to as temporarily affecting the hospital's operations.

DISPOSITION

The case was settled on behalf of the physicians. Outcomes for the cases against the two hospitals are unknown.

More on improper performance at https://www.tmlt.org/resource/about-improper-performance.

More on risk management for hospitalists at https://www.tmlt.org/resource/risk-management-for-hospitalists.

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