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Claim Review

Communication Fail at Transition of Care

A physician misses a positive blood culture result on a post-partum woman at discharge causing a failure to diagnose and treat a Group B strep infection resulting in sepsis with pyomyositis.

SPECIALTY	ALLEGATION	PATIENT SAFETY & RISK MANAGEMENT FOCUS
⁄ Hospital ⁄ Family medicine	⁄ Failure to diagnose and treat infection	⁄ Follow-up system failures ⁄ Breakdowns in transitions of care/failed handoff communication

Constellation data reveals that 35% of claims involved breakdowns in communication among the health care team

Facts of case

A 25-year-old woman gave birth to a healthy baby at her local community hospital. On day one post-partum, she developed a fever. The on-call physician ordered blood cultures and IV antibiotics. During her hospital stay, she complained of bilateral hip pain, but all her physicians attributed it to a long second-stage labor with her hips flexed.

Early the next morning, the lab reported a preliminary blood culture result indicating gram positive cocci to the on-call physician, a different physician from the day before. He wrote a progress note indicating a need to check for final culture results and sensitivities before discharge. A third physician examined the woman the next morning but did not see the Group B strep (GBS) blood culture results and did not read the progress note from the previous day. He discontinued the antibiotics and discharged her home with instructions to follow up in six weeks. There was no formal handoff communication between the multiple physicians caring for this patient during her hospital stay.

Seven days later, the woman came to the emergency department (ED) with complaints of severe leg pain and backache. The physician in the ED could find no cause for her pain and discharged her with instructions to use over-the-counter medication for pain. Ten days later, she presented to the ED again with extreme leg pain. She was transferred to a tertiary center where she was diagnosed with sepsis with pyomyositis (a bacterial infection of the skeletal muscles which results in pus-filled abscesses) due to an untreated GBS infection. She was later diagnosed with septic arthritis in her hip joints and later underwent bilateral hip replacement.

The woman filed a malpractice claim against the hospital and the physicians alleging failure to diagnose and timely treat GBS infection.

Disposition of case
The malpractice case was settled against the hospital and the physicians.

Patient safety and risk management perspective
The investigation into this case revealed that the standard of care was breached by not reviewing and communicating the positive blood culture result and treating the GBS infection. The expert reviewers stated that not all physicians would have ordered blood cultures based on a post-partum fever, but once the blood cultures were ordered, the standard of care required review of the results and treatment of the infection.

The experts felt her physicians dismissed the complaints of bilateral hip pain due to her long second-stage labor but failed to investigate further when the pain did not resolve in the weeks following delivery. Each subsequent treating physician followed the previous physician's assessment that labor caused the pain and did not expand their differential diagnosis list.

The experts also noted that there was a breakdown in communication among her physicians at transitions of care. They thought the handoff from the physician who was notified of the blood culture result indicating gram positive cocci should have been formally communicated to the discharging physician. During the investigation of the claim, it was determined that neither the hospital nor the physician group had a formal communication process for patient handoffs.

Follow-up system failures
Our review of Constellation medical professional liability claims revealed 17% of all diagnostic error claims originate in the inpatient setting. When diving deeper into the contributing factors of diagnosis-related claims, we found that follow-up system failures contribute to 42% of patient injuries and claims.

Follow-up systems are those processes used to communicate about and coordinate patient care. This analysis revealed that even when appropriate clinical steps are taken to make a correct diagnosis (the ordering of blood cultures in this case), diagnostic errors still occur due to follow-up system failures (the failure to review, communicate and treat the GBS blood culture result in this case).

Breakdowns in communication among the care team
Breakdowns in communication at transitions of care, or handoffs, are a frequent contributing factor in adverse events and patient injury. In the review of our claims, we found that 35% involved breakdowns in communication among the health care team and over half involved miscommunication about the patient's condition. Many health care organizations lack formal processes to assist clinicians and care teams in communicating about the patient condition and treatment plans.

Care for caregivers

Multiple physicians were involved in this woman's care, and all felt guilt and remorse for letting this young woman down by missing her diagnosis because of a failure to review the culture results and communicate with each other at handoffs of care. The physicians recognized, too, that had processes been in place to prevent follow-up system failures and manage communication at transitions of care, this outcome could have been prevented.

Questions for senior leaders

- ☐ Does your organization provide support and tools to prevent diagnostic errors, including clinical decision support tools and reliable follow-up systems?
- ☐ Does your organization have a formal handoff communication process (e.g., I-PASS) for transitions of care?
- ☐ Does your organization have an internal support program to provide support for clinicians in the event of an adverse outcome?

Resources

Find links to prevent diagnostic errors and improve OB care on the MMIC and UMIA websites by navigating as follows: MMICgroup.com or UMIA.com Login > Risk Resources > Bundled Solutions
- ⁄ Preventing Diagnostic Error
- ⁄ OB Risk Solutions

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