Promoting Patient Safety in Your Practice
Five Tips to Reduce Risk and Avoid Claims

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Patient Safety Awareness Week
March 3 to 9, 2013
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First in Patient Safety
As an organization founded by doctors for doctors, we are fiercely committed to advancing, protecting, and rewarding the practice of good medicine. We support this mission by assisting physicians and other health care practitioners to improve the quality of patient care and decrease the number of adverse events—thereby reducing the risk of claims. We were the first medical malpractice insurer to establish a patient safety department.

The Doctors Company is the nation's largest medical malpractice insurer, with 73,000 members and $4 billion in assets, and is rated A by A.M. Best Company and Fitch Ratings.
Shared Responsibility for Preventing Malpractice Suits—Patient Interactions

Each member of a medical care team plays an important role in reducing the number of incidents that cause patient dissatisfaction.

Why Do Patients Sue?
The basic ingredients in any medical liability action are surprise, disappointment, and anger. These emotions can be triggered by a wide variety of causes that include miscommunication and medication errors.

Communication Errors
Remember that patients may experience uncomfortable emotions, including uncertainty, embarrassment, shyness, and fear. A failure to respond appropriately can create negative feelings that have serious consequences and trigger a chain of events ending in litigation. By contrast, comforting words, gestures of kindness, or simple expressions of caring will often evoke positive patient reactions and promote favorable relationships.

Telephone Conversations with Patients
For many members of a professional medical staff, the telephone is often the primary mode of patient communication. All medical professionals should note the following points:

• Be courteous and maintain professionalism; remember that you cannot read your patients’ nonverbal cues—use your best listening skills.
• Make sure that any member of your patient care team who has the slightest doubt about giving instructions or advice to a patient first checks with the physician. If the physician is not immediately available, the staff member should assure the patient that his or her call will be returned as soon as possible and should then verify that the patient’s call was returned.
• Make sure that staff members obtain as much detailed information as possible on a patient’s medical problem and its degree of urgency before conveying it to the doctor for evaluation.
• Establish procedures in your hospital or office for physicians and patient care staff to effectively manage urgent problems, scheduling difficulties, and unexpected visits.
• Ensure that patient requests, problems, and issues received by telephone are addressed in a timely manner.

Face-to-Face Encounters
The following tips can help you and your staff develop and maintain therapeutic interactions with patients:

• Initiate personal contact with the patient by expressing cordial, individual attention.
• Make a favorable impression through your demeanor. Any interaction with any member of the team may represent the patient’s first, last, and most enduring impression of the physician, hospital, or office.
• Explain unavoidable delays in the office schedule to the patient. If appropriate, offer to reschedule the appointment. Most patients will appreciate being informed.
• Maintain strict confidentiality. Do not discuss any patient problems outside the hospital or office. Even when discussing a matter pertaining to a patient with another staff member, do not do so in a public area or within hearing range of other patients.
• Always alert the physician to disgruntled or hostile patients so that the situation can be defused immediately. Patients will frequently tell medical support staff information that they will not tell the physician, so be sure the physician is informed of any significant statements.
• Never give advice beyond your competence or scope of care. Assure the patient of a prompt inquiry and response and follow through as soon as possible to make sure the patient gets the appropriate information or referral.
• Encourage patients to write down their questions for the doctor or questions regarding the doctor’s instructions. Studies have shown that patients remember only a small portion of what they are told. Provide written instructions or educational information for patients to take home.
• Incorporate Ask Me 3 into your practice. This technique, which encourages patients to participate in their health care, has been shown to improve communication. Download free educational materials at www.npsf.org/askme3.
Methods to Enhance Consent
Although obtaining informed consent is the physician’s responsibility, staff members often become involved in assisting or answering additional questions from the patient.

- Do not promise too much when reassuring anxious patients. Be supportive and reassuring.
- Take time to answer questions. Informed patients are less anxious and more cooperative.
- Familiarize yourself with legally required consent forms.
- Remind patients of their instructions by using preprinted fact sheets for commonly performed procedures, tests, or treatments, including preparation requirements and instructions following discharge.

Steps to Avoid Medication Mistakes
Avoidable medication errors can result in severe patient injury. These steps can help reduce the risk of errors when administering medications:

- Review with the patient all medications he/she is taking at each visit and reconcile any discrepancies.
- Double check the vial or bottle label against the order before drawing up a substance. Never use unlabeled vials or bottles.
- Make sure you understand the amount of the dose ordered. Fifteen and 50 sound similar, but the difference in dosage can be catastrophic.

- Ask the patient if he or she has an allergy to the drug or drugs to be injected or ingested before administering any medication by any route—even when there is no indication of drug allergy in the patient’s chart.
- Know the location and proper use of oxygen and other resuscitative equipment and drugs for emergent conditions.
- Develop guidelines to manage prescription calls and refills, and always record the calls with the date and time in the patient’s chart.
- Ensure that all medical staff personnel who deal directly with patients are trained in cardiopulmonary resuscitation.
- Always make sure that all of the “six rights” are correct: the right drug, right date, right dose, right route, right frequency, and the right patient.

Summary
Improving office or hospital procedures and communications in health care are the responsibilities of all personnel. By following the guidelines in this article, you can make a vital contribution to safe patient care.

By Laura A. Dixon, JD, RN, Patient Safety/Risk Manager, and Susan Shepard, MSN, RN, Director, Patient Safety Education.
Accurate Medical Records: Your Primary Line of Defense

Every medical malpractice suit can be won or lost based on the quality and content of the medical records.

A suit without merit can be lost because the medical record was vague, incomplete, or altered. Conversely, a potentially damaging suit can be won because the medical record was precise, thorough, and accurate—and events were well documented.

The Doctors Company is adamant about the critical need for every physician to maintain meticulous records. If you are faced with a malpractice claim, your record keeping will help us provide the best possible defense.

General Guidelines

The following general guidelines should be observed when completing a medical record:

- **Ensure** medical record entries are clear and readable. If possible, dictate all long entries that require more than brief or routine annotations.
- Include a detailed and accurate medical history, physical findings, differential diagnoses, treatment plan, care rendered, advice given, and all other matters pertinent to the patient's medical course.
- **Never** squeeze words into a line or leave blank spaces. Draw diagonal lines through all blank spaces after an entry.
- **Never** erase, write over, try to ink out, or use whiteout on an entry. In case of error, draw a single line through the incorrect entry, and write the date, the time, and your initials in the margin.
- **Never** add anything unless you write a separately dated and signed note. The patient, a third-party payer, or a plaintiff’s attorney may have obtained a copy of the original records.
- **Always** indicate the date and time of an entry. Ensure each page includes the patient’s name and that each progress note is accompanied by the date and time. Make certain all entries are initialed or signed.
- **Avoid** personal abbreviations, ditto marks, or initials. Use only standard and accepted medical abbreviations.
- Do not use lengthy, self-serving entries. These may appear defensive in nature when explaining a complication or medical catastrophe.
- **Do not use the patient’s record as a place to record** confidential communications between you and your professional liability insurance carrier or your attorney—or to criticize another caregiver.

- **Always** keep a record of when and by whom your medical record is photocopied.

Using Specific Language

Avoid imprecise language, generalizations, and the use of statements that are subjective rather than objective.

Examples include the following:

- **Imprecise:** Doing OK.
- **Accurate:** Less pain today. Ate full diet.
- **Subjective:** Appears depressed.
- **Objective:** Crying and worried about progress.
- **General:** Wound OK.
- **Specific:** Surgical incision healing. No sign of infection.

Rely on your senses. Describe your observations:

- **See:** Color, abnormality, posture.
- **Smell:** Breath, drainage, excretions.
- **Hear:** Sounds of breathing, crepitation, bowel sounds.
- **Feel:** Hot or cool, dry or moist, soft or firm.

Document patients’ verbatim statements:

- **Incorrect:** Patient apparently fell.
- **Correct:** Patient states that he “tried to get up, tripped, and hit head on the corner of the bed.”

Detailed documentation is most important in the following situations:

- When absent from practice, include the name of the physician you have signed out to and the date and time you signed out, pertinent observations, and follow-up of any abnormal situation.
- Justification of your failure to comply with—or your rejection of—a consultant’s advice.
- Your viewpoints and reasons for any disagreement on patient care between you and a hospital utilization review committee, a preferred provider organization, or a managed care receiver.
PROMOTING PATIENT SAFETY IN YOUR PRACTICE

• Explanations of delayed responses to a nurse or house staff calls, including dates and times.
• Responses to nurses’ pertinent observations of a patient. (Be sure to record follow-up in your progress notes.)
• A patient’s negative reaction to any treatment or medication.

A Checklist Helps to Protect You
The following entries should appear in the office or hospital records of each patient:

• Results of a patient’s physical examination, specifically noting the absence of abnormality.
• Patient history, a list of all medications with particular emphasis on current medications, to include over-the-counter drugs and supplements, and any allergies or drug sensitivities.
• Specific notation on the patient’s experience, if any, with drug or alcohol abuse and family or emotional problems.
• Progress notes, entered after each office visit, about any change in status. (If negative, your follow-up should be indicated.)
• Signed and witnessed consent forms for special procedures or surgery.
• Patient response to medication or procedures.
• Patient failure to follow advice or to keep appointments and any refusal to cooperate. (Log missed appointments and follow-up telephone calls and letters.)
• All significant laboratory or x-ray reports and the dates when they were ordered and read.
• Copies or records of instructions of any kind (including diet) and directions given to the family.
• Records of consultations with other physicians and their written or oral responses, with the dates and times.
• Thorough documentation of any patient’s grievance, including the date and time.

Patient Care Instructions
• Always record your instructions in writing.
• Review your instructions with the patient and the patient’s family.
• Ensure comprehension. Use a teach-back method to ensure that the patient can accurately describe his or her treatment plan. Record the patient’s response.
• Document language limitations and attempts made to overcome them through the use of translators, as well as any questionable comprehension. Note any literature provided to the patient and family.
• Retain a copy of instructions given to the patient and family.
• Note patient failure to comply with instructions and your efforts to inform the patient of the risks of noncompliance.

Instructions to Include (When Applicable)
• Specific wound care.
• The amount of incisional bleeding to be expected.
• Limitations of activity, position, or exercise.
• Dietary restrictions.
• Specific instructions for medications, including possible side effects and when to resume preoperative medications.
• Anticipated postoperative pain and time frames for analgesia.

Conclusion
As a company built by doctors for doctors, we are fiercely committed to helping you minimize risk. Your medical records are a vital part of your defense in the event of a claim. Using these guidelines is crucial to your protection and defense.

This article, published in 2003, was updated in 2008 by Governor Emeritus Mark Gorney, MD, FACS, Paula A. Jenkins, Senior Vice President of Claims, Laura A. Dixon, JD, RN, Patient Safety/Risk Manager, and Susan Shepard, MSN, MA, RN, Director, Patient Safety Education.
Missed Opportunities

It’s no secret that key information can go missing during the multitude of handoffs that occur in a hospital on any given day. Communication between providers continues to be one of the most frequently cited risk management issues found in our closed claims analyses. As the following case illustrates, miscommunication and missed opportunities resulting from hurried handoffs can produce fatal results.

A 37-year-old female presented at 9:11 pm to the community hospital emergency medicine department (EMD) complaining of nausea, vomiting, and numbness of the left side of her face and left arm. She had anxiety, difficulty swallowing, fever, chills, severe intermittent abdominal cramps, and abrupt onset of chest pain for a few hours prior to admission. The patient, who was five feet four inches tall and weighed 192 pounds, had a blood pressure of 190/120.

The patient reported a history of hypertension, but she had stopped taking her blood pressure medication approximately six months before due to financial problems. The emergency medicine (EM) physician ordered a complete blood count, chemistry profile, cardiac enzymes, and an electrocardiogram.

After receiving Vistaril and Phenergan, the patient’s nausea improved. Cardiac enzymes were within normal limits, white blood count was 12,700, blood urea nitrogen was 27, and creatinine was 2.6. The ECG (read by the computer) showed sinus bradycardia, left ventricular hypertrophy, and nonspecific ST and T wave abnormality.

The EM physician diagnosed dehydration and renal failure and contacted the on-site hospitalist for admission. The patient was admitted to the floor. At 1:00 AM, the patient’s skin was pale, and she complained of back pain.

The nurse called the hospitalist, obtained an order for Tylenol for the back pain, and administered it 30 minutes later. At that time, the patient’s blood pressure was recorded as 190/100. An hour and a half later, the nurse called the hospitalist again to report that the patient continued to complain of nausea and of back pain. There was no note to indicate that the nurse reported the elevated blood pressure.

The hospitalist stated that because the blood pressure was unchanged from when the patient was admitted in the EMD, she did not consider reporting it. She understood that the hospitalist was already aware it was elevated. The hospitalist stated she was not aware of the elevated blood pressure and, if she had been notified, would have seen the patient and ordered additional testing. The doctor ordered Percocet and Compazine; the Percocet was given to the patient.

Forty-five minutes later, the licensed practical nurse working under the registered nurse was unable to obtain a blood pressure reading using a conventional cuff. She switched to a blood pressure machine, which recorded the pressure as 212/162. She reported this reading to the RN.

The RN, according to hospital policy, reported the elevated blood pressure to the nursing supervisor. The supervisor later stated that she thought the nurse reported the pressure as 212/16; when asked if the patient was symptomatic, the nurse said no. The supervisor testified she decided not to call the doctor and did not direct the RN to call the doctor because the patient’s blood pressure was not significantly different from the reading taken in the EMD.

The patient continued to complain of chest tightness and back pain with no radiation. Her skin was warm and dry, and she was up to the bathroom. At 6:30 AM, the nurse noted that the patient was sitting quietly in the bedside chair with unlabored respirations and normal skin color.

While taking another patient to surgery at 6:55 AM, the nurse passed the patient’s door and noted the patient lying on the floor. Her color was dusky, and she was unresponsive. A code was called and resuscitation attempted, but it was unsuccessful. The patient was pronounced dead at 7:21 AM.
The autopsy listed the cause of death as cardiac tamponade caused by acute aortic dissection that had developed over hours. The autopsy also noted that aortic dissection was caused by “years of hypertensive cardiovascular disease” and that the heart was enlarged (it weighed 550 gm). The dissection extended from the root of the aorta to the iliac arteries—the full length of the aorta. Also noted were left ventricular concentric hypertrophy and arterionephrosclerosis.

What Went Wrong
Critical lapses in communication and in understanding what was being communicated were major factors in this case. The EM physician and the hospitalist gave widely divergent accounts of what was communicated during their handoff. Handoffs between providers—whether via an electronic template or a written or verbal exchange—need to be structured and consistent in order to standardize the information exchanged.

Patient Safety Recommendations
• Watch for human errors. Opportunity for errors is multiplied when workload, hour restrictions, or other factors increase or complicate handoffs.
• Implement a structured handoff protocol. Communicating required information in a consistent way will help decrease human error. The Society of Hospital Medicine introduced the concept of the structured electronic tool for transfer of critical information.1
• Handle sign-offs with care—actively listen and take notes.
• Ask about any anticipated patient care problems, including considered diagnoses, pending significant laboratory results, procedures, or consultations.
• Think about what else the problem could be—have a backup plan in place.
• Encourage staff to go up the chain of command until all concerns are addressed.
• Ask for critical information to be repeated back.

Reference
Medication-Related Errors and Liability: What Can You Do?

Medications are increasingly complex and can be a source of errors resulting in patient injury and liability.

This was clearly illustrated in a claim presented in The Doctor’s Advocate (“A Tragic Lesson in Drug Safety” in the third quarter 2011 issue) involving a physician who prescribed Tussionex (hydrocodone and chlorpheniramine) to a four-year-old for treatment of a cough.

The child died from respiratory depression. An FDA Alert indicating reports of life-threatening events in children taking Tussionex had been issued the week before the prescribing event occurred. The manufacturer’s “Dear Provider” letter advising that prescribing Tussionex to children under six was contraindicated had been released the following week. A new edition of the Physicians’ Desk Reference (PDR) in the physician’s office contained the warning. The pharmacist filling the prescription received an electronic Drug Utilization Review Alert requiring him to contact the physician regarding its safety. He overrode the Alert and filled the prescription.

Safe Use Initiative and Know the Label Campaign
The FDA introduced the Safe Use Initiative in 2009 to create and facilitate public and private collaborations within the health care community. Its goal is to identify specific, preventable medication risks and then develop and implement interventions to promote safe medication use.

In collaboration with the FDA’s Safe Use Initiative, PDR Network and medical professional liability carriers launched a national Know the Label campaign early in 2011. Because almost 25 percent of drugs have clinically relevant changes made to their FDA-approved labels annually, it is difficult for busy physicians to keep up with label changes for medications.

The campaign allows physicians to earn free continuing medical education (CME) credits for reviewing the FDA-approved labeling for drugs they most commonly prescribe. We encourage our members to join the PDR Alert Network to receive FDA Drug Alerts and label changes via e-mail. Physicians can earn free CME credits for reading Alerts and label changes and taking a short online test on their content. PDR Network hosts the CME programs, and The Doctors Company provides the CME credits.

PDR BRIEF
While the tragic outcome in the case outlined above could have been prevented by receiving the FDA Alert (Boxed warning) on the PDR Alert Network, it would have been prevented by using PDR BRIEF on the electronic health record (EHR).

The critical information (date of last label update + boxed warning) would have been brought to the physician’s attention at the point of care when Tussionex was e-prescribed. PDR BRIEF provides drug information on four brief lines (as shown above) whenever a drug is e-prescribed or when the drug name is detected on the EHR screen or in any EHR application or Web site. The highlighted word(s) provide links to the information detail.

PDR BRIEF serves as a companion to existing embedded drug database and drug interaction checking tools. It also provides access to the latest FDA-approved patient education and financial assistance information, which will improve medication adherence and patient satisfaction.

Recent Studies
Adverse drug events have become a subject of considerable attention, both in the medical literature and lay press. A recent study conducted by researchers from the Centers for Disease Control and Prevention reported that adverse drug events account for nearly 100,000 hospital admissions each year for adults 65 years of age or older.
Approximately two-thirds of these admissions are related to unintentional overdoses involving a few commonly used medications. Roughly one-third involved warfarin, and another one-third involved insulins, oral hypoglycemic agents, and oral antiplatelet agents. In another report, the National Center for Injury Prevention and Control found that the number of overdose deaths from prescription painkillers (including hydrocodone, oxycodone, oxymorphone, and methadone) is greater than deaths from heroin and cocaine combined and accounted for nearly half a million emergency department visits (resulting from both misuse and abuse) in 2009.

Claims Analyses
Because malpractice claims involving prescription medications are common, and the FDA-approved labeling is often the standard to which physicians are held, The Doctors Company has performed several claims analyses to determine the incidence of medication-related errors and to identify the drugs most commonly involved. The results are summarized below.

We reviewed 363 consecutive claims from The Doctors Company that settled in an indemnity range of $100,000 to $500,000 between January 2004 and January 2006. These claims involved all medical specialties. Medication-related errors were present in 12 percent of these claims and accounted for 32 percent of total system errors. Overall, 48 percent of these medication-related errors occurred in internal medicine, psychiatry, and family practice claims.

- 43% were monitoring errors (one-third involved Coumadin)
- 26% were dosage errors
- 10% involved inappropriate medication
- 10% involved medication side effects
- 7% were medication reconciliation errors
- 4% involved medication allergic reactions

Since settlement requires concurrence of the patient (and his or her attorney) with the physician (and his or her insurance company) and generally requires the consent of the insured physician, settled claims contain a higher incidence of medical and/or system error than the universe of all medical professional liability claims. Therefore, the 12 percent incidence of medication-related errors in this study is predictably higher than one would expect when looking at all closed claims.

We also reviewed 3,310 consecutive claims from The Doctors Company that closed in 2010. These involved all medical specialties. Medication-related errors were present in 6 percent of these claims.

- 31% were monitoring errors involving Coumadin, Lovenox, and gentamicin
- 19% involved giving the wrong medication
- 17% involved failure to follow a guideline or protocol
- 14% involved giving the wrong dosage
- 14% were drug administration errors
- 5% were ordering errors

Because of the large size of this sample that included all closed claims and all specialties, the 6 percent incidence of medication-related errors is probably an accurate estimate of their incidence in all medical professional liability claims.

We reviewed 369 internal medicine claims that closed between 2000 and 2007 from a subsidiary of The Doctors Company. Medication-related errors were present in 10 percent of these claims, and 58 percent of these errors involved improper medication management. The following medications appeared repeatedly in these claims:

- 59% involved anticoagulants, and 81% of these involved Coumadin; 46% of the Coumadin claims resulted from failure to monitor using the international normalized ratio (INR)
- 15% involved gentamicin ototoxicity and nephrotoxicity
- 15% involved improper antibiotics selected for pneumonia
- 11% involved injury related to steroids

Since nearly one-half of medication-related errors occur in internal medicine, psychiatry, and family practice claims, the 10 percent incidence of medication-related errors in this study confined to internal medicine claims is also predictably higher than one would expect when looking at closed claims from all medical specialties.

We reviewed 140 medication-related internal medicine claims that closed from 2000 through 2011 from The Doctors Company and a subsidiary. The following medications were most frequently involved:

- 24% involved anticoagulants (Coumadin 20%, Lovenox 4%)
- 18% involved opioids (oxycodone, hydrocodone)
- 7% involved gentamicin
- 10% involved steroids (Kenalog 5%, prednisone 5%)
Summary
The incidence of medication-related errors in medical professional liability claims is approximately 6 percent. The classes of drugs most frequently involved in medication-related errors are anticoagulants (chiefly Coumadin), antibiotics (particularly gentamicin), opioids, and steroids. Monitoring is the most common medication-related error—which accounts for the prevalence of Coumadin and gentamicin in these medication-related claims.

References

This article originally appeared in The Doctor’s Advocate, first quarter 2012 (www.thedoctors.com/advocate).

Strategies for mitigating medication-related errors include:
1. Signing up for the free online PDR Drug Alert service at www.PDR.net.
2. Reading the entire FDA-approved labeling for the drugs most commonly prescribed to earn free CME credits at www.thedoctors.com/label.
3. Using an EHR that provides the full updated FDA Alerts and labeling from the PDR BRIEF service.

By David B. Troxel, MD, Medical Director, Board of Governors.
To Text or Not to Text

As the first medical professional liability insurer to establish a patient safety department, The Doctors Company remains the leader in developing innovative tools that can help you reduce risk and keep your patients safe.

Texting is instantaneous, convenient, and direct. It makes pagers seem as outdated as carrier pigeons. Without appropriate safeguards, however, texting can lead to violations of the Health Insurance Portability and Accountability Act (HIPAA).

Physicians are smartphone “super-users.” According to Manhattan Research, over 81 percent of physicians use a smartphone to communicate and access medical information. The attractions are obvious: Phone applications put libraries full of information at your fingertips, and drug alerts (such as PDR.net) are just a click away. Texting reduces the time waiting for colleagues to call back and may expedite patient care by sending and receiving critical lab results and other necessary patient data.

Safeguard Against HIPAA Violations

The very convenience that makes texting so inviting may create privacy and security violations if messages containing protected health information (PHI) are not properly safeguarded. Text messages among colleagues should be encrypted and exchanged in a closed, secure network.

However, according to a member survey conducted by the College of Healthcare Information Management Executives, 96.7 percent of those surveyed allowed physicians to text, and 57.6 percent of those surveyed did not use encryption software. The underlying reasons for poor compliance with encryption could be due to lack of technical knowledge or to avoid the inconvenience of sending a message to someone who may not be able to unencrypt it.

With penalties starting at $50,000 per HIPAA violation, safeguarding texts should be of utmost priority. In addition to encrypting texts, consider installing autolock and remote wiping programs. Autolock will lock the device when it is not in use, and it requires a password to unlock it. Wiping programs can erase data, texts, and e-mail remotely. Both types of safeguards provide additional protection in the event a device is lost or stolen.

Do Not Text Orders

On November 10, 2011, The Joint Commission noted that texting is not the same as a verbal order. Texting provides no method for recipients to verify the sender’s identity and no reasonable method for preserving or incorporating the original message into the medical record.

Ensure Accuracy To Avoid Liability Concerns

A cavalier attitude when composing a text message can also pose a legal risk. The informal nature of text messages may at times lead to using shorthand, which can increase miscommunication. Additionally, a deleted text is never fully deleted, and metadata (the “data behind the data”) is also producible in a lawsuit. It’s important to ensure accuracy, particularly when patient information is exchanged by text.

Finally, texting cannot substitute for a dialogue with a colleague concerning a patient. If there is a critical matter or any doubt about the communication, pick up the phone.

Take Steps To Protect Your Practice

Consider the following steps to safeguard your practice:

• Enable encryption on your mobile device.
• Have a texting policy that outlines the acceptable types of text communication and situations when a phone call is warranted.
• Report to the practice’s privacy officer any incidents of lost devices or data breaches.
• Install autolock and remote wiping programs to prevent lost devices from becoming data breaches.
• Know your recipient, and double check the “send” field to prevent sending confidential information to the wrong person.
• Avoid identifying patient details in texts.
• Assume that your text can be viewed by anyone in close proximity to you.
• Ensure the metadata retention policy of the device is consistent with the medical record retention policy, and/or in accordance with a legal preservation order.

• Ensure that your system has a secure method to verify provider authorization.

• When conducting your HIPAA risk analysis, include text message content and capability.

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