Failure to timely treat infection

Orthopedic closed claim study

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Clinical presentation
On April 2, a 67-year-old man came to an orthopedic surgeon with a two-month history of right foot and ankle pain. He was a long-term patient of another physician at the clinic with a history that included lumbar spine injury that warranted several spine surgeries, including lumbar fusion. Other history included hypertension, hyperlipidemia, emphysema, and asbestosis.

Physician action
After examination, the physician noted a probable tear of the right Achilles tendon. The patient and physician discussed conservative treatment, including casting and surgery. The patient went home to consider his options and returned on April 22 to discuss possible surgery. The physician again discussed the diagnosis of a rupture of the right Achilles tendon and recommended surgical repair.

On May 8, the physician performed a secondary repair of the Achilles tendon rupture, using a split flexor hallucis muscle transfer to secure the repair. Routine antibiotic therapy was administered both pre- and postoperatively. The surgery went well and the patient was discharged from the hospital on May 9.

The patient returned to the clinic for postoperative evaluation on May 16. The exam revealed that the tendon was intact, but that there was “some skin irritation- min drainage.” The physician decided to leave the sutures in and see the patient for removal in one week. On May 23, the patient returned to the clinic for follow up. The sutures were removed, and examination revealed slight incision drainage and minimal wound granulation, with the tendon intact. The physician ordered daily wet to dry dressing changes, and instructed the patient to monitor the incision for symptoms of infection. He asked the patient to pay special attention to any increased redness, drainage, or fever, and to report any changes to the clinic immediately. The patient was scheduled to follow up at the clinic in four weeks.

The patient returned to the clinic on May 30 with complaints that his right foot felt warm, but he had no fever. The patient reported that he had been washing the incision with hydrogen peroxide, and that he had not been instructed to perform wet to dry dressings at the prior visit (although it was documented in the physician’s note). Examination revealed a 2.5 x 3.5 cm hole in the incision area, with minimal cellulitis and no exposed tendon. The physician provided the patient with a prescription for Duoderm skin dressing and instructions were given for wet to dry dressings.

On June 3, the patient phoned the office to report that the incision drainage was worse and had an odor. He was instructed to continue the dressing changes and antibiotics, and to come in and be examined by another physician in the practice the next day (his physician was scheduled out of the office). It was not clear in the telephone note what antibiotic therapy the patient was on, but the surgeon later reported that he had prescribed Cipro at or around the time of the May 30 visit. The prescription was not documented in the medical record.

This closed claim study is based on an actual malpractice claim from TMLT. The case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

continued on page 2
continued from page 1

On June 4, the patient was examined by another physician in the practice, who noted that the patient mentioned that he would finish the course of Cipro in two days. The physician ordered a wound culture and sensitivity study, and provided the patient with a prescription for Augmentin. The physician also advised him to complete the Cipro prescription he had already been given, and continue the daily dressing changes. Photographs were taken, and the patient was asked to follow up with his original physician in the following week. Later in the afternoon, the patient’s daughter called to inform the physician that the patient was allergic to Augmentin, and a prescription for Cleocin was substituted.

On June 7, the patient presented to a wound care center. The examining physician noted there was no dressing on the wound, and that the wound measured 38 mm, width 20 mm and depth 2-10 mm. The impression was full thickness dehiscence with a significant amount of necrotic subcutaneous tissue and complete absence of skin in the surgical incision. A necrotic tendon and a significant amount of necrotic subcutaneous fatty tissue were noted. The wound was debrided and cultured, and the antibiotic regimen was left unchanged. No elevated white blood cell count was noted on the CBC.

The patient’s wound culture was reported on June 9 as demonstrating *Actinomyces meyeri*, sensitive to all antibiotics tested except clindamycin and metronidazole. The patient was seen by his original physician on June 10. The physician noted that the wound was enlarged, measuring approximately 3 x 5 centimeters and with tendon exposed. The patient was immediately referred for a plastic surgery consult, which took place the same day. The patient was admitted for wound care and IV antibiotic therapy. Subsequently, the patient underwent several surgical procedures to close the wound, including grafting and tissue transfer from the wrist. The patient reported continuing pain, swelling, and limitations in active and passive range of motion of the right foot and ankle, as well as continued problems with the skin flap donor site.

**Allegations**

A lawsuit was filed against the orthopedic surgeon. Allegations included failure to properly assess the patient after surgery and failure to adequately treat his postoperative infection in a timely fashion.

**Legal implications**

Consultants agreed that the choice of surgery and the physician’s surgical technique were not in question. Although consults were generally supportive of the physician’s care, there were some concerns that the postoperative infection could have been diagnosed more expediently. There was also some argument about whether the most effective antibiotic therapy was chosen. *Actinomyces meyeri* does not respond to Cipro, but consultants noted that because it is a very rare type of bacteria for surgical wound infection, the physician could not have been expected to prescribe appropriate antibiotics without culture results available. They opined that a reasonable physician would have treated the patient with antibiotics for staph, the most common wound infection, which is what the physician did. Additionally, *A. meyeri* does respond to clindamycin, which the patient was prescribed on June 4.

There was also some confusion about the date that the first antibiotic was prescribed, since there was no note of it in the medical record. Plaintiff’s and defense experts disagreed about whether the physician should have cultured the wound when drainage was noted on May 23. They also argued about whether the wound symptoms indicated infection at the May 30 visit, and disagreed about whether the physician should have debrided the wound at that time. Consultants noted that the patient’s poor circulation could have been the cause of the wound dehiscence, and the patient’s care of the wound may have been sub-optimal.

**Disposition**

Although consultants were generally supportive, they did admit that the infection could have been treated more aggressively. The patient was a sympathetic witness who had a very difficult post surgical course, which was documented with photographs. In light of the above, the case was settled.

**Risk management considerations**

A complete medical record with detailed documentation of all patient encounters can be an important defense tool. Documentation about the patient’s noncompliance with treatment recommendations can enhance a physician’s defense. In this case, the physician had good documentation in the record about his patient instructions and orders for wet to dry dressings. Although the patient later stated that he had not been told, the instructions were clearly documented in the record. There was, however, some confusion about when the initial antibiotic was prescribed, since there was no documentation in the record. Details about prescriptions given to the patient are crucial to establishing a correct timeline of care; prescriptions should be documented in the record at the time they are given. A complete medical record is a physician’s best defense in the event of a malpractice claim.

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TMB enforces new rules for medical record documentation

by Jane Holeman and Jon Porter

For years, the Texas Medical Board (TMB) rules regarding medical record documentation merely required that physicians maintain “adequate medical records,” defined as “any records documenting or memorializing the history, diagnosis and treatment of any patient.” 1 Recently however, TMB staff determined that this rule was incomplete and failed to convey the importance of the medical record. As a result, the TMB radically rewrote the rules defining the requirements for “adequate” medical records.

What exactly does the TMB require?

The rule governing medical record documentation may be found in either the Texas Administrative Code Section 165.1, or in the Board rules posted on the TMB’s web site. 2 The Texas Administrative Code is the legal designation for the TMB’s rules. The rule states medical records must be “…complete, contemporaneous and legible.” 1 Therefore, documentation must include complete details for each patient encounter, be created close to the time the physician treated the patient, and be legible to the average person.

Contemporaneous

The TMB rule does not specifically define “contemporaneous.” However, by practice, most TMB members emphasize that documentation should be completed immediately after, if not during, the actual patient encounter. If a physician chooses to complete the records at the end of the day instead of after the patient encounter, it appears that he or she would be in compliance, assuming the physician did not see a considerable number of patients that day. However, many TMB members are of the opinion that the records then become too general, and it is likely the physician may forget relevant information.

Legible

Legibility has long been an issue for physicians. The advent of electronic medical records and transcribed records is beginning to have a positive impact. However, for physicians who still handwrite notes, illegibility will likely be viewed by the TMB as a lack of compliance with Board rules. When evaluating standard of care issues, all records are reviewed by at least two TMB consultants. These consultants must be able to read the records.

Use caution when employing templates or preprinted forms that contain “check boxes” to designate systems as normal or abnormal. This includes emergency department records and the forms suggested by Medicaid. These forms are often intended to facilitate documentation by “prompting” the physician to address multiple aspects of the patient encounter. However, often the space for handwritten entries is limited, resulting in illegible notes. When using such forms, write legibly and use an additional page to fully describe findings, if necessary.

Complete

The Board requires that each patient encounter must be documented and include the following:

- a. reason for the encounter and relevant history, physical exam findings, and prior diagnostic test results;
- b. an assessment, clinical impression, or diagnosis;
- c. plan for care, including discharge plan; and
- d. the date and legible identity of the observer. 1

There is an expectation that an appreciable connection be made between each of the above four requirements, and that the connection is explored and documented. Therefore, physicians need to demonstrate how they got from the objective and subjective findings to the diagnosis and treatment.

The rule also requires that “past and present diagnoses should be accessible to the treating and/or consulting physician.” 2 This means that records should be readily available to physicians treating the patient.

Furthermore, the rationale for (if not apparent) and the results of diagnostic testing and other ancillary services should be included in the medical record. 1 This may even include an explanation of the results and how they affect the treatment of the patient.

The rule also requires that the patient’s progress be documented, including response to treatment, change in diagnosis, and the patient’s noncompliance. 1 Defending a standard of care case by alleging the patient was noncompliant may be disregarded if there is a lack of documentation in the record supporting that stance.

Finally, the TMB has traditionally required that physicians document patient follow-up instructions in the medical record. Again, it is recommended that a comment be included regarding how the follow-up instructions were provided to the patient.

Informed consent

The new rules also require documentation of informed consent. Documentation needs to demonstrate that the physician provided the patient (and/or the patient’s family) with education on the diagnosis and treatment, as well as the risks of any treatment. Board members have been critical of physicians who did not document that the diagnosis was adequately explained to the patient, including the differential diagnosis and the affect on the method of treatment.

Treatment plans

The TMB rules also require an appropriate written treatment plan for patients. 1 However, the Board fails to define “appropriate.” As the rules are written, include the following in the plan section of a SOAP note:

1. treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
2. any referrals and consultations;
3. patient/family education; and
4. specific instructions for follow up. 1

continued on page 4
In certain situations, the Board members may expect to see a treatment plan containing more information than what is listed in the four requirements. They actually may request a formal “treatment plan.” This is a written course of action given to the patient with both subjective and objective measures to which the physician and patient agree in order to achieve their stated medical goal.

Generally, TMB members expect a formal treatment plan for patients who have complex or chronic medical conditions. A treatment plan is a requirement when treating patients for issues of chronic pain. The treatment of chronic pain has very specific rules and requirements that are not covered in this article. Physicians who provide treatment for chronic pain, should closely review the TMB rules on that subject and contact people with expertise on this rule, such as TMB staff, attorneys specializing in representing physicians before the TMB, or physicians specializing in pain management.

Referrals and consultations
If the physician determines that a referral or consultation is necessary, the rules require that it be documented in the medical record. A copy of the referral or consulting physician’s report should be placed in the medical record. To facilitate patient safety and continuity of care, it is recommended that the referring physician provide a copy of the patient’s medical record or a summary of the patient’s care to the consultant.

Physicians being investigated by the TMB are often unable to demonstrate that they have reviewed the records of prior treating physicians. The TMB rule states that records received from other health care professionals involved in the care of the patient shall be maintained as part of the patient’s medical records. This means that physicians are required to maintain not only the records they create, but also those they have received from other physicians.

Patient education
There have been instances during informal settlement conferences where a physician has written nothing more than “patient education” in the medical record. In those situations, the Board has emphatically told the physician that the documentation was inadequate. TMB members require that the documentation provide some indication of what was discussed and how the patient was educated.

Conclusion
The rules for medical records are complex and can cause confusion. Carelessness and lack of knowledge of TMB rules have resulted in TMB sanctions for many physicians. Taking time to create and maintain appropriate medical records can help physicians provide better patient care and avoid TMB complaints.

Sources
1. Texas Administrative Code. Section 165.1.

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