Case Study: Trust But Verify

This is an example of how a mistake in charting lab results can lead to further communication errors

The Case

On June 23, 2004, a 31-year-old married woman, with an unremarkable health history, presented to the fertility clinic of Physician A for a consultation for in-vitro fertilization. The patient was examined and instructed to have standard blood work completed prior to the initiation of treatment. The next day the patient had the requisite lab work performed, the results of which were reported back to the Physician's office the following Monday, June 28th. The results revealed a positive result for Hepatitis C.

Upon receipt of the lab report, the clinic's nurse transcribed the results onto a contemporaneously dated progress note. The note indicated the lab values as being within normal limits, failing to indicate the positive finding of Hepatitis C.

On July 12, 2004, the patient returned to the clinic to discuss her treatment options. Despite extensive conversation about the risks, benefits and alternatives of the treatment options, and a chart notation reflecting that the lab values were reviewed, there is no indication of any discussion of the positive Hepatitis C finding with the patient. On October 5, 2004, the patient consented to in-vitro fertilization (IVF) treatment utilizing fresh rather than frozen sperm, due to the patient's concern about potential contamination of the latter. The chart entry again indicates that the labs were reviewed, yet there was no mention of the Hepatitis C finding, or any discussion about it with the patient. After completing six months of unsuccessful fertility treatments, the patient decided not to continue with additional IVF attempts.

In November 2005, upon receipt of the patient's written authorization, Physician A forwarded a copy of the patient's treatment records to Physician B, an OB/GYN.

In January 2006, Physician A received a letter from the patient indicating that she was five months pregnant and had recently learned of her positive Hepatitis C status. She expressed outrage and devastation that the results had not been revealed to her two years prior, when they were initially reported by the lab.

Shortly after delivery, it was determined that the infant had contracted the Hepatitis C virus, and would require lifetime treatment.

The Analysis

Even in practices where care is taken to ensure patients are given extensive and thoughtful explanations to assist them in making informed choices, if all of the

information is not “available,” it becomes more likely that some piece of critical information will be left out.

The Physician’s role in the error:

In this scenario, the Physician thought to do all of the right tests, had what he believed to be a system in place for reviewing the results, and took an extensive amount of time explaining the relevant information to the patient. Unfortunately, a critical piece of information was left out of these discussions due to his failure to actually review the lab report. It is always possible that human error may result in a lab result being misread; however, the likelihood of this occurring decreases, and the opportunity to mitigate the consequences increases, when the actual lab report is reviewed along with relevant summaries prepared by others in the office.

The chart entries indicated that the lab results were reviewed on at least three separate occasions, however, the positive result was never spotted. It was later determined that the documentation indicating review of lab results was actually a review of the nurse’s transcribed summary and **not** the actual lab report. It is possible for anyone to make an error in transcribing, which makes it that much more important to review the most reliable source for confirmation, in this case the actual lab report. At each of the patient’s subsequent visits an opportunity was lost by failing to identify the error prior to her conception.

Systems error:

It is acceptable to have ancillary personnel, particularly highly trained individuals such as an RN, transcribe results onto a progress note for easier reference. However, this summary should never become a substitute for a thorough review of the original source (in this instance, the lab report). The flaw in this scenario was not so much the process by which the lab results were documented in the chart, but rather that the Physician relied solely on that one piece of information and never bothered to compare the summary with the actual lab report. When lab results, consultation notes, or any other information regarding treatment outside the practice is received, practice policy should outline a method for Physician review prior to filing. The manner by which this is accomplished is not as important as the assurance that it is consistently done.

<u>Key Points</u>

- Never file lab results prior to review by the Physician. Review of labs by ancillary personnel should not be the final review of the labs prior to filing. In some circumstances it may be appropriate to allow the transcribing of the lab values on the chart by someone other than the Physician; however, those notations, along with the actual lab report, should be reviewed and signed by the Physician before the chart and lab report are filed away.

- It is more reliable to review the actual report rather than a summary. While it may not be practical to review each and every lab report on each and every visit, certainly when the report is initially received it should be reviewed by the Physician. If the practice has a policy whereby certain items are transcribed into the record by someone other than the Physician, those notations should be compared to the report for accuracy. To do otherwise may result in accidental reliance on incomplete or inaccurate information.

- In treatment notes, write what you did, and do what you write. In this case the chart clearly reflects numerous occasions that labs were reviewed. If the **actual** lab reports had been reviewed, the positive value would have been detected, if not at first glance, at least at one of the subsequent visits. While it may be helpful to have a notation in the progress notes concerning the results of labs, such notation can not be the sole source of information that is relied on when making clinical determinations. Chart notations should be clear as to what was reviewed, actual labs, summaries of lab results, etc. If you believed that the test was important enough to do, it should be important enough to review. Likewise, when you describe your treatment you should be explicit about the actions you undertook.