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MEDICAL EDITION

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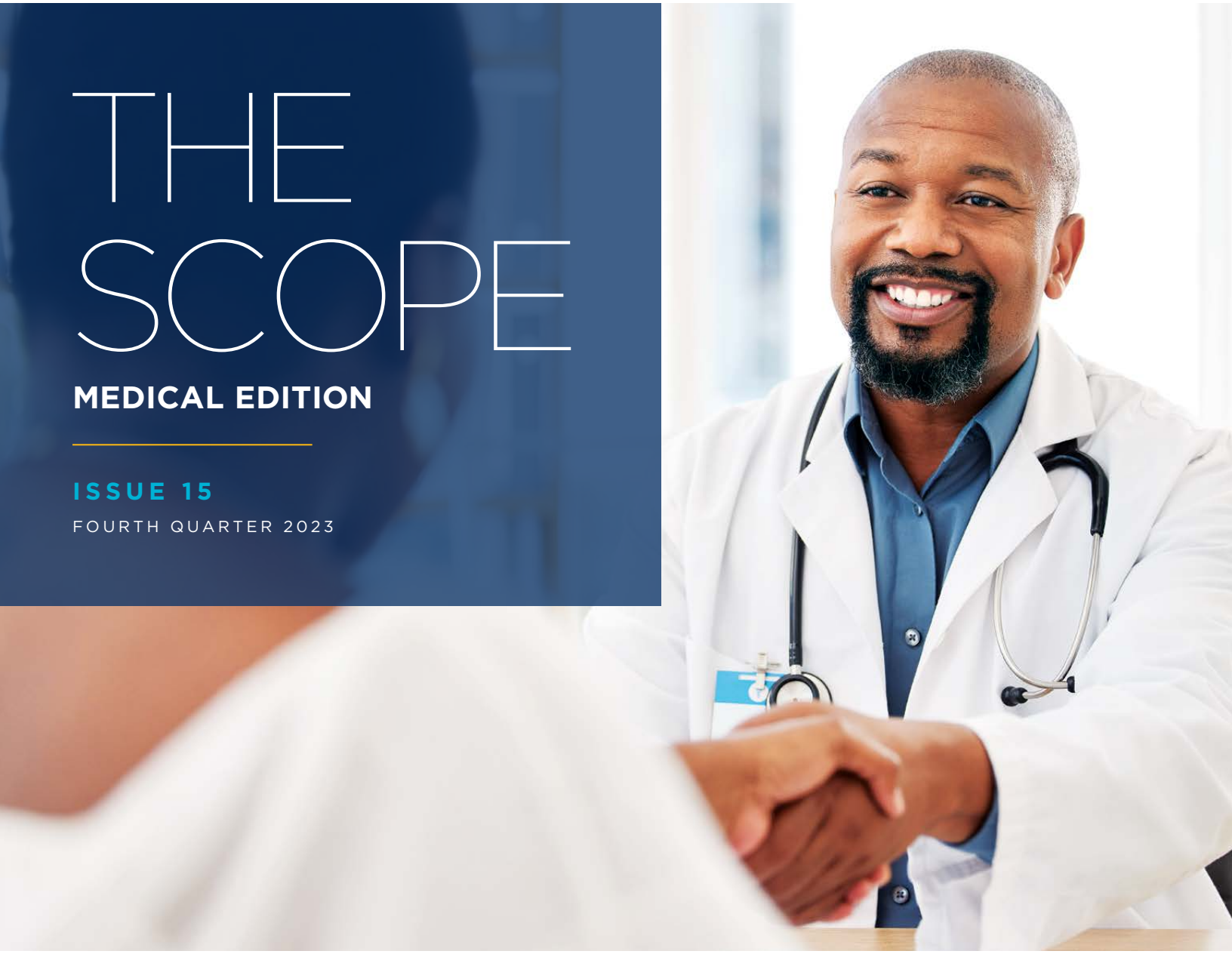

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Dear Colleagues,

When most doctors sign up for malpractice insurance, the desire that is foremost in their minds is a wish to be protected from a disastrous malpractice action. Fear of this weighs on all of us, whether or not one has yet to be sued.

Physicians turn to MLMIC Insurance Company because of our unparalleled record of success at trials, our almost 50-year history of defending doctors, and our rock-solid financial stability. A few years back, a medical malpractice carrier literally closed its doors on a Friday afternoon, leaving doctors being sued without coverage and responsible for their legal bills. This horrible scenario will NEVER happen at MLMIC. I hope other carriers can say, and do, the same.

What often goes unnoticed by doctors when they purchase insurance are the many ways that MLMIC can assist them in what is now the difficult effort to maintain a practice or to work for a hospital or health system. I, for one, was ignorant of the benefits MLMIC offered when I purchased my first policy many years ago.

A full range of MLMIC's services are available by consulting MLMIC.com, but I thought I'd mention a few. First, MLMIC offers a multitude of opportunities for a discount on your policy. Second, it provides CME credits for its extensive risk management programs. Third, it provides almost immediate legal advice for the most difficult of practice situations. For example, it can provide specific and prompt information on how to discontinue from your practice a difficult or disruptive patient. Our risk management programs can recommend specific ways you can modify your office and practice procedures in order to improve your financial situation and lessen the chance of being sued and found liable. I have availed myself of many of these opportunities.

The list of MLMIC benefits goes on and on, and you'll continue to hear about them in future issues of *The Scope*. For the good of your financial and professional wellbeing, familiarize yourself with them. You won't be disappointed.

As always, feel free to contact me with questions and suggestions as you continue to engage in the increasingly difficult but most personally rewarding practice of medicine.

With gratitude for all you do, your colleague,

John W. Lombardo, M.D., FACS
Chief Medical Officer, MLMIC Insurance Company
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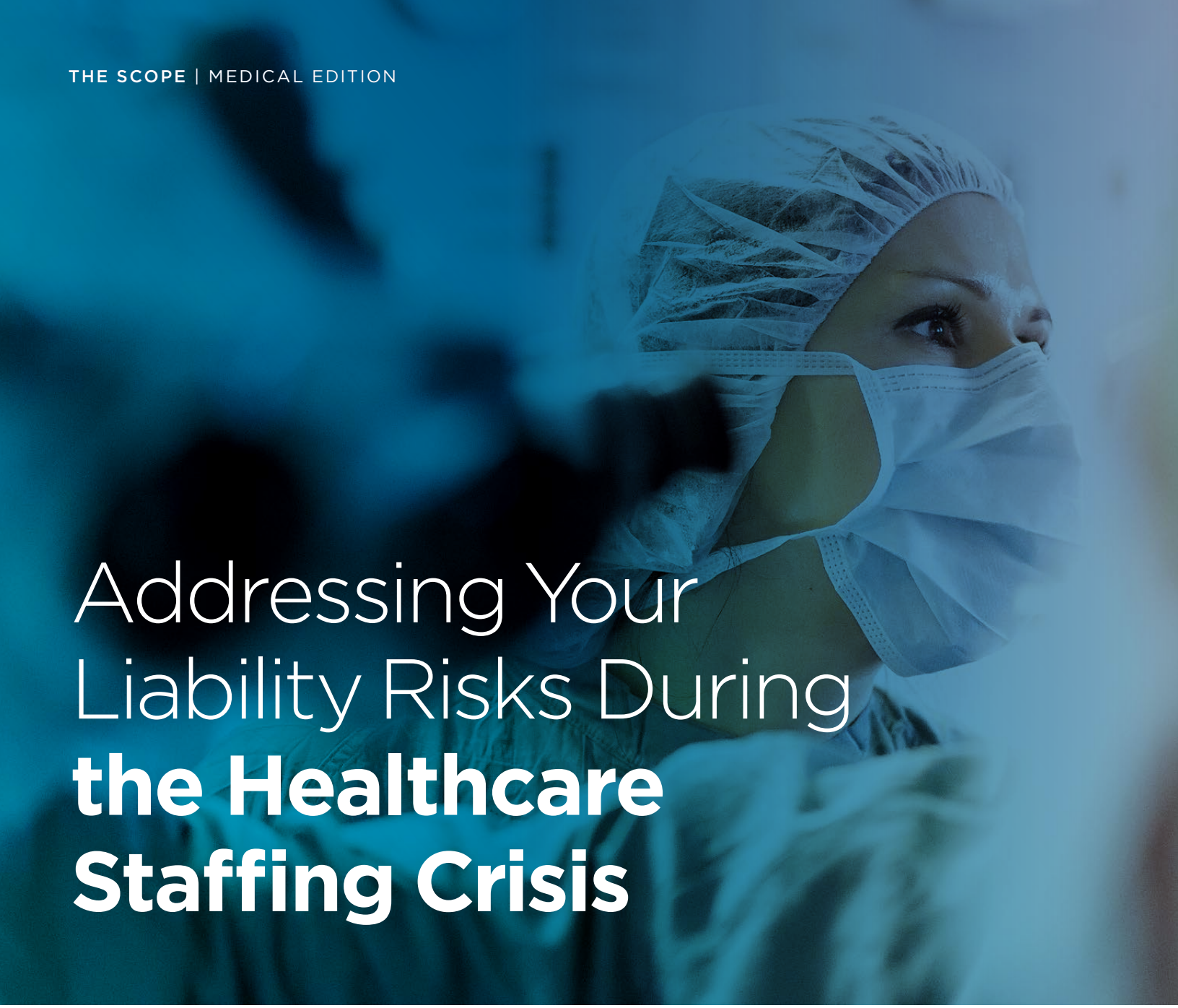


Addressing Your Liability Risks During **the Healthcare Staffing Crisis**

According to a comprehensive study by the National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers, it is estimated that **800,000 nurses will leave the workforce by 2027**. While the alarms originally sounded during the COVID-19 pandemic when roughly 100,000 nurses left the profession, this must be put into perspective. Taken together, **the number of nurses who have left and are projected to leave the profession in the next few years equates to one-fifth of the 4.5 million nurses in the workforce today.**[1]

The Crisis Explained

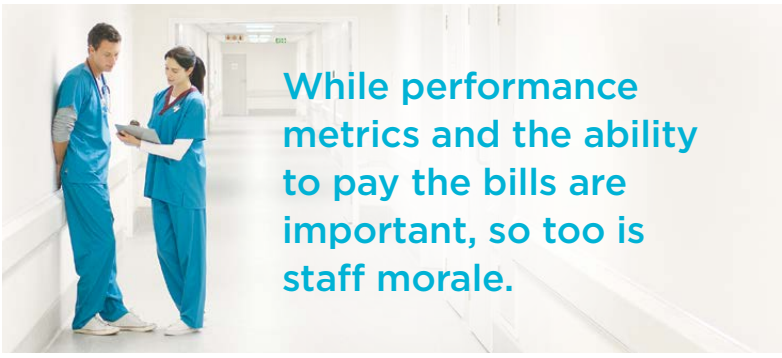
It is no secret that the current staffing crisis goes far beyond nursing, impacting all areas of healthcare, and is leading to ongoing delays related to boarding in emergency departments, prolonged admission to hospitals, and delayed elective and emergent surgeries. All of these contribute to adverse outcomes, morbidity, and mortality.

The past few years have also seen an increase in medical errors. The Joint Commission, a major agency that monitors hospitals and other healthcare facilities, reported a 19% rise in adverse events in 2022. After several decades of creating a safety culture in healthcare, this is a chilling statistic. Unfortunately, staffing healthcare facilities with temporary workers may play a significant and expanding role in this negative trend.[2] Simply stated, the staffing crisis will continue to impact the quality of care.

While all areas of healthcare are impacted, this article will focus primarily on the nursing profession since it is the largest segment of the healthcare workforce. Aside from it being the largest sector of the personnel, it is also the most visible one to patients. Nursing is where much of the external research on healthcare shortages has been concentrated, but, as a healthcare professional, you will see that many of the issues and solutions for the nursing profession are universally applicable to other areas in your organization where adequate staffing may be lacking.

Over the past few years, the cost of providing patient care has skyrocketed. According to data from Syntellis Performance Solutions, overall hospital expenses increased 17.5% from 2019 to 2022. By comparison, Medicare reimbursement has only increased 7.5% in that same time frame. Administrators had been paying attention to revenues and health outcomes, but many lost sight of staffing. While performance metrics and the ability to pay the bills are important, so too is staff morale. Healthcare systems cannot deliver high quality, safe, and effective care with a compromised workforce, so they must take care of their employees.[3]

As noted above, U.S. healthcare lost at least 100,000 nurses during the pandemic. It is disconcerting to note that of the 800,000 nurses intending to leave the profession in the next five years, 24% of them are the new, younger nurses, which is a shift from prior data that used to suggest the majority were leaving the profession due to retirement.[4]



The inability for healthcare systems to retain nurses has a significant impact on their bottom line. We are seeing registered nurse (RN) vacancy rates of 17% and graduate nurse turnover rates of 31.7%. On average, the cost of replacing an RN is $52,350, with the range averaging from $40,200 to $64,500. This is a significant increase of $6,250 from 2021, when the average cost was $46,100. To further put this into perspective, each percentage change in RN turnover will cost or save the average hospital $380,600 per year.[5,6]

This begs the question, why are nurses leaving the profession? A 2022 survey determined that nursing is an aging workforce, with the average age of an RN being 50. Additionally, burnout contributed to 34% of those nurses that planned to leave their jobs by the end of 2022, with 60% of those leaving the profession altogether.

1 https://www.beckershospitalreview.com/nursing/crisis-looms-as-800-000-more-nurses-plan-to-exit-workforce-by-2027-study/
2 https://time.com/6291392/american-health-care-staffing-crisis/
3 https://publichealth.tulane.edu/blog/hospital-staff-shortages/
4 https://www.beckershospitalreview.com/nursing/crisis-looms-as-800-000-more-nurses-plan-to-exit-workforce-by-2027-study/
5 https://www.aha.org/aha-center-health-innovation-market-scan/2023-05-09-how-ai-improving-diagnostics-decision-making-and-care
6 https://www.beckershospitalreview.com/workforce/the-cost-of-nurse-turnover-in-24-numbers-2023/

Balancing a career and family is another factor contributing to this crisis as the majority of the workforce is female. Nurses struggle on a daily basis with work overload issues such as patient volume and time commitment, as well as safety concerns such as violence and lack of PPE. Each of these is furthering a declining workforce.[7,8]

Crisis Ramifications

As previously noted, this crisis is just not a nursing problem but also a healthcare system problem, with quality and safety coming into question, too, as inappropriate staffing endangers patients, nurses, physicians and advance practice providers, and interdisciplinary teams/departments.[9] For example, the CDC reports that bloodstream infections have risen 47% as a result of the nurse staffing crisis. There is also a correlation between decreased staffing levels and an increase in mortality, medication errors, falls, pressure injuries, restraint use, and hospital-acquired infections and pneumonia.[10] Furthermore, nurses who commit errors may experience feelings of guilt and inadequacy, potentially resulting in anxiety, depression, and feelings of incompetence, which may lead to their leaving of the profession.[11]

Other nurse-sensitive patient outcomes that are strongly impacted by inadequate staffing include increased length of stay, decreased patient satisfaction scores, poor quality of nurse-delivered care, a rise in post-operative complications, and higher readmission rates.[12] Studies show that nurses in appropriately staffed units have much lower numbers of incidents of missed nursing care, and nurses on those units were significantly less likely to miss turning patients, performing mouth care, bathing and skincare, performing patient assessments on each shift, and assisting with toileting, feeding, and setting up meals.[13] Therefore, it can be concluded that inadequate staffing increases the nursing workload and can contribute to turnover.

The debate of staffing levels has gone on for years. A 2002 landmark study conducted by Penn Nursing found that each additional patient per nurse was associated with increases in the likelihood of patients dying within 30 days of admission (7%), the probability of failure-to-rescue or the failure to respond effectively to post-surgical complications (7%), the incidence of nurse burnout (23%), and job dissatisfaction (15%).[14] While New York law only mandates staffing ratios for critical care patients at a ratio of one nurse to every two patients, hospitals are required to establish clinical staffing committees comprised of RNs, licensed practical nurses (LPNs), ancillary staff, and administrators, whereby the committees develop clinical staffing plans that must be submitted to the state by July 1 of each year.[15]

> **Further, a lack of adequate staff contributes to worse patient outcomes and decreased patient satisfaction scores.**

The lack of adequate staff contributes to injuries, which results in increased costs. Patient falls lead to an average of $17,500 increase in costs to care for a patient. Pressure injuries increase the cost of care by $37,800. Further, a lack of adequate staff contributes to worse patient outcomes and decreased patient satisfaction scores. The Hospital Consumer Assessment of Healthcare Providers and Systems survey results (HCAHPS is the first national, standardized, publicly reported survey of patients' perspectives of hospital care) equate to decreased reimbursement by the Centers for Medicare & Medicaid Services (CMS). In addition, when factoring in the average cost of $52,350 to

7 https://www.ncbi.nlm.nih.gov/books/NBK493175/
8 https://publichealth.tulane.edu/blog/hospital-staff-shortages/
9 https://www.beckershospitalreview.com/nursing/what-it-will-take-to-fix-the-nurse-staffing-crisis-report
10 https://www.patientsafety.com/en/blog/staffing-shortages-affects-patient-safety/
11 https://www.sciencedirect.com/science/article/abs/pii/S1546084321000018
12 https://www.patientsafety.com/en/blog/staffing-shortages-affects-patient-safety/
13 https://online.emich.edu/degrees/healthcare/rn-to-bsn/nurse-staffing-affects-patient-safety-satisfaction/
14 https://ldi.upenn.edu/our-work/research-updates/how-inadequate-hospital-staffing-continues-to-burn-out-nurses-and-threaten-patients/
15 https://www.beckershospitalreview.com/workforce/new-york-mandates-1-2-nurse-patient-ratio-for-critical-care/

replace, orient, and train a new nurse every time one leaves, retaining staff leads to increased savings and can avoid some of the costs identified above. As a whole, over the course of the pandemic, staffing shortages cost hospitals $24 billion.[16]

Recommendations

When healthcare entities lack adequate or experienced staff, organizations then must ask how new staff should be trained and recruited.

Solutions to rebuilding healthcare staffing should include a goal of restoring the sense of passion that drew staff to the profession to begin with. Consider the use of incentives that attain organizational commitment. Listen to what the employees need. A recent Tribe benchmarking survey indicates that 87% of employees have placed a high priority on mental and emotional wellness. Forty-six percent of respondents also indicated that work-life balance has become a higher priority. Other higher priorities include physical health and wellness, at 40%, and financial wellness, at 23%. The career needs and preferences of today's workforce are loud and clear: Ninety-six percent of working professionals want more flexibility. In fact, they now expect flexibility about as much as they expect a 401(k).[17]

Healthcare can't afford to lose clinicians, and flexibility is key to retention. Most healthcare systems know they need to do more to attract and retain a flexible workforce, but internally they need the technology and recruiting support to manage this flexible workforce. The importance of flexibility in staffing solutions, like adopting a "gig economy" to staffing, can have many benefits to healthcare. The gig economy uses real-time technology and apps to seek out individuals on their terms, and employers hire based on their immediate needs.[18]

> **Forty-six percent of respondents also indicated that work-life balance has become a higher priority.**

Building your own internal staffing program or "agency" can offer flexibility to existing employees as a retention tool and can assist in attracting new staff seeking short- or long-term contract work or gig work. Tapping into your community's workforce may also bring forward the local talent who are searching for flexible work arrangements, are home between travel assignments, or are on contract in your area, as well as those returning to the workforce.[19]

In efforts to retain staff, leadership should look to empower individuals, as it motivates people to rejuvenate and stay engaged. Leaders should

16 https://www.amnhealthcare.com/amn-insights/news/inadequate-staffing-harms-quality/
17 https://www.beckershospitalreview.com/hr/4-post-pandemic-priorities-of-employee-messaging-per-hr-leaders/
18 https://www.beckershospitalreview.com/the-value-of-local-in-a-gig-economy/
19 https://www.beckershospitalreview.com/the-value-of-local-in-a-gig-economy/

also engage others and foster an environment of autonomy with decision making. Not only should health systems invest in new technologies, but they should also specifically introduce new technologies to assist staff with efficiency, such as remote patient monitoring, kiosks for check-in, artificial Intelligence, and tools that enhance patient education. They should also look at areas of staff frustration surrounding technologies and seek strategies that improve usability, like streamlining electronic health record (EHR) documentation.[20]

Let's not ignore that nursing and many other healthcare professions are primarily or traditionally "female roles." It is time to untap other resources, uncover the gender stereotypes, and recruit men into these positions. The reverse should also be said for those traditional positions viewed as "male roles."[21]

> **It is time to untap other resources, uncover the gender stereotypes, and recruit men into these positions.**

When it comes to professionals, everyone should be allowed to work at their full licensure, permitting PAs, NPs, and RNs to focus on the care they uniquely provide. Consider how the LPN is utilized and if an expansion of their duties is appropriate. This may be the perfect opportunity to use a different skill mix to meet patient care needs.

Examine the needs of the patients, as they are likely not the same as they were five years ago. Based off of this, examine your staffing models and institute changes where necessary. As previously noted, New York state law requires hospitals to establish clinical staffing committees to develop clinical staffing plans. By changing the staffing model from numbers to patient acuity, burnout could be decreased. Other areas of focus for burnout should include examining workloads and reducing administrative work for bedside nurses and creating wellness programs

inclusive of peer groups to support staff. Leaders need to continue to value their staff by celebrating the "little" wins by rewarding and recognizing staff and doing things to make them feel special, like sending personalized birthday cards.[22]

Engage your employees and listen to them. "Nurses want to practice nursing and not be the organizational sponge that absorbs all other tasks that other professionals will not, cannot, or are unwilling to complete."[23]

Turn complaints into opportunities, make suggestions actionable initiatives, and consider views of divergent cultures (diversity, equity, and inclusion). Include front-line employees in staffing decisions and leverage cost data. Build relationships between educational institutions and healthcare systems to provide a pipeline for future employees. When you have found the right fit for your organization, streamline the hiring process.[24] While the credentialing process can be long, consider other internal roles or opportunities for these employees as they await their final approval.

Develop a strong nurse residency program that aims to increase RN retention by 20% or higher. Such programs should deliver and measure evidence-based clinical practices and provide a scaled foundation for new nurses.[25]

continued on page 12

20 https://www.ncbi.nlm.nih.gov/books/NBK493175/
21 https://www.beckershospitalreview.com/nursing/how-get-more-men-into-nursing-per-21-male-nurses
22 https://www.beckershospitalreview.com/workforce/healthcare-employment-sees-gains-but-labor-shortages-drag-on-5-reasons-why
23 https://www.ormanager.com/briefs/nurses-want-to-practice-nursing-not-be-organizational-sponge
24 https://www.beckershospitalreview.com/workforce/less-talk-more-action-how-small-fixes-retain-employees
25 https://www.aha.org/aha-center-health-innovation-market-scan/2023-05-09-how-ai-improving-diagnostics-decision-making-and-care

A Message of Thanks From MLMIC

As another year draws to a close, MLMIC Insurance Company would like to take this opportunity to express sincere thanks and gratitude to all of you — our healthcare heroes, our loyal policyholders, and everyone working on both the front lines and behind the scenes to ensure the highest quality of care possible is delivered to our fellow New Yorkers.

We appreciate your continued trust in MLMIC. We remain vigilant in defending you and the practice of medicine within the State of New York.

Built on 45+ years of New York-specific experience, MLMIC has successfully defended more New York physicians than any other New York medical professional liability insurer.

As a valued policyholder, the following benefits are available to you.

MLMIC Risk Protect
Take advantage of New York-specific risk management services designed to help manage risk, reduce exposure, and prevent adverse outcomes.

MLMIC 24/7 Hotline
Gain 24/7 immediate access to New York-specific risk management advice, guidance, and resources.

MLMIC Analytics
Put 45+ years of MLMIC data to work, uncovering key trends and potential risks using MLMIC's exclusive claims and adverse event analysis service.

MLMIC CME+
Access a growing library of cutting-edge, online CME programs.

In addition to these benefits, you may be qualified for further savings. **Give us a call at (800) ASK-MLMIC to review your policy or see for yourself how you could save up to 30%.**

MLMIC is truly here for you.

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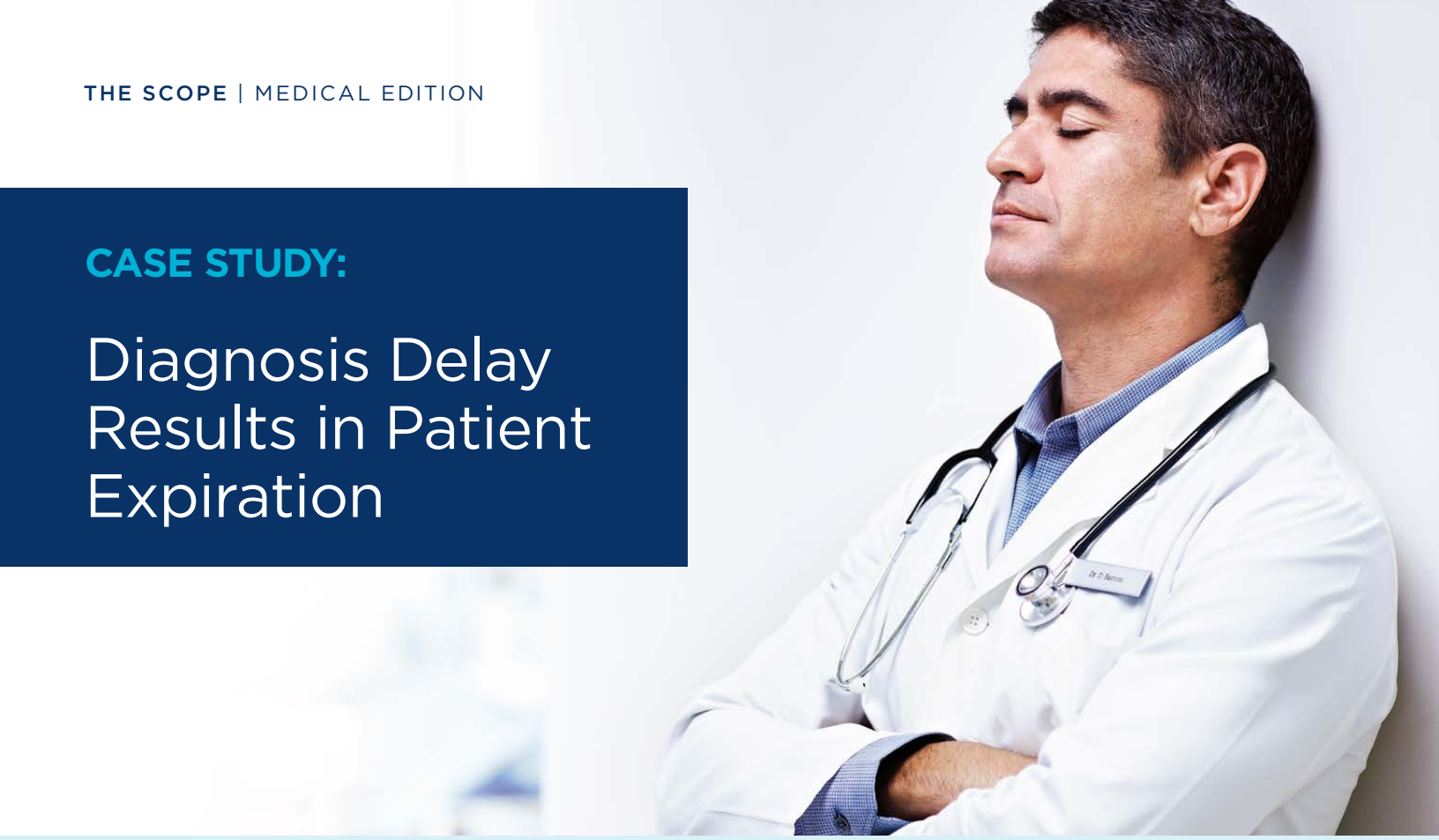

CASE STUDY:

Diagnosis Delay Results in Patient Expiration

This case involves allegations of a delay in the diagnosis and treatment of a pulmonary embolism that resulted in the death of a 51-year-old male.

Initial Treatment

The patient was admitted to the emergency department (ER) on August 5, 2015, with complaints of chest pain and shortness of breath. His medical history was significant for morbid obesity, high cholesterol, cardiomyopathy, pericarditis, prior cardiac catheterization, diverticulitis, and prior knee surgery.

A cardiac event was suspected, and the patient was given Plavix and underwent cardiac catheterization with the administration of Heparin, but the catheterization failed to reveal the cause of the patient's symptoms. The patient's pulse and lung sounds were normal. A chest x-ray revealed mild cardiomegaly, and vascular congestion was seen. A D-dimer study was elevated, a lower leg Doppler study was negative for deep vein thrombosis, and an order for an echocardiogram was given.

The MLMIC-insured pulmonologist saw the patient the following day, and he was resting comfortably. Based upon the D-dimer results and the chest x-ray, he suspected a pulmonary embolism and ordered a CT angiogram. However, the pulmonologist did not document his suspected diagnosis in the record, and the CT was not ordered on a STAT basis due to concerns that injecting dye could lead to kidney failure in a patient who recently underwent a cardiac catheterization. The pulmonologist also ordered Lovenox.

> Based upon the D-dimer results and the chest x-ray, he suspected a pulmonary embolism and ordered a CT angiogram.

Patient Condition Worsens

Later that day, at 9 p.m., the patient developed shortness of breath and chest pain and was administered oxygen. The covering pulmonologist (also a MLMIC policyholder) was notified, and he ordered a chest x-ray and advised the nurse to obtain arterial blood gases and contact the PA with the findings. The patient's blood gas was slightly

abnormal, and his oxygen saturation continued to drop. He was also tachycardic and experienced some chest pressure.

A PA saw the patient and administered Lasix due to the suspected congestive heart failure as seen on the chest x-ray. He also ordered a CT angiogram be performed, STAT, which revealed extensive bilateral pulmonary emboli with the echocardiogram revealing right heart strain.

At 4 a.m., the PA administered Lovenox. The PA attempted to reach the covering pulmonologist, but did not hear back until 6 a.m. due to insured's phone being inadvertently turned off. When the covering pulmonologist was reached and advised of the patient's condition, he informed staff that the other insured pulmonologist would be in shortly.

At 9 a.m. the following morning, the first pulmonologist saw the patient and, based upon test results, including an elevated troponin level, was concerned the patient was going into heart failure. Even though the patient had received Lovenox six hours earlier, which would still be in his system, he felt the benefits of administering TPA outweighed the risk of an intercranial bleed.

TPA was discussed with the patient, including the risks, and the patient agreed to TPA administration. A few hours later, the patient became confused. A CT scan revealed he had suffered a large bleed in his brain. Surgery was unsuccessful in removing the blood or alleviating the swelling, and the patient expired the following day.

Lawsuit and Settlement

A lawsuit was filed, with the allegations centered around the negligent administration of anticoagulant and TPA resulting in intracranial hemorrhage, craniotomy, and the death of the patient. The plaintiff's focus was on the elevated D-dimer and troponin results from the initial examination and also an alleged a delay in the diagnosis and treatment of pulmonary embolism.

Experts opined that both pulmonologists failed to meet the standard of care. The first pulmonologist should have ordered a CT angiogram STAT and made sure the patient was receiving sufficient heparin. There was an approximately 48-hour delay in the diagnosis and treatment of the pulmonary embolus. There was also a delay in returning phone calls by the overnight on-call pulmonologist. There were no alternative diagnoses to better explain the patient's shortness of breath and tachycardia. That, along with a positive D-dimer, should have led to a high likelihood of pulmonary embolism and the start of full-dose anticoagulation.

The plaintiff's demand was $6.5 million, and the case settled on behalf of both insured pulmonologists for a total of $2.55 million.

A Legal and Risk Management Analysis

Delayed diagnosis is a common claim in medical malpractice cases and is attributed to both human and system-level factors. The plaintiff's focus in this case was on human error attributed to the pulmonologists — inadequate assessment, untimely on-call response, and failure to appear and perform a patient evaluation in person.

From a risk management focus, it is important for the organization to look beyond the plaintiff's claim. The organization must perform a deeper dive to determine whether organizational or system factors contributed to the human error. These factors include time-related pressures or situational and environmental factors such as time of day, overcrowding, and workforce/staffing shortages.

The multi-million-dollar settlement in this case also shows that the **Grieving Families Act** is not needed to provide for a significant recovery in a wrongful death action.

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INSIDE MLMIC'S

Customer Service Department

In this section, *The Scope* will highlight the various departments of MLMIC Insurance Company and their roles in supporting the healthcare practitioners of New York.

Customer Service at MLMIC isn't just a department within the organization; it's a part of our company's culture and embedded in everything we do. It's important to everyone at MLMIC that we reliably assist our customers in the most efficient way we can. Our focus is to fit our processes with you, the customer, always in mind.

As is true with everything in the world, our Customer Service department has been through a transition in recent years and has grown so that we can continue to be here for you with more team members and added training on a variety of topics to assist with policy-related questions and online tools, plus additional coverage hours with trained MLMIC staff.

As an example, MLMIC's toll-free phone numbers are answered by skilled professionals, ready to help you with any type of question. MLMIC doesn't utilize an automated interactive voice response or phone tree system because we know they can be frustrating and time consuming. Our toll-free phone numbers ring directly to our Customer Service staff, who are ready to assist you right away.

MLMIC continues to expand our technology to better support you with our customer portal and access to information online via MLMIC.com. And should you have a question about your bill, need to update your contact information, or are logging in to the portal for the first time to complete a Risk Management course, the Customer Service staff who are answering your calls and emails are ready to assist you. Our team also responds to your credentialing needs and provides documentation upon request. We understand the urgency of these requests and always respond as quickly as possible.

By working closely with all of the departments within MLMIC, Customer Service will be sure to connect you with the right person to assist with any type of question you may have.

Jennifer Kirshman is the Director of Customer Service at MLMIC Insurance Company.

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How can we help you today? Please call us at **(800) ASK-MLMIC/(800) 275-6564** or send an email to **customerservice@mlmic.com**. We look forward to assisting you.

USE OF TECHNOLOGY CHECKLIST #29

DOCUMENTATION CONSIDERATIONS FOR OPEN NOTES

The 21st Century Cures Act was enacted in part to increase communication among healthcare providers and remove some of the barriers patients face when trying to obtain their health information. To accomplish this, the Act affords both providers and patients greater access to more complete patient histories and empowers patients to become more engaged in their healthcare decisions. This improved patient engagement allows providers the opportunity to improve documentation accuracy, enhance patient safety, increase patient compliance, develop stronger patient relationships, improve efficiency of care, and enhance the overall patient experience.

Considering the increased patient access to their health information, the following strategies can help your patients better understand their records, become active participants in their healthcare, and create stronger physician-patient relationships.

	YES	NO
1. The electronic health record (EHR) system vendor has confirmed that all required information can be accessed by your patients and how that information will appear on their screen.	☐	☐
2. EHR format is understood, functions are maximized, and applications such as portal access, spell check, and reminder notifications are functioning properly.	☐	☐
3. The patient remains engaged and feedback is solicited from them: • You dictate or type notes with the patient present; you talk during the visit about what you are documenting. • Patients are encouraged to refer to the notes as a reminder of the treatment plan to increase their compliance.	☐	☐
4. Resources are in place to support increased patient engagement. Written policies and procedures address: • How patients and their representative can access their health information. • The confidentiality of minors' information. • How patient comments or questions about the documentation of their encounter will be managed.	☐	☐
5. Documentation of the encounter is assessed for negative effects it may have on your patient. Your documentation: • Does not sound judgmental. You avoid terms that may be offensive or emotionally charged. For example, document "Patient reports s/he did not the take medications" vs. "noncompliant" or "unreliable." • Uses objective measures like BMI vs. "obese" or "overweight." • Is mindful and care is taken when using abbreviations, e.g., "[Patient] is "SOB." • Uses a supportive tone when possible: "Lost five pounds and is motivated to continue" vs. "Still needs to lose another 15 pounds." • Emphasizes that you are writing clear instructions: "Weigh yourself every morning" vs. "Patient needs to monitor weight." • Avoids the copy and paste feature of your electronic record system, as the information copied and pasted may be redundant, outdated, or inaccurate and create the wrong perception about your records.[1]	☐	☐

DOCUMENTATION CONSIDERATIONS FOR OPEN NOTES

6. The health literacy level of your patient is assessed.[2] Plain language is used in your documentation: • Avoid the use of jargon. • Define medical terms when possible. Consider providing a list of terms and abbreviations frequently used in your documentation.	☐	☐
7. Educational information is provided to patients on Open Notes: • A practice policy is implemented to address questions on patient access and • How to increase communication and access through media such as: 1. Email 2. The patient portal 3. Your website 4. Social media 5. Information sheets and/or flyers in the office	☐	☐

1 See MLMIC's Risk Management Tip #20: Reducing the Risk of the "Copy and Paste" Function in Electronic Health Records *https://www.mlmic.com/why-mlmic/services-resources/risk-management-tips*

2 See MLMIC's Risk Management Tip #17: Communicating With Low Health Literacy Patients *https://www.mlmic.com/why-mlmic/services-resources/risk-management-tips*

Addressing Your Liability Risks During the Healthcare Staffing Crisis — continued

Mentoring programs are also good tools to bridge the gap between nursing school and new job orientation and their career as a nurse. These programs can also be utilized throughout healthcare systems for new clinicians and leaders, PAs, NPs, and managers.[26]

In conclusion, invest in technology such as virtual companions and robots. Educate staff on their use and limitations, while ensuring policies and procedures that reflect current standards and technology. Use focused assessments on high-risk areas like the emergency department, obstetrics, surgical services, orthopedics, and primary care. For assistance, reach out to MLMIC, as focused assessments are a MLMIC Risk Management service. Always know the scope of practice for licensed professionals, their chain of command, what tasks can be delegated, and what level of supervision is required.

Always remember to document. The EHR is a tool that should assist, not hinder, care delivery. Record the care delivered or "tell the story." Remember, the EHR vendor should still be available as a resource when opportunities arise to make modifications or when questions come up. Maintain open communication throughout the organization, engaging patients and families and defining acceptable modes of communication, and document all exchanges that have occurred.

Ensure follow-up by incorporating assessment findings in the plan of care. For example, "Fall Risk — activate bed alarms and respond to them." Finally, manage expectations by engaging patients and families to set realistic expectations. While we know there is a staffing crisis, families will not care as they are now dealing with their own crisis. However, you can communicate with them to set realistic treatment expectations and time frames.

Mark Ambrose is a Senior Risk Management Consultant with MLMIC Insurance Company.

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26 https://www.beckershospitalreview.com/nursing/mentoring-is-miracle-gro-for-nurses-and-key-to-future-success

FROM THE BLOG

Get to Know ECMS President Stacey Watt, M.D.

I had the honor and privilege of sitting down to enjoy a cup of pumpkin cinnamon coffee with Stacey Watt, M.D., interim chair and clinical professor of anesthesiology at the **Jacobs School of Medicine and Biomedical Sciences** at the **University at Buffalo**, who will be installed as the **Erie County Medical Society's (ECMS)** seventh female physician president. Dr. Watt is a pillar in the Western New York medical community and an advocate for physicians throughout the state. Her energy is contagious.

In the following conversation, we discuss her career as an anesthesiologist, her athletic history, her plans as the incoming president of ECMS, and her advice for young female physicians.

What drove you to study medicine?

"My pathway was akin to many other individuals. It was never a straight line..."

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Protecting Yourself From the Risks of Using "Copy and Paste" in the EHR

The electronic health record (EHR) has been beneficial to both healthcare providers and patients. Healthcare providers can easily access patient records from consultants, hospitals, and other healthcare facilities. Patients also have direct access to their medical records through patient portals. However, one concern for healthcare providers when using the EHR is the "copy and paste" function.

The **electronic copy and paste function** is a major problem in healthcare. A study published in ***JAMA Network Open*** in September 2022 found that half of the medical records reviewed as part of the study contained duplicative information from prior documentation. The study revealed that physicians, nurses, and therapists routinely use the copy and paste function in the EHR.

This blog will discuss some of the risks to consider when using the copy and paste function.

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