Key Areas of Risks for Dietetic Professionals

Reducing Risks and Enhancing Patient Safety

Abstract

This white paper identifies key and emerging areas of risk for dietetic practitioners and provides practical strategies for enhancing patient safety and reducing risks.

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INTRODUCTION

Beginning in 1999 with the Institute of Medicine's report, "*To Err is Human: Building a Safer Health System*," there has been a heightened awareness of the frequency and severity of medical errors in the U.S. The report described the nation as, "experiencing an epidemic of medical errors."[1] The Institute of Medicine revisited the issue in a 2001 report, "*Crossing the Quality Chasm: A New Health System for the 21st Century*" and reinforced the alarm stating, "The

nation's health care delivery system has fallen far short in its ability to translate knowledge into practice and to apply new technology safely and appropriately."[2] It is hard to know the exact number of medical errors in the U.S, but a study performed at Johns Hopkins claimed that more than 250,000 people die from medical errors, making it the third leading cause of death.[3] For comparison, there were 629 deaths from airplane crashes in the U.S. in 2016 [4] Many patients survive medical errors, but are harmed as a result of miscommunication, flawed systems, lack of training and resources, and inadequate policies and procedures. When a patient experiences an unexpected an outcome, the chances of a lawsuit are higher. As such, almost every healthcare professional faces some degree of professional liability. In an article in the Journal of the American Dietetic Association, there had not been a single successful malpractice case against a dietitian up to1988.[5] Some thirty years later, the tide has turned. More adverse actions and malpractice payments have been reported to the National Practitioner Data Bank (NPDB)[1], however the frequency and severity of paid malpractice payments against dietetic practitioners are generally lower in comparison with other allied health professionals. Nonetheless, allegations of malpractice are not reserved for doctors and nurses. More than ever, dietetic professionals must practice defensively and regard risk management and patient safety as a priority.

THE US MALPRACTICE CLIMATE

Based on data from the NPDB, 27 malpractice payments and 197 adverse action reports were filed on behalf of a dietitian or nutritionist.[6] Of the 27 malpractice payments, the highest payment reported was $495,000 and the average payment is $99,113.[7] The most common allegation that gave rise to the claim or adverse action was improper management and failure to monitor.[8]

The number (frequency) of medical liability claims in the U.S. has been declining from the period of 2007 to 2017.[9] Almost 87% of the paid claims reported to the NPDB were on behalf of a physician or dentist, with the remaining 13% on behalf of another healthcare professional.[10]

The reduction in medical liability claims has been influenced by effective tort reform. Nonetheless litigation remains costly, with the average indemnity for all healthcare specialties at

[1] The NPDB was established in 1986 and requires hospitals, health plans, licensing boards, and medical liability companies to report adverse actions and malpractice payments. This information is available to the general public.

$335,578.[11] Based on information from CNA, NSO, the average indemnity paid for on behalf of a Registered Nurse is $165,491, almost 70% higher than for Registered Dietitians.[12] For closed claims in all healthcare specialties, improper performance, errors in diagnosis, failure to supervise or monitor case, medication error, or failure to recognize a complication were among the top factors.

KEY AREAS OF RISK FOR DIETETIC PROFESSIONALS

The degree of professional liability exposure for dietitians is primarily determined by the practice location and type of patients treated. Dietetic professional working with hospitalized patients and patients in skilled nursing facilities are exposed to greater liability risk than those working with a healthy populations such athletes in sports nutrition practice setting. Some key and emerging areas of risk are discussed below.

I. The Skeleton Remains in the Hospital Closet

The 1974 landmark study by Harvard surgeon Dr. Charles Butterworth, "*The Skeleton in the Hospital Closet"* raised the alarm about the prevalence of malnutrition among hospitalized patients and its association with increased morbidity and mortality.[13] Dr. Butterworth placed a spotlight on iatrogenic malnutrition, citing case examples and undesirable practices that affected the nutritional health of patients. Among these were failure to records accurate height and weights, discontinuity of care among the healthcare team, withholding meals for diagnostic tests, failure to assess nutritional status of surgical patients and failure to recognize increased nutritional needs based on injury or illness.[14] Decades after this report, malnutrition among hospitalized patients remains a significant patient safety concern. The issues that Dr. Butterworth pointed to as causative factors, such as discontinuity and failed communication among the healthcare team, remain common themes in sentinel events and medical liability claims.

It is estimated that one-third of patients have malnutrition when they are admitted to the hospital and that two-thirds will experience further decline during their stay.[15] In another study of nearly 6 million adult hospitalizations, researchers found that only 5 percent of patients had been given a malnutrition diagnosis. Even those patients who do not have a malnutrition diagnosis at the

time of admission can experience a rapid decline when nutrition support is withheld. For example, patients who are admitted to the ICU in a healthy state can experience a rapid decline in nutritional status when they are in a hypermetabolic state for an extended period of time. Research by Dr. Paul Wischmeyer and his colleagues at Duke University have research showing that ICU patients receive only about half the calories they need and about one- third of the protein they need during the pendency of their critical care stay.[16] His team is leveraging technology - a ventilator that monitors the patient's metabolic needs to determine the patient's individualized caloric needs.[17]

Patients who experience malnutrition have increased risk of pressure injuries, decreased wound healing, higher rates of infection, longer hospital stays, more hospital readmissions, and greater health care costs.[18] There is both a human and economic toll on the patient and the organizations that care for them. With the implementation of value-based purchasing initiatives and penalties for hospital-acquired conditions, it is imperative to recognize patients at risk for malnutrition and begin a treatment plan at the time of admission. Compounding the economic loss are the professional liability risks associated with patients who experience associated conditions resulting from malnutrition.

The case of the Estate of Doris L. Cote, et al v. Five Star Quality Care, Inc., et al. is an example of the human and economic toll of the failure to treat malnutrition. The complaint alleged that Cote become *malnourished and dehydrated* after overmedicating her with painkillers. This resulted in a pressure injury that become infected and eventually caused her death. The family alleged that the facility consciously disregarded its own procedures designed to prevent pressure ulcers and intentionally falsified medical records to cover it up.[19]

II. Pressure Injuries Result in 60,000 Deaths per Year- Frequently Associated with Professional Liability Claims

The national incidence rate of pressure injuries (PIs) for hospitalized patient is 2.5%, resulting in 60,000 deaths per year.[20] Individuals who developed PIs are more likely to die during the hospital stay, have generally longer hospital lengths of stay, and be readmitted within 30 days after discharge.[21]

The prevalence of PIs is also significant in other healthcare institutionalized settings such as long term care and rehabilitation settings. In additional to the human toll of PIs, their economic impact on the U.S. healthcare system is between 9-11billion per year.[22] In 2008, the Centers for Medicare and Medicaid Services (CMS) began to reduce payments to hospitals for patients who develop hospital acquired conditions, such as pressure injuries, central line-associated blood stream infections (CLABSIs), and venous thromboembolism (VTE). Malnutrition and poor dietary intake are significant risk factors for the development of PIs and wound healing.

Medical liability claims related to PIs are not uncommon. According to an article published in Today's Wound Clinic, "Pressure ulcers are highly litigated and are the second most common cause of civil suits alleging medical malpractice — superseded only by wrongful death suits."[23] The average settlement of a PI lawsuit is $250,000, with some awards topping $312 million. Plaintiffs are favored in up to 87% of these cases.[24,25]

III. Expanding the Scope of Practice and Increasing Risks

The scope of practice for RDNs has continued to evolve and expand. In 2017 the Academy of Nutrition and Dietetics (Academy) revised the Scope of Practice for Registered Dietitian Nutritionist (RDN).[26] As the healthcare system is challenged to meet quality and patient safety initiatives with fewer resources, there has been a nationwide movement to expand the scope of practice for many allied health professionals. Advanced practice clinicians, such as nurse practitioners, physician assistants and pharmacists have been successful in expanding their scopes of practice many states. Although the expanded scope of practice for RDNs creates new opportunities, it can also create new risks.

The scope of practice describes the actions that a healthcare practitioner is allowed to undertake based on their professional licensure. A scope is typically statutorily defined by a state practice act, regulations set forth by a professional licensing board, or state and federal organizations such as those set forth by the Centers for Medicare and Medicaid Services. Practicing outside of your legal scope of practice is violation of your practice act and may place you at risk for an adverse action with your professional licensure board. As the scope of practice for RDNs continues to evolve, it is important to understand and practice within the boundaries of your scope of practice.

One of the most notable changes to the RDN's scope of practice is the regulation changes in the CMS Conditions of Participation for Hospitals, Critical Access Hospitals, and Long-Term Care Facilities, which allow a hospital or long-term care facility the option of granting RDNs ordering privileges and/or delegated orders for therapeutic diets and nutrition-related services.[27,28,29] This permits qualified RDNs and qualified food and nutrition professionals to perform these acts consistent with state laws and privileges with the facility. Although the majority of states in the U.S .either have no statutory or regulatory impediments to a qualified RDNs seeking hospital privileges to order therapeutic diets and nutrition-related lab tests, the Academy is working to remove statutory and regulatory impediments to taking full advantages of the opportunities presented by the CMS rule.[30] "CMS stated that, "in revising the provision was to provide the flexibility that hospitals need under federal law to maximize their medical staff opportunities for all practitioners, but within the regulatory boundaries of their state licensing and scope-of-practice laws."[31]

The Revised 2017 Scope of Practice for the RDN also contains a list of tasks that can be performed by RDNs who have demonstrated and documented competence and the required knowledge, skills, and training. Once verified competent, an RDN can measure blood pressure, conduct waived point-of-care tests, initiate pharmacotherapy plans, and perform a nutrition-focused physical exam.[32]

In 2001, the American Dietetic Association (ADA), with the support of the Dietitians in Nutrition Support practice group, adopted the American Society for Parenteral and Enteral Nutrition's (ASPEN) standards of practice for Nutrition Support Dietitians (NSD). With respect to the NSDs ability to participate in the implementation of the standard states,

The NSD's involvement with implementation may occur at several levels depending on their job responsibilities, professional licensure, and institutional clinical privileges. Levels of involvement include recommending not only the placement and management of enteral access devices *but also the actual placement and management of nasoenteric access devices after special training and certification.*[33]

ASPEN and the Academy of Nutrition and Dietetics (Academy), in standards of practice guidance states that "the individual scope of practice in nutrition and dietetics has flexible boundaries to capture the breadth of the individual's professional practice" [34] This was a significant leap forward in terms of expanding the scope of practice for dietitians practicing in the role of a NSD.

IV. The Dietitian's Role Maternal Health

The maternal mortality rate in the United States is on the rise. The Centers for Disease Control and Prevention (CDC) reported an increase in the maternal mortality ratio in the United States from 18.8 deaths per 100,000 births to 23.8 deaths per 100,000 births between 2000 and 2014, a 26.6% increase. Although the number of maternal deaths have fallen worldwide, the number of maternal deaths in the United States has almost doubled.[35] In 2016, as many as 900 women between the ages of 16 and 43 died from pregnancy- and childbirth-related causes.[36] The U.S. *ranks at the bottom* among developed countries in rates of women dying during pregnancy, childbirth, or the postpartum period.[37] Conditions such as diabetes, obesity, and hypertension–all having a dietary component are also rising in the United States. Each of these have a nutrition-related component and are implicated in the growing number of maternal deaths. According to the CDC, almost half of these deaths should be preventable.[38] Dietitians practicing in the area of maternal health have opportunities to influence improved outcomes, but should be aware of the emerging risks and increased litigious environment among this patient population.

OB/GYN Surgery is one of the highest risk specialties in medicine; ranking first among all specialties in the total number of closed claims and third in average indemnity payment.[39] Although the OB/GYN physician is the target of a lawsuit, allied health providers can be named as co-defendants. A plaintiff can also name an employer or an organization. Under the legal theory of "respondeat superior" employers may be found liable for their employees' actions that resulted in harm to a patient. This principle, "makes an employer or principal legally responsible for the wrongful acts done by an employee or agent, if such acts occur within the scope of the employment or agency."[40]

In July 2018, USA Today published an article exposing patient safety lapses that contribute to maternal deaths. The article reported that, "every year thousands of women suffer life-altering injuries or die during childbirth because hospitals and medical workers skip safety practices known to head off disaster."[41] The article pointed out that the lapses were often the result of *failure to perform basic tasks* that do not require expensive technology.

In addition to the risk of hypertension, hyperglycemia and gestational diabetes mellitus (GDM) one of the leading causes of maternal mortality. Diabetes affects one out of every six pregnancies around the world and left untreated can have devastating consequences for the mother and baby.[42] The International Federation of Gynecology and Obstetrics (FIGO), states that "given the link between hypertension, in pregnancy, poor pregnancy outcome, and future risk of diabetes in both mother and offspring, a focus on prevention, screening, early diagnosis and managing hyperglycemia in pregnancy is needed globally.[43] The Academy of Nutrition and Dietetics has established evidenced-based nutrition guidelines for gestational diabetes. The treatment goal is to maintain normal glycemic levels and appropriate weight gain, while meeting essential nutrients for pregnancy to promote positive maternal and fetal outcomes.

V. Bariatric Procedures and Litigation

Medical liability claims involving bariatric surgery are not uncommon. Although the physician is most often the target of a medical liability action, other members of the healthcare team are not immune to an allegation of malpractice. Bariatric surgeons, because of their increased risk, typically pay higher professional liability premiums than surgeons who do not perform these procedures. When a bariatric surgeon is sued, the facility and other members of the interdisciplinary team are often named as co-defendants. RDNs play an important role in the patient's pre and post-operative care and can be at risk for getting caught in the crosshairs of bariatric litigation.

More patients are opting for a surgical approach to obesity. Data from the American Society for Metabolic and Bariatric Surgery (ASMBS) showed a steady increase in the number of procedures performed over the past seven years- an estimated 228,000 were performed in 2017.[44] The gastric sleeve was the most commonly performed bariatric procedure (59%).[45] Conservative

approaches to obesity such as diet, exercise, and medications are the preferred approach, but success rates remain marginal, especially when the patient has an impediment to physical activity. Minimally invasive techniques have made these procedures a much more attractive option for patients with morbid obesity.

Nationally, 39.8% (93.3 million) adults are obese according to 2015-2016 data from the CDC.[46] As cited in the Clinical Endocrinology News, at the current rate, it has been estimated that close to half of the US adult population could be obese by 2030.[47] Obesity is a significant national health problem –its related conditions including heart disease, hypertension, stroke, type 2 diabetes and certain types of cancer represent some of the leading causes of preventable death.[48] Although bariatric procedures carry risks, many patients ultimately decide that the obesity-related health risks are greater than the risks of undergoing a bariatric surgery. The prevalence in obesity, coupled with the minimally invasive approach has contributed to the increased demand for a surgical option.

Patients who chose to have bariatric procedures often have complex medical histories with coexisting conditions such as diabetes, hypertension, dyslipidemia, obstructive sleep apnea, and gastroesophageal reflux. Despite advances in surgical procedures, the patient's co-morbidities potentiate the risk of complications. Many complications related to bariatric surgery are associated with these coexisting health conditions. The procedural risks coupled the intrinsic risks related to the patient's health conditions create a suitable environment for complications, thereby increasing the risk of bariatric litigation.

A study of 140 closed medical liability claims related to bariatric surgery was published in the Journal of Gastrointestinal Surgery in January 2017. Notable highlights from the study are:

- 32% of the claimants were male
- The mean age of the claimant was 43
- The most common procedure litigated was the Roux-en-Y gastric bypass (76 %)
- The most common alleged reason for a malpractice claim was delay in diagnosis or management of a complication in the postoperative period (47%)
- The most common complication was an anastomotic leak (45%)

- Death was reported in 74% of the cases
- 47% of closed claims were decided in favor of the patient
- The median award payout was $1,090,000 [49]

The hospital was implicated in 28% of the cases.[50] This indicates that the hospital assumed liability related to its processes, procedures, and/or acts of its employees and credentialed practitioners.[51] In 5% of the closed claims, there was an allegation of failure to manage the nutritional status of the patient following bariatric surgery.[52] Complications included Wernicke-Korsakoff syndrome, iron deficiency anemia, thrombocytopenia and malnutrition. The patient expired in three of the cases that involved a nutrition-related allegation.[53] The number one allegation in the research population was related to patient selection – the patient was an inappropriate candidate for the bariatric procedure.[54]

In another study reported in Clinical Endocrinology News, four of the nation's largest medical malpractice carriers collaborated with members of the ASMBS task force and studied 175 claims closed from 2010-2015. The panel determined that the cause of the complication was provider-related in 50% of cases, system-related in 29%, and intrinsic to the patient's disease in 21%.[55] The task force reported that the one theme to emerge from the lawsuit analysis *was poor communication with the health care team and/or family*, noting the communication performance to be appropriate in only 20% of cases.[56] This mirrors reports from the Joint Commission on the central role of communication in sentinel events. A communication issue was identified as the third most frequently identified cause of a sentinel event reported to The Joint Commission from January 1-December 31, 2015.[57]

EVALUATING AND REDUCING RISK

I. Evaluate Your Insurance Needs

Your need for insurance coverage is based on your practice setting and risk exposure. Although professional liability coverage for clinical acts is likely the most important risk to consider, other exposures may exist based on your employment model. For example, dietitians in a self-employment setting should consider the business exposures in addition to the professional

liability risks. Dietitians who bill insurance companies have exposure for billing errors. If the self-employment model involves maintaining an office that is available to clients, you may need to consider maintaining general liability coverage.

Most healthcare professionals employed by a hospital, nursing home or other healthcare setting are covered by the organization's insurance policy. Hospital professional liability policies typically cover employed medical professionals for their professional acts, errors, or omissions. To assess whether you need to maintain a separate policy, you should know whether you share limits with the organization or if a separate policy is maintained. Maintaining individual insurance coverage may be a "double-edged sword" as it may increase the likelihood of being named individually in a professional liability claim. Consult an insurance professional as you contemplate the type(s) and amount of insurance coverage you need.

II. Adhere to Your Scope of Practice

The scope of practice describes the actions that a healthcare practitioner is allowed to undertake based on their professional licensure. A scope is typically statutorily defined by a state practice act, regulations set forth by a professional licensing board, or state and federal organizations such as those set forth by the Centers for Medicare and Medicaid Services. Practicing outside of your legal scope of practice is violation of your practice act and may place you at risk for an adverse action with your professional licensure board. As the scope of practice for RDNs continues to evolve, it is important to understand and practice within the boundaries of your scope of practice. Refer to the Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist and the Scope of Practice Decision Tool.

III. Maintain Accurate, Complete and Timely Documentation

The primary purpose of the medical record is for communication with the health care team. It is the primary tool to plan, coordinate, and document the care provided to the patient. Documentation impacts the safety of our patients and the quality of documentation is often equated with quality of care. It is also a legal document that serves as evidence in a medical liability claim. A 2015 report by CRICO, a division of The Risk Management Foundation of the Harvard Medical Institutions, Inc., found that "communication failures were linked to 1,744 deaths in five years and communication was a factor in 30% of 23,658 cases filed from 2009-2013".[58] Documentation is directly linked to communication. Failure to communicate promptly and appropriately for the situation and failure to document medical care continue to be the two factors commonly associated with defensibility of all medical profession liability claims. Ensure that your documentation is accurate, complete, and timely as it will support that the standard of care was met.

IV. Practice in a Setting Committed to Patient Safety

The RDNs professional liability risks are directly linked to the practice setting. Lower medical error rates have been linked to organizations that are committed to safety principles. Some of the key features of an organization with a "culture of safety" include:

- acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
- encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- organizational commitment of resources to address safety concerns[59]

V. Use Evidenced-Based Nutrition Guidelines

Evidenced-based nutrition guidelines are guiding statements and treatment algorithms based scientific evidence. In a professional liability claim, experts will likely rely of the evidenced-

based guidelines that were in effect at the time of the alleged incident. The Academy of Nutrition and Dietetics maintains a list of practice guidelines. Some of the guidelines are accompanied by other resources documents such as documentation templates and education modules. Despite disclaimers that these are guidance documents, expert witnesses in professional liability claims will often point to practice guidelines to establish standard of care. When the patient's circumstances or condition warrants a deviation from evidenced-based guidelines, it is important to document the rationale to support the clinical decision making.

VI. Maintain a Good Relationship with Patients

Studies have shown a correlation between patient satisfaction and lawsuit experience. In one study, researchers looked for a correlation between patient satisfaction scores and malpractice risk. They evaluated a total of 543 patient responses and found that almost 53% of the providers who were rated poor or very poor had a previous lawsuit filed against them.[60] Another study showed that when it comes to litigation those who are much more likely to be sued are not the "bad" doctors. They are the doctors who had poorer relationships with their patients.[61] Patient satisfaction ratings are largely driven by their perception of customer service skills rather than the quality of clinical care. One of the best deterrents to a professional liability claim is to provide patient and family-centered care that embraces four core concepts: dignity and respect, information sharing, participation and collaboration.[62]

CONCLUSION

The number of professional liability claims against dietetic professionals remains low when compared to other allied health professionals, however, reports to the National Practitioner Data Bank have increased. As the practice of dietetics continues to evolve and the scope of practice expands, dietetic practitioners may engage in acts that will create a greater exposure to professional liability. Certain practice settings and patient populations create a higher amount of risks. These factors should be considered in determining how much risk you are willing to assume or transfer. Regardless, of your practice setting, it is important to remain vigilant about the potential legal pitfalls and make patient safety a priority.

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