

Risk Pearls: May 2017

By Julie Loomis, RN, JD

Do you have a procedure for handling a missed appointment during which follow-up care or treatment was to be provided? To avoid patient harm and a claim of missed or delayed diagnosis, it is important that practices have a procedure to ensure that no-shows and cancellations are communicated to the treating provider and any actions taken are documented in the medical record. Generally, the efforts required to contact the patient are commensurate with the patient's medical condition and potential consequences of missed treatment. If a patient is at minimal risk (e.g. a well checkup), no action may be required or a single phone call or letter may be sufficient. For patients at moderate risk, such as those who need ongoing monitoring or treatment, a more concerted effort should be taken to contact the patient. Usually two documented phone calls and a certified letter should be adequate. All communications should inform the patient in layman's terms about the consequences of failure to receive needed treatment in a timely manner. As with all patient communication, staff should document the date, time of the call, and place a copy of the missed appointment letter in the patient's medical record. If a patient fails to return to the office repeatedly, after appropriate contact attempts have been made, the treating provider may take steps to discharge the patient from the medical practice. Please visit svmic.com for resources or consult an SVMIC Claims attorney for assistance with individual situations.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.