Hospitals

A Clinically Coded Case Analysis

2025

MedPro Group

MLMIC
MLMIC Insurance Company
CELEBRATING 50 FIFTY YEARS

Report Scope

This report details stories and data arising out of MedPro and MLMIC closed hospital cases. Even though well-meaning hospital staff, physicians and surgeons intend to provide the highest quality of care, failures in the process of care do occur, and can result in a long-lasting impact on both patients and providers.

We trust you'll read our data and associated case stories with an eye on both clinical risk management and on how these events might have been prevented, for the benefit of patients and providers.

Throughout this report, we'll answer the following questions, among others, and support the answers with data:
Which case types are most common?
Who is responsible for the patient's injury, and how serious are the injuries?
Where do the events occur?
How do failed processes of care, known as contributing factors, impact patient outcomes?

Key Points

Almost 5000 clinically coded closed hospital cases were referenced for this report.	A comparison of data from cases arising in critical access facilities to those in non-critical access facilities yielded relatively few differences.
Surgical and diagnostic case types are most common.	A proportionately higher volume of diagnosis-related cases was identified in the critical access facilities.
Events arising in patient rooms and the ED are most common.	The emergency department accounted for more than one-quarter of the critical access case volume, whereas patient rooms, including ICUs, account for more than one-quarter of the non-critical access case volume.
Nursing, surgical, medical and emergency services account for the largest volume of cases.	Nursing is more often noted as responsible in the non-critical access setting, while emergency medicine cases are more common in the critical access facilities.
The types of contributing risk issues are similar across facility types.	Diagnostic decision-making, failures to follow policy/procedure, suboptimal communication between providers, and insufficient/lack of documentation are among those commonly noted in cases reflective of both clinical and financial severity.

MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367)

Clinical Risk Analysis

The following section details clinical risk insights from closed hospital cases, including critical access, across case open years 2014-2023.

A key point of the clinical coding process involves the categorization of cases into types. Case types characterize the underlying processes of care which most directly impacted the patient's outcome, and/or initiation of a claim/suit. There is always one primary case type, and often several secondary types.

Primary Case Types Defined

Anesthesia-related: Management and treatment of the anesthesia patient; inclusive of pre-, intra-, and post-anesthesia periods, including performance of anesthesia procedures, diagnosing complications and immediate post-procedure pain management

Diagnosis-related: Encompasses delayed, missed and wrong diagnoses; inclusive of management of incidental findings

Medical treatment & procedures: Management and treatment of patients to address diseases and disorders; inclusive of the performance of medical and diagnostic procedures

Medication-related: Reflective of the medication delivery process, including ordering, dispensing and administering; inclusive of technique issues during administration

Primary Case Types Defined

OB-related: Management and treatment of pregnancy; inclusive of antepartum, labor, delivery and post-partum periods; inclusive of diagnosing pregnancy-related maternal and fetal health conditions and performing OB procedures

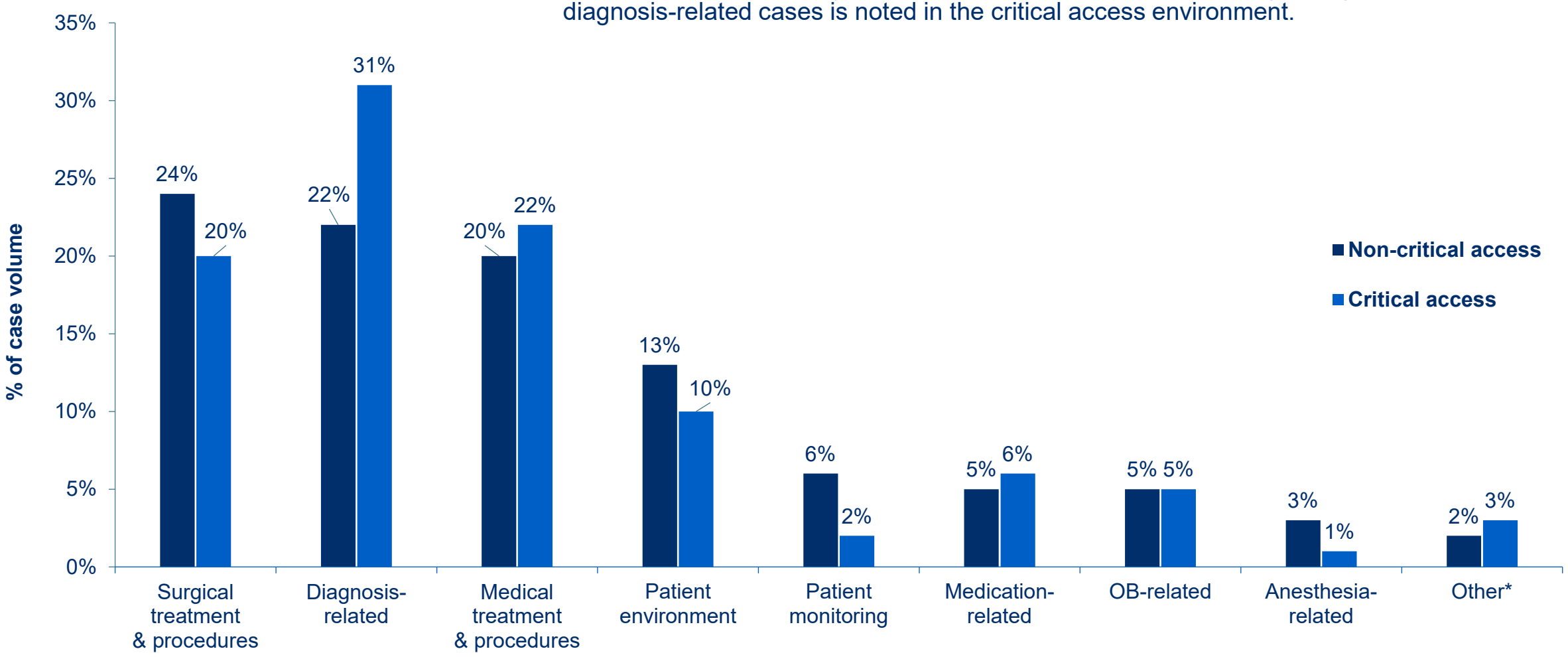
Patient environment: Inclusive of falls and other preventable injuries during care, including physical safety (i.e., injury from equipment, surgical fires), infection control in the patient care areas, and security issues (i.e., assault)

Patient monitoring: Reflective of bedside observations and response to patients' physiologic or psychiatric reactions to disease, condition, injury or treatment

Surgical treatment & procedures: Management and treatment of the surgical patient; inclusive of pre-, intra-, and post-operative periods, performance of surgical procedures, and retained foreign bodies

Primary Case Types

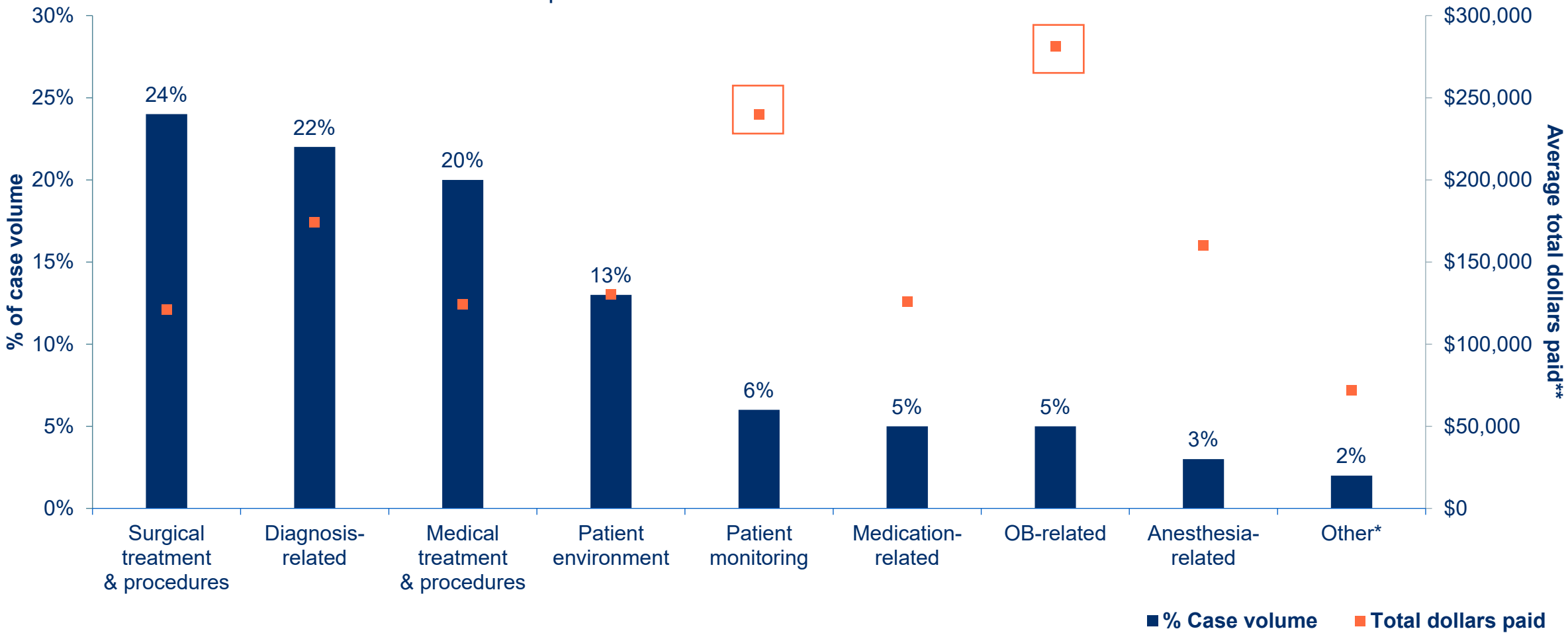
The distribution of case types is similar between facilities, although a higher volume of diagnosis-related cases is noted in the critical access environment.



MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Other = case types without significant volume

Primary Case Types & Financial Severity: Non-Critical Access

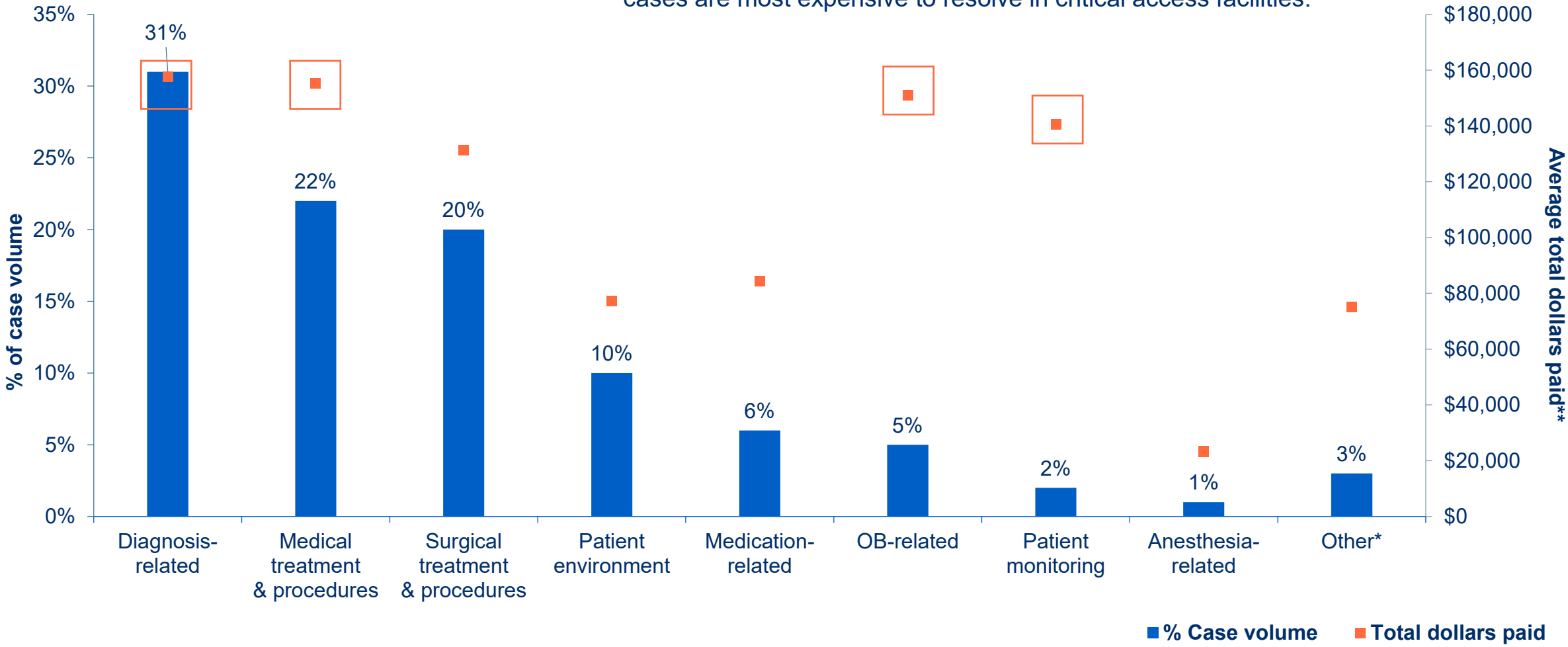
By average cost per case, patient monitoring and OB-related cases are most expensive to resolve in non-critical access facilities.



MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Other = case types without significant volume; **Total dollars paid = expense + indemnity

Primary Case Types & Financial Severity: Critical Access

By average cost per case, diagnostic, medical, OB and patient monitoring cases are most expensive to resolve in critical access facilities.

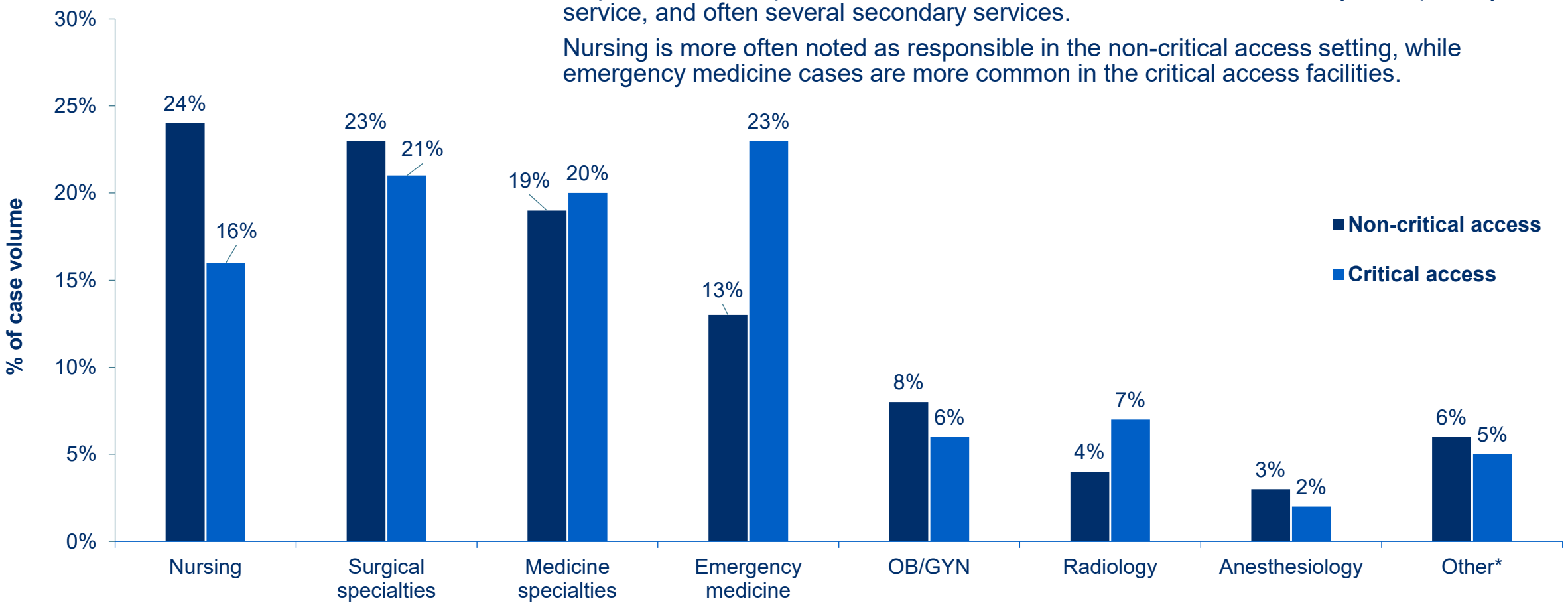


MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Other = case types without significant volume; **Total dollars paid = expense + indemnity

Primary Responsible Services

Responsible services indicate the clinical service of the provider(s) most directly responsible for the patient's care at the time of the event. There is always one primary service, and often several secondary services.

Nursing is more often noted as responsible in the non-critical access setting, while emergency medicine cases are more common in the critical access facilities.



MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Other = services without significant volume

Primary Responsible Services by Most Their Common Case Types

Regardless of hospital setting, the case types attributed to each responsible service are similar. Case types with the highest volume, along with the most common sub-types, are noted here.

Nursing

Patient environment
Failure to prevent falls
Patient monitoring
Failure to monitor physiologic status

Surgical specialties

Surgical treatment & procedures
Improper performance of surgery
Improper management of surgical patient

Medicine specialties

Diagnosis-related
Failure/Delay/Wrong
Medical treatment & procedures
Improper management of course of treatment

Emergency medicine

Diagnosis-related
Failure/Delay/Wrong
Medical treatment & procedures
Improper management of course of treatment

OB/GYN

OB-related
Delay in treatment of fetal distress
Surgical treatment & procedures
Improper performance of surgery

Radiology

Diagnosis-related
Failure/Delay/Wrong
Patient environment
Failure to prevent falls
Medical treatment & procedures
Improper performance of procedure

Anesthesiology

Anesthesia-related
Improper performance of anesthesia procedure
Improper management of anesthesia patient

MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367)

Clinical Severity*

No significant differences in clinical severity outcomes are noted.

Clinical severity* categories	Sub-categories	% of non-critical access volume	% of critical access volume	Definitions
LOW	Emotional Injury Only	**9%**	**5%**	Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay
	Temporary Insignificant Injury			Lacerations, contusions, minor scars, rash; no delay in recovery
MEDIUM	Temporary Minor Injury	**42%**	**47%**	Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed
	Temporary Major Injury			Burns, drug side effect; recovery delayed
	Permanent Minor Injury			Loss of fingers or loss or damage to organs; includes non-disabling injuries
HIGH	Significant Permanent Injury	**49%**	**48%**	Deafness, loss of limb, loss of eye or loss of one kidney or lung
	Major Permanent Injury			Paraplegia, blindness, loss of two limbs or brain damage
	Grave Injury			Quadriplegia, severe brain damage, life-long care or fatal prognosis
	Death			Death
		25%	**25%**	**% of cases resulting in patient death**

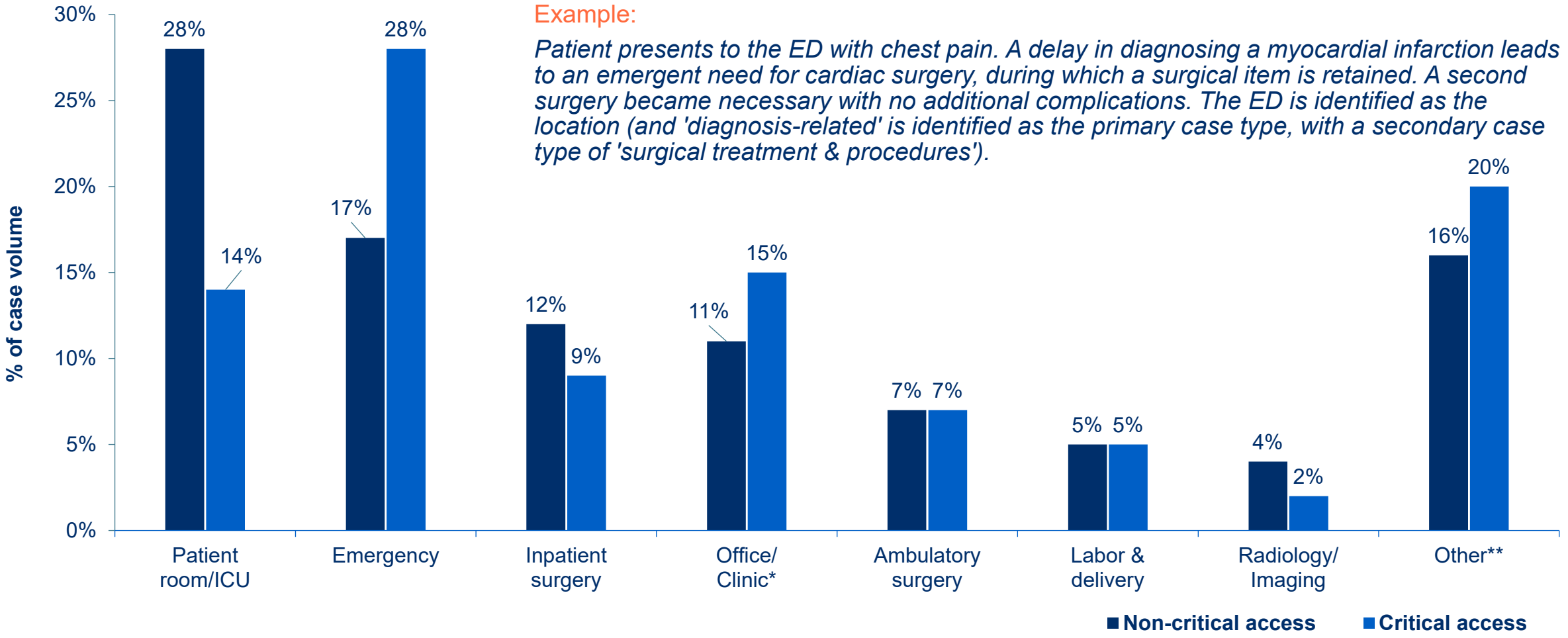
MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Locations

Locations reflect where most significant injury occurred.

Example:

Patient presents to the ED with chest pain. A delay in diagnosing a myocardial infarction leads to an emergent need for cardiac surgery, during which a surgical item is retained. A second surgery became necessary with no additional complications. The ED is identified as the location (and 'diagnosis-related' is identified as the primary case type, with a secondary case type of 'surgical treatment & procedures').



MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Office/Clinic = cases arising in office/clinic practices associated with the hospital; **Other = locations without significant volume

Contributing Factors

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

Contributing Factors Defined

Administrative: Factors related to the reporting of adverse events, adequacy of staffing, staff education/training, ethics, failure to follow and/or need for policy/protocols

Behavior-related: Factors related to patient non-adherence to treatment or behavior that offsets care; also, provider behavior including breach of confidentiality or sexual misconduct

Clinical environment: Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)

Clinical judgment: Factors related to patient assessment, diagnostic decision-making, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc.), choice of practice setting, failure to question/follow an order, practice beyond scope

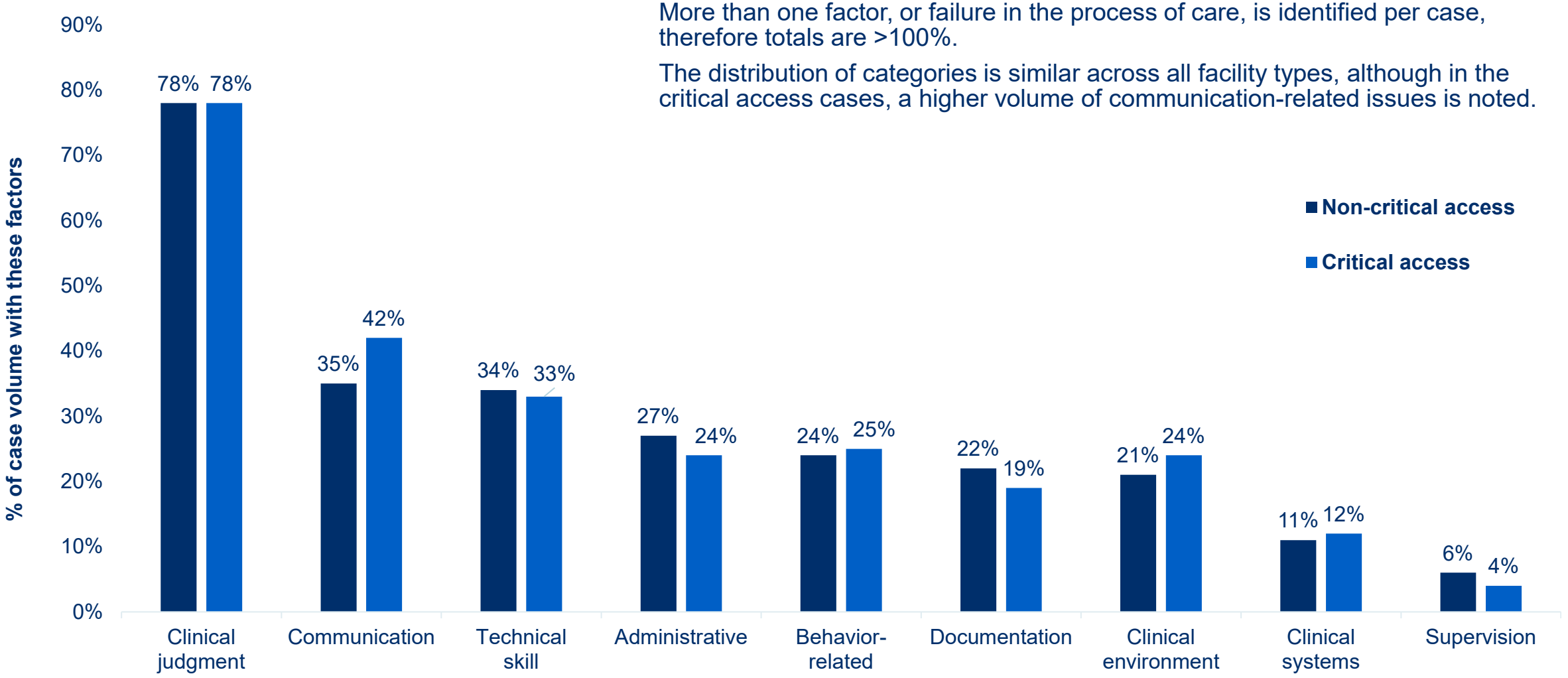
Contributing Factors Defined

- **Clinical systems**: Factors related to coordination of care, failure/delay in ordering diagnostic testing, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
- **Communication**: Factors related to communication between providers, among patient/family and providers; includes electronic communication (texting, email, etc.) and telehealth/tele-radiology
- **Documentation**: Factors related to inaccuracy, insufficiency, altered or inappropriate content
- **Supervision**: Factors related to supervision of nursing, staff, advanced practice clinicians
- **Technical skill**: Factors related to improper use of equipment, medication errors, retained foreign bodies, and the technical performance of procedures

Contributing Factor Categories

More than one factor, or failure in the process of care, is identified per case, therefore totals are >100%.

The distribution of categories is similar across all facility types, although in the critical access cases, a higher volume of communication-related issues is noted.

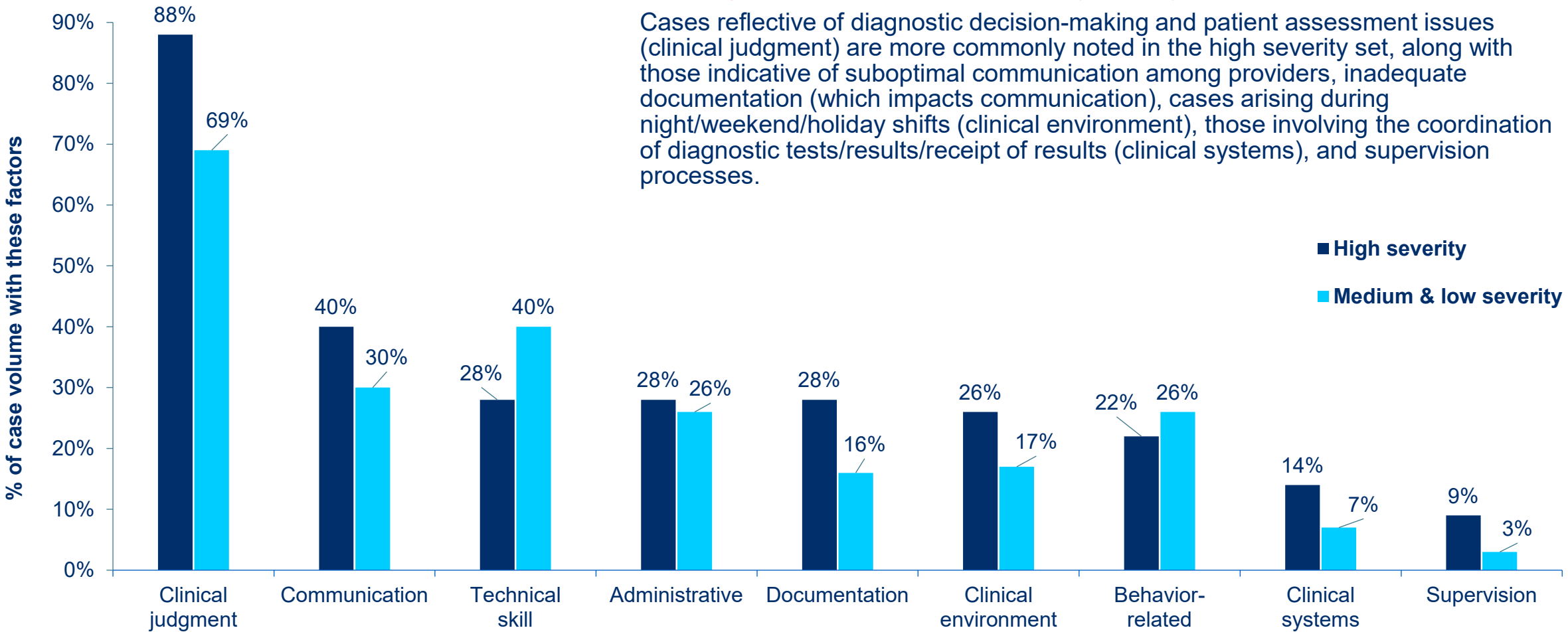


MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367)

Focus on Contributing Factors by Clinical Severity*: Non-Critical Access

A few significant differences are noted by severity in the non-critical access cases.

Cases reflective of diagnostic decision-making and patient assessment issues (clinical judgment) are more commonly noted in the high severity set, along with those indicative of suboptimal communication among providers, inadequate documentation (which impacts communication), cases arising during night/weekend/holiday shifts (clinical environment), those involving the coordination of diagnostic tests/results/receipt of results (clinical systems), and supervision processes.



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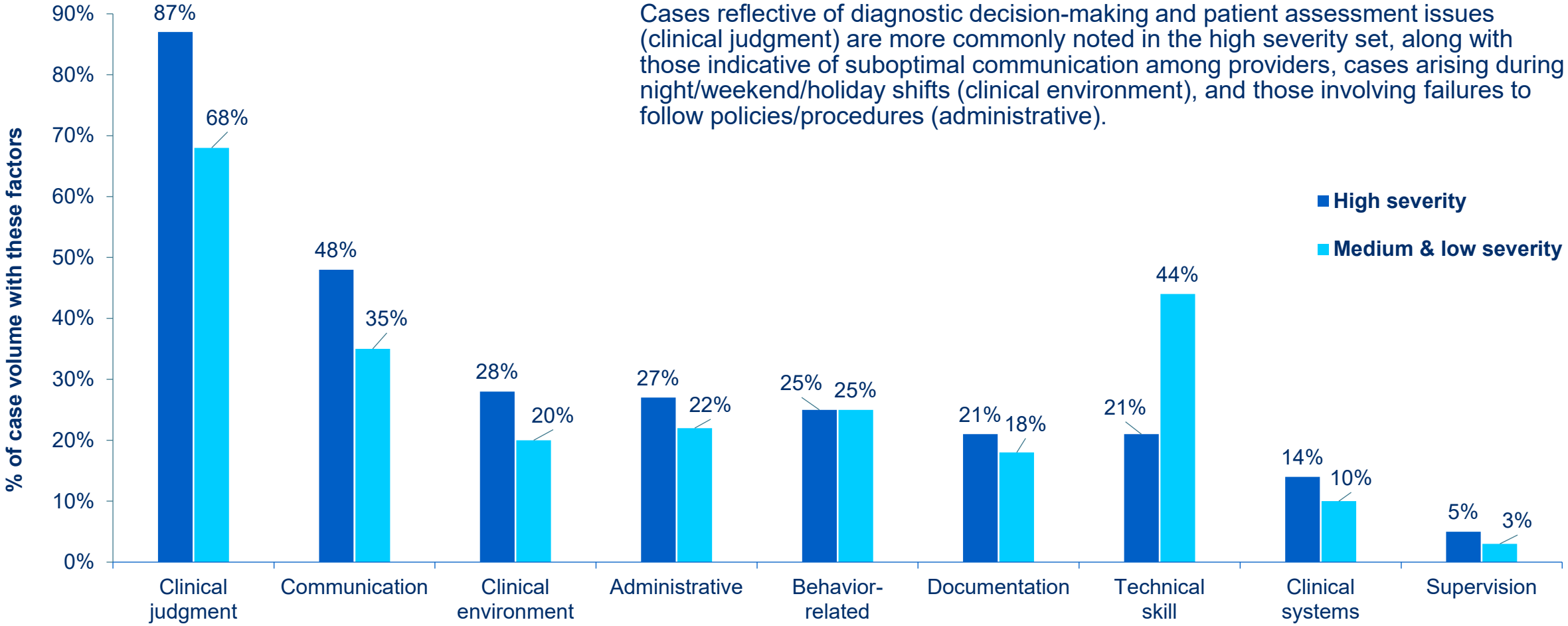
Focus on Contributing Factors by Clinical Severity*: Critical Access

A few significant differences are noted by severity in the critical access cases.

Cases reflective of diagnostic decision-making and patient assessment issues (clinical judgment) are more commonly noted in the high severity set, along with those indicative of suboptimal communication among providers, cases arising during night/weekend/holiday shifts (clinical environment), and those involving failures to follow policies/procedures (administrative).



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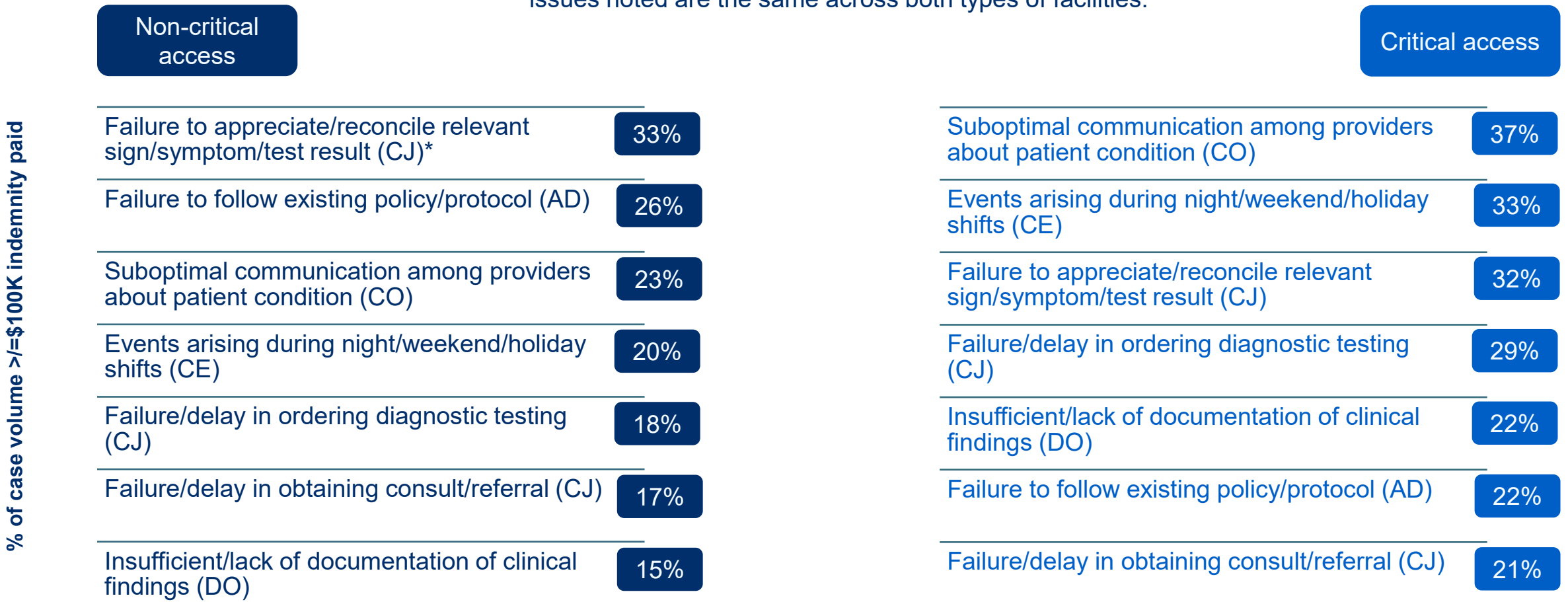
Contributing Factors as Drivers of Financial Severity

These failures in the process of care are among those most commonly noted in cases closed with an indemnity payment of at least $100,000. Other than the distribution by volume, the issues noted are the same across both types of facilities.



MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Abbreviations: AD=administrative; CE=clinical environment; CJ=clinical judgment; CO=communication; DO=documentation

Case Examples: Contributing Factors as Drivers of Financial Severity

Non-critical access

Administrative

Failure to follow policy/protocol

Non-reassuring fetal heart tones (FHT) identified during overnight shift in labor/delivery but nurse failed to notify OB and no interventions implemented. As labor progressed, decision to convert to C-section was delayed despite maternal hypertension and no improvement in FHT. Infant with developmental delays and left-sided hemiplegia. ***($1M indemnity paid)***

Documentation

Lack of documentation

Patient presented to ED with chest pain, presumed to be acute infarction. Chest x-ray revealed widened mediastinum (classic for aortic dissection), documented in "details" section of report, but not in "impression" portion of report. Emergency physician and radiologist did not discuss findings and no one read the "details" section. Patient died due to ruptured aortic aneurysm. ***($600K indemnity paid)***

Critical access

Communication

Suboptimal communication among providers

Nurse practitioner failed to notify emergency physician of patient in waiting area who presented with epigastric pain and met criteria for immediate cardiac care protocol. Patient remained in waiting area where initial vital signs were obtained; he died due to cardiac arrhythmia during that process. ***($450K indemnity paid)***

Clinical judgment

Failure to appreciate signs/symptoms

After admission to med/surg unit, nurse did not appreciate significance of decreased oxygen levels in a post-op patient, and failed to notify surgeon or anesthesiologist. Two hours later, patient suffered respiratory arrest. Intubation was delayed due to laryngeal hematoma; he could not be revived. ***($1M indemnity paid)***

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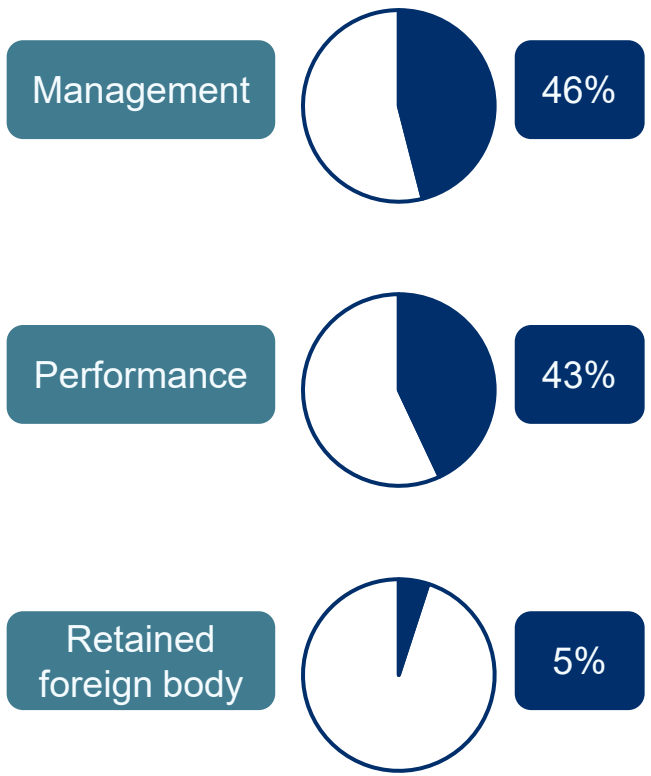
Focus by Case Type

The following pages provide additional insights by case type.

Focus on Surgical Treatment & Procedure Cases: Non-Critical Access

Management and performance issues drive surgical case volume in non-critical access facilities.



Most common…

Management case details:

Treatment and management of the patient through the pre-, intra-, & post-op periods; includes diagnosing surgical complications and wrong site procedures

Procedures in performance cases:

Hip, knee & shoulder replacements: 11%

Cholecystectomies: 9%

Treatment of fractures: 7%

Hysterectomy: 7%

Injuries in performance cases:

Puncture/perforations: 25%

Nerve damage: 13%

Laceration/tear: 12%

Responsible services in performance cases:

Orthopedic surgery: 29%

General surgery: 23%

Gynecology: 14%

Contributing factor details in all case types:

Recognition & management of complications: 50%

Procedural decision-making process, including appropriateness of the patient for the procedure: 44%

Failure to appreciate/reconcile relevant sign/symptom/test result: 27%

Poor procedural technique: 15%

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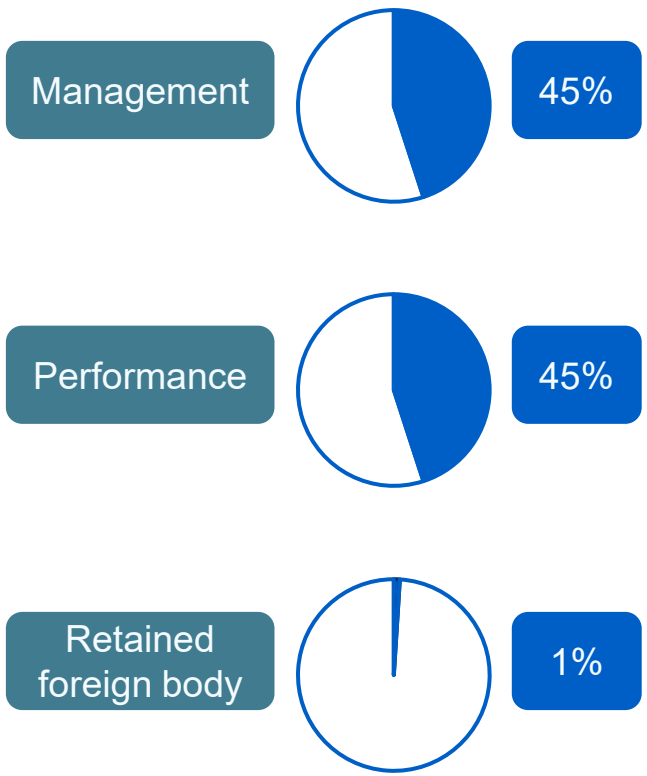
Focus on Surgical Treatment & Procedure Cases: Critical Access

Management and performance issues drive surgical case volume in critical access facilities.



Most common…

Management case details:

Treatment and management of the patient through the pre-, intra-, & post-op periods; includes diagnosing surgical complications and wrong site procedures

Procedures in performance cases:

Hip, knee & shoulder replacements: 21%

Treatment of fractures: 18%

Cholecystectomies: 15%

Injuries in performance cases:

Need for additional surgery: 15%

Infection: 12%

Puncture/perforation: 12%

Responsible services in performance cases:

Orthopedic surgery: 47%

General surgery: 35%

Gynecology: 9%

Contributing factor details in all case types:

Recognition & management of complications: 56%

Procedural decision-making process, including appropriateness of the patient for the procedure: 41%

Failure to appreciate/reconcile relevant sign/symptom/test result: 35%

Poor procedural technique: 23%

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Focus on Diagnosis-Related Cases: Non-Critical Access

Inclusive of wrong diagnoses, failures/delays, and misdiagnoses

No additional differentiation is made between wrong diagnoses, failures/delays and misdiagnoses.

% of case volume

Most common…

Diagnoses:

Circulatory system: 21% (cardiac & cerebrovascular disease)

Malignancies: 19% (lung, breast, colon, genitourinary)

Complications: 18% (post-operative infections, puncture/lacerations, device complications

Injuries:

Malignancy: 17%

Infection: 11%

Infarction: 8%

Fracture: 6%

Responsible services:

Emergency medicine: 38%

Primary care: 15%

Radiology: 11%

Medical hospitalist: 3%

Contributing factor details:

Failure to appreciate/reconcile relevant sign/symptom/test result: 44%

Failure/delay ordering diagnostic test: 38%

Narrow diagnostic focus (failure to establish differential diagnosis): 30%

Inadequate assessment resulting in premature discharge from care: 28%

Delay in obtaining consult/referral: 26%

MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367)

Focus on Diagnosis-Related Cases: Critical Access

Inclusive of wrong diagnoses, failures/delays, and misdiagnoses

No additional differentiation is made between wrong diagnoses, failures/delays and misdiagnoses.

% of case volume

Most common…

Diagnoses:

Malignancies: 22% (lung, breast)

Circulatory system: 19% (cardiac & cerebrovascular disease)

Complications: 19% (post-operative infections, puncture/lacerations, device complications)

Injuries:

Malignancy: 20%

Infarction: 10%

Infection: 9%

Fracture: 8%

Responsible services:

Emergency medicine: 44%

Primary care: 27%

Radiology: 13%

Contributing factor details:

Failure to appreciate/reconcile relevant sign/symptom/test result: 51%

Failure/delay ordering diagnostic test: 43%

Narrow diagnostic focus (failure to establish differential diagnosis): 36%

Inadequate assessment resulting in premature discharge from care: 28%

Delay in obtaining consult/referral: 21%

MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367)

Focus on Diagnosis-Related Cases

Note key opportunities to reduce errors along the diagnostic process of care*. Each percentage indicates the volume of cases impacted by the issues in each phase.

The distribution of cases by phase is almost identical across all facility types.

Non-critical access

Critical access

Phase 1

Initial diagnostic assessment	Patient notes problem & seeks care
81%	History & physical
81%	Patient assessed, symptoms evaluated
	Differential diagnosis established
	Diagnostic testing ordered

Phase 2

Testing and results processing	Performance of diagnostic tests
29%	Interpretation of diagnostic test results
28%	Test results transmitted to/received by ordering provider

Phase 3

Follow-up and coordination	Physician follows-up with patient
52%	Referrals/Consults
52%	Patient information communicated among care team
	Patient compliance with follow-up plan

MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367); *Each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on All Other Case Types

Across all hospital cases, the remaining most common case type details are similar.

Medical treatment & procedures

Improper management of course of treatment

Improper performance of treatment/procedure

Medication-related

Improper management of medication regimens (most often anticoagulants, narcotics and antibiotics)

Ordering errors (most often wrong medication, wrong dose, failure to order)

Patient environment

Failure to prevent patient falls

Miscellaneous safety issues, including injuries from equipment, facility-acquired infections

OB-related

Delay in treatment of fetal distress

Improper performance of delivery

Improperly managed labor

Patient monitoring

Inadequate observation/recognition/response to changes in patient's physiologic condition (i.e. changes in vital signs, level of consciousness)

Inadequate monitoring of non-invasive bedside medical treatments

Anesthesia-related

Improper management of patient under anesthesia

Improper performance of anesthesia procedure (most often intubation and nerve injections)

MedPro Group + MLMIC closed hospital cases, open years 2014-2023 (Non-critical access N=4,473; Critical access N=367)

Case Examples

These case examples provide insight into the challenges faced by healthcare providers. Learning from these events, we trust that you will take the necessary steps to assess current practices in your facility.

Post-Operative Management of Hypotension

Critical access
$300K indemnity paid

Patient Description
A 45-year-old female with a history of congestive heart failure and smoking underwent a scheduled total vaginal hysterectomy to treat chronic pelvic pain and dysmenorrhea.

Case Scenario
Following surgery, the patient developed persistent hypotension. The gynecologist was notified and ordered a fluid bolus. For several hours, the patient's blood pressure remained critically low, but there was a failure to recognize the severity of her symptoms, a delay in ordering necessary diagnostic tests, and reportedly poor communication between providers. Inadequate physician coverage available was also noted as an issue. A late-ordered lab test revealed a critical drop in hemoglobin.

Outcome
The patient was transferred to another facility for management of hypovolemic shock. She suffered a fatal cardiac arrest during an emergency surgical procedure to repair a hemorrhage.

Risk Assessment Summary
A cascade of clinical judgment and system failures led to a preventable patient death from post-operative hemorrhage. Several factors contributed to this adverse outcome:

- Delayed recognition of hemorrhage: Despite persistent and profound hypotension, providers failed to recognize the clinical emergency, delaying definitive action and investigation into post-operative bleeding.
- Systemic communication breakdown: Poor communication between nursing and the surgical team was a significant factor. Problems with having adequate physician coverage available and difficulties reaching a provider resulted in critical delays in escalating care.
- Failure in diagnostic workup: The delay in ordering a hemoglobin and hematocrit test, a fundamental step in evaluating a hypotensive post-operative patient, prevented the timely diagnosis of hypovolemic shock.

Vigilant post-operative monitoring, a high index of suspicion for complications, and robust communication systems are essential. Clear on-call coverage and escalation protocols are vital to prevent such catastrophic outcomes.

Narrow Diagnostic Focus in Emergency Department

Critical access
$950K indemnity paid

Patient Description
A 57-year-old male presented to an emergency department (ED) on a weekend evening with the sudden onset of severe abdominal pain after a meal.

Case Scenario
The ED was staffed by a family medicine physician who diagnosed gallbladder inflammation without ordering imaging studies. An ultrasound the next day was inconsistent with this diagnosis, but there was a failure to order necessary diagnostic tests or request a surgical consult. Poor communication between providers and insufficient documentation were noted as the patient's condition deteriorated. A CT scan was considered but not ordered, even as the patient developed excruciating pain and requested a transfer.

Outcome
The patient suffered a cardiac arrest during transfer and was found to be in septic shock from a perforated bowel, requiring multiple surgeries including a total gastrectomy and a partial esophagectomy.

Risk Assessment Summary
A profound failure in the diagnostic process during weekend care resulted in a catastrophic, preventable outcome. Several factors contributed to the delay in treatment:

- Diagnostic anchoring: The clinical team failed to recognize important signs when the ultrasound was inconsistent with the working diagnosis, incorrectly understanding the results and not expanding the differential diagnosis despite the patient's decline.
- Delayed diagnostics and consultation: A failure to order a necessary CT scan or obtain a timely surgical consultation occurred, even as the patient’s condition worsened with excruciating pain and signs of sepsis.
- Systemic communication failures: Poor communication between on-call providers about the patient's deteriorating status, compounded by insufficient documentation, led to fragmented care and a critical delay in appropriate intervention during night and weekend shifts.

A cascade of clinical judgment errors and communication breakdowns highlights the essential need for robust diagnostic protocols and clear care escalation pathways, particularly during off-hours.

Poor Resuscitative Technique in Surgical Suite

Non-critical access
$1M indemnity paid

Patient Description
A 34-year-old male with a history of obesity presented for a robot-assisted laparoscopic gastric sleeve surgery.

Case Scenario
During surgery, while the patient was in steep reverse Trendelenburg position (head down, feet up), he developed a pneumothorax and suffered a cardiac arrest. A critical delay in resuscitation occurred as staff were initially unable to reposition the locked operating table. Equipment to treat the pneumothorax was unavailable, and protocols for advanced cardiovascular life support (ACLS) were not followed. Following a lengthy resuscitation, the surgeon resumed the elective procedure, with the patient again in the same position, which delayed therapeutic hypothermia (brain cooling) for one hour and further diminished blood flow to the brain.

Outcome
The patient sustained a severe anoxic brain injury.

Risk Assessment Summary
A cascade of systemic failures and critical errors in clinical judgment during a planned surgical procedure led to a preventable catastrophic neurological injury. Several factors contributed to this outcome:

- Inadequate preparation and training: A failure to have necessary surgical and emergency equipment readily available, combined with inadequate staff training on operating the surgical table during an emergency, created the initial delay.
- Ineffective emergency response: Critical delays in repositioning the patient for effective cardiopulmonary resuscitation and failure to follow established ACLS protocols contributed significantly to the poor outcome.
- Poor post-resuscitation judgment: The decision to resume the elective surgery instead of initiating immediate brain cooling protocols represented a critical deviation from the standard of care, further compromising the patient's neurological status.

Ultimately, the case underscores the vital importance of robust crisis management protocols, thorough staff training on all equipment, and a clinical culture that prioritizes immediate patient stabilization over procedural completion during a life-threatening emergency.

Poor Communication About Anticoagulation Regimen

Non-critical access
$750K indemnity paid

Patient Description
A 61-year-old female with a history of long-term anticoagulation to treat pulmonary emboli and antiphospholipid antibody syndrome presented to the emergency department after four weeks of rectal bleeding.

Case Scenario
Her anticoagulant was held and she was stabilized before transfer from the ICU to telemetry. She developed tarry stools, but these were not reported by the nurse to the attending hospitalist, who then ordered a full-dose heparin infusion. During a night shift, a partial thromboplastin time was critically prolonged. A delay in processing a repeat specimen and poor communication between providers resulted in the infusion not being stopped in a timely manner, reflecting inadequate monitoring.

Outcome
The patient was found unresponsive and actively hemorrhaging. Resuscitation attempts were unsuccessful, and she died from an uncontrolled hemorrhage.

Risk Assessment Summary
A fatal outcome resulted from the suboptimal management of anticoagulation, marked by multiple system and judgment failures.

- Inappropriate medication dosing: The decision to initiate a full-dose heparin infusion, against a recommendation for a prophylactic dose and in a patient with active bleeding signs, represented a significant failure to recognize important signs and symptoms.
- Failure in clinical monitoring: Inadequate monitoring of the patient's response to the medication was evident when nursing staff did not report new tarry stools or promptly stop the infusion after a critically elevated laboratory value was known.
- System and communication breakdowns: Poor communication between providers, coupled with significant delays in laboratory processing during a night shift, created a critical window where the patient remained over-anticoagulated without intervention.

Safe administration of high-risk medications demands vigilant monitoring, robust communication protocols, and efficient clinical systems. Clear accountability across all shifts is paramount in preventing such catastrophic errors.

Environment of Care

The following page offers insights covering environmental safety issues identified during onsite client assessments.

Focus on Safety Assessments: Most Common Findings

Onsite environment of care assessments across both critical access and non-critical access facilities indicate these most common findings.

% of assessments with these findings

	Infection control	Environmental safety issues	Electrical	Miscellaneous
	19%	**16%**	**15%**	
Examples	Dirty/Stained equipment & surroundings (ceilings, floors, walls, furniture)	Call bell cords (wrapped around objects)	Unauthorized access to circuit breakers	Fire/Smoke doors wedged open or not able to close properly
	Uncovered linens	Unauthorized access to controlled areas	Mislabeled breakers (on/off/areas served)	Equipment/patient care supplies stored in corridors
	Storage of equipment/supplies on the floor	Trip hazards	Use of non-listed power strips in patient care areas	Inadequate medical gas labeling and valve blockage
				Inadequate eyewash station maintenance and placement

MedPro Group + MLMIC aggregated examples from onsite hospital client assessments

Risk Mitigation Resources

Access More Information, Tools, and Education

MedPro on LinkedIn

MedPro Publications

MedPro on X

MedPro Education

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.