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INSIDE

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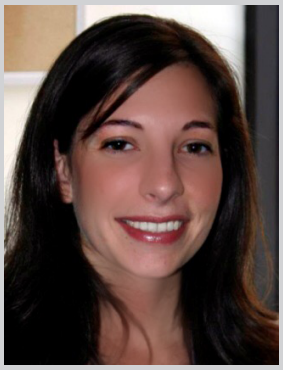
Risk managers should disclose errors to staff, not just to the patient

Most hospitals have embraced the idea of disclosing medical errors to the patient and family members, but Brigham and Women's Hospital in Boston goes a step further by informing all staff about these incidents. The policy could provide information to be used against the hospital in litigation, the risk manager says, but educating staff and improving patient safety are worth the risk.

Brigham and Women's spreads the word about medical errors and other safety issues through its *Safety Matters* monthly electronic newsletter, which is part of a campaign that includes other initiatives to improve patient safety. *(For more information on the other parts of the campaign, see the story in this issue. The* Safety Matters *website is http://tinyurl.com/hhwqayu.)* Part of the hospital's commitment to safety includes telling the stories of its mistakes, what was learned from them, and the systems improvements that were undertaken as a result, says Senior Risk Manager **Mary White**, RN, MBA, CPHRM.



"IF SOMETHING HAPPENS, WE NEED A WAY TO QUICKLY AND CLEARLY DISSEMINATE THE LESSONS LEARNED."
— KAREN FIUMARA, PHARMD, BRIGHAM AND WOMEN'S HOSPITAL

Telling patient safety stories through *Safety Matters* helps to support a culture in which people acknowledge mistakes, openly discuss them in a blame-free environment, and take steps to prevent similar errors in the future, White says.

"Our goal is transparency," White says. "Greater transparency and discussion about patient safety events allows for communication across the hospital and promotes sharing and spreading of ideas for change."

Recent issues of *Safety Matters* have

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EXECUTIVE EDITOR:
Joy Daughtery Dickinson
(404) 262-5410
joy.dickinson@AHCMedia.com
DIRECTOR OF CONTINUING EDUCATION AND EDITORIAL: Lee Landenberger

EDITORIAL QUESTIONS
Questions or comments?
Call Editor **Greg Freeman**, (770) 998-8455.

addressed incidents in which a newborn was harmed by a tubing connection error, and one in which a patient's radiologist did not send a critical abnormal notification for a CT scan suggesting lung cancer. Clinicians, patients, and family members are interviewed about the incident, and their comments are included in the story. The accounts often emphasize the emotional impact of the errors. *(For more on the content of the newsletters, see the story in this issue.)*

Sharing lessons learned

The effort began in 2010 with the goal of sharing important lessons learned from errors in the hospital, explains **Karen Fiumara**, PharmD, director of Patient Safety at Brigham and Women's. Prior to that, the lessons were discussed only in the particular unit or part of the campus where the error occurred, Fiumara says.

"We knew that the same mistake that occurred on one floor in a particular building could happen at another building, but we didn't have a good way to share that information," she says. "If something happens, we need a way to quickly and clearly disseminate the lessons learned. That's the immediate fix while we're correcting the problem in the system and making that problem less likely to occur again. Building awareness is the first step."

The idea of openly discussing errors with all hospital staff members was discussed for almost a year before Brigham and Women's leaders were confident that any risks were outweighed by the potential benefits. "There was a lot of internal discussion before we could launch our first issue. There were different perspectives, with my patient safety team feeling very strongly that this kind of transparency supports our core values," Fiumara says. "We brought in the risk management team also and hospital leadership. Everyone had to buy in to this."

Fiumara recalls that a key concern was whether the information could be used against the hospital in court, and everyone acknowledged that there was a risk of that happening. The risk manager was obliged to consider how public discussion of a mistake could lead to a malpractice lawsuit, but White says they concluded that the information could be disseminated.

"When you tell a story about errors that have occurred in the hospital and the lessons that we've learned as a result, there is an inherent risk in that, but one that we were willing to accept given the potential this program has to prevent similar missteps in the future," White says.

There also was concern about how telling these stories publicly would affect the clinicians, patients, and

EXECUTIVE SUMMARY

Medical errors can be used as teaching opportunities for staff. A Boston hospital routinely disseminates information about errors to staff.

- There is a risk that the information could be used against the hospital in a lawsuit.
- The hospital uses a newsletter to inform the staff.
- Many of the stories come from the risk management department.

family members involved. Knowing how much clinicians are affected when a mistake leads to patient harm, the Brigham and Women's team worried that telling the whole staff about their errors would be traumatic for them. Ultimately, the team decided that they could not predict the impact on the involved clinicians.

Posted on the Internet

The first issue was published in January 2011 and until October 2015, the *Safety Matters* newsletter was available only internally at Brigham and Women's. Now it is available to the general public on the Internet.

"That speaks to our commitment to transparency, and we do hope that other hospitals can learn from our experiences," Fiumara says.

The stories selected for the newsletter are almost always those in which a patient was harmed by the error, rather than near misses. Fiumara acknowledges the learning potential from near misses, but she says they don't have the same emotional impact as an incident that harms someone. The stories in *Safety Matters* are intentionally chosen and written in such a way as to emphasize how people were affected by the error.

"When you have thousands of people on staff and you're trying to get their attention, to get them to actually read this story, you're going to have better results with a story that tugs at your heartstrings," Fiumara says.

The willingness of the clinicians and patients to discuss the experience also factors into what stories are told. Physicians and staff members are encouraged to participate, but the hospital respects the wishes of patients or family members who are not comfortable talking about the error or being quoted.

Liability considered

White and her colleagues in risk management consider the potential for liability when a story is suggested for the newsletter, but most can be used without putting the hospital at too much risk, she says. Patient names are changed, and the stories do not identify Brigham and Women's physicians or staff involved in the incidents.

"There are no formal rules about what stories can be told. In fact, our team is often the source of the stories that are ultimately written about in *Safety Matters*," White says. "The risk management team is involved in the collective decision about which stories will be most impactful, and multiple considerations, including the perspective of clinicians, patients, and family members, are factored into that decision."

Fears about how clinicians would respond to seeing their mistakes spread throughout the entire organization proved to be overblown, Fiumara says. The response from clinicians and the patients or family members involved in the incidents has been overwhelmingly positive, she says, partly because the newsletter follows the hospital's just culture philosophy, and it focuses on improvements and not blaming people.

"When we first launched, the staff was initially surprised that we were openly talking about our errors," Fiumara says. "Now it's seen as part of our culture here that we talk about these things and try to learn from our mistakes."

SOURCES

- **Karen Fiumara**, PharmD, Director of Patient Safety, Brigham and Women's Hospital, Boston. Email: kfiumara@partners.org.
- **Mary White**, RN, MBA, CPHRM, Senior Risk Manager, Brigham and Women's Hospital, Boston. Phone: (617) 264-5853. Email: mlwhite@partners.org. ■

TV screens, 'WalkRounds' promote safety messages

Discussing mistakes in its *Safety Matters* newsletter is only one way that Brigham and Women's Hospital in Boston encourages patient safety.

In another effort, television screens across the hospital campus communicate safety messages to staff, patients, and visitors. In addition to slides displayed on the Community Connects screens, the screens also feature short videos as another way to call attention to safety topics, such as patient identification, patient safety, hand hygiene, and medical orders.

Brigham and Women's also uses executive "WalkRounds" to enhance the culture of safety at the hospital and improve processes to make care safer for patients. These visits to patient care areas by hospital executives occur twice a month on different units or departments in the inpatient and ambulatory settings.

WalkRounds provide an opportunity for staff members to share their safety concerns directly with Brigham and Women's executive leaders and the Patient Safety Team. WalkRounds help to reinforce patient safety as a priority at the hospital and increase awareness about patient safety issues.

The goal is to obtain information from staff about issues that impact patient safety to help prioritize improvement efforts, explains **Karen Fiumara**, PharmD, director of Patient Safety at Brigham and Women's. Patients often are included in the WalkRounds.

Executive WalkRounds allow for real-time feedback to leadership, Fiumara says. Discussions during WalkRound sessions have prompted several patient safety improvements, he notes. Examples include forming a "Spring Cleaning Team" to address concerns about equipment repair and maintenance and standardizing the way supplies are stocked on units. ■

Hospital recounts NICU mistake and how staff did not disclose properly

A recent issue of the *Safety Matters* publication at Brigham and Women's Hospital in Boston told the story of how a tubing connection error occurred in the neonatal intensive care unit (NICU), which caused intravenous fluid to damage the baby's skin at the wrist.

As part of a routine tubing change, a nurse intended to separate the arterial tubing from the umbilical vein tubing, which was infusing liquid nutrition and intravenous medications, by running them through separate portholes in the incubator. After a shift change, another nurse realized the liquid nutrition tubing mistakenly was connected to the arterial tubing.

The incident left the newborn with a scar on his wrist but no other harm. The *Safety Matters* account explains that the error was not properly disclosed to the parents, who learned of the incident days later when it was mentioned in passing. A main theme of the story told in *Safety Matters* was the parents' disappointment and how the lack of proper disclosure caused them unnecessary stress. The parents considered moving the baby to another hospital for care, but they ultimately stayed with Brigham and Women's.

The story goes on to dissect what went wrong with the tubing error and how the clinicians failed to follow the hospital's protocol on disclosure.

"There was also no documentation of the initial conversation with the covering evening shift physician in the Baby Oliver's chart, so the primary team was unaware that the parents did not know about the error. They realized this at the family meeting, when the parents reacted with surprise," the newsletter explains. "The covering physician and team had not followed the appropriate disclosure protocol, which requires documentation of the disclosure conversation including: names of participants; the date, time, and communication to the primary team; and that the parents had been informed of the error."

The story concludes with a rundown of what Brigham and Women's is doing to prevent a recurrence of the problem, including working with a vendor to obtain tubing that is designed to prevent the type of connection error in this case. The hospital also re-educated nurses about the potential for this type of error. The newsletter also included summaries of the handoff process that can reduce errors at shift change, and the hospital's disclosure and apology process. The *Safety Matters* newsletter is available online at http://tinyurl.com/j3kdr3g. ■

Concurrent surgeries: How much is too much?

Massachusetts General Hospital in Boston has been the focus of controversy over the safety of concurrent surgeries and whether patients have a right to know when surgeons are dividing their attention. One patient safety leader tells *Healthcare Risk Management* that the practice is not necessarily improper but should be monitored by risk management.

The controversy arose with a lengthy story in *The Boston Globe* about a malpractice suit filed by a plaintiff who was paralyzed during spinal surgery. He contends that his injury was due, in part, to the fact that his surgeon was splitting his time between that operating room and another where he was operating on a second patient at the same time. Massachusetts General has since limited surgeons from double-booking some complex surgeries.

A hospital spokesman also told the newspaper that while surgeons are "encouraged and expected" to tell patients when they'll be absent for part of the surgery, they are not explicitly required to do so. *(The* Boston Globe *story is available online at http://tinyurl.com/zowtss6.)*

The hospital went to extraordinary

lengths to respond to the story. It issued a statement saying, "We are confident that our surgical practices are very safe and among the strongest in the nation. The American College of Surgeons, in fact, called our overlapping surgery policy a best practice and said it exceeds national standards. We have reviewed the complication rates in overlapping and non-overlapping surgeries and found the rates to be the same. We also have reviewed overlapping cases with complications from 2013 and 2014 and found no association between the complications and overlapping. Several studies from other hospitals around the country have shown similar results."

But Massachusetts General went far beyond the standard statement by creating several pages on its web site devoted to explaining concurrent surgery, the hospital's policies and experience, and medical literature regarding its safety.

A link to the material is placed prominently on the hospital's home page. *(The link is http://tinyurl.com/jrn9kob.)*

No link with malpractice

Healthcare Risk Management contacted The Doctors Company, a malpractice insurer based in Napa, CA, to determine how often concurrent surgeries are cited in malpractice cases. **Robin Diamond**, MSN, JD, RN, senior vice president of patient safety and risk management, says the data show no indication of a correlation. A review of 7,330 surgery malpractices in the company's database from the past eight years found no mention of concurrent surgery as a factor, she says.

Diamond also says the medical literature is scant on any connection between concurrent surgery and malpractice or patient safety. However, she says the lack of data doesn't necessarily mean there is no reason to worry.

"Sometimes, until there is a big case or a focus on an issue by regulators, the medical community doesn't shine a light on an issue, and the data is not collected," Diamond says. "I think some of this recent publicity will raise public awareness, and risk managers are going to need to look at the issue more closely."

The issue might become problematic for hospitals as members of the general public become more aware of a practice that is common but largely unknown to them, she says. Patients will not react favorably when they learn that their surgeons leave the operating room during their procedures and divide their attention, she says.

"You leave me anesthetized and go down the hall to work on somebody else? And I'm just lying there waiting for you to come back?" Diamond says. "That's not going to go over well with most people. And, at that point, the question of how it actually affects patient safety can become secondary to the fact that people don't like it and feel threatened by it."

Assess your hospital's use

Diamond advises risk managers to determine how much overlapping surgery occurs in their facilities. The practice is common and has been accepted for so long that it might be happening in a hospital without anyone other than the surgical team taking note.

Diamond suggests conducting a failure mode effects analysis (FMEA) to assess the risk. This FMEA will help the risk manager get a handle on how many surgeons do concurrent procedures and whether there are any restrictions in place.

There should be policies that limit who can do concurrent surgeries and how much procedures can overlap, Diamond says. Even if concurrent surgery is an accepted practice at your facility, it should not be done by just anyone. Only experienced surgeons should have this option, she says.

"There should be a competency and privileging process for this," Diamond says. "If you are allowing any surgeon to overlap, you are going to get into trouble eventually. The leading hospitals have policies that make sure this is an option only for the surgeons who have proven they can do this without endangering patients."

Surgeons also should be required to justify why concurrent surgeries are necessary. Busy OR schedules can be justification enough, Diamond says, but there should be some reason beyond the surgeon simply wanting to double up and get out of the hospital sooner.

Risk managers should urge full disclosure of concurrent surgery to

EXECUTIVE SUMMARY

A controversy at one healthcare facility has raised questions about the safety of concurrent surgeries. The practice is common but should be addressed by risk managers.

- Concurrent surgeries can be allowed without undermining patient safety.
- The hospital responded with extensive information on its web site.
- Hospitals should limit concurrent surgeries to only some surgeons and situations.

patients, Diamond says. The policy should be part of the informed consent process, she says.

Documentation also is an issue. Diamond suspects that concurrent surgery often is not documented in the surgery record, possibly only in the OR administrative record. Facility policy should require that concurrent surgeries are documented fully in the OR record, including the surgeon's exit and return times for each procedure.

"Risk managers also should look at the times of the overlap," Diamond says. "How long are patients waiting, and are they left waiting under anesthesia longer than is reasonable?"

Hospital policies on concurrent surgeries often require that a supervising or attending surgeon be immediately available to respond if a patient needs help while his or her surgeon is in a second operating room, but Diamond says those policies often are vague.

"Immediately available" can be interpreted as in the next room, down the hall in the doctors' lounge, or even 10 minutes away conducting rounds, Diamond says. Such policies should be included in the risk assessment.

Concurrent surgeries require good patient handoff procedures, Diamond notes. The surgeon's exit and return should be accompanied by a standardized script that notes information such as the patient's vital signs, status of the procedure, when to call the surgeon on standby, and changes since the surgeon's departure.

Diamond also expresses concern that concurrent surgeries might interfere with some safety processes, such as the preop checklist and timeout.

"Is the surgeon doing the preop checklist and timeout on both patients? Or did the rest of the team in the second OR do it without him, and then he shows up later?" she says. "That's a major concern for me, because it is such an important part of the safety process."

SOURCE

- **Robin Diamond**, MSN, JD, RN, Senior Vice President, Patient Safety and Risk Management, The Doctors Company, Napa, CA. Telephone: (707) 226-0291. Email: rdiamond@thedoctors.com. ■

Wrong-site surgery traced to lack of timeout

A surgeon's wrong-site error on a patient's brain happened because he failed to perform a timeout before the procedure, according to a recent court decision that also describes how the physician tried to hide his error and did not report the sentinel event to administrators.

After suing the hospital and surgeon, the plaintiff sued the university employing the doctor, which put the case in the hands of the Arkansas State Claims Commission, which handles claims against state agencies. The commission members determined recently that doctors and administrators at the hospital at which the surgeon was employed were negligent because they failed to follow the hospital's timeout policy. Furthermore, they said the surgeon and other team members tried to cover up their error and did not report it properly.

Court records indicate that a 15-year-old boy underwent an operation in 2004 to remove a brain lesion thought to be the cause of a seizure disorder. The surgery took place at a children's hospital and was performed by a surgeon employed by a university hospital.

Interestingly, a newspaper reporter was present in the OR. The hospital had invited the reporter to observe the procedure and take photographs, with the parents' permission. The surgeon began the procedure without a timeout and made an incision into the left side of the brain, when, in fact, the correct site was the right side. When the surgeon realized his error, court documents indicate, he had the reporter removed from the room before the staff repositioned the patient.

The surgeon completed the procedure on the right side of the brain. Afterward, the court documents say, the surgeon told the patient's family that he had started the procedure on

EXECUTIVE SUMMARY

A plaintiff received almost $15 million for injuries after a surgeon removed the wrong part of his brain. The surgeon tried to hide his error from the patient and family, according to a court decision.

- The surgical team failed to perform a timeout before beginning the procedure.
- A reporter and photographer were present in the operating room.
- The error was discovered months later when an MRI showed tissue had been removed from the wrong side of the brain.

the wrong side but that he realized his error before doing any damage to the brain. The family found out the truth 15 months later when an MRI showed that both sides of the brain had been operated on.

In the subsequent medical malpractice lawsuit, the plaintiff was awarded $20 million from the hospital where the surgery took place, but the circuit judge overseeing the case reduced the amount to $11 million. The surgeon settled with the parents for $1 million.

The commission reviewed the testimony from the original malpractice case and determined that the surgeon and his employer were at fault.

The surgeon"admitted that he started the procedure on the wrong side of the brain, but denied that he removed any part of the left amygdala, stating that he merely did a biopsy on the left side," the commission wrote. The surgeon "acknowledged that he acted below the standard of care" and "further admitted that he failed to do a complete, consistent, and accurate charting of [the patient's] history and physical," the commission wrote."

The surgeon explained that a "sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or risk thereof, and that there was no question that what happened with [the patient] was a sentinel event," the commission wrote, adding that the surgeon "stated that the procedures that follow a sentinel event did not occur in this instance, including having a hospital administrator present during discussions with the family."

The surgeon "told other doctors and people around the hospital that he started the surgery on the wrong side, that no harm was done to the brain, and that he then operated on the correct side," the commission wrote. The surgeon "could not recall whether a timeout occurred prior to [the patient's] surgery," the commission wrote. The court documents are available online at: http://tinyurl.com/zydr7t6. ■

(Editor's note: This article was updated in June 2018.)

Occupational Safety and Health Administration offers tools on workplace violence

The Occupational Safety and Health Administration (OSHA) recently unveiled a webpage developed to provide employers and workers with strategies and tools for preventing workplace violence in healthcare.

The webpage, http://tinyurl.com/ngs7g29, is part of OSHA's Worker Safety in Hospitals website and complements the updated *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, published in 2015. Similar to the guidelines, the new strategies and tools focus on workplace violence prevention programs that include elements such as management commitment and worker participation; worksite analysis and hazard identification; hazard prevention and control; safety and health training; and recordkeeping and program evaluation.

"Too many healthcare workers face threats and physical violence on the job while caring for our loved ones," said **David Michaels,** MD, assistant secretary of labor for occupational safety and health, in a statement. "It is not right that these valuable workers continue to be injured and sometimes killed on the job. Most of these injuries are preventable and OSHA is providing these resources to help combat these incidents and raise awareness that violence does not need to be part of the job."

From 2002 to 2013, incidents of serious workplace violence were four times more common in healthcare than in private industry on average, according to Bureau of Labor Statistics data. Healthcare accounts for nearly as many serious violent injuries as all other industries combined. The webpage addresses this issue by providing healthcare administrators with information on the risk factors, associated costs, and actions that can be taken to manage the problem.

The new webpage includes actual examples from healthcare organizations that have incorporated successful workplace violence prevention programs, and models of how a workplace violence prevention program can complement and enhance an organization's strategies for compliance and a culture of safety.

In one example that is listed on the webpage, each shift at St. Vincent's Medical Center in Bridgeport, CT, begins with a "safety huddle" led by a senior hospital executive. All departments, including medical and support services, are required to attend. Together, they review any patient or associate safety issues or concerns, recognize "good catches," and share updates on the status of any safety-related projects or initiatives, in process or on the horizon. ■

Tampa hospital reduces falls 16% in facility's common areas with simple changes

Determined to reduce slips, trips, and falls in common areas, a safety team at St. Joseph's Hospital in Tampa, FL, studied incident reports to determine the most common causes and potential solutions. After implementing several mostly simple safety initiatives, the hospital saw a 16% reduction in falls from the previous year.

The project arose after hospital leaders realized that a significant number of slips, trips, and falls were occurring in common areas of the hospital campus such as lobbies, waiting rooms, stairwells, sidewalks, and parking garages. Past efforts to reduce falls in patient care areas had not specifically addressed these common areas, and in 2012 the risk management department contacted facilities manager **David D. Miller** to express concern that there recently had been a dozen falls in one of the hospital's parking garages, including some that led to litigation.

Falls are costly, with the Centers for Disease Control and Prevention (CDC) estimating that costs tied to hospital falls average $35,000 per incident. (*Information is available at http://tinyurl.com/mf3ua5j.)*

An investigation found that about 60% of falls in the hospital's parking garages were people tripping over the concrete car stops at each parking space. Miller researched the building code in Tampa and found that car stops were not required in parking garages except for the spaces on the perimeter of each floor. Miller had all the unnecessary car stops removed and eliminated that tripping hazard.

That change led to Miller thinking about what other changes might be needed on the 35-acre campus, which led to him working with risk management to hire a consulting company for a pedestrian accommodation survey. The company produced a report with more than 50 recommendations, and St. Joseph's implemented most of them. These were some of the significant changes:

- At pedestrian crosswalks, the hospital prohibited cars from parking on either side. Cars parked close to the crosswalk might shield pedestrians from drivers' view as they step into the street.
- The hospital removed shrubs and other vegetation from entrances and exits to the parking decks, to avoid blocking drivers' view of pedestrians.
- The hospital changed speed bumps to speed tables, which have a gradual incline and a flat plateau and then a gradual decline. Several falls at St. Joseph's were attributed to people tripping over the speed bumps.
- The hospital installed a mid-block pedestrian crosswalk at a point where people were crossing a four-lane road instead of going to the corner crosswalk.

Still seeing room for improvement, Miller formed the Non-Patient Care Slip and Fall Committee in late 2012 that included himself and representatives from risk management, safety and security, and environmental services. He obtained the hospital's slip and fall data from non-patient care areas for the previous five years, and the committee studied them for evidence of falls that could have been prevented. The committee met monthly, reviewed any falls from the previous month, and visited the location of the fall to look for possible solutions.

Most of the remedies were fairly simple and inexpensive. Where people were walking off a sidewalk edge because they were busy looking at their phones, the committee installed a yellow chain on the sidewalk to get people's attention. When there were falls in the cafeteria from ice melting on the floor, they installed mats in front of the ice machine. Falls also occurred in the cafeteria when people spilled their coffee or soft drinks, so the hospital provided lids at the cashier and instructed the cashiers to encourage people to use them.

One of the most influential changes at St. Joseph's, Miller says, was the installation of pop-up safety cones and paper towel dispensers in elevator lobbies and many other common areas. Next to the paper towels and cones are signs that say, "If you see a spill, don't pass it up. Wipe it up." The slogan was promoted through in-house publications and other employee communications.

EXECUTIVE SUMMARY

A Florida hospital has reduced falls in common areas by 16%. A team studied incident reports and implemented several simple changes to policies and the facility.

- The project was aimed at common areas rather than patient care areas.
- Simple physical modifications had significant effects on safety.
- The changes were cost-effective when compared to the costs of falls.

"The biggest concern we got was that our staff didn't know what they were cleaning up, and so they didn't want to touch it. We told them to just put a paper towel on it, put a cone on top of it, and call housekeeping," Miller says. "Then we led by example. I do rounds weekly with the president of the hospital, and we use the supplies every time we see a spill."

Other changes included the following:

- Lighting was improved in parking lots and parking garages.
- Crosswalks with amber flashing lights were installed in parking decks.
- Walk-off mats and umbrella holders with plastic bags were provided at all entrances.
- After several falls in parking deck stairwells, the hospital posted signs at each landing encouraging people to use the handrails.

A year after the committee's changes, falls in non-patient care areas were down 16%, from 46 in 2012 to 35 in 2013.

"None of the changes were all that creative or groundbreaking, but we found that you can make a real difference with attention to the details," Miller says. "The changes also were not costly in most cases, and the expenses were more than offset by the savings from the fall reduction." ■

LGBT concerns overlooked by some facilities

Healthcare facilities are risking legal liability by not adequately addressing the needs and concerns of lesbian, gay, bisexual, and transgender (LGBT) patients, warns a health professional who has addressed the issue for years.

Refusal of care and postponement of care continue to be concerns for LGBT patients, says **Grace Blodgett**, PhD, who spent 50 years as a registered nurse and 20 years in the sexology arena. She is the author of *Understanding Patients' Sexual Problems* (Bookbaby, 2015). Healthcare institutions might be reluctant to care for a transgender patient, for example, and they might claim to have no understanding of the patient's needs, she says.

Healthcare facilities also violate the rights of LGBT patients and their family members by failing to recognize their relationships and denying visitation rights, she says. For many facilities, the concerns of LGBT patients are considered a minor issue, Blodgett says.

"People who are LGBT, and especially those who are transgender, are considered unimportant because they are a small, small percentage of the total population," Blodgett says. "So the physicians and nurses who already have a huge workload can't and won't take the time out to deal with their concerns. They also see transgender as being an illness, and they don't like to spend time on patients they can't cure."

The pivotal case for LGBT concerns in healthcare occurred in 2010 when the trauma center at Jackson Memorial Hospital in Miami denied Janice Langbehn access to her dying partner, Lisa Marie Pond. The couple had been together 18 years and had three children. The hospital refused to accept information from Langbehn regarding Pond's medical history, according to a summary provided by Lamda Legal, the rights organization that supported Langbehn in suing the hospital. Even after a power of attorney was provided, the hospital would not allow Langbehn or the couple's children to see Pond for eight hours.

Langbehn filed a federal law suit claiming negligence and intentional infliction of emotional distress. A U.S. District Court in Florida couldn't find any legal basis to support the lawsuit but emphatically condemned the actions of the trauma center. The center "exhibited a lack of compassion and was unbecoming of a renowned trauma center ... Unfortunately, no relief is available for these failures based on the allegations plead in the amended complaint," the court concluded. The hospital announced it had changed its policies regarding LGBT patients. It added a non-discrimination policy that includes sexual orientation,

EXECUTIVE SUMMARY

Some healthcare facilities are risking litigation by not accommodating the needs of gay and lesbian patients. Visitation is among the issues often handled poorly, some critics say.

- Facilities should consider education programs for staff about lesbian, gay, bisexual, and transgender patient issues.
- Courts have recognized the rights of patients to sue healthcare facilities for discrimination related to sexuality and gender identity.
- Providers risk legal liability for exploiting transgender patients with unnecessary exams.

gender identity, and gender expression; a patient's bill of rights that states the hospital's commitment to providing quality care for LGBT patients; and a visitation policy that updates the definition of family to include same-sex partners and other people who might not be legally related to a patient.

More recently, a transgender man sued Fairview Southdale Hospital in Edina, MN, and alleged that he was a victim of discrimination and mistreatment by an emergency department physician on the basis of gender identity. A U.S. District Court judge ruled that Jakob Rumble had a "plausible" case and denied a motion by the doctor's employer and Fairview to dismiss the case. *(The judge's ruling is available online at http://tinyurl.com/jmympok.)*

The ruling is believed to be the first extensive federal court analysis of Section 1557 of the Affordable Care Act, which prohibits discrimination by healthcare providers and is the first federal civil rights law barring sex discrimination in healthcare.

In addition to training clinicians and administrators on the legal rights of LGBT patients and families, Blodgett urges healthcare facilities to implement training programs that will help physicians and staff address their perceptions and possible prejudices toward LGBT patients. "The goal is to help them develop empathy for LGBT patients, to recognize that the stigma attached to being an LBGT person is pretty huge," Blodgett says. "The other primary concern is the development of language: the use of pronouns other than 'it,' and addressing people properly, with respect."

Healthcare professionals can become frustrated when an LGBT patient is offended by a seemingly innocuous reference, such as calling a transgender person by the wrong pronoun, Blodgett notes. Some of the interactions that are hurtful to the LGBT patient are not intentional, but they could be avoided by a greater understanding of this patient community, Blodgett says.

"When you do make a mistake, the best remedy is to apologize the patient and ask for help in understanding how to better relate to this person," Blodgett says. "The simple act of looking the patient in the eye and apologizing can have a tremendous impact on someone who is used to being held in disdain by others."

Forms and electronic documentation also should accommodate the sexual identities of patients by including more options than male and female, she says. Unisex bathrooms with one toilet are the best way to avoid many issues with transgender patients, she says.

LGBT patients, and particularly transgender patients, also are at risk of exploitation and voyeurism under the guise of medical education, Blodgett says. This issue is still common, she says, and it easily could be the foundation of a lawsuit alleging assault and sexual misconduct.

"The attending physician will bring in 10 or 20 students around, especially with someone who is transgender or who has ambiguous genitalia, and they will pull those bed covers back, exposing the genitalia. There will be snickering, laughing, and rolling their eyes," Blodgett says. "Or there will be repeated examinations of these patients that is utterly unnecessary. The patient is in a vulnerable position and feels unable to protect himself or herself." ■

DOJ recovers $1.9 billion from healthcare FCA cases

The Department of Justice obtained more than $3.5 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, and $1.9 billion came from companies and individuals in the healthcare industry.

The total marks the fourth year in a row that the department has exceeded $3.5 billion in cases under the False Claims Act (FCA), and it brings total recoveries from January 2009 to the end of the fiscal year to $26.4 billion, according to Benjamin C. Mizer, JD, principal deputy assistant attorney general and head of the Justice Department's Civil Division.

Two of the largest healthcare recoveries this past year were from DaVita Healthcare Partners, the leading provider of dialysis services in the United States. DaVita paid $450 million to resolve allegations that it knowingly generated

COMING IN FUTURE MONTHS

- Nurse fatigue risks patient safety
- Delayed triage in the emergency department
- Privacy and mobile messaging apps
- Reducing workers' comp premiums

unnecessary waste in administering the drugs Zemplar and Venofer to dialysis patients, and then billed the government for costs that could have been avoided. DaVita paid an additional $350 million to resolve claims that it violated the FCA by paying kickbacks to physicians to induce patient referrals to its clinics. DaVita has its headquarters in Denver and has dialysis clinics in 46 states and the District of Columbia.

Hospitals were involved in nearly $330 million in settlements and judgments this past year. A cardiac nurse and a healthcare reimbursement consultant filed a *qui tam* suit against hundreds of hospitals that were allegedly implanting cardiac devices in Medicare patients contrary to criteria established by the Centers for Medicare and Medicaid Services with cardiologists, professional cardiology societies, cardiac device manufacturers, and patient advocates. The department settled with nearly 500 of these hospitals for a total of $250 million, including $216 million recovered in the past fiscal year.

Several settlements involved violations of the Stark Law. Hospitals settling false claims involving Stark violations include Adventist Health System, an organization that operates hospitals and other healthcare facilities in 10 states, for $115 million; North Broward Hospital District, a special taxing district of Florida that operates hospitals and other healthcare facilities in Broward County, FL, for $69.5 million; and Georgia hospital system Columbus Regional Healthcare System and Andrew Pippas, MD, for $25 million plus contingent payments up to an additional $10 million. The Adventist settlement also involved allegations of miscoding claims to obtain higher reimbursements for services than allowed by Medicare and Medicaid. ■

HHS report: Hospital-acquired conditions decreasing

A recent report from the Department of Health and Human Services (HHS) indicates that an estimated 87,000 fewer patients died in hospitals and nearly $20 billion in healthcare costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2014.

Hospital patients experienced 2.1 million fewer hospital-acquired conditions from 2010 to 2014, a 17% decline over that period. HHS previously reported in December 2014 that 50,000 fewer patients died in hospitals and $12 billion in healthcare costs were saved between 2010 and 2013.

HHS notes that although the precise causes of the decline in patient harm are not fully understood, the increase in safety has occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events. The report, is available online at http://tinyurl.com/jh9gg6z. ■

Hospital safety scores show some improvements

The Hospital Safety Scores released recently by The Leapfrog Group show key shifts among many hospitals on the letter grades rating them on errors, injuries, accidents, and infections. While overall progress remains elusive, the data showed encouraging signs, with hospitals taking steps to make safety a priority by consistently maintaining an "A" score or by raising a lower score to an "A" over time. These are key findings:

• Of the 2,530 hospitals issued a Hospital Safety Score, 773 earned an A, 724 earned a B, 866 earned a C, 133 earned a D, and 34 earned an F.

• 133 hospitals earned the "Straight A" designation, which calls attention to hospitals that have consistently received an A grade for safety since the Hospital Safety Score launched in 2012.

• Zero hospitals in the District of Columbia, Alaska, North Dakota, New Mexico, Vermont, or Wyoming received an A grade.

• Due to a considerable data update, 46% of hospitals changed at least one letter grade.

The Hospital Safety Score assigns letter grades to more than 2,500 U.S. hospitals twice per year. For more information and to view the list of state rankings, visit www.hospitalsafetyscore.org. ■

CME/CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. describe the legal, clinical, financial, and managerial issues pertinent to risk management;
2. explain the impact of risk management issues on patients, physicians, nurses, legal counsel, and management;
3. identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

HEALTHCARE RISK MANAGEMENT™

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to the AHCMedia.com site to take a post-test. Go to "My Account" to view your available CE activities. First-time users will have to register on the site using the subscriber number printed on their mailing label, invoice, or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed.

4. After completing the test, a credit letter will be emailed to you instantly.

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CME/CE QUESTIONS

1. **According to Mary White, RN, MBA, CPHRM, senior risk manager at Brigham and Women's Hospital, what is the legal risk of publicizing the hospital's medical errors in an electronic newsletter?**

   A. The risk is too great, and dissemination of this type should be prohibited.
   B. There is no legal risk from the publication.
   C. There is some legal risk, but it is worth taking because of the potential improvements to patient safety.

2. **In a review of 7,330 surgery malpractices in the company's database from the past eight years at The Doctors Company, how strong was the correlation between malpractice claims and concurrent surgery?**

   A. The review found no mention of concurrent surgery as a factor.
   B. Concurrent surgery was cited in 5% of the malpractice cases.
   C. Concurrent surgery was cited in 37% of the malpractice cases.

3. **In the malpractice case recently before the Arkansas State Claims Commission, what did the Commission members determine was one cause of the wrong-site surgery incident?**

   A. The surgical team did not perform a timeout.
   B. The surgical team performed the timeout before the surgeon arrived.
   C. The surgical team ignored the concerns of a nurse during the timeout.
   D. The surgical team used the wrong patient record.

4. **What was one of the most influential changes made by the Non-Patient Care Slip and Fall Committee at St. Joseph's Hospital?**

   A. The hospital hired additional housekeepers.
   B. The hospital outsourced facilities maintenance.
   C. The hospital provided pop-up safety cones and paper towels in elevator lobbies and other common areas.
   D. The hospital installed additional security cameras to verify the legitimacy of slip-and-fall claims.

LEGAL REVIEW & COMMENTARY

EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Patient's complaints of pain lead to incomplete exam and $2.2 million jury award

*By **Damian D. Capozzola**, Esq.*
The Law Offices of Damian D. Capozzola
Los Angeles

***Jamie Terrence**, RN*
President and Founder, Healthcare Risk Services
Former Director of Risk Management Services (2004-2013)
California Hospital Medical Center
Los Angeles

***David Vassalli**, 2016 JD Candidate*
Pepperdine University School of Law
Malibu, CA

News: In 2012, a man involved in a logging accident severely injured his back. He was transported to a local hospital, where a physician ordered X-rays of the man's back. During the course of the man's X-rays, he complained of being in too much pain to complete the thoracic spine series the physician had ordered. The X-ray technician ceased the X-ray process, and the physician sent the incomplete series of X-rays to a radiologist for review.

The radiologist took nearly six hours to file her report. The report allegedly was unclear as to the severity of the man's back injury and failed to include a recommendation for a CT scan, that the patient should be immobilized, and that he should be treated as a potential spine fracture patient. The man spent an additional three days in the hospital before being released by a second physician. The man, who was suffering from an undetected fractured spine, then spent another two days at home and experienced extreme pain for those two days. The pain became so extreme that he had to be life-flighted to another hospital, where it was determined the man was now a paraplegic. He spent the next two months at the second hospital learning how to function as a paraplegic and undergoing life-threatening surgeries to battle blood clots and other complications.

The man filed a medical malpractice suit against the first physician for not following up on the X-rays or ordering a CT scan, the radiologist for her unclear report and for failing to warn the physicians about the man's condition, and the second physician who released the man with a broken back and ribs. The jury found the physician who released him was held 50% liable, the physician who failed to administer all of the X-rays was held 30% liable, and the radiologist who filed an unclear report was held 20% liable. The radiologist works at a separate facility, and the two physicians work in the same hospital. As such, the hospital with the two physicians was held 80% liable and the group with whom the radiologist works was held 20% liable for the $2.2 million jury award.

Background: In the summer of 2012, a man in the logging industry was struck in the back by a 500-pound treetop. He arrived at a nearby hospital on a backboard and was sent for X-rays of his back.

After images were taken of the spine region below where the tree struck the man's back, but before X-rays were taken of the rest of the man's back, the man complained that the pain was too extreme for him to get into the necessary positions to complete the examination. The hospital was equipped to administer a CT scan, which would have allowed the man's back to be fully examined without having to be repositioned, but the man was not offered or given a CT scan.

The physician sent the incomplete series of X-rays to a radiologist for review. The review took six hours, and recommendations were not made for a CT scan, for the

Financial Disclosure: Co-authors Jamie Terrence & David Vassalli, author Greg Freeman, Exec. Editor Joy Daughtery Dickinson, & Nurse Planner Maureen Archambault have no financial relationships with companies having ties to this field. Co-author Damian Capozzola represents Currie Medical Specialties in an action against Tenet Healthcare and is in an administrative action against Westside Regional Center. Arnold Mackles, physician reviewer, writes CME/CE courses, is on The Sullivan Group advisory group, & is a stockholder, speaker, author & consultant for Innovative Healthcare Compliance Group.

man to be immobilized, or for the man to be treated as a potential spine fracture patient. The man spent two additional days in the hospital and was never given a CT scan or follow-up X-rays to discover the fracture in his spine in the region where the 500-pound treetop struck his back. After two more days of pain in the hospital, his attending physician released him.

The man spent two painful days at home before the pain became unbearable. The man then was life-flighted to another hospital for treatment of his back. However, the man was paralyzed by the time he arrived at the second hospital. In addition to being paralyzed from the waist down, the man had to undergo life-threatening care for blood clots and infections. As a result of the incident, the 50-year-old man permanently lost his ability to walk, had to relearn how to do simple tasks, and described his current state as living in a "3-foot by 3-foot prison cell." He filed a medical malpractice suit against the physician for not following up on the X-rays or ordering a CT scan, the radiologist for her unclear report and for failing to warn the physicians about the man's condition, and the other physician who released the man with a fractured spine and broken ribs.

At trial, a surgeon at the second hospital told the jury that if the man had been given proper care, including obtaining complete images of his back and immobilizing him, that the man would be walking today. The jury awarded the man $2.2 million and found the physician who released him was held 50% liable, the physician who failed to order all of the X-rays was held 30% liable, and the radiologist who filed an unclear report and failed to investigate further was held 20% liable. The radiologist works at a separate facility that was held responsible for her 20% liability. The two physicians work in the same hospital that, accordingly, was held 80% liable. The award consisted of $300,000 for past pain and suffering, $1.7 million for future pain and suffering, and $200,000 for the man's wife's loss of consortium.

What this means to you: This case illustrates that the duty of care a physician must follow doesn't dissipate because of a patient's complaint. In this case, the man struck with a 500-pound treetop required a complete series of images of his spine. Despite his complaints of pain and not wanting to continue the examination, the physician is expected to order the necessary tests to uncover vital and life-altering information, particularly when a reasonable alternative is readily available. Had the man been given a CT scan or been strongly urged to complete the examinations, the fracture in his spine likely would have been detected, he would not be paralyzed, and the hospital employing the two physicians who failed to order the required test and released the man without them would have avoided liability. As such, a prudent physician dealing with a patient who cannot complete a necessary examination should seek alternative means of obtaining the necessary information, urge the patient to continue if it's reasonable to do so, and then document the courses of action the physician took, including the alternatives offered and whether the patient is refusing treatment.

In this case, providing pain relief before sending the patient to radiology should have been the physician's first course of action after having ruled out contraindications such as a head injury. Immobilization, which occurred in the field with the use of a backboard, should have been continued in the emergency department until the need was ruled out through diagnostic studies. Had the physician fully considered that an item weighing 500 pounds that falls from a distance and lands on a person will cause bodily injury, he probably would have handled the patient differently. If this information had been communicated to the radiologist reading the results, her recommendations might have included additional studies and immobilization.

Another lesson from this case is that each physician has a separate duty of care he or she must satisfy, yet liability can arise from work of another physician. This situation is seen in the radiologist's 20% liability. The radiologist reviewed all the material she was sent from a separate facility and gave her medical opinion. However, the radiologist was held liable for not recommending that other physicians administer more tests or treat the patient, whom she had never seen, as a spine fracture patient. This situation demonstrates that the radiologist cannot avoid liability simply by relying on the sensibilities of other physicians. Rather, the radiologist had a separate duty to the patient for whom she is separately liable and responsible. Bearing this duty in mind, physicians and hospitals seeking to avoid liability must evaluate the condition and circumstances of each patient to whom they provide medical care, even if their role is to evaluate the test results of another physician's chosen course of action. ■

REFERENCE

Crawford County Court, Pennsylvania, Case Number 13 AD-2012-1473 (Oct. 30, 2015).

Medication mix-up leaves 51-year-old patient with permanent brain damage after heart surgery

Hospital and physicians liable for $12.2 million jury award

News: In 2011, a 51-year-old man was undergoing heart surgery when complications requiring resuscitation arose. The man required cardioversion and was resuscitated after being shocked five or six times. The surgeon then ordered 150 mg of amiodarone, which is a medication used to normalize abnormal heart rhythms. The anesthesiologist retrieved three vials of what he believed to be 50 mg of amiodarone to intravenously administer to the man. However, and unbeknownst to the surgeon and anesthesiologist, each of the three vials that the anesthesiologist did administer to the man contained 900 mg each. The man's heart stabilized, and the surgeon completed the surgery successfully. The man soon after had a second episode of ventricular fibrillation, which caused the lower chambers of his heart to quiver and prevented it from pumping blood and oxygen to his brain. This situation allegedly was caused by an amiodarone overdose and led to the man being permanently brain damaged, being unable to function on his own, and requiring medical services for the rest of his life. The man brought a medical malpractice suit against the hospital where the medication mix-up occurred, the anesthesiologist who administered the incorrect dosage, and the healthcare provider for whom the anesthesiologist worked. The anesthesiologist acknowledged he administered an incorrect dosage. The hospital denied liability but admitted there was breakdown in communication at the hospital. In a two-week trial, the jury awarded the man $12.2 million, which consisted of $6.4 million for past and future medical costs, and $5.8 million for pain and suffering. The jury further determined that the hospital was 60% responsible, the anesthesiologist was 25% responsible, and the healthcare provider for whom the anesthesiologist worked was 15% responsible for the jury award.

> THE BOTTLES THAT WERE IN THE OR CONTAINED 900 MG EACH OF AMIODARONE, WHICH WAS AN ERROR COMMITTED BY THE HOSPITAL'S PHARMACY.

Background: In March 2011, a 51-year-old-man underwent cardiac bypass surgery to replace a heart valve. When the man was taken off of the bypass machines, he developed a ventricular fibrillation and required resuscitation through cardioversion. As a result, the surgeon ordered lidocaine and 150 mg of amiodarone be administered to the man. The bottles that were in the OR room contained 900 mg each of amiodarone, which was an error committed by the hospital's pharmacy. The pharmacy is to release medication in their minimal dosages so the physicians do not need to measure out their dosages. Nevertheless, the anesthesiologist administered 2,700 mg of amiodarone to the man, which temporarily stabilized his heart and allowed the surgeon to successfully complete the surgery. Soon after the surgery concluded, the man allegedly overdosed from the amiodarone and suffered a second ventricular fibrillation. This situation caused a restriction of blood and oxygen to his brain and left him with a permanent brain injury, loss of ability to function, and in need of around-the-clock medical care for the rest of his life.

The man filed a medical malpractice suit against the hospital for mixing up the dosage of the medication in the pharmacy, the anesthesiologist for administering the incorrect dosage of the medication, and the healthcare provider for whom the anesthesiologist worked for the conduct of its employee. The man alleged these mistakes fell below the standard of care and caused his permanent injuries. The hospital admitted at trial that the medication mix-up was due to a hospital system failure, and the anesthesiologist admitted to administering the wrong dosage, but all parties denied liability and asserted the overdose of amiodarone did not cause the man's brain damage.

The jury agreed with the man and awarded him $12.2 million in damages. The man was awarded

$6.4 million in economic damages for medical expenses, lost wages, and earning capacity, as well as an additional $5.8 million for pain and suffering. The jury also found all three parties responsible and allocated 60% of the liability to the hospital, 25% of the liability to the anesthesiologist, and 15% to the healthcare provider for whom the anesthesiologist worked. In Oregon, where this case took place, all defendants are jointly liable for the entire amount of damages to plaintiffs. As such, the hospital, anesthesiologist, and the healthcare provider for whom the anesthesiologist works are liable for the entire $12.2 million if the other parties cannot pay.

What this means to you: This case shows the physician's need to confirm what he or she is administering to a patient. In this case, an anesthesiologist, who didn't work for the hospital where he was assisting, simply followed the direction of the hospital's surgeon by administering three doses of amiodarone, which each presumably contained 50 mg of the medication. However, each dose actually contained 900 mg of amiodarone, which led the man to receive 2,700 mg of the medication. As was seen in this case, the fact that the anesthesiologist was following direction and the medication doses being mixed-up was not his doing did not shelter him or his employer from liability.

Medication administration requires checking and double checking for the many "rights:" the right patient, the right drug, the right dose, the right time, the right route, etc. It is not just for nurses. All providers must follow these steps. Amiodarone is considered a high-risk medication and should be labeled with that statement along with the dosage. Simply reading the label on the vials should have alerted the anesthesiologist that he was not holding a vial of 50 mg, but in fact 18 times that dose. The pharmacy did not send the dose expected, and that issue is one with preparing and dispensing the medication. However, the duty of the person administering the medication to double check the label is a built-in step to catch these types of errors. Eliminating even one step in the medication administration process can have serious consequences or even be deadly.

MEDICATION ADMINISTRATION REQUIRES CHECKING AND DOUBLE CHECKING FOR THE MANY "RIGHTS" ...

Checking the medication he might be administering prior to the surgery or during the surgery, and documenting such actions, likely would have diminished or entirely avoided liability for the anesthesiologist and his employer. As such, medical practitioners seeking to avoid liability should check the label to ensure his or her assumptions are correct when possible before the medication is administered to a patient.

Additionally, during an urgent situation, such as heart surgery, staff might easily become stressed. During periods of high stress, more errors are likely to occur. It is critical that caregivers step back, become composed, communicate with each other, and follow each step of every procedure. Simply asking another person to read the label on the vial to confirm the dose would have favorably altered the outcome.

The other lesson from this case is directed toward hospitals and calls for increased attention to automated systems that deal with sensitive medical materials. The technological mishap in this case occurred with an alleged mistake reading the computer screen when receiving the medication from the pharmacy that caused the 900 mg doses of amiodarone to leave the pharmacy and end up in the surgery room instead of the standard 50 mg. Technology undoubtedly streamlines hospital processes, but heavy reliance upon it can cause a false sense of security for staff. When, as was the case here, hospital protocol is for the physician to expect the minimum dosages of medication to be available, there should be a system in place to ensure the medications are being disseminated in the lowest dosage rates. This relatively easy error to commit resulted in nearly $8 million worth of liability to the hospital and permanently injured a man. Considering the high cost of such an error, it is cost-efficient and in the best interest of physicians and patients for hospitals to implement a safeguard against solely relying on the accuracy of emerging technologies, to monitor such systems regularly to ensure they are functioning properly, and to constantly educate hospital staff on how to operate all the technology associated with patient care. ■

REFERENCE

Circuit Court of Oregon, Lane County, Case Number 1161413229 (Sept. 29, 2015).