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INSIDE

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Hospital Realizes Value of Disaster Planning When Bus Crashes

Leaders at a hospital in Utah saw the value of mass casualty planning and communication with other facilities when a tour bus crash killed four people and seriously injured 25 more. To make matters even more challenging, all victims were from China and spoke no English.

The incident was a significant challenge for Intermountain Garfield Memorial Hospital in rural Panguitch, located in the southwest part of Utah, that sees about 2 million tourists per year. About 1,500 people live in Panguitch, and Garfield Memorial is a critical access hospital that serves the region with 15 beds, four physicians, two advanced practice practitioners, and 125 employees.

> DESPITE ITS SIZE, GARFIELD MEMORIAL WOULD BE THE KEY MEDICAL FACILITY BECAUSE THE OTHER CLOSEST HOSPITALS ARE INTERMOUNTAIN'S OTHER LOCATIONS 90 MINUTES OR FOUR HOURS AWAY.

The ED includes two trauma bays and two exam rooms, for a total of four emergency beds. On its busiest days, at the height of the summer tourist season, the ED might see 20 patients — few of them trauma. Responding to an incident of this size would require coordination with other Intermountain facilities and resources.

Garfield Memorial had planned for such a mass casualty event, and was ready to activate its teams and protocols. Ironically, health system leaders were on site that day to assess the hospital's plans for a mass casualty event. Instead of going through PowerPoints and three-ring binders, they saw the hospital respond to a disaster.

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In Salt Lake City, Intermountain Garfield Memorial Hospital Administrator **Alberto Vasquez** had just left a meeting at 11:30 a.m. on a Friday when an assistant texted him to ask if he heard about the tour bus that crashed 18 miles from the hospital.

"This was only about 20 minutes from our hospital, so we knew that we would be the primary resource for responding and caring for these patients," Vasquez says. "It was a tour bus with about 30 tourists from China that overcorrected on a highway, turned over, slid, and hit a rail."

Four passengers died at the scene. Everyone else was injured, many of them seriously. Several other tourists passing by happened to be first responders and medical professionals, so they assisted the passengers until local authorities could respond.

Trauma Response Under Review

The scope of the accident triggered the Garfield County 911 center to notify all emergency responders and hospitals in the region. Despite its size, Garfield Memorial would be the key medical facility because the other closest hospitals are Intermountain's facilities in St. George, about 90 minutes away, and Salt Lake City, nearly four hours away.

At Intermountain Garfield Memorial, Nurse Administrator **Deann Brown**, RN, was about to attend a meeting led by **Rachelle Rhodes,** RN, Intermountain's executive director of clinical operations in the specialty-based care group. Rhodes is an experienced trauma nurse, and was visiting the hospital with three team members to review Garfield's trauma response, among other issues.

When they heard about the bus crash, Brown and Rhodes canceled the meeting and rushed to Garfield Memorial's ED. They found that the ED staff was gathering supplies and had texted off-duty nurses to come in if they could.

Rhodes and her team gowned up and prepared to assist with incoming patients. It was not long before patients began arriving by ambulance and helicopter. The health system had immediately dispatched two helicopters and two airplanes to Panguitch after assessing the scope of the bus accident, delivering additional personnel, medical supplies, equipment, and blood.

Intermountain coordinators determined that 19 crash victims would to be sent to Garfield Memorial for initial treatment

EXECUTIVE SUMMARY

A small hospital was the main facility receiving patients after a serious bus crash. The hospital coordinated with other facilities in the health system to manage the incident.

- Planning for such a mass casualty event made the response successful.
- A language barrier presented a challenge.
- The hospital saw room for improvement in personnel management and radiology reviews.

and stabilization, although many likely would be transferred to other facilities for further care because Garfield Memorial did not have enough beds. First responders triaged patients on site, sending three or four to Garfield Memorial every 20 minutes. The first patients arrived around noon.

Garfield Memorial's ED manager was in the ambulance bay triaging patients as they arrived, sending green noncritical patients to the clinic, while those needing immediate emergency care were sent to the ED, Brown explains.

Significant Language Barrier

Adding to the challenges, the ED received two cardiac arrest patients unrelated to the bus crash — one just before the crash, and the other just as the accident victims began arriving.

The health system's virtual hospital, Intermountain Connect, helped coordinate the response, explains **Bill Beninati**, MD, senior medical director. The virtual hospital provided two-way audio and video connections to the Garfield Memorial trauma rooms so that trauma and critical care experts at other Intermountain facilities could consult and coordinate care plans, he says.

The communication was particularly important for planning the transfer of patients from Garfield Memorial after their stabilization, to keep that hospital and others in the health system from becoming overwhelmed, Beninati says.

Intermountain's APP team also assisted Garfield Memorial. The APP director of anesthesia, based at Cedar City Hospital, texted staff at Garfield Memorial and confirmed they need more personnel. She dispatched four APPs from Cedar City, and another APP moved from a different hospital to provide coverage at Cedar City.

To address the language barrier with the Chinese patients, Intermountain's Language Services team sent four iPads the hospital staff could use to help with translations. A volunteer Panguitch firefighter also helped with translations. Additionally, Chinese-speaking students at Southern Utah University, about 60 miles away, drove to the hospital after hearing about the accident so they could help translate and comfort the patients.

> GARFIELD MEMORIAL RESPONDED WELL OVERALL TO THE BUS CRASH, ALTHOUGH THERE ARE LESSONS TO BE LEARNED FROM ANY INCIDENT OF THIS SIZE.

"They were not certified translators, so we tried to keep it to just basic information that they discussed with the patients. It wasn't ideal but we worked with what we had available to us at the time," Vasquez says. "That could be a risk issue, but we did what we had to do to care for the patients."

At Intermountain Dixie Regional Hospital in St. George, where some of the patients were transferred, a clinical dietitian had the entire room service menu translated into Mandarin.

Good Response, But Lessons Learned

Garfield Memorial responded well overall to the bus crash, Vasquez says, although there are lessons to be learned from any incident of this size. Communication with local first responders was excellent because hospital leaders had worked closely with them to coordinate and include them in all incident response plans, he says.

"Our folks fell into the roles that they had trained for, positions like incident commanders, and they performed very well," Vasquez says. "We learned that we didn't have some of the more formal procedures ingrained in us, things like grabbing the incident commander vest so that everyone can see who is in that role. Everyone did their part and worked well with the other facilities, but we could have been more formal in some of the things we did."

Being part of a health system greatly improved the hospital's response, Brown notes. Personnel at Garfield Memorial could focus on patient care more because of the support provided by Intermountain leaders elsewhere, she explains.

"Life Flight just dispatched, and when they were here, they said 'Don't worry about the arrangements because it's been taken care of by Intermountain.' Normally, in a trauma transfer, we'd have to make the arrangements with specific hospitals, but in this case they said, 'Don't worry about it, we'll take them where they need to go,'" Brown says. "That freed us to focus on the patients we still had coming in and needing more care."

The air ambulances made repeated round trips between Garfield Memorial and the other

Intermountain hospitals, transferring patients and ferrying supplies to Garfield. The hospital had enough supplies on hand, but the health system resupplied some critical material and delivered particular blood types to Garfield Memorial so it did not have to take the time to cross-match its own supplies to patients.

Many Volunteers to Manage

Another potential lesson from the experience was the need to manage the influx of additional staff and volunteers, Brown says. The community responded so quickly that it might have been useful to have more coordination and oversight of the off-duty personnel from its own hospital and neighboring facilities, as well as private citizens like the college students who provided translations, she says.

There were no problems with them, but the hospital was not quite prepared to manage the number of people who stepped up to help, she says. Vetting the skills and credentials of people who volunteer to help would improve the incident response, Brown says.

The hospital's radiology group also is studying how to notify radiologists from other facilities who can help read CT scans and similar images, Vasquez notes. There was some delay in reading images the day of the crash, so leaders are arranging to notify radiologists at other locations and allow them to access the queue of images.

Garfield Memorial used numbers as patient identifiers for the bus crash victims because most came in without identification, and the language barrier made it difficult to obtain their names. The hospital changed the patient identification to the name when it became known, but Vasquez says the hospital may stick with numbers through the initial triage and stabilization process because the foreign names were difficult for staff.

The hospital also is looking at tightening security during a mass casualty incident. With the hospital running full throttle, all the doors were open and people were coming and going without much vetting or restrictions, Vasquez says. Nothing problematic occurred, but hospital leaders realized that there should be more formal security.

"Someone was being nice and ordered in pizza for our ED staff, and the pizza delivery person just walked right into the ED in the middle of all this," Vasquez recalls. "It was OK, but we realized that is the kind of thing you probably shouldn't have going on when you're dealing with a mass casualty event. We also had some looky-loos come by just to see what was going on. We could tighten that up a bit."

The hospital also received scam calls during and after the incident, Vasquez says. Some callers claimed to be from the FBI and wanted information on the Chinese patients, such as what province they were from, which the hospital did not know. There were other calls from people claiming to be from insurance companies offering to pay the patients' bills and asking for personal information about them. The hospital also had to deal with several state and federal investigators who needed to gather information from the patients, Brown notes.

When Vasquez left the hospital at 11 p.m. on the night of the accident, only one patient from the accident remained. He says he left feeling proud of his team's performance and confident they could handle another such incident if necessary.

"We were more prepared than I realized, more prepared than any of us realized," he says. "You do all the planning, and put all the right processes in place, and hope that it works when needed, but you don't know until you're tested. We were tested, and Intermountain rose to the occasion by working together." ■

SOURCES

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Nurses Require Their Own Education on Malpractice Prevention

Nurses need education on malpractice prevention and liability risks that is tailored specifically to their concerns and working conditions, but too often they receive only cursory information that is tacked on to the risk management efforts directed at physicians. Education developed for nurses can reduce the liability risk for them and their employers.

Most nurses do not receive adequate instruction in malpractice prevention and reducing liability, says **Dawn Grace-Jones**, JD, RN, an attorney and consultant in Miami who specializes in educating nurses about malpractice prevention and risk management. Previously, she was risk manager at one of the largest hospital systems in Florida.

"When you were in nursing school, you were not exposed to anything legal or what you need to be thinking about to protect yourself, or how serious it can be," she says. "Nurses are looking at their work and their documentation one way, but we don't really teach them that there are other people who are looking at it in a very different way. We have to bring more awareness among nurses about the risks they face and how to protect themselves."

Unprepared for Depositions

Liability related to the electronic medical record (EMR) is a significant concern for nurses, the same as it is for physicians, Grace-Jones says. Risk managers should alert nurses to the potential liability risks of EMRs, which can include roadblocks to proper patient care. When an EMR makes good nursing care difficult or challenging to document properly, nurses must speak up, she says.

"Nurses tend to be agents of change because they are on the front lines and know exactly how things operate on a daily basis. They know what works and what doesn't," Grace-Jones explains. "We are advocates for the patient, and we are the ones who need to scream out when the system isn't working adequately for us. If the system lacks information or isn't allowing the nurse to send information to someone who needs it, we have to address that kind of problem to avoid litigation."

Healthcare organizations also fail to prepare nurses for their involvement in litigation, Grace-Jones says. Nurses often are deposed as part of malpractice suits, but with little or no preparation. They often do not understand why they are being questioned, or why an attorney is asking questions that seem to have little to do with the matter at hand or the nurse's work, Grace-Jones says.

"Often, we are not prepared for those because no one has spoken to us about it before we're deposed, or our statements taken. We are afraid, and we feel pressured," she says. "It is useful to give nurses a scenario and role-play a deposition with them so that they can see how it plays out. They need to know how the attorney will be looking for specific information, and why they are asking certain questions that may seem unnecessary if you don't understand how the process works."

Encourage nurses to seek advice and legal counsel when they do not feel comfortable with their involvement in litigation, Grace-Jones advises. Make the hospital's legal counsel available to answer questions about the nurse's obligations, potential exposure, and how the employer's insurance applies.

Less Patient Contact

Grace-Jones also urges risk managers to address how nursing has changed in recent years, and how that might affect the informed consent process. Nurses who have been in the profession for many years know they used to have more personal contact with patients, she says. Now, nurses

EXECUTIVE SUMMARY

Nurses often are undereducated on malpractice prevention and risk management because efforts focus more on physicians. Education focused on nursing concerns can help reduce the risk for themselves and their employers.

- Nurses sometimes are not adequately prepared for depositions and questioning following an adverse event.
- The demands of electronic record systems can pull nurses away from patient care and increase liability risks.
- The routine work of nurses should not be underestimated when considering what is documented in the medical record.

are so busy working in the electronic system that they do not connect with the patient, she says.

"Nurses used to touch their patients much more often. You looked in their eyes and you knew what the patient was feeling. Your assessments were more detailed, and your communication was more intact because you made that a priority," she says. "Now, we're so busy trying to document, and our backs are turned that we don't know how our patients are feeling. This spills over into the informed consent process in that we don't know if this patient really understands what the doctor said and what you said, and what you're confirming when you sign as a witness."

Grace-Jones urges nurses to recognize that problem and make a point of stopping to establish eye contact with the patient. Nurses also can urge the patient to interrupt at any point with a question or comment, saying "I have to enter this in the system but I'm listening, so please tell me if there's anything you want to say."

"Everything is getting so impersonal. A lot of times in healthcare, it is the smallest thing that makes the patient angry, things that we could have worked out if we had communicated more," she says. "There may be no real injury but it may be something that shouldn't have happened, and that a simple apology might have remedied. We're so rushed and our focus is elsewhere, and our patients are getting angry at the system."

Similar Key Elements for Nurses

The key points to cover when educating nurses about liability risk and malpractice prevention are the elements that have to be proven for a plaintiff to make a malpractice claim against a nurse, says **Diane Pradat Pumphrey,** JD, partner at Wilkins Patterson Smith Pumphrey & Stephenson in Jackson, MS, and a member of the Medical Defense and Health Law Committee of the International Association of Defense Counsel (IADC).

"I use the elements of duty, breach, causation, injury, and foreseeability with real-life situations to show them how a claim is made and proven," she says. "I always tell the nurses that I talk to that they should pay attention to their gut or 'Spidey senses' in situations. I also make a point to nurses that they are the first line of defense in malpractice claims. Additionally, nurses need to pay attention to their patients and treat them with respect."

Risk managers should inform nurses that they are liable for their own actions, and generally are covered by their employee's malpractice insurance and/or their immunities, she says. Nurses should be reminded that they can purchase their own malpractice insurance.

Regarding malpractice claims, the elements of risk management are the same for nurses and physicians, Pumphrey says. However, nurses may have defenses that a physician does not, and they need to be aware of those defenses.

The most common type of allegations against nurses are failure to monitor and assess, or failure to communicate changes in condition, she notes.

The nurse is generally the first line of defense. They need to know how — and how not — to document, Pumphrey says. Although good documentation is essential, Pumphrey cautions against what can be a tendency to diminish the important but routine activities of nurses.

"It is my opinion that the old mantra of 'If it is not charted, it is not done' needs to be removed from their lexicon," she says. "Nurses do so much more than they chart, and there are many things that they pay attention to and do that are never in the chart because it is part of their routine."

For instance, in taking vital signs, nurses talk to patients, determine whether their skin is warm, dry, cool, or damp, and whether they are awake, alert, confused, or any number of things, Pumphrey explains.

"If there are no negative findings, they don't necessarily chart the positive findings. It is a given," she says. "Nurses should be taught to chart what they have reported to the physicians, and the physicians' response. They also should chart their instructions to the patient and family. The chart is their shield."

Nurses also should be cautioned about not practicing outside their scope of practice, Pumphrey adds.

Relationships Reduce Risk

The overall liability risk for nurses can be lower than for physicians simply because patients and family members tend to have a closer and more positive relationship with nurses, Pumphrey says.

"I find that people love their nurses in general, especially those who they feel are trying to help, who listen to them, who give them information, and that they feel like are doing their best to provide care," she says. "This makes the liability risks somewhat less than that of the physician. However, they are responsible for their actions. Plaintiffs are interested in those with

the deep pockets, and this generally is not the nurse."

On the other hand, nurses may not have received enough education on liability and risk reduction because risk management tends to focus more on physician education, Pumphrey says.

"Since nurses are not the target in malpractice suits, they don't get as much education about liability issues. Physicians know that they are targets," she says. "Nurses I speak to are very interested in this subject. They want to be educated on how best to defend themselves, and how they should approach patient care and documentation."

It is rare for nurses to have been taught the elements of a lawsuit in the same way that physicians are, says **Julye Johns Bailey**, JD, a medical malpractice and healthcare attorney at the law firm of Huff Powell & Bailey in Atlanta, and a member of the IADC.

"Nurses may only hear the notion that lawsuits are filed because of bad outcomes, not bad care," she says. "It is important for nurses to know that malpractice is defined as a violation of the nursing standard of care that caused a patient's damages. The standard of care should be explained using the reasonableness definition. Nurses and other healthcare providers are not expected to be perfect."

Bailey agrees with Pumphrey's suggestion that the routine activities of nurses can be discounted because they are not explicitly documented, with nurses often simply told that if it was not documented, it was not done.

"Not only is that not true — nurses do plenty of things that they cannot and do not have the time to document — but it is insufficient. Nurses need to be educated on how to document, when to document, and, especially in the era of EMRs, where to document," she says. "Nurses should be encouraged to review their documentation. They should use narrative or event notes as needed to fill in the gaps left by the mouse clicks and selections from drop-down menus reflected on flowsheets. Risk prevention goes beyond documentation, of course, but it is a key feature of every malpractice case involving a nurse."

Employer Coverage Can Ease Fears

Bailey notes that because many nurses are employed by the hospital, clinic, or organization, they often do not procure their own malpractice insurance or have to pay annual premiums. That can keep malpractice prevention and liability risks from the forefront of their minds as it tends to be with physicians. Risk managers should try to remind nurses that they do face substantial risks.

Conversations with nurses should be tailored to their level of experience in nursing and with litigation, Bailey notes. "There is an ever-growing focus on the 'second victim' in physician circles, but less so in nursing," she says. "Risk managers and lawyers should keep in mind the psychological impact a malpractice suit can have on a nurse."

Many nurses are employed by hospitals, clinics, or organizations that will bear the brunt of any settlement or verdict. But if they have their own malpractice insurance, nurses are not immune from payouts and the concomitant fears of higher premiums and cancellation, Bailey notes. Further, there are similar concerns of a report to the state nursing board or the National Practitioner Data Bank.

The topic of nursing liability may be covered in a nurse's education or initial orientation, but they do not tend to receive any additional or ongoing training or education beyond that, Bailey says. Moreover, the education often is focused solely on charting and documentation. As a result, they tend not to think as much about liability risk as their physician counterparts, she says.

Although the risk may be lower for nurses, it is still real, especially in some areas, Bailey says. "In the hospital, nurses who work in higher acuity areas — the emergency department, intensive care units, and obstetrics — should be prepared for the reality of litigation," she says.

Nurses often face liability for the lack of monitoring and poor charting, Bailey says. Failing to follow orders, administer medications as ordered, question the physician, or supervise adequately can lead to liability. Failing to document accurately also can result in liability.

"One other major feature of almost every nursing case is an allegation that the nurse should have gone up the chain of command," Bailey notes. "This rarely is an allegation against a physician, and is therefore a different liability risk. Nurses should be aware of the chain of command, but be encouraged to work collaboratively in teams." ■

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Google/Ascension Partnership Shows HIPAA Gray Areas

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is investigating a huge data-sharing project between Google and Ascension, one of the country's largest nonprofit health systems, in a case that analysts say highlights the uncertainties of exactly what is and is not allowed under HIPAA.

HHS Director **Roger Severino** announced that OCR is investigating "to learn more information about this mass collection of individuals' medical records with respect to the implications for patient privacy under HIPAA."

Google launched Project Nightingale in 2018 to analyze healthcare information from Ascension patients, including their diagnoses, lab results, and medications. The goal of the Google project is to develop best practices and new tools, and to identify deviations from standard care. Google has stated publicly that the data-sharing project is part of Google's partnership with the St. Louis-based Ascension. The two companies also have stated that they are working to move Ascension's on-premise data centers to Google's cloud-computing system.

Both companies have issued statements saying Project Nightingale is HIPAA-compliant, even though Ascension patients were not notified because Google signed a business associate agreement with the health system. *(The Ascension press release is available at: https://bwnews.pr/348II8P.)*

Eduardo Conrado, Ascension's executive vice president of strategy and innovations, wrote in a blog post that, "All of Google's work with Ascension adheres to industry-wide regulations (including HIPAA) regarding patient data, and come with strict guidance on data privacy, security and usage. We have a business associate agreement (BAA) with Ascension, which governs access to protected health information (PHI) for the purpose of helping providers support patient care.

"This is standard practice in healthcare, as patient data is frequently managed in electronic systems that nurses and doctors widely use to deliver patient care. To be clear: Under this arrangement, Ascension's data cannot be used for any other purpose than for providing these services we're offering under the agreement, and patient data cannot and will not be combined with any Google consumer data." *(The blog post is available online at: http://bit.ly/2YJAa7p.)*

EXECUTIVE SUMMARY

A data-sharing project between Google and Ascension health system raises questions about HIPAA compliance. HHS's Office for Civil Rights is investigating.

- Project Nightingale uses patient data to search for improvement in care, and to identify deviations.
- Patients were not notified that their data were to be shared with Google.
- Google signed a business association agreement with the health system.

Business Associate Boundaries?

The project raises questions about how patient can be shared between a healthcare organization and a third party like Google, says **Elizabeth Litten**, JD, partner and HIPAA privacy and security officer with Fox Rothschild in Princeton, NJ.

A key issue is that Google appears to be using the information to develop a healthcare data analysis service rather than strictly acting as vendor performing data analysis for a client, she says.

"I think this really highlights the gray areas of HIPAA in that it stretches the boundaries of what a business associate is permitted to do with PHI under HIPAA. It's one thing to provide services on behalf of the covered entity, but when the PHI is being used for Google's own parallel efforts to sell its services to other covered entities, that pushes into a different realm."

Litten also is curious if Ascension's Notice of Privacy Practices adequately alerts patients to how Google might be using their PHI. She took particular notice of the statements from Google and Ascension stressing that they are not using the information for advertising. That is fine, she says, but it is just one of the ways that they should not be using the information.

"There often is the perception that if information is deidentified, then you're fine, and the patient's privacy is not going to be at risk.

Even among healthcare attorneys, there is the misconception that the deidentification of the information for the business associate to be able to sell that information is all fine under HIPAA," Litten says. "My view is that it is not appropriate."

Deidentification is not always enough, Litten says, because an aggregate of enough data could make it possible to identify someone.

Public Reaction Matters

The Google/Ascension project is a large-scale example of the same principles that apply to any healthcare organization entering into a BAA with a vendor, says **Matthew R. Fisher**, JD, partner with Mirick O'Connell in Worcester, MA. The healthcare organization needs to be completely comfortable with knowledge that the vendor is complying with HIPAA and other potentially relevant regulatory requirements. Ascension must have performed due diligence in that regard, he says.

The situation also illustrates the need to anticipate the reaction of patients and the public to news of such a data-sharing project, he says. The Google/Ascension project requires the public to trust both large organizations will protect their privacy, and Google's name carries some baggage, Fisher says.

"From an organizational risk management standpoint, it is important to get ahead of any public relations or communications impact of an arrangement like this, particularly when you're talking about the sharing of patient data because people can be quite sensitive and skeptical about that," Fisher says. "That seems to be one of the bigger issues that has arisen from the Google and Ascension project. They're saying that they're doing everything right, but everyone is just looking at the name Google, which they associate with internet searches, and assuming that the data are going to be misused."

The trust factor and the public perception of a potential partner company should be considered when evaluating potential deals, Fisher says. Partnering with a company that the public sees as sketchy in terms of privacy could cause patients to shy away from using the healthcare organization, he says.

Could Affect Other Projects

Even for healthcare organizations not involved with Ascension or any similar project, there could be some blowback from publicity surrounding the project, Fisher says. Consumers may become aware that hospitals and health systems can share their patient information in this way, and fearful that it is happening without their knowledge or permission, he says.

"Any response to a question along those lines should be framed carefully, because HIPAA does allow for a lot of uses and disclosures of information that the individuals don't know about," Fisher explains. "Legally, there is nothing wrong with that, but if someone starts asking questions, you want to delicately respond by not saying anything untruthful but by explaining some of the benefits of that relationship. The goal should be to allay some of the concerns raised by individuals, not to dismiss them by simply saying you're not violating any regulations."

Fisher says it appears that Google and Ascension have taken the proper steps to share the patient data under the restrictions of HIPAA, but he is not surprised that OCR wants to take a closer look. The scale of the project and the public attention it has received likely prompted the OCR involvement, he says.

"Data-sharing is happening like this all the time, and there are a lot of vendors trying to gain access to a large swath of data. This type of arrangement is not surprising," he says. "The names involved happened to draw greater interest and attention."

Other health systems are likely to enter into similar arrangements with Google, Fisher says. Any entity considering such a relationship should be careful to conduct due diligence on the other party's compliance with all privacy and security requirements, he says.

"They might want to include the ability to audit the compliance on an ongoing basis, and actually exercise that option to do an audit. I see that provision in a business associate agreement frequently, but when I talk to clients who are business associates they say they never get audited by the covered entity," Fisher says. "Also, proactively consider what the public's reaction might be if they hear about this relationship. It might be preferable to announce the establishment of that relationship so that the healthcare organization is controlling the story, rather than reacting when the public finds out through some other means." ■

SOURCES

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Program Trains Administrative Staff to Prevent Falls

Fall prevention efforts focus almost exclusively on clinicians such as nurses and therapists. Sometimes, it includes other healthcare employees who encounter patients regularly, such as those in housekeeping or dietary services. But clerical office staff typically are not included.

They are included in a program offered by SCAN Health Plan, based in Long Beach, CA. SCAN offers several Office Staff Training (OST) courses to medical groups. One of the most popular is a fall prevention course called Stand Up 2 Falls — Maximizing Mobility.

Over the past 18 months, more than 230 front and back office staff, representing seven provider groups, have participated in the fall prevention course. The program covers fall risk factors, best practices, and various assessments, giving staff the tools to identify their patients at risk for falls and create individualized action plans, including education and mobility interventions.

SCAN is a Medicare Advantage plan serving only senior patients, so fall prevention is a top priority, says **Eve Gelb**, senior vice president of healthcare services with the health plan. The fall prevention efforts target senior patients in community settings, rather than inpatient facilities, she explains.

"Our office staff training is about working with our provider partners, the physicians, and their staff in the ambulatory setting to help them understand the fall risk for seniors, and how to prevent falls when they're out and about in the community," Gelb says.

The physician only spends a few minutes with each patient, but office staff often spend much more time with them, Gelb says. That means they could prevent falls if they are properly trained.

"They're the ones who watch the patient walk in from the street. They observe the patient getting up from a chair in the waiting room and walking to the exam room," she says. "These folks are in a great and unique position to identify people who are at risk from falling, because a lot of that identification comes from observing gait, how quickly someone can get up from a sitting position, how steady they are on their feet."

Physician practices can train their entire staff, or they can send designated employees for a train-the-trainer program, Gelb explains.

"It's about educating staff to understand the importance of preventing falls among seniors, to create that desire to do something about it. We teach them how to perform specific fall screening to identify seniors who are at risk of falls or have balance issues," she says. "We teach them how to coach patients about falls risk and mobility, because a lot of seniors don't think falling is a big deal and they don't want to draw attention to it. They think that if they tell someone they're falling, people will think they can't take care of themselves, and put them in a nursing home." The program is extremely well received by both the office staff and physicians, Gelb says.

The program teaches office staff to bring up the subject of falls with seniors because the patients are unlikely to bring it up themselves, Gelb says. Office staff receive suggested questions to ask seniors, along with simple tests that can be performed with patients to assess fall risk.

"We also give them tool kits for their offices that include things like a 10-foot tape measure they can use to mark the distance in the hallway, and time how long it takes a patient to walk that distance," Gelb says. "We teach them how to do the assessments and give them some of the tools they will need." ■

SOURCE

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Cameras Help Monitor Compliance, Reduce Patient Falls

A health system based in Florida has found using cameras can improve compliance with quality and safety efforts, especially when the camera includes a speaker for communicating with people.

Cameras already were in use for security purposes at Lee Health's facilities, but leaders recently decided to start using a type of camera that includes a speaker, according to **Sean Owens**, CPP, PSP, CHPA, ACP, director of security technology and non-acute care. In one use, the cameras are employed as "sitter cams."

Previously, the health system paid a retired nurse to sit at a patient's bedside when the patient need to be watched constantly for falls or other risks. The paid sitters were hard to staff because they were needed on short notice — and they were expensive.

Lee Health changed to a system in which the same sitters were stationed in a room with monitors for cameras watching several patients at once. The cameras do not record anything in a patient room, but the observer can summon help immediately to any room. "Not only did we see a reduction in falls, but we were able to expand our monitoring of at-risk patients," Owens reports. "Patients who were only borderline fall risks before might not have gotten a sitter because ... they didn't meet the clinical criteria for requiring one."

Beyond preventing falls, Lee Health uses cameras to monitor a particular stairwell that staff, patients, and visitors used for convenience despite multiple efforts by the hospital to stop the habit. The high volume of traffic in the stairwell was thought to be a safety hazard, with a high risk of trips and falls. Administrators declared the stairway off limits, even though no one could lock the doors for fire safety reasons.

Previously, leaders tried signage, admonitions from supervisors, and even stationing security officers at the exits to remind people of the policy. None of that worked, so administrators installed a camera with a speaker, triggered by motion, in the stairwell. "Imagine you're in the stairwell and you hear a recorded announcement that this is an emergency exit only. The message even guides you to the proper exit — nothing authoritative or scolding," Owens explains. "Within the first week of implementing it, that message was enough to change their behavior instantly. We had complete compliance moving forward."

The camera system also can help with infant abductions, Owens notes. The National Center for Missing and Exploited Children, which tracks infant abductions, indicates that people looking to abduct an infant usually will hang out around obstetrical units for some time, watching staff and patients as they wait for the right opportunity.[1]

"We debuted a camera that uses video motion analytics for loitering. Anyone who spends an extended amount of time in an area will trigger a notification to our security operations center so we can make contact with that person and ensure everything is all right," Owens says. "We're able to home in on the human behavior that really matters to us."

Similarly, Lee Health addressed a problem with transients and drug abuse in a hospital parking lot. An exterior camera uses motion video analytics in the area to detect anyone loitering on the property after hours, triggering a recorded message telling them they are being watched and to leave. "There has been a complete turnaround in that location. We have had almost complete compliance just by using the audio," Owens says.

Other than patient safety, hospitals also can use cameras to monitor compliance with handwashing and other infection control policies.[2] Here, the camera typically is oriented to capture only the handwashing sink or other work station, with no coverage of patients so as to protect their privacy. Most hospitals using this approach have recorded the video to be reviewed later for compliance, sending feedback and metrics as soon as possible.

In one study, a door sensor triggered the camera to start recording a handwashing station, and the video was sent to a third-party vendor who assessed compliance and sent feedback to the unit.[2] ■

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2. Armellino D, Hussain E, Schilling ME. Using high-technology to enforce low-technology safety measures: The use of third-party remote video auditing and real-time feedback in healthcare. *Clin Infect Dis* 2012; 54:1-7.

SOURCE

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HEALTHCARE RISK MANAGEMENT™

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Which is one way Intermountain Garfield Memorial Hospital handled a language barrier posed by numerous Chinese patients during a mass casualty event?**

   a. An online translation service
   b. iPads with translation programs
   c. Calls to the Chinese embassy
   d. A manual of common Chinese translations

2. **What does Matthew R. Fisher, JD, suggest is one reason the public is concerned about privacy with the Google/ Ascension data-sharing project?**

   a. Google is associated with internet searches, and the public assumes the data will be misused.
   b. OCR has said the companies violated HIPAA.
   c. Ascension has accused Google of violating its business associate agreement.
   d. Google has accused Ascension of violating HIPAA rules governing the covered entity.

3. **Which does Dawn Grace-Jones, JD, RN, cite as one example of how nurses are not adequately educated in malpractice prevention and risk management?**

   a. They are not involved enough in the informed consent process.
   b. They often do not understand why they are being deposed or questioned regarding litigation.
   c. They generally do not think they can be named as defendants in malpractice lawsuits.
   d. They usually are unaware of malpractice insurance available to them.

4. **What is one area in which Garfield Memorial Hospital leaders think they might be able to improve their response to a mass casualty event?**

   a. Better management of the many off-duty personnel and volunteers.
   b. Better communication with other hospitals.
   c. Better management of the air ambulance and helicopter dispatch system.
   d. Better triaging of patients as they arrived at the ED.

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Failure to Treat High Blood Pressure Results in Kidney Failure, $31 Million Verdict

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News: A federal court of appeals affirmed a significant portion of a $31 million verdict in a medical malpractice action, but ordered further proceedings to determine whether the patient was partially at fault. The complaint alleged the federally funded clinic failed to adequately treat the patient's high blood pressure, which resulted in kidney failure.

The appellate court analyzed the method the trial court used in calculating damages and found that the trial court did not abuse its discretion. However, the court indicated that further proceedings consistent with its opinion were appropriate since the trial court failed to cite a legal standard when it found that plaintiff was not comparatively negligent and did not contribute to his own injuries. Thus, the $31 million award was largely affirmed, even though the final amount may change if the patient is found to have been negligent.

Background: After failing a pre-employment medical examination, a patient visited a federally funded clinic to receive care for severe hypertension. At his first visit, a nurse practitioner ordered a routine checkup and diagnosed the patient with obesity and hypertension. During a follow-up visit, the patient received a prescription for his hypertension and ordered to return the following week; however, the patient failed to return to the clinic for two years.

After failing a second employment-related physical exam, the patient finally returned to the clinic. In the subsequent two years, he visited the same nurse practitioner 10 times. The nurse practitioner never explained to the patient the risks related to hypertension, and why it was important that he take his medication even if he showed no symptoms. According to the patient, he would often skip taking his medication if he did not feel ill, and would allow long periods to pass before going to the clinic for a follow-up visit. Furthermore, three years after the patient's initial visit to the clinic, the nurse ordered new lab work, but she never reviewed the results.

THE NURSE PRACTITIONER NEVER EXPLAINED TO THE PATIENT THE RISKS RELATED TO HYPERTENSION, AND WHY IT WAS IMPORTANT THAT HE TAKE HIS MEDICATION EVEN IF HE PRESENTED NO SYMPTOMS.

During trial, it was revealed that had the nurse reviewed the results, she would have immediately discovered evidence of kidney damage and referred the patient to a nephrologist. Another year and a half passed before a doctor diagnosed the patient with end-stage renal disease and the patient learned that his hypertension had caused the severe damage to his kidneys. The patient was placed on hemodialysis and the kidney transplant waiting list. Ultimately, the patient received a successful kidney transplant, but his condition likely will require continued hemodialysis as well as one or more transplants in the future. Medicare covered the costs of hemodialysis, and also may cover part of the patient's future costs.

The patient sued the United States under the Federal Tort Claims Act (FTCA) for the nurse practitioner's negligence because the nurse practitioner and her employer were employees of the United States Public Health Service. After a five-day bench trial, the court found in favor of the patient and awarded $31 million in damages. On appeal, the government challenged three aspects of the ruling on damages, as well as the court's failure to consider the patient's own negligent actions based on the patient's failure to take his hypertension medication. The court of appeals ordered further proceedings regarding the determination of the patient's comparative negligence but found no reversible error regarding the ruling on damages.

What this means to you: A critical lesson from this case focuses on the legal concept of comparative negligence, which concerns whether a patient's own negligent conduct played a role in causing or worsening his or her injury. While there are different methods of application depending on the state, one such application is straightforward: If a jury finds the patient's fault was 20%, then the damages awarded would be reduced by 20%. It is important to closely evaluate the patient's actions to determine whether raising comparative negligence as a defense is a worthwhile strategy.

One of the government's main issues on appeal was that during trial, the standard by which to determine the patient's comparative negligence had not been articulated, nor had any legal authority been cited. Both parties agreed the appropriate standard by which to measure the patient's conduct was a "reasonable person" standard. In other words, the court must determine how a reasonable person would have acted in the specific circumstances of the case, and evaluate the patient's conduct accordingly.

The court of appeals found the district court analyzed the case incorrectly. While the court did not doubt the negligence of the nurse practitioner, it focused its determination of comparative negligence based on how the patient acted with his limited understanding of his condition. Simply put, the court erroneously evaluated whether the patient was partially at fault based on what he understood were the risks associated with his behavior, not based on how a reasonable person would have acted in his circumstances.

As noted, the nurse practitioner failed to inform the patient of the risks and complications of hypertension. Further, the patient was not advised of the importance of regular medical evaluations and consistently taking prescribed medications. Because of this, the patient waited two years after his initial diagnosis before returning to the clinic. When he eventually received a prescription, he admitted that he only took it when he felt ill, rather than consistently. Based on his behavior, the patient clearly did not understand the risks associated with hypertension, nor did he understand how his prescribed medications should be taken to treat the condition.

Since the appellate court sent the matter back to the trial court for further proceedings, the trial court determined whether this patient's behavior is negligent based on the reasonable person standard. If the court finds that the patient was negligent, it also will determine what percentage of negligence is attributable to the patient compared to the nurse practitioner. It is possible that the court will find that a reasonable person diagnosed with obesity and hypertension would have been more diligent in following up with a physician. It also is likely that a reasonable person would take medication as prescribed, rather than only when feeling ill.

Thus, it is likely that the $31 million award will be reduced in proportion to the patient's negligence. Nonetheless, the patient's recovery still will be substantial because the nurse practitioner's negligence in failing to educate the plaintiff on his condition, the possible complications, and failing to review the results of the second checkup, which clearly indicated initial liver damage. The care provider's negligence was not an issue raised on appeal.

This is a classic example of failure to follow two basic rules of risk reduction tactics designed to mitigate or prevent litigation for care providers. The first involves the meticulous documentation of patient education regarding the patient's condition. The healthcare provider must provide the patient with the medical plan of care. Documentation confirming the patient's understanding of the information is critical if litigation subsequently arises. Care providers should train staff on proper methods for documenting. Although there are no magic words to confirm a patient's understanding, using standard language may help documentation procedures. This can include phrases like, "the patient was able to accurately repeat their antihypertensive medication instructions back to me" or "the patient and his wife were given appointment cards before leaving, and will receive appointment reminder phone calls per my practice policies."

The second risk reduction tactic involves diagnostic testing. Unfortunately, it is not uncommon that care providers fail to follow up on diagnostic studies they order for patients. Instead, physicians may rely on their office, radiology, and laboratory staff to notify them of abnormal results. At best, this can lead to a false sense of security. At worst, if a reasonable physician in the same or similar circumstances would review the diagnostic studies himself or herself, then the failure to do so constitutes malpractice.

Well-designed programs are available to keep track of ordered tests and results. Regardless of how communication is designed to flow from test performed to test result reported, it is ultimately the responsibility of the ordering practitioner to review and follow up on the results of diagnostic studies ordered. One cannot completely rely on electronic programs and automatic reminders, as there must be human interaction and review. Care providers must be diligent about reviewing studies. ■

REFERENCE

Decided on Nov. 7, 2019, in the United States Court of Appeals for the Seventh Circuit, Case Number 18-3060.

Appellate Court Orders Retrial Due to Physician's Improper Testimony

News: An appellate court ordered a new trial in a medical malpractice case where a physician allegedly negligently performed a patient's hernia repair surgery. The court found the physician had been improperly allowed to testify based on his course of habit when he could not recall performing the specific procedure. The patient alleged that during the procedure, the physician stitched a piece of mesh incorrectly on the patient's abdominal wall. Following the procedure, the patient suffered severe pain and intestinal injuries.

The appellate court ruled that evidence of habit is admissible only after a party makes a showing that he or she follows a strict routine for a repetitive practice, and is likely to have followed that same strict routine for the conduct in question. In this case, the court found the doctor's testimony based on habit was improper, and ordered a new trial.

Background: In 2005, a patient was under a physician's care for treatment of an incisional hernia. The physician attempted to surgically repair the hernia by using a Composix Kugel mesh patch, which is designed with a rough and a smooth side. The rough side is applied to the abdominal wall, allowing the tissue of the abdominal wall to grow into the patch. The smooth side is designed so that the patient's organs do not stick to the patch. As a distinctive feature, the Composix Kugel includes a pocket to protect the intestines.

During the procedure, the physician sutured the mesh patch against the patient's abdominal wall; however, shortly after the surgery, the patient complained of severe abdominal pain. It was discovered that part of the mesh patch was hanging from the patient's abdominal wall with the rough side facing the patient's internal organs. While the rough side of the patch should have been facing the patient's abdominal wall, the displaced portion had instead adhered to the patient's intestines and omentum.

The patient and her husband sued for malpractice, alleging the physician failed to satisfy the appropriate standard of care by improperly suturing the mesh patch. During the deposition, the physician claimed that he did not recall performing the surgery on this patient. Furthermore, the operative report the physician contemporaneously prepared did not contain a detailed account on the number or placement of the sutures that had been used to secure the patch.

Before the trial, the plaintiffs sought to preclude the physician from testifying on the manner in which he normally performs hernia repairs using the Composix Kugel patch. The trial court initially ruled in favor of the plaintiffs, but subsequently permitted the physician to testify how he habitually placed sutures on patches during hernia repair surgeries. However, the appellate court found that the trial court erred in admitting the physician's testimony. The appellate court explained the trial court's error was not harmless because it affected an essential issue. The court reversed the judgment, and the matter was sent back for a new trial.

What this means to you: This case raises an interesting legal issue that may be important and applicable to medical care providers'

defense of medical malpractice actions. Since litigation often arises years after the underlying services are provided, the care providers may no longer remember specific details for one patient who received services years ago. Under specific circumstances, courts permit individuals to testify about their courses of conduct when such courses rise to the level of "habit." Jurors may consider this testimony of habit to evaluate whether the care providers complied with the applicable standard of care. If a physician has performed one specific surgery 1,000 times, and each and every time the physician follows a set order of operations, this testimony may sway a jury to determine that the physician performed the same course of actions in this case, even though he or she may not remember it years later.

The fundamental question analyzed by the court of appeals regarded whether the defendant physician should be permitted to rely on evidence of custom and practice in his defense when he lacked specific knowledge as to his actions in one case. In other words, whether the physician should have been allowed to testify as to his habitual practice of suturing mesh patches during hernia repair surgeries, and if such testimony would be admissible as habit evidence. Generally, the court noted that evidence of habit is "admissible to allow the inference of the persistence of the habit" on a given occasion. However, if conduct varies from time to time, evidence of such conduct, regardless of frequency, may not be admitted as evidence of custom or practice.

In this case, the physician testified that when performing a hernia repair with a Composix Kugel mesh patch, the procedure enters through the pocket and places the sutures two to three centimeters apart circumferentially along the outside of the patch. Once that is completed, a final check is to be performed. If any gaps appear to be too large, additional sutures can close the gaps. The physician testified that the distance between the sutures depends on the contour of the specific patient's abdominal wall, which in turn is determined by whether the patient's size and weight. Additionally, the physician testified about the differences between performing this procedure using a Composix Kugel patch and a generic mesh patch, which does not include a pocket and requires sutures to be placed around the periphery of the mesh.

The appellate court explained that such testimony should not have been admitted as evidence of habit because, according to the physician's own testimony, the conduct of placing sutures inherently varies from patient to patient as a result of the contour of the specific patient's abdominal wall. Furthermore, the court noted how the physician was not able to recall the number of surgeries he had performed using the Composix Kugel patch, although he testified to having performed hundreds of hernia repairs using generic mesh patches.

In a medical malpractice case, the issue of whether any departure from the standard of care has occurred is essential. Expert testimony almost always is required to demonstrate how the defendant physician's conduct did not meet the applicable standard. By contrast, the defendant physician often will testify how his or her conduct met the applicable standard of care. However, the physician testified during his deposition that he had no recollection of performing the surgery on this patient, and the operative report did not specify how many sutures had been placed, where they had been placed, and the distance between them. Because of the lack of recollection, the defendant wanted to testify as to his habit of suturing patches during such procedures. Had the physician completed a detailed operative report shortly after completing the procedure, he could have referenced the report as a source of the details needed to meet the habitual requirements.

A detailed operative report should include every aspect of the procedure, including adverse events such as organ perforation or excessive bleeding. A complete and accurate operative note can help a physician in the event of future litigation by demonstrating performance of standards of care and remedial actions taken, if necessary. As noted on appeal, such testimony should not have been admitted as evidence of habit because there were too many variables; thus, it was impossible for each procedure to be performed in the same way on every occasion. Consequently, the error in admitting the testimony of habit was not harmless because it affected the essential element of the case. As a result of this significant error, the appellate court stated that a new trial is required. While the defendant physician has another opportunity to defend himself, he will not be able to testify about his purported habit. ■

REFERENCE

Decided on Oct. 16, 2019, in the Supreme Court of the State of New York, Appellate Division, Second Judicial Department, Case Number 2016-02572 17469/07.