SAME-DAY SURGERY

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AHC Media

College of Surgeons Addresses Aging with Controversial Statement

The first sign of trouble happened when the surgeon was 78. He performed surgery on a woman who subsequently developed a pulmonary embolism. The nurses made urgent calls, but he didn't respond. The woman died.

The hospital reported the doctor to the state medical board. However, the surgeon continued to operate for four years. Finally the hospital board sent him for a competency assessment at the University of California, San Diego. The surgeon's neuropsychological exam was "very abnormal," according to the director of the physician assessment program there, quoted in *The New York Times*. According to the director, the surgeon had visual-spatial abnormalities, his fine motor skills were impaired, he couldn't retain information, and his verbal IQ was significantly lower than they expected. However, he thought he was fine, and no one else knew about his cognitive deficits. Once this information was known, the surgeon was asked to

"WE TRIED TO BE PRETTY BROAD AND GIVE A LOT OF FLEXIBILITY."
— ROGER PERRY, MD, FACS

Special Focus: How to Avoid Lawsuits

This month's issue has tips on improving safety and avoiding liability. The issue covers aging surgeons; a patient who recorded abusive comments and potential malpractice in the OR; a $750,000 HIPAA settlement; and tips for patients with dementia. Our *SDS Manager* column offers steps to take today to address safety. Enjoy this special issue! ■

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surrender his medical license. *(To access the article, go to http://nyti.ms/1TjvnAY.)*

It's an issue that isn't going away. About one-third of all practicing surgeons are older than 55, according to the American College of Surgeons. Hospitals and surgery centers have been slow to address this issue for many reasons, including pushback from the medical staff. However, this year the College released a highly controversial *Statement on the Aging Surgeon.*

When the College was trying to develop a policy on this topic, surgeons became very angry and had a visceral response, almost "like we're trying to take away people's guns," says **Roger Perry**, MD, FACS, former chair of the Physician Competency and Health Workgroup at the American College of Surgeons, who took the lead on the aging surgeon statement.

Physician in general, and surgeons in particular, feel that they are losing control, he says. They face multiple mandates for training in areas ranging from bloodborne pathogens to sexual harassment, he says. "We didn't want to come up with something viewed as another mandate that would be onerous," Perry said.

Everyone agreed that the College should not give a firm age at which surgeons should no longer be able to operate. "Everyone agreed, but beyond that, it was extremely controversial," Perry says.

Best way to address it?

It's common knowledge that everyone, including physicians, has deteriorating neurocognitive function and skills as they get older, but there is significant variability from person to person, Perry says.

"Firm and hard and fast rules were very difficult, especially due to the paucity of data," he says. "Any policy like this generates a tremendous amount of controversy."

However, leaders at some healthcare facilities are taking a position. In April, Sinai Hospital in Baltimore passed a policy that every practitioner, including nurse practitioners, physicians, and nurse anesthetists, who turns 75 must have three tests to continue practicing: a general physical exam, an eye exam, and a brief neurocognitive exam that tests one's thinking ability and memory. The hospital pays for any testing not covered by insurance. They also must have these three tests conducted at recredentialing, which is every two years at Sinai.

Only a handful of hospitals in the country have such a policy, says **Mark R. Katlic**, MD, MMM, FACS, chairman of the Department of Surgery and surgeon-in-chief at Sinai Hospital and director of the

EXECUTIVE SUMMARY

The American College of Surgeons has published a *Statement on the Aging Surgeon* that offers guidelines on how to address surgeons' cognitive and physical decline. The *Statement* includes warning signs and testing information.

- Surgeons can be referred for extensive testing if needed.
- One hospital is testing all practitioners age 75 and older before credentialing and recredentialing.

Sinai Center for Geriatric Surgery, also in Baltimore. The policy was passed unanimously by the hospital's Credential Committee, Medical Executive Committee, and Board of Directors.

"We just arbitrarily picked age 75, because I felt it would be less controversial, and everyone would agree that's reasonable," Katlic says. "The hospital has an obligation to make sure all doctors are capable of performing what they've been given credentials to do. The ASC would too."

The testing scores go to the Credentials Committee and the chief of that person's department to determine whether the practitioner can continue with full privileges. With this type of testing, if a provider's results are far below what is considered "normal" for the general public, those results should raise some questions, Katlic says.

Have a policy

Every hospital and surgery center should have a policy on aging practitioners, Katlic says.

"That way, you're doing your duty to make sure everyone who practices in your facility is competent," he says. "I'm not a lawyer, but I would think having a policy on the books would be helpful if there were a problem, because it would show that the ASC was taking this seriously. My fear is that if we don't do it, the federal government might impose a mandatory retirement age … ."

When looking for guidelines to develop a policy, healthcare facilities can use the College's *Statement on the Aging Surgeon,* which includes the following points:

• Surgeons might not recognize that their clinical skills and physical and cognitive function are declining. Peers can help identify surgeons who show deterioration.

Warning signs include forgetfulness, unusual tardiness, evidence of poor clinical judgment, major changes in referral patterns, unexplained absences, confusion, change in personality, disruptiveness, drastic change in appearance, and unusually late and incoherent documentation.

• At age 65 or 70, surgeons should have confidential baseline physical exams and visual testing by their personal physicians. This step should be voluntary, according to the College.

• After that baseline exam, regular re-evaluation at intervals is advised. "Surgeons are encouraged to also voluntarily assess their neurocognitive function using confidential online tools," the College says. "As a part of one's professional obligation, voluntary self-disclosure of any concerning and validated findings is encouraged, and limitation of activities may be appropriate."

Perry recommends a Dementia Risk Assessment developed by Jason Brandt, PhD, director of the division of medical psychology at Johns Hopkins Medicine. "It is free and available at www.alzcast.org," he says.

• Peers must be able to share concerns about a surgeon's performance and any decline related to age without fearing retribution. "In addition, the surgeon's quality and outcomes of patient care is the ultimate measure of ongoing competence and safety for surgeons of all ages." For that reason, the College recommends that recredentialing include peer review, with evaluation of a surgeon's professional practice on an ongoing basis. "If a potential issue is identified, additional methods of evaluation may include chart reviews, peer review of clinical decision making, 360-degree reviews and patient feedback, observation or video review of operating room cases, and proctoring," the College says. The surgeon might need more reviews that are more detailed, such as focused professional practice evaluation.

• Some surgeons will need a referral to a comprehensive evaluation program. There are several specialized centers where surgeons can have tests to measure their neurocognitive function. The facility or medical staff should pay for this testing, not the surgeon, the College says. "These results cannot be used in isolation to determine continuation or withholding of hospital and surgical privilege but should be incorporated as an additional piece of information as part of an overall evaluation ...," the College says. *(For details on such a program, see story included in this issue.)*

• Once the medical staff or facility leaders have evaluated all evidence, then a decision should be made regarding privileges. Confidentiality must be maintained, and the staff and leaders should follow medical staff bylaws and due process, the College says. "As always, the best interests of the patient remain the first priority, while at the same time the confidentiality, dignity, and contributions of the surgeon must be respected," it says.

• If surgeons who are leaving their clinical roles are interested, and their abilities permit them, they should be given opportunities to contribute through teaching, surgical assisting, conducting research, or being in administration.

All facilities that deliver surgical care are encouraged to develop policies that comply with government regulations. *(The Statement also lists items that should be included in a comprehensive neuropsychological assessment. To see the statement, go to*

http://bit.ly/22dDHpl.)

"The statement is purposely designed to be general and provide guidelines, understanding that each institution has its own challenges and situations which may be different from another institution," Perry says. "We tried to be pretty broad and give a lot of flexibility." ■

Surgeons Referred for Comprehensive Program That Tests Their Cognitive and Physical Skills

In addition to a requirement for in-house practitioners to undergo testing at age 75 and older to be credentialed or re-credentialed, Sinai Hospital in Baltimore also has developed a comprehensive two-day program for surgeons who are referred to them by any facility for more extensive testing of cognitive and physical skills or capabilities.

"Many experienced OR nurses or surgical residents or surgical assistants have occasionally noticed an older surgeon is not quite on their game," says **Mark R. Katlic**, MD, MMM, FACS, chairman of the Department of Surgery and surgeon-in-chief at Sinai Hospital and director of the Sinai Center for Geriatric Surgery, also in Baltimore. "Either it's in operations, or they're forgetting things, or it's their appearance. They might not be as well-dressed or shaven or well-kept as before, or something else may not be quite right."

If concerns are raised with the chief of surgery or president of the organization, then he or she needs to respond, Katlic says. "They can't rely on hearsay," he says. "This person's career is at stake."

Some surgeons have retired when their facilities have threatened to send them for evaluation, Katlic says. For those who do go for the evaluation, they stay at a hotel near the hospital. They come to the hospital for a physical exam and general neurology exam, followed by physical and occupational therapy testing. Those tests include examination of hand-eye coordination and fine motor skills in which they're timed. These tests are followed by neuropsychological testing, which includes memory, attention span, frustration level, emotions, and some visual/spacial ability.

The second day includes more neurocognitive testing, more occupational therapy testing, and an eye exam. A comprehensive report follows that compares the surgeon's results to those of the general public.

The cost is $17,000, which Katlic acknowledged is high, but he says that amount covers the cost of the PhD neuropsychologists and specialist physicians who are involved in the testing. "It's cheaper than a malpractice case or even defending one," he says. "It's almost the only thing that exists that gives the hospital some objective evidence of whether a person's faculties are good or not."

When testing aging surgeons, look at both sides of the issue, Katlick says.

"I say all the time, the goals of this program are to balance patient safety on one side with the dignity of this committed surgeon on the other side."

RESOURCE

- **The Aging Surgeon Program,** Sinai Hospital, Baltimore. Contact JoAnn Coleman, DNP, ACNP, ANP, AOCN, GCN, Program Coordinator for The Aging Surgeon Program, Clinical Program Coordinator for the Sinai Center for Geriatric Surgery. Email: jocolema@lifebridgehealth.org. ■

Hospital Manager Dismisses Patient's Complaint After She Secretly Records Comments in the OR

Patient heard remarks suggesting sexual abuse, plus possible malpractice

A patient's secret recording of her surgery revealed what one risk manager calls "inexcusable and reprehensible" behavior, including disparaging remarks about her body, comments that could be considered racially offensive, and suggestions that the woman be touched inappropriately by members of the OR team. The recording also documents what could be malpractice: a surgeon administering

penicillin after he verbally acknowledged her allergy.

The response of the hospital's risk manager also is being criticized as insufficient and likely to encourage a lawsuit.

Patient was concerned

Ethel Easter was concerned about her surgeon's attitude after an office encounter in which she felt he had been rude and dismissive, so before surgery at Lyndon B. Johnson Hospital in Houston, she hid a small recording device in her hair braids, according to a report in *The Washington Post.* (*The* Washington Post *story can be accessed by readers online at http://wapo.st/1oEw4cM.)* Soon after she was sedated, the surgeon recounted their dispute to the other doctors and said, "She's a handful. She had some choice words for us in the clinic when we didn't book her case in two weeks."

The comments soon became personal and disparaging, with the surgeon and the anesthesiologist repeatedly referring to her navel and laughing. At one point, the anesthesiologist said Easter was "always the queen," and the surgeon responded, "I feel sorry for her husband."

The surgeon also called the patient "Precious" several times, which Easter interpreted as a disparaging reference to a 2009 movie character who is African American (like Easter), illiterate, obese, and sexually abused. At one point, the anesthesiologist asked, "Do you want me to touch her?" and the surgeon replied "I can touch her." "That's a Bill Cosby suggestion," someone said. "Everybody's got things on phones these days. Everybody's got a camera."

The surgeon twice asked, "Do you have photos?" He "thought about it," he said, "but I didn't do it."

The recording makes clear that the surgeon knew Easter was allergic to penicillin but decided to administer Ancef, an antibiotic that causes side effects in some penicillin-allergic patients, and said a small amount should not produce any significant reaction. After surgery, Easter's arms swelled, she developed a persistent itch, and had trouble breathing. She eventually had to go to the hospital emergency department for treatment of the allergic reaction.

Easter sent a complaint letter and a copy of the recording to the director of risk management and patient safety at the hospital, who replied that she had taken the step to remind surgical staff of the need for proper decorum, but said, "After carefully listening to the recording that you provided, Harris Health does not believe further action is warranted at this time."

The risk manager also pointed out that the hospital is part of the Harris Health System, but the doctors in the recording are employees of the University of Texas Health Science Center at Houston. Easter interpreted that information as the risk manager saying that the problem was not the hospital's responsibility. Both organizations issued statements declining to comment.

The behavior of the surgical team indicates a facility culture that does not respect patients and could threaten patient safety, says **R. Stephen Trosty**, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management (ASHRM). Trosty has dealt with serious OR misbehavior in the past when he was the risk manager at a hospital, and he calls this incident "inexcusable and reprehensible."

The comments and the suggestion of sexual contact cannot be tolerated, Trosty says.

"It must be dealt with in the most stern and severe manner, and this means more than just talking to the physicians and operating room staff. Physicians or staff who commit these type of actions have to be disciplined, up to and including loss of privileges or firing," Trosty says. "If this is allowed to continue, or it appears not to be taken seriously, then it will continue. This is the problem in many, if not most hospitals, and why it remains such a recurring problem."

If the only consequence of such behavior is having an administrator remind you to behave, there is little incentive to discontinue this type of conduct, Trosty says. People who act in this manner either do not see why they are wrong or do not care, he says, and either situation must be changed.

EXECUTIVE SUMMARY

A patient secretly recorded her surgical team making disparaging remarks about her, including some that can be considered racially offensive and suggestive of sexual abuse. The hospital's risk manager responded to the patient in a way some critics say was dismissive and insufficient.

- The recording also documents the surgeon acknowledging the patient's penicillin allergy but ordering the drug anyway.
- The patient is considering a lawsuit.
- No action was taken by the hospital apparently, other than reminding surgical staff to behave.

It appears that malpractice was committed by giving the patient the antibiotic after discussing that she was allergic to it, Trosty says.

"This is clearly in violation of the standard of care and in the common sense practice of medicine," Trosty says. "To say that it is only a small amount, and so should not have a negative effect, is nothing short of malpractice and a blatant disregard for the patient."

To suggest that the facility was not responsible because the doctors were employed by another entity demonstrates a clear lack of understanding of the law related to this behavior and what it takes to constitute malpractice on the part of the facility for actions of physicians working there, Trosty says. The doctors had to be credentialed and privileged by the facility, have to abide by facility policies and procedures, and have to be subject to discipline by the facility. The facility can't evade responsibility merely by claiming the physicians were employees of another entity.

"I think that this risk manager did everything wrong that could be done wrong," Trosty says. "It is a clear statement that what happened to the patient does not seem to warrant the time or attention of the risk manager or the hospital."

The risk manager apparently did not take this situation seriously, another risk management expert says. Was there any investigation to determine if these types of disrespectful, mocking comments are typical in this facility or an outlier, asks **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of ASHRM. If there was an investigation, the findings should have been discussed as part of a disclosure session with the patient, she says.

Kicklighter notes that research has shown that decorum in the operating room can affect patient safety. She wonders how many times this patient abuse happens, but is never known, because there was no recording and surgical staff do not report it. She asks why other members of the team aren't stopping these inappropriate comments.

These situations should be referred for peer review, and some disciplinary action should result, she says. Consideration also should be given to requiring the physicians and staff to attend a medical ethics course, she says. The matter also should have been referred to the facility's ethics committee, she says.

"The root issue with these types of situations is that if OR staff do not report such remarks during the procedure so the supervisor can step in and intervene, or at least write an incident report that makes its way to risk management, we will never know how prevalent this unacceptable behavior is," Kicklighter says. "It used to be that empathy and compassion were traits required when caring for patients, but now many of my friends and acquaintances remark that their animals receive better care, and better informed consent, from their veterinarians than they do from their personal physicians. Communication is a lost art or skill in the medical field, and I predict it will get worse with the overwhelming use of email, texts, and social media in general." ■

Certified Registered Nurse Anesthetist Sues Hospital For Suspension Related to Suicidal Comments

When do an employee's personal troubles threaten patient safety and justify limiting work duties? A certified registered nurse anesthetist (CRNA) recently sued a hospital after it put her on sick leave and demanded a psychiatrist approve her return to work, which was prompted by her statements suggesting suicidal thoughts and the concerns voiced by her coworkers.

The case went to an appeals court after initially being dismissed and, in the process, raised questions about how facilities can protect patients without treating an employee unfairly. **Peggy J. Barnum**, CRNA, sued Ohio State University Medical Center (OSUMC) for putting her on sick leave and demanding that she first secure a fit-for-duty recommendation from a psychiatrist, and then sign a release letting the hospital talk to the psychiatrist, before it would agree to reinstate her. Hospital officials claimed that she had expressed suicidal thoughts at work and was so distracted that she could no longer care for patients safely. Barnum's lawsuit accused the hospital of retaliation and of violating various First Amendment and disability-related rights. An appeals court recently sided with the hospital and affirmed a lower court's dismissal of her claims.

EXECUTIVE SUMMARY

A certified registered nurse anesthetist (CRNA) sued a hospital for putting her on sick leave in response to her comments about being suicidal and to concerns expressed by colleagues. The hospital kept her out of work for 13 months.

- An appeals court sided with the hospital.
- The nurse's lawyer says the hospital overreacted.
- The hospital's lawyer claimed that there was reason to doubt the nurse's ability to work.

Barnum was out of work for the next 13 months, but was not given any disability payments or leave-of-absence payments, says her lawyer, **Daniel H. Klos**, JD, of Columbus, OH. He says the dispute began when Barnum was overheard by another CRNA saying something to the effect of, "Maybe I'd be better off if I wasn't here. Maybe I should just put a gun to my head. Maybe I should just not be here." Barnum was said to be having marriage difficulties and other personal problems at the time. An anesthesiologist also reported concerns to administration and said he and several other surgeons and anesthesiologists thought Barnum was unable to concentrate on patients. During one surgery, the surgeon had to ask Barnum at least twice to raise a patient's table. When she finally replied, the anesthesiologist claimed, Barnum said, "I'm worthless. What good does it do or what difference does it make? Why should I even be here? Maybe I should do everybody a favor and not be around." The head CRNA and other CRNAs also reported their concerns.

Hospital administrators instructed Barnum to report to the ED for a suicide risk evaluation, which she did. A physician there released her and said she was not a threat to herself but that he could not determine whether she was fit for duty, Klos says. Her work history and reviews at the hospital were exemplary, he says. Nevertheless, the hospital put Barnum on sick leave and demanded a psychiatrist report saying she was fit for duty. Hospital officials also required Barnum to give her permission for them to talk to the psychiatrist and for the psychiatrist to release information about her. She produced the fit-for-duty report four months later, but the hospital still refused to reinstate her for another nine months, her lawyer says.

The Americans with Disabilities Act (ADA) requires an employer to provide reasonable accommodation to an employee with a disability, but Klos says OSUMC refused to accommodate her, even as its leaders insisted she was disabled with suicidal thoughts. However, the appeals court ruled that requiring Barnum to undergo a psychiatric examination did not amount to labeling her as disabled and that it was reasonable for OSUMC to insist that it be allowed to talk to her psychiatrist before reinstating her. According to Klos, the hospital's actions were based on hearsay that included the alleged ability to plug in a motorized bed and allegedly becoming teary-eyed when discussing the death of a family pet.

Hospital overreacted?

Klos says the case raises questions about an employer's ability to take actions such as requiring a psychological evaluation and suspending, reassigning, or dismissing an employee for statements that are unusual but have no bearing on the person's duties in the workplace. Any statement Barnum made implying suicidal thoughts were taken too seriously and did not affect her performance, he says.

"They had one instance of one hearsay complaint by an employee who said, 'I think she could use some time off for herself,'" Klos says. "Those are the exact facts that existed on the day she was ordered to the ED. That is not enough to justify an egregious violation of her privacy and her rights under the ADA."

A spokesman for OSUMC declined to comment because the litigation is pending, but in the oral arguments before the appeals court, **Rory Callahan**, JD, an attorney with the Ohio attorney general's office, represented OSUMC and argued that the hospital's actions were in response to more than just the comments overheard at work. The concerns of her coworkers raised legitimate questions about her ability to perform her duties, he said. An appeals court judge questioned why those concerns were not documented. Callahan responded that there was an incident reporting system at OSUMC, but comments were not documented.

"I would argue that OSU doesn't have to wait for an accident to occur before they can report something," Callahan argued.

Even though the hospital won the appeal, Klos notes that it spent significant time and money on the defense. He suggests that healthcare facilities must be far more cautious about responding to comments overheard in the workplace and that significant evidence is needed

before intruding so significantly in an employee's personal life and career. The court found there was sufficient evidence to support their claim of the need to protect patients based on the hearsay reports of the ability to plug in a bed and becoming teary-eyed over the pet's death, Klos says. "It was a bureaucratic quagmire," regarding the hospital's request for additional information, he says.

"If a hospital reacted this way to every emotional comment at work from someone who's going through a divorce, the Spanish Inquisition would be a cakewalk in comparison," Klos says. "They had no documents to support this. They probably have six different records to document giving out an aspirin, but they have no incident reports, nothing written, just anecdotal reports that aren't even documented, and they say that justifies sending her for a psych evaluation."

The court records are available online at http://1.usa.gov/1TlsJft. The audio of the oral arguments before the appeals court is available online at http://1.usa.gov/1RNIwhQ. ■

$750,000 Settlement Highlights Need for HIPAA Business Associate Agreements

Raleigh Orthopaedic Clinic of North Carolina has agreed to pay $750,000 to settle charges that it potentially violated the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules by failing to execute a business associate agreement prior to turning over protected health information (PHI) of 17,300 patients to a potential business partner. The settlement includes a robust corrective action plan.

HIPAA-covered entities cannot disclose PHI to unauthorized persons, and the lack of a business associate agreement left this sensitive health information without safeguards and vulnerable to misuse or improper disclosure, according to the Department of Health and Human Services (HHS) Office of Civil Rights (OCR). OCR initiated its investigation following receipt of a breach report from Raleigh Orthopaedic.

OCR's investigation indicated that Raleigh Orthopaedic released the X-ray films and related PHI of 17,300 patients to an entity that promised to transfer the images to electronic media in exchange for harvesting the silver from the X-ray films. Raleigh Orthopaedic failed to execute a business associate agreement with this entity prior to turning over the X-rays and PHI, OCR says. "Note that the issues were centered around the lack of the business associate agreement and the breach occurrence and not whether PHI was misused," says an OCR spokesperson who, under department policy, asked not to be named.

Raleigh Orthopaedic is required to revise its policies and procedures to do the following:

- establish a process for assessing whether entities are business associates;
- designate a responsible individual to ensure business associate agreements are in place before disclosing PHI to a business associate;
- create a standard template business associate agreement that complies with the requirements in the HIPAA privacy rule;
- establish a standard process for maintaining documentation of a business associate agreement for at least six years beyond the date of termination of a business associate relationship;
- limit disclosures of PHI to any business associate to the minimum necessary to accomplish the purpose for which the business associate was hired. *(To read the Resolution Agreement, go to http://1.usa.gov/23L9a1v.)*

OCR is conducting a second round of audits to assess compliance with HIPAA. Unlike the first round, OCR is including business associates. OCR is emailing notices to entities that might be audited. A questionnaire will help determine audit targets. Auditors will be looking for non-compliance issues that were most common in the first round.

One of the best ways to prepare for a potential round two audit is to study OCR's audit protocols. The protocols are available online at http://1.usa.gov/24hFxqF. Model business associate agreement language from HHS can be accessed at http://1.usa.gov/1PfLUk8. The language may be adapted for a contract between a business associate and subcontractor.

Jessica Forbes Olson, JD, an attorney with the law firm of Fox Rothschild in Minneapolis, MN, says, "Covered entities and business associates often make the mistake of believing that HIPAA compliance is a one-time project, rather than an

all-the-time practice. The upcoming OCR audits should be the impetus many entities need to do a self-audit and ensure their HIPAA 'ducks' are in order. Recent OCR enforcement activity has shown that the cost of compliance is a drop in the bucket compared to the cost of non-compliance we've seen come in the form of OCR settlements of hundreds of thousands or millions of dollars." ■

False Information from Your Patients with Dementia Threatens Their Safety

Growing concern about the patient safety risks posed by dementia is prompting some healthcare facilities to address the issue with policies and procedures designed to avoid misinformation and other threats.

The prevalence of dementia increases with age, with estimates ranging from 1% to 2% of adults at age 65 up to a high of 30% by age 85, according to the Alzheimer's Association. Physicians fail to recognize dementia in 19% to 67% of patients in the outpatient setting, the Alzheimer's Association reports.

A primary concern with dementia patients is receiving incorrect or incomplete information from them and basing care decisions on that bad data, says **Marcus Escobedo**, MPA, senior program officer with The John A. Hartford Foundation in New York City, which focuses on improving the care of older adults. However, in addition, dementia increases the risk of wandering and complicates communicating with the patient, he notes. Falls also are greatly increased with dementia patients.

"This is a huge risk. Patients with dementia are at greatly increased risk for everything from medication errors to elopement, and healthcare providers often do not realize how great that risk is," Escobedo says. "These are patients that require an increased level attention in all aspects of healthcare."

Healthcare professionals and staff members also can be at risk because patients with dementia can be physically abusive in response to their confusion, fear, and agitation, Escobedo says.

The Pennsylvania Patient Safety Authority began investigating patient safety threats from dementia when a patient's family member reported several near misses prompted by the patient providing incorrect information to healthcare employees, says **Michelle Feil**, MSN, RN, CPPS, senior patient safety analyst with the Authority, in Harrisburg. Feil recently authored a report on the problem and potential risk reduction strategies. *(The report can be accessed online at http://bit.ly/1YdxyY6.)*

Healthcare facilities reported 3,710 events through the Pennsylvania Patient Safety Reporting System between January 2005 and December 2014 involving patients with dementia or potentially unrecognized dementia, she found, and 63 were traced to healthcare staff members obtaining inaccurate information or consent from these patients. Feil and her colleagues identified these five ways in which dementia led to patient safety concerns:

- failure to recognize pre-existing dementia;
- failure to assess competence and decision-making capacity of patients with dementia;
- failure to identify a reliable historian or surrogate decision-maker for patients with dementia;
- failure to contact a reliable historian or surrogate decision-maker when information or consent was required for care;
- failure to communicate the patient's dementia diagnosis, competence, and decision-making capacity with all members of the healthcare team.

Detection is key

Detecting the dementia is the first step to avoiding patient safety risks, Feil says.

"Risk managers have to make sure that clinicians have a process in

EXECUTIVE SUMMARY

Dementia poses a threat to patient safety. Physicians fail to recognize dementia in 19% to 67% of patients in the outpatient setting, the Alzheimer's Association reports.

- Managers should ensure that all patients older than 65 are screened for dementia. A popular screening tool takes only three minutes to administer.
- Wandering and incorrect information are major concerns.

place to screen patients for cognitive impairment," she says. "Any patient 65 years or older should be screened on admission. It's a problem that goes undetected because the patient or family may be unaware or in denial, or perhaps it is not as obvious when they are home in a familiar environment."

Escobedo notes that healthcare facilities instituting routine screening for older patients have detected much higher rates of dementia than otherwise would have been documented.

Feil recommends the Mini-Cog screening tool, which takes about three minutes to administer. *(The tool is available at http://bit.ly/1UynKpO.)* The family member who reported the problem to the Pennsylvania Patient Safety Authority lobbied for healthcare facilities to use a black wristband to denote dementia risk, but facilities resisted adding another wristband color after recent efforts to standardize the wristbands, Feil says. Instead, some facilities are using a special sticker that can be added to any wristband for a patient with cognitive impairment, and similar notifications can be placed at the bedside or on the door to a patient's room.

Healthcare professionals must be careful, however, not to assume cognitive impairment with all elderly patients, Feil notes. Doing so would be disrespectful and deprive patients of their autonomy. Even when patients do have dementia, Feil says, they still should be allowed to make decisions that do not affect their health or safety.

Dementia can go unnoticed in healthcare settings even when it is documented, Feil points out. The primary physician may have noted the dementia diagnosis in the patient's record, but other members of a multidisciplinary team may not notice and will accept inaccurate information from the patient. That bad information then is entered into the patient's record and can lead to patient harm.

Once dementia is known, the healthcare team should work closely with a family member or friend who is familiar with the patient's condition, Escobedo advises. In addition to helping provide correct information, this caregiver can help avoid situations in which the patient becomes agitated and removes tubing or fights someone trying to provide care.

"It is important to have a system in place to identify those family members or friends and bring them into all conversations about the treatment or goals of the patient," he says. "Behavioral problems should be turned around and seen as expressions of unmet needs, and it's the role of the provider to determine what those needs might be by talking to the family caregiver about what is comforting, what is agitating, what helps the person remain calm in certain situations."

If the conditions stipulated by the power of attorney have been met, then that person now has the authority to make decisions for the patient.

The American College of Surgeons' (ACS') *Statements on Principles* has an informed consent section that identifies mental competence and who will obtain consent if the patient is not competent. *(To access the* Statements, *go to http://bit.ly/22vyt8D.)* A spokesperson for the ACS says that if dementia or cognitive impairment is identified, teaching skills or delivering instructions is done to the family, according to **Kathleen Heneghan**, PhD, RN, PN-C, assistant director of patient education at the ACS.

Once patients arrive for procedures, some healthcare facilities place dementia patients in rooms that have a clear line of sight from the nursing station, which helps prevent wandering and other potentially dangerous behavior, Escobedo says. Medications also should be monitored to avoid those that are known to worsen dementia symptoms, he says.

"The first hurdle is getting people to realize that dementia poses this kind of risk that is not found with all patients, or even all elderly patients," Escobedo says. "Once that risk is known, there are effective ways to address it."

RESOURCES

- The American College of Surgeons has two documents that include information on dementia:
  - *ACS NSQIP/AGS Best Practice Guidelines: Optimal Preoperative Assessment of the Geriatric Surgical Patient.* Web: http://bit.ly/1qP9YW1.
  - *Optimal Perioperative Management of the Geriatric Patient: Best Practices Guideline from ACS NSQIP/American Geriatrics Society.* Web: http://bit.ly/1TJHWWg. ■

COMING IN FUTURE MONTHS

- Controversy over operating on smokers
- Advice on handling ASC patient transfer agreements
- Avoid claims denials for "no authorization"
- Do specific drinks pre-surgery help boost patients?

How to Improve Safety and Reduce Liability

By ***Stephen W. Earnhart****, MS*
CEO, Earnhart & Associates
Austin, TX

Patient errors *in our industry* are a major cause of U.S. deaths. More than 251,000 people each year come into healthcare for help, advice, and loving care, and *we kill them!* It is a significant challenge for staff and a facility to recover from a patient death caused by human error.

Patient safety is not cheap; in fact, it is massively expensive. It cannot be compromised. If it is — and clearly it is — then you enter into the horrible world of catastrophic events from which there is no escape.

As a Medicare inspector for the Centers for Medicare and Medicaid Services, I know the standards we all vow to live by are sound, but the breakdown often comes from failure to abide by those strict standards. I am going to give advice from my perspective. If possible, cut out the following and post it.

1. Empower your safety officer with indemnification from *anything* that doesn't abide by the accreditation standards or dictates from the Association of periOperative Registered Nurses, government agency, and any other agency your facility is associated with, or is just plain common sense. Every facility is required to have a safety officer listed by name. Who is yours? Most do not even know.

2. Post the following in your waiting room, change areas, and registration desks: "Please ask questions about every aspect of your care today. Please feel free to question anything and everything we do, and ask to speak with the administrator if something does not seem right!"

You *must* encourage patients to speak up and let someone know if something that is being done to them is not what they expected. Most of our patients just assume that we are doing the right thing for them, but more than 251,000 patients died last year because we didn't.

3. Staff meetings. Talk about patient safety!

4. Create a patient advocate who wears a nametag that says "Ask me about your safety today!" Rotate that advocate. Most of our patients do not know whom to ask when they have questions. They just assume we know what we are doing, and clearly we don't always know. Leave your egos at home.

5. Your safety officer should randomly ask members of your staff, including anesthetists and surgeons, questions about your policies on patient safety issues. If they cannot answer them, be a leader and report them in violation of your standards. After three such violations (I would suspend them after one and fire them after three) they should have to reread the policies and be quizzed before they can return to duty. It also should be noted in their personnel file, and it should impact any future pay increases or bonuses.

You don't need to have friends in your workplace when it comes to patient safety and making sure staff members follow the rules. The world is going to judge the United States for this terrible stigma we have earned for many, many years. It will take time, effort, and money to correct this situation, but let it start with you. ■

CMS Releases ASC Quality Data

The Centers for Medicare and Medicaid Services (CMS) has released comprehensive ASC quality data reports from its Ambulatory Surgery Center Quality Reporting Program, according to the Ambulatory Surgery Center Association. The data, collected in 2013 and 2014, is available at http://1.usa.gov/27wF6ew. Data are available for ASC-1 through ASC-10.

The tables available online contain results by facility, state, and nation. Results for measures reported using G-codes are provided per 1,000 cases. For measures ASC-1 through ASC-4, lower numbers are better. For ASC-5, higher numbers are better. ■

CE/CME OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

SAME-DAY SURGERY

CE/CME 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 AHCMedia.com then select "My Account" to take a post-test. *First-time users must register on the site.*

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

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

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE/CME QUESTIONS

1. **According to the American College of Surgeons *Statement on the Aging Surgeon*, what are warning signs of deterioration by surgeons?**

   A. Unusual tardiness and unexplained absences
   B. Drastic change in appearance
   C. Unusually late and incoherent documentation.
   D. All of the above

2. **According to Leilani Kicklighter, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group, how should reports of patient abuse in an OR be handled?**

   A. The situation should be referred for peer review.
   B. Some disciplinary action should result.
   C. Consideration should be given to requiring the physicians and staff to attend a medical ethics course.
   D. The matter should be referred to the facility's ethics committee
   E. All of the above.

3. **How did the appeals court rule in the case of a hospital requiring a CRNA to undergo a psychiatric examination after she expressed suicidal thoughts?**

   A. Requiring the CRNA to undergo a psychiatric examination did not amount to labeling her as disabled.
   B. It was reasonable for OSUMC to insist that it be allowed to talk to her psychiatrist before reinstating her.
   C. A and B
   D. Neither A nor B.

4. **According to Michelle Feil, MSN, RN, CPPS, senior patient safety analyst with the Pennsylvania Patient Safety Authority, when should patients with dementia be allowed to make decisions?**

   A. Never
   B. When the decision does not affect the patient's health or safety
   C. When the decision has no long-lasting consequences
   D. Always, unless a family member says otherwise ■

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

The Joint Commission Defends Standards Under Fire as Opioid Abuse Grows

The Joint Commission (TJC) has clarified its position on pain management, and it is underscoring its belief that drugs are not always required to manage pain. The statement followed a letter sent by more than 60 non-profit groups and medical experts to TJC that asked it to revisit its pain management standards.

The letter specifically took issue with what it said were guidelines instructing doctors to routinely ask patients to assess their pain.

"The Pain Management Standards foster dangerous pain control practices, the endpoint of which is often the inappropriate provision of opioids with disastrous adverse consequences for individuals, families and communities," the letter said. Deaths linked to misuse and abuse of prescription opioids rose to almost 19,000 in 2014, according to the Centers for Disease Control and Prevention.

The letter effort was led by Physicians for Responsible Opioid Prescribing, which encourages alternative treatments to opioids, including non-opioid pain relievers, psychotherapy, and physical therapy. *(For more information on this group, readers can access their web page at http://www.supportprop.org.)*

> "IN THE ENVIRONMENT OF TODAY'S PRESCRIPTION OPIOID EPIDEMIC, EVERYONE IS LOOKING FOR SOMEONE TO BLAME."

3 steps from Joint Commission

TJC responded with a statement that said healthcare providers should do the following:

- educate all licensed independent practitioners on assessing and managing pain (applies to hospitals);
- respect the patient's right to pain management (applies to hospitals and ambulatory organizations);
- assess and manage the patient's pain (applies to hospitals, ambulatory organizations, and office-based surgeons).

TJC leaders said the statement was an attempt to combat misconceptions about its recommendations. Specifically, TJC said the following:

- It does not require treatment until pain scores reach zero.
- It doesn't push doctors to prescribe opioids.
- Its standards have not led to a dramatic increase in opioid prescriptions.

David W. Baker, MD, MPH, executive vice president of healthcare quality evaluation at the TJC, said, "In the environment of today's prescription opioid epidemic, everyone is looking for someone to blame. Often, TJC's pain standards take that blame. We are encouraging our critics to look at our exact standards, along with the historical context of our standards, to fully understand what our accredited organizations are required to do with regard to pain. We believe that our standards, when read thoroughly and correctly interpreted, continue to encourage organizations to establish education programs, training, policies, and procedures that

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improve the assessment and treatment of pain without promoting the unnecessary or inappropriate use of opioids." *(To access the statement, go to http://bit.ly/1sklA58. For more information on this topic, see "Researchers show rising opioid prescriptions following low-risk surgeries,"* Same-Day Surgery*, May 2016, at http://bit.ly/1rgmCi6.)*

ASA and AMA speak out

The American Society of Anesthesiologists (ASA) has formed a committee to address opioid abuse and encourage co-prescribing of naloxone.

The Ad Hoc Committee on Prescription Opioid Abuse will focus on identifying common-sense ways to reduce prescription opioid abuse and promote safe and effective treatments for patients with chronic pain. Additionally, ASA announced the release of its statement by ASA's Committee on Pain Medicine encouraging physicians to consider co-prescribing naloxone with an opioid for patients at high risk of overdose.

As part of ASA's efforts to reduce the misuse and abuse of prescription opioids, ASA worked with the White House Office of National Drug Control Policy to develop a wallet-sized card describing the signs and symptoms of an overdose, as well as instructions for assisting someone suspected of an overdose, including instructions to administer naloxone and call 911. *(To access the card, go to http://bit.ly/1kEtXgD.)*

ASA is also working with groups on efforts that include supporting prescription drug monitoring programs, enhancing physician education on pain care, and increasing research directed at pain medicine therapies.

In other news, Steven Stack, MD, CEO of the American Medical Association, has called on physicians to limit the amount of opioids prescribed for postoperative care and acutely injured patients.

In an open letter on the opioid epidemic that was published in the Huffington Post Blog, Stack urged physicians to avoid initiating opioids for new patients with chronic non-cancer pain unless the benefits outweigh the risks. He also urged physicians to register for and use their state Prescription Drug Monitoring Program, identify and help patients with opioid use disorder obtain evidence-based treatment, and co-prescribe naloxone to patients at risk for overdose. *(Readers can access the letter by going to http://huff.to/1T5DxOB.)* ■

Final Rule Published on Fire Safety Requirements

The Centers for Medicare & Medicaid Services (CMS) has announced a final rule to update ambulatory surgery centers (ASCs), hospitals, and other healthcare facilities' fire protection guidelines to improve protections from fire for all Medicare beneficiaries in facilities.

The new guidelines apply to ASCs, hospitals, and other healthcare facilities. This rule adopts updated provisions of the National Fire Protection Association's (NFPA) 2012 edition of the *Life Safety Code* (LSC) as well as provisions of the NFPA's 2012 edition of the *Health Care Facilities Code.*

"This final rule meets healthcare facilities' desire to modernize their environments while also ensuring the necessary steps to provide patients and staff with the appropriate level of safety," said **Kate Goodrich**, MD, MHS, director of the Center for Clinical Standards and Quality, CMS.

"... ENSURING THE NECESSARY STEPS TO PROVIDE PATIENTS AND STAFF WITH THE APPROPRIATE LEVEL OF SAFETY."

The provisions in this final rule cover construction, protection, and operational features designed to provide safety for Medicare beneficiaries from fire, smoke, and panic.

Some of the main requirements in this final rule include:

• For ASCs, all doors to hazardous areas must be self-closing or must close automatically. Additionally, alcohol-based hand rub dispensers may be placed in corridors to allow for easier access.

• Healthcare facilities in buildings that are taller than 75 feet are required to install automatic sprinkler systems within 12 years after the rule's effective date.

• Healthcare facilities are required to have a fire watch or building evacuation if their sprinkler system is out of service for more than 10 hours.

With this rule, CMS is adopting provisions of the 2012 edition of the *LSC* and provisions of the 2012 edition of the *Health Care Facilities Code* to bring CMS' requirements more up to date. In addition, the 2012 edition of the NFPA's *Health Care Facilities Code* gives more detailed provisions specific to different types of healthcare facilities.

Providers affected by this rule must comply with all regulations within 60 days of the publication date of the final rule, which was May 4, 2016, unless otherwise specified in the final rule. To access the final rule, go to http://bit.ly/1VIhkbw. ■

The Joint Commission Reverses Position, Ends Ban on Texting Orders, With Caveats

The Joint Commission (TJC) has reversed its position and says that effective immediately, "licensed independent practitioners or other practitioners in accordance with professional standards of practice, law and regulation and policies and procedures may text orders as long as a secure text messaging platform is used and the required components of an order are included," according to an article in the May 2016 *Perspectives.*

The ban has been in effect since 2011, when the TJC published a frequently asked question and stated that physicians or licensed independent practitioners should not text orders for patient care, treatment, or services to the hospital or other healthcare settings. TJC leaders were concerned about personal mobile devices being used to send unsecured text messages between providers. Also, with texting, there was no method to verify the identity of the person sending the text and no method for retaining the original message to validate the information entered into the medical record. The TJC says that, at that time, there was no technology to provide safe and secure text messaging of orders.

TJC says that as technology has evolved, there are more secure text messaging platforms. "Therefore, effective immediately, The Joint Commission has revised its position on the transmission of orders for care, treatment, and services via text messaging for all accreditation programs," it said in *Perspectives*.

TJC SAYS THAT AS TECHNOLOGY HAS EVOLVED, THERE ARE MORE SECURE TEXT MESSAGING PLATFORMS.

Furthermore, TJC says that healthcare facilities can allow orders to be sent through text messaging, as long as a secure text messaging platform is used that includes the following:

- a secure sign-on process;
- encrypted messaging;
- delivery and read receipts;
- date and time stamp;
- customized message retention timeframes;
- specified contact list for individuals who are authorized to receive and record orders.

TJC says that accredited facilities are expected to do the following:

• Comply with Medication Management Standard 04.01.01.

This standard pells out the required elements of a complete medication order and actions that must be taken when orders are incomplete or unclear.

• Develop policies and procedures for text orders.

These policies and procedures should spell out how orders transmitted via text messaging will be dated, timed, confirmed, and authenticated by the practitioner who is submitting the order.

• Consider how to document text orders in the patient's medical record.

For example, consider the following questions:

• Does the secure text messaging platform integrate directly with the electronic health record? • Or will the texted order be entered manually?

TJC suggests that providers use requirements addressing verbal orders, Provision of Care, Treatment, and Services Standard PC.02.01.03, and Record of Care, Treatment, and Services Standard 02.03.07, to write policies and procedures for text orders.

While TJC staff determine whether the current standards will be adjusted, it advises accredited organizations to do the following:

- Develop an attestation documenting the capabilities of your secure text messaging platform.
- Define when text orders are appropriate or are not appropriate.
- Monitor how frequently texting is used for orders.
- Assess compliance with texting policies and procedures.
- Develop a risk management strategy, and perform a risk assessment.
- Conduct training for staff, licensed independent practitioners, and other practitioners on applicable policies and procedures.

SOURCE/RESOURCE

- Christina Cordero, PhD, MPH, Project Director, Department of Standards and Survey Methods, The Joint Commission. Email: cordero@jointcommission.org.
- Office of the National Coordinator for Health Information Technology. Information on mobile devices and their privacy/security. Web: http://bit.ly/1RYbXD6. Information on managing mobile devices that are used in healthcare settings. Web: http://bit.ly/286o4nS. ■

Institute for Medical Quality Granted Medicare Deemed Status

The Institute for Medical Quality (IMQ) in San Francisco has been approved as a national accrediting organization for ambulatory surgery centers (ASCs) that participate in the Medicare or Medicaid programs.

IMQ accredits 122 organizations in eight states. IMQ's Ambulatory Accreditation program accredits ambulatory surgery centers, office-based surgery practices, endoscopy centers, medical groups, oral and maxillofacial surgery/dental practices, pain management centers, urgent care centers, and women's health centers. IMQ also has programs for the accreditation of healthcare delivered in California correctional facilities and accreditation of continuing medical education providers.

IMQ said that it understands the unique attributes of ambulatory care settings because most of the surveyors are actively practicing physicians. IMQ says that its peer-to-peer methodology increases the value of the accreditation process because IMQ surveyors understand how an ASC's regulatory compliance activities directly impact patient outcomes.

"Our physician surveyors are highly experienced in systems that promote optimal patient care," said **Neal Shorstein,** MD, chair of ambulatory accreditation programs.

In January 1996, the California Medical Association launched IMQ, a not-for-profit subsidiary to help improve the quality of care delivered to patients in California. The organization now accredits organizations inside and outside of California. IMQ emphasizes education, counseling, and direct involvement of practicing physicians. Its mission is to improve the quality of care provided to patients through a range of educational, accreditation, consultation, and certification programs. Some, but not all, IMQ programs involve surveys of facilities and medical practices. IMQ is a 501(c)3 corporation overseen by a board of directors of academic and community physicians and business leaders. For more information about IMQ's approval, contact Victoria Samper at vsamper@imq.org ■

New Scoring Methodology Helps Facilities Prioritize Corrective Actions

Project REFRESH, The Joint Commission's multiphase process improvement project, includes an approach for identifying and communicating risk levels tied to deficiencies cited during surveys. This Survey Analysis for Evaluating Risk (SAFER) approach provides facilities with more information related to risk of deficiencies to help them prioritize and focus corrective actions.

This approach allows the facility to see areas of noncompliance on an aggregate level. Facilities can see significant components of risk analysis, including the likelihood to harm a patient, staff, or visitor and the scope of a cited deficiency.

Accreditation and certification programs will begin receiving this matrix in their reports after Jan. 1, 2017. *(To access a copy of the SAFER matrix, readers can go online to http://bit.ly/1OJMs8m.)* ■

The Joint Commission Unveils New Design for Standards Frequently Asked Questions

The Joint Commission's frequently asked questions about standards have a new format to make it easier to find information about patient safety and healthcare quality.

The answers to questions about standards are vetted by The Joint Commission's Standards Interpretation Group and are the most current information available.

Based on customer feedback, the site was redesigned so users can do the following:

- Print the frequently asked questions individually, by chapter, or by manual.
- Search by manual, chapter, and/or keyword.
- Vote thumbs up or thumbs down, with optional comment section.
- View featured and new frequently asked questions for two weeks. ■