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Successful kidnapping of baby shows weakness in hospital security systems

High-tech devices fail hospital and child

Loyola University Medical Center in Chicago learned a tragic lesson recently when a woman kidnapped a premature baby from its nursery: Even a host of high-tech electronic devices may not stop someone from simply picking up a baby from the nursery and walking out the door.

The incident was shocking not only because the baby died, but also because the hospital appeared to have taken many sophisticated precautions to avoid such a crime. An elaborate alarm and door-locking system were not enough, says **Anthony Barbato**, MD, president and chief executive officer of Loyola University Health System and Loyola University Medical Center.

"This is the first incident of this type that Loyola University Medical Center has experienced in over 31 years of serving the community and delivering approximately 38,000 infants," he says. "We are determined that it will never occur again."

Other hospitals may be discouraged to learn that their precautions against baby kidnapping could prove equally ineffective.

Thirteen-day-old Zquan Wakefield was in the nursery at Loyola on May 1, but his mother, 21-year-old Zandra Wakefield of Maywood, IL, had been discharged already. The baby had been born April 18 at only seven months gestation and was still in the hospital because of low birth weight, only 4 lbs.

Cook County Sheriff's Department officials and Loyola officials provide this account of what

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COMING IN FUTURE ISSUES

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happened that day: On May 1 at about 10 p.m., a woman visiting the nursery apparently picked up the child and headed toward an exit. A transmitter on the baby's wrist bracelet was supposed to activate alarms and "mantrap" doors that would trap the woman between two sets of locked doors. The alarms did sound, but for some reason the mantrap doors did not lock. The woman was able to leave the hospital without being stopped by anyone.

Police target a suspect

Hospital security personnel responded to the alarm and began searching the building, after the nurses' head count revealed that the baby was missing. After about an hour, when there was no sign of the baby, the security officers called the sheriff's department to report the kidnapping. Sheriff's deputies reviewed the security videotapes from the nursery and saw that a woman had left with a coat draped over her arm. They now think the woman hid the baby under her coat.

By checking the list of approved visitors to the nursery, authorities quickly zeroed in on 24-year-old Vanecha Cooper of Chicago. Police say she was approved to visit the baby of a family member in the nursery. When police went to her home at 2 a.m., they took her and her boyfriend in for questioning. Five hours later, police went back to the apartment and searched for the baby. They found the baby under laundry in a hamper, apparently smothered.

Though the police wasted no time in finding the suspect, they have offered no reason they did not search for the child when first visiting the apartment, other than to say that the suspect was cooperative and they had no search warrant. Hospital officials have not said why they waited an hour to contact authorities.

Police say Cooper had told friends she was pregnant, but actually she was not. She has been charged with murder and kidnapping.

For Loyola, the crime was a dramatic revelation that its safety procedures were inadequate. An expert in hospital security says the Loyola incident is the best proof yet that technology is not the solution. **Edward Flores**, senior director of security at the New York University Medical Center and president of the International Association for Healthcare Security and Safety in Lombard, IL, says high-tech devices to prevent baby kidnapping have proliferated in recent years. But Flores says the incident shows that you

have to depend more on an overall plan in the hospital.

"Technology is part of a good system, but it's not a major part," he says. "Education of parents and staff are more important, and so is having a good plan in place for prevention and response. Electronics is always more of a backup, the same as with any other security in the building."

Flores cautions that it is easy for hospitals to rely too heavily on door sensors and transmitters on the baby, or other systems such as the doors that were supposed to lock the kidnapper in the Loyola nursery. All of those can be worthwhile, but if they fail, a baby can be lost.

"Never rely on just one thing," he says. "This crime can happen anywhere, no matter how much electronics and security you have, so you have to approach it with a well-rounded plan. Losing a baby like this is a black eye that is very, very hard to take care of, whether you are at fault or not, so you have to try to prevent it."

As for the door-locking system that failed at Loyola, Flores says such systems can be effective. "[A door-locking system is] not a bad idea, but the system has to be tested and it has to work," he says. "And you still have the question of what is that person going to do to the baby while they're trapped in there, knowing they've been caught? I'd be happier with a system that just prevents the person from going through the first set of doors."

(See p. 77 for advice on how to structure a plan to prevent and respond to baby kidnappings.)

Hospital hit quickly with HCFA rebuke

The Health Care Financing Administration quickly issued a statement of deficiencies in response to the crime, requiring the hospital to explain how it plans to improve. The incident also qualifies as a sentinel event with the Joint Commission on Accreditation of Healthcare Organizations, so the hospital will have to conduct a root-cause analysis and report to that organization as well. Loyola already has provided a plan of correction to HCFA. **(See p. 77 for a summary of the plan.)**

"Loyola University Medical Center and all of its physicians, nurses, administrators and staff take extremely seriously the tragic incident which occurred on May 1, 2000," Barbato wrote to HCFA when submitting the plan. "Since May 1, 2000, I have convened a series of policy and procedure reviews with the nursing and security and administrative leadership from the hospital to be sure that our policies reflect everything we have learned from this incident. All revised policies are attached for your reference. We have also conducted joint in-service training for all Newborn Nursery / Maternity Unit / Labor and Delivery nursing personnel and all security personnel in these new policies and procedures."

Profile of the suspect

Barbato's letter says the hospital's internal review of the incident revealed the following circumstances:

- "The person now accused of the abduction was attending to her family member in the nursery. This individual was an adult family member approved to participate in the care of another infant in the nursery by that infant's 14-year-old mother. Our records confirm that these visits were authorized in accordance with previous hospital policy. At least one Registered Nurse was in the nursery during her visits. All of our nurses are oriented to infant safety issues, including the conduct of visitors in the nursery. The suspect was never observed violating any of the policies of the nursery, including the restriction that she could only have contact with her relative.
- "Nothing she did on May 1, or on the prior occasions in which she was in the nursery caring for her nephew, caused any staff member to be suspicious of her activities. She left the nursery on May 1 in apparently normal fashion. Nothing alerted the staff to a possible abduction until the alarm was triggered by the wrist transponder bracelet.
- "Unfortunately, while the infant alarm sounded, the mantrap doors outside the unit that were designed to close and lock with the triggering of the alarm failed to do so. That allowed the suspect to leave the building before the security officers could detain her. These doors were working properly on April 22, 2000, and worked properly during prior occasions when they were inadvertently activated, e.g., if a staff member had a sensor bracelet in his / her pocket and walked between the sensor panels.
- "Immediately following this incident, the unit alarm and mantrap door-locking system were completely checked. We believe that the door-locking system failed because of a wiring problem. It is now tested daily and we are maintaining records of those tests."

In addition to correcting the wiring problem, Barbato says the hospital added an override button to provide a backup for the mechanism that closes and locks the alarm-activated security doors. The hospital also posted security personnel to ensure 24-hour, seven-day-a-week security coverage for the nursery.

System required visitors to have permission

Trisha Cassidy, senior vice president for system development and strategy with the Loyola University Health System, says the system already in place on May 1 was considered a sophisticated deterrent to kidnapping. When visitors come to the unit to visit a baby, they walk down a hallway and stand behind a yellow line so they can be seen through locked glass doors by the receptionist, who sits in a reception area outside the locked nursery, she says.

If the receptionist allows visitors to enter the reception area, they must sign in. Visitors will be allowed further into the unit only if a baby's parent has given them approved access. The receptionist then will allow them to pass through another set of locked doors. At this point, visitors still will be outside of the secure nursery area. The only way to gain entry to the nursery is for the nurse in the unit to unlock and open the door.

Loyola has a wristband alarm system for the newborns. Each baby admitted to the nursery receives a band, which contains an electronic sensor. That sensor works in conjunction with other devices just outside the entryway to the reception area and will cause an alarm to sound if the bracelet passes between the sensor plates located in the hallway walls. The system is designed to close security doors at the far end of the hallway and lock those doors electromagnetically. Simultaneously, an alarm sounds in the Security Command Center, and security officers are dispatched to the nursery and to the primary hospital exits.

"When the alarm sounded, the nursing staff began a physical count of the infants, some of whom were 'rooming-in' with their mothers," Cassidy says. "Although the initial count did not reveal a missing infant, this count was immediately repeated, and our staff determined that an infant was missing."

Loyola reports that it was contacted within days by attorneys representing both the mother and the father of the infant. Information from the National Center for Missing and Exploited Children (NCMEC), which closely monitors infant abductions from health care facilities, indicates that the previous success of prevention efforts has increased the risk for hospitals that fail to enact them successfully.

The hospital is more likely to be sued in cases where the abductor impersonated a hospital employee than in those cases in which the abductor used another method to obtain the child, the NCMEC reports. Lawsuits became more common in the 1990s, it says.

Infant abductions rank as one of those problems that is not statistically likely to hit your facility, but the enormity of the tragedy makes it necessary to prepare for the possibility nonetheless. The best estimate for the frequency of infant abductions by nonfamily members comes from the NCMEC, which says 12 to 18 infants are abducted from hospitals each year. If you add abductions by family members, which usually occur when they hear the child will be turned over to child protective services, the number rises.

The National Center for Missing and Exploited Children says 12 to 18 infants are abducted from hospitals each year.

The NCMEC reports that 88 infants were abducted from hospitals between 1983 and 1995. Five of the infants were never recovered. The International Association for Healthcare Security and Safety, the professional group for hospital security directors, reports a slightly higher number of infant abductions that includes the last few years — 94 abductions from health care facilities since 1983. Last year was the first since 1983 without a baby kidnapped from a hospital.

Infants can be abducted from any hospital or birthing facility, according to NCMEC data. Eight percent of the abductions have occurred in facilities with no more than 200 beds, 45% in facilities with between 201 and 400 beds, 21% in facilities with 401 to 600 beds, and 26% in facilities with more than 600 beds. Fortunately, 94% of the babies were located and safely returned within a few days to two weeks of the abduction.

Fifty-seven percent of the infants were taken from the mother's room, 15% from the nursery, 17% from the pediatric area, and 11% were taken while outside the hospital but still on hospital property. ■

Education, fast response can prevent kidnappings

Preventing and responding to baby abductions in the hospital take a great deal of planning, says **Edward Flores**, senior director of security at the New York University Medical Center and president of the International Association for Healthcare Security and Safety in Lombard, IL.

Flores offers these tips:

1. **Rely on staff and family education as the key components of the plan.** All staff, especially nursery staff, should be educated about the danger of baby kidnapping and the ways in which the crimes usually occur. Also, be sure to educate the baby's family members about the risk and how important it is never to allow an unidentified person to take the baby.

"It's very important for parents to know that the baby is never given to someone you don't know, even if they are in medical garb," he says. "If that person doesn't have an identification card, the parent should immediately call the nursing station or security and not give up the baby."

Both family and staff should be warned to never leave the baby alone, for any reason, no matter how briefly.

2. **Choose the electronic components carefully.** The electronic safety devices should be difficult to defeat. They should sound an alarm if they are tampered with, and they should make it difficult for the baby to be taken off the premises. In addition to locking exit doors, they should shut down elevators and set off a general alarm.

3. **The alarm system should be baby-specific.** When the transmitter on a baby's bracelet or clothing sets off the alarm, the computer system should register which baby set off the alarm. That way, staff can see whether the baby is where it should be, confirming quickly whether there is an actual kidnapping or just a false alarm. If the transmitter only sets off a nonspecific alarm, the staff will have to do a complete head count, and they may lose valuable time.

4. **Make sure the alarm sounds in the nursery and the security department simultaneously.** There is no time to waste when a baby is kidnapped, so security should receive the alarm automatically, without waiting on a call from the nursery. Security officers must respond immediately to seal off exits and look for the baby.

5. **Call local authorities right away.** It is important to call the local police department as soon as the alarm sounds. Don't wait until you've searched the hospital on your own and can't find the baby. The police have to be called immediately so the baby might be recovered without delay.

"If you haven't found the baby in five minutes, it is either completely out of the building or hidden," Flores says. "It's better to be safe than sorry, so call the police. It's OK to say that while they were on the way, you found the baby.

"The fire department comes when an alarm sounds, even if it turns out to be a false alarm. Calling the police for a potential kidnapping shouldn't be any different." ■

Correction plan calls for equipment upgrades

Staffing changes also listed

This is the plan of correction submitted by Loyola University Medical Center in response to the statement of deficiencies issued recently by the Health Care Financing Administration after a baby was kidnapped from the hospital:

PLAN OF CORRECTION SUMMARY

I. Policy and Procedure Review/Revisions

- Collaborative review of nursing policies by nursing staff and security
- Collaborative review of security policies by security staff and nursing

❑ **Revised Policies**

- Policy No. SC-018: Security Response — Newborn Infant Security Policy
- Policy No. 13.4021.2: Visiting Newborn & Special Care Infant Nursery Policy
- Policy No. S7: Newborn Infant Security Policy
- Policy No. NA-2: Visitor Policy

❑ **Visitor Restrictions Implemented**

- Sign-in badge/log
- Photo identification/green banding
- Four-part OB banding
- Visitor hours limited and hours posted

❑ **Daily Testing and Documentation of Security System**

❑ **Panic List for Staff at Visitor Check-in Area Posted**

❑ **Review of Nursing Staffing Levels**
Reviewed nursing staffing levels in accordance with American Academy of Pediatrics and American College of Obstetrics and Gynecology standards

❑ **Code Pink Drill Scheduled**

❑ **Security Guard Presence at Visitor Check-in Area**

II. Staff Training
- All security personnel inserviced on infant safety
- All staff in maternity/newborn nursery, labor and delivery inserviced on infant safety (No staff will be allowed to work in these areas prior to receiving inservice training.)

III. Facility Improvements
- Inspected and repaired mantrap doors
- Installed override button to allow independent closure of mantrap doors by nursing staff
- Installed audible alarm inside newborn nursery
- Installed audible alarm in labor and delivery
- Installed panic button inside newborn nursery ■

Revisions seek to reduce restraints and seclusion

Not as bad as expected

The Joint Commission on Accreditation of Healthcare Organizations has released major revisions to its standards that seek to reduce the use of restraints and seclusion. The revisions are intended to provide greater assurance of safety and protection of individuals when placed in restraint or seclusion for reasons related to psychiatric disorders or substance abuse. While more elaborate than the previous requirements, the revised guidelines are not as strict as the original proposal.

The revised standards restrict use of restraints and seclusion to emergency situations in which there is imminent risk that the individual may harm himself or others. Even then, restraints are to be used only as a last resort.

"These standards underscore the importance of applying great care in using interventions that can harm or even kill patients," says **Dennis O'Leary**, MD, president of the Joint Commission. "This need is especially compelling in this vulnerable patient population."

In addition to limiting the reasons for restraining or secluding an individual, the standards place special emphasis on staff education. For example, staff must demonstrate an understanding of the factors that influence behavior and may result in the need for restraints and seclusion. The standards also place specific time limits on the length of an order for restraints or seclusion and require that only a licensed independent practitioner issue such an order.

The strengthened focus on staff training and education seeks to enhance staff skills in monitoring and evaluating patients and to promote effective communication between the staff and the responsible physician or other licensed independent practitioner, O'Leary says.

The Joint Commission expects staff education to enhance patient safety in these ways:

• Staff are trained and competent to minimize the use of restraints and seclusion and in their safe use.

• All individuals placed in restraints or seclusion, regardless of age, must have an order for restraints and seclusion issued by a licensed independent practitioner within one hour of the initiation of the restraints or seclusion.

"These standards underscore the importance of applying great care in using interventions that can harm or even kill patients."
— Dennis O'Leary, MD

• The length of the initial and any subsequent order for restraints and seclusion cannot exceed a range of one hour for children under age 9 to four hours for adults.

• Upon expiration of an order for restraints or seclusion, a new order — either written or verbal — must be issued by a licensed independent practitioner within a range of every one hour for

children under age 9 to every four hours for adults.

• An individual must be evaluated in person by a licensed independent practitioner within four hours of the initiation of restraints or seclusion for adults ages 18 and older, and within two hours for individuals ages 17 and younger.

• Individuals who continue in restraints or seclusion must be reevaluated, in person, by a licensed independent practitioner every eight hours for individuals ages 18 and older, and every four hours for individuals ages 17 and younger.

• The licensed independent practitioner must conduct an in-person evaluation of the individual within 24 hours of the initiation of restraints or seclusion if the individual is no longer in restraints or seclusion when an original verbal order expires.

When the new restraint guidelines for behavioral health care were first proposed in 1999, many risk managers feared they could be a burden and expose the organization to several types of increased risk. **Leilani Kicklighter**, RN, ARM, MBA, DASHRM, assistant administrator for safety and risk management at North Broward Hospital District and a past president of the American Society for Healthcare Risk Management in Chicago, says the final version is less onerous.

The standards address the holding of patients and call for staff training in the use of de-escalation techniques, mediation, and self-protection in order to avoid the use of restraint or seclusion. Staff also are to be taught to recognize signs of physical distress in an individual who is being held, restrained, or secluded.

New standards, requirements

The standards also include the following new requirements:

• continuous monitoring of individuals in restraints;

• a careful assessment of an individual in restraints or seclusion every 15 minutes;

• efforts to contact family members when restraints or seclusion are applied if the individual has requested that they be so advised;

• a debriefing, within 24 hours of the use of restraints, among the individual, his or her family (if appropriate), and staff;

• establishment and communication of behavioral criteria that will lead to discontinuation of restraints or seclusion. Staff are expected to work with the individual to help him or her meet the criteria;

• establishment and communication of the organization's philosophy on the restricted use of restraints and seclusion to all staff who have direct care responsibilities.

A subset of the standards — those related to criteria for the use of restraints or seclusion, initial and subsequent evaluation, time-limited orders, periodic assessment, and continuous monitoring — will apply also in nonpsychiatric settings in which restraints or seclusion are used for reasons related to psychiatric disorders or substance abuse.

The new requirements, posted on the Joint Commission Web site at http://www.jcaho.org/trkhco_frm.html, become effective January 2001.

Phone call makes compliance easier

In the proposed version in 1999, Kicklighter was disturbed by a key provision requiring a "licensed independent practitioner" to authorize the restraint or seclusion and then monitor the patient frequently, at least every eight hours.

The Joint Commission defines that person as "Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges (these individuals may be referred to by other terms, such as 'independent care provider'). In many behavioral health organizations, licensed independent practitioners include physicians, psychologists, and social workers."

If the periodic assessment must be made by a physician in most cases, Kicklighter says that would have been a problem for some facilities that do not have access to physicians or social workers around the clock. But in the final version, the Joint Commission says the practitioner can approve the continuation of restraints by phone instead of seeing the patient in person.

"That still might mean that a qualified professional will have to be awakened in the middle of the night, but they won't have to put their trousers on and come to the hospital in the middle of the night," she says. "That's an improvement over what we feared a few months back. A phone call doesn't seem nearly as difficult as bringing someone in all the time."

A potential conflict exists between the new

standards and the restraint guidelines from the federal Health Care Financing Administration (HCFA). The interim final rule set forth by HCFA in July 1999 provides for a one-hour time frame for the initial in-person evaluation by a licensed independent practitioner of an individual placed in restraints.

However, "the Joint Commission believes that its revised standards provide for an equal or greater level of protection and safety for these individuals," according to information released by the Joint Commission. In addition, significant emphasis has been placed on the health care organization's provision of qualified, capable staff who are trained to defuse emergency situations safely and quickly.

"Despite the distinctive safeguards in our standards, we recognize that HCFA may still determine that the 'one-hour' rule must be enforced for hospitals participating in Medicare," O'Leary says. "If this occurs, the Joint Commission has agreed to work with HCFA to enforce this requirement for hospitals seeking deemed status." ■

VA, NASA to develop no-penalty error reporting

System designed to reduce fear of reprisal

In an effort to recreate for health care what is hailed as a strong point of the aviation industry, senior officials of the Department of Veterans Affairs (VA) and the National Aeronautics and Space Administration (NASA) have signed an agreement to create a system to report health care errors and close calls in VA health care facilities. The system is intended to create an environment in which health care workers are more comfortable reporting incidents without fearing punishment.

The agreement commits the two agencies to create a voluntary external patient safety reporting system for the VA. That reporting system will be operated by NASA and modeled after the Aviation Safety Reporting System (ASRS), which NASA operates for the Federal Aviation Administration.

Thomas Garthwaite, MD, the VA's acting undersecretary for health, signed the agreement on behalf of the VA. **Henry McDonald**, MD, director of NASA's Ames Research Center at Moffett Field, CA, signed on behalf of the space agency. Ames Research Center will operate the VA Patient Safety Reporting System.

"We will use our experience operating the Aviation Safety Reporting System to develop VA's Patient Safety Reporting System," says McDonald. "I am confident that the new system — which will use data reported by health care providers in the front line of patient safety — will enable VA to set new standards for patient safety and further improve the quality of health care in this country."

The VA operates 172 medical centers across the country and last year had more than 3 million patients enrolled in its health care system. In 1997, VA began consolidating its longstanding patient safety programs and, in 1998, created the National Center for Patient Safety.

Ames Research Center is NASA's lead center for Information Technology, Aviation Capacity and Aerospace Operation Systems. It has operated the ASRS since it was established in 1976. The system collects aviation operation reports submitted from pilots, air traffic controllers, flight attendants, mechanics, and others who are involved in or observe an incident or situation that may compromise aviation safety. All submissions are voluntary and held in strict confidence.

The VA already requires that employees report certain serious errors, but Garthwaite says it is widely known in the health care community that many incidents go unreported because people are afraid they will be punished for their involvement. That secrecy is particularly frustrating with near misses, he says, because the incident could be used as a learning experience so that a patient is not harmed in order to make improvements. The aviation industry relies on a program that allows pilots to report near misses without being held personally responsible.

Under the planned VA program, health care workers can report medical mistakes they make or witness. After questioning the health care worker for more details, NASA will strip all identifiers from the report so there can be no personal repercussions. The information will be analyzed by medical experts hired by NASA to determine how the incident occurred and what might be learned from it.

The similar aviation safety system, run by NASA for the Federal Aviation Administration, receives 35,000 reports a year. ■

Columbia's liability likely to exceed $1 billion

Letter sets no limit on Columbia's liability

The proposed Columbia/HCA settlement announced recently is only the first step in resolving a series of whistle-blower (qui tam) lawsuits against the company, leaving many, including one filed seven years ago, still unresolved. The total liability for Columbia/HCA could exceed $1 billion, according to attorneys handling the litigation.

The seven-year-old qui tam lawsuit, brought by James Alderson, a former Columbia/HCA chief financial officer in Montana, and another qui tam case, brought by John Schilling, a former Columbia/HCA reimbursement manager in Florida, represent what is probably Columbia's biggest outstanding liability, the attorneys say. The lawsuits allege that the company and its corporate predecessors submitted fraudulent "cost reports" to Medicare, defrauding the government of more than $1 billion.

Although Columbia has said its $1 billion letter of credit with the government will be reduced to $250 million, that's not an indication of the remaining liability the company faces, says **John Phillips**, JD, an attorney with Phillips & Cohen in Washington, DC, which represents Alderson and Schilling and two other whistleblowers whose lawsuit was included in the recent settlement.

"The $1 billion letter of credit does not set a limit on Columbia's liability and should not be interpreted as such," Phillips says. "We expect the total of all settlements to far exceed that amount."

Misrepresenting its costs

Among Phillips & Cohen's clients who will share in the rewards of the $745 million settlement are two Utah doctors who filed a qui tam lawsuit five years ago to stop a corporate practice of bilking Medicare. Robert Rothfeder, MD, and Dennis Wyman, MD, charged in their qui tam lawsuit that Columbia hospitals routinely billed Medicare for blood tests that were not requested by doctors and were not medically necessary.

The proposed settlement also covers a portion of the qui tam lawsuit brought by Schilling that alleged Columbia misrepresented its costs so the federal government would unwittingly finance its acquisition of home health care agencies from Olsten Corp.

"Columbia figured out a lot of ways to overbill the government," says **Mary Louise Cohen**, JD, another attorney with Phillips & Cohen. "The company pressured managers to increase government reimbursements, which led to many different scams that boosted profits."

Rothfeder and Wyman were independent contractors working as staff emergency physicians at Lakeview Hospital in West Valley City, UT, when they became aware of the billing fraud. Lakeview was a wholly owned subsidiary of HealthTrust, which later merged with Columbia/HCA.

Their lawsuit states that each time a physician ordered a basic blood test (a complete blood count, or CBC) for a patient in the emergency room or outpatient services, Columbia hospitals ordered additional blood chemistry tests, known as "CBC indices."

In addition, the lawsuit says, when a doctor ordered a "chemistry profile" for a patient in the emergency room or outpatient services, the hospitals also charged for various other blood tests that had not been ordered.

The doctors were extremely concerned about the amounts mischarged to patients and public and private insurers, Cohen reports. When Wyman questioned a hospital manager about the practice, he was falsely told that the additional tests did not result in an additional cost to patients, Medicare, and other insurers, she says.

The portion of the recent settlement involving Columbia's purchase of Olsten's home health business results from a separate lawsuit that was filed by Schilling. When Columbia acquired the home health business in 1994, it paid Olsten wildly inflated management fees instead of a realistic purchase price. The cost of management fees can be passed on to Medicare through cost reports.

Once in the home health business, Cohen says Columbia shifted marketing and other hospital expenses into the home health agencies so that they could be reimbursed, again through the cost reports, at a higher rate.

Olsten Corp. paid the federal government nearly $41 million last year to settle allegations that it had acted with Columbia to defraud Medicare. ■

Kids need more protection from medication errors

Important safeguards are underused

Greater protections are needed to shield pediatric patients from potentially tragic medication errors, according to the nonprofit Institute for Safe Medication Practices (ISMP) in Fulton, MD.

The ISMP reached that conclusion after surveying hospitals about practices they follow in pediatrics. The group surveyed hospitals through a newsletter and received 312 responses. The survey disclosed that while a number of safety practices were used fairly consistently, other important safeguards were greatly underutilized.

The most prevalent safety practices reported by all respondents included entering the patient's age into the pharmacy computer system before processing orders, providing specialized training to nurses who work with pediatric patients, and requiring a pharmacist to double-check all pharmacy-prepared parenteral solutions. However, there were significant gaps in full implementation of even the most prevalent safety practices and variations between care settings.

Differences noted between departments

While 95% of pediatric intensive care unit (PICU) respondents noted that orders always require entry of the patient's age before processing, only 80% of general pediatric unit (GPU) respondents reported they always do so. Further, only about half of all respondents reported that the patient's weight is always entered into the computer before processing orders to allow the system to warn practitioners about drug doses that exceed safe limits.

While 88% to 89% of PICU and neonatal intensive care unit (NICU) respondents always require specialized training for pediatric nurses, only 66% of GPU respondents had similar training requirements. Respondents also noted that specialized training for pharmacy staff who prepare pediatric parenteral solutions is dangerously inconsistent.

Two of the least prevalent safety practices included listing the mg/kg dose as part of the drug order and having clinical pharmacists actively participate on units. Three quarters of all respondents said that prescribers inconsistently or never list the mg/kg dose with pediatric drug orders. Although about two-thirds of NICU and PICU respondents reported that pharmacists always verify the mg/kg dose and recalculate the specific patient dose before dispensing drugs, only half reported that such safety measures are consistently carried out for all pediatric drug orders, regardless of the setting of care.

In addition, a large proportion of pediatric doses are obtained from floor stock, which typically bypasses pharmacy double-check processes to verify the correct dose. While it may be expected that noncritical care units would report less participation of clinical pharmacists, only about two-thirds of NICU and PICU respondents reported strong clinical pharmacy involvement. Further, more than a third of NICU respondents reported the total absence of clinical pharmacists in those high-risk patient care units.

Two of the least prevalent safety practices included listing the mg/kg dose as part of the drug order and having clinical pharmacists actively participate on units.

Most hospitals report that they have fully implemented a unit dose drug distribution system, but respondents reported that pharmacy dispenses an average of only 81% of pediatric drugs in unit doses and 84% of all pediatric parenteral solutions. With the exception of drugs with stability issues, all pediatric IV admixtures should occur in pharmacies that provide 24-hour service, the ISMP says. Yet less than half of respondents reported that essentially all parenteral solutions were dispensed by pharmacy.

While about two-thirds of all respondents noted that standard dosing/infusion rate tables are frequently or always available for reference, 32% of NICU respondents noted a complete absence of such guidelines. Further, only about 30% of all respondents noted that nursing calculations and parenteral medications are independently verified by another nurse before drug administration. Respondents also reported that about a quarter of all products are obtained from floor stock. Even though nursery and NICU respondents frequently obtain most products (75%) from floor stock, at least a quarter of them reported obtaining less than 5% of all products from floor stock. ■

Beth Israel disputes article on Allan Zarkin

To the Editor:

I recently read, with great disappointment, the edition of *Healthcare Risk Management* dated March 2000. Your characterization of Beth Israel Medical Center, and its handling of the case involving Dr. Allan Zarkin, could be no further from the truth!

Upon learning of Dr. Zarkin's barbaric act, we promptly suspended his privileges at the hospital, and he was allowed no further involvement in patient care. We reported the incident to the New York State Department of Health-Office of Professional Medical Conduct and the National Practitioner Data Bank (NPDB). We cooperated fully in the DOH's investigation, as well as an investigation by the Manhattan District Attorney's Office, regarding Dr. Zarkin's act.

Contrary to reports, there was nothing in Dr. Zarkin's files at the Medical Center or at the NPDB that gave the slightest hint that he would pose a risk to any patient. This was an irrational, random, and egregious act that could not have been prevented.

What was most disturbing about your reporting of the Zarkin case is that you relied greatly on speculation from individuals with absolutely no knowledge of the case — other than what they read in the newspapers or saw on television. Many news reports of the case were inaccurate as well, so, in essence, your publication simply served to promulgate misinformation. You would be hard pressed to defend that as responsible reporting!

Every day, year in and year out, tens of thousands of physicians, nurses and staff of Beth Israel provide the highest quality care to those individuals who turn to us for help. It is most unfortunate when the senseless act of one individual overshadows the highly effective efforts of so many others.

Matthew Fink, MD
President and Chief Executive Officer
Beth Israel Medical Center
New York City ■

From the Editor:

Healthcare Risk Management reported in its March issue that the state health department of New York investigated the incident and released a report Feb. 3 saying that Beth Israel Medical Center was aware of aberrant behavior by Dr. Allan Zarkin before the carving incident and did not intervene.

HRM made several requests for comments from officials at Beth Israel, but a spokesperson at the medical center, and an attorney representing it, refused those requests.

The Manhattan district attorney's office reports that Zarkin recently was sentenced to five years of probation and banned from practicing medicine as part of a plea bargain. He also must receive psychiatric care. ■

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Digital age poses risks for health care providers, Lloyd's chairman warns

The chairman of Lloyd's of London, the venerable insurer of risks worldwide, is calling upon the U.S. health care industry to prepare for the risks of the digital age.

Addressing the Physician Insurer Association of America recently in Washington, DC, **Max Taylor** warned that with new technology come new risks. Computer viruses and hackers presents an increasingly real threat, he said.

"As we become more reliant upon technology, the health care industry faces serious challenges," Taylor said. "If a hacker or technology glitch damaged all systems, would organizations be able to cope — to function, even? Could patients be admitted? Could patients be treated?"

"Health care organizations need to encourage much closer partnership between their IT [information technology] departments and risk managers."
Max Taylor, Lloyd's of London

Taylor said the recent "Lovebug" virus was "the tip of the iceberg" in terms of virus threats, but he warned that more sinister threats are posed by computer hackers. Recent instances of patient security breaches include a case where hackers gained access to a U.S. academic medical institution's records and maliciously published them on an Internet bulletin board. The implications for a facility involved in this sort of incident do not stop at the inconvenience of a disabled network or the costs of litigation that may follow from those whose private details are made public, he said.

"Invasion of patient confidentiality is a huge issue on a number of fronts," he explained. "In the longer term, poor public perception is a problem that could result in physicians leaving and [being] unwilling to practice in a facility and patients unwilling to be treated there due to fears regarding security."

His comments come as new Health Industry Portability and Accountability Act legislation forces the U.S. health care industry to change the way it operates. Lloyd's recently began offering insurance coverage that extends traditional policies to the loss of intellectual property, extortion, and costs associated with hackers and viruses and fraudulent acts by employees. The first two policyholders were academic medical institutions.

However, Taylor warned that insuring against hackers and viruses is not the end of the line.

"Health care organizations need to encourage much closer partnership between their IT [information technology] departments and risk managers," he says. "By working together, the risks of damage to individual network systems and the need for insurance coverage can be more accurately assessed, but there is also more scope to reduce these risks in the first place." ■

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Chain of events leads to brain damage: $4.95 million

By **Mark K. Delegal**, Esq., and **Jan Gorrie**, Esq.
Pennington, Moore, Wilkinson, Bell and Dunbar, PA
Tallahassee, FL

News: A chain of events left a man catastrophically brain damaged. After settling with the physician for an undisclosed amount and settling the claim for loss of consortium, a jury returned a verdict of $4.95 million. With statutory caps on damages, the recovery actually approaches $2 million.

Background: A 37-year-old plaintiff was being treated at a Colorado hospital for reflex sympathetic dystrophy (RSD). The man had developed RSD as a result of the amputation of a finger arising from a work-related accident five years earlier. The normal, routine treatment of his RSD entailed an injection of guanethidine, which dulls the nerve endings. Because of the severity of his phantom pain, the guanethidine was given to him several times a week.

Typically, he was sedated during the procedure. However, in this instance, at his bedside was the chemical phenol (carbolic acid) in a vial that was identical to his intended medication. Phenol, an acid that kills nerve tissue, is used rarely as a pain management tool. It had been used by another anesthesiologist, who allegedly disposed of the phenol vial after using it on another patient. Contrary to the hospital's unit dose policy, the vial apparently had not been disposed of by either the physician who had used the material or the nursing staff.

The plaintiff's anesthesiologist took the vial containing phenol from the nerve block tray and, although it was clearly marked as phenol, he injected into the plaintiff. The vial did not have a warning label. Because the patient immediately arched his back in what the anesthesiologist thought was pain, he gave the patient a second injection from the same vial. Several hours later, the patient still appeared to be in pain.

The anesthesiologist believed the plaintiff had suffered from an allergic reaction to the guanethidine and said so out loud. Upon hearing the perceived diagnosis, the head nurse shared that the patient had not in fact been given the guanethidine. It seems that she had known this for some time but had not shared the information. The anesthesiologist checked the sharps box where he had disposed of the vial he had used and discovered the vial marked phenol.

As a result of the injection of phenol, the plaintiff had to undergo emergency surgery. In order to prevent the further development of compartment syndrome, which could have resulted in the loss of his arm, the patient had a fasciotomy. The fasciotomy involved making an incision from his fingertip to elbow.

At the time of the emergency surgery, the patient and his wife were told of the initial mishap. Two days later, the anesthesiologist who had inadvertently administered the phenol determined that, in order to decrease the pain during the standard bandage change from the fasciotomy incision, the patient should be consciously sedated. Against hospital policy during the conscious sedation, the patient was not placed on standard monitoring equipment, which included a pulse oximeter, automatic blood pressure cuff, and an EKG machine.

Therefore, when at some point after the procedure his heart and breathing stopped, no one was aware of the situation.

Allegedly, his breathing had stopped for at least five minutes before his condition was discovered at around 8 a.m. The noted time is significant because, based on the hospital's medical record, the staff nurse responsible for regularly checking the patient's vital signs had seemingly not done so as routinely required. When she went back to amend the record, she inadvertently posted that at 8 a.m. the patient was alert and his vital signs were within normal parameters.

The hospital's medical personnel were able to resuscitate him, but the patient remained in a coma for four days. The patient suffered an anoxic encephalopathy and will remain catastrophically brain damaged for the rest of his life. He does not recognize his wife or his child who was born several months after the incidents. He lives apart from his family in a supported-living facility where he receives 24-hour-a-day supervision and care.

The anesthesiologist admitted to inadvertently injecting the plaintiff with phenol. He also admitted to declining the standard monitoring equipment when performing the conscious sedation during the bandage change and electing instead to monitor the patient, which he admittedly failed to do. Prior to trial, the plaintiff settled with the treating anesthesiologist pursuant to a confidential settlement agreement.

Plaintiff alleges negligence

Statutorily in Colorado, hospitals are not liable for the actions of physicians; however, the plaintiff maintained several claims against the hospital for the actions of their personnel. The plaintiff alleged that the hospital was negligent in not removing the phenol contrary to the hospital's unit dose policy, which was in effect at the time of the incident. The plaintiff also alleged that the hospital was negligent in not placing a warning label on the phenol.

In addition, the plaintiff claimed that the hospital was negligent in failing to monitor him during the conscious sedation in keeping with hospital's policy, despite the fact that the doctor did not want it done. The plaintiff's wife settled her claim of loss of consortium against the hospital prior to trial for a payment of $100,000 plus waiver of pursuit of outstanding medical bills that amounted to approximately $200,000. The claims against the hospital proceeded to trial, where the jury awarded the plaintiff $4.95 million, including the loss of consortium claim, which was statutorily capped at $250,000 despite the earlier settlement.

With other statutory limitations in place, the actual award was approximately $2 million. In addition to the suit against the hospital, the plaintiff brought a negligence suit against the anesthesiologist who seemed to have not properly disposed of the phenol as required the hospital's protocols. This action resulted in a summary judgment in favor of the physician; however, the plaintiff has successfully appealed that decision.

What this means to you: This case includes several obvious pitfalls, most of which involve failure of the physicians and/or hospital staff to follow established hospital policies and procedures. The issues of assessing staff competency and correcting related shortcomings as well as the facility's processes for taking proper interventions when dealing with known performance problems also are raised.

The failure of the practitioners involved in the case to properly clean their work area resulted in the Phenol being available in the first place. "If it had been disposed of or at least removed from the nerve block tray according to policy, the error with this patient would not have occurred. Failure of the hospital pharmacy to properly label the phenol with an appropriate, highly visible warning label also contributed to the initial incident," says **Mary Susan Keaton**, RN, BSN, director of performance improvement and risk management at Summersville (WV) Memorial Hospital.

"The anesthesiologist's failure to read the label on the phenol container, which violates a cardinal rule of administering any drug, is the basis for the entire chain of events which followed, including the catastrophic outcome. Apparently the nursing staff somehow became aware of the error before the anesthesiologist did, but they contributed to the devastating effects of the mistake by not reporting it to the doctor and their managers as soon as possible. This delay in reporting may well have contributed to the severity of the tissue injury which the patient incurred," adds Keaton.

"The additional failure of the anesthesiologist to properly monitor the patient during the dressing change constitutes a blatant disregard for widely accepted standards of care, as well as an overt violation of facility policy. The nursing staff who were present during this procedure and failed to safeguard the patient to the best of their ability when it was obvious the physician was not doing so were also at fault. They then compounded the problem

by changing the medical record after the fact," says Keaton.

"The less obvious problems I see with this case involve the facility's practices relating to a variety of issues, including orientation and training of staff and physicians, reporting and resolution of practice concerns, communication with patients and families about medical errors, and documentation of care," she notes.

All hospital employees and physicians should receive a thorough orientation when they begin work at a facility, including procedures for reporting quality concerns, errors, and near-misses as well as documentation do's and don'ts. The hospital's risk management and performance improvement programs should foster a facility-wide attitude of teamwork and cooperation with a focus on solving problems by way of process review and refinement as opposed to placing blame on individuals. Doing so will encourage proper reporting and channeling of information, allowing potential problems to be dealt with *before* actual harm or injury occurs.

"In this particular case, it seems that the nursing staff was reluctant to, first, report the use of the wrong medication and, second, to intercede proactively on their patient's behalf during the conscious sedation procedure," Keaton says. "This reluctance resulted in actual harm to the patient on both occasions and must be addressed immediately by hospital management. Why did the nurses knowingly fail to take appropriate action? Perhaps they feared retribution by the anesthesiologist or maybe management historically had sent an unspoken message to not cause trouble, or, worst of all, maybe the staff was apathetic. It is possible and very conceivable, based on his behavior in this one case, that the anesthesiologist routinely ignored policies and procedures and that previous attempts by staff to report such concerns had fallen on deaf ears or otherwise proved futile.

"Employees become very disheartened when they try to address problems through established procedures, such as reporting through their chain of command, but then the issues are never effectively addressed. After a while, they will stop trying. It is up to management and administration to encourage communication and for that communication to be two-way, that is to get back to the employee and let them know how their concerns are going to be channeled," she says.

Managers, administrators, medical staff officers, and committees need to take reports of improper conduct and/or failure to follow established protocols very seriously, validate them as objectively as possible, and then address them as expeditiously as possible. Medical staff peer review and privileging/credentialing processes must be well-defined and invoked in a timely manner when quality-of-care issues arise.

In this case, failure of this system could account for the same anesthesiologist being allowed to continue working unsupervised after making such a serious medication error. If the medication error had been reported immediately, appropriate investigation performed as quickly as possible, and a plan or correction imposed on the anesthesiologist (which may have included additional education, monitoring by a peer, imposed probation, or even removal from duty), the opportunity for the second series of mistakes related to the lack of monitoring might not have occurred. This system is particularly useful in instances such as this, where the patient has been informed of the error and still chose to be cared for by the physician who had admitted the error.

Proper documentation a must

One last concern is that the staff nurse responsible for regularly checking the patient's vital signs during the conscious sedation and dressing change went back to amend the record and, in doing so, entered erroneous information. "All staff should know how to document properly and how to make proper corrections, if necessary, to medical records. The descriptions given in this scenario gives the impression that the nurse was not writing an addendum of assessments which were actually performed but not initially charted. Rather, it sounds like she was falsifying records in an attempt to protect herself," notes Keaton.

The facility must have clearly written procedures for how to document and well-defined definitions of acceptable behavior. Most facilities consider falsification of records to be grounds for immediate dismissal, and they may be required to report such events to state licensure boards. This tragic outcome could have been prevented or at least minimized had policies, procedures, and protocols been followed.

Reference

Robert Rodriguez, by and through his next friend and legal guardian, Lori Rodriguez v. HealthONE d/b/a Aurora Presbyterian Hospital, Denver County (C) District Court, Case No. 96-CV-1446. ■

Pump insertion causes paraplegia: $3.3 million

News: A woman walked into a Florida hospital to have a morphine pump inserted. She left in a wheelchair when the procedure resulted in injury to her spinal cord. The physician group settled for $1 million, and the verdict against the hospital was $2.3 million.

Background: The 60-year-old, married, retired woman had experienced a physical trauma that resulted in her having severe chronic lower back pain. In order to alleviate the pain she was seen at the hospital's Center for Pain Management, where anesthesiologists determined that she was a candidate for a morphine pump. She was admitted to the hospital for what was routinely a two-hour procedure. However, it lasted seven hours because the two physicians were unable to properly place the pump's line in the patient's spinal column. In the course of the seven hours, her spine was punctured approximately 18 times.

The failed attempts to insert the morphine pump line resulted in severe swelling and the severing of her spinal cord. She was discharged from the hospital a paraplegic. Her husband cared for her for the next three years, tending to her every need, including bathing, cleaning of her bowels, and dressing, and then she died of unrelated complications.

The plaintiffs alleged that after two hours, the anesthesiologists should have stopped the procedure and brought in a consulting neurosurgeon. The physicians settled the suit for their policy limit of $1 million. However, the plaintiff's suit against the hospital proceeded to trial. At trial, the plaintiffs claimed that while the physicians were not actually employed by the hospital, they were agents of the hospital inasmuch as the hospital's representations in their advertisements for the Center for Pain Management, their signage, and their requirements for admission would lead reasonable people to believe that they were being treated by employees and/or agents, real or apparent of the hospital.

The hospital maintained that the anesthesiologists were independent contractors and that the hospital was immune from the physicians' mistakes. The jury saw it differently and delivered a $2.3 million dollar verdict against the hospital. Initially, there was discussion of an appeal, but that has not yet occurred.

What this means to you: The facts in this case suggest the hospital employees, specifically the nursing staff, were found to be in compliance with applicable policies and procedures and were not negligent in performing their duties. In Florida, there are no statutory prohibitions that prevent hospitals from being liable for the actions of physicians. Accordingly, after the plaintiff settled with the two physicians for their medical malpractice insurance limits of $500,000 each, the plaintiffs proceeded with their suit against the hospital under the theory of vicarious liability. Vicarious liability is defined as legal responsibility for someone else's actions, which is more commonly found in employer/employee situations.

The plaintiffs were able to argue that while the physicians were not employed by the hospital, their practice of pain management was inexorably linked to the hospital. This link was based in part on the hospital's development and advertising of the Center for Pain Management. In addition, patients of the Center for Pain Management only gained admission to the hospital's center and subsequently, if necessary, admission to the hospital if they met the criteria established by the physicians even though they were not actually employees of the hospital.

Vicarious liability is one of the most difficult risk issues in the health care arena, particularly when facilities are attempting to provide a full range of services in an effort to gain market share. As this case demonstrates, the increased use of contracted agents likewise increases the risk of vicarious liability. This is particularly true in instances where it is not readily apparent to the general public that a contracted physician's practice is separate and distinct from the hospital.

"Risk managers should be involved in the formulation of business plans and business decisions for their facilities. In making business plans and decisions, careful consideration must be given to the benefits of a contracted service. A facility's risk manager should be involved in the identification, assessment, and evaluation of any potential risks that accompany such arrangements," says **Cheryl A. Whiteman**, RN, MSN, HCRM, risk manager, state of Florida, CIGNA HealthCare of Florida.

Reference

Robert Karstetter, as personal representative of the estate of Eleanor Karstetter, deceased, and Robert Karstetter, individually v. Adventist Health System/Sunbelt, Inc., d/b/a Florida Hospital, Orange County (FL) Circuit Court, Case No. CI97-4422. ■