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ED managers must dig beneath the surface to uncover all potential sources of liability

Examine near misses, as well as mistakes, that ended up in court

(Editor's note: In this special issue, we highlight an all-important topic: avoiding litigation. We cover issues such as department-level risk assessments, preventive actions to reduce risk; key areas of risk; a three-step strategy for risk management; changes in your department's culture to reduce risk; the use of patient satisfaction as a best practice; best practices and tools for physician, nurses, and other practitioners; admission of mistakes; and the critical role of patient advocates. We know you'll find a host of important strategies to hone your risk management program.)

Lawsuits are not only unpleasant, but expensive — not just for the hospital itself, but often for the physicians and nurses who were involved in the cases that led to litigation. Experts say there is much ED managers can do to minimize lawsuits. They add, however, that improvement efforts will be less than optimally effective unless you've performed a proper risk assessment of your department. And that, they emphasize, must go far beyond the most obvious areas such as common complaints and sources of previous suits.

"We were doing a study for a hospital in Pennsylvania on 'cases against' in pediatrics suits," recalls **Mike Williams**, MPA/HAS, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. "What we found was if we just used numbers — throughput, labs, radiology 'miss' rates, basic parameters — they were all fine, so we realized something must

Executive Summary

Studying your data on issues such as radiological miss rates and identifying common complaints that have led to lawsuits will identify areas where your ED might be legally vulnerable. However, dig deeper to uncover all areas of potential legal trouble.

- Perform chart audits to examine issues such as aggressive use of midlevel practitioners for acute care.
- Review operational risks, as they could lead to legal problems down the road.
- Measure how well you are listening to your patients and their families.

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not be right." When the firm probed more deeply for activity related to issues such as aggressive use of midlevel practitioners for acute care, or documentation, "those didn't show up in the numbers," he says.

How do you assess areas such as these? "You have to go down to the charts and see what happened," says Williams. If you aren't using a process that's granular and drills down to the patient care event and documents critical elements, "you'll miss a lot of high-risk opportunities," he says.

Assess ED risks on a global scale, "not simply from a medical malpractice environment," says **Martin E. Ogle**, MD, regional director for the southern division of CEP/MedAmerica, an Emeryville, CA-based provider of ED management and staffing solutions. "If there are other risks that are operational, or employee risks or an unsafe environment for patients or providers, they will probably have repercussions downstream on malpractice," he says. For example, if your ED is inefficient, it is likely you'll have medical issues arising because patients are exposed to the ED environment longer than they need to be, Ogle says. "We see that pretty clearly in our EDs around the country," he adds.

However, **Tom Syzek**, MD, FACEP, director of risk management for Dayton, OH-based Premier Health Care Services, takes a slightly different approach. His group looked at all the previous suits that had been brought over a 20-year period. "I characterized them according to chief complaint, and then found the frequency and severity of the chief complaint," he says. With this approach, he can determine how often and what percentage of total money was paid out related to a single condition. Thus, he was able to identify some chief "culprits" such as chest pain, abdominal pain, adult headache, and pediatric fever.

Armed with such information, the ED manager can start education programs and develop process improvement tools and programs to address those risks, Syzek says. "If you develop these programs, insurers will take this into account, and sometimes you can use that to negotiate lower med-mal rates, so there are additional economic benefits," he notes. Syzek acknowledges that such programs can cost a lot of time and money, "But if you just prevent one average suit a year, it will pay for your entire risk management program," he says.

Gerald B. Hickson, MD, professor of pediatrics, associate dean of clinical affairs and director of risk prevention at Vanderbilt University School of Medicine in Nashville, TN, says, "The single most important thing you can do to assess [risk] is a comprehensive surveillance of how well you are collectively listening to families and to other members of the team." This assessment can be done through standardized satisfaction measures, he says, "but we believe in doing that by phone, not on paper." The reason for that approach is because you not only get standard responses to standardized questions, "but you also have the opportunity to talk to families in more real-time," he says. "If things are not going well, it gives us second chance."

A second element of "assessment and mitigation" used at Vanderbilt is an active patient advocate ombudsman service. Hickson notes that research he

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and his team have conducted found that malpractice claims are not randomly distributed against ED docs; nor is complaint generation. "We use those complaints to identify those emergency medicine physicians who have more than their fair share of risk," he explains. "We send peer messengers to sit down in confidence and share with them that they stand out."

Individuals are trained throughout the institution to perform these functions, Hickson says. The physician gets a confidential letter asking for a time to sit in their office. The message delivered, basically, is: "You stand out, but this is a confidential process designed to give you an opportunity to act to reduce your personal risk." They are also told that if they do not respond, "We will get you a little help," says Hickson. On rare occasions, they are taken to their superior to "work out a special plan."

A third approach Vanderbilt uses is to "Take your near-misses and adverse events, and have a very vigorous M/M [morbidity and mortality] improvement process so the organization is committed to learning," adds Hickson. "We use a standardized approach throughout the institution built on the Ichikowa fishbone [quality improvement] process where you tease apart the factors that set the stage for these events. This, in turn, is linked to an 'accountability matrix' so an owner is identified for the issues, and their commitment is obtained to fix the problem."

Daniel Sullivan, MD, JD, FACEP, president and CEO of The Sullivan Group, an Oakbrook Terrace, IL-based provider of patient safety, risk management, and performance improvement solutions, has developed a scientific approach to risk assessment. Being a JD as well as an MD, Sullivan said he "had really developed a passion for trying to drill down and understand what was at the root of medical error."

Ultimately, Sullivan shares, his risk management company put together a risk, safety, and quality audit and performs baseline audits for EDs across the country. "It is very, very clear where medical errors come from," he asserts. "For example, abdominal pain in patients who are over 50, or chest pain — the biggest losses in emergency medicine." ■

'Ounce of prevention' can help avoid suits

Risk assessment might be a critical strategy to use in your effort to minimize lawsuits, but it shouldn't be the first, says **Tom Syzek**, MD, FACEP, director of risk management for Dayton, OH-based Premier Health Care Services.

"It takes a systemwide approach for doctors, groups, and their EDs," Syzek says. "It starts with good, qualified practitioners; so on the hiring and credentialing side, you really want to review practitioners' qualifications and backgrounds and any history of complaints or litigations they may have."

Second, he says, each group and department needs to develop its own culture about how it is going to handle risk. "You need to identify champions or name a director of risk management to serve in that capacity as a leader," Syzek says. "Risk management, or the prevention of litigation, does not just happen. It takes effort.

Once qualified staff members have been hired, he says, you should include key risk management concepts in the orientation process for practitioners. "You should have an orientation manual that includes operational and risk-related items, and all practitioners should be familiar with it," says Syzek. If your ED has a physician group, their orientation also should include a brief overview of the risk management culture, he adds.

From that point on, Syzek says, an ongoing program for nurses and doctors should include education in the form of newsletters, bulletins, online courses, and paycheck stuffers. Topics include: Potentially disastrous drug interactions exceptional customer service, guidelines for dealing with confidential information, documentation, and risk-laden conditions and chief complaints. **[A copy of Syzek's risk alerts on patient turnover, patients who leave against medical advice, and chest pain are available with the online issue of *ED Management.* For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]**

The Sullivan Group (www.thesullivan group.com) also is a good source of ongoing education.

"Some groups even have their own educational divisions where CME is provided for doctors," Syzek says. "It's optimal if department nurses and doctors can go through their own versions of the same topics." *(Editor's note: AHC Media, publisher of* ED Management, *offers 110 online CME courses and 40 CNE courses related to emergency and trauma medicine. For more information, go to www.ahcmedia. com. On the left side of the page, select "Online CME.")* ■

Get at root causes to reduce risk

Patient surveys can be invaluable source

How can an ED manager reduce the risk of lawsuits once problem areas have been identified? Experts agree you've got to get to the root cause of those problems. Sometimes, they say, it might take the use of formal quality improvement tools such as root-cause analysis. Other times, it can be a simple as listening to patient complaints.

"If a theme is identified, you must find the root cause and try to eliminate that theme or attitude," says **Corey M. Slovis**, MD, FACEP, FACP, FAAEM, chair of emergency medicine at Vanderbilt University Medical Center in Nashville, TN. The Vanderbilt ED began a concerted risk reduction program about 30 months ago. "I believe some of our earliest themes were things like patients not knowing who their doctor was," Slovis says.

As the department interviewed patients to identify the root cause of this problem, they learned that even though the provider might say who they were, the name tags and picture IDs would flip around. "I was able to convince the hospital this was an important theme, so now we have two name tags, one on the front and one on the back, so no matter which way it spins, the person's name, title, and picture stand out," says Slovis.

The ED team places a strong emphasis on follow-up calls to ascertain whether a follow-up visit might be required and to enhance patient satisfaction **(For information about patient satisfaction as a risk management best practice, see p. 114.)** ED nurses try to make follow-up calls to 100% of all "treat-and-release" patients, says Slovis. "We reach more than half," he reports. The purpose of the call is to provide excellent customer service and to ensure appropriate follow-up for the patients. The nurses have a short script that starts with "I'm a nurse from Vanderbilt; I'm just calling to check on you." They also ask if the patient got a prescription and if they filled their prescription. Finally, they ask if they think they had a good visit to the ED.

Like many ED managers, Slovis recognizes that unhappy patients are more likely to sue. He uses the Omaha, NE-based patient satisfaction firm Professional Research Consultants to conduct random surveys on such issues as quality of care, cleanliness, and professionalism. **(For information on Professional Research Consultants, see resource box, p. 113.)** The surveys are telephone-based and are implemented on a weekly basis via a random sample of ED patients, according to **Denise G. Rabalais**, director of survey research strategic development at Vanderbilt. The results are accumulated online on a daily basis, but most managers review the results monthly. "The cost varies based on volume, and it is a corporate-level expense overseen by the department," she notes.

The quality and satisfaction ratings are distributed to each doctor and nurse. "When a theme is developed, you get the appropriate group together and ask how we can fix it," Slovis says. "If the staff create the policies and protocols, they are much more likely to support them; and the more you empower them to make changes, the more likely they are to adhere to those changes." So, for example, when the patients said that they did not like the discharge instructions because they were illegible and the instructions were too generic, "that drove us to invest in discharge instruction software, to retrain physicians on the importance of discharge instructions to patients, and for nurses to ask the patient about understanding of discharge instructions prior to signing the patient out of the ED," says **Brent Lemonds**, MS, RN, EMT-P, FACHE, administrative director of emergency services.

Areas of risk can widely vary from ED to ED, notes **Martin E. Ogle**, MD, regional director for the southern division of CEP/MedAmerica, an Emeryville, CA-based provider of ED management and staffing solutions. "At one hospital, the primary problem was on the front end," Ogle says. "They couldn't get patients into the treatment area, and the 'left-before-treatment' [LBT] number was very high."

Patients leaving before being treated can be very dangerous, Ogle points out. "You do not know what they have, but you have probably established some degree of responsibility even if [they get sicker] when you're not there," he explains.

To address this problem, says Ogle, his organization identified a solution that enabled the ED to drop the

Executive Summary

To address and eliminate areas of liability concern, the first step is to identify the root causes of those problems.

- Conduct follow-up calls with as many "treat-and-release" patients as possible to get their input.
- Use patient satisfaction surveys to uncover areas of concern in terms of quality and professionalism.
- Let your staff know that lawsuits are not inevitable and that there are positive steps they can take to address areas of weakness.

Resource

For more information on patient satisfaction surveys, contact:

- **Professional Research Consultants**, 11326 P St., Omaha, NE 68137-2316. Phone: (800) 428-7455. Fax: (800) 553-4500. Web: www.prconline.com.

LBT number from 11% to less than 1% in 30 days. "The biggest change was cultural, to get buy-in from all the players including the CEO, nursing leadership, and physicians, to follow what we thought was the right solution," he says. **(A major key to the risk reduction success at Vanderbilt was culture change, notes Slovis. See the story on p. 114.)**

The solution began with a clear articulation of the revised processes Ogle's firm proposed to not only nursing leadership, but also to the highest levels of hospital leadership to gain their support. "In addition, having access to other sites in our network that have been successful in rolling out this process, we organized a site visit with selected clinical ED nursing leaders, the ED nurse manager, the CNO, the director of registration — a crucial stakeholder — and the ED medical director," he says. "In one day, we were able to visit two sites, both with [LBT] below 1% and average time-to-provider below 20 minutes, were toured by the medical directors and the ED nurse manager, and most importantly, we observed the process live with real patients being cared for in an incredibly efficient manner." Ogle says that with this approach he could "see the light bulbs going off above the groups' heads."

Because of the wide range of challenges faced in risk management, Ogle says his firm has hired experienced and trained internal consultants with a wide variety of backgrounds. "Several are experienced ED management nurses, some are industrial engineers, one is a risk manager, and we call each of those 'malpractice management consultants,'" he explains. "If, for example, we see a PA issue or credentialing is not as tight as it should be — which could certainly create an issue downstream vis-à-vis scope of practice — we can bring in the appropriate expert to explain state requirements or hospital bylaws and give us a best practice to make that piece a little safer."

A realistic attitude on the part of your staff is also critical in successfully reducing risk, adds **Gerald B. Hickson**, MD, professor of pediatrics, associate dean of clinical affairs, and director of risk prevention at Vanderbilt University School of Medicine in Nashville. "If you ask me, one of the most important things to do if you want to address unnecessary risk in the ED is to dispel and explode the old myths, like, 'We're in the ED, and we're just gonna get sued,' or 'We're at risk because of our discipline,'" he says. "Until you explode those myths, you're not going to effectively address this." To do that, says Hickson, emergency department leaders need to encourage their colleagues to simply review the evidence-based literature about malpractice and to decrease reliance on antidotes and war stories. ■

Education may not be enough

Educating your staff about risk management might be important, but education itself will not reduce risk, says **Daniel Sullivan**, MD, JD, FACEP, president and CEO of The Sullivan Group, an Oakbrook Terrace, IL-based provider of patient safety, risk management, and performance improvement solutions for health care professionals.

"The information transmitted in a lecture or via audiotape will not change the error or litigations landscape," says Sullivan, who lectures to about 100 ED medical directors twice a year at events sponsored by the American College of Emergency Physicians. "A dog-and-pony show will not work."

The only thing that will work, he maintains, is a systems approach similar to that used by airlines. "It's a system built into the 'moment to moment' of taking care of people in the ED," Sullivan says. "It addresses how doctors think, the biases in their subconscious, and so on." For example, practitioners cannot remember lists of risk factors and forget to inquire whether a febrile neonate has been exposed to strep or herpes in the maternal birth canal. "When you walk into a room and you do not have a tool [to remind you], there is a missed opportunity to make a diagnosis," Sullivan says. "This is a critical clinical practice issue."

Build a tool kit

A key part of the solution is to build a medical record tool to be used at the point of care as a reminder for the staff, he says. So, for example, electronic health records can make key information immediately available, can remind practitioners about key risk situations that might easily be forgotten, and can alert practitioners to an abnormal vital sign prior to patient discharge.

For EDs that do not have electronic medical records, Sullivan has built visual tools, such as a paper template or freestanding software program that provides immediate access for a complete evaluation of

Culture change can reduce risk

The ED at Vanderbilt University Medical Center in Nashville, TN, has achieved "a significant reduction in the number of lawsuits," according to **Corey M. Slovis**, MD, FACEP, FACP, FAAEM, chair of emergency medicine, who says it wouldn't have been possible without significant culture change. According to **Gerald B. Hickson**, MD, professor of pediatrics, associate dean of clinical affairs, and director of risk prevention at Vanderbilt University School of Medicine, overall Vanderbilt University Medical Center has reduced malpractice suits by 50% "during a time when we have more than doubled in size."

Slovis says in terms of the ED, changing culture and attitude "has got to be both bottom up and top down. You have to involve all members of the team: residents, attending faculty, nurses, and all your support staff." To involve them, you need to target each group in multiple ways, he suggests.

The groups are targeted through meetings, special presentations, and e-mail, and by having senior faculty and nurses model the behavior. Clovis confesses that early on in the process, he was teased for adopting specific phrases to say to the patient, such as "I'm closing the door for your privacy." He also says hello to everyone in the room and introduces himself to the patient. The primary item he emphasized was for the staff to think about how they would want a family member to be treated in an emergency.

"We made it very clear that we behave in a certain way, and if you don't, you are an outlier, and outliers need to have their actions and words corrected," says Slovis. Also, residents are evaluated on customer service, he says. "Part of the faculty bonus is based on customer satisfaction, and part of the nurses' evaluation is based on how patients perceive bedside care," he says. "We talk about it, teach it, measure it, and reward it."

Finally, Slovis says, whenever he receives patient comments that are positive, he removes all specific patient identifiers, and then an edited version is sent to the doctors or nurses involved. He compliments them and shares the information with the staff. "People look for compliments; they try and earn complements, and so more and more patients get better care," Slovis explains. "The more you say early on, the more this becomes ingrained and natural." ■

the hand. "Most practitioners cannot remember the names of the extensor tendons of the hand or how to examine each one," he explains. "You need something immediately available in case you have a laceration that requires tendon evaluation."

Once you have these tools, Sullivan says, you measure performance. "Until you show people how they are doing, they are never going to consistently change their behavior," he says. So, for example, in 2003, Sullivan's firm began working with one of the largest health care organizations in the United States, providing care for several million emergency patients per year. Initially the data showed that 19% patients with very abnormal vital signs were discharged home without a single repeat of the abnormal vital signs.

The practitioners were educated about the vital sign issue through web-based CME and CNE and then viewed their personal clinical performance through an audit provided by Sullivan's firm. Over time, the physicians and nurses altered their clinical practice and dramatically improved the vital sign issue and overall patient care.

"All it takes is letting doctors and nurses know a critical issue exists, and giving them something to help them at the point of care," Sullivan says. "We want to do a great job, but we need help at the point of care because we can't remember everything we need to." ■

Patient satisfaction is a best practice

'It's hard to hate someone who's been good to you.'

If ED physicians and nurses could choose only one strategy for avoiding lawsuits, it should be to keep patient satisfaction levels high, say several experts interviewed by *ED Management*.

CEP/MedAmerica, an Emeryville, CA-based provider

Executive Summary

There are several best practices ED physicians and nurses can adopt to minimize the likelihood of a lawsuit, but perhaps none is more important than ensuring high patient satisfaction scores.

- Research shows a definite correlation between increasing patient satisfaction and decreasing the medical malpractice frequency.
- Bad outcomes are more likely to lead to lawsuits if the patient doesn't like their doctor or nurse.
- Being attuned to patients and their perspective is one of the best ways to prevent complaints, which eventually can lead to lawsuits.

Nursing Best Practices Can Minimize Complaints

- **Acknowledge patients when they walk up to you.** (None of us likes to be ignored.)
- **Develop strategies to ensure that you are 100% present.** For example, as you enter the ED, remind yourself that no matter what is going on in your life, you must "leave it at the door." The patients and your colleagues need your full attention to keep everyone safe and free from errors.
- **Encourage open communications between all members of the care team.** Everyone should be encouraged to speak up if they identify a problem or potential issue.
- **Know the patient's plan.** Encourage physicians to communicate the full plan of care, allowing nurses to anticipate any problems and provide early warning about changes in condition.
- **Take care of yourself.** Get enough sleep, and eat properly; fatigue causes inattention.
- **Keep patients informed.** (None of us likes to be kept waiting without knowing the plan.) Touch base every 30 minutes at a minimum.
- **Be honest about wait times for labs or radiology.** This honesty helps manage patient expectations.
- **Show compassion.** No matter how frustrated, stressed, or distracted you are, smile, listen, and be respectful. Treat others like they were your children, spouse, parents, or dearest friends.
- **Conduct follow-up calls every shift.** Bring patients back if they aren't improving, and show you care.
- **Use thank-you cards or small tokens of appreciation for immediate service recovery.** (Some active hospitalwide service recovery programs have a small budget for giving staff access to the gift shop for small purchases.)

Source: Diana S. Contino, Deloitte Consulting, Los Angeles.

of ED management and staffing solutions, has conducted internal research regarding malpractice risk. "We track patient satisfaction, door-to-provider time, and medical malpractice cases per 20,000 visits," says **Martin E. Ogle**, MD, regional director for the southern division. "There is a definite correlation between increasing patient satisfaction and decreasing the medical malpractice frequency."

In fact, there is "almost a linear relationship between the highest and lowest levels of satisfaction," he says. "We've seen up to a threefold reduction in the number of claims over a million patient encounters," Ogle reports.

Gregory Henry, MD, FACEP, risk management consultant for Emergency Physicians Medical Group in Ann Arbor, MI, says, "It's hard to hate someone who's been good to you. The smart ED doctor understands you have to get very close to the family, particularly when things are going badly." He reports that as much as 50% of what he does is "schmoozing."

Corey M. Slovis, MD, FACEP, FACP, FAAEM, chair of emergency medicine at Vanderbilt University Medical Center in Nashville, TN, agrees. "For so long, older doctors — me included — thought the measure of our job was how smart we were, how expert we were in emergency care," he says. "I now have begun to appreciate that you have to layer on customer service and both perceived and delivered quality." In short, he says, delivering the right dose of the drug at the right time "does not make you a great ED doc."

Any patient can have a bad outcome, says **Tom Syzek**, MD, FACEP, MD, FACEP, director of risk management for Dayton, OH-based Premier Health Care Services. "Who gets sued? The doctors and nurses the patient does not like," he says.

The personal approach is no less important for nurses, adds **Diana S. Contino**, RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles. "One of the best ways to try to prevent complaints is to be very attuned to patients and their perspective," she says. Building personal skills that enable you to relate to patients helps you anticipate and avoid problems, she says. "The best way to do that is to constantly ask yourself why a person might be doing what they're doing and try to understand where the person is coming from," Contino notes. **(Contino, who says complaints can be the first step toward litigation, has a list of best practices for minimizing complaints. See the box, left.)**

Ogle says, "For me, it's also the simple stuff like being your optimized self; coming in well rested, focused; not taking calls from your broker; not texting and 'tweeting'; and focusing on your patients' needs. It's not rocket science, but I can't tell you how many times people have personal crises, and there is a real negative impact on their medical practice." ■

Seek out aids to risk prevention

ED managers should take advantage of the tools available to help them reduce the risk of lawsuits, says **Tom Syzek**, MD, FACEP, MD, FACEP, director of risk management for Dayton, OH-based Premier

Health Care Services.

"Identify the appropriate tools for paper or dictation templates, or, with emergence of electronic health records, work with vendors and select a system that not only optimizes billing and data capture, but has a built-in risk overlay: prompts, resources, and reminders that will appear at the bedside," Syzek advises. For example, if there are severely abnormal vital signs at the end of the encounter, a system "pop-up" should remind you not to let this patient go home unless you address those findings, he says.

In addition, you should include a performance improvement program as part of your risk management program, Syzek says. "Generally, that means some type of chart review, a chart audit system," he says. "Nurses, for example, should do triage audits, to ensure the proper triage levels are being assigned, since having a patient triaged to a lower acuity level than they merit could have adverse consequences. You could pick any piece of the ED process and build around it. For example, the whole department could do a stroke audit to see if documentation and clinical practice match up with established clinical guidelines." ■

Admit mistakes, show your concern

Honesty is often the best policy

ED experts agree that when patients feel they have been treated poorly, or that medical mistakes have been made, the most effective way of diffusing the situation and avoiding litigation is to listen carefully to the complaint, admit mistakes if they have been made, and then take concrete action to demonstrate your desire to prevent such mistakes in the future.

"Several medical malpractice citations suggest the frustration of the patient or family is often due not to the egregious behavior of the provider, but to the fact that they did not acknowledge [mistakes] or develop a plan of action, so could it not happen again," notes **Mike Williams**, MPA/HAS, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. He recalls an incident when a patient died at a hospital, and officials there not only acknowledged the hospital's role in the death, but put the mother of the patient on their quality improvement committee. It was cited as a best practice by the Boston-based Institute for Healthcare Improvement, Williams says. "[The hospital] did not brush the event aside, but made it central to their mission," he explains.

Executive Summary

Complaint management strategies and service recovery in particular, can be extremely effective in reducing the likelihood that a dissatisfied patient or family member will sue.

- Acknowledge your mistakes, and take concrete steps designed to ensure they will not be repeated. If possible, involve the patient or family member in the solution.
- Make sure the complaining individual realizes that you are listening to him or her and that what he or she says is important to you.
- Be proactive. If a patient appears unhappy, engage him or her in conversation and ask what's wrong.

Karen Erickson, JD, manager, claims and insurance, for Sharp Healthcare, a San Diego, CA-based health system, says, "If you do a really good job of managing complaints, the likelihood of litigation is small. Typically the patient says, 'I wasn't heard,' or 'My complaints were not appreciated,' especially in the ED where there are often so many people there, that patients feel they are not being paid attention to."

Gerald B. Hickson, MD, professor of pediatrics, associate dean of clinical affairs, and director of risk prevention at Vanderbilt University School of Medicine in Nashville, TN, agrees. "You have to listen, even if you fundamentally disagree," he says. "Listening is one of the great ways to show respect for others." Most of the people who complain are thoughtful individuals who want to use your services again, but just need to share their complaints, Hickson says.

Tom Syzek, MD, FACEP, director of risk management at Premier Health Care Services in Dayton, OH, says, "You have to teach and practice service recovery. If you see an unhappy patient, ask them, 'Is there is something more you thought I should be doing today? Is there a worry today you think I should address?'" Syzek advises that you ask such open-ended questions to keep the conversation going and to allow the perception that you care about the patient's key concerns. **(Sharp Healthcare uses patient advocates to handle service recovery. See the story, p. 117.)**

Service recovery must be a team effort, adds Hickson. "You need a team, including an advocate, whose sole role is to listen and respond," he shares. The rest of the team, he says, is "anyone who's down there," such as physicians and nurses. "They have to all take the same approach: 'Thank you for sharing that. I want to get your complaint to someone appointed by the organization, because your complaint is important to us and the

organization,'" Hickson says.

The bottom line is "to try and make right what they think is wrong," Hickson says. "So, for example, if they feel you did not handle their care properly, issue a personal apology."

At Sharp, apologies are handled on a case-by-case basis, according to Erickson. "We always encourage people to say, 'I'm sorry for what you've been through, or that things turned out differently than you expected them to,'" she says. "Sometimes the doctor or I will say, 'We did the wrong thing here, and you are entitled to compensation.'"

This response comes most often when a suit has been filed and the parties are in mediation. "I will bring someone from the hospital to say, 'I'm sorry this happened to you' — usually a nurse," says Erickson. (The physicians at Sharp are independent contractors and have separate counsel.) "This can diffuse the situation and often helps avoid a jury trial," she says.

While this apology occurs after a suit has been filed, and it costs the hospital compensation, "it still keeps expenses down because we do not have to pay a lawyer," Erickson explains. ■

Patient advocates are 'first line of defense'

Karen Erickson, JD, manager, claims and insurance, for Sharp Healthcare in San Diego, CA, believes that if patient complaints are handled well, the likelihood of litigation is small. In an effort to better address complaints, each Sharp facility has patient advocates whom she considers "the first line of defense in handling patient complaints."

The patient relations staff, which serve the ED as well as other departments in the hospital, "do a lot of mediating, interpreting, and facilitating," says Erickson. "They may, for example, go to an ED doctor or nurse and say, 'Jane Doe does not feel you spent enough time with her.'" Then, she says, the doctor or nurse can go to the patient and apologize.

"Since the ED is such a busy place, sometimes the problem will not get uncovered until the patient is gone, at which point the patient relations representative will tell the patient they will bring the problem to the people against whom the complaint is lodged and discuss it," says Erickson. "After they talk, they might get back to the patient and say, 'I talked to Nurse Smith about the complaint and made her aware of the problem.'" Depending on the complaint or situation, they might apologize to the patient or have the offending staff member apologize, if appropriate.

"Sometimes I've had to call a doctor and say, 'This issue is really with you; do you mind calling?' but that does not happen very often," Erickson notes. ■

Scribes, EMR please docs, save $600,000

New system a big selling point to attract physicians

Several EDs have introduced physician scribes to free up doctors to spend more time with their patients, but most of those departments use paper charting. At Tri-City Medical Center in Oceanside, CA, physician scribes work within the context of an electronic medical record (EMR). The approach has made a world of difference in terms of physician satisfaction, while generating financial savings of $600,000, says **Gene Ma**, MD, FACEP, chairman of the Department of Emergency Medicine and assistant clinical professor at the University of California San Diego School of Medicine. In addition, the department has seen a billing increase of 10% per provider per hour.

"I absolutely love it," Ma says. "We all had some hesitation at the very first, but a month into it, I couldn't take it away from the docs or they would rebel." Many physicians have said they enjoy practicing again, he says.

"It's a big selling point as well," Ma says. "We have a lot of applicants who want to come here because it's a workflow incentive, and all the part-time physicians fight to get shifts here."

Reid F. Conant, MD, FACEP, IT physician liaison

Executive Summary

The leaders of the ED at Tri-City Medical Center have come up with an initiative that has saved them $600,000, generated a billing increase of 10% per provider per hour, and won over physicians: using physician scribes in concert with their electronic medical record (EMR).

- It eliminates the concern that EMRs will slow them down. They have seen a 6.45% increase in productivity based on patients seen per hour.
- The physicians can focus on the bedside and look at the patient at the same time the scribe enters information into the electronic chart.
- Scribes prepare the discharge forms, including medication reconciliation, so they are ready for the doctor to sign.

at Tri-City Medical Center, says, "It makes me feel I'm providing more and better patient care. It gives a more personal experience to the patient and provides a better record." Conant also is chief medical information officer at Tri-City Emergency Medical Group and president of Conant and Associates, an independent IT consulting firm that also is based in Oceanside.

The new system has done more than win over the physicians, adds Ma. "We saved $600,000 in the first year by using scribes, and that was the most expensive year because of the training costs," he says. A quick look at how the system works makes it clear why it's both a staff pleaser and a performance improvement vehicle. "We think it eliminates concerns with EMR for the ED physicians who think it's not as quick as they'd like, because we take lot [of the work] out of the docs' hands so they can focus on the bedside and look at the patient at the same time the scribe enters the information," Ma explains.

The scribe, who stands in the back of the patient's room, grabs a small 'web tablet' when he or she sees the physician begin speaking to the patient. **(The tablets are from Research in Motion based in Waterloo, Ontario, Canada. For more information on how they are used, see the story, right.)** The physician calls out parts of the physical exam and medical history, and the scribe enters the information. "Then we go back to the work station, I do my CPOE [computerized physician order entry] while the scribe cleans up my history. Whatever I couldn't get from the patient, they will pull in from the medical history, enter all meds into the history, complete the physical, ask me if there's anything I want to change or adjust, and then we're ready for the new patient," says Ma.

With this system, Ma explains, the physician's workflow doesn't stop for charting. As soon as the chart is complete, the scribes remind the physicians about labs or X-rays that are back, notify the physicians when the disposition is ready, and enter the diagnosis. They also prepare the discharge forms, including medication reconciliation, so they are ready for the doctor to sign.

Conant appreciates how the system enables him to multitask. "If I'm in the middle of a busy shift, I may be seeing 10 or 12 patients at a time, and I struggle to keep my head above water," he says. "With the scribe, I can be on the phone with the consultant, have a discussion, hang up, and then say, 'It sounds like Dr. Smith wants to admit the patient.'" The scribe will note that and then document his discussion with the family. "It allows the doctor and scribe to work together in parallel and leverages those strengths," Conant says.

Ma says, "If you ask doctors what they dislike most about medicine, most will say paperwork. This makes it so seamless for us and puts the focus back on the patient."

Conant says productivity has increased dramatically. "The typical response in an ED with EMR is a 20%-30% drop [in productivity], but we've seen a 6.45% increase in productivity based on patients seen per hour," he notes. "And, we've seen a billing increase of 10% per provider hour."

In addition, he says, "We have more complete charts and more robust documentation that is more easily codable to an appropriate level." **(For more information on physician scribes, see "Expanded scribe role boosts staff morale," *ED Management,* July 2009, p. 75.)** ■

Sources

For more information on using scribes with an electronic medical record, contact:

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- **Gene Ma**, MD, FACEP, Chairman, Department of Emergency Medicine, Tri-City Medical Center, Oceanside, CA, Assistant Clinical Professor, University of California San Diego School of Medicine. Phone: (760) 940-3820.

Simple technology for complex work

Given the complex tasks of the physician scribes at Tri-City Medical Center in Oceanside, CA, you'd think that the technology they use to interface with the department's electronic medical record (EMR) from Cerner Systems would be anything but user-friendly. After all, the scribes use electronic tablets, go to the bedside with the doctor, and document everything in real time using their tablets in such a way that by the time the doctor walks out of the room, the history and physical are completed. The doctor then enters all their orders by computerized physician order entry (CPOE), while the scribe tidies the chart at the workstation, to which their tablet docks.

They pull in all the labs, imaging, and old studies that are pertinent. They can pull prior personal medical history and social history. They can document procedures done using the system templates, pull in discharge medications and discharge instructions, and by

the time the patient leaves, the chart is completed.

But the technology is "not difficult at all," according to **Reid F. Conant**, MD, FACEP, chief medical information officer at Tri-City Emergency Medical Group, IT physician liaison at Tri-City Medical Center, and president of Conant and Associates, an independent IT consulting firm also based in Oceanside. "It's very easy," he says. "The tablets have 12-inch screens. They're light and portable, and they can dock them at a desktop and type information using the keyboard."

The tablets are not expensive, adds **Gene Ma**, MD, FACEP, chairman of the Department of Emergency Medicine and assistant clinical professor at the University of California San Diego School of Medicine. "Although they are integrated with Cerner, we bought them separately from Research in Motion [based in Waterloo, Ontario, Canada], and they cost about $1,800-$2,000," says Ma. He has purchased enough to have one per scribe per shift, or six in all. However, he adds, "there are others you can get for less, including Dell's, which are about $1,200, so we may be switching."

The scribes' integration into the ED is eased by a six-week training program provided by Lancaster, CA-based Scribe America, which also handles the recruiting. "For us, it's pretty seamless," says Conant, who notes that the total cost of annual training is $350,000. However, he adds, "The cost of dictation was $2 million a year before we started [the scribe system]." After a six-week training program, the scribes go through a few shadow shifts where they follow other scribes, before they go live.

As for the scribes themselves, says Ma, he has no difficulty recruiting them. "We have pre-med students from all over the area eager to get on the waiting list to work in our setting, as they realize what a fantastic and unique opportunity it is to gain invaluable insight into the medical realm, and they love it," he says. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the **March** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME *questions*

1. According to Gerald B. Hickson, MD, professor of pediatrics, associate dean of clinical affairs, and director of risk prevention at Vanderbilt University School of Medicine, which of the following approaches are used by Vanderbilt University Medical Center to assess and mitigate risk in the ED?
   A. Comprehensive surveillance of how well the staff are listening.
   B. An active patient advocate ombudsman service.
   C. Vigorously addressing near-misses and adverse events.
   D. All of the above.
2. Tom Syzek, MD, FACEP, director of risk management for Premier Health Care Services, says that there are many steps ED managers can take even before risk assessment to lessen the chances the department will be sued. Which of the following was not included in his list of strategies?
   A. Reviewing candidates' qualifications and backgrounds and any history of complaints or litigations they may have.
   B. Conducting chart audits.
   C. Developing a culture about how the ED is going to handle risk.
   D. Creating an orientation manual that includes operational and risk-related items.
3. Corey M. Slovis, MD, FACEP, FACP, FAAEM, chair of emergency medicine at Vanderbilt University Medical Center, uses random surveys conducted by Professional Research Consultants to develop quality and satisfaction ratings for each staff members. Which of the

COMING IN FUTURE MONTHS

- ■ Study of voluntary diversion ban
- ■ Parking deck triage for disaster response
- ■ New patient screening program
- ■ How to cut your diversions to zero

following is *not* measured?

A. Quality of care.
B. Cleanliness.
C. How well physicians and nurses communicate.
D. Professionalism.

4. According to Gregory Henry, MD, FACEP, risk management consultant, Emergency Physicians Medical Group, Ann Arbor, MI, what percentage of his time on the job is spent "schmoozing" patients?

A. 50%
B. 40%
C. 30%.
D. 20%

5. According to Karen Erickson, JD, manager, claims and insurance, for Sharp Healthcare, the complaint management responsibilities of patient advocates include:

A. mediating.
B. interpreting.
C. facilitating.
D. All of the above

6. According to Gene Ma, MD, FACEP, chairman, Department of Emergency Medicine, Tri-City Medical Center, his physician scribes perform several functions while using the department's electronic medical record. Which function do they *not* perform?

A. Performing medication reconciliation.
B. Using computerized physician order entry (CPOE).
C. Completing patient histories.
D. Preparing discharge forms.

CNE/CME answers

1. D; 2. B; 3. C; 4. A; 5. D; 6. B.

Physician & PA Alert

Premier Health Care Services, Inc. May 2005

Monthly Physician & PA Alerts are intended to provide you with relevant and timely tips to reinforce excellent clinical care, reduce medical-legal risk, and improve customer service. Your feedback is welcome.

— Tom Syzek, MD, FACEP, Director, Risk Management

PATIENT TURNOVERS: TICKING TIME BOMBS

I call it the "Fred Flintstone Syndrome." At the end of a work shift, your replacement arrives, the clock strikes 5 p.m. (or 11 p.m., 7 a.m., whatever), the whistle blows, and the voice in your head screams "Yabba-Dabba-Do!" The temptation is give a 2-second report to your partner about the patients you are turning over, and get OTD, OTB, and HFH (out-the-door, on-the-bus, head-for-home). **STOP RIGHT THERE!** You and your partner have just entered one of the most dangerous areas in all of medicine – the "Change of Shift Transition Zone." One false move in this Zone and your turnover patients may suffer a preventable bad outcome, while you and your partner are transported to the next level – the Malpractice Zone.

Change of shift in the emergency department is a time of great potential danger to the patient and emergency practitioners. For the practitioner who is ending his shift, it can be difficult to effectively communicate to his partner all the details of a patient's workup, his medical reasoning, and working diagnosis. For the newly arrived practitioner, the temptation is to quickly label and disposition the turnover patients, and move on to the rack full of new patients to be seen. Patient safety can be ensured and conducting an orderly and careful process at the change of shift can minimize risk to practitioners.

TIPS FOR THE DEPARTING PRACTITIONER

1. Minimize the number of patient turnovers if at all possible.
2. Consider a period of staffing overlap to avoid turnovers and maximize communication.
3. Avoid turning over patients whose evaluation and ED course are highly complex.
4. Sometimes the best course of action is to stay and finish the difficult patient – regardless of compensation.
5. Consider making bedside "rounds" with your replacement and introduce him/her to your turnover patients.
6. Communicate the key details of each turnover patient to your partner; including at least the chief complaint, brief history and exam, diagnostic results ordered and pending, treatment provided, differential and working diagnoses, likely consults, and anticipated disposition.
7. Consider developing a template "change of shift" report on which you record these key details for each patient.
8. Tell the patient, patient's family, and the primary nurse you are leaving and who will be assuming care of the patient.

Side 1 of 2

9. Document your history, exam, test results, ED course, and medical reasoning up to the point of turnover.
10. Document who is assuming care of the patient, and the time of turnover.

TIPS FOR THE ONCOMING PRACTITIONER

1. Arrive a few minutes early to allow time for the turnover process.
2. Listen carefully and respectfully to your departing partner – you will have turnovers also!
3. Accept the fact that you are now the practitioner of record, responsible for completing the patient encounter.
4. Mark the patient tracking board to reflect that you are now the responsible practitioner.
5. As soon as feasible, introduce yourself to each turnover patient and family, informing them that you are now the practitioner responsible for their care.
6. On each turnover patient, take a history and perform an exam sufficient for you to be comfortable that you know each patient.
7. Avoid tunnel vision – use an open mind and high index of suspicion to form a differential diagnosis for each patient based on your own observations.
8. Follow up on the result of EVERY test ordered by you AND your departed partner.
9. Document your own evaluation, test results, medical reasoning, and disposition plan for each patient.

A poorly conducted "change of shift" process can result in patients being forgotten and delays in evaluation, diagnosis, treatment, and disposition. A cavalier attitude by either the departing or oncoming practitioner can contribute to patient dissatisfaction, bad outcomes, and malpractice litigation. An orderly, systematic, well-documented process results in improved patient safety and reduced liability. Remember that turnover patients are ticking time bombs – they must be handled with great care to prevent disaster.

Source: Premier Health Care Services, Dayton, OH.

With HIN1 vaccine shortage expected, highest-risk groups go to front of line

Who is at risk for serious infections and why?

By **Gary Evans**
Senior Managing Editor
Hospital Infection Control & Prevention

With a vaccine shortage projected for novel H1N1 influenza A, only the highest priority groups are likely to be offered the shot when initial lots are cleared for distribution this fall. These groups include critical support personnel such as health care workers, as well as people at risk of severe complications if infected: pregnant women, young children, and those ages 5 to 18 with chronic medical conditions.

Time is of the essence. The estimated mid-October initial vaccine release date is expected to coincide with a resurging wave of the first pandemic flu virus in 41 years. "There is a lot of circulating H1N1 virus in the Southern Hemisphere right now causing a lot of trouble," says **Donald Kennedy**, MD, a professor of infectious diseases who is running clinical trials on the H1N1 vaccine at St. Louis University. "The anticipation is that this is coming back."

Donald Kennedy

A wider risk pool of H1N1 vaccinees was initially identified, but public health officials are now expected to target the highest-risk groups because there will be considerably fewer doses than the 120 million originally projected.

"It appears we are going to have about half [of what was estimated]," Kennedy says. "The second half is going to take longer to manufacture. It may not be until December or later and that's a problem."

Public health officials estimate that up to 195 million doses may be distributed incrementally by the end of 2009. However, with two doses required per vaccinee, many people will remain at risk if H1N1 spreads as widely as anticipated. In particular, the immunocompromised still could be in jeopardy even if vaccinated. No vaccine is 100% effective in any case, but they may also struggle to mount an immune response. That essentially means that the people at risk for H1N1 complications also warrant immediate consideration for antiviral treatment if symptomatic. Though it was unclear which group would be at the absolute front of the line, the people cited by the Centers for Disease Control and Prevention to receive H1N1 vaccine during a shortage are detailed as follows:

• Health care and emergency services personnel with direct patient contact

Frontline health care workers are a high priority because immunization will protect both them and patients, particularly those with underlying conditions. In a case that set an ominous tone for the resurging pandemic, a healthy 51-year-old oncology nurse who worked in Carmichael, CA, died in July of a coinfection with H1N1 influenza A and methicillin-resistant *Staphylococcus aureus* (MRSA). With MRSA endemic in many hospitals, this deadly bacterial-viral coinfection may hit other health care workers as the pandemic unfolds. In general, older people seem to have some residual immunity to H1N1, so younger health care workers may be at more risk of infection. There are concerns about maintaining adequate staffing to deal with a pandemic if health care workers are infected, or for that matter, not offered the vaccine. "I don't want to come to work and take care of an H1N1 patient if I am not vaccinated against H1N1," Kennedy says.

• Pregnant women

Historically at risk of flu infection, pregnant women appear to be highly vulnerable to H1N1 infection. "The highest-priority message is to treat pregnant women with influenza-like illness as soon as possible; treatment should not be withheld pending results of testing for influenza,

Supplement to *AIDS Alert, Alternative Medicine Alert, Critical Care Alert, Clinical Trials Administrator, Contraceptive Technology Update, Case Management Advisor, Drug Formulary Review, ED Nursing, ED Management, ED Legal Letter, Emergency Medicine Reports, Hospital Employee Health, Hospital Infection Control & Prevention, Hospital Case Management, Hospital Peer Review, Hospital Medicine Alert, Hospital Home Health, Healthcare Risk Management, Internal Medicine Alert, Infectious Disease Alert, IRB Advisor, Medical Ethics Advisor, OB-GYN Clinical Alert, Occupational Health Management, Patient Education Management, Primary Care Reports, Pediatric Medicine Reports, Practical Summaries in Acute Care, Same-Day Surgery, State Health Watch,* and *Travel Medicine Advisor.*

if testing is done," the CDC reports on its H1N1 web site. An excess of influenza-associated deaths among pregnant women was reported during the pandemics of 1918-1919 and 1957-1958. Adverse pregnancy outcomes have likewise been reported following previous influenza pandemics, with increased rates of spontaneous abortion and preterm birth, especially among women with pneumonia, according to the CDC.

The reasons pregnant women are so vulnerable are not completely understood, but prevailing theories include some compromise of the immune system, Kennedy says. "This is an observed phenomenon — when pregnant women get the flu, they get it bad," he says. "They can have a lot more morbidity and mortality compared to age-matched controls that were not pregnant."

• People who live with or care for children younger than 6 months of age

"When a child is born the only immunity he has is what is passed from the mother at the time of birth," Kennedy notes. Of course, if the mother has been immunized during pregnancy, some residual protection against H1N1 may occur in the infant. In general, however, unless their caregivers are immunized, infants with fledgling immune systems could be infected with H1N1. Safety concerns trump risk in terms of actually vaccinating babies, who may not have an immune response to the shot anyway, he adds.

• Children 6 months through 4 years of age

This group is expected to be able to achieve immunity, though the six-month cut point is somewhat arbitrary. "The older they get, the better they respond to protective immunity," Kennedy says. Some think this group and possibly older children may be particularly prioritized because children do not generally practice hygiene etiquette and are robust viral shedders when infected. Thus, immunizing children could have the secondary effect of protecting their adult contacts.

• Children 5 through 18 years of age who have chronic medical conditions

"People with underlying medical conditions — diabetes and renal failure, etc. — their immune systems are not normal," Kennedy says. "When they get flu infections they tend to be more severe. If you're going to target a protective strategy with limited resources you are going to be looking at who is likely to get [HIN1], but also who is going to do poorly if and when they get it."

According to the CDC, underlying conditions that could complicate H1N1 infection in all age groups include cancer, blood disorders (including sickle cell disease), chronic lung disease [including asthma or chronic obstructive pulmonary disease (COPD)], heart disease, kidney disorders, liver disorders, neurological disorders (including nervous system, brain, or spinal cord), neuromuscular disorders (including muscular dystrophy and multiple sclerosis), and people with weakened immune systems (including people with AIDS or those who are receiving chemotherapy).[1]

CDC recommendations for people with chronic conditions during the pandemic include:

— Seek medical attention if you have a fever and symptoms of the flu.

— Limit contact with crowds and avoid crowded places. If you can't avoid crowded settings, consider wearing a facemask or respirator to decrease your chances of getting infected.

— Be careful not to touch your face, and wash your hands often.

— It is estimated that staying at least 6 feet away from a person who sneezes or coughs may be a safe distance.

— Talk with your doctor about having a two-week supply of medication.

— Keep the name, phone number, and office address of your doctor or health care provider with you at all times. Find out the best way to communicate with your doctor.

— Get a written record of the kind of chronic disease(s) you have and the treatment you are receiving. Keep this information with you at all times.

— Prepare a typed or printed list of all medications usually taken and the times of day they are taken. Also include necessary medical supplies or equipment such as syringes, strips, lancets (if you have diabetes), or oxygen (if you have COPD).

— Determine how you will access ongoing medical care such as chemotherapy or radiation therapy. Ask your health care provider if they have a plan to deal with a severe flu outbreak.

— If you use medications for your condition, continue taking them even if you become sick with the flu, unless your doctor or health care provider says otherwise.

— Be alert to changes in your breathing, especially if you have heart failure, congestive heart disease, or COPD. Promptly report changes to your doctor or health care provider.

Reference

1. CDC. Information about the Flu — including the new H1N1 Flu — for People with Certain Medical Conditions. Available at: http://www.cdc.gov/flu/professionals/flugallery/2009-10/pdf/certain_medical.pdf. ■