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Fifth wrong-site surgery brings harsh penalties, scrutiny

Hospital must install surveillance cameras in OR

When the same "never event" happens five times in two years at the same hospital, something is terribly wrong. Risk managers and patient safety experts are aghast at the reports coming from Rhode Island's largest hospital and wondering what it means about the culture of that institution and the state of patient safety efforts across the country.

But at the same time, they are sympathetic to the challenges facing Rhode Island Hospital, the teaching hospital for Brown University's Alpert Medical School in Providence. The hospital is facing unprecedented sanctions from the state health department after admitting to its fifth wrong-site surgery since 2007.

State health director **David Gifford** recently announced that the hospital had agreed to unusually strict oversight after a wrong-site surgery involving hand surgery. That incident occurred in October 2009, with a patient who was scheduled to have surgery on two fingers. Instead, the surgeon performed both operations on the same finger. Gifford says the surgery site was not marked, and the surgical team did not take a timeout to ensure it was operating on the right patient, the right part of the patient's body, and doing the correct procedure.

According to Gifford, the surgical team marked the wrist, rather than

EXECUTIVE SUMMARY

A Rhode Island hospital recently reported its fifth wrong-site surgery in two years, bringing attention to the issue of never events and patient safety. The hospital is facing unusual sanctions from the government.

- The hospital already was working to prevent wrong-site errors.
- A compliance order requires video surveillance of surgeons.
- The failure to stop for a timeout is cited as a key problem.

each finger, and the surgeon did not mark the site himself.

After completing the first procedure, the team did not take a timeout before the second surgery and mistakenly performed it on the same finger as the first. (The hospital has released few details about the exact nature of the mistake, but some news reports indicated that the second procedure was done on the correct hand and finger but the wrong joint.) When the team discovered the error, they asked the patient's family whether they should go ahead and perform the surgery on the correct site.

The family said yes, and the surgical team proceeded. But amazingly, Gifford says, the team still did not do a timeout before proceeding with the third procedure, which was completed on the correct finger.

The October 2009 incident was the fifth to happen at the same hospital in two years. The state fined Rhode Island Hospital $50,000 after neurosurgeons operated on the wrong part of patients' heads on three occasions in 2007, and there was a fourth wrong-site surgery that has been acknowledged but not described by the hospital. The Joint Commission estimates that wrong-site, wrong-side, and wrong-patient procedures occur more than 40 times every week in the United States. **(See p. 4 for another recent incident.)**

When the hand surgery error was reported, Rhode Island Hospital CEO **Timothy Babineau** issued a statement saying the hospital is conducting "a thorough analysis" of what went wrong. "Thus far, we have identified an ambiguity in the timeout process for hand surgery when more than one procedure is being performed, which may have contributed to the error," he wrote.

Hospital officials declined a request from *Healthcare Risk Management* for further comment. **(See p. 4 for more on the hospital's ongoing effort to improve surgical protocols.)**

The health department responded to the fifth wrong-site surgery by imposing a $150,000 fine and requirements intended to prevent a sixth from ever happening. A compliance order from the department requires Rhode Island Hospital to assign a clinical employee who is not part of the surgical team to observe all surgeries at the hospital for at least one year. That person will monitor whether doctors are marking the site to be operated on and taking a timeout before operating to ensure they're operating on the proper body part.

The order also requires the surgeon to be involved in marking the surgical site, which already is recommended by patient safety protocols. The state also gave the hospital 45 days to install video and audio recording equipment in all its operating rooms. The cameras do not have to record every surgery, but each doctor must be taped performing

Correction

In the December 2009 issue of *Healthcare Risk Management*, the name of the CEO of The Graham Company in Philadelphia was incorrect. The chairman of the board/chief executive officer is William A. "Bill" Graham IV, CPCU, CLU. ■

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surgery at least twice every year. The hospital can decide whether to tell surgeons when the cameras are recording, but it will obtain permission from patients or their families.

In a press conference regarding the sanctions, Gifford said he had never heard of such requirements, but that they were necessary in this case.

"Clearly, there's a culture of making mistakes, so if they're hesitant to have someone to look over their shoulder, that says to me that we're doing the right thing," he said.

Repeated never events should prompt a review of the hospital's culture, says **Georgene Saliba**, RN, HRM, CPHRM, FASHRM, administrator for claims and risk management at Lehigh Valley Hospital & Health Network in Allentown, PA, and 2009 president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. She wonders what the string of errors might suggest regarding the culture at Rhode Island Hospital, particularly whether patient safety protocols are truly valued vs. being seen as just window dressing, and whether staff feel empowered to speak up.

"We have the Universal Protocol, and we can use the aviation model with the checklists; but people have to be engaged in the checklists," she says. "We can give them the tools and the processes, but they have to actually do it. They can't just go through the motions."

Saliba says she is particularly troubled by the reports that there was no timeout before the hand procedures, because the timeout is the final opportunity to catch any errors that might have crept in earlier.

"That's the last time you can catch something that might have been missed at 16 other steps along the way," Saliba say. "You absolutely cannot skip this final, crucial step, where you have a last chance to catch a problem before it becomes a serious, possibly tragic mistake. You should have a culture in which no one in that OR would ever allow you to skip that step, a culture in which you'd have a chorus of voices piping up to stop that procedure, because you didn't do a timeout."

Most never events are tied to a breakdown in communication, she says.

"We have to be a team. Without that team approach, there will be a break in process, and errors will occur," she says. "And you have to have a culture with a 'stop-the-line' mentality, where people will speak up even if the surgeon is the biggest surgeon who brings in the most revenue. Even if he huffs and puffs and blows your house down, you have to be willing to stop that procedure."

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The negative publicity from not just one never event, but a string of incidents, can be crippling, says **Don Hannaford**, senior vice president of Levick Strategic Communications, in Washington, DC, who has extensive experience as a crisis management counselor for health care providers. In this respect, he says, Rhode Island hospital is doing the right thing by publicly acknowledging the incident and not trying to make excuses.

The best approach is to admit that it happened. You never increase the patient's comfort that it is unlikely to happen in the future if you don't acknowledge something that clearly happened in the past, Hannaford says.

The hospital also must go along with the state's corrective action with no complaints, he advises.

"Rhode Island Hospital has to take their medicine, with the video cameras and the other requirements. And they have to tell their doctors to shut up and stop acting like whining brats who don't want Big Brother looking over their shoulders. They deserve to have Big Brother looking over their shoulders because they [made significant errors] five times in two years," Hannaford says.

The unusual and extensive sanctions actually can work in the hospital's favor, he says. After such an egregious error, it is not enough to say that you already had the right policies and procedures in place and admit that you did not follow them. To make amends and promote confidence, the provider must take additional steps beyond whatever precautions already were in place — even if those existing precautions should have been adequate.

The only exception would be if the hospital were willing to fire the one person who violated policy, Hannaford says. But that would only work when the error can be pinned on an individual, and the incident happened once. After five never events, even the general public gets the idea that there is

some sort of systemic problem.

"You must do something more to show that there is heightened attention," he says. "That could be an extra step, an additional person, some additional measure. You can't just say you had all the right policies in place and you didn't follow them, but you promise you will next time. That doesn't inspire confidence in anybody." ■

Hospital already was trying to prevent errors

Ironically, the fifth wrong-site surgery occurred at Rhode Island Hospital as it continues working with The Joint Commission's Center for Transforming Healthcare on improving surgical protocols. The hospital volunteered for the project to improve the safeguards to prevent patients from undergoing wrong-site, wrong-side, and wrong-patient surgical procedures.

Rhode Island Hospital CEO **Timothy Babineau** said the hospital has put "a tremendous amount of work" into error prevention after the string of embarrassing wrong-site surgeries, which included participating in the national pilot program to prevent surgical errors. In June 2009, the Hospital Association of Rhode Island announced that all hospitals and surgical centers in the state had agreed to follow the same process to prevent surgical errors, making Rhode Island the first state in which a uniform protocol was voluntarily adopted by all surgical providers.

"This error reminds us of the extraordinary complexity and difficulties in preventing medical errors — particularly wrong-site surgery," Babineau said.

The Joint Commission project is addressing the problem of wrong-site surgery using Robust Process Improvement (RPI), a systematic and data-driven, problem-solving methodology. RPI incorporates specific tools and methods from Lean Six Sigma and change management methodologies. The project team includes hospital leadership, surgeons, operating room staff, and physicians from Rhode Island Hospital and a team from the center that is expert in RPI.

The Joint Commission Center for Transforming Healthcare recently developed and recommended solutions that are designed to reduce the risk of wrong-site surgery at Rhode Island Hospital. The solutions include:

- Check and verify documents at the time of scheduling a procedure.
- Surgeon to mark the correct surgical site in the preoperative area.
- Point to the surgical site during the timeout.
- Streamline paperwork to further decrease distractions.
- Define the roles and responsibilities of team members for conducting preoperative marking, identification, and timeout.
- Empower everyone on the team to stop the process if there are any concerns.

These solutions are focused on caregivers being in the right roles and performing the right tasks. The solutions also build on The Joint Commission's Universal Protocol. Rhode Island Hospital will be testing these solutions over the next few months, according to The Joint Commission.

Patient safety experts also urge hospitals to involve the patient and family members in efforts to avoid wrong-site surgery. **Martine Ehrenclou**, author of *Critical Conditions . . . The Essential Hospital Guide to Get Your Loved One Out Alive*, notes that there is a growing trend for health providers to actively encourage family members to act as an advocate for the patient who is going to have surgery.

"The family member can ask the surgeon, anesthesiologist, or nurse to verbally repeat exactly which site is to be operated on and request that it be marked there and then," she says. "If no family member is available, the patient can also mark the surgery site on his or her body before entering the operating room. Hospitalized patients need watchdogs. What better watchdog than a family member who has a personal vested interest in the safety of the patient?" ■

SOURCE

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CT scan of pregnant woman after ID error

The string of wrong-site errors at Rhode Island hospital may be attention-getting, but the

SOURCE

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hospital is not the only one experiencing this never event. An identification error led to a pregnant woman undergoing a CT scan intended for another patient at Banner Thunderbird Medical Center in Glendale, AZ, which is now prompting litigation.

Kerry Higuera of Peoria, AZ, was three months pregnant when she experienced bleeding and sought care at the hospital's emergency department in February 2008, according to her attorney, **David Patton**, JD, of Scottsdale, AZ. Higuera says she was told to wait in a room until a nurse came for her, and then a nurse came and told her the doctor wanted a CT scan. The woman questioned whether that was correct, but the nurse repeated that the doctor wanted a CT scan of the abdomen and pelvis, Patton says. She underwent the CT scan.

An hour later, she was visited by the emergency physician, two radiologists, and a hospital administrator who told her, "We made a mistake. We did something we shouldn't have done," according to Patton. The clinicians and administrator explained to Higuera that the CT scan was intended for another patient of the same age and also named Kerry, Patton says. The hospital staff did not confirm the patient's identity with other identifiers such as birth date or case number, he says.

The emergency physician, who happened also to be pregnant, cried as she explained that the baby could suffer mental retardation, growth problems, or a low IQ because of the radiation exposure in the first trimester, Patton says.

"The hospital offered her coupons for the cafeteria and asked what kind of flowers she liked so they could send flowers to her home," Patton says. "Other than that, there has been no effort to correct this. We offered to settle very early after the incident, but the hospital declined."

The child is being watched closely by pediatricians, and Patton says he is showing some signs of the damage that can come from radiation exposure, including a small head circumference.

"We are monitoring all the potential ways that radiation exposure in the first trimester can manifest itself, and based on what we're seeing, we expect to pursue litigation in early 2010, possibly as early as January," he says.

Bill Byron, senior director of public relations and online services for Banner Health, the parent company of the hospital, tells *Healthcare Risk Management* that because Higuera is represented by legal counsel and appears to be moving toward litigation, Banner Health is unable to provide any comment. ■

Avoid being drawn into billing fraud

It is challenging enough to ensure compliance with Medicare billing rules within your own organization, but don't forget that you also can be drawn into someone else's scam. Federal authorities are cracking down on billing fraud that originates outside your hospital, and if you aren't careful, you can be caught up in the prosecution, with all the attached liability.

Just recently the U.S. Attorney's Office in Los Angeles charged 20 people with fraudulent Medicare billing in seven cases that totaled $26 million in unneeded or undelivered medical equipment, the result of a joint investigation by the FBI, the U.S. Department of Health and Human Services (HHS) and the California Attorney General's office. One 30-year-old man from Long Beach was arrested for allegedly recruiting relatives and members of the Brook Street Gang, based in Santa Ana, to act as owners for fake medical supply companies, which billed Medicare $11.2 million for unneeded wheelchairs and equipment. In another case, the owners and employees of four medical suppliers, who live in Inglewood,

EXECUTIVE SUMMARY

Health care providers can be drawn unwittingly into fraudulent Medicare billing schemes, with significant liability. Risk managers must take the necessary steps to screen for fraudulent billing and avoid any questionable relationships.
- Providers can be liable for vendor-generated fraud.
- The appearance of impropriety can be costly, even if no fraud is proven.
- Many scams can be detected with a simple visit to the vendor's work site.

Los Angeles, the San Fernando Valley, and Las Vegas, were arrested for allegedly billing Medicare more than $12 million for equipment that either was given to people who did not need it, never supplied, or billed on behalf of dead patients.

Such brazen fraud likely would not go unnoticed by a risk manager if it originated within the organization, but it still is possible to get involved in these schemes unless you take the right precautions, says **Brian D. Roark**, JD, an attorney with the law firm of Bass, Berry and Sims in Nashville, TN.

"On the criminal side, the federal government is devoting significant resources to prosecuting street-level fraud cases where Medicare or Medicaid is billed for services not rendered, such as individuals setting up fake medical supply companies," he says. "Additionally, the government is employing increasingly sophisticated investigative techniques to spot fraud, such as using data mining to find aberrations in claims-filing patterns and using pre-payment claims editing to compare new claims to previous claims and detect fraud in almost real time. Some of the primary areas of focus by the government are on durable medical equipment [DME], prosthetics, orthotics and supplies, home health agencies, and infusion therapy."

Roark also points out that the Fraud Enforcement and Recovery Act of 2009 (FERA) made significant amendments to the False Claims Act (FCA), which is the primary civil enforcement tool for health care fraud. The result of the FERA amendments was to expand liability under the FCA, take away certain defenses previously available to defendants, make it easier for the government to share information with *qui tam* whistle-blower plaintiffs, and expand whistle-blower protections. **(See p. 8 for more on FERA.)**

"The FERA amendments likely will increase the number of FCA lawsuits brought against health care providers," Roark says.

Roark says a key way to avoid involvement in such fraud is to make compliance the responsibility of the entire organization and provide mechanisms for employees to raise any compliance concerns.

Fraud cases of all types are on the rise because of the economic turndown, says **Frank Pinder**, president, Fraud & SIU Services, GlobalOptions Group Inc., an investor relations firm in New York City. When times are tough, people look for any way to keep the cash flowing, and that means more scams.

"The number of fraud cases has dramatically increased. Risk managers in this environment have to be very proactive in detecting fraud," Pinder says. "You have to be, because everyone who is dishonest is trying to figure out ways to scam the system."

Even the appearance of fraud can be costly, says attorney **Alan Lambert**, MD, JD, an attorney in the New York City office of the law firm Butzel Long. Once impropriety is alleged, the provider may have to bring in outside auditors and legal counsel, with the meter running.

"While you may wind up with a satisfactory outcome, it can be a tremendous cost to your institution and your reputation, even if you did nothing wrong," he says. "So, it is important to remember that it is not enough to stay away from outright fraud. You need to steer clear of situations that, while not fraudulent, are close enough or create suspicions that could lead to an investigation somewhere down the line."

Lambert cautions against the mistaken notion that the health care provider won't be liable for an outside vendor's fraud as long as you were dealing with that vendor in good faith.

"In fact, the government sees the provider as the originator of a Medicare or Medicaid claim and therefore responsible, at least to some degree, for what happens afterward," Lambert says. "They are, in fact, responsible for what happens with other links in the chain, with regard to fraud or the appearance of impropriety."

Pinder says auditing and oversight from outside auditors can detect what amounts to obvious fraud, once someone actually takes the time to look. For instance, he says health care providers can become the victims of scam artists who bill for fraudulent treatment of workers' comp patients.

"We would send an investigator out to the clinic to see that the vendor is what they say they are,

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that the equipment supposedly used on this patient actually exists," Pinder says. "Then, we would interview the actual patient to make sure they were really treated with that piece of equipment. Risk managers can do the same sort of facility inspection, whether it is a clinic or a DME vendor."

Be on the lookout for the hallmarks of a scammer's way of business. If the business address is a post office box, proceed cautiously. DME vendors are required to have a showroom in which all its products are on display, so a risk manager can send an investigator over to verify that the equipment exists and that the business appears legitimate, Pinder says. **(See article, right, for more on vetting vendors.)**

"That may take an hour of time and a couple hundred dollars, but it can save you a tremendous amount of money on the back end," he says. "When your investigator gets there and finds an empty warehouse, you know right away that you've got a scam. A legitimate operation will have no problem showing you around, showing you its records for shipping equipment to a particular patient. If a company balks at showing you that documentation, you need to stop all transactions and assume it's a fraudulent [company] until they prove otherwise."

Health providers can avoid some types of patient fraud through address/phone/name matching and running patient identifiers against the Social Security Administration's Death Master File, says **Christopher Chenoweth**, chief information officer and founder of CDYNE Corp. in Chesapeake, VA, which provides information technology services.

"There are web services that can be implemented by IT personnel directly into the patient management system, so that when patients are processed initially — or sign in to view health records online — their information can be compared to the Death Master File to weed out deceased-person identity theft, and reverse lookups can be performed instantaneously in real time by phone and address for verification."

Lambert also recommends being on the lookout for situations in which one employee at your institution oversees a significant revenue stream with an outside vendor.

"If you have a multimillion-dollar revenue cycle dealing with ordering supplies, for instance, you want to make sure it's not just one employee involved from beginning to end and who can engage in some kind of corrupt practice," Lambert says. "With others involved, the fraud becomes more difficult, as they would have to co-opt others into the scheme. And that oversight should feed back into the compliance program and the whistle-blower hotline." ■

Vet vendors, watch out for fraud warnings

Risk managers are obligated to take the proper steps to detect fraudulent activity and to avoid becoming a naive conspirator, says **Steve Lee**, an investigator with Steve Lee & Associates, a forensic accounting and litigation consulting firm in Los Angeles. He has consulted on a number of high-profile fraud cases and says risk managers can reduce their vulnerability to billing scams with a few simple precautions.

But not enough do.

"Most hospitals, including the big research hospitals, fail miserably when it comes to having the controls in place that can spot this kind of fraud and keep you out of it before it's too late," Lee says. "If you were to pick up their audit reports, there typically are paragraphs describing all the failures to have controls in IT, invoicing, purchase orders — all the areas subject to fraud. That's what fraudsters look for. They exploit those gaps."

Much of the defense involves checking out the other party that you will be doing business with, reviewing documents, and even the physical facilities to make sure that the business is what it says it is.

"You need to bring the same kind of skepticism that auditors rely on," Lee says. "Don't assume that anything is true or that it is reasonable. Use a critical eye."

That means looking for red flags such as duplicate bills and documents, records that appear to be the same except for changing the patient's name, or durable medical equipment (DME) that is associated with no freight charges.

"You'd be surprised at how many invoices pass through a provider for DME with no reasonable freight charge," he says. "It's very rare for risk managers to step back and question the good deal you're getting from a vendor and ask why it is so cheap. If you have a vendor who is offering something that is way out of the cost range quoted by other vendors, that should make you very suspicious."

Some precautionary steps are easy and free, such as checking with the Better Business Bureau

SOURCE

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(BBB). The vendor need not be a member of the BBB necessarily, but a score lower than a B- might raise suspicions, and the lack of any rating would be cause for worry. Also, checking the vendor's web site can be helpful, Lee says. If it provides no physical address, or contact is difficult, it could be a fly-by-night outfit.

Also, most states offer business information through the Secretary of State's office that can reveal the basic background of the company, such as the incorporation date and who the officers are.

"All this requires is time," Lee says. "It is basic diligence in terms of vetting a vendor, but it can be difficult, because you're taking people whose core job is moving paper and moving it as fast as possible, and now you're asking them to apply some skepticism to what they're seeing."

Lee also recommends establishing a fraud hotline through which employees and consumers can alert you to any concerns about impropriety. The difficulty here is maintaining vigilance with the hotline, Lee says.

"Just because Old Man Meyers has called six times and he's been wrong each time doesn't mean the seventh time he's automatically wrong," he says. "Maybe he sees black helicopters following him all the time, but the seventh time he's run into a crooked wheelchair provider who's trying to get him into some crooked deal." ■

Qui tam changes may bring more fraud suits

As if the False Claims Act (FCA) wasn't already enough of a headache for risk managers, recent changes to the law could bring even more reason to worry. Risk managers should be aware of how the Fraud Enforcement and Recovery Act of 2009 (FERA) will affect them, says **Richard Glovsky**, JD, a partner with the Boston-based law firm Prince Lobel.

The message for risk managers is clear, Glovsky says: Whatever you were doing in regard to the FCA before is not enough. You have to step up your game.

FERA brought important changes to the FCA, the primary civil enforcement tool for health care fraud and the source of *qui tam* whistle-blower plaintiffs. The FERA amendments expand liability under the FCA and may make it more difficult to defend some cases, Glovsky says.

Some of the provisions are retroactive, and the amendments provide more resources for the Department of Justice to pursue fraud cases. That means risk managers can expect more enforcement efforts in the coming year.

"In a down economy, the government is looking for new ways to bring in money, just like everyone else. Finding more of those who are defrauding government is a popular way to do it," he says. "Given the limited tax dollars, the government is providing prosecutors with more resources and telling them to go find more false claims."

Glovsky cites one part of FERA called the "Reverse False Claims Act" as particularly worrisome for risk managers. Under this new provision, if you recognize that you were overpaid by the government, even through no fault of your own, you must return the excess funds, and will face penalties and criminal prosecution if you don't. That means the provider is obligated to recognize that the government made a mistake and overpaid; even if the fault lies entirely with the government, it is the health care provider's responsibility to find the error and rectify it. By creating the obligation for the health care provider to act affirmatively, this puts an onus on health care providers that did not exist before, Glovsky says.

In response to FERA, Glovsky says risk managers must ensure their revenue systems are set up in such a way as to flag overpayments.

"It is no revelation to say that the federal government occasionally makes mistakes, but now if Uncle Sam errs and you don't catch it, you could conceivably have exposure," Glovsky says. "It looks like the government is going to take these issues very seriously and delegate substantial authority to the attorney general's office to deal with them."

In particular, the government has broadened civil investigatory demands, a tool whereby prosecutors can request documents, interrogatories, and testimony to facilitate FCA investigations.

The revisions also mean that the government no longer needs to show intent on the part of the health care provider to prove fraud, Glovsky says. Now, the government only needs to show that the

SOURCE

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provider was reckless or deliberately indifferent — such as might be the case if a provider dealt with a fraudulent durable medical equipment supplier without properly investigating the company up front.

"There is a lot more muscle to this law now," Glovsky says. "I suspect that on the law enforcement side, there will be more vigor in pursuing these cases." ■

Lean management can work to risk manager's favor

Lean management is a big trend in the business world these days, including the health care arena, but risk managers may assume that the "lean" is all about budget cutting and belt tightening. Not at all, say the experts in this strategy and the health care providers who are using it.

Lean is not a "budget-cutting" or "cost-cutting" program, explains **Mark Graban**, a senior fellow with the Lean Enterprise Institute in Cambridge, MA.

"Lean is really a quality improvement methodology that also leads to lower costs. From a risk management standpoint, it's important to note that patient safety can be dramatically improved with lean methods — preventing patient falls, infections, and other adverse events," Graban says. "That's the real power of lean."

Rather than being something to dread, lean management actually can be an asset to a risk management program, says **Marc Hafer**, CEO of Simpler, a consulting firm based in Ottumwa, IA, that teaches business strategies to health providers. Hospitals can see powerful transformations if they teach their managers and employees how to see and eliminate waste in everything they do, he says.

Hafer explains that lean is a management approach that enables the true performance potential of a business, like a hospital, or a process, like admitting patients, to be realized. The concept of lean management was developed by the auto manufacturer Toyota in its Toyota Product System that used lean principles throughout the enterprise to produce products at lower volumes with fewer defects. In practice, lean management achieves this through the fundamental applications of various tools that help employees see and eliminate waste.

So, how is delivering health care like manufacturing Toyotas? Hafer explains that any process, whether it is treating patients or building cars, is susceptible to eight common forms of waste that are often roadblocks to optimizing a process:

1. Overproducing: Making or spending too much time on something that doesn't add value to the customer.

2. Waiting: Idle time when no value is being added to a process.

3. Transportation: Delays in moving materials or unnecessary handling of patients, staff, or materials.

4. Inventory: Capital investments, stock, or corresponding control systems that do not yield profits.

5. Unnecessary Motions: Movement of people or equipment that do not add value to a process.

6. Processing Waste: Work carried out on the wrong machines or work that was the wrong procedure.

7. Defects: Wasted effort on inspection or work that was already done.

8. Unused Human Potential: Using problem-solving skills that do not add value to the patient or staff.

Hafer points out that a lean management approach can dovetail nicely with risk management efforts, because improving the flow of work processes inevitably helps improve patient safety and reduce errors.

EXECUTIVE SUMMARY

Lean management strategies may cause risk managers to fear a growing emphasis on cost cutting and personnel reduction, but the philosophy may work to the risk manager's advantage. Lean management does not necessarily involve severe budget reductions.
- The concept was developed by Toyota.
- Lean can improve patient safety by eliminating inefficient processes.
- Risk managers should seek opportunities to include lean strategies.

"If you look at the work processes of nurses, for instance, we find that in most cases, they spend 30% of their time at the bedside with the patients and 70% of their time with inefficient processes that take up more of their time than necessary. If we can use lean management to change that ratio, you have nurses at the bedside providing better quality care to the patient," Hafer says. "We find that more than 90% of the time for some health care workers is spent not in adding value to the patient, but in dealing with problems in flow and the work process, and devising workarounds to compensate for those issues. All of that entails risk."

Cost savings possible

Although lean is much more than just budget cutting, the approach does make it possible in many situations to reduce costs. **Einar Seadler**, a senior executive in the management consulting practice of Accenture, a consulting firm based in New York City, explains that lean strategies make it possible for risk managers to save money — which always is a goal for any administrator — while simultaneously improving patient safety.

"When lean is applied, it is focused on eliminating waste from the customer's point of view, and when you look at waste that way, you start to see the business differently," Seadler says. "The doctors, nurses, the CEO, the staff will be able to see the waste in what they do. When you start addressing prescription errors and secondary infections, lean will help you find the root causes of those problems, and you end up saving money while you also improve patient care and reduce risk."

Vicki Smith-Daniels, PhD, has been studying lean management since the 1980s and teaches in the supply chain management department at the W.P. Carey School of Business at Arizona State University in Tempe. She says lean is about removing everything from a system that does not add value, a concept which she says risk managers should welcome.

"As a risk manager, you should view lean from a positive perspective, because it is getting rid of everything that does not promote patient care and patient safety, or caregiver safety," she says. "The downside to these initiatives can be that they sometimes do not include a risk manager on the team, and so they don't get that valuable perspective. They may miss some of the ramifications of the changes they want to make, and they could actually increase the risk."

SOURCES

For more information on lean management, contact:

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- **Marc Hafer**, CEO, Simpler, Ottumwa, IA. Telephone: (888) 532-6888. E-mail: marc@simpler.com.
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- **Vicki Smith-Daniels**, Professor, Supply Chain Management Department, W.P. Carey School of Business, Arizona State University, Tempe. Telephone: (480) 965-6473. E-mail: vicki.smith-daniels @asu.edu.

That is why it is essential for risk managers to be directly involved in lean at the highest levels, Smith-Daniels. Embrace the concept and all it can offer, but have a direct say in the decision-making process by being on the lean process teams.

"There are too many cost initiatives in hospitals that are being labeled as lean," Smith-Daniels says. "In too many cases, the people involved think they are leaning out their processes and achieving improvements to the system, but they're seeing it only from their perspectives — and they don't see how some of the changes can have other effects. Lean has plenty of good to offer, but risk managers have to be in there to make sure their knowledge is factored in." ■

Hospital reduces ED wait with lean management

Lean management techniques helped Lahey Clinic Medical Center, North Shore, in the city of Peabody, MA, boost patient satisfaction and reduce emergency department (ED) waiting times.

Lahey is a full-service hospital featuring a 24-hour ED, the only ED in Peabody. More than 17,000 patients visit the ED annually. In October 2007, Lahey partnered with an Ottumwa, IA-based consulting firm to coach hospital staff on the application of lean management skills by revisiting their processes in the emergency department and identifying more efficiencies to improve patient care.

SOURCE

For more information on the lean management projects at Lahey Clinic Medical Center, North Shore, contact:

- **Bob Schneider**, Senior Vice President, Lahey Clinic Medical Center, North Shore, Peabody, MA. Telephone: (781) 744-5100.

The first problem identified was the increased volume of ED visits, which resulted in long wait times for patients, says **Bob Schneider**, senior vice president at the hospital. With the goal of preserving patient care, Lahey began a series of rapid improvement events to help physicians, nurses, and staff see work more efficiently in their daily tasks. Schneider says the goal was to improve patient flow and reduce waiting time. Facilitators led selected members of the hospital and patients in an intensive forum where new ideas for improvement were piloted.

When Lahey decided to pursue lean management practices in the ED, the organization had a particular interest in better serving patients not deemed in critical, urgent need of assistance, Schneider explains. These are patients who may present with symptoms like a sore throat or sprained ankle and often, when more critical patients enter the ED, these nonurgent patients take a back seat.

By following the lean management approach, Lahey developed new roles and work processes that addressed those issues and significantly reduced the wait time for all patients. First, Lahey added the role of "air traffic controller" jointly managed by the unit secretary and charge nurse with help from the triage nurses. It is now their responsibility to help monitor patient flow throughout the department and to match available physicians with patients who have been waiting long periods of time and match them up accordingly, Schneider explains.

Second, to address repetition of data collection from patients, Lahey revised its process to minimize the amount of information collected at registration and synthesize the process of nurses and physicians collecting information. Instead of having the triage nurse, primary nurse, and physician approach patients at different times, the triage nurse collects information at the time of registration, and the treating nurse and physician collect information from the patient together. The result: Lahey's information-gathering process is streamlined.

Finally, Lahey developed a "fast-track" process for noncritical patients. Rather than wait to see a physician, patients are now under the direct care of a nurse practitioner, with an attending physician overseeing their care, Schneider says. When it is determined at registration that a patient is not in critical condition, he or she is automatically put onto the "fast-track" list. The ED is currently building a new fast-track area with a separate waiting area and staff that will serve these patients in the future.

With the new processes Lahey has adopted, the average patient's time in the ED was cut almost in half, to the current 2.5 hours. Waiting time to see a doctor reached a record low, with 75% of all patients now seen by a physician in less than 25 minutes. As a result of the changes, 86% of Lahey ED patients now report that they would be willing to recommend the hospital's ED to a friend. ■

CME objectives

After reading this issue of *Healthcare Risk Management*, the CNE participant should be able to:

- **describe** the legal, clinical, financial and managerial issues pertinent to risk management
- **explain** the impact of risk management issues on patients, physicians, nurses, legal counsel and management
- **identify** solutions to risk management problems in health care for hospital personnel to use in overcoming the challenges they encounter in daily practice. ■

COMING IN FUTURE MONTHS

- ■ Preparing for HIPAA crackdown
- ■ Strategies for reducing OR fires
- ■ How patients can trigger RAC audits
- ■ Predictive analytics to spot fraud claims

CNE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

1. In the October 2009, wrong-site surgery at Rhode Island Hospital, what was the nature of the error?
A. A patient who was scheduled to have surgery on two fingers. Instead, the surgeon performed both operations on the same finger.
B. A surgeon performed surgery on the wrong side of a patient's brain.
C. The patient was supposed to have eye surgery but instead the surgeon removed his tonsils.
D. A surgeon opened the wrong side of the patient's body for a spinal surgery but realized the error before continuing.

2. In the alleged case of misidentification at Banner Thunderbird Medical Center, what does the patient's attorney say happened?
A. The hospital staff put the wrong identification bracelet on the patient.
B. The hospital staff used duplicate case numbers for two patients.
C. The hospital staff confused two patients with the same first name and did not confirm other patient identifiers.
D. The hospital staff properly identified the patient but performed the wrong procedure.

3. According to Richard Glovsky, JD, what is the significance of the "Reverse False Claims Act"?
A. The act guts the False Claims Act and eliminates most of the liability risk previously faced by health care providers under the old law.
B. The act allows the provider to sue the government for chronic underpayment if a case can be made that the shortfall was consistent and significant.
C. The provider is obligated to repay an overpayment only if the government brings the mistake to the provider's attention within 90 days of the payment.
D. The provider is obligated to recognize that the government made a mistake and overpaid; even if the fault lies entirely with the government, it is the health care provider's responsibility to find the error and rectify it.

4. According to Vicki Smith-Daniels, PhD, which is true of lean management and risk managers?
A. Risk managers should have a direct say in the decision making process by being on the lean process teams.
B. Risk managers should not be involved in lean but should wait to see what senior administration develops from the process.
C. Risk managers should actively oppose the implementation of lean strategies in their organizations.
D. Risk managers should encourage nursing supervisors to participate in lean but avoid having anyone from their own departments involved.

Answers: 1. A; 2. C; 3. D; 4. A.

Healthcare Risk Management™

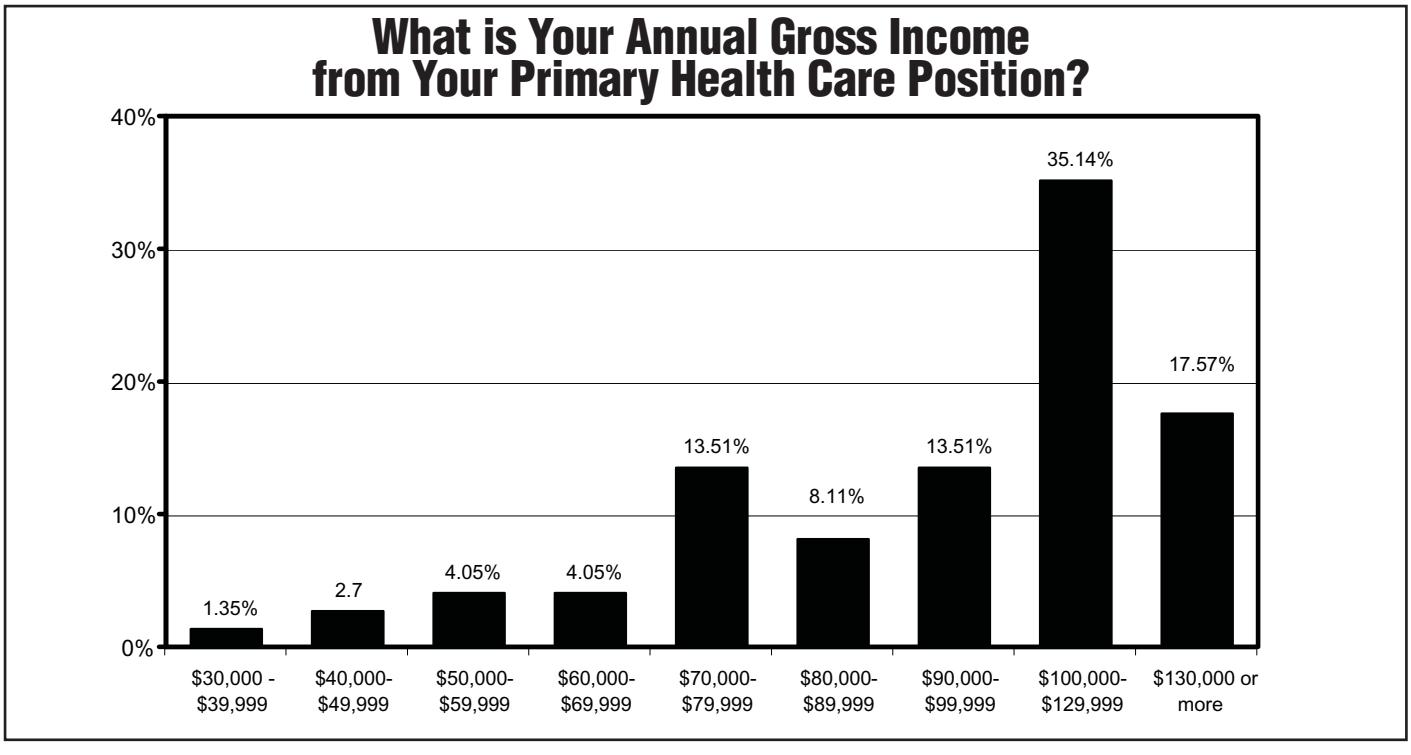
Risk managers remain valued players in health arena

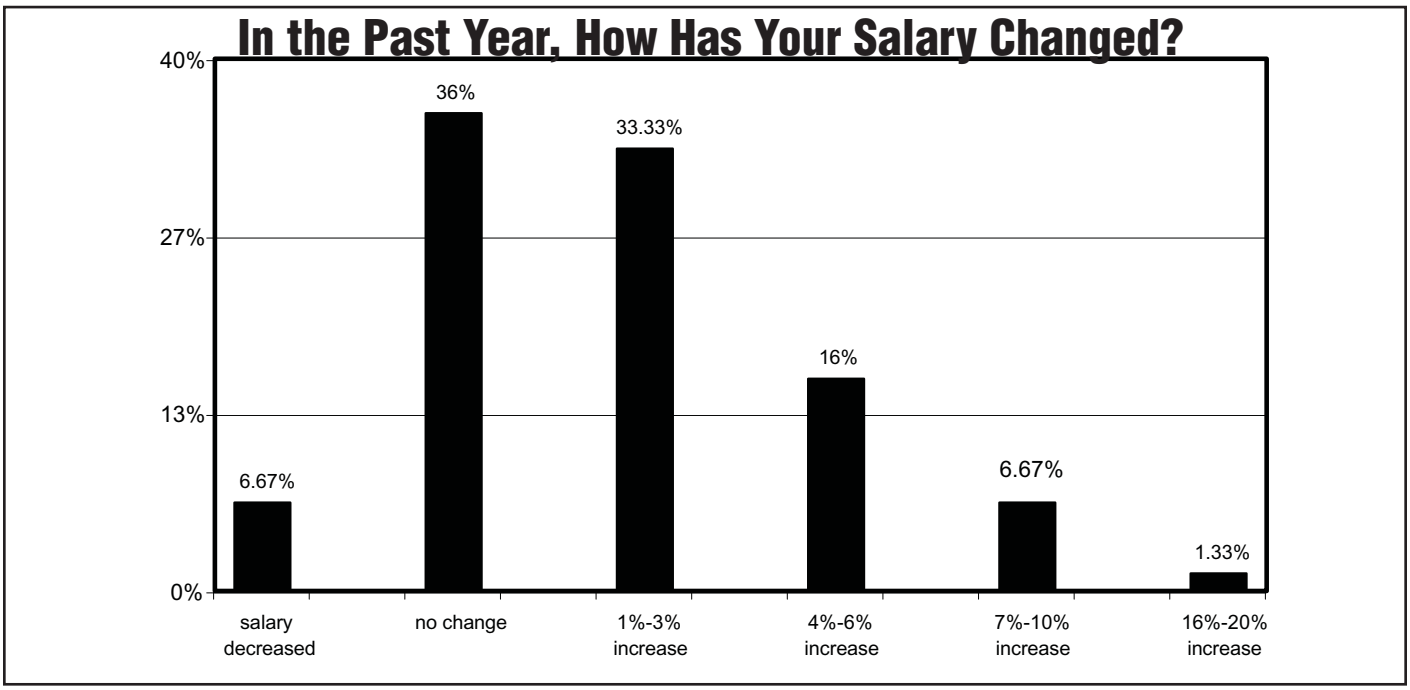
Focus on never events, health care reform presents opportunities

With so much focus on health care these days — reform, malpractice, and never events on everyone's mind — risk managers are uniquely situated to influence the debate and display their value to employers.

Career prospects for risk managers remain strong, says **Georgene Saliba**, RN, HRM, CPHRM, FASHRM, administrator for claims and risk management at Lehigh Valley Hospital & Health Network in Allentown, PA, and 2009 president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

"With 25 years-plus in risk management and still going strong, I wouldn't still be in this business if I didn't think we had good prospects and a strong future ahead of us," she says. "We still have challenges, similar challenges to those we have faced over the years, and certainly health care reform is opening up plenty of questions and probably some new challenges for us. The continuing focus on never events and nonpayment for never events means risk managers are going to





remain at the forefront of the health care field."

Risk managers should continue focusing on developing the processes and procedures that will reduce never events, Saliba says, as this issue clearly will remain an important one for the health care industry, and it is one that risk managers are uniquely qualified to address. Not only are risk managers able to understand the issue and take preventive steps better than other health care administrators, but they also can make the direct connection to the liability costs associated with never events.

In that regard, the intense focus on never events is a great opportunity for risk managers, Saliba says. Another high-profile topic in health care is technology, with health care providers adopting high-tech solutions and using sophisticated computer systems to improve many processes, but Saliba says the growing use of technology can be a double-edged sword for health care providers.

"Technology can mitigate certain risks, as we see when adopting computerized physician order entry for medications. The handwriting issue goes away," she says. "But then we see entirely different risks introduced. Are the systems speaking to one another? Who has access? What information does the system rely on? So, even when you have something positive for the provider, like this technology, the risk manager still has a vital role to play."

Risk managers should position themselves as key players in any technology decisions within the organization, Saliba says. Don't shy away from technological projects because the subject matter is too technical and assume that the IT people will consider all the potential ramifications. The risk manager's role — and it can be an opportunity to position yourself in a high-profile project — is to ferret out any potential problems that could increase liability risks or threaten patient safety.

Involvement in such projects will improve the risk manager's position within the organization, which Saliba says should be an ongoing goal for any risk manager. To further your career and advance the role of risk management in general, it is crucial to be part of the decision-making process at the highest levels and to participate in initiatives and projects that are seen as the domain of the "big players" within the organization, she says.

"That means stepping up and, not just asking to participate, but showing why your skill set is needed and why it is vital that you have input in this project," she says. "You have to get out there, you have to be known. You can't just sit behind your desk."

A risk manager's career prospects can hinge on participation in such projects, Saliba says. Develop a rapport with leaders so that they call on you for input on organizational changes, so that they see you as a resource who contributes value.

Changes in health care usually present risks and challenges for providers, which can be good for a risk manager's career, notes **Gregory L. Terrell**, MS, CSP, ARM, CPHRM, FASHRM, senior director of patient safety in the clinical quality department with the Tenet Healthcare Corp. in Dallas. With so many changes going on in health care now and more looming on the horizon, risk managers should have good career prospects if they position themselves to take advantage of the opportunities, he says.

"Risk managers have to stay as current as

possible, and one of the ways to do that is through their professional organizations like ASHRM and their local chapters," he says. "It is more important than ever to continue with our ongoing educational opportunities and not be stagnant."

Even with budget cuts that restrict travel to conferences and other events, risk managers still should seek out education options locally and online, he says. Terrell also advises risk managers to broaden their skill sets whenever possible, rather than staying in one area of talent.

"We often have one skill set that we are comfortable with and which got us to where we are, but if we want to advance, we will need to broaden that and learn more skills that can be valuable to our employers," he say. "We can't be narrow-minded."

Terrell also sees opportunities in the efforts to enact health care reform. Fortunately, health care providers were not hit as hard as some other industries by the economic recession, and any changes brought by health care reform probably will open up a whole new batch of risk management issues to address, he says.

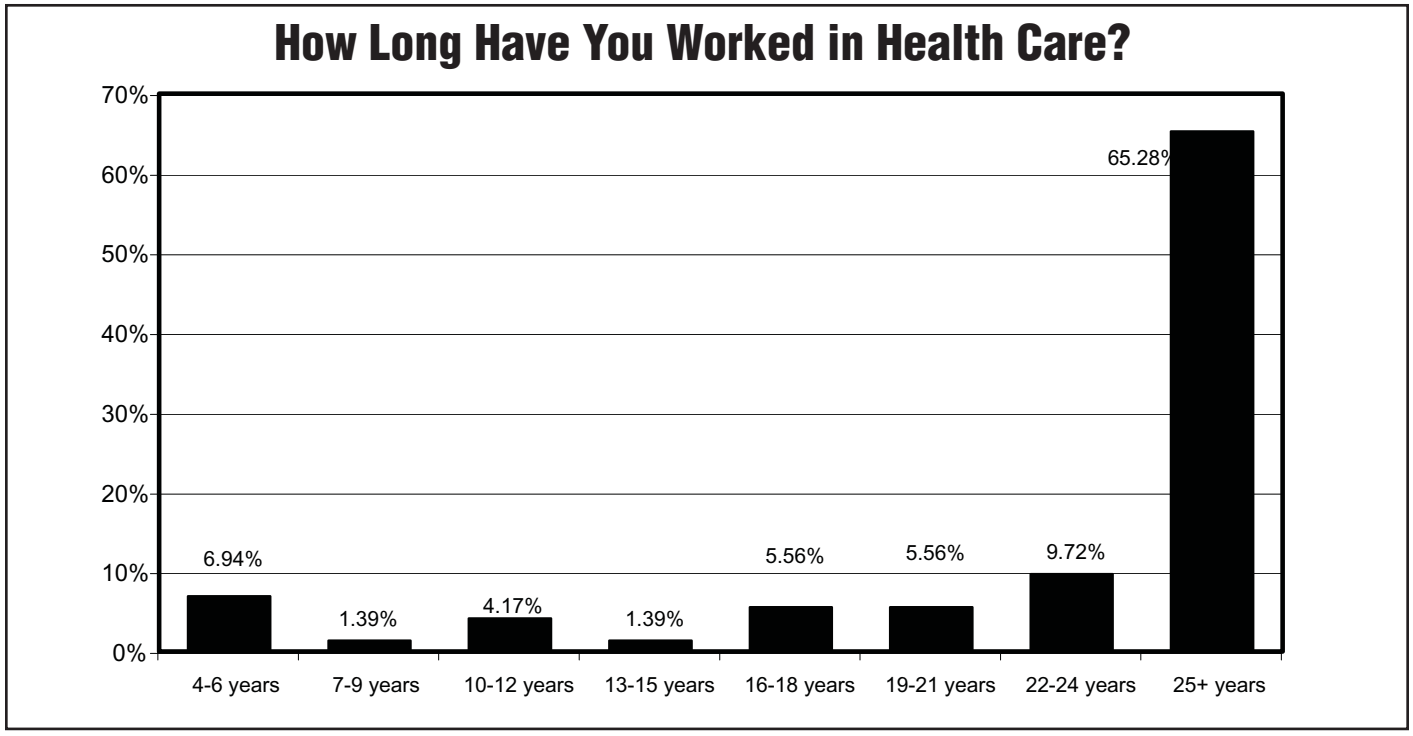
"I believe health care is a great industry to be in these days," he say. "There are lots of opportunities to blend risk management, patient safety, and quality. We need to continue to foster our relationships and reduce the silos whenever possible."

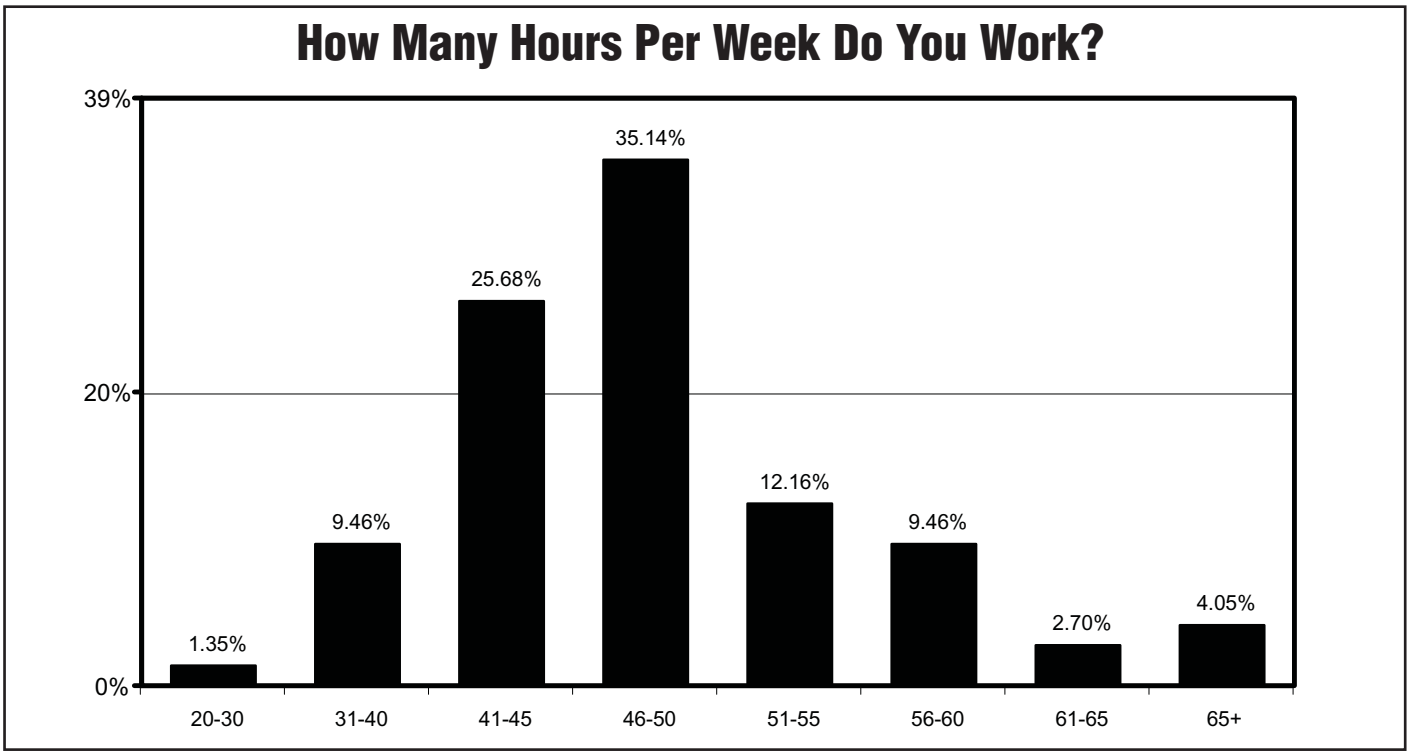
Risk managers have to realize that their jobs have changed over the years and almost certainly will continue to change, says **Ben Gonzalez,** CPHRM, PhD, director of risk management with the Montana Health Network in Billings. Thirty years ago, a risk manager's job was much more about managing claims than it is today, he notes. Malpractice claims certainly still are a primary responsibility, but the job has grown to entail much more, partly because risk managers have been successful in reducing the severity of claims in health care.

"We are seeing now that, while the frequency of claims might be up, the severity of claims is down, and there is reason to think that the severity will remain lower than it was in the past," Gonzalez says. "That is because we in the risk management field have our hospitals positioned in the best defensive position before we ever have to get involved in litigation. The challenges that we continue to have are more in the area of new laws and regulations, which require more reporting, record keeping, and standardization."

Career advancement will depend on staying abreast of the new developments and realizing what obligations — and what opportunities — are embedded in them, Gonzalez says.

"As a profession, we have evolved and will continue to evolve," he says. "The risk manager used to be a position that someone, often a nurse, took on because the insurance companies said you had to have one. Now, it is a recognized field, and people come into this field by choice, because it offers a challenge and because providers value what we can do. We have to continue ensuring that we make the most of every possibility to contribute and build our worth to health care organizations." ■





Income on the rise for risk managers

The economy may be struggling, but *Healthcare Risk Management's* Salary Survey indicates that income for health care risk managers is generally on the upswing.

The exclusive 2009 *Healthcare Risk Management* Salary Survey was sent to about 1,200 readers in the June 2009 issue. A total of 75 were returned, for a response rate of 6%. The results were tabulated and analyzed by AHC Media LLC, publisher of *HRM*.

The median income for health care risk managers in this year's survey is $125,000, up from last year's $95,000, which was the same as 2007, which had seen a significant increase from the $85,000 in the 2006 survey. **(See the chart, p. 1.)** The increase in this year's survey may signal a positive trend, overcoming the stagnation reported in the 2005 and 2006 survey results. A full 35% of respondents reported income in the $100,000 to $129,999 range, and 18% reported income of $130,000 or more. Another 14% reported income in the $90,000 to $99,999 range.

The median salary increase over the past year was 1% to 3%, lower than the 4% to 6% reported in both the 2008 and 2007 survey but consistent with the median increase that was much more common in years prior. **(See the chart, p. 2.)** One-third of respondents report salary increases in the 1% to 3% range. Sixteen percent report increases in the 4% to 6% range, and 7% report increases in the 7% to 10% range. One lucky respondent reports an increase in the 16% to 20% category.

Thirty-six percent report that their salaries did not change this year, and 7% report that their salaries decreased in 2009. That could be a true indicator of how the economy is hitting risk managers, as only a single reader, 0.83%, reported a decrease in the income in the 2008 report.

Hours worked increased

Incomes may be up, but so are the hours worked. The 2007 and 2008 surveys had suggested that hours worked was leveling out, but 2009 is showing risk managers behind the desk longer this year. In the 2008 survey, 27.5% reported working 46 to 50 hours per week, down from the 33% in 2007, but that figure jumps to 35% in this year's survey. **(See the chart, above.)** Twelve percent report working 51 to 55 hours per week in 2009, and 10% report working 56 to 60 hours a week, about the same as the figures for 2008 and 2007.

Three percent report working 61 to 65 hours, up 1 percentage point from the 2008 survey. In this year's survey, 4% of respondents report working more than 65 hours per week and probably won't have time to read these results. ■

Dear *Healthcare Risk Management* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

Healthcare Risk Management, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help your staff make informed decisions concerning treatment options and administrative practices. Our intent is the same as yours — the best possible patient care.

The objectives of *Healthcare Risk Management* are to:

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

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You then can compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester, you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form, we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is health care risk managers and other professionals.

If you have any questions about the process, please call us at (800) 688-2421 or outside the United States at (404) 262-5476. You also can fax us at (800) 284-3291 or outside the United States at (404) 262-5560. You also can e-mail us at: customerservice@ahcmedia.com.

On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,

Cynthia Molnar
Director, Continuing Education
AHC Media LLC

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

Patient under observation commits suicide: Verdict for the defense

By **Jon T. Gatto**, Esq.
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Tampa, FL

Barbara Reding, RN, LHCRM, PLNC
Citrus Memorial Health System
Inverness, FL

News: A man with a history of suicidal ideation was involuntarily admitted to the hospital. The next day, the man was transferred to an acute care psychiatric facility and placed on 15-minute observation status by the on-call physician. The next day, the admitting psychiatrist interviewed the man, who denied suicidal ideation. An antipsychotic medication was prescribed. Later that same day, the shift RN interviewed the man, who appeared withdrawn and isolated but again denied suicidal ideation. A psychology technician ("PT") observed the man every 15 minutes from 3:15 p.m. until 4 p.m. and noted nothing of concern. At 4:15 p.m., the PT went to observe the man and found him hanging from the top of the bathroom door with a sheet. CPR was commenced and the man was transferred to an acute care hospital for further care. One week later, the family consented to removing the man from life support, and he was pronounced dead shortly thereafter. The jury found in favor of the psychiatric facility.

Background: A 27-year-old single male was admitted to an acute care hospital on an involuntary hold due to a possible danger to himself. Twenty-four hours later, he was transferred to another acute care hospital on a 14-day involuntary hold. Ten days later, he was discharged with a prescription for chlorapromazine and instructions to follow-up with outpatient psychology counseling.

About a week later, while on his way home from a bankruptcy hearing with his father, the man pulled a knife and threatened to commit suicide. The man's father was able to struggle with the man and retrieve the knife, thereby thwarting the suicide attempt. That same day, the man again tried to commit suicide with a knife in a locked bathroom. The father again intervened and was able to prevent the man from hurting himself. The man's father called the police, who took the man back to the original acute care hospital and placed him on involuntary hold. Twenty-four hours later, the man was transferred to an acute care psychiatric facility because of the lack of inpatient beds at the hospital.

Upon arrival at the psychiatric facility, the charge nurse obtained physician's orders to place the man on Q15 checks, suicide watch. The following morning, the man was examined by the attending psychiatrist, who found him to be calm and cooperative and without suicidal ideation. The physician's diagnosis ruled out paranoid schizophrenia and major depression. The physician ordered that olanzapine be administered. An unlicensed social worker also interviewed the man, and the social worker indicated that the patient was cooperative and denied suicidal ideation. Again that same day, the shift RN documented that the man, while withdrawn and isolated, denied suicidal ideation.

The PT was assigned to view the man every 15 minutes and did so four times between 3:15 p.m. and 4 p.m. At 3:50 p.m., the man exited his room and questioned a staff member about who had

been assigned to room checks. At 4:15 p.m., just prior to completing her head counts, the PT went to the man's room and found him in the bathroom hanging from the inside of the door with a sheet tied around his neck. Staff members on the hall commenced CPR and called paramedics. The man was transferred to an acute care facility, where he remained on life support for six days. At the end of the six days, the family requested that he be removed from life support. The man died shortly thereafter.

The plaintiff, the man's father, brought suit against the psychiatric facility, alleging that the man was at high risk for suicide and that he should have been placed on one-to-one observation or line-of-sight observation. The father claimed that if either of these approaches had been implemented, the man would not have been able to hang himself. The plaintiff also argued that the man's denial of suicidal thoughts should have been ignored given the man's history of poor judgment.

The defendant contended that its actions were at all times appropriately within the standard of care and that a lapse in care was not the cause of the man's death.

At trial, the social worker who had interviewed the man testified that she had received a telephone call from one of the man's family members, who indicated that the man was hearing voices that were urging him to kill himself. The social worker recalled conveying this information to the charge nurse, though no notation was made. The charge nurse denied learning about this call.

Plaintiff's expert testified that the attending physician failed to adequately assess the man for suicide risk, and that he irresponsibly relied on the patient's denial of suicidal ideation. Other experts addressed facility issues related to the length of hallways, the existence of items that could be used for suicide, and the fact that patients slept on metal beds with wheels. The defendant's expert countered by testifying that not one risk factor or set of risk factors can be used to predict which patient will commit suicide. The fact that the man denied suicidal ideation, coupled with his overall demeanor, placed him at a low risk for imminent suicide. Given these facts, it was appropriate to place the patient on Q15 checks.

The jury agreed with the defense's argument and ultimately found in its favor.

What this means to you: According to the American Foundation for Suicide Prevention, more than 33,000 people in the United States die by suicide every year. Suicide is the fourth-leading cause of death in adults between the ages of 18 and 65. There are four male suicides for every female suicide and, every day, approximately 90 Americans take their own lives, while 2,300 more attempt to do so. A person dies by suicide approximately every 16 minutes in the United States. A suicide attempt is made approximately once per minute. Warning signs of suicide include observable signs of serious depression, increased alcohol and/or other drug use, recent impulsiveness and taking unnecessary risks, threatening suicide or expressing a strong wish to die, making a plan (giving away prized possessions, sudden or impulsive purchase of a firearm or obtaining poisons or medications), and unexpected rage or anger.

Given such statistics, The Joint Commission in its National Patient Safety Goal (NPSG) 15.01.01 requires an organization to identify patients at risk for suicide. This requirement only applies to psychiatric hospitals and patients being treated for emotional and behavioral disorders in general hospitals. The Elements of Performance for this NPSG state that: 1) the risk assessment is to include identification of specific patient factors and environmental features that may increase or decrease the risk for suicide; 2) the hospital is to address the patient's immediate safety needs and the most appropriate setting for treatment; and 3) the hospital is to provide information such as a crisis hotline to individuals at risk for suicide and their family members. The Joint Commission's rationale for this NPSG is: "Suicide of a care recipient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals." The Joint Commission recognizes the frequency of suicide even in staffed, round-the-clock organizations. The national statistics uphold the "success rate" of those who are determined to end their life by their own hand.

The 27-year-old in this case had a history of suicide attempts, including two attempts in one day using a knife. Upon transfer to an acute care psychiatric facility, the patient underwent several interviews by health care professionals over time, including a psychiatrist, a registered nurse, and a social worker. All interviews revealed a judgment based on assessment and a conclusion of no suicidal ideation by the patient at the time of each interview. The details of the risk assessment process are defined by the health care organization, according

to The Joint Commission.

In accordance with Joint Commission requirements and recommendations, the acute psychiatric care facility assessed the patient within the above referenced Elements of Performance and placed the patient on every-15-minute suicidal watch checks. The Q15 checks were performed timely as ordered.

While arguments were made by both sides as to the precautions instituted or the lack thereof, there is no easy answer in this case or whenever a person chooses suicide. Based on the trial findings, it seems that the jury understood the difficulties of protection and prevention. What remains key to the defense of any organization caring for these at-risk individuals is the performance of a thorough initial assessment, appropriate diagnosis, reassessments on a consistent basis, timely and appropriate monitoring, and observation of each patient, and accurate, pertinent, and timely documentation. Monitoring closely for any change in patient status and immediate reporting of noted changes to the attending physician is critical. Evidence of ongoing staff education in the arena of risk factors for suicide is beneficial. Environmental rounds for safety and risk factors performed on a regular basis by different sets of eyes each time is required. And, when a patient commits suicide in a health care setting, emotional support must be provided for the staff.

Reference

- Los Angeles Superior Court/Pomona; Docket No. KC051107. ■

Settlement in hypoxic injury case

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Inverness, FL

News: A woman presented at a hospital emergency department with complaints of headaches, blurry vision, and shortness of breath. Her work-up included a CT scan of her head, chest X-rays, and routine blood tests. She was released later with a diagnosis of a type of headache and possible anxiety. Three days later, the woman was found unconscious and taken to another hospital, where she was admitted to ICU and placed on a ventilator. Six days later, the patient was intubated. Following the extubation, the woman was found to be in distress and the woman sustained a profound hypoxic injury. All of the parties settled prior to trial.

Background: A 30-year-old cosmetologist complaining of a headache in the frontal portion of her head, blurry vision, and shortness of breath presented to the ED of a local hospital. She was triaged as urgent, and the ED staff did a work-up, which included a CT scan of her head, chest X-rays, and a routine blood test. Several hours later, she was released with a diagnosis of cephalgia, possible hyperventilation, and possible anxiety reaction.

Three days later, the woman was found unconscious and was rushed via ambulance to a second hospital, where she was admitted to the intensive care unit. She was intubated and put under the care of a pulmonologist. Five days later, the hospital staff attempted to wean the woman from the ventilator, but attempts were unsuccessful. The next day, the pulmonologist ordered that the woman be extubated but did not order arterial blood gases. Fifteen minutes later, the woman was extubated.

Within hours, the woman's oxygen saturation became unstable, falling to as low as 90% at one point. Although noted in the woman's chart, the nurses did not notify the pulmonologist of the woman's status. Along with this, the nurses noted that the woman became combative and agitated and had trouble managing thick, brown secretions. Two-and-a-half hours later, the woman was found to be in distress, a code was called, and CPR was performed. Her pulse was restored, but the woman had already suffered a profound hypoxic injury. The woman stayed at the hospital for another 13 days, when she was transferred to an extended care hospital. She lives in a persistent vegetative state on a ventilator and is fed through a gastronomy tube.

The woman's brother, on behalf of the woman's estate, sued both hospitals and the pulmonologist. Counsel for the plaintiff argued that the first hospital should have completed a more thorough work-up which, if done, would have led to the woman's hospitalization and could have prevented further deterioration. A review of the woman's arterial blood gases, the plaintiff argued, would have informed the pulmonologist that extubation was improper.

In the case against the second hospital, the plaintiff focused on the nurse's failure to appreciate the

deteriorating nature of the woman's condition and the failure to report the woman's status to the pulmonologist. The plaintiff requested $5.5 million to compensate plaintiff for future lost earnings and lifetime care. The parties settled for $4.05 million, with the first hospital being responsible for $50,000 and the second hospital responsible for $4,000,000.

What this means to you: Hypoxia is a condition where there is a deficiency of oxygen in the body. It may be caused by environmental factors, such as high altitudes or toxic chemicals; illness such as pneumonia or COPD; or by a restriction in blood supply due to constricted or blocked blood vessels. Signs of hypoxia include elevated blood pressure, elevated heart rate, rapid breathing, cyanosis, poor coordination and/or judgment, stupor, and lethargy to name a few. Symptoms may include headache, dizziness, euphoria, visual impairment, nausea, air hunger, hot and cold flashes, tingling, and mental and/or muscle fatigue. Left untreated, hypoxia may lead to unconsciousness, organ failure, and death.

In this case, a 30-year-old cosmetologist presented to the ED of a local hospital and was triaged as urgent, with symptoms of a frontal headache, shortness of breath, and visual impairment. A CT scan of the head, chest X-ray, and a "routine" blood test were ordered. Given the patient's age, occupation, and symptoms severe enough to cause the patient to seek evaluation and treatment in an emergency setting, an in-depth assessment including oxygen saturation monitoring and an arterial blood gas (ABG) to measure blood pH and acid-base balance would have been prudent. The patient demonstrated signs and symptoms of hypoxia. Discharging a patient from the ED with the diagnoses of cephalgia (headache), "possible" hyperventilation (vs. shortness of breath, which begs the question as to the cause), and "possible" anxiety reaction once again prompts the question of the physician "on what did you base your diagnoses?" Use of the word "possible" insinuates an incomplete assessment or guess. The plaintiff understandably argued that earlier and appropriate diagnosis and treatment of this patient could have prevented negative outcomes.

Three days after her discharge from the local hospital, the patient was found unconscious and rushed to another hospital via ambulance. She was intubated and admitted to the ICU. Five days after intubation, attempts to wean the patient from the ventilator proved unsuccessful. On the sixth day, the pulmonologist assigned to her care ordered extubation. No ABG studies were ordered prior to extubation, and the patient was extubated within 15 minutes of the physician's order. The patient deteriorated, coded, and survived CPR. The patient now remains on a ventilator and in a vegetative state.

The Agency for Healthcare Research and Quality has conducted studies regarding the criteria for weaning from mechanical ventilation, seeking scientific information from agencies and organizations on which to base clinical guidelines, performance measures, and other quality improvement tools. The Institute for Healthcare Improvement continues to research and report evidence-based practices regarding weaning from mechanical ventilation. Volumes of information regarding such criteria are readily available and easily accessible. Weaning and extubation protocols from hospitals throughout the country and the world are but a fingertip, e-mail, or telephone call away. Extubation protocols consistently apply the use of pulse oximetry for a minimum of eight hours post-extubation. Protocols also indicate that if a patient's SpO_2 remains below 90% for 20 minutes, the physician must be notified.

When multiple attempts to extubate have failed, the wise and prudent physician should seek diagnostic evidence to assist in determining cause for the failure. Protocols for extubation include assessing level of consciousness, muscle strength, respiratory mechanics such as a spontaneous respiratory rate less than 30 breaths per minute, ABG results, oxygen saturation rates, and hemodynamics, such as a heart rate less than 120 per minute. To even consider extubation without a complete assessment and evaluation of a patient's readiness is simply reckless and demonstrates disregard for the well-being of the patient.

Failure to communicate the patient's change in status also contributed to the tragic outcomes for this patient. A change in patient status warrants immediate notification to the physician in charge of the patient's care. There is no defense for failure to notify. The wise and prudent nurse not only monitors his or her patient's condition throughout their shift, but also recognizes those changes in patient status that may lead to a need for medical or surgical intervention and then immediately reports those changes.

The pivotal points in this case rest in assessment, evaluation, and failure to communicate.

Reference

• Anonymous Parties, Superior Court of San Bernardino County (CA), Rancho Cucamonga. ■

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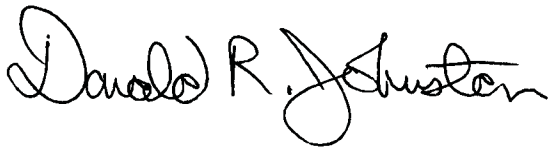

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