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Benchmarking study shines light on surgical malpractice causes

Patient expectations often at the root of problems

A benchmarking report on some of the major causes of surgical malpractice cases has provided information that hospital quality managers and risk managers can use to improve performance and reduce adverse events.

For example, among its findings is the fact that risks are inherent in all stages of the surgical process — from issues related to preoperative decision making, to technical issues in the operating room, to those that occur post-operatively, such as recovery management and communication. It also highlights that errors leading surgery patients to allege malpractice primarily are due to narrow clinical judgment, poor technical performance, or miscommunication among team members.

But it does more than point out causes of malpractice cases, says **Larry Smith**, senior vice president of risk management for Columbia, MD-based MedStar Health. "This report represents what I hope is an indication of a new way for all of us in health care, including those who work in claims programs, to look at the causation of these events differently than we have in the past so we can do something to stop these preventable adverse events from happening," Smith declares.

KEY POINTS

- Benchmarking expands reach of data and the number of facilities that can identify opportunities to improve.
- More structure needed for OR teams, who sometimes do not know the other members.
- Safety checklist, improved training identified as keys to reducing likelihood of malpractice suit.

The report, entitled "Annual Benchmarking Report: Malpractice Risks in Surgery," was produced by RMF (Risk Management Foundation) Strategies, a division of CRICO/RMF, the medical malpractice insurer for the Harvard medical institutions. Based on data from 3,300 surgery-related medical malpractice cases that closed from 2003 to 2008, it is designed to provide hospitals nationwide with insight into areas of medical malpractice across the surgical spectrum so that hospital leadership, physicians, and surgical staff can identify areas of vulnerability and implement programs to improve patient safety.

Bob Hanscom, JD, is vice president of loss prevention and patient safety at RMF and the driving force behind RMF Strategies' Comparative Benchmarking System (CBS), which published the report. "Malpractice cases are a very small tip of the iceberg, but below the surface are a lot of vulnerabilities. The tip is a 'divining rod' guide to where the risks are; you can actively use the analysis of these cases and help drive change," he says.

The causation 'revolution'

Smith is excited about the approach the report has taken. "I may be appropriately accused of exaggeration, but I think this report is an indication of a revolution in the way we are using our claims data," he says. Smith notes that in April 2010 he made a presentation at a meeting of the Risk and Insurance Management Society (RIMS) about the "causation factors" that are now embedded in the claims management software his system uses.

"When cases are closed or mature enough for us to know enough about them, we are able to take the information and code causation into three categories — individual factors, or things individuals are responsible for; systems problems, where most quality folks have been focused for the last 10 years; and patient problems, such as noncompliance, where patients do something to cause their own outcome," he explains. "What I like about this approach is that we have gone from the '90s, looking at blaming individuals, to the 2000s and blaming the system; finally in the next decade we will focus on the fact that causation is complex, that it involves individual and systems failing and patients and their failings, and unless we look at it in this complex fashion, we lose the opportunity to put in place interventions to reduce, and hopefully eliminate, many of these errors."

The report, he continues, takes a similar approach. "We took our data, and ran the same analysis they ran for this report, and I was thrilled to see that when you take the elements there, their results our virtually identical to ours." So, he explains, when he looked in the report at clinical judgment, technical knowledge and skill, and communications — three of the key factors leading to claims that fall under the "individual" findings — the report data and his system data were virtually identical. "For example, clinical judgment appeared in about 60% of the claims for the group they studied," he notes. "When I look at our data for six years, it was anywhere from 54% to 79% of the cases, but the average came out to 60%."

This way of looking at data, says Smith, "can help us look benevolently at innovation." So, for example, looking at individual failures is impor-

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tant, "because if you look at surgical preventable injuries, our individual clinicians are day in and day out asked to make critical decision about what route to take, what process to use, tests to order, how to treat certain conditions, and in 60% of malpractice cases that judgment is in question; it is a target for malpractice claims," notes Smith. 'So the question is, what can I do about that? I can do simulation training to get better and better and better at knowing what to do when faced with an emergency. I can do didactic teaching and e-training to help them understand the clinical judgment issues faced in practice."

What the report also did, he continues, was allow him to bring to his board this information, and say to them he believes he is on the right track. "These data have more validity and say to me the focus we're talking about on how to prevent errors is headed in the right direction," says Smith, "and I can now garner more resources."

Other key findings

Among the report's many findings is the fact that risks are inherent in all stages of the surgical process — from issues related to pre-operative decision making, to technical issues in the operating room, to those that occur post-operatively such as recovery management and communication. It also highlights that errors leading surgery patients to allege malpractice are primarily due to narrow clinical judgment, poor technical performance, or miscommunication among team members. It "really relates to this whole 'allegation' category of technical error. Of course [provider error] is alleged in a lot of malpractice cases, but when you look at the facts, you're not always sure it occurred. What you do see are outcomes the patient or family was simply not expecting," says Hanscom.

Sometimes, he says, patients could not distinguish between a normal risk of complication or an error. "It may have been covered in informed consent, but done in such way that most patients or families do not understand how much risk there really is," says Hanscom. "Communication really needs to happen with patients ahead of time, so they are much more aligned with the reality of what they are undergoing; some procedures are much more risky than they understand them to be."

The second key point raised in the study, says Hanscom, is that "there are errors that occur, which we believe are quite preventable." While some can be traced back to training or skills, he says, "There are a number of distractions in the operating environment that pull skilled surgeons away from concentrating on the procedure." This raises "very important opportunities for training or thoughts about the environmental factors surgeons operate under," he says.

In addition, notes Hanscom, surgeons could be greatly helped by a much more team-based environment. "Many surgeons go into a room that has just turned over, with a team of nurses or techs whose names they do not know, and they try to do very high-level procedures," he explains. "To me, I hope this study gives rise to having a much more structured way of getting surgeons and the people who help them aligned with each other; the data scream out for interventions along these lines."

Suggestions are offered

The report is more than a gathering of statistics. There are miniature case studies of how member facilities have addressed areas of weakness they uncovered, as well as suggestions of strategies that could help many health care facilities, including

- the use of a surgical safety checklist;
- developing a unified curriculum and standards for simulation-based team training;
- creating interactive workshops using malpractice cases to help surgeons better communicate realistic expectations to patients and families.

The checklist, says Hanscom, was developed by Harvard's Atul Gawande and the World Health Organization (WHO) about two years ago. "It's not rocket science; a lot of industries do this to help reduce human error," he notes. "It makes sure that all of the i's are dotted and t's are crossed in terms of the inter-operative and post-op phases of care. It does not take a huge amount of time for a surgeon to be sure he or she adhered to protocols and did not leave anything undone."

Hanscom acknowledges that there are other checklists out there, although he advocates the WHO checklist as the one that ought to be used. "People have come up with shortened versions, and it's kind of frustrating and a little amusing," he says, "But we hope that wherever this lands, you really do have a safety net so patient care does not somehow fall through the cracks. That's where we see the biggest problems arise — jumping over a step or failing to do something."

Hanscom says the Harvard system already has used unified curricula and standards for simulation-based team training. "A few years ago we used it with obstetrics," he says. "We ultimately created simulation-based team training for labor and delivery."

The staff members, he says, were very enthusiastic and embraced the new approach. "Essentially it teaches all providers how to communicate in such a way that they do not lose information; every voice is heard, and everyone is accountable for follow-through on what they need to be doing," he explains. "It's a much more highly coordinated environment."

The process, he continues, involves role-playing, where a number of scenarios are acted out. "Its experiential learning versus didactic learning, and the information seems to have much more ability to be embedded with the learner — and they learn much faster," Hanscom shares. "We are now trying to replicate that curriculum in the OR."

He concedes that the OR environment is "very challenging, because unlike labor and delivery, it is very hierarchical. Still, every voice needs to be heard, and that's tough culturally," Hanscom says. "But it involves open communication and a team-based environment, and if a 'lowly' tech sees something worrisome, they can speak up and be heard."

Creating interactive workshops using malpractice cases "to help surgeons better communicate realistic expectations to patients and families" is part of this whole process, Hanscom explains. "We bring together all the players with malpractice case studies in front of them, and use them to open discussion and analysis."

Vital role for quality managers

When participants in the benchmarking group receive their reports, Hanscom says, the quality manager becomes a key player in the improvement process. "In my mind, they are the people who should be the agents of change," he says. "In a lot of ways, this is the sort of report that is written for them."

The reports help further understanding on the part of the frontline staff, "but you've got to have those people who are in the position of saying, 'We've got to initiate new way of doing things.' Very often, it's the safety and quality leaders; those are the people who are in position to really use this sort of data as an evidence-based platform to help propel change forward."

As RMF disseminates the reports, says Hanscom, "We make sure they get to those very people. Hopefully, they will think of malpractice activity as a way for them to focus, since they have a very broad agenda. Maybe it will give them a bit more focus on where they need to prioritize; that's the hope here."

Smith shares that hope. "We have been giving lip service to quality and malpractice claims people getting together and working on the same page, but we do not do that," he observes. "I hope now that we are finding in claims data ways we can translate that data into a taxonomy that relates to what quality people are all about. Maybe what we can do is use the report for analysis, come up with some 'gems,' and then turn them over to quality people so they can drive the changes that need to be done."

[The surgical report is available through at http://www.rmf.harvard.edu/files/documents/2009_annual_benchmark.pdf. For more information, contact Bob Hanscom. Phone: (617) 679-1519; E-mail: rhanscom@rmf.harvard.edu.] ■

Program aims to combat 'compassion fatigue'

Stressed providers cannot offer optimal care, leaders say

The Woman's Hospital of Texas, based in Houston, is offering caregivers in several units a "compassion fatigue" program, designed to target a little-known stress disorder that its proponents say prevents providers from giving their patients optimal care.

"Compassion fatigue [CF] is a stress disorder that was first identified in the 1950s, primarily among vocations that provide care for people in crisis," says **Bruce G. Coe**, MDiv, chaplain, quality resource management at the hospital. "When I came here three years ago, I quickly determined a goodly number of our staff was under the disorder. I tried to get some interest at the time and did not get what I hoped for, but due to recent situations and circumstances in the country, hospital leadership began to pick up on it — and this program is something you can offer."

Exactly what is compassion fatigue? "Compassion fatigue is the gradual lessening of a person's ability to provide compassion," Coe explains. "Each nurse, doctor, or other caregiver only has so much compassion. The textbook definition says it comes on gradually, but one crisis can drain the will, and providers can find themselves unable or unwilling to provide care."

When a provider suffers from compassion fatigue, "quality of care suffers," says **April Spreeman**, LMSW, a social worker involved in the program. "We have to have a lot of compassion to build rapport with patients and make connections."

Coe agrees, "HCAHPS [the Hospital Consumer

KEY POINTS

- There is a limited amount of compassion each provider has to offer patients.
- A key to healing is to recognize that the problem exists.
- Providers with CF may cease providing prompt care, or eliminate key process steps.

Assessment of Healthcare Providers and Systems — a publicly reported survey of patients' perspectives of care] not only demands that we provide good clinical care, but we know that people want those warm, fuzzy feelings," he notes. "If we do not have them, that will reflect on our scores and cause even more stress."

The condition, he says, not only affects the ability to show compassion, but also begins to show up in clinical care. "I had unit managers come to me several times telling me that nurses who never had issues or events are having them," Coe shares. "We believe it's directly related to stress levels in their lives at work and at home. If it goes unchecked, it shows up in clinical care; they begin to not do some things or do things they've not done before."

Lack of compassion, he observes, is an attitude. "These people are tired, unmotivated, not giving prompt care," says Coe. "They may not be making clinical mistakes, but they are not providing normal, effective care."

Accordingly, adds Spreeman, staff compassion fatigue was beginning to affect HCAHPS scores. "I talked with our patient advocate, and said if you want to improve those scores you need to look at CF," she recalls. "She did not know about the condition; very few people in the medical profession are aware of it," says Spreeman, who notes that she learned about it in a previous position in hospice. Ultimately, its HCAHPS scores became a selling point for the program.

How the program works

The program itself is, by and large, a "self-care" program, explains Coe. "We provide a lecture for nursing units consisting of a plan for them to develop; we provide a framework," he shares. The lectures, he adds, are built into their monthly meetings.

"We run a PowerPoint presentation and go through a definition of CF, and we also talk about symptoms; one of the biggest steps is self-awareness," says Spreeman. For example, she says, staff members may avoid a particular patient on purpose because they know he or she is difficult. "Another is irritability with patients and with co-workers," she says. Additional symptoms, she notes, include extreme nervousness or anxiety, and even physical symptoms such as constipation."

"The point is for them to first acknowledge they have the condition," says Coe. "Then, we ask them to make a promise to care for themselves; our responsibility is to ask them if they are keeping their promise."

The promise, he continues, is that staff members will do something for themselves once a day. "I wrap up the session by sharing how my day is spent hearing stories about death, disease, discouragement, and despair — imagine what I'd be like at the end of day if I did not decompress?" he says. "It might be as simple as meeting a buddy at a restaurant and having a cup of coffee, or taking a long walk when I get home. Once a week I plan something big so I can look forward to it; that's how simple it is."

The program has been offered in nine different units over a couple of months, and "it could not have been better received," says Coe. "Our administration is trying to build this in as a more regular part of our lecture series and orientation for employees. We've even had another hospital make inquiries about what we're doing."

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Medicare project focuses on readmissions

QIO, hospitals, nursing homes collaborate

Since DCH Regional Medical Center in Tuscaloosa, AL, and the Alabama Quality Assurance Foundation began collaborating on a Medicare demonstration project to determine the most effective ways to reduce readmissions for Medicare patients, the hospital has increased its referrals to home care, nursing homes, community resources, and medication assistance programs.

The project began in August 2008 in the Tuscaloosa Hospital Referral Region and involves

seven hospitals, 13 nursing homes, and 12 home health agencies in seven counties, according to **Sherrie Smith,** RHIA, CPHQ, lead quality resource specialist, Alabama Quality Assurance Foundation with headquarters in Birmingham.

The Alabama Quality Assurance Foundation was one of 14 state Quality Improvement Organizations (QIOs) awarded a contract for the Medicare Care Transitions project.

The project's main goal is to reduce readmissions for Medicare patients hospitalized for all diagnoses, Smith says. The project also measures readmission rates for patients with heart failure, acute myocardial infarction, and pneumonia.

A key component of the project is increasing communication between post-acute providers and the hospital as patients transition to another level of care, Smith says.

"There are a lot of people who may impact whether a patient stays out of the hospital after being discharged. When patients are transferred from one provider to the next, in many cases, neither provider knows what the other's issues and requirements are. Home care agencies and nursing homes have to be involved in any project to reduce readmissions," Smith says.

Before the project began, DCH Health System already had embarked on several initiatives to reduce readmissions, says **Brian Pisarsky**, RN, MHA, ACM, CPUR, director, case management services, DCH Regional Medical Center and Northport Medical Center in Tuscaloosa, AL.

"We are looking at readmissions of all patients with all payers, from self-pay to commercial insurance to Medicare and Medicaid," he says.

The health system began what it calls the Hospital-to-Home case management program to identify additional patients who would benefit from being discharged with home care.

A dedicated case manager reviews patients throughout the facility to determine which ones might benefit from a home health referral.

"She looks at all patients, not just those who might be expected to need home health because of their diagnosis. These include patients who had outpatient surgery and those who are receiving observation services and are sick but not sick enough to be admitted," he says.

The Hospital-to-Home case management program has resulted in a 32% increase in referrals to home health, which in turn is likely to reduce readmissions, Pisarsky says.

"The home care agencies are very concerned with helping patients avoid readmissions because one of their quality measurements is the number of patients who are readmitted. They have the same kind of incentives we have to make sure patients don't need to be readmitted," Pisarsky says.

KEY POINTS

- Along with decrease in readmissions, hospital increases referrals to home care and other post-hospital care programs.
- Key element is increasing communication between post-acute providers and the hospital.
- Hospital-to-Home case management program resulted in a 32% increase in referrals to home health.

The Medicare Care Transitions project expanded on several initiatives that were already in place at DCH Health System, Smith adds.

In an effort to improve communication as patients transition from one level of care to another, the health system was meeting regularly with representatives from nursing homes to discuss what kind of information needs to be shared and to collaborate on how the communications and referral process can be improved.

"In the past, we have talked on the telephone. By meeting face to face, we get to know each other, and now the case managers have someone to talk to at each facility," Pisarsky says.

Each facility brings a representative case to each meeting and discusses the issues that arose as the patient transitioned between facilities.

"Early on, the teams functioned to put out fires and focuses on the issue du jour. As time went on, we changed the focus to do a root-cause analysis to determine what the issues are and opportunities to improve the transitions in care. These meetings have helped each side understand what issues the other side has," Smith says.

The hospital holds similar meetings with representatives from home health agencies who collaborate with the hospital case managers on ways to improve the transition in care.

The home health improvement team is reviewing the educational materials patients receive at each level of care to make sure they are consistent throughout the continuum.

"It's confusing when patients get one set of materials in the hospital and a different set from the home care agency. They may say the same thing, but when they are worded differently, the

patients may get confused," Smith says.

Since the project began, DCH Health System has implemented case management in the emergency department from 7:30 a.m. to 11:30 p.m., seven days a week. The department added an additional 1.4 FTE in staff in order to expand the emergency department coverage.

The emergency department case managers identify patients who are being readmitted as soon as they arrive.

"The case manager is aware that the patient has been recently discharged and intervenes to verify what we could have done better. The purpose is not just to stop patients from being readmitted. It's to help them find a medical home," Pisarsky says.

While assessing the patients who are readmitted, the emergency department case manager answers questions on the admission assessment screen to provide details on the reason the patient came back to the hospital.

The information on readmissions is reviewed by the multidisciplinary length-of-stay team, which is responsible for reviewing the cases of patients who have been in the hospital for more than six days.

The team examines each readmission separately and looks for trends and areas where the discharge process can be improved.

For example, analysis has shown that many of the patients are being readmitted because they did not understand their medication regimen, Pisarsky says.

As a result, the hospital has implemented a "time out" for its medication reconciliation and education efforts. Now, when a patient is about to be discharged, the medication orders are reviewed by the nurse. Then, a second nurse, a pharmacist, or case manager reviews the discharge medications and verifies that they have been reconciled and that the medication is appropriate.

The hospital has added one FTE to its staff to make follow-up calls to patients with pneumonia, heart failure, and surgical patients after they have been discharged.

The discharge follow-up case manager, an RN, makes several hundred calls a month to check on patients three or four days after they have been discharged.

"We're trying to find any way possible to ensure that patients don't have to be readmitted. We have instituted multiple processes to close any gaps in treatment that may have occurred after discharge," Pisarsky says.

The case manager reviews the discharge information in the patient's computerized medical record and asks a series of questions that are customized based on patient history.

She asks patients if they have a follow-up visit, if they have filled their prescriptions, and if the home care nurse has visited.

"We have found at times that our case manager sets up home care, but because of miscommunication, the nurse doesn't arrive. The same is true of durable medical equipment. We want to intervene and correct the problem as soon as possible," Pisarsky says.

The discharge follow-up case manager also asks patients questions about adherence to their treatment plan and answers any question or concerns, then takes appropriate action.

For instance, if the patient doesn't have a follow-up doctor's appointment, she sets one up. Sometimes patients can't afford their medication so she helps them get medication assistance.

If patients seem to be unable to care for themselves, the follow-up case manager can set up home care visits.

Sometimes patients refuse home care when they are in the hospital, but after they get home, they are uneasy about changing their dressing, are confused about their medication, or don't understand what to do when they have symptoms, Pisarsky says.

"A lot of times, patients who thought they didn't need home care find out that they do need help in adhering to their treatment plan. We are taking proactive steps to make sure they can stay safe and healthy at home," he says.

Since the project started just 18 months ago, it's too soon to have definitive data on reducing readmissions, Smith says. However, the hospital reports increases in referrals and other processes that are expected to affect the readmission rate.

Since the initiatives began, the hospital has experienced a 32% increase in home care referrals, a 7% increase in referrals to nursing homes, a 30% increase for community resources, and a 50% increase in referrals to programs that help indigent patients with their medication, Pisarsky says.

The QIO is working with community partners to ensure that the patients are educated on how to plan for their discharge and are trained and encouraged to assume responsibility for their health.

One staff member at AQAF is dedicated to working with community agencies, such as soup kitchens, senior centers, and organizations for the aging, Smith says.

The QIO has partnered with the University of Alabama School of Nursing on a project to measure patients' level of activation in taking respon-

sibility for their own care.

As her school project, a student at the University of Alabama School of Nursing visits patients in the hospital and administers the Patient Activation Measure (PAM), which is used to determine which patients are at high risk for readmission and most appropriate for coaching.

The QIO is paying for a coach to visit the patients in their homes after discharge to go over the patients' health records, help them understand their medication regimen, ensure that they have a follow-up visit with a physician, and if necessary, goes to doctor visits with the patients.

"The coach encourages the patients to keep a personal health record updated and coaches them on what questions to ask their physicians and how to ask them," Smith says.

The coach makes three follow-up calls within 30 days of discharge to make sure the patient is managing his or her own care.

The project focuses on readmissions for Medicare patients but should have an effect on readmissions for patients with all types of insurance or no insurance, Smith says.

"The information we learn from this project and the processes that the hospitals put in place should reduce avoidable readmissions for all patients," she says.

[For more information, contact Brian Pisarsky, RN, MHA, ACM, CPUR, director, case management services, DCH Regional Medical Center and Northport Medical Center, e-mail: bpisarsky@DCHSYSTEM.COM.] ■

MI system leads in effort to improve transitions

Hospitals will be hearing a great deal more about care transitions and reducing readmissions in coming years. Discharge planners and hospitalist leaders will be searching for models that are affordable, effective, and sustainable.

The University of Michigan Health System in Ann Arbor is involved in a collaborative care transition project that builds on its use of Project BOOST (Better Outcomes for Older adults through Safe Transitions) tools and strategies.

Hospitals and leaders involved in discharge planning should keep in mind that medical staff and DP staff try their best to provide high-quality care to patients, but the nature of their schedules can make communication among providers challenging, says **Christopher Kim**, MD, MBA, an assistant professor of internal medicine in pediatrics and an assistant medical director for the faculty group practice at the University of Michigan Health System in Ann Arbor. Kim, who is closely involved in the care transition project, also is an assistant chief of staff for the office of clinical affairs at the health system.

"We collaborate to ensure each patient's hospital stay is the best it can be, but when it's time for patients to leave, the process could be improved," Kim says. "This is one of the quality improvement needs that Project BOOST has helped us recognize."

Patient care transitions require input from all disciplines, including hospitalists, floor nurses, discharge planning nurses, social workers, therapists, and primary care physicians, he notes.

"But often, we're not working purposely together; we're working at our own pace and direction," Kim says. "BOOST helps us focus our efforts and energy better as we work on that particular phase of the patient's care."

Based on the health system's Project BOOST experience and its more recent involvement in the Michigan provider-insurer care transition initiative, Kim offers these suggestions for how hospitals can improve their discharge planning communication and process:

• **Use a risk assessment tool to identify at-risk patients:** Hospitals could develop their own risk assessment tool or select one that has been used successfully by other facilities.

Kim recommends they check out Project BOOST's 7P screening tool (available for download at www.hospitalmedicine.org).

The two-page checklist covers these seven main risk assessment areas:

— problem medications;
— punk (depression);
— principal diagnosis;

KEY POINTS

• In discharging patients, use a risk assessment tool to identify at-risk patients.

• Create interventions based on findings from screening tool:

• Multidisciplinary collaboration is key to positive discharges.

— polypharmacy;
— poor health literacy;
— patient support;
— prior hospitalization.

"These are pretty broad categories," Kim notes. "But what using the tool has helped us recognize in our own patient population is that most of our patients actually have one or more of these problems when we screen them."

• **Create interventions based on findings from screening tool:** "The next step is how do we engage the hospital's health care staff to address those aspects of the patient's risks?" Kim says.

The BOOST 7P screening tool includes recommended interventions under each of the risk areas. For example, the problem medications section has these checkboxes:

— medication-specific education using teach-back provided to patient and caregiver;
— monitoring plan developed and communicated to patient and aftercare providers where relevant (e.g. warfarin, digoxin, and insulin);
— specific strategies for managing adverse drug events reviewed with patient/caregiver;
— follow-up phone call at 72 hours to assess adherence and complications.

The screening tool's second page includes a nine-point universal patient discharge checklist, plus five considerations for increased risk patients.

"This tool helps us to ensure the patient's transition and needs have been addressed by somebody," Kim says. "It includes a look at the patient's social needs prior to going home and medication reconciliation."

The additional considerations list such items as having direct communication with the principal care provider before discharge and having phone contact with the patient or caregiver within 72 hours post-discharge to assess the patient's condition, discharge plan comprehension, adherence, and to reinforce follow-up.

"In the past, we've probably recognized that the patient had one or more risk factors or needs, but how we intervened was a siloed process," Kim says. "Now, we want patients actively monitored from the get-go, and we'll have the entire team involved in the discharge process."

• **Focus on education and using teach-back method:** Hospital discharge planning should continually assess and improve patient education strategies.

Kim recommends using the teach-back method, which also is promoted in BOOST materials.

The teach-back concept encourages patients to actively participate and become engaged in their medication and medical condition, Kim notes.

A first step is to explain how the patient's medications have changed and listing prescriptions that are added or deleted. Then the discharge planner will reinforce what the patient already knows about existing prescriptions.

The teach-back part is when the discharge planner asks patients to acknowledge their understanding with a question such as: "We'd like to be sure we did a good job of explaining this to you. Would you mind repeating back to me what I just explained to you about your condition or medication?"

• **Think outside the hospital care box when addressing patients' transition issues:** The BOOST 7P screening tool includes a general assessment of preparedness (GAP) section that lists logistical issues and psychosocial issues that generally fall outside the purview of hospital medicine.

"We use the risk assessment to collect more information about patients' needs, perhaps to pick up on something we've overlooked," Kim says. "Perhaps we could have made more of an effort to speak with the patient and caregivers at home, or we could have ensured a better handoff to the primary care physician."

The screening tool's logistic issues include assessing whether the home has been prepared for the patient's arrival and whether the patient will have transportation to the initial follow-up visit. Under psychosocial issues, the tool has providers assess whether the patient's substance abuse/dependence has been evaluated and whether a support circle for the patient has been identified.

Another example of thinking outside the box involves having hospital transition planning include consideration of palliative services.

"Patients who are hospitalized multiple times for chronic diseases sometimes are deemed terminal, but they might not have the opportunity to discuss the option of consulting with a palliative care specialist," Kim explains. "Palliative care is a specialty area that could be very helpful to the patient and patient's family."

If hospital discharge providers identify patients who have had repeated hospitalizations within a six-month period, and their chronic disease status appears to be worsening, they might suggest the patient and family speak with a palliative care specialist, he adds.

Some hospitals will make a palliative care consultation an automatic referral when such patients are identified.

• **Stress collaboration:** "A critical piece is how

we can all work together to improve the transition phase of patient care," Kim says.

It's no longer useful for each discipline to do their part alone.

"This is why we've initiated discharge or transition care rounds where we gather together all of these disciplines," Kim says. ■

What to include in informed consent

When performing informed consent, there are several critical elements for hospitals, including a list of the procedures that your facility has compiled that require informed consent, says **Sue Dill Calloway**, RN, Esq., BSN, MSN, JD, a nurse attorney and medical legal consultant in Columbus, OH. Calloway recently presented an audio conference on "Informed Consent 2010: The Latest in CMS and Joint Commission Consent Requirements" for AHC Media.

This list is a requirement of the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission. "You have to have a list of procedures that you do in the hospital, and you have to say 'yes' or 'no,'" Calloway says. "Make sure that all of the procedures that your physicians and your licensed independent practitioners are credentialed and privileged for are on that list."

CMS says that signed informed consent forms are needed for all hospital surgeries except in emergencies, she says. It "doesn't matter whether they're inpatients or outpatients," Calloway says.

Calloway supports individualized consent forms for each procedure, although she acknowledges that such forms take a lot of time and effort and they must be kept updated. "But I really think it's worth it, having been a defense attorney," she says.

CMS surveyors are told to confirm that the policy discusses state law and that the state law requirements are included on the consent form. They also are told to pull six medical records from the hospital. They also are told to ensure the consent forms have the minimal or mandatory elements, she says. Those elements are:

• **The name of the facility**. When a patient is having elective surgery and is receiving the consent form in a doctor's office, the doctor doesn't always think to put the name of the hospital on the form, Calloway says. "That's one of the two that the doctors miss," she says.

• **The procedure.**

• **Description of the surgery, plus risks and benefits.** The description of the surgery should include the anesthesia to be used, Calloway says. You have the option of spelling out the risks, benefits, and alternatives, or simply saying on the form, "The risks and benefits and alternatives have been discussed with me," she says.

"And of course, having been a defense lawyer, I would really like to say `the risks include but are not limited to,' and that you specifically name the reasonably known risks," Calloway says.

• **The practitioner.**

• **Who is going to perform the surgery.** The Centers for Medicare and Medicaid Services (CMS) requires that you list whoever is doing important parts of the surgery, even if the surgeon is in the OR supervising the entire time, Calloway says. Patients must be informed about staff who are assisting, such as the RN first assistant, surgical physician assistant, or surgical resident, she says. However, you aren't required to list the names of the assistants, Calloway says.

She says that one teaching hospital says in its consent form, "We are a teaching hospital, and as such we have surgical residents on most of our cases and they do help us with important parts of the surgery including helping make the decision, helping close up the incision," etc.

List all potential physicians

Be careful, Calloway warns. "If you're in a group where you cover for each other like gastroenterologists..., just say, 'Anyone in our group could be doing the procedure including A, B, and C.' Or 'Dr. A is going to be doing it, but often, the way that we're set up, any of the [doctors] can fill in, and so you have permission for Dr. B, C, and D,'" she says. If you have one doctor listed, and another doctor performs the procedure, "you don't have any informed consent," she says.

• **Signature/date/time.** The time is the second element that physicians often miss, Calloway says. Representatives from CMS and The Joint Commission want everything timed: "every time of every order, time of every consult report, a time of everything in the progress note," she says.

• **The state law requirements.**

Recommendations for surgery centers

For ambulatory surgery centers, CMS officials say that a well-designed informed consent process would most likely include a discussion of the fol-

lowing:

- a description of the proposed surgery, including the anesthesia to be used;
- the indications for the proposed surgery;
- treatment alternatives, including the attendant material risks and benefits;
- who will conduct the surgery and administer the anesthesia;
- whether physicians other than the operating practitioner will be performing important tasks related to the surgery. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices, and placing invasive lines;
- whether, as permitted by state law, qualified medical practitioners who are not physicians will perform important parts of the surgery or administer the anesthesia, and if so, the types of tasks each type of practitioner will carry out; and that such practitioners will be performing only tasks within their scope of practice for which they have been granted privileges.

Don't forget the implants

In addition, informed consent documentation should include details of the implant, legal sources say.

One option is to list the specific type and size of implement, such as 450 cc Mentor silicone implant, says **Patricia S. Calhoun**, JD, associate at Buchanan Ingersoll & Rooney in Tampa, FL.

"The physician should have already thoroughly discussed this information with the patient, but by putting it in writing, the [ambulatory surgery center] can have some additional assurance that the patient is truly informed," Calhoun says.

However, the physician might not know ahead of time exactly what size implant will be used, which would mean that the consent would have to include a list of the options or a range of possible options, she says. In addition, the facility might not have that information in advance and would have to wait for the physician to provide the information before the consent is signed, which could cause delays, Calhoun says.

"And there is the problem about what happens when the physician no longer wants to use the proposed size or style, based upon his or her surgical findings," she says. "Surgery is an art, not just a science, and decisions made based on the findings during surgery are well within the standard of care"

Managers will have to weigh the options and determine if adding that information to the consent improves their outcomes and/or the quality of care, Calhoun says. ■

NEWS BRIEFS

Fewer complications for bariatric high performers

The number of bariatric surgeries in the United States skyrocketed from 13,386 in 1998 to 220,000 in 2008. But a new study released by Golden, CO-based HealthGrades finds that the nation's hospitals have wide variances in both complication rates and lengths of stay, which largely correlate with the number of times the hospital performs bariatric procedures.

According to the study, patients undergoing bariatric surgery at hospitals rated with five stars by HealthGrades experienced, on average, 43% fewer complications and 10% less time in the hospitals than patients at average hospitals.

Hospitals receiving a five-star rating in bariatric surgery have complication rates that are, to a statistically significant degree, lower than expected based on their patient population. Hospitals receiving a three-star rating performed as expected, and those receiving a one-star rating have complication rates that are higher than expected to a statistically significant degree.

COMING IN FUTURE MONTHS

- What can be done to reduce multiple readmissions?
- HHS unveils patient safety, medical liability demonstration projects
- What changes should you make to accommodate obese patients?

The study found that:

• Patients having bariatric surgery at five-star-rated hospitals are 42.66% less likely to experience in-hospital complications than patients at three-star-rated programs, and 66.55% less likely compared to one-star-rated programs.

• Five-star-rated hospitals had an average case volume of 646 surgeries performed over three years, while one-star-rated hospitals averaged 384 cases.

• While in-hospital mortality is generally an uncommon complication, patients had ,on average, a four times higher risk of dying if they had a bariatric surgery performed at one-star-rated hospitals compared to five-star-rated hospitals.

• If all bariatric programs from 2006 through 2008 had performed at the level of five-star-rated hospitals, 5,046 patients could have potentially avoided a major in-hospital complication across the 19 states studied.

• Patients having surgery at five-star-rated hospitals spent, on average, less time in the hospital (two days) compared to patients treated in three-star-rated hospitals (2.21 days), and almost a half a day less than patients having surgery in one-star-rated hospitals (2.48 days).

• Bariatric Centers of Excellence (COE) were more likely to receive a five-star rating than non-COE programs (25.6% of COE programs were five-star rated while only 10.9% of non-COE programs received a five-star rating).

The full study and individual hospital ratings for bariatric surgery and other procedures can be found at www.healthgrades.com. ■

PA hospitals lead in preventing CLABSI

Data released today by the Centers for Disease Control and Prevention show that Pennsylvania continues to be a leader in the prevention of central line-associated bloodstream infections (CLABSIs), with Pennsylvania's hospitals reporting infection rates below the national average for the first six months of 2009. Pennsylvania's standardized infection ratio is 0.70, significantly below the national average of 0.82. (The infection data can be found in the CDC's *Morbidity and Mortality Weekly Report* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a6.htm.) ■