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Suicides in the hospital: The liability risk nobody wants to talk about

Most prevention focused on psych care, but ED also is high risk for suicides

The phone on your desk can ring with news of a wide variety of events that will make your heart sink and yield trouble for the hospital for months to come, but few can rival being notified that a patient has committed suicide in your emergency department (ED).

It doesn't happen routinely, but it happens too much, and the risk manager can play a large role in reducing the likelihood of this tragedy and this huge liability risk for the organization. The challenge is that most health care providers don't want to talk about suicides in acute care.

It's not supposed to happen, and when it does the provider just wants the incident to go away with little attention.

That reluctance to discuss the risk of suicide stands in the way of prevention efforts, says **Edwin D. Boudreaux**, PhD, professor in the departments of emergency medicine and psychiatry at the University of Massachusetts Medical School in Worcester. Boudreaux is studying suicides in acute care settings, particularly the ED, and he says risk managers must acknowledge the risk and address it head on. (*See the story on p. 28 for more about Boudreaux's research.*)

His research has shown that 8% to 10% of all patients in the ED have some level of suicidality — a level that he says warrants serious attention.

"There aren't a lot of evidence-based strategies to recommend with research to back them up," Boudreaux says. "People have been risk-averse

EXECUTIVE SUMMARY

Patients commit suicide in hospitals at an alarming rate, and most health care providers do not adequately screen for patients at risk. The emergency department is one of the most common sites of patient suicides.

- Research suggests 8% to 10% of ED patients are at risk of suicide.
- Providers are reluctant to talk about patient suicides because of the stigma and negative publicity, as well as the legal liability.
- Universal screening of all ED patients for suicide risk may be the best solution.

to doing research in this area because doing research with people who are suicidal is the least attractive to a researcher because of all the ethical, human subject, and investigational review issues that come up.”

Patient jumps out window

In his career, Boudreaux has been witness to two

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Editorial Questions

For questions or comments, call Greg Freeman, (770) 998-8455.

suicides in another hospital in which he worked previously. The two instances illustrate how different suicides can be and how prevention efforts must be tailored to include both. In the first instance, a patient on a general medical floor became agitated and said he was going to kill himself.

“He ripped a TV off the wall, threw it through the window and then jumped after it,” Boudreaux recalls. “He plummeted eight stories to his death.”

The second suicide, in the same hospital, involved a patient who had a known psychiatric history but was not screened for suicide risk in the ED. The patient asked to go to the bathroom and hanged himself from the rafters there.

“So it can be very dramatic, the most dramatic exit you can imagine, or it can be someone realizing that the patient hasn’t returned from the bathroom in an hour and going to check on him, only to find him hanging,” he says.

Hospital increases screening

After the suicide in the ED, the hospital conducted a sentinel event analysis and a root cause analysis. As a result, the hospital implemented a universal screening program for all emergency patients during the triage process — the earliest opportunity to discover the risk. Waiting until the patient is seen for treatment is too late, because the patient may commit suicide while in the waiting room.

“The waiting room in the ED is a nightmare, and you don’t want to throw someone who is suicidal into that,” Boudreaux says. “Patients have killed themselves after waiting hours in the ED, so it doesn’t help you much to wait until they are in the exam room to start asking about suicide risk.”

The hospital also implemented a “wraparound safety system” for any individuals identified as a suicide risk by the triage nurse. From that point on, there is a warm handoff of the patient from point to point, so that the person is never left alone. The triage person walks to the patient to the treatment area and makes sure that another nurse is in the room before leaving. From that point on, the patient is never left alone until discharge or it is determined that the patient is not at immediate risk of suicide.

TJC calls for more attention

Within the behavioral health community, and on the psychiatric units of acute care hospitals,

providers are much more oriented toward screening for suicide risks and taking the appropriate precautions, Boudreaux says. But in other health care settings, the risk of suicide receives little attention unless there is an overt threat — and sometimes not even then, he says.

The Joint Commission recently addressed the risk in a Sentinel Event Alert that emphasized the need for more prevention efforts in inpatient settings other than behavioral health. “It is noteworthy that many patients who kill themselves in general hospital inpatient units do not have a psychiatric history or a history of suicide attempt — they are ‘unknown at risk’ for suicide,” according to the alert. “Compared to the psychiatric hospital and unit, the general hospital setting also presents more access to items that can be used to attempt suicide — items that are either already in or may be brought into the facility — and more opportunities for the patient to be alone to attempt or re-attempt suicide.” (*The entire Sentinel Event Alert is available online at http://www.jointcommission.org/assets/1/18/SEA_46.pdf.*)

Suicide has ranked in the top five most frequently reported events to The Joint Commission (TJC) since 1995. The Sentinel Event Database includes 827 reports of inpatient suicides. Of the 827 reports, 14.25% occurred in the non-behavioral health units of general hospitals, and 8.02% occurred in the ED of general hospitals. Another 2.45% occurred in other non-psychiatric settings such as home care, critical access hospitals, long-term care hospitals, and physical rehabilitation hospitals.

TJC notes, however, that most of the events are voluntarily reported and represent only a small proportion of actual events. The actual incidence of suicide in non-behavioral health units likely is higher, according to TJC.

“Even though 827 is not a huge number, it’s shocking that that many people committed suicide on the grounds of our hospitals,” he says. “That’s a sentinel event for sure, and when it happens, it shakes up the hospital in a big way — the negative publicity, the lawsuits that are very likely afterward, and the impact it has on the staff who witnessed the suicide or could have prevented it.”

Among the reported events, the location of the suicides included bathroom, bedroom, closet, shower and other locations, or they occurred after discharge or leaving the hospital against medical advice. The methods of suicide included hang-

ing, asphyxiation by other than hanging, gunshot, jumping from a height, drug overdose, laceration, drowning, jumping in front of a moving vehicle, ingestion of poison, stabbing, and burning.

The alert from TJC should be taken seriously because it is prompted by the number of actual suicides and not just a theoretical risk, says **Cindy Baldwin**, RN, MS, CNP, director of risk management and patient relations at Sanford Health in Sioux Falls, SD. EDs are inherently unsafe for suicidal patients because it is impossible to remove all potentially dangerous items, she notes.

In her facility, the alert prompted a multidisciplinary meeting that included the risk manager, other administrators, environmental safety officers, physicians, and nurses to discuss what precautions already were in place and what additional improvements could be taken. The hospital already screened everyone in the ED for mental health issues, but the meeting served as a reminder that it is everyone’s responsibility to be alert to suicidal risks, she says.

“Everyone who comes into contact with the patient and family is a resource, eyes and ears to alert us to any change in status or comments that could signal danger for that patient,” Baldwin says. “We emphasize that we want to hear about anything, even a comment that sounds just random or not so serious, if it could mean the patient is suicidal.”

If a patient is identified as a possible suicide risk, the ED staff take precautions such as removing items from the room that could be dangerous, assigning a staff member to be with the person at all times, and searching the patient’s belongings for anything that could be used for harm. ED staff have access to a summary of the hospital’s policy and procedures on patients at risk of suicide, which includes a checklist of items to remove from the exam room and a reminder that patients under suicide observation cannot be left alone even when using the restroom.

The recent meeting revealed another problem that needed attention.

“We can take away dangerous items from the high-risk patient, like the belt and shoelaces, but then the patient may call his family and ask them to bring new clothes, or a blow dryer or curling iron,” Baldwin says. “The family wants to help and may not realize they are giving the patient something to harm himself with. So we increased our education for the family, explaining what items could not be brought into the room.”

In addition, the Sanford Health ED now has a policy of considering every patient who comes in with a drug overdose to be high risk for suicide, whether the overdose was thought to be intentional or accidental.

Sometimes no obvious signs of risk

TJC's National Patient Safety Goal 15.01.01 requires behavioral health care organizations, psychiatric hospitals, and general hospitals treating individuals for emotional or behavioral disorders to identify individuals at risk for suicide. That suggests that hospitals are obliged to screen ED patients for suicide risk only when there is reason to suspect emotional or behavior disorders, but the alert clearly encourages liberal screening and a low threshold for suspicion.

Boudreaux says that touches on part of the problem: Sometimes you don't know that a patient being treated for a physical ailment is suicidal because he or she shows no outward signs of mental distress. "Sometimes hospitals assume that you only have to screen for suicidality with people who have obvious risks of being suicidal, such as people who come into the ED with a psychiatric problem," he says. "The vast majority of people who come into the ED are not being screened. Of the people who commit suicide in the ED, there's going to be some who were identified and adequate precautions weren't taken, but some significant percentage will be people who were never identified as a suicide risk."

At a minimum, Boudreaux recommends broadening the conditions that would trigger a screening for suicide risk. Rather than screening only those patients with psychiatric conditions, for instance, you can also screen those with substance abuse problems, teenagers, those who are very upset, and anyone whose injury might be self-inflicted. The best option, however, would be to screen all patients in the ED for suicide risk, he says.

"Look at it like screening for hypertension. No one would come into the hospital and not get their blood pressure checked, regardless of whether they had any risk for high blood pressure," Boudreaux says. "Similarly, you could screen all patients for thoughts of harming or killing themselves, or whether they have ever made an attempt."

Boudreaux acknowledges that ED staff and physicians will not welcome the addition of another

screening to add to the long list of other required screenings. Many will question whether it is necessary to spend time and effort screening for something that doesn't happen often.

"They're right that too many people are urging them to screen for everything under the sun. But if they're going to prioritize screening, I'd say the ones at the top of the list are those that can potentially lead to death," he says. "A much larger proportion of patients in the ED are either thinking of killing themselves or have thought about it in the last 30 days than are hypertensive. In terms of risk reduction, suicide should be a priority because it can kill your patient imminently, not some time down the road."

SOURCES

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Study will focus on suicide prevention in ED

The Department of Emergency Medicine at the University of Massachusetts Medical School, Worcester is conducting a \$12 million, multisite study funded by the National Institutes of Mental Health aimed at improving suicide prevention in hospital emergency department (ED) patients.

Edwin D. Boudreaux, PhD, professor in the departments of emergency medicine and psychiatry at the University of Massachusetts Medical School in Worcester, is leading a team of colleagues conducting the Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) trial, which is expected to enroll 1,400 participants over five years.

"We're asking two main questions with this study: Does universal screening increase the detection of suicidality? And, can care for patients be improved to reduce attempted and completed suicides?" Boudreaux says.

There have been relatively few controlled trials that evaluate interventions to reduce suicidal

behavior, despite the public health significance, Boudreaux says. He notes that the ED setting is well suited for this type of research. In 2006, there were more than 500,000 ED visits related to intentional self-harm, and the rate of ED patients having active thoughts of suicide is estimated to range from 3% to 8%, he says.

“We believe we may have an opportunity to impact suicide by connecting with patients while they’re in the ED,” Boudreaux says.

ED-SAFE will be conducted in three phases. The first phase will assess “treatment as usual” (TAU) for patients, which typically consists of evaluating suicide risk only among those emergency department patients who have psychiatric risk factors, such as depression, suicidal thoughts or behavior, or substance abuse. Often these patients are put under observation while at the hospital and are evaluated by a mental health provider. While some may be referred to a mental health professional outside the hospital, few receive adequate follow-up care after they are discharged, Boudreaux says.

During the second phase of the study, a universal screening process will be tested in which all patients, regardless of whether they exhibit typical risk factors for suicide, will be screened for thoughts of suicide. The researchers will compare universal screening with TAU to determine how well each detects suicidal patients.

“People are familiar with the type of questions they’re routinely asked in doctor’s visits, such as whether they have pain or whether they smoke,” Boudreaux says. “Those questions help physicians screen for possible health risks and refer the patient to appropriate care. Applying that same model, we’re looking to see whether asking whether individuals have thought about killing themselves, or have had a past attempt, will help identify those at risk so we can intervene before they take any action.”

During the third phase, a more intensive intervention that includes screening, brief counseling, an evaluation by a mental health provider, referral to outpatient care and other components will be implemented. Patients will then receive follow-up phone counseling after their ED visit. The intensive intervention will be compared to TAU and to universal screening.

The study will be conducted at eight sites, selected to represent both broad geographic regions of the United States and patient demographics. ■

Not just patients: Physicians also at risk

Risk managers focusing on the risk of suicide should remember that their own physicians also can be at high risk, says **Matt Steinkamp**, vice president of service delivery at Physician Wellness Services, a company based in Minneapolis that helps employers deal with impaired physicians.

Compared to the general population, physicians have a significantly higher rate of suicide, Steinkamp says. In the general population, the rate of suicide is much higher among men, but among physicians the rates of suicide are almost the same among men and women, he says.

“The reasons for the high rates of suicide among physicians are because they have the knowledge of how to effectively commit suicide and they have the access to the pharmacology that gives them the means to do it,” Steinkamp says. “The success rate for female physicians is significantly higher, in the neighborhood of 200% to 300% higher, than for females in the general population.”

There are several reasons for the increased risk. Physicians tend to hold themselves to high standards and can be perfectionists, so medical errors can have devastating effects. They also work in high-pressure situations and can be workaholics, he says. The resulting stress can be magnified for those who feel a strong duty to their patients, Steinkamp says. Health care employers are starting to recognize that the physician population is at special risk of suicide, and some are addressing the problem, he says.

Physician suicides take place in the health care facility, but providers are reluctant to talk about such instances, Steinkamp says. Particularly when the physician was diverting drugs, possibly for some time before the suicide, the health care provider will not be eager to draw attention to the matter, he says.

Preventing drug diversion can be one of the most effective ways to prevent physician suicide, Steinkamp says. Physician wellness committees and other resources for troubled doctors also can help. Physicians who are struggling will respond best to their peers, so a wellness committee or physician leaders who promote dialogue about stress and other concerns can make a difference, Steinkamp says.

Physicians also need to understand how the

employer can help them with their problems, especially substance abuse issues. The doctor will be extremely concerned about losing his or her license, so the employer should stress that it will do everything possible to get help for the physician without endangering the license, Steinkamp says.

The culture at the hospital has to emphasize that physicians can get help without facing punitive measures, he says. Also, physician leaders and administrators should be on the lookout for warning signs such as being withdrawn, a change in personality, and irritability.

“If you’ve gotten to the point that the physician is diverting drugs and contemplating suicide, you’ve missed some warning signs,” he says. “People don’t just decide to kill themselves on the spur of the moment. There were signals there if anyone was paying attention.”

SOURCE

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Analytics help improve physician response

Analytics help hospital defend malpractice cases

Most hospitals have no documented information about communication events — phone calls, pages, texts, voicemails — between their nurses, physicians and other clinicians that occur hundreds of times each day. One hospital in Ohio not only is capturing detailed data on these incidents, but also is using it in creative ways to manage risk, safeguard patients, and improve the responsiveness of its medical staff.

St. Rita’s Medical Center in Lima, OH, serves a 10-county area in northwestern Ohio and is the largest hospital in a 70-mile radius. Since 2005, the hospital has been using a sophisticated clinical communications system to ensure that calls and messages route to the right clinicians at the right time, based on their workflow, call schedules contact preferences, and the clinical situation.

In addition, the hospital has found ways to benefit from the data analytics that are possible with the service, says **Herbert Schumm**, MD, St. Rita’s

vice president of medical affairs.

The system processes about 180,000 clinical communication events annually among St. Rita’s clinicians and provides analytics, which enable detailed reporting about each contact event, Schumm says. This information gives St. Rita’s invaluable insights into its clinical communication processes — and the outliers that increase risks.

St. Rita’s uses the PerfectServe system from the company based in Knoxville, TN. Other vendors of communications and analytics systems include Vocera, based in San Jose, CA. Check with your communications vendor for similar options.

A system like the one in place at St. Rita’s eliminates the need for subjective interpretations when the hospital must establish the steps and timeline of a communication process preceding an adverse event, Schumm explains. Using the system’s analytics, the hospital can quickly identify and drill into data that shows the specific time each communication event was initiated; the originating department and number; the intended recipient; the actual recipient; the contact modality (cell phone, voicemail, text message); the length of the call; and, for calls that employ failsafe contact processes, whether and when a specific call was answered by a clinician and the elapsed time to retrieve a voice message.

‘Black box’ for adverse events

The hospital uses this data whenever it is investigating cases relating to quality or risk management. In fact, St. Rita’s decided to implement PerfectServe after it was unable to prove that one of its nurses had contacted a physician three times, Schumm says.

“This is our ‘black box’ for communications that lets us piece together exactly what happened and when,” Schumm says. “Also, our physicians have become conscientious about being responsive, in part because they are aware that

EXECUTIVE SUMMARY

An Ohio hospital reports significant improvements with a software system that collects and analyzes data from communication among caregivers. The system has improved patient safety and efficiency.

- The system improves documentation and malpractice defense.
- Handwriting interpretation was improved so much that clarification calls dropped 40%.

we automatically document the communications process.”

Using the system’s analytics, the hospital can quickly identify and drill into data whenever it is investigating cases relating to quality or risk management, Schumm says. After an adverse event, the hospital can quickly determine what calls were made between the physician and the unit, with exact time frames.

Documentation can be pivotal

“It really helps us start to put together a timeline,” he says. “From a risk management standpoint, it’s a huge help with the root-cause analysis. Normally you would have the charts and people’s recollections, but with the analytics system you have the exact time of every phone call. That becomes powerful.”

Some of that information can be found in a hospital’s normal phone system, but St. Rita’s found in the past that like most such phone systems, the memory only stored a fairly small amount of information before erasing it. Once they were aware of a problem or lawsuit months later, the data often was unavailable. Going through the phone company was slow and laborious, and the hospital had to pay for the research.

For those reasons, St. Rita’s rarely relied on phone records to investigate problems or defend lawsuits. Now Schumm can pull up the phone records for any incident on his own computer within a couple of minutes. He notes that avoiding just one malpractice settlement can pay for several years of subscribing to a communications system.

“We’ve had two cases recently where the documentation was pivotal in the defense, because we were able to show that calls did go out and exactly when,” he says. “I just had a physician come and ask for the calls he made to St. Rita’s a couple of years ago, because he was being sued. I got them up and printed them off while he waited just a few minutes.”

Data can defend physicians

The system can come to the physician’s defense as often as it catches their failures. Schumm recalls a case in which a patient’s care was compromised because the physician supposedly did not respond to several calls from an in-house clinician. The staffer claimed to have called the physician several times and provided the exact times of her calls.

“It didn’t match up at all with our call logs,”

Schumm says. “Those calls just weren’t there. That is very persuasive when I can sit down with a manager and say, ‘Here’s what your staff person says happened, and here’s what our objective data shows us.’”

Schumm notes that such discrepancies are not always the result of deception. They can result from poor communication and simple mistakes, he says. For instance, a nurse may stop by the unit desk and say to another nurse, “Give Dr. Jones a call about the heparin for Mrs. Smith.” She leaves and assumes the call is made, even notes in the chart that the doctor was called. If the second nurse is distracted and does not make the call, the first nurse may assume the doctor never called back.

“We made another change so that on our units every nurse carries a modular phone and can place the call directly, going right into our system, and the doctor is paged to call straight back to that handset,” he says. “We’ve streamlined the communications system, and that has helped tremendously.”

Data help avoid arguments

According to the Joint Commission, communications breakdown is the single greatest contributing factor to sentinel events and delays in care in U.S. hospitals. St. Rita’s uses its analytics system to track a key source for such breakdowns, such as physicians who do not respond to calls.

Of the hospital’s approximately 15,000 monthly communication events processed by the system, about 15 to 25 are directed to the PerfectServe Help Center to report a problem with a physician not responding. Schumm and the patient safety team use monthly reports from the Help Center as a way to open a constructive dialogue with physicians whose names repeatedly appear on this list.

“It really helps to have such clear, objective evidence for the physicians,” Schumm says. “Most of the time, showing them the reports is enough to prevent future incidents. We also avoid the ‘he said, she said’ situations because the data shows us the process of what actually happened, helping us look past the emotions and get to the root cause of the problem.”

Not only does the system log when calls were placed to the physician, but it also records how long before the physician responded. This can be important information when the physician insists that he or she always responds promptly, Schumm says.

“We now have the verifiable data to say they are responding promptly or they aren’t,” Schumm says. “From the medical staff standpoint, that becomes what the Joint Commission calls focused performance practice evaluation, a way to monitor the performance of the physician who is not responding to calls. We’ve now had two physicians who just admitted they weren’t getting calls returned, and they left our staff.”

Since the system collects communications process information automatically, nurses do not have to “tattle” on doctors who do not always respond in a timely manner, Schumm notes. This not only relieves nurses of an uncomfortable task, but also enables St. Rita’s to avoid adversarial situations that can undermine physician-nurse relationships.

The hospital also works with physicians to manage their call volume.

“We keep an eye on how many calls physicians are getting and when they are getting them, so we can sit down and find ways to manage and prioritize them, which really helps the high-volume physicians,” Schumm says. “One of our nephrologists showed me his log for the day, and he’d taken 150 calls in one day. He couldn’t manage that, so we worked with his group to prioritize the calls and also to encourage more text messaging so he wouldn’t have to return so many calls.”

SOURCE

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Doc, can you read this?

Data helps to improve physician legibility

At most hospitals, the vast majority of physician orders are still written by hand. That means a lot of hurried squiggles that no one can decipher, and time-wasting phone calls to clarify the order, not to mention the threat to patient safety.

But St. Rita’s in Lima, OH, found that if you have the data to prove which doctors have the worst handwriting, you can cut the clarification phone calls by 40%.

A recent report found that only 14% of all U.S. hospitals are entering at least 10% of orders electronically — the level of computerized physician

order entry required to reach the federal government’s proposed standard for Stage 1 of meaningful use.

The legibility of these orders can be a problem that is more pervasive — and more of a threat to patient safety — than most hospitals realize, says **Herbert Schumm**, MD, St. Rita’s vice president of medical affairs. According to the Agency for Healthcare Research and Quality, poor penmanship is responsible for an estimated 6% of all hospital medication errors.

To address this issue, St. Rita’s used its communication and analytics system to document and measure incidents of illegible handwriting. For defined periods of time, the phone system prompted callers to indicate when they were calling to clarify an illegible order. The system captured data on where the order was received and who wrote it. The system then compiled this information into reports for the Patient Safety Steering Committee.

“We sat down with about four or five doctors and showed them the number of calls that were made to clarify their orders,” Schumm says. “We also reminded them to use pre-printed order sets whenever possible, and we explained that if they work on legibility, they can cut down on the calls they’re getting for clarification. Everyone wants fewer calls.”

The analysis showed that, during the first three months of the study, an average of more than 80 calls per week were made to clarify orders. On two subsequent analyses, after discussions with some of the doctors, the average was only 53, a drop of more than 40%. ■

EHR coming on strong, but so are security risks

You may be proud of your hospital’s progress towards adopting electronic health records (EHR), but you could be overlooking the additional risks of data security breaches.

A recent study found that many hospitals are rushing to adopt EHR in an effort to cash in on government incentives, but they are not adequately addressing data security and data privacy issues.

The study researchers coaxed health care leaders into providing candid, unvarnished assessments of their data security, and the results are alarming.

Nearly three-quarters of hospitals reported inadequate resources for protecting data, and more than half said they had no confidence in their ability to prevent data breaches.

Data breaches can result in significant liability — \$2 million per incident, according to the study. Lawsuits filed by patients are one risk, as illustrated by a class action lawsuit recently filed against AvMed Health Plans in Gainesville, FL.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 requires health care providers to provide stronger safeguards for patient data and to notify patients when their information has been breached, so the Ponemon Institute in Traverse City, MI, developed the study to determine how well health care providers are managing security as they increase the use of EHR. Ponemon conducts independent research on privacy, data protection and information security policy, as well as providing consulting services.

The “Benchmark Study on Patient Data Security Practices” also examines each health care organization’s privacy and data protection compliance activities, including policies, program management activities, enabling security technologies and security governance practices in addition to their ability to comply with the notification requirements mandated by HITECH.

(The full study can be found online at http://www2.idexpertscorp.com/resources/healthcare/healthcare-articles-whitepapers/ponemon-benchmark-study-on-patient-data-security-practices/?utm_source=Ponemon%2BRedirect&utm_medium=Online&utm_campaign=Ponemon%2BRedirect/)

Cloud computing needs attention

The study results suggest problems not just for the security of data within a hospital but also for that data when it is aggregated into off-site resources — “cloud computing” is one example — that allow easier access and synthesis, says Roy E. Hadley Jr., JD, a partner with the Cloud Computing and Cyber Security Practice of the Atlanta law firm of Barnes & Thornburg.

“It is readily apparent that securing the cloud is a work in progress and probably a work in its infancy,” Hadley says. “What you see from the

EXECUTIVE SUMMARY

Hospitals are making progress toward adopting electronic health records, but at the same time they are increasing the potential for data security breaches. The breaches can result in significant liability and harm for health care providers.

- Most hospitals report they are not confident they can prevent data security breaches.
- A data breach can cost the hospital about \$2 million in remediation and legal liability.
- Breaches often are detected first by the patient, not the provider.

work at the Ponemon Institute is that there are still a lot of data breaches, and a lot of them are still of the physical kind where someone lost a laptop or tossed records in a Dumpster. But I’m worried that as we move more to the cloud, data security breaches are going to become more prevalent. That’s the big concern.”

Risk managers must ensure that data security is a top priority when others in the organization are touting the benefits of EHR and getting everyone excited about making the switch, says John L. Watkins, JD, also a partner with the Cloud Computing and Cyber Security practice of Barnes & Thornburg in Atlanta.

As the government and both political parties push the health care industry to adopt EHR and off-site data management, such as cloud computing, the potential risks may not be getting enough attention, he says.

“When you aggregate information in a central location, you create a target-rich environment for bad actors,” Watkins says. “That has to be considered when you think about moving medical records to the cloud, which conceptually sounds like the logical way to do it.”

More than half starting EHR

The researchers interviewed senior-level personnel at health care providers to collect data on the actual data loss and data theft experiences at their organizations. A total of 65 health care organizations participated in the study. The health care organizations participating in the study are integrated delivery systems — a network of health care organizations under a parent holding company (35%), part of a health care network (46%) and stand-alone hospital or clinic (17%).

Fifty-six percent of respondents have either fully implemented or are in the process of implement-

ing. Respondents interviewed work in all areas of the organization: security, administration, privacy, compliance, finance, and clinical.

“Our study found that data breaches remain a frequent occurrence at health care organizations — threatening patient privacy and leaving healthcare organizations with a heavy financial burden,” the Ponemon researchers concluded.

These are some key findings of the study:

- **Data breaches are costing the health care system billions.**

According to respondents in the study, the economic impact of data breach incidents over a two-year period is approximately \$2 million per organization — the direct costs and associated financial losses of remediating a data breach incident.

Because the study primarily focuses on hospitals, researchers calculated the total economic burden created by data breaches on U.S. hospitals as almost \$12 billion.

- **Most health care organizations experience undetected breaches of patient data due to lack of preparation and staffing.**

Health care organizations in the study reported inadequate resources (71%), few (if any) appropriately trained personnel (52%), and insufficient policies and procedures in place (69%) to prevent and quickly detect patient data loss. These realities have left organizations with little or no confidence in their ability to appropriately secure patient records (58%).

- **Protecting patient data is not a priority.**

Seventy percent of hospitals say that protecting patient data is not a top priority. The majority of responding organizations have less than two staff dedicated to data protection management (67%). Most at risk is patient billing information and medical records, which are not being protected. In addition, patients are typically first to detect a significant number of breaches at health care organizations (41%).

- **Federal regulations have not improved the safety of patient records.**

The passage of the HITECH Act widened the scope of privacy and security protections under HIPAA to provide stronger safeguards for patient data. Despite the intent of these rules, the majority (71%) of respondents do not believe these new federal regulations have significantly changed the management practices of patient records.

(See the story on p. 35 for more results from the study.)

False sense of security is common

The results suggest health care providers are not fully considering the impact of switching to EHR, the researchers say. They often are under the impression that EHR improves security, when the opposite can be true.

“Respondents in our study believe the move to EHR may make patient records more secure,” the researchers write. “While the move to EHR may solve some of the security issues that health care organizations now face, it also creates new concerns for organizations to manage. This massive shift to digitized records makes patient data available to many more individuals within and outside the provider organization and leaves the data more vulnerable to the growing threat of cyber crime.”

The pattern of results suggests respondents are not very confident about their organization’s security environment, Watkins says. They appear to be most confident about standard agreements with business associates that clearly explain the requirements for data protection, training and awareness programs for all system users and compliance with legal requirements and policies, including privacy laws and statutes, he says.

Watkins notes that the study results suggest providers are nervous about what happens to patient data when it leaves their facilities. While 85% believe they comply with the legal requirements of HIPAA, only 10% are confident that they are able to protect patient information when used by out-sourcers and cloud computing providers.

“We’ve got health care providers adopting EHR faster than we’re adopting the security for them,” Hadley says. “Part of the problem is figuring out how to secure the information while still making the information available and usable in the way that everyone envisions. One of the things that ultimately will slow down adoption of EHR is if the health care industry can’t get a handle on how to keep that information secure.”

SOURCES

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Two data breaches a year is typical for hospitals

These are more results from the “Benchmark Study on Patient Data Security Practices,” conducted by the Ponemon Institute in Traverse City, MI:

- Sixty percent of organizations in the study had more than two data breaches in the past two years. The average number for each participating organization was 2.4 data breach incidents.

- The average number of lost or stolen records per breach was 1,769. A significant percentage of organizations either did not notify any patients (38%) or notified everyone (34%) that their information was lost or stolen.

- The top three causes of a data breach were: unintentional employee action, lost or stolen computing devices, and third-party errors.

- Forty-one percent discovered the data breach as a result of a patient complaint.

- Sixty-three percent of organizations say it took them between one to six months to resolve the incident.

- Fifty-six percent of respondents have either fully implemented or are in the process of implementing an electronic health records system. The majority (74%) of those who have an EHR system say it has made patient data more secure. ■

Reinertsen honored with Eisenberg award

James L. Reinertsen, MD, received a 2010 John M. Eisenberg Patient Safety and Quality award for individual achievement from The Joint Commission and the National Quality Forum.

A senior fellow with the Institute for Healthcare Improvement, Reinertsen now heads a consulting group, the Reinertsen Group in Alta, WY. He practiced rheumatology for more than 20 years and served as CEO of CareGroup, Beth Israel Deaconess Medical Center, and Park Nicollet Health Services.

Health care organizations must support the quality leaders and personnel, Reinertsen says. When those leaders “see a change that’s evidence-based and works and they now want to extend it to the whole organization” but they

encounter any kind of resistance — whether it’s resistant doctors or nurses or other providers or whether it’s financial resistance to support the change, they need the will of senior leadership, he says. “You need a board and a senior executive team that has backbone and is committed to this and has the will to make it happen.”

In order to activate boards, you must help them “see” the problems. You don’t do that by sending them data that are difficult to understand or too technical, he says. “You send them and tell them stories about harm that’s happening in your hospital this month,” and then you can give them the data.

“If there are 4.2% of your people getting some particular problem, how many actual people is that? Count them. That’s what you report to the board. You don’t report the rate; you report the number of people affected.” He says, many quality professionals he works with now show their boards the first name and last initial of the patient, and the date and name of the event. “That’s what they report to the board. Not technical data in complicated charts, but people. In essence, what I’m saying is that you make the board see the human side of this problem.” ■

CNE OBJECTIVES

Upon completion of this educational activity, participants 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. ■

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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 letter of credit. When your evaluation is received, a credit letter will be mailed to you.

8. According to Edwin D. Boudreaux, PhD, what percentage of ED patients typically are at risk of suicide?

- A. 3% to 5%
- B. 8% to 10%
- C. 15% to 20%
- D. 30% to 35%

9. How many inpatient suicides are reported in the Sentinel Event Database?

- A. 827
- B. 341
- C. 201
- D. 1,618

10. How much did St. Rita's Medical Center reduce calls to clarify physician orders?

- A. 10%
- B. 20%
- C. 30%
- D. 40%

11. According to research by the Ponemon Institute, how much does a data security breach typically cost a hospital?

- A. \$500,000
- B. \$1 million
- C. \$2 million
- D. \$3 million

ANSWERS: 8. B; 9. A; 10. D; 11. C

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Plaintiffs Allege Failure to Assess Severity of Condition; \$11.5 Million Verdict in Illinois

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NEWS: A 30-year-old pregnant woman presented to a hospital ER complaining of abdominal pain at a level of 10 out of 10. The woman was seen by an ER physician who diagnosed the woman as having a partial bowel obstruction. No further testing or procedures were immediately ordered, and the ER physician communicated to the surgeon that the situation was not serious. A few days after presenting to the hospital, the woman began experiencing the increased level of pain initially complained of and requested morphine. The woman's blood pressure also dropped at this time, and she was transferred to the postpartum unit. Early in the morning, the woman tried to access the rest room but became unconsciousness. It was discovered shortly thereafter that the woman had suffered a miscarriage. Ultimately, the woman underwent surgery, which uncovered that the woman's small intestine was twisted around the superior mesenteric artery, causing the small intestine to become ischemic and necrotic. As a result, five meters of the woman's intestine were removed and she ultimately had to undergo an intestinal transplant. The woman sued the ER physician, surgeon and hospital. A jury verdict in favor the woman and against the hospital was entered in the amount of \$11.5 million.

BACKGROUND: A 30-year-old woman,

14 weeks pregnant, began experiencing severe abdominal pain requiring her to leave her place of employment. She was unsuccessful in reaching her husband and ultimately called 911 and had an ambulance transport her to a local hospital. Around five hours after first experiencing the pain, the woman was seen by an emergency room (ER) physician, who determined that the pain was related to the woman's pregnancy and ordered an ultrasound. The ER physician consulted with the OB-GYN physician, who determined that the pain was not pregnancy-related. Based on this information, the ER physician then determined that the pain was related to partial bowel obstruction and consulted with a surgeon.

Fluids were ordered for the woman, and during this time her pain fluctuated between a 5 and 10 on a scale of 1 to 10. The woman's blood pressure was also not stable and at one point dropped from 126 over 72 to 87 over 52. The woman was transferred to the hospital's postpartum unit. A couple of days after being in the hospital, a nurse noted that the woman's pain had increased and that she had requested morphine. In the early morning, the woman attempted to access the rest room, where she lost consciousness and bladder control and went into septic shock. It was confirmed later that her baby had died.

Later that day, the woman underwent surgery, where it was discovered that she was suffering

from a twisted small intestine which was cutting off blood supply to the intestine, causing the small intestine to become ischemic and necrotic. As a result, the surgeon was forced to remove five meters of the woman's intestine. The woman remained in the hospital for nearly a month with no fluids or food before being discharged home. Five months later, the woman developed liver failure and jaundice, and an intestinal transplant was performed in order to save her life. Following the transplant, the woman and her husband lived in a hotel while she underwent constant evaluation and biopsies. One year after the transplant, the woman was able to ingest solid foods.

The woman sued the ER physician, surgeon, and the hospital for medical malpractice and alleged that the ER physician had not recognized the severity and urgency of the woman's situation based on her medical history and sought recovery of \$6.7 million in past and future medical costs. The plaintiffs, which included the unborn baby, sought wrongful death damages for loss of consortium. The woman also sought damages for psychiatric, psychological, and/or emotional injuries, as well as other unspecified personal and pecuniary damages. The woman's spouse sought compensation for loss of spousal consortium.

The plaintiffs alleged the hospital failed to recognize a significant and abnormal decrease in the woman's baseline blood pressure upon arrival in its emergency room; failed to assess her blood pressure upon arrival on the floor and compare it to her baseline blood pressure; failed to recognize her increasing heart rate; and failed to recognize pain disproportionate to the admitting diagnosis ruling out ileus for abdominal discomfort.

Specifically, the woman alleged that the hospital's nursing staff was negligent in failing to monitor her condition and call a physician when her pain increased to a 10 out of 10. At the time she requested morphine, the woman claimed, no morphine was administered and no physician was called. The plaintiff's expert agreed with the woman's claim and stated that the nursing staff should have appreciated the severity of the situation given the woman's pain and her falling blood pressure. The plaintiff introduced a number of experts in various fields that set forth damaging testimony for the defense regarding the circumstances surrounding the woman's miscarriage and ultimate need for a transplant.

Counsel for the defendants argued that the ER physician acted properly based on the diagnosis

of a partial bowel obstruction and the woman's pregnancy. The hospital's counsel also maintained that morphine was administered to the woman, which was evidenced by the woman's drop in blood pressure.

The surgeon's counsel also contended that he acted within the standard of care based on the information presented. Further testimony was presented that the woman's intestine had, in fact, died approximately five hours prior to the woman presenting at the hospital.

Considering only the claims against the hospital the ED physician and the surgeon, a jury returned a verdict finding only the hospital negligent. It awarded the woman and her husband \$2 million for past and future pain and suffering, \$2 million for past and future loss of a normal life and \$6.5 million for past and future medical expenses. It also awarded the woman, as special administrator of the estate of the unborn baby, \$1 million for wrongful death.

The judge in the case entered judgment in accord with the jury verdict the same day.

REFERENCE

Circuit Court of Illinois, Eighteenth Judicial Circuit, DuPage County, No. 05L1192

WHAT THIS CASE MEANS TO YOU: This case presents an interesting study on the interaction of various natural biological and pathological processes and the diligence that physicians and nurses must apply to the art of diagnosis and treatment.

While pregnancy is a natural biological condition, it can also be a potentially life-threatening pathological process when something unexpected and/or unnatural occurs. In the absence of a trauma-induced event, the emergency room physician appeared correct in his initial assumption that the patient may have been experiencing complications of her pregnancy.

The abdominal ultrasound would have been the first step in ruling out common complications of early pregnancy such as an ectopic pregnancy or miscarriage. The ultrasound examination will show whether the uterus contains a developing fetus or if masses are present elsewhere in the abdominal area. But the ultrasound might not be able to detect every ectopic pregnancy. The physician should also complete a pelvic exam to locate the areas causing pain, to check for an enlarged, pregnant uterus, or to find any other suspicious

masses. There are also blood tests that are useful in diagnosis of ectopic pregnancy. In this case there is no indication in the narrative that any other testing was completed when the ER physician consulted with the OB-GYN physician.

Eventual miscarriage is the probable outcome of ectopic pregnancy. As the fetus grows, it will eventually burst the organ that contains it. This can cause severe bleeding and endanger the mother's life. A classical ectopic pregnancy does not develop into a live birth. Presentation of a pregnant patient with classic symptoms of ectopic pregnancy is a medical emergency that requires immediate attention, not a five-hour delay.

Her severe abdominal pain is classic of both situations. The first warning signs of an ectopic pregnancy are often pain in the pelvis and abdomen. Most women describe the pain as sharp and stabbing. It may concentrate on one side of the pelvis and come and go or vary in intensity. Additional symptoms that also suggest an ectopic pregnancy include vaginal spotting, lower-back pain, dizziness or fainting, and low blood pressure. The latter are generally attributed to blood loss.

The narrative does not indicate why the ER physician came to the conclusion that the patient's pain was attributable to a partial bowel obstruction, but he did refer the case to a surgeon, which was an appropriate course of action.

An intestinal obstruction is a significant impairment to the passage of contents through the bowel. The symptoms include, cramping pain, vomiting, constipation, and lack of flatus. The diagnosis is usually confirmed by X-rays. Obstruction of the bowel may be partial or complete. About 85% of partial small-bowel obstructions resolve without surgical intervention; however, about 85% of complete bowel obstructions result in surgery. The standard treatment for small-bowel obstruction is IV fluids, nasogastric tube, and IV antibiotics. The patient received IV fluids; however there is no mention of a nasogastric tube, or antibiotics. It also appears that no other diagnostic studies were performed prior to her surgical emergency.

Strangulating obstruction is obstruction with compromised blood flow; it occurs in nearly 25% of patients with small-bowel obstruction (SBO). Strangulating obstruction can progress to infarction and gangrene in as little as 5-6 hours. Venous obstruction occurs first, followed by arterial occlusion, resulting in rapid ischemia of the bowel wall. The ischemic bowel becomes edematous and infarcts, leading to gangrene and perforation. If

untreated, strangulated obstruction causes death in 100% of patients.

In a study conducted by Meyerson S, Holtz T, Ehrinpreis M, Dhar R., at two Detroit hospitals, it was determined that over a 20-year period, nine cases of SBO were identified and 150,386 deliveries occurred (one case per 16,709 deliveries).¹ Abdominal X-rays were compatible with SBO in seven patients. Ultrasound identified SBO in one of four cases. Patients were hospitalized 6 h to 23 days before surgery. The admission diagnosis was incorrect in four cases. One patient was treated conservatively and, at 36 weeks, vaginally delivered a healthy infant. The eight surgical patients had lysis of adhesions, with one requiring resection of gangrenous small bowel. There were three fetal deaths (at 22, 24, and 30 wk of gestation). No maternal deaths occurred.

Furthermore, only one-third of patients with prenatal bowel obstruction complete term pregnancies after operative resolution of their obstruction. These findings emphasize the importance of remembering that two patients are at risk when intestinal obstruction complicates pregnancy. The delay from presentation to admission and from admission to definitive management continues to be a significant cause of morbidity and mortality. A high index of suspicion is mandated in this patient population, especially in those women presenting with a history of previous abdominal or pelvic surgery. The high incidence of necrotic bowel found in this subset of patients demonstrates the need for aggressive surgical intervention. Only through diligent and urgent intervention can the morbidity and mortality be decreased. The diagnosis and treatment of a pregnant patient suspected of having a bowel obstruction should be no different from those given to a non-pregnant one.

The conclusion was that SBO is a rare, but often catastrophic, complication during pregnancy. Clinical suspicion is critical and should be increased in a patient with abdominal scarring as internal adhesions seem to play a significant role in SBO during pregnancy. If suspected, prompt abdominal X-rays, ultrasound, and surgical consultation are warranted, all of which initially occurred in this case.

Additionally, the severe pain associated with obstruction will frequently subside after the initial event, particularly with rupture as the pressure is released. Then as the bowel becomes necrotic and inflammation and infection develop within

the perineum, the pain intensifies. Eventually sepsis sets in and surgical intervention is the only recourse to save the patient's life. In this case, unfortunately, the patient had to endure the removal of 5 meters of her small intestine. The removal of the small intestine resulted in the patient being unable to absorb the necessary nutrients to sustain her. Patients who have their small bowel removed have different nutritional requirements. They receive nutrition called total parenteral nutrition (TPN), which is delivered through a central venous catheter. No food or fluids can be taken by mouth. The use of long-term TPN can result in complications including bone disorders, catheter-related infections, and liver failure.

The woman developed liver failure after five months, requiring an intestinal transplant. After receiving the transplant, patients can be transitioned from TPN to an oral diet, which much improves their health and quality of life. However, intestinal transplant should not be considered a cure, but a last-resort therapy, which requires diligent medication administration and close monitoring to be successful.

The ER physician apparently arrived at an appropriate diagnosis, but the surgeon decided to treat the patient conservatively, perhaps because he was under the impression that the woman's symptoms based primarily on her pain threshold were not serious. The patient was admitted to the hospital and treated palliatively with the reasonable expectation that the nursing staff would monitor her pain, vital signs, and any indications of fetal distress, reporting concerns to the managing physicians. This is where the standard of care appears to have deviated from reasonably accepted norms to a situation that most likely represented the end result of this case.

Either the postpartum staff were poorly acquainted with the dangers of bowel obstruction

or they were aware but failed to report significant findings to the surgeon in a timely manner. Nurses on the postpartum unit do not frequently encounter this type of presentation as the bowel occlusion is rare. Perhaps a better situation for pregnant patients with medical complications not related directly to the pregnancy would be on a surgical unit where the nursing staff is better informed on the perils of bowel obstruction.

In this case, obviously the surgeon mounted a reasonable defense, but the hospital had some extremely weak areas to overcome. It is clear from the narrative that the documentation did not support the contention that the patient was receiving morphine as ordered and that the physician had been notified of her increased pain levels and diminishing blood pressure. In every litigation the medical record becomes the verification that the standard of care was met. The old adage "not documented, didn't occur" applies, and it becomes extremely difficult to overcome important missing documentation.

In most root-cause analyses, failure in communication is usually one of the primary causes. It appears that in this case, if there had been better communication, a more timely diagnosis could have been accomplished and may not have resulted in this serious loss.

The hospital's liability was most likely evident during pre-trial discovery, and there should have been some attempt to avoid a courtroom trial as juries are very sympathetic to any individual who not only lost a child but also required an organ transplant to remedy a serious breach in the recognized standards of care. Settlement after mediation may have proven to be more judicious.

REFERENCE

1. Meyerson S, Holtz T, Ehrinpreis M, Dhar R. *Am J Gastroenterol.* 1995 Feb;90(2):299-302. ■