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Note: New CNE/CME procedures. See p. 75 for details.

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AHC Media

Do staff speak up about dangers, or give them `the silent treatment'?

Prevent shortcuts, address missing skills, or risk patient harm

(Editor's note: This issue includes the first part of a two-part series looking at the problem of staffing keeping silent when danger looms. This month we discuss the recently released report The Silent Treatment. We examine why staff don't speak up and how to address that problem. In next month's issue, we offer four recommendations to create a culture in which people speak up effectively about concerns.)

A new nurse was called into the OR for a lengthy case. At the end of the case, the nurse turned to break down the back table and noticed the indicator strip in the instrument pan had not changed.

"We had done the whole case with unsterile instruments, and it was entirely my responsibility for not noticing it when I was first setting up my case," says **Jan Davidson**, MSN, RN, perioperative education specialist at the Association of periOperative Registered Nurses (AORN). Davidson turned to the vascular surgeon and said, "I need to tell you what I did." "He never once became angry with me," she says. "He knew how devastated I was."

The following day, they went to meet with the patient and the family. "He presented it to them in a way that made it sound as if 'we, the team' have let you down; never 'she, the scrub nurse,'" Davidson says. "I worried about that patient for several years, always afraid he would get an infected

Special issue: Avoiding lawsuits in outpatient surgery

This month we feature one of our most anticipated newsletters of the year: a special focus on how to avoid getting sued in ambulatory surgery. We tell you how you can get your staff to speak up when they detect a dangerous situation. We tell you what policies and procedures on wrong-site surgery will put you at the forefront of safety innovation. We give you specific tips to avoid medical identity theft. We tell you how to avoid your anesthetics being stolen and used as murder weapons. We also discuss computer-based informed consent and how it can keep you out of court.

Read these stories to stay proactive at avoiding liability!

graft that would be detrimental to him. As far as I know, with the administration of strong postoperative antibiotics, he never did."

Davidson scrubbed for many years with that surgeon, and he never mentioned the incident again. "Without his support, without the support of my manager, without the support of the anesthesiologist, and without the support of my fellow nurse who was circulating the case, I don't know that I would have continued to work in the OR and perhaps would have left nursing altogether," she says. "Instead, I felt supported for speaking up and empowered in knowing I could speak up again if I felt we were not practicing safe patient care. That was over 30 years ago, and we are still working on fostering that culture!"

Her views are seconded by a recently released report titled *The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*, conducted by the Association of periOperative Registered Nurses (AORN), the American Association of Critical-Care Nurses (AACN), and VitalSmarts, which is a corporate training company in Provo, UT. The study collected data from more than 6,500 nurses and nurse managers who were members of AACN and/or AORN. *(For the full study results, go to http://silenttreatmentstudy.com and select "Download the study.")*

The Silent Treatment found that 85% of respondents have been in a situation in which a safety tool warned them of a problem. Of the nurses who had been in situations where safety tools worked, 58% percent had been in situations in which they felt unsafe to speak up about the problems or in which they were unable to get others to listen. The implications are serious: Upward of 195,000 people die each year in U.S. healthcare facilities because of medical mistakes.

Is your staff taking shortcuts?

The Silent Treatment concludes providers fail to raise concerns about shortcuts when risks are known, which undermines the effectiveness of current safety tools.

Eight-four percent of respondents say that 10% or more of their colleagues take dangerous short-

EXECUTIVE SUMMARY

A recently released report conducted by the Association of periOperative Registered Nurses (AORN) and other groups says providers' failure to raise the following three concerns when risks are known undermines the effectiveness of current safety tools: dangerous shortcuts, incompetence, and disrespect.

- Staff members need to feel empowered to speak up about potential harm to a patient when they are pressured to quickly turn over rooms or admit patients.
- Provide staff with tools and/or training when they assume new responsibilities, such as infection prevention specialist.
- Use a code of conduct to discourage disrespectful behavior.

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cuts. Of those respondents, 26% say these shortcuts have harmed patients. Despite these risks, only 17% have shared their concerns with the colleague in question.

"Dangerous shortcuts are absolutely a problem in outpatient surgery," Davidson says. Volume equals money, she points out. "Staff may take shortcuts in an effort to get their rooms turned over quickly," Davidson says.

For example, staff might inadequately wipe down the surfaces of the OR table and equipment between cases. "In the pre-op area, you may see the nurses, in an effort to be efficient and prepared, spike all their IV bags and prime the tubing at the beginning of the day so they are all ready when the patient comes in to be admitted," Davidson says. "This is a prime source of infection." The Association for Professionals in Infection Control and Epidemiology (APIC) recommends that spiked IV solutions be used within one hour of being prepared.

Members of the staff need to feel empowered to speak up about potential harm to a patient when they are pressured to quickly turn over rooms or admit patients, Davidson says. "In their haste to be efficient and fit in that 'one more case for the day,' they risk putting their patient in harm's way, which could result in an event far more costly than the revenue they generated from that one more case," she says.

Another potential problem area is postop care, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI. "One of the concerns is, do they have adequate monitoring, and is the patient kept there an adequate time, or is he/she sent home sooner than they should be," Trosty says. If employees have not been adequately trained, and they aren't monitoring patients closely enough, "you can have a potential negative result," he says.

The Silent Treatment signals a need for zero tolerance regarding workplace behavior that threatens patient safety, says **Linda Groah**, RN, MSN, CNOR, CNAA, FAAN, executive director/chief executive officer of AORN and a co-researcher on the study. "Shortcuts are not acceptable. Incompetence will be reported, and those without adequate judgment and skills will be held accountable," she says. "Disrespect will not be tolerated, and managers have the responsibility to respond and to react to the information they receive from their staff. It is their responsibility to support their staff and be respectful in their communications." *(For more information on incompetence and disrespect, see stories below and on p. 68.)*

The study also underscores the need for teamwork, Groah says. "It is a call to action for members of the surgical team to sit down together and map out clear strategies that will result in a culture of safety," she says. "That means a culture of trust in which all members of the perioperative team are encouraged to provide safety-related data and are acutely aware of the distinction between acceptable and unacceptable behaviors."

Managers: Don't fail to train staff

'Incompetency' might be lack of education

While "incompentence" showed up as a primary patient safety issue in the recent study The Silent Treatment, this problem is not specific to any one surgery setting, says **Jan Davidson**, MSN, RN, perioperative education specialist at the Association of periOperative Registered Nurses (AORN). AORN sponsored the study, along with the American Association of Critical-Care Nurses (AACN) and VitalSmarts, a corporate training company in Provo, UT.

"It should never be assumed by anyone that working in an outpatient setting is somehow an easier job and that the nurses that work in such a setting are somehow not as skilled as the nurse that works in another perioperative setting," Davidson says. "That is far from the truth."

However, outpatient surgery staff often work with very limited resources, she adds. "Managers need to hear them when they say, 'help us to be better by allowing us time for regular and ongoing education.'"

Nurses and other clinicians in outpatient surgery wear many hats. "We fail them when we don't provide them with the necessary tools and/or training they need to also assume the role and responsibility for something they have never had to do before, such as the facility radiation safety officer or the infection prevention specialist," Davidson says. "We also fail them when we don't provide them regular and consistent time allotted for continuing education and in-services."

Managers need to provide tools and/or training to refine staff members' critical thinking skills and/or their critical care skills such as with advanced cardiac life support (ACLS) and pediatric advanced life support (PALS), she says. In The

Silent Treatment study, 82% of respondents said that 10% or more of their colleagues are missing basic skills and, as a result, 19% say they have seen harm come to patients. Only 11% have spoken to the incompetent colleague.

Stephen Trosty, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI, says, "The question is, are you making sure your personnel have adequate training in CPR, if patients have heart-related problem, and that you not only know how to respond, but you have adequate equipment to respond and stabilize them before 911 or emergency personnel can get there?"

Have an emergency plan, Trosty advises. "There should be an early indication of basic skills and understanding, to help prevent potential harm to a patient, should one of these potentially negative events occur," he says. ■

A primary safety issue: R-E-S-P-E-C-T

Is a respectful attitude missing among your staff? It has to come from the top down, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI.

For example, while surgeons traditionally are seen as captains of the ship, "that doesn't mean [they] need to be discourteous, rude, curt, or insulting toward [their] employees," Trosty says.

The same advice goes for nurses toward each other, and clinicians toward clerical staff, he says. Any time you're a negative team, you're putting patients at a greater risk, Trosty says.

Disrespect showed up as a primary concern in the recent study The Silent Treatment, sponsored by the Association of periOperative Registered Nurses (AORN), the American Association of Critical-Care Nurses (AACN), and VitalSmarts, a corporate training company in Provo, UT. Eighty-five percent of respondents said that 10% or more of the people they work with are disrespectful and therefore undermine their ability to share concerns or speak up about problems. Only 16% have confronted their disrespectful colleagues.

One solution is a code of conduct, as required by The Joint Commission. The code of conduct, which includes information on how to handle disrespectful behavior, should be reviewed with new employees, says **Jan Davidson**, MSN, RN, perioperative education specialist at the Association of periOperative Registered Nurses (AORN).

"Disrespectful behavior amongst peers or physicians should never be allowed, and there should be language in the medical staff bylaws and the employee handbook that emphasizes a zero tolerance for disrespectful behavior," Davidson says. *(For more information on this topic, see package of stories in* SDS Accreditation Update supplement*, October 2008, including "Steps to developing a code of conduct," p. 2. The Joint Commission's brochure on having a code of conduct can be accessed at http://www.jointcommission.org/Code_of_Conduct.)* ■

Legal risks rise when clinicians date patients

It's ammunition for plaintiff's counsel

A few months after performing breast augmentation on a patient, a California surgeon had a consensual three-month relationship with her. Darshan Shah, MD, neglected to document in the patient' chart that he had severed the doctor/patient relationship and neglected to send her a dismissal letter by certified mail, according to medical board records. The Medical Board of California placed Shah on probation for five years and said he must have a third party chaperone when examining female patients. He also is restricted from supervising physician assistants.

Shah's attorney says the patient shared her story more than three years after her relationship with Shah ended. The attorney also said the woman is married to a plastic surgeon who Shah considers to be a competitor.

Developing personal relationships with patients involves ethical, as well as possible legal implications, says **William Sullivan**, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a Frankfort, IL-based practicing attorney. "Some ethicists have questioned whether it is wise to merge one's social and professional lives," he adds.

The best practice is to consider patients and former patients to be off limits for personal relationships, says **Arthur R. Derse**, MD, JD, FACEP, professor of bioethics and emergency medicine at the Medical College of Wisconsin in Milwaukee. Derse notes that several medical examining and licensing boards specifically state that having an

inappropriate relationship with a patient violates their codes. "In some of these, a patient is defined as up until two years after medical care was provided," he says. "There is a large potential danger area."

While these codes are generally meant to apply to ongoing doctor-patient relationships, as in psychiatry, says Derse, a savvy lawyer could use this information in a malpractice lawsuit, as evidence that a physician was acting inappropriately.

Jennifer Lawter, RN, JD, vice president of risk management at EPMG in Ann Arbor, MI, says that if a patient decides, at any point in time, to bring an action for medical malpractice, the nurse or physician named in the lawsuit would be at a significant disadvantage if a personal relationship existed. "Past mates make vengeful plaintiffs," she says. "If you're going to get romantically involved with a patient, ideally it should be later in time, after treatment has terminated."

Ann Robinson, MSN, RN, CEN, LNC, principle of Robinson Consulting, a Cambridge, MD-based legal-nurse consulting company, says that when you become involved with a patient, "you have crossed the line of an agreement. It's muddy water, at the very least." If a patient sued the facility, and a jury learned that a nurse or physician had dated that patient, she says, "it would be very difficult for the [facility] to defend itself. Its credibility would be undermined." The social relationship with the patient "would be ammunition for the plaintiff's counsel to prove the hospital was not looking out for the best interest of the patient," says Robinson.

Evidence against physicians

If a physician dates a patient, says **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, "the first place where you'd get into trouble is not necessarily legally, but with the state board of medicine."

Most complaints against physicians alleging an improper relationship with a patient ultimately end up at the state board of medicine or the hospital ethics board, which often reports to the hospital executive board, notes Burton. If a patient complains to the medical examining board, says Derse, this complaint might be used as evidence against the physician in a subsequent malpractice lawsuit.

If their behavior is sanctioned, warns Burton, this will be on their record and most likely would get reported out to the National Practitioner Data Bank. "These things are increasingly being investigated aggressively and reported out to boards, which have very little tolerance for these kinds of activities," Burton says. "And if the board investigates it, you'd better get a lawyer because your whole career is on the line."

Most medical and nursing societies have guidelines and/or rules that they enforce when it comes to moral and ethical obligations of their members, Lawter says. "Physicians and nurses need to be concerned about these expectations, as well as the various state-licensing organizations, so that they do not run afoul of the requirements," she says. *(To see the American Nurses Association's code of ethics for nurses that addresses professional boundaries in section 2.4, go to http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses.aspx.)*

Most insurance coverage for medical-malpractice litigation doesn't typically cover licensing investigations, which can be costly, adds Lawter. "You may find yourself with licensing-violation allegations or perhaps be 'kicked out' of professional societies," she says. "While this may not be as scary as a medical-malpractice lawsuit at first glance, it can lead to more problems than you may be prepared for. These issues will nearly always show up in any future litigation."

The best approach is to have a policy that discourages physicians dating patients, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI. "If that type of relationship occurs, the patient should be discharged," Trosty says.

He points out that in a physical relationship, there "could be a fine line between doing something you consider part of relationship, as opposed to something that crosses that line, from a clinical perspective." ■

Warning! Some drugs diverted for murders

A 35-year-old nurse practitioner was convicted for the murder of her husband. She became a murder suspect after investigators discovered she had lied about an extramarital affair and had surreptitiously left the hospital and driven to her house shortly before the house was discovered on fire with her husband inside.

Test results of the deceased husband showed rocuronium concentrations of 4.9 mcg/ml in the blood and 14.4 in the liver. Review of the burned house materials revealed a charred needle cap, similar to those used in the hospital where the nurse practitioner worked.

In another case, the wife of an anesthesiologist died suddenly and unexpectedly. Although the initial death certificate did not list homicide, the father of the wife suspected foul play. An investigation was launched. An anesthesiologist reviewing information about this case learned that the husband anesthesiologist had previously been tried for murder, and found not guilty. This previous trial followed the sudden and unexpected death of the husband of a woman with whom he had allegedly been having an affair. The district attorney and consultant anesthesiologist theorized that the anesthesiologist had injected the buttocks of the first victim with succinylcholine while he slept.

The body was exhumed and, on detailed examination, was discovered to have a fractured hyoid bone. It then was speculated that an injected dose of succinylcholine had produced apnea but begun to wear off before death, so the victim was strangled. A second autopsy of the deceased wife found a high concentration of choline in her buttocks. The husband anesthesiologist was tried for the murder of the second wife, found guilty, and sent to jail.

In a recently published study, a group of anesthesiologists recount these cases in which drugs stolen from healthcare facilities were used to kill and clinicians were convicted of murder.[1] The anesthesiologists are warning that, in addition to the perennial problem of drugs being diverted for personal use or resale, some powerful drugs are stolen from providers to be used as murder weapons.

They note that anesthetic drugs, opioids, and muscle relaxants can depress breathing and other vital processes enough to kill, and these drugs have thus been used for euthanasia, suicides, and state executions. Criminals also have recognized the lethal capabilities of anesthetic drugs, and during recent years they have committed homicides using hypnotics, inhalational general anesthetics, opioids, and muscle relaxants, they say.

An analysis of 523 homicidal poisonings occurring between 1999 and 2005 found their rate increasing and that 65% involved medicines, according to the study. An increasing recognition of the use of muscle relaxants and anesthetic drugs for homicides means anesthesiologists are likely to be involved in more homicide investigations and prosecutions, sometimes as an expert witness, but sometimes as the defendant, says **Robert E. Johnstone**, MD, in the Department of Anesthesiology at West Virginia University in Morgantown and one of the authors of the study.

"Anesthetic drugs can be used for harm as well as healing. That's really new information for a lot of people," Johnstone says. "This was a revelation for me, and I think it will be for many anesthesiologists. We think of using these drugs carefully with our patients and protecting them from diversion for abuse, but the idea of preventing their use for criminal purposes is really a new thing."

Johnstone advises managers to consider the potential criminal exploitation of anesthetic drugs when addressing drug security and diversion. "The drugs have been diverted primarily from hospitals, and of course we live in a very litigious society," he says. "We're seeing evidence that this is becoming more common, and I think it's probably only a matter of time before we see a hospital dragged into an ugly murder case with allegations that the hospital bears responsibility for not preventing their theft and use in a crime."

REFERENCE

1. Johnstone RE, Katz RL, Stanley TH. Homicides using muscle relaxants, opioids, and anesthetic drugs: anesthesiologist assistance in their investigation and prosecution. Anesthesiology 2011; 114:713-716. ■

Same-Day Surgery Manager

Three lessons for staying in the OR, not in court

By **Stephen W. Earnhart**, MS
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Austin, TX

Oh my. This is such a litigious time we live in. People are hurling themselves in front of moving buses, throwing themselves down steps, and falling in food stores, all in an effort to cash in on unearned and undeserved booty from insurance companies in frivolous lawsuits. Fortunately many of these antics are caught on video cameras

that businesses set up for just such shenanigans, but still far too many dishonest people collect their retirement early because it is often cheaper to pay them off than to fight them.

The health profession has long been the target of lawsuits — some perhaps deserved, some not. But as an industry, we spend billions of dollars in blatantly unnecessary tests, procedures, and protocol to cover ourselves.

Look at the TV ads on new drugs: "Suicidal thoughts." "Changes in vision or hearing." "Erections lasting longer than 4 hours?" All of this information is intended to keep us aware of remote side effects so we don't sue them should they occur. While I would never want to take a drug that could cause my "tongue to swell" and my "throat to close," sometimes you have no choice. The billions of dollars spent to keep these companies out of court does work, but not always I would guess, based upon the attorney ads for "bad drugs" on TV. You can do only so much to protect yourself, but protect yourself you must!

How can we, in our own little microcosm, avoid the steely stare of some prosecutor in court? Quite a bit actually.

Bear in mind, I am not an attorney. I don't want to get sued here by giving advice! Consider for example that something happened to me in your operating room that didn't necessarily cause me to lose an arm or other valuable appendage, but just maybe made me uncomfortable or inconvenienced me. If I liked you and knew it was just an accident, I could let it go. If I got a Bovie burn on my thigh or an infection and I thought you we sincerely sorry and empathic to my situation, and you made it right by not charging me for scar revision or meds, I could let it go. But if I didn't like you, or I thought you were rude or unsympathetic, or you charged me for other services needed to correct what was done wrong, look out! I'm a comin' for you.

Thus lesson number one is that if you see something is wrong or some untoward event happened, show a truly sympathetic and caring manner. Patients and visitors can spot sincerity, so let it flow naturally. Avoid an "attitude!" Rarely is there anything more gratifying then nailing someone that cops an attitude. Saying you are sorry is not admitting guilt. It can just mean that you are sorry. *(For more on this topic, see these stories in the March 2007 issue of* Same-Day Surgery: *"When you have a serious adverse event should you apologize, waive charges?" p. 29, and "Weigh waiving charges after an adverse event, p. 32.)*

Lesson number two is obvious: Follow procedure! While you may be caught in a widely cast net by some attorney in a malpractice suit, if you followed procedures established by your hospital or surgery center, chances are you will be OK. It is only when we act outside of those procedures that we get in trouble.

A good example would be allowing a staff member to drive a patient home after surgery, and they get into an accident. I don't know of any facility that would allow that to occur, but I know it does. You would be on your own for that infraction, along with your employer! *(For more on this topic, see "What are your options when patients show up without an escort to drive?"* SDS, *July 2008, p. 73.)* Other examples could be looking the other way when you know a staff member is incapacitated in some way but still doing patient care. You are responsible for reporting that situation, and if you don't, you are just as guilty in a jury's eyes as the person who did the misdeed.

Lesson three. Never, ever, ever, ever try to cover up something! We all make mistakes, and we are responsible for them, but they are still just mistakes. Once you try to cover up something — be it on the chart, the med dose, or whatever — you have crossed the line from making a mistake to conducting an illegal act that could have disastrous results for you and your employer. A true professional will never ask you to "cover up" something that happens in the workplace. If they do, you need to refuse and report them to their boss. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Twitter: SurgeryInc.]* ■

Facility revamps safety after wrong-site surgery

(Editor's note: This issue includes the first part of a two-part series on how a hospital addressed a wrong-site surgery. This month, we look at the details of the event and how the facility responded. Next month we look at what specific changes were made and how the top leader started networking with other CEOs on safety issues.)

When a surgeon at Cayuga Medical Center in Ithaca, NY, performed a procedure on the

wrong side of a patient's back in 2008, the sentinel event stunned the hospital's administration. But it wasn't long before hospital leaders were formulating a plan to make sure it never happened again.

The result has been a series of improvements that make the hospital a leader in patient safety.

The wrong-site error occurred in June 2008, says Cayuga CEO **Rob Mackenzie**, MD. The state health department investigated and issued an order in October 2008 that stipulated a fine of $8,000, along with requiring a plan of correction, continuing reviews of documentation of the surgical protocol checklist, three observations of pre-surgery procedures every day at the main campus and two a day at the hospital's outpatient surgery center, and quarterly progress reports to be submitted to the health department, according to information provided by the health department. Cayuga submitted its plan of correction by the end of 2008 and implemented it over the next two years.

The wrong-site surgery occurred because a staff member and the surgeon didn't follow the hospital's safety protocol, says **David Evelyn**, MD, vice president for medical affairs at Cayuga. Before the surgery intended to relieve the female patient's back pain, the surgeon and patient had agreed the operation would address only the left side, the source of the worst pain. But when the surgeon made a midline incision and found diseased tissue on both sides of the patient's back, he erroneously operated on the right side, Evelyn says

When that procedure was complete, the surgeon realized his error and operated on the left side, Evelyn says. The surgeon informed the patient and her family of the error immediately, and the hospital informed the state health department, Mackenzie says. The woman's back pain was relieved, and she did not sue the hospital.

The error happened because two steps of the hospital's safety protocols were not followed, Evelyn says. First, the scheduler did not specify on the schedule the exact location of the surgery, and the surgeon did not mark the surgical site beforehand.

EXECUTIVE SUMMARY:

Cayuga Medical Center in Ithaca, NY, took an aggressive approach to improving patient safety after a wrong-site surgery incident.

- Several new policies and procedures now put the hospital at the forefront of safety innovation.
- The hospital implemented "safety cells" to encourage teamwork.

Though the wrong-site surgery resulted in no grievous harm to the patient, Mackenzie says he and his colleagues considered it a serious warning sign that patient safety was not receiving proper attention at the hospital. He called together the medical executive committee and board of directors, and he asked them to form a task force on hospital safety. "That task force worked quickly over the next six weeks to hear from all parts of our organization, not just surgery, but also environmental services, pharmacy, patient units, and we learned that we had not raised safety to the level we needed to," Mackenzie says. "We needed to say that safety at Cayuga Medical Center is the foundation for our clinical care and really needs to be job one."

Studied high reliability

The task force studied high reliability organizations such as the National Aeronautics and Space Administration (NASA) and the aviation industry to look for characteristics that were common and to determine how Cayuga could develop them within its organization, Evelyn says. One of the first conclusions was that organizations known for safety had a culture different from the typical hospital, and it was one in which safety was always at the forefront of everyone's mind.

Secondly, these organizations all had a specific safety leader to whom everyone looked for guidance and support. Also, they all had organizational structures uncommon in hospitals, in which safety was emphasized and monitored at the lowest levels rather than being mandated from the top. But at the same time, they had an executive-level emphasis on safety that supported the culture of safety.

The high reliability organizations also had boards that were actively involved in promoting a culture of safety, Evelyn says. "Clearly there were common themes among these high reliability organizations, and we needed to adopt these at Cayuga," he says. "We wanted to be a high reliability hospital and we set out to achieve that."

Incident reporting simplified

The hospital implemented a just culture approach to encourage reporting of incidents and near misses, and part of that change was making the reporting procedure much simpler. Rather than using a multi-page written form, Cayuga staff now can report concerns on a one-page online form, Mackenzie says. As a result, the number of

reported incidents went up sharply, Evelyn says.

Those reports are used to deploy resources and tailor training efforts to the hospital's particular needs, he says. Staff satisfaction surveys also are showing significant improvement on questions related to whether employees feel their superiors listen to their concerns and how they rate the hospital as a good place to work.

Since implementing the changes, there has been no new wrong-site error or other sentinel event, Evelyn says. The hospital has achieved 100% compliance with the Universal Protocol. During a recent survey by The Joint Commission, the surveyors complimented the hospital on how every physician knew the Universal Protocol procedure by heart.

"They said they've never seen that before. In other organizations, it's always led by the nurses, or there is a script on the wall," Evelyn says. "We've seen a dramatic change in the way people think about things. It's not just about how to get through your work day anymore; it's about how to get your patient through the day as safely as possible." ■

ID theft — Should you spend more on security?

One-third of providers say their organization has had at least one known case of medical identity theft, and some of those cases might not have been reported, according to the most recent annual survey results from the Healthcare Information and Management Systems Society (HIMSS).

The survey interviewed 272 IT and security professionals at hospitals and medical practices. Now in its third year, the HIMSS Security Survey, sponsored by Intel, reports the opinions of information technology (IT) and security professionals from healthcare provider organizations across the country regarding key issues surrounding the tools and policies in place to secure electronic patient data at healthcare organizations.

The rate of medical identity theft is surprising to **Eduard Goodman**, JD, a privacy lawyer and chief privacy officer for Identity Theft 911, a company in Scottsdale, AZ, that provides data protection and similar services. He was surprised that healthcare providers still are facing so much identity theft, even with significant penalties from the the Health Insurance Portability and Accountability Act (HIPAA) hanging over their heads.

"HIPAA is one of the few areas of law in which the injury is just the release of the information itself. It's not about whether anyone uses that information to commit a crime," Goodman says. "With that in mind, you would expect providers to work harder to protect that data, and a third are saying they've failed on that point."

Results of the survey

These were some key results from the most recent survey conducted by the Healthcare Information and Management Systems Society (HIMSS):

Medical identity theft: One-third of respondents reported that their organization has had at least one known case of medical identity theft at their organization. Those working for a medical practice were much less likely to report that an instance of medical identity theft occurred at their organization (17%), when compared to those working for a hospital organization (38%).

Patient identity: Half of respondents indicated that they validate patient identity by requiring a government/facility-issued ID and checking the ID against information in the master patient index. A similar percent reported that they have a formal process for reconciling duplicate records in their master patient index.

Security budget: About half of respondents reported that their organization spends 3% or less of their organization's IT budget on information security. However, while this was consistent with what was reported last year, many respondents indicated that their budget actually increased in the past year, primarily as a result of federal initiatives. There is little difference in response in this area by organization type.

Risk analysis: Slightly more than half of respondents (59%) that reported that their organization conducts a formal risk analysis indicated that this type of analysis is conducted annually.

EXECUTIVE SUMMARY:

Medical identity theft has occurred in one-third of health care facilities, according to new survey results.

- More than half of the respondents conduct a formal risk analysis annually.
- Some providers are spending more of their IT budgets on security.

SOURCE/RESOURCE

Eduard Goodman, JD, Chief Privacy Officer, Identity Theft 911, Scottsdale, AZ. Telephone: (888) 682-5911. E-mail: egoodman@idt911.com.

The Federal Trade Commission (FTC) has Frequently Asked Questions (FAQs) to help healthcare providers minimize the risk of medical identity theft and help their patients who are victims of medical identity theft. Go to http://business.ftc.gov. Under "Privacy and Security," select "Health Privacy." Then select hyperlink for "Medical Identity Theft: FAQs for Health Care Providers and Health Plans [PDF]."

Susceptibility to internal threats and external threats are nearly universally included in the risk analysis.

Patient data access: Surveyed organizations most widely use user-based and role-based controls to secure electronic patient information. User-based security requires the user to log on with credentials such as a username and password, whereas role-based security restricts access to authorized people in certain roles. More than half of respondents from hospital organizations reported that they used two or more types of controls to manage data access, compared to 40% percent of respondents from medical practices. About half of respondents reported that their organization allows patients/surrogates to access electronic patient information.

Security in a networked environment: About 85% of respondents reported that their organization shares patient data in an electronic format. Data is most frequently shared with third party providers, state government, and other facilities within the corporate organization. While respondents from hospitals are somewhat more likely to report (83%) that they will share data in the future than are those from medical practices (77%), the likelihood of data sharing in the future is high among both groups. ■

Is informed consent better on a computer?

There's a new trend in outpatient surgery toward computer-based informed consent. But does this method offer any advantages, legal or otherwise? Yes, according to sources interviewed by *Same-Day Surgery*.

"One of the biggest advantages of computer-based informed consent is the immediate viewing/verification of the consent form in different areas of the hospital," says **Michael S. Fladland**, MSN/HCA, RN, manager of the Portland Outpatient Procedures and Surgeries (POPS) unit at Portland VA Medical Center.

At his facility, the ORs are on separate floors. Patients having outpatient procedures will be checked in on the POPS floor, then transferred to an OR suite in a different area of the hospital. "The OR nurses are able to verify the consent is complete electronically prior to the patient entering the room," Fladland says.

The VA hospitals in Portland and other locations use the iMedConsent program from Dialog Medical in Atlanta for all procedures. The program is designed for doctors and patients to review together. There are some versions written for patients with a sixth-grade reading level.

"We also use the computer-based discharge education form [developed inhouse and added to iMedConsent] where the patient/family member will sign that they received the document and then save electronically," Fladland says. "If a patient encounters difficulty post-discharge and calls the advice line, the advice nurse has access to the exact discharge form to refer the patient or family member to for assistance." Staff go over the patient's education in the form and then have the patient sign using the electronic signature pad.

This discharge education does offer a legal advantage, he says, as patients often don't remember the discharge form or discard it. "We've had multiple occasions where patients/families stated they did not receive discharge education, and the computer-based model offers the nurse physical documentation that education was provided and signed for by the patient or family member," Fladland says.

EXECUTIVE SUMMARY

Computerized informed consent is a new trend among outpatient surgery providers. It offer some advantages, legal and otherwise.

- Advantages include being able to view the signed form in various departments and by various staff, including post-discharge when patients say they didn't receive such education.
- Caveats include making computers available to patients who might not have them at home, having the right number of computers, and ensuring education is still provided by physicians to patients.

RESOURCES

For more information on computerized consent, contact:

• **Tim Kelly**, Vice President, Marketing, Dialog Medical, 30 Perimeter Park Drive Atlanta, GA 30341. Phone: 800-482-7963, ext. 54. Fax: (770) 736-5725. E-mail: tkelly@dialogmedical.com. Web: www.dialogmedical.com. For one physician, the price for year one is $695 annual license fee, plus $295 for each additional specialty per physician. For subsequent year renewals for one physician, the annual license fee is $295, plus $125 for each additional specialty per physician. Reduced fees are offered for practices with additional physicians, and discounts are offered for groups including the American College of Surgeons. Hospital prices are based on several factors including number of beds, type of implementation, interfaces, and extent of implementation and training services.

• **Jordan Dolin**, Founder & Vice Chairman, Emmi Solutions, Chicago. Phone: (312) 568.4010. Fax: (312) 568-4110. E-mail: jdolin@emmisolutions.com. Web: www.emmisolutions.com. A demonstration is available at http://www.emmisolutions.com/patient_education_solutions.html. The price varies by institution size and depth of product.

At University of Chicago Medical Center, the Emmi program from Emmi Solutions in Chicago is required for patients sent by primary care physicians for a colonoscopy.

Patients view a video that is 20 minutes long and "explains in layman's terms what a colonoscopy is, what a patient can expect on the day of the procedure, and also highlights some of the risks and benefits of the procedure," says **Leslie Wallene Yang**, MD, assistant professor of medicine in the Department of Medicine, Section of Gastroenterology, Hepatology & Nutrition. "We have so far received positive feedback from patients that they felt less anxious about the procedure and had a better understanding as to why their physician ordered the procedure after watching the video. We are currently studying whether watching this video improves patient attendance and bowel prep." If you are adding computerized informed consent, plan ahead to have the right number of computers to ensure a smooth continuous process "or you set yourself up for delays," Fladland says. "Often times the physicians want to complete a consent prior for pre-op at the same time the nurses are discharging, so there needs to be adequate computer availability."

Downtime "creates chaos"

Another potential problem occurs when computers aren't functional. "Computer downtime is always a problem and creates chaos, but we always have our paper forms to refer back to when necessary." Fladland says.

Consider what obstacles might exist for patients using such a system, Yang advises. "For instance, we were concerned that some patients would not have computer access at home, so we set up computer kiosks in our clinic for EMMI viewing," she says. Primary care physicians also have the option of sending patients to the gastroenterology clinic for further consultation if there is any concern that they patient cannot view or understand the program for any reason, Yang says. "Ultimately, our goal is to enhance patient education of the procedure, so we try to make the process as convenient as possible for our patients and referring physicians."

Another caveat is that the computer cannot take the place of the physician educating the patient, Yang says. "This program should be used in addition to the standard physician informed consent and not as a substitute," she says. "While it does go over risks and benefits of the procedure, it is still important that the physician review them with the patient prior to the procedure." ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

■ ASCs under the microscope again for infection control practices

■ Outpatient surgery department increases POS collections by 47%

■ Is Shellac nail polish safe in the OR?

■ Should your patients wash their hands too?

CNE/CME OBJECTIVES

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

CNE/CME QUESTIONS

1. In the recently released report, The Silent Treatment, what percentage of nurses who had been in situations where safety tools worked had also been in situations in which they felt unsafe to speak up about the problems or in which they were unable to get others to listen?
   A. 19%
   B. 27%
   C. 39%
   D. 58%

2. At Cayuga Medical Center, what was the cause of the 2008 wrong-site error that prompted safety improvements?
   A. The patient's identity was not confirmed with two forms of identification.
   B. The scheduler did not specify on the schedule the exact location of the surgery, and the surgeon did not mark the surgical site beforehand.
   C. The surgeon marked the wrong surgical site before the procedure.
   D. The patient indicated the wrong surgical site to nurses before the surgery began.

3. Which of the following was a finding of the 2010 Healthcare Information and Management Systems Society (HIMSS) Security Survey?
   A. One-third of respondents reported that medical identity theft had occurred at their institutions.
   B. Most respondents said their IT security budgets had tripled in the past year.
   C. Almost none of the respondents reported that medical identity theft had occurred at their institution.
   D. Almost all of the respondents said their institution has an employee dedicated solely to IT security.

4. At University of Chicago Medical Center, what is the feedback from patients regarding computerized informed consent?
   A. They received negative feedback that patients did not like the impersonal nature of using a computer.
   B. They received negative feedback that patients did not understand the video.
   C. They received positive feedback that patients felt less anxious about the procedure and had a better understanding as to why their physician ordered the procedure.