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AHC Media

Be prepared — Don't let errors with medications happen on your watch

A patient arrived from an assisted living facility with a documented allergy on the chart. Despite this safeguard, the patient still received an incorrect medication prior to the procedure. Fortunately, in this case, there was no lasting harm to the patient.

"Frequently, as with any medication error, it's a process issue, not just one individual," says **Charlotte Huber**, RN, MSN, senior patient safety analyst at ECRI Institute, a Plymouth Meeting, PA-based nonprofit organization that researches approaches to improve patient care. ECRI helped produce the *Pennsylvania Patient Safety Advisory* for the Pennsylvania Patient Safety Authority in Harrisburg, which recently reported on medication errors in ambulatory surgery facilities (ASFs) in the state. The mandatory reporting is required by the state.

Huber thinks this error with the patient from assisted living involved one particular mode of the medication process: medication reconciliation. "What's interesting about outpatient surgery — certainly what makes that setting vulnerable to more medication errors — is that the success of outpatient surgery heavily relies on the quality of patient information," she says. "This patient information is supplied by many sources: the surgeon, primary care physicians, and in this particular example, assisted living — or even a patient."

If information isn't relayed to the providers, or the patient isn't able to provide reliable information, an allergy or other important information can be missed, Huber says. Keep in mind that patients can be allergic to over-the-

EXECUTIVE SUMMARY

A recently released report on medication errors at Pennsylvania ambulatory surgery facilities found 502 medication errors from June 28, 2004, through Dec. 31, 2010. Facilities reported that 3.6% of the events resulted in patient harm, which compares to 0.6% of medication errors reported by acute care facilities.

- Consider standardized orders that address areas such as antibiotics, and consider standardized medications. Limit the varieties of concentrations, and examine whether medications are stored next to each other and could be confused.
- Ensure you have all documentation, including the history & physical.
- Follow checklists. Study near misses.

counter medications, herbal remedies, or vitamins, she says. "If it's not communicated or reconciled with the outpatient surgery clinic, you can have some problems, and certainly an issue such as this [overlooking allergy information] can occur, Huber says.

One way to avoid overlooking allergy information is to ask patients what reaction they had, says **Matthew Grissinger**, RPh, FISMP, FASCP, director of error reporting programs at the Institute for Safe Medication Practices (ISMP) in Horsham, PA, which helps produce the *Pennsylvania Patient Safety Advisory,* and senior patient safety analyst for the Pennsylvania Patient Safety Authority.

Also note that reactions can range from an upset stomach to death, Grissinger points out. "Many providers see that a patient has an allergy, but they don't see the reaction, so they make a decision with incomplete information," he says.

Monitoring error/documented allergy was one of the most common types (17.1%) of medication errors reported to the Pennsylvania Patient Safety Authority from June 28, 2004, through Dec. 31, 2010.[1] Others included drug omission (26.7%) and the wrong drug (22.3%). Pennsylvania ASFs submitted 502 medication error reports to the authority from June 28, 2004, through Dec. 31, 2010. Pennsylvania had 265 licensed ambulatory surgery facilities (ASFs), which performed more than 960,000 procedures between July 1, 2008, and June 30, 2009, according to the Pennsylvania Patient Safety Advisory. ASFs reported that 3.6% (18) of the events resulted in patient harm, which compares to 0.6% of medication error reported by acute care facilities.

On the plus side, outpatient surgery facilities might find it easier to focus on avoiding medication errors because generally they are not using as large a variety of medications as a hospital is. However, the "business aspect" of outpatient surgery, having one case immediately following another, could be to its detriment, Grissinger says. "The minute something goes wrong and you are 15 minutes late, that sets the tone for the rest of day, in terms of playing catch up to get things done on time," he says. "That's the nature of the beast."

Both inpatient and outpatient settings fall prey to not using double checks, he says. "It's so simple to do a little double check," Grissinger says. "Real serious events can be caused by not shoring up that process."

With a verbal order, the only person who understands the order or knows the intent is the prescriber, he points out. "If there is no double check, you're assuming you got the right thing," Grissinger says.

Ongoing staff competencies and an on-site pharmacist also can assist with medication reconciliation issues, Huber says.

The best say to avoid medication errors? Accuracy, Huber says, "not just figuring out their first and last name or their demographics, but their history, having medication reconciliation, having an assessment of risks and other illnesses, asking the patient the reason for surgery, and getting an accu-

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rate patient screening." *(See more tips, p. 115)*

REFERENCE

1. Grissinger M, Dabliz R, Ambulatory surgery facilities: a comprehensive review of medication error reports in Pennsylvania. *Pennsylvania Patient Safety Advisory* 2011; 8:85-93.

RESOURCES

• The September 2011 *Pennsylvania Patient Safety Advisory* contains "A review of medication errors in ambulatory surgery facilities (ASFs)." For the advisory, go to www.patientsafetyauthority.org. Under "Patient Safety Advisories," select "Advisory Library," then the September 2011 issue.

• For an updated *List of Confused Drug Names* from the Institute for Safe Medication Practices (ISMP), go to http://www.ismp.org/Tools/confuseddrugnames.pdf. The Joint Commission web site no longer maintains a look-alike/sound-alike medication list. ■

Most common? Antibiotics omitted

Steps you can take now

In a recently released advisory on medication errors at ambulatory surgery facilities in Pennsylvania, the most common drug omissions were patients who needed antibiotics before surgery.[1]

Often these omissions occur due to breakdowns in communication of the drug order, says **Matthew Grissinger**, RPh, FISMP, FASCP, director of error reporting programs at the Institute for Safe Medication Practices (ISMP) in Horsham, PA, which helped produce the *Pennsylvania Patient Safety Advisory,* and senior patient safety analyst for the Pennsylvania Patient Safety Authority in Harrisburg, which published the advisory.

For example, the advisory reports a case in which an elderly patient was admitted for a procedure, and the preoperative orders were transcribed by the admitting nurse. After the nurse transcribed the orders, the physician prescribed a preoperative antibiotic. The nurse wasn't notified verbally. The PACU nurse determined that the order was not given and notified the physician. The antibiotic was administered in the PACU.

To avoid cases such as this one, consider standardized orders that include the possibility of giving antibiotics, Grissinger advises. "The order should be standardized or protocols should be standardized, with at least a suggestion of giving antibiotics on the order form, versus expecting a doctor to remember writing it every time," he says.

Errors of omission also can occur because the patient isn't able to communicate or because of patient misidentification, says **Charlotte Huber**, RN, MSN, senior patient safety analyst at ECRI Institute, a Plymouth Meeting, PA-based nonprofit organization that researches approaches to improve patient care. ECRI helped produce the *Pennsylvania Patient Safety Advisory*. For example, a nurse will walk into a room where there are three people and ask, "Are you John?" The wrong person answers.

Here are some of the other most common medication errors in outpatient surgery, along with tips on how to address them:

• Drugs confused.

In the ambulatory surgery medication error report, there were a significant number of reports of eye drops being mixed up, says Grissinger, who acknowledges that the large number of eye cases performed outpatient contributes to the number of errors.

Providers might experience mix-ups between similar-looking eye drops or mix-ups between injectable products for a variety of reasons, he says. Standardization can help avoid problems, he says. "Look at the big picture in your ASF, the drugs you have in stock," Grissinger says. "Confirm what you need and don't need, so you have some standardization on the types of medications."

Limit the varieties of concentrations as well, he says. Also examine how they are stored, Grissinger says. "If you have two eye drop bottles, and you store them next to each other, someone will choose the wrong one at some time or another," he says. "People in healthcare aren't good about looking proactively at what could go wrong. They're often in the business of `putting out fires' versus putting good strategies in place."

Another problem that causes medication errors is confusing look-alike, sound-alike medications. Huber says. *(See Resources, top left, for information on updated list of confused drug names.)*

• Lack of labeling medications.

In outpatient surgery, providers sometimes neglect to label medications, Grissinger says.

"They may draw up a syringe of drugs, put it down, and come back," he says. "Or they might get a vial of a product and pour the contents into a stainless steel bowl, to draw up in a syringe." Patients have died, because a bowl with a clear solution wasn't labeled, Grissinger says.

• Missing documentation.

"There are many pieces of patient information

that are essential to be sure surgery is successful," Huber says. Those pieces include paperwork from the primary care provider, including lab tests, and the history & physical.

Checklists are "wonderful" tools to ensure no pieces of the documentation are missing, she says. Huber points to the World Health Organization (WHO) Surgical Safety Checklist as one that is useful. "Consider using that during patient sign in, the timeout, and sign out, which is immediately after surgery," Huber says. (Editor's note: The WHO checklist can be accessed at http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html.)

Keep in mind that anesthesia staff members need to conduct interviews and examinations, because those providers are introducing medications as well, she points out.

Also, study near misses with medication, Huber says. "Those are a really great opportunity for facilities to learn from some of their processes and issues they have, to see how they're prevented, and to share them regularly with staff," she says.

REFERENCE

1. Grissinger M, Dabliz R, Ambulatory surgery facilities: a comprehensive review of medication error reports in Pennsylvania. *Pennsylvania Patient Safety Advisory* 2011; 8:85-93. ■

$3.3M verdict after surgeon says 'sorry'

The problem may be that he said more

A $3.3 million verdict against a surgeon who apologized to his patient's family for her death is leading some outpatient surgery professionals to wonder if the push for apologies and transparency has a dark side. Are managers encouraging physicians to say something that actually will work against them in court?

Michael Knapic, DO, and his attorney certainly think so. They say he is being punished for expressing regret about his patient's death and that the Ohio apology statute intended to protect such statements has no value. Others say Knapic lost the case not because he said he was sorry, but because of what else he said.

The plaintiff, Leroy Davis of Glenmont, OH, sued Knapic, of Wooster Orthopaedics and Sports Medicine in Wooster, OH, after his 49-year-old wife Barbara Davis passed away following a lumbar microdiscectomy performed on July 23, 2004. The plaintiff accused him of severing Davis's left common iliac artery, lacerating her iliac vein, and "failing to timely diagnose and treat" the resulting medical condition, according to court records.

According to the trial transcript, Davis testified that, after the surgery, "Dr. Knapic … said the back surgery went OK but he nicked an artery, and he takes full responsibility and it was my fault." Later, the jury heard Davis's adult daughter, Pamela Bickel, testify that, after the surgery, Knapic "said as far as the back surgery, everything went fine, but … when they rolled her over that her blood pressure started to drop and they did an ultrasound and s[aw] that she was bleeding, that at some point an artery was nicked. … And he said, 'It's my fault. I take full responsibility.'"

During her pre-trial deposition, Bickel reported that Knapic said he was "sorry." However, that testimony was not submitted as evidence during the trial.

EXECUTIVE SUMMARY

A plaintiff was awarded $3.3 million from an Ohio orthopedic surgeon in a case that hinged on how the surgeon told the patient's family he was sorry for the outcome. The doctor argued that his comments should have been protected by the state's apology statute.

- An appeals court ruled that while the apology was not admissible, the doctor's statement of responsibility was.
- The doctor claims that his statement taking responsibility was part of the apology statement and should be protected.
- The case illustrates the importance of teaching physicians exactly what to say and what not to say when apologizing.

Broad interpretation needed, doctor says

Both sides involved in the case agreed that Ohio state law prohibits a healthcare professional's statement of sympathy as evidence in malpractice cases. They differed sharply, however, on whether admissions of liability or fault could be admitted.

Knapic's attorney, **Christopher Humphrey**, JD, of Canton, OH, argued that the definition of "apology" implies an expression of fault and admission of error. The state law intends to protect the physician-patient relationship following adverse medical events, he told the court, and so the legislature

must have wanted Knapic to be able to say he took responsibility without that being used against him in court.

The plaintiff, however, argued that the law does not exclude a direct admission of fault as evidence. The trial court agreed. Knapic and his practice group challenged the verdict, but the Ohio Court of Appeals upheld the lower court's ruling. The court of appeals stated in its decision that the intent of the law is "to protect pure expressions of apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence, but not admissions of fault." *(See the story at right for more on how to avoid admissions of fault.)*

The court went on to explain that a "physician may speak with a patient or a patient's family members and express his heartfelt sympathy for their pain following a negative outcome without risk of that expression of sympathy being used against him in court." *(See the story on p. 118 for more details from the appeals court opinion.)*

The case will be appealed to the Ohio Supreme Court, says **Christopher Humphrey**, JD, an attorney with the law firm of Buckingham, Doolittle & Burroughs in Canton, OH. The appeals court interpretation of the Ohio apology law effectively renders the statute meaningless, he argues. "I think a risk manager has to advise people now that until this is clarified you can't really say anything because we don't know what is fair game," Humphrey says. "The court is essentially saying that you can say you're sorry, but anything after that is an admission against interests."

Knapic denies that statement is admitted liability to the patient's family, Humphrey says. The case should have hinged on whether the surgeon was liable for nicking the artery or whether that was a known risk of the procedure and the doctor did not violate the standard of care, he says. Instead, Humphrey says the trial was focused on what the surgeon said to the family afterward.

Under the rulings of the trial court and appeals court, Humphrey says, a doctor can say only "I'm sorry" and not much else. That is not realistic, he says.

"If you say anything other than 'I'm sorry that that happened,' you're essentially saying 'I violated the standard of care in a way that directly and proximately resulted in harm, and you're entitled to damages,'" he says. "In that case, the statute is meaningless. If you say you're sorry, and the family and asks 'for what?' and you say you can't comment any further, you've just made it worse." ■

Take a pause after the apology

Surgeons who already were skeptical about apologizing to patients might start citing the recent malpractice case against Michael Knapic, DO, as evidence that, rather than diminishing their malpractice risk, an apology could seal their fate in court. That's a misinterpretation of this case, says **Doug Wojcieszak,** founder of the Sorry Works! Coalition in Glen Carbon, IL, which promotes apologies from healthcare providers.

Telling the family he was sorry was not what lost the case for Knapic, Wojcieszak says. It was telling them he was responsible.

"The real issue is that physicians have to be careful about exactly what they say and can't blurt out confessions of liability in addition to saying they're sorry about the events that transpired," Wojcieszak says. "For me, a better statement following the back surgery would have been, 'The back surgery itself went fine, but when she was rolled over, the blood pressure dropped and an ultrasound discovered bleeding. I am sorry this happened. And we are going to learn how this happened.'

Wojcieszak goes so far as to say the Ohio apology statute and all others like it are unnecessary and can even be counterproductive when they lead to debates such as the one in this case. Some of the most successful disclosure programs in the country operate without apology laws, and even those that do have laws on their state books don't pay attention to them, he says.

"What's the secret to their success? Good event management. Teaching their staff to be proactive with empathy and customer service, but pause before admitting anything," he says. "Even if the staff believes a mistake was truly made, plenty of time down the road to cross that bridge with the patient and/or family. Hunches in the heat of the moment are often wrong, but once you've admitted fault, it's hard to go back over that bridge."

And when you try to backtrack, it will look like a cover-up, Wojcieszak cautions. "The patient or family will truly start to hate you, and litigation will soon follow," he says.

That pause is crucial, he says. Physicians must learn how to say they are sorry without babbling on to say it was their fault, which is a fine distinction sometimes but absolutely vital, Wojcieszak says. *(For more information on the difference, see story, p. 115.)* ■

Difference between `sorry' and 'my fault'

Control what is said can be difficult for a healthcare provider in the highly stressful, emotional conversation with a patient or family member after a bad outcome, says **Grena Porto,** RN, MS, ARM, CPHRM, principal with QRS Healthcare Consulting in Hockessin, DE, and former president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. For many people, their sympathy and regret compel them to take responsibility, and they say too much, Porto says.

"As human beings, we like to confess. We really buy into the notion that confession is good for you and makes you feel better," she says. Some providers attempt to make themselves feel better by taking ownership and responsibility, Porto says. "You can do that, but there's a risk, she says. "You can't unring the bell. You have to be prepared to live with that statement."

Porto says courts distinguished between a surgeon's apology and an additional statement of responsibility. Managers should urge physicians to consult with them for a primer on exactly what to say and what not to say before speaking with the patient or family, Porto says. *(See the story on p. 119 for more on how to word an apology.)*

"Taking responsibility is a statement of fact, not an apology," Porto says. "Even saying 'I nicked an artery' is not necessarily an admission of liability, since that is a known risk of the procedure. But saying 'It was my fault' is hard to get away from." ■

Court weighs 'I'm sorry' vs. 'I'm responsible'

In the recent opinion from the Ohio Court of Appeals concerning a malpractice case against Michael Knapic, DO, by plaintiff Leroy Davis, the court carefully considered the question of what the Ohio legislature meant to protect with its apology statute.

"Dr. Knapic has argued that drawing a distinction between an acknowledgment of fault and an expression of sympathy violates the intent of the statute because the word 'apology,' as commonly defined, includes an expression of fault, admission of error, or expression of regret for an offense or failure," the court wrote in its opinion. "Dr. Knapic has also argued that the statutory intent behind Section 2317.43 is to avoid the obvious detriment to the physician-patient relationship that can follow an adverse medical outcome, especially if the doctor refuses to show some compassion and speak to the patient or the family. According to Mr. Davis, however, a direct admission of fault and responsibility is not what is intended by the plain and unambiguous words of the statute."

The court noted that among the 36 states that have adopted similar laws, the majority explicitly distinguish between statements of sympathy and admissions of fault or liability. Under California's apology law, for example, only "[t]he portion of statements … or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident … shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault … which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section."

Seventeen of the states that have explicitly distinguished between expressions of sympathy and admissions of fault have chosen to admit expressions of fault while excluding from evidence any part of a statement that expresses sympathy. On the other hand, eight of the states that have explicitly made the same distinction between expressions of sympathy and admissions of fault have chosen to exclude both types of statements from evidence.

"For instance, by adding the term 'fault' to the same litany of sentiments found in Ohio's statute, Colorado's statute makes it clear that both admissions of fault and expressions of sympathy are inadmissible. In Colorado, 'any and all statements … expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider … to the alleged victim [or] a relative of the alleged victim … which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as a result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.'

Knapic's attorney argued that the word "apology" could reasonably include at

least an implication of guilt or fault. But the court noted that an apology does not always imply taking responsibility, saying that "when hearing that someone's relative has died, it is common etiquette to say, 'I'm sorry,' but no one would take that as a confession of having caused the death."

"Thus, looking to the rules of grammar and common usage, the appearance of the term 'apology' in

Section 2317.43(A) creates some ambiguity. Reading the term in context with the litany of other sentiments to be excluded under the statute, however, leads us to believe the General Assembly did not intend to include statements of fault within the statute's ambit of protection. The other five protected sentiments clearly do not convey any sense of fault or liability, indicating that the statute was intended to protect apologies devoid of any acknowledgment of fault."

The court concluded that "[t]he statute was intended to protect pure expressions of apology, sympathy, commiseration, condolence, compassion or a general sense of benevolence, without excluding from trial a medical professional's admission of fault for a claimed injury."

The entire text of the appeals court opinion can be found online at http://tinyurl.com/3lqzbem. ■

Must be 50 ways to say you're sorry

Paul Simon said there were 50 ways to leave your lover, and **Grena Porto,** RN, MS, ARM, CPHRM, says there are at least that many ways to say you're sorry ... without admitting responsibility.

Porto, a principal with QRS Healthcare Consulting in Hockessin, DE, and former president of the American Society for Healthcare Risk Management (ASHRM) in Chicago, rejects the idea that an apology naturally segues into an admission of guilt. It just has to be phrased correctly.

If you only say "I'm sorry" and leave it at that, then the patient is likely to ask, "Sorry for what?" And in the heat of the moment, a stressed and regretful physician might blurt out something like, "I'm sorry for nicking the artery and causing her to bleed out."

Above all else, don't use words like "my fault" or "my mistake" or "I made an error," she says. "Once you use a word like 'fault' in this scenario, you're behind the eight ball," Porto says. "You may regret that later."

In the immediate aftermath of a bad outcome, the right way to apologize is to say you're sorry for the situation and the effects on the patient, rather than stating as fact what caused that outcome, she says. A full statement of what happened and why might come later after a proper investigation.

These are some possible ways to apologize without admitting fault:

"I'm sorry this happened to you."

"I'm sorry for the suffering this caused you."

"I'm sorry this means you will have to undergo additional treatment."

"I'm sorry this didn't go as well as we hoped."

"I'm sorry this procedure was not a complete success."

"I'm sorry that you developed complications."

"I'm sorry that there was a bleeder during the surgery, and we did everything we could to repair it." ■

When, how to disclose a provider's errors

Disclosing a medical error is never easy, but it can become especially complicated when you need to tell the patient that a previous provider was in the wrong. This delicate situation often requires communication with the other provider before you tell the patient anything.

Once you have identified that an error occurred with another provider, or you suspect so, there should be no question about following up, says **John C. Metcalfe,** JD, FASHRM, vice president of risk management services with MemorialCare Health System in Fountain Valley, CA. It is unacceptable to simply ignore the situation and make no effort to inform the patient, he says.

However, in many situations, it is important that you not simply tell the patient as soon as you suspect there has been an error, he says. The second provider should contact the first and discuss the concerns, he says. "We contact the other hospital and make a determination in collaboration with that hospital about the disclosure," Metcalfe says. "We give the other hospital the opportunity to follow their own procedures for disclosure, because they might not have known about the error or the consequences of the error."

That collaboration might not always be possible, however. If a patient's X-ray reveals a retained sponge or needle from surgery at another facility, for instance, Metcalfe says there would be no time for collaborating because the patient would need immediate surgery. In such a case, Metcalfe's hospital would inform the patient right away and then alert the other provider about the finding.

Even determining the provider that committed the error can be difficult, Metcalfe says. If the patient had undergone a series of surgeries, for instance, it might not be clear who left a sponge

behind. "We've had cases in the past where the patient indicated they had undergone a surgery fairly recently, and the easy assumption is that's where the error occurred," Metcalfe says. "Then we found out that the error actually occurred up the road a bit more, two or three surgeries back."

When the provider at fault is not clear, Metcalfe's hospital tries to contact all the providers that might be responsible to alert them and let them determine the answer. But he says the facility ultimately is not obligated to determine which other provider committed the error and sometimes must simply inform the patient and let him or her pursue the matter further.

Each case must evaluated individually, says **Vivian Barker Miller**, CPHQ, LHRM, CPHRM, FASHRM, senior risk management specialist with American Society for Healthcare Risk Management (ASHRM). There is no single correct way to address disclosing another provider's error, she says. "The goal must be to do the right thing for the patient, the family, and also the provider," she says. "Don't forget that this will be a significant issue for the provider. They are going to feel awful about this error and the consequences."

Although swift disclosure is necessary in some cases, providers usually should take a step back and carefully consider the situation before informing the patient that another provider erred, says **Matson Sewell,** MS, MPH, CPHRM, principal with Matson Sewell Healthcare Consulting in Sacramento, CA. Sewell has held multiple risk management positions with healthcare providers and was chair of an ASHRM task force on disclosure after adverse outcomes.

Providers should be cautious in declaring that another hospital erred because it did not treat the patient as they would have, Sewell says. *(See the story, below, for one doctor's experience with disclosing another's error. See the story on p. 121 for potential risks from being too quick to disclose.)*

First determine if the other hospital's treatment falls into an acceptable range of treatment, Sewell advises. "Are we assuming that if they didn't do it exactly the way we would have done it, that it's an error?" she says. "Sometimes it's absolutely clear cut that they took the wrong approach, but I've often seen people assume it was a wrong approach when it really just wasn't the way they would have done it." ■

Doc tells patient provider not happy

Doing the right thing doesn't guarantee that everyone is going to be pleased, says **Frederick S. Southwick**, MD, professor of medicine in the Division of Infectious Diseases and quality projects manager for the senior vice president for health affairs at the University of Florida Shands Health System and the University of Florida College of Medicine in Gainesville.

Shands has a policy of transparency when it comes to medical errors, Southwick explains. When an error occurs, the policy is to immediately inform the patient and offer restitution. The result has been a marked reduction in malpractice insurance premiums, Southwick says._

"Legal fees have plummeted, and the money they spend goes to the people who deserve remuneration: the injured patient and their family," he says. "Under the standard approach, over 60% of malpractice funds go to the lawyers."

Southwick once encountered a situation in which had to disclose to a patient that an error had occurred under previous care by another physician, and he says the experience shows how difficult that can be. "As an infectious disease consultant, I was asked to see a patient who had a severe postoperative infection after a prolonged delay in the initiation of antibiotics. The patient asked me if he should have been treated earlier, and in the spirit of honesty and openness, I told him, yes he should have been treated earlier," Southwick says. "I then informed the physician who had consulted me about the patient's concerns, and we together contacted our risk management team. They in turn discussed in detail the patient's concerns with him, and they forgave his hospital bills and provided him with compensation for his lost time at work."

The patient was satisfied, Southwick says, but the other physician's initial reaction was not positive. "The physician who inadvertently delayed the initiation of antibiotics was unhappy with my response, but after I explained that this strategy would greatly reduce the likelihood of a malpractice suit, he understood my approach, and we remained friends and close colleagues," he says. ■

Hasty error disclosure can damage others

Tertiary care providers can be so influenced by seeing the end results of a supposed error — the patient's condition is worsened — that they make overly harsh judgments about the previous provider's care, says **Matson Sewell,** MS, MPH, CPHRM, principal with Matson Sewell Healthcare Consulting in Sacramento, CA. Those judgments can cause serious damage to the facilities.

What seems to be an error or substandard care should be judged not with perfect hindsight but in light of what information was available to the provider at that time, Sewell says. "That's the mistake that I see people make: an assumption of error without investigating whether an error really occurred," she says. "I'm afraid a lot of tertiary care facilities do have a certain amount of professional arrogance with respect to the community hospitals' care."

The provider that discovers the error can assume it is doing the right thing by immediately informing the patient, but that self-satisfaction can come at a price. Rushing to disclose a supposed error to the patient, without first confirming that the other facility truly was at fault, can damage your relationship with that facility, Sewell cautions. "Unfortunately what I see usually happen, and around Boston this is almost epidemic, the provider basically criticizes the care of the referring hospital, never even tells that hospital there was even a concern, and that is taking professional potshots from a distance," she says. "It does cause problems. In small communities you have to work and shop and go to PTA meetings with the doctor you're criticizing, so you just want to be sure about what you're saying."

Sewell also points out that disclosing a provider's error might lead to a legal claim, and the doctor who discovered it might be called as an expert witness. This potential situation is not a reason to avoid disclosing a true error, but it is a reason to avoid being overly judgmental about the other provider's care or too hasty with disclosure, she says.

"The other thing to know is that if litigation is initiated, your own care will come into scrutiny," Sewell says. "I've seen cases in which the disclosing physician ended up being the primary defendant, not the person whose error he disclosed, and the plaintiff was awarded damages." ■

Same-Day Surgery Manager

Please take note: Top surgeon irritants

By **Stephen W. Earnhart,** MS
CEO
Earnhart & Associates
Austin, TX

Seemingly, no one is happy with his or her block schedule at the hospital or the surgery center. After spending too much time on this issue with our own centers and hearing about others concerns, it is, quite honestly, irritating that such a simple process can be such a conundrum for most everyone.

In its simplest application, block booking is merely a reservation. Like any fine restaurant, you want to make sure your valued customers have a table (in this case, an operating room) available to them when they arrive.

There are some surgeons who are abusing the system by not utilizing this free service, and there are some surgical services personnel not following their own guidelines. Blocking posting of cases works! However, you must adhere to established parameters to make it fair and rewarding for all.

No one hates memorandums more than I do. Why write it when you can say it? However, there are times when you need to circulate the same message to all at the same time. Everyone's policies and procedures on block time are different (though I don't know why — heavy sigh). You need to refresh them, share them, and then, most importantly, stick with them. This complaint is one of the most common ones I hear from surgeons. Make it go away!

Consider these other top irritants for surgeons:

• **Rude staff members.**

As incredible as it sounds, this issue is a significant one with surgeons, and, according to the surgeons, it is getting worse! I have read in recent articles that customer service in general is declining, but in healthcare! Apparently so. While there are effective measures you can take to eliminate rude staff members, most are illegal.

One method that does seem to work is to get the name(s) of staff members from the surgeons that

(they feel) are rude and confront the individual. I've done it several times this month. Each time the staff member is surprised, not defensive. While it doesn't seem like it is a personal issue toward the surgeon, it is perceived to be. Making the individuals aware of the matter seems to help a great deal.

• **Preference cards.**

Really? The majority of "operational and process audits" we do for hospitals and surgery centers always reveal problems in this area. Almost all surgeons interviewed have a problem with this area. (No, not your center.) They claim that they are not asked to sit down and review their cards and that when they change their preference for a case, it is not noted for the next case. There is, surprisingly, a strong resentment toward facilities not paying attention to this rather basic management tool.

• **Missing instruments.**

You cannot blame the surgeons for being upset when they stick their hand out and ask for something that should be in their tray and it is not there. Avoid telling them that you did not pick their case or that someone forgot. Consider instead telling them it was stolen by parties unknown and the new one just arrived. Seriously, this problem, according to surgeons, has become a significant area of irritation.

• **Staff hanging around** (while they are waiting to start their case).

I do have empathy for the surgeons. They are impatiently waiting for their case to get started or getting the patient in the room at least, and they see "crowds" of staff just hanging around. Again, this issue is one that is growing for them. Sometimes "out of sight" is a better place to meet.

• **Turnaround time.**

Whether any of us like it or not, turnaround time to the surgeon is from the time they leave the room until the time their next patient enters. It's not fair, but perception is reality. I have documented turnaround time (their example) of 25 minutes and then asked the surgeon how long it was. Their answer: 45 minutes, they say with conviction. Not an easy fix by any standard. We might have to punt on this issue.

Best recourse is, once again, to let everyone know the definition of turnover time. Post the results in the lounge, or distribute them to the surgeons.

• **Delayed start times.**

Enough said. [*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.] ■

Innovative ideas for patient education

Educators often talk about "teachable moments," those times when the patient is ready to learn. This moment might be in a waiting area, exam room, or a hospital bed. To take advantage of these times, staff members in the Section of Patient Education at Mayo Clinic in Rochester, MN, look for new ways to deliver patient education.

"Our core mission is to get the right materials, to the right patient, at the right time," says **Becky Smith**, RN, MA, manager of patient education.

The ideas for innovative delivery methods are developed through careful assessment of clinical areas by an educator. The assessment addresses needs in inpatient and outpatient settings. To be implemented, education needs must be integrated into a one-year plan for that clinical area.

"We do factor in the cost, especially with new innovations, before going forward," Smith says. "It is part of the equation along with potential patient outcomes and satisfaction."

In 2011, a major project incorporated exam room computers in the outpatient setting into the education process. Shorter videos (60 seconds long) were created in-house for these computers to take advantage of the time patients wait for their physicians. For example, patients might view a short video on an impending surgical procedure while they wait for their appointment with an orthopedic surgeon.

The computers also can be used to call up the database of hundreds of approved written materials created by the Section of Patient Education or to access consumer health information on Mayo's web site (www.mayoclinic.com/health-information).

In the Mayo Clinic outpatient waiting areas, anatomical models and interactive touch screens provide learning opportunities that are department-specific, such as ear, head, and neck in otorhinolargyngology. Also available are computer workstations that help patients navigate reliable web sites. Adjacent to an orthopedics waiting area are screens suspended from the ceiling with animations highlighting information about the knee joint or hand. Video on-demand is available throughout Mayo's outpatient and inpatient settings, with 900 videos accessible on an array of medical topics.

Innovative educational delivery methods also have been created to reach patients at home. A patient portal on Mayo Clinic's Web can be accessed through a safe, secure password for such informa-

tion as lab results and appointment schedules. The portal makes it possible to deliver instructions on preparations for tests and procedures. Patients are notified via e-mail of impending appointments with a reminder to access the portal for instructions.

Another innovative way to deliver high level messages is a printed wellness calendar. The calendar includes a separate section listing titles of educational pamphlets, classes, CDs, and videos available in the various clinical areas.

Not every area has the same educational tools, says Smith. "We use a patient-centered approach to assess and identify patient needs and the most suitable innovative delivery method," she explains. "Meeting the needs of our patients is always foremost." ■

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 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

■ New tips for an old problem: Unintended retention of a foreign body

■ How to evacuate patients in an emergency

■ A look ahead: What changes should you be preparing for now?

■ Accreditation surveys and the drug shortage

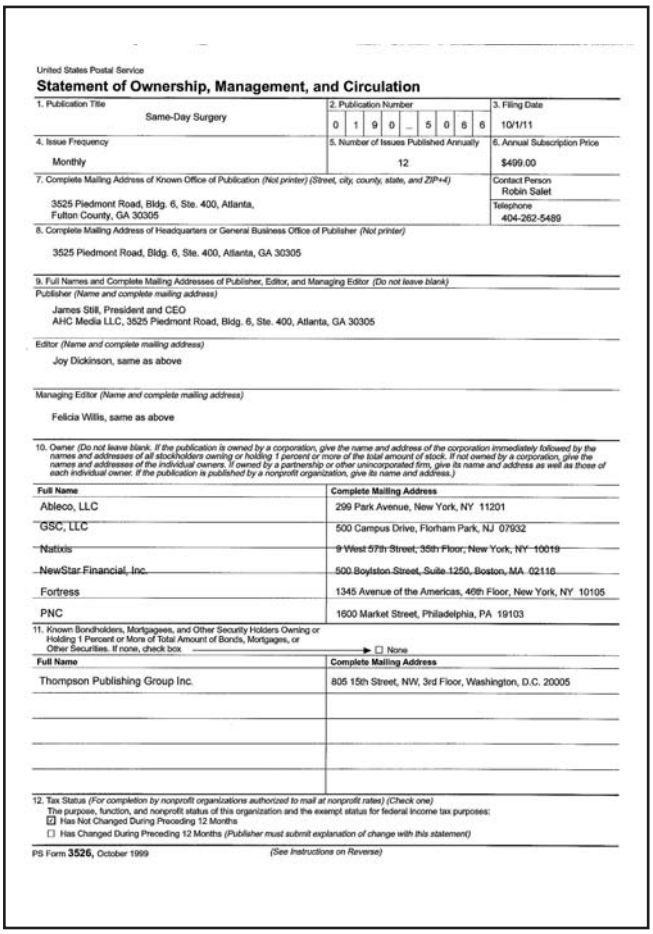
CNE/CME QUESTIONS

1. In the malpractice case filed against Michael Knapic, DO, which of the following is true regarding his statements to the plaintiff?
   A. Knapic said he was "sorry." However, that testimony was not submitted as evidence during the trial.
   B. Knapic never said he was sorry or took responsibility for the patient's injury.
   C. Knapic said he was "sorry." That statement was submitted as evidence during the trial, and Knapic confirmed having said it.
   D. Knapic said he was "sorry." That statement was submitted as evidence during the trial, and Knapic denied having said it.

2. What did the Ohio Court of Appeals conclude concerning the state's apology statute in the malpractice case filed against Knapic?
   A. The statute was intended to broadly protect all expressions of apology, regret, and admissions of responsibility by a healthcare provider after an adverse outcome.
   B. The statute was unconstitutional because it barred the admission of relevant evidence by the plaintiff.
   C. The statute did not apply in the Knapic case because the facts of the case clearly demonstrated negligence by the physician.
   D. The statute was intended to protect pure expressions of apology ... without excluding from trial a medical professional's admission of fault for a claimed injury.

3. What does John C. Metcalfe**,** JD, FASHRM, vice president of risk management services with MemorialCare Health System in Fountain Valley, CA, do when it appears a patient has been injured by a previous provider, but it is not clear which previous provider is at fault?
   A. Metcalfe's hospital immediately informs the patient and takes no further action.
   B. Metcalfe's hospital tries to contact all the providers that might be responsible, but ultimately is not obligated to determine which other provider committed the error.
   C. His hospital notifies the state board of medicine, which initiates an investigation.
   D. His hospital notes the finding in the medical record but does not notify the patient or other providers.

4. What is the solution for surgeons' complaints about turnover time, according to Stephen W. Earnhart, MS, CEO of Earnhart & Associates?
   A. Let everyone know the definition of turnover time.
   B. Send out a harsh memo.
   C. Tell surgeons what the turnover time is at the average hospital.
   D. None of the above.



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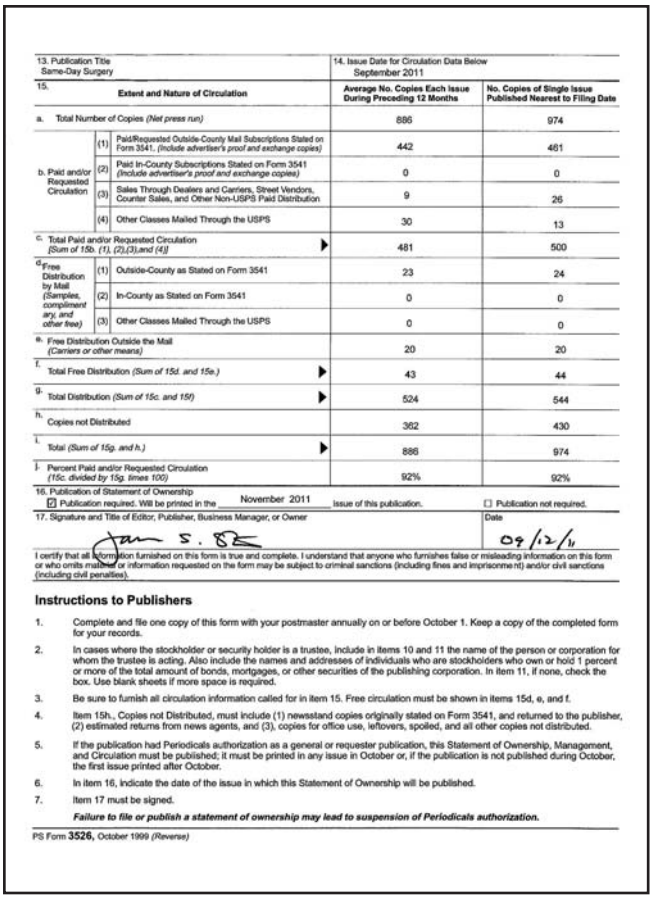

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