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AHC Media

Patient info on Facebook traced to temp staff, raises questions

Poster mocked patient: 'It's just Facebook … not reality'

One hospital's experience with a temporary employee who posted a patient's information on online — making fun of her condition and showing no remorse when challenged — is raising questions about how hospitals can ensure temporary staffing agencies provide adequate compliance training.

The temp employee of Providence Holy Cross Medical Center in Los Angeles posted a photo of a woman's medical record, which clearly showed the woman's name and admission date, according to a report by the Los Angeles Daily News, which obtained a printout of the Facebook page before it was deleted. The photo was accompanied by the comment, "Funny but this patient came in to cure her VD and get birth control."

When others posted on the page with comments scolding the employee for violating the woman's privacy, the employee responded with "People, it's just Facebook … Not reality" and "It's just a name out of millions and millions." He refused to take down the information, but it eventually was deleted when hospital officials were notified.

Providence immediately released a statement saying that the employee had been supplied by a temporary staffing agency and would no longer be allowed to work in any Providence facility. The staffing agency was supposed to have trained the employee in compliance with the Health Insurance Portability and

EXECUTIVE SUMMARY

A Los Angeles hospital is facing negative publicity and possible penalties after a temporary employee posted patient information on Facebook and mocked her. The employee was not remorseful and insisted there was nothing wrong with posting the information.

- The incident raises questions about how temporary employees are trained in compliance.
- Hospital officials say the temp agency was required to provide adequately trained employees.
- Criminal and civil penalties are possible from the breach.

Accountability Act (HIPAA), a hospital spokesman told Healthcare Risk Management. *(For more of the hospital's response, see the story on p. 27. For a monitoring option that can help prevent breaches, see the story on p. 27.)*

The hospital's potential liability from the privacy breach might depend on the quality and effectiveness of its HIPAA compliance polices and training, says **Philip D. Mitchell**, JD, an attorney with the law firm of Epstein Becker Green in Newark, NJ. Providence reports that its contract with the temporary staffing agency requires such training, but Mitchell says a lawsuit could hinge on whether that was just boilerplate language or the hospital actually backed it up by confirming that the agency trained people properly.

"It all depends on their existing policies and procedures," Mitchell says. "How did they hire this person, and how did they train him? If all they can say is that the contract required he be trained by the temp agency, but they didn't do any due diligence to see how that agency complies, that could be problematic. You could argue that they had a responsibility to know how these people were trained before you accept them as an employee."

Could plead willful misconduct

Mitchell notes, however, that the egregious nature of the violation could give the hospital a valid defense of willful misconduct by a rogue employee. Unlike a more nuanced violation of HIPAA, a defense attorney could argue that any reasonable person would know the posting of a medical record on Facebook was wrong, he says.

"It's such a deliberate act and out of the norm that it could be hard to hold the hospital responsible for that," Mitchell says. "This person clearly has no regard for confidentiality, and unless the hospital had some way of knowing that, they can say this was someone purposefully breaking the law regardless of what training was or wasn't provided."

Any legal action taken by the patient most likely would result in only a modest settlement, Mitchell surmises, but he notes that the hospital is taking a bigger hit in the court of public opinion. The negative publicity attached to the hospital's name could be the worst result, he says.

Not easy to escape blame

Another attorney with experience in HIPAA enforcement says the hospital's response that the staffing agency was responsible for training the employee might be shortsighted. The employee's comments indicated he had no understanding of HIPAA, much less any respect for it, and the hospital has to take some responsibility for that lack of understanding, says **Joseph P. Paranac Jr.**, JD, an attorney with the law firm of LeClairRyan in Newark, NJ.

"Everyone may maintain the fiction that those temporary staffers are employed only by the staff-

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ing agency," Paranac says. "But in reality, those temporary staffers are probably joint employees of the staffing agency and the hospital. I suspect that on a daily basis, these temps are taking direction from hospital supervisors, so I would make sure that everyone who comes in to the hospital as an employee, and who has access to information, receives a two-hour training course on HIPAA."

Paranac notes that HIPAA puts the onus on healthcare providers to make sure employees are trained, and that responsibility cannot be casually passed on to another party such as a staffing agency. "If you want to hold to the idea these are not your employees and so you don't want to train them, then I would send someone to the staffing agency's training class and document what you see there," he suggests. "If their training is not sufficient, you can offer to help them improve it and not accept any more employees until they do."

Policies must be in sync

In addition to the negative publicity from a privacy breach, the potential ramifications are significant. Healthcare providers and individuals such as directors, employees, or officers of the covered entity, who "knowingly" obtain or disclose individually identifiable health information in violation of the regulations, face a fine of up to $50,000 as well as imprisonment up to one year. Offenses committed under false pretenses allow penalties to be increased to a $100,000 fine, with up to five years in prison. Finally, offenses committed with the intent to sell, transfer, or use such information for commercial advantage, personal gain, or malicious harm permit fines of $250,000 and imprisonment for up to 10 years.

The "knowingly" element requires only knowledge to the actions that constitute an offense, Paranac explains. Specific knowledge of an action being in violation of the HIPAA statute is not required.

Another potential problem is that hospitals often have separate policies on HIPAA compliance and social media, and the two don't always mesh well, Mitchell says. In many cases, they are drawn up by different people with different purposes, rather than having one comprehensive policy. *(See the story on p. 28 for more on social media and healthcare.)*

"Often, the social media policies are set up by marketing or the IT folks, whereas the confidentiality policy usually comes from compliance, risk management, or the general counsel's office," Mitchell says. "If they don't sync up, you have potential gaps that will be a problem when you have to show your training was adequate, and there can be ambiguities that allow employees to make mistakes." ■

SOURCES

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Hospital requires agencies to comply

The risk manager at Providence Holy Cross Medical Center in Los Angeles declined to be interviewed about the incident in which a temporary employee posted patient information on Facebook, but the parent company, Providence Health & Services, provided this statement:

Providence Health & Services, guided by core values that include respect and dedicated to compliance with state and federal privacy laws, takes patient privacy very seriously and regularly trains employees on the importance of guarding patient records.

As we reviewed this isolated incident, we worked with the staffing agency to ensure the individual is not allowed to work in the future in any Providence facility. We also reaffirmed to the agency involved in this matter that language in our standard contract with staffing agencies requires that any contract workers sent to a Providence facility recognize and adhere to all state and federal laws, particularly those protecting patient privacy.

Providence also has a social media policy that requires employees, vendors, volunteers, and others working in the hospital to follow laws and policies designed to protect patient privacy on both public and private Web sites. ■

Activity monitoring can spot privacy breaches

With growing attention to the threat of privacy breaches through social media, some healthcare organizations are utilizing "user activity monitoring" to help ensure compliance with the Health Insurance Portability and Accountability Act

(HIPAA).

With user activity monitoring, organizations can monitor, capture, and analyze all user and user group activity on the employer's device — including e-mail sent and received, chat and instant messages, web sites visited, applications and programs accessed, web searches, file transfers, and data printed or saved to removable devices. The system also can take screenshots of employees' activities at pre-set intervals.

McKenzie (TN) Medical Center implemented Spector360 user activity monitoring after noticing high bandwidth usage as well as issues with worker productivity. *(See Resource at end of this article for information on purchasing the software.)* The medical center employs more than 30 medical providers and almost 300 support staff. Unrestricted access to the Internet, personal e-mail, and social media presented potential legal liability, and the center wanted to ensure that all employees were complying with HIPAA regulations, says **Don Page**, IT manager and security officer.

User activity monitoring allows hospitals and healthcare organizations to track employees' activity on social networking sites and receive alerts regarding potential suspicious activity based on established key words, Page says. It is also beneficial to employee training, he says, with hospital administrators able to flag issues and discuss them with employees. For example, if an employee posted confidential information on Facebook, hospital administrators can provide proof and discuss with the employee how he or she violated regulations.

With the user activity monitoring software, McKenzie was able to quickly identify more than $18,000 worth of time where employees were spending time on non-work related computer use. The clinic director then reminded employees of the company's Internet usage policies and spoke with offenders regarding the new monitoring process.

Since implementing user activity monitoring, McKenzie has increased productivity and reduced non-work related online activities, Page says. Not wanting to be too severe, the center also allows employees limited access to the Internet for personal reasons, such as paying bills online or visiting Facebook. Four computers have been set up in the lunch room for employees' use during their lunch break.

Although McKenzie originally implemented user activity monitoring to address productivity concerns, Page says it has become a valuable tool in HIPAA compliance. During HIPAA compliance investigations, McKenzie Medical is able to replay all activity that took place on an employee's screen or activity logs relating to alleged incident. In some instances, employees have been cleared of wrongdoing after the hospital reviewed their activity.

"Protecting our patients' privacy and ensuring that meet HIPAA compliance regulations is our foremost concern," Page says. "With user activity monitoring, we're able to address and respond to HIPAA concerns in a timely manner."

SOURCE

• **Don Page**, IT Manager and Security Officer, McKenzie (TN) Medical Center. Telephone: (731) 352-7907.

RESOURCE

• SPECTOR 360 7.3 is available for purchase at www.spector360.com or by calling SpectorSoft Corporate Sales at (888) 598-2788. Standard pricing is $115 per endpoint for a perpetual license. ■

New guidance from ECRI on social media, healthcare

Driven by concerns about the many risks social media poses, the healthcare industry has been slower than others in adopting social media. However, the rate of adoption has increased in the past two to three years. As of October 2011, more than 1,000 hospitals have recognized the benefits in improved community outreach and are actively using social networking tools, according to ECRI Institute, an independent nonprofit in Plymouth Meeting, PA, that researches approaches to improving patient care.

These hospitals' 4,000 social networking sites include 1,068 Facebook pages and 814 Twitter accounts, ECRI reports. ECRI has been closely following the rapid emergence of social media over the past five years and published a new risk analysis, Social Media in Healthcare, to help healthcare providers face the unique risks social media poses.

ECRI found that hospitals and other healthcare organizations use social media in ways that attempt to meet consumer demand. ECRI recommends that in doing so, these hospitals must create and enforce social media plans that define how engaged the organization will be, who its audience will be, and who will be responsible for managing social media outlets, as well as establish policies and procedures for managing risks related to privacy, reputation

management, and employment issues.

Paul Anderson, ECRI Institute's director of risk management publications has spoken extensively on the topic to risk management and patient safety professionals across the country. "I won't tell you that you have to join Facebook or set up a Twitter account, but your patients and staff are using these tools," Anderson says. "Healthcare managers would be shortsighted not to consider both the risks and benefits that social media presents. Yes, there are privacy and reputational risks, but social media can present tremendous opportunities for hospitals to communicate with their communities, patients, and staff."

The complete risk analysis on social media is available online at no charge at http://tinyurl.com/87b7olu. ■

HIPAA breaches up 32%, half from missing devices

Data breaches in healthcare organizations are on the rise, according to the Second Annual Benchmark Study on Patient Privacy & Data Security released recently by The Ponemon Institute in Traverse City, MI.

The frequency of data among the healthcare organizations in the study increased 32% from the previous year. In fact, 96% of all healthcare providers in the study say they have had at least one data breach in the last two years. Most of these were due to employee mistakes and sloppiness; 49% of respondents in the study cite lost or stolen computing devices, and 41% note unintentional employee action.

Another disturbing cause is third-party error, including business associates, according to 46% of participants. The full study is available at no charge at http://tinyurl.com/87fkkzx.

To reduce the risk of a data breach, Ponemon recommends that healthcare personnel who handle sensitive and confidential patient information should be trained and aware of the policies and procedures governing the protection of this information. "Billing records and medical files are considered by respondents to be the most frequently lost or stolen patient information," the report states. "However, the perception is that not all personnel who are responsible for these documents understand the importance of protecting them."

Sixty percent of respondents agree that medical billing personnel in their organizations do not understand the importance of patient data protection, and 58% say IT personnel do not understand its importance. In contrast, 58% of respondents say administrative personnel do understand the importance of protecting patient data. *(See the story below for more results of the study.)*

Widespread use of mobile devices also is putting patient data at risk, the report suggests. Eighty-one percent of healthcare organizations in the study report that they use mobile devices to collect, store, and/or transmit some form of protected health information (PHI). However, 49% of participants admit their organizations do nothing to protect these devices.

"Despite policies and federal mandates, prevention of unauthorized access to patient information is not a priority in many organizations in this study," the report says. "Forty-seven percent of respondents agree that their organization has sufficient policies that effectively prevent or quickly detect unauthorized patient data access, loss, or theft. This is an increase from 41% of respondents last year." ■

EXECUTIVE SUMMARY

Data breaches increased significantly in 2011, with nearly all healthcare providers reporting a breach in the past two years, according to a new study. Many employees report not understanding data security requirements.

- Many breaches were the result of lost or stolen computers and other devices.
- Third-party error also accounts for a large proportion (46%) of breaches.
- Employees have less confidence that electronic health records improve security.

Impact of data breach averages $2.2 million

These are some key findings from the Second Annual Benchmark Study on Patient Privacy & Data Security released recently by The Ponemon Institute in Traverse City, MI.:

- Privileged user and access governance should be a higher priority, the report suggests. Only 29% of respondents agree that the prevention of unauthorized access to patient data and loss or theft of such data is a priority in their organizations.
- Diminished productivity and financial consequences for healthcare organizations can be severe

when a data breach incident occurs. Respondents reported that the average economic impact of a data breach was $2.2 million, up 10% from last year. In addition, most respondents believe their organization has suffered from time and productivity loss (81%) followed by brand or reputation diminishment (78%) and loss of patient goodwill (75%). The potential result is patient churn; the average lifetime value of one lost patient (customer) is $113,400, an increase from $107,580 in last year's study.

• Medical identity theft poses a greater risk to patients. Employees are the group most likely to detect the data breach, according to 51% of participants. However, more than one-third (35%) of respondents say that data breaches were discovered by patient complaints. Once a breach is discovered, 83% of hospitals say that it takes in excess of 1-2 months to notify affected patients. Twenty-nine percent of respondents say their data breaches led to cases of identity theft, a 26% increase from last year.

• While 90% of healthcare organizations say that breaches cause harm to patients, most of them (65%) do not offer protection services for the affected patients. This might be due to the fact that 72% of respondents do not believe credit monitoring is effective and believe another solution for the prevention and detection of medical identity theft is needed.

• The average number of lost or stolen records per breach was 2,575. This is an increase from an average of 1,769 reported in the previous year.

• The percentage of organizations fully implementing or in the process of implementing an electronic health records (EHR) system has increased from 56% last year to 66% in this year's study.

• Perceptions that EHR systems create more security decreased from 74% in last year's study to 67% of respondents this year. ■

Video made in-house to educate staff on falls

Finding a new way to educate employees about fall prevention is a big challenge because, though the topic is important, it can be hard to keep people's attention. One hospital found that an educational video starring its own employees and presented with a bit of humor effectively delivers the necessary information.

The effort began about two years ago when leaders at Long Beach (CA) Memorial Medical Center were seeking a way to improve education efforts and comply with the National Patient Safety Goal on fall prevention, explains **Miriam Wedemeyer**, OTR/L, JD, ergonomics program director at the hospital, part of MemorialCare Health System (MHS).

"To deal with this issue, our ergonomics team formed a consortium of representatives from adult and pediatric nursing, Occupational Medical Services, the Patient Safety Committee, and adult and pediatric rehabilitation therapies," Wedemeyer says. "After some discussion about how to get people's attention and what we had already done in the past, we knew the ultimate solution was a video."

In preparation, the team members developed a storyboard presentation and piloted it at the hospital's next nursing skills education fair. From there, they located a professional production company that worked closely with the consortium to write the script, film, edit, and produce the video.

"The consortium itself was cohesive, and ideas flowed freely. Each constituency brought its own expertise to the table," Wedemeyer says.

The project team determined the necessary criteria for a successful training video:

• evidence-based;
• entertaining and interesting;
• simple and practical;
• brief: preferably 5 and no more than 10 minutes;
• multiple scenarios;
• repeatable by multiple trainers to reach all employees;
• consistent message, no matter who presents it and when.

Six month investment of time

From concept to finished product, the project took six months, including securing funding. The video production was funded by grants from the Memorial Medical Center Foundations. Consortium members contributed time as part of their jobs. *(See the story on p. 31 for the key information presented in the*

EXECUTIVE SUMMARY
Seeking a new way to educate staff about fall prevention, one hospital decided to produce its own video. Staff volunteers acted in the video, which used humor to convey key messages about fall prevention.
• The project took six months to complete.
• An outside company was hired to produce the video.
• The video was presented to all employees and is used for continuing education.

video.)

Casting was one of the most important tasks, Wedemeyer says. The consortium wanted to use hospital employees instead of professional actors for two reasons, she explains. First, hospital employees would give the video more of a realistic feel and make it specific to Long Beach Memorial rather than looking like an off-the-shelf education video.

The second reason was that the employees watching the video could see their friends and colleagues in the video, which would keep them interested and entertained, especially in the more comedic moments. *(See the story below right for more on the comedic element.)* "We wanted as many employees as possible from every one of our six hospital campuses in Los Angeles and Orange counties in the MemorialCare Health System," Wedemeyer says. "They had to be believable, yet entertaining in their roles."

The consortium also wanted a corporate executive to open and close the video, to give it credibility. MHS Executive Vice President and Chief Operating Officer **Tammie Brailsford**, RN, stepped in.

The video shoot took place over two days in an unoccupied patient room and other non-patient locations.

Prior to release, each constituency previewed the video and approved the content. To release the video, Brailsford encouraged the consortium to put on a movie premiere, complete with popcorn. "It became a celebration for the entire enterprise," Wedemeyer says. "Hundreds of employees attended the premiere, where we staged a ceremony for comical awards with statuettes and short acceptance speeches."

The video is made available on the MHS intranet and is frequently used for nursing education. Wedemeyer says it has been a huge success. The keys to the success of the project were the inclusion of multiple constituencies, sponsorship by C-suite executives, and serving up serious material with a "spoonful of humor," she says.

"More than a year later, I still get compliments from employees on how great the video is and that it has impacted their knowledge and implementation of fall prevention procedures and activities," Wedemeyer says. "Its light-hearted nature, especially when the audience knows the players, makes it a highly effective teaching tool."

SOURCE

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Hospital identifies topics for falls video

While planning its in-house education video on fall prevention, project members at Long Beach (CA) Memorial Medical Center, developed a list of topics to include and criteria for effective training.

These were the important topics and messages they wanted to include:

- Always practice safe patient transfer and ambulation techniques.
- Anyone can fall. Always anticipate the possibility, and prepare a place to sit.
- Err on the side of caution. Get help if unsure of the patient's transfer status.
- Always be in "teaching mode."
- Use firm vocal commands to direct the patient.
- Don't panic, and help the patient remain calm.
- A strong directive such as "Stand!" might elicit a response that provides assistance to minimize potential injury.
- Learn the mechanics of what happens during a fall.
- Keep the patient close. Minimize reaching.
- Don't try to hold up a falling patient. Instead, allow the patient to slide down your thigh. This response accomplishes several goals. It decreases the speed of the fall, decreases the height of the fall, and decreases the risk of injury to the caregiver.
- Don't twist.
- Protect vulnerable anatomical parts.
- Protect the head.
- Target buttocks to floor.
- What to do after the fall:
    - o Remain calm. What's done is done. The patient isn't going anywhere.
    - o Get a pillow and make the patient as comfortable as possible.
    - o Have a nurse assess the patient for injury.
    - o Don't "gang" lift the patient. Get a mechanical lift device to raise the patient back onto the bed or gurney.

Humor helps get the message across

No one wants to sit through another boring education video, so Long Beach (CA) Memorial Medical Center decided to lighten things up with

their fall prevention video.

The comedy woven into the educational elements keeps the viewer's attention, explains **Miriam Wedemeyer**, OTR/L, JD, ergonomics program director at the hospital.

"We knew we wanted it to be comedic, because people are inundated with really serious information. Normally when you put on a video, people immediately go to sleep," she says. "We needed to catch their attention with something that was interesting and entertaining even as we were presenting important messages about fall prevention."

With a topic as serious as falls and the potential injuries, the team at first wondered how they could make anything about the video funny. But then they realized that the serious information could be portrayed with a light touch simply by giving the cast the leeway to be silly and goofy in the way they portrayed some scenes, along with some props, Wedemeyer says. The fact that viewers know the actors makes it much funnier than if a stranger were performing, she says.

Several scenes in the movie portray fall hazards in the healthcare environment. They point out to the viewer what is wrong in the scenario, such as cords left exposed in the patient room or bed rails left down. A patient fall is portrayed to show how the hazards led to the fall, and then the scene is shown again with the hospital employee responding appropriately to eliminate the hazards.

Another key part of the video illustrates what the caregiver should do during a fall. Long Beach teaches its employees to facilitate a controlled fall, which allows the patient to slide down the caregiver's leg, rather than trying to hold up the patient. Attempting to hold up the patient puts the caregiver at risk, Wedemeyer says.

"We intended this for nurses and other caregivers, but one of the things I'm most proud of is that others have seen the video and learned some of these important techniques," she says. ■

'Distracted doctoring' recognized as hazard

All manner of electronic devices are common in any healthcare setting, and individuals increasingly are likely to use their own smart phones, tablets, and other personal electronics while at work. The proliferation of electronics is leading some patient safety experts to worry that patient safety might be threatened by "distracted doctoring."

The problem is moving higher on the long list of patient safety concerns, says **Gail Gazelle**, MD, an assistant professor of medicine at Harvard Medical School in Boston and one of the first physicians in the country to start a direct patient advocacy practice, www.MDCanHelp.com.

"It is a rare person who does not admit to arriving at a destination while on their cell and not recalling how they drove there. Just as we understand that drivers are distracted by cell calls, cell calls to physicians and nurses provide a concerning distraction," Gazelle says. "There is no question that this can compromise patient care."

Research indicates that clinicians sometimes are astonishingly comfortable about mixing patient care with using their own personal devices. An article in the journal Perfusion documented that 55% of technicians who monitor bypass machines admit to talking on their cell phones during heart surgery. Fifty percent also said they had texted during surgery. *(For more on that research, see the story on p. 33.)*

About 40% of the technicians said that talking on the cell phone during surgery was "always an unsafe practice," and 50% said the same about texting.

The spectrum of effects is broad, Gazelle says. At one end, focus on a text or call leaves patients feeling as if there is less focus on them, which leaves them even more vulnerable and disempowered, thus less likely to speak up about concerns or problems.

"Knowing what we do about the importance of patient participation in avoiding medical errors, this may not be a small concern," she says. "At the extreme end of the spectrum, the distracted clinician is at risk for overt errors in concentration, judgment, and technique."

Hospitalwide policies on the use of personal electronics are necessary but will not solve the problem, Gazelle says. A culture change is more important. Solving the problem will require getting the ear of physician leadership, Gazelle says. Physician leaders

EXECUTIVE SUMMARY

The increasing use of electronic devices in the healthcare workplace creates the risk of distraction that can threaten patient safety. Risk managers should address the risk with policies and practical methods to reduce distraction.

- The risk comes from personal devices and healthcare instruments.
- Healthcare employers should have policies to address personal devices.
- A culture change within the hospital is the most effective solution.

must agree that distracted doctoring is a problem, then lead by example, she says. Surgeons in particular, as the captain of the ship in the operating room, should make clear they will not be distracted by their own devices and will not accept others on the team using personal electronics during surgery, she suggests.

Keley John Booth, MD, chairman of anesthesiology at Integris Health in Oklahoma City, OK, also is concerned about distracted doctoring and agrees that a culture change within the institution is the foundation of any solution. "Just as The Joint Commission posted an alert on the disruptive clinician in 2008, I believe we are due for an alert on the use of cellular devices," Booth says. "I also believe that patients and clinicians need to be empowered to tell users that their behavior is putting patients at risk."

Because each subsequent generation is more used to using their devices all the time, Booth predicts that the use of personal devices will only increase unless the institution delivers the message that the healthcare workplace must be an exception to their typical usage.

"We can't stop people from using this technology, but we can make it clear that some times are not appropriate. We have to create an atmosphere in which people are comfortable asking a coworker why they are using their cell phone during patient care," Booth says. "It can be done in a way that isn't confrontational, but by asking you can remind them to think more about when they're pulling out their smart phone and maybe wait until a more appropriate time."

SOURCES

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• **Keley John Booth**, MD, Chairman of Anesthesiology, Integris Health, Oklahoma City, OK. Telephone: (405) 636-7147. E-mail: Keley.Booth@surgerylogistics.com. ■

Heart surgeons use cell phones in surgery

Research from SUNY Upstate Medical University in Syracuse, NY, documents that heart bypass technicians admit to using their cell phones during surgery, but they also contend that the practice is unsafe.[1]

There were 439 respondents, with age ranges of 20-30 years (14.2%), 31-40 years (26.5%), 41-50 years (26.7%), 51-60 years (26.7%), and more than 60 years (5.9%). The use of a cell phone during the performance of cardiopulmonary bypass (CPB) was reported by 55.6% of perfusionists. Sending text messages while performing CPB was acknowledged by 49.2%.

For smart phone features, perfusionists report having accessed e-mail (21%), used the internet (15.1%), or have checked/posted on social networking sites (3.1%) while performing CPB.

Safety concerns were expressed by 78.3% who believe that cell phones can introduce a potentially significant safety risk to patients. Speaking on a cell phone and text messaging during CPB were regarded as "always an unsafe practice" by 42.3% and 51.7% of respondents, respectively. Personal distraction by cell phone use that negatively affected performance was admitted by 7.3%, whereas witnessing another perfusionist distracted with phone/text while on CPB was acknowledged by 33.7% of respondents.

The researchers noted that there are clear generational differences in opinions on the role and/or appropriateness of cell phones during bypass.

"This survey suggests that the majority of perfusionists believe cell phones raise significant safety issues while operating the heart-lung machine. However, the majority also have used a cell phone while performing this activity," the authors wrote. "Such distractions have the potential to be disastrous."

REFERENCE

1. Smith T, Darling E, Searles B. 2010 Survey on cell phone use while performing cardiopulmonary bypass. *Perfusion* 2011; 26:375-380. ■

Most hospital errors unreported, HHS says

Hospital incident reporting systems captured only an estimated 14% of the patient harm events experienced by Medicare beneficiaries, according to a new report by the Department of Health and Human Services (HHS).

Hospitals investigated those reported events that they considered most likely to lead to quality and safety improvements and made few policy or practice changes as a result of reported events, according

to the report "Hospital Incident Reporting Systems Do Not Capture Most Patient Harm." *(The report is available online at http://tinyurl.com/7np8gvu.)*

Hospital administrators classified the remaining events (86%) as events that staff did not perceive as reportable (61%) or as events that staff commonly report but did not report in this case (25%). (*For more findings in the report, see the story at right.)*

The report notes that as a condition of participation in the Medicare program, federal regulations require that hospitals develop and maintain a Quality Assessment and Performance Improvement (QAPI) program. To satisfy QAPI requirements, hospitals must "track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital." To standardize hospital event reporting, the Agency for Healthcare Research and Quality (AHRQ) developed event definitions and incident reporting tools known as the common formats.

For the report, HHS requested and reviewed incident reports from hospitals regarding patient harm events. All of the hospitals reviewed had incident reporting systems designed to capture events. Hospital administrators interviewed indicated that they rely heavily on the systems to identify problems. Hospital accreditors reported that they do not investigate event collection methods, such as incident reporting systems, unless evidence of a problem emerges through the survey process.

"Because hospitals rely on incident reporting systems to track and analyze events, improving the usefulness of these systems is critical to hospitals' efforts to improve patient safety," the report says. "Therefore, we recommend that AHRQ and the Centers for Medicare and Medicaid Services [CMS] collaborate to create and promote a list of potentially reportable events for hospitals to use. We further recommend that CMS provide guidance to accreditors regarding their assessments of hospital efforts to track and analyze events."

EXECUTIVE SUMMARY:

Incident reporting systems are inadequate at most hospitals and fail to capture most errors, according to a government report. Part of the problem is the lack of understanding about what is reportable.

- Nurses report most errors.
- Some incidents are known to be reportable but still not reported in individual cases.
- Accreditors typically do not investigate how incident reports are collected.

HHS also says CMS should suggest that surveyors evaluate the information collected by hospitals using AHRQ's common formats. Additionally, CMS should scrutinize survey standards for assessing hospital compliance with the requirement to track and analyze events and reinforce assessment of incident reporting systems as a key tool to improve event tracking, the report says. ■

Hospitals rely on reporting systems

Report says there is little effect

Administrators from all hospitals with reported events indicated that they rely on incident reporting systems to capture a large portion of the information about events that they use to conduct patient safety improvement activities, but they are not capturing most errors, according to a new report by the Department of Health and Human Services (HHS).

The administrators acknowledged that incident reporting systems provide incomplete information about how often events occur, but they continue to rely on the systems primarily because they value staff accounts of events, the report says.

These are more findings from the report:

- Nurses most often reported events, typically identified through the regular course of care.
- Nurses most often identified events through patient observation and routine hospital safety assessments.
- Twenty-eight of the 40 reported events led to investigations, and five led to policy changes.
- Information regarding one-quarter of events was not accessible to the staff responsible for monitoring patient safety within the hospitals and for making policy changes.
- Hospitals investigated the events they considered most likely to yield information that would inform quality and safety improvement efforts and made few changes to policy or practices as a result of reported events.
- Hospital accreditors reported that in evaluating hospital safety practices, they focus on how event information is used rather than how it is collected. Accreditors view incident reports within the context of larger hospital quality and patient safety efforts.
- Officials indicated that to assess hospitals, surveyors are most likely to review the results rather

than review the methods used to track hospital adverse events. Surveyors would not specifically investigate these methods, such as incident reporting systems, unless evidence of a problem emerged through the survey process. ■

Claims frequency, severity on the rise

Claims frequency has been rising slightly, which contrasts to the past few years in which claims frequency had declined or stabilized, according to the sixth annual benchmarking report on professional liability claims trends in the hospital industry from Zurich, a property and casualty insurance provider based in Schaumberg, IL.

The report also finds that claims severity continues to rise. Between 2002 and 2008, severity rates rose 6.3% per year. *(For the full report, go to http://tinyurl.com/76djdb7.)*

Illinois, New York, and Pennsylvania continue to have the highest severity, the report says. But although the difference in severity between "all states" and the three states with highest severity is relatively stable, their severities are moving closer together. Illinois, which has the highest severity of the states shown for eight out of 11 years, actually has a flat annual trend from 2002 to 2008.

New York, another high severity state, has an annualized average trend of just 3.9%. This number is 2.4% lower than the national average. Pennsylvania has the highest annual trend of the states shown at more than 10% from 2002 to 2008. While severity has moderated somewhat in the high severity states, the other states have seen relatively greater increases in severity.

Other highlights of the study included:

• Differences in claims severity trends between different types of organizations narrow.

In the past, non-profit hospitals have seen considerably lower severity rates than for-profit hospitals. Now, non-profit hospitals have higher claim severity than for-profit organizations.

• Comparing faith-based and non-profit healthcare organizations.

The report reviewed loss cost, frequency, and severity. Overall, loss costs for faith-based and non-profit organizations are similar. But the report finds that frequency rates are higher in faith-based organizations, while severity rates are lower.

• Claims severity by facility type.

The report compared acute care, children's hospitals, teaching hospitals, and outpatient facilities. Teaching hospitals are defined as those that are part of academic institutions or sponsor resident education programs. Children's hospitals continue to have the highest severity over time. This difference likely is due to the high costs of providing medical care over the child's lifetime, the report says. Teaching hospitals contribute significantly to overall severity. ■

CNE INSTRUCTIONS

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.

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

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

COMING IN FUTURE MONTHS

- Captive pros, cons, and tips
- Minimize risk of cloud computing
- Firing a verbally abusive doctor
- Know limits of peer review protection

CNE QUESTIONS

1. When the medical record of a patient at Providence Holy Cross Medical Center was posted on Facebook, what did the hospital say happened?
   A. A temporary employee from a staffing agency posted the record, and the person apparently was not properly trained in privacy issues.
   B. The record was on a lost laptop computer.
   C. A longtime employee of the hospital took the record and posted it after being fired by the hospital.
   D. The record was inadvertently posted by the patient.

2. According to the Second Annual Benchmark Study on Patient Privacy & Data Security released recently by The Ponemon Institute, which of the following is true?
   A. Sixty percent of respondents say that medical billing personnel in their organizations fully understand the importance of patient data protection.
   B. Sixty percent of respondents agree that medical billing personnel in their organizations do not understand the importance of patient data protection.
   C. Ninety-six percent of all healthcare providers in the study say they have had no data breach in the last two years.
   D. Ninety-six percent of all healthcare providers in the study say they have had at least five data breaches in the last two years.

3. In developing the fall prevention video at Long Beach Memorial Medical Center, what did the project team determine was an important element for success?
   A. A light, comedic touch to keep the viewer's attention.
   B. A focus on data and statistics showing the risk of falls.
   C. A detailed explanation of the employer's policy on fall prevention.
   D. A review of workers' compensation cases stemming from falls.

4. According to the sixth annual benchmarking report on professional liability claims trends in the hospital industry from Zurich, which is true of trends in claims?
   A. Frequency is increasing, but severity is decreasing.
   B. Frequency is decreasing, but severity is increasing.
   C. Both frequency and severity are decreasing.
   D. Both frequency and severity are increasing.

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

Hospital found to be negligent in rape of female inpatient, $150,000 award given

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News: In 2006, a patient was admitted to a local hospital after she attempted to commit suicide. Shortly after her admission, the patient and her roommate began to socialize with a male patient who was also admitted to their unit. The male patient entered the woman's room in the middle of the night and raped her. The woman sued the hospital for negligence, and a jury found the hospital negligent through its nurse staff and mental health workers. The jury awarded the female patient $150,000 in damages.

Background: A female patient was admitted to a local hospital after attempting to commit suicide. The patient and her roommate began taking walks and playing cards with a male patient in the same unit at the hospital. One evening when the patient and her roommate were getting ready for bed, the male patient came into her room and stated "later today, I'm going to have to come to bed with one of you." A male nurse entered the room, removed the male patient, and warned him not to go into other patients' rooms. He was escorted back to his room; however, no other precautions were taken to prevent him from returning.

Later that night, the male patient re-entered the woman's room and sexually assaulted her. The woman and her roommate testified that she repeatedly asked him to stop. Shortly after the attack, a worker alerted the nursing staff that the male patient was standing in the doorway of his room looking "startled." The nursing staff then placed a desk in the hallway to monitor the patients. Sometime later, the assaulted woman's roommate reported to a nurse that the male patient had been in her room and she "knew what he was doing." The assaulted patient testified that she was too scared to immediately report the attack herself. Instead she confided in her psychiatrist the following morning. The hospital staff then transferred her to the emergency department, where she was evaluated and interviewed by police.

The assaulted patient sued the hospital and alleged one count of negligence. At trial, experts testified that psychiatric patients are a vulnerable population, and hospitals have a higher duty to these patients to keep them safe. One expert indicated that when there is a rule violation on a mental health unit, you do not just tell the offending patient the rule. She testified that the hospital staff must do everything they can to ensure the safety of every patient. The expert also testified that "every time there is a sexual assault on a psychiatric unit, it is due to not upholding the standard of care, which is ensuring the safety of the patient." Another expert testified that "rape is something for which one can watch and that is always preventable." This expert explained that there is a Mental Health Code that outlines what should be done to protect patients, what kind of treatment is allowed, what

Financial Disclosure: Author **Greg Freeman**, Executive Editor **Joy Daughtery Dickinson**, and Nurse Planner **Maureen Archambault** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Leslie Mathews**, guest columnist, discloses that her husband is an employed physician at Bradenton (FL) Cardiology Center. **Barbara Reding** and **Lynn Rosenblatt,** guest authors, have no relationships to disclose.

providers must be careful of, and how to provide a safe environment. The expert agreed that "if a rape occurs in a hospital, it is malpractice and a violation of care."

The jury returned a verdict in the female patient's favor. It found that the hospital was negligent through its nursing staff and mental health workers. The jury awarded the patient $100,000 in non-economic damages and $50,000 in economic damages. The hospital appealed; however, the appellate court has since affirmed the jury's decision.

What this means to you: Emphasis on patient safety in healthcare settings is well publicized through avenues such as The Joint Commission's National Patient Safety Goals (NPSGs), national patient safety organizations' statements and educational publications, Centers for Medicare and Medicaid Services' (CMS') Conditions of Participation, state regulatory requirements, and plaintiff attorneys advertisements. Healthcare consumers are encouraged to be their own healthcare advocate or designate an advocate to ensure their safety and monitor their care when hospitalized in an acute care facility or in a long-term care setting; however, health care providers have a clear duty to ensure the safety and security of their patients.

One NPSG requires hospitals to identify safety risks inherent in its patient population, with no exceptions. In this case, the hospital staff was to evaluate risks inherent in the male and the female patient. NPSG 15.01.01 requires psychiatric hospitals to identify patients at risk for suicide, and the same is true for patients being treated for emotional or behavioral disorders in general hospitals. In this case, a female was admitted to a local hospital after a suicide attempt. As an emotionally fragile patient with a history of attempted suicide, a risk assessment must be conducted to identify specific patient characteristics and environmental features that might increase or decrease the risk for suicide in accordance with NPSG 15. This safety goal also requires the organization to "address the patient's immediate safety needs and most appropriate setting for treatment." Ensuring a suicidal patient's safety includes such interventions as closely and regularly monitoring the patient in person and/or through the use of surveillance equipment and designated surveillance rooms. Visitors must be monitored. A policy and procedure for suicide precautions is imperative. Safety considerations are a must for all patients, and additional monitoring a necessity for suicidal or emotionally fragile patients. Frequent rounding, assessment, and observation are a few ways to provide a safer patient environment.

A breach of duty occurred when a male patient was witnessed entering the female patient's room, was escorted back to his room by a male nurse, and no other interventions were implemented to prevent a reoccurrence of such activity. Only after another staff member later reported observing unusual behavior on the part of the male patient was additional monitoring and securing of the environment put into place. Unfortunately for the female patient, this safety measure was initiated too late.

One could argue that the female patient was responsible for reporting the rape sooner rather than later. One might propose she could have cried out for help when the male patient entered her room or screamed as the violation began to unfold. Given the female patient's emotional state, she might have been incapable of such responses. Such arguments are overruled by the duty to ensure a safe patient environment at all times. Expert testimony supported such a duty. The jury in this case agreed and awarded $150,000 in non-economic and economic damages. The appellate court supported the breach of duty by upholding the jury's decision and holding the hospital accountable.

There is no "reasonable" settlement or award for rape. The effects of rape can be devastating, lifelong, and destructive. So can the experience of a healthcare provider's failure to ensure patient safety. These are among the reasons healthcare providers have an obligation to institute and perform all possible safety measures to provide a secure environment to all who trust in their care.

REFERENCE:

State of Michigan Court of Appeals, Washtenaw Circuit Court LC No. 09-000094-NH ■

Severe preeclampsia causes massive stroke

$900K awarded for alleged negligent monitoring

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News: A patient with a history of pregnancy-induced preeclampsia was admitted to the hospital for the delivery of her fourth child. After delivering her child via caesarean section, her physician ordered close monitoring of bleeding, blood pressure, and heart rate. Despite a falling heart rate, rising pulse, and lack of urine output, all classic signs of blood loss shock, a physician was not contacted for several hours. When the patient was found to be unresponsive, she was moved to the intensive care unit. The patient suffered massive blood loss, which caused oxygen deprivation to the brain and a massive stroke. The patient sued the hospital and physicians for negligence. During a bench trial, the court entered a judgment against the hospital for $900,000.

Background: In February 2005, a patient was admitted to the hospital for the delivery of her fourth child. The patient had a history of pregnancy-induced high blood pressure, or severe preeclampsia. The patient gave birth to a baby boy in the evening and later was transferred to another room for recovery. The patient was attached to a machine to closely monitor her blood pressure and heart rate.

The patient's nurse was assigned only one patient for the night. She was instructed to check the patient's incision site and uterus for bleeding initially every half-hour and then every hour. The patient's partner reported that over the next several hours, the patient's heart rate and blood pressure were erratic, her urine output declined, and her physical condition declined. When he noticed that the patient was sweating and having hot flashes, he called the nurse several times and received no response. An hour and half later, he again called the nurse when he noticed the patient's heart rate was increasing and her blood pressure was dropping.

At 2:26 a.m., another nurse responded to a significant difference in the patient's systolic and diastolic arterial blood pressures. This nurse instructed the patient's nurse to administer intravenous fluid. Shortly thereafter, the patient's blood pressure descended precipitously. At this time, the patient was clammy, unresponsive, and sweating profusely. At 2:48 a.m., the nurses began summoning the patient's physician. After at least two calls were made, the physician responded by phone at 3:08 a.m. At 3:10 a.m., the house resident arrived in the patient's room. She was emergently transferred to the surgical intensive care unit (ICU).

Upon evaluation in the ICU, it was determined that the patient had lost about half of her blood volume, which caused oxygen deprivation to the brain and a massive stroke. The patient underwent additional surgery as well as transfusions. As a result of the stroke, the patient suffered severe and painful physical and cognitive impairments.

The patient filed a suit against the hospital in response to the nurse's negligence and filed a suit against the physicians for medical negligence. The patient's expert OB-GYN testified that falling blood pressure, rising pulse rate, and lack of urine output are "classic signs of blood loss shock" that can be a result of excessive bleeding. The expert also testified that excessive bleeding was a well-known risk to patients with preeclampsia. The doctor stated that he believed the patient suffered from hemolyses low platelets (HELLP) syndrome, a severe form of preeclampsia.

During a bench trial, the court entered a judgment against the hospital for $900,000. The hospital appealed the decision. It stated that the OB-GYN was barred from testifying as an expert witness with respect to the standard of care for a nurse's postpartum monitoring of high risk patients with preeclampsia. The appellate court disagreed with the hospital and upheld the district courts award of $900,000 to the patient.

What this means for you: There is no question that the nurse assigned to monitor an immediate postoperative C-section patient with a known history of preeclampsia failed in providing an acceptable standard of care. She failed to monitor a high risk patient after specifically being ordered to do so, and she did not appropriately respond to the obvious evidence that the patient was in fact experiencing large volume blood loss. It appears that the assumption was that the patient was hypertensive as a result of preeclampsia and after the delivery by C-section her blood pressure would stabilize without issue. However, there were other risk factors that the nurse should have considered, as preeclampsia was not this patient's only issue as a post surgical patient having undergone a C-section delivery of a fourth infant.

After delivery, some women experience postpartum hemorrhage from the uterus, or significant bleeding after childbirth. Postpartum hemorrhage can be caused by several factors, such as placental problems or uterine atony. Uterine atony is when the uterus does not contract after the placenta is delivered. In a fourth pregnancy following a C-section, atony is certainly a possibility that a responsible OB nurse should have considered.

Additionally some women develop problems with the placenta during pregnancy that may cause unexpectedly heavy bleeding during a C-section. For

example, the placenta sometimes grows into and attaches itself more strongly to the wall of the uterus than is normal during the pregnancy. This can prevent easy separation of the placenta after the baby is delivered and cause it to bleed.

In rare cases, fragments of the placenta can be left behind and also can be a major source of bleeding. Placental problems are more common in women who have had at least one previous C-section or have had placental problems in the past. We know this patient had a history of preeclampsia which involves irregularities of the placenta, and this was her fourth pregnancy.

The expert witness stated that he believed the patient suffered from HELLP syndrome. HELLP stands for Hemolysis (breakdown of red blood cells), Elevated Liver enzymes (liver function) and Low Platelets counts (platelets help the blood clot). It is thought that preeclampsia occurs when the placenta abnormally invades the uterus by growing into the spiral arteries of the uterus incorrectly. The body regards the placenta as a tumor and is resistant to high blood pressure, which can result in poor pregnancy outcome. Some clinicians expect preeclampsia to be "cured" with the delivery of the child. But recent studies show that in some women, preeclampsia may develop in the postpartum or worsen following a pregnancy.

In this case, the nurse was ordered to check the patient's incision site and uterus for bleeding initially every half-hour and then every hour. Such visual inspection together with monitor readings are standard postsurgical recovery room processes and are basic to the nurse's role in that setting. If the nurse was checking the patient every 30 minutes for evidence of bleeding, she should have become concerned over the erratic blood pressure readings, fluctuating pulse rate, and diminished urinary output, as these are in fact classic indicators of rapid and/or prolonged blood loss.

Later that evening, the patient was noted by her partner who was at her bedside to be diaphoretic, which is the medical term for perspiring profusely. This is also indicative of blood loss. While he had summoned the nurse to check the patient, his perception was that the nurse was indifferent to the situation as she failed to respond to his repeated calls. One might surmise that such poor response and failure to react to what obviously was a life-threatening situation indicates a dereliction of duty and serious evidence of malpractice.

Eventually another nurse correctly identified the patient's failing condition as hypovolumnia from low blood volume. She ordered the first nurse to increase the circulating blood volume by administering a bolus of fluid to raise the patient's diastolic pressure, as it was evident that the patient was in shock. Additionally, the second nurse notified the attending physician. It is unclear what exactly transpired from the time of the first call to the physician to the second nearly 30 minutes later when the patient had become unresponsive. What is clear is the fact that she had been profusely bleeding for some time and the assigned nurse had failed in her duty to properly monitor the patient. It is also clear that this patient demonstrated a near textbook picture of drastic blood loss, but it went unrecognized by a nurse who was assigned to monitor just that possibility.

Cases such as this one require root case analysis, which is a mandate from The Joint Commission when investigating sentinel events that result in significant patient harm and/or adverse outcomes. The question that arises is what was the nurse actually doing that night when this was her only assigned patient and where she had been given specific orders to check the patient at 30 minute intervals? Did she even check for bleeding?

One would also wonder why the nurses did not immediately notify the resident staff of a life-threatening emergency when they could not reach the attending physician immediately. The entire episode lacks the credibility of a knowledgeable and caring staff that is well-trained in how to conduct emergency responses. As a result, the patient suffered a stroke. Had the bleeding been identified earlier, routine measures could have been taken to prevent and/or reduce the possibility of stroke and/or death. There was every indication that it could have been prevented, and unfortunately the delay was irreparable.

The hospital's argument on appeal was that the OB-GYN was barred from testifying as an expert witness with respect to the standard of care for a nurse's postpartum monitoring of high risk patients with preeclampsia. That appeal was denied. While professional expert witnesses frequently are called within their own professions, a physician certainly can testify to the expectations that the medical staff rely on in terms of trained and knowledgeable nursing support. In this case the hospital clearly was liable for the negligence of its staff.

REFERENCE

United States Court of Appeals, Fourth Circuit. No. 10-1183. ■