Healthcare RISK MANAGEMENT

February 2013 | Vol. 35, No. 2 Pages 13-24

# Leapfrog safety scores spur debate: How reliable are they?

*Some low-scoring hospitals say results are invalid — Leapfrog unperturbed*

Low patient safety scores from The Leapfrog Group have some hospitals crying foul and claiming that the group's data is old and the scoring methodology flawed. If you didn't get the score you were hoping for, should that be cause for alarm, or can you dismiss it?

The answer depends on who you talk to, but by and large most hospital administrators and quality experts consulted by *Healthcare Risk Management* say the Leapfrog scores are considered reliable. That doesn't mean they are an exact assessment of your patient safety experience, but they are the closest anyone outside your organization is going to get, says **Leah Binder**, president and CEO of The Leapfrog Group.

"I would send my family to a hospital that got an A, and I would be cautious at a hospital that got less than an A," Binder says. "I put my own family's health at stake when assessing the validity of this score. That's a strong statement, but a true one."

*The Leapfrog Group have some hospitals crying foul and claiming that the group's data is old and the scoring methodology flawed.*

The Hospital Safety Score was first launched in June 2012, measuring 2,652 hospitals on 26 factors that the group says indicate the level of overall patient safety. Hospitals are given a score of A, B, C, D, or F, and more than 1,200 hospitals earned a C or below. The 26 factors are measured through a voluntary survey to hospitals and also from the Hospital Compare data compiled by the Centers for Medicare & Medicare Services (CMS). *(See the story on p. 15 for more on the scoring methodology and recent scores.)*

Over the summer of 2012, the Blue Ribbon Expert Panel convened to review the methodology in the light of the first launch, considered commentary from experts and associations including the American Hospital Association (AHA), conducted data analyses, and looked at additional evidence. The Blue Ribbon Expert Panel recommended maintaining the original scoring methodology, with the exception of two alterations that give certain hospitals more credit on two of the measures. The Leapfrog

## INSIDE



AHC Media

www.ahcmedia.com

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.

Board approved the recommended methodology.

As soon as the first batch of scores was released, complaints were heard from some of the hospitals that did not fare well — including some respected providers. Mount Sinai Medical Center in New York City criticized the safety scores and called the grade "an incomplete and imperfect snapshot" in a statement to The Wall Street Journal's Heath Blog. The hospital added that "much of the analysis is based on outdated information from disparate sources." *(See the full comments at http://tinyurl.com/wsjstatement.)*

The Cleveland Clinic in Ohio received a C and rejected that assessment for the same reason. The clinic said The Leapfrog Group used old data. Some hospitals, including Cleveland Clinic, have opted not to participate with the Leapfrog surveys on which the scores are based because they don't have confidence in the system. But administrators from those hospitals also have claimed that the participating hospitals have an advantage because they are scored on more elements.

Completing the survey is labor and time-intensive, without yielding much useful information for the hospital, explains **Shannon Phillips**, MD, MPH, quality and patient safety officer at the Cleveland Clinic. "We decided we wanted those same talented people to be doing something that made a difference in patient safety rather than spending that time on the survey," Phillips says. "The Leapfrog score is one of many scores that are generated with different data and methodologies, and anything that suggests we don't provide safe care isn't going to make anybody happy. But we're staying very focused on our safety and quality goals, and these scorecards are not part of our institutional strategy."

The AHA also criticized the Leapfrog scores in June 2012 and said they were "neither fair nor accurate" and that "no one should use it to guide their choice of hospitals." *(See the full letter at http://tinyurl.com/letterfromAHA.)* AHA President and CEO Richard J. Umbdenstock even went so far as to accuse The Leapfrog Group of manipulating data to give some hospitals poor scores. *(See p. 16 for a summary of The Leapfrog Group's response.)*

In response to criticism of the scoring methodology, Binder acknowledges that "we have excellence, but not perfection." The most frequent complaint is that the data does not reflect the most current sta-

## *Executive Summary*

The patient safety scores issued to hospitals by The Leapfrog Group have some hospitals criticizing the validity of the scoring methodology. Leapfrog says the scores are a reliable measure of patient safety.

- ✦ Some hospitals say Leapfrog uses outdated information.
- ✦ The Leapfrog Group contends the data is as current as possible and yields valid scores.
- ✦ Many of the complaints come from low-scoring hospitals.

**Healthcare Risk Management®** (ISSN 1081-6534), including HRM Legal Review & Commentary™, is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Healthcare Risk Management®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

Healthcare Risk Management® is intended for risk managers, health system administrators, and health care legal counsel. Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Executive Editor: **Joy Daughtery Dickinson** (404) 262-5410 (joy.dickinson@ahcmedia.com), Production Editor: **Kristen Ramsey.** Senior Vice President/Group Publisher: **Donald R. Johnston.**

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $545. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $87 each. (GST registration number R128870672.)




Editorial Questions

Questions or comments? Call **Greg Freeman,** (770) 998-8455.

tus of a hospital's safety, but Binder says that always will be impossible.

"When we hear that the data is too old, it's from 2011, and I don't think that's very old," Binder says. "Sure, I'd like to have a ticker tape in my office that gives me up-to-the-minute data on every hospital, but we don't have that. We use the latest data available to us, and I trust these scores with my family's health."

Binder also offers to work with any hospital association to urge CMS to release data on a more timely basis. "We do support the idea that we should get the data faster, but having said that, this can't wait," she says. "Consumers need the information."

The complaints probably are driven in part by the fact that hospitals are not accustomed to transparency with their safety data by having it available to the public and assessed for an overall score, Binder says. Risk managers and other hospitals administrators also might be acting on the fact that their own internal data is different from that used by Leapfrog and might sometimes portray a more favorable picture, notes **Patrick Romano**, MD, MPH, professor of general medicine and pediatrics at the University of California, Davis, and a member of the panel that assessed the Leapfrog methodology.

It is understandable that a hospital's internal data could paint a different picture if it is more current and complete than what was available to Leapfrog, Romano says. That does not invalidate the Leapfrog scores, he says, but it should be impetus to provide Leapfrog with that information.

"Realize that The Leapfrog Group is going to assess the data and score your hospital whether you participate or not, so it is to your advantage to participate and help us gather the most complete, accurate picture of your patient safety experience," he says.

### SOURCES


- **Leah Binder**, President and CEO, The Leapfrog Group, Washington, DC. Telephone: (202) 292-6713.
- **Shannon Phillips**, MD, MPH, Quality and Patient Safety Officer, Cleveland Clinic, Cleveland, OH. Telephone: (216) 444-4998.
- **Patrick Romano**, MD, MPH, Professor of General Medicine and Pediatrics, University of California, Davis. Telephone: (916) 734-7237. E-mail: psromano@ucdavis.edu. ✦


# Safety scores based on 26 measures

The Leapfrog Group updated its Hospital Safety Scores in November 2012, five months after the first scores were released. More than half of the hospitals received the same score as in June 2012, and 23% earned a higher grade.

Nineteen percent earned a lower grade, and some of the hospitals that did not fare well complain that the scores are not valid. Predictably, the hospitals scoring well tend not to find fault. The scores are available to the public at http://www.hospitalsafetyscore.org.

The latest update to the Hospital Safety Score shows that hospitals are making some progress, but many still have a long way to go to reliably deliver safe healthcare, says **Leah Binder**, president and CEO of The Leapfrog Group.

"Everybody has a role in improving this terrible problem with safety in American hospitals," Binder says. "Consumers, patients, families of patients, employers, unions, and hospitals themselves can all make a difference if we resolve here and now to make patient safety a national priority."

While there are several other hospital ratings in the market, many of which use Leapfrog data for their calculations, Binder says the Hospital Safety Score is unique in that it is offered free to the public, along with a full analysis of the data and methodology used to calculate each individual hospital's Hospital Safety Score. The Hospital Safety Score relies on the advice of the nation's foremost patient safety experts, she says, and their participation is a voluntary contribution to Leapfrog's nonprofit mission.

Calculated under the guidance of The Leapfrog Group's nine-member Blue Ribbon Expert Panel, the Hospital Safety Score uses 26 measures of publicly available hospital safety data to produce a single score representing a hospital's overall success in keeping patients safe from infections, injuries, and medical and medication errors.

These were some of the key findings from the latest Leapfrog report:

- Of the 2,618 general hospitals issued a Hospital Safety Score, 790 earned an "A," 678 earned a "B," 1,004 earned a "C," 121 earned a "D" and 25 earned an "F."
- 58% of hospitals maintained the same grade level as they had in the scores issued in June 2012. Another 34% of hospitals changed by one grade level (some higher, some lower). About 8% of hospitals showed more dramatic change by moving two grade levels or more up or down.
- A wide range of hospitals earned "A's," with no one class of hospitals (such as teaching hospitals or public hospitals) dominating among those showing the highest safety scores. Hospitals earning an "A" include academic medical centers New York Presbyterian Hospital, Brigham and Women's Hospital, and Mayo Clinic. Many rural hospitals earned an "A," including Geisinger Medical Center and Blessing Hospital.
- Hospitals with myriad national accolades, such as Massachusetts General Hospital, Duke University Hospital, and Cleveland Clinic Florida each earned an "A."
- "A" scores also were earned by hospitals serving highly vulnerable, impoverished, and/or health-challenged populations, such as Bellevue Hospital Center and Detroit Receiving Hospital.
- In analyzing statewide performance, Massachusetts and Maine showed outstanding hospital safety results, with 83% of Massachusetts hospitals and 80% of hospitals in Maine awarded "A's. ✦

# Leapfrog responds strongly to AHA accusations

When the American Hospital Association (AHA) criticized The Leapfrog Group for its patient safety scoring methodology, Leah Binder, president and CEO of The Leapfrog Group, struck back. Here is an excerpt from the letter she sent in response:

"With regard to the idea that Leapfrog deliberately manipulated data: this is a very serious charge for you to make without offering a single example to support it. We will launch a full investigation of any such example should you find one. You can also investigate this for yourself, as Leapfrog is transparent and makes 100% of the data used to calculate each hospitals safety score available to the public at HospitalSafetyScore.org.

"The fact AHA would level this charge against Leapfrog, which has an unrivaled record for integrity and a panel of experts and advisors second to none, suggests you are expressing something beyond sincere concerns about the methodology. So to be clear on the issue of "manipulation of data": disappointing though many of these grades may be to many of your member hospitals, Leapfrog, along with our expert advisors, members, advocates, and supporters, did not make these scores up. The Hospital Safety Score grades reflect real problems threatening the lives of people who depend on America's hospitals.

"We urge you to address those problems quickly." ✦

# Culture change and 'red zone' improve patient safety

A hospital in Casper, WY, has reduced medical errors by changing the staff culture about patient safety and by instituting a system that notifies others when a staff member is involved in a high-risk task and should not be interrupted.

Wyoming Medical Center's effort to improve patient safety kicked into high gear in 2009, says Risk Manager **Shawna Willcox**, CPHRM, MBA. Three years later, the hospital saw a 70% reduction in errors that cause serious harm to patients and a corresponding improvement in malpractice costs, she says.

The hospital worked with a consultant, **Craig Clapper**, PE, CMQ/OE, founding partner and chief knowledge officer of Healthcare Performance Improvement in Virginia Beach, VA. Together they reviewed sentinel events and other errors.

"We found that we weren't as safe as we thought we were, once we looked at the hard data," Willcox says. "We were not unsafe on the national average numbers, but we were just average. We thought we should do better and do something different."

One of the first tasks was to conduct individual interviews with staff members to ask what was wrong with patient safety at the bedside. The interviewers sought specific information about processes and procedures that did not work, for example, and the workarounds that staff actually used. That information was enlightening, Willcox says. "Based on that information we pulled 65 people, mostly bedside staff but a few managers, to an off-site retreat," she says. "During that retreat, we determined what our safety behaviors needed to be and what safety or error prevention tools we needed to use. One thing we learned is that our communication was not good."

Communication breakdowns were tied to about 85% of all errors, Willcox says. Working with their consultants, Willcox and her colleagues instituted some changes designed to improve communication. One is the "three-way repeat back," which is similar to the familiar "two-way read back" used when a nurse is receiving orders over the phone — but with one more step.

The three-way repeat back can be used over the phone or in person. One person gives the instructions, the second person repeats those instructions, and the first person confirms that it's all correct. Requiring an affirmative confirmation in that third step, as opposed to just not objecting, means the first person must listen to what is being said, Willcox explains.

The patient safety improvement effort was spurred partly by a tragic medication error in 2007 that resulted in the death of a child, Willcox says. In that case, a nurse mistakenly gave one child's morning medications to another child. Afterward, the confusion was traced back to the nurse being distracted by other staff. *(See the story on below for the improvements that resulted from that incident.)*

The hospital also encourages staff to nurture a "questioning attitude," Willcox says. Reviews of past errors revealed that there almost always was someone in the room who suspected something was not right but didn't speak up.

"When things are going south and you think something is wrong, we tell our people that you have to speak up, you

## *Executive Summary*

A hospital is reporting a 70% reduction in errors that cause serious harm to patients. The improvement is the result of a culture change and some specific process improvements.

- ✦ The hospital uses red badges and red zones to deter interruptions.
- ✦ The safety improvement program has reduced malpractice costs.
- ✦ A pediatric death spurred some improvements.

absolutely must voice your concerns," she says. "I believe that is a huge tool. When I teach new staff and retrain existing staff, I tell them over and over again that if a question pops into their brains, they have to ask it and make sure they receive an answer."

SOURCES


• Craig Clapper, PE, CMQ/OE, Funding Partner and Chief Knowledge Officer, Healthcare Performance Improvement, Virginia Beach, VA. Telephone: (757) 226-7479. Email: info@hpiresults.com.

• Shawna Willcox, CPHRM, MBA, Risk Manager, Wyoming Medical Center, Casper. Telephone: (307) 577-2306. Email: swillcox@wyomingmedicalcenter.org. ✦


# 'Red zones' help deter distractions, improve safety

When Risk Manager **Shawna Willcox**, CPHRM, MBA, was investigating the death of a child who mistakenly was administered another patient's medications at Wyoming Medical Center in Casper, she found that the nurse had been distracted while preparing the morning meds.

"He was interrupted five times while he was pulling the meds and going to the patient's room," Willcox says. "The interruptions absolutely were a root cause of him making this error, because he was pulling meds for one patient and the interruptions were about the patient he ended up giving the meds to."

The red zone program is modeled after rules used in commercial airliners, where flight below 10,000 feet requires a "critical performance mode" in which no conversation is allowed except that necessary for the flight tasks at hand. Willcox and her colleagues realized that the same approach could be used in healthcare, and med passing requires critical performance mode with no distractions.

Red zones were marked on the floor around the automated drug dispensing units in the hospital, and staff were instructed that a nurse in the red zone cannot be interrupted for any reason. The nurse in the red zone is not allowed to converse with anyone outside; for example, nurses cannot chat or even discuss work matters while one is in the zone and the other is waiting her turn to obtain meds. In addition, nurses wear prominent red badge on lanyards from the time they leave the red zone until they have completed dispensing the med to the patient, in the hallways, the patient's room, and anywhere else the nurse might stop. When the red badge is visible, no one else is allowed to converse with the nurse because he or she should concentrate fully on dispensing the meds correctly.

The red badges are on a lanyard rather than a shirt clip so that when the nurse's back is to the patient room's door, the badge can be flipped over to her back to keep it visible. The hospital originally tried using a red towel thrown over the shoulder, but it turned out to be an infection control hazard, plus housekeeping had a hard time keeping the towels red and not turning the rest of the laundry pink.

"The red zones and badges have been a terrific success. We've seen a 30% decrease in red zone interruptions since we instituted the system," Willcox says. ✦

# Workers' comp claim frequency expected to drop

You can expect fewer workers' compensation claims this year, but the ones you do see are likely to be more severe, according to the first Health Care Workers' Compensation Barometer report from Aon Risk Solutions, the global risk management business of healthcare consultant Aon, based in Chicago.

The report is based on a study of workers' compensation exposures from more than 1,000 healthcare facilities across the country. For the 2013 accident year, Aon projects that healthcare systems across the country will experience an annual loss rate of $0.79 per $100 of payroll, which continues the stability that has been in place since 2008. Aon's study also shows that loss rates will continue to increase at a 1% annual rate. *(An abridged version of the report is available online at http://tinyurl.com/aonbarometer. See the story below for key results.)*

The stability in workers' compensation loss rates has been driven by the decrease in claims frequency, which has experienced a steady decline over the past decade and is expected to continue that trend at an annual rate of 1% in 2013, explains **Dominic Colaizzo**, chairman of Aon Risk Solutions' Health Care Practice in Philadelphia. "We think there is a correlation between employee safety and patient safety," Colaizzo says. "We did


## *Executive Summary*

Workers' compensation claims will decrease in frequency but rise in severity in 2013, according to a report by the healthcare consulting company Aon. More access to trained and experienced nurses is cited as one reason for fewer claims.

✦ The use of technology also is making the workplace safer.
✦ Patient handling is the biggest workers' comp concern for risk managers.
✦ Three-fourths of survey respondents self-insure their workers' comp risks.

this study because it had never been done before, and this is a key expense area in risk management."

Colaizzo says there are several factors likely responsible for the consistent decrease in frequency, including these:

• The healthcare industry's intense focus on patient safety has direct implications for workers' safety, as an environment that is safe for patients is also an environment that is safe for employees.

• The use of new technology, including beds and patient lifting devices, has helped to make the workplace safer.

• With nursing staff turnover at the lowest levels in years, the average experience and competency has risen dramatically with favorable implications for workers' compensation.

Claims frequency remains low, but claim severity, including medical, indemnity, and expense costs, has been steadily increasing and projected to continue at a rate of 2% per year. There are several reasons causing the increase, mostly related to outside influences such as the challenging economy, Colaizzo says.

"We were surprised to see that two-thirds of the hospitals do not have a return-to-work program," which provides physical therapy and other ongoing care as part of a specific plan to help employees heal and get back to work, Colaizzo says. "It's been very well established that return-to-work programs help the injured employee and save the hospital money, so it's a concern that so many facilities do not use them. That's a lost opportunity."

*"We were surprised to see that two-thirds of the hospitals do not have a return-to-work program."*

The costs associated with workers' comp can vary significantly by state, Colaizzo notes, so healthcare providers in the high cost states should be even more motivated to make the changes within their control.

"You can't change your venue, but you can change the way you do business," he says. "People have done that for medical malpractice, and these results tell me we may have to do the same thing for employee safety."

The workers' comp rates are directly tied to issues of nurse staffing, says **Greg Larcher**, FCAS, MAAA, regional director and actuary with the Actuarial & Analytics group within Aon Global Risk Consulting. "It is interesting to note that employee turnover is at the bottom of our report's list. The economic condition of the last several years has dramatically changed the employment landscape for nurses," Larcher says. "Part-time nurses are working full-time, and nurses that left the profession for other industries are coming back to nursing. The bright side for healthcare providers is that they are now able to select the best and brightest to join their staff."

Colaizzo says, "This benchmarking report allows healthcare leaders to gauge their level of performance against their peers, providing opportunity to differentiate themselves in the market and identify key areas for improvement and growth. In addition, the report is a critical tool for any organizations looking to measure and promote patient and employee safety."

### SOURCES


• **Dominic Colaizzo**, Healthcare Practice Chairman, Aon Risk Solutions, Philadelphia. Telephone: (215) 255-1728. Email: dominic.colaizzo@aon.com.

• **Greg Larcher**, FCAS, MAAA, Regional Director and Actuary, Actuarial & Analytics Group, Aon Global Risk Consulting, Columbia, MD. Telephone: (410) 381-2254. Email: gregory.larcher@aon.com. ✦


# Patient handling is top workers' comp concern

These are additional findings from to first Health Care Workers' Compensation Barometer report from Aon Risk Solutions, the global risk management business of Aon, based in Chicago:

• Patient handling tops the list of greatest concerns for risk managers, as claims connected to patient handling account for 25% percent of all healthcare workers' compensation claim payments. It also has the highest average indemnity payment. Absence management, management of costs, and an aging workforce round out the remaining top concerns for risk managers.

• The availability of registered nurses has allowed healthcare systems to decrease their reliance on unlicensed personnel. While employee turnover might be low on the list of concerns, the shift in the overall experience and competency of nurses has important considerations for workers' compensation results.

• Seventy-five percent of respondents self-insure their workers' compensation risks.

• Retentions between $500,000 and $750,000 are the most popular. Only 20% of respondents have retentions greater than $750,000.

• Two-thirds of the survey respondents do not have a return-to-work program or do not have any way to test the effectiveness of their return-to-work program. Of respondents with metrics in place to test the effectiveness of their return to work programs, 100% of them deem it to be effective.

• One-third of respondents discount medical services performed on injured employees in their facilities. Of those who provide discounted medical service, the most common discount was 50%. ✦

# Avoiding bad hires requires healthcare insight, auditing

Screening of potential hires is particularly important in the healthcare industry because many employees have access to vulnerable patients or protected health and financial information. But who is overseeing that screening? The risk manager or a mid-level manager in human resources? Maybe an outside recruiter?

Too often, however, the screening is left to administrators who have no real understanding of the particular risks posed by allowing someone with a bad history to work in a healthcare setting, says **Diana Acuna**, healthcare product manager at HireRight, a company based in Irvine, CA, that provides screening services to employers.

"The people who are actually responsible for the background checks of these caregivers often are administrative recruiters who have no previous experience in healthcare or may not understand the dynamic of what is involved with hiring healthcare providers," Acuna says. "It is helpful for them to understand exactly how those risks can play out in a healthcare setting and how that situation can be different from other employment settings."

Acuna worked with a hospital once that had hired several people who should have been prevented from working in healthcare because they showed up on Medicare exclusion lists. The hospital ended up paying $500,000 in penalties once government regulators became involved, she says. "That was really just a human error by the person doing the screening, due to a lack of understanding how critical certain screening and exclusion checks are in healthcare," Acuna says.

Avoiding hires is complicated by 2012 guidance from the federal Equal Employment Opportunity Commission (EEOC). In April 2012, the EEOC stopped short of banning criminal background checks but said refusing to hire someone who has a criminal record could constitute illegal discrimination if such decisions disproportionately affect minority groups. Any decision not to hire must be "job related and consistent with business necessity" and must take into account factors such as the nature and gravity of the criminal offense, the amount of time since the conviction, and the relevance of the offense to the job being sought, the panel said. *(See the story below for more on criminal background checks.)*

Acuna advises healthcare providers to audit any vendor providing screening services. Initial screening of potential hires is only the start, she notes. Healthcare employees should be screened periodically for exclusions, license problems, and any other issues that might arise during employment.

"A lot of organizations don't follow through after the in initial screening. It's a big mistake to do the bare minimum," Acuna says. "Healthcare providers tend to be better about this than other employers, but still, you need to know what your vendors and recruiters are doing to screen out bad hires. Having them tell you that they are screening and taking care of it is not enough."

### SOURCE

• **Diana Acuna**, Healthcare Product Manager, HireRight, Irvine, CA. Telephone: (949) 428-5800. Email: dacuna@hireright.com. ✦

### *Executive Summary*

Potential hires should be screened for past employment history or crimes that might make them unsuitable for healthcare employment. The screening should be performed by professionals who understand the particular risks of bad hires in healthcare.

- ✦ Do not trust recruiters to screen potential hires without knowing details.
- ✦ Guidance from the Equal Employment Opportunity Commission (EEOC) has complicated screening for criminal backgrounds.
- ✦ Ongoing screening should be conducted in addition to pre-employment screening.

# Employers want criminal background checks

A group representing employers across the country has asked the U.S. Commission on Civil Rights to closely examine new guidelines on the use of criminal background checks to screen job applicants. The group says the regulations threaten to undermine employers' attempts to protect their customers and employees.

Criminal background questions need to remain on employment applications, says **Richard Mellor**, vice president for loss prevention for the National Retail Federation in Washington, DC. "This vital information is every bit as relevant as an applicant's education, previous employment experience, and formal training," Mellor says.

Mellor was among witnesses testifying at a hearing the civil rights panel held recently on guidelines issued in April 2012 by the Equal Employment Opportunity Commission (EEOC). The EEOC did not ban criminal background checks but indicated that refusing to hire someone who has a criminal record could constitute illegal discrimi-

nation if the practice disproportionately affect minority groups.

"Employers who ask about criminal backgrounds run the risk of being charged with discrimination, but those who do not are not provided with any legal protection against lawsuits if an unscreened hire later commits a crime on the job," he says. "Earlier interpretations of the guidelines were working fairly, but this overly burdensome guidance will add risk, increase expenses, and cause confusion and legal challenges."

The guidelines were enacted without giving employers a chance for input, Mellor says. Hearings were held only with a "select group of predetermined stakeholders," and actual text of the guidelines was released only the same morning that they were approved and implemented by the EEOC. Employers were given no phase-in period to adjust to the new guidelines, he says.

### SOURCE

• Richard Mellor, Vice President of Loss Prevention, National Retail Federation, Washington, DC. Telephone: (800) 673-4692. Email: mellorr@nrf.com. ✦

# Health workers still reluctant to report unsafe acts

In spite of significant efforts over the past two decades to improve healthcare quality and safety, it is widely recognized that there is more work needed to eliminate preventable harm in the U.S. healthcare system. Part of the problem continues to be that healthcare providers are unwilling to speak up about threats to patient safety, according to a new report from the National Association for Healthcare Quality (NAHQ).

"While a strong and just safety culture has been recognized as a key element for improvement, a critical deficit that has not yet been fully addressed is the lack of protective infrastructure to safeguard responsible, accurate reporting of quality and patient safety outcomes and concerns," according to the report Call to Action: Safeguarding the Integrity of Healthcare Quality and Safety Systems. *(The report is available online at http://tinyurl.com/Nahqreport.)* "In fact, as attention to creating a culture of safety in healthcare organizations has increased, so have concomitant reports of retaliation and intimidation targeting staff who voice concern about safety and quality deficiencies."

Some healthcare providers acknowledge that they fear reporting events or conditions that could endanger quality and patient safety, the report notes. Some professionals whose direct responsibilities include the monitoring and reporting of quality and patient safety outcomes have experienced pressure, outright harassment, or even serious legal and licensure challenges when they recognize and report events of concern.

"Only with integrity in reporting can healthcare organizations identify and eliminate the root causes of systemic problems that threaten patient safety," the report says. "The accelerating implementation of new financial models that tie quality outcomes to payment will raise the stakes associated with quality results. The need will be even greater for a protective infrastructure to safeguard accurate reporting of quality data and patient safety concerns."

The report builds on concerns in a February 2012 report from the Agency for Healthcare Research and Quality (AHRQ), which found most health professionals are reluctant to report errors because they are afraid of a punitive hospital culture. *(That report is available online at http://tinyurl.com/AHRQsurveyreport.)* The NAHQ, along with 11 other organizations, is calling on hospitals to incorporate protective policies that encourage better reporting in an honest culture of safety.

The NAHQ report urges hospitals to focus on accountability, such as helping clinicians recognize their responsibility for quality and safety. Hospitals also must protect workers who voice concerns about safety and quality deficiencies and ensure their data and reports are comprehensive, transparent, and accurate.

Hospitals should immediately examine and respond to any concerns, using an attitude of "appreciative inquiry" when looking into quality and safety issues, the report says. ✦

# Nurses speak up when they feel safe, study says

When nurses feel safe admitting to their supervisors that they've made a mistake regarding a patient, they are more likely to report the error, according to an international team of researchers.

In addition, when nurse leaders' safety actions mirror their spoken words — when they practice what they preach — unit nurses do not feel caught between adhering to safety protocols and speaking up about mistakes against protocols, says **Deirdre McCaughey**, PhD, assistant professor of health policy and administration at The Pennsylvania State University in University Park and a lead author of the study. The results appeared online in the *Journal of Applied Psychology*. *(An abstract and full text purchase option are available online at http://tinyurl.com/nursesandsafety.)*

"Patient errors remain a major source of avoidable patient harm in the United States," McCaughey says.

McCaughey and her colleagues examined the notion that care providers might experience a conflict between the strong enforcement of safety procedures on the one hand and the reporting of safety/patient errors on the other hand.

The researchers surveyed 54 nursing teams in four hospitals in Belgium to determine if the leadership actions of head nurses were aligned with the verbal expectations they had given to staff nurses, as well as to examine the effect of that congruence on nurse/employee commitment to following safe work protocols and willingness to report a patient treatment error. Six months later, the team then examined the relationship between fostering safety and reporting patient errors to determine if they were related to a reduction in errors regarding patients.

In their study, the researchers considered a team to be composed of one head nurse and a minimum of three nurses who reported directly to the head nurse. They distributed paper surveys to nurses and head nurses within the different nursing departments and asked the nurses to deposit the surveys in a sealed box or envelope to ensure anonymity.

The surveys examined the behavioral integrity of head nurses, the psychological safety felt by staff nurses, and team priority of safety using a variety of statements that participants ranked on a scale ranging from "completely disagree" to "completely agree." To examine the behavioral integrity of head nurses, the surveys included such statements as, "My head nurse always practices the safety protocols he/she preaches."

To examine the psychological safety felt by staff nurses, the surveys included such statements as, "If you make a mistake in this team, it is often held against you." To examine team priority of safety, the surveys included such statements as, "In order to get the work done, one must ignore some safety aspects." The researchers then analyzed the data using structural equation modeling.

The researchers found that when nurse managers' spoken expectations regarding safety aligned with their commitment to safety, their teams had a stronger commitment to acting safely while carrying out work duties, as well as a greater rate of reporting errors. In addition, this greater emphasis on safety resulted in a reduction in patient treatment errors.

"The study offers support for the efficacy of leaders' behavioral integrity — walking the talk, if you will — and it demonstrates the importance of leadership in promoting a work environment in which employees feel it is safe to reveal performance errors," McCaughey says. "This benefits patients because work environments in which error is identified offer employees the opportunity to learn from those errors and, ultimately, prevent similar errors from occurring."

### SOURCE

• **Deirdre McCaughey**, PhD, Assistant Professor of Health Policy and Administration, The Pennsylvania State University, University Park. Telephone: (814) 863-8130. Email: dxm68@psu.edu. ✦

# Staffers often dismissed when they voice safety concerns

Disruptive behaviors, intimidation in the workplace, and a culture of disrespect among healthcare professionals have repeatedly surfaced as significant barriers to patient safety. However, the nonprofit Institute for Safe Medication Practices (ISMP) in Horsham, PA, warns that there is a risk that often goes unnoticed: Staff do speak up about potential concerns, but they are too easily convinced that their concerns are unfounded.

When a person voices a concern, there's often no disruptive, disrespectful, or obvious intimidating behavior involved per se, but rather an explanation from competent practitioners that dispels the initial concern too quickly, before it has been given sufficient consideration, the ISMP explains.

For example, a pharmacist reassures a technician that the compounding directions are correct when questioned about an unusual volume of ingredients; a pharmacist assures the nurse that the strength of the infusion is correct when questioned about the final volume; a nurse reassures a patient that the medication is correct when questioned about its appearance; or a physician convinces a pharmacist that the prescribed dose is correct when questioned because it differs from a protocol. *(For the full ISMP report, go to http://tinyurl.com/ismpalert.)*

*To improve patient safety, all healthcare practitioners need to encourage and be receptive to staff members who ask questions.*

To improve patient safety, all healthcare practitioners need to encourage and be receptive to staff members who ask questions, the ISMP advises, even if staff just have a sense that "something" is wrong or can't articulate the concern well. In particular, the ISMP cautions that healthcare providers should never accept these responses when voicing a safety

concern:

• The attending told me to order it that way.

• The patient says that's how he takes it at home.

• It was published in [a medical journal].

• This is a special case.

• The patient's been titrated up to that dose.

• The patient is on a protocol [without being specific about the protocol].

• The dose is the same as listed on the patient's old chart.

• That's the way the dose is written in the progress notes.

• It's on the list of medications the patient gave me.

• We always give it that way.

ISMP refers to a 2010 study conducted by VitalSmarts, the Association of peri-Operative Registered Nurses (AORN), and the American Association of Critical-Care Nurses (AACN), that offers insight into the key skills that can encourage an appropriate response to voiced concerns. *(That report is available online at http://tinyurl.com/c9nyv8f.)*

To encourage a useful response that does not dismiss patient safety concerns, the study offered these tips:

• Explain your positive intent, how you want to help the caregiver as well as the patient.

• Use facts and data as much as possible to support your concern.

• Assume the best, but speak up.

• Make an effort to communicate the concern in a safe environment — away from patients and caregivers, if possible — to avoid defensive posturing.

• Don't show frustration or anger. Keep emotions in check, even if the initial response is not as expected.

• Avoid telling negative stories, making accusations, or using threats.

• Diffuse or deflect the person's anger and emotion by staying calm. ✦

# TJC publishes patient and worker safety monograph

The Joint Commission (TJC) has released a free monograph, "Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation," to draw attention to the need to create a culture that focuses on the safety of patients and the healthcare workers who care for them.

The monograph contends that high rates of injuries and illnesses among healthcare workers serve as a warning that the healthcare environment as a whole must be transformed to improve safety. The monograph highlights examples of healthcare organization practices that address patient and worker safety simultaneously and the benefits and potential cost savings attained through collaboration between employee and patient safety departments. The monograph also identifies functional management systems and processes, strategies and tools that have been used to successfully integrate health and safety activities.

The monograph explores high reliability in healthcare organizations and the benefits to improving safety for patients and workers. It describes barriers to recognizing and addressing patient and worker safety issues and suggests strategies to overcome them and make safety a priority. In addition, the monograph recommends action steps that healthcare organizations can take to improve safety for patients and workers, as well as topics for future research.

Copies of "Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration" and Innovation can be downloaded at http://www.jointcommission.org/improving_Patient_Worker_Safety. ✦

# E-health records prompt safety focus

Texas researchers are calling for a national strategy to address patient safety in electronic health records (EHRs).

For example, hospitals need to prepare to provide timely care when the computer system running a hospital's EHR system goes down, they say. That's why the researchers would like to see contingency plans developed for such occasions, as well as a way to monitor new EHR-related patient safety issues that were not seen before.

Device failures and natural and man-made disasters are inevitable, says **Dean Sittig**, PhD, faculty member at the University of Texas Health Science Center at Houston, who specializes in clinical information systems and clinical decision support. Sittig was the lead author in the report.[1] The potential consequences of an EHR failure become of increasing concern as large-scale EHR systems are deployed across multiple facilities within a healthcare system, often across a wide geographic area, he says.

"To create a coordinated, consistent, national, strategy that will address the safety issues posed by EHRs, we propose that a concerted effort be made to improve health care safety in the context of technology use," Sittig and his colleagues say in the report. "This effort should address preventable risks that may hamper endeavors to create a safer EHR-enabled health care system."

Further discussion and consensus is needed among national agencies such as the Office of the National Coordinator for Health Information Technology, the Agency for Healthcare Research and Quality, The Joint Commission, and the Centers for Medicare and Medicaid Services, the

authors write. "However, this approach must be given immediate priority considering the rapid pace of EHR adoption and the resulting changes in our nation's health care system," the authors write in the report. "National EHR-related patient-safety goals are needed to address current problems with existing EHR implementations and failures to leverage current EHR capabilities."

Goals must be technically feasible, financially prudent, and practically achievable within current constraints and be accompanied by specific guidance on achieving them, the authors say. Input on these goals must be sought not only from EHR developers and clinical end users, but also from cognitive scientists, human-factors engineers, graphic designers, and others with expertise in patient safety in complex healthcare environments.

"Creating unique EHR-related national patient-safety goals will provide new momentum for patient-safety initiatives in an EHR-enabled health system," the authors write.

### *Reference*

1. Sittig DF, Singh H. Electronic health records and national patient-safety goals. *NEJM* 2012; 367:1,854-1,860.

### SOURCE

• **Dean Sittig**, PhD, School of Biomedical Informatics, The University of Texas Health Science Center at Houston. Telephone: (715) 500-7977. Email: dean.f.sittig@uth.tmc.edu. ✦

# Groups to help patients with safety

The Society to Improve Diagnosis in Medicine (SIDM) and the Cautious Patient Foundation have announced a collaboration to help patients avoid diagnostic errors in their own care.

The Cautious Patient Foundation has committed to providing substantial grant support to SIDM to raise awareness of diagnostic error as a significant patient safety issue and create training and tools to empower patients to avoid these errors. As part of this collaboration, SIDM will be working closely with the Cautious Patient Foundation to facilitate development of SIDM patient-directed programming and engagement.

SIDM is an independent, non-profit organization devoted to making diagnosis accurate, timely, efficient, and safe. SIDM unites the many stakeholders impacted by diagnostic error, including patients, clinicians and their healthcare colleagues, health systems, payers and risk managers. SIDM spurs collaborative efforts to improve the quality of the diagnostic process while reducing errors and unnecessary healthcare costs. Through outreach, dialogue, research and education, SIDM sets the quality and safety agenda for improving diagnosis.

The Cautious Patient Foundation provides services to encourage patients to cooperatively engage with their doctors and participate in their own healthcare for best results. ✦

## COMING IN FUTURE MONTHS

- ✦ Sign educates parents about infant security
- ✦ Trends in surgical fires
- ✦ Perinatal safety: What ideas offer good results?
- ✦ The risks you probably overlook

## 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.

## CNE INSTRUCTIONS

Nurses participate in this CNE 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 QUESTIONS

1. What data is used to compile the Hospital Safety Scores issued by The Leapfrog Group?
   A. A mandatory survey to hospitals and also from the Hospital Compare data compiled by the Centers for Medicare & Medicare Services (CMS).
   B. Only data from Hospital Compare data compiled by CMS.
   C. Only data from a voluntary survey to hospitals.
   D. A voluntary survey to hospitals and also from the Hospital Compare data compiled by CMS.

2. According to Shannon Phillips, MD, MPH, quality and patient safety officer at Cleveland Clinic, why does her organization not take part in The Leapfrog Group's patient safety survey?
   A. Completing the survey is labor and time intensive without yielding much useful information for the hospital.
   B. The hospital's top administrators thought the survey questions were not valid.
   C. Patient safety is a low priority at the facility because it has had few adverse events.
   D. An outside consultant determined that the organization could not achieve a satisfactory score.

3. At the Wyoming Medical Center in Casper, what is the rule associated with the "red zone?"
   A. No one may enter the area designated by the red zone.
   B. Only physicians or pharmacy techs may enter the red zone.
   C. No one may speak to a caregiver who is inside the red zone.
   D. Only patients are allowed in the red zone.

4. In April 2012, the Equal Employment Opportunity Commission stopped short of banning criminal background checks but said refusing to hire someone who has a criminal record could constitute illegal discrimination if what is true?
   A. Such decisions disproportionately affect minority groups.
   B. It unfairly affects the person's economic opportunities.
   C. The decision is based on gender issues.
   D. The crimes in question were misdemeanors.

Legal Review & Commentary

A Monthly Supplement to HEALTHCARE RISK MANAGEMENT

# Colonoscopy with unclean equipment causes hepatitis C, results in 1.25M award

By **Jonathan D. Rubin**, Esq.
Partner
Kaufman Borgeest & Ryan
New York, NY

**Stacey L. Schwimmer**, Esq.
Associate
Kaufman Borgeest & Ryan
New York, NY

**Leanora Di Uglio**, CPHRM, CPHQ
Corporate Director, Clinical Risk Management
Health Quest Systems
LaGrangeville, NY

**News:** This case involves a 69-year-old male who underwent a colonoscopy with lesion removal at the hospital. Following the procedure, the patient received a letter advising him to be tested for certain bloodborne illnesses, including hepatitis, because it was discovered that some of the equipment that was used in the endoscopies and colonoscopies that were performed at the hospital were not properly sanitized in between patient procedures. The patient was tested four days later and tested positive for hepatitis C, which can cause severe liver damage. After a bench trial, the plaintiffs were awarded $1.25 million.

**Background:** On June 13, 2007, the patient presented to the hospital for a colonoscopy with lesion removal. The procedure was performed that day with an endoscope. Two polyps were removed during the patient's colonoscopy. On March 23, 2009, the patient received a letter from the hospital stating, that although the endoscopic equipment was properly cleaned and disinfected, an attached section of the tubing was rinsed rather than disinfected according to the manufacturer's recommendations. The letter further explained that he was at risk for infection and suggested he undergo a blood test. The patient subsequently had a blood test on March 27, 2009, and tested positive for hepatitis C. On Aug. 4, 2006, plaintiff had been tested for hepatitis C, and the results were negative.

*The hospital's cleaning method placed patients at a risk for developing bloodborne pathogens*

About 10 months after his hepatitis C diagnosis, plaintiff and his wife filed a medical malpractice action against the hospital for improperly sanitizing medical equipment and infecting patients with bloodborne diseases, including HIV, hepatitis C, and hepatitis B. To prove their claim, plaintiffs' explained the hospital was rinsing the tubes, rather than sterilizing the tubes with steam and chemicals as instructed by the manufacturer. The hospital's cleaning method placed patients at a risk for developing bloodborne pathogens, as biological materials could be transferred from one patient to another. This risk was demonstrated further by investigators who dismantled water tubes on some of the equipment at the hospital that allegedly were clean and ready for use, but instead were found to have discolored liquid and debris.

Plaintiff argued that it was because of the hospital's improper sterilization procedures that the patient contracted hepatitis C after his colonoscopy. Specifically, plaintiff explained, through the testimony of his expert hepatologist, that because this patient had two lesions removed during his colonoscopy, he was placed at an increased risk of becoming infected with a bloodborne pathogen. A biopsy that was taken after the patient was diagnosed with hepatitis C further

FINANCIAL DISCLOSURE: 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. **Stacey L. Schwimmer**, **Leanora Di Uglio**, and **Jonathan D. Rubin**, co-authors, have no relevant relationships to disclose.

supported plaintiff's argument that the disease was newly acquired. These facts, combined with the fact that the patient had no other risk factors for hepatitis C, led plaintiffs' experts to conclude that the patient's colonoscopy caused his hepatitis C.

Although defendant conceded that the hospital breached the duty of care by failing to properly sterilize the endoscope, defendant denied that this failure caused plaintiff's injury. Defendant introduced testimony from an expert in internal medicine who explained that a number of unlikely circumstances would have had to occur in order for a patient to contract hepatitis C from an unsanitized endoscope. He concluded that there was a 0% chance that the patient contracted hepatitis through his colonoscopy.

After the non-jury trial and an extensive deliberation, the judge ruled in favor of the patient and his wife, and the judge awarded them a total of $1.25 million for their injuries. The judge acknowledged that although he recognized the chances of the patient acquiring hepatitis C under these circumstances was slight, "there was nothing to preclude the patient from being one of those two persons in a trillion or billion who do get the virus."

**What this means to you:** The estimated frequency of contracting an infectious agent after a GI endoscopic procedure is 1 in 1.8 million procedures (Kimmey MB, et al. Transmission of infection by gastrointestinal endoscopy. *Gastrointest Endosc* 1993; 36:885-888). Failure to adhere to infection control practices generated by governmental and professional organizations, as well as the manufacturer's recommendations, might dramatically increase the risk of infectious microorganism transmission to the patient and the healthcare provider. In this case, the hospital acknowledged it failed to properly sterilize the endoscope, and the judge concluded that this breach in the duty of care resulted in plaintiff contracting hepatitis C.

Endoscopy infection control guidelines have been published by numerous organizations, including the Centers for Disease Control and Prevention (CDC) and the American Society for Gastrointestinal Endoscopy (ASGE). (Editor's note: See guidelines at http://bit.ly/WJQazi and http://bit.ly/WJPzO1.) These guidelines have been standard operating procedures in hospitals for many years. So the question must be asked, "What special circumstances were present that created the opportunity to breach operating procedures?"

To answer this question, a thorough review must be undertaken to identify and minimize opportunities for noncompliance with established guidelines and policies. An evaluation of the current infection control policies is a good first step.

The policies should be reviewed to confirm the manner in which endoscopic equipment is cleaned, disinfected, and processed is in compliance with governmental and professional organizations as well as the manufacturer's recommendations. The policy should not just focus on infection control practices for cleansing and disinfecting the endoscope, but it should also address infection control practices for equipment that is needed during the endoscopic procedures, such as needles, forceps, or tubing. The endoscope and the related equipment might require different post-use handling and cleansing.

Staff education and competency also should be assessed. Hospitals traditionally have good processes in place to provide in-service education sessions when new equipment or procedures are introduced into the work environment, but the hospital also needs to have a process to provide in-service sessions when policies have been changed or revised. Providing updates to staff on revised policies is a hospital responsibility that is often overlooked and can become difficult to defend during a professional liability trial.

Staff competency should be assessed throughout the year and not only annually to meet requirements from the human resources department for compensation purposes. Staff competency assessments can blend in nicely with ongoing quality audits of infection control practices. The quality audit can focus on environmental infection control practices (i.e., availability of cleansing/disinfection chemicals) but also should include direct observation of staff in the cleansing, disinfection, and post processing of the equipment. Staff also should be asked to demonstrate how to access internal policies as well as the manufacturer's instruction.

Other very important, but sometimes overlooked, areas that require assessment are patient volume, staffing levels, and staff fatigue. Did the breach in the standard result from staff trying to keep up with the high patient volume, or was there a lower number of staff on duty that might have caused staff to work around a normal process, or both? The Joint Commission urges healthcare entities to create a fatigue management action plan that includes scientific strategies to minimize fatigue as a contributing factor in adverse events.

Although it is not clear that the hospital's failure to properly sterilize the endoscope caused the patient to contract hepatitis C, it is clear that plaintiff now has a chronic and life-altering medical condition. However, assessing current policies, staff education, and competency processes; ensuring ongoing quality audits; and establishing fatigue management strategies are action steps risk managers can take to identify and mitigate potential adverse events associated with infection control practices not only in the GI suite but throughout the organization.

## *Reference*

10-21439-CIV-JORDAN, U.S. District Court, Southern District of Florida, Miami Division (2012). ✦

# $5 million awarded to family of suicidal man hit by a car before discharge from hospital

**News:** This case involves a 24-year-old single father who was involuntarily committed to the hospital for severe depression, including suicidal and homicidal ideations. Following his presentation, the patient remained in the emergency department and was placed in an examination room, where he remained for 18 hours until he left the hospital through an unguarded exit. About 10 hours later, he was hit by a car and sustained multiple injuries including catastrophic brain damage and multiple fractures, which resulted in his death. It was alleged that the hospital's failure to properly monitor and supervise the patient was the proximate cause of his death. A jury awarded the patient's estate $5 million.

**Background:** On April 5, 2011, the patient presented to the emergency department concerned about his thoughts of hurting himself and others. According to hospital records, the patient had a history of drug abuse, depression, and paranoid delusions. A psychiatric evaluation of the patient was performed, which included an evaluation of his degree of dangerousness and depression. Following the evaluation, the patient was involuntarily committed to the hospital until a bed became available at a 24-hour facility for temporary custody. In the interim, the hospital staff kept the patient in a corner examination room at the back of the emergency department. The room was adjacent to an unlocked and unguarded exit. Hospital staff allegedly checked on him every 15 minutes. The morning of April 6, 2011, the patient walked out of the hospital through the unlocked exit. The hospital alerted law enforcement, and a silver alert was issued, which commonly broadcasts information about missing persons, especially persons with mental disabilities. About 10 hours later, the patient walked in front of a car and suffered a massive brain injury and leg fractures. He died the following day.

A few months later, the patient's estate commenced a medical malpractice and wrongful death action against the hospital. Plaintiff alleged that the hospital was negligent in failing to adequately assess the degree of the patient's depression, failing to properly monitor and supervise the patient, and failing to prevent the patient from leaving the hospital. To prove their allegations, plaintiff introduced expert testimony from a psychiatrist that revealed that the initial assessment form that was utilized by the hospital to evaluate the patient's degree of depression and dangerousness failed to include that the patient was excessively abusing drugs and had PCP (phencyclidine) in his system, despite the fact that the drug screen performed in the emergency department revealed this information. Had the form included the patient's suicide risk as demonstrated by his suicidal thoughts and potentially increased by his use of a dissociative drug, the patient would have been placed on one-to-one observation, which should have prevented him from leaving.

Plaintiff showed the jury a surveillance tape of the nurse's station at the hospital that demonstrated one instance in which the nurse was absent from the nurse's station for only 13 seconds when she went to check on the patient. This length of time, combined with the fact that the patient had been gone for 10 hours before the car accident, made the jury question whether anyone at the hospital was regularly checking on the patient or actually looking for the patient after he left the hospital.

The hospital attempted to defuse plaintiff's allegations by arguing that the staff acted in accordance with hospital policy as soon as the patient's absence was recognized. However, plaintiff's objective was to prove that the hospital's policy was inadequate and was able to do so by telling the jury a story of another man who was involuntarily committed to the same hospital and was able to leave in the same manner as this patient. The jury was convinced that additional safety measures needed to be taken to avoid any future incidents.

After a six-day trial and only two hours of deliberation, the jury awarded $5 million to the patient's estate. The award went to the patient's daughter, who was 5 years old at the time of trial.

**What this means to you:** Due to state and federal budget cuts relating to inpatient and community resource treatment centers for people with mental illness, a general emergency department often is the only or most accessible healthcare setting for people who are experiencing an acute psychiatric condition. The lack of alternative healthcare settings has increased the frequency and length of time in which psychiatric patients are being held in an emergency department while waiting placement in an appropriate inpatient psychiatric setting. During this extensive boarding time, patients might not receive the specialized psychiatric monitoring and treatment that is needed, which appears to have been true in the above described case scenario.

The psychiatrist's evaluation resulted in the patient being involuntarily committed to an inpatient setting for further evaluation and treatment due to his suicidal and homicidal thoughts. Although it does not appear that plaintiff's counsel had cause to argue against the appropriateness of the involuntary commitment, it does appear that plaintiff's counsel had legitimate arguments about the subsequent care as well as the physical environment safety elements that were in place in the emergency

department.

A patient who has been involuntarily committed for inpatient psychiatric care should be automatically considered a flight risk. Couple this situation with the fact that this patient was determined to have suicidal or homicidal thoughts — this patient would have benefited from direct one-to-one observation by a staff person who remains in close proximity to the patient at all times. From the case scenario, the patient allegedly was being monitored by a staff member every 15 minutes, and plaintiff's counsel proved that this level of patient monitoring was a deviation from the standard of care. It is unclear if this deviation from the standard was due to inadequacy of hospital policy or was a workaround because of emergency department staffing. Whatever the reason, a more thorough review of internal policies for monitoring psychiatric patients in the emergency department against best practices is warranted.

Emergency department physicians often are uncomfortable with ordering psychiatric medications, and they rely on the consulting psychiatrist for these orders. It is unclear from the case scenario whether the psychiatrist wrote covering orders while the patient was waiting for transfer to an inpatient setting. However, it appears that this patient was in the emergency department for 18 hours without the benefit of any psychotropic medications or other therapeutic interventions he might have needed while waiting for transfer to an inpatient unit. We would suggest that a patient who is being monitored in the emergency department for a cardiac condition should receive routine cardiac meds while waiting for disposition. Why should it be any different for a psychiatric patient waiting transfer to an inpatient unit? As psychiatric hold patients are becoming more common, it is in the best interest of the patient, healthcare provider, and hospital to review current policies and practices to ensure the therapeutic interventions are continued in the emergency department.

It is generally acknowledged that the emergency department is not the ideal therapeutic environment for psychiatric patients. The department often doesn't have an area specifically dedicated to a psychiatric patient, especially a patient who is actively suicidal or homicidal. Since emergency departments generally are very busy environments that might exacerbate a psychiatric patient's condition, psychiatric patients typically are placed in rooms that are not in the center of all the activity. These rooms often are at the end of the hall by an exit, which appears to have been the room of choice in this case. If it is necessary to use the room furthest from the hub of the emergency department for boarded patients, precautions should be taken to ensure that a patient cannot easily leave without being noticed. The hospital should consider some type of monitoring system that can be used, i.e. alarms, exit buttons, or wander guards, that would alert staff that the patient is leaving the room and/or building while ensuring that these egress alerts do not interfere with building egress safety requirements.

Although the hospital tried to defend the staff's actions after it was discovered that the patient eloped, the video surveillance camera evidence did not support actions that might have been taken after the silver alert was called. There might have been a reasonable explanation for why the emergency department nurse left the nursing station for only 13 seconds, but there is no description of other documentation the hospital had to demonstrate that its internal silver alert policy was carried out. Once an elopement alert has been called, it is important to document in the patient's medical record all activities undertaken by the hospital staff, including who, what, when, and where. Who performed the internal house rounds, and when was the internal search completed? Who notified the police department, and when did they respond? Who contacted the patient's family, and what was their response? An elopement, especially an elopement by a patient who has voiced suicidal and homicidal thoughts, is a serious event that can result in tragedy and heartbreak for many people.

As an increasing number of psychiatric patients are boarded in the emergency department, nursing protocols should be established to meet the special needs associated with these patients. These needs include ongoing and proactive behavior assessments to identify escalation of symptoms, identification and fulfillment of basic patient needs, such as nutrition, toileting, and hygiene, as well as the provision of diversionary activities, such as television and newspapers, to keep patients calm and comfortable while waiting transfer. These often are overlooked issues because these diversionary activities are not needed or appropriate for the typical emergency department patient.

This case describes a very unfortunate event that might have been prevented had appropriate policies and practices been in place for psychiatric patients who are boarded in the emergency department. Patients who remain in the emergency department without the benefit of psychotropic and therapeutic interventions are at higher risk for elopement and escalation of unwanted behaviors. Appropriate physician-to-physician and physician-to-nurse communication is essential to ensure appropriate evaluation and monitoring of the patient's condition. Nursing protocols for the identification and fulfillment of the special needs associated with boarding psychiatric patients are required. If the trend with decreasing inpatient and outpatient services for patients with mental illness continues, emergency departments will see a corresponding increase in risk exposure if these safety nets are not put in place.

## *Reference*

JAS NC Ref. No. 271033 WL (N.C. Super.), 2012 WL 5506957. ✦