Healthcare RISK MANAGEMENT

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Choose your words carefully with patients to reduce liability, improve safety

What you say/don't say can influence how a patient responds to adverse events

With many healthcare providers adopting policies of full disclosure and apology, clinicians can be left wondering exactly what to say, how to say it, and what not to say to patients and family after an adverse event. With multimillion-dollar verdicts resting on what was said, even the best doctors can benefit from coaching on how to talk to patients at a critical juncture.

> *"If you look at why patients sue, it's because they suffered a bad outcome and they lost trust in you."*

What clinicians say after an adverse event has been proven to be instrumental in determining whether the patient or family will pursue a malpractice case, says **Peter Pronovost**, MD, PhD, FCCM, a practicing anesthesiologist, critical-care physician, professor, and senior vice president of Johns Hopkins Medicine in Baltimore, MD, and senior vice president and director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins.

"If you look at why patients sue, it's because they suffered a bad outcome and they lost trust in you," he explains. "There doesn't have to be an error. The loss of trust is a big factor, and they are going to determine whether they trust you during that conversation after the bad outcome."

In many cases, it is wise to include the patient's family members in the discussion, with permission, he says. Involving the family has been shown to improve patient safety overall, Pronovost notes, and it can be particularly important when discussing a poor outcome. *(See the story on p. 100 for more on the benefits of including family members.)*

Most physicians have no specific plan on how to talk to patients and family when there is an adverse event or when they are upset about the care provided, Pronovost says. "Most of them just shoot from the hip, with no structured way to do it," he says. "They may say they try to

INSIDE

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listen and explain, but when everyone is upset about what's happening, that conversation can go downhill pretty quickly."

Pronovost advises risk managers to help educate physicians and nurses on the most effective way to have those conversations, using role-playing scenarios when possible. At Johns Hopkins, he trains physicians using a mnemonic that reminds physicians to anticipate, listen, empathize, explain, and negotiate. *(See the story on p.99 for more on the ALEEN technique.)*

Pronovost recalls one incident in which a woman was upset that her father had been given insulin to control his blood sugar level — the common and correct treatment for that condition. "The daughter starts screaming and gets really upset, saying insulin makes his blood sugar up and he can't take it. That's just not medically correct, but she certainly believed it," he says. "I let her unload a lot of emotions on me, empathized with her, and calmly explained how the insulin works and why we decided on that treatment. Then we talked about how we could decide when was the best time to give her father insulin."

By the end of the talk, the woman was calm and complimented the care team on their skills and how they wanted the best for her father.

One potential pitfall with this approach is that doctors can try so hard to empathize with the patient and family that they admit to more blame than is appropriate or state information that is not yet known to be fact. This situation can be the case especially if the doctor is feeling remorse after a poor outcome, Pronovost says.

An apology can be appropriate, but it does not have to include an admission of responsibility, he explains. The doctor can say, "I'm sorry this turned out the way it did and you're suffering because of it" without also saying "and it's because we made a mistake."

The apology coupled with the admission of guilt is most associated with lowering the risk of litigation, Pronovost notes. However, you sometimes do not know at that point if there was an error, and it is dangerous to suggest that there was an error until you are sure.

"Don't go beyond the facts," he

Executive Summary

In addition to being part of good patient care, communicating clearly and effectively can reduce the chance of a patient seeking legal action. Better communication also improves safety and helps to avoid adverse events.

- ✦ A mnemonic device can help physicians remember the key discussion points.
- ✦ Never admit fault if you're not sure yet what happened.
- ✦ Avoid the tendency to become defensive.

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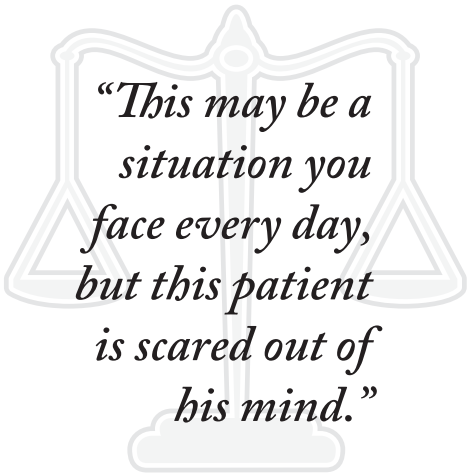
Editorial Questions

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

says. "If you know more later, you can go back and give a more detailed apology. Don't fill in the blanks with what you don't know. Be transparent and say you don't know everything yet, but you're going to find out."

Physicians might need to be reminded to speak in a way that the patient can understand the information, says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of the American Society for Healthcare Risk Management (ASHRM). Some of the information might be complex, but it is important to avoid medical jargon and terms that the other person might not understand.

Remember that the other person might be reluctant to admit being confused by what you're explaining. Make the information as clear as possible without talking down to the person, she says. "Have a discussion. Don't talk at the patient," she says. "You have to have empathy for the person. This may be a situation you face every day, but this patient is scared out of his mind. For him, this is the most important thing in the world right now, and you can't talk about it like it's just another thing on your to-do list."



Kicklighter notes that many pieces of this advice applies just as much to informed consent and other discussions as it does to talking after an adverse event. The goal in all patient interactions should be clear and effective communication, she says.

As for what not to say to patients, Kicklighter says she has been astounded by the cavalier approach some physicians take when talking about devastating topics. When her sister was diagnosed with pancreatic cancer, she happened to be in the doctor's office on her birthday. The doctor flippantly told her that he hoped he'd be able to wish her happy birthday next year. When Kicklighter heard of the comment, she told her sister to change doctors immediately because he was too insensitive.

"Sometimes I think doctors can try so hard not to get all caught up in the emotions of every patient that they go too far in the other direction and get callous," Kicklighter says. "A thoughtless comment like that colors the entire relationship and can make a difference if the patient is wondering whether to hold you responsible for a bad outcome."

SOURCES

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ALEEN helps doctors remember key points of discussion

At Johns Hopkins Medicine in Baltimore, MD, Senior Vice President **Peter Pronovost**, MD, PhD, FCCM, uses a mnemonic device to train physicians on how to talk with patients or family members who might be upset.

The mnemonic is ALEEN:

- **Anticipate.** "When you're walking in to talk with an upset family, you have to know that they're going to be emotional and may yell at you. You can't take that as an affront on your self-worth," Pronovost says. "So many physicians go on the defensive and argue back about how good a doctor they are. That's not the right response."
- **Listen.** When people are upset, they need to speak, Pronovost says. If you don't allow them to get their feelings and concerns out, they grow more and more frustrated. Doctors tend not to be the best listeners, so they have to remind themselves to just stay quiet and not interrupt.
- **Empathize.** "Be human about it," Pronovost says. "You can say, 'Geez, if I thought someone was hurting my loved one, I'd be upset too.' You don't have to admit responsibility or agree with what they're alleging, but you can acknowledge that their feelings are normal and you get it."
- **Explain.** Tell them the facts as you understand the situation so far, and acknowledge any ongoing questions or uncertainties. Explain the reasoning behind certain decisions that were made, even if they prove to be the wrong move in the end.
- **Negotiate.** Involve the patient and family in crafting the solution so that they will buy into it. You can explain what steps you think are necessary at this point and ask if that sounds like a good plan. The doctor also should ask if there is anything else that they think should be done. The key is to involve the patient and family rather than just telling them what is going to happen. ✦

Engage family members in crucial conversations

Anyone facing a hospital stay probably has heard the advice: Take someone with you to lend support, ask questions, and serve as a care partner and advocate.

But is the clinical team including this person in crucial conversations? It is important to include the patient's family member or other advocate because that person can help solidify the doctor's relationship with the patient, says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of the American Society for Healthcare Risk Management (ASHRM).

"If it comes to the point that they're considering legal action, they may not take that step if they feel like they have a good relationship with the doctor and they know that he or she really had the best interests of the patient at heart," she says. "Being inclusive with these conversations is a way to get that bond. If you're talking only with the patient, even if you do it well, later on they might have family members who see the doctor in a different light."

Risk managers should counsel physicians to include family members in crucial conversations, with the patient's permission, suggests **Karen Curtiss**, president of PartnerHealth, a company in Illinois that promotes patient safety.

Curtiss became concerned about family involvement in patient care when a series of medical errors occurred in her family. After a successful lung transplant at a top academic medical center, her father died from complications resulting from a fall that went untreated for 57 hours, which led to pneumonia, blood clots, a pulmonary embolism, and two infections. Her husband spent 18 months recovering from sepsis and an infection, stemming from improper surgery preparation and care afterward. And her young son would have undergone an unnecessary operation had she not questioned a doctor and sought a second opinion.

Determined to help other families avoid similar fates, Curtiss, a consultant with more than 25 years of market research experience, started digging for answers. Curtiss compiled her research into "Safe & Sound in the Hospital," a new handbook designed to educate patients and their families about how to prepare for a hospitalization, stay on top of the many issues that can arise during a hospitalization, and help prevent another hospital stay. The book provides practical tips, creative tools, and quick checklists that care partners can use to help prevent common hospital hazards and promote a safe recovery.

Curtiss suggests that risk managers train clinicians to pass these tips to family members:

• Keep your loved one safe from infection.

o Make sure everyone, especially doctors and nurses, washes his or her hands before touching your loved one. Make colorful tent card signs for your loved one's room with messages such as "Thank you for washing your hands!" or "For my safety, please wash your hands."

o Clean TV remotes, door knobs, telephones, bed rails, call buttons, faucets, toilet flush levers, and personal items with alcohol wipes and bleach wipes to help prevent infection. Repeat cleaning after every touch or brush with clothing.

• Speak up and ask questions. Get to know everyone who takes care of your loved one. Ask questions in a friendly, respectful way. Don't be afraid to admit if you don't understand their answers and need a 'plain English' translation.

• Find out how to call for a Rapid Response Team if you feel like your loved one is going downhill and no one seems to be taking action. Trust your gut; you know your loved one best.

• Ask the nurse to pause and double-check each medication just before it's given. Verify the prescription, the dose, and intended patient. NEVER interrupt a nurse in the middle of administering a drug unless you sense a mistake.

• Understand that virtually every patient is at risk to take a fall. Look for items in the room that might cause a trip, and bring non-skid socks or slippers for your loved one to wear. Ask the nurses about a cane for your loved one to use. Make sure someone is available to help your loved one to the bathroom and back.

"In my experience, everyone in hospitals is well-intentioned. We just need more eyes and ears on patients, and who could be more patient-centered care partners than families?" Curtiss says. "It's so important for families to be engaged and vigilant and to have their eyes wide open when someone they love is in the hospital."

SOURCE

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Variety of overhead pages can pose safety risk

Overhead pages are a common sound in any hospital, but no one seems to use the same terminology or codes. Is code red a fire in this hospital, or is it a violent incident requiring security staff?

Variations in the use of overhead paging in hospitals can cause confusion among caregivers, staff, and patients

and can lead to adverse patient safety events, says **Tania Daniels**, PT, MBA, vice president of patient safety at the Minnesota Hospital Association (MHA) in St. Paul. MHA conducted a survey in 2010 and found 22 codes for patient abduction; 18 codes for a security alert; code green indicated four different emergencies; and code yellow had five meanings.

"Communication failures are the top reason for adverse events to happen, and this is definitely a communication problem," Daniels says. "It obviously is a patient safety issue."

Staff members often do not know all the color or name codes for various emergencies within their own facility, and the problem can be much worse for healthcare professionals who work in more than one hospital, Daniels says.

A primary strategy should be reducing the use of overhead paging altogether, she says. With the use of cell phones, computer stations, and other devices, it might be possible to eliminate many overhead pages, she says. That elimination will improve patient safety simply by eliminating much of the noise pollution in the hospital, she notes.

When using overhead paging, reducing the use of codes could solve much of the problem, Daniels says. Minnesota hospitals are making efforts to implement plain language for overhead codes, and many hospitals are minimizing overhead pages by communication through other means. MHA developed an Emergency Overhead Paging Tool Kit to help hospitals move toward the use of plain language in overhead pages and to determine which emergency situations need to reach the patients' and all staff awareness. (The tool kit is available online at http://tinyurl.com/pagingtoolkit.)

An example of a plain language announcement would be "Fire alarm, fourth floor, west wing. No action is required of patients and visitors at this time." Another would be "Rapid response team to room 412."

Plain language paging can be better than patients and visitors hearing a coded announcement, Daniels says. The previous thinking was that hospitals should not alarm patients by openly announcing a fire emergency or a cardiac arrest, for example, but Daniels says current research is showing that the coded announcements can be worse. "When a code red or code blue is called, that can create anxiety because they know something dire is going on but they don't know what it is or how it affects them," Daniels says. "Transparency is the better option, and that means stating plainly what is happening and whether action is needed by the people who may hear the page."

An MHA study of 322 consumers found that people overwhelmingly favor plain language announcements. These were some of the results:

- 87% stated that patients and visitors should hear a fire announcement;
- 94% stated that patients and visitors should hear a medical emergency announcement;
- 67% stated that patients and visitors should hear a "person with a weapon" announcement;
- 90% stated that patients and visitors should hear a missing person announcement;
- 94% stated that patients and visitors should hear a severe weather announcement.

Security announcements pose the most challenge, Daniels says. Even hospitals that favor plain language paging might balk at openly announcing a security problem. She suggests including security leaders, including local law enforcement, in making that decision. It is possible that plain language will not be the solution in this case, but there might be a need for consistency.

"In many communities, law enforcement has a standard way they refer to certain situations, and they have worked this out with other departments and schools, for instance," she says. "If that is the case, you will want to be consistent so that there is never any confusion about your situation and how you need people to respond."

Executive Summary

Hospitals use a wide variety of overhead pages, potentially leading to confusion that could threaten patient safety. Uniform pages could reduce the problem.

- ✦ Confusion is possible when clinicians travel from one facility to another.
- ✦ Coded overhead pages might alarm patients and visitors if they do not understand the meaning.
- ✦ Plain language might be more effective than coded pages.

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Manage risks of electronic records to avoid liability

Electronic medical records (EMRs) are quickly becoming the standard in healthcare, but managing the risks posed by the technology might be lagging behind, cautions **Allan Ridings**, senior risk management and patient safety specialist with the Cooperative of American Physicians (CAP) in Los Angeles.

CAP was formed in 1975 by a group of California physicians who came together to tackle the problem of ever-increasing medical malpractice costs. Ridings says the use of EMRs is a positive step for healthcare but

that risk managers might need to step up their risk assessment because some hazards are surprising.

Take pediatric weights and measures, for example. Some EMRs default to the imperial weights and measures used in the United States, but all medications are measured with the metric system.

"It seems so obvious, but it's the kind of thing that can go overlooked until you have a problem," Ridings says. "You need to be consistent across the board so that when you're entering information you don't have to remember to enter it in imperial measures here but then switch to metric for the medications. That's the kind of thing that should be addressed when you're first setting up your EMR."

Ridings notes that he once saw a physician practice using an EMR system that allowed a patient to be pregnant for nine years. Users expect that sort of obvious error to be impossible, he says, but simple computer programming errors can allow failures that threaten patient safety.

EMRs also are sometimes are set up with no controls on what medication a physician can order, notes **Joseph Wager**, also a senior risk management and patient safety specialist at CAP. He recalls working with one hospital that had an EMR allowing a physician to order 25,000 units of heparin, for example.

"The system should catch entries that are way out of the ballpark like that," Wager says. "Your system has to have controls in it."

Naming conventions also are a risk, Ridings says. The EMR should recognize that a drug is not correct for pediatrics, for instance, or that the method of administration is not conventional.

Drop-down menus can be risky, as well. Wager recalls an incident in which a doctor inadvertently ordered the wrong dosage of a drug by clicking on the wrong item in a drop-down menu.

Altering the EMR must be done correctly, Ridings notes. As with paper records, an EMR must reflect the actual record and not be altered, but the doctor or nurse can add to it. "Data is always discoverable, so you don't want to alter the record by going in and just erasing some entry and putting in the new information," Ridings says. "Some systems allow clinicians to just write over the information, and that is a very dangerous practice. The record should be locked once information is entered and only additions are allowed."

Ridings and Wager urge particular caution with EMR systems that do not come with sufficient training for users. Some less expensive systems come with little or no training, they note.

"Everyone should be trained appropriately on the system and especially on any changes that you make to the system as you use it and find ways to improve it," Wager says. "An EMR can be a terrific tool for a healthcare provider, but it is a tool that comes with lots of hidden risks."

Executive Summary

Electronic records bring additional risks that must be managed. The rapid adoption of electronic records means that some of these risks might be overlooked.

- ✦ Security is the primary concern.
- ✦ The preservation of data must be addressed.
- ✦ Pediatric measurements for drugs pose a particular risk.

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Health system, doctors accused of kickbacks, DOJ sues

Cardiologists and the Infirmary Health System in Mobile, AL, needlessly exposed patients to radiation in a kickback scheme that lasted nine years and cost Medicare, Medicaid, and Tricare an estimated $522 million, according to the U.S. Department of Justice (DOJ).

The DOJ announced recently that it is joining a whistleblower's lawsuit against Infirmary and the independent Diagnostic Physicians Group. The lawsuit alleges that IMC — Diagnostic and Medical Clinic billed Medicare for services referred by Diagnostic Physicians Group physicians, in violation of the Stark Law and Anti-Kickback Statute. IMC — Diagnostic and Medical Clinic is owned by Infirmary Medical Clinics, a subsidiary of Infirmary Health System, also based in Mobile.

The allegations involve nuclear stress tests, a type of imaging in which patients ingest radioactive dye and are exposed to low levels of radiation to test blood flow through the heart. The lawsuit alleges the tests were blatantly overused because doctors were financially rewarded for ordering more tests, even though they expose patients to small doses of radiation.

The whistleblower is a physician who says in his lawsuit that he was told that the way the hospital paid its physicians was "legally defensible" even though it "could be illegal" under the Stark Law.

The lawsuit was filed in July 2011 by former Diagnostic Physicians Group physician Christian Heesch, MD, under the qui tam, or whistleblower, provisions of the False Claims Act. The act authorizes private parties to sue on behalf of the United States and receive a portion of any recovery. The act also permits the government to intervene and take over a lawsuit, as it has done in this case.

According to his complaint, the whistleblower sued after he was warned to stop asking questions about how the doctors were paid. Mark Nix, CEO of Infirmary Health System, issued a statement that the clinic denies the allegations and will fight them vigorously.

The DOJ reports that it intervenes in only about 20% of all whistleblower claims and a primary reason for joining a case is the belief that the alleged wrongdoing goes beyond financial matters and affects patient health. "Financial arrangements that compensate physicians for referrals encourage physicians to make decisions based on financial gain rather than patient needs," said **Stuart F. Delery**, acting assistant attorney general for the civil division said in a statement announcing the DOJ involvement. "The Department of Justice is committed to preventing illegal financial relationships that corrupt the integrity of our public health programs."

Enforcement of the Stark Law and the Anti-Kickback Statute is intended to ensure that physicians' medical judgment is not compromised by improper financial incentives, Delery said. The Stark Law forbids a clinic or hospital from billing Medicare for certain services referred by physicians who have a financial relationship with the entity. The Anti-Kickback Statute prohibits offering, paying, soliciting or receiving remuneration to induce referrals of services or items covered by federal health care programs, including Medicare.

The lawsuit alleges that the IMC — Diagnostic and Medical Clinic improperly paid Diagnostic Physicians Group physicians compensation that included a percentage of the money collected from Medicare for tests and procedures the doctors referred to the clinic. These improper payments, and resulting submission of false claims to the Medicare program, violated the Stark Law and Anti-Kickback Statute, the DOJ claims.

Since January 2009, the Justice Department has recovered a total of more than $14.7 billion through False Claims Act cases, with more than $10.7 billion of that amount recovered in cases involving fraud against federal healthcare programs. ✦

OTC med blamed in lawsuit against children's hospital

A judge recently awarded the family of an 8-year-old girl from Snoqualmie, WA, $15.2 million after a University of Washington doctor at Seattle Children's Hospital improperly recommended an over-the-counter medication that left the child with permanent brain damage.

The case, filed Oct. 28, 2011, in King County Superior Court, alleged that the University of Washington and Seattle Children's Hospital committed medical negligence. MacKenzie Briant, who had undergone a heart transplant as an infant, was given a dose of the nasal decongestant Afrin at the direction of a cardiologist. It caused the cardiac event, which deprived her brain of oxygen and led to extensive brain damage.

According to court records, MacKenzie's mother, Elaine Briant, called Seattle Children's Transplant Service, where MacKenzie received care, because MacKenzie had developed a cold and stuffy nose. The mother's call was returned by Cory Noel, MD, a cardiology fellow who was working in the Transplant Service.

> *"... this is one of the most heartbreaking medical negligence cases I have seen."*

Court records show that Noel then spoke to transplant cardiologist Yuk Law, MD, who provided treatment suggestions to Noel and specifically warned that MacKenzie should not be given Afrin because it could cause hypertension or other cardiac issues.

Noel misunderstood, and he instead directed MacKenzie's mother to give the child Afrin – exactly the opposite of what he was instructed. Within minutes after receiving Afrin, MacKenzie suffered a cardiac arrest, explains **Ralph Brindley**, JD, partner of The Luvera Law Firm in Seattle, and the attorney representing the Briant family.

Paramedics arrived and restarted her heart, but not before her brain was starved of oxygen, causing irreparable brain damage. MacKenzie spent nearly two months in Seattle Children's Hospital before she was released. She now requires around-the-clock nursing care.

"In all my years representing families dealing with medical malpractice, this is one of the most heartbreaking medical negligence cases I have seen," Brindley says. "When we talk about medical errors, rarely is the error as elementary and vivid as failing to verify and follow a verbal order, especially as simple as something like 'do not use Afrin.'"

Brindley noted that had Noel repeated Law's order back to him, Law would most certainly have corrected Noel's error. "Tragically, Dr. Noel did not follow the procedures to deliver an acceptable standard of care, and as a result, MacKenzie will spend the rest of her life unable to speak or feed herself," he says.

MacKenzie was born in 2004 with a congenital heart defect and received a heart transplant at 110 days old. After that transplant, MacKenzie had enrolled in school, and was in good health, according to court documents.

Afrin, like many nasal decongestants, is a vasoconstrictor, which can cause increased blood pressure, which puts unnecessary stress on the heart for vulnerable pediatric heart-transplant patients. "The medical literature is clear. Giving a heart transplant patient a dose of Afrin is unacceptable," Brindley says.

Noel testified that he does not know where the miscommunication took place, but that he had directed Briant to give Afrin to MacKenzie, even though Law testified he told him not to.

"This was an incredibly hard-fought case," Brindley says. "While the University of Washington and Seattle Children's finally admitted its doctors were negligent, they steadfastly argued that the Afrin was not the cause of MacKenzie's cardiac event, although she coded soon after her mother administered the dose."

Briant notes that Law continues to be MacKenzie's cardiologist.

SOURCE

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WellPoint pays HHS $1.7 million for PHI accessible over Internet

The managed care company WellPoint Inc. has agreed to pay the Department of Health and Human Services (HHS) $1.7 million to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

"This case sends an important message to HIPAA-covered entities to take caution when implementing changes to their information systems, especially when those changes involve updates to Web-based applications or portals that are used to provide access to consumers' health data using the Internet," according to the HHS announcement.

The HHS Office for Civil Rights (OCR) began its investigation following a breach report submitted by WellPoint as required by the Health Information Technology for Economic and Clinical Health, or HITECH Act. The HITECH Breach Notification Rule requires HIPAA-covered entities to notify HHS of a breach of unsecured protected health information (PHI).

The report indicated that security weaknesses in an online application database left the electronic protected health information (PHI) of 612,402 individuals accessible to unauthorized individuals over the Internet.

OCR's investigation indicated that WellPoint did not implement appropriate administrative and technical safeguards as required under the HIPAA Security Rule. Specifically, the investigation indicated WellPoint did not:

- adequately implement policies and procedures for authorizing access to the online application database;
- perform an appropriate technical evaluation in response to a software upgrade to its information systems;
- have technical safeguards in place to verify the person or entity seeking access to electronic protected health information maintained in its application database.

As a result, beginning on Oct. 23, 2009, until March 7, 2010, WellPoint impermissibly disclosed the PHI of 612,402 individuals by allowing access to the PHI of such individuals maintained in the application database. This data included names, dates of birth, addresses, Social Security numbers, telephone numbers, and health information.

"Whether systems upgrades are conducted by covered entities or their business associates, HHS expects organizations to have in place reasonable and appropriate technical, administrative, and physical safeguards to protect the confidentiality, integrity, and availability of electronic protected health information, especially information that is accessible over the Internet," HHS said. ✦

HHS issues final health IT safety plan

A plan to guide health information technology (IT) activities across the Department of Health and Human Services (HHS) to eliminate medical errors, protect patients, and improve the quality and efficiency of healthcare was issued recently by HHS.

The final "Health IT Patient Safety Action and Surveillance Plan" addresses the role of health IT within HHS' commitment to patient safety. The plan builds on recommendations from the 2011 Institute of Medicine report, titled "Health IT and Patient Safety: Building Safer Systems for Better Care," and from public comments. *(The plan is available online at http://tinyurl.com/hhsITplan.)*

"When implemented and used properly, health IT is an important tool in finding and avoiding medical errors and protecting patients," says **Farzad Mostashari**, MD, national coordinator for health IT. "This plan will help us make sure that these new technologies are used to make healthcare safer."

The plan, implemented by the Office of National Coordinator for Health IT (ONC), outlines the responsibilities to be shared across HHS and details significant participation from the private sector. The plan will facilitate these improvements:

- ONC will make it easier for clinicians to report health IT-related incidents and hazards through the use of certified electronic health record technology (CEHRT).
- The Agency for Healthcare Research and Quality will encourage reporting to Patient Safety Organizations and will update its standardized reporting forms to enable ambulatory reporting of health IT events.
- The Centers for Medicare & Medicaid Services (CMS) will encourage the use of the standardized reporting forms in hospital incident reporting systems and train surveyors to identify safe and unsafe practices associated with health IT.
- Working through a public-private process, ONC will develop priorities for improving the safety of health IT. ONC and CMS will consider adopting safety-related objectives, measures, and capabilities for CEHRTs through the Medicare and Medicaid EHR Incentive Programs and ONC's standards and certification criteria.

To accompany the plan's surveillance of safety-related capabilities in CEHRT, ONC issued guidance clarifying that ONC-Authorized Certification Bodies will be expected to verify whether safety-related capabilities work properly in live clinical settings in which they are implemented.

In addition to the plan, Mostashari announced ONC has contracted with The Joint Commission (TJC) to better detect and proactively address potential health IT-related safety issues across a variety of health care settings. TJC will expand its capacity to investigate the role of health IT as a contributing cause of adverse events and will identify high priority areas for expected types of health IT-related events. ✦

New NPSG addresses clinical alarm safety

The Joint Commission (TJC) has approved a new National Patient Safety Goal (NPSG) on clinical alarm safety (NPSG.06.01.01) for 2014 for hospitals and critical access hospitals.

The new goal will be implemented in two phases: Phase one begins Jan. 1, 2014, when hospitals will be required to establish alarm safety as an organizational priority and identify the most important alarms to manage based on their own internal situations. Phase two begins Jan. 1, 2016, when hospitals will be expected to develop and implement specific components of policies and procedures, and to educate staff in the organization about alarm system management. *(The NPSG is available online at http://tinyurl.com/NPSGalarms.)*

TJC will publish the phase one and two requirements at the same time to provide complete information about the ultimate requirements of the NPSG. The proposed phase two requirements might be enhanced before they are implemented in 2016. These changes could arise from hospitals' experience with phase one requirements as well as newly emerging evidence about best practices.

TJC notes that efforts are underway that will support the implementation of phase two requirements. For example, the Association for the Advancement of Medical Instrumentation's (AAMI) Healthcare Technology Safety Institute (HTSI) is engaged in activities that promote safe alarm system management, including conducting a survey and study of hospital practices in setting alarm parameters. They also are posting literature on the HTSI website about best practices on alarm system management.

The proposed NPSG was reviewed by Joint Commission advisory committees, which supported the NPSG because it focuses attention on the safety issue; however, they noted that solutions will be evolving over many years. *(TJC's recent Sentinel Event Alert on clinical alarms is available online at http://tinyurl.com/cygrc4. For more on the patient safety risks associated with clinical alarm fatigue, see* Healthcare Risk Management, *August 2013, p. 93.)* ✦

Mobile devices pose breach risk, action needed

Many healthcare organizations are not taking the necessary steps to protect sensitive data on mobile devices and in the cloud, according to a recent report from Ponemon Institute, a research organization in Traverse City, MI.

Fifty-four percent of respondents to a survey have had on average five data breach incidents involving the loss or theft of a mobile device containing regulated data, the report says.

The Risk of Regulated Data on Mobile Devices study was intended to assess the risks associated with employees' access to regulated data through their own or company's mobile devices and the challenges to ensure compliance with the privacy and data protection laws for regulated data on mobile devices.

"The research reveals that many organizations are in the dark about the need to ensure that the use and access of regulated data on mobile devices is in compliance with data protection laws," the report says. "Many respondents are uncertain or do not know whether these laws apply to the safeguarding of regulated data on mobile devices."

As an example, 67% of respondents say their organization must comply with privacy and data breach laws, yet only 18% believe these laws specify the protection of regulated data on mobile devices. "Such perceptions result in organizations not being in compliance and facing potential regulatory fines and legal action," the researchers concluded.

The findings reveal that regulated data on mobile devices and in the cloud are at risk because of the following conditions that exist in organizations:

• People do not know how much regulated data is on mobile devices used by employees or transferred to cloud-based file-sharing applications.

The findings reveal that regulated data on mobile devices and in the cloud is at risk ...

• Companies do not prevent employees from accessing regulated data using unsecured mobile devices.

• Leaders do not take the risk of having regulated data on mobile devices seriously and, as a result, do not make it a top security priority.

• Companies do not take steps to monitor employees who access and use regulated data on mobile devices.

• Organizations do not make sure employees are aware of the importance of protecting regulated data on mobile devices. Respondents believe that most employees at one time or another circumvent or disable required security settings on their mobile devices.

• Companies do not have the necessary oversight or governance practices in place.

The researchers offer these six recommendations:

1. Create awareness throughout the organization that regulated data on mobile devices should be just as protected and secured as other sensitive and confidential information.
2. Make sure security policies include guidance on what employees should be doing to protect the regulated data on the mobile devices they use. This includes emphasizing the importance of not circumventing or disabling security features.
3. Conduct a data inventory of sensitive and confidential information to understand what regulated data is on the mobile devices of employees.
4. Understand who is accessing regulated data through mobile devices and for what purposes in order to increase visibility of people and business processes.
5. Consider data-centric protections for personally owned devices.
6. Consider investing in technologies that specifically address the regulated data risk. These include mobile device management, mobile digital rights management, and mobile application management.

The full report is available online at http://tinyurl.com/k24gant. ✦

Researcher's travel expenses cited in $2.93 million settlement

Research grants should not be used to pay for food and hotel expenses for a researcher, his family, and his friends. That's the key message from a False Claims Act lawsuit that resulted in Northwestern University in Evanston, IL, agreeing to pay the United States $2.93 million to settle claims of cancer research grant fraud.

The alleged fraud involved a former researcher and physician at the university's Robert H. Lurie Comprehensive Cancer Center in Chicago. Northwestern agreed to the settlement in a federal False Claims Act lawsuit that was unsealed recently after the government investigated the claims made by a former employee and whistleblower who will receive a portion of the settlement.

The U.S. Department of Justice (DOJ) claims that Northwestern allowed one of its researchers, Charles L. Bennett, to submit false claims under research grants from the National Institutes of Health (NIH). The settlement covers claims that Bennett submitted for reimbursement from the federal grants for professional and consulting services, subcontracts, food, hotels, travel, and other expenses that benefited Bennett, his friends, and family from Jan. 1, 2003, through Aug. 31, 2010, according to the DOJ.

The allegations were made in a civil lawsuit filed under seal in 2009 by Melissa Theis, a former employee of the Lurie Cancer Center, who will receive $498,100 in settlement proceeds. Her allegations were investigated by the Department of Health and Human Services Office of Inspector General, the Federal Bureau of Investigation, the NIH, and the U.S. Attorney's Office. At the same time the settlement was announced, the whistleblower lawsuit that initiated the case was unsealed: United States, et al., ex rel. Melissa Theis v. Northwestern University, Dr. Charles L. Bennett, et al., No. 09 C 1943 (N.D. Ill.).

Northwestern fully cooperated during the investigation but did not admit liability as part of the settlement, **Gary S. Shapiro**, JD, United States Attorney for the Northern District of Illinois, said in announcing the settlement.

"Allowing researchers to use federal grant money to pay for personal travel, hotels, and meals, and to hire unqualified friends and relatives as 'consultants,' violates the public trust and federal law," Shapiro said. "This settlement, combined with the willingness of insiders to report fraud, should help deter such misconduct, but when it doesn't, federal grant recipients who allow the system to be manipulated should know that we will aggressively pursue all available legal remedies."

Northwestern University President Morton Schapiro, PhD, and other leaders at the school issued a statement saying that though the university does not admit any guilt, "Northwestern was nonetheless disappointed to see the allegations in the complaint because they are at odds with the University's commitment to a culture of compliance in the administration of federal research grants. Northwestern takes its grant administration responsibilities seriously, and fully cooperated with the government's investigation of these allegations in an effort to demonstrate their inconsistency with its institutional values."

Although Northwestern expressly denied wrongdoing by any current faculty members as part of the settlement agreement, the university elected to settle the case rather than engage in protracted litigation that would divert time and resources from its primary missions of education and research, Schapiro said. ✦

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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.

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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 motivates most patients to sue, according to Peter Pronovost, MD, PhD, FCCM, a practicing anesthesiologist, critical-care physician, professor, senior vice president of Johns Hopkins Medicine?**
   A. It's because they suffered a bad outcome and they lost trust in you.
   B. A financial downturn has left them needing money.
   C. An error occurred.
   D. Risks were not adequately explained.

2. **In the mnemonic ALEEN, what does the A stand for?**
   A. Accept
   B. Anticipate
   C. Allow
   D. Avoid

3. **According to Tania Daniels, PT, MBA, vice president of patient safety at the Minnesota Hospital Association, who is particularly likely to be confused by inconsistency in overhead pages?**
   A. People who work in more than one hospital
   B. Patients
   C. Doctors
   D. Nurses

4. **According to the complaint filed against Cardiologists and the Infirmary Health System, what prompted the whistleblower to sue?**
   A. He was fired.
   B. He was demoted.
   C. He was locked out of the alleged kickback scheme.
   D. He was warned to stop asking questions about the questionable payment system.

Legal Review & Commentary

A Monthly Supplement to HEALTHCARE RISK MANAGEMENT

Second largest verdict in NY state history awarded to family of girl for negligent delivery by local hospital

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News: A jury in Suffolk County, NY, recently handed down the second largest malpractice verdict in the state's history, awarding a Long Island family $130 million for the allegedly botched delivery of their now-brain damaged daughter. The verdict was awarded against a large hospital in the area that was found to have departed from obstetrical standards of care 10 years ago while delivering the infant plaintiff, causing the child to be born with cerebral palsy. The nine-figure verdict was handed down after the plaintiffs' attorney turned down an $8 million settlement offer and proceeded to try the case in front of two separate juries, the latter of which resulted in a hung jury.

Background: On Nov. 1, 2002, the plaintiffs presented to a local hospital for the delivery of their daughter. However, according to the plaintiffs' attorney, the hospital nurse attending to the plaintiff mother committed several acts of medical malpractice during the delivery. The girl, now 10 years old, has severe cerebral palsy, and her injuries have left her, as the plaintiffs described it, a "prisoner in her own body." Although the infant-plaintiff is able to comprehend and understand her surroundings, she is unable to speak or walk as a result of oxygen deprivation at birth that resulted in severe brain damage.

... her injuries have left her ... a "prisoner in her own body."

At trial, plaintiffs' attorney argued that the labor and delivery nurse committed easily avoidable errors. They said that had she communicated with the obstetrician just 20 minutes sooner, the infant plaintiff's injuries could have been avoided. Specifically, the plaintiff's attorney claimed that she failed to notify the obstetrician that an Intrauterine Pressure Catheter (IUPC) was not working for approximately 30 minutes on the evening that the plaintiff was born and failed to reapply an external monitor on the plaintiff mother's abdomen when the IUPC stopped working.

IUPCs are used during labor to measure the frequency, duration, and strength of uterine contractions. Although rare, there are several reports of neonatal morbidity and adverse outcomes associated with the use of IUPCs. In addition, plaintiffs' counsel presented evidence that the hospital nurse failed to notify the obstetrician of decelerations in the fetal heart rate that were "nonreassuring;" that she failed to timely reposition, provide oxygen and sufficient fluids to the plaintiff mother; and that she failed to timely discontinue the drug oxytocin, which is used to induce and enhance labor. Also presented at trial were the undisputed facts that the

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. **Alyssa M. Panaro, Carol Gulinello,** and **Jonathan D. Rubin,** co-authors, have no relevant relationships to disclose.

plaintiff mother suffered a uterine rupture during labor and that the infant plaintiff was born with cerebral palsy. Furthermore, plaintiffs' counsel argued that these departures resulted in the obstetrician's failure to perform a timely emergency cesarean section that might have prevented the infant plaintiff's sustained brain injuries, including the inability to walk or talk. At an earlier trial, the obstetrician conceded a departure by the labor and delivery nurse, which vindicated him from liability and left the hospital as the sole target of the lawsuit for the nurse's departures.

In response, at trial, defense counsel argued that there were no departures by the hospital because the labor and delivery nurse was measuring the plaintiff mother's contractions by hand during the time and was analyzing the fetal heartbeat from the audible sounds emanating from the fetal heart rate monitor during the time the IUPC was not working. Furthermore, defense counsel also argued that the infant plaintiff's injuries resulted from the plaintiff mother's suffering a uterine rupture and abruption of the placenta approximately 30 minutes subsequent to the alleged negligence by the obstetrics team at the hospital and approximately 15 minutes prior to the infant plaintiff's delivery by emergency cesarean section.

Despite defense counsel's arguments, the jury believed the plaintiff's counsel's rebuttal that the plaintiff mother's medical complications were relatively minor problems that did not cause the infant plaintiff's catastrophic injuries. As a result, the jury unanimously awarded $130 million dollars to the plaintiffs, which includes, among other calculations, $82.5 million for the infant plaintiff's future pain and suffering, $10 million for her past pain and suffering, $5.8 million for home health aides and other costs of supervised living, $5.5 million for lost earning capacity, $4.2 million for physical therapy, and $1.4 million in speech therapy. The state's Medical Indemnity Fund, established in 2011, will cover all future healthcare costs awarded to the infant plaintiff. The hospital's insurance carriers will have to cover the cost of the plaintiff's attorney fees.

Though only the second highest total malpractice verdict in state history, the $82.5 million award for future pain and suffering far exceeds that of any prior malpractice ruling. In fact, the single larger verdict, totaling $212 million, apportioned only $20 million for future pain and suffering, and even that amount was lowered to $4 million by an appellate court. Accordingly, counsel for the defendant hospital likely will appeal the verdict in a higher court.

What this means to you:
Professional associations routinely publish recommendations/guidelines for providing the standard of care in their respective clinical specialty. The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) is the professional organization that governs the standards for women's health nursing.

The AWHONN position paper (approved by AWHONN in 1998, and revised and retitled in November 2008) articulates the organization's position on key issues within the field of fetal heart monitoring. Clinical recommendations of other professional organizations, based on seminal research, also are noted. According to this research, the frequency of assessment using auscultation in these studies varied from every 15-30 minutes during the active phase of the first stage of labor to every 5-15 minutes during the second stage of labor. In most studies, a 1:1 nurse-patient ratio was used.

The components of fetal monitoring, according to AWOHNN, include application of fetal monitoring components, intermittent auscultation, ongoing monitoring and interpretation of fetal monitoring data, initial assessment of the laboring woman and her fetus, and ongoing clinical intervention and evaluations of the woman and her fetus.

In this case, the labor room nurse stated she measured the mother's contractions by hand and auscultated the fetal heart from the audible sounds emanating from the fetal monitor. What is not mentioned in the summary is the frequency and duration of the monitoring provided and the length of time she actually "laid hands" on the patient to monitor the strength and frequency of the contractions. The patient's prenatal history also would be relevant in this situation. Was this the patient's first pregnancy and, if not, what was her experience with her prior pregnancies? Apparently this was not well-documented.

Although it is acknowledged by AWOHNN as an acceptable nursing practice to monitor patients in labor as described above, it is routine to utilize advanced technology in the monitoring of patients in the clinical setting. One method of monitoring the frequency, duration, strength, and regularity of contractions is by the use of an IUPC monitoring device. One of the benefits of using this device is to alert the practitioners to any signs of deviations from the norm, recognize the nuances of the uterine contractions, and appreciate early evidence of hyperstimulation of the uterus. Unrecognized hyperstimulation of the uterus with the use of oxytocin, a labor-enhancing drug, predisposes a patient to a uterine rupture, as was noted in this case. Should an IUPC not be available, the use of an external monitor applied to the patient's abdomen to measure contractions would be expected. Along with measuring the quality of maternal contractions, fetal heart monitoring data is essential in alerting the caregiver to episodes of fetal distress. Fetal distress, evidenced by non-reassuring decelerations, is con-

sidered an emergency and requires immediate resuscitation that should include repositioning the patient from the supine position to the lateral position, administering oxygen and IV fluids, and discontinuing oxytocin. According to the case summary, none of these interventions were performed by the labor room nurse. This was a deviation from the standard of care.

Additionally, critical information was not immediately relayed to the attending physician regarding the signs of fetal distress, which would allow him/her to take urgent steps to reconsider the patient's treatment plan. Communication and escalation to the attending in charge are an integral part of a culture of safety and are an expectation for patent safety.

The development of a culture of safety and teamwork is encouraged to ensure optimal patient outcomes. In addition to relevant policies and procedures, practical approaches to patient care such as simulation drills to address emergencies, required communication, escalation, and documentation of these emergencies are prudent risk management strategies.

Reference

Reilly v. St. Charles Hospital and Rehabilitation Center, Index No. 071904, Sup. Ct., Suffolk County (2013) (citation pending). See Reilly v. Ninia, 81 A.D.3d 913 (2011) (prior decision). ✦

$17.5 million awarded to family of teenager for hospital's improper administration of anesthesia

Incident happened during routine jaw-wiring surgery

News: A DeKalb County jury awarded the family of a gunshot victim $17 million after finding a major Atlanta hospital to be liable for causing the victim's brain injuries. The victim, a then 19-year-old male who was struck in the face by a stray bullet, presented to the emergency department for injuries resulting from the shooting. However, when the hospital performed a jaw-wiring surgery to stabilize his injuries, the patient was deprived of adequate oxygen for an extended time, which resulted in a coma and severe detrimental brain injuries. A jury found the hospital, anesthesiologist, and physician's assistant liable for failing to follow the proper anesthesia procedures when the patient was coming out of surgery.

Background: On April 9, 2008, a 19-year-old male was rushed to the emergency department of a major Atlanta hospital after he was struck in the face with a stray bullet in a local Wal-Mart parking lot. By all accounts the patient was an innocent bystander, and he was not involved in the drive-by shooting that led to his bullet injuries. At the emergency department, the male patient was responsive and "very much like his normal self" according to his mother, also a plaintiff to the lawsuit. Despite the alarming nature of a bullet to the face, the patient's mother was assured that her son's perforated cheek was not life-threatening.

After two days at the hospital, physicians decided to wire the patient's jaw shut in an extremely routine surgery, which usually comes with few to no expected adverse reactions. Jaw wiring, also known as maxillomandibular fixation, is a surgical procedure in which metal pins and wires are anchored into the jaw bones and surrounding tissues to keep the jaw from moving. It is used in situations in which the jaw might be fractured to keep the bones aligned and stable while the jaw heals. The hospital physicians decided to proceed with the surgery despite knowing that the patient's airway remained partially obstructed and swollen. The fact that the surgery was elective, and not medically necessary, later fueled plaintiffs' arguments that it should have been delayed until the patient's airways were sufficiently healed.

Physicians planned for the patient to be discharged the day after his surgery. However, when the plaintiffs arrived at the hospital the next day, they found their son as non-responsive, in a coma. Hospital staff informed the plaintiffs that the patient had been deprived of oxygen for seven to eight minutes during the procedure, resulting in massive brain injuries which continue to inhibit the now 24-year-old's ability to walk and communicate.

At trial, defense counsel presented evidence that the patient was partly responsible for his lack of oxygen during the procedure as he "emerged violently from anesthesia and began fighting with physicians and other medical providers, and ultimately pulled out his own breathing tube." In addition, attorneys for the hospital argued that hospital personnel acted swiftly to save the patient's life.

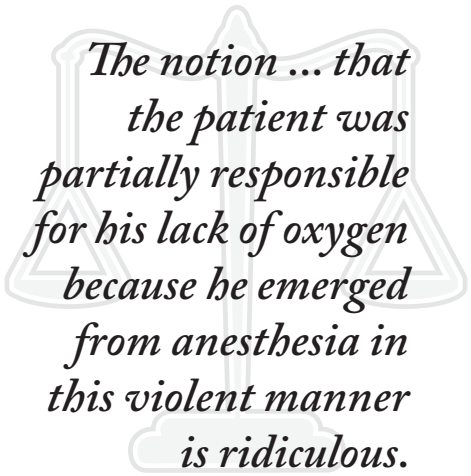
However, the plaintiffs' attorney claimed that the hospital had departed from the standard of

care by failing to follow its own policies and procedures regarding the administration of anesthesia. Specifically, the attorney argued that the anesthesia team brought the patient "out of unconsciousness too quickly," which resulted in the patient becoming "combative and agitated." Furthermore, plaintiffs' attorney further claimed that the hospital failed to keep sufficient staff on its floors during the patient's surgery. Plaintiffs also argued that the hospital was aware of the tendency to become agitated when extubating a patient with swollen airways, as evidenced by their plan to have four extra people in the room to restrain the patient as he came out of anesthesia. Yet when the patient was being moved to recovery after the surgery, there were only two people present to restrain him. He was therefore able to remove his endotracheal rube and flip over his bed, leading to the delay in re-intubation that ultimately caused the brain injuries at issue in this case.

In terms of damages, plaintiffs' counsel contended that the patient now has "the mind of an infant" as he is unable to walk and write, and he can barely talk, although he is making slow improvement with speech as a result of speech and physical therapy. In addition, the patient's mother claimed that she took off nine months from work to provide her son with 24-hour care, seven days a week.

A jury found the hospital, anesthesiologist, and physician's assistant liable for $17.5 million in damages. The hospital has shared that it plans to appeal the verdict.

What this means to you: This case pivots around the lack of monitoring of a patient who is emerging from anesthesia; the inability to recognize the stages of anesthesia recovery and a patient's response to that recovery; and most importantly, the lack of bedside safety precautions when caring for a postoperative patient who has just undergone maxillomandibular fixation, i.e.: wire clippers.



There are four stages of anesthesia recovery. The second of these stages is called the stage of emergence delirium. The signs and symptoms of emergence delirium or agitation after anesthesia include excitement and alternating periods of lethargy followed by excitement and disorientation. Inappropriate behavior such as screaming, kicking, and use of profanities might occur. Also, patients generally do not respond appropriately to commands. This appears to be the scenario described in the case summary. The notion, presented by defense counsel, that the patient was partially responsible for his lack of oxygen because he emerged from anesthesia in this violent manner is ridiculous. Clearly the defense attorney was making a futile attempt to depend on something that was useless. This state of mind and behavior is completely involuntary, and the onus is on the hospital staff to ensure the patient's safety.

Every post-anesthesia care unit (PACU) nurse, certified registered nurse anesthetist (CRNA), and anesthesiologist must be aware of these signs and symptoms. As such, precautions to avoid self-extubation or the ramifications of other harmful, jerky movements must be anticipated and always must call for a quick staff response.

Once this patient exhibited these symptoms, it was incumbent upon the postoperative staff to ensure the patient's safety. One safety precaution could include soft wrist restraints or mittens to avoid self extubation. Of utmost importance is the presence of wire clippers. These small devices always must be readily available at the beside, whether in the immediate postoperative area or on the nursing units, should the patient's airway become compromised. The mandibular wires can be cut to release the mandible/jaw and allow for suctioning to clear the airway of any secretions or even allow for the ability to intubate the patient should it be deemed necessary.

According to the case summary, the plaintiffs' attorney further claimed that the hospital failed to keep sufficient staff on its floors during the patient's surgery. What this claim suggests is that the staffing was such that no one was present to notice and respond to the signs and symptoms of respiratory distress for 7-8 minutes. In fact, it appears that the hypoxia did not occur during the actual surgery but immediately postoperatively when the patient emerged violently from anesthesia. He self-extubated, with a wired jaw, and there was not a quick staff response to remedy the event, thus this situation allowed the patient to be deprived of oxygen.

This is a sad case that appears, from the facts presented, to have been both predictable and preventable.

Reference

Parents of Sheriod Merritt v. Emory University. Dekalb County Court (Ga. 2013) Unpublished citation. ✦