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Who is covering for you on off hours? Process can break down without a plan

Risk managers encourage employees at all levels to contact them if they have concerns about a patient safety issue, or when any situation arises that could result in a lawsuit or other liability. But when one of those issues arises when you're not at work, who is covering for you?

Off-hour call coverage should be designed to make sure a risk manager is available any time the person at the hospital needs one, says **John C. Metcalfe**, JD, FASHRM, vice president of risk management services with MemorialCare Health System in Fountain Valley, CA. That availability means at night, on weekends, and even when you're away on vacation.

But that requirement doesn't mean you can never relax. Not every incident needs to be handled by a risk manager, and even when it does, the director of risk management probably is not the only person to call, Metcalfe says.

The important point, he says, is that you should carefully construct a plan that ensures risk management concerns are never given short shrift on off hours. All of your risk management efforts can go awry if hospital staff don't call for help during off hours and you subsequently lose hours or days of response time after an incident.

"Each week we assign off-hour call coverage to one of our nine Department of Risk Management Services team members. The call schedule is circulated to each campus within our MemorialCare healthcare system," Metcalfe says. "In addition, each campus has telephone numbers for back-up risk management call coverage should the team member on-call not respond in a timely manner."

That system makes the Department of Risk Management services available 24/7, 365 days a year, he says.

That approach might be more difficult for smaller hospitals or health systems, notes **R. Stephen Trosty**, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management (AHRM) in Chicago. He has worked in facilities ranging from 45 beds to 600 beds. In the larger facilities with several staff in risk management, on-call duty was rotated among them in the same way as at MetCalfe's hospital.

When he worked for medium size facilities in which there was only one risk manager, that person was on call, but only for extreme emergencies. Examples include any serious and significant injury to a patient, such as a severed spinal cord or brain injury due to too much anesthesia, as well as legal minefields such as a pregnant patient who refused a blood transfusion necessary to save the baby. "Staff also called when it was felt that family should be spoken with before Monday, on a weekend, or even before morning in rare occasions," Trosty

INSIDE

cover

enclosed

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says. "In these instances, we wanted a risk manager called."

This same approach was used in the small facilities, in which the risk manager usually was also the quality improvement person and often the utilization review person. In these small hospitals and nursing homes, there was not the luxury of having a dedicated risk manager, Trosty explains.

"Therefore, it became even more important to educate and train all staff on identification of risk management issues and basic risk management approaches and responses before the risk manager was again in the facility," he says.

Payment for on-call service should not be an issue because risk managers, administrators, heads of nursing, and chiefs of medical staff are salaried, and off-hour call is part of job description, Trosty says.

Train others to back you up

Jane McCaffrey, DFASHRM, MHSA, recently director of compliance and risk management at The Blood Connection in Greenville, SC, and a past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago, says, "When you are a risk management department of one, it is crucial that clinical supervisors and medical staff leaders are coached in the first actions necessary in a risk situation." Those first actions include communication with patient and family, staff communication, factual documentation, preservation of evidence, and understanding what can be evidence.

The training should emphasize that the first few minutes and hours are critical to gathering the necessary information and evidence, and for proper communication with the patient and family. Because such off-hour situations are infrequent, checklists can provide the best support, McCaffrey says. The training and checklists should extend to public relations staff as well as administrative staff, she says. *(For more on training staff and using checklists, see the stories on p. 87.)*

"I have even heard of facilities conducting crisis or risk event exercises to be sure training and support material maximizes intent," McCaffrey says. "I also suggest that each sentinel event review should include questions such as 'What if this happened at night? What if it was during a storm? Did the checklist and training guidance give support? Were the right people available? And so on...'"

When staff members should call a risk manager also is another point that should be established from the outset. Training

Executive Summary

Off-hour call coverage for the risk manager should be carefully planned. For some concerns, the risk manager should take calls at any hour.

✦ Risk management staff should rotate on-call duty.

✦ If there is only one risk manager, that person must be available at any time for extreme situations.

✦ Clinicians should be trained and use checklists to decide when to call a risk manager.

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and checklists can eliminate some questions, but there still will be gray areas. Metcalfe says he wants a call any time someone even wonders about calling for help, and he educates hospital staff that there are no barriers to calling an off-hours risk manager.

"We promote and encourage call to our service anytime a MemorialCare facility believes it has a need for it. We believe it is imperative that our organization understands we are here to be called and consulted each and every time one of our facilities believes they have a need for us," he says.

McCaffrey and Trosky take a similar approach to this issue, and they say that they would rather have the occasional call for an issue that doesn't truly need their attention than find a memo on their desk Monday morning about a crisis that happened over the weekend.

"As risk management champions we have to be ready to serve 24/7/ 365 days a year, year in and year out," Metcalfe says.

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Educate staff for late-night risks

Risk managers can't be on site all the time, especially when there are only one or two staff members in the department, but you can create deputy risk managers by training those employees who work the graveyard shift, weekends, and holidays.

At one hospital where he was risk manager, **R. Stephen Trosty**, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago, focused first on the administrative staff who took phone calls from concerned patients or family, as well as the head of nursing and chief of staff. They were trained annually on essential risk management issues, with an emphasis on how to respond to weekend situations that could not wait until Monday.

"We attempted to have personnel who were familiar enough with risk management actions and approaches in order to provide immediate responses until the risk manager arrived on his or her next day. If the administrative personnel, head of nursing, or chief of staff felt that it was necessary or appropriate, the risk manager was called," Trosty says. "He or she would either come into the facility or provide guidance on the phone that would allow the staff member on call to provide immediate and appropriate risk management services."

The risk manager was to be called if the individual employeess had any concerns or felt that the situation was beyond what they could handle. Afterward, these situations were reviewed with the members of the administrative staff , the head of nursing, and the chief of staff to assess the response and, if necessary, to determine how the situations should have been handled better.

This training was a requirement for all new hires and on an annual basis for all employees, including administrative and medical staff. Identified risk management situations and issues from the facility were incorporated into this training. "We wanted all staff members to have at least a basic understanding of risk management principles, how to identify issues that should be reported to risk management, what method to use for such reporting, and when it was necessary to also alert senior personnel," Trosty says. "We attempted to train each member of the staff to assist with being the eyes and ears for risk management on a regular and continuous basis."

The large and medium size hospitals in which he worked also offered risk management seminars for physicians and provide continuing medical education (CME) credits.

"We would present sample situations that involved risk management and clinical-related issues. We would discuss the sample cases in terms of the clinical issues and problems that existed, how they presented risk management issues and concerns, appropriate responses to these issues, lessons learned," Trosty says. "We found that physicians enjoyed these types of presentations, and we got relatively decent attendance and participation. That is not to say that the CME did not assist in getting them to show up." ✦

Checklists offer help on off hours

Checklists are a good resource for helping staff assess situations that might or might not need intervention from a risk management professional, says **R. Stephen Trosty**, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

The checklists also should guidance on what to do immediately in such situations,

even if the call is going out for a risk manager, he says.

Trosty says the checklists should include advice on these points:

- communication with physicians;
- contacting on-call administrators (where this exists);
- appropriate communication with family, patients, and other staff members;
- collecting and preserving evidence;
- appropriate documentation;
- the basis for contacting a risk manager;
- when a risk manager will next be in the facility.

Checklists should be reviewed annually by the risk manager and/or the corporate risk management staff to determine if any additional or new information is required.

The checklists, as well as the training, should include any legal issues that are relevant or required for your specific state. ✦

Hone skills for working with C-suite execs

Maybe you meet with the CEO every week, or maybe you just got word that you'll be speaking to the hospital's executive board for the first time. Either way, you should know that communicating with top level executives is not the same as speaking with your colleagues, and preparation can make your meeting much more successful.

With risk managers increasing moving into executive positions and increasing their stature within the organization, the chance of interacting directly with top leaders in the C-suite is more frequent. The first step is realizing that those meetings are different from your other meetings, says **Andrew A. Oppenberg**, MPH, CPHRM, DFASHRM, director of risk management and patient safety officer at Dignity Health Glendale Memorial Hospital and Health Center in Glendale, CA. Oppenberg also is a former president of the American Society for Healthcare Risk Management (ASHRM).

Improving the stature of risk managers has been a goal for ASHRM for several years now, Oppenberg says, and learning to communicate with C-suite executives is a necessary component. "Increasingly, risk managers want to be included in the senior management discussions, and they want to become chief risk officers," he says. "Many risk managers, however, become complacent about some of the skills necessary to achieve that presence. Some come up through the clinical path and are very comfortable in that area, but they need to develop the communication skills and know how to offer their services to the people in the C-suite."

A consultant who works directly with a healthcare risk manager says you should consider your audience's background when preparing to meet. A CEO or other executive with a clinical background will seek information in a different way than, for example, a CEO with a finance background, says **Mark Tomaszewski,** MPH, a director with the consulting firm Jabian in Atlanta. Learn to speak the language of your key audience member. "If you're talking about patient safety or a clinical risk, be ready to talk about that in a way that a physician will absorb it well," he says. "Deliver clinical information that you know he or she will want to know, and be ready to answer questions that a doctor might ask but a finance professional would not."

Also be aware that C-suite executives frequently think risk managers are like Chicken Little, blowing risks far out of proportion, Tomaszewski says. Risk managers must keep that in mind and filter out any warnings of doom that might seem over the top. It is easy to go overboard trying to explain that a risk carries potentially huge ramifications, even if it is unlikely to happen, he says. "Once you've gone too far and they think you're exaggerating to get the funding or whatever resources you want, you've lost them," Tomaszewski says. "It can be a delicate task for risk managers because part of your job is to bring these risks to their attention and alert them to the consequences."

The healthcare risk manager that Tomaszewski assisted had a problem common for those not used to C-suite encounters. She went into too much detail about the problem and its background, so he helped her get in the habit of providing the key information in bullet form rather than talking on and on. *(For more information on making the most of your time with executives, see the story on p. 90.)*

Communicate their way

Remember that C-suite executives are looking for a different type of information than most managers, says **Leslie G. Ungar**, author of *Pragmatic Coaching for Dramatic Results* in Akron, OH.

"The higher up you go in an organization, the more the strategic is appreciated. The lower on the chart, the more people talk about the tactical. Clarity is valued at the C level," Ungar says. "If you want to be perceived as one of them, you need to look, sound, and approach them as though

Executive Summary

Communicating with top executives can be different than talking with others in your organization. Preparation can help you make the most of the interaction.

✦ Know the executive's communication style before the meeting.
✦ Don't try to improve your image by showing all you know about risk management.
✦ Know when to stop talking.

you were one of them.

A primary difference is that the C-suite execs want the message to be quick and clear, says **Linda D. Henman**, PhD, president of Henman Performance Group, a consulting and training company in Chesterfield, MO. "Senior leaders don't care about the details. They care about speed and good decisions. They care about taking mitigating risk, but they don't want to make that their main goal," Henman says. "Risk managers who realize that their listeners have a different orientation can position their advice to increase the receptivity of the listener."

Ungar explains that, from a communication perspective, the speaker controls themselves, their message, and their environment, but they do not control their audience. That perspective means risk managers need to concentrate on themselves and how they are communicating their message rather than focusing on the executives, he says. *(For more tips on effective communication with top leaders, see the story on p. 90.)* "C-level people in particular require clarity in their communication. They want the speaker to get to the results with the minimum amount of time spent in process and how they got there," Ungar says. "Risk managers on the other hand, tend to want to tell the C-suite person what all they did to mitigate risk. All the C-suite person wants to hear is the end result."

Sometime a risk manager meets with a C-suite exec to give bad news about a malpractice case or other problem, and Oppenberg says those encounters should carefully planned.

"If you have to bring a problem to the executive, bring a solution," he says. "Sometimes you can have several solutions and tell the person 'this is your call, and that's why I'm bringing it to you.' Unfortunately sometimes risk managers dump things on the person's desk and expect them to handle it. That's not what they're paying you for."

Preparation will help you avoid a cardinal sin: wasting the CEO's time, says **Billie Blair,** PhD, an organizational psychologist and president/CEO of the international management consulting firm Change Strategists in Los Angeles. Wasting someone's time is to be avoided no matter how high or low the person is in the food chain, but the concern is still higher with top executives. "You have to have something like an elevator speech, the kind of short, to-the-point answer you'd give if someone on the elevator asked you what you're working on," Blair says.

> ***"Senior leaders don't care about the details. They care about speed and good decisions."***

Don't damage your image

Not having a grasp of the facts or taking a long while to get to them will not just annoy the executive, notes **Greg Bustin**, a leadership and strategic planning consultant in Dallas. That response also will damage your image. *(See the story on p. 91 for an account of how face time with the CEO can go wrong.)*

Some executives want to hear all the background, all the steps of the investigation, and all the facts behind your recommendation or request, while others want just the headlines, Bustin says. Your job is to know which tack is preferred by the person or people you are meeting with. In some cases such as a presentation before the board, you might find that certain individuals crave more data than others, Bustin notes. In that case, you might try to satisfy both types by compromising and targeting your data comments to the person you know is more interested.

Remember that it can be a compliment when the executive doesn't want to hear all of the background, all the facts, and the story of how you came to the relevant points. "Not only might that be their style of processing information, but they're also telling you that they have confidence in you," Bustin says. "They're saying that they trust you did your job well and they don't need to know all the background and check your work."

Also, don't be discouraged if the CEO has little time for you, Bustin says. It is the nature of running a company, he says, to have people lined up at the office door waiting for a few minutes with the leader. The CEO usually has to keep it short with everyone, so don't take it personally. Expect about five minutes to make your case if you are invited to meet with the CEO or executive board, Blair says. That time is your opportunity to get the person's attention, and then you might need to answer questions, she says. But even if you're ultimately in a long conversation with the executive, that first five minutes is your make-or-break moment.

"Don't prepare a 30-minute presentation for a CEO," she says. "The CEO will not listen."

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Use your 'elevator speech' for quick communication

One trick for being ready to discuss risk management with a C-suite executive is to have an "elevator speech" ready at all times, says **Andrew A. Oppenberg**, MPH, CPHRM, DFASHRM, director of risk management and patient safety officer at Dignity Health Glendale Memorial Hospital and Health Center in Glendale, CA. Oppenberg also is a former president of the American Society for Healthcare Risk Management (ASHRM).

An elevator speech is a short but informative statement that you can use any time you run into an executive in the elevator, for example, and you have only a short time to make an impression or answer a question about how your work is going. With an elevator speech you can make the most of that brief encounter, and you also might pull it out during a formal meeting if an executive asks you a general question about your role or your goals. It also is useful in making introductions to anyone else within the organization.

This is how Oppenberg's elevator speech begins: "Hi, I'm Andy Oppenberg, and I'm all about safe and trusted healthcare for our patients. I'm the risk manager you pay to prevent problems so you can sleep at night. How can I be of service to you?"

From there he might explain a project he is working on, time permitting. When speaking with clinicians on a unit, he introduces himself the same way, but with a smile he adds this statement: "The risk manager is your friend. Call me any time I can help you."

Knowing what is going on in the C-suite also helps you tailor your elevator speech for those chance encounters with reprsentatives of that area.

"If I know that the chief financial officer is responsible for renewals, I'll ask if he needs more data for the application. That is far more useful and will make a better impression than just saying 'let me know if I can help with anything,'" Oppenberg explains. ✦

Tips for your trip to the C-suite

Consider these tips before making your high-stakes trip to talk to the CEO or other top executives:

• Communicate the way your audience communicates.

That advice means "you need to get to the end first, speak with clarity, live in strategic rather than tactical, ask for buy-in, and answer questions in the time it takes to walk across a room, not a state," says **Leslie G. Ungar**, author of *Pragmatic Coaching for Dramatic Results* in Akron, OH.

• Start with a one-sentence statement of the problem or issue and a one-sentence recommendation for remedy.

This sentence immediately gains attention and direction, says **Linda D. Henman**, PhD, president of the Henman Performance Group in Chesterfield, MO. The goal is to have senior leaders understand the issues and the consequences to different decisions. If risk managers lead with a win/lose mentality, they often lose and have their requests denied.

• Find out how your audience likes to receive information or conduct a meeting.

Knowing this information might require some pre-meeting reconnaissance by asking others who have met with the executive what is expected, says **Billie Blair**, PhD, an organizational psychologist and president/CEO of the international management consulting firm Change Strategists in Los Angeles. How sensitive is the executive to time constraints? Does he or she expect you to generally be wise about time usage, or does the executive routinely give people five minutes? Does the executive always ask for bullet points? Does he or she like or dislike multimedia? Is this executive someone who thrives on a significant amount of numbers and data points, or is this someone whose eyes glaze over when you throw a lot of data?

• End your talk gracefully.

Know how the CEO ends meetings, Blair advises. Watch for the cues, and know what they mean. Don't override the CEO's gesture. Sometimes it can be subtle, such as closing a notepad, but people who meet with him or her regularly will know, Blair says.

• Determine the tone of the meeting.

The risk manager needs to remember this meeting is not a chummy kind of meeting but rather a serious business encounter.

At the same time, however, Blair says you also should know if the CEO is the type who likes to start off with a little chat before getting down to business. If that is the case, you should know what interests him or her, such as golf, fishing, or traveling.

"The risk manager should not say anything that's not true, like saying you're an avid golfer if you're not, but if there is some natural point that makes for an amiable chat, the risk manager should be prepared for that, but I emphasize only if the CEO starts off with a chat," Blair says. "Don't go in thinking you're going to start off asking about his golf game to break the ice. Let the CEO signal whether you're starting off with some light talk."

• If you're asked what time it is, don't build a clock to demonstrate your answer.

Risk managers might be inclined to show their work and lead with a lengthy explanation of the issue at hand, says **Greg Bustin**, a leadership and strategic planning consultant in Dallas. Be aware of this tendency and resist it, he says. Just answer the question you were asked. If the CEO wants more background, he or she will ask for it. ✦

Poor prep leads to bad meeting with the execs

Many people are nervous about meeting with the CEO or other top-level executives, but preparation will make you more confident and improve your chances of being viewed favorably, says **Greg Bustin**, a leadership and strategic planning consultant in Dallas.

Not preparing well, however, can lead to disaster. Bustin recalls one meeting in which a mid-level executive was presenting to a board of directors and stated one fact that someone attending the meeting realized was wrong. When the mistake came up, the group discussed the discrepancy, and the presenter admitted he was wrong. He moved on with his presentation. Then he stated another number that was wrong, and again someone pointed out his error. Then it happened a third time.

Barely half an hour into the scheduled one hour meeting, the CEO ended the meeting because the man's credibility was shot. The experience tainted his career with the company.

"If you haven't done your homework, if you haven't double- and triple-checked your data, you are risking your own reputation. This is a high-stakes encounter," Bustin says. "One wrong fact is not deadly, but it does put a chink in the armor. It calls into question your reliability. More errors will sink you." ✦

Rushing to new tech can threaten patient safety

A too-rapid adoption of new medical technology can threaten patient safety, according to a new study in *JAMA Surgery*. Risk managers should work to prohibit new devices until physicians and staff have been sufficiently educated and trained on the patient safety risks, the authors suggest.

The researchers focused on the adoption of robotic surgery systems, particularly the da Vinci surgical robot by Intuitive Surgical in Sunnyvale, CA. In 2003, there were about 600 robotic prostatectomies performed in the United States, increasing to 37,000 in 2009, the researchers found. The fast rise in procedures resulted in a brief but "substantially diminished perioperative patient safety," the researchers say.

In 2005, a patient was nearly twice as likely to experience an adverse event at a teaching hospital after robotic surgery compared with the traditional open surgery, according to the study. The prevalence of patients undergoing the robotic procedure at teaching hospitals had reached 10% by 2006. By 2007, the number of patient-safety events doubled among nonteaching hospitals.

The authors reached their conclusions using data from the Agency for Healthcare Research and Quality's Nationwide Inpatient Sample. They studied records of 401,325 patients who underwent radical prostatectomy between Jan. 1, 2003, and Dec. 31, 2009. Eighty percent of them had the new robotic procedure, while 20% had the traditional surgery.

Among the 1,460 patient safety events reported, the most frequent were accidental punctures or lacerations, postoperative respiratory failure, pulmonary embolism and deep vein thrombosis, and postoperative hemorrhages. *(An abstract of the study is available online at http://www.ncbi.nlm.nih.gov/pubmed/24990549.)*

FDA warned company

After investigating a flurry of injury reports involving the da Vinci robot, the Food and Drug Administration investigated and issued a warning to Intuitive Surgical in July 2013 that criticized the company's safety reporting of patient adverse events and highlighted the need for thorough training on the device. Health officials in Massachusetts and New Hampshire also are investigating safety concerns stemming from increases in patient complications.

Officials at Intuitive Surgical questioned the findings of the recent study and say the procedure codes required to identify minimally invasive prostatectomies were not available in the database used by the authors prior to Oct. 1 2008. That lack of codes would make safety events from the pre-da Vinci era seem inaccurately low, the company says.

Even if the numbers as disputed, there is no doubt that adopting new medical technology without adequate education and credentialing is a threat to patients, says **Stephen G. Pereira**, MD, FACS, a New Jersey surgeon who specializes in minimally invasive laparoscopic and robotic surgery. Pereira was a member of the two surgeon team to perform the first robotic surgical procedures in the Northeast United States. He has been performing robotic surgeries for more than 10 years.

Executive Summary

Adopting new technology too quickly can threaten patient safety. Researchers are suggesting a revamp of the system for approving the use of new technology.

✦ A recent study suggests the surgical robots might have been adopted too quickly by some surgeons.

✦ Patient safety events increased when teaching hospitals adopted the new technology.

✦ The maker of a surgical robot says the data are misleading.

To counter that threat, risk managers can work collaboratively with the chairman of the department surgery — or a similar leader — to assess and, if necessary, improve the credentialing process, Pereira says.

When Hackensack (NJ) University Medical Center acquired a surgical robot in 2001, Pereira helped develop guidelines and requirements for general surgeons who wanted to use it.

"When things really took off the radical prostatectomies and neurologists, some of oversight got a little relaxed," he explains. "There was a turf battle where the neurologists wanted to have control and do their own criteria, the general surgeons wanted the same, and so on. The result was that the requirements first put in place weren't adhered to as much as originally intended."

The specialty surgeons created their own criteria for robotic surgery, and then compliance improved at the hospital, Pereira says. Different requirements can be appropriate if their function is to highlight the concerns unique to that specialty and if the general requirements apply across the board, he says.

Pereira notes that many hospitals now have a chief of robotics, a surgeon who is specifically tasked with developing criteria for privileging robotic surgery and enforcing the requirements.

"The goal is the same as with granting privileges for any type of surgery: to confirm that the surgeon is properly trained and experienced," he says. "When a new field comes along that is very different, like what happened with laparoscopy and robotic surgery, the medical community can stumble and require some time to catch up with the technology. We're there now with robotics."

Source

• Stephen G. Pereira, MD, FACS, Hackensack, NJ. Email: drstephenpereira@gmail.com. ✦

EHRs threaten patient safety long after startup

Electronic health record (EHR) patient safety issues persist long after the "go-live" date when everyone expects there to be a learning curve and a period of glitches, according to new research in the *Journal of the American Informatics Association*. Risk managers should heed the warning and persist in monitoring EHR-related safety issues long after it seems the system has been successfully integrated.

Sophisticated monitoring systems are needed to unearth the complex mix of human and technological causes behind these problems, say the authors from the Department of Veterans Affairs (VA). EHRs can improve the quality of patient care, they say, but recent evidence suggests that they also can prompt new patient safety concerns when computer glitches cause clinical decision support to suddenly stop working, for example, or when network outages occur.

Many of these problems are complex and multifaceted, and they are difficult to detect and prevent, says **Hardeep Singh**, MD, MPH, patient safety researcher at the Veterans Affairs Center for Innovations in Quality, Effectiveness and Safety in Houston, TX, and one of the study's authors. To better understand the nature of these patient safety concerns, Singh and his colleagues reviewed 100 closed investigations involving 344 technology-related incidents arising between 2009 and 2013 at the VA. *(An abstract of the study is available online at http://tinyurl.com/oeqsgka.)* The VA adopted EHRs in 1999 and is a leader in patient safety and the use of health information technology. It runs a voluntary reporting system for health information technology safety reporting and analysis. The authors looked at safety concerns related to technology itself as well as human and operational factors such as user behaviors, clinical workflow demands, and organizational policies and procedures involving technology.

Three quarters of the investigations involved unsafe technology, while the remainder involved unsafe use of technology. Seventy percent of the investigations identified a mix of two or more technical and/or non-technical underlying factors. The most common types of safety concerns were related to the display of information in the EHR; software upgrades or modifications; and transmission of data between different components of the EHR system.

More often than not, Singh says, the concerns arose as a result of the complex interaction between non-technical dimensions, such as workflow, and technical dimensions, such as software/hardware and the user interface.

Long after introduction

Interestingly, the serious patient safety errors still were present long after the

Executive Summary

Research shows that electronic health records (EHRs) can threaten patient safety long after they are first implemented. The cause is a mix of human and technological errors.

- ✦ Healthcare organizations must carefully monitor EHR-related safety issues long after the first implementation.
- ✦ The time after an EHR-system upgrade is particularly risky.
- ✦ Risk managers should seek out harmless-sounding EHR problems that might lead to uncovering a safety threat.

go-live date for the EHR, not just in the initial introduction phase.

"EHR-related concerns were still happening many, many years after the EHR had been implemented," Singh explains. "Unless you have a robust infrastructure to detect and analyze these events, you really can't learn a lot. You have to have that in place so you can learn from the problems you're experiencing."

Improving the detection of EHR-related threats is of paramount importance, because that's the first step to correcting them, says another of the study's authors, **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. "With electronic health records, I don't think people understand that some of the things they do are a lot more dangerous than others," Sittig says.

The patient safety threats come in many varieties. Some types of computer screens can be more difficult to read in certain lighting, and some can be more or less sensitive to touch inputs. On a laboratory results screen, for example, Sittig notes that the digits might be too small or the high and low values appear in the same color, which makes it difficult to tell the difference. (*See the story below for more on how errors can creep into an EHR.)*

Upgrading an EHR system creates a period of high risk, Sittig says. People in the IT department brace for this period because they know they will receive many calls about errors and breakdowns. "But I'm not sure everyone else in the hospital knows that," Sittig says. "They may think that the upgrade means things are better now, and they don't realize that they should be on high alert for conflicts and errors. The risk manager may not even know the upgrade is happening."

Risk managers should be aware of upgrades, and they should plan to actively investigate the effects rather than waiting for someone to report patient safety issues, he says. Go to the clinicians on the floor and ask them how the upgrade is going, how the system is different from before, and what problems they are seeing now.

Don't only ask if there are any patient safety issues as a result of the upgrade, Sittig says. That question will keep you from hearing about how everyone is having trouble printing from the EHR now, for example. If all the printers are now misconfigured for the EHR, you should wonder what else was changed. What else is the EHR not communicating with?

"Risk managers can play a pretty strong role in this because many of these concerns are not easily detected," Singh says. "We think that the reported incidents are only about 5% of the errors, but if we have a more robust detection strategy that involves the risk manager, we might be able to uncover far more EHR-related concerns than we currently know about." *(For more information on the role of the healthcare risk manager, see story at the bottom of this page.)*

Sources

• Hardeep Singh, MD, MPH, Patient Safety Researcher, Veterans Affairs Center for Innovations in Quality, Effectiveness and Safety, Houston, TX. Telephone: (713) 794-8601. Email: hardeeps@bcm.edu.

• 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. ✦

Old drug remains active on EHR

One common problem electronic health records (EHRs) is that lists and medication lists are not updated, says Bill Fera, MD, principal with the Ernst & Young Americas Advisory Health Care Sector in Pittsburgh, PA.

Temporary medications or diagnoses can linger if users do not update appropriately.

Fera recalls an incident when his wife was being prepared for surgery. A preop nurse asked if she was still on Lovenox, a potent blood thinner taken as a shot used primarily after orthopedic procedures for a short time to prevent blood clots. She replied that she had not been on Lovenox for two years. She had been asked about the drug before and had always replied that she no longer uses it, but the Lovenox persists in her record as an "active medication."

"The same thing can happen with temporary diagnoses as benign as sinusitis to those that are more impactful like acute renal failure," Fera says. "Users of the system have to be sure that information is up to date and that old or inaccurate information does not persist."

Source

• Bill Fera, MD, Principal, Ernst & Young Americas Advisory Health Care Sector, Pittsburgh, PA. Telephone: (412) 644-0551. Email: bill.fera@ey.com. ✦

Risk managers should sign off on EHR system

Risk managers should be directly involved with choosing an electronic health record (EHR) system and also with building the system, says **Robert Hitchcock,** MD, FACEP, a practicing ED physician in Dallas and an Emergency Department Practice Management Association (EDPMA) board member. He also is vice president

of T-System, a Dallas-based company that consults on regulatory issues.

Many EHRs are purchased as a technology platform on which the user builds an EHR according to their needs. In those cases the risk manager needs to have the same signoff on that purchase and design as the clinicians have for the clinical workflow, Hitchcock says. In addition, the patient safety issues related to EHRs might be amplified when a hospital or health system adopts a large system for the organization all at once.

"I think people may need to reconsider this 'all-in' model that is a single data platform model, which really on the back end isn't a single data platform. That creates issues you thought you were avoiding with that model," such as the incompatibility problems often found when using data platforms are known to be different, he says. "Turning away from that opens the opportunity to choose systems that are more appropriate for the medical applications and environments in which they are used."

Above all, Hitchcock says, the risk manager needs to be alert to potential for EHR-related safety threats and be ready to address them just as thoroughly as with any other patient safety issue.

"Probably the most valuable thing a risk manager can do is to develop a root cause analysis program that is specially tailored to gathering the information necessary from the EHR issues for that analysis," he says. "They also need to give the EHR system the same benefit that they give people in a root cause analysis: not blaming them for the error, but looking for the root cause that allowed it to happen. People who implement and maintain EHRs can be very defensive, and they don't want a snap judgment that the system doesn't work."

Source

• Robert Hitchcock, MD, FACEP, Vice President, T-System, Dallas. Telephone: (972) 503-8899. ✦

Surgical quality collaborative saves $75 million in lower costs

Ten hospitals in the Tennessee Surgical Quality Collaborative (TSQC) have reduced surgical complications by 19.7% since 2009, resulting in at least 533 lives saved and $75.2 million in reduced costs, according to new results presented at the recent national conference of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP).

The hospital collaborative was formed in 2008 as a partnership of the Tennessee chapter of the American College of Surgeons and the Tennessee Hospital Association's (THA) Center for Patient Safety, with support from Blue Cross Blue Shield's Tennessee Health Foundation. ACS NSQIP is a nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care in hospitals. The program provides a prospective, peer-controlled, validated database of preoperative to 30-day surgical outcomes based on clinical data. Through the ACS NSQIP program, TSQC hospitals collected clinical 30-day outcomes data from 10 participating hospitals to examine and identify trends in and evaluate best practices. Between 2009 and 2012, participating hospitals collected data on more than 55,000 surgical procedures, and researchers examined rates of 17 types of surgical complications.

Compared with complication rates in 2009, participating hospitals in 2012 achieved 19.7% fewer postoperative occurrences ($p < 0.001$), and the postoperative mortality rate dropped 31.5% ($p < 0.001$). Hospitals prevented an estimated 3.75 deaths per 1,000 surgical procedures and avoided $75.2 million in excess costs.

13 of 17 complications improved

The collaborative saw improvements in 13 of the 17 types of complications, and nine improved significantly ($p < .05$).

The areas of most improvement included all types of surgical site infections, pneumonia, and urinary tract infections, which all dropped by approximately one-third.

"Our results show not only have Tennessee hospitals improved care, but we've been able to sustain those improvements over time," said **Brian Daley**, MD, MBA, FACS, lead author of the study and professor of surgery and chief of the Division of Trauma and Critical Care at the University of Tennessee Medical Center, Knoxville. "Our collaborative approach and use of robust clinical outcomes data through ACS NSQIP is an effective model for quality improvement across our state and nationally."

An earlier study based on TSQC data was published in the *Journal of the American College of Surgeons* in 2012. It showed the 10 TSQC members reduced complication rates and saved more than $8 million in excess costs from 2009 to 2010. This new study shows TSQC hospitals continued to improve in the years after the program was launched. In 2012, the collaborative expanded and now includes 22 Tennessee hospitals.

Oscar Guillamondegui, MD, MPH, FACS, chair of TSQC's leadership committee, said, "Participation in an ACS NSQIP collaborative is helping Tennessee hospitals accelerate their improvements by sharing data, comparing results, and evaluating best practices among peers." Guillamondegui is an associate professor of surgery and director of the Vanderbilt multidisciplinary traumatic brain injury clinic at Vanderbilt University Medical Center in Nashville, TN.

Craig A. Becker, THA president, said, "The TSQC has helped align the efforts of hospitals and surgeons around quality improvement, which supports the THA board's commitment toward zero incidents of preventable harm in our state's hospitals. This collaborative is an excellent example of how the hospital association, physicians, hospitals, and payers can work together to improve care using clinically valid measures in a cooperative way." ✦

Drug approved to treat rare disorder associated with anesthesia

The Food and Drug Administration (FDA) has approved Ryanodex (dantrolene sodium) from Eagle Pharmaceuticals for injectable suspension indicated for the treatment of malignant hyperthermia (MH), along with the appropriate supportive measures. Ryanodex can be prepared and administered in less than one minute by a single healthcare practitioner.

"When a patient experiences malignant hyperthermia during surgery, it is a life-threatening emergency requiring immediate treatment including the administration of the 'antidote' drug dantrolene sodium," said **Henry Rosenberg**, MD, CPE, a founder and president of the Malignant Hyperthermia Association of the United States (MHAUS). "The ability for healthcare professionals in hospitals and surgery centers to more quickly prepare and administer this new formulation of the antidote dantrolene sodium is expected to bring the crisis under control more rapidly and prevent severe complications from MH."

Ryanodex is the first significant enhancement to MH treatment options in more than three decades, and it has been reformulated to improve performance in managing MH. The product enables anesthesiologists to deliver a therapeutic dose of the only antidote for MH (dantrolene sodium) in a much more expedient manner than possible with existing formulations of IV dantrolene sodium.

Malignant hyperthermia is an inherited genetic disorder found in an estimated one out of 2,000 people. MH crisis situations are triggered by commonly used general anesthetics and the paralyzing agent succinylcholine and result in a biochemical chain reaction response in the skeletal muscles of susceptible individuals. General signs of MH crisis include increased heart rate, greatly increased body metabolism, muscle rigidity, and/or fever that might exceed 110 degrees Fahrenheit along with muscle breakdown. MH crisis mortality is extremely high without immediate recognition and treatment with the antidote.

MHAUS provides information and resources to medical and lay communities through conferences, educational materials, ID tags, 24-hour MH Hotline (800-644-9737), and the MHAUS website: http://www.mhaus.org. ✦

HRM makes move to per-issue testing

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COMING IN FUTURE MONTHS

✦ Newest information on alternative risk financing

✦ Seven Pillars approach to cutting adverse events

✦ Reducing risks with obstetrics cases

✦ Latest ways to address surgical fires

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. Scan the QR code below, or log on to www.cmecity.com to take a post-test; tests are taken after each issue. 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 test, 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 emailed to you instantly. ✦

CNE QUESTIONS

1. According to John C. Metcalfe, JD, FASHRM, vice president of risk management services with MemorialCare Health System, how does his facility ensure risk management coverage on off hours?
A. Risk management calls are directed to Department of Quality Assurance.
B. Risk management calls are directed to the in-house legal counsel.
C. Metcalfe is always the designated risk manager to call on off hours.
D. Off-hour call coverage is assigned weekly to one of the nine Department of Risk Management Services team members.

2. According to Metcalfe and other risk management leaders, how should staff be instructed regarding when to call for risk management on off hours?
A. Calls should be restricted to only the most extreme circumstances.
B. Staff members should call whenever they think the situation warrants risk management input, and they should err on the side of calling rather than not calling.
C. Staff members should call only when they already have contacted all managers in their own department.
D. Calls should be made only when risk managers are due back in the facility in more than 12 hours.

3. What does Billie Blair, PhD, an organizational psychologist and president/CEO of Change Strategists, recommend when meeting with top executives of your organization?
A. Expect to have about five minutes to make your presentation.
B. State from the outset that you would like 30 minutes to speak.
C. Prepare a 30-minute presentation, but be ready to go longer if the audience is receptive.
D. Present all of your background research before stating what you have concluded and your recommendation.

4. Research by Hardeep Singh, MD, MPH, patient safety researcher at the Veterans Affairs Center for Innovations in Quality, Effectiveness and Safety, revealed which of the following about electronic health records (EHRs)?
A. Almost all patient safety threats occur in the first three months of implementation.
B. Patient safety threats can continue to occur long after the implementation of an EHR.
C. Most EHR-related patient safety threats are now well documented.
D. EHR-related patient safety threats are mostly minor and not life-threatening.

Legal Review & Commentary

Expert analysis of recent lawsuits and their impact on healthcare risk management

Family members are awarded $7.9 million after botched gallbladder procedure causes death

By **Damian D. Capozzola**, Esq.
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While the procedure was underway, the patient awakened from the propofol and regained consciousness.

News: The patient, a 24-year-old woman, sought treatment from a hospital and was complaining of abdominal pain and related stomach problems. After admission, a physician prepared to perform an endoscopy to diagnose the stomach problems. An anesthesiologist gave the patient propofol as a sedative. However, during the procedure, the patient regained consciousness with the laryngeal mask airway (LMA) tube, used to keep her airway open and help pass oxygen into her lungs, still in her throat. Disoriented from the sedation, on awakening, the patient panicked and began to flail about. She gasped for air and screamed in pain for 20-30 seconds before falling unconscious. The patient went into acute respiratory failure and suffered cardiac arrest twice. She was unable to be resuscitated after the second arrest. The patient's family brought suit against the hospital, the anesthesiologist, and the anesthesiologist's practice. The family claimed that the patient's medical treatment was negligently performed. The defendants claimed that the care provided was appropriate. The jury found the physician and hospital liable and awarded the patient's family $7.9 million in damages.

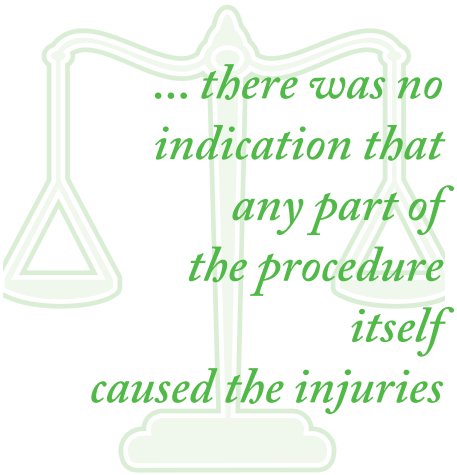
Background: In this matter, the patient was a 24-year-old mother of a 10-month-old son and was a local healthcare worker. She had been suffering from severe stomach problems for a few months and eventually sought treatment at a hospital in September 2009. The patient was scheduled to undergo an endoscopy by a surgeon to diagnose the stomach problems. Before the procedure, an anesthesiologist gave the patient propofol, a short-acting medication used to help relax patients before and during general anesthesia, or to provide moderate sedation during a minor procedure such as an endoscopy. The patient was not under general anesthesia. While the procedure was underway, the patient awakened from the propofol and regained consciousness. She still had the LMA tube stuck down her throat and began thrashing about on the operating table while in a panic. Witnesses stated that she was gasping for air and screaming in pain for 20-30 seconds before falling unconscious again. Her situation deteriorated quickly after this incidence. The patient went into acute respiratory failure and was airlifted to a nearby hospital. At this hospital, she suffered cardiac arrest, but she was successfully revived. However, she did not survive long. The patient became extremely sick on a respirator, went into cardiac arrest for a second time, and died as a result.

The patient's family brought suit against the anesthesiologist, his practice, and the hospital, The family alleged that the anesthesiologist was negligent during the procedure and the hospital was responsible for the negligence as well. The plaintiff's experts testified that the anesthesiologist's failure to intubate the patient before beginning the procedure was action falling below the standard of care. Intubation likely could have saved this

FINANCIAL DISCLOSURE: Author **Greg Freeman**, Executive Editor **Joy Daughtery Dickinson**, Nurse Planner **Maureen Archambault,** and coauthors **Damian Capozzola**, **Jamie Terrence** and **Tim Laquer** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

patient's life, even despite the shortcomings of the anesthesia. This opinion was largely based on the fact that the patient was 5-foot, 2-inches tall and weighed 270 pounds. Given the patient's significant weight, the plaintiff argued that a general anesthetic should have been used in addition to or instead of the propofol, as well as the endotracheal tube, to decrease the likelihood of complications. The plaintiff argued that because the anesthesiologist failed to perform these safety measures, the patient suffered catastrophic injuries and death. The defendants attempted to argue that the care provided was appropriate given the circumstances, but the jury disagreed. In a unanimous verdict, the jury found the anesthesiologist and hospital liable, and it awarded $7.9 million in damages.

What this means to you: The primary issue in this case was whether the anesthesiologist fell below the standard of care in sedating the patient for the procedure. Although the procedure was interrupted, there was no indication that any part of the procedure itself caused the injuries. Rather, the sole cause of injury was the patient awakening from the sedation, which was caused by the anesthesiologist's reliance on propofol and lack of consideration for the patient's current medical condition. In this case, the patient was obese. While obesity increases fat and lean masses, the percentage of fat tissue increases more than lean mass does. Drug and anesthetic dosages, including propofol dosages, need to be calculated based on the total body weight of the patient, so a patient who is obese must be given special consideration for proper medication dosage. Physicians must be sure to carefully take into account the patient's past and current medical condition while evaluating the proper course of treatment for any patient. In this case, the anesthesiologist improperly calculated or delivered the dosage for the sedation. The sedation wore off mid-procedure, which allowed the patient to wake disoriented. Another consideration should be that the anesthesiologist bases his or her determination of drug dosage on the patient's actual weight, not the stated weight. It is not uncommon for obese individuals to be unaware of, or in denial of, their actual weight. Many preop nurses will simply ask the patient what he or she weighs rather than have the patient stand on a scale during the admission assessment. Hospitals should ensure that physicians have access to the proper medical files for physicians to review a patient's history, but for conditions or statuses that are obvious upon casual observation, such as a patient's obese status, a physician should be able to recognize this status without any assistance.



Physicians and hospitals, while hoping for the best, should be prepared for the worst. Knowing what to do in the event treatments and procedures go wrong is a critical part of the job, particularly in a hospital environment where events happen quickly and seconds can make the difference between life and death. In this case, the anesthesiologist prepared the patient for the procedure, but he did not consider and prepare for what would happen if the propofol wore off, as it did. Had the anesthesiologist considered this, he could have prepared the endotracheal tube to decrease the chance of complications. Although redundancies are not always necessary, they can provide an extra layer of protection when a patient's condition is questionable.

This case also illustrates an important point regarding state tort reform laws. Many states have passed their own versions of tort reform, which can set caps for damages awards. These reforms, largely based on personal injury and medical malpractice cases, were enacted for the same reason that this supplement exists: to protect physicians and hospitals from enormous verdicts (in addition to lowering medical insurance costs). Such reforms have been and remain an issue of significant political contention. In California, for example, the Medical Injury Compensation Reform Act of 1975 caps non-economic damages (which include damages for pain and suffering, and loss of consortium) at $250,000, among other effects. The plaintiff's bar has long argued that this cap is so restrictive as to make it economically impractical for lawyers to bring many malpractice cases that otherwise have merit. In November, California voters will weigh in on a ballot measure to raise the cap to current inflation standards (slightly more than $1 million). The measure also seeks to crack down on drug and alcohol abuse by physicians. It requires testing and reporting of positive tests to the medical board.

As applicable to this case, Michigan's version of tort reform requires the courts to reduce any damages awards to the set caps: For a medical malpractice case, such as the one here, the court reduces non-economic damages, which includes permanent disability, disfigurement, and the vague pain and suffering, to less than $1 million. This process happens after the jury already has announced its verdict, and many individuals are not aware that this process occurs. Juries can award significant amounts for "pain and suffering" because any calculations proposed by the plaintiff can be inflated by a sympathetic jury. However, if the state has a cap in place on non-economic damages, the jury's award will be substantially nullified. Thus, while the jury awarded a total of $7.9 million, this patient's family will receive a significantly reduced amount, because a large portion of that total award was likely non-economic damages.

Reference:

Circuit Court of Wayne County, MI. Case No. 12-004153-NH. June 9, 2014. ✦

Birth injury results in brain damage and $14.5 million verdict from jury

News: The patient, a 36-year-old woman, was pregnant with her second child in 2003. Near the end of her second trimester, the patient went into labor three times and was admitted to a medical center for a total of 11 days, during which time her labor was stopped with medication and bed rest. However, six days after her third discharge, the patient's water broke, and she again was admitted to the medical center. She requested a caesarian section, but the nurse and residents on call did not believe it necessary. The attending obstetrician confirmed that monitors showed the baby was healthy. This status did not last, and the baby went into distress, requiring an emergency caesarian section. The baby suffered a massive brain hemorrhage, resulting in permanent injuries. On behalf of herself and her baby, the patient brought suit against the attending obstetrician as well as the medical center, and she alleged that both were negligent and failed to fully inform the patient of the risks associated with fetal distress. The physician and medical center denied any wrongdoing. The jury found the physician and medical center jointly liable and awarded the patient $14.5 million in damages.

Background: In this matter, the patient was a 36-year-old woman who was pregnant with her second child in 2003. Her first pregnancy, 11 years prior, resulted in an emergency caesarian delivery at 32 weeks gestation. The patient's second pregnancy took a similar course of events. During her second trimester, the patient went into labor three times beginning on March 20. She was admitted to a medical center on each occurrence, staying four days, one day, and six days, respectively. The medical center treated the patient with medication and bed rest, which stopped the labor temporarily each time. The patient was discharged for the third time on April 4. The patient consulted with her primary physician, and, given her history of pregnancy complications and early labor and delivery, the two discussed that she should have another caesarian section. On April 10 at 12:30 p.m., a mere six days after being discharged for the third labor incidence, the patient's water broke, and she was admitted to the medical center.

After admission, the patient requested that her baby be delivered via caesarian section soon. However, the nurse and residents on call did not grant her request as they believed it was not necessary at the time. The attending obstetrician visited the patient at 5:30 p.m., and again the patient requested to have the baby delivered via caesarian section. After the obstetrician checked the fetal monitors, he told the patient that the baby was healthy and that a caesarian delivery was not necessary. The baby's healthy status did not last though, as it later showed signs of distress. The patient did end up having an emergency caesarian section at 9 p.m., but by this time, the baby had suffered a massive brain hemorrhage. Evidence at trial showed that this hemorrhage occurred after 5:30 p.m. As a result of the hemorrhage, the child, age 11 at the time of the trial, suffers from cerebral palsy, cognitive delays, visual impairments, and other issues that require lifelong care.

The patient, on behalf of herself and her injured son, brought suit against the attending obstetrician and the medical center. The lawsuit alleged that the physician was negligent for delaying the delivery by failing to perform the caesarian section earlier, thus allowing for unnecessary time that allowed the baby to go into distress. Furthermore, the patient claimed that the hospital and the physician failed to inform her that there was a significant risk of a brain hemorrhage if the baby went into fetal distress. The physician and medical center defended on the basis that the baby was born premature, at just over 24 weeks into the pregnancy, and that nothing could have changed what occurred. Ultimately, the jury agreed with the patient and found the physician and medical center jointly liable for $14.5 million in damages: $8 million for the child's future medical care, $5 million for pain and suffering, $1 million for the mother's past medical care, and $500,000 for past economic losses.

What this means to you: Birth injuries, while uncommon, do occur despite best efforts of physicians and hospital staff, especially in cases of extreme prematurity. At 22 weeks, a fetus is not considered viable, but here, born at 24 weeks, the chance for survival was enough to allow this particular child to live with a significant amount of medical intervention. However, in this case, there was critical data available to the physician and staff that was not used to provide the safest delivery method for the mother and infant. If a medical professional deviates or fails to meet the standard of care, then medical malpractice likely has been committed, and the physician and hospital might be liable to the parents and/or injured child.

The primary issue becomes heavily factual, determining what the physician knew and did, along with what the physician should have known and should have done. Medical professionals must follow strict protocols in monitoring the child's vital signs and must take all necessary precautions to help prevent injuries during birth. All obstetrics patients should be monitored electronically during delivery; there is external monitoring that can measure uterine contractions and the fetal heart rate in response to them. The hospital staff and physician did take the proper steps to monitor the child, but these steps were insufficient. In this case, during a prenatal visit, the patient's primary physician had agreed that a caesarian section was necessary. The patient's medical history should have played a more critical role in the staff and physician's

determination of how to treat the patient. With the knowledge that the patient had previous issues with her first pregnancy, the physician should have been on notice and proceeded with caution while dealing with a new pregnancy.

Another consideration should have been the risks involved in vaginal birth after caesarian section (VBACs). VBACs risk uterine rupture and require the consent of the mother. Even though the fetus was small, uterine contractions still can put a stress on the uterus. In this case, this additional risk was not discussed, and consent was not obtained.

The American Congress of Obstetricians and Gynecologists (ACOG) has established guidelines for physicians to follow during labor. Perinatal risk is high. Hospitals spend more money defending "bad-baby" claims than any other type of malpractice. Obstetricians and other physicians that deliver babies, such as family practice and general practitioners, face higher insurance costs to protect their careers from these claims. If a physician fails to follow ACOG guidelines and a hospital allows the medical staff to practice outside of these guidelines, both might be held responsible for an adverse outcome, as seen in this case.

If the mother has had prenatal care, the physician and hospital must make arrangements to have those records available at the time of delivery. These records should be reviewed by the physician for data that might indicate a higher risk during delivery, such as issues in a prior pregnancy. Additionally, keep in mind that residents are students of their specialty, and their opinions should be evaluated by the more experienced attending before agreeing with them, especially when the patient's history was not known to the residents.

An important issue in this case relates to the fact that the physician did not fully inform the patient about her options and the risks associated with them. The patient requested a caesarian section early, but hospital staff and the physician believed the child was safe at that time. A patient's preferences should be given weight, but the ultimate concern of the physician is guaranteeing a safe delivery for mother and child. Reducing risks is extremely important, and all parties should consider different options before settling on one choice. Physicians generally must inform patients of all the risks and effects of procedures to allow the patient to make an informed decision.

Moreover, physicians should consider not only having clear and detailed discussions with patients about the pros and cons of various procedures, but documenting those conversations. Often this documentation is largely accomplished in connection with obtaining a patient's signature on a procedure consent form, but some physicians have a practice of writing out the various options on a sheet of paper during their communications with patients and then keeping that page in the file so that if ever an issue arises later, there is a written record of exactly what various procedures were discussed.

Reference:

Court of Common Pleas of Cuyahoga County, OH. Case No. CV-11-757131. June 25, 2014. ✦

Obesity malpractice claims up 64% in five years

Obesity-related lawsuits against providers have risen 64% in six years, according to a claims analysis by national medical liability insurer The Doctors Company, based in Napa, CA. Claims associated with obesity totaled 415 between 2007 and 2012, an increase of 64% in the number of such lawsuits from the period between 1992 and 2002.

The Doctors Company offers these tips for reducing obese malpractice claims:

• **Communicate.** Have open and clear communications. Obese patients should be warned of all the hazards associated with being overweight, including the nature and frequency of possible complications.

• **Document.** Document any and all discussions you have with a patient related to the need for weight loss.

• **Manage closely.** Provide intensive patient management. Develop criteria for preop management of the obese patient. Criteria are especially valuable for elective procedures.

• **Delay surgery.** When the patient doesn't meet the recommended criteria, suggest a delay in elective surgeries, with weight loss as a goal.

• **Obtain assistance from other specialties.** If faced with an emergent or urgent surgery, obtain as much help as possible from appropriate consultants in medicine, endocrinology, anesthesia, and other fields.

• **Strengthen the informed consent process.** A medication treatment plan should include an informed consent discussion on how the medication works, side effects a patient might experience, and the expected weight loss. Ensure the medical record properly reflects this discussion.

Discuss and document risks, benefits, and alternatives to treatment. The informed consent process becomes even more significant on emergent or urgent procedures. Convey the additional risks and complications, as appropriate to the procedure and patient's size.

• **Always perform bariatric surgery in a hospital.** Even when performed laparoscopically, bariatric surgery is almost always undertaken in a hospital setting. It requires properly trained and experienced staff in an operating room environment specifically designed to accommodate morbidly obese patients. Claims arising from bariatric surgery performed outside a hospital setting can be difficult to defend.

• **Be certain.** When in doubt, don't perform the procedure. More information on the study can be found online at http://tinyurl.com/pzaepyd.