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INSIDE

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Stored cord blood may not pose major risk, but some precautions necessary

New trend raises liability questions about storage, transport, security

Storing umbilical cord blood for future use is a relatively uncommon practice, but publicity from the general media and from several cord blood storage companies is increasing the chance that parents will come to your facility and expect this service. If they do, will your staff know how to comply without taking on significant liability?

Because most delivery units do not encounter the request at all, and it's rare even in the busy "baby factories," it is likely that your organization does not have a formal policy for handling such requests. More than likely, your staff just do their best to comply with parents' requests to preserve the blood and package it for transport to a storage unit. But now that more parents are hearing about the practice, it may be time to develop a formal policy to address potential liability for facilities delivering babies.

For the moment, the liability risks from stored umbilical cord blood appear minor but not altogether negligible, says **Greig Coates**, MD, JD, an attorney with Mithoff and Jacks law firm in Austin, TX. He previously practiced medicine and now is a malpractice attorney.

"A lot of the risk with this issue is theoretical, but if you have all the wrong factors at all the wrong times, I can see how this practice could cause problems for risk managers," he says. "I'd place it on the level of the many theoretical problems that can occur at your hospital but probably never will, and you still have policies and procedures in place just in case.

Executive Summary

Subject:
More parents are wanting to store their babies' umbilical cord blood for future use, and that raises liability questions.

Essential points:
- ❑ The practice is still relatively uncommon, but you should have a policy.
- ❑ Most risk management experts think the liability risk is low for health care providers, but that's true only if you avoid taking on some of the storage facility's risk.
- ❑ The importance of cord blood, and therefore the liability risks, may grow in the near future as more uses for it are discovered.

The problem is that this practice has sort of snuck up on some of us in this profession, and we have it going on without any policies to cover it."

Umbilical cord blood is stored as a sort of insurance in case the newborn gets sick in the future with a disease that can be combated with his or her own stem cells. The blood is taken from the placenta and umbilical cord and contains the stem cells, the building blocks of the blood and immune systems, which are found mostly in the bone marrow in adults. Recent advances in stem cell research have revealed treatment options for patients suffering from a range of blood-related disorders. **(See p. 44 for more on how stem cells from umbilical cord blood can be used.)**

It is unclear how much risk the delivery hospital has before custody of cord blood is transferred to a storage facility.

Several private companies around the country are promoting the option of stored umbilical cord blood to prospective parents and providing collection kits for them to take to the hospital at delivery time. The storage companies may take on substantial liability risk once the blood is in their hands, but it is not so clear how much risk the delivery hospital has before custody is transferred.

Storage errors unlikely to affect hospitals

The good news, Coates says, is that it's unlikely the hospital would be held liable if, years later, the cord blood is found to be unusable because it was handled or stored improperly.

"There are so many things that can go wrong from the time of collection to the time of thawing decades later, and it would be virtually impossible to show that something happening in your facility was the cause," he says. "Most problems are going to be related to storage, and that's not your responsibility."

Fortunately, your staff are in possession of cord blood just briefly, Coates says. As soon as they release it for delivery to the storage facility, your organization's liability risks should end right there, Coates says. That analysis is echoed by **Jeannie Sedwick**, ARM, risk manager with The Medical Protective Co. in Cary, NC, and a former president of the American Society for Healthcare Risk Management. She says you should focus on transferring as much potential liability to the storage facility as soon as possible.

"If a third-party contractor is going to take this material and be responsible for caring for it properly, then it's best to get it out of your hands and into theirs as soon as possible. Don't hold onto it at all, if possible," Sedwick says. "Once you turn it over to them with all the proper paperwork and sign-offs showing that it was done correctly, I don't think you have to worry about what happens from that point forward. Whatever happens, it can't be blamed on your staff."

Both Sedwick and Coates recommend establishing policies and procedures for responding to cord blood requests. **(See p. 43 for additional information.)**

Questions about future evidentiary use

The main liability questions seem to center on who would take the blame if a specimen turned out to be unusable, but there are other thorny issues to consider. For instance, is it wise for your staff to hand over cord blood to the parents when that blood could be evidence in a future lawsuit? Sedwick and Coates both say it does seem odd to send parents home with such valuable evidence, but on the other hand, the blood might not prove useful in a malpractice case no matter who has custody of it.

"Clinically, there isn't going to be a whole lot you can do with it later, after it's frozen and thawed," Coates says. "You can't freeze the pH level. Any evidence that is going to show up in a blood-gas analysis just isn't going to be there when a really intrepid attorney goes to dig it up years down the road."

It's unlikely the plaintiff's attorney will spring evidence on you that wouldn't have been available if the blood had not been stored. Coates does point out, however, one related problem that could be serious: If the doctor orders a

blood-gas analysis, but your overzealous staff provide the cord blood to the parents without noticing the order, the specimen may be released and the remainder of it destroyed before you obtain that critical evidence.

Only a small amount of blood is needed for the blood-gas analysis, so there is no conflict between doing the test and preserving the cord blood. Just make sure your staff doesn't overlook the testing order before officially handing over custody of the blood, Coates says.

Handing off the specimen to grandpa

Another odd aspect of cord blood storage is that your delivery staff will be handing over a potentially valuable specimen to lay parents, grandparents, or friends. Storage companies provide parents with collection kits and instruct them to deliver the specimen by mail, courier, or in person.

Proper care is important for preservation of the blood, and knowing that, some clinical staff could be uneasy about letting grandpa walk out with it. But Coates and Sedwick say there is no real alternative because you shouldn't take on the liability burden by mailing the specimen yourself.

Coates also points out that risk managers should look at all the potential liability risks as only the current risks with cord blood storage. These risks could grow, and new risks could emerge, as cord blood storage becomes more common and stem cells prove more useful in treatment.

"If, down the road, we get into gene therapy such that the stem cells could be put to much more use, the risks could be bigger than we anticipate now given the current use of the cells," he says. "The perceived small risk now could blossom with the advent of medical technology advances." ■

Sources

- ❑ **Greig Coates**, Mithoff and Jacks, 111 Congress Ave., Suite 1010, Austin, TX 78701. Telephone: (512) 478-4422.
- ❑ **Jeannie Sedwick**, The Medical Protective Co., 2000 Regency Parkway, Suite 295, Cary, NC 27511-8506. Telephone: (919) 467-8370.

Some paperwork, policies necessary for cord blood

Risk managers should not assume there is no need for action just because risk of liability from cord blood storage is relatively low, two experts agree. **Jeannie Sedwick**, ARM, risk manager with The Medical Protective Co. in Cary, NC, and a former president of the American Society for Healthcare Risk Management, and **Greig Coates**, MD, JD, an attorney with Mithoff and Jacks law firm in Austin, TX, believe risk managers should be prepared.

If your facility delivers babies, you should devise a policy and procedure for requests to store umbilical cord blood, they say. Your staff should be educated on why cord blood is stored, how the process works, and how they are likely to be confronted with the issue. Remind them that parents may alert them early they will be storing cord blood, or they may mention it for the first time in the delivery suite. Either way, your staff should be prepared to respond in a way that minimizes any liability risk.

Sedwick and Coates recommend the following:

• **Explain to staff that such requests must be accommodated.**

Even if you are uneasy about some aspects of cord blood storage, such as handing the blood over to a layman, refusing the request may be risky. Further, the liability risk is much higher if your staff refuse to cooperate because they are unfamiliar with the issue. The parents could sue, theoretically at least, on the basis that you discarded a substance that might have saved their child's life in later years. "Educating your staff about this should be a priority," Sedwick says. "If a mistake is going to be made, it is much more likely that it will be made by staff who just aren't familiar with storing blood."

• **Use a chain-of-custody log.**

Records should indicate when the baby was delivered, when the specimen was obtained, and when the specimen was turned over to a third party. That will help prove your staff handled the blood in a timely manner and document when your responsibility ended.

• **Have the third party sign a release form.**

When you give the blood to a parent, grandparent, or friend, have that person sign a release form indicating clearly the specimen is now that person's responsibility and not the hospital's. It

also would be wise to include a warning that the specimen must be handled carefully.

"It can be a standard type of release form, with some information noting that this is an important blood product and emphasizing the need for rapid, safe transport," Coates says. "The release should leave no doubt that the safety of the blood is no longer your problem once that form is signed." ■

Cord blood collection simple, quick procedure

Many clinicians are unfamiliar with the process of umbilical cord blood storage, so it is no surprise that most risk managers know little about it. This primer on the topic was compiled from information provided by several companies specializing in storage of umbilical cord blood:

• **Why is cord blood so special?**

Cord blood is rich in stem cells, normally obtained from bone marrow and used to treat a number of diseases. Unlike the stem cells obtained from a bone marrow transplant, stem cells from cord blood are from the patient's own body and are unexposed to most diseases and environmental stressors that may weaken an adult's stem cells. When cord blood is used instead of cells from a bone marrow transplant, there is much less risk of rejection because it's a perfect match, having come from the patient's own body years earlier.

• **How long has this practice been around?**

The first recorded use of umbilical cord blood was during a procedure in 1988 in France for a patient with Fanconi's anemia.

• **What are some uses of the blood?**

Cord blood can be used to treat a number of diseases, including leukemia, Hodgkin's disease, lymphoma, anemias, inherited metabolic disorders, myelodysplastic syndrome, and immune system deficiencies.

• **Does everyone agree it's a good idea?**

No, not everyone. Many clinical experts doubt whether the expense and trouble of maintaining a frozen blood specimen is worthwhile because there is little chance it will ever be used. Some see umbilical cord blood storage as overly cautious.

• **How is the blood collected?**

Cord blood is collected immediately after birth but before the placenta is delivered. Storage companies give parents collection kits to be used by delivery staff. Staff clamp and cut the umbilical cord in the usual manner and use a sterile syringe or blood bag to draw blood from the cord.

• **How is the blood transported?**

The blood is packed in special shipping material provided in the storage kit. Storage companies sometimes provide pickup service, but often they tell the parents to get the blood to them any way they can, including using a courier or personally driving it to the company's site. Most companies say cord blood must be delivered within 24 hours.

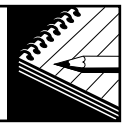
• **How long can the stem cells be stored?**

It is not known how long stem cells might be stored or how long they remain usable when thawed, but most experts expect they will survive long-term storage if handled properly.

• **How much does the service cost?**

Parents pay storage companies between $1,200 and $1,500 for collection and initial processing, then about $100 a year for storage. The hospital receives no compensation. ■

GUEST COLUMN



Reduce liability risk from personal harassment

By **G. Michael Barton**, SPHR
Vice President of Human Resources
Regional Medical Center
Madisonville, KY

(Editor's note: This is the second of a two-part article on the risks of personal harassment in the health care workplace. See the March 1999 Healthcare Risk Management *for the first part, which explains the nature of personal harassment and how it poses a liability risk for health care providers.)*

An effective effort to avoid personal harassment claims in the health care workplace will require an extensive look at your existing policies and procedures, and you most likely will have to modify them or establish new ones.

The effort is necessary because personal harassment violates the Civil Rights Act. Personal harassment can include any conduct that creates an intimidating, hostile, or offensive working environment, and employees can seek

Executive Summary

Subject:
To prevent personal harassment claims, you must establish a work environment in which intimidation and personal attacks are not tolerated. That will require an assessment, and probably a revision, of your policies and procedures.

Essential points:
- ❑ Your facility should have a zero tolerance policy.
- ❑ An assessment checklist is helpful **(see p. 47)**.
- ❑ Offenders may need to be transferred or terminated.

relief from the Equal Employment Opportunity Commission. To avoid that risk, health care employers must not allow supervisors to belittle, intimidate, or denigrate employees, and employees must not be allowed to engage in personal attacks, unwanted taunting**,** and other unacceptable behavior with co-workers.

Begin with an initial assessment of your existing policies and procedures to see if your institution already has addressed the issue in some manner. **(For a sample assessment checklist, see p. 47.)** After the initial assessment is completed, it is essential to amend current practices and policies.

Establish a zero tolerance policy

The first step is to clearly communicate to employees and supervisors that personal harassment will not be tolerated. As with sexual harassment, it must be firmly established that the organization has a zero tolerance for any behavior that creates an intimidating, offensive, or hostile working environment.

Your corporate compliance program is the perfect vehicle for defining acceptable behavior. Specifically, a code of conduct, which should be widely distributed to employees, should address this important issue.

Here is an example of an opening statement for a code of conduct: "A general code of conduct is established in order to provide a framework from which everyone in the organization can effectively work with one another. It will provide a basis from which trust, respect, honesty, and open communication can flourish. We shall maintain a working environment that is free of harassment of any type. Employees are expected to show proper respect and consideration for one another at all times."

The code of conduct also should establish these distinct responsibilities, which employees must support:

1. All managers should treat co-workers and employees with dignity and respect. This means managers and employees must identify objective methods for dealing with disagreements and problems.

2. Any differences in opinion should be referred to appropriate management levels for resolution and discussion.

3. All employees must be honest and forthright in their dealings with one another.

4. It is the responsibility of all employees to avoid intimidation in their interactions with co-workers. No individual should fear reprisals or be discouraged to give their input because of overt threats.

5. Reputation is important to all members in the organization. It is unfair to attach negative stereotypes to any individual.

6. Everyone's input is valued and should be respected regardless of length of service, position, age, personal appearance, or any other personal characteristic.

7. The organization shall provide reasonable training to employees to ensure they can perform their duties in a professional manner.

8. Any violations of the above responsibilities should be reported to the corporate compliance officer or human resources department.

Transfer may be necessary

Once you receive a report of personal harassment, you must take immediate corrective action. **(See story, p. 46, for advice on how to respond.)** Most individuals will take advantage of the opportunity to make a positive change in their behavior. In some serious cases, it may be necessary to transfer or even terminate individuals who are not committed to changing their negative behavior. Organizations can avoid such drastic action by providing ongoing training that focuses on how to deal with personal harassment.

An effective prevention program includes a commitment to ongoing training and communication. Diversity training seminars, which help managers, employees, and physicians deal with various age groups, nationalities, genders, religions, and racial distinctions, are an important first step.

The goal of diversity training is to teach employees how to respect and understand all individuals they encounter in the workplace. Such training should be mandatory for all employees and physicians.

Personal harassment should be part of this training. The more employees know about how destructive personal harassment can be in the workplace, the more likely it will cease to be a factor.

Technology doesn't eliminate the problem

As organizations become more high-tech, it will be more important to communicate that personal harassment will not be tolerated. E-mail, voice-mail, and the Internet will not eliminate the personal harassment issue.

Organizations must communicate consistently to employees the importance of treating each other with respect. All employees, regardless of age, status, race, gender, or how well liked they are by their supervisor or co-workers, should have the right to a positive and equal opportunity work environment.

When personal harassment is allowed to rear its ugly head, it can have a severe impact on employee morale and team productivity. It is a mistake to believe that we are going to like everyone in the workplace. It is an even bigger mistake to allow some individuals to destroy workplace harmony by unjustly harassing their fellow workers.

Personal harassment has now become an issue that organizations can no longer take lightly. It represents a serious challenge to the ultimate success of the organization. ■

Source

❑ **Michael Barton**, Corporate Vice President of Human Resources, Regional Medical Center, 900 Hospital Drive, Madisonville, KY 42431. Telephone: (502) 825-5100.

Take immediate action when violations occur

Five steps for investigating a complaint

By **G. Michael Barton**, SPHR
Vice President of Human Resources
Regional Medical Center
Madisonville, KY

Once personal harassment has been spotted, it is important to address it immediately. Follow these five steps when investigating a personal harassment complaint:

Step one: Find out what happened.

All individuals involved in the alleged harassment should be interviewed to pinpoint what occurred. A member of the human resources department or the corporate compliance officer should conduct the investigation.

Step two: Develop a corrective action plan.

If it is determined that a violation occurred, a corrective action plan should be developed that identifies what is appropriate to rectify the situation. For example, if it is determined that a supervisor harassed an employee, the action plan may include using appropriate training resources to assist the individual in recognizing and correcting the inappropriate behavior.

Step three: Establish clear goals.

In the above example, the supervisor must demonstrate clearly that employee relations have improved after the training is completed. This could be determined by using confidential surveys or individual interviews with employees, conducted by the human resources department or the corporate compliance officer.

The immediate goal should be to resolve the employee's complaint as quickly as possible. All other goals should focus on improving the work environment and eliminating the threat of personal harassment.

Step four: Set a timetable.

The individuals involved should have a specific time limit for taking corrective action. In serious cases, there should be a short timetable to resolve the complaint, such as immediately or within 72 hours. The timetable should never exceed 90 days because the original action soon will be forgotten. Obviously, making an organizationwide change involving personal harassment will involve a longer time frame. The

Sample Assessment Checklist for Personal Harassment

- ❑ Are there areas experiencing high turnover?
- ❑ Has management received any training regarding personal harassment?
- ❑ Has management discussed with employees the ramifications of personal harassment?
- ❑ Have employees received training regarding personal harassment?
- ❑ Are there any current practices by management or physicians that could contribute to creating an intimidating, hostile, or offensive work environment?
- ❑ Do employees feel managers interpret and enforce policies consistently?
- ❑ Are promotion and transfer policies free of personal bias?
- ❑ Does the organization have a code of conduct in place?
- ❑ Does a grievance or problem-solving procedure exist for employees to voice concerns confidentially?
- ❑ Has the organization communicated to employees that no form of harassing behavior will be tolerated?
- ❑ Has an employee ever reported personal harassment?
- ❑ Is the organization committed to providing training and making the necessary changes to address personal harassment?

Source: Regional Medical Center, Madisonville, KY.

timetable should not be open-ended in any case. Personal harassment is an important issue and should receive immediate and consistent attention.

Step five: Determine whether the plan was successful.

Interview all parties involved in the alleged harassment to make sure the complaint has been resolved. If the complaint involved a supervisor, monitor the supervisor's behavior and determine if changes were made.

If the complaint involved an employee, make sure there is a commitment to sustain the changed behavior. Gather information from various members in the work group to determine if the problem truly has been rectified. ■

Workplace bullying can be dangerous liability

Campaign aims to end the practice

Bullying in the workplace should not be dismissed as trivial, especially because it can lead to expensive litigation by frustrated employees. That's the message of the Campaign Against Workplace Bullies, a group trying to stamp out a dangerous practice that many supervisors assume is no more serious than a schoolyard spat.

Even bullying in the schoolyard can be serious, but many health care risk managers assume that bullying in the workplace is just a personal matter between co-workers, seeing no reason to intervene. That's a big mistake, says **Gary Namie**, PhD, coordinator of the national campaign. He says recent rulings in personal harassment law make it clear that employers will be held responsible for bullying by co-workers, or even by patients. The Campaign Against Workplace Bullies is a nonprofit organization based in Benicia, CA.

Harassment that ignores usual boundaries

Namie defines bullying as "a deliberate, destructive interpersonal harassment which ignores gender, rank, race, and age boundaries." Those distinctions set bullying apart from sexual harassment and other forms of abuse that would instantly raise a red flag for risk managers. Namie contends, however, that bullying can be just as dangerous and result in substantial exposure for the employer. The good news is that there are ways to stop it.

"The economic benefits from reducing exposure to liability from misconduct by bosses or co-workers, leading to a hostile work environment, certainly appeal to executives and risk managers in any organization," Namie says. "Fortunately, employee stress also is improved by reducing stress and its physical complications."

Namie says the group's research indicates that 25% to 66% of employees witness or experience bullying, with the most common effects being emotional stress, depression, and post-traumatic stress syndrome. About 75% of those bullied are chased from their jobs, leaving the employer open to major financial liabilities and the expense of replacing workers.

Source

❑ **Gary Namie**, Campaign Against Workplace Bullies, Benicia, CA. Telephone: (707) 745-6630. Web site: http://www.bullybusters.org.

To reduce bullying and its liability risk, the group urges employers to take part in a program called the "Challenge." Participating employers will receive the Workplace Bullying Liability Management System, which includes a training program, a conduct code that forbids bullying in the workplace, and methods for recognizing, punishing, and monitoring bullies. Participants agree to submit data to the campaign for use in future research.

As a special incentive to participate, consultants working with the campaign will provide services to participating employers at a 50% discount during 1999. ■

Federal crackdown puts damper on overpayments

Recently released statistics may prove what risk managers know from firsthand experience: When the government starts showing up at hospitals with armed agents and threatening every conceivable punishment for Medicare overbilling, people tend to pay attention.

It is no surprise that Medicare overbilling has dropped significantly in the past year, on the heels of a fierce campaign by federal regulators to eliminate widespread fraud. Risk managers already could see that the campaign was working, but the numbers released recently by the U.S. Department of Health and Human Services in Washington, DC, show just how successful the campaign has been. Regulators announced that improper Medicare payments to hospitals, doctors, and other health care providers declined dramatically last year to the lowest error rate since the government initiated comprehensive audits three years ago.

The error rate for fiscal year 1998 was an estimated 7.1%, representing estimated improper payments of $12.6 billion, according to a copy of the report obtained by *Healthcare Risk Management*. That compares with an error rate of 11% in fiscal year 1997, representing an estimated $20.3 billion, and 14% in fiscal year 1996, representing an estimated $23.2 billion in improper payments.

That's a 45% reduction in improper payments in only two years. Auditors from the Office of the Inspector General arrived at those figures with the support of medical experts, who helped review a comprehensive, statistically valid sample of Medicare fee-for-service claim expenditures and supporting medical records to determine the accuracy and legitimacy of the claims. They looked at a statistical selection of 600 beneficiaries nationwide with 5,540 claims valued at $5.6 million and determined that 915 of the claims did not comply with Medicare laws and regulations.

By projecting the sample results over the universe of Medicare fee-for-service benefit payments, which totaled $176.1 billion during the 1998 fiscal year, the regulators calculated that $12.6 billion was the midpoint in the estimated range of improper payments.

The improper payments ranged from inadvertent mistakes to outright fraud and abuse, but the portion attributable to intentional fraud could not be quantified. Two major problem areas were identified: billing for services that were not medically necessary and upcoding services to secure a higher reimbursement than was justified. Those problems accounted for about $9.3 billion of the estimated $12.6 billion in improper payments. Another $2.1 billion in overpayments was attributed to documentation discrepancies, and the remaining $1.2 billion was traced to billing for services not covered by Medicare, along with various other errors.

Hospitals, physicians, and home health agencies accounted for more than 77% of the improper payments, with about 39% of the erroneous claims attributable to hospitals, nearly 26% to physicians, and nearly 13% to home health agencies. The rest of the improper payments were traced to skilled nursing facilities, nonprospective-payment system hospitals, laboratories, end-stage renal disease centers, ambulance companies, ambulatory care centers, durable medical equipment suppliers, and hospices, in that order.

Examples include a community mental health provider that was paid $21,421 for services later determined by medical reviewers to be medically unnecessary. In another case, a skilled nursing facility billed Medicare $10,428 for a 51-day skilled nursing stay by an elderly patient, but medical records showed the patient received maintenance-

level, unskilled care. In a third case, a physician billed Medicare $871 for 40 hospital visits when the medical records showed only 18 visits.

[Editor's note: For more information or a free copy of the report, contact the Department of Health and Human Services at (202) 690-6145 or go to the Web page at http://www.hhs.gov.] ■

Physicians warned about home care equipment

The latest growl from the Medicare watchdog is directed toward possible fraud by physicians approving expenses for home care services. Consider yourself warned.

The U.S. Department of Health and Human Services' Office of the Inspector General (OIG) is issuing a special warning to physicians that they should authorize only necessary medical equipment, supplies, and services for Medicare beneficiaries. Inspector General June Gibbs Brown issued the Special Fraud Alert recently, saying the government was concerned about physicians inappropriately ordering equipment, supplies, and services for Medicare patients. The alert cautions physicians not to order items for patients as a courtesy without first determining medical necessity. The alert also warns against signing false or misleading medical certifications and/or accepting any form of kickbacks for signing off on Medicare items and services.

"A physician is not liable for erroneous claims due to mistakes, inadvertence, or simple negligence," Brown said in a press briefing. "However, knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil, and administrative penalties."

The Fraud Alert notes that any orders for durable medical equipment or other supplies for Medicare beneficiaries must include this information: beneficiary's name and address, physician's signature, date of the order or prescription, description of items needed, start date, diagnosis, and a realistic estimate of the length of time the medical equipment will be needed by the patient. Drug prescriptions require the same information.

The warning was prompted by recent data in an OIG report showing that 40% of home health claims were improper. ■

Guidance issued on use of restraints, seclusion

Two leading professional organizations have issued guidelines to help minimize the use of restraints and seclusion in behavioral health services. The guidelines suggest it may not be possible, or even necessary, to eliminate the use of restraints and seclusion altogether, but that each instance must be carefully justified and monitored.

The advice was prompted in part by a recent analysis of sentinel events by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Restraints and seclusion have drawn increased attention from family members and consumers in recent years, and regulatory bodies such as the JCAHO increasingly are looking at restraint and seclusion as a sign of poor quality of care. Federal hearings on restraints and seclusion are planned for spring 1999.

The American Hospital Association (AHA) and the National Association of Psychiatric Health Systems (NAPHS) issued the guidelines recently to help hospitals prevent death and injury related to the use of restraints or seclusion.

The AHA and NAPHS both serve on the Joint Commission's board-level task force on restraint and seclusion, which is holding public hearings this spring and will make recommendations on any needed changes to current restraint and seclusion standards. The groups also are working with the American Psychiatric Association to identify best practices.

Infrequent, emergency use of restraints

This is the advice from the AHA and NAPHS:

- A patient's overall treatment should be based on a comprehensive, individualized treatment plan that includes appropriate patient and family involvement.
- Hospitals and other treatment settings serve individuals with severe mental illnesses and substance abuse problems who are, at times, dangerous to themselves or others.
- Restraint and seclusion should be used as infrequently as possible and only when less-restrictive methods are considered but are not feasible.
- Restraint and seclusion are emergency interventions that aim to protect patients in danger of

harming themselves or others and to enable patients to continue treatment successfully and effectively.

• Prevention of injury and death is essential.

• Hospitals and other treatment settings must ensure that staff are well-trained and continuously educated regarding the proper use of restraint and seclusion. Detailed policies, procedures, and systems must be developed with input from physicians and other mental health professionals, and they must be understood and followed by all staff.

System assessment needed for improvement

To improve and reduce the use of restraints and seclusion in your facility, the AHA and NAPHS suggest you organize a team to make a systemwide assessment of your restraint and seclusion policies and procedures. The team should include key clinical staff such as the medical director, quality assurance director, program directors, director of nursing, and intake director, along with key administrative staff such as the administrator, marketing or public relations director, security director, and others.

This type of review should be part of your organization's continuous quality improvement process, with the review conducted frequently. Frequent reviews will help ensure that policies are up-to-date and followed by all employees.

Groups favor these program components

The AHA and NAPHS conclude that restraint and seclusion can be life-saving and injury-sparing emergency interventions when used properly. The two groups recommend these components of a good program:

• policies and procedures on how to employ restraint and seclusion safely (including understanding the risks and benefits of intervening and not intervening);

• a process for continuously reevaluating the need for restraint or seclusion;

• a process for continuous monitoring to ensure patients' safety and other needs are met;

• a policy requiring that a physician (or other licensed practitioner as permitted by state law) should authorize use of restraint or seclusion in a timely manner. This licensed clinician must be involved in the decision to continue the use of restraint or seclusion;

• consideration of the safe and appropriate use of medication as an alternative to restraint and seclusion and in reducing the length of any episode;

• a system for assessing and understanding the needs of patients before they enter treatment;

• well-trained and adequate numbers of staff to handle the complexity of the patients served;

• a clinical strategy for intervening as early as possible before behavior has escalated to a point requiring seclusion or restraint;

• a system for carefully and routinely monitoring use of restraint and seclusion so you can evaluate ways to reduce its use in the future.

In reviewing your current policies and procedures, the AHA and NAPHS suggest looking at the following factors:

• assessment activities (such as preadmission screening, history of aggressive behavior or assault, previous experience of restraint or seclusion, history of trauma, review of triggers, input of family and others);

• development of an individualized, comprehensive, multidisciplinary treatment plan that addresses issues identified during the assessment process with focused attention to the needs of special populations (such as children, adolescents, elderly, and developmentally disabled);

• role of patients, family, and others, as appropriate, in the development of the treatment plan;

• consideration of the use of medication in both the ongoing and emergency treatment of the patient;

• staff development with special emphasis on management strategies, assessment, identification of early signs of behavioral change, early intervention / crisis prevention techniques, de-escalation techniques, specific implementation of restraint or seclusion procedures (with opportunities for regular drills or practice), safe care and observation of patients in restraint or seclusion, review and analysis of restraint and seclusion episodes with attention to impact on patients, staff, and others;

• comprehensive plan for monitoring performance improvement that includes appropriate goals for reducing use of restraint and seclusion, collection and analysis of aggregate data with attention to trends, and analysis of efficacy and appropriateness;

• review of accrediting and regulatory bodies'

Sources

- ❑ **Kathleen McCann**, RN, DNSc, NAPHS Director of Clinical Services, 1317 F. St., N.W., Suite 301, Washington, DC 20004. Telephone: (202) 393-6700, ext. 11.
- ❑ **Karen Milgate**, AHA Senior Associate Director of Policy, 325 Seventh St., N.W. Washington, DC 20004. Telephone: (202) 626-4628.

(JCAHO, the Health Care Financing Administration, state law, local departments of health, etc.) requirements;

• review of the procedures for reporting routine information as well as for reporting critical and sentinel events;

• plan for soliciting and incorporating feedback, as appropriate, from consumers and families regarding their experience of restraint and seclusion;

• plan for managing concerns or complaints of patients, family members, and consumer groups regarding restraint and seclusion.

[Editor's note: Free copies of the guiding principles may be obtained from NAPHS by calling (202) 393-6700, ext. 15.] ■

Justice sues Columbia/HCA for false Medicare claims

In the latest chapter of the government's crackdown on fraud, the U.S. Department of Justice announced recently it had filed suit against Columbia / HCA Healthcare and Quorum Health Group for alleged false Medicare claims.

The action follows the Justice Department's decision last fall to join a whistle-blower lawsuit brought against the companies. The suit was filed in U.S. District Court in Tampa. Justice Department spokesman **Chris Watney** says the suit alleges that 220 Columbia / HCA hospital and 34 Quorum Health Group facilities committed fraudulent billing practices.

Once it filed suit, the government requested a stay in the case against Columbia / HCA because the parties had been discussing a settlement. ■

Joint Commission, CARF to improve joint survey

The Joint Commission on Accreditation of Healthcare Organizations and CARF…The Rehabilitation Accreditation Commission are beefing up their agreement to jointly evaluate freestanding medical rehabilitation hospitals.

The two groups began offering a combined CARF / Joint Commission survey option in 1997, involving a modest level of integration of the separate survey processes of the two organizations. The newly enhanced combined survey process creates efficiencies by providing a greater coordination of the on-site survey activities, including joint staff and patient interviews, review of key documents, and daily briefings with the hospital leadership. Following pilot-testing and final refinements in November 1998, the enhanced combined survey is now available to all freestanding

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Source

❑ **Millie Perich**, Associate Director, Cooperative Accreditation Initiative, Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5709.

rehabilitation hospitals scheduled for a survey in 1999 and thereafter.

A complimentary manual with guidelines to the survey process, the interview schedules, and a comparison of Joint Commission and CARF standards is given to freestanding rehabilitation hospitals upon receipt of their applications for a combined survey. Each accrediting body will continue to render its own decision, issue its own survey report, and charge its customary survey fee. ■

Smart tips for avoiding patients' narcotics fraud

Some patients will be crafty about seeking improper narcotics prescriptions, but preventive measures can make it much harder for them to succeed, according to **Debra McBride**, JD, assistant vice president for risk management at Midwest Medical Insurance Co. in Minneapolis.

McBride spoke on the topic at the recent meeting of the American Society for Healthcare Risk Management in San Diego, noting that patients often call after hours and use various ploys to convince the on-call physician a prescription is appropriate. Some patients alter legitimate prescriptions to obtain more than the prescribed number of pills.

She suggests clinics have a clear policy on how to handle such requests for narcotics refills. The policy is particularly important for after-hours requests. Over-prescribing of narcotics, she adds, is a liability risk, and these preventive steps can greatly reduce the chance of patient injury and malpractice claims for over-prescribing:

• Write initial prescriptions only after examining the patient.

• Process refill requests only during clinic hours and inform your patients of that policy.

• Refill controlled substances only with the approval of the original ordering physician.

• Handle off-hours requests for narcotics by prescribing a very limited quantity, possibly only enough to get the patient through the night. An alternative is to refer the patient to the emergency department for evaluation.

• Document all prescriptions and refills on the medication record to prevent over-prescribing.

• Urge your staff to avoid using digits for medication quantities. The word "ten" cannot be altered to "100" the way the figure "10" can. Use the word "none" for refills, not "0."

• Document when established patients make inappropriate refill requests by indicating that the refill was denied. If you see many such entries for a patient, consider patient counseling.

• Keep medications / prescription pads locked up. Report thefts of drugs or prescription pads. ■

Source

❑ **Debra McBride**, Assistant Vice President for Risk Management, MMIC, 6600 France Ave., No. 245, Edina, MN 55435. Telephone: (612) 922-5445. Fax: (612) 922-7323. E-mail: Debra.mcbride@mmic.com.