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INSIDE

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A reimbursement lesson is in order as Medicare changes raise ICU payments

Department budgets, staffing levels may benefit from shift to managed care

For most hospitals, managed care just got bigger. As Medicare phases in a sweeping managed care plan, some critical care nurses are advocating a greater participation by colleagues in reimbursements — a move that could directly affect department budgets and staffing levels.

Recent changes in the taxpayer-financed health insurance program establish a new way to pay hospitals for everything from nursing care to X-rays. For hundreds of providers nationwide, the difference will mean potentially millions of additional dollars in reimbursements.

Insurance payments are something that nurse managers and their staff have traditionally left to others, says **Sandra Swanson**, RN, MSOD, nurse manager of the neonatal intensive care unit at The Ronald McDonald Children's Hospital in Maywood, IL. But the changes in Medicare, which are already being felt by hospitals, will affect the financial picture for resource-intensive units such as critical care.

Most insurers and managed care organizations (MCOs) know a great deal about general surgery and medicine, but they know virtually nothing about what occurs in a critical care unit, Swanson says. Yet, these same payers determine reimbursement contracts that affect how much your hospital will be paid. In turn, those amounts influence nursing budgets in critical care and how many staff and technicians you are

EXECUTIVE SUMMARY

Should ICU managers play a bigger role in reimbursements? As Medicare shifts to managed care, some nurses advocate more involvement in payment issues by ICUs. But traditionalists worry their involvement will distract from patient care. Proponents argue that:

- Unit managers show little taste or knowledge for reimbursement matters.
- Recent dramatic changes in Medicare policy signal continued fluctuation in hospital budgets.
- Inefficiency and human error abound regarding reimbursements.
- Nursing schools follow a possible trend by adding managed care to curricula.

allowed to retain in your department, she adds.

Nurses such as Swanson stop short of suggesting that ICU managers get involved in billing or contract negotiations. However, managers should have a practical knowledge of how the managed care system works, Swanson observes. If they can play even a small role in helping a hospital's financial outlook, the effort ultimately will benefit their ICUs.

In the process, they may learn exactly why they face such pressure to get patients in and out sooner and improve their performance on readmissions and length of stay, she adds.

A process of self-education

A few years ago, Swanson made the effort to educate herself, reading everything she could find on managed care. Her reading list consisted of business journals, health industry publications, and the daily press.

"I felt that nurses needed to take the initiative, to understand the basis for all the complaints about managed care," Swanson says.

One discovery she made early was that hospital and payer groups know very little about each other.

Traditionalists stick to the belief that nurses should stay out of reimbursements. The underlying fear is that an involvement in payments will diminish their primary focus, which is patient care, says **Patricia Johnson**, RN, MS, a nurse practitioner in Phoenix. Until recently, Johnson served as interim executive director of the National Association of Neonate Nurses in Chicago.

"The health care system is geared so that nurse managers are held accountable for costs, not reimbursements," Johnson adds. As a result, critics of the situation say nursing administrators are getting only half the picture regarding hospital finances.

Swanson makes clear that hospital administrators don't deliberately keep nurses in the dark. It's up to nurses as individuals to do more to keep pace with managed care. "If they don't, who will?" Swanson asks. **(See story on increasing your knowledge of managed care, p. 63.)**

The Health Care Financing Administration must have asked itself the same question. Over the past three years, the agency, which administers the Medicare and Medicaid programs out of Baltimore, helped Congress amend the federal Social Security Act (via the Balanced Budget Act of 1997) and set in motion Medicare's transition into a full-blown managed care system.

Health care policy wonks have described the change as something of a quiet revolution. The changes aren't likely to affect the clinical aspects of care rendered to ICU patients. "Despite years of complaining, managed care has brought more discipline to patient care," Johnson acknowledges.

The Medicare reimbursement changes will directly affect the bottom line for ICUs. According to Johnson, in a system rife with flawed, inconsistent data, wouldn't it be nice to know that the hospital is getting properly paid? **(See story on changes in Medicare on p. 64.)**

Johnson echoes the sentiments of other veteran nurses: "No one at any hospital I know seems to know what is going on in reimbursements," she says. "There are people issuing bills who have no idea what they are billing for."

Government cracks down on alleged fraud

Indeed, the number of claims issued for services that were never rendered or improperly billed has triggered federal investigations. Since 1995, more than 500 hospitals have been accused and fined for allegedly over-charging Medicare. In most cases, human error — not intentional fraud — was to blame.

The nursing profession as a whole is trying to become a bigger participant in managed care. The American Nursing Association in Washington, DC, has a working group on Medicare, which drafted its own plan for Congress to save the system.

Some nursing schools may be ahead of the trend. In 1995, The University of Nebraska Medical Center's College of Nursing in Lincoln introduced managed care principles to its Bachelor of Science degree curriculum.

The training focuses on clinical aspects of patient care in a managed care environment, but it signals a beginning in effective, cost-conscious nursing care, says **Kathleen Duncan**, RN, PhD, assistant professor of nursing.

The exposure involves two semesters of course work and activity training in a variety of managed care subjects, including patient classification systems in acute and post-acute phases of illnesses, critical pathways, and patients-as-customers strategies.

The training, dubbed The Continuum of Care Experience, helps future nurses develop critical thinking skills by making them "active participants in their learning" about managed care, according to a 1998 study of the program published in the journal *Nurse Educator*.[1]

"Nurses don't need to get involved in billing issues, but they should be introduced to managed care financing," says Duncan. "You can't work in health care today and not be at least concerned about the economic viability of your unit."

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Managed care numbers game can help ICU outlook

Use your patient data to strengthen unit finances

Those who say managed care is a numbers game are inherently correct, according to **Sandra Swanson**, RN, MSOD, nurse manager of the neonatal intensive care unit at The Ronald McDonald Children's Hospital in Maywood, IL.

Ironically, in critical care, most hospitals and managed care organizations (MCOs) do not keep good data to measure cost according to patient acuity. Consequently, they are incapable of making accurate assessments about payments for ICU care, she adds.

The process used by MCOs to determine payment rates is both complex and esoteric. Health plans use insurance actuaries to determine what it probably costs to render medical care by diagnosis at a specific hospital, and they negotiate payment rates on these calculations.

The key term is "probably." Says Swanson, "MCOs don't understand what critical care units do from a cost standpoint. They don't know what data sets are significant and what to do with these numbers in setting rates." Hospital officials themselves have difficulty defining cost-effective care in the ICU.

The reasons are obvious, according to nurse practitioner **Patricia Johnson**, RN, MSN, former interim executive director of the National Association of Neonate Nurses in Chicago. Critical care units have high patient acuity, severe morbidity, and high mortality rates, compared with other departments.

Yet, the process of setting ICU rates involves studying volumes of patient data and making comparisons with national and local benchmarks, including Medicare and Medicaid morbidity and mortality statistics. Much of this data are available free or at a price; but in most cases, they aren't hospital-specific.

Nurse managers are in a good position to change the situation, according to Swanson. Here's how:

- **View your patient data in a new light.** By seeing the unit's performance data as a financial resource, you can consider the relevance of reimbursements to patient care, Swanson says. For example, the data you generate on readmission rates, average length of stay (ALOS), average cost per admission, and discharge or diagnosis are hospital-specific quality indicators that can help determine more equitable payments for you facility, Swanson says.
- **Work with your hospital to understand the numbers.** The probability is great that administrators don't know how to interpret your ICU's performance, Swanson notes. Critical care is a special situation.

Reduce return appearances

A short length of stay in your ICU may sound great on paper, but it means something else if patients are readmitted within 48 hours because you got them discharged too soon, Swanson observes. Less focus on lowering ALOS and more on appropriate discharge planning may reduce repeat admissions costs and boost quality and patient satisfaction, she adds.

- **Determine what's important in managed care**. Learn the language through reading and discussion groups, Swanson adds. Find out what health plans mean when they agree to "risk withholds" or when they pay within a "risk corridor." Understanding these concepts will help explain administrators' insistence on early discharge planning.

Risk withholds are portions of payments kept by plans and paid later if providers meet expected targets. Risk corridors are specific limits under which payers will pay for medical care. They usually refuse to pay, or pay at a lower rate, beyond the stated corridor. The more you know, the more effective you will be as a manager, Johnson states.

- **Question the status quo.** Many contracts pay ICUs on a per diem basis. The fixed, packaged-pricing per diagnosis is meant to cover the cost of each day of inpatient care. But in reality, per diems pose a disincentive to lower lengths of

stays, says Swanson.

Most nurses know that the last few days of ICU care are the cheapest. The patient is usually stable and nearing transfer. "These are the days when the hospital can actually make money. There's actually no motivation to cut your LOS," she observes. Hospital officials need to know these effects on payments when negotiating equitable contracts. ■

ICU payments may rise as Medicare attempts fairness

New payment method based more on acuity

As of 1999, Medicare has officially made the transition from a largely cost-based payment system to one built on fixed payments for inpatient care.

The program, dubbed Medicare+Choice Plus, officially kicked off in January and will be phased in over five years. For critical care nurses, the change involves important financial issues, including:

• **More fairness in hospital payments.** By replacing the existing complex formula for setting payment rates to managed care organizations (MCOs), the Health Care Financing Administration (HCFA), which administers Medicare, says it has finally brought more fairness to inpatient reimbursements.

Under the old system, MCOs received payments based on regional economic factors, such as area wage and cost figures. Under the new method, patient acuity will be the basis for setting rates. Critical care units are expected to benefit.

• **Greater relevance to actual patient utilization.** New rates will be set by competitive bidding and based on actual patient utilization. The information will be taken from each hospital's database. In prior years, the agency depended on aggregate statistics to set rates.

As part of the change, your hospital is likely to be paid an amount based on the degree to which your unit actually serves its patients. That could mean higher or lower payments depending on your patient volume, according HCFA.

• **Higher payments for critically ill patients.** Units that care for critically ill patients will probably be paid more than what they currently receive under cost-based Medicare. They will also receive more than medical-surgical departments, according to **Trinita Robinson**, MA, a managed care analyst with the Health Care Financial Management Association (HFMA) in Chicago. The professional society is composed of health care financial executives.

And certain services rendered to the critically ill will be paid more than others, Robinson adds. For example, end-stage renal disorder will be paid at a higher rate than other disorders, due to the resource intensity of providing care to these patients. But these are statistical differences and may result in no actual increase to certain providers. The rate will be based on the total number of high acuity patients admitted in a one-year period, Robinson says.

• **More emphasis on hospital-specific diagnostic data.** The managed care system effectively diminishes the use of diagnosis-related groups (DRGs) of illness classifications, or the well-known DRGs, in paying hospitals. DRGs have been the cornerstone of Medicare's traditional cost-based fee-for-service system and will continue to be offered as an option to some beneficiaries (those who may not qualify for enrollment in an HMO).

The new system shifts the focus to the amount of financial risk a provider or health plan assumes in treating more seriously ill patients. Critically ill cases are more expensive to treat and therefore will receive higher payment rates. But a hospital's costs also will be considered, which may raise payments for some providers.

The rates will be based on a system called principal inpatient diagnostic cost groups (PIP-DCGs). The PIP-DCGs will replace the area-wide wage and cost calculation, which is called the average adjusted per capita cost (AAPCC) method.

• **More emphasis on grouping payments into lump sums.** Payments will be set at a fixed amount for every Medicare patient enrolled in the HMO. In some places, the amount will be a pre-paid per member-per month (PMPM) rate. In others, a per diem or case rate will form the payment base. The difference will be determined by the contract. In all cases, the payment rate will reflect the PIP-DCGs. Most ICU care is reimbursed per diem.

All hospitals will receive an annual rate increase of up to 2%. For some providers, the change will mean an increase in reimbursements. But other facilities may see their payments drop. "The system flipped the tables on most hospitals," Robinson says.

Hospitals that struggled from year to year with

virtually no increases due to their areawide economic status will likely see their reimbursements rise by a designated 2% across the board. Others that enjoyed a 10% per year rise will be disappointed.

Other factors that will determine actual payments include: a plan's administrative costs, the size of the plan's enrolled population, and the mix between singles, couples, and families covered by the same plan. Overall, "payments will become fair over time. But it won't happen overnight," Robinson says.

(Editor's Note: To obtain more details on the Medicare+Choice Plus rates, log on to HCFA's Web site at www.hcfa.gov/stats/hmorates/aapccpg.htm. Also, contact HFMA regarding managed care information at www.hfma.org.) ■

Is there a normal healing rate for wounds in ICUs?

Set aside special time to re-assess interventions

Intensive care nurses should set aside a special period of time each day for assessing wound management strategies with other members of the clinical team. Discussions with physicians, nutritionists, and respiratory therapists should be appropriately timed to avoid interfering with daily patient assessments or other business, according to a surgeon who authored a study on ICU wound management.

The additional time will be worth the effort, says **Douglas M. Geehan**, MD, assistant professor of surgery at the University of Missouri School of Medicine in Kansas City.

Time for discussion

By setting aside more time, nurses will have the freedom to fully assess prescribed interventions, make necessary alterations to care plans, and discuss particular factors about a patient's progress, Geehan explains.

The notion that patients will respond to therapies according to predictive timetables can be misleading, Geehan adds. It assumes that wound management techniques can be subordinated on a list of other "more important" patient-care considerations.

In fact, the progress of wound healing affects other morbidities and therefore requires special attention, Geehan states. One study indicates that wound infection increases hospital stays by nearly 10 days.[1]

Although there is a "normal" healing rate for wounds, "there is enough variability to make it difficult for us to say that any wound is healing normally," Geehan states.

However, there may be systems for predicting infection rates. A joint study conducted by the University of North Carolina in Charlotte and Baylor University Medical Center in Dallas attempted to establish predictive measures in the development of sternal wound infections.

Researchers identified 19 risk factors most often associated with sternal wound infections (SWIs) in the ICU including gender, obesity, impaired immune responses, preoperative ICU stays, and hypotension or hypoperfusion in the ICU.

The scale produced more than 62% correct predictions of infection and non-infection. A more advanced version of the scale (with 21 factors) produced 72.8% correct predictions. According to the research, making proper patient diagnoses for risk can lead to higher predictability.[2]

Nurses in step-down or telemetry units can quickly complete the predictive infection scale by reviewing the patient's chart and identifying which risk factors apply to the patient, states the study.

In the SWI project, assigned scores were given to each risk factor. If a score was higher than 27 (numerical value is arbitrary) — which is the cut score on the SWI scale — the patient was at risk of developing infection, researchers state.

No one healing protocol effective with wounds

However, the scale is only relevant to sternal wounds and not to other wound infection types, says **Barbara Leeper**, RN, MN, CCRN, an ICU nurse at Baylor and study investigator. It also predicts the infection rate, not necessarily the healing rate for wounds, she points out.

Interventions can vary dramatically, so nurses should be vigilant about varying degrees of healing, Geehan states. A wound that is left open rather than immediately closed doesn't necessarily mean a setback in healing time, he adds.

Geehan identifies three forms of wound healing strategies **(see chart on p. 66)**:

- **primary intention;**
- **secondary intention;**
- **delayed primary closure.**

ICU Wound Management Terminology

TERMINOLOGY	DEFINITION
Primary intention	Cut edges of the wound are closed (directly approximated). Wound is not left open.
Secondary intention	Cut edges of the wound are left open. Wound develops granular tissue, re-epithelialization, and contraction prior to closure.
Delayed primary closure	Wound is initially left open. Debris is eliminated, infection cleared, granulation initiated prior to closure. Timing of closure is variable but can be accomplished within five days.
Clean	An operative classification describing absence of inflammation; may call for surgical entry into gastrointestinal, respiratory, or genitourinary tract if urine is infected.
Refined clean	Clean case considered elective and closed primarily without drainage.
Clean contaminated	Minor entry/try into genitourinary tract if urine is infected.
Contaminated	Major entry required. Acute bacterial inflammation without pus; spillage from gastrointestinal tract, fresh traumatic wound.
Dirty	Presence of pus; perforated viscus; old traumatic wound.

Source: Geehan DM, Pemberton LB. Management of wounds and wound infections in the intensive care unit. *Crit Care Nurs Q* 1997; 20:69-78.

Some wounds require immediate approximation (closure) while others may be left open. Differences in dressing changes and antiseptic use in cleaning can also alter the degree of "normal" healing, Geehan says.

For this reason, a strict adherence to a multidisciplinary team in carefully assessing wounds is highly recommended, he adds.

"The management of a patient in the ICU who has a significant wound or a wound infection requires the synthesis of multiple areas of knowledge and skill" to return the patient to a normal state of function in the least amount of time, Geehan says.[3]

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States tighten grip on ICU's patient restraints

Creating protective care plan can meet compliance

While the use of physical restraints in the ICU has been an accepted practice at most hospitals, critical care nurses are being cautioned about a growing trend. States are taking a firmer stand in discouraging the application of wrist and leg restraints, regardless of safety concerns for patients.

"Critical care units have not been exempted from the laws," warns **Vanessa Alvarado-Greer**, RN, MSN, CCRN, an adult nurse practitioner at the Veterans Affairs Central California Healthcare System in Fresno, CA. Regulatory agencies are asking for more proof that the use of restraints was warranted, she says. Nurse managers will have to supply that proof when it's requested.

The heightened demand is resulting in additional documentation and proof of proper authorization for every incident of restraint use. Nurses

Compliance Guidelines for Physical Restraints

- Explain to the patient and/or family use of restraint as a safety measure.
- Apply restraint over the patient's gown.
- Ensure that restraints have not been applied too tightly or too loosely and can be released with one pull.
- Secure the restraint to the bed frame, not the railings.
- Document the patient's condition every two hours on a standardized protective care plan of car.
- Release restraints for 10 minutes every two hours.
- Provide educational materials to patient and family.
- Obtain a physician's order when initiating restraints and when they are renewed every 24 hours.

Source: Vanessa Alvarado-Greer, Veterans Affairs Hospital, Fresno, CA.

are also required to maintain constant checks on patients to re-evaluate the situation hourly or at shorter intervals. **(For suggested regulatory compliance guidelines, see chart above.)**

Providers have to prove threat of self-injury

In California and several other states, extended care facilities are barred from physically strapping down patients to a chair. But acute-care hospitals are permitted to use restraints to prevent agitated patients from injuring themselves under certain conditions.

However, providers will have to prove there was a threat of self-injury, and a written physician's order explicitly stating the reasons for the restraints must be available in the medical record, Alvarado-Greer says.

Restraining an agitated patient to a bed has never been standard practice, even for critical care, she says. Alvarado-Greer has taught courses on patient protective care for hospital personnel.

In the ICU, extremely agitated patients may have their wrists and sometimes their ankles tied to bed frames with foam or leather ties when they have attempted to extubate themselves or tamper with cables or tubing.

But nothing in the literature shows that the use of physical restraints increases patient safety in the ICU, Alvarado-Greer says.

"Because there is no evidence in the research, we don't have any jump-off point, except to say that we've all been using them," she adds.

Patients who suffer extreme anxiety or pain in the ICU are most likely to be restrained. Use of restraints may actually exacerbate these conditions and result in increased heart rate, respiration, arrhythmia, and oxygen consumption. Nearly 90% of ICU patients experience anxiety or agitation.

Instead of implementing physical or pharmacologic interventions, clinicians should determine *why* the patient is anxious or agitated and take appropriate steps to remedy the problem, Alvarado-Greer observes.

If restraints are warranted, a standard protective care plan form should be used by nurses that encompasses 12 to 24 hours of monitoring and covers the following:

- **A clear description of the patient's observable problems.**
- **Objective of the physical restraint intervention.**
- **A patient assessment.** Is the patient confused, anxious, agitated, combative, etc.? Assess pain or agitation on a scale of 1 to 4. Record time of each assessment.
- **Explanation of possible reasons for the agitation or pain.** Is there hypoxemia due to a low hemoglobin or hematocrit? What is the oxygen saturation? Are there possible metabolic reasons for the agitation, such as an electrolyte imbalance?
- **Patient/family response to restraint use.** Does the patient understand the potential for self-injury? Is family support available?
- **Description of results of initial or primary intervention.** Are tubes or lines moved out of reach? Was comfort therapy applied, i.e., pillows, reduced noise, relaxation exercises, music therapy, frequent repositioning, family visits?
- **Assessment of primary intervention.** Was intervention successful? If not, why?
- **Medication interventions.** Were medications administered? Did physician order it? When? What types of medications? Was medication effective? Respond on a sedation scale of 1 to 5. The time and date of this intervention must be recorded.
- **Physical or secondary interventions.** What type of restraint was used, i.e., left or right wrist, left or right ankle? What time were they applied?
- **Protective care maintenance log.** What time interval was used for each visual check of patient? The patient should be visually checked every 15 minutes, and physical needs met every

two hours such as water, bathroom visits, and skin integrity.

Finally, a patient must only be secured to a bed or chair that has wheels for fire safety reasons, Alvarado-Greer says. When securing a restraint to a bed or chair, the knot must be an easy-release hitch that can be undone by the pull of one tie. Leather belts with metal buckles are not to be used, she adds.

"Vendors are developing new and better products for physical restraints such as Gore-Tex materials and elbow restraints that free the patient's wrists while restricting their reach," Alvarado-Greer says. "These are helping to reduce the added anxiety caused by the restraints." ■

Avoid patient bottlenecks with these helpful hints

Consistent controls can reduce gridlock

It often takes a crisis to make things work. Getting patients transferred out of the intensive care unit on a smooth timetable is every manager's wish, but more often it's a quagmire. Patient gridlock in critical care units is getting worse, says **Linda Kosnik**, RN, MSN, chief nursing officer at 450-bed Overlook Hospital in Summit, NJ.

Patients can await transfer to a step-down floor for up to 10 hours while other cases are held up in trauma or the emergency department pending admission. The bottleneck slows down everyone and everything, says Kosnik.

Yet, when a crisis occurs, such as a natural disaster, it's surprising how efficiently the system can work, adds **Nancy Levy**, RN, MPA, Overlook's unit manager for adult critical care. Suddenly, patients are transferred promptly, there are ample open beds downstream, and capacity in the ICU seems to emerge from nowhere. Why can't things work that way under normal circumstances?

Patient gridlock is people-created problem

They can, according to a study of ICU operations conducted by the Institute for Health Care Improvement. Like most operational problems, patient gridlock in the ICU is a people-created situation, according to the group. The Boston nonprofit investigates ways to implement effective strategies in health care.

Overlook participated in the Institute's groundbreaking study of adult ICUs along with more than a dozen other acute-care hospitals. After analyzing the patient gridlock problem, the organization presented a set of operational improvements, which it called "process changes."

Hospitals that have implemented those changes tend to experience fewer gridlock problems, according to Levy. Two of the study participants, including Overlook, suggest the following:

• **Prepare patient transfer orders well in advance.** Most ICUs find this process difficult. But the reason has to do with inconsistent oversight. The unit charge nurse has to be well informed and effective in keeping track daily, even hourly, of a patient's readiness for transfer. "She has to stay on top of things," Levy says.

Having the orders done during the previous evening or night is a good idea, says Levy. This means planning 24 hours in advance with the patient's attending physician. Nurses usually have only one opportunity to discuss the pending transfer with the attending physician, and that time is during early morning rounds. Most delays, as every nurse knows, occur when the attending physician fails or is too busy to review the notes and give a signed approval to move the patient out of the ICU. Many of these suggestion are included in a 1998 Institute report on process change.[1]

• **Consider retaining intensivists.** Hospitals with full-time intensivists on each shift have solved this problem. The intensivist can review the notes during the night and sign the orders, Levy says. By morning, the patient can be cleared for transfer.

The advance work also will give the charge nurse ample time to coordinate a bed availability with the step-down floor, Kosnik adds. But to make this work, nurses within the ICU and on the receiving floor have to be willing to work in sync, she says.

If the hospital won't retain an intensivist, empower residents and nurses working as a team to make the diagnostic assessment ahead of obtaining the necessary transfer approvals. This can shorten the time involved by the attending physician in reading the patient notes and filling out the transfer documents. The purpose would be to speed up the approval process not to give residents and nurses transfer authority, Levy states.

• **Establish an open ICU.** An open unit policy can make admissions and discharges simpler. The patient's own physician can be responsible for the patients discharge plan, says **Michael C. Witte**,

DO, medical director of the ICU at Mercy Hospital Medical Center in Des Moines, IA.

Some critical care specialists have touted multidisciplinary assessment teams as effective. During morning rounds, the team can collectively identify patients early who may be ready for transfer that afternoon or the following morning, Witte says. "The literature shows that they can be effective in getting appropriate patients out sooner and lowering lengths of stay as well," he adds.

• **Use point-of-service (POS) testing.** Hospitals are improving their record on testing by moving more technology to the bedside. The institute found POS testing can significantly reduce delays and bottlenecks. Overlook administrators have supplemented these changes by giving critical care official priority in all patient testing, moving the pharmacy closer to the ICU, and emphasizing collaboration between ICU personnel and others such as lab staff and respiratory therapists.

• **Transfer patients before, not during or after, shift changes**. The reason should be obvious, says Levy. There is too much confusion during shift change. Delays on one shift may cause further delays on the next, Levy adds. Some nurses say that an oncoming shift is better staffed or better able to implement transfers "because it's quieter," Kosnik says. Nevertheless, patients who are ready should be transferred at the earliest possible time, she stresses.

• **Develop dedicated capacity for high-volume activities and procedures**. "Predict the need and develop the dedicated capacity," the Institute report indicates. This involves ensuring that physicians are up-to-date at all times on the 20% of patients who are most likely to be sicker or not responding to optimal care than others, Witte says.

On that basis, identifying patients who are likely to transfer within 24 hours can be easier. The average ICU stay ranges around five days, which is down from 10. That alone should help yield indicators on transfer candidates, says Kosnik. To prevent bottlenecks in times of urgent need, at Overlook nurses keep track of at least one patient who can be transferred as the need arises. The status of the patient is re-checked hourly to assess changes, Levy notes.

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Denver hospitals braced for worst during shootings

Blend of luck, professionalism make the difference

Hospitals that received most of the wounded in the Columbine High School shootings in Littleton, CO, initially thought they would run out of intensive care beds in trying to accommodate the expected number of wounded victims. Initial reports from the scene indicated dozens of victims in need of immediate transfer to area hospitals.

In fact, the number ultimately admitted to each of the intensive care units (ICUs) was far less.

"Fortunately, we received only four in our ICU. Three went straight to surgery. A fourth was admitted to the pediatric ICU," recalls **Vicki Owens**, RN, nursing operations manager of the emergency department and surgical ICU at Denver Health Medical Center. The hospital was one of three Denver-area facilities that received the most seriously wounded.

Minutes after the first news reports filtered in, hospital staff performed a quick bed availability assessment and began coordinating with all floors on patient triage and transfers to make ICU beds available, Owens says.

At Centura St. Anthony Central Hospital, 15 miles away from the school, officials anticipated going into disaster alert based on early casualty reports. "That's how bad we thought things would be," recalls **Cindy Elger**, RN, clinical nurse manager of the surgical ICU.

The 12-bed unit ultimately admitted two patients. A third was sent directly to a step-down floor. All three needed surgery to repair internal injuries.

Staff had close connection with school

And at Swedish Medical Center, the hospital closest to Columbine High, three of the four worst cases were admitted to the ICU following surgery. But at least a dozen more were treated in the emergency department and either released or admitted to general medical floors, says **Ann Randall**, RN, director of patient care for the critical care unit.

"The first of the patients was admitted from surgery at about 3 p.m.," Randall recalls. (The shootings began at about 11:30 a.m. Denver time.)

Officials at the three hospitals credited a combination of luck, professionalism, and strong

community spirit for results that day. "Many of us at the hospital grew up in this community. Some of us have kids who go to Columbine High. All of us were in shock and disbelief that this could happen here," Owens told *Critical Care Management*. "But it brought us together."

Fortunately, staffing wasn't a problem. Nurses and other ICU personnel arrived for work early once they heard the news reports; and at Swedish and Denver Health, there were extra nurses on hand due to inservice programs originally scheduled that day.

Emergency department physician Chris Colwell, MD, was among the first clinicians on the scene with paramedics and triaged most of the patients to area hospitals. "He did a great job to make sure no one hospital got overloaded," Elger says.

Aside from the initial anxiety, the hardest part involved coping with the crush of people, the nurses stated. Families were searching for their children. The media, police, and curious hospital employees made a tense situation unintentionally worse, Randall recalls.

The April 20 shooting rampage claimed 15 lives, including the two gunmen, who died of self-inflicted gunshot wounds at the scene. ■

ICU nurses run risk of being sued for malpractice

Attorney advises some to get insurance

Critical care nurses are being advised that they may become the targets of a new generation of malpractice lawsuits filed against health care providers by disgruntled patients or family members. Plaintiffs are beginning to go beyond suing physicians and hospitals for mishaps sustained during their patient care experience.

As a result, critical care nurses should consider obtaining malpractice liability insurance to protect them from potential lawsuits, according to a former nurse, who is now a health care attorney.

Nurses today are more likely than ever to be named as defendants in a malpractice case, says **Ruthe Catolico Ashley**, RN, JD, a health care attorney in Sacramento, CA. Critical care nurses are especially vulnerable due to the high morbidity and acuity levels of patients under their care, Ashley says.

While 90% of medical malpractice cases generally don't get to trial; of those that do, few are dismissed, says Ashley. The percentage of cases that are ultimately litigated is high enough to raise concerns for nurses that they face considerable risk, she adds.

As nurses achieve more authority and clinical decision-making responsibility, the public's perception is that they also should be held accountable for clinical outcomes and unforeseen occurrences, Ashley notes.

Nurses are vulnerable outside the workplace

"Nurses are directly in the line of fire," says Ashley, who spoke to an audience of critical care nurses last month at the American Association of Critical Care Nurses National Teaching Institute annual meeting in New Orleans.

Ashley says she can't point to any one landmark case that illustrates the growing exposure by nurses to malpractice suits. But she indicates that the number of cases in which nurses' names appear as defendants shows a growing trend.

Nurses are particularly vulnerable to so-called "scope of employment" suits, she indicates. These are malpractice claims filed against nurses when they render medical care to people in need while off duty.

According to Ashley, "it is imperative that nurses are aware that when they respond to ethical and professional responsibilities beyond the scope of employment, they also assume the legal duty with all the ramifications of liability that accompany it."[1]

In 1997, nearly half (40%) of medical malpractice awards involved monetary

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damages exceeding $1 million. Plaintiffs won 35% of cases filed for misdiagnosis. Forty percent were won for surgical negligence. Cases involving the patient's death comprised 23% of the total number of plaintiff verdicts.

The average malpractice award involving a patient exceeded $2.1 million. The figures come from Jury Verdict Research, a Horsham, PA, firm that tracks civil lawsuits. **(The chart below shows additional annual figures.)**

The number of malpractice suits filed against all health care providers is undergoing a change, according to Carol Golin, publisher of a Glenview, IL, periodical *Medical Liability Monitor*. Malpractice premiums are declining over all due to large-scale mergers in the malpractice insurance industry.

Ashley recommends that some nurses consider obtaining malpractice coverage if they believe they run the risk of being sued due to the nature of their job. A hospital or physician's insurance coverage isn't likely to protect a nurse. In most cases, a potential conflict of interest discourages a hospital from extending its coverage to the nursing staff, Ashley notes.

Hospitals aren't likely to want to be viewed as culpable for a nurse's alleged mistake or wrongdoing, Ashley explains. A nurse should not expect to receive protection from his or her employer.

In fact, the American Nurses Association (ANA) has long maintained that nurses cover themselves against potential medical liability. Even if a hospital or physician settles in a case, other aspects of the case may still hold a nurse responsible, says **Winifred Carson**, JD, the ANA's legal counsel in Washington, DC.

Reference

1. Ashley RC. Avoiding malpractice — beyond the scope of employment. *Jou Nurs Law* 1997; 4:45-49. ■

Most Common Injury Claims in Medical Malpractice

Year	Award Median	Probability Range	Total Range	Award Mean
1987	$ 318,000	$ 238,500 - 477,000	$ 340 - 30,000,000	$ 911,413
1988	300,000	85,000 - 869,110	1 - 22,000,000	908,686
1989	348,607	115,000 - 977,500	88 - 54,791,243	1,202,109
1990	431,125	135,975 - 1,185,000	500 - 28,700,000	1,476,314
1991	415,544	145,225 - 1,248,546	2,776 - 21,700,000	1,434,587
1992	350,000	116,418 - 1,246,000	1 - 90,300,000	1,729,289
1993	500,000	157,750 - 1,500,000	2,274 - 72,650,000	2,003,068
1994	375,000	121,375 - 1,000,000	1 - 53,492,800	1,201,437
1995	500,000	175,500 - 1,400,000	1,000 - 98,337,338	2,090,369
1996	500,000	150,000 - 1,638,667	950 - 35,600,000	2,051,052
1997	551,750	225,000 - 2,053,561	1,350 - 40,924,000	2,189,089

Most Common Injury Claims in Medical Malpractice ... This analysis of plaintiff verdicts in medical malpractice cases indicates that the most frequently claimed injury was death. Death cases accounted for 23 percent of the total number of plaintiff verdicts, while severe brain damage, emotional distress and spinal nerve injuries being the second, third, and fourth most frequently reported injuries, each accounted for 4 percent of the total. Mild to moderate brain damage made up 3 percent of the total, while arm/leg amputations, breast cancer, and burns each made up 2 percent of the total. All other injuries each accounted for 1 percent or less of the total number of plaintiff verdicts.

Source: Jury Verdict Research Series. *1998 Current Award Trends in Personal Injury.* Horsham, PA: LRP Publications; 1998. Used with permission.

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Four nurses fired for refusal to treat patient

Issue related to $5-an-hour pay dispute

In a sign of the worsening effects of the nurse shortage in critical care, four registered nurses in California were fired by their hospital in April for refusing to treat a critically ill patient. Their refusal, according to hospital officials, stemmed from a $5-an-hour wage dispute.

Officials of 242-bed Community Memorial Hospital in Ventura, CA, dismissed the nurses following an investigation on April 19 into violations of hospital nursing policy. The four RNs were assigned to the emergency department (ED). They allegedly refused to care for the critically ill patient who was awaiting transfer from the ED to the intensive care unit. The incident occurred shortly after the RNs reported for work on Saturday morning, April 17.

According to **Carol Dimse**, RN, Community Memorial's assistant executive director, the nurses refused to take responsibility for the case allegedly because they had not been given a $5-an-hour increase that had been previously granted to nurses in the ICU.

The RNs performed their regular duties in the ED, but refused to care for the critically ill patient despite being told to do so by the nurse manager on duty, Dimse says.

The nurses were not sent home. However, the department had to be assisted by RNs from other critical care floors until the patient was transferred to the ICU, Dimse told *Critical Care Management.* The following Wednesday, the hospital fired the four nurses. The nurses could not be reached for comment.

Dimse indicated that during the investigation, the nurses acknowledged their refusal to provide care was based on a dispute over pay. Earlier in the month, the hospital agreed to demands from its ICU nurses for a $5-an-hour wage increase that would match a similar raise given to ICU nurses at a neighboring hospital, St. John's Regional Medical Center, in Oxnard.

Nurses at Community Memorial's ED then requested a similar increase. According to Dimse, the hospital was about to grant the ED nurses the same raise (each time they cared for a critically ill patient) until that happened.

"The incident surprised everyone," Dimse says. "Using a patient as a pawn over money was completely inappropriate. The entire nursing staff is repulsed by this."

As *CRM* went to press, hospital officials planned to give nurses in the ED the proposed pay raise but added that the four RNs would not be rehired.

According to John Masterson, a Community Memorial spokesman, the incident reflects the tensions stemming from a severe critical care nurse shortage in the local hospital community. Earlier this year, St. John's Regional was forced to close certain critical care beds and had to offer the wage increase to attract nurses to its ICU. ■

CE objectives

After reading each issue of *Critical Care Management,* participants in the continuing education program should be able to:

- identify particular clinical, administrative, or management issues related to the critical care unit;
- describe how those issues affect nurse managers and administrators, hospitals, or the health care industry in general;
- cite practical solutions to problems that critical care / intensive care managers and administrators commonly encounter in their daily activities. ■