Healthcare Risk Management®

Celebrating our 25th year as your first source of risk management information. 25th year

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

DECEMBER 2003
VOL. 25, NO. 12 • (pages 133-144)

EMTALA: It's here, it's new, and it's still prompting questions for risk managers

ASHRM hot topic is on the minds of many

One of the hottest sessions at the recent meeting of the American Society for Healthcare Risk Management (ASHRM) in Nashville, TN, addressed the recently issued final rule for the Emergency Medical Treatment and Labor Act (EMTALA). Questions came fast and furious from the standing room-only crowd, showing that risk managers still have plenty of questions about what the law means and how it will apply to their unique situations.

The final rule, which was to clarify all the questions surrounding EMTALA, didn't cover all the bases, according to **Daniel J. Sullivan**, MD, JD, FACEP, president of the Sullivan Group, a consulting company in Oak Brook, IL, that specializes in EMTALA interpretation. He told ASHRM attendees that the Centers for Medicare & Medicaid Services (CMS) promised to make EMTALA easy to understand, but "in the end, when they were faced with some difficult questions, they mostly copped out."

That failure left risk managers wondering how to apply the law in specific situations, he says. Some trepidation is warranted, he says, and advises risk managers not to let their guard down regarding this law. In fact, Sullivan says, you may need to step up your EMTALA education program.

"You need to educate your on-call physicians regarding EMTALA," he urges. "They haven't been educated much before, and they don't understand why they can't make the transfer decision. If they think the final word is theirs when they're called at 1 a.m., you can get into a lot of trouble."

Can violate EMTALA if physician won't come

Some hospitals have begun including a mandatory one-hour EMTALA education session as part of the re-credentialing system for physicians, Sullivan notes. Such education efforts are important because the on-call physician can be a weak link in your EMTALA plan, he adds. Even if everyone in your emergency department (ED) or obstetrics unit responds

properly, the EMTALA violation can occur if the on-call physician refuses to come in and see the patient when necessary, Sullivan says.

Physicians who refuse to come in may force you to transfer a patient to another hospital for care, yet the hospital has little power to force that physician to get out of bed, Sullivan notes. You may hold the physician responsible after the fact, he says, but by then you may have transferred a patient who could have been treated at your facility. That often will constitute an EMTALA violation, he says.

However, it is sometimes acceptable to transfer a patient who could be treated if the physician on call came to the hospital, Sullivan says. The determining factor is why the physician recommended a transfer instead of coming to the hospital. "It's 3 a.m., and I don't want to deal with it" is never a good reason, but EMTALA is not violated if the physician advises that the patient would receive better care at another facility.

Reason for transfer is paramount

For instance, consider a patient who arrives at an ED not equipped to handle trauma. The initial presentation suggests minor injuries from a motorcycle accident but then tests reveal free air from a ruptured intestine, elevating the case to trauma. When the surgeon on call is queried about the case, he or she refuses to come in and says the patient should be transferred to the nearest trauma center. Is that an EMTALA violation?

Not necessarily, Sullivan says. Sure, the surgeon probably is capable of addressing the known problem — the ruptured intestine — but there also is reason to think the patient could need other services such as a urologic surgeon and a generally higher level of surgical care. If the hospital's policy is to transfer all such trauma cases because you never know what else they will need, EMTALA does not prevent the transfer, Sullivan says.

"It depends on why the patient is being transferred. If you're doing it because the patient will receive better care, that's acceptable," he says. "Now if Hospital B refuses to accept the patient because they think Hospital A's on-call physician should have come in, then *Hospital B* is violating EMTALA because they have special abilities and must accept those transfers."

Transfers vs. transports

Sullivan also points out that EMTALA makes an important distinction between *transfers* and *transports*. The former involves moving a patient from one health care provider to another. It requires a good reason and paperwork. The latter is considered merely a practical consideration, like moving a patient from one department to another.

What many risk managers don't know, he says, is that multiple facilities under one Medicare provider number can *transport* a patient from one facility to another without EMTALA transfer paperwork.

"It's not an EMTALA transfer because CMS sees them all as different facilities on one campus, even if they're all over town," Sullivan says. "This means that if a visitor collapses in your pediatric emergency department, you can transport that patient to your regular ED miles away

Healthcare Risk Management® (ISSN 1081-6534), including **HRM Legal Review & Commentary**™, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Healthcare Risk Management**®, P.O. Box 740059, Atlanta, GA 30374.

Healthcare Risk Management is approved for approximately 18 nursing contact hours. This offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $519. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 18 CE nursing contact hours, $569. Two to nine additional copies, $415 per year; 10 to 20 additional copies, $311 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

Editor: **Greg Freeman**, (770) 998-8455.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@thomson.com).
Production Editor: **Nancy McCreary**.

Editorial Questions

For questions or comments, call **Greg Freeman**, (770) 998-8455.

instead of having to treat him where you only have pediatric equipment. You're still expected to provided all the necessary first aid, of course, but it's not an EMTALA transfer."

Most urgent care centers covered

Hospitals and health systems also may need to provide more EMTALA education to urgent care centers, Sullivan says. There was some debate initially as to whether the final EMTALA rule covered urgent care centers, but he says the answer now is a definite yes for most urgent care centers. The final rule establishes three criteria that can be used to define a "dedicated emergency department," a term that makes a facility subject to EMTALA:

1. It is licensed by the state as an emergency room or ED.
2. The facility is held out to the public as providing care for emergency medical conditions without requiring an appointment.
3. During its previous calendar year, it has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.

That third criterion means that nearly all urgent care facilities are included, Sullivan says.

"They don't know this. You need to go tell them," he says. "They are not tuned in like emergency facilities are, but they carry the same risks. They must coordinate their EMTALA plans with the main campus."

(Editor's note: Watch for more coverage of the ASHRM meeting in upcoming issues of HRM.) ■

Visit *HRM*, *ED Legal Letter* site

We now offer free on-line access to www.hrmnewsletter.com for *Hospital Risk Management* subscribers. The site features current and back issues of *HRM* and *ED Legal Letter*, also from Thomson American Health Consultants.

Included on the site and in its archives are links to every article published in *HRM*'s *Legal Review & Commentary* supplement from January 1999 to present.

There also are links to every article published in *Healthcare Risk Management*'s *Patient Safety Quarterly* and *Patient Safety Alert* supplements from January 1999 to present.

HRM's 2001 salary survey also is available in its entirety.

Find links to other web sites that are essential references for risk managers. There also is a guide to upcoming conferences and events of interest to risk managers. Click on the User Login icon for instructions on accessing this site. ■

Plenty questions remain about EMTALA's final rule

Risk managers have struggled for a long time to interpret the Emergency Medical Treatment and Labor Act (EMTALA), but the recent release of the final rule promised to clear up a great deal of disagreement and differing takes on what the law requires. Some of that promise was fulfilled, but there still is plenty of room to worry about what EMTALA really means, say legal experts who continue to study the law for its many nuances.

As soon as the final rule was released, one of the first questions for risk managers dealt with the infamous 250-yard rule, which was prompted by a case in which emergency department (ED) staff did not leave the hospital grounds to aid someone nearby. Many legal experts interpreted the final rule to mean that risk managers could worry much less about the 250-yard rule because EMTALA now applies only to a much more narrowly defined definition of hospital property. **(See *Healthcare Risk Management*, October 2003, cover story, for more on the final EMTALA rule.)**

But that may not be a safe way to interpret the final rule, says **William M. McDonnell**, MD, JD, a fellow in pediatric emergency medicine at The Children's Hospital in Denver. McDonnell takes issue with other legal analysts who have suggested that hospitals will not incur EMTALA liability by refusing to evaluate and stabilize individuals with emergency conditions who seek care in public areas within 250 yards of the hospital. Some analysts interpret the final rule to mean that a person on a public street, for instance, no longer triggers EMTALA even if he or she is within 250 yards of the hospital.

A Centers for Medicare & Medicaid Services (CMS) official tells *Healthcare Risk Management* that such an interpretation is accurate, but McDonnell says he still would be cautious about telling ED staff that they have no obligation to an injured person lying in the street. The only interpretation that matters is the one CMS uses when an allegation is made against the hospital, he says, and the wording of the law leaves plenty of

room for disagreement.

McDonnell notes that the 250-yard rule was instituted after an incident in 1998 in which ED personnel at Ravenswood Hospital in Chicago refused to leave the hospital campus (in accordance with hospital policy) to assist a teen-age gunshot victim. The Department of Health and Human Services' Office of Inspector General fined the hospital, arguing that the patient's presence in the close vicinity of the hospital's main buildings constituted "coming to the ED." Subsequent EMTALA regulatory amendments specifically included regulations defining the "hospital campus" as areas "located within 250 yards of the main buildings, and any other areas, determined on an individual case basis, by the HCFA [now CMS] regional office, to be part of the provider's campus."

McDonnell takes issue with how some legal analysts have concluded that the final rule eases the hospital's obligations to such patients. He says they may rely on a single word change in the final rule, which now defines "hospital property" rather than the previous "property."

"This distinction is of little significance for purposes of the 250-yard rule," he says. "EMTALA was, and continues to be, triggered when a patient comes to the emergency department. The new regulations substitute 'hospital property' for 'property' now, stating that 'for purposes of this section, 'hospital property' means the entire main hospital campus as defined . . . "

The new regulations then proceed to expressly preserve the 250-yard rule in the definition of "hospital property" and "hospital campus."

Definition of property in question

Some analysts also may rely on provisions in the new regulations which specifically exclude from the definition of hospital property all unrelated, privately owned and operated facilities such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities, he says.

The assumption may be that since public property off the hospital campus is "other nonmedical facilities," EMTALA will not apply, he says.

"However, the new regulations clearly envision some nonmedical areas as still within the scope of EMTALA, expressly including hospital parking lots, driveways, and sidewalks," he says. "Moreover, the specific exceptions to the 250-yard rule are only for specified 'areas or structures of the hospital's main building.' These exceptions are not addressed toward areas outside the hospital's main building, including public roads and sidewalks."

McDonnell interprets the final rule to say that with specific exceptions, all of the regulatory language that imposed EMTALA obligations on a hospital with respect to a patient known to be seeking treatment for an emergency medical condition within 250 yards of the hospital continues under the new regulations.

"In addition, by expressly reasserting the 250-yard rule, the new regulations seem to reflect an agency decision that the underlying rationale of the rule is still valid and applicable," he says. "CMS presumably still believes that a hospital is best suited to provide initial care to an individual with an emergency condition known to be seeking assistance within 250 yards of the hospital, other than in a privately owned and operated facility. Prudent hospitals will continue to provide emergency medical screening and stabilization for such patients."

A CMS official acknowledges that the 250-yard rule can be confusing. **Charlotte Yeh**, MD, FACEP, CMS regional administrator in Boston, tells *Healthcare Risk Management* that the final EMTALA rule did not eliminate the 250-yard rule but it did change where EMTALA applies. In other words, the 250-yard rule still holds true but only in areas that otherwise would qualify for EMTALA coverage, she says. That means public areas with no connection to the hospital do not qualify even if they are within 250 yards, she says.

"The original regs talked about the 250-yard rule and it was not clear. It appeared that everything within that 250 yards counted as hospital property, whether the hospital had any ownership or relationship to it or not," she says. "The final rule better clarifies what land and structures within the 250-yard rule can trigger EMTALA."

Yeh adds that dedicated EDs definitely count and so does any other hospital property within the 250 yards, including sidewalks, driveways, and parking lots. But EMTALA excludes provider-based entities operating under a different Medicare provider number and nonmedical facilities, even if they are within those 250 yards.

"This would mean that a public highway within the 250-yard rule would not fall under EMTALA," she reports.

With varying interpretations, the best bet for risk managers, McDonnell says, is to continue with a

cautious approach that ensures anyone who could even remotely be considered to coming to your ED receives proper care. Besides providing the best liability protection, it's also just the right thing to do, he says. **(For more advice on dealing with the fine distinctions of EMTALA, see below story.)**

Although the exact designation of "250 yards from the main buildings" may be somewhat arbitrary, McDonnell says, the rule enforces the notion that a hospital ED is in the best position to provide immediate assistance to an individual in close proximity with an emergent condition. That should be obvious to anyone, he says, and you risk a great deal by trying to split hairs about what is and isn't covered, he says.

"It is conceivable that CMS will change its position and choose not to enforce the 250-yard rule in situations like the Ravenswood incident, which involve patients on public property," he says. "However, medical directors, risk managers, and emergency physicians may choose not to gamble their Medicare provider agreements, possible administrative fines, and potential civil liability on that possibility." ■

Don't get cute with EMTALA; do the right thing

Just because the final Emergency Medical Treatment and Labor Act (EMTALA) eased some of the prior burden on hospitals doesn't mean you should go overboard in trying to divine exactly what is and isn't allowed, says **Mark Cohen**, ARM, RPLU, CPHQ, CPHRM, risk management consultant with Sutter Health in Sacramento, CA.

If you focus too much on what you might be able to get away with now, you may be missing the big picture and setting yourself up for other liabilities that are just as bad, he adds.

Cohen has been fielding questions from risk managers since the final rule was released and says there is a tendency to become bogged down in minutiae at the expense of doing what you otherwise would know is right. People try so hard to interpret the confusing details of the law that they can overstress how much those details matter, he notes.

In many cases, the risk manager and clinical staff can rely on doing what seems like the sensible, most well-intended thing when it comes to responding to those seeking help. Though the final EMTALA rule eases some previous obligations, that doesn't mean the hospital should seize the opportunity to turn people away, Cohen says.

EMTALA isn't only risk to avoid

"Keep your eye on the prize, which is providing good, expeditious patient care. You can discuss how many angels can dance on the head of a pin as long as you want, but you risk losing sight of the whole point of the exercise," he says. "Even if you're complying technically with EMTALA, you could be exposing yourself to civil liability or malpractice. If you do the dumb thing because you think you're being cute in living right on the edge of EMTALA, you could really regret it when you find out the other ways you can be held liable."

If someone is hurt on or even near your property, it won't be hard for the plaintiff's attorney to find a way to allege you were responsible. If you avoid providing prompt care for that person because EMTALA did not apply, you only make things worse when it comes time to settle the case, Cohen adds.

"Besides, it's just good business to have a good visitor safety program. If someone is walking across your parking lot and falls, does it really matter whether they're covered by EMTALA? Is your response going to be any different?" he asks. "If people keep their heads on straight and remain committed to their mission, it becomes almost academic whether some incidents are EMTALA or not."

Calls to private physician still risky

Cohen points out another area in which health care providers may let their guard down too much after hearing that the final EMTALA rule made things easier. The previous version of EMTALA allowed only physicians at the hospital to call the patient's private physician for additional information that could aid in providing proper treatment. The final rule eased that restriction by saying that any qualified medical person, such as a nurse, may make the call instead of the physician.

That's a welcome modification, Cohen says, but the emergency staff still should be cautious about how those calls are made. The call must be restricted only to gathering information that is needed for assessing and treating the patient. Any other information takes you into dangerous territory.

"You certainly can't make that call for the purpose of requesting authority to see the patient. Emergency doctors need to be sensitive to that," he says. "If they're going to be calling that primary care doctor and talking about payment or anything else not related to the patient's immediate care, they're running the risk of an EMTALA violation."

Emergency department staff also must understand that this call can lead to inadvertent EMTALA violations if the primary care physician gives instructions that would interfere with the required screening and treatment.

"If the contacted physician says, 'Just send the patient to me and don't do anything,' you can't respond to that. You still have to assess and treat the patient as you see fit," Cohen says. "Don't be drawn in to an EMTALA violation by another doctor who says, 'Don't treat my patient.'" ■

11 mistakes that cripple your root-cause analysis

You might think you've done enough root-cause analyses (RCAs) that they're old hat by now and you can just cruise through the process.

If so, you're probably making common mistakes that create inconclusive analyses that fall short of addressing the problem.

Even if you're not cocky and still feel intimidated by the RCA process, you're susceptible to the same fatal errors, according to experts who have conducted plenty of RCAs and seen more than a few fall flat. Vigilance is the way to keep your RCA skills sharp and avoid wasting your time, says **Patrice Spath**, RHIT, a consultant in Forest Grove, OR, who specializes in helping health care providers comply with the standards set by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Risk managers have adopted RCAs as a standard tool, as JCAHO intended, but using it too frequently can dull its edge.

"This is a tool that we all use on a regular basis and it's easy to get complacent about how it's done," Spath says. "Any risk manager would benefit by stepping back and assessing just how you're doing this analysis. There probably is room for improvement."

Kenneth A. Hirsch, MD, PhD, director of Medical Risk Management Associates, a consulting firm and a practicing psychiatrist in Honolulu, seconds that warning. His company specializes in assisting providers with RCAs and other investigations. When *Healthcare Risk Management* asked Spath and Hirsch for the most common mistakes risk managers make with RCAs, they identified 11 errors to avoid:

1. Not doing enough RCAs.

Spath says the most common error occurs when selecting which incidents or issues require an RCA. Near misses are overlooked far too often, she says.

"The biggest mistake with RCAs is that people don't do enough of them," Spath says. "Because an RCA takes resources, people are reluctant to initiate an RCA and then they end up having a more severe event later on that could have been prevented if they had done the RCA on a near miss or a pattern of near misses."

Risk managers go wrong when they rely only on JCAHO's criteria for when to do an RCA, Spath says. You're better off if you consider those criteria the minimum standards for when an RCA is required and then create your own internal decision-making process, she says.

The criteria will differ for each health care provider, but Spath suggests setting certain benchmarks that signal a potential problem. For instance, you may want to flag all cases in which the length of stay was more than two days beyond the expected period.

Having clear, objective criteria will ensure that you do more RCAs on potential sentinel events, near misses, and other patterns that might otherwise fail to prompt a full investigation, she says.

"When a situation comes to your attention, there should be a discussion among the risk manager and other senior leaders about whether an RCA would be valuable. Often that discussion doesn't occur, or if it does you don't have any objective criteria to base a decision on," she says. "So they look at their schedule, see that they're busy already, and it's easy decide that an RCA isn't really needed here."

2. Including too few people.

Organizations often attempt to do an RCA with only one or two people, instead of as a team, Hirsch says. It is more expensive to do the analysis as a team and it takes longer, but the quality of the product is infinitely better, he adds.

The first major effort in any RCA is coming up with a very detailed sequence of events. If you don't include all the people who were involved, major steps are overlooked, Hirsch notes. And it is not enough to have a manager saying, "Here's

what I think the staff do in that situation," or "Here's what they're supposed to do."

"You have to have the staff there to say, 'I know we're supposed to do it this way, but we can't because we're short staffed,'" he says. "Interviewing them is not a good substitute because they feel intimidated and end up just answering your specific questions. You need them to participate so they can relate what they know."

Otherwise, Hirsch says, you will miss variations from the process, and the real-world practices that people build in to make up for those shortfalls.

"My RCAs are open to every person in the department," he says. "We make sure certain people attend the meeting, and then anyone else is free to come if they want. Some will attend only the first or second meeting, and that's OK."

3. Not including your attorney.

If hospital counsel is present at the RCA meetings, the proceedings become attorney work product, which provides an added layer of protection from future disclosure, Hirsch says.

4. Failure to flowchart the processes.

People tend to avoid flowcharting during an RCA because it is tedious, he says. Maybe so, but you should do it anyway.

"It's a nuisance but the visual display really helps people more than just stating the sequence of events," Hirsch says. "And ask questions. Between these two blocks, is there anything else that happens? If you're skipping steps, you're missing possible sources of variation."

5. Focusing too much on a single root cause.

The name of the RCA implies, intentionally or not, you're trying to find one single cause. That's rarely the case, Hirsch says.

"I think we should focus more on contributory causes. It's more likely a number of factors that came together, not just one huge thing," he says. "Look for the multiple things that increased the likelihood of this happening."

6. Performing an insufficient barrier analysis.

A good RCA should include time spent brainstorming on what barriers should have prevented or minimized the impact of the incident. The barrier can be physical, such as a handrail, or a policy or procedure that should have prevented the bad outcome.

"Most people do a barrier analysis, but they don't do enough," Hirsch says. "Ask what barriers existed and didn't work optimally, and why. And what barriers didn't exist but might have been helpful?"

7. Not going deep enough with the overall analysis.

RCA teams have a tendency to stop before getting deep enough, Hirsch says. Often, the analysis stops right at the point where the problem can be attributed to a lack of resources or shortcomings in leadership. That shouldn't be the end unless you've determined why there was a lack of resources and what leadership could have done differently.

"You can always ask another question, but know you've gone deep enough if you can no longer *meaningfully* ask why or how," he says. "You can stop when you just don't have the information and can't get it. Or when you have the answers and can make an impact by changing them."

8. Overlooking environmental issues.

RCAs often fail to address environmental issues, meaning all the factors that affected the individuals involved. Was the person distracted? Was it noisy in the area? Was the employee on mental overload because you were asking her to do too much at one time?

9. Not including leadership in your RCA.

For RCAs related to sentinel events, you always should have someone from senior leadership involved in every meeting of the team, Hirsch notes.

"When JCAHO sees involvement of senior leadership, you've scored big points. And if they see that you had no leadership involvement, you're going to get hit for that and deservedly so," he says. "Upper management doesn't have to be all that active in the meetings, but they must be there and participating. Be sure to document who's present in your meeting records."

For other RCAs, it is not as crucial to have senior leaders involved. But those meetings could be good way for them to get experience and be ready for the sentinel event RCAs, Hirsch says.

10. Not following through.

Most facilities don't have a good tracking system set up for the various improvements coming out of an RCA, Hirsch says. You identify the contributory factors and what to do about them, what must be measured in the follow-up, what deadlines must be met, but then there is no system to assess how all that turns out.

"A lot of RCA teams will come up with final recommendations and leave it at that," he says. "They never really know if it was implemented, or if it was implemented, they don't know if it had an impact."

Many RCA teams also do not adequately

apprise senior leadership of their results, Hirsch says. It is typical for teams to specify many details of each recommendation, such as who is going to implement it and by what deadline, but Hirsch says there should be one more item on the checklist: leadership response.

11. Not spreading the word of what you learn.

People tend to make the most of the information gleaned from the RCA in the area in which the incident occurred, but those lessons learned often are not disseminated through the organization, Spath says. If the incident occurred in the intensive care unit, such as mixing medications improperly because the label can be misread easily, that information could be applicable to other units in the hospital.

"Often the people who learn the most from the RCA are the ones in the units where that incident occurred, which sounds fine at first," Spath says. "An RCA should be much more useful to the organization as a whole. Too often there is no mechanism for providing that information to others in the organization." ■

Incentives, lifting devices cut back injuries to nurses

One of the best methods for eliminating costly back injuries in health care settings is to stop lifting patients. No lifting equals no back injuries, the experts say.

But how do you go about it? Isn't lifting an unavoidable job for health care workers? Not at all, say leaders at two institutions that have successfully eliminated manual lifting through the use of mechanical lifting devices and incentive programs. The equipment and incentive payments may be costly, but they're nothing compared to the high cost of the back injuries you prevent, they say.

An institution that has made progress in reducing back injuries is Beverly Enterprises Inc., with headquarters in Fort Smith, AR. One of the nation's largest nursing home operators with 408 facilities nationwide, Beverly recently adopted specific measures to reduce back injuries for employees involved in lifting nursing home residents. The improvements came as part of a settlement agreement with the Occupational Safety and Health Administration (OSHA). The company agreed to establish a training program and purchase mechanical lift equipment even though officials there thought they already had an effective ergonomic program in place, reports **Jim Zoesch**, director of safety and loss control.

The issue is a hot topic for risk managers at all health care facilities because transfer injuries and other musculoskeletal injuries can happen in any setting. According to the American Nurses Association (ANA), back injuries affect up to 38% of all nurses; and lifting, transferring, and repositioning patients are the most common tasks that lead to injury. In fact, in a recent survey by ANA, 60% of nurses cited disabling back injuries as their top health and safety concern on the job.

OSHA settlement spurs more action

The settlement applies to all Beverly Enterprises facilities within federal OSHA jurisdiction, according to a report from OSHA. The agreement settles citations issued by OSHA to five Pennsylvania nursing homes following a 15-month investigation that began in May 1991 in response to complaints that workers were suffering back injuries related to lifting and transferring residents. The agency found that the company's injury and illness records revealed numerous musculoskeletal injuries sustained by nursing assistants that resulted in extensive lost work time and restricted work duty.

The Service Employees International Union, District Local 1199P and Local 668, which represent workers at the Pennsylvania facilities, also signed the settlement agreement. Under terms of the settlement agreement, Beverly agreed to withdraw its contest of the citations and OSHA agreed to withdraw the proposed penalties.

Zoesch says Beverly already was in the process of purchasing mechanical transfer equipment for every facility but accelerated that program as part of the OSHA settlement. By providing the equipment and education on how to avoid manual lifting, the company hoped to dramatically reduce the incidence of back and other musculoskeletal injuries. The most common injury at all Beverly facilities was musculoskeletal injury from patient transfers, he says.

It soon became obvious to Beverly leaders that simply providing the means to avoid manual transfers weren't enough, Zoesch says. The company had to find a way to persuade employees to use the lift devices.

"What really has changed in the last year is we have implemented a companywide incentive program that focuses on preventing lost time injuries," he says. "As a result, lost time injuries are down

12% over last year. About two-thirds of our facilities complete each quarter without a lost-time injury."

Beverly sets aside funds for each facility to use in celebrating its success. After each quarter, the facility submits its OSHA log of injuries to the headquarters, where Zoesch reviews it and confirms that there were no lost time injuries. Then he informs the facility of how much money it has to spend on a celebration, which will vary depending on the size and location of the facility.

Beverly advises the local facility's safety committee to come up with ideas on how to celebrate and then let the staff make the final decision. The celebrations range from the typical pizza party to more unusual rewards, such as buying monogrammed lab coats for all the staff to wear at work.

"We're finding that success breeds success," he says. "We've got facilities that have gone all three quarters without lost time, but we have one that is working on five years and another working on 10 years."

Close review of all transfer injuries

Zoesch says the lifting devices and similar strategies are key to reducing musculoskeletal injuries and their associated costs, but he says they will be of limited use without some type of incentive program that gets the employees to actually use them. Though Beverly hands out cash to facilities with good results, the investment is well worth it when the injuries decrease, he says.

"Twenty-five years ago, I thought incentives were a total waste. My position was that we pay you a day's wages for a day's work, and that's it," he says. "But I've really seen in this industry that we're beating people on the head all the time with requirements and you have to give them some pats on the back when they're successful."

Beverly employs other strategies as well, such as having Zoesch review all transfer injury claims sent to its third-party administrator. For every transfer injury claim, Beverly sends e-mail to the facility's director of operations and asks for an explanation of how the injury happened and what is being done to prevent recurrences.

"That has created a high level of awareness, a sense that we take transfer injuries very seriously," he says. "They know they're going to be asked about it, so they investigate them right away instead of just accepting it as another injury."

Beverly also made accident prevention part of its corporate quality council to make the topic high profile with top administration. Upper management attends the quality council every month and hears an update on how the company is reducing transfer injuries.

"We also publish in our quarterly newsletter the names of all the facilities that were successful in avoiding lost time injuries," Zoesch reports. "People see that success, and those that were sitting on the fence start thinking maybe they should get in on the action, too."

No-lift environment yields fast results

Another facility taking a hard-line approach to transfer injuries is Forsyth Medical Center in Winston-Salem, NC. Forsyth became one of the first hospitals in North Carolina to begin converting to a completely lift-free environment, investing $500,000 in equipment that will help staff lift and transfer patients from beds, stretchers, wheelchairs, and even cars. The program immediately started helping prevent back injuries among staff, while increasing comfort and safety for patients, notes **Kathy Avery**, BSN, director of employee occupational health, which includes workers' compensation claims.

The Get a Lift program has three main goals: To help prevent neck, back, and shoulder injuries among nurses at Forsyth and therefore reduce lost work hours, and to help recruit and retain nursing staff. Even though Forsyth has a vacancy rate of just 4.5% to 5%, well below the national average of 11%, Forsyth nursing leaders believe this extra measure will be an added benefit that can help recruit staff, Avery says.

"We've had applicants come in from other parts of the country and ask what kind of lifting devices we use," she says. "This is an issue that nurses are recognizing more and more as a way to differentiate between hospitals where they want to work."

The new equipment includes a hydraulic system that can lift up to 880 pounds and will be available for use in every department of the hospital. Forsyth does a good number of bariatric surgeries, so it is common to have patients weighing up to 500 pounds, making every transfer potentially hazardous, Avery says. For more typical patients who are not able to sit up or walk on their own, using the new equipment will be more comfortable, safer and faster than manual lifting. It will eliminate risks to both patient and staff member by preventing falls that can occur during

lifting or transferring, and reducing the number of staff needed to transfer patients.

Forsyth selected the new equipment by working closely with the physical therapy department, where staff are specially trained and experienced in transfer techniques, and also by holding vendor fairs in which manufacturers could bring equipment in for staff to try out. The staff who would use the equipment was instrumental in making the final selections, Avery says.

"We got approval from administration pretty easily because they saw the cost of back injuries," she says. "We averaged about $100,000 a claim, so it wasn't hard to convince them that we should buy the equipment."

After buying the equipment, the next question was how to educate the hospital's 4,000 employees on how to use it. Forsyth leaders didn't think they were equipped for that task, so they opted to use an outside educational firm. The consultants provided training 24 hours a day for two weeks to ensure that all staff were properly educated.

The new equipment arrived in June 2003 and the original plan was to implement a strict "no-manual-lifting" policy by the end of the month. But then the staff realized that the lifts would not work with about 20 of the beds in the hospital, so the deadline was extended to Oct. 30 so the beds could be modified.

The hospital now forbids staff from lifting patients manually, with some exceptions granted to physical therapists because of the nature of their work and their advanced training in transfer techniques.

Even before the policy became mandatory, the addition of the lifting devices had an immediate effect on injuries, Avery says. There were 89 back injuries at the hospital in 2002 and only 14 in 2003. Staff suffered 14 shoulder injuries last year, down to four in 2003.

"We're still analyzing the return on investment, but there is no doubt that we will save a great deal more than we spent on the equipment and training," she says. "It's obvious that the money was well spent. With 89 back injuries last year and 14 this year, we've saved money on medical and indemnity, so there is no doubt. I think the equipment will pay for itself within the year."

The no-lifting policy also enables work-restricted nurses to get back on the job faster because there is no requirement for lifting. Avery says the no-lift environment has been received well by the staff, which sees this as an indication that someone cares about their welfare.

To determine when lifting aids are necessary, every patient is assessed on admission. If the patient meets certain criteria for posing a lifting hazard to staff, that chart is flagged and a special Get a Lift magnetic sticker is posted on the patient's door. That signals the staff that all patient transfers for that patient must be done with the aid of one of the lifting devices.

Avery notes that an important part of making the program work is that there are enough lifting devices in all patient areas of the hospital. The administration avoided the typical hospital purchasing approach of "if we need 30, we can probably get by with 10," she says.

"We purchased enough so that these devices are available on every floor, all the time," she says. "We're being very strict about requiring their use, so we didn't want staff to say that they couldn't find one and didn't have time to go to the seventh floor to get one. If you're serious about having a lift-free environment, you have to provide enough tools to make that possible."

Post-op infections most costly and deadly injuries

Medical injuries during hospitalization result in longer hospital stays, higher costs, and a high number of deaths, according to a study from the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD. Postoperative bloodstream infections had the most serious consequences, resulting in hospital stays of almost 11 days longer than normal, added costs of $57,727, and an increased risk of death after surgery of 21.9%.

Based on these data, researchers estimate that 3,000 Americans die each year from postoperative bloodstream infections. The next most serious event was postoperative reopening of a surgical incision, with 9.4 excess days, $40,323 in added costs, and a 9.6% increase in the risk of death. This equates to an estimated 405 deaths from reopening of surgical incisions annually. Birth and obstetric trauma, in contrast, resulted in little or no excess length of stay, cost, or increase in the risk of death.

AHRQ researchers reported that the impact of medical injuries varies substantially.[1] The one common theme was they all have the potential for tremendous liability and expense, says AHRQ director **Carolyn M. Clancy**, MD.

"This study gives us the first direct evidence that medical injuries pose a real threat to the American public and increase the costs of health care," she says. "The nation's hospitals can use this information to enhance the efforts they already are taking to reduce medical errors and improve patient safety."

The study used AHRQ's Patient Safety Indicators and Healthcare Cost and Utilization Project's National Inpatient Sample data to identify medical injures in 7.45 million hospital discharges from 994 acute care hospitals across 28 states in 2000. The study provides, for the first time, specific estimates for excess length of stay, charges, and the risk of death for each of 18 of the 20 AHRQ Patient Safety Indicators.

Reference

1. Zhan C, Miller M. Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. *JAMA* 2003; 290:1,868-1,874. ■

COMING IN FUTURE MONTHS

- ASHRM 2003 coverage, from Nashville, TN
- Preparing staff for depositions
- Suicide guidelines reduce liability risk
- Reducing delays in diagnosis
- Conducting a mock infant abduction

CE objectives

After reading this issue of *Healthcare Risk Management,* the CE participant should be able to:

1. Describe legal, clinical, financial, and managerial issues pertinent to risk managers in health care.
2. Explain how these issues affect nurses, doctors, legal counsel, management, and patients.
3. Identify solutions for hospital personnel to use in overcoming challenges they encounter in daily practice. Challenges include HIPAA and EMTALA compliance, medical errors, malpractice suits, sentinel events, and bioterrorism.
4. Employ programs used by government agencies and other hospitals (such as EMTALA, HIPAA, and medical errors reporting systems) for use in solving day-to-day problems. ■

CE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. **The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

21. Under the final EMTALA rule, who is allowed to call a patient's primary care physician to obtain information necessary to provide better care in the emergency department?
A. No one
B. Anyone
C. A physician only
D. Any qualified medical personnel

22. According to the American Nurses Association, back injuries affect ___ of all nurses.
A. Up to 16%
B. Up to 38%
C. Up to 58%
D. Up to 89%

23. How much did Beverly Enterprises reduce its lost time injuries by implementing the use of lifting devices and an incentive program for employees?
A. 8%
B. 12%
C. 36%
D. 48%

24. In a recent report by the Agency for Healthcare Research and Quality, what complication posed the most serious consequences for patients, resulting in hospital stays of almost 11 days longer than normal, added costs of $57,727, and an increased risk of death after surgery of 21.9%?
A. Wrong-site surgery
B. Improper medication administration
C. Falls
D. Postoperative bloodstream infections

Answers: 21-D; 22-B; 23-B; 24-D.

Healthcare Risk Management™

Incomes looking up, but so are the hours you spend at work

Field still changing rapidly, demands improved skills

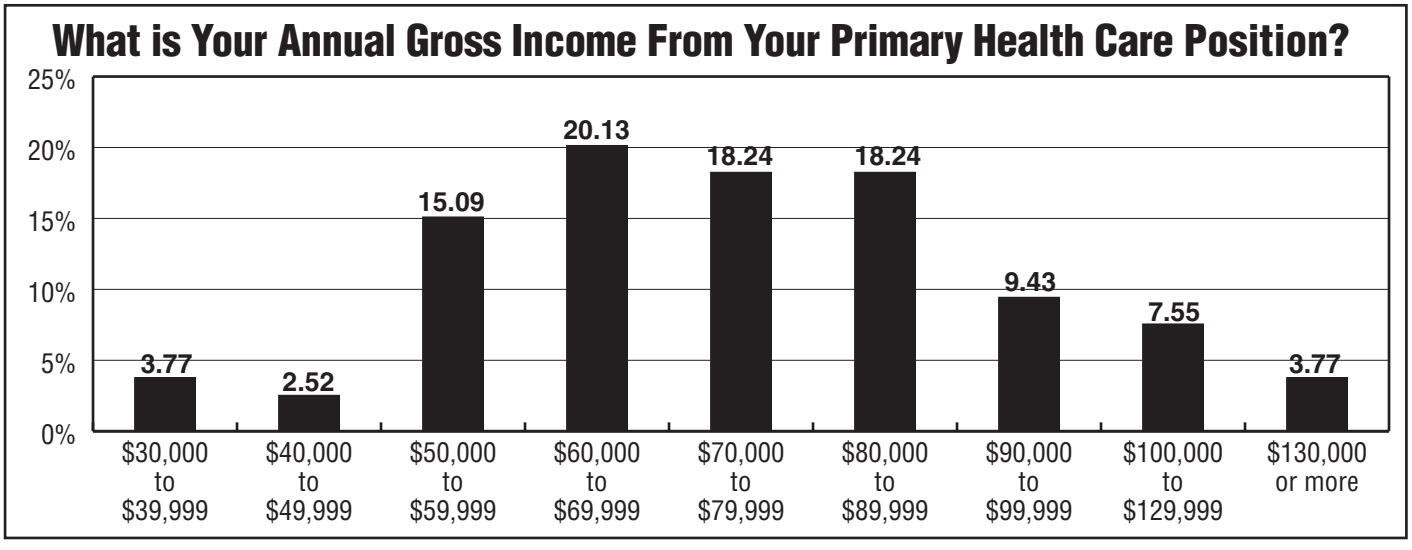
Incomes are up slightly for health care risk managers this year, but you may be staying much later at the office. Health care risk management is a rapidly evolving field, the experts say, and you must take the initiative to pursue the right path if your career is going to flourish.

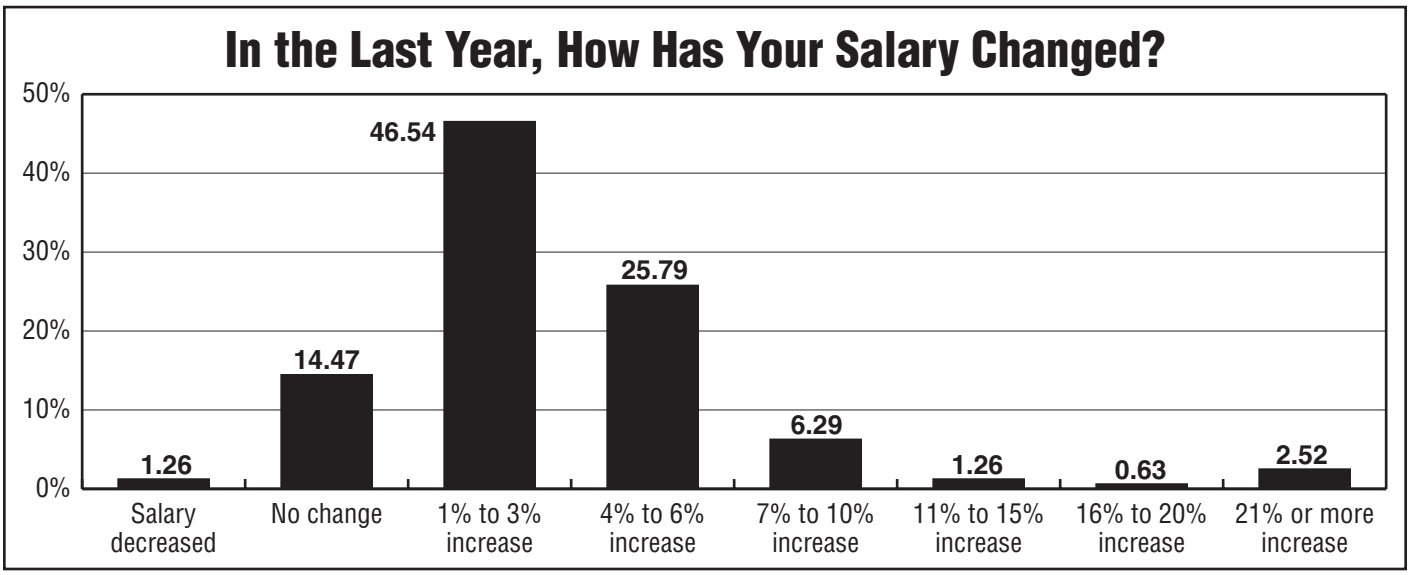
The exclusive 2003 *Healthcare Risk Management* Salary Survey was sent to about 1,200 readers in the June issue. The results were tabulated and analyzed by Thomson American Health Consultants, publisher of *HRM*.

The median income for health care risk managers in this year's survey is $70,000, up slightly from the $65,000 reported for the previous three years. In 2000, the median income was $62,500, the same as for 1999. Before that, the median income for directors of risk management was in the high-$50,000 range.

Though the salary figure has increased, respondents still report a median salary increase over the past year of only 1% to 3%, the same as last year. This year, 47% report increases in that range, up from last year's 40% and 39% the year before. Another 26% report increases of 4% to 6%, down from 34% last year. Fifteen percent report no change in their incomes, compared to 10% last year, and 1% reported a decrease.

You're still working long hours, maybe even more than last year. Last year, 35% reported that they work 46-50 hours per week, but this year only 26% reported that figure. Last year, 13% reported that they work 51-55 hours per week; but this year, that figure nearly doubled to 23%. Another 13% reported working 56-60 hours a





week, and 6% reported working 61-65 hours.

Risk management positions probably aren't going to be eliminated in any great numbers, but how prominent a role you play in the future is another question, says **Jane J. McCaffrey**, DFASHRM, MHSA, risk manager at Oconee Memorial Hospital in Seneca, SC, and president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. If you continue with business as usual, she says, don't expect to see a better income or more prominence in your organization.

Chances are good that your position has changed recently, and it's likely you'll see more change in the future, McCaffrey says. Many risk managers have seen a title change, most commonly to chief risk officer or patient safety officer.

"They can be just changes in title, but sometimes it's a substantive change as well," McCaffrey says. "If you become a chief risk officer, you could end up with a real change in duties with more financial responsibility, but sometimes that is more data collection, and the real decision making resides with the chief financial officer."

Higher compensation usually comes to risk managers when they are hired for a global risk management position and given a title such as chief risk officer, as opposed to the more traditional role of risk manager over one facility or organization, she says.

"Legal or medical background also results in higher compensation, but the level of responsibility plays a key role also," McCaffrey notes. "Otherwise, most of us are just plodding along with the same salary levels we've had for a while. But I don't see a reduction in positions, so I guess we can be thankful for that."

As for skill sets required by risk managers these days, she says the picture is clear: You must have skills in risk financing and patient safety if you expect to advance your career. Traditionally, the risk manager has been familiar with risk financing but not heavily involved, she says. That should change.

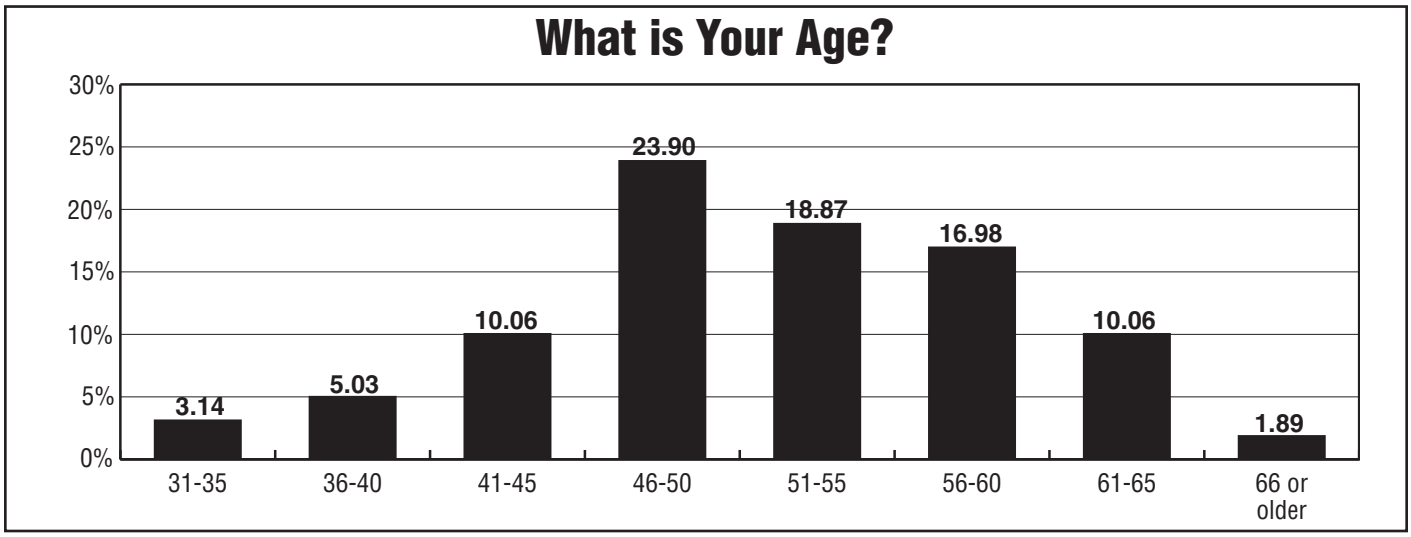
"If you're not the primary risk financing person, you need to make that a goal," McCaffrey says. "You have to get involved with the details of insurance, workers' comp, fleet coverage and property coverage, and minimizing your premium. It's an opportunity if you haven't been doing it."

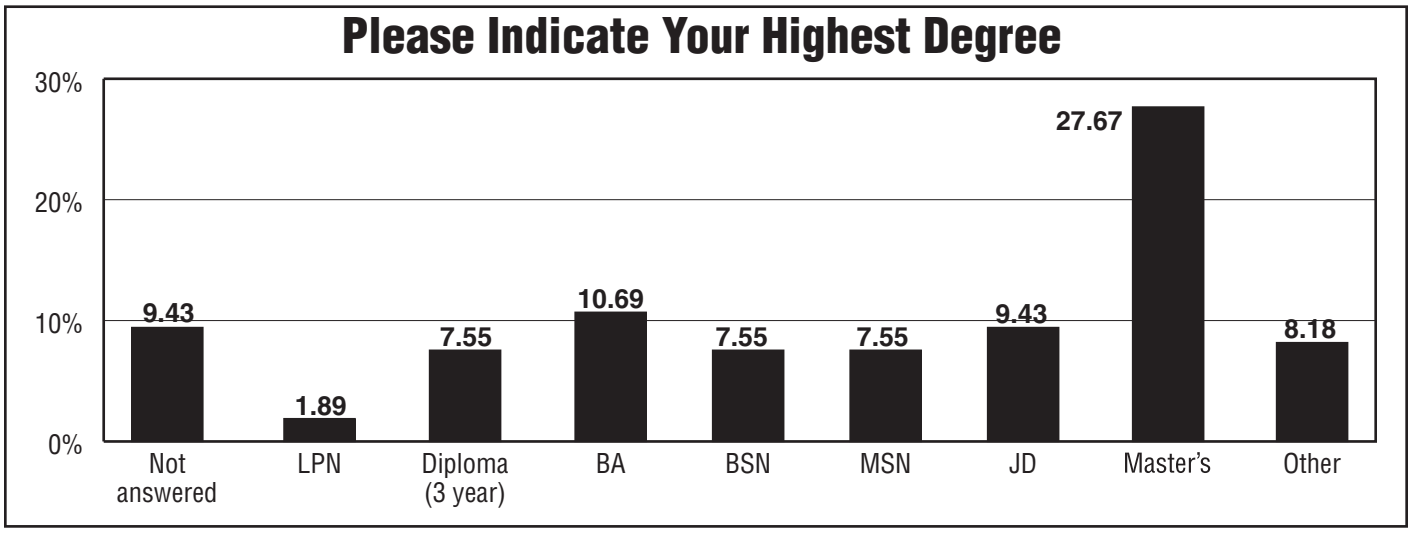
McCaffrey notes that involvement in risk financing will give you the opportunity to do risk assessments throughout your facility. The insurer may want to know how old your boiler is and what backup systems you have when determining your premium, for instance, and that's information that should be valuable in any traditional risk assessment.

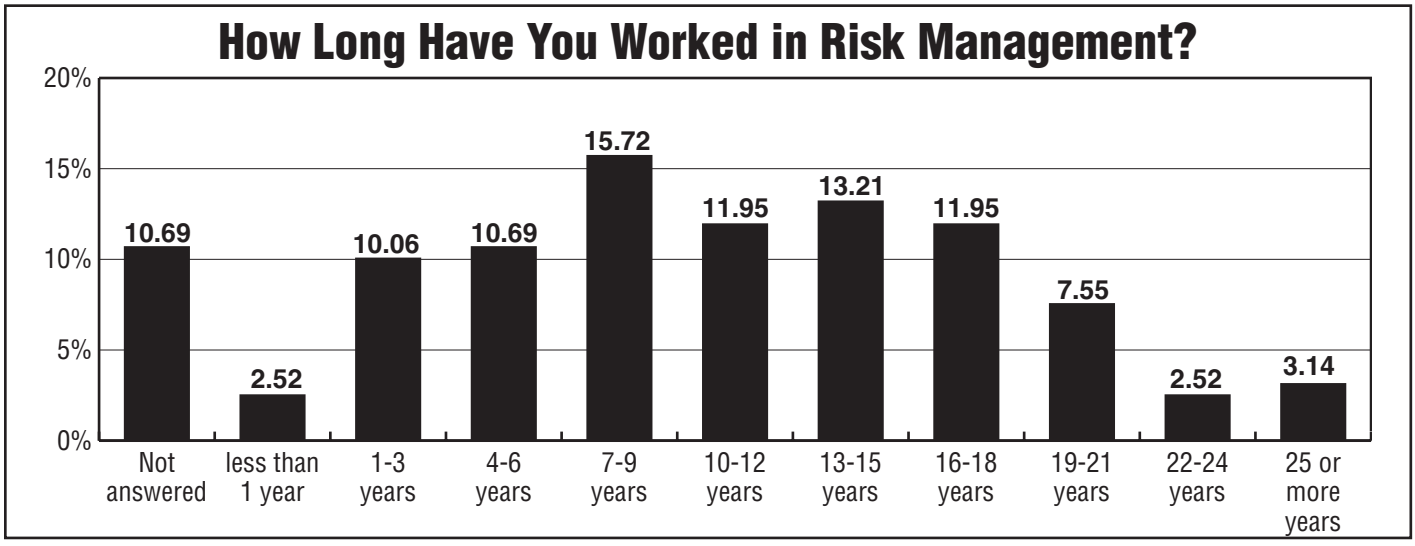
More involvement in risk financing gives you the opportunity to affect the employer's bottom line, and that is always good for your career, McCaffrey says. "One of the best measures to the person who writes your paycheck is how much money you've been able to save them," she says. "Risk managers can make a good argument that they save money all the time, but the more you can show a direct impact, actual dollars you saved, the better you will fare."

The good news is that risk managers don't have to pursue entirely new skills or education, McCaffrey says. You might find it necessary to sharpen your skills in some areas, particularly financial skills, but all the new demands and opportunities play off of the same skills that got you where you are today.

That idea is seconded by **Monica Berry**, BSN, JD, LLM, DFASHRM, CPHRM, regional director of risk management with SSM Health Care of



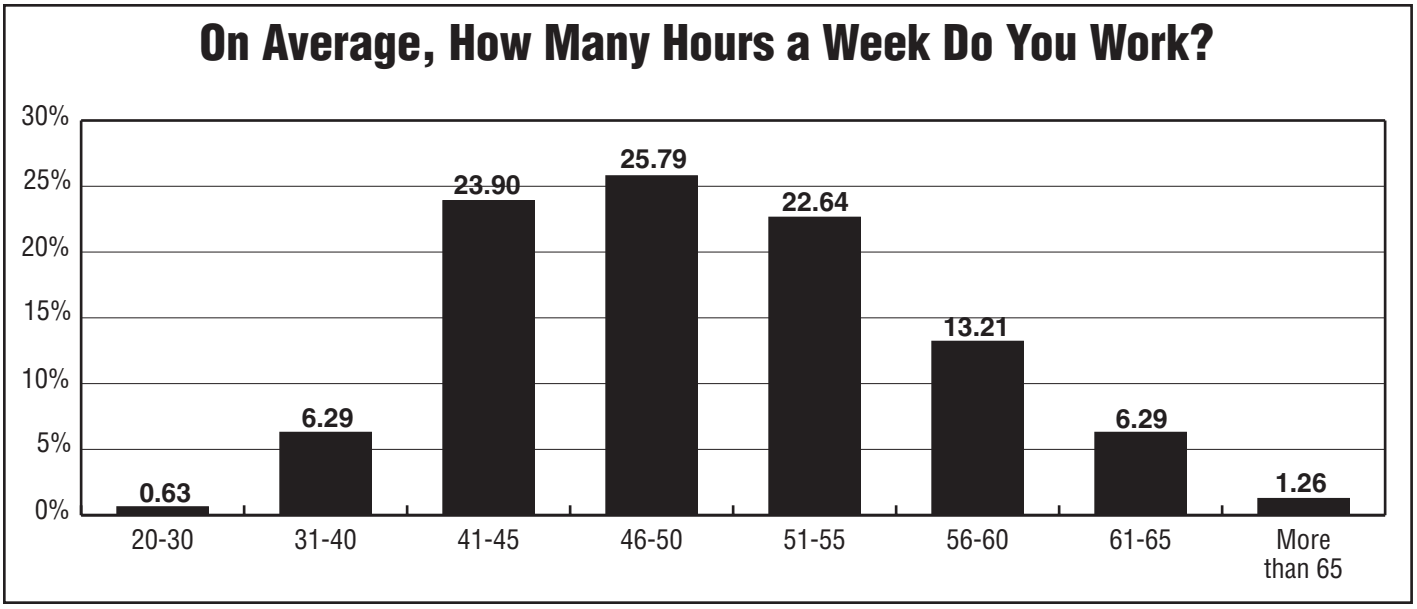




Wisconsin in Madison, and past president of ASHRM. She says risk management is moving toward an "enterprise model," and you have to decide whether you want to come along.

"A good number of risk managers are very focused and have interplay with a clinical risk model, but the enterprise model moves us beyond just that clinical perspective," Berry explains. "It takes us into the arena of the technical, the strategic, the human capital, legal, financial and regulatory. Not all risk managers have these skill sets to address these issues they need to appropriately assess the organization's enterprise exposures."

The enterprise model encapsulates all the trends in risk management that changed your job so much in the past years, but it also promises



many more changes, Berry says. The real effect of this approach to risk management is that it makes you more valuable to your employer, she says. But only if you have the skills to pull it off.

"I've been advising risk managers to take a really hard look at their skill sets and see what you might need in terms of education and new skills," she says. "Look for a mentor in your organization who can provide you that additional education or experience."

For each of those areas in the enterprise model, you might have a different mentor. The chief financial officer might help you gain the right skills in that area, for instance. But that might not always be an option, Berry says. Then you might need to seek a more formal education in that area.

Berry cautions that she sees the potential for budget cuts and the elimination of risk management positions in the near future, so it is imperative to make sure you have skills that are valuable to the organization. Patient safety is one major focus that you can't afford to ignore, she adds.

"If you don't have the skill sets to respond to patient safety concerns in a meaningful way, you need to jump on that bandwagon right away," Berry says. "We're going to start seeing a huge focus among risk managers to the patient safety side, moving from a more traditional reactive mode to a more proactive stance."

So what does the future hold? Berry says that all depends on your skills and what you're doing to improve yourself. If you stick with a traditional, clinically oriented approach to risk management, you're probably not going to see much opportunity for advancement, she says.

"It depends on how far you expand your role," she says. "The compensation should increase as your responsibilities increase, or at least you have a good argument for why it should. But if your duties stay the same while they find someone else to do these things, you can't expect them to offer you more money." ■

Visit *HRM*, *ED Legal Letter* site

We now offer free on-line access to www.hrm newsletter.com for *Hospital Risk Manage-ment* subscribers. The site features current and back issues of *HRM* and *ED Legal Letter*, also from Thomson American Health Consultants.

Included on the site and in its archives are links to every article published in *HRM*'s *Legal Review & Commentary* supplement from January 1999 to present.

There also are links to every article published in *Healthcare Risk Management*'s *Patient Safety Quarterly* and *Patient Safety Alert* supplements from January 1999 to present.

HRM's 2001 salary survey also is available in its entirety.

Find links to other web sites that are essential references for risk managers. There also is a guide to upcoming conferences and events of interest to risk managers. Click on the User Login icon for instructions on accessing this site. ■

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

A delay of nine months leads to a spread of cancer and a $2.8 million judgment

By **Jan Gorrie**, Esq., and **Blake J. Delaney**, Summer Associate
Buchanan Ingersoll Professional Corp.
Tampa, FL

News: A 70-year-old man went to the emergency department (ED) complaining of shortness of breath. Although chest X-rays showed a suspicious mass in the patient's left lung, physicians did not notify the patient or his primary care doctor. Nine months later, when the patient returned to the hospital complaining of shortness of breath, physicians discovered the man had lung cancer. Physicians attempted to remove the mass from the man's lung, but the cancer had spread to his brain. The patient filed suit, alleging the delay in diagnosis significantly reduced his chance of survival. A jury awarded the patient and his wife more than $2.8 million.

Background: In February 1998, a 70-year-old man experiencing shortness of breath went to his local hospital's ED. The hospital, owned and operated by a not-for-profit foundation, offered a variety of health-related services. Additionally, the foundation was associated with a clinic association, located next door, which ranked as one of the largest multispecialty group practices in the country. Although the foundation and the clinic were separate organizations, physicians from the clinic often worked in various departments of the hospital, including the ED. The ED physician who treated the patient in this case was a clinic employee.

Upon the patient's arrival, the ED doctor immediately ordered a chest X-ray. The next day and after the patient had been discharged to home, the hospital's radiologist interpreted the X-ray and discovered a suspicious mass in the patient's left lung. The radiologist made note of a "potential developing malignancy" in the lungs and relayed the report to the ED. Despite the radiologist's request for careful follow-up, the ED physician did not notify the patient or the patient's family doctor; the X-ray was merely forwarded to the clinic. The failure to act violated the clinic's administrative procedures, which required either the ED physician or the clinic itself to notify the patient's primary care doctor.

More than nine months later, in November 1998, the patient returned to the ED with complaints of vertigo and shortness of breath. Another chest X-ray was ordered and again the radiologist identified the presence of a suspicious mass in the patient's lung. When the doctors asked the man if he had been treated for the lesion, the patient was shocked, stating that he was unaware of any abnormality. The patient was formally diagnosed with malignant lung cancer in December.

A year after the radiologist's initial diagnosis, surgeons from the clinic operated on the patient in an effort to remove the cancer. Although the doctors thought they had successfully removed the tumor, tests performed a year later showed that the cancer had spread to the man's brain. The patient underwent radiation and chemotherapy, but doctors classified the cancer as a Stage IV disease, which meant the man had, at most, a

20% chance of surviving five years.

In November 2000, the patient sued the clinic and the hospital, asserting claims of failure to properly evaluate his symptoms, properly diagnose and treat the cancer, refer him to a proper specialist, and inform him he had cancer. The patient's wife also sued for loss of companionship and loss of services. In January 2001, the plaintiffs voluntarily dismissed the hospital as a party to the lawsuit, leaving the clinic as the only defendant. Though the error occurred at the hospital's ED, those involved in the delay were employed by the clinic. The patient did not sue any physicians individually, though, because he alleged the problem lay with the clinic's "incredibly antiquated record reporting system." Unlike many large clinics, the defendant clinic did not have a full-time employee charged only with coordinating and managing records.

The plaintiff alleged he initially had a Stage IA, nonsmall cell, lung cancer and his chance of cure and surviving five years was 80%, the best possible prognosis for lung cancer. The plaintiff claimed that the cancer metastasized to his brain as a result of the nine-month delay in diagnosis, leaving him with a 20% chance of survival. This reduction of 60%-80% meant the clinic, more probably than not, caused the man to lose his chance of survival.

The defendant clinic admitted it acted negligently by not following its standard-of-care procedures. The clinic conceded that it should have followed up on the report and that there was a nine-month delay in diagnosing the cancer. However, the defendant asserted it was speculative as to when the brain metastasis took place. The plaintiff's cancer was slow-growing and could have metastasized prior to his original visit to the ED, or even as a result of the surgery in February 1999. The clinic maintained that, as a result of the delay in diagnosis, the cancer only progressed from Stage IA to Stage IB. A Stage IB cancerous mass would result in a 60% chance of five-year survival. Defense experts argued that this 20% loss in the patient's chance of survival might not have impacted the man's life expectancy at all. Indeed, it certainly was not "more probably than not" the legal cause of the man's loss of chance of survival. The plaintiff's counsel, however, got the defendant's expert witness to concede that a year delay in diagnosing malignant lung cancer would lessen the effectiveness of any subsequent treatment.

As an additional defense, the clinic maintained that the patient's other medical conditions limited the plaintiff's life expectancy. The clinic argued that the man's chronic obstructive pulmonary disease and heart disease hurt his chance of responding to the cancer treatment. Also, the defense attempted to introduce testimony of the plaintiff's history of smoking cigarettes, but the judge disallowed any such evidence.

The plaintiff was alive during the trial, but he could not testify in person because of his illness. Instead, he testified by videotape. The man's 62-year-old wife did testify at trial. The jury returned a verdict in favor of the plaintiffs in the amount of $2,842,000. The man was awarded approximately $1 million for his loss of normal life, $225,000 for pain and suffering, and $218,000 for emotional distress. The jury awarded his wife $1.2 million for loss of companionship and $71,000 for loss of services.

What this means to you: "The failure of caregivers to actively obtain and follow through on the results of ordered diagnostic studies is tragically avoidable and sadly, far too common. In this case, the ball was dropped on a number of levels, and attempts at defending this case may have exacerbated an already bad situation," states **Candy Hodgson**, LHRM, insurance and risk coordinator, University of South Florida in Tampa, FL.

The importance of communication among the providers, particularly among caregivers presumed to be associated by virtue of their working in a health care system of hospitals, clinics, and surgery centers.

"One of the first questions that comes to mind with this scenario relates to the initial viewing of the chest X-ray and the subsequent communication between the providers. It isn't clear from the case synopsis whether or not the chest X-ray was seen by the ED physician, or anyone else for that matter, prior to the patient's discharge from the emergency department. Although a radiologist did not see the film until the following day, it seems highly unlikely that the ED physician would not have at least looked at the film. Regardless of whether or not the ED physician would have had the expertise to identify the suspicious mass, it would be interesting to know whether he ever saw the X-ray," notes Hodgson.

"Presuming that the ED doc did not see the X-ray, it is the usual practice following emergency department visits to advise the patient to follow up with his/her primary physician. Again, the case synopsis is silent as to this matter, but it seems unlikely that this would not have occurred.

Carrying our presumption a bit further, if the patient did, indeed, see his primary care physician at anytime during the nine months between ER [emergency room] visits, it would seem to me to be incumbent upon the primary care physician to attempt to find out what had transpired during the ER visit. Some kind of written report would have been generated by the radiologist and placed in the patient's ER record. The primary care physician, if aware of the ER visit, could have requested a copy of the record of that visit and seen the radiologist's interpretation, potentially preventing the degree of delay, which ultimately occurred," adds Hodgson.

Further, given the common ownership and common employer of the practitioners, one might assume that obtaining and transferring records could have easily been accomplished.

The failure of the ED physician and/or clinic employees to notify the patient or his primary care physician of the X-ray result was, by admission, a deviation from the clinic's administrative procedures.

"Administrative procedures are only words on paper if there is no oversight or accountability for their adherence. The further revelation that this was a recognized problem and the fact that, unlike other similar practices, the clinic did not have a dedicated records coordinator effectively rendered this claim indefensible," says Hodgson.

"Once the claim had been presented, it seems to me that this was a case which should never have gotten beyond the stage of a negotiated settlement. Attempting to base the defense of a preventable delay in diagnosis and treatment on the patient's underlying medical condition and chances of survival, absent the error, is folly," states Hodgson.

The word "cancer" connotes fear, and "juries are only confused by expert testimony debating the type and level of cancer, and the tossing about of survival percentage rates which, at best, are nothing but cold, arbitrary statistics. Although we in risk management like to talk about the four elements of negligence, which are duty, breach, damage, and causation, the reality of the situation is that juries don't go to law school. What a jury will hear and understand about this case is that there was a preventable error, the ball was dropped on more than one occasion, this violated the clinic's own policies, and the defense is now trying to persuade them that it didn't matter anyway because of the patient's underlying medical condition. Putting this case before a jury was probably not the most effective way to control the damages in this situation," notes Hodgson.

In order to move forward, the clinic and foundation should discern why the ED physician failed to notify anyone of the of the X-ray result.

"Inquiries such as, was it an isolated oversight because of a frantic work load, a pattern of behavior, distraction due to personal problem, an ill-advised delegation of responsibility, should be made. And whatever the underlining reason(s), the risk manager needs to 'peel back the onion' and discern the cause of the breakdown at this level, and take corrective measures as appropriate," says Hodgson.

Further, while the clinic had an administrative procedure on point to the situation presented, why didn't it work?

"Back to the onion for the risk manager, to determine why the employee failed to adhere to the policy or whether there were systemic roadblocks preventing the successful adherence to the policy. The risk manager will need to identify the mechanism of failure — be it in system design or personnel issues — and undertake to fix the breakdown," notes Hodgson.

"Lastly, the decision to defend this claim, presumably that of the clinic's insurance company, was, in my opinion, an unfortunate one. I suspect that resolution of this matter outside of a courtroom, as well as undertaking to fix the problems, like the hiring of a full-time record coordinator, could have been accomplished for far less than the nearly $3 million it ultimately cost," she concludes.

Reference

• Champaign County (IL) Circuit Court, Case No. 00L-303. ■

An employee, hepatitis C, and a $3.5 million verdict

News: A floor nurse discovered she had hepatitis C six years after testing positive for the disease. The nurse and her former spouse sued the nurse's employer for withholding the information and were awarded $2.9 million and $575,000, respectively.

Background: Through accidental needlesticks and spills, the floor nurse was exposed to patients'

blood three times between July 1991 and March 1997 at the hospital where she was employed. During that period, the nurse claimed that she was tested at least three times for hepatitis exposure during routine medical staff screenings and testing after exposures.

During those six years, the nurse, who was married, gave birth to two healthy children. Toward the end of that time, she and her husband separated and eventually divorced.

In February 1998, following a conversation with a supervisor over whether she had tested positive for hepatitis C during routine staff medical screenings, she personally reviewed her files in the office computer and discovered that her first positive diagnosis was dated December 1992. Hospital officials failed to inform her that she had tested positive.

During the next year, the nurse and her former spouse brought suit against the hospital for failure to properly and legally inform her of her positive test finding or alternatively that the hospital falsely informed her that her testings were negative. As a result of her exposure to and contracting hepatitis C, the nurse suffered from the symptoms of the disease, including chronic fatigue and severe irritability. Although this form of hepatitis can be sexually transmitted to a partner, and *in utero* to infants, neither her former husband nor her children were infected.

The jury awarded the nurse $2.9 million and her former husband $575,000. An appeal is expected; the hospital will likely claim that the nurse's only recourse was through worker's compensation.

What this means to you: Exposure to patients' blood poses a potential work injury for most all health care practitioners. However, when coupled with the failure to inform the health worker of positive test results, the hospital exposed itself to liability.

"There are definitely two separate issues presented in this case. One involves a workers' compensation claim for the initial injuries by needlestick and/or spill, and the second is a legal claim for failure to disclose the information," states **Patricia Specian**, MSN, JD, risk manager at West Palm Beach, FL-based Columbia Hospital.

"Any employee injured in a work-related injury in any setting should be referred for treatment, as needed. And injuries related to the incident should be covered under workers' compensation — including follow-up care, missed work, and counseling, if needed. Many health care providers, and particularly hospitals have an employee health nurse or clinic where employees may seek medical care, but regardless this nurse should have been treated, tested, and informed immediately," she adds.

Although the Needlestick Safety and Prevention Act was not passed until 2000, which postdates this case, all health care organizations were required to have a needlestick prevention program in place under standards established under OSHA in 1991. The risks of infection from a contaminated needle or blood spill are well known, and unfortunately such incidents were very prolific at the time the nurse was first exposed. The Centers for Disease Control and Prevention estimated that health care workers sustained more than 600,000 such injuries annually with most involving nurses.

Technology has addressed some of the prevalence of needlestick injuries, but in all such instances. Health care workers should be encouraged to report all incidents, and those injuries should be treated accordingly.

"The hospital's failure to inform the nurse of her adverse test results was a breach of duty on behalf of the hospital. Had the nurse known from the outset that her results were positive, she could have sought timely medical treatment and counseling. Additionally, had the nurse known she could have taken precautions during intercourse with her husband and also received counseling as to the advisability of becoming pregnant and inherent risks related to children she would conceive," Specian says.

Although the hospital was not responsible for the sharps injury, unless they failed to implement safety precautions to prevent such occurrences —and we have nothing to indicate that in the record — they were responsible for prompt notification in the event of positive lab findings. "In my opinion, the $3 million award is excessive, despite seemingly the sympathetic plaintiff. Additionally, the ex-husband's award is questionable as he was not infected and due to lack of knowledge, did not undergo any type of emotional trauma during the period with which he could have converted. It will be interesting to see what happens with the appeal," concludes Specian.

Reference

- Passaic County (NJ) Superior Court, Case No. L2395-99. ■

Healthcare Risk Management™

2003 Index

When looking for information on a specific topic, back issues of Healthcare Risk Management *newsletter, published by Thomson American Health Consultants, may be useful. To obtain back issues, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcpub.com or go on-line to your free subscriber web site at hrmnewsletter.com. Editorial Group Head: Lee Landenberger.*