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Prevention of falls and fires may make their way to the top of new safety goals

Start now to assess your risk, improve prevention efforts

Several perennial worries of risk managers are under consideration by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as new National Patient Safety Goals for 2005, and experts in two of the hottest topics say you should assess your efforts in these areas now.

Both topics — harm from patient falls and the risk of surgical fires — need your attention even if they don't become National Patient Safety Goals, experts say.

The fact that JCAHO is considering them as new National Patient Safety Goals is evidence of the threat they pose, says **Mark E. Bruley**, vice president for accident and forensic investigation with ECRI, a nonprofit health and safety research organization in Plymouth Meeting, PA. He worked with JCAHO to compose advice regarding surgical fires in 2003 and has worked extensively with state agencies on the topic.

If JCAHO adopts them as National Patient Safety Goals, the bar is raised considerably higher because failure to address them could result in sanctions from the accrediting body. Start now, and you'll be in better shape if JCAHO says you must address these hazards, Bruley says.

JCAHO spokesman **Mark Forsteneger** confirms that risk from patient falls and surgical fires are both being considered as National Patient Safety Goals for 2005, and JCAHO is considering comments from health care providers. **(See p. 78 for the 2005 proposed safety goals.)**

Bruley says surgical fires were considered last year as a National Patient Safety Goal, but other topics took precedence. He tells *Healthcare Risk Management* that he hopes surgical fires will become a National Patient Safety Goal for 2005.

"At ECRI, we get at least one report and sometimes four every week," he says. "We estimate that there are at least 100 surgical fires a year, and of those, about 20% are serious and one or two are fatal. This is a true risk, not something theoretical."

Bruley suspects the risk of surgical fires actually is greater than that of wrong-site surgery, which has received so much attention lately. The number of reported fires appears to be on the increase now that JCAHO and others are addressing the risk more prominently, he notes.

However, Bruley warns that a key recommendation for preventing surgical fires is not receiving enough attention. The recommendation is that clinicians question the need for 100% oxygen delivered to the patient's face through a nasal cannula or mask.

"That is something that a risk manager could encourage," he says. "Urge the anesthesiology department and other clinicians to seriously consider some practices they might take for granted."

Many fire prevention efforts in hospitals overlook the problems posed by interdepartmental friction, Bruley says. This is where risk managers can play a key role, he suggests. In developing processes to reduce the risk of fire, and especially after a fire has occurred, there can be tremendous conflicts between surgery, anesthesiology, and nursing.

"Surgical fires are very much a cross-cultural hazard. The best analogy is with wrong-site surgery, with the way everyone now recognizes that every single person on the team is responsible for preventing wrong-site surgery," he says. "The risk manager can act as a coordinator between those departments so that they see their roles and how they can work together, and not try to say someone else is responsible."

Like wrong-site surgery, Bruley says virtually all surgical fires are preventable.

Fires already a major focus

JCAHO already has made surgical fires a focus point with its *Sentinel Event Alert* on June 24, 2003. **(To access the *Alert*, go to www.jcaho.org and search for *Sentinel Event Alert* issue No. 29.)** In that *Alert,* JCAHO reiterated advice that ECRI also has offered for more than 20 years, Bruley says. First, administration and risk managers should be proactive in preventing surgical fires. Second, the surgical team needs to understand heat sources and manage fuels, especially alcohol-based prepping agents. And third, the team should minimize oxygen buildup under drapes.

"If it becomes a Patient Safety Goal, the hospital as a whole is going to be assessed for how well it is addressing this hazard, so the risk manager can make a good case for having policies and procedures, along with a good education program," he says. "Risk managers have a vital role to play in all of this."

Aside from protecting patients, the risk manager should be concerned with the potential liability of not preventing a surgical fire, Bruley says. His experience with surgical fires suggests that they lead to costly lawsuits.

"They can certainly go into the millions of

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dollars. I've seen that," he says. "If it's a teaching facility where all the physicians, anesthesiologists, and nurses are insured by that facility, then the entire liability may fall on the institution. If there is segregated insurance between surgery, anesthesia, and OR [operating room] nurses, then that's where the interdepartmental difficulties can come in with lots of finger pointing and blame."

Bruley notes that risk managers will have to address both clinical issues, such as whether 100% oxygen is really necessary for a patient, and also procedure issues such as what team member is responsible for placing electrosurgery tools on standby when not in use so they cannot be accidentally fired.

"Risk managers must encourage discussion of the clinical decisions, even if the decision still has to be made by physicians," he says. "Develop a culture that encourages discussion and makes it OK to talk about it. The proposed goals will make it necessary to talk about it, so you're better off if you start now with creating that culture."

(For more on surgical fires, see box, right. For a surgical fire safety poster you may reproduce, see p. 76.)

Most surgical fires involve electrosurgical gear, oxygen

These facts about surgical fires are provided by ECRI, a nonprofit health and safety research organization in Plymouth Meeting, PA:

- **About 68% of surgical fires involve electrosurgical equipment as the ignition source, and another 13% involved lasers.** Other potential sources of ignition include electrocautery tools, fiberoptic light sources, defibrillators, and high-speed burs.
- **About 34% of reported fires occur in the airway.** Twenty-eight percent occur on the face and another 24% elsewhere *on* the patient. The remaining 14% occur elsewhere *in* the patient.
- **Oxygen-enriched atmospheres are present in 74% of surgical fires.** ■

Focus on reducing harm from falls

Concerning patient falls, JCAHO is focusing specifically on reducing *harm* from falls rather than simply *reducing* falls, says **Marianna Grachek**, CNHA, MSN, RN, JCAHO's executive director for long-term care and assisted-living accreditation. She also is executive director of health care staffing certification.

"We know that falls are going to happen in the care setting, but we need to look at how we can reduce the harm from those falls," Grachek says. "This National Patient Safety Goal involves early detection, a risk assessment, and identifying the appropriate strategies to reduce falls and injuries from falls."

Grachek's background is in gerontological nursing, so she is familiar with reducing falls and patient harm in long term care settings but notes that the National Patient Safety Goal, if accepted by JCAHO, would apply across all health care settings. The distinction between reducing falls and reducing harm from falls may be familiar to those in a long-term care setting but might seem like a new perspective to others, she says.

"The population you're working with will determine how you apply this goal in your organization," Grachek says. "If you have many elderly residents, the things you do to reduce harm from falls will be different from what you do if you have mostly children. There will be nuances in how you pursue this goal."

Reassess previous strategies

Reducing the risk of harm from falls starts with assessing the patient, Grachek says. Assessing their physical functioning, cognitive abilities, gait, and endurance, for instance, will help you identify those patients most at risk and guide your prevention efforts. Of course, risk managers have worked to reduce falls for many years, so the basic idea is nothing new. But Grachek says changes in health care necessitate looking at the problem with a fresh perspective.

The dramatic reduction in the use of restraints over the past few years, for instance, has changed the way providers must address the risk of falls.

"Even side rails are not being used as much anymore. When I first started out in nursing, if you were a patient over 65, the side rails just automatically went up because we didn't want you to fall," Grachek recalls. "The whole goal was to prevent falls by imposing barriers. But now I'm getting close to 65, and I don't want you to put my side rails up, either."

The health care community has moved away

(Continued on page 77)

Only *You* Can Prevent Surgical Fires

Surgical Team Communication Is Essential

The applicability of the following recommendations must be considered individually for the needs of each patient.

At the start of surgery:

- Both O_2 and N_2O support combustion. Be aware of possible enriched O_2 and N_2O atmospheres near the surgical site under the drapes, especially during head and neck surgery.
- Question the need for 100% O_2 for open delivery during head/neck surgery.
- As a general policy, use air or FiO_2 ≤30% for open delivery.
- Arrange drapes to minimize O_2 and N_2O buildup underneath.
- Use an incise drape to isolate head and neck incisions from O_2 and alcohol vapors.
- Do not drape the patient until all flammable preps have fully dried.
- Coat facial hair near the surgical site with water-soluble surgical lubricating jelly to make it nonflammable.
- Fiberoptic light sources **can** start fires. Complete all cable connections before activating the source. Place source in STANDBY when disconnecting cables.

During oropharyngeal surgery:

- Scavenge deep within the oropharynx with separate suction.
- Wet gauze or sponges used with uncuffed tracheal tubes to minimize leakage of O_2 into the oropharynx. Keep them wet.
- Moisten sponges, gauze, and pledgets (and their strings) to render them ignition resistant.

When performing electrosurgery, electrocautery, or laser surgery:

- Stop supplemental O_2 (if O_2 concentration is >30%) at least one minute before and during use of the unit, if possible.
- Activate the unit **only** when the active tip is in view (especially if looking through a microscope).
- Deactivate the unit **before** the tip leaves the surgical site.
- Place electrosurgical electrodes in a holster or another location off the patient when not in active use (i.e., when not needed within the next few moments).
- Place lasers in STANDBY when not in active use.
- Do not place rubber catheter sleeves over electrosurgical electrodes.

Reference: ECRI. A clinician's guide to surgical fires: how they occur, how to prevent them, how to put them out [guidance article]. *Health Devices* 2003 Jan;32(1):5-24.

ECRI
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from restraint so much that risk managers must reassess some of the fall reduction strategies that were sufficient in past years, she says. When patients are left to be more mobile, more creative fall-and-harm reduction strategies may be necessary, she says.

"A fall-reduction strategy might be, for instance, to have very low beds for residents at risk so that if they fall, they don't have far to go," Grachek says. "But you need to tailor these strategies to your own setting. Those very low beds might be appropriate in a long-term setting, but in an acute care facility, it might not be feasible to provide care to someone so low to the floor."

Start now to reduce harm from falls

As with surgical fires, Grachek notes that risk managers should address the risk of harm from patient falls whether JCAHO adopts the National Patient Safety Goals or not. And if they are adopted, she says risk managers will be glad they started reducing risk as early as possible. The first step, she says, is to gather data about your current situation.

"It's all about continuous improvement. The first thing to do is identify your falls rate and then set realistic goals for reducing the fall rate," Grachek says. "You will need to collect data that helps guide your efforts in reducing the severity of falls and multiple falls. When I was in a nursing home setting, we would have weeks with a high number of falls, but that may not have been a high number of individuals falling."

Identifying those high-risk individuals can dramatically reduce the overall number of falls and injuries from falls, she says. Once those patients are identified, an interdisciplinary team should seek solutions appropriate for that particular patient.

"Remember that this is not an issue that is just the responsibility of nursing," Grachek says. "You must involve the physician, pharmacy, therapists, anyone involved in the care of the patient."

It also is important to educate patients and their families about the risk of falls, both in the clinical setting and once they go home. Similarly, it is important for providers to communicate about the risk of falls when transferring patients from one facility to another, or from one level of care to another.

"Communicate the risk factors, the care plan interventions, the effectiveness of things they have tried, so the receiving organization can follow through on that," she says. "If you are receiving the patient and that information is not offered, ask for it."

Analyze staffing and falls

Grachek also recommends analyzing falls data according to staffing levels. Are there more falls when you use more agency staff? Do falls increase at a certain time of day when staffing levels are low? Are there more falls when unlicensed personnel work with patients?

But also, Grachek recommends caution when assessing whether more falls occur with certain types of personnel, like unlicensed personnel. Even if it turns out that they are involved in more falls, the real responsibility may lie with the licensed personnel who should educate them in avoiding falls and injuries from falls.

"I would be very careful because, in a nursing home situation for instance, 80% of the care is provided by nursing assistants, so it's not realistic to think that you're going to have a [registered nurse] or [licensed practical nurse] assisting with the basic activities of daily living," she says. "Those are the people who care for patients all day, and if there are more falls you can't just conclude that they are careless. You have to look at the training and education you provide those staff and ask if it is adequate." ■

Looking to avoid trouble? Take a look at these goals

Here are the proposed 2005 National Patient Safety Goals for hospitals. The goals differ somewhat from one health care setting to another.

For more on the proposed 2005 National Patient Safety Goals, go to www.jcaho.org and select "accredited organizations," then "patient safety."

• Improve the accuracy of patient identification.

The steps include using at least two patient identifiers (not the room number) when administering medications or blood products, and when taking blood samples or other specimens for testing. The goal also would require implementing bar code technology for patient identification no later than Jan. 1, 2007.

• Improve the effectiveness of communication among caregivers.

This goal would require the person receiving critical test results verbally or by phone to "read back" the results to verify accuracy. Providers also would need to standardize abbreviations, acronyms, and symbols. The goal also requires a process for improving the timeliness of reporting test results.

• Improve the safety of using medications.

Steps include removing concentrated electrolytes from patient care units, as well as standardizing and limiting the number of drug concentrations available. JCAHO also would call for restricting intravenous drug preparation to the pharmacy and identifying a list of look-alike/sound-alike drugs.

Infusion and infection

• Improve the safety of using infusion pumps.

Infusion pumps can be made safer by ensuring there is free-flow protection on all general use and patient-controlled devices. An independent double-check also is necessary whenever programming the devices.

• Reduce the risk of health care-acquired infections.

JCAHO would require providers to comply with current guidelines on infection control and to treat as sentinel events any health care-acquired infection that resulted in permanent loss of function or death.

• Accurately and completely reconcile medications and other treatments across the continuum of care.

This goal is intended to ensure that providers document the patient's medications and treatments and reconcile them with any currently provided medications and treatment. One licensed independent practitioner should be designated to coordinate the patient's care and field questions from other clinicians.

• Reduce the risk of patient harm resulting from falls.

Strategies include assessing and periodically reassessing each patient's risk of falling (and including the risk associated with medications), implementing and evaluating a fall-reduction program, modifying the environment to minimize harm from falls, using bed alarms for high-risk patients, using low beds, and avoiding full-length bedrails.

• Reduce the risk of surgical fires.

JCAHO urges providers to educate staff, develop and test procedures for the response of all surgical team members to a fire in the operating room, and to report surgical fires to the appropriate organizations. ■

Typical surgical fire involves oxidizers, fuel

Consider this true example, taken from the December 2003 issue of ECRI's *Health Devices,* of how a fire can occur during surgery:

During a tonsillectomy, the surgeon had packed the space around the uncuffed tracheal tube with dampened gauze pledgets. The patient was receiving a mixture of O_2 and N_2O. Some time into the surgery, electrosurgery was used to cauterize the tonsil bed.

The pledgets either had been insufficiently wetted or had been allowed to dry somewhat from the gases leaking through them from the patient's lungs. One of the tissue embers landed on a dry pledget and ignited it in the oxidizer-enriched atmosphere in the airway. The burning pledgets ignited the outside of the tracheal tube and the red rubber catheter used for retraction of the soft palate.

The fire was extinguished with saline solution, but not before the patient sustained burns in the upper oropharynx. ■

Living wills called useless; power of attorney is better

Living wills don't work and waste your time when you promote them to patients, according to researchers at the University of Michigan (UM) in Ann Arbor. Even aside from what's best for patients, living wills may lull risk managers into a false sense they have avoided potential difficulties by encouraging patients to address them up front, they say.

They base their conclusions on a comprehensive review of hundreds of studies of living wills, end-of-life decisions, and the psychology of making choices. The authors are taking on a document that has become ingrained in American medical culture that the law of almost every state specifically recognizes, and that hospitals are required by federal law to tell their patients about.

Carl E. Schneider, JD, the Chauncey Stillman Professor of Law at the UM Law School and professor of internal medicine at UM, says living wills don't fail for lack of effort, education, intelligence, or goodwill. They fail because of basic traits of human psychology, he says.

For instance, studies show that people have great trouble predicting their own preferences about even simple, everyday things like what snacks they will want or what groceries they will buy next week.

"If they have trouble predicting what is familiar," Schneider asks, "why should we expect them to succeed when they are predicting what they will want in circumstances they have never experienced and can't foretell?"

Conventional wisdom is wrong?

The need for living wills has become conventional wisdom among many health care providers without any proof that they work, Schneider says. The news that living wills don't work may hit hardest at the institutions where risk managers have encouraged more than a perfunctory mention of their availability, the minimum required by the federal Patient Self-Determination Act. Many health care professionals may be surprised to learn that the latest research indicates that trying to get patients to sign living wills is "at the very least, a waste of your time and energy and money."

Schneider and fellow researcher **Angela Fagerlin**, PhD, a research scientist with the UM Medical School and Veterans' Administration Ann Arbor Healthcare System, recently released a study in which they analyzed how living wills actually were used and how much they reduced the end-of-life debates they were intended to address.[1] Their basic conclusion was that a living will is "a nice idea, but it doesn't work," Schneider says.

The living will, Fagerlin notes, was designed by bioethicists who wanted to give patients a chance to spell out what treatment they would want and what treatment they would reject if they became unconscious or unable to make their own decisions for some other reason. The idea of the living will is to allow people to maintain control even at the end of life but they have proven to be impractical.

Fagerlin says she thinks most risk managers would be surprised by just how useless living wills tend to be.

"It might not be the best use of a health care provider's limited time to discuss living wills," she says. "People want living wills to work, and it seems like they should in an ideal world. So there's some disappointment that they don't."

Fagerlin says there is no evidence that living wills work, yet health care providers spend thousands of dollars every year promoting them to patients, partly because the law requires them to and partly because there is a strong belief that living wills are "the right thing to do."

"Our research might be welcomed by those who already suspected that there were limits to living wills and might be relieved that they don't have to engage in this futile exercise," she says. "It's important to note that this isn't just our opinion, but that it's based on solid research with how living wills are actually used."

'A kind of malpractice'

Schneider urges risk managers to reconsider how living wills are promoted in their institutions because he says they are, at best, a waste of time. But he goes a step further and suggests that you are doing your patients a disservice by encouraging them to sign something that ultimately will not be useful.

"I do think it is a kind of malpractice to be pretending to patients that these documents are really going to have an effect," he says. "People are making these really serious decisions based on little information, seeing it as just one more form to fill out. And you're telling them that they have addressed a very serious matter when in fact they have not."

It is unlikely that patients could find a successful

way to sue the provider when a living will does not fulfill its promise, but Schneider says risk managers are fooling themselves if they think that living wills will help them avoid thorny situations like the Terri Schiavo case in Florida, in which a patient's husband and parents have fought a long legal battle over whether she should be kept alive.

Courts are reluctant to uphold living wills when push to comes to shove, and largely for good reason, Schneider says.

"The courts recognize that the document was signed before the patient was in the current state and before they could even understand what specific issues are being contested," he says. "Courts are likely to say that the living will is not legally binding."

Fagerlin notes that a living will would not have made any difference at all in the Schiavo case, yet the media were suggesting that it was a good example of why everyone should have a living will. In the Schiavo case, the dispute centers on exactly what the patient's condition is, a question that is not answered in a living will.

"But if she had had a durable power of attorney saying she wanted a particular person to make that decision for her, then there would be no conflict," she says. "That is a good example of the usefulness of a durable power of attorney vs. a living will."

Challenging common practice

Schneider says he can imagine circumstances where the living wills may be useful for patients who facing imminent death, who know their medical circumstances and who have strong and specific beliefs about them. But far more often, he says, living wills offer a false promise of control over end-of-life treatment.

The best patients can do, the researchers argue, is to use a durable power of attorney to appoint someone to make decisions for them when they can no longer make their own decisions.

Schneider says the way many health care providers encourage patients to complete living wills is part of the problem. Often, the living will starts as a blank form for patients to fill out in writing, stating their individual preferences. The instructions might suggest that patients write down whether they'd want to be kept on life support machines if they had a catastrophic accident or were terminally ill.

For instance, according to the instructions for the form on the UM Health System web site, a patient could write, "Do whatever is necessary for my comfort, but nothing further," or, "I authorize all measures be taken to prolong my life." Patients also can write about their wishes regarding specific medical interventions, such as respirators, cardiopulmonary resuscitation, surgery, and blood transfusions. And they could say how they feel about receiving food and water administered through feeding tubes.

But what do those options really mean? When a living will is called into play, it is very common for family members and others to find room for argument, Schneider says. Is the patient "terminally ill" as required to use the living will? If the doctor says the patient has a 50% chance of living six months, a case can be made on both sides that the patient is and is not terminally ill.

What about pain relief? Does that include inserting a Foley catheter to relieve a full bladder?

"People sign these documents thinking they have made some important decisions, but in reality, they have no way to anticipate the specific circumstances," Schneider says. "You end up with someone saying, 'But he has a living will,' and someone else saying, 'Yeah, but it doesn't apply to this situation here.'"

What to do?

But risk managers cannot just have their staff stop promoting living wills altogether because the federal Patient Self-Determination Act requires hospitals to tell patients about living wills and other advance directives. Fagerlin and Schneider recommend focusing much more on the alternatives to living wills.

"Durable powers of attorney only require a few simple choices, and they don't differ significantly from the existing system of allowing family members to make medical decisions about incompetent patients," Schneider says. "They also allow the decision maker to use the information about the patient's condition that's available at the time a decision is needed, rather than asking the patient to guess about something far in the future. And they're inexpensive."

Legally the hospital is relieved of the burden to make decisions for the patient when a durable power of attorney is in play, he notes. The durable power of attorney is legally clear and enforceable — everything a living will is not.

"They're documents that the court understands, and the court can just say yes," Schneider explains. "But when you present them with a living will

that has all these vague terms and health care situations the court is unfamiliar with, they often start looking for someone else to make the decision for them, like the bioethics committee. The ball comes right back to you."

The Schiavo case, and many others in which parties fought over end-of-life decisions, could have benefited form a durable power of attorney, Schneider says. That is what elevates a living will from merely useless to potentially dangerous. They are dangerous when they lead patients to stop there and not create the more effective legal document, he says.

"That can lead to sticky legal problems that hospitals surely want to avoid," he says. "If I were a hospital risk manager thinking about reducing friction between me and my patients, I don't think living wills will do that; whereas, a durable power of attorney can."

Fagerlin advises risk managers to review their policies and procedures to ensure that patients are encouraged to complete both a living will and a durable power of attorney. The living will, even if it is not entirely enforceable as a legal document, can help guide the person assigned the durable power of attorney, she says.

Schneider says that if he were a risk manager, he would want the patient to assign decision-making capabilities to one person who can then address those difficult issues with guidance from the health care providers. That way, a patient's end-of-life concerns don't become fodder for academic questions and legal maneuvering.

"I wouldn't want my care and end-of-life decisions to be settled in a meeting of the bioethics committee," he says.

Reference

1. Fagerlin A, Schneider CE. Enough: The failure of the living will. *Hastings Center Report* 2004; 34:30-42. ■

Establish ground rules with your legal counsel

Expectations are key to having a good working relationship with legal counsel, says **Pamela L. Popp**, MA, JD, FASHRM, CPHRM, vice president for health care practice with McQueary Henry in Dallas, which provides insurance products and risk management services. Popp also is the president-elect of the American Society for Healthcare Risk Management.

"Risk managers spend a lot of time teaching providers how to set realistic patient expectations," she notes. "The same thing applies to working with counsel. Even it's been a 10-year relationship, you should sit down and discuss what you need to do for each other."

Better communication will help you get the most out of your relationship with counsel, Popp says. With a good rapport, counsel will be able to help you in many situations other than when you have to call with notification that a lawsuit has been filed. The good relationship also will make it more likely that the attorney will be willing to speak to you informally — and at no charge — when you have a quick question or just want to keep him or her apprised of some development, Popp says.

Remember who's paying for service

A friendly relationship also will make the risk manager more likely to call.

"A lot of risk managers are not comfortable making those phone calls to just ask for advice or to let counsel know that you've decided to address a problem in a particular way," she says. "Being very cost-oriented, the risk manager might expect to be charged for that even though you haven't discussed it. And there can be a lot of intimidation, particularly if your outside counsel plays golf with the hospital CEO. They don't feel like they are on equal footing."

Don't be intimidated by the fact that the person on the other end of the phone is a lawyer, if you're not. Remember that you are the consumer and can demand quality service, she says.

"Apply the same standards that you would to buying any other service," Popp advises. "If you're not satisfied with the work that's being done, the communication that's coming your way, you should speak up even if your hospital has worked with this counsel for years."

Establishing ground rules and expectations up front is key to avoiding conflicts, but better communication also can help you get more for your dollar.

Popp notes that malpractice defense attorneys have been hit hard by recent economic downturns and are looking for ways to be more value-added to their clients. So the risk manager is in a position to ask for additional services without being charged for every minute of the lawyer's time.

"Don't by shy about asking," she says. "Particularly if it's a law firm with a lot of associates, they may appreciate the opportunity to introduce their

associates into the mix."

Of course, you probably don't want an associate handling your complex malpractice case. But by the same token, you shouldn't have a partner handling routine matters that are well within an associate's abilities.

"You're better off setting down with them up front and set these expectations. You're going to pay top money for a lead lawyer sometimes, but you should make clear that associates and paralegals are involved in appropriate ways for the daily work," she says.

Inservices often offered free

Popp notes that outside counsel often will provide in-house education for clinicians and staff on topics such as depositions and what it is like to be sued — but you usually have to ask. In a previous position with Tenet Healthcare, Popp says the company lawyers were required twice a year to provide inservices to the hospitals they worked with.

"We found that it tremendously strengthened the relationship between the risk manager and the defense counsel because they were there on a proactive basis," she says. "It also made defending cases easier because the providers and staff knew these people already and they weren't strangers when the time came for a deposition."

When dealing with more than one law firm for outside counsel, Popp urges risk managers to know them well enough to distinguish between their strengths and weaknesses, as well as their particular interests. Some firms, and individual attorneys, will be better negotiators and others will be better at trial. It also is common for some to be more interested in particular fields, such as cases involving the emergency department, than others.

A good relationship also should help clarify when the attorney is needed, and when the risk manager can handle the issue alone.

"Particularly when you're talking about trying to develop a nonpunitive environment and having proactive conversations with patients, the risk manager should be comfortable with knowing when to involve outside counsel," she says. "Think about utilizing counsel in a way that is much more expansive than just the person you send your malpractice cases to."

A good way to outline such expectations by preparing a document called "Defense Counsel Guidelines." The law firm may offer such a document that you can alter as necessary, but Popp says the best guidelines are not overly specific. The goal should be to specify general expectations without trying to define every possible situation. That only drives the attorneys crazy as they try to comply, she says.

"If you do that up front, you can avoid a lot of animosity that occurs when you get the bills," she says.

The alternative is to just wait and see what the law firm bills for and then hire someone else to perform a bill audit to determine what is reasonable and customary. Such audits are becoming more common, Popp says, but they can wreak havoc on your relationship with counsel.

Risk managers also should ask for an estimate of total charges when first discussing the case or problem with counsel, Popp says. While you cannot expect an exact accounting up front, the law firm should be able to give a ballpark figure for what your total charges will be. "Five years ago, you could not find defense counsel willing to give you a number. But a lot of carriers and self-insurance programs have started demanding it, and individual risk managers can, too."

Be careful not to expect too much from the estimate. Popp says it is reasonable to expect that counsel can tell you a case is not overly complicated, is likely to settle before trial, and similar cases have incurred charges of $25,000. Then as work progresses, counsel can keep you abreast of whether the case is still on track for that expected charge or not.

At Tenet, counsel was held to a 10% variance. That limit wasn't really enforced in any way, but it served as a prompt for communication between counsel and risk manager. When the budget started going more than 10% over what was projected, counsel was expected to pick up the phone and update the risk manager.

"The number they give you up front is more of a talking point than anything else," she says. "They can estimate up front, and then six months later they know for sure whether they have to go to Europe for a deposition. You want a relationship that makes it automatic for them to call you and update you when they know."

Aside from talking about the cost of legal counsel, the relationship should ensure that both parties receive all the information necessary to work efficiently and produce the best outcome. Popp has one immediate word of warning: Be careful when using e-mail.

E-mail has become so common that risk managers may be tempted to use it for communicating with counsel about legal matters, but Popp says the

confidentiality risk is too great. Restrict e-mail use to mundane matters such as scheduling a meeting or passing on the name of an expert, she says. Don't use it to provide confidential information like answers to interrogatories or a doctor's licensure history.

Popp also reminds risk managers that they have to be available to counsel when necessary. When establishing a relationship with counsel, or meeting with long-term counsel to improve communication, she suggests going over some of the practical aspects of how to reach each other and exchange information.

Does the attorney want to come in and look over the records before you copy them, just to speed things up? Do you want records sent by courier or is it easier to have someone from the law firm stop by? What about the best times to reach the risk manager by phone? Should the attorney leave a message or have the risk manager paged?

Standardizing information also is a good way to improve communications. For instance, you can provide updates each year or twice a year so that counsel does not have to ask for routine information for each case, Popp says. One example would the new insurance policy number.

"Send it to counsel as soon as you have the number at renewal," she says. "Be proactive a little bit and you can avoid a lot of the same questions over and over." ■

JCAHO updates advice on avoiding wrong-site errors

Continuing the effort to eliminate what it calls an entirely preventable class of error, the Joint Commission on Accreditation of Healthcare Organizations has updated its frequently asked questions on how to avoid performing a procedure on the wrong body part, wrong person, or the wrong procedure on the right patient.

JCAHO has urged a zero-tolerance policy toward this type of error and offered a new Universal Protocol to standardize pre-surgery procedures for verifying the correct patient, the correct procedure, and the correct surgical site.

The protocol focuses attention on marking the surgical site, involving the patient in the marking process, and taking a final "time out" in the operating room to double check information among all members of the surgical team. **(For more details on what the Universal Protocol requires, see www.jcaho.org. Also, see *HRM*, September 2003, pp. 97-100; and February 2004, pp. 13-17.)**

This question was updated recently: For "right/left" cases, is it acceptable to mark the opposite site with a "NO" rather than marking the intended operative site? JCAHO responds with, "No, that is not acceptable. The protocol specifies marking the *intended site* of the procedure. Marking the nonoperative site instead of or in addition to the operative site is explicitly prohibited by the protocol unless necessary for some other aspect of care (such as to warn against using a particular extremity for venous access because of a prior surgical procedure)."

A new question also was added, asking whether it is necessary to mark the site for laparoscopic procedures. JCAHO says, "If the target site is for organs that are paired, site marking is required to indicate the intended side, even though the site of insertion of the instrument is in the midline."

In response to a question about what type of marker is appropriate, JCAHO advises using a marker that is "sufficiently permanent to remain visible and will not wash off when the site is prepped" and cites commonly available surgical markers or pens as an example.

JCAHO also addresses whether a separate form is needed to document that the site was marked, saying the protocol does not specify the type of documentation. However, JCAHO points out that the Universal Protocol does require you to document, in some way, these elements:

- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of implants
- Availability of special equipment or special requirements. ■

COMING IN FUTURE MONTHS

- Reducing workers' comp from falls
- EMTALA violations you may overlook
- What to expect when underwriters visit
- Improving your visibility with management

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. After completing this activity each semester, 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.

1. Which of the following is *true,* according to ECRI's Mark E. Bruley?
A. Surgical fires are extremely rare and mostly a theoretical risk.
B. Surgical fires are a true risk, not something theoretical.
C. Surgical fires almost never result in injury.
D. Surgical fires pose a risk to clinicians but not to patients.

2. According to Marianna Grachek, CNHA, MSN, RN, what is the primary focus of the proposed 2005 National Patient Safety Goal regarding falls?
A. Eliminating all falls in health care settings.
B. Reducing patient harm from falls.
C. Increasing the use of restraints to reduce patient falls.
D. Making patients more responsible for fall prevention.

3. According to Carl E. Schneider, JD, what is the primary reason that living wills do not work?
A. Patients must predict what they will want in circumstances they have never experienced and can't foretell.
B. The language in living wills is overly complex.
C. Patients do not take the living will seriously when they sign it.
D. Living wills often are not provided to clinicians when the patient is terminally ill.

4. What does Pamela L. Popp, MA, JD, FASHRM, CPHRM, recommend for getting more service out of your legal counsel?
A. Don't be afraid to ask because defense counsel is eager to provide value-added service.
B. Don't ask because the request could ruin your relationship.
C. Feel free to ask but the attorney will be reluctant to provide any service at all without billing.
D. Don't ask because attorneys are prohibited from providing any service without billing.

Answers: 1-B; 2-B; 3-A; 4-A.

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

When it comes to background checks for employees, follow your own rules

By **Jan J. Gorrie**, Esq., and **Blake Delaney**
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News: The parents of a newborn baby retained a home health agency to provide in-home child care. The agency failed to follow its screening procedures when selecting the nurse's aide and overlooked her history of drug abuse and theft. After 12 nights of adequate baby-sitting, the parents hired the aide directly, outside of her contract with the agency. One night, while in the aide's care, the 5-month-old died as a result of shaken baby syndrome. After a trial in which the nurse's aide and the agency were co-defendants, the jury thought it possible that the mother or father had shaken the baby and was not convinced that the aide was responsible. Consequently, the jury returned a defense verdict for the nurse's aide. Nonetheless, the jury awarded $75,000 against the home health agency because it exposed the family to danger through its negligent screening process.

Background: In July 1995, a baby boy was born with esophageal reflex, causing him to vomit day and night. The child's condition prevented the mother and father from sleeping through the night. In addition, the mother suffered from postpartum depression. Seeking relief four months later, the couple's insurance company retained a home health agency to provide overnight in-home child care for 12 nights.

When selecting the particular nurse's aide for the job, the agency failed to comply with its pre-hiring screening policies — neither the agency nor the parents knew that the nurse's aide was addicted to Vicodin (hydrocodone), a narcotic pain reliever. As with all narcotics, Vicodin has been known to impair a person's mental and/or physical abilities by causing hallucinations, mental clouding, and severe confusion. The couple also did not know that the nurse's aide allegedly had stolen a credit card from a previous client of the home health agency. Nevertheless, the aide was given the 12-night assignment in November and she provided adequate care for the baby during that time.

When the couple's insurance benefits ran out in December 1995, the agency discontinued its overnight child care in the parents' home. Later that same month, the mother began treatment for severe depression and panic disorder at an outpatient psychiatric clinic. Consequently, the couple offered to hire the nurse's aide to moonlight at their home. Despite a clause in the aide's contract with the home health agency prohibiting such unofficial services, the aide agreed to the couple's offer in late December.

On Dec. 29, the nurse's aide baby-sat overnight without incident. The aide next baby-sat during the early hours of Jan. 3, when the parents asked her to watch the boy for the last six hours of the night. The following morning, the aide saw the baby was unresponsive and called the father, who attempted to resuscitate the child while waiting for the paramedics to arrive. The baby

was pronounced dead as a result of blunt trauma and shaken baby syndrome. The most noticeable injuries were brain and eye hemorrhages.

An Illinois state court convicted the nurse's aide of murder. In her appeal, the aide argued that because so many people had access to the baby that night, including the mother and father, it was improper for a jury to have found her guilty beyond a reasonable doubt. After spending several years in prison, the Illinois Second District Appellate Court reversed the aide's conviction in May 2000. At that time, she pleaded guilty to attempting to obtain prescription drugs without a prescription and to theft of a credit card.

Following the reversal of the aide's criminal conviction, the parents sued the nurse's aide for willful and wanton conduct. The couple also sued the home health agency for negligence, claiming the agency's failure to comply with its screening policies caused the baby's death. The parents alleged that the agency's screening policies would have led to discovery of the Vicodin addiction, and the plaintiff's expert argued that the Vicodin addiction led directly to the killing of the baby.

The defendants first argued that the injuries happened before the nurse's aide arrived at the couple's home on the morning of Jan. 3. Defense experts testified that the injuries could have occurred any time during the 24 hours before the baby boy's death and the fact that the aide was only present during the last six hours of the night created enough doubt about whether the aide was responsible. Furthermore, the defense argued that either the father or the paramedics were responsible for the eye and brain hemorrhages, given that the father observed none of those injuries when he was first called by the aide to attend to the unresponsive baby.

The second defense offered by the home health agency was that the aide's private contract with the parents released the agency from any liability. In response to this, the parents contended they relied on the agency's background check in making their decision to hire the nurse's aide.

At the conclusion of the trial, the jury was not convinced that the nurse's aide was responsible for shaking the baby and returned a defense verdict in her favor. The jury then found that the home health agency was negligent in conducting its screening process. It found that the agency's negligence exposed the family to danger, even though the danger never materialized into any real damages. As a result, even though arguably inconsistent, the jury's verdicts released the aide from all liability, yet awarded the parents $75,000 in damages from the agency.

What this means to you: Because a home health care provider, by its very nature, has no control over the environment in which its employees will deliver the health care services, such providers universally establish procedures for screening prospective employees during the hiring process.

"This case presents a classic illustration of why it is absolutely imperative that an organization follow the rules, especially when it was the organization itself that wrote the rules," states **Ellen Barton**, JD, CPCU, a risk management consultant in Phoenix, MD.

All screening procedures undoubtedly ensure an applicant's satisfaction of licensing and other technical qualifications required for providing medical care. However, part of the rules should also include reviewing a prospective employee's suitability for the unsupervised nature of home health care service.

"The very core of a home health agency's operations is the delivery of care in a client's *home*. Thus, the agency not only needs to assure itself that the prospective staff are clinically competent, but also that the prospective staff can be trusted to deliver care in a safe and effective manner," Barton says.

During the screening process, a home health care provider should evaluate several aspects of an employee's background relevant to providing medical care while in a patient's home.

"First, no one would disagree that it is prudent for an organization in the home health business to conduct screening procedures that include criminal background checks on all applicants," states Barton.

A criminal history can signify an employee's general disregard for following rules and, depending on the specific nature of the criminal record, may indicate particular problems that are likely to arise in a home health care situation.

A second relevant aspect of a prospective applicant's background is the employee's lifestyle, including any illegal or destructive habits, such as alcoholism and other drug addictions. In this case, although the aide's Vicodin addiction would not have surfaced during a routine criminal background check, such information is nevertheless relevant to the quality of care that the home health care agency should expect from

her. As the plaintiff's expert opined in this case, the narcotics habit may have impaired the mental and physical abilities of the nurse's aide to the point of causing the killing of the baby.

Thus, while a home health care agency has no control over the environment in which the care will be delivered, it does have some control over the staff that it hires to provide services. Such control will not only lead to a higher level of patient satisfaction, but it also will reduce liability in a field that depends upon unsupervised individuals providing care in the most intimate of settings: the patient's home.

"If the agency had followed its own screening procedures and conducted an appropriate background check, it is unlikely that the nurse's aide would have been hired. Even if the agency had not discovered the aide's drug addiction and criminal background, but had followed its own screening procedures, it is unlikely that the agency would have been held responsible for exposing the family to danger," states Barton.

This is because it would be difficult for a jury to find that a home health care agency acted negligently if the agency could show that it acted reasonably according to the relevant standard of care.

"On the other hand," Barton says, "What if the home health agency had conducted a background check, discovered the red flags in the prospective employee's background, and chosen to ignore them because of what it perceived as a business need to hire staff? It's likely that under those circumstances, the agency could have exposed itself to both civil and criminal liability.

"The lesson from this case is simple: Follow the rules!" concludes Barton.

Reference

- DuPage County (IL) Circuit Court, Case No. 97L-1403. ■

Neck injury leads to an $18 million verdict in LA

News: A young woman injured her head and neck in a severe car accident. Before transporting her to the hospital, emergency medical technicians (EMTs) secured her neck with a cervical safety collar. Upon arrival at an emergency department (ED), doctors took only an X-ray of the woman's neck but did not perform a CT scan or MRI. As a result, the doctors neglected to find that the woman had three fractured vertebrae in her neck. After doctors removed the cervical collar, the woman moved her neck around, leading to the development of quadriplegia two days later. She filed suit against her doctors alleging negligence, and a jury awarded the woman more than $18 million in damages.

Background: In 1995, an 18-year-old nursing student was a passenger in a pickup truck. Another vehicle forced the truck off the road, causing it to roll over. The young woman suffered head and neck injuries.

EMTs arriving on the scene immediately began treating the woman for blunt trauma. Although unaware that the young woman had three fractured vertebrae in her neck, the EMTs followed suggested protocol by stabilizing the woman's head and spine and applying a c-collar to immobilize her neck. The EMTs transported her to an ED, where doctors performed a CT scan of her abdomen and head. As for the woman's neck, however, the doctors took only an X-ray. They failed to properly assess the patient's bone and soft-tissue components, which some experts suggest can be achieved only by a performing an MRI. As a result, the doctors incorrectly determined that the woman's neck was not severely injured and they removed the cervical safety collar.

Two days later, the young woman developed quadriplegia. She conceded that the fractures occurred in the truck accident but she argued that the paralysis occurred when she was flipping her head back and forth in the ED with no cervical spine protection.

The woman filed suit against the ED physician and the attending neurosurgeon. In her complaint, she alleged that the physicians violated the standard of care by not ordering an MRI or CT scan of her neck before removing the collar. If they had done so, they would have detected the three fractured vertebrae in her neck. By leaving her condition untreated, the fragments of the broken vertebrae eventually pierced her spinal cord, causing complete paralysis from the shoulders down. The plaintiff's attorney noted that the woman was able to move her extremities on the way to the hospital, demonstrating that she was not paralyzed in the accident.

The jury returned a verdict of $18.2 million for the plaintiffs. In Louisiana, however, medical malpractice caps limit awards for noneconomic damages to $500,000 per patient per incident. The

liability of each qualified health care provider is limited to $100,000 plus interest per patient per incident. Awards in excess of $100,000 per provider are paid out of the Patient's Compensation Fund, which is subsidized by the state of Louisiana and surcharges paid by private practitioners to the Louisiana Insurance Rating Commission. These caps on damages reduced the plaintiff's award to $10.5 million.

What this means to you: This case highlights a breakdown in procedure in caring for a woman injured in an automobile accident.

"At the outset, emergency personnel at the scene carried out the proper emergency trauma care and procedures," says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, director of risk management services at Miami Jewish Home and Hospital for the Aged and past president of American Society for Healthcare Risk Management.

Emergency care protocol calls for the careful handling of victims of motor vehicle accidents because of the potential risk of spine injury. An EMT should assume that unconscious victims have spine injuries and should carefully assess conscious victims for evidence of neck or spine injuries before attempting to move them.

Accident victims with numbness in their arms or legs are usually assumed to have spinal injuries. First, an EMT should place the victim's head in a neutral in-line position, unless it were difficult to do so or the patient were to complain. Next, the EMT should place the victim's head in alignment with the spine and maintain constant, manual in-line immobilization until the patient is properly secured to a backboard with the head immobilized. Then, the EMT should perform an initial assessment of the victim's extremities and vital signs and apply a properly fitting cervical safety collar.

Despite the proper procedure implemented by the EMTs, the process broke down in the emergency department. However, the exact source of medical error is unclear. Kicklighter suggests conducting a series of inquiries to get to the heart of what should have been done to prevent this injury and to prevent recurrence. A root-cause analysis might be appropriate for this situation. It may be that the error resulted from not having an official reading of the X-ray by a radiologist. If a radiologist were available on site, it should be questioned why the film wasn't read immediately. It is also important to examine the hospital's process for comparing wet readings to the official readings, and to question whether there is a system in place to track and analyze discrepancies between the two readings. Furthermore, a risk manager should question to what specialty the patient was admitted. If she were admitted, the specialist should have known the standard of care and, in reviewing the record, he should have recognized it was not met and taken appropriate remedial steps. Similarly, it is important to know if a neurologist was called in to examine the patient and to discover who removed the c-collar.

Kicklighter also recommends evaluating whether there was a standing protocol for caring for a patient with potential neck or head trauma. If such a protocol were in place, then a risk manager should ascertain whether it was followed and whether it has been updated so as to meet all the standards of care in a situation such as this. Indeed, the basic question is, Kicklighter says, "If an MRI is the standard to identify significant swelling, a subluxation or a fracture is the standard for performing a MRI to verify a lack of subluxation, then why wasn't it followed?

"All of the above questions should be addressed in your own institution, and steps should be taken to remedy any deviations from the standard process," Kicklighter recommends.

Specifically, all staff, nursing, and physicians should be educated so that the nurses can remind the physician when certain steps in the process are not met. In any event, this event should be referred to both the ED department chair and to the medical staff QA peer review committee to evaluate the care given.

When addressing this particular type of potential injury, the task force should include nurses and physicians from the emergency department, radiology, orthopedics, neurosurgery, and trauma.

"After all," says Kicklighter, "it appears as though this woman's ultimate injury was preventable."

Reference

• Jefferson Parish (LA) District Court, Case No. N 557-708. ■

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Finding root causes without blame helps eliminate errors

Initiative boosts staff support for improvement efforts

Searching for the root causes of adverse patient safety events under its new "nonpunitive environment policy" has helped Good Samaritan Hospital in Vincennes, IN, not only eliminate errors but also boost staff morale and engender staff support for improving performance.

The new policy has been in effect for approximately one year, notes **Elaine Shaw**, director of quality resources at the full-service facility.

"We started talking about it back in 2002. There was a lot of information out there about creating a safer environment for patients, and one of the possible strategies was to have a nonpunitive environment where employees did not feel threatened about addressing errors," she recalls.

Removing the blame factor

One significant obstacle to improved root-cause analysis, she observes, is a long history of blame-oriented investigations and tort actions that can cause individuals to be reluctant to share information about mistakes.

"We wanted to perform an investigation of an incident that would focus on real, fixable root causes rather than focusing on blame," Shaw explains.

The Good Samaritan Quality Council, which includes administration, medical staff, and Shaw (as facilitator), recommended the new policy to the board, which formally adopted it.

"When we updated our patient safety management plan for 2003, we put the wording in and officially implemented the policy," she says.

This was followed up by amnesty reporting, which stated, among other things, that if a staff member reported an error within 48 hours, no disciplinary action would be taken.

Investigating an incident

"The first incident we chose to investigate was one that, in the past, would probably have been very blame-oriented; a wrong patient was given the wrong drug intravenously," recalls Shaw. "This is a violation of our '5 Rights' policy (right patient, right medication, right dose, right time, right route) that is standard practice throughout the medical industry."

The investigation was conducted using the TapRooT System®, created by Systems Improvement in Knoxville, TN. "TapRooT helped people focus on what happened and what could be done to improve performance, rather than focusing on who to blame," Shaw notes.

Actually, Good Samaritan had been using TapRooT since 1998 to conduct root-cause analyses for systems improvement.

"We liked the scientific approach," Shaw notes. "We were able to pick out causal effects, go through the process, and drill all the way down to the generic or root cause. It made the process clearer and allowed us to focus on what was important."

The system can be used either as software or manually. "When we train our people, we give them the manual paper pack, because if an incident has to be investigated [in another location] they can take it with them, and they have all the forms they need," Shaw explains.

"But they are also trained on how to use the software, which can only be accessed on their computer." TapRooT can be used not only for

very serious events, but also to analyze processes staff want to improve, she adds.

"By using TapRooT, we found causes beyond the normal 'policy was violated' causes that we had expected [in this first incident]," notes Shaw. The analysis found the following:

- The IV bag design had changed, and now it was the same size as other bags.
- The font and type used to label the bags was small and could easily be misread.
- The nurses hurried because of unnecessary, repetitive paperwork that could be reduced to allow more time with patients and in administering medications.
- The IV bags were being hung unnecessarily high, which made them hard to read for short nurses (especially if the nurse wore bifocals).

The increased information obtained led to a better understanding of the contributors to the errors and helped the investigation team develop corrective actions that previously would not have been considered. These included:

- Increasing the type size that is printed on the label of the IV bags.
- Putting the patient's name in **bold** type to make it easier to find on the label.
- Lowering the height of the bags for IVs being delivered by IV or PCA pumps.

"Implementing these corrective actions did not reduce the importance of the 5 Rights policy," Shaw explains. "The corrective actions actually highlighted the fact that hospital management was taking action to ensure that the 5 Rights policy could be implemented more effectively. This reinforces to our staff the importance of the policy and their compliance with it."

Impact on staff

The initiative had a positive effect on staff, says Shaw. "The people involved understood we were looking at processes and systems — not individual performance," she says.

"They felt freer, and they became as eager to solve this problem and find out why it occurred as management was. You had to be sitting in that room and see the light bulbs go on when we realized we had IV poles sitting where they did not need to be," Shaw points out.

Years ago, hospitals did not have IV pumps, and so they relied on gravity to produce the desired flow. "Today, however, if you have a nurse who is 5 feet tall, is in her 50s, and wears bifocals, they'd have a hard time reading the print on a bag that's up in the air," she observes. "So there was a break in the system."

Staff attentiveness to the new policy did not occur by chance; the new message was driven home through targeted strategies. "It was accomplished mainly through continuing education. We made some poster boards, put story boards on the 5 Rights in areas where the staff would see them, and talked about it in staff meetings. We also made sure that in orientations sessions we placed enough emphasis on medication administration; we made a conscious effort to use that opportunity to drill home the importance of the 5 Rights," Shaw says.

As a result of the new policy, the following was accomplished:

- Staff were more willing to openly share mistakes that they had made.
- The investigation team identified causes they previously would have missed.
- The hospital implemented corrective actions that will improve performance and improve compliance with a policy without blame or disciplinary action.

Another key to success, says Shaw, was that the nurses came to these decisions by themselves — that, for example, regardless of how busy they were, they should always follow the policy.

"They came up with that during an actual root-cause analysis," Shaw notes. "It made you feel good that it came from staff. We realized that we were dealing with human beings, and that errors do occur, but that it is the process that breaks down, not the employee."

She says the new policy has been successful. "There's always been a little doubt, because for so many years in health care people have been used to blame being placed on an individual," Shaw notes. "In some ways, it's easier for the new employees who hear about it during orientation; they do not have as hard a time with it as the older employees do. Still, behavior has started to become more accepting."

Her team recently conducted a survey, asking employees if they felt they could report error without fear of reprisal. "We got better scores than we anticipated," she reports.

The type of error studied in the first root-cause analysis has not occurred again.

[For more information, contact:

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