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INSIDE

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New restraint guidelines could be a problem for risk managers

JCAHO guidelines meant to protect patients, but compliance difficult

New restraint guidelines for behavioral health care could be a burden for clinicians and expose the organization to several types of increased risk, says a risk manager who studied the issue for *Healthcare Risk Management*. The guidelines will be difficult to implement, and they might be unnecessary, she says.

The guidelines were proposed recently by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. *HRM* asked **Leilani Kicklighter**, RN, ARM, MBA, DASHRM, assistant administrator for safety and risk management in the North Broward Hospital District in Fort Lauderdale, FL, to review the guidelines for risk management concerns. Kicklighter is a past president of the American Society for Healthcare Risk Management in Chicago.

She says the proposed guidelines should worry risk managers. While the guidelines obviously are a well-intentioned effort to protect patients from the abuse of restraints and seclusion, she says facilities will find it difficult to comply with some of the specifications. "I know the intent is to protect the patient, but I think most facilities already

Executive Summary

Subject:
New restraint guidelines from the Joint Commission would mean frequent checks by a doctor or other licensed professional, such as a social worker. Risk managers may find the guidelines are problematic and increase the risk of compliance liability.

Essential points:
- ❏ The guidelines go beyond those found in the Medicare Conditions of Participation.
- ❏ Compliance may be difficult and increase hospital costs.
- ❏ Staff may be reluctant to use standards because of the fear of noncompliance, increasing the risk of injury and liability among combative patients.

are doing all they can to reduce the use of restraints," she says. "That may not be the perception sometimes because of some bad cases covered in the media, but I don't think most organizations abuse restraints to the extent that we would need these guidelines to prevent it. I don't understand why the restraint standards of care already in place aren't good enough to be applied to the entire organization, instead of coming up with special guidelines for behavioral health."

Kicklighter says the new guidelines are not bad for the patient in any way, and she would not mind following them in a world where staffing and physician access were no problem. But she suspects they are an overreaction to the cases in which restraints have been abused by some behavioral health centers. Instead of requiring those providers to adhere to existing standards, Kicklighter says it appears the Joint Commission wants to impose stronger standards on all behavior health centers.

"It's sort of like they're punishing everyone for the acts of some," she says.

Input solicited from providers

The Joint Commission has solicited comments on the proposed guidelines for a short time and now is considering possible changes based on those comments, says spokeswoman **Charlene Hill.** It is unlikely that risk managers had a chance to provide much criticism, however, because providers were given less than a month to get their comments in by Nov. 22.

The Joint Commission sought input on the draft standards, sending them to more than 3,000 individuals and organizations, including professional associations, consumer groups, government agencies, all organizations accredited by the Joint Commission under the Comprehensive Accreditation Manual for Behavioral Health Care, and those organizations accredited under the comprehensive Accreditation Manual for Hospitals that are freestanding psychiatric hospitals or hospitals with inpatient psychiatric units, residential treatment facilities, or partial hospitalization programs.

The Joint Commission's restraint-use task force will review the results of the field evaluation in December. The feedback received will be incorporated into the standards for final consideration by specific Joint Commission advisory committees and the Standards and Survey Procedures Committee of the Board of Commissioners during the first quarter of 2000.

Among the provisions in the draft standards is the statement that restraint and seclusion be used only in emergency situations — that is, when there is an imminent risk of an individual physically harming himself or others. Lesser interventions should be the first choice, the standards suggest, unless safety demands an immediate physical response.

A key provision of the guidelines is that a "licensed independent practitioner" must authorize the restraint or seclusion and then monitor the patient frequently, at least every eight hours. The Joint Commission defines that person as "any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges (these individuals may be referred to by other terms, such as 'independent care provider'). In many behavioral health organizations, licensed independent practitioners include physicians, psychologists, and social workers."

The guidelines do not make clear whether some other potentially qualified professionals might fit the bill. Kicklighter wonders about a master's-prepared psychiatric nurse, for instance, who usually is allowed more independence in Florida. Some clarification about who might be considered a "licensed independent practitioner" could eliminate some compliance challenges, she says.

If the periodic assessment must be made by a physician in most cases, Kicklighter says it will be a problem for some facilities that do not have access to physicians or social workers around the clock. At a minimum, she says, facilities will have

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to call on physicians more frequently and at all hours, which will increase costs and tension.

"If that's at two in the morning, you're going to be able to hear the doctor screaming from my office," she says. "I'm not belittling the need for patient safety, but I think we can get to that without the stringent criteria on who can make this assessment. If it's four in the morning and you don't have a psychologist or a physician in-house 24 hours a day, someone's going to have to get out of bed and come in."

The cost of caring for the patient increases if you call the practitioner in or if you change staffing patterns to ensure that a licensed practitioner is present around the clock, she says.

Staff may back off necessary restraint use

Kicklighter raises the possibility that the new guidelines could backfire if the behavioral health staff think they are too difficult to comply with. No nurse wants to wake a doctor in the middle of the night to assess a patient in restraints, so the nurse might just decide to forego restraints in that case. If the patient truly were dangerous to himself or others and the restraints were justified, that decision would increase the risk of injury and liability, Kicklighter says.

There also is the possibility, though Kicklighter says it is less likely in a well-run institution, that staff will go ahead with the restraints but ignore the requirement to have the patient reassessed.

Either way, the result is a problem for the risk manager. "I'm concerned about people using restraints less because of the difficulty of the standards, putting our employees at risk, as well as other patients and even visitors," she says. "I would hope that good patient care and nursing judgment prevail."

[Editor's note: Copies of the standards are available at www.jcaho.org or by calling the Joint Commission's customer service center at (630) 792-5800.] ■

Source

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Guidelines require frequent patient contact

The new restraint guidelines from the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, contain strict requirements for a patient to be seen frequently by a doctor or other licensed professional.

The following example provided by the Joint Commission illustrates how time requirements would play out in the use of restraint or seclusion with an adult for 24 consecutive hours. The example also illustrates the *minimum* expectations for participation by a licensed independent practitioner. The Joint Commission stresses that the example does not presuppose that 24 hours is a desirable length of time to restrain or seclude an individual; it is simply an illustration of how multiple cycles of assessment would be expected to occur over a 24-hour time frame.

In this timetable, the citations in parentheses indicate the applicable guideline:

- **0 hour:** Initiation of restraint or seclusion (TX.3.4.1). Individual is assessed and continuous monitoring begins (TX.3.6).
- **Every 15 minutes:** Individual assessed by qualified staff member (TX.3.6).
- **Within one hour**: Verbal order obtained from a licensed independent practitioner (TX.3.4.3). Order is limited to four hours from the time of initiation TX.3.5).
- **Promptly:** Face-to-face evaluation by a licensed independent practitioner (TX.3.4.4). (The Joint Commission has not defined "promptly" but may do so when the guidelines are final.)
- **End of 4th hour:** Authorized, qualified staff reevaluate the individual. If restraint or seclusion continues, either a new order is obtained or the original order is continued (TX.3.7). The new order or continued order is limited to four hours (TX.3.5).
- **End of 8th hour:** A licensed independent practitioner reevaluates the individual. If restraint or seclusion continues, the licensed independent practitioner furnishes a new order (TX.3.7). The new order is limited to four hours (TX.3.5).
- **End of 12th hour:** Authorized, qualified staff reevaluate the individual. If restraint or seclusion continues, either a new order is obtained or the order is continued (TX.3.7). The new order or continued order is limited to four hours (TX.3.5).
- **End of 16th hour:** A licensed independent practitioner reevaluates the individual. If restraint

or seclusion continues, the licensed independent practitioner furnishes a new order (TX.3.7). The new order is limited to four hours (TX.3.5).

• **End of 20th hour:** Authorized, qualified staff reevaluate the individual. If restraint or seclusion continues, either a new order is obtained or the order is continued (TX.3.7). The new order or continued order is limited to four hours (TX.3.5).

• **End of 24th hour:** A licensed independent practitioner reevaluates the individual. If restraint or seclusion continues, the licensed independent practitioner furnishes a new order (TX.3.7). The new order is limited to four hours (TX.3.5). Clinical leadership is notified (TX.3.7.1). ■

Sources

- ❑ **National Association of Psychiatric Health Systems**, 1317 F St. N.W., Suite 301, Washington, DC 20004. Telephone: (202) 393-6700. Free copies of the guiding principles may be obtained from the NAPHS by calling (202) 393-6700, Ext. 15.
- ❑ **American Hospital Association**, 325 Seventh St. N.W., Washington, DC 20004. Telephone: (202) 626-4628.

JCAHO restraint guidelines follow other groups' leads

Restraints have been a hot issue in health care recently, and the more recent guidelines follow on the heels of those issued by two leading professional organizations. Most of the guidelines suggest that the use of restraints and seclusions can be reduced significantly in some situations and that any use must be well-justified.

The most recent guidelines for restraints and seclusion in behavioral health come from the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, but the issue has been addressed recently by the American Hospital Association (AHA) and the National Association of Psychiatric Health Systems (NAPHS), both in Washington, DC. Both organizations serve on the Joint Commission's board-level task force on restraint and seclusion, which recommended the measures in the new guidelines.

(*Healthcare Risk Management* has covered the issue of restraint use extensively. For details, see "Guidance issued on use of restraints, seclusion," April 1999, p. 49; "JCAHO: Zero tolerance on restraint deaths," July 1999, p. 86; and "New regs on restraint use follow JCAHO's lead," September 1999, p. 111.)

These are the guiding principles established by the AHA and NAPHS:

• A patient's overall treatment is based on a comprehensive, individualized treatment plan that includes appropriate patient and family involvement.

• Hospitals and other treatment settings serve individuals with severe mental illnesses and substance abuse problems who are, at times, dangerous to themselves or others.

• Restraint and seclusion should be used as infrequently as possible, and only when less-restrictive methods are considered and are not feasible.

• Restraint and seclusion are emergency interventions that aim to protect patients in danger of harming themselves or others and to enable patients to continue treatment successfully and effectively.

• Prevention of injury and death is essential.

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

How to minimize claims from hiring, firing staff

Employment claims in the health care industry are "going through the roof," according to **John Lyncheski**, JD, an attorney with Cohen & Grigsby in Pittsburgh. He cautions that health care risk managers must pay more attention than ever to the hiring and firing processes, always with an eye to minimizing the liability when an angry ex-employee tries to get even.

"Employment claims are the largest class of federal claims, bar none," he says. "Employees are incredibly aware of their rights to sue their employer. Why are they so aware? We tell them. Go down to the human resources department and you'll see the poster on the wall explaining

Executive Summary

Subject:
Employment claims related to hiring and firing are increasing steadily, and the payout for hospitals can be substantial. Some commonly held beliefs about how to fire employees can encourage them to file lawsuits.

Essential points:
- ❑ Large payouts are common with employment cases.
- ❑ Lies on job applications can be good defense tools.
- ❑ Sensitivity in the firing process can decrease the likelihood of a lawsuit.

how to sue you for discrimination."

Recent years have seen both an increase in the number of employment claims filed and a change in the type of claims, he says. It used to be that only white-collar employees responded with "you'll hear from my lawyer" when they were fired, Lyncheski says. "But now you hear that from the guy you fired from the laundry," he says. "Everybody has a lawyer today."

Lyncheski spoke on the issue at the recent meeting of the American Society for Healthcare Risk Management in Chicago. He told the risk managers in attendance that they must partner with the human resources department more closely than most currently do, so they can get involved in preventing employment claims from an early point. **(See p. 142 for examples of how not to hire and fire and p. 143 for Lyncheski's advice on handling employment claims.)**

Michael Barton, corporate vice president of human resources at Regional Medical Center in Madisonville, KY, tells *Healthcare Risk Management* that health care providers are seeing many more lawsuits related to hiring and firing than they saw in past years.

"People are suing, and I see an upswing, with people more aggressive about it, particularly among young people," Barton says. "I think part of it is that health care organizations have tended to overlook the inexperienced applicant. If the job posting says 'no experience necessary' and then you screen them out because they have no experience, they can get aggressive about it."

In such a situation, the applicant may assume you overlooked the person for some other reason, such as age, race, or sex. In reality, the organization often just finds that experienced and, therefore, more desirable applicants appeared even though the job posting did not require experience. In that case, Barton suggests posting the job description again so it asks for experience. "You can say that you've looked at the job again and decided that you need some experienced applicants after all," he says. "Let them see that you've altered the specifications. We usually repost job specifications for three to five days. There's no legal requirement to do that, but it makes sense."

You also might tell the applicant in such a situation that other positions within the organization are available without experience, and refer the person to those posted positions. If no such positions are available, you can tell the person the application will be held on file for six months. (Barton also recommends caution with implied promises. **See p. 142 for more information.**)

However you decide to handle the situation, keep in mind that people can react very poorly if you seem callous or abusive. That applies even when you have no real relationship with the person beyond looking at a job application. Barton says risk managers are seeing an upswing in the number of people charging personal harassment because you asked for more information or questioned items on their applications.

"Particularly now, people are violent when you start playing with their careers, their jobs, their money," Barton says. "I'm not saying they're going to shoot you, but they get very upset very quickly, and they can get aggressive in filing lawsuits."

Lawsuits possible even when firing justified

Federal job discrimination lawsuits are increasing at a rate of about 20% per year, Lyncheski says, according to data from the Equal Employment Opportunity Commission in Washington, DC. Lawyers increasingly are willing to take plaintiffs' cases alleging employment discrimination, he says.

Some legislative changes in recent years have encouraged more job discrimination lawsuits. The Civil Rights Act of 1991 opened the door to jury trials, compensatory damages, and punitive damages. More opportunities for lawsuits came along with the Americans with Disabilities Act, the Family and Medical Leave Act, the Age Discrimination in Employment Act, the National Labor Relations Act, the Fair Credit Reporting Act, the False Claims Act, and the Health Insurance Portability and Accountability Act of 1996.

Class actions also are being approved more frequently by the courts, and they carry even higher

Beware of implied promises, unneeded examinations

When your supervisors are interviewing job applicants, be sure they do not increase your risk of liability by implying a promise they may not be able to fulfill, cautions **Michael Barton**, corporate vice president of human resources at Regional Medical Center in Madisonville, KY.

Implied promises can be particularly dangerous when applicants already are anxious about getting a new job and sensitive to any type of misdeed in the application process, Barton says. An implied promise would be something like telling the applicant, "You have this job contingent on your reference checks and certain examinations." The supervisor may think that is not much of a commitment, but the applicant may assume the job is secured. The gap between those two assumptions can foster a lawsuit, he says.

It is better to avoid telling applicants that they "almost" have the job. Just wait until the reference checks or examinations are complete, Barton suggests. The only exceptions are preplacement physical examinations and drug screens. In most situations, the job must be offered before those examinations, so you should clearly explain how the offer is contingent upon those examination results.

When requiring examinations as part of the hiring process, be sure they are necessary for the particular job in question. Otherwise, you can be subjected to a discrimination claim alleging that you used the examination to screen out certain types of people.

"If you're hiring a housekeeper, it's probably not necessary to have them do a math test, but if you're hiring a pharmacy technician, sure," he says. "Whatever the test, make sure it has some valid connection with the position and isn't just a routine test." ■

potential liability than individual lawsuits. Lyncheski cites these average awards for litigated cases related to employment discrimination:

- age discrimination — $219,000;
- race discrimination — $147,799;
- sex discrimination — $106,728;
- disability discrimination — $100,345.

Employment cases are second only to medical malpractice as the type of jury verdict most likely to surpass $1 million, Lyncheski says. That gap is closing fast, he says.

Defense legal fees average $44,000 per case. "And that's with an experienced attorney who knows what he's doing with this type of case," he says. "Your legal fees can reach six figures when the attorney is not experienced."

Lyncheski says his experience and various studies have shown that juries are likely to believe a terminated employee, and a majority of jurors think it is part of their job to send a message to employers in hopes of changing their behavior. ■

What *not* to do when hiring and firing staff

Lawsuits alleging wrongful dismissal are among the most common employment claims, and they can result in costly payouts, according to **John Lyncheski**, JD, an attorney with Cohen & Grigsby in Pittsburgh. Unfortunately, hospitals eventually have to compensate former staff even when many of those dismissals were legitimate.

Failure to follow all the proper steps in hiring and firing can make that outcome more likely, and Lyncheski says an employer's insensitive handling of a dismissal can prompt a costly lawsuit that might not have been filed if the situation had been handled better.

Inform employee of reason for dismissal

Lyncheski offers these true examples of how *not* to handle dismissals within your health care organization:

- A finance director had worked her way up the corporate ladder in more than 20 years at the company. The outplacement director advised hospital leaders to give no reason for her dismissal and have her escorted from the premises. Though the hospital offered a generous severance package, she rejected the severance and outplacement services, choosing instead to sue for wrongful termination.

"It really was a legitimate dismissal, but because they wouldn't tell her anything about their reasons, she thought there must be some hidden motive. I don't think that's unreasonable for a person in that situation to think," he says. "They settled for $50,000."

- In two other cases, fired employees alleged "defamation by action" when they were forced to pack their belongings in the presence of co-workers

and then were escorted to their cars. Their employers settled.

• A pharmacy sales representative was fired in a public restaurant and then followed home so his car and samples could be retrieved.

"They left him standing there in his driveway, watching them drive away with his car and his job," Lyncheski says. "So this 50ish guy sues for age discrimination and public humiliation. He got $8 million, including punitive damages."

• An executive was fired for absenteeism on Bring Your Child to Work Day. His child actually saw him get fired before they both had to leave the office.

"You know the legal term for that? 'Stupid!'" he says. "Absenteeism cases are some of the cleanest dismissals, and they screwed it up in a big way." ■

Check job applications when facing claims

As with most risk management issues, some employment problems can be prevented, but others still will demand attention afterward. The following advice for handling employment claims is from **John Lyncheski**, JD, an attorney with Cohen & Grigsby in Pittsburgh:

1. Check for supporting information in the job application.

The very first thing to do after an employment claim is filed is to check the job application with a fine-toothed comb, he says. Almost any job application plainly says that any falsehood, misleading statement, or material omission is reason for immediate dismissal, no matter when discovered. If you find that the employee lied or withheld information on the job application, you can use that as a trump card to end the lawsuit in many cases.

If you discover irregularities in a job application of an employee who is suing for wrongful termination, consider a second, separate termination action against the employee. That second "firing" is likely to stick and at least will end the employee's claim on earnings past that point.

2. Do criminal record checks.

These are a must in health care employment, Lyncheski says.

3. Tell the person why he or she is being fired.

Many human resources professionals advise managers to avoid any direct criticism of the employee's performance and to say something general instead, like "Your services are no longer required." The theory is that providing a specific reason provides the fired employee with ammunition for a lawsuit.

"I absolutely, wholeheartedly disagree," says Lyncheski. "You need to give them a cogent reason or they will go straight to an attorney. They will be suspicious, and the jury will be suspicious."

4. Do not surprise employees with their firing.

If a dismissal is legitimate, the supervisor should have alerted the employee that dismissal was possible or even imminent. Avoid any method that surprises the employee, even though some supervisors think that is a better approach because it can prevent the employee from sabotaging work or taking other adverse action in the workplace. From a risk management perspective, a surprise firing is like just begging for a lawsuit.

"Surprised employees are vindictive, and vindictive employees sue," Lyncheski says.

5. Do not fire someone on a Friday at 5 p.m.

Again, this is a practice that some supervisors mistakenly believe will make the dismissal easier. Actually, it can exacerbate any feelings of resentment.

"The fired employee won't be able to talk with anyone in human resources to explore what options are available and how the dismissal will be handled," he says. "Instead, they will stew and get angry and suspicious before they can talk to anyone again. By Monday, they might decide to call a lawyer instead of human resources." ■

Sources

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

Scope repair lawsuit is cause for concern

A lawsuit filed against "third-party" endoscope repair companies should get the attention of risk managers, even though health care institutions are not the subject of the lawsuit, says a risk manager whose facilities use the repair companies.

Karl Storz Endoscopy America is suing two laparoscope repair companies, alleging that their work on Storz endoscopes and laparoscopes misleads the medical community into thinking that Storz did the repair work. A great many hospitals use third-party companies to repair scopes, mostly because they offer cost savings of about 50% over what the original scope manufacturer would charge for repairs.

The two defendants in the lawsuits are Fiber Tech Medical Inc., whose endoscope business recently was sold to and is now being conducted by General Electric Company, and Surgi-Tech, whose endoscope business recently was sold to and is now being conducted by Cardinal Health Inc. Neither company returned calls seeking comment on the lawsuits.

Though the lawsuits are based on trademark infringement, Storz's real concerns relate to the quality of the repairs, says **Rick Kilgus**, manager of Karl Storz repair services in Stanford, CT.

"What many people don't know — including doctors, OR nurses, hospital administrators, and patients — is that our highly complex endoscopic devices are too often being repaired by companies using unauthorized parts and altering the original specifications, which could result in missed diagnoses or even injury to a patient," Kilgus says.

In particular, the Storz company is upset with the practice of "reshafting and refibering" scopes, he says.

"The practice of reshafting and changing nearly all of the critical optical components of our endoscopes confuses and misleads medical professionals, who still see our Karl Storz logos on these endoscopes," he explains. "They assume these devices contain genuine Karl Storz parts and workmanship and meet our stringent quality control requirements. We want to inform the users of the risks and the fact that these are no longer our devices."

The Karl Storz lawsuit poses no direct threat to hospitals and other providers, but it still should get the attention of risk managers, says **Steve Johnson**, director of risk management for WellStar Health System in Marietta, GA. There is no problem with the overall concept of using third-party repair companies, he says, and WellStar uses a third-party repair company. The Storz lawsuit indicates a serious protest by the company, however, and Johnson fears that providers could get caught up in the fight.

Risk managers should evaluate the language in the repair relationships closely to make sure the facility's exposure is minimized. It is possible that providers could become involved in lawsuits alleging that a scope was not repaired properly and injured someone, he says.

There have been cases in which the hospital, the repair company, and Storz all were sued, says the attorney representing Storz. Any scope manufacturer is likely to claim it is not liable because its product was altered significantly, says **William Speranza**, JD, with Wiggin & Dana, also in Stanford.

Executive Summary

Subject:
An endoscope manufacturer is suing "third-party" repair companies for trademark infringement. Though hospitals and other providers are not the focus of the lawsuits, risk managers should take the opportunity to reassess their facilities' use of such repair services.

Essential points:
- ❑ Third-party repair companies can save your facility 50% on scope repair costs.
- ❑ Hospitals may be left to defend a malpractice case if the scope maker says it is no longer responsible.
- ❑ Agreements with repair companies should include indemnification.

Sources

- ❑ **Rick Kilgus**, Manager of Repair Services, Karl Storz Endoscopy America, Karl Storz Endoscopy-America, 600 Corporate Pointe, Culver City, CA 90230-7600. Telephone: (310) 338-8100 or (800) 421 0837. Fax: (310) 410-5527.
- ❑ **Steve Johnson**, Director of Risk Management, WellStar Health Systems, 805 Sandy Plains Road, Marietta, GA 30066. Telephone: (770) 792-7536.
- ❑ **William Speranza**, Wiggin & Dana, 301 Tresser Blvd., P.O. Box 11325, Stanford, CT 06911. Telephone: (203) 363-7600.

"We've had cases where we were sued along with the hospital and the surgeon, and it turned out that equipment that had the Karl Storz label on it had been repaired by someone else," says Speranza. "In at least one or two of those, Karl Storz was dismissed from the lawsuit as not liable. That still leaves the surgeon and the hospital to be sued."

Johnson says the hospital should have a contract with the third-party repair company that specifically indemnifies the user against any claim that should arise as a result of the scope repair. Insist on actually seeing proof of the insurance, he says. ■

Deselection suits likely to increase, attorney says

If your organization has any close relationships with physician group practices — and whose doesn't? — you may have a new form of trouble brewing in the form of "deselection" litigation filed by physicians who were dismissed from the group.

There are reasons to believe that deselection litigation will increase in the near future, says **Dan Groszkruger**, JD, MPH, CHE, an attorney with Chapin, Fleming, McNitt, Shea & Carter in San Diego. Hospitals and other organizations are at risk even if they do not directly own the physician groups.

Groszkruger spoke on deselection at the recent meeting of the American Society for Healthcare Risk Management in Chicago, telling attendees that the health care industry should learn from the recent deselection case involving Thomas Self, MD, a physician in San Diego. The case illustrates the risks faced by health care providers and suggests some protective measures, he says.

"A lot of observers have predicted that deselection litigation is bound to increase, given the oversupply of physicians in certain areas and the cost-containment imperatives of managed care," he says. "It is very likely that your own organization is facing the same or similar circumstances that gave rise to the Self litigation. The Self litigation represents just one variation on the broader conflicts between quality and costs under capitated managed care."

Groszkruger, who also is a San Diego Superior Court judge, watched the case closely. He suggests that risk managers should study the Self case and then look for similar situations within their own organizations. The Self case involved a dispute between the pediatrician and his former medical group, Children's Associated Medical Group (CAMG). Self claimed that he was forced out of the medical group for refusing to place corporate profits above the welfare of his patients. He sued the physician group, claiming that he was wrongfully "deselected" from participating in the group. CAMG officials denied the allegations and said the deselection was purely a business decision.

The trial gained attention in the San Diego area, largely because the doctor was portrayed in the media as having been pilloried for his devotion to his patients. A jury determined that CAMG had acted with malice when it dismissed Self and that he had been defamed by disparaging comments made when his patients asked where he was. The jury awarded the doctor $1.75 million in the compensatory damages phase on theories of wrongful termination, improper retaliation against a physician for advocating appropriate care, and defamation. Before the jury could discuss punitive damages, CAMG settled the case for $2.5 million.

Self had argued that he was fired for spending too much time with patients, ordering too many tests (especially tests that did not generate a profit), and for refusing to perform unnecessary surgery. Groszkruger says there was no proof during the trial that any harm had come to patients, but "the jury must have concluded that CAMG placed profits above patient care."

Self had been with the practice for 12 years. CAMG defended itself by claiming that Self was terminated because he was difficult to work with,

Executive Summary

Subject:
Physicians are suing their group practices for dismissing them or "deselecting" them from participation in the managed care group. Hospitals and anyone else even remotely affiliated with the group could be included in the litigation.

Essential points:
- ❑ Juries often favor physicians who claim they were fired for caring too much about patients.
- ❑ Payouts can be quite large.
- ❑ Risk managers should try to intervene early to head off lawsuits.

inflexible, and demanding. CAMG officials acknowledged that managed care plans had complained about Self's performance.

Groszkruger tells *Healthcare Risk Management* that the Self lawsuit demonstrated how deselection cases can draw in unsuspecting provider organizations. Even though the pediatrician was employed by the medical group, a local children's hospital was named as a defendant.

"You just don't know how little things along the way will affect your involvement," he says. "In the Self case, the hospital had provided staff to the medical group to field calls and take messages, and they got dragged into the suit because those messages were supposedly part of the defamation. I'm sure administrators at the hospital never thought they were exposing themselves to that when they agreed to provide support to this closely aligned medical group."

Any health care organization is at risk for inclusion in such a lawsuit "if you're involved in capitated managed care even a little bit," he says.

Outcome doesn't bode well for future

Regardless of whether you accept the jury's verdict as the final word on what really happened in the Self case, Groszkruger says the case might be reason to fear such cases involving your own organization. In particular, he says the case shows that juries will be sympathetic to a physician plaintiff who says he was punished for trying to protect his patients. The defendant may see the situation very differently, of course, but a jury may be predisposed to believe the physician. That is partly the result of negative media coverage of managed care organizations, he says.

Many jurors will believe that "rationing" of health care is common in order to improve profits, he says, and they often assume that delays and denials of necessary treatment are common.

"This case was deliberately designed to play to the negative perceptions held by the public about managed care. Dr. Self was described throughout this case as the only member of CAMG who really cared about patients. CAMG and its president were portrayed as money-hungry and eager to put profits above patients," he says. "Juries will punish health care providers who appear to place their own financial interests above the health and safety of their patients. The verdict sends a clear message that the public will believe that physicians and other health care providers deny necessary care to save a buck and that patients are shortchanged in the pursuit of corporate profits."

As a preventive measure, Groszkruger suggests that risk managers investigate any affiliated physician groups or physician arrangements with the hospital, seeking out any disputes that might benefit from risk management intervention before a lawsuit is filed. Remind those responsible for dismissing physicians that juries will not look favorably on any allegations that the dismissal was prompted by concerns over profitability.

"The place to start is the contractual relationships that almost all provider entities are increasingly becoming involved in," he says. "If there's a typical situation, it'll be that you're a hospital or medical group that is involved in a contractual arrangement to provide services under a health plan. These risks should have been addressed in the due diligence phase of entering into the contract, but they probably weren't because you concentrated on the financial issues."

Groszkruger emphasizes that you must look at all types of partners who might have such a dispute brewing, because a deselection lawsuit can draw in anyone who has even the most tangential relationship with the physician group. If it appears that such disputes are present, risk managers should take steps to defuse them or at least to distance their organizations from the fight.

In trying to avoid lawsuits similar to the Self case, it is not enough for the practice officials to satisfy themselves that the dismissal is legitimate, Groszkruger notes. Risk managers should emphasize that any case with even a hint of a dispute like that in the Self case should be brought to the attention of the risk manager immediately, and the dismissal must be supported with better-than-average documentation showing that the decision was made for legitimate reasons.

"If there used to be some positive presumptions that accompanied physicians and health care providers into the courtroom, they are unlikely to survive in the face of adverse financial motives," he says. "Allegations of greed and cost-cutting at the patient's expense appear to be quite effective at canceling out any positive image enjoyed by health care providers." ■

Source

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How to avoid transfusion error sentinel events

JCAHO recommends training, system redesign

Twelve transfusion error sentinel events have been investigated by the Joint Commission on Accreditation of Healthcare Organizations in the past three years, and the Joint Commission recently issued advice based on the root cause analyses of those events.

According to information released recently by the Joint Commission, 10 of the cases resulted in patient deaths, and the other two patients recovered. Eleven of the cases were hemolytic reactions, while one was an infectious reaction. Eleven of the transfusion reactions took place in a general hospital, with eight occurring in high-risk areas: the operating room, emergency room, intensive care unit, or during resuscitation. One of the 12 cases was in a long-term care organization.

Multiple failures are usually to blame

Incomplete patient/blood verifications were identified as at least one of the causes in eight of the 12 cases. Three of the 12 cases involved the handling or processing of blood samples or blood units for more than one patient at the same time in the same location. In all but one case (contaminated platelets), there were multiple failures to follow established procedures, usually involving the verification of patient identity and correct blood unit for that patient.

The Joint Commission learned of eight of the 12 cases through self-reporting. Three events were reported by state or federal regulatory agencies, and the Joint Commission learned about one case through media coverage.

Transfusions inherently risky and difficult

The report from the Joint Commission notes that blood transfusions involve many factors that increase the risk of an adverse outcome. There is variable input because the patients have different blood types, complexity because of the technical aspects of cross-matching as well as administering and monitoring the effects of blood, and inconsistency because there is no standardization across all hospitals.

Another problem is what the Joint Commission calls "tight coupling." That refers to a situation in which steps in a process happen so closely together that if a failure occurs in one step, there is little opportunity for intervention. With a blood transfusion, it is difficult to interrupt the sequence of the process, especially in an emergency room, operating room, or intensive care unit.

Transfusions also require a higher level of consistency than is reasonably achievable by health care workers without computer support, the report says. Tight time constraints, especially in an emergency room, operating room, or intensive care unit also can increase errors.

The transfusion sentinel events' root causes fell into these seven general areas:

- patient assessment, such as incomplete patient/blood verification;
- patient assessment, such as the signs and symptoms of a transfusion reaction not being recognized;
- care planning, such as no informed consent for a transfusion;

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• laboratory procedures, such as multiple samples cross-matched at the same time or a cross-match being started before the order was received;

• staff-related factors, such as insufficient orientation and training or insufficient staffing levels;

• equipment-related factors, such as blood for multiple operating room patients being stored in the same refrigerator;

• information-related factors, such as incomplete communication among caregivers or patient identification band, specimen label, or blood-label errors.

Prevention strategies suggested

The organizations that have experienced sentinel events suggested staffing and training improvements, along with technical system redesign efforts such as enhanced computer support or new patient identification band system. Those organizations also suggest discontinuing use of an operating room refrigerator for multiple blood units or adding laboratory workstations.

In addition, the Joint Commission suggests the following actions:

• Prohibit simultaneous cross-matching of multiple patients by the same technologist.

• Do not use the patient's room number to identify blood samples or transfusion units.

• Consider the use of "unique" identification bands for patients receiving blood transfusions.

• Introduce a computerized verification step into the process. ■

Former ASHRM president joins *HRM* editorial board

Healthcare Risk Management is pleased welcome **Leilani Kicklighter**, RN, ARM, MBA, DASHRM, to the publication's editorial board. She is assistant administrator for safety and risk management with the North Broward Hospital District in Fort Lauderdale, FL, and a former president of the American Society for Healthcare Risk Management.

Kicklighter joins other past presidents of ASHRM on the editorial board. ■

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

Milk infused into baby's central line: $7.18 million

By **Pearl Schaikewitz**, JD
Legal Consultant, Atlanta

News: The parents of a brain-damaged baby have reached a $7.18 million settlement with the hospital where the child was injured. The mishap occurred when a temporary float nurse infused breast milk into the baby's central line instead of her abdominal feeding tube.

Background: The infant was born in April 1996 without complications. Her Apgar scores were seven and nine. She had difficulty feeding and was unable to suck or swallow. A cranial ultrasound and CTs were performed, with normal results. The infant continued to lack suck or swallow reflexes, and an apparent seizure was noted. An EEG had abnormal findings, but the results of an MRI were normal.

The baby was fed through a nasal gastric tube and discharged at the age of 2 weeks. Diagnostic tests did not uncover the source of her ongoing inability to suck or swallow. A feeding tube was placed in the baby's abdominal wall in May. However, it did not provide sufficient nutrition, and a catheter was inserted into her right jugular vein to allow for additional feeding.

When the child improved, the central line was discontinued and nutrition was administered through the abdominal feeding tube. The day the baby was supposed to be discharged, the feeding tube was removed and the parents were allowed to take her out for a walk. They were gone for several hours. When the parents returned the baby to her room, her primary pediatric nurse was on a lunch break. A temporary float nurse reattached the feeding tube and restarted breast milk feeding. However, the breast milk adaptor was attached to the central line, and milk was infused into the baby's jugular vein.

When the pediatric nurse returned, she stopped the infusion immediately, but milk emboli already had blocked the blood supply to numerous portions of the brain. The infant developed seizures and went into a coma. A bacterial infection developed, but the child began to recover and was discharged in late June 1996. CT scans confirmed a devastating injury. The child had some paraplegia and cognitive deficits but was able to stand with some assistance as of March 1999. Her suck and swallow deficit did not improve until that time.

What it means to you: "The baby in this case had both a tube going into her stomach and a tube going into her jugular vein. The breast milk was in a bag hanging on the pole. Unless the health care provider traces the line from the pole, it is possible to hook up the line into the wrong port," says **Georgene Saliba**, RN, BSN, FASHRM, HRM, director of claims/risk management for Lehigh Valley Hospital and Health Network in Allentown, PA.

That is what can happen when the health care provider does not look to see where the line is ultimately going. "Unless you trace the line up to the bag and down to the port where it connects, you can make this mistake. You think the line you have in your hand is the correct line. You think

you are connecting to what you believe is the correct thing in your other hand. When in actuality, as happened in this case, you have in your hand the tubing that goes to the jugular vein instead of to the stomach," Saliba says.

This is a systems issue as well as one of basic nursing principles, she says. She suggests these types of incidents can happen if you have the same type of connecting adaptor at the end of the each line: both a leurlock or a slip lock. "Humans make mistakes. If the tubing looks exactly the same, the lines are not color-coded, and the connectors are the same, that error can happen."

To reduce the possibility of this type of error, a facility can create "fail-safes," Saliba advises. "You can color-code the tubing, like putting blue tape on both ends of one line and green tape on both ends of the other line, so you know that blue and green cannot go together. Or you can change the color of the tubing or the type of adapter on it. Of course, proper nursing means that you should know the port of administration. But if you have a system that allows the error to be made, you need to look at how you can improve the system and prevent a reoccurrence. The system should not allow the health care provider to attach the 'wrong' solution to the wrong port. The result of such an event can be devastating, as it was in this case."

Reference

Anonymous settlement, King County (WA) Superior Court. ■

Subdural hematoma causes death: $1 million

News: A Florida nursing home reached a $1 million settlement with the family of a resident who died after sustaining a subdural hematoma in a fall. The resident did not receive medical attention until four hours after the incident.

Background: The woman was admitted to the nursing home after surgery for peptic ulcers. The goal was to keep her for seven to 14 days of rehabilitation, after which she would return home to live with her daughter. On March 4, 1996, 2½ months after her admission, the resident fell, sustaining a subdural hematoma to the right occipital portion of her skull. Her neurologic condition deteriorated, and she exhibited slurred speech, elevated blood pressure, and sluggish pupils.

The plaintiff alleged that the resident did not receive any medical or emergency care for more than four hours. The charge nurse testified that the resident's attending physician was called at home but would not authorize her transfer to the emergency room until he saw her. Other nurses testified that her condition did not warrant the transfer. However, two certified nursing assistants (CNAs) who had observed the resident two hours after she fell told the charge nurse that the resident was unresponsive, her vital signs were grossly abnormal, and she had vomited. The charge nurse went to check on the resident, who was unresponsive and had fixed or dilated pupils as well as abnormal vital signs. The charge nurse allegedly started shaking the patient, telling her to "wake up" and "stop faking it."

Florida home violated resident's rights

The patient's attending physician arrived and ordered the resident transferred to the emergency room. She died the next day as a result of the injury sustained in the fall. Her family filed suit, alleging wrongful death and violation of her resident's rights under Florida law. The plaintiff claimed that the resident received substandard care, causing her mental and physical condition to deteriorate significantly.

The complaint alleged that despite the resident's request for assistance to go to the bathroom, she was told to urinate and defecate in her bed and wheelchair and would be cleaned later; that she suffered a 19% weight loss because the home failed to provide her with appropriate nutrition; that the home failed to obtain an order for antidepressant drugs despite knowing of the resident's admitting condition of depression and anxiety; that the resident developed a urinary tract infection because the staff failed to properly clean her Foley catheter, and that she developed a stage II pressure ulcer on her coccyx.

What it means to you: The first red flag in this case is the fact that this patient was still in the nursing facility 2½ months after she was admitted for what was planned as two weeks of rehabilitation, says **Betty Svoysky**, JD, director of risk management for Medical Mutual Liability Insurance Society of Maryland in Cockeysville. "Why was she still there? The answer might be found in the daughter's allegations that her

mother was not given adequate nutrition and not properly cared for as far as her personal needs were concerned."

Svoysky says the patient's urinary tract infection and pressure ulcer probably were left to fester because of the lack of any kind of treatment or rehabilitation plan. If the woman was elderly, those conditions put an added strain on her recovery and possibly increased her depression and anxiety, for which she received no apparent medical attention, she adds. Svoysky attributes the patient's fall to a combination of factors, including the allegedly poor nutrition and the failure to maintain her on her antidepressant medications, which probably made her weak and unsteady.

Also, there appeared to be no orders for her to be restrained, monitored, or accompanied to the bathroom. "If the daughter's allegations are true, the staff at the facility probably spent more time cleaning her up than assisting her in either getting to the bathroom or to rehabilitation," Svoysky says.

Where was the on-call physician?

The staff's reaction to the fall was inappropriate, Svoysky says. "Apparently the nursing staff believed the patient was all right, while the CNAs reported a significant change in her vitals and mentation. I sincerely hope the vast differences in opinion were not based on turf battles but merely represented folks looking at her at different time frames. However, I find it hard to believe that a patient can 'fake' abnormal vital signs and fixed or dilated pupils. What about a coma score?" she points out.

That the patient's physician refused to have her transferred to the emergency department because he wanted to examine her first also is a red flag, she says. "Didn't the facility have a doctor on call for just such an emergency? Also, where patient welfare is concerned, can't a charge nurse or nurse administrator, who is on the premises, overrule a physician who is off-site?"

Finally, Svoysky says the $1 million dollar settlement the facility paid should serve as a warning to other nursing and extended-care facilities that this kind of patient abuse and neglect will not be tolerated.

Reference

Anonymous settlement, Pasco County (FL) Circuit Court. ■

Suit reinstated based on death of ECT patient

News: A New York appeals court reinstated a suit brought against a hospital and three physicians based on the eventual death of a patient after electroconvulsive therapy (ECT). The patient, who had chronic obstructive pulmonary disease (COPD), suffered sustained status epilepticus during the procedure and lapsed into a coma afterward.

Background: In July 1990, the patient was diagnosed by a physician at this hospital with COPD. She was prescribed theophylline. She returned on Aug. 27, 1990, in a state of severe depression and was voluntarily admitted to the hospital's psychiatric department. The patient had achieved some relief with ECT in the 1960s. Her psychiatrist consulted with several specialists and conducted various lab tests to determine whether she was a viable candidate for ECT. The psychiatrist consulted with the patient's internist concerning her pulmonary condition because the pulmonologist who examined her in July was unavailable.

The psychiatrist decided to perform the procedure. Blood levels of theophylline taken on Aug. 29 and 30 were in the therapeutic range. In preparation for the ECT, the patient's internist reduced her dosage from 400 mg to 300 mg to reduce the risk of status epilepticus. The ECT was performed on Sept. 7. Shortly after the intended seizure was induced, the patient experienced status epilepticus that lasted for several hours. The psychiatrist left the treatment room at some point to obtain assistance. The patient lapsed into a coma for approximately 10 days and sustained permanent injuries, including bilateral deafness, memory loss, and seizure disorder. She died six years later.

The patient's husband sued the hospital, psychiatrist, internist, and anesthesiologist, alleging, among other things, failure to obtain a pulmonary consult before the ECT, failure to consult other physicians about discontinuing or lowering the theophylline dosage, failure to take theophylline blood levels shortly before the ECT, and failure to properly monitor the ECT and control the status epilepticus. The suit claimed the hospital was vicariously liable for the physicians' alleged negligence.

At trial in late 1997, the judge dismissed the claims against the hospital, ruling the plaintiff did not prove that any of the doctors were

employed by the facility. The jury returned a verdict in favor of the doctors. The appeals court reversed the judgment, reinstating the claims against the hospital and the physicians.

The court reinstated the claims against the physicians because the trial judge had refused to let three of the plaintiff's expert witnesses testify — a pulmonologist, a psychiatrist, and a neurologist. The court order noted that the only expert who was allowed to testify for the plaintiff was an individual with a PhD in clinical psychology and experimental psychopathology. The psychologist was not qualified to give, and did not offer, any medical opinions. The pulmonologist apparently would have testified that the patient's pulmonary condition rendered her unfit for ECT and that she could have been safely taken off theophylline to reduce the risk of prolonged seizures. The psychiatrist apparently was prepared to testify that alternative, less dangerous forms of treatment were available for the patient's depression.

The plaintiff's neurologist would have testified that the ECT was negligently performed and was the cause of the patient's injuries, court records show. The defendants' neurologist testified that the patient's injuries resulted from a congenital vascular malfunction of the brain. The plaintiff's neurologist should have been permitted to respond to that theory, court records show.

The appeals court also ruled that the evidence could lead a jury to decide that the hospital was vicariously liable for the acts of the physicians. The psychiatrist had an office in, and received compensation from, the hospital, and the anesthesiologist was a member of the hospital's medical staff, suggesting that they could be hospital employees, court records show. Even if they were not, the evidence raised a question as to whether the patient could have properly assumed that the treating doctors and staff were acting on the hospital's behalf, according to court records. The patient had entered through the emergency room and sought treatment from the hospital. She did not request a specific doctor, the court's opinion notes.

What it means to you: Sue Wilson, RN, MBA / MHA, a risk manager at St. Joseph's Hospital in Atlanta, says the evidence of ventricular abnormalities established by the autopsy report likely will be the hospital's primary defense at a retrial. She says it should have been asserted earlier in the litigation.

Next, Wilson points out that the psychiatrist in this case should have obtained a pulmonary consult rather than relying solely upon the internist's evaluation of the patient's COPD status. The internist likely would not have been named as a defendant had she advised the psychiatrist to consult with a pulmonologist, Wilson says. "Anesthesia is riskier with COPD patients. After all, ECT is an induction of a seizure. Knowing that theophylline might complicate the ECT process provided an even greater reason to consult with a pulmonologist, and perhaps even a pharmacist."

As for the evidence that the psychiatrist left during the ECT to obtain assistance, it is unclear whether the anesthesiologist and psychiatrist requested help quickly enough once status epilepticus was diagnosed, Wilson says. Moreover, without having taken the theophylline level just prior to ECT, it is impossible to say whether the reduction in the dose resulted in a low enough blood level to be compatible with ECT, she says.

The patient also claims that the hospital provided a physician to her through the ED and is thus vicariously liable for the physicians' actions. It is more difficult to defend against that claim when a physician resembles an employee in terms of office location, compensation, and similar factors, Wilson notes. "Unless the patient specifically requests a particular physician or severs the relationship with the attending physician on call, it is reasonable to assume the patient is choosing to receive care from the hospital, particularly if the appropriate consent-for-treatment forms are completed.

"Did the hospital have a general admission consent form asking patients to acknowledge that the physicians treating her were independent contractors? This form helps to establish independence but does not always successfully relieve the hospital of liability if medical staff are not clearly defined as, and treated as, independent contractors. Even when patients sign such acknowledgments, the lay public, and thus, juries, still tend to see physicians as extensions of, or 'approved' by, hospitals," she says.

Finally, Wilson asks whether the hospital follows its bylaws with regard to medical staff privileges and credentialing. "For example, did the hospital credential the anesthesiologist to perform ECT? If not, vicarious liability is difficult to defend against in these cases."

Reference

Shafran v. St. Vincent's Hospital and Medical Center, 1999 WL 682023 (N.Y.A.D. 1 Dept.). ■

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