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AMRPA Conference Coverage

Improvement in recording patient assessment scores affects PPS

Training, audits improve payment documentation

[Editor's note: In this issue of Rehab Continuum Report, *there are several articles based on sessions at the 2004 annual Educational and Leadership Conference of the American Medical Rehabilitation Providers Association (AMRPA), held Nov. 3-5 in New Orleans. Prior to the conference,* RCR *interviewed several of the scheduled session presenters to learn about the big picture of the issues concerning the rehab industry this year. The cover story discusses achieving excellence in documentation for the prospective payment system (PPS), and inside stories discuss forming a violence prevention program and determining an organization's compliance with inpatient rehabilitation standards.]*

Performance improvement and staff education about PPS are as important in 2005 as they were five years ago when the rehab industry was anticipating the change, experts say.

For Southern Kentucky Rehabilitation Hospital in Bowling Green, PPS preparation entered a new phase of performance improvement

Prepare your hospital for a very unusual flu season

Vaccine shortages may wreak havoc with hospital EDs, absenteeism

With the unprecedented shortage of influenza vaccine this flu season, hospitals are scrambling to prepare for what may be a record number of flu patients presenting to their already overcrowded emergency departments (EDs) and for staff shortages due to record absenteeism. After almost half of the United States' planned vaccine supply was contaminated, high-risk

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once the original 18 months of training were ended.

The rehab hospital's staff prepared for PPS for 18 months, planning for this significant change in the rehab industry, says **Lou Anderson**, MS, CCC, SLP, director of rehabilitation services at the hospital.

"And after the implementation, we continued the process improvement to increase the accuracy of our information that goes into the patient assessment instrument [PAI]," Anderson says. "So for the past two years, our hospitalwide performance improvement project has been focusing on accuracy with the PAI."

Since the Centers for Medicare & Medicaid Services (CMS) requires rehab facilities to capture scores over a 72-hour period, the rehab facility's staff have worked hard to obtain the most accurate measurements from nurses and other staff, says **Jan Bohannon**, RN, PPS coordinator.

"We feel we've done an exceptional job of getting nursing staff trained to a level where they're accurate and making sure training helps us get the right number of scores for placing patients in the right categories," she says.

Here is how the rehab facility has maintained its performance improvement focus:

• **Update training.**

"We've revised our training several times," Anderson says. Training includes videos, lectures, and hands-on sessions in which rehab staff train nurses to some therapy tasks, she explains. "We let them see what it feels like when a patient is doing 50% of a task. We go through quite a few scenarios so they can get some ownership and feel like they can make a judgment call on correct [scoring] numbers."

Staff attend a catch-up training session once a quarter, and new employees attend follow-up training sessions every other week, Anderson says.

Bohannon monitors how staff rate patients according to PAI and will present specific examples of problem areas during these staff meetings.

"We watch our therapists and see how they compare with the night shift and evening shift; and if there's a difference in scoring, we see whether there is communication between the shifts," she says. "We expect to see in the daily notes that they talked with the evening staff and trained them on a particular transfer or feeding technique."

• **Change care planning format.**

"We've changed our care planning format for our patients," Anderson adds. "This is to make sure patients on the night shift are doing comparably to what they're doing in the day shift."

The functional improvement numbers do not tell the whole story, so staff compare scores from the evenings and nights to daytime scores to make certain patients are achieving their personal highest functional levels, she says.

Before the care planning format was changed, the interdisciplinary team would meet weekly and discuss current status reports on patients.

However, they didn't discuss the barriers that existed from an interdisciplinary team standpoint, Anderson explains. For instance, from a nursing perspective, a patient might need a bowel and bladder program, but from a therapy perspective, the patient may need to focus on transfer technique, she says.

Other issues include family education and the

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barriers that keep a patient from being ready to return home, Anderson says.

"The barriers to the successful completion of rehab have become the focus and lead patients to achieve higher functional outcomes," she points out.

The staff are excited about the care planning process changes because they feel it will help their patients achieve better functional outcomes, Anderson adds.

The case manager serves as a facilitator who discusses care plans with the staff.

For example, she says, the case manager might name an area of function, saying, "Locomotion — what are our barriers?" or "With activities of daily living [ADLs] — what are our barriers?"

Case managers also point out the differences recorded by night shift, evening shift, or day shift; and those differences are discussed to see what might be the cause.

"Maybe there's a certain medication that creates problems for a patient," Anderson says.

• **Focus on pain management.**

Because rehab staff see patients completing ADLs successfully in the rehab setting, they sometimes overestimate the patient's ability to succeed after discharge to the community, she notes. "At the discharge date, the patient may still be a significant burden of care."

And often pain is a barrier to successful completion of rehabilitation, Anderson adds. "Patients may have pain in ambulation or pain in ADLs, and suddenly we all realize that even though they're taking pain medication and even with that, the pain is inhibiting more movement."

Pain also might lead to depression, and a lack of motivation to succeed could come into play, she explains.

So it's important for rehab staff to focus on pain management before therapy and monitor it as the patient prepares for discharge, Anderson adds.

• **Audit charts.**

Bohannon checks patients' rating numbers daily and writes a monthly report in which numbers are compared.

"I write monthly confidence rating scores, and we do a presentation on the different aspects that we'd be comfortable with on a score," she says.

The goal is to know which levels would indicate accurate scores and then to compare those levels to the actual scores, Bohannon explains.

For example, when rehab managers compare functional improvement scores from day shifts to night shifts, they needed to understand why scores were different and what justified those differences, Anderson says.

"If we saw a score that was different, then we had to go back to the documentation and written information to support the scores we saw," she notes. "We looked at the different areas and decided what was acceptable at each level."

For instance, a seven point difference in scores would be difficult to justify, while a two-point difference could be explained by how a patient receives more assistance with locomotion in the evening than in the daytime, Anderson explains.

"Or if a patient is on medication in the evening to help him rest, then we'd say that two-point difference is acceptable," she says.

If Bohannon sees a significant difference in scores, she will call the nurse or therapist to obtain verification for the scores.

"Maybe there's something that I don't understand about the scores," she says. "Or maybe their documentation doesn't match the number they put down."

Also, checking back with rehab staff helps to improve the process by giving everyone an additional learning experience regarding documentation and scoring, she says.

It helps if someone can act as an outside auditor and remain objective when reviewing the scores, Bohannon notes.

"I try not to superimpose my judgment of what I feel like the scores should be," she says.

"It's not that we want a higher or lower score, but we want a correct score, and we want documentation to support that," Bohannon adds. ■

AMRPA Conference Coverage

Victims of violence go public for prevention

Prevention model fits large and small efforts

Imagine training young men who survived being shot in the head or back during gang violence to speak with children and youths about avoiding violent situations, helping not only the children but also the ex-gangsters by giving them a meaningful role to perform despite their severe injuries.

This is exactly the sort of work that many rehab facilities now are doing as part of a

national violence prevention effort that is promoted by the Think First National Injury Prevention Foundation of Rolling Meadows, IL.

More than 125 rehab facilities participate in the Think First program and, while most of them do not work with former gang members, all have patients who were injured because of violence or car crashes, says **Dorothy Zirkle**, MSN, RN, chief executive officer of the Think First Foundation, which has 258 chapters in the United States and 40 chapters internationally. (Web: www.think first.org.)

VIPs reach out to youth

Called VIPs, which stands for Voices for Injury and Violence Prevention, people, ages 18 to 40, who have suffered from traumatic brain injuries or spinal cord injuries serve as a cornerstone of the prevention program. They train to be speakers who promote violence prevention to children and youths, she says.

"The work gets people back into the community, and it gets them up out of bed," Zirkle explains. "They build self-worth and value in their lives, and their depression decreases as their productivity increases."

Children who have had traumatic injuries also may participate in after-school events, such as health fairs, she says.

VIPs often are paid for their time, and their skill at speaking is developed with practice and mentoring by rehab nurses and therapists who also participate in the program, Zirkle adds.

The key to Think First's success is its dual role in providing a needed service to the community and in providing goals and positive work to people who have disabilities due to violence.

"There are ex-gangbangers like some VIPs in San Diego who were shot in the head or back or who were beaten over the head with a bat, locked in a trunk, and shot," she continues. "These are kids who had no aspirations before and now have become part of the program and are productive citizens."

These ex-gang member VIPs go to juvenile halls to speak with at-risk kids about their own injuries and violence, Zirkle says.

"Our VIPs have tattoos on the back of their heads; these were bad kids, and they were severely at-risk youths who were killing people," she says. "And now they've turned their lives around by going to rehabilitation and being approached by our program to go out and speak with kids."

Some of the VIPs were so empowered by their speaking experiences that they've returned to school and even enrolled in college courses, adds Zirkle.

Likewise, rehab patients who had been injured in car crashes also prove to be good prevention speakers.

"Most of our speakers are motor vehicle crash victims," she says. "We call it car crash and not accident because chances are that no matter what it was it could have been prevented.

"Motor vehicle crashes are the leading cause of death and injury for people before age 34," Zirkle says. "The unique thing about creating your own injury prevention, community-based program is that whatever is happening in your community, those are the kids who will end up in your rehab center."

If there's a problem with snow machine and skiing accidents, then those are the patients from whom a rehab facility could recruit VIPs, she notes.

"VIPs usually talk about who they were before the injury, how they sustained the injury, and what their life is like now," Zirkle says. "It's not meant to be a downer — it's a very positive program that is more encouraging than depressing."

VIPs answer questions from kids, and the rehab staff or other speaker will provide the audience with background information about that person's experience in rehabilitation and trauma centers, she adds. "The VIP is never out there by himself."

The person who accompanies the VIP will facilitate the speech by telling the VIP's story the first time the VIP is speaking before an audience and then asking the VIP to fill in certain details, she points out.

"You nurture and guide these kids, helping them create a craft and enhancing their voice," Zirkle says.

The rehabilitation professionals also may fill in with an introductory video and information about anatomy, physiology, the permanency of injury, statistics, and the possibility of becoming injured based on age, she says.

Rehab facilities pay $500 to start a Think First chapter, a price that includes training, Zirkle says.

"You can grow the program to whatever cost you want it to be," she explains. "It can be as minimal as utilizing individuals working for the rehab facility and using volunteer VIPs and finding grants to cover expenses."

Or it could grow to a program that is budgeted at $500,000 a year from philanthropic sources, as is the program at Sharp HealthCare in San Diego,

where the program includes 19 paid VIPs, five full-time community health educators, and research and injury prevention activities, Zirkle says.

"When [Sharp] started the program, the nurses were expected to drive their own cars and the families drove the VIPs to the schools where they'd speak," she says.

Now, 15 years later, Sharp's Think First program has two wheelchair accessible vans for transporting VIPs and health educators, and the program connects with 300,000 people each year, Zirkle adds. ■

AMRPA Conference Coverage

Don't assume the 75% rule will be modified

Know the conditions of participation rules

In the era of continual regulatory changes for rehab providers, it's very important to stay focused on following the conditions of participation (COPs) rules since these provide the best guide for compliance, an expert advises.

"We've been having our clients focus on making sure they're in compliance with the conditions of participation, relative to maintaining their rehabilitation certification," says **Michael Soisson**, MS, MHA, a senior consultant with Gill/Balsano Consulting in Norcross, GA.

Many in the rehab industry continue to hope for the permanent elimination or major modifications to the 75% rule, which requires that at least 75% of a rehab facility's diagnoses fall into 13 diagnoses that were determined years ago for rehab providers. However, it does not appear as though Congress will make any changes to the 75% rule before the end of 2004, he says.

Effective July 1, 2004, the moratorium on the 75% rule was lifted with a four-year phase-in strategy that will require facilities to meet 50% through June 30, 2005; 60% from July 2005 to June 2006; 65% from July 2006 to June 2007; and 75% thereafter, Soisson explains.

"We always felt that it doesn't necessarily make sense that the diagnosis of patients coming into your facility are driving your certification as a facility," he says. "It seems like a patient's medical condition and functional status is what should determine whether they go into rehab or not."

However, the reality is that the 75% rule has continued to exist, and rehab providers may have to learn to live with it, Soisson adds.

Two years ago, a study showed that only 13% of rehab providers were in compliance with the 75% rule, so this could be a major problem for the industry, he notes.

The software rehab providers use to track their compliance with the 75% rule also could pose problems, Soisson says.

The software isn't as sophisticated as needed to capture all of the patients who should fall within the 75% rule diagnoses, so he advises rehab providers to conduct their own medical record reviews, looking specifically at the primary reason for admission.

"The second issue is you need to be able to document and prove it," Soisson says. "Just because your coder or admissions person says the patient is admitted for that condition doesn't make it accurate."

The doctor's physical, the medical records, and the patient's history all need to document and back up the claim that the patient is admitted for a particular condition related to rehab, he says.

For example, patients who have polyarthritis in multiple joints qualify for the 75% rule, but if physicians do not document that patients had arthritis in other weight-bearing joints, they don't qualify for the 75% rule, Soisson says.

He offers these additional tips for improving compliance with the conditions of participation:

- **Provide close medical supervision.**

Each patient should receive close medical supervision, as well as rehabilitation nursing care, therapy, and psychosocial services as needed, Soisson says.

Physicians should document that the rehab services are needed and document the medical supervision, he advises.

"Sometimes, we see that a physician who is supposed to be closely monitoring the patient comes in every day or every other day," Soisson says. "When you look at the documentation, it says, 'The patient is doing fine; continue treatment," and that's it."

But if there are four or five days in a row of that type of documentation, then it would be questionable whether the patient is receiving close medical supervision, he explains.

"What should happen is that the physician documents that he talked with the therapist and nurses and met with the patient and saw the patient in the therapy gym and documents how

the patient progresses," Soisson says. "Then every two weeks, there's a team conference that pulls together that information."

• **Document the plan of treatment.**

Likewise, there should be a documented plan of treatment, he says.

"Each patient has a plan of treatment that is reviewed and revised by the physician and rehab team," Soisson notes. "Some patients will stay a week, and some will stay three weeks; so the plan is reviewed as appropriate, and it at least has to have the doctor's name on it."

• **Coordinate the multidisciplinary team approach.**

"There has to be evidence that there's a multidisciplinary approach to care with therapy, nursing, doctors, and other consults as needed," he says. "And at least every two weeks, there's a team conference where the patient's goals and treatment plans and discharge plans are being discussed."

• **Use preadmission screening.**

Rehab facilities can run into problems if there is no formal screening process to make certain patients are candidates for rehab, accompanied by documentation that shows why, Soisson says.

"The preadmission screening process is a problem area," he notes. "Rehab staff think a patient is a good candidate for rehab, but no one has signed off and said, 'Yes, the patient is a good candidate for rehab, and here's why.'"

The solution is to document a review of the medical record while the patient is in acute care, perhaps by having the physician conduct a consultation on a patient in acute care and applying the rehab criteria to the case before saying that the patient would benefit from rehab services, Soisson says.

• **Encourage nurses to be certified.**

Another troublesome area involves adequate nurse staffing because of the nursing shortage, he points out.

If an organization doesn't have some of its nursing staff certified in rehab nursing, then there's the question of whether the facility truly is providing rehab nursing, Soisson says.

"So we're encouraging clients to get as many nurses certified as possible, but if that's not practical in the short run, then do continuing education with specific rehab nursing issues," he says.

• **Make certain patient meets requirement for medical necessity.**

"The expectation is that the patient meets the criteria for medical necessity," Soisson says.

"The problem is that Medicare looks at this in a retrospective review," he says.

So if a rehab facility has admitted a patient who doesn't meet medical necessity criteria, the facility would not know that this is Medicare's decision until after the patient has been treated for a couple of weeks and the claim was submitted, Soisson says.

"Then you lose all you've provided and don't get paid for that," he says. "And you run the risk, if you have enough cases of those, to have the fiscal intermediary say that you don't look like a rehab provider because you're providing a level of care that's not rehabilitation."

This past year, there has been a trend of fiscal intermediaries publishing their own review policies, and these seem to present a consistent view of what constitutes medical necessity, Soisson notes.

"As the Centers for Medicare & Medicaid Services (CMS) forces fiscal intermediaries to be more diligent organizations, then rehab providers will have to make sure patients are meeting those criteria," he adds.

• **Audit medical records admission.**

"We feel strongly that some medical record audits for preadmission and admission acceptance and continued stay need to be done on a regular basis," Soisson says.

"At least on a yearly basis, a rehab facility ought to get some outside help with auditing because you can get too close to it yourself, and you are not always as objective as you need to be," he says.

"So the real issue is having someone take a really good look at medical records to see if you are, in fact, proving that these patients belong in rehab and are staying as long as they should have stayed," Soisson explains.

For instance, if a patient could have gone to a skilled nursing facility, then the patient should not have been admitted to rehab, he says.

"They need to have that inpatient rehab level of care, and that's an intensity of service condition," Soisson says.

Patients admitted to inpatient rehab must require 24-hour nursing care, regular physician interaction and monitoring, three hours of therapy a day, five days a week, and documentation for all of these services, he adds.

Rehab providers will need to continue to monitor compliance with the COPs, including medical necessity, because CMS has vowed to hold facilities accountable for the COPs, Soisson says. ■

Consider partnering with long-term care facilities

Expert offers a how-to for contracts

Rehab providers can provide some obvious benefits to long-term care facilities by providing a service that will increase residents' independence, such as in an assisted-living facility, to help nursing home residents improve their mobility and strength.

However, arranging a contract with a long-term care facility requires some planning and knowledge about how the system works, says **Brent Campbell**, director of health care marketing for Seroka Healthcare Marketing of Seroka & Associates Inc. of Waukesha, WI.

For instance, a rehab provider should know how many staff hours are allocated to a specific long-term care facility, he suggests.

"Allocate the fewest number of hours possible for the greatest number of patients," Campbell says.

Set up parameters before you sign

Rehab providers should decide before signing the contract whether they prefer being paid for a set number of hours per week or on a per-patient basis, he adds.

"When you are going into the contract, sign with the understanding that those parameters will change from time to time, but the contract has set the guidelines," Campbell explains.

Another aspect to consider is whether the facility has a high turnover rate and a high acuity level, he says.

"Perhaps if a long-term care facility has a higher acuity level of residents, then there will be a higher turnover rate of residents," Campbell notes. "So if you are a rehab facility, you might contract on a per-patient basis rather than hourly."

On the other hand, if the facility appears to have residents who are more stable, then the rehab contract might be for strength training and wellness programs to extend the residents' quality of life, he explains.

In this case, the rehab provider might offer to visit the facility three times a week for an hour each time, providing a program for all of the residents, Campbell says.

Rehab providers should make it clear to staff what the rules are for the facility and what the responsibilities are for each rehab employee, he says.

"Be clear as to draw the line, showing the chain of command and support structure for all personnel," Campbell points out. "Staff should know that everything that happens in the facility is the responsibility of the administrator solely."

From the long-term care facility administrator's perspective, he or she still is held responsible if anything goes wrong, even if the problem was related to a contracting rehab provider, he adds.

"Rehab providers need to put parameters in place to protect their employees, as well," says Campbell.

For example, one rule is that when a long-term care facility's residents are evacuated in the case of a fire alarm, there must be a facility staff member present, so it would be wrong for a rehab therapist to begin the evacuation of a wing where no staff member is present, he explains.

"They can't allow people they contract with to escort people out of their building," Campbell continues. "So those types of issues need to be addressed."

Also, rehab providers should discuss with long-term care facilities who will handle the paperwork and report the incident if a resident falls in the company of a rehab therapist, he suggests.

"There needs to be a system in place for communicating between the rehab staff, the assisted-living team, and the resident's family," Campbell says.

Likewise, problems will arise if the contracting rehab therapist doesn't share information with the long-term care facility's staff. For example, the therapist hands the resident a list of exercises that need to be done, including strength conditioning exercises, he says.

And perhaps the therapist has discussed these exercises with the family because the family happened to be visiting while the therapist was working with the resident, Campbell adds.

But if the therapist then completes the work and leaves the facility without communicating the same information to the staff, there is a documentation and communication problem, he says.

"This happens from time to time, so there needs to be a system put into place addressing this," Campbell says. ■

Words from the other side: Lawyers, slips, and falls

Here's what they think

You've probably got a defense attorney or two giving you advice on how to avoid liability in slip-and-fall cases, but wouldn't it be great to hear from the other side? Imagine if a plaintiff's attorney explained, "Here's how to win when my client sues you."

P. Christopher Ardalan, JD, is a trial attorney in Sherman Oaks, CA, who often represents plaintiffs in slip-and-fall cases. His first words of advice: Never forget that you make an attractive target.

"With a health care facility, you've got a much sexier argument for a jury," he says. "If I were making a closing argument, I'd say, 'Ladies and gentlemen, we go to a hospital to be helped and healed. The last thing we would expect is to go to this place we consider a safe haven and be exposed to this type of danger.'"

The health care defendant may be held to a higher standard than, for example, a grocery store. A hospital setting offers more of an emotional appeal that can inspire a jury to mete out some justice in the form of a large award to the plaintiff, Ardalan says.

"Even if there is no legal differentiation in the case from a slip and fall in another setting, a good plaintiff's lawyer who knows how to evoke the emotion of a jury will be able to clinch liability and evoke more emotion in the jury," he adds.

A large payout also is much more likely with a health care defendant, Ardalan says.

Prevention is first question

The first thing a plaintiff's lawyer will look at is whether you could have prevented the fall, he says. A trial lawyer will want to see the sweep sheets, the records that show when floor surfaces were inspected and cleaned.

For instance, Ardalan compares accidents in which people fall in a grocery store and in a hospital. In both cases, they fell because a liquid was spilled five minutes after the most recent floor inspection. The inspections are done every half hour, so the liquid remained hazardous for 25 minutes until the fall occurred just as the next inspection was scheduled.

"In the supermarket, that's a tough case for the plaintiff because 25 minutes doesn't seem all that long for something to be on the floor, and it may have originated from a customer spilling a drink or something similar," he says. "If you have a similar fact pattern in a hospital, you're generally going to have better liability against the health care provider because the hazards are usually created by the hospital employees themselves."

In other words, a plaintiff's attorney will be much more interested in the hospital case because — while both defendants could be accused of not cleaning up the spill fast enough — it's easier to prove that the hospital staff caused the hazardous situation in the first place.

Ardalan notes examples such as blood, vomit, or urine on the floor from health care activities, or spills from leaky equipment. Even floor cleaning efforts can create the hazard if too much water is left behind or warning signs are not used.

In a retail establishment, the defendant can rely largely on the sweep sheet defense: "We check the floors regularly, but that spill occurred in the interim. Therefore, we were doing our best and can't be held responsible."

But Ardalan says that defense won't be of much use for health care defendants.

"Even if the hazard originates from a nonemployee like a patient, you have nurses and others there who are charged with caring for that patient, and they must take action when they see a floor hazard," he says. "They should call housekeeping and put up cones to keep people away."

So how does Ardalan decide whether to accept a slip-and-fall case against a health care client? He says there are two main questions to ask:

- **Should they have caught that hazard and prevented the accident?**

The answer is not always yes. Sometimes, the facts of the case show that the provider did all the right things; but still a hazard existed for some short period of time, and the potential client was just unlucky enough to come by then. That's the best position you can be in as the potential defendant, he says.

- **How badly was the victim injured?**

The worse the injury, the more this factor can overcome the first.

Special health care concerns

To reduce your liability from slips and falls, Ardalan offers these tips from the plaintiff's point of view:

1. Train staff in the special concerns of health care facilities.

When the plaintiff is in the business of caring for people who are infirm or physically challenged, it's easy to prove in court that you should have taken more care to protect them from falls.

"If you say you mopped the floor and put up warning cones, so the patient shouldn't have fallen, I'm going to say, 'But you had six 85-year-old people who couldn't see 2 feet and were using walkers,'" he explains. "You're not going to argue that they were on their own and it's their own fault they all broke a hip."

Those special obligations mean that risk managers should ensure staff are specially trained for preventing falls in health care settings, Ardalan suggests.

Your maintenance staff may be experienced and might understand the need to prevent falls, but do they have experience in health care settings? If not, you might need to explain the particular concerns and what can be done.

"What you can do for floor maintenance on a typical floor might not be right when you have a floor of elderly folks with walkers," he says. "But you can't expect the maintenance guy to think about that if you don't bring it up. For him it's just another floor to mop."

2. Be sure staff respond quickly to floor hazards and document your prevention efforts.

Once a spill or other hazard is recognized, never leave it unattended. Mark it with signs, and if necessary, have someone stand over it until housekeeping can respond.

Documentation can be used against you

Also be sure your sweep sheets or other documentation of inspections and cleaning are always filled out. Don't let them become just another bit of paperwork that staff ignore, Ardalan says.

Caution employees about the danger of putting their initials on a sweep sheet without actually doing the inspection.

After a fall, Ardalan will use that document to question just how negligent the staff were if they inspected the area four times — according to the initials on the sweep sheet, at least — and didn't spot the hazard.

"That can be worse than just not doing the inspection at all," he says. "A risk manager might want to consider making that kind of false documentation a very serious offense. Their job should be on the line if they're discovered doing this."

3. Never be rude to the victim.

You can avoid a lot of lawsuits by treating people better after the accident, Ardalan says.

A good portion of the people who come to his office wanting to sue for slip-and-fall accidents are angry and resentful about how they were treated afterwards, he says. Many of those who were treated well never decide to sue.

"When people are hurt, they want to see compassion, especially in a health care setting where they expect people to be caring," he says. "But the health care profession is notorious for having rude nurses, and that kind of treatment really upsets people when they already feel like a victim of your carelessness."

Ardalan advises risk managers to train staff that they should be helpful and sympathetic in such situations — but at the same time, he admits that he would jump on the opportunity to use those words against you if staff sound too apologetic.

The key, he says, is to express sincere sympathy and concern without admitting liability.

"The best thing you can do is to try to make their stay easier, any little concessions to show that you care," Ardalan explains. "Ultimately, you want them to walk away feeling like it's not the right thing to go to a lawyer, rather than making that decision simple for them."

Ideally, the patients should leave feeling like the incident truly was just an accident and your staff did everything possible to treat them well and make up for an unfortunate turn of events.

"You want them to say, 'How can I sue those nice people?'" he points out.

Don't go overboard with niceties

4. But don't make the victim suspicious either.

While you should be nice to the person injured in your facility, Ardalan says you also should be careful not to go overboard and give the victim any ideas about liability.

It is possible that the victim thought from the start that the fall was no big deal, and he or she is satisfied with how the staff responded.

But if you then start laying on the niceties with a heavy hand, the victim may start wondering why.

That's especially true if the risk manager breezes in with a big smile and offers another pillow.

"They can get suspicious if they wonder why you're going overboard with being nice," he says.

"At that point, they might think they should sue you because you're obviously afraid of being held responsible for whatever you did."

Ardalan acknowledges that risk managers and hospital staff have to walk a tightrope: Be very nice to people after a fall, but not so nice as to make them wonder what the fuss is all about.

No rolling your eyes, please

5. Show some sympathy in mediation.

Ardalan says he has attended many mediation sessions in which the risk manager clearly was exasperated and unsympathetic to his client. Maybe there is some justification for feeling that way, he says; but for your own good, you need to hide your emotions.

"This is mediation. You're supposed to try to come to some resolution of the dispute," he says. "Don't roll your eyes and say rude things to the person who's hurt."

If you feel compelled to defend your position vigorously or even to criticize the plaintiff, do it privately. Ask the mediator to meet with you privately and never say such things in front of the plaintiff. That only makes you look cold, and that will not help you in the mediation process.

6. Listen to your lawyers.

Ardalan also has seen risk managers who come to the table with their minds made up about liability and how much a case is worth, and then they ignore their lawyer's best advice.

"That's good for me because it puts them at a disadvantage when they can't recognize the dynamics of what is going on," he says. "There may be letters going back and forth between the lawyers, and your attorney might know more about law than you do."

Watch your lawyer work

7. But don't leave everything up to your lawyer.

The risk manager always should attend the mediation sessions, he says. You may not actively participate much, but you need to see how your lawyer is handling the case.

"If a lawyer is screwing up and they're worried about losing the hospital's business, they're not going to report to the risk manager how they've done everything wrong," he says. "You need to see what's going on for yourself."

Ardalan points out that when a risk manager is present, the plaintiff's attorney will direct most comments to him or her. They know that the facts of the case and negotiation may be different from what you have heard from your defense attorney.

"Some law firms are notorious for their billing in litigation so they're not motivated to settle anything early on," he says.

"Pay attention and the plaintiff's attorney might send you signals that settlement is possible, and that might be news to you."

8. Read the case materials yourself.

It is dangerous to rely only on the summary letters and reports from your own attorney, Ardalan says.

"You can't always assume you have the best lawyer," he says. "Or they may be a great lawyer, but they're not handling this case the way you want them to."

9. Consider direct discussions with the plaintiff's lawyer.

Don't circumvent your own lawyer, but if it appears the two attorneys are just butting heads and getting nowhere, Ardalan says it can be useful for the risk manager to speak directly with the other side.

You may find that the plaintiff's attorney is about to take the case to trial because he's given up on any kind of agreement with your lawyer, he notes.

"Some contact at that point can't really hurt, and you might be able to reach some understanding before you take that next big step," Ardalan explains.

Don't anger the jury

10. Avoid the disingenuous defense.

Jurors tend to pay out a large sum in two scenarios. In the first, they see the defendant as having done something egregiously wrong.

In the second, maybe the wrongdoing wasn't so dramatic but the jury was offended by the defense strategy.

"A lot of times, you have defense attorneys who are handling a lot of cases for the insurer and they pick just a few dispassionate defenses that they repeat over and over," Ardalan points out.

"They get up in front of a jury and try to say the 85-year-old blind man in a walker should have watched where he was going. The jury gets so upset with the defense and says, 'You guys are just jerks.' They express that with a big award to the plaintiff." ■

Why JCAHO cares about hospital ergonomics

'Environment of Care' targets worker safety

The Joint Commission on Accreditation of Healthcare Organizations wants you to use ergonomic interventions.

That is an argument your hospital administration will have a hard time ignoring as you promote the use of tools, equipment, and training to reduce patient-handling injuries among your staff.

The Environment of Care standard specifies that facilities should provide a safe environment for patients, staff, and visitors. To underscore the point about safe working conditions, the Environment of Care newsletter recently highlighted ergonomics with a two-part series on the hazards of repositioning.

Specifically, surveyors may look for compliance with standards that require hospitals to identify risks and develop processes to minimize them, as well as a human resources standard that requires staff training.

Surveyors have been educated about ergonomic hazards as they relate to the Environment of Care standard, says **John Fishbeck**, RA, associate director of the Joint Commission's division of standards and survey methods.

In the new style survey, surveyors track patients through their care and may ask their caregivers about ergonomics, says Fishbeck, including: "What have you been told about how to safely move or reposition this patient? Have staff up here had any injuries related to lifting or ergonomics issues?"

Investing in ergonomics

The Joint Commission's interest in ergonomics can provide justification for an investment in ergonomic equipment, says **Deborah Fell-Carlson**, RN, COHN-S, loss control consultant with SAIF Corp. in Salem, OR, a nonprofit workers' compensation insurer.

"The Joint Commission clearly wants a safe environment for everybody," she says. "If we're not providing a safe environment for everybody, then we're really not providing what Joint Commission is intending."

Hospitals can use ergonomic indicators as part of the performance improvement process that is required by JCAHO.

"The Joint Commission's 2004 rules require one failure mode effects analysis every year [that is] reported to the board," Fell-Carlson says.

"Some of the facilities are using that to evaluate the cause and effect of safe patient handling strategies," she explains.

At the hospital at which she previously worked, Fell-Carlson used the overall lost workday case incident rate as a benchmark.

Using the Bureau of Labor Statistics formula, she determined that the hospital's lost workday incident rate was 6.3 per 100 full-time equivalent (FTE), compared to an industry average of 4.4. (The industry average is available at http://stats.bls.gov/iif/oshwc/osh/os/ostb1244.txt; the hospital sector is SIC code 806.)

The hospital developed a comprehensive ergonomics program, which included the analysis of workstations by an occupational therapist, education of staff on the use of patient-handling equipment, and the purchase of new devices. The hospital bought repositioning devices, total body lifts, and stand-up lifts to help patients ambulate.

With the interventions, the lost workday incident rate dropped to 1.3 per 100 FTE. "It really did show that what we were doing was very effective," Fell-Carlson says.

A tour of safety

At Samaritan Lebanon (OR) Community Hospital, a safety team conducts safety tours every month in a different department, marking areas of concern on a hazard log. Ergonomics is included in that hazard review, says **Joseph R. Haralson**, CHE, vice president for ancillary/support services.

Managers are required to address the hazards identified within 30 days, and the hazard log is a regular item on the safety committee's monthly agendas. Items remain on the hazard log until they have been resolved, he says.

A quarterly status of the environment report, including a safety report, is presented to the board.

During a Joint Commission survey in May, surveyors made some positive comments about the hazard log and reporting process, Haralson explains.

"That was exactly what they wanted to see, a chain of communication and coordination between all levels of the organization," he adds.

Ergonomics may arise in Joint Commission surveys based on the new tracer methodology, which tracks the care of specific patients, he says.

"Let's say they pulled a chart, and it happened to be a patient who weighed 350 pounds. Then I would say they would probably have a lot of questions about ergonomics, employee safety, and lift devices," Haralson continues.

Training also is important to the Joint Commission. Twice a year, Samaritan Lebanon holds safety fairs for employees.

They travel from station to station, receiving an update about ergonomics, security, needle safety, hazardous materials, and other safety issues.

Employees must answer a quiz to demonstrate knowledge of the safety information, he says.

Beyond federal regulations

The Joint Commission, always a strong influence, has an even larger role to play in the absence of a regulatory standard on ergonomics.

"Anytime we can integrate occupational health and safety into an organization's current work, their current priorities, it breaks down some of the obstacles that are preventing them from doing this," says **Chuck Easterly**, loss control manager at the SAIF Corp.

Oregon OSHA decided not to pursue an ergonomics rule, but wanted to focus on the hospital and construction industries to reduce MSD injuries, he explains.

A committee of labor, hospital, and insurance representatives formed the Oregon Coalition for Healthcare Ergonomics. The coalition recently held a conference to discuss "real-world solutions for people who are in the real world."

A way to demonstrate compliance

Fell-Carlson spoke about using ergonomics to demonstrate process improvement in the Joint Commission's Environment of Care standard.

"[Hospital administrators] frequently say, 'We would love to do that, but . . . we don't have the money; we don't have the resources; we've got to do these things first. We'll get to it after the survey,'" Instead, they can focus on ergonomics as part of Joint Commission compliance, she points out.

"People say the Joint Commission is for patient safety. But everywhere the Joint Commission says patient safety, they also say patients, staff members, and visitors," Fell-Carlson adds. ■

(Continued from cover)

candidates — including the very young, the elderly, those with chronic illnesses, pregnant women, the immunocompromised, and health care workers with direct patient care — have been identified as those to receive the vaccine.

In response to the national shortage of vaccine, Thomson American Health Consultants has developed an influenza sourcebook to ensure you and your hospital are prepared for what you may face this flu season.

Hospital Influenza Crisis Management will provide you with the information you need to deal with ED overcrowding, potential liability risks, staff shortages, and infection control implications for staff and patients. This sourcebook will address the real threat of a potential pandemic and the proposed response and preparedness efforts that should be taken in case of such an event. Major guidelines and recommendations for influenza immunization and treatment are included, along with recommendations for health care worker vaccination and the efficacy of and criteria for using the live attenuated influenza vaccine. Don't miss out on this valuable resource.

Hospital Influenza Crisis Management also will offer readers continuing education credits. For information or to reserve your copy at the pre-publication price of $149 (a $50 discount off the regular price), call our customer service department at (800) 688-2421. Please reference code **64462**. ■

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