Healthcare Risk Management®

Celebrating our 27th year as your first source of risk management information

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

MARCH 2005
VOL. 27, NO. 3 • (pages 25-36)

Study: Infighting among doctors and nurses is frequent and harms patients

Disruptive behavior directly threatens patient safety; what you can do

Arguments, nasty comments, and demeaning behavior — what health care professional can't tell stories of how some co-worker or colleague made life miserable for people just trying to do their jobs? Disruptive behavior is all too common in health care, but now experts are warning that the harmful effects fall on more than just the health care professionals.

New research conducted by VHA Inc. has found that disruptive behavior between physicians and nurses occurs frequently and affects patient outcomes. As a result of this behavior, these providers report that patients are experiencing pain or prolonged pain, receiving medications or antibiotics late, being mistreated or misdiagnosed, or dying.

Can a lawsuit be far behind? Something along the lines of, "The doctors and nurses were so busy arguing with each other that they missed the patient's obvious signs of distress until it was too late." That scenario definitely can happen, researchers say, and it probably already has.

More than three-quarters (86%) of nurses who participated in the survey and nearly half (49%) of physicians said they have witnessed disruptive behavior.[1] Research also revealed disruptive behavior between nurses is prevalent. Sixty-eight percent of nurses and 47% of physicians who responded said they have witnessed disruptive behavior between nurses and from nurses aimed at other hospital staff.

Direct effect on patient safety found

Previous studies have shown the harmful effects of disruptive behavior on staff and health care operations, but the recent study is the first to decisively show that patient safety is undermined. The latest research comes from **Alan H. Rosenstein**, MD, vice president and medical director at VHA in Irving, TX, and **Michelle O'Daniel**, director of member relations for VHA. The study was initiated to assess perceptions of the impact of disruptive behavior on nurse-physician relationships and to determine

what physicians, nurses and hospital administrators believe to be its effects on patient care.

Surveys were distributed to 50 VHA member hospitals in more than 12 states and results from more than 1,500 participants were evaluated.

The survey found that most respondents (94%) believe disruptive behavior impacts adverse events, medical errors, patient safety, patient mortality, quality of care, and patient satisfaction. Sixty percent of the respondents were aware of potential adverse events that may have occurred from disruptive behavior.

For the purposes of the study, disruptive behavior refers to any inappropriate behavior, confrontation or conflict, ranging from verbal abuse to physical and sexual harassment.

Direct patient harm from personal conflicts

In perhaps the most disturbing finding, 17% of the respondents reported that they knew of a specific adverse event that occurred as a result of disruptive behavior and 78% of those respondents felt the adverse event could have been prevented.

"The survey suggests a serious problem within and across disciplines," Rosenstein says. "It's not just disruptive physician behavior either. That's a common myth. It's disruptive nurse behavior also and disruptive staff behavior across the board."

In the VHA study, the respondents confidentially reported incidents in which disruptive behavior among coworkers resulted in actual harm to patients and plenty of near-miss incidents as well. Comments included incidents such as a nurse making a medication error because a confrontation with a doctor had upset her. **(See p. 28 for more examples.)**

Throwing placentas and scalpels at nurses

The survey also found that disruptive behavior affects nurses' and physicians' stress levels (94%), frustration levels (94%), concentration (83%), communication (92%), collaboration (90%), information transfer (87%), and workplace relationships (91%). Each of those psychological and behavioral variables can directly affect patient safety, Rosenstein notes.

O'Daniel says part of the problem can be traced to generational differences in the expectations of health care professionals. Nurses, for instance, used to put up with far more outlandish behavior than would be tolerated today. O'Daniel recalls speaking to one older, very accomplished OB/GYN who read the study results and said he could be one of the unidentified physicians cited in the confidential reports.

"He said, 'We used to throw placentas and scalpels at the nurses,'" she recalls. "He went on to say that the doctors learned not to do such overtly physical and violent things, but that they still might not think of some of these other verbal confrontations as being so hurtful and disruptive."

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $519. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 18 CE nursing contact hours, $545. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

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

In order to reveal any potential bias in this publication, and in accordance with the American Nurses Credentialing Center's Commission on Accreditation guidelines, we disclose that Consulting Editor Bishop and Editorial Advisory Board members Archambault, Dunn, Johnson, Porto, Sedwick, and Trosty report no relationships with companies related to the field of study covered by this CE program. Board member McCaffrey is an officer and member of the American Society for Healthcare Risk Management. Board member Kicklighter reports involvement with ECRI and Kendall Endoscopy Surgical Center. Board member Metcalfe is a consultant with Sharyn O'Mara & Associates.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.
Editor: **Greg Freeman**, (770) 998-8455.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@thomson.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

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

Yelling and condescending comments might not be seen by some as disruptive behavior, O'Daniel says, but they should be. Such behavior often is tolerated as part of the tradition in the medical community, particularly when it comes to doctors yelling at nurses.

Risk managers and other leaders may be hesitant to confront physicians who bring business to the hospital, but other demands are changing that, Rosenstein says. The severe staffing shortage in some areas means that no one wants a good nurse driven away because she can't stand the verbal abuse. And there is the question of secondary liability from any harassment lawsuits, plus the very real possibility of a malpractice lawsuit stemming from disruptive behavior.

But remember, the bad guy is not always the doctor.

"Nursing disruptive behavior is as prevalent as physician disruptive behavior," Rosenstein says.

Might not be easy to address

William Lynagh, MD, is a former practicing physician and health care administrator who moved into consulting and now is the founder of the Center for Holistic Leadership in Greensboro, NC. Lynagh has helped health care organizations resolve disruptive behavior problem and he says he encountered plenty in his own medical career as well. He advises risk managers to make sure they have a "culture of openness" because otherwise you'll never even hear about a lot of disruptive behavior.

"You need to have clearly stated values, be open to listening, and then have the strength and courage to act on that value system," he says. "Health care still has very much a mentality in which doctors give orders and expect nurses to carry them out without question. Good communication and respect is not always valued as highly as it should be, so this is not always easy for a forward-thinking risk manager to address."

When you try to address disruptive behavior, the person accused of acting improperly may be genuinely shocked and not understand what he or she did wrong, Lynagh says. Don't underestimate the wide variation in how people can interpret the same behavior or the way certain comments can come across far differently than the speaker intended.

"People often can have a certain behavior — a tone of voice or a habit of speaking loudly — and have no idea how it affects other people," he says. "Sometimes you have to acknowledge that they don't mean any harm from that behavior, but you have to convince them that they still need to manage the way people react to it. If you're not really so angry, OK, but how can you *manage* the fact that people think you are?"

Allow people a graceful way to improve

That can be less threatening to the personality of the person in question and encourage a more productive response. Allow the person to be part of the solution and allow them a face-saving way out. If the person can say, "Gee, I didn't know people thought I was so angry. I guess my loud tone comes from growing up in a big family where we were all loud," he or she can act on that realization.

And whether it is completely true or not, that is much easier than simply admitting you're an unpleasant person to work with.

"You're not trying to beat them into submission and get them to say how terrible they are," Lynagh explains. "You're trying to change the behavior, and that works best when they can do it without having to feel terrible about themselves."

Reference

1. Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: Perceptions of nurses & physicians. *Am J Nurs* 2005; 105:52-62. ■

Risk managers must act on disruptive behavior

Risk managers must act on disruptive behavior, says **Alan H. Rosenstein**, MD, vice president and medical director at VHA in Irving, TX. Do not dismiss disruptive behavior as merely an unfortunate fact in any work environment because in health care, the result is not a bad batch of widgets. It's a patient who is needlessly harmed.

"Disruptive behavior needs to be addressed at the organizational level," he says. "Hospitals need to invest time and resources into performing self-assessments, increasing staff awareness of the issue, opening lines of communication, and creating greater collaboration between peers. If hospitals don't do this, the problem will continue to grow and patients will continue to needlessly suffer."

This is what Rosenstein recommends:

• **Raise awareness.** The first step often is simply raising awareness among health care staff and physicians, say Rosenstein and **Michelle O'Daniel**, director of member relations. Present the evidence to show that disruptive behavior is dangerous to patient safety and establish that your organization will not tolerate it.

• **Assess the severity of your own problem.** Do an internal assessment, looking for the problems that may have been kept secret because no one thought leadership was interested in helping. This may require a confidential survey or some other method that allows people to report problems without retribution.

• **Provide structured educational programs.** Topics might include communication skills, phone etiquette, conflict management, and diversity training. The idea is to train people to prevent disruptive behavior and also how to respond so that initial confrontations do not escalate. One of the most effective ways to improve relationships between physicians and nurses, for instance, is to train nurses in the proper way to call physicians at home. **(See p. 29 for more on phone etiquette.)**

• **Establish a zero-tolerance policy for disruptive behavior.** Such a policy must apply across the board, O'Daniel notes. "It can't just be for the physicians or just for the physicians who don't bring in a lot of money," she says. "It has to apply to everyone and they must know what happens when they don't adhere to it."

Many organizations already have a code of conduct that is applied unevenly or ineffectively, O'Daniel says. Merely having a code of conduct or a zero-tolerance policy doesn't help unless you are willing to enforce it, she says. ■

Confidential reports reveal impact on patient safety

Personal conflicts are inevitable among coworkers. So why should a risk manager get involved? Consider the following examples of how those conflicts directly affected patient safety. These are real responses to a confidential survey[1]:

• "The environment of hostility and disrespect is very distracting and causes minor errors. I have caught myself in the middle of mislabeling specimens after confrontations that have been upsetting."

• One nurse wrote that when a patient was brought to her unit for gastrointestinal bleeding, the patient saw a doctor yelling at nurses. The patient asked if that was his doctor and was told yes. The patient refused treatment and was transferred to another hospital.

• Another nurse wrote that a doctor "became angry when RN reported decline in patient's condition and did not act on information. Patient required emergency intubation and [was] transferred to ICU. This caused family much unnecessary heartache and disruption in family grieving process."

• "In the past year, Dr. X (a female physician) has chosen to be argumentative, demeaning, and rude, not just to nurses but to [physician] colleagues. We are all a team, but unfortunately, patient care and morale have suffered. Nurses are afraid [and] intimidated to talk to Dr. X and delay that for as long as possible, sometimes avoiding Dr. X all together. I want to work in an environment where we, as a team, set patient goals and achieve them together.

• "Physicians who are disruptive are usually chronic disrupters and have run-ins with several nurses. There are also nurses who are chronic disrupters. These people are often avoided by other staff, which leads to lowered communication. I am sure that a serious incident is just around the corner."

• "Employee stress as a result of a physician yelling resulted in decreased patient safety."

• "Intimidation of RN led to lack of communication and patient intervention."

• "Delay in patient receiving meds because RN was afraid to call MD."
• "Most nurses are afraid to call Dr. X when they need to, and frequently won't call. Their patient's medical safety is always in jeopardy because of this."
• "Adverse event related to med error because MD would not listen to the RN."
• "RN did not call MD about change in patient condition because he had a history of being abusive when called. Patient suffered because of this."
• "Cardiologist upset by phone calls and refused to come in. RN told it was not her job to think, just to follow orders. Rx delayed. MI extended."
• "Difficult endoscopy. Physician angry, frustrated, abusive to patient and technician. Patient safety compromised."
• "Communication between OB and delivery RN was hampered because of MD behavior. Resulted in poor outcome in newborn."
• "MD yelled at RN for calling at night, patient condition not addressed, resulting in a negative patient outcome."
• "RN called MD multiple times re: deteriorating patient condition. MD upset with RN calling. Patient eventually had to be intubated."
• "RNs did not want to call MD after IV ran out. No antibiotic therapy for four days. RN afraid to call MD. Patient expired."

Reference

1. Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: Perceptions of nurses & physicians. *Am J Nurs* 2005; 105:52-62. ■

Phone etiquette can help prevent disruptive behavior

Many of the confidential comments from the VHA study concerning disruptive behavior concerned nurses who were afraid to call physicians at home because they knew the doctor would be angry. But that's not always because the doctor is a jerk, researchers say.

In many cases, the doctor is understandably angry because the nurse calls in the middle of the night without any of the information the doctor needs to provide orders. **Michelle O'Daniel**, director of member relations for VHA in Irving, TX, says physicians report that they commonly receive calls from nurses who don't even know the patient's name or vital statistics, yet they expect the doctor to cheerfully approve the nurse's suggested order.

"It's not an excuse for the physician to be disruptive, but it shows that there's more to this than just a mean doctor and an innocent nurse," she says.

Train nurses in good phone etiquette

O'Daniel suggests training nurses in specifically how to call a physician, even though they may think they know already. When trying to get physicians to respond in a more pleasant way, ask them for suggestions on what they would like to hear when a nurse calls. Then use that information to train the nurses.

The VHA researchers suggest that, at a minimum, the nurse should be ready with this information: patient name, vital signs, diagnosis, and the type of surgery the patient had or is scheduled to have. Also, the nurse should identify herself or himself clearly — by name and position. This basic information especially is important when a physician is covering another doctor's patients.

Some hospitals even post reminders by the phone or on cards the nurses can carry and consult before calling the doctor. These are common reminders to post:
• Have I reviewed any standing orders?
• Have I seen and assessed the patient before calling?
• Do I have the patient's chart in hand with the most recent meds?
• Have I read the progress notes?
• Have I discussed this with my charge nurse?

How to wake up a physician

O'Daniel provides these examples of bad and good phone etiquette when waking the physician at 3 a.m.:

The *Wrong* Way to Call the Physician:
Doctor: Hello . . .
Nurse: Can I give Mr. Jones some morphine?
Doctor: Who is this?
Nurse: Jean. He needs some morphine.
Doctor: Are you a nurse?
Nurse: Yeah, I was thinking 2 milligrams.
Doctor: Who is Mr. Jones?
Nurse: The guy with the hand thingy.
Doctor: Is he scheduled for surgery?
Nurse: Yeah. He's not breathing too well, by the way.

Doctor: Can you present the patient to me?
Nurse: Huh?
Doctor: Is he healthy? Does he have any heart or lung problems?
Nurse: I don't know. I'm only covering for Christine.

The *Right* Way to Call the Physician:
Doctor: Hello . . .
Nurse: Sorry to bother you. This is Jean, the nurse in the ICU. I'm taking care of Mr. Jones, the patient in Room 212. He has asthma but is otherwise healthy and is scheduled for open reduction of the wrist later. He is currently 5 out of 10 on the pain scale. Can I have an order for pain medication?
Doctor: Yes, you can give 2 milligrams of morphine. ■

Open talk helps diabetes clinic torn by staff conflict

As daily workplace demands rise, overtaxed leaders often target other decision makers — the CEO, a head nurse, technician, or doctor — as the source, says psychologist **Anna Maravelas**, a conflict resolution consultant and president of TheraRising.com in Minnesota.

Maravelas has been resolving conflict for more than 20 years in hospitals, prisons, police departments, corporations, and universities. She says that kind of finger pointing is the root cause of workplace factions and cross-functional tension. When leaders go toe-to-toe in a public display of hostility and blame, even patient safety becomes secondary, she says, because the battle for reputations and careers takes precedent.

Stop it, or else

Maravelas tells this story she says is typical of how such conflicts can disrupt health care operations and threaten patient safety:

Several years ago, she was asked to intervene in a troubled dialysis unit. "Alice," the division's vice president, told her, "I've tried everything to stop the three leaders of this unit from fighting and you're my last hope. If you can't resolve the conflict between the head nurse, the assistant head nurse, and the technical supervisor, I am going to close the unit and tell the doctors to take their patients somewhere else. I can't allow the unit to continue as it is."

After gathering extensive background information, Maravelas met alone with each of the three supervisors to get their individual perspectives. During their private interviews, each said to her, "I know I have the majority of the staff behind me because the staff tells me I'm the most competent leader on the unit."

Obviously that wasn't possible, so Maravelas knew the supervisors were being played. She also knew her first step was to break through their individual illusions that they had more staff support than their peers.

With their knowledge, she drew up a confidential survey for their 65 direct reports. When the surveys were returned to her office, anger and resentment toward all three supervisors poured off the pages. Assured of confidentiality, the nurses and technicians were passionate and bitter — and their comments were laced with disparaging remarks about the leaders' immaturity and irresponsibility. Most of their employees were particularly enraged that their management team had compromised their responsibilities to patients in order to play out a private vendetta.

Met with supervisors as group

Maravelas typed up their comments, removed identifying information, made copies, and asked the three supervisors to meet with her as a group. As they read through the responses, their self-righteousness and smugness evaporated and they shifted uncomfortably in their seats.

The two-hour meeting was a major turning point for the management team. Four months after the first meeting, relations had improved among the clinic leaders enough that they regularly got together for a beer after work.

"Interpersonal staff conflict can cost organizations millions of unmeasured dollars and put a hard-earned reputation for excellence at risk," Maravelas warns. "Very rarely is the source of the problem the other party's personality. When leaders want to understand the behavior of another person or department they would be well served to focus on their performance measures, restraints and demands, rather than their personalities."

Maravelas says blaming people for problems is worse than ineffective; it alienates the people you need to solve the problem.

"Turf wars and blame aren't human nature," she says. "They are reflexive reactions to frustration, and they are easily changed." ■

Detailed documents needed to avoid malpractice suits

Detail always is good. More detail always is better.

That's the rule of thumb when it comes to documentation, according to **Cecilie Loidolt**, JD, a medical malpractice defense attorney with Meagher & Geer in Minneapolis.

The top malpractice concerns don't really change with the passage of time, Loidolt says, but defense attorneys learn more every year about how you can keep yourself out of trouble. Complications from surgery and childbirth, particularly brain-damaged babies and death during related to delivery, and failure-to-diagnose claims still are some of the biggest concerns for risk managers and defense attorneys, she reports.

But Loidolt says the frequency of those claims may be on the rise now because many states are enacting tort reform that could sharply restrict the payouts from those claims. Plaintiffs are rushing to get those suits in motion before the tort reform takes effect, she says.

One new trend, Loidolt says, is an increase in claims related to Cytotek, which was approved by the FDA for treating ulcers but often is used off-label for induction of labor. Another common claim is a patient suffering a known complication of surgery but claiming that he or she was never informed of that particular risk.

"So it becomes an issue of conformed consent," she says. "And it's also a claim that the complication would not have occurred if the physician had followed accepted standards of medical practice. I probably have five cases right now involving that kind of claim."

Loidolt offers these tips for warding off those problems and other medical malpractice lawsuits:

• **Push for more detailed documentation of the informed consent process.** With surgery, in particular, the chart should indicate *in detail* what the physician discussed with the patient during the informed consent process. "I discussed the known complications and risks" is insufficient. The record should state something more like, "I discussed with the patient the risks of this procedure including injury to other organs, infection, bleeding, possibility of recurrence . . ." and so on.

It's OK for the physician to use boilerplate language in every chart for that procedure if it accurately reflects the conversation with the patient. Warn physicians that it never is enough to say, "I always discuss those things, but I don't write down every little thing."

• **Document telephone calls better.** Any contact with the patient should be documented if there is any discussion regarding the care rendered. Loidolt says she often is surprised by doctors who receive calls after hours and do not document them.

"Put it on a piece of paper and staple it into the chart the next day," she says. "You can indicate in the note that you 'took this call at home at 9 p.m. on Dec. 21. Patient complained of pain in the incisional area. She was told that if pain persists, she needs to be seen.' That is so important because when I go try the case, I can show the documentation that this call did occur and she was told she needed to be seen. It gets past a lot of the disputes about who said what."

• **Improve documentation of discharge instructions.** The ideal chart will include details about what the patient was told at discharge. Again, boilerplate language is acceptable if it accurately reflects what the patient was told. But general statements such as, "The patient was provided discharge instructions," are not much help.

Early deposition is red flag

• **Watch for lawsuits related to Vioxx and Celebrex.** The claims against those two recalled drugs will be aimed at manufacturers first, but frontline providers can be targeted for prescribing them. The risk is much higher if the drugs were prescribed for off-label use.

• **Bariatric surgery may soon produce a rash of lawsuits**. The surgery involves a higher risk of complications and therefore may spawn lawsuits related to the informed consent process. With bariatric surgery, or any other high-risk surgery, risk managers should spend more time counseling the doctor on the importance of a thorough, detailed informed consent process.

"Physicians may say that if they spend all that time explaining the risk of every surgery, no patient will ever consent to the procedure," she says. "But the risk with bariatric surgery is so much higher that it justifies more detail and more diligence. The riskier the procedure, the more you need to make sure you're having a very good discussion and answering every question."

• **Watch for requests to depose the defendant very early.** As soon as you see that early request for deposition, a red flag should go up. The plaintiff's attorneys probably have been researching

the case for some time before the summons and complaint is served, so if they request deposition within a month, they're probably trying to take advantage of their head start. They want to get the deposition before you have a have a chance to research the case on your side and catch up.

One tactic for risk managers is to get your investigation rolling quickly. You might want to refuse to produce the defendant for the deposition if you feel that you have not had time to gather the medical records and other basic information. Don't put the defendant doctor in the position of answering questions in a deposition before you have all the facts.

• **Help physicians avoid being tricked into testifying against colleagues.** It is common for plaintiff's attorneys to seek out nontreating medical providers for supporting testimony but to then maneuver them into criticizing their colleagues. For instance, an attorney may ask a physician currently providing care to the plaintiff (but not involved in the alleged malpractice) to testify as to the patient's condition. But once on the stand or in deposition, the doctor often is maneuvered into criticizing the defendant physician's care.

Plus, the doctor may not know yet if the plaintiff intends to include him or her in the lawsuit. So speaking too freely could be detrimental.

"Risk managers can get involved and sit in when the plaintiff's attorney wants to meet with the physician, particularly if the doctor is an employee of the hospital," she says. "At least ask them to speak with you before meeting with the plaintiff's lawyer. Encourage them not to handle the meeting on their own."

• **Warn clinicians not to hide after a bad outcome.** A common complaint after a bad surgical outcome, for instance, is that the doctor never came around to discuss it, or only visited once and then wouldn't make eye contact. That poor bedside manner seriously increases the likelihood and severity of a malpractice lawsuit.

Remind physicians that, while they should not admit culpability, extending compassion and making yourself available to the patient always is a good thing.

"Availability is a very big deal," Loidolt says. "It comes out during the trial that the doctor was emotionally cold and unavailable, and that can really color the way a jury sees the defendant. And patients sue the doctor they don't know, the one who didn't sit by the bed and tell them what happened and how much they want to help make it right." ■

Minnesota first to report errors under federal rule

Twenty patients died in Minnesota hospitals over 15 months from medical errors or oversights, according to a new report released recently by the state health department.

Minnesota is the first state to report its medical errors mistakes under standards developed by the National Quality Forum, a Washington, DC-based nonprofit group.

New Jersey and Connecticut also adopted the standards, and other states are considering them.

The causes of the errors reported by Minnesota included falls, faulty medical equipment, and administering the wrong medication, the state health department said.

The report documented 99 serious errors between July 1, 2003, and Oct. 6, 2004. The most common problem not resulting in death or disability was doctors leaving foreign objects such as surgical sponges inside patients at the end of operations. The Minnesota report included 31 such instances.

St. Luke's Hospital in Duluth reported the most deaths due to medical errors, with four — a fall, a medication error, a malfunctioning medical device and a burn. Three patients died after medical errors in Mayo Clinic facilities in Rochester and Mankato, including two who received incorrect medications and one apparently healthy patient who died after an operation.

In a 1999 report, the Institute of Medicine estimated that 44,000 to 98,000 Americans die annually because of medical mistakes. Since then, 22 states have adopted laws requiring hospitals to report serious mistakes, according to the National Academy for State Health Policy. ■

Learning packets help staff reduce falls, improve safety

Educating your staff is an ongoing challenge, but one hospital has found that patient safety packets with practical, goal-oriented information can be especially effective in helping reduce falls and other hazards.

JCAHO recently awarded its Eisenberg Award to the University of Pittsburgh Medical Center

(UPMC) in McKeesport, PA, for development of personalized patient safety self-learning packets. JCAHO praised UPMC for creating tools that "demonstrated their effectiveness in creating an organization culture of patient safety that facilitates the resolution of problems associated with hospital-acquired infections and falls."

UPMC began working on the patient safety packets in 2002, says **T. Michael White**, MD, senior vice president for value and education at UPMC. The hospital built on previous work at the University of Pittsburgh that suggested instead of waiting until a patient was near death to call a code, it is better to call the code as soon as the patient becomes significantly unstable. The researchers called this "Condition C."

Codes go up, deaths go down

To encourage calling codes at Condition C, UPMC put a learning packet together and called it "Keeping Each Patient Safe (By Calling for Help Early)," White explains.

"These are learning packets for our professionals. Once we had the educational material ready, we used them to teach each professional individually," he says. "We can do that in a room of 30 doctors, each with their own packet, and the attendings get continuing medical education credit for that."

Or the packets can be used to teach clinicians one at time. The nursing departments make use of the same packets. And the results of that first learning packet suggested that the method worked for getting across the new strategy on calling codes.

Prior to July 2002, UPMC had about six codes per month and about half of the patients survived. The packets were introduced in July and August, and suddenly the number of codes shot up to about 30 codes a month, with nearly all of them surviving.

The data also showed that one unit of the hospital was not calling codes early, and a review of the records revealed that was the only unit that had been overlooked in the training program. That oversight was rectified.

Then doctors reported that physical therapy was calling too many of the early codes, so UPMC conducted a root-cause analysis and found that actually the department was not calling too many codes. The real problem was that patients going to physical therapy were having a difficult time enduring the ride down, the wait for a therapist, and finally the therapy itself. The codes were valid; the patients were just being pushed to the brink.

"So we changed our policy so that we bring therapy to the patient so that it can be done at the bedside," he says.

More learning packets developed

The success of the Condition C packet led UPMC to develop others. There are now five learning packets now, each under the rubric of "Keeping Each Patient Safe . . . : By Calling for Help Early, By Preventing Hospital-Acquired Infections, From Falls and Confusion, With Standardized Admission Orders, and With Excellence in the Discharge Process."

Rich Kundravi, director of risk management and patient safety at UPMC, says the topics were selected through root-cause analyses and trends in data. The hospital's patient safety committee drove the process, he says.

"From a risk management perspective, some topics are always a concern, like patient falls," he says. "Historically, we had tried several fall reduction programs that we thought would be very helpful but when we looked back at our data we were consistently at the same fall rate. Our staff was making an effort to prevent falls, but when we studied the root causes, we found that patient confusion was something we could address within our organization."

As part of that learning packet, medication experts at UPMC studied the drugs that were most often the cause of delirium in patients and eliminated those from the formulary.

Studying the data specific to UPMC allowed the patient safety team to implement solutions that addressed what actually happening at their hospital, not just general solutions to general problems, he says.

White says the learning packet helped clinicians at UPMC develop a common language regarding falls, so that nurses more commonly alerted physicians that a patient was "confused," and both professionals knew that the word had particular meaning regarding the risk of falling. The number of patients diagnosed with delirium has increased, he says, because the culture encourages the diagnosis and treatment.

The learning packets are different from the typical inservice education materials, White says. (For examples of the packets and the overall UPMC patient safety effort, see this web site: http://mckeesport.upmc.com/keepingpatients

safe.htm.) The packets provide a primer on each topic and are written in a language that is easily understood by each of the target audiences: physicians, nurses, therapists, and other clinicians. The same packet is used for everyone.

"That was a key goal, providing the information in a way that they could easily digest and put to use," he says. "So many times, physicians go to a seminar and sit there for an hour, understand everything that is said, but when we go to take care of our patients our behavior is not changed. These packets lead to immediate change in behavior."

For instance, Kundravi says the patient safety committee determined that nurses at UPMC were assessing patients for falls but the physicians often were not aware that patients were at risk of falling. So the learning packets also provide a linkage between departments and different professionals by providing a common language and encouraging everyone to focus on the same priorities.

Each professional receives a packet to keep and can refer back to the resources inside. Kundravi says the packets also encourage a blame-free environment because they encourage staff to share information, with the goal of protecting the patient rather than punishing staff for oversights. White says staff have responded well to the learning packets. Participation is mandatory for nurses and the patient safety sessions are part of the nurses' annual competency requirements.

"Physicians have responded with enthusiasm, although it is not mandatory for them, and they report a positive change in the care of their patients," he says. ■

Reader Question

No EMTALA risk if patient elopes after screening

Question: What is our obligation under EMTALA when a patient leaves the emergency department after screening but before treatment is complete? We know that we can get in trouble when a patient leaves before being assessed and treated, but what if they're in the middle of treatment and just slip out because they're tired of waiting for the doctor to come back and release them?

We currently have a nurse call them at home, if possible, to check on them and assure them that they would have been treated fully. Is that enough?

Answer: This is a common situation in emergency departments, but it does not necessarily pose any risk of an EMTALA violation, says **Holley Thames Lutz**, JD, a health law attorney with the firm of Gardner Carton & Douglas in Washington, DC. There are other reasons to be concerned, however, and to make sure you have appropriate protocols in place.

The risk and necessary response increase when the patient has an emergency medical condition. she says the federal government has made clear in recent EMTALA interpretative guidelines that the hospital has not committed an EMTALA dump when a patient walks out unless you suggested the patient leave or you're dragging your feet about making a timely transfer when the patient cannot be treated at your facility.

"Let's say an emergency medical condition is identified, you start treatment and leave to go get the phlebotomist and the person decides to go home. In that kind of scenario, EMTALA is not your problem unless you met one of those two conditions," Lutz explains. "But that doesn't mean you can forget that patient and move on to the next."

In essence, she says, the patient has left against medical advice (AMA). AMAs are not uncommon in hospitals and certainly not in emergency departments, so you probably have a protocol in place already to address that problem. When a patient just slips out of the emergency department, however, you may not be able to apply the same standards of talking to the patient about the risk of leaving, recruiting family members to talk him out of it, and having him sign statements acknowledging the risk.

"Assuming the patient just walks out and doesn't afford you the opportunity for that kind

COMING IN FUTURE MONTHS

- New efforts to avoid medication errors
- The best way to teach EMTALA to staff
- Counseling the doctor who always has to be right
- Reducing adverse perinatal outcomes

of good communication, the next best thing is to call the patient at home and go over some of that information like the diagnosis, test results, anything you think the patient should know about his or her condition," Lutz says. "Tell the patient 'you have an emergency medical condition and you need to be treated somewhere.' It's a very good idea to tell the patient that you'd be glad to see him again if he wants to return to the emergency department, and that you would have completed treatment if he had stayed."

If the intake information included the patient's personal physician, she suggests having a nurse call that physician to inform him or her that the patient was in the emergency department and left without completing treatment.

Lutz says risk managers should ensure that when a patient elopes after an emergency medical condition is identified, staff clearly document the situation. A patient with a simple headache who leaves the emergency department because he feels better is a different situation; the same level of diligence is probably not required or practical in a busy hospital. But an emergency medical condition is serious, by definition, so staff should document thoroughly.

"I would chart up one side and down the other about how the patient received an emergency medical screening, what condition you found, the plan of treatment, and what the plan of treatment was at X hour when the patient left," she says. "Document that you never suggested the patient go, that you were surprised when the patient left. Illustrate that you told the patient what was going to happen and for reasons unknown to you the patient just walked out. You're painting a picture that the patient knew treatment would continue but just got impatient."

For patients who do not have an emergency medical condition and slip out of the emergency department during treatment, the gold standard would be following all the AMA protocol you would employ elsewhere in the hospital. A call to the patient's home to follow up still is a good idea. But Lutz also acknowledges that, as a practical matter, the level of concern for that patient is lower and may not justify spending the limited resources in an emergency department.

"I'm more concerned about the patient with a documented emergency medical condition," she says. "That patient may accuse you of a constructive dump by saying you told him to leave because he had no insurance. If it comes to your word against the patient's, you want the documentation to prove what happened. And if that patient with heart palpitations goes home and has a heart attack, you want to be able to show that you did your best to help him and he just left before you could." ■

Prepare your hospital for a strange flu season

It's not over yet!

This year is a wild card, and anything could still happen. First, we had a dangerous shortage of influenza vaccine, followed by many high-risk people who couldn't get or decided to forgo immunization. Fortunately, this has been a mild flu season — so far.

But February and March are the historical peak months for influenza activity, and the large numbers of high-risk unprotected people make this a potential recipe for disaster. Influenza vaccine shortages and delays are a recurring problem, and at some point, we will inevitably face another influenza pandemic.

Are you and your hospital prepared if we run out of luck? Do you know where to turn for guidance and help? Do you know how to prevent the spread of this infectious disease? Or how to handle major staff shortages due to record absenteeism?

Thomson American Health Consultants has developed an influenza sourcebook to ensure you and your hospital are prepared for what could happen this flu season — or the next flu season.

Hospital Influenza Crisis Management provides the information you need to deal with ED overcrowding, potential liability risks, staff shortages, and infection control implications for staff and patients. This sourcebook addresses 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.

Hospital Influenza Crisis Management will offer readers continuing education credits. For information or to reserve your copy at the price of $199, call (800) 688-2421. Please reference code **64462**. ■

CE objectives

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

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

CE Questions

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

9. According to recent research by Alan H. Rosenstein, MD, and Michelle O'Daniel, which of the following is true?
A. Doctors are the source of almost all disruptive behavior.
B. Nurses are the source of almost all disruptive behavior.
C. Doctors and nurses both are sources of disruptive behavior.
D. Doctors and nurses almost never are disruptive, but other clinical staff are.

10. What do Rosenstein and O'Daniel suggest when a nurse must call a physician at home regarding a patient?
A. The nurse should not identify herself, instead proceeding immediately with the request for orders.
B. The nurse should identify herself only as a nurse caring for the patient.
C. The nurse should identify herself immediately and clearly — by name and position.
D. The nurse should identify herself only if asked by the physician.

11. According to Cecilie Loidolt, JD, what is true of documenting patient calls received after hours?
A. They do not need to be documented.
B. They should be documented if the physician considered them important.
C. They should be logged but it is not necessary to document the content.
D. They should be documented clearly and thoroughly and attached to the patient chart the next day.

12. According to Holley Thames Lutz, JD, which of the following is true when a patient with an emergency medical condition leaves the emergency department before treatment is complete?
A. It is an automatic violation of EMTALA.
B. There is no need to follow up with the patient.
C. Emergency medical technicians should be dispatched to the patient's residence.
D. It is not necessarily an EMTALA violation, but staff should call the patient to follow up and encourage him or her to seek treatment.

Answers: 9. C; 10. C; 11. D; 12. D.

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

Minister's vocal cord damaged by feeding tube — $100,000 Nevada verdict

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

News: A feeding tube was improperly inserted into a minister who was recovering from surgery. This lead to an extended hospitalization and post discharge vocal cord and lung problems. At trial, he was awarded $70,000, and his wife $30,000, a total verdict of $100,000.

Background: The plaintiff, a retired Air Force chaplain and an active minister in his early 70s, was in the hospital recovering from surgical repair of an aortic dissection. During his recovery, a hospital nurse incorrectly inserted a Dobbhoff feeding tube into his lung and initiated nutrition without confirming proper tube placement with an X-ray. The misplaced tube caused respiratory distress and 12 more days in intensive care with a ventilator.

The patient also claimed that his post-discharge recovery from surgery was extended by several months due to resulting weakness and debilitation. The plaintiff also claimed that permanent lung and vocal cord damage kept him from performing the number of marriage ceremonies he had been performing at an area hotel and casino.

The hospital admitted liability but contested the nature and extent of the plaintiff's injuries, maintaining that the plaintiff had fully recovered and that he did not suffer any latent voice, lung, or vocal cord damages. The jury disagreed and awarded $100,000 to the minister and his wife.

What this means to you: It is important to realize that once this case got before a jury it became not a question of liability, but how much was that liability worth.

"The hospital admitted that the nurse had failed to provide an acceptable standard of care. From that point it was the jury's responsibility to determine the extent of injury and the patient's loses," notes **Lynn Rosenblatt**, CRRN, LHRM, risk manager, HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL.

There was no question that the patient experienced an extended stay and serious life-threatening complications as a result of the nurse's failure to properly insert the feeding tube.

"Testimony reinforcing the likelihood of the adverse consequences due to the inadvertent introduction of foreign matter directly into the lungs would certainly impress any jury as to the seriousness of such negligence," says Rosenblatt. "Without a doubt, the plaintiff would advance the argument that the nurse did not demonstrate the basic level of competency that would be expected from a staff nurse assigned to a post-surgical unit. This would likely cause the jury to see the amount of the reward as a punitive measure to compensate for the perceived negligence of both the nurse, who was clearly shown to be incompetent, and the hospital, who had failed to train the staff adequately to insure competency."

Insertion of a feeding tube is a fairly common

procedure following surgery.

"An essential part of the competency of inserting a nasal gastric feeding tube is to ascertain that the tube is actually in the stomach and not in the lungs. Standard operating policy would determine the manner in which the tube is checked for proper placement following insertion," notes Rosenblatt. "Patients should not be fed until the position of the tube is determined. This is a well-established safety precaution.

"The nurse failed to follow policy and did not safeguard the patient from harm. This situation certainly speaks to the need for adequate education and training of staff and recurring competency evaluations," adds Rosenblatt.

Once a jury determines that the standard of care is breached or the defense admits to such, the plaintiff must make the case for the damages, if any, incurred. Evidence of the incurred and future economic and noneconomic damages would be presented. In this case, the primary consideration in the determination of economic damages would be the retired minister's ability to continue to perform marriage ceremonies. The use and perhaps the quality of his voice would be put before the jury.

"Any compromise to his diction would certainly be seen as an impediment to his ability to perform marriage ceremonies. It is likely the jury heard his distorted voice and concluded that his voice had been adversely affected by the hospital's negligence," notes Rosenblatt.

In addition to his ability to earn wages from performing weddings, the jury also would be presented with evidence of the medical costs.

"Although given his age and the fact that he retired from the military, it is unlikely that he was responsible for any of his own medical expenses, and doubtful that the jury took those damages in to consideration in making their award," adds Rosenblatt.

In addition to economic damages, the jury would likely be asked to consider awarding noneconomic damages.

"The jury would be exposed to the pain, suffering, and loss to society that the alleged injuries would cause. Noneconomic damages are the most difficult to defend against as it is difficult, if not impossible, to put a dollar amount on any particular person's loss of function or the impact that loss might have on their spouse. In this case, the quality of patient's voice was integral part of who the man was and had been during his career," says Rosenblatt.

"In conclusion, if liability is a foregone conclusion, a case of this type may be less costly to settle in mediation, where the plaintiff is put in the position of acceptance of an appropriate level of compensation. Mediation avoids prolonged legal fees and may serve to reduce the exposure by eliminating the unknown jury verdict," notes Rosenblatt.

Reference

- Clark County (NV) District Court, Case No. A-459369. ■

Negligent pre-op leads to $2.5 million settlement

News: A man suffering from a blockage in the main artery of his leg underwent femoral bypass surgery at a local hospital. Although he suffered from a disease causing a reduction in his normal blood flow, medical staff failed to determine whether the man's underlying condition would prevent him from undergoing surgery. After surgery, the nursing staff inadvertently administered 10 times the amount of heparin ordered, which caused him to bleed excessively. During a second procedure to determine the cause of the

bleeding, the nursing staff administered a toxic dose of heparin, and the man died soon thereafter. After filing suit, the plaintiff settled with the hospital and physicians for $2.5 million.

Background: Complaining of pain, the 53-year-old man was admitted to a local hospital. Upon examination, doctors discovered a blockage in the main artery of his leg. Two days after being admitted, a vascular surgeon scheduled a femoral bypass surgery, during which the surgeon would attempt to provide a blood supply to the patient's lower leg by using another leg vein to bypass the blockage.

Prior to surgery, the hospital learned that the patient suffered from peripheral vascular disease. A buildup of plaque in the arteries outside his heart was reducing the normal flow of blood and depriving various extremities of necessary oxygen. Nevertheless, the hospital's medical staff failed to perform a stress test or any other cardiac diagnostic testing to determine whether the man's cardiac function would be sufficient to withstand the femoral bypass surgery. The surgery proceeded as scheduled.

The vascular surgeon performed the bypass surgery without any problems or complications. Afterwards, the surgeon gave his usual orders for nurses to administer 2,500 units of heparin, a naturally produced anticoagulant, every eight hours continuously. However, the medical staff misread the medication instructions and began administering 25,000 units of heparin every eight hours. The excessive dosage caused the patient to continually bleed, reduced his urine output to zero, and increased his heart rate to more than 130 beats per minute. By the next morning, the man was experiencing abdominal pain and his hemoglobin and hematocrit levels were low. The vascular surgeon called a nephrologist and cardiologist to examine the patient, but none of them could determine the cause of the man's symptoms. The surgeon did not consider that his orders were not followed with respect to the heparin administration.

Later that evening, a second surgeon scheduled an exploratory laparotomy to examine the man's abdominal organs. In preparing the patient for the procedure, the hospital's nursing staff again misinterpreted the vascular surgeon's orders and administered 25,000 units of heparin. During the exploratory laparotomy, the surgical team recognized the profound and serious bleeding, but none of them could determine the cause. Ten hours later, the second surgeon completed the procedure and the man was transferred to the recovery unit. While in recovery, he died from a coronary thrombus, a blood clot that had totally blocked the blood supply to his heart muscle.

The patient's estate filed a lawsuit alleging negligence against the hospital, the vascular surgeon, and the surgeon who performed the exploratory laparotomy. The plaintiff principally alleged that the defendants' failure to adequately perform a preoperative cardiac work-up and their negligent administration of toxic levels of heparin caused the decedent's death. The hospital admitted that the nurse, acting as an agent of the hospital, breached the relevant standard of care in administering 10 times the amount of heparin ordered, but the hospital denied that the nurse's conduct had any effect on the patient's ultimate death. The matter proceeded to trial, but after the jury was selected, the parties settled for $2.5 million. The hospital and the vascular surgeon agreed to pay $1.5 million, and the second surgeon contributed $1 million.

What this means to you: "With knowledge that the patient had peripheral vascular disease and thus, a buildup of plaque restricting the blood flow to his arteries, it would seem logical to determine whether this disease process included his cardiac arteries. Unless emergent surgery was needed for the blockage in his femoral artery, a basic cardiac work-up should have been done prior to surgery. This could have allowed preventative steps to be taken during surgery and in the postoperative course. While it may not have affected the outcome of this case, lack of such a work-up set the stage for the claim of suboptimal care," says **Cheryl Whiteman**, RN, MSN, HCRM, clinical risk manager for Baycare Health System in Clearwater, FL. "The surgeon would expect the nursing staff to administer the anticoagulants as ordered. However, recent literature is replete with examples of how erroneous orders or orders that are not clearly written are all too often misinterpreted by nurses and pharmacists."

It is errors such as these that have lead many hospitals and health systems to explore e-prescribing and other e-pharmacology information systems to curtail untoward incidents relating to handwriting, dosage, and drug name. Ideally, such e-systems would have eliminated the numeric error in the first place or would have caused the numeric error to have been flagged

somewhere in the system — both prior to administration of the drug overdose to the patient at hand. However, not all facilities have the financial means to engage and employ the latest technology, but there are ways in which such errors can be mitigated.

"A root-cause analysis or similar process review should be conducted to evaluate the physician's order and determine how it was implemented," says Whiteman. "The key questions that should be raised in such process include: Did a pharmacist review the order? Did the nurses question that the order they interpreted was for a very high dose of heparin? Were nurses allowed to mix anticoagulant drips? Alternatively, are premixed bags available? And, finally, are vials with large amounts of anticoagulants available on nursing or critical care units? The process review should reveal how this error was allowed to occur. The next challenge would be to implement changes that would prevent such an event from happening again. Certainly the knowledge of the nursing staff in regards to anticoagulation therapy needs to be assessed and an educational program provided as indicated.

"Another issue relates to the monitoring of a patient on anticoagulation therapy. It would be expected that the patient's anticoagulation status be monitored at regular intervals. If the appropriate laboratory tests been done and monitored, the staff should have been alerted to a sharp increase in coagulation times. The lab should have criteria for critical values that are reported immediately to a caregiver who can act upon the information. In the absence of such a methodology, the risk manager would need to work with involved departments to urgently implement a process to address potentially life-threatening situations. Certainly, the patient's lack of urine output should have triggered some investigation as to the underlying cause," adds Whiteman.

"While it made sense to involve a cardiologist and nephrologists in this patient's care, based on the presenting symptoms after the first surgery, it would appear that attention to low hemoglobin and hematocrit levels would indicate bleeding. This development warranted anticoagulation studies, assuming they weren't being done already, thus alerting them to significant anticoagulation," she states.

"It is events such as this one have prompted the Joint Commission on Accreditation of Healthcare Organizations to enact National Patient Safety Goals in regards to the use of abbreviations, handwriting, and critical lab results," concludes Whiteman. ■

Reference

- Cook County (IL) Circuit Court, Case No. 98 L 7257. ■