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## IN THIS ISSUE




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# Preventing falls among elderly patients means a focus on their special needs

*Noise, lighting play important role for geriatric population*

How often have you walked into a patient care area and been blasted by an array of television sets with the volume cranked up to 11? How about the lovely shade of beige wall paint that flows seamlessly into the lovely shade of beige floor tile?

For your elderly patients who already are dealing with a number of physical and mental challenges, these are more than just annoyances. They can be real dangers, contributing to the already high likelihood of falls among elderly patients in your facility.

The experts say that when it comes to elderly patients, your usual fall prevention strategies might not be enough. There are special steps risk managers should take.

The environment in your facility is a special concern, more so than when you're preventing falls among patients in general, says **Jennifer M. Bottomley**, PT, MS, PhD, a geriatric rehabilitation program consultant and president of the section on geriatrics of the American Physical Therapy Association in Alexandria, VA. Seemingly inconsequential details — like that beige paint and beige floor tile — can conspire against the elderly patient to cause a serious fall and liability when the same factors might not affect a younger patient much, if at all.

"There are so many factors that affect an elderly population differently or more than they affect your other patients, so it is very important to look at them as a group with special needs when it comes to preventing falls," Bottomley says. "It's not a small distinction. It is absolutely a big divide when it comes to how you prevent falls in this group."

### Screen patients early and often

Elderly patients face multidiagnostic, complex medical situations, often with multiple medications that may have a range of effects — dizziness, sleepiness, confusion, an urge to urinate, for instance. Blood pressure


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problems can cause the patient to be unsteady. Nutrition and hydration issues can contribute to falls, as can vision and hearing problems.

"The cause of falls can be much more complex," Bottomley says. "With younger patients, the cause of a fall tends to be more clear cut and more easily remedied."

All of the fall prevention strategies that you employ throughout the organization — such as minimizing clutter and monitoring medications that may lead to falls — will benefit elderly patients as well. But you can take additional steps with the elderly, probably your most at-risk patients.

Bottomley recommends that risk managers start addressing falls among the elderly with a program for interdisciplinary screens beginning with every patient at admission and then repeating the screens as necessary, depending on the patient's particular condition. But at a minimum, she says, every elderly patient should be screened every six months.

**Roberta A. Newton**, PhD, professor of physical therapy at Temple University in Philadelphia, says risk managers must include all staff in the effort, and they must be empowered. Environmental services staff are critical, she says. They can make sure spills are cleaned quickly and clutter is cleared, especially in the path from the patient's bed to the bathroom. Those staff are in the rooms frequently and so they can be empowered to watch for various hazards, such as the bed raised too high, and either correct them or report them to a nurse.

"A lot of times when we think of a multidisciplinary team, we only think of the clinical staff," Newton says. "But you can include nonmedical so that everyone is empowered to help reduce falls based on their own level of skills. The housekeeper may not be trained to assist patients, but that person can do certain things that contribute to the overall safety of the patient."

Newton is a firm believer that bedrails should be down whenever possible. If the rail is down and the patient falls out of the bed, the injury probably will be less severe than if the patient had to crawl over the rail and then fell, she says. The real issue in that scenario, of course, is why the patient tried to get out of bed. Going to the bathroom is the usual cause, so Newton encourages frequent monitoring of the patient so assistance can be provided when needed.

## Small changes can make a difference

Managing the patient's environment may be the strategy that is the most different for elderly patients as opposed to reducing falls in the overall patient population, Bottomley says. The elderly patient's vision, hearing, balance, gait, attention, and cognition issues can lead to situations in which seemingly innocuous factors in the environment create fall hazards. Manage those hazards ahead by

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### Editorial Questions

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

looking at the environment from the point of view of your elderly patient, Bottomley suggests. **(See article, below right, for more advice on improving the elderly patient's environment.)**

"You can have a substantially lower rate of falls by modifying environmental concerns like this," she says. "Environment is often neglected."

Even small issues in the environment can have a big impact, Newton says. Make sure the call button and other frequently needed items are in reach so that the patient does not have to reach.

Shiny floors are a particular problem, Newton says. Even if the floor is not actually slippery, the shininess creates a glare that can cause difficulty for the patient with vision deficits. Lighting should be of good quality, producing an even light throughout the room. Don't forget to compensate for the varying conditions caused by sunlight at different times of the day.

### *Staffing ratio also a key issue*

Bottomley says risk managers should also focus on the staffing ratio with an elderly patient population, especially those with Alzheimer's or other dementia. Strength conditioning and physical therapy also are key, she says. All patients who are able to participate, even minimally, should be encouraged to participate in some sort of exercise program.

Videotape-guided exercises are good, as are tai chi classes and similar low-impact classes. Walking is always a good exercise option, and Newton says one good technique is to put interesting pictures and diversions along the hallway so that patients are encouraged to take a stroll.

Newton also advises putting elderly patients in a sitting position as much as possible. The reason for that is that if a patient is lying and then sits up suddenly, dizziness and confusion may result. **(See p. 40 for more of Newton's advice on the physical differences with elderly patients.)** When possible, have the patient sit in an area with a view or where he or she can interact with others, to keep the mind active.

Remember also that the patient is at the highest risk for falls in the first six weeks of entering a new facility or a different unit. The surroundings are unfamiliar and cognitive problems may make it difficult for the patient to adjust quickly, Newton says.

"Don't forget education also," she says. "It's important to educate everyone about the risk of falls and how to prevent them, and that includes staff, the patients, and family members, too." ■


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# Colors, noise level key to reducing falls in the elderly

That armchair in the common area might be more than just ugly. It might actually be contributing to falls if your elderly patients look at it and get dizzy from the pattern.

**Jennifer M. Bottomley**, PT, MS, PhD, a geriatric rehabilitation program consultant and president of the section on geriatrics of the American Physical Therapy Association in Alexandria, VA, outlines these common environmental hazards that can lead to falls among the elderly:

- **Poor color distinction:** When the beige wall flows into the beige carpet or floor tile, the elderly patient with poor depth perception may have trouble determining his or her location in the room, and the proximity to furniture or a doorway. It's better to have contrasting colors so the corners and edges can be distinguished. The doorway can be painted a different color than the wall, for instance. Furniture also should stand out clearly from the wall and floor.
- **Colors that agitate:** One key to reducing falls among the elderly is to keep them calm, rather than agitated and restless. Restraints and medication usually are not acceptable ways to calm patients,

but the proper environment can help patients relax. Pastel colors, for instance, have been proven to have a calming effect. A bright red or bright orange room, on the other hand, can lead to agitation.

• **The wrong music in the background:** Like the colors in the environment, the music you play in the background can influence whether your patients are calm or restless. Led Zeppelin is out; the 101 Strings Orchestra is in.

• **Small patterns on furniture and carpet:** Upholstery and carpet should be in either bold colors or large patterns. The smaller patterns can cause a vestibular reaction for the elderly patient, resulting in dizziness from looking at all those tiny dots or flowers.

• **Too much noise in the patient area:** Elderly patients often are more prone to distraction by noises in their immediate area. If they hear an overhead speaker making an announcement, or a television playing loudly across the room, they may be startled or confused by the sound. That can cause them to turn suddenly toward the sound, perhaps thinking someone is speaking to them, and turning the head quickly can lead to dizziness.

"We'd rather see the nurses use beepers and the desk clerks with phones that use a light instead of a bell," Bottomley says. "Studies have shown that when patients are distracted by a noisy environment and turn their heads suddenly, their risk of falling goes up dramatically." ■

# To prevent falls, know your elderly patients

Elderly patients pose special challenges when it comes to falls, so your prevention strategy must take into account the factors unique to this population. This summary is offered by **Roberta A. Newton**, PhD, professor of physical therapy at Temple University in Philadelphia:

• **Vision:** Visual acuity decreases with age. Therefore, periodic eye exams or checkups are recommended. Be aware that either old prescriptions or new prescriptions can alter the visual field and cause falls. Also, clean glasses daily.

Changes in contrast sensitivity occur. This is related to the ability to detect and discriminate objects in the environment. One way to accommodate this is to increase the lighting, such as using higher wattage bulbs.

Decline in depth perception occurs as a decreased ability to judge distances and relationships among objects in the visual field. Stairs, carpets with patterns, and curbs are risk factors for individuals with such declines in depth perception. The person may have difficulty estimating the height of the step and therefore misplace the foot. Or the person may think that the carpet is uneven and alter balance and walking to accommodate the misperception.

The ability to recover from a sudden exposure to a bright light or glare decreases. When moving from a dimly lit to a brightly lit environment or the reverse, the person should pause a second to allow the eyes to accommodate to the change in light.

• **Hearing:** Periodic hearing checkups are recommended. Because we rely on sound for orientation in the environment, a person may not be as quickly aware of a potentially hazardous situation when hearing is decreased.

• **Feet and shoes:** More than 75% of older adults have foot pain. Foot pain is caused by, but not limited to, thin heel pads, corns, bunions, dry and cracked skin, ingrown or overgrown toenails, and sores. Foot pain can cause a change in the biomechanics or alignment of the body, thereby increasing the risk for falls.

Another potential risk factor for falls is decreased sensation in the feet. This is more noticeable in the person with diabetes, but gradually occurs with the aging process. Sensation can be tested on the person using a Q-tip or something soft and brushing it on the sole of the foot. Caregivers also may consider a daily foot inspection for red areas, sores, condition of toenails; application of cream; avoidance of abrasive substances such as pumice stone or acid to reduce calluses or corns; and, shoe inspection for worn areas.

Also noteworthy is the condition of the person's currently worn shoes and slippers. Ill-fitting or badly worn footwear can lead to tripping and falling or sprains and strains. This problem is especially hazardous when combined with ill-fitting clothing that drags on the floor.

• **Medications:** Four or more medications constitute an automatic risk factor for falls. Single or multiple medications (polypharmacy) can cause side effects such as dizziness, drowsiness, or low blood pressure. Prescription medicines and regularly taken over-the-counter medications should be checked by the physician or pharmacist.

• **Balance and gait:** A gradual decline in balance abilities and speed of gait occurs with age. These

two are linked with activity level. One cause of tripping and stumbling is the anterior tibialis muscle, which dorsiflexes the ankle and toes to clear the toes during walking. With age, it becomes a little out of sync in its timing with other muscles in the leg. As a result, the timing of toe clearance is a little off and the toe may catch on the floor. During walking, toe clearance is approximately 1 cm.

Gait speed also decreases, and the person may not have sufficient time to get out of the way or may have to hurry to perform various activities. To have to walk faster, particularly when it is associated with anxiety, can cause a fall.

Remaining active and participating in leisure and social activities helps maintain balance and gait.

• **Blood pressure:** Both high and low blood pressure can cause a person to become unsteady. When moving from one position to another, such as either from the bed to sitting or from a chair to standing, the person should pause for a couple of moments to let the blood pressure adjust and to orient to the new position.

(For more advice on preventing falls among the elderly, see www.temple.edu/older_adult/fppmanual.html.) ■

# 7 steps to take for a claims management strategy

Open discussion of medical errors and other liability issues actually can help drive claims down, not up, as many risk managers fear, says **Kathryn K. Wire**, MBA, CPHRM, president of Enhanced Claim and Risk Services in St. Louis. The big hurdle, she says, is getting health professionals past their fear of talking after years of being told to keep quiet.

Too often, she says, risk managers and other health care leaders only talk to the patient or family member who feels like the victim of negligence in two situations: either the patient or family member is demanding money or you think he deserves money. That creates a situation in which money is the sole focus even if you dance around the issue with other talk about doing the right thing and improving quality.

"Why do we limit our interaction with the patient and family to reimbursement talk?" Wire asks. "Why not make them part of the larger process? What better time to get their input?"

Full disclosure of medical errors and negligence has been gaining steam in recent years, but she says you still are likely to do encounter substantial resistance when you start encouraging clinicians to talk more openly. To get around those obstacles, Wire encourages risk managers to take on the role of coach and provide the support that staff need to make this significant change in thinking and process.

## *7 steps to full disclosure*

At the recent meeting of the American Society for Healthcare Risk Management in Orlando, FL, Wire outlined a seven-step plan for encouraging full disclosure and embracing poor outcomes as a claims management tool. These are her seven steps:

**1. Make sure you can count on early and complete event reporting.** Staff should complete a preliminary investigation and preserve evidence as soon as possible. Encourage staff to report nearly everything with a very low threshold for what constitutes an "error" or "adverse event." Infections and tape burns should be reported, she says, though that doesn't mean every reported incident will be investigated.

**2. Work to secure cooperation and support form the patient's attending physician and the medical staff in general.** "Let's face it. Nothing goes well in a hospital or clinic if the doctor doesn't like it," Wire says. "You have to get them on board."

The good news, she says, is that most doctors want open communication. They just don't know how to go about it. So put on your coach's hat and help them by providing examples and walking them through realistic scenarios. Lots of hand-holding might be needed.

Wire also advises working with the physicians' insurance company claims agents to get them on board with full disclosure and open communication. That will help avoid any conflict (real or perceived) with your philosophy and the insurance company's.

**3. Contact the patient or family when an issue arises. Don't wait for them to come to you.** First, determine who will contact the patient or family. If the issue is staff-related, a unit supervisor may be appropriate. If the issue relates to physician care, or if there will be significant issues about the patient's condition and ongoing care, the physician probably should make contact. The risk manager should handle any money questions.

Remember that contacting the patient or family is a multistage process. Offer a time line for when they might expect more information. Tell them about any legitimate impediments to your process, but be careful not to offer hollow excuses. Also outline for the patient or family what can and cannot be shared.

"Be careful what you say, because nothing is worse than giving bad information," she says. "You should assume that the patient will get an attorney who will investigate. If you don't know for sure yet, just say so."

## Report investigation results to family

**4. When appropriate, quickly confer with the insurer or claims committee.** Wire explains that there is a window of time in which you can resolve claims in the most painless way possible. That window opens when the event happens and closes shortly after the investigation is finished.

"The earlier you can talk business, the more seriously the patient or family will take your position," she explains. "Remember, plaintiffs' attorneys don't get a fee on money you offer before they are involved."

**5. Conduct a full investigation.** Wire points out that this is *not* the first step. You should make contact with the patient or family first. When organizing the investigation, include the staff and attending physician. Conduct your full investigation parallel to the sentinel event and defense investigations.

The risk manager does not have to direct or control this investigation. If you need to bring in outside expertise for your investigation, do not use the same experts who do your physician peer review. That could destroy the confidentiality of your peer review process.

**6. When the investigation is complete, go back to the patient or family with results.** Disclose all factual information that is not purely protected, such as peer review outcomes for physicians. Talk about system changes if you can or, if you can't, promise that you will get back to them with specifics as soon as possible.

When possible, involve the patient or family in the changes that may result from your investigation. Wire says you should be ready to deny a claim or talk dollars at this point, but only if the other party raises the issue.

**7. When payment is appropriate, don't delay.** No matter how constructive and conciliatory your response after an adverse event, there is no getting around the bottom line: If the patient or family is due some money, you will have to write a check. Get authority quickly and don't delay the payment unnecessarily.

## Four obstacles and ways around them

When employing that strategy, Wire cautions that you are likely to encounter obstacles in form of other participants who are reluctant to proceed in the way you know will yield the best result for everyone. Here are the four most common obstacles and her strategies for getting around them:

• **The physician who won't disclose.** This is a common problem because for years physicians have been taught to keep their mouths shut when something goes wrong, or when they are accused of an error. Wire advises reminding physicians that the tide has changed and not only is disclosure a good idea, but it is required in some situations. Cite the ethical need to disclose.

"The important thing to know is that doctors really want to disclose, but they're just scared," she says. "Offer support. You have to acknowledge that this is something that can be very intimidating to them."

Also, Wire says you must make sure the physicians know about the open disclosure approach before they have an incident requiring disclosure. Bringing up the subject for the first time in the midst of an adverse event will not go over well.

• **Hospital administration will not support your effort.** Like physicians, hospital administrators often have a firm belief that you should keep quiet when bad things happen. The risk manager can counter that by discussing the disclosure strategy at every level before an event occurs. Stress the good financial results and the positive public relations that can accrue from disclosure.

Notify administration quickly about adverse events, and outline an emergency authority structure in advance. Be prepared for resistance when you request large sums for payout with a short lead time.

"Be ready to persuade administrators over and over again," she says. "You have to keep repeating the No. 1 reason you're doing this: It's the right thing to do."

• **Defense counsel is against full disclosure.** Lawyers rarely want their clients to admit liability. It goes against everything they do as lawyers. But your defense counsel needs to be aware of your disclosure plan up front and available to advise on damage questions during the disclosure process.

Wire advises that the defense counsel and administration might gang up against you. They will feed each other's worries about the disclosure plan and you will have to be ready with a good argument in support of your plan.

• **Greedy or glory-seeking plaintiff's attorneys fight your disclosure plan.** This can be one of the most challenging obstacles, Wire says, and there is no immediate way to overcome the influence of an attorney who discourages a client from participating in your disclosure process. You can work with the local plaintiff's bar to exert some peer pressure on attorneys who act against their clients' best interests, but expect only limited success.

Rest assured, however, that an attorney who steers his client toward a more combative approach will eventually look bad when you admit liability at trial or mediation and point out that you wanted to do so early on. Be prepared to talk with the client directly if he or she separates from the attorney in an effort to resolve the case. ■

# JCAHO calls for reform of liability system

JCAHO has issued a call to reform the nation's medical liability system, urging the current proposal for caps on noneconomic damages be expanded to pursue intermediate and long-term system changes which its experts say "truly facilitate improvements in patient safety."

JCAHO says that by its basic design "the current medical liability system chills the identification and reporting of adverse events in health care and thus, undermines opportunities for learning that could provide the basis for significant safety improvements."

The call to action is set forth in the Joint Commission's newest public policy white paper, "Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury." The report urges intensified attention to patient safety and medical injury prevention by health care providers and practitioners; emphasizes the critical importance of open communication between patients and practitioners; and urges the creation of an injury compensation system that is patient-centered and serves the common good.

Any redesign of the medical liability system should assure appropriate compensation for all injured patients, says JCAHO president **Dennis S. O'Leary**, MD. The plan also should encourage health care providers and practitioners to surface errors, learn from mistakes in the design and performance of care processes, and take action to ensure that adverse events do not recur, he says.

"The ultimate goal is to make health care as safe as it can be, while also assuring appropriate redress for patients when this is warranted," O'Leary says. "The medical liability system in place today simply falls short of this goal."

## *Expert Roundtable offers advice*

The white paper was developed in collaboration with an Expert Roundtable whose 29 members represent a wide diversity of interests relevant to medical liability. The report contains 19 specific recommendations and identifies accountabilities for each of those. As with its other public policy initiatives, JCAHO intends to work in collaboration with other parties at interest to see that each of those recommendations is eventually met.

The current medical liability system, the JCAHO commission suggests, fails patients because it does not effectively deter negligence, truly offer corrective justice, or provide fair compensation to those who have been injured through the care process. It also is accurate to say that too little progress has been made in improving patient safety since the release of the Institute of Medicine's ground breaking report on medical error five years ago, O'Leary says. Finally, he notes that a very small proportion — 2% to 3% — of injured patients receive compensation through the medical liability system; those who do receive highly variable recompense for similar injuries.

## *Improve patient safety, communication*

The expert roundtable assembled by JCAHO identified these three strategies for achieving its overall goal:

• **Actively pursue patient safety initiatives that prevent medical injury.** Specific recommendations address the need to encourage the creation of cultures of safety in health care organizations; to strengthen oversight and accountability mechanisms for ensuring the competency of doctors and nurses; and to provide health care researchers access to open liability claims to permit timely identification of problematic trends in care. "Pay-for-performance" programs that provide incentives for improving patient safety and health care quality

also must be part of the solution.

• **Promote open communication between patients and practitioners.** Emphasize that patients must become members of the health care team. Ineffective communication and lack of disclosure are the most prominent complaints of patients, and their families, who are victims of medical error or negligence. As one of its recommendations, the report urges pursuit of legislation that would protect disclosure of mistakes and the associated apologies from being used against practitioners in litigation. Other recommendations encourage the nonpunitive reporting of errors to third parties to support the development of patient safety solutions, and enactment of pending federal patient safety legislation that would provide legal protection for medical errors and adverse events reported to designated patient safety organizations, such as JCAHO.

• **Create a patient-centered injury compensation system**. Specific recommendations emphasize the need to conduct demonstration projects of alternatives to the current medical liability system that promote patient safety and provide swift compensation to injured patients. While these efforts are under way, the report also advocates for prohibition of confidential settlements known as "gag clauses" that prevent learning from events that lead to litigation; use of court-appointed, independent expert witnesses; and the redesign or replacement of the National Practitioner Data Bank which the experts contend has never fulfilled its promise to be the premier resource for meaningful, valid, and reliable information about physician performance. ■

# Microchip promises to reduce wrong-site errors

The FDA recently approved a new device that the manufacturer says could dramatically reduce the incidence of wrong-site surgery by applying a microchip with detailed patient information directly to the planned operative site.

The SurgiChip Tag Surgical Marker System, manufactured by SurgiChip Inc. of Palm Beach Gardens, FL, consists of an adhesive tag with an integrated microchip that acts as a transponder, along with a printer, an encoder and a handheld device for reading the microchip. The maker says this product is the first such surgical marker to use radio frequency identification (RFID) technology to mark an anatomical site for surgery.

While the microchip containing detailed information is at the heart of the system, the chip is not actually embedded in the patient. Instead, it is affixed within an adhesive label that goes on the patient's operative site. **Todd Stewart**, vice president for product development at SurgiChip, explains that the steps begin when a small computer chip is programmed with the following critical information: date of surgery, patient's full name, surgical site, a description of the operation to be performed, and surgeon's name. The chip may be programmed at the preoperative outpatient visit, in the emergency department, or on the hospital floor if the patient is an inpatient.

A nurse or physician then scans the chip with an RFID reader and the patient reviews the information to be sure it is correct. The chip is locked to prevent inadvertent or intentional altering or deletion of the data.

### *Chip info verified by patient before surgery*

On the day of surgery, the chip again is scanned and the information is reviewed with the patient before he or she is sedated. If correct, the chip is applied to the skin where the incision is to be made. Since the patient assists with the programming and placing of the chip, the chance of error is diminished, Stewart says. The chip is left in place during transport to the operating room, while an anesthetic is administered and while the patient is positioned for surgery.

Stewart says this method diminishes the chance that the information regarding patient identity and surgical procedure will accidentally be switched with that of another patient as may occur when the information is contained in a separate hospital chart. Also, it may prevent mistaking left for right if the patient is positioned prone instead of supine.

In the operating room, the chip is scanned and the information reviewed by the surgical team.

"They don't have to rely on recognizing the patient with a cap over her hair, a tube in her throat, no makeup, no dentures, and so on," Stewart says. "Reading the operative consent in a chart and confirming the name on a wristband may accomplish the same objective, but occasionally one of these steps is overlooked."

The physical presence of the SurgiChip tag is a major strength of the system, Stewart says. The surgical team is less likely to omit the review of information since the chip would then remain in

place as a barrier to the incision, he says.

Of course, if the team fails to locate, read, and remove the SurgiChip — because they're looking on the wrong leg, for instance — it will offer no protection. But Stewart says that risk will be lowered if the SurgiChip becomes so common that clinicians routinely expect to find it at the operative site.

After the accuracy of the information on the chip is confirmed, the tag with the embedded chip is removed and placed in the chart. Since the word "yes" or the surgeon's signature also is written on the incision site in accordance with the Universal Protocol, and remains intact during the final surgical prep, an identifying mark still is present after the chip has been removed.

### More protection than simply signing site

But Stewart says the SurgiChip procedure provides significantly more protection than a simple "yes" written on the operative site. Stewart says the SurgiChip is designed to complement and work within the other strategies already employed to prevent wrong-site surgery. When a surgical team takes a "time out" to stop and confirm vital information before beginning a procedure, the SurgiChip could be a reliable way to access patient information, he says.

"It's almost like you're writing a great deal of information right there on the patient's leg," Stewart says. "But instead of writing from the knee to the ankle or writing a Cliff's Notes version, you're able to put a lot of information in a reliable, legible form."

### Higher costs in first year of use

But couldn't a hospital just use a stick-on tag and write or type the critical information on it? Stewart says the answer is yes, and decals used to identify the proper surgical site, patient, and procedure are commercially available. But to be practical, the tag must be reasonably small. Since the amount of information which can be written or typed on a decal is therefore limited, abbreviations or partial descriptions of the procedure are frequently used and that may lead to error. Any system that relies on handwriting is prone to error, he notes.

So what would this cost you? As with many clinical systems, the cost will be higher up front. Stewart says the average first year cost is $9 to $11 per case. From the second year on out, the cost is half of that because you've already paid for the hardware and support that is necessary when setting up the system. The ongoing cost is $2.50 per label, plus ongoing support and maintenance, for a total of about $5 per label. ■

## Med-mal awards rise some but are starting to level off

Jury awards for medical-malpractice claims rose fractionally in recent months while awards for all personal-injury liabilities fell significantly, according to a report from *Jury Verdict Research* in Horsham, PA.

After steadily climbing more than 100% from 1996 to 2000, the compensatory jury award median for medical-malpractice cases has leveled off the last three years studied. The percentage of $1 million or more medical-malpractice verdicts remained the same from 1999 through 2002 at 52%, says **Jennifer Shannon**, *Jury Verdict Research* managing editor.

While the medical-malpractice plaintiff recovery rate (ratio of plaintiff verdicts to total verdicts) was up two percentage points in 2002, defendants still won the majority of those cases. "From the jury-award median to the plaintiff recovery rate to the percentage of million-dollar awards, our med-mal statistics have remained relatively flat the last few years," Shannon says. "It's safe to say the trend is no trend, according to our latest figures."

On the other hand, the overall compensatory jury-award median for personal-injury cases fell 30% in 2002. The study of personal-injury jury awards also reported that the compensatory jury-award median for premises-liability cases was up less than 1% to $150,000, while the plaintiff recovery rate declined four points to 49% in 2002. The products-liability jury-award median dropped 7% to $1.8 million, but the plaintiff success rate jumped five points to 61%. ■

## Study: Medication errors often occur at admission

Medication errors are common at the time of hospital admission, and some have the potential to be harmful, according to a recent report in the *Archives of Internal Medicine* (2005; 165:424-429).

A medication use history is an integral part

of the hospital admission process, but errors in the history may result in failure to detect drug-related problems or lead to interrupted or inappropriate drug therapy during hospitalization, according to background information in the article. Earlier studies suggest that these errors are a potentially serious safety issue. The current study was designed to identify unintended discrepancies between physicians' admission medication orders and a comprehensive medication use history and the potential clinical significance of the discrepancy.

**Patricia L. Cornish**, BScPhm, a researcher at the University of Toronto, and colleagues screened medical charts from three months of admissions to the general internal medical clinics at an affiliated hospital and included patients in the study if they reported use of at least four medications and were either able to communicate or had a caregiver who could communicate for them. One hundred and fifty-one patients were included in the study.

Eighty-one patients (53.6%) had at least one unintended discrepancy. "We identified 140 unintended discrepancies among these 81 patients," the authors wrote. "The most common error (46.4%) was omission of a regularly used medication. Most (61.4%) of the discrepancies were judged to have no potential to cause serious harm. However, 38.6% of the discrepancies had the potential to cause moderate to severe discomfort or clinical deterioration."

Cornish concludes that the processes for recording medication histories on admission to the hospital are "inadequate, potentially dangerous, and in need of improvement." ■

# JCAHO alters goal about standard abbreviations

JCAHO recently altered the 2005 requirements for meeting National Patient Safety Goal 2b that requires organizations to standardize abbreviations, acronyms, and symbols used throughout the organization, including a list of abbreviations, acronyms, and symbols not to use.

JCAHO modified the goal so that it applies only to orders and medication-related documents, a reduced requirement. The goal applies to preprinted forms, for which 100% compliance is expected. This change extends the requirement beyond handwritten documentation, but it is a reduced requirement from that originally planned for 2005.

The minimum expected level of compliance for handwritten documentation remains at 90%, JCAHO explains. In 2001, the Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations and implemented the National Patient Safety Goal as an accreditation requirement in 2003.

During 2003 surveys, approximately 15% of accredited organizations were found to be out of compliance with the abbreviations requirement. In 2004, the Joint Commission sought to further address this issue by issuing a "minimum list" of dangerous abbreviations, acronyms and symbols that must not be used. ■

## Reader Question

# Check before offering to subsidize docs' insurance

**Question:** Can our hospital subsidize physicians medical liability insurance without facing prosecution under the portion of the Social Security Act that addresses kickbacks? We've heard that the government recently approved these arrangements but we don't want to go ahead without being sure it's OK.

**Answer:** You're right to be cautious, says **Leonard J. Nelson III**, JD, a professor of health care law at Samford University's Cumberland School of Law in Birmingham, AL. There may be a way for you to subsidize the physicians' insurance, but you will need to ask federal regulators to assess your specific situation, he says.

Risk managers took notice recently when, for the second time in less than six months, the Department of Health and Human Services' Office of Inspector General (OIG) issued an advisory opinion saying that a hospital could subsidize physicians' medical liability insurance without facing prosecution for kickbacks.

The most recent opinion stemmed from a situation in which a hospital's two neurosurgeons faced nonrenewal, apparently through no fault of their own. The insurance companies chose not to renew the policies because neurosurgery is a high

risk specialty. The two doctors planned to retire, which would have forced patients in the community to travel 45 miles to see a neurosurgeon. To try to avoid that situation, the hospital paid for the physicians' tail coverage with the old insurer and covered 75% of the cost increase between the new and old insurance.

The hospital asked the OIG if such an arrangement was acceptable, and the OIG noted that patients in the community would suffer if the two physicians no longer practiced there. So even though the arrangement could violate the anti-kickback statute, the OIG said it would not punish the hospital or the physicians for the arrangement. The OIG noted these factors that led to the special permission:

- The arrangement is temporary and in response to an urgent situation.
- It is structured to prevent a significant financial boon for the physicians.
- The arrangement requires that physicians to provide certain services for the hospital, and it covers services at sites other than the hospital.

The full opinion can be found on-line at oig.hhs.gov/fraud/docs/advisoryopinions/2004/ao0419.pdf.

The problem, Nelson says, is that the government is very specific in assessing such requests. The recent opinion may be encouraging if you are in a similar situation, he says, but you must be careful not to interpret it as a blanket statement or a safe harbor that may apply to a lot of health care providers. So far, the OIG is only approving such arrangements on a case-by-case basis, other than the pre-existing safe harbor for obstetricians.

But that's good news of a sort, Nelson says. It means that you can request an OIG opinion and if you get a "yes," then you can rest assured that you have rock solid approval as you proceed.

"In the recent opinion, it was pretty clear that there was not much risk of this turning into a situation of payment for referrals," he explains.

"They needed these neurosurgeons and they were going to lose them if they didn't help with the insurance. They were trying to provide service in the community, and the OIG said it was done in a way that minimized the chance of paying for referrals," Nelson adds.

The recent OIG opinion is limited to two years, reflecting the fact that the hospital was responding to an urgent need. The limit also underscores the OIG's concern that permission of this sort not be so general that it can be abused.

"These opinions are very narrow. They are limited to the specific situation outlined in the request to the OIG," he says. "You can learn something from an opinion issued to someone else, but it would be a mistake to take that opinion and proceed as if it applied to you as well."

The recent opinion suggests that the OIG is amenable to subsidizing insurance when it is necessary to preserve patient access to specialists or health care in general. But Nelson says the best bet is to request an opinion from the OIG for your own situation. And be forewarned: Don't try anything tricky with the request. If you have any motive other than preserving patient access to health care, you could be in for big trouble down the road.

"It's a criminal statute. If they find that just one of the purposes of the arrangement was to induce referrals, you could face criminal prosecution," Nelson says. "Plus, you could be excluded from Medicare and face civil monetary penalties. There are lots of bad things that can happen if you're not careful." ■


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## COMING IN FUTURE MONTHS

- Saying 'I'm sorry' works to reduce lawsuits
- Computerized order entry cuts errors 50%
- EMTALA inservices: Ideas that work
- Checklists can help reduce medication errors

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## 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.

13. Which factor does Jennifer M. Bottomley, PT, MS, PhD, cite as a potential fall hazard for elderly patients?
A. The color of walls and floors
B. The height of wall switches
C. The length of curtains
D. The width of doors

14. According to Roberta A. Newton, PhD, how many medications constitute an automatic risk factor for falls in the elderly?
A. 2
B. 4
C. 6
D. 8

15. When does Kathryn K. Wire, MBA, CPHRM, recommend you contact the patient or family member after an adverse event or other potentially litigious situation?
A. As soon as the situation occurs
B. Only after the patient or family contacts you
C. Not until you have consulted with your attorney first
D. Only after fully investigating the incident and reaching a conclusion

16. According to advice from Leonard J. Nelson III, JD, when can you subsidize medical malpractice insurance for physicians, other than those covered by the obstetrician safe harbor?
A. Never
B. Always
C. When you think your situation is sufficiently similar to that in an opinion issued by government regulators
D. When you have specifically requested an opinion based on your particular situation and the answer is yes

**Answers: 13. A; 14. B; 15. A; 16. D.**

Healthcare Risk Management's
Legal Review & Commentary™
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# Untreated subdural hematoma leads to brain damage: $1.9 million verdict against hospital

By **Jan J. Gorrie**, Esq.
Buchanan Ingersoll PC
Tampa, FL

**News:** An elderly gentleman with a history of fainting presented to a hospital emergency department (ED) was admitted for observation and testing then discharged without a conclusive diagnosis or treatment plan. One month later, he fell, was re-hospitalized, and surgery was performed to relieve a subdural hematoma. He was left brain damaged and unable to live independently. His sister sued the practitioners and hospital on his behalf. The neurosurgeon settled for an undisclosed amount prior to trial. A jury awarded a $1.9 million verdict against the hospital.

**Background:** The retired and single 75-year-old man with a history of fainting presented to the ED. He was admitted and consultations were made with several specialists, including a neurologist and neurosurgeon. A computed tomography (CT) scan was performed before he was first seen by the neurologist. An MRI was attempted but discontinued when the patient became agitated. During the course of his admission, another MRI was not attempted on the advice of the neurologist and neurosurgeon, who jointly concluded there was no medical basis for one.

Over the next 30 days, the discharged patient was seen by physicians on four separate occasions and by his home health nurse. On the 30th day, the man fell in the bathroom. His sister, with whom he was living, testified at trial that he was lethargic and disoriented following the fall and that she took him to back to the ED the next day. Once readmitted, he was diagnosed as having suffered from a subdural hematoma and evacuation surgeries were performed. Following this hospitalization, he was discharged to long-term care with no hope of independent living.

The plaintiff brought suit against the treating physicians and hospital, claiming that he should not have been discharged in the first instance without an MRI. The plaintiff maintained that the MRI would have conclusively shown he suffered from a subdural hematoma at the time of the first admission and that more timely treatment would have saved him from a debilitating brain injury.

The neurosurgeon settled for a confidential amount prior to trial. The hospital contended the patient had pre-existing dementia and that all his complaints stemmed from it. The hospital and physicians maintained the patient was not suffering from physical signs or symptoms that required a repeat of the MRI during the first admission. This theory was bolstered by the fact that he was seen by several other practitioners between admissions, that none of them believed more testing was necessary, and that none ordered more extensive follow-up testing. The defendants said the sole cause of the subdural hematoma was the fall in the bathroom and that the damage was more extensive due to the delay in getting him to the hospital.

The neurosurgeon settled for a confidential amount. The jury trial moved forward against the

hospital only. The jury found the hospital negligent and found it liable for $1.9 million in damages.

**What this means to you:** "The case history provided indicates that the hospital acted in good faith and that the treatment provided met the standard of care. It appears from the evidence provided that the fall was the cause of the subdural hematoma since the patient was able to continue living independently in the community for a month prior to the accident. The fall also seems to be the participating factor in his neurological decline, even if one factors in the known history of dementia," observes **Lynn Rosenblatt**, CRRN, LHRM, risk manager, HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. "The only definitive evidence from the first admission that the patient may have had a cerebral bleed was the period of agitation mentioned in connection with the MRI attempt, and that is weak. Many people experience anxiety when faced with the claustrophobic confines of an MRI tube — not simply those with clinically diagnosed dementia. Since the determination of the need for an MRI is certainly within the purview of a neurologist and/or a neurosurgeon, responsibility of not attempting a second MRI scanning should be placed with the physicians.

"Perhaps the only error made was to discharge the patient without having reached a conclusion regarding the nature of the fainting episodes," she notes, "for, in any event, diagnosis and prescribed treatment of the patient's condition including discharge to community care is the responsibility of the physicians not the hospital. Hospitals are responsible for discharge planning, but it must in accordance to the physician's instructions.

"Either the jury could not understand that concept or it choose to ignore it and found against the hospital for what is a very large verdict. It appears that in some manner the settlement by the physician influenced the jury to assume that there was in fact a misdiagnosis at the time of the first admission," notes Rosenblatt.

The fact of settlement involving co-defendants is purposely withheld from the jury so that it will not influence its determination of negligence on the party at trial, but testimony frequently provides enough information for the jury to draw conclusions.

"The narrative indicates that the various physicians involved in treating the patient testified that there was no indication of a subdural hematoma at the time of the initial admission, and it did not appear to show up to the time he fell a month later. It is not clear what type of expert witnesses the defense called or how it depicted the hospital's position. Also the relationship of the physicians to the hospital is not clearly defined as to staff or independent practice," notes Rosenblatt.

"The jury award of near $2 million appears out of line for the amount of liability incurred by the hospital. An appeal to the court to reduce or reverse the verdict is the only possibility as a means to rescue this case, which clearly demonstrates how juries perceive hospitals as dangerous places despite evidence to the contrary," adds Rosenblatt.

"Hindsight is said to be 20/20, but one way to avoid the large judgment may have been for the hospital to follow the physicians' lead and settle before the case went to the jury. A pre-emptive decision to settle would have allowed the hospital to better control the amount of the award rather than leave that to an unpredictable jury pool. Of course a settlement does not allow for the possibility that the hospital could have prevailed in its on defense and won acquittal," concludes Rosenblatt.

### *Reference*


• Macomb County (MI) Circuit Court, Case No. 01-1350-NH. ■



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

# Medication error results in $120,000 California award

**News:** A patient received quinine sulfate when she should have gotten quinidine sulfate. The medication error resulted in her experiencing a multitude of medical aliments. Once the prescription drug error was corrected, many of the symptoms subsided; however, she continued suffering from peripheral neuropathy. She brought action against the provider who dispersed the wrong medication and was awarded $120,000 through a mandatory arbitration process.

**Background:** The plaintiff, 54, had taken quinidine sulfate on a regular basis after suffering an episode of paroxysmal atrial fibrillation at age 19. In March 2002, after 35 years on the medication, the pharmacy erroneously dispensed quinine sulfate.

As a result of the mistake, she began to suffer a variety of aliments. Her adverse reaction to the erroneously filled medication included bilateral hearing loss, hair loss, itchy and scaly skin rashes, crumbling fingernails, fatigue, swelling, pain, numbness and tingling in her feet and legs, and, to a lesser extent, numbness and tingling in her hands.

A neurologist diagnosed the plaintiff as having idiopathic peripheral neuropathy; however, it was not until July 2002, when she went in for a refill, that the medication error was detected and corrected. Once off the quinine sulfate and back on quinidine sulfate, the patient's symptoms dramatically improved. Her hearing returned to normal, her hair grew back and the rashes disappeared. Her peripheral neuropathy, however, remained.

The woman and her husband brought action against the pharmacy for negligent dispensing. The defendant admitted the prescription drug error but denied that the peripheral neuropathy was related to quinine sulfate, arguing that there was no evidence in medical literature of such a connection. The mandatory arbitration resulted in an award to the plaintiffs of $120,000.

**What this means to you:** Preventing medication mistakes is the subject of JCAHO's most recent Speak Up safety initiative, an effort to proactively involve patients in their care so that they and their caregivers are more aware about medications. JCAHO's brochure specifically instructs patients to keep a medications log, which includes not only prescription medications but over-the-counter as well as vitamins, herbs, dietary supplements, and homeopathic remedies.

The medications list also provides space for alcohol and other drugs so that patients may be aware of potential interactions.

Medications awareness is one tool that should be used to address an ongoing medication issue and one that gives rise to potential error, such as with sound-alike and/or look-alike drugs.

"Furthermore, this case demonstrates that medication errors are not restricted to new drugs since quinidine sulfate is certainly not new to the market. Despite the fact that the literature is replete with such examples, these errors continue to be made, which is in part JCAHO motivation for focusing patient awareness efforts in this regard. Identification of and ultimately prevention of medications errors should be everyone's responsibility," observes **Cheryl Whiteman**, RN, MSN, HCRM, clinical risk manager for BayCare Health System in Clearwater, FL.

In this particular case, the patient had been taking quinidine sulfate for 35 years. Given that history with the medication, one might assume that the patient should have been more aware of what she was taking and how it should have made her feel.

"Despite this lengthy regime, she apparently did not question the pharmacy about the pills perhaps looking different. However, as the cost of drugs stays under constant scrutiny,


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pharmacies are always shopping for the best price available. As a result, the characteristics of a generic pill may change somewhat regularly as manufacturers are changed.

"Companies that dispense drugs would do well to inform their customers whenever there is a change in the manufacturer of the prescribed drug. This will alert the patient to a new look to their routine medication and hopefully cause the patient to check with the pharmacy should the drug unexpectedly look different than it has in the past. Providing such information to patients enables them to participate in safe administration of their prescribed medications," notes Whiteman.

JCAHO also has been concerned with medication management and created a separate chapter for such in January 2004, and JCAHO has recently embarked on an effort to gather data from providers and others to access the strengths and weaknesses of those standards.

"As demonstrated by the outcome in this case, facilities are responsible for their pharmacies, and those pharmacies have the latitude to determine how drugs are shelved. In this instance, it is very likely that the quinine sulfate and quinidine sulfate were located in close proximity to each other. It is well established that those dispensing or administering medication will frequently read what they *expect* to see," says Whiteman, "researchers refer to this as confirmation bias. The person who is selecting the drug does not recognize that the wrong product is being chosen. One way to alert the person selecting the drug is 'tall man lettering,' wherein part or all of the drug name is written in tall and/or bold letters to act as an alert that the name must be read carefully so as not to confuse it with another drug. Warnings on shelves or bins and strategic storing of such drugs are also prompts used to prevent such errors.

"Safe medication dispensing and administration requires continuous vigilance. The prudent risk manager should participate in pharmacy, medication usage, and medication safety committees to promote safe practices. And, as noted in JCAHO's recent publications, providers would do well to educate and empower patients to become proactively involved in their care, so that they, too, can assist in identifying when an error has occurred or ideally prevent such from happening," she concludes. ■


## Don't miss 'Law of the Land' infection rate conference

*State after state considering legislation*

Is your state next? Laws requiring disclosure of individual hospital infection rates are sweeping the nation. Four states — Pennsylvania, Illinois, Florida, and Missouri — have passed infection rate disclosure laws, and 20 others have introduced bills.

Driven by consumer demands for patient safety, infection rate disclosure laws are expected eventually to be passed in most states or required federally under standardized requirements.

Thomson American Health Consultant's audio conference, **Law of the Land: Meeting the Challenge of Mandatory Infection Rate Reporting** will help you prepare for these looming regulations. Join us on April 7, 2005, from 2:30 to 3:30 p.m. EST to find out more about the Centers for Disease Control and Prevention's (CDC) recently released template for new state laws or a national reporting system. Crafted by the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), the document recommends three process measures and two outcome measures that could be reported under infection rate disclosure laws.

Our distinguished faculty includes one of the principals behind the new CDC guidance, **Patrick Brennan**, MD. A hospital epidemiologist at the University of Pennsylvania in Philadelphia and HICPAC chairman, Brennan also worked with state officials when the law there was under discussion. Likewise, our other speaker was heavily involved in the shaping of the infection rate disclosure law in Missouri. **Eddie Hedrick**, BS, MT (ASCP), CIC has been an infection control professional for 34 years. A veteran of hospital epidemiology, he now is the emerging infections coordinator at the Missouri Department of Health and Senior Services in Jefferson City.

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PATIENT SAFETY ALERT™

*A quarterly supplement on best practices in safe patient care*

# Keystone project yields results in six months

*Hospital achieves significant improvements in ICU care*

By participating in a statewide patient safety program sponsored by the Michigan Health & Hospital Association (MHA), William Beaumont Hospital in Royal Oak, MI, has seen significant improvement in a number of key areas of intensive care unit (ICU) care, including reduced bloodstream infections and ventilator-associated pneumonia (VAP).

The Keystone Center for Patient Safety & Quality in Lansing, MI, established in early 2003, currently has 70 hospitals and 130 ICUs participating in its ICU patient safety project, explains **Chris Goeschel**, RN, MHA, the center's executive director.

The project, she notes, is completely voluntary, although statewide participation is more than 90%. "It grew out of an acknowledgement in Michigan that ICU care was important and costly, and that there were things being learned at Johns Hopkins [in Baltimore] and implemented at the VHA that were transforming ICU care," Goeschel recalls.

"I approached Peter Pronovost [MD, PhD, an anesthesiologist, critical care physician, and associate professor who is spearheading the patient safety efforts at Johns Hopkins and leading nationwide safety projects] when he had a federal grant opportunity to improve patient safety to talk about working together and implementing what was being done at Hopkins throughout the entire state of Michigan," she adds.

What resulted, she says, was something entirely unique. "Using the state hospital association as the node for the dissemination of evidence-based care had not been done before," Goeschel asserts.

Beaumont got involved with the Keystone project in the winter of 2004 and kicked off its surgical ICU initiative in June, says **Robert Welsh**, MD, surgical intensivist and chief of thoracic surgery.

As outlined by Keystone, the first step for each site is to assemble a team committed to accomplishing the objectives in each intervention. The team should include a senior executive (vice-president or above), an ICU director, ICU nurse manager, ICU physician, ICU nurse, pharmacist, and a department administrator.

The ICU physician and nurse (either the manager or the staff person), each must commit 20% effort to this project. In addition, each team must commit to collecting the data required and to attending two meetings and two conference calls per year. As with all participating hospitals, Beaumont was tasked with implementing five interventions:

- Implement and evaluate the impact of the comprehensive unit-based safety program (CUSP), which can include the ICU safety reporting system (ICUSRS).
- Implement and evaluate the effect of an intervention to improve communication and staffing in ICUs.
- Implement and evaluate in a cohort of Michigan ICUs the effect of an intervention to reduce or eliminate catheter-related blood stream infections in ICUs.
- Implement and evaluate in a cohort of Michigan ICUs the effect of an intervention to improve the care of ventilated patients in ICUs.
- Implement and evaluate an intervention to reduce ICU mortality.

"This is a general guideline; each institution then tries to implement that outline according to its resources," Welsh explains. Beaumont's efforts

started with a questionnaire regarding the safety attitudes of nurses, respiratory therapists, and the pharmacy.

"Beyond that, we developed the format of setting daily goals for each individual patient and also reviewed the interventions we started with initially, and how to implement them," Welsh adds.

The Beaumont team included Welsh, **Kathy Schumacher**, MSA, Beaumont's data outcomes manager, two nurse managers on the surgical ICU unit, the pharmacist, and the respiratory therapist.

Staff buy-in was critical. "Essentially, you're changing the culture of how you approach patients with regard to safety," Welsh says. "You make it a priority, and by doing that, you are implementing better medicine."

Expectations had to be realistic as well. "We all came in with the idea that this would be an evolving process," Schumacher adds. "We did not expect to get it right the first time out of the gate."

## Encouraging results

Nevertheless, they must have gotten something right, because in six short months, they have seen some important changes.

"In the five-month period of June to October, compared to the same period in 2003, we started to see some numbers drop post-implementation," Schumacher reports. These numbers, she says, include bloodstream infections, VAP numbers, and unit throughput. "We are starting to build a business case for doing Keystone," she asserts.

And while the team has not yet directly addressed reducing mortality, "it has already happened as a result of the other interventions. We *know* that what we did in those early two interventions certainly decreased mortality," Welsh asserts.

What have been the keys to the early success at Beaumont? "First was the commitment from intensivists that we present ourselves consistently to unit rounds — always at the same time," says Welsh. "Now the nursing staff know when we will be there, and we are now drawn into rounds. They've asked to interact with us, to express concerns about patient conditions not evident to anyone else, and they speak up."

Having now implemented four of the five interventions, Schumacher says the setting of daily goals has had the greatest impact.

"We've started to see a reduction in LOS, and we have tied other results to daily goals — such as removing unnecessary lines to lower infections, and decreased ventilator use, which has lowered the pneumonia rate," she notes.

The CCU joined the initiative in January, Welsh reports, and the Medical ICU may join shortly. "We are very pleased at this point in time," he says. "In our eyes, this is the new way to practice and to emphasize safety in the ICU, and we have every expectation this will permeate throughout the hospital."

## Other states want in

Not only is the project spreading within hospitals, but it is reaching other states as well, notes Goeschel. "These include New Jersey, Maryland, and Rhode Island — and there are many others in the queue," she says. "We have multistate conference calls to share what's being learned and to discuss implementation practices. We have a workshop in Michigan coming up, and we have invited other state project directors to join us."

The state of Michigan has much to share. "Since we began, we've already seen dramatic reductions in catheter-related bloodstream infections, and we will have been collecting data for just one year in March," Goeschel reports. "We have 26 ICUs that have been going for more than six months, with no infection reported since implementing the project; that's breathtaking."

The entire state has reported similar results, and the same with reduced VAP, she adds.

What makes Keystone so good?

"My sense is it is a combination of things," says Goeschel. "For one thing, having a hospital association as a node eliminates any agenda or competitiveness — every hospital is of equal concern. Plus, we are partnering with *the* national experts [on patient safety], in the belief we can improve care in the whole state.

"Also, I think we have developed a strong model of communication with members, including monthly conference calls, a dedicated participant web site, and e-mail back and forth regularly," she notes.

All of this has drawn together clinicians "to the heart of why we did this in the first place — to help the patient," Goeschel says. "As we do this, we are drawn to our passion, and the results are absolutely motivating. We can change the world for health care." ■