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IN THIS ISSUE

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E-mail for doctors is here to stay, but precautions are needed to curb the risk

'Take two aspirin and e-mail in the morning' creates serious risk

First of two parts on risk and e-mail

E-mail is becoming increasingly common in health care, but chances are your policies and procedures have not kept up with the serious risks that can be created when people send e-mail without stringent safeguards.

Recent inducements for physicians to e-mail patients more could dramatically increase the risk, some experts say.

Some computer-savvy doctors have used e-mail to communicate with patients for a while, but they weren't paid for it. Now health plans and medical groups across the country are beginning to pay doctors to reply by e-mail in the same way they pay for office visits. Blue Shield of California, for instance, pays doctors $25 for each on-line exchange, the same as it pays for an office visit. Some other insurers pay less for e-mailing, and some patients are charged a $5 or $10 copayment that is billed to their credit card and relayed to the doctor.

The new payments are part of an effort to improve efficiency and cut the costs of office visits, the insurers say. The convenience appeals to both doctors and patients.

Anthem, Blue Cross, Cigna, and Harvard Pilgrim report they have been paying for e-mail consultations for about a year. Blue Cross and Blue Shield plans in California, New York, Florida, Massachusetts, New Hampshire, Colorado, and Tennessee are beginning to pay between $24 and $30, including any copayment, for on-line consultations. Empire Blue Cross and Blue Shield recently began testing a payment system with New York doctors at the Columbia University and the Weill Cornell Medical Center.

Kaiser Permanente reports having tested a payment system in the Pacific Northwest and is starting the program this year in Hawaii and Colorado. Kaiser's salaried physicians receive credits for sending e-mail, and those credits are used to increase their pay.

Inside: 2005 Salary Survey

Those payments are making some risk managers worry. Anything that encourages more e-mail could foster a more casual attitude, they say, but it appears there's no stopping the trend.

With everyone else in the world using e-mail so much, it is unrealistic to think that doctors will not use it to communicate with patients, says **Mark Coel**, JD, an attorney with Michaud Buschmann in Boca Raton, FL, who regularly counsels physicians and physician groups on a variety of legal and regulatory matters. However, he warns that there are serious liability risks if doctors do so without the proper safeguards.

In particular, he is concerned that payments for using e-mail could encourage doctors to use e-mail too much and without considering all the ways an e-mail message could backfire. Risk managers should set up practice parameters that outline what doctors (and other health care professionals) can and cannot discuss by e-mail.

Some of those parameters will involve clinical decisions about when a patient must be examined in person and what can be discussed by e-mail. Generally, Coel says, the proper use of e-mail would be for the same type of query or information exchange that could safely and appropriately take place over the phone — a patient asking whether it is OK to take one medicine with another, for instance, or asking if a symptom warrants a return visit.

In those situations, e-mail serves the same purpose as a phone call but might be more efficient for both parties.

"E-mail can be perfectly fine as long as everyone knows where the line is and doesn't step over it," he says. "You don't want to use the Internet for something that really should be handled in an office visit. The things that require seeing the patient in person and examining him with your own hands have not changed just because it is convenient to send off an e-mail in 30 seconds."

Watch what you say and how you say it

Physicians must be especially careful about the content of e-mail sent to patients, says **Edward C. Mintzer Jr.**, a partner with the law firm of Rawle & Henderson in Philadelphia. Mintzer focuses his work on malpractice defense, and he also is a judge pro tem and mediator for the Philadelphia Court of Common Pleas. The e-mail will become a permanent record and requires the same care as writing any other part of the record, he says. **(See p. 75 for more on the obligation to preserve e-mail communications.)**

E-mail is notorious for being unable to accurately convey the writer's tone — what you mean as a serious warning may come across as a mere suggestion, or vice versa. A friendly joke that would make the patient chuckle if you said it in person might come across as snide and unprofessional in an e-mail.

"Plus, there is the question of the recipient's

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reading ability, and all the ambiguous or complicated terms that a doctor might use," Mintzer says. "Some patients will be illiterate or nearly so, and some will have PhDs. How can you expect a doctor to write an e-mail that anyone can understand?"

All of those factors can undermine the informed consent process, he notes. And consider how often e-mail delivery fails. How can a physician be certain that the patient received each e-mail containing important information?

It also is possible to violate the Health Insurance Portability and Accountability Act (HIPAA) with e-mail to patients, he notes. A simple typing mistake in the address can send the e-mail to a total stranger or a work colleague.

Coel agrees that HIPAA violations are a serious risk and he advises using encryption software to make the messages more secure. **(See p. 76 for more on the HIPAA risk.)**

There also is the question of which patients should receive e-mail from a physician or other health care provider. Blanket use of e-mail with patients is risky, but Mintzer says it could be used with minimal risk if the doctor already has an established relationship with the patient.

"That changes the picture when you know the patient and his condition, you know his education level, you know how to effectively communicate with him by e-mail," Mintzer says. "And conversely, you may have some patients you know very well but you know that this person is not a good candidate for this kind of exchange. If the patient is not educated, has trouble seeing, or has any other condition that would impede his ability to understand your e-mail, just stick with the tried-and-true methods."

E-mail use in health care is different from e-mail in most other settings, says **Philip Rosenberg**, JD, chairman of The New York State Bar Association's Health Law Section and a partner in the firm of Wilson Elser based in the firm's Albany, NY, office. The health care provider's obligation to keep information confidential creates an added risk that might not be found in, for instance, a manufacturer communicating with clients and vendors by e-mail.

"One of the questions that arises is what happens when there is a breach of confidentiality and whether that breach would be covered by the provider's professional liability carrier or if additional insurance is needed," he says. "I advise risk managers to take a look at their existing insurance policies to see whether or not such a breach would be covered. My guess is there would be some resistance."

Written guidelines are a must, Rosenberg says. The guidelines should cover technical aspects such as encryption but also content guidelines and the need to preserve electronic documents, he says.

"I also would want the patient to sign a consent authorizing the provider to communicate by e-mail," Rosenberg says. "That consent should explain the risk of unintended recipients and require the patient hold you harmless for any unintentional disclosure of confidential information. The e-mail communication is in large part for the convenience of the patient, so the quid pro quo would be for the patient to hold you harmless."

(Editor's note: In next month's Healthcare Risk Management, *the second part of this story will further examine how risk managers can use policies and procedures to lower the risk from e-mail.)* ■

Preserving e-mail applies to whole range of litigation

Litigation regarding e-mail in health care already has reached the trial level, says **Edward C. Mintzer Jr.**, a partner with the law firm of Rawle & Henderson in Philadelphia.

"This is not a theoretical risk," he says. "It's in the court system."

For risk managers, one big concern should be how e-mail can become discoverable evidence in malpractice cases or other litigation, Mintzer says. Courts are ruling that health care providers have a duty to preserve e-mail as part of a litigation hold in the same way you would preserve paper documents. The need to preserve e-mail applies to the entire range of litigation that could face a health care risk manager — everything from malpractice to wrongful termination, slip and fall, and sexual discrimination.

However, you don't necessarily have to preserve all electronic data related to the case because that could be crippling to a large organization. A federal court in New York recently determined that employers, including health care providers, have a duty to preserve "accessible data," which it defined as "active on-line data, near-line data that is readily accessible, and off-line storage and archive that is readily accessible."[1]

The court's ruling was important in helping define what "readily accessible" data is, Mintzer says. It said that backup tapes might not be readily accessible, and erased, fragmented, or damaged data might not be either.

The ruling says the duty extends to "key players involved in the litigation," including supervisors and managers. Trial attorneys will not only look at the printed e-mail copies you provide but will want to investigate earlier permutations in the computer system to see if anything was changed before printing them for discovery. (Don't ever do that, Mintzer warns. Not only is it dishonest and possibly criminal, but you will look like a guilty fool when the plaintiff's techie expert shows how he found earlier versions in the computer system, he says.)

"Risk managers now have to preserve and protect, if not collect, any and all e-mail once they know that that type of electronic communication is necessary for the litigation," he says. "It's very onerous for a risk manager."

Risk managers must take the lead on preserving e-mail because they are often among the first to know that an organization is facing a lawsuit, Mintzer says. Once you are on notice of a potential claim, someone in the organization must monitor compliance with the litigation hold and electronic document preservation.

Mintzer advises taking these three steps to ensure compliance with e-mail preservation:

1. Implement a litigation hold immediately.
2. Communicate with the key players involved with the case.
3. Preserve, protect, and produce the electronic copies of the information. Make sure it is stored in a safe place.

Reference

1. *Laura Zubulake v. UBS Warburg, LLC,* No. 02 Civ. 1243 (SAS) U.S. District Court, Southern District of New York (July 20, 2004). ■

HIPAA violations possible unless e-mail is controlled

With more and more health information being transferred electronically, risk managers must be more cautious than ever about complying with the Health Insurance Portability and Accountability Act (HIPAA), says **Cheryl Camin**, JD, an attorney on the HIPAA practice team at the Dallas law firm of Gardere Wynne.

The new Security Standard portion of HIPAA specifically requires that electronic protected health information, including e-mails, be protected. There must be administrative safeguards as well as physical and technical protection. The strategies for compliance can include everything from shutting down computer screens when the user is away to encryption of messages.

"You can have serious violations of the Security Standard by e-mailing things back and forth. Even if the breach is not intentional, things get forwarded from one person to another and before you know it someone's health information is in front of a thousand people," she says. "Less is always more when it comes to protected health information. If you don't have to disclose it, if it doesn't deal with the treatment at hand, if it doesn't have to go in that e-mail, don't put it in there."

Also don't put anything confidential in the "Re:" line on an e-mail, not even anything general like "your test results" or "treatment plan," which could pique someone's interest.

Risk managers may be tempted to write a policy that prohibits sending certain kinds of information by e-mail, but Camin cautions that such a strategy can backfire.

"The difficulty is that you do want to contain the risk, but if you're too restrictive, people will violate the policy left and right," she says. "That's not good for your employees and you also would

have people in violation of your own policy, which never looks good when you're accused of a HIPAA violation."

If you already have an e-mail policy, Camin recommends revisiting it because chances are good that the policy has not kept up with recent advances in how e-mail is used. Years ago, providers did not send as many documents, the same type of documents, or image files, she notes.

"Some of it is common sense, too. People have to understand that e-mail can be protected information and treat it that way," she says. "Just because you might go to Starbucks and read your e-mail, not caring if someone looks over your shoulder and sees the note from your mom, that doesn't mean you can do the same thing with e-mail to a patient. That is protected information, and you still have to treat it that way even when it is in e-mail form."

The good news is that federal officials are not out prowling Starbucks looking for a doctor who is sloppy with protected health information. Camin says HIPAA violations are all complaint driven, so someone has to be upset enough to report the breach.

"It's usually because you sent the e-mail to the wrong person, especially if it lands in the hands of the patient's employer," she says. "It usually has to be egregious, but people can get very upset about their employers or their relatives getting information about their health status. That's why you have to be so very careful." ■

E-mail guidelines call for strict privacy safeguards

The American Health Information Management Association (AHIMA) in Chicago offers extensive guidelines for reducing the various risks associated with e-mail use in health care. These are some excerpts:

- Establish a policy and educate patients about appropriate types of e-mail (prescription refills, appointment scheduling, lab results) and queries that will not be responded to via e-mail (HIV, mental health).
- Electronically copy and paste e-mail addresses and/or use the reply button to minimize mistyped e-mail addresses.
- Answering e-mail messages from home requires the clinician to have a private e-mail address with privacy and security procedures in place.
- The clinician must not communicate with patients in the context of their professional relationship using personal e-mail accounts such as America Online, EarthLink, or any other nonemployer e-mail system.
- Requests from patients to discuss subject matter that is not appropriate for the electronic medium should be resolved via telephone or in person. The following topics should not be discussed in e-mail transactions:
  — protected diagnosis (e.g., mental health, substance abuse);
  — communication related to a diagnosis of HIV/AIDS;
  — workers' compensation injuries and disability;
  — confusing or abnormal test results;
  — new diagnoses;
  — bad news;
  — anything urgent.
- When communicating confidential medical information via e-mail, a banner similar to the one below should be displayed prominently at the beginning of the e-mail message:
  THIS CONFIDENTIAL COMMUNICATION CONTAINS INFORMATION PROTECTED BY PROVIDER-PATIENT PRIVILEGE.
- Develop and enforce policies defining and prohibiting emergency email messages.
- Use the signature line for all outgoing messages to communicate important guidelines and information, such as:
  — physician's full name and contact information;
  — response time;
  — instructions for when response time is not met;
  — instructions for urgent communication and patient emergencies;
  — other abbreviated guidelines as needed.
- Web pages used as links or given to patients should reflect active links and credible web sites.
- The patient should initiate e-mail messages. Providers should respond to patients by using the reply button.
- Include the patient's original message in any reply.
- The original e-mail, with reply, should be filed in the electronic record or printed for the paper record. The provider should initial and date the paper copy for the paper record.
- Develop policies and procedures for retention and storing (filing) e-mail messages in the paper medical record or electronic health record.

• Use e-mail system functionality (e.g., automatic reply to acknowledge receipt or notify senders that the physician is out of the office, return receipt to confirm patient receipt).

• Develop policies and procedures to guide the use of group e-mail messages. For example, patients should not see names of all intended receivers.

• A health care entity should have a standardized template for e-mail in place to ensure the appropriate information is communicated and captured.

• Lengthy e-mail messages or prolonged correspondence with a patient may necessitate scheduling an appointment with the patient or calling the patient.

• Establish a policy for e-mail turnaround time. It should include:

— priority for different types of messages.

— identification of what may require urgent, emergent handling;

— instructions for when the turnaround time is not met.

(For more of the AHIMA guidelines on e-mail, see http://library.ahima.org/xpedio/groups/public/documents/ahima/pub_bok1_022164.html.) ■

2006 Patient Safety Goals include labeling of meds

The Joint Commission on Accreditation of Healthcare Organizations has announced the 2006 National Patient Safety Goals and related requirements for each of its accreditation programs, with new requirements for safely handing off patients from one caregiver to another.

Among the major additions to the safety goals is a new requirement in all of the programs that handoffs of patients between caregivers be standardized, with particular attention to assuring the opportunity for asking and responding to questions. This requirement is part of the Goal: "Improve the effectiveness of communication among caregivers."

In addition, a new requirement for all types of accredited organizations that provide surgical or other invasive services specifies that all medications, medication containers, and other solutions used in perioperative settings are to be labeled. This requirement is part of the Goal: "Improve the safety of using medications."

New Goals in other selected programs address the prevention of pressure ulcers and encourage the active involvement of patients and their families in the patient's care as a patient safety strategy. (The full text of the 2006 Goals and Requirements is posted on the Joint Commission web site at www.jcaho.org.) Compliance with the requirements or alternatives judged to be acceptable is a condition of continuing accreditation or certification for Joint Commission-accredited or certified organizations and programs.

As in past years, the development and annual updating of the National Patient Safety Goals and Requirements was overseen by an expert panel that includes widely recognized patient safety experts as well as nurses, physicians, pharmacists, risk managers, and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings. Each year, the Sentinel Event Advisory Group works with the Joint Commission to undertake a systematic review of the literature and available databases to identify candidate new Goals and Requirements. Following a solicitation of input from practitioners, provider organizations, purchasers, consumer groups, and other parties of interest, the Advisory Group determines the highest-priority Goals and Requirements and makes its recommendations to the Joint Commission.

Some old requirements now deleted

To maintain the focus of accredited organizations on the most critical patient safety issues, the Sentinel Event Advisory Group also recommends the retirement of selected Goals and Requirements each year. The following requirements will be retired for all applicable accreditation programs in 2006:

• The requirement to remove concentrated electrolytes (including but not limited to potassium chloride, potassium phosphate, sodium chloride greater than 0.9%) from patient care units. This requirement will continue to exist in relevant accreditation manuals.

• The requirement to ensure free-flow protection on all general use and patient-controlled analgesia intravenous infusion pumps used in an organization. Compliance with this requirement has been greater than 99%, and equipment manufacturing and availability issues for all health care setting have been satisfactorily resolved.

The Board of Commissioners also affirmed the six existing do-not-use abbreviations that constitute

a single requirement under the Goal: "Improve the effectiveness of communications among caregivers," but acted to delete a related stipulation that each organization also identify an additional three organization-specific do-not-use abbreviations that have been integral to this Requirement as well.

Failure to substantially eliminate the utilization of do-not-use abbreviations in medication orders remains — at 27% — one of the most frequent noncompliance findings during Joint Commission surveys. ■

OR fire risk can increase with alcohol-based prep

The use of alcohol-based surgical preparations in the operating room is gaining new attention as a potential fire risk, and one expert says risk managers should ensure that OR staff take specific steps to prevent serious injury.

Concern about the OR risk comes on the heels of a decision by CMS to allow hospitals to place alcohol-based hand rub containers in hallways, a decision that came only after CMS was assured that the alcohol would not be an unreasonable fire risk. Infection control professionals had pushed for more widespread use of the alcohol rubs, and the concern about the fire risk may have led to more focus on similar risks in the OR.

Now safety experts are reacting to a ruling by a regional CMS officer that prohibits the preparations containing alcohol when cautery, electrosurgery or laser devices are in use. The ruling came after a device sparked a surgical fire and burned a patient in Nebraska.

Alcohol has been a mainstay of antiseptic procedures, and infection control professionals expressed concern that its removal from operating rooms could lead to an increase in surgical site infections.

A National Fire Protection Association committee will meet in July to consider issuing clarification on the issue as a Tentative Interim Amendment (TIA) to the fire code. CMS is also working with the NFPA and the American Society for Healthcare Engineering (ASHE) of the American Hospital Association to allow the use of alcohol-based surgical preparation solutions if there is a timeout to allow the substance to dry.

In the meantime, risk managers should ensure that OR staff take a time out to allow the alcohol to dry before proceeding, advises **Susan McLaughlin**, MBA, CHSP, MT(ASCP)SC, president of SBM Consulting in Barrington, IL, and a codes and standards consultant to ASHE. She says the risk of fire from alcohol preps is real, but that forgoing them can raise the risk of infection. It's a balancing act, she says.

"Of course, we have the risk of surgical site fires, and unfortunately there have been some," she says. "But we're trying to reduce the number of hospital acquired infections. It truly becomes an education process that we have to undertake in the health care industry, to be able to use the materials that we need to use to provide the patient care, and use them safely."

The fire code doesn't prohibit the use of alcohol-based products in the operating room, ASHE asserts in an advisory (www.ashe.org): "In fact, NFPA 99 (the fire code used by CMS) specifically addresses germicidal solutions in surgery and provides conditions for their safe use."

You can use the alcohol-based preparations safely with cautery or lasers if you follow a strict protocol, according to the Temporary Interim Amendment proposed by ASHE. Operating room personnel should make sure the solutions do not pool under the patient's drapes, and should implement a timeout before starting a surgical procedure to make sure the solution has completely dried, ASHE advises.

Steps for avoiding alcohol fires in OR

McLaughlin says risk managers would be prudent to reinforce fire safety procedures in the OR and specifically address the safe use of alcohol-based preps. In addition to overall fire prevention strategies in the OR, make sure you enforce these three rules:

1. Call a time out to check for drying before drapes are applied to the patient. "The key issue is that if these materials are used appropriately, and that means allowing them to dry before the drapes are applied, they should be effective in reducing the infection risk without contributing to fire during surgery," McLaughlin says. "OR staff must understand that if the drapes are applied too soon, before the alcohol has dried, the alcohol can pool under the drapes and then ignite from any number of sources during surgery."

2. Use unit-dose applicators whenever possible. That ensures that nurses and techs use enough for reducing infections without using too much and increasing the fire risk, McLaughlin says.

3. Any material that becomes soaked in the alcohol prep must be removed from the surgery area entirely.

The Nebraska case dramatically highlights the fire hazard in an operating room. An 86-year-old woman was undergoing a biopsy when the linens supporting her head caught fire. She received severe burns to her head, neck, and shoulders and died of pneumonia a month later, according to news reports.

Meanwhile, CMS officially has allowed the placement of containers of alcohol-based hand rubs in hospital hallways. As of May 24, CMS is adopting the amendment to the NFPA Life Safety Code that allows the dispensers.

The amendment dictates the size, spacing and placement of the containers. For more information, see www.ashe.org/ashe/codes/handrub/index.html. ■

Claims and costs way up for long-term care providers

If your organization provides any long-term care services, you've probably seen your liability costs go through the roof recently. You're not alone, according to data from Aon, a Chicago-based provider of risk management services and insurance.

Aon recently released information showing that, across the United States, the frequency of claims filed annually has more than doubled and severity has tripled in the long-term care sector since 1996. The Long-Term Care 2005 General Liability and Professional Liability Benchmark Analysis found that general liability and professional liability (GL/PL) costs for the long-term care profession have increased 182% since 1996. It also recorded that the annual patient care liability cost for each occupied bed in a long-term care facility has grown from $430 in 1993 to $2,310 in 2004, explains **Theresa Bourdon**, FCAS, MAAA, managing director and actuary at Aon.

"Following trends initially observed in Florida and Texas, an alarming number of states are experiencing dramatic increases for GL/PL coverage," Bourdon says. "In fact, 14 of the 16 states analyzed experienced double-digit annual increases in their GL/PL costs over the past decade, with a majority of them experiencing loss cost trends in excess of 25%."

The most notable states experiencing escalating loss costs are Arkansas, Mississippi, California, Georgia, Alabama, Arizona, and Tennessee.

"This is not good news for providers," Bourdon says.

No one safe from liability costs now

The rising costs of long-term care liability now are hitting everyone, she warns.

"Even if you're not operating in what were notoriously the worst states for liability against long-term care providers — Florida and Texas for instance, — you should still be concerned," Bourdon says. "This issue is spreading across the country."

A casual reading of the Aon report could suggest the costs are leveling off, but Bourdon warns that many factors are driving a continuing increase in costs. Some states have seen a leveling off because some deep pocket insurers left Florida and other states with a lot of retirees, and tort reform has helped in other states, including Texas.

One significant improvement in Texas was the provision of the state's tort reform that limits "stacking," in which multiple relatives of an injured or deceased family member would file separate claims. Caps on the total payouts also had a large impact, Bourdon says.

The study, which represents 23% of the total number of long-term care beds in the United States, reveals that tort reform passed in Texas in 2003, and strengthened by a constitutional amendment, appears to be having the greatest impact among the states analyzed on reducing GL/PL claim costs. GL/PL loss costs in Texas peaked at $6,720 in 2002 but have dropped substantially to $3,390 in 2004.

The study also found that the number of claims per year that long-term care operators incur has more than doubled, from 6.2 per 1,000 occupied skilled nursing care beds in 1996 to 13.1 in 2004, and the average cost per claim has increased to close to $180,000. As well, the study found that annual commercial insurance premium levels have increased for the fourth straight year.

Time to revisit your prevention strategies

Bourdon says risk managers should see the cost data as reason to revamp their prevention efforts in long-term care, making it a special focus for all clinical and general risk management efforts.

"Address all you can internally and also be active in policy debates on tort reform," she says.

"This is a cost of doing business and it is showing no signs of decreasing. It needs to be recognized across the country, not just in what had historically been a few states that were especially hard hit by these costs."

Bourdon recommends that nursing and long-term care providers should join forces with the physician community to be front and center in the fight for tort reform.

"Physicians have made some headway in recent years. Long-term care providers should learn from that success and push for more protection," she says.

Funds diverted from other needs

Hal Daub, president and CEO of the American Health Care Association and the National Center for Assisted Living, both in Washington, DC, says the increased liability costs are hurting more than just health care providers.

"The long-term care liability crisis is forcing scarce Medicaid taxpayer dollars intended to fund quality long-term care services for our nation's frail, elderly, and disabled to be diverted to pay for unnecessary defense costs and inordinately expensive settlements," he says. "This Aon study illustrates that trial attorney fees and other litigation expenses make up nearly half of the total amount of costs paid for liability claims in long term care. These are funds that ought to be directed to patient care."

The analysis is based on data from 76 long-term care providers operating around the country. The participants combined currently operate approximately 445,000 long-term care beds, consisting primarily of skilled nursing facility beds, but also including a number of independent living, assisted living, home health care and rehabilitation beds.

To access the complete study and gather more detailed information on individual states, go to www.aon.com or www.ahca.org. ■

Defensive medicine comes at a high cost to doctors

More than 90% of surveyed physicians in Pennsylvania reported defensive medicine practices such as overordering of diagnostic tests, unnecessary referrals, and avoidance of high-risk patients, according to a recent study.

Defensive medicine, defined as the deviation from sound medical practice that is induced primarily by a threat of malpractice suits, has been reported widely in the United States and abroad. However, its prevalence and characteristics remain controversial.

According to the recent study, defensive medicine may supplement care (additional testing or treatment), replace care (referral to another physician or health facility), or reduce care (refusal to treat particular patients) (*JAMA* 2005; 293:2,609-2,617). Some practices, described as "assurance behavior" (sometimes called "positive" defensive medicine), involve supplying additional services of marginal or no medical value with the aim of reducing adverse outcomes, deterring patients from filing malpractice claims, or persuading the legal system that the standard of care was met.

Other practices, described as "avoidance behavior" (sometimes called "negative" defensive medicine), reflect physicians' efforts to distance themselves from sources of legal risk. Defensive medicine, particularly avoidance behavior, encompasses both day-to-day clinical decisions affecting individual patients and more systematic alterations of scope and style of practice. ■

Infections acquired in the hospital continue to rise

Hospital-acquired infections are worsening in the United States, according to a recent report from Colorado-based Health Grades Inc. And a hospital's infection rate may be correlated with its likelihood for medical errors, the group suggests.

"Hospital-acquired infections rates worsened by approximately 20% from 2000 to 2003 and accounted for 9,552 deaths and $2.60 billion — almost 30% of the total excess cost related to the patient safety incidents," the report says.

The infections include antibiotic-resistant bacteria that are very difficult to treat, including staphylococcus and streptococcus infections. Health Grades, which evaluates the quality of hospitals, physicians and nursing homes, found more than 300,000 patients died after suffering some sort of adverse, hospital-related incident in 2001, 2002 and 2003. More than 80% of these deaths could be attributed to the incident.

"Hospital-acquired infections correlated most

highly with overall performance and performance on the other 12 patient safety incidents, suggesting that hospital-acquired infection rates could be used as a proxy of overall hospital patient safety," the report says.

The hospitals with good overall records on patient safety tended to have a "culture of safety," says Health Grades vice president of medical affairs **Samantha Collier**, MD. "A culture of safety requires rapid identification of errors and root causes, and the successful implementation of improvement strategies, which can only be achieved with strong leadership, critical thinking, and commitment to excellence."

The report calls for further dissemination of the results to the public. "For patients, it's important to know which hospitals meet this standard, as they are nearly 200% less likely to have an incident at hospitals in the top 10%," according to the study results. ■

Despite new technologies, drug-ordering errors persist

Errors in drug ordering, dosage, and monitoring that may have serious consequences for patients persist in hospitals even after the adoption of computerized medication systems, according to a recent study.

Several broad-based studies during the past 15 years have demonstrated that adverse drug events account for up to 41% of all hospital admissions and more than $2 billion annually in inpatient costs, according to the study. Many of these studies have also suggested that as much as a quarter of inpatient adverse drug events might be prevented through the use of computerized physician order entry (CPOE) and related computerized medication ordering and administrative systems.

Jonathan R. Nebecker, MS, MD, of the Veterans Affairs (VA) Salt Lake City Health Care System and colleagues conducted a daily review of the electronic medical records from a random sample of patients admitted to a VA hospital during a 20-week period in 2000 (*Arch Intern Med* 2005; 165:1,111-1,116). Because the VA Healthcare System is a leader in implementing multiple computerized interventions, including computerized physician order entry, bar code-controlled medication delivery, a complete electronic medical record, automated drug-drug interaction checking, and computerized allergy tracking and alerting, the authors suggest that a VA hospital offers an appropriate setting for testing the impact of computer systems on adverse drug events. Pharmacists used standardized criteria to classify adverse drug events.

Among 937 hospital admissions, 483 clinically significant inpatient adverse drug events were identified. An adverse drug event was considered clinically significant when a change in the patient's treatment plan was required. There were 52 adverse drug events per 100 admissions. One quarter of the hospitalizations had at least one adverse drug event. Nine percent of the adverse drug events resulted in serious harm; the other 91% were classified as moderate, requiring monitoring, interventions or discontinuation or adjustment of the dose of the problematic drug. The most common error types were failure to provide for expected adverse drug reactions — for example, prescribing potassium with diuretics to avoid a low potassium level (36%); failure to start or complete adequate monitoring for common adverse drug reactions (33%); and prescription of improper doses (33%) or inappropriate medications (7%).

The authors note that the computer system was successful in eliminating problems reading physicians' orders (transcription), but did not resolve the other problems associated with administering medication, drug selection, dosage, and monitoring.

Overall, the study found high rates of clinically important adverse drug events even after adopting CPOE. Nebecker says "purchasers of CPOE systems should not rely on generic CPOE and bar code medication administration systems alone" to dramatically reduce adverse drug event rates. Instead, health care organization should consider whether computerized medication systems offer decision support functions that address the most troublesome aspects of the medication administration process, he says. ■

Reader Question

Patient transfer from ED can raise EMTALA risk

Question: Our ED transferred a patient to a sister facility for evaluation to be admitted to the detox unit. This was not a doctor-to-doctor transfer.

The patient signed discharge paperwork from our ED, with the instructions that he go to detox. The other facility acknowledged receiving the fax of all his paperwork and said they would take him. An ED nurse called the other facility to give report to the one RN on duty there but could not reach her before the ambulance arrived to transport the patient.

The patient went ahead, and later our ED nurse got the other facility's nurse on the phone after calling four times. The other facility's nurse said the patient was already there, that he needed immediate treatment, and she accused our nurse of violating the Emergency Medical Treatment and Labor Act (EMTALA) for not giving a report before he arrived. It seems to me that there is no EMTALA violation since the patient was actually discharged and we just arranged transportation. But should I change any policy and procedure here?

Answer: You probably should change some policies and procedures, and you might need to have an inservice to refresh ED staff about EMTALA requirements, says **Ashley Adams Feldman**, JD, an attorney with The Phoenix Law Group of Feldman Brown in Scottsdale, AZ.

She works closely with health care providers now but previously was a prosecutor who brought charges against hospitals for EMTALA violations. She offers the unique — and hard-nosed — perspective of someone who frequently had to look at a situation and decide whether to pursue an EMTALA charge.

As to whether your ED staff violated EMTALA, Feldman says there is room for argument but as a prosecutor she probably would have considered you in violation. From the description of the incident, Feldman says it sounds like the patient may not have been stable enough for the type of transfer that happened. The statute requires that the facility making the transfer have contact with the other facility before the patient is actually moved. In this scenario, they never got in touch with anyone to discuss the patient's condition, and successfully faxing the paperwork doesn't count for fulfilling that obligation, she says.

"I realize that the patient was discharged and that may have led the hospital to believe they didn't have any more responsibility for that patient, but it sounds like there was something going to make the other facility think something was wrong. Either he was not stabilized or he was deteriorating in some way," Feldman says. "The law doesn't have anything to say about discharging a patient and that making everything okay. Under the rule, you simply cannot transfer a patient who is not stabilized, whether that patient has been discharged or not."

If the physician at your facility determined the patient was stable, the physician at the other end apparently disagreed.

"It sounds like it may have been a wrongful discharge," she says. "You want to be overly cautious because the penalties associated with EMTALA are so severe. If you're not sure whether a patient's condition is deteriorating, it's better to be safe than sorry."

Feldman acknowledges that the medical decisions regarding when a patient is stable can be difficult, and individual physicians will disagree. But nevertheless, she advises educating your ED staff about what EMTALA requires in terms of stabilization. The ED should have a protocol in place that requires contacting the other facility before the transfer, with clear documentation that receiving facility has been informed and has *accepted* the transfer.

The real problem in this scenario may be that the ED staff were led astray by the idea that the patient was discharged and that they were arranging transfer to the detox unit almost as a courtesy and nothing more.

"When you take on the responsibility of effecting that transfer, you are taking on the responsibility of meeting all the EMTALA obligations," Feldman says. "Even if the patient has been discharged, if you are going to in any way assist with that transfer you need to contact the other party, confirm the transfer, make sure they accept the transfer, and then send those records along with the patient."

With fines of $50,000 per incident possible, Feldman says risk managers should ensure their

COMING IN FUTURE MONTHS

- More advice on safe e-mail use
- CPOE cuts hospital's adverse drug events 75%
- Reducing falls in pediatric units
- How to assess your program for weaknesses

policies always require staff to be super strict with EMTALA requirements. "With fines like that, it's foolish to play too close to the line," she says. ■

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 management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and other hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

CE Questions

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

1. What does Mark Coel, JD, advise regarding e-mail in health care?
   A. It is acceptable for doctors to communicate with patients by e-mail as long they follow certain guidelines.
   B. It is never acceptable for doctors to communicate with patients by e-mail.
   C. Doctors should accept e-mail from patients but never respond by e-mail.
   D. Doctors can send information to patients by e-mail but should never read e-mail from patients.
2. What does Philip Rosenberg, JD, suggest regarding consent for e-mail use?
   A. Consent from the patient is not necessary.
   B. Consent is necessary only if the patient seems uncomfortable with communicating by e-mail.
   C. Consent is necessary only when discussing potentially sensitive topics by e-mail.
   D. Consent should be obtained from any patient wishing to communicate by e-mail, and the consent should hold the provider harmless from any resulting breach of confidentiality.
3. What does Susan McLaughlin, MBA, CHSP, MT(ASCP)SC, advise risk managers to do regarding the risk of surgical fires from alcohol preps?
   A. Nothing
   B. Prohibit the use of alcohol preps
   C. Require that drapes be placed over the patient immediately after the alcohol prep is applied.
   D. Educate OR staff about the need for a time out to allow the alcohol prep to dry before drapes are applied.
4. What does Ashley Adams Feldman, JD, recommend regarding EMTALA?
   A. ED staff must contact the other facility before transferring a patient, and the other hospital must accept the patient before the person is transferred.
   B. It is not necessary for ED staff to contact the other facility before beginning the transfer.
   C. ED staff should try to contact the other facility but it is acceptable to continue with the transfer if there is no answer.
   D. ED staff should contact the other facility only if the patient is unstable at the time of transfer.

Answers: 1. A; 2. D; 3. D; 4. A.

Healthcare Risk Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely.** Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- O A. risk manager
- O B. risk management director
- O C. vice president
- O D. director/manager of quality
- O E. medical director
- O F. director of nursing
- O G. other _____

2. What is your highest degree?

- O A. LPN
- O B. diploma (3-year)
- O C. BSN
- O D. BA
- O E. BSN
- O F. MSN
- O G. JD
- O H. master's
- O I. PhD
- O J. other _____

3. What is your sex?

- O A. male
- O B. female

4. What is your age?

- O A. 20-25
- O B. 26-30
- O C. 31-35
- O D. 36-40
- O E. 41-45
- O F. 46-50
- O G. 51-55
- O H. 56-60
- O I. 61-65
- O J. 66+

5. What is your annual gross income from your primary health care position?

- O A. Less than $30,000
- O B. $30,000 to $39,999
- O C. $40,000 to $49,999
- O D. $50,000 to $59,999
- O E. $60,000 to $69,999
- O F. $70,000 to $79,999
- O G. $80,000 to $89,999
- O H. $90,000 to $99,999
- O I. $100,000 to $129,999
- O J. $130,000 or more

6. Where is your facility located?

- O A. urban area
- O B. suburban area
- O C. medium-sized city
- O D. rural area

7. In the last year, how has your salary changed?

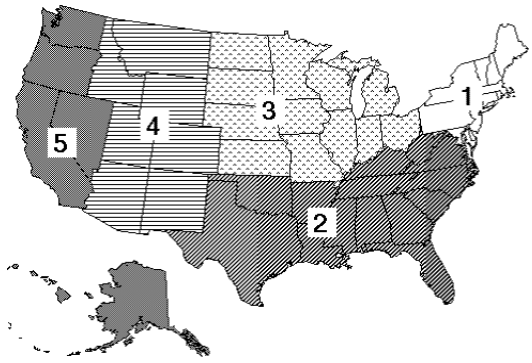
- O A. salary decreased
- O B. no change
- O C. 1% to 3% increase
- O D. 4% to 6% increase
- O E. 7% to 10% increase
- O F. 11% to 15% increase
- O G. 16% to 20% increase
- O H. 21% increase or more

8. What is the work environment of your employer?

- O A. academic
- O B. agency
- O C. health department
- O D. clinic
- O E. college health service
- O F. consulting
- O G. hospital
- O H. private practice

9. Please indicate where your employer is located.

- O A. region 1
- O B. region 2
- O C. region 3
- O D. region 4
- O E. region 5
- O F. Canada
- O G. other



10. Which best describes the ownership or control of your employer?

- O A. college or university
- O B. federal government
- O C. state, county, or city government
- O D. nonprofit
- O E. for profit

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11. How long have you worked in risk management?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

12. How long have you worked in health care?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

13. Which certification best represents your position?

- O A. ARM
- O B. CHPA
- O C. FASHRM
- O D. MSM
- O E. DFASHRM
- O F. other _____

14. How many hours a week do you work?

- O A. less than 20
- O B. 20-30
- O C. 31-40
- O D. 41-45
- O E. 46-50
- O F. 51-55
- O G. 56-60
- O H. 61-65
- O I. 65+

15. If you work in a hospital, what is its size?

- O A. <100 beds
- O B. 100 to 200 beds
- O C. 201 to 300 beds
- O D. 301 to 400 beds
- O E. 401 to 500 beds
- O F. 501 to 600 beds
- O G. 601 to 800 beds
- O H. 801 to 1,000 beds
- O I. >1,000 beds
- O J. I don't work in a hospital

Deadline for Responses: September 1, 2005

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, Thomson American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.

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

Latex used despite known allergy — cysts develop: $3.75 million GA verdict

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

News: Prior to surgery, a patient informed the hospital of her allergy to latex. Despite this warning, a latex catheter was used and she subsequently developed interstitial cystitis. She brought suit against the health care providers and was awarded $3.75 million in damages.

Background: Upon admission to the hospital for abdominal surgery, the 53-year-old woman advised the hospital that she was allergic to all latex products. Though the surgery required she be catheterized, a latex catheter was inserted into her bladder. The patient suffered an allergic reaction and she subsequently developed interstitial cystitis, which rendered her disabled and in constant pain.

Although the defendant hospital admitted that the latex catheter was used after notification of the allergy, it proceeded to defend the case claiming that the reaction could not have caused her interstitial cystitis. The jury sided with the plaintiff and awarded her $3.75 million in damages.

What this means to you: "Latex allergies were rare, if not unheard of, until the last 20 years or so. As time progresses, the incidence of recognized latex allergies increases. Sometimes these allergic reactions are misdiagnosed and sometimes the diagnosis is a reaction to soap or powder rather than to latex. In the health care arena, the allergic reactions are usually attributed to the latex gloves commonly used by health care workers, where the distinction between dust, powder, and latex may be muted. For instance, the powder in the gloves can carry the latex molecule, which is why air ducts must be periodically cleaned in areas where powdered latex gloves are used. Regardless of the source of exposure, some latex allergies are so severe they result in death, and so providers beware," says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, CHT, past president of the American Society of Healthcare Risk Management, and director of risk management services for the Miami Jewish Home and Hospital for the Aged in Miami.

The prevalence of latex allergies in the health care setting is recognized as a risk to employees and patients, "so much so that some organizations have banned any type of balloon except the foil type because of the latex and other types of risks. Many health care organizations have converted to powderless gloves or to a latex-free environment throughout. As a part of this initiative, hospitals and ambulatory surgery centers have set up latex-free carts and processes as they relate to surgery and patients with known latex allergies," she notes. "In the case at hand, the patient notified staff and the organization upon admission of her allergy to latex, and it is standard practice that the medical record is clearly and visibly noted with any reported or known allergies and for the patient's arm band to be noted as well. In the case of a patient with a known latex allergy, other notices may be posed

on the door and in the room since so many common everyday products have latex.

"Typically when a facility is aware of a patient's latex allergy, surgery is usually scheduled as the first case of the day in a room that has been prepared to deal with a patient with a latex allergy. The preparation commonly includes terminal cleaning of the room and cleaning of the room's air ducts prior to the scheduled surgery. Usually operating rooms have latex-free carts made up with latex-free equipment normally used in surgeries, including latex-free catheters, tape, and other materials. Some things are made only latex free, such as NG tubes and ET tubes," notes Kicklighter.

"When a patient presents with a known allergy, and that condition is apparently duly noted but for some reason not considered in the care of the patient resulting in an untoward outcome, it warrants a root-cause analysis to identify what happened, why and how to prevent recurrence," she says.

"What this means to risk management is to revisit this issue in your own institution to verify that there are policies and procedures in place, to deal with, not only latex allergies, but all reported allergies" notes Kicklighter. "Particular emphasis should be placed on how patients with known allergies are identified and how the medical record is notated. A validation audit should be conducted to verify that staff and the physicians are aware of their duty to inquire and to address any known allergies of a patient and follow-up so that the information is actually reviewed so appropriate preparations are made," says Kicklighter. "As it relates in particular to latex allergies, it would be prudent to conduct inservice sessions with all employees as to the significance of this particular allergy in the face of so many products that are used in everyday life that are made of latex. The operating room staff should [have inservice training] regarding the process for doing surgery on patients with latex allergies, and policies and procedures governing these cases should be revisited.

"If the organization does not have a task force to address latex allergies, consideration to implementation of one should be given. Latex allergies affect employees as well as patients and all areas are risks to the human factor and the organization. The operating room policies, procedures, and practices undertaken when a patient with a latex allergy is scheduled for surgery should be revisited and modified as necessary in light of this type of situation. In addition, the department of surgery should be encouraged to establish a task force focusing on latex allergy and educational programs for continuing medical education should be arranged," adds Kicklighter.

"Risk management should verify that the employee health program has established a process to obtain information of known allergies or initial post offer employee processing and annually thereafter, with particular emphasis on latex allergies. The medical director of the employee health program should become well educated in this condition and be involved in this process. Because of the frequency of misdiagnosis of true latex allergies, when an employee indicates they are allergic to latex, further information should be obtained. This sometimes may require the employee health physician to make contact with the employee's physician to discuss the diagnosis. Depending on where the employee is assigned to work, if possible, a latex-free work area will need to be developed, or the employee reassigned," says Kicklighter.

"If a particular organization has not yet evaluated the risks, costs and benefits of a powder-less or latex free environment, it should be considered. Risk management should lead the evaluation task force. In addition, OSHA has established latex allergies as one area of emphasis as it relates to the workplace. Risk managers should become educated about the risks of latex allergies and be

familiar with all rules and regulations relating to latex allergies in particular," notes Kicklighter. "It would appear that this organization was lucky this patient did not have an anaphylactic reaction to the latex in the urinary catheter."

Reference

• DeKalb County (GA) Superior Court, Case No. 020CV-7285. ■

Trip over vacuum cord leads to a $150K award

News: A patient tripped and fell over a vacuum cord after he had been discharged from the hospital, dressed, and was walking toward the nursing station to retrieve his valuables. He was readmitted for surgery to repair his torn medial meniscus. He sued the hospital and its cleaning service and was awarded $150,000 in damages.

Background: A 52-year-old retiree had been an inpatient in the hospital for six days to receive treatment and observation for severe abdominal pain. He had been given his discharge papers, was dressed in regular street clothes and waiting for his ride home. While waiting, he remembered that $300 in cash and his wristwatch had been taken from him at the time of admission. He inquired about his belongings at the information desk and was told that they were being held at the nursing station.

As he approached the nursing station, he noticed that a cleaning service employee was vacuuming the hallway. The person vacuuming had plugged the vacuum cord into an outlet near a corner of the hallway. He was vacuuming at the other end and so the cord was lying on the carpet across the hallway. The former patient claimed that the worker was vacuuming approximately 25 feet away from the outlet and had his back to the hallway down. The patient reported that just as he stepped over the cord, the worker pulled the cord off the floor, causing him to trip, fall, and injure his knee.

After the injury, the discharge from the hospital was canceled and he was readmitted to undergo surgery to repair the torn medial meniscus in his knee. Once discharged for the second time, the patient brought suit against the hospital and its cleaning service alleging premises liability and negligence.

The plaintiff contended that the defendants were negligent in creating a dangerous condition for patients as well as former patients, employees, and visitors. He argued that the worker who had been vacuuming admitted that he felt a pull on the cord of the vacuum he was handling and then turned around and saw the patient on the floor. However, the defendants contended that the patient tripped on purpose and/or had faked the fall and that the fall could not have happened as the patient described. The hospital and cleaning service also claimed that the patient only suffered a knee bruise. Despite these allegations, the patient maintained that he suffered multiple tears of the left medial meniscus, which required arthroscopic surgery and three months of intensive outpatient physical therapy. He also claimed that the injury worsened to the point that he was forced to use a cane and wear a knee brace to walk. His orthopedic surgeon testified that the fall caused the injury requiring surgery.

The jury awarded the plaintiff $150,000. The cleaning service was found to be 30% liable and the hospital 70%.

What this means to you: Several risk exposures are evident in this scenario that should concern the risk manager of any organization.

"The first is to remember that while the facility might contract for a service such as housekeeping, all the risks and responsibilities of that contract entity are not transferred and the facility may remain ultimately responsible for the contracted services," says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, CHT, past president of the American Society of Healthcare Risk Management, and director of risk management services for the Miami Jewish Home and Hospital for the Aged in Miami.

"It would be my argument that there are standards of practice even related to housekeeping tasks. For instance, it is a standard of practice that when mopping or buffing a floor, only one side is to be mopped or buffed at a time, and caution cones are to be placed along the center of the hallway to keep traffic off the freshly mopped side. Such standards relate to the use of extension cords and would apply to vacuum cleaner or other equipment cords as well," she notes.

"Another question comes to mind as to the method of transportation of this patient out of the hospital. Was the patient transported by

wheelchair to his ride home? That is the usual practice. Does staff usually wait until the ride arrives or wait until the ride is there to even take the patient to the front door? This might be an area risk management should explore to verify the policy against the practice regarding the mode of transportation of discharged patients. If this patient was being transported by wheelchair, where in the continuum to the front door did he remember his belongings and why was he allowed to go back to the unit on his own power?" Kicklighter asks.

"The risk manager might also want to look into the policy compared to actual practice as it relates to the steps of the discharge process," she adds. "In particular, it would seem that to check for and return all personal items and valuables that have been secured for a patient on admission would be a standard component of the discharge process. Had that been done in this situation, the need for the patient to return to the unit to retrieve his personal belongings and valuables would have been avoided. In some facilities, the personal valuables and monies are logged into, maintained by and released by the cashier rather than put this burden on the nursing unit staff. The facility may want to consider transferring this function to another area if it is assigned to the nursing unit.

"Even though the hospital has contracted with a third party to do the housekeeping tasks, the organization is still responsible for oversight. The oversight provisions should be contained in the contract; specifically the requirement should read that all contractor's staff will be educated in safe practices including equipment power cords. We must remember, while a facility doesn't directly and actually *do* certain things, those things are done within the confines of the building, and the organization has the obligation to see that standards are met. The principle is the same for as relates to agency staff or private duty staff; the organization is still ultimately responsible for the care of the patient," adds Kicklighter.

"While it sounds like this call might have been an accident, a person moving a power cord just as someone was stepping over it, the issue here is that it is in a hospital. Risk management should meet with the housekeeping supervisor to review policies and practices, whether written or not, especially as it relates to power cords. For instance, common sense would dictate that one should not extend a cord across a corridor; in the event it is absolutely necessary, a caution cone should be placed over the cord. Hospitals have many electrical outlets along the hallways, and right inside the patient rooms, therefore there should not be a need to run an electrical cord down a hallway. The practice should be to vacuum in segments and move the cord to coordinate with that segment where vacuuming," she notes.

"This type of situation is a recognized potential safety hazard. This is one that staff should be sensitive to when observed and be empowered to correct on the spot. This is an area that risk management might wish to explore with the patient safety officer and safety officer in that this hazard could be a potential accident for an employee, visitor or another patient. The use of extension cords is a recognized hazard; equipment power cords pose the same hazard and should be recognized as a hazard and addressed. A hazard for one stakeholder is a likely hazard for any other stakeholder or client," concludes Kicklighter.

Reference

• Los Angeles County (CA) Superior Court, Case No. BC238434. ■