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IN THIS ISSUE

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'Just culture' model called better, allows discipline for reckless behavior

No-punishment method can hamper error reduction

(Editor's note: This month's Healthcare Risk Management *includes the first of a three-part series on the "just culture" approach to improving patient safety. This month's issue includes stories on how the just culture approach works and some potential problems with implementation. Next month,* HRM *will include tips for implementing a just culture, the types of behavior that can result in discipline, and the criteria for deciding when to punish an employee. The following issue will include a report on one hospital's experience in adopting a just culture.)*

The popular belief that a nonpunitive approach will reduce errors and not get in the way of proper discipline of employees is being challenged by new research that suggests the tactic may not be entirely compatible with efforts to improve patient safety.

The surprising research results were presented at the recent annual meeting of the American Society for Healthcare Risk Management by **Geri Amori**, PhD, ARM, FASHRM, a consultant with The Risk Management & Patient Safety Institute (RM&PSI) in Lansing, MI, and past president of

EXECUTIVE SUMMARY

Attempts to promote patient safety with a "nonpunitive" approach may pose significant problems for risk managers. A "just-culture" approach that allows punishment in some circumstances may be a better alternative.

- Recent survey results show that risk managers have difficulty implementing the nonpunitive approach.
- Promising not to punish employees can prove unrealistic and undermine trust in administration.
- Employees often respond negatively when they think even reckless behavior will not be punished.

the American Society for Healthcare Risk Management (ASHRM), and **Margaret Curtin**, CPH, also a consultant with the institute. They reported the results of an RM&PSI survey of risk managers at 30 hospitals selected randomly nationwide, of which 80% have nonpunitive policies intended to promote greater reporting of potential safety issues.

One of the questions in the survey asked the participants to respond to this statement: "A nonpunitive culture has been described as blame-free by many. Has this complicated the overall error handling in regard to accountability determination and action?" Forty-five percent of the respondents said yes, 24% said they weren't sure, and 31% said no.

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Editor: **Greg Freeman**, (770) 998-8455.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (lee.landenberger@thomson.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

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

When asked how the nonpunitive approach has complicated error handling, the respondents cited several problems. The policy must still include accountability for carelessness, and there can be inconsistency in handling errors and disciplinary actions, they said. "They also reported that staff show disregard for rules and policies because they think they won't be disciplined for their actions," Amori says. "Plus, some respondents pointed out that the policy is still punitive in many instances, even when you call it nonpunitive."

Amori says the nonpunitive approach is rooted in the right philosophy, which is the idea that fixing the systemic errors that threaten patient safety is more important than punishing a single staff member, and that the fear of punishment can discourage people from coming forward with trouble reports. But in practice, she says, the nonpunitive approach brings its own problems, she says.

Follow-through can be a big problem with the nonpunitive approach, she says. Trust issues can develop if disciplinary action is taken when risk managers say it won't be used, she says, so you have to really commit yourself to a nonpunitive approach 100%, or the concept falls apart. Unfortunately, many organizations have difficulty with that when they are faced with a difficult situation in which it seems punishment is justified, she says.

"With nonpunitive, people think they can get away with anything, that there are no ramifications for any behavior," Amori says. "With 'just culture,' you are held accountable for things that you can control, but not for things that are rightly the responsibility of the system." **(For more on the nonpunitive approach and why some adherents say it can work well, see *Healthcare Risk Management*, April 2004, p. 43.)**

Blame game not good either

Curtin and Amori advocate a just culture approach as a sort of middle ground between the nonpunitive approach, which the survey results suggest isn't all it has been touted to be, and the old "blame and shame" management style that nearly everyone agrees discouraged the reporting of errors and patient safety concerns.

A just culture model is based on some of the same ideas as a nonpunitive approach, but it allows for situations in which a staff member recklessly or willfully disregarded policies intended to protect the patient, Curtin explains. In that way, it can be a more realistic way to encourage open reporting, one

SOURCES

For more information on adopting a just culture approach to patient safety improvement, contact:

- **Geri Amori** and **Margaret Curtin**, The Risk Management and Patient Safety Institute, 6215 W. St. Joseph Highway, Lansing, MI 48917. Telephone: (517) 703-8464.

that won't put the manager in a frustrating position when an employee is clearly in the wrong, she says.

Like a nonpunitive approach, a just culture is based on the idea of transparency and encouraging the free and open communication and reporting of errors and patient safety issues. Rather than immediately blaming the staffer who is caught with the wrong drug syringe, for instance, the hospital with the just culture would investigate the systemic failures that allowed her to inject the patient with the wrong medication.

The just culture also views near-misses and events as opportunities and it acknowledges that punishment — the old-fashioned way of punishing whoever happened to be the person who committed the error, no matter what systemic problems encouraged it — can drive reporting underground. "The just culture still encourages managers to look further upstream in an organization for the origin of the error," Curtin says. "But it is not a no-blame culture, because that is not feasible or desirable. A blanket amnesty on all unsafe acts would lack credibility."

That is the key difference between a nonpunitive approach and a just culture, Amori and Curtin maintain. Employees want to know that they will not be punished for reporting an error, but they lose respect for a management style that is *so* reluctant to blame anyone that a reckless or willfully negligent co-worker is not held accountable. A just culture creates a line between acceptable and unacceptable behavior and draws a distinction between an honest mistake and a more willful act of disobedience, Curtin explains.

Reckless behavior is over the line

So if the basic idea of a just culture is that you encourage employees to report concerns without fear of punishment, yet you still reserve the ability to punish those who truly require discipline, how do you know where to draw the line? Amori says there are some rules of thumb to follow.

First, you don't discipline all employees who disregard safety policies or threaten patient safety. That's too broad a category without drilling down further into what prompted the employee to act that way. The just culture requires a recognition that professionals will make mistakes and that even professionals will develop unhealthy habits and standards that can threaten patient safety. "Those are the things you don't punish, but you do take the steps to correct the problems," Amori says. "But at the same time, a just culture requires a fierce intolerance for reckless conduct."

To encourage a just culture, the risk manager must distinguish between negligence and reckless behavior, Amori says. Risk management and human resources policies must make that distinction clear, she says. Be sure to include language in the policy's purpose statement that describes the organization's support of a just culture and the employee's responsibility for recognition, reporting, and participation in the improvement of patient safety related issues. The policies also should include definitions of near miss or good catch, an event or variance, sentinel event, and other possible scenarios. **(See article, below, for more advice on how to introduce a just culture.)** ■

Defining reckless behavior hard with just culture

The difficult part of adopting a "just culture" philosophy may be defining exactly what constitutes reckless and willful behavior, says **Grena Porto**, RN, ARM, DFASHRM, a health care risk manager and principal with QRS Healthcare Consulting in Hockessin, DE, and past president of the American Society for Healthcare Risk Management.

Porto acknowledges that risk managers who embrace a nonpunitive approach can face dilemmas when an employee seems to be willfully and wantonly defying safety procedures, but she says it can be difficult to reach that conclusion with confidence. Porto gives the example of a night shift nurse who repeatedly fails to call physicians with important questions or patient updates, despite being warned to do so and with no apparent reason not to. Under a just culture, that behavior might be deemed willful and reckless, justifying discipline.

SOURCE

For more information on possible difficulties with the just culture approach, contact:
- **Grena Porto**, QRS Healthcare Consulting, 7454 Lancaster Pike, No. 301, Hockessin, DE 19707. Telephone: (302) 235-2363.

"But if you keep digging, you might find out that she didn't call because physicians consistently yell at nurses for waking them at night," Porto says. "The nurse didn't want to cite that as the reason because she might appear weak or not a team player," she explains. "So, what at first seemed like a willful and reckless behavior actually has a systems cause, and you're not achieving anything by punishing the nurse," Porto says.

She doesn't disagree, necessarily, with the just culture advocates who say there will be some situations in which the employee acts recklessly, with full awareness of the potential danger to the patient, with no systems component. But Porto contends that those situations are so rare that they don't justify abandoning the nonpunitive approach.

She's concerned that the just culture approach uses the term "willful" a little too liberally. "That's where this philosophy can fall apart," Porto says. "Just because someone does something willfully doesn't mean there isn't more to the story, more to the explanation about why the person willfully chose to do something that violates the rules." ■

System settles charity suit, and other payouts likely

The recent settlement of the Scruggs charity care lawsuit by a prominent West Coast health system means that more are probably on the way, says **Bryan Liang**, MD, PhD, JD, a professor of law, medicine, and public policy, and executive director of the Institute for Health Law Studies at California Western School of Law in San Diego.

The lawsuits filed nationwide in 2004 charge that nonprofit hospital systems and hospitals have failed to provide government required charity care to uninsured patients. There are 60 lawsuits against hospitals and health systems, covering hundreds of facilities, the plaintiffs' attorneys report. **(For more information on the lawsuits, see *Healthcare Risk Management*, September 2004, p. 97.)**

Providence Health System in Portland, OR, recently announced a settlement in a lawsuit filed in December 2004 that questioned Providence's charity care practices and billing policies. The agreement reached with plaintiffs in the case is one of the first settlements among scores of similar lawsuits filed around the country challenging charity care standards and billing and collections practices affecting uninsured patients at dozens of large nonprofit hospitals, says Providence chief executive **Russ Danielson**.

"While we disagree with the allegations made in the lawsuit, settling it made sense to avoid the tremendous costs associated with a trial and allow us to focus on our mission," he says. "The content of the settlement affirms our efforts over the past several years to make our charity care and financial assistance policies clearer and more consistent."

Settlement retroactive three years

Danielson says under terms of the settlement, Providence's current charity care policies will be applied retroactively to supplement the charity care previously made available to uninsured patients who obtained care at Providence hospitals in Oregon over the last three years. The system's current charity care policies provide financial assistance for uninsured patients with limited assets and incomes at less than 400% of the federal poverty level. Patients with limited assets earning 200% or less of the federal poverty level pay nothing.

EXECUTIVE SUMMARY

A major health system in the Northwest has settled a lawsuit claiming that it misused charity care funds and overcharged indigent patients for care. Legal observers say the agreement may herald more settlements among the 60 pending across the country.
- The health system decided settling was better than spending more on the lawsuit.
- The settlement includes a retroactive provision going back three years.
- Protecting your public image should be a major concern.

SOURCES

For more information about the charity care lawsuits and how to protect your organization from similar allegations, contact:

- **Brian Campf**, Williams Love O'Leary Craine & Powers, 9755 S.W. Barnes Road, Suite 450, Portland, OR 97225. Telephone: (503) 295-2924.
- **Russ Danielson**, Chief Executive, Providence Health System, 4805 N.E. Glisan St., Portland, OR 97213. Telephone: (503) 215-1111.
- **Bryan Liang**, Institute of Health Law Studies, California Western School of Law, 350 Cedar St., San Diego, CA 92101. Telephone: (619) 515-1568. E-mail: Baliang@alum.mit.edu.
- **John Phillips**, The Phillips Law Group, 315 Fifth Ave. S., Suite 1000, Seattle, WA 98104-2682. Telephone: (206) 382-6163.
- **Richard F. Scruggs** and **Sid Backstrom**, The Scruggs Law Firm, 120A Courthouse Square, P.O. Box 1136, Oxford, MS 38655. Telephone: (662) 281-1212.

Providence also offers to discount billings for all uninsured patients, regardless of their income, to the same "preferred provider" rates paid by most of its insured patients. Providence's charity care policies adjust uninsured patients' personal responsibility for their hospital bills based on their individual financial circumstances, assets, and income.

Providence also has agreed to continue to make information about how to access its financial assistance programs available to all patients and will continue to work with patients individually to offer financial help that takes into account the individual patient's ability to pay. Under some circumstances, Providence also will forgo interest on debts.

Avoiding a long court war

Danielson says the settlement was a pragmatic move that allows the organization to focus on providing care to the needy instead of fighting a lengthy court battle. "Given our values, we feel it was more important to use our resources for the good of our communities instead of expending them in costly litigation," he says.

John Phillips, JD, lead attorney for the plaintiffs, says the settlement restores some fairness to the system for uninsured patients at Providence. "Other hospital systems continue to fight these suits and fail to appreciate that charging uninsured patients more than anyone else makes no sense morally or economically, and is clearly indefensible — especially for a nonprofit hospital system," Phillips says. **Brian Campf**, JD, one of the Oregon attorneys representing the uninsured plaintiffs in the case, called the Providence settlement historic and added that it "levels the playing field between a powerful hospital system and the uninsured whose rights are too often overlooked and whose voices are too often unheard."

Sid Backstrom, JD, of the Scruggs Law Firm, praised the Providence move and said that other hospitals should take the same step. "From the beginning, Providence expressed its interest in leading the way for fair treatment of the uninsured. Other hospitals around the country should take a hard look at this resolution and do what is morally right," he says. "Clearly, investing a huge amount of resources to fight these cases will ultimately be a losing formula for these hospitals. This issue, when exposed to the decent working people of America on juries all over the country, will incite outrage at the hospitals, and justice will certainly prevail."

Likely more to follow

Liang says he expects more hospital systems to follow in Providence's foot steps and settle their cases.

"People are going to start to settle these things because the costs are racking up," he says. "All the state cases are a little different, and no two hospitals are looking at exactly the same situation, but when a large system like Providence settles, that has to give momentum to the plaintiffs and make the other hospitals look harder at that option."

Settlements can start to look like a good option if you think the lawsuits are starting to hurt your public image, Liang says. He suspects that concern was a driving force in the Providence settlement. Plus, the image of your organization can determine whether this type of lawsuit is ever brought against you in the first place.

"If your community sees you as a facility that is basically raping the uninsured consumer, then you are going to be seen as a big corporate behemoth that needs to be taken down," he says. "But if you are seen doing good things for people in the community, people aren't going to feel it necessary to go after you. Your public image is everything." ■

Look closely at EMTALA in light of Scruggs suits

Allegations of Emergency Medical Treatment and Labor Act (EMTALA) violations as part of the charity care lawsuits should prompt risk managers to take yet another hard look at how their emergency department staff discuss payment with patients, says **Bryan Liang**, MD, PhD, JD, a professor of law, medicine, and public policy, and executive director of the Institute for Health Law Studies at California Western School of Law in San Diego.

Watch for systems and procedures that skate a little too close to the edge of what's allowed and what's not. For example, look for practices in which the staff wait until the examination is under way or just finished, and then they go to the patient with paperwork and start discussing finances. That discussion does not happen before stabilization, so technically it probably wouldn't be a violation, Liang says. But it's so close that it can look like coercion.

"Any appearance of impropriety can invite a closer look and fines," he says. "With the lawsuits creating this atmosphere of closer scrutiny, you don't want to play it that close to the edge."

To be safe, Liang recommends waiting until the patient is discharged before asking about a payment plan or other options. Your collections department may not be crazy about that strategy because some patients may be eager to get out the door instead of talking finances, but Liang says it is the risk manager's job to contradict those optimal collections practices when they put the organization at risk.

"Risk managers have a responsibility to say that optimizing revenue can't always be the main concern, no matter how important that can be to the organization," he says. "That attitude can lead to serious risks down the road." ■

Partnering with patients, family can improve safety

Partnering with patients and family members can provide dramatic new insight into patient safety issues and directly reduce medical errors, according to the experience of Dana-Farber Cancer Institute in Boston. The hospital has used a formal Patient and Family Advisory Council (PFAC) for seven years and reports that it consistently reveals patient safety issues and solutions that might not have been raised by health care professionals.

Dana-Farber formed the PFAC when the hospital was merging its cancer center with that of Brigham and Women's Hospital, a merger that understandably made patients and family members nervous about continuity of care and patient safety. The PFAC started out as a way for them to voice their concerns and influence how the merger took place, and then it took on an important patient safety role, says **Maureen Connor**, RN, MPH, vice president for quality improvement and risk management at Dana-Farber.

"This partnership with patients and families can transform your organization in ways you can't even imagine," she says. "This is led by patients, not administrators at Dana-Farber. It is for patients and by patients."

There are at least 15 members of the PFAC at any time, and members serve terms of one to three years. Dana-Farber recently started a pediatric council also. The purpose of the councils is to include patients and family members in all discussions and decision making within the hospital that might affect them, Connor says. They are included in clinical oversight committees, care improvement teams, and education efforts for new employees and physicians in training. In addition, council members sit on the hospital's Joint Committee on Quality Improvement and Risk Management, a board-level committee comprising about 30 top executives.

The committee addresses sentinel events and other serious matters, with the council members invited to join in most discussions. That committee still holds executive sessions for some matters,

EXECUTIVE SUMMARY

A formal partnership with patients and family members can help an organization improve safety in ways that health care professionals can't do alone. Results from one hospital's experience show dramatic improvements.

- Input from laymen provides a new perspective.
- Patient safety rounds help uncover problems.
- Include a patient safety "champion" on each unit to improve results.

SOURCES

For more information on working with patients and families, contact:

- **Maureen Connor**, Vice President, Quality Improvement and Risk Management, Dana-Farber Cancer Institute, 44 Binney St., Boston, MA 02115. Telephone: (617) 632-4263.
- **Mary-Dana Gershanoff**, Adult Patient and Family Advisory Council, Dana-Farber Cancer Institute, 44 Binney St., Boston, MA 02115. Telephone: (866) 408-3324.

so PFAC members are not privy to all discussions. PFAC members are sometimes included in root cause analyses. "We also involve council members in our search committees, and all candidates for executive level positions should expect to be interviewed by a patient," Connor says. "That comes as a shock to some candidates."

Much of the PFAC members' input takes the form of a different perspective that might never occur to health care professionals. For instance, Connor says one committee recently was trying to solve a problem in the hospital with a solution that meant longer wait times in the clinic. The health care professionals dismissed the longer wait as just an unfortunate by-product, but the PFAC member spoke up and said it was absolutely unacceptable to extend the already lengthy wait time.

"The plan was changed on just that one patient's input," Connor says. "It makes a difference to have that person in the meeting with a different view."

The PFAC members' input affects quality of care, patient satisfaction, and patient safety, Connor says. These are some of the improvements stemming from PFAC input:

- Medication safety pamphlets were improved with more thorough and clear information and distributed to patients and family.
- Wait time has been reduced in some areas, with suggestions such as providing pagers to patients in some clinics so that they can be called just before the clinician is ready to see them.
- Disclosure of medical errors was made a higher priority by hospital leaders. Hospital leaders were motivated, in part, by hearing from families and patients who explained how withholding information made the adverse event worse.
- New signage was installed in elevator waiting areas explaining infection control procedures to patients and family.
- A pediatric PFAC member participated in the planning and design efforts for a clinic renovation.
- A separate eating area was established for pediatric patients, so that NPO patients did not have to see others eating the food brought in by parents and to lessen the risk of NPO patients getting to the food.
- The emergency department developed a special "Crowd Risk" protocol for children with leukemia and others who should not be exposed to others with contagious illness. Under this program, parents are given a Crowd Risk placard that allows them to park in front of the emergency department and take the child directly to a private room to await treatment.

One of the PFAC efforts most directly affecting patient safety is the introduction of "patient safety rounds," in which staff and PFAC members personally inquire about potential safety issues on each unit. **(See article, below, for more on patient safety rounds.)**

PFAC members must be adults and are selected based on their willingness to participate in various hospital activities and their ability to communicate clearly. They go through a general orientation and must sign the same confidentiality statement as hospital staff. The council members also undergo training for compliance with the Health Insurance Portability and Accountability Act.

Mary-Dana Gershanoff is a former breast cancer patient at Dana-Farber and has been a member of the PFAC since 2001. She says the members take the effort quite seriously and are not shy about providing input to the health care professionals who are used to making decisions for the patients. In addition, she has helped Dana-Farber by interviewing patients during patient safety rounds and role-playing the patient when staff were preparing to do similar interviews.

"We've seen that patients are eager to tell their stories if they can see that we are sincere in wanting to improve patient safety and their overall experience," she says. ■

Patient safety rounds help problem reporting

One of the most successful Patient and Family Advisory Council (PFAC) efforts at Dana-Farber Cancer Institute in Boston is the practice of "patient safety rounds," in which PFAC members

SOURCE

For more information on organizing a patient and family advisory council, contact:
- **Deborah Duncombe**, MPH, Risk Manager, Dana-Farber Cancer Institute, 44 Binney St., Boston, MA 02115. Telephone: (617) 632-3253.

and hospital staff make rounds on hospital units to inquire about any problems that may endanger patients.

Deborah Duncombe, MHP, is risk manager at Dana-Farber. She explains that the patient safety rounds are based on an infection control model of proactive surveillance for nosocomial infections. With PFAC's encouragement, the hospital began the patient safety rounds to get a better idea of what might be compromising patient safety.

"Patients know what is going on out there, and they know that there are more patient safety issues than what comes across your desk every day as the risk manager," she says. "Incident reports don't really tell us what is going on out there."

Duncombe leads the interdisciplinary team making the rounds, which always include a PFAC member. The team visits the unit and talks to any staffer they run into, asking, "Has anything happened today or recently that you think is an obstacle in providing safe patient care?"

The questions asked during the round are crucial to getting the right information, Duncombe says. People tend to think in narrow terms and only report specific medical problems if they are not prompted correctly. As the rounding went on, Duncombe developed more teaser questions to get at the big picture. These are some of the most effective:

- "So where do you think you will make your next mistake?"
- "What interrupts you? How do you control it?"
- "Do you have any standard work-arounds?"

Champion on unit improves results

Mary-Dana Gershanoff, a former breast cancer patient at Dana-Farber and a PFAC member, was involved with a recent Dana-Farber's study of how PFAC helped improve patient safety. She says one of most important findings was that including a staffer who is particularly interested in improving patient safety in each unit, a PFAC initiative, led to better results.

In one unit, adding a champion to the unit nearly doubled reports during patient safety rounds from 59 concerns in 11 rounds to 107 reports in 12 rounds.

"Having that one person on the unit who really believes in the cause encourages other people to speak up," she says. "It's amazing how much more you can achieve when one just person working on that unit is excited about the work." ■

Mandatory flu shots create dilemma for risk managers

Once again, clinical experts are debating whether it is necessary to require flu vaccinations for health care works but risk managers must look at the issue a little differently from infection control professionals and epidemiologists. For risk managers, the question comes down to which tactic is more likely to create a liability risk: requiring flu shots or not requiring them.

Either path carries risks, the experts say. Not requiring flu shots can lead to charges that you did not do everything necessary to prevent flu spread in your facility, where it can kill fragile patients. But requiring flu shots opens a Pandora's box of labor issues. While there is no definitive answer, some analysts suggest the safe path for risk managers is to adhere as closely as possible to any state requirements and the standard of care offered by the clinical experts. That is the advice from **Jeffrey Braff**, JD, an attorney with Cozen O'Connor in Philadelphia.

"The benefits of the vaccine are so great, with

EXECUTIVE SUMMARY

Mandatory flu vaccination programs are endorsed by some clinical experts, but the risk management implications can be complicated. Some analysts advise falling back on any state requirements and educating employees about the benefits of vaccination.
- Professional groups do not agree on whether mandatory vaccination is necessary.
- Even with a mandatory program, employees must be allowed some exceptions.
- Employer/employee relations can be strained by a tough flu shot policy.

medical authorities recommending vaccination so strongly, that I think risk managers would be well advised to adopt at least a very aggressive voluntary program if not a mandatory vaccination program," Braff says. "In terms of what puts you on the best footing for future liability, you probably should side with the medical authorities who are saying that vaccination helps save lives."

The problem is that the clinicians don't always agree on whether it is prudent to require vaccinations for health care workers. **(See the story on p. 10 for more on the debate.)** Because of that dispute and varying labor laws across the country, it can be difficult for employers to impose mandatory vaccinations, Braff says. Many opt instead for strongly persuading health care workers to obtain the vaccination, he says.

Even if you decide to have mandatory flu vaccinations, you must make exceptions for employees who cannot be vaccinated for health reasons or religious conflicts, Braff says. The employer is obligated to make a reasonable accommodation for that person, such as reassigning the employee to a position that does not involve patient contact.

"But if that person could not be accommodated, or if the person refuses vaccination without a legitimate reason, you could show a strong interest in requiring the vaccination and discharging that individual for their refusal," Braff says. "I think that should be sustained in the courts. Now whether that is a good idea for you in terms of employee relations is another thing to consider."

If you require flu shots, you could model the program after hepatitis B vaccination programs already in place, which usually include employee education, automatic vaccinations if there is no contraindication, and declination forms if the employee refuses, Braff says. It also is a good idea to notify employees at hiring that flu vaccinations are mandatory, he says. Then if the employee refuses without a good reason, you can use that as a defense in any labor dispute.

"You can point to the experts who say this is a good idea and show that you made this a condition of employment," he says. "I think then you would be on good footing to defend any claim of wrongful discharge."

Expect employee resistance

One health care analyst cautions that, no matter how much the folks in infection control tell you it's a good idea, you should expect some blowback from employees if you require vaccinations. Health care workers tend to be much more aware of the debate over the safety and effectiveness of flu vaccines, says **Nan Andrews Amish**, a health care management consultant on the faculty of the University of San Francisco. They may not be correct about their assumptions necessarily, but they will be more skeptical than the average person, she says.

"They do not believe in vaccines the way the rest of the population has been trained to believe," she says. "As a result, if organizations demand mandatory vaccination as condition of employment, there will be potentially wrongful termination suits by health workers who will provide testimony that they were required to put their life and health at risk to maintain their employment."

Also, Amish suspects that if a health worker reluctantly submits to the vaccine and subsequently gets a severe case of the flu, the employee may sue and claim the shot caused the illness. That is not possible with the flu shot, but Amish says that won't necessarily stop employees from filing a lawsuit. But the biggest risk, she says, is not lawsuits but the loss of scarce talent.

With shortages of nurses, physical therapists, and technicians at many health care institutions, Amish wonders how many might leave for institutions that do not have mandatory vaccination programs.

Another risk, she says, is the loss of management credibility if the flu shots turn out not to be necessary. She points to the resistance health employers faced when the government urged smallpox vaccinations for health care workers as a precaution for biological warfare.

"The program was scrapped because the health workers were unwilling to be vaccinated," she says. "I think you can expect the same kind of resistance if you try to force flu shots on people." ■

SOURCES

For more information on mandatory flu vaccinations, contact:

- **Jeffrey L. Braff**, JD, Cozen O'Connor, 1900 Market St., Philadelphia, PA 19103. Telephone: (215) 665-2048.
- **Nan Andrews Amish**, P.O. Box 2555, El Granda, CA 94018. Telephone: (650) 560-9800.

Experts debate pros, cons of requiring flu vaccination

Most experts agree that offering flu vaccinations is a good idea, but the issue of requiring them can stir up a debate.

A professional group that focuses on worker safety says mandatory shots are unnecessary for health care workers. The American College of Occupational and Environmental Medicine (ACOEM) in Elk Grove Village, IL, recently issued a position statement that falls squarely on the side of employees who resist mandatory vaccination efforts. **(Editor's note: The full position statement can be found on-line at www.acoem.org/guidelines/article.asp?ID=86. For more on the ACOEM position, see *Healthcare Risk Management*, November 2005, p. 131.)**

In that statement, ACOEM says it does make sense for health care employers to sponsor flu vaccination programs for employees and to encourage participation, but mandatory shots are a different matter. ACOEM points out that vaccinating employees does not prevent flu transmission to patients, who still will be exposed by friends and family.

ACOEM also notes that forcing employees to be vaccinated can harm the employer-employee relationship. The ACOEM position statement specifically cautions against requiring employees to sign a "declination statement," which signifies that they were offered the vaccine but refused. The declination statement is often seen as heavy handed and punitive by employees, ACOEM argues.

Best way to protect your staff?

On the other side of the debate is a hospital epidemiologist and flu expert who says mandatory vaccination of all health care workers is the best means of protecting patients and hospital staff from widespread outbreaks of the viral illness. **Trish Perl**, MD, MSc, an associate professor of medicine and pathology at The Johns Hopkins University School of Medicine in Baltimore, says mass vaccination policies are required to prevent patients from accidentally contracting the virus directly from an infected medical staff worker or indirectly from other patients or visitors via medical staff.

"We have gone as far as possible with vaccination programs emphasizing education and health promotion," Perl says. "It's now time to go the extra step, requiring active declination or even making vaccination a mandatory part of the job, linked to patient safety, along with such tasks as keeping hands clean and getting mandatory [tuberculosis] tests."

Perl says that hospital staff members tend to report that the most common reason cited for not getting a vaccination is a lack of time, and a surprisingly high number of staff members believe they could catch influenza from the flu shot, which is false.

How to make shots successful

To make a flu shot program successful, Perl recommends free shots for all staff, easy access to flu shot clinics on site, flexible vaccination hours, emphasis on patient safety aspects of the program, education to counter beliefs that the shots can make you sick, and encouragement from hospital leaders to get the vaccine.

Perl's position is backed up by the Association of Professionals in Infection Control and Epidemiology (APIC) in Washington, DC, which recently

SOURCES

For more information on flu vaccinations, contact:

- **Trish Perl**, Johns Hopkins University School of Medicine, Department of Medicine-Division of Infectious Diseases, Osler 425, 600 N. Wolfe St., Baltimore, MD 21287. Telephone: (410) 955-8384.
- **Sue Sebazco**, President, Association of Professionals in Infection Control and Epidemiology, 1275 K Street N.W., Suite 1000, Washington, DC 20005-4006. Telephone: (202) 789-1890. Web site: www.apic.org.

COMING IN FUTURE MONTHS

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endorsed mandatory flu vaccinations for health care workers who have direct contact with patients. In a statement, APIC president **Sue Sebazco**, RN, CIC, explained that it concerns APIC that "a mere 36%" of health care workers opt for vaccination. "Even those health care facilities that promote immunization through aggressive voluntary campaigns show that 30%-50% of health care workers remain unvaccinated," she said. ■

Doctors often ignore 'black box' warnings on drugs

The "black box" warning on medications is the health care system's strongest way to say, "Danger! Take extreme caution with this drug!" But a recent report suggests that your physicians might not be fazed by the warning.

In a study of approximately 930,000 ambulatory care patients, researchers from the department of ambulatory care and prevention at Harvard Medical School and Harvard Pilgrim Health Care in Boston found that 42% received prescriptions for drugs with black box warnings, and physicians' compliance with the recommendations of the warnings was highly variable.

The findings suggest that better methods are needed for ensuring the safe use of medications that carry serious risks, says **Anita Wagner**, PharmD, MPH, DPH, assistant professor in the department. In the categories studied, doctors' noncompliance with the black box warnings ranged from 0.3% to 49.6%. These results are reported on-line in the Nov. 18, 2005, issue of *Pharmacoepidemiology and Drug Safety*. *(Editor's note: See the study at www3.interscience.wiley.com/cgi-bin/abstract/112141666/ABSTRACT.)*

Wagner notes that in ambulatory care settings, approximately 1.4 billion prescriptions are written per year and until now, there has been no information about how frequently doctors prescribe black box warning drugs, nor whether prescribing is consistent with the warnings. "This study tells us that these drugs are prescribed often and that in some categories, prescribing is inconsistent with the warnings," she says.

To examine prescribing compliance, Wagner and her colleagues examined approximately 217,000 enrollees who had received at least one of 19 black box warning drugs. From this group, most noncompliance with warnings occurred when patients should have received lab tests as they began a medication; 49.6% of all prescriptions that should have been accompanied by a lab test at the onset of a prescription were not. Recommendations for pregnancy tests were most frequently not observed (for example, when women of childbearing age were given prescriptions for acitretin, which treats severe psoriasis).

On the other hand, warnings that indicated a medication was unsafe to take while pregnant had excellent compliance. Women of childbearing age received almost 79,000 prescriptions for black box warning drugs that should be avoided during pregnancy. Only 95, or 0.3%, may have occurred during pregnancy.

Wagner says the findings suggest that risk managers should review compliance with black box warnings and consider ways to improve it. Automated systems that warn the physician of a potential conflict with a black box warning can help, she says, as can any other method that prompts the physician on a case-by-case basis instead of trusting that he or she will realize the warning applies to that patient. ■

Correction

In the December 2005 *Healthcare Risk Management*, an article about criminal activity by hospital employees should have stated that **Kenneth N. Rashbaum**, JD, was familiar with the case of Charles Cullen, a nurse who pleaded guilty to the murders of 13 patients. Rashbaum's correct telephone number is (212) 422-0202. ■

CE instructions

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 semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

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

1. According to Margaret Curtin, CPH, what is a key way that the "just culture" approach is better than the "nonpunitive" approach?
   A. It allows discipline in situations in which a staff member recklessly or willfully disregarded policies intended to protect the patient.
   B. It eliminates all possibility that the employee will be punished as long he or she comes forward to report misbehavior.
   C. It is simpler for risk managers to administer in a large workplace.
   D. It creates less paperwork for the human resources department.
2. Which of the following is true of the just culture approach advocated by Geri Amori, PhD, ARM, FASHRM, a consultant with RM&PSI?
   A. Employees always are eligible for punishment if the patient was seriously injured by the misbehavior.
   B. Employees are never held accountable for misbehavior even if the patient was serious injured.
   C. Accountability is determined by the patient's outcome, but the employee is not always punished.
   D. Accountability is not determined by the patient's outcome or the level of harm.
3. According to Russ Danielson, why did Providence Health System settle the lawsuit regarding its charity care?
   A. It made sense to avoid the tremendous costs associated with a trial and allow the organization to focus on its mission.
   B. A recent court ruling practically guaranteed that the plaintiffs would prevail.
   C. The Providence defense counsel had exhausted all possible legal strategies.
   D. A mediator instructed the parties to settle immediately.
4. What is a main reason to conduct patient safety rounds, according to Deborah Duncombe, MHP, risk manager at Dana-Farber Cancer Institute?
   A. To comply with a directive from the Joint Commission on Accreditation of Healthcare Organizations.
   B. Patients know what is going on, and incident reports don't really tell you what all the patient safety issues are.
   C. The rounds are less expensive than other monitoring methods.
   D. More information can be collected with fewer staff involved.

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

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

Development of decubitus ulcers leads to death, $250,000 verdict in Ohio

By **Blake Delaney**
Buchanan Ingersoll PC
Tampa, FL

News: An 83-year-old nursing home resident developed severe decubitus ulcers. After the nursing home failed to treat the ulcers, they became infected, and the woman subsequently died. Although the decedent's family attributed the death to the infected decubitus ulcers, the nursing home claimed that her death was the result of underlying complications. The jury awarded $250,000 to the plaintiff.

Background: The plaintiff's decedent, aged 83, was admitted to the nursing home in June 2001. Three days later she was admitted to a hospital, but she was returned to the nursing home 11 days later. The nursing home subsequently discovered that the woman had developed severe decubitus ulcers on her feet and body.

Decubitus ulcers result from pressure being exerted on the skin, soft tissue, muscle, and bone by the weight of an individual against a surface beneath. In patients who are unable to avoid long periods of uninterrupted pressure over bony prominences, such as the elderly, neurologically impaired patients, and patients who are acutely hospitalized, the risk of necrosis and ulceration developing increases. In fact, two-thirds of pressure sores occur in patients older than 70 years of age; the prevalence rate in nursing homes has been estimated to be 17-28%. (Revis DR. *Decubitus ulcers.* Web: www.emedicine.com/med/topic2709.htm.)

Decubitus ulcers in nursing home patients often form from a constant compression of the tissues by an external force, such as a mattress, wheelchair pad, or bed rail. Irreversible changes may occur after as little as two hours of uninterrupted pressure. No surface of the body can be considered immune to decubitus ulcers if they experience long periods of uninterrupted pressure.

The most widely accepted classification system for staging decubitus ulcers is that of Shea, as modified to represent the present National Pressure Ulcer Advisory Panel classification system. This system consists of four stages of ulceration, but not all decubitus ulcers necessarily follow a standard progression from Stage I to Stage IV. Instead, the system describes the depth of a decubitus ulcer at a specific time of examination in order to facilitate communication among the various disciplines involved in the study and care of such patients.

Stage I ulcers are characterized by intact skin with signs of impending ulceration. Stage II ulcers demonstrate a partial thickness loss of skin involving epidermis and possibly dermis, possibly manifesting as an abrasion, blister, or superficial ulceration.

Stage III decubitus ulcers have a full thickness loss of skin, with extension into subcutaneous tissue (but not through the underlying fascia). Finally, Stage IV ulcers are characterized by a full thickness loss of skin and subcutaneous tissue and extension into muscle, bone, tendon, or joint capsule.

The plaintiff's decedent in this case exhibited

massive stage IV decubitus ulcers, which became infected after having been left untreated by the nursing home facility. Ultimately, the woman developed sepsis and subsequently died. Her estate brought suit against the nursing home, claiming that steps should have been taken to prevent the pressure ulcers by turning and repositioning the patient every two hours. The plaintiff also claimed that once the ulcers developed, staff should have treated the infection more aggressively.

The defendant nursing home maintained that her underlying health issues, not the care and treatment of the ulcers, were the cause of her death. A $250,000 verdict was returned.

What this means to you: Although the facts are not clear as to when the patient developed her decubitus ulcers, this case raises issues of patient skin assessment and care at the point of admission and during a patient's stay at a health care facility. At the point of admission, it is important to assess a patient's skin to determine what kind of care plan is required for the patient.

"Every patient should undergo a full-body initial skin assessment as soon as they are admitted in order to determine the potential of skin breakdown," says **Kenneth R. Nanni**, PhD, health care risk manager and director of the Graduate Certificate in Health Care Risk Management Program at the University of Florida in Gainesville.

This assessment should include documenting all pressure ulcers for location, size, stage, the presence of any sinus tracts, undermining, tunneling, exudate, and necrotic tissue, Nanni advises. The admissions staff also should assess whether the patient has any contributing medical, nutritional, or hydration problems.

From a risk perspective, the initial assessment should be a standard procedure performed on all residents, and the results of the screening should be documented fully and accurately. "If the patient is determined to be at high risk for skin breakdown, then the facility must develop an appropriate initial nursing care plan," says Nanni.

This case also raises concerns about how the sore was permitted to develop into a stage IV decubitus ulcers if, in fact, the patient was admitted with no signs of pressure sores.

> . . . Assessment should include documenting all pressure ulcers for location, size, stage, the presence of any sinus tracts, undermining, tunneling, exudate, and necrotic tissue.

"Every facility, but especially long-term facilities which treat those who are prone to skin breakdown, should have policies in place to treat patients who develop decubitus ulcers after admission," notes Nanni.

Such a policy initially should include formulating a plan of wound care that involves the entire treatment team, including the physicians and wound care specialists, he advises.

The first step in resolution is to reduce or eliminate the cause (i.e., the pressure). Many options are available, including specialized support surfaces for bedding and wheelchairs, such as foam devices, air-filled devices, low-air loss beds, and air-fluidized beds.

Regardless of the support surface used, the focus of the treatment should be on turning and repositioning the patient. Repositioning is often performed every two hours, even in the presence of a specialty surface or bed. Further, the wound and surrounding skin must be kept clean and free of urine and feces, and bacterial contamination must be assessed and treated appropriately. The wound must be appropriately dressed, which may vary, depending on the stage of the wound, from simply applying a hydrocolloid occlusive dressing to using an isotonic sodium chloride solution with vacuum-assisted closure sponges.

Finally, the patient's nutritional status should be optimized, which may include dietary supplements, enteral feedings, or even parenteral feedings. Nanni emphasizes that every aspect of the wound care treatment plan be documented in the patient's medical chart.

A policy for preventing and treating decubitus ulcers extends beyond the treatment plan. "Equally important to a facility's skin breakdown policy is appropriate training of the staff, including the direct care CNA [certified nursing assistant] staff," says Nanni. This training should educate team members on the early identification of pressure ulcers and on properly documenting orders, such as an "order to turn resident every two hours.

"Furthermore," Nanni says, "a facility's policy should outline the procedure for the reassessment of all pressure ulcers on a routine basis by the nursing staff." Nanni notes that when necessary, this could include providing a surgical consult for debridement, the process of removing devitalized, or dead tissue from a wound bed.

Nanni is concerned with the risk control techniques exhibited by the defendant long-term care facility in this case. Nursing homes must have in place a standard admissions procedure, which demands the performance of full-body skin assessments and the development of initial nursing care plans for all patients. Further, such facilities must ensure that positioning and wound care techniques are in place so that decubitus ulcers are not permitted to develop or get worse once discovered.

Nanni advises facilities to implement appropriate daily skin assessments and reporting processes so that the CNA staff can be the first line of defense. "How could this sore have developed to a stage IV decubitus ulcer?" he questions.

Reference

• Cuyahoga County (OH), Court of Common Pleas, Case No. 486250. ■

Improper transfer to nursing home results in death

News: A 73-year-old woman with a history of peripheral artery disease underwent elective femoral bypass surgery. Post-surgical complications developed, but six weeks later she returned to the nursing home where she had been prior to the hospitalization. The nursing home refused the transfer, and she was taken back to the hospital. The hospital then transferred the patient to another nursing home, where she died 24 hours later. Her estate brought suit against the hospital, which settled the case for $325,000.

Background: The nursing home resident was admitted to the hospital to undergo elective femoral bypass surgery on her left leg. The elective surgery was intended to address conditions related to her peripheral artery disease by leading some of the blood from the unblocked artery carrying blood to the woman's right leg to the blocked artery in her left leg via a new piece of artificial artery called a vascular graft.

The surgery was successful; however, significant post-surgical complications developed. The principal complication was a large ulcer in the groin area at the site of the vein harvest for the surgical procedure. The harvest site became infected, and the wound would not heal.

At the six-week post-surgery appointment, the hospital attempted to transfer the patient back to the nursing home despite the open wound. Upon the patient's arrival at the nursing facility, staff refused to admit her because she was not stable and they were not able to treat the ulcers.

The woman was returned to the hospital, where she stayed in the emergency department (ED) three hours without any further evaluation. The woman then was taken by ambulance to a second nursing home. She was admitted, but died 24 hours later. The emergency medical services technicians maintained that throughout the transports, the patient's leg looked and smelled gangrenous. An autopsy revealed that the plaintiff died of sepsis, a severe illness caused by overwhelming infection of the bloodstream by toxin-producing bacteria.

The patient's estate alleged violations of the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA imposes an affirmative obligation on the part of the hospital to provide a medical screening examination to determine whether an emergency medical condition exists, imposes restrictions on transfers of persons who exhibit an emergency medical condition, and imposes an affirmative duty to institute treatment if an emergency medical condition does exist. As soon as a patient is formally admitted to the hospital for treatment, the application of EMTALA ceases. Therefore, if an individual develops an emergency medical condition while an inpatient, EMTALA does not apply. If the patient presents to the ED without an emergency medical condition, the statute imposes no further obligation on the hospital.

The plaintiff in this case argued that the hospital violated EMTALA's requirements. The plaintiff alleged that because an ED doctor signed the transfer papers without having seen and evaluated the patient, the physician failed to screen the patient before ordering her transfer.

The plaintiff also argued that the patient was not stable before she was transferred to either nursing home. The hospital maintained in its defense that the decedent was stable at the initial transfer and that she was evaluated upon her return to the ED.

The hospital also claimed that the patient's death so soon after the transfer to the second nursing home was just a coincidence. Prior to trial, the hospital reached a $325,000 settlement with the decedent's estate.

What this means to you: Every time a patient presents at the ED, EMTALA requires that a prescreening take place.

"The biggest issue in this case appears to be a lack of education," says **Kenneth R. Nanni**, PhD, health care risk manager and director of the Graduate Certificate in Health Care Risk Management Program at the University of Florida in Gainesville. It appears neither the physician nor the admissions staff knew about EMTALA's requirements.

"Appropriate staff education involves a risk manager who knows about EMTALA and who can educate the entire staff about the law," Nanni says. "EMTALA's requirements should be understood not just by the admissions nurse, but also by the admissions clerk in the emergency department and the doctors."

> Every staff member on the entire campus should be aware that EMTALA requires a screening exam and stabilization or a transfer.

Every staff member on the entire campus should be aware that EMTALA requires a screening exam and stabilization or a transfer. In fact, Nanni suggests that EMTALA training be made mandatory for all new members of the medical staff as condition of privileges and that continuous training be provided for all staff.

Considering that violations of EMTALA can carry civil monetary penalties of up to $50,000 per violation and/or decertification of Medicare decertification, Nanni strongly recommends that every hospital have a policy in place to ensure compliance with the law.

A hospital's policy should include: identifying dedicated EDs, which must comply with EMTALA; designating qualified medical personnel who will perform screening examinations on behalf of the hospital; maintaining a list of on-call physicians to help the ED determine if a patient has an emergency medical condition and to help treat patients that the hospital accepts in transfer; defining the hospital's "standard medical screening examination process," which should focus on excluding the presence of an emergency medical condition and stabilizing patients who do have an emergency medical condition; addressing the treatment of nonemergencies; making triage decisions without knowledge of the patient's insurance status; ensuring that all patients get the exact same screening exam based on their chief complaint and medical condition; and implementing an "EMTALA checklist," which helps to ensure that the medical staff effectively executes EMTALA's directives by providing an easy screening tool.

Items on the checklist should include: documentation of initial medical evaluation and stabilization; informed consent disclosing the benefits and risks of being transferred; medical indications for the transfer; and any physician-to-physician communications with the names of the accepting physician and the receiving hospital.

This case highlights several important aspects of EMTALA compliance. Nanni suggests that the entire hospital staff is educated as to the meaning of statutory and regulatory definitions of common medical terms, that EMTALA policies and procedures are drafted very carefully, that the hospital and medical staff cooperate in implementing these policies and procedures, and that accurate documentation is emphasized as a critical step in complying with the statute.

If all of these steps had been followed in this case, the hospital likely could have avoided liability.

Reference

• U. S. District Court, District of Michigan, Case No. 2:03-CV-72598. ■

Thomson American Health Consultants
Building Six, Suite 400
3525 Piedmont Road NE
Atlanta, Georgia 30305-1515
Tel (404) 262-7436 Fax (404) 262-7837
www.ahcpub.com

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This issue of your newsletter marks the start of a new continuing education (CE) semester and provides us with an opportunity to review the procedures.

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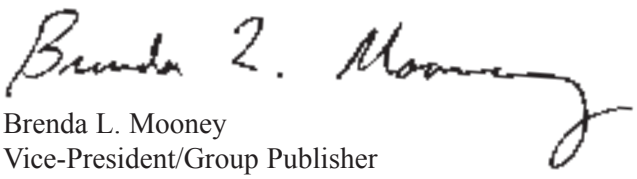

Brenda L. Mooney
Vice-President/Group Publisher
Thomson American Health Consultants

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Health care workers may imperil patients by snubbing influenza vaccinations

SHEA: Use declination forms to push flu vaccine

In cold fact, some unknown number of hospital patients and nursing home residents die of influenza — year in, year out — because they were treated by health care workers who declined flu vaccination.

Maybe the workers mistakenly thought the vaccine would give them the flu, a myth that persists like an urban legend despite the fact that the annual concoction uses killed flu virus. Maybe they work in a setting that refuses to remove logistical barriers of cost or inconvenience. Maybe no one has bothered to inform them of the clear epidemiological link between patient infections and treatment by unvaccinated health care workers. They may not know that they can transmit flu during the asymptomatic onset of influenza or during a mild infection that is little more than a nuisance to them. One study found that 28% of health care workers with serologically confirmed flu infections did not recall having a respiratory infection during the period.[1]

The patient may not be so lucky. Already immune-deficient, he or she may die of a respiratory infection that may not even officially be diagnosed as influenza unless it occurs in the context of a nosocomial outbreak. The huge proportion of health care workers who defer flu vaccination each year in the United States — almost two-thirds of the total work force by some estimates — may not know all of the above. Yet many an infection control professional goes to bed at night knowing it all too well.

"Unvaccinated health care workers kill the people they take care of. It's that simple," says **Allison McGeer**, MD, FRCPC, director of infection control at Mount Sinai Hospital in Toronto.

A succession of randomized clinical trials have shown the protective effect upon patients when health care workers are vaccinated against influenza, she says. "At the [European] influenza meeting in Malta this year, they presented a *third* randomized controlled trial of vaccinating health care workers," she says. "Exactly the same results as the first two — [a] 40% decrease in all causes of [patient] mortality."

In an age of patient safety, there is broad agreement that the status quo no longer is acceptable. "Health care worker influenza vaccine is not just a health care worker issue. It's a patient safety issue. That message has been diluted or lost," says **Thomas R. Talbot**, MD, MPH, assistant professor of preventive medicine at Vanderbilt University Medical Center in Nashville, TN, and lead author of a new position paper on health care worker flu immunizations by the Society for Healthcare Epidemiology of America (SHEA).[2]

The SHEA paper reports that in two separate studies in geriatric long-term care facilities, total patient mortality was significantly lower in those sites where health care workers were vaccinated when compared to sites where routine vaccination was not offered to HCWs (10% vs. 17% and 14% vs. 22%).[3,4] Increased rates of HCW vaccination also correspond with a significant decrease in the incidence of health care-associated influenza.[5]

While SHEA did not go as far as recommending mandatory flu vaccinations for health care workers, others argue it is time for the "m" word to be brought into play. The authors of a recent paper advocating mandatory flu vaccinations for health care workers note that the current immunization apathy among clinicians would simply not be

tolerated if the annual virus had a more exotic profile.[6]

"If we had a safe and effective vaccine against a newly emerging infection such as SARS or avian influenza, would we allow health care workers to care for infected patients without having received the vaccine?" they ask. "Conversely, would we allow infected health care workers to care for uninfected patients? In fact, concerns about the ethics of such behavior would surface almost immediately. Yet, we allow precisely these situations to occur with a virus that kills 36,000 Americans every year."

While many nursing homes are getting the message, many hospital administrators remain unconvinced it's a significant problem, McGeer says. "We're not making the diagnosis [in hospitals]," she explains. "We really only diagnosis it in nursing home outbreaks. When you don't diagnose it, people don't see it and they don't recognize it. That has fostered this attitude that influenza doesn't kill people. Until people see that influenza kills people, we are not going to make the progress we need to on this."

Concurring with McGeer, Talbot says the sense of complacency around flu vaccination stems in part from inadequate case surveillance in the nation's hospitals.

"The difficulty of pushing forward health care worker influenza vaccination is that it is very hard to define the burden of nosocomial transmission of influenza," he says. "Unless you are really looking for it or you have a larger outbreak, you're not going to really have a sense of that burden. We have a lot of accounts of bad outbreaks, but that is just the tip of the iceberg regarding the impact of nosocomial flu. We don't recognize it because we don't do the intensive surveillance to pick it up for every unexplained respiratory illness in our hospitalized patients."

The SHEA position paper recommends that facilities conduct routine surveillance for health care-associated influenza to assess the impact of their worker vaccination program. The SHEA guidelines also address the difficult and ethical issue of allotting flu vaccine during the kind of shortage that occurred last season.

"The allocation guidelines are something that no one has tried to take a stab at, at least in health care workers," Talbot says. "We felt we needed to come to the forefront and provide out rationale as a society on how we would allocate and prioritize vaccinations for health care workers."

Of course, rather than scrambling for vaccine during a shortage, the typical flu season finds health care workers turning their back on an abundance. "There is still a very pervasive myth that [they] are going to get sick from the flu vaccine," Talbot says. "[We thought] surely people don't think that anymore since we've gotten more data. It really does persist. Studies as recent as last flu season suggest that a substantial portion of people don't want the flu vaccine because [they think] they are going to get sick."

While some trace this distrust to the swine flu debacle in the 1970s, Talbot says it is more likely a result of acquiring other respiratory infections after being immunized for flu. There is no shortage of circulating bugs during the winter months and an infection may be incubating when the worker receives the flu shot. As they become symptomatic, they may think they acquired flu from the vaccine. As a result, they vow never to take the shot again and reinforce the myth with their personal testimony to co-workers. Less elaborate disincentives also exist.

"Some institutions make them pay for it," says **David Weber**, MD, a co-author of the SHEA paper and director of epidemiology, occupational health, and environmental health and safety at University of North Carolina Hospitals in Chapel Hill. "It should be given free. Some tell them to go to their own doctors and get it done. Some say you have to make an appointment two weeks ahead of time or that [shots] are only available Friday at noon. There are logistical barriers that many institutions have in place." ■

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