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# Healthcare Risk Management™

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## IN THIS ISSUE



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# Infant abduction yields lessons and warnings for risk managers

*Some security measures worked, but woman posed as nurse*

*(Editor's note: This month's* Healthcare Risk Management *includes special coverage on the issue of infant abduction. The cover story focuses on lessons learned from a recent incident in Texas. Another article addresses the difficulties of allowing people to wear scrubs in the newborn unit, and we also include a feature on the potential liability from an abduction. Another article discusses an insurance rider that can help in these cases.)*

A Texas hospital was recently involved in an infant abduction case that shows some strengths of the typical measures employed on many newborn units, but it also demonstrates the weaknesses that can make babies vulnerable if staff are not vigilant. Risk managers and experts on infant abduction say the case shows what can happen if a facility depends on high-tech security systems to the detriment of vigilance by the staff.

**Special Report: Infant Abductions**

## EXECUTIVE SUMMARY

A recent infant abduction in Texas shows that while the hospital's high-tech security measures apparently worked, the kidnapper still was able to pose as a nurse on the newborn unit. The incident shows strengths and weaknesses of the measures employed by many facilities.

- Security measures apparently discouraged kidnapping the baby from the hospital.
- The kidnapper was able to convince the mother she was a nurse on the unit.
- Good judgment and vigilance cannot be replaced by high-tech devices.

While the infant was not abducted on the hospital premises, the woman accused of kidnapping him apparently was able to pose as a nurse and ingratiate herself with the mother, explains **Roy Bassett**, a lieutenant with the Lubbock, TX, police department. The mother, Erica Ysasaga, gave birth to the child at University Medical Center in Lubbock in May and soon was visited in her hospital room by 33-year-old Stephanie Lynn Anderson Jones, Bassett says.

Ysasaga reported that Jones was friendly and interested in the newborn. She visited often and took the time to learn about the mother. Jones apparently never tried to take the baby from the newborn unit, Bassett says. He theorizes that she was discouraged by the security systems in place at the hospital, which include monitors on the children that set off alarms if they are taken past checkpoints at the exits.

After becoming friendly with the Ysasaga at the hospital, Jones visited the mother at her home, ostensibly to check on the baby's jaundice, Bassett explains. She took a walk with them, supposedly to get the baby some sun exposure for the jaundice, and when Ysasaga was distracted by her 2-year-old, Jones took the 4-day-old infant and ran, Bassett says. Police tracked Jones down about 36 hours later and charged her with kidnapping. They found the baby abandoned in a car seat under a condominium carport in 104-degree heat.

### *Scrubs prove key to abduction*

Bassett says Ysasaga's report, along with information from the hospital staff, show that Jones was wearing scrubs each time she visited. That fact proved crucial in understanding how the woman was able to abduct the child, he explains. He says the nurses reported noticing Jones in scrubs but did not assume she was a nurse at the hospital or that she was trying to pose as one. Many people from other units of the hospital, or even from unrelated clinics in town, visit in their scrubs, the nurses reported, so they saw no reason to be suspicious.

Ysasaga, however, assumed that Jones was on staff at the hospital because she was wearing scrubs, Bassett says. That made her more receptive to Jones and her efforts to learn more about the mother and child, he says. Ysasaga did not question why Jones wore scrubs of a different color than the other nurses on the unit or why she had no hospital identification.

There was nothing that raised a red flag with the family; they believed Jones was part of the hospital staff, Bassett says. "The hospital staff knew she was not one of theirs; but at the same time, she was not doing anything at the hospital to draw their attention," he explains. "Whether by good planning or sheer dumb luck, she hit it just right so that the baby's family thought she was hospital staff and the hospital staff thought she was just a good friend or family member."

Bassett says police investigators now believe Jones' actions were an intentional effort to make Ysasaga comfortable with her and gain enough information to facilitate the kidnapping at the family's home. "It's safe to say that because of the hospital safeguards, she never really planned to take

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the baby at the hospital," he says. "I'm convinced that if she had tried to take the baby at the hospital, those security systems would have kicked in, and she would have been caught before she ever got out." A spokesman for the University Medical Center did not return calls from *Healthcare Risk Management.*

Bassett says Jones is being held on charges of kidnapping and endangering a child.

## Case shows strengths, weaknesses

The Texas case highlights both the strengths and weaknesses of the systems typically employed to prevent infant abductions, says **Barry Mangels**, CPHRM, director of risk management and compliance at Good Samaritan Hospital in Los Angeles. He says the Lubbock incident is typical of many abduction scenarios in the way the woman is thought to have posed as a nurse to gain access to the infant.

Mangels says the Texas facility deserves praise for employing security systems that apparently discouraged the woman from kidnapping the baby at the hospital, and the incident underscores the need to have such systems in place for all newborn units. But at the same time, he says, the incident shows how risk managers must not rely too much on those systems.

"They appeared to have a human breakdown, a fault in how their staff monitored people coming on the unit," he says. "They had someone coming on to this unit in scrubs, looking like she could be a nurse, and no one ever challenged her about why she was wearing the wrong color scrubs and didn't have identification."

Mangels says the staff should have challenged Jones about her identity instead of assuming she was a family member or friend. A good infant abduction prevention system requires that the staff know more about who is visiting than would be the norm in most other units of the hospital, he says.

## The problem with scrubs

The scrubs are a particularly difficult issue in this case, Mangels says. Scrubs are so common in hospitals that it is difficult to avoid having people wear them in the newborn unit, but this case shows that they can lead to confusion among family members, he says. At the very least, Mangels says, staff should be aware of this potential confusion and actively inform family members about who is and is not on staff. **(For more on potential problems with scrubs, see p. 88.)** There is a question about whether the family was educated adequately about the hospital's procedures for keeping infants safe. Mangels points out that it is possible for a hospital's ultra-strict security measures to be thwarted when a family member doesn't understand them.

"One of the important things for obstetrical staff to do is to educate the family about the staff protocol — how the staff will be dressed, what identification to look for, how they will ask for the baby and so forth," Mangels says. "That probably was a breakdown in this situation in Texas."

## Human factors still important

While the hospital was fortunate that the abduction did not take place on its property, there still is some potential liability and the negative media attention from having been involved. Mangels says the hospital's defense could hinge on what appears to be effective use of security systems on the unit. **(See p. 88 for more on the potential liability.)**

But Mangels also says the Texas case shows that the high-tech measures are not enough. In fact, they can lead staff to let their guard down in some ways, he cautions. Staff should never put so much faith in the security devices that they fail to be alert and challenge unknown people on the newborn unit, he says.

"The electronic security measures, the policies and procedures, those are absolutely essential, and they can be very effective, as this case shows," Mangels says. However, human factors can never be underestimated, he says. "All the security devices in the world are not as good as having staff who are willing to question suspicious people and know who should and should not be on their unit," Mangels says. ■

## SOURCES

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# Scrubs are difficult issue for newborn unit security

Many hospitals have their newborn unit staff wear a distinctive scrubs color or other uniform so that it is easier to recognize that they are authorized to handle the infants, but the proliferation of scrubs in a hospital can create confusion for staff and patients, says **Barry Mangels**, CPHRM, director of risk management and compliance at Good Samaritan Hospital in Los Angeles.

The recent infant abduction in Texas shows how simply wearing scrubs into a newborn unit can help a kidnapper gain the confidence of a mother, he says, even if the hospital staff are not fooled.

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The ultimate solution would be to ban scrubs from the newborn unit for anyone other than the staff there, but that is impractical, Mangels says. A step down would be to ban anyone from outside the hospital from visiting the newborn unit in scrubs. That way, the unit staff could at least know that anyone in scrubs should have hospital identification, he says.

"We have a doctor's building attached to our hospital, and so we have plenty of people coming in to the hospital in scrubs, but we still require them to have a badge," he says. "If someone comes onto our neonatal unit in scrubs and no badge, our staff would look at them very closely and challenge them to make sure they are known to the family. We also would make a point of mentioning to the family that this person is not staff even though they're wearing scrubs."

### *Enforce dress code strictly*

The infant abduction case also highlights the need to rigidly enforce a dress code in neonatal units, says **A. Kevin Troutman**, JD, an attorney with the law firm of Fisher & Phillips in New Orleans who previously worked as a hospital administrator for 17 years. Dress codes and the proper use of identification badges are important in all areas of the hospital, but especially so in this unit, Troutman says.

He suggests that the apparent reluctance of the hospital staff in Texas to challenge someone in scrubs and no identification could signal a facilitywide problem with the attitude toward identification measures. "I've seen a lot of resistance from staff, complaining that the people enforcing these rules are being too picky, but this kind of incident is exactly why you have these rules," Troutman says. "When you have your own staff walking around the hospital in scrubs, maybe in the wrong color scrubs, with no badge or the badge turned over so you can't read it, all of that contributes to the kind of situation you see in this abduction incident."

If it is not uncommon to see people you know to be on staff without the proper identification, that encourages a lackadaisical attitude with other people who may or may not be on staff, he cautions. Consistently enforcing identification policies is crucial, Troutman says.

This is an area where there is no room for leniency, he says. "The patients also need to know with 100% confidence that the staff will always have identification visible," Troutman says. "They need to know that someone without a badge is someone to be questioned." ■

**SOURCE**

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# Liability risk even though baby abducted at home

The infant abduction in Lubbock, TX, didn't happen until the baby had been discharged and was at home with her mother, so what's the potential liability for the hospital?

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Plenty, replies **Barry Mangels**, CPHRM, director of risk management and compliance at Good Samaritan Hospital in Los Angeles.

The liability for the hospital can be huge, even if it doesn't take place in the hospital, Mangels says. "Whether you could be sued successfully for your involvement in an off-site abduction remains to be seen, but it's a certainty that this is

nothing you want to be involved in from a risk management standpoint," he says. "You just don't want your name associated with the abduction of an infant born at your hospital."

Mangels says he would not be surprised if a plaintiff's attorney found a way to successfully argue liability when the abductor first gained access to mother and child at your facility. But before that even becomes an issue, your hospital suffers a terrible blow to its public image when every media report of the kidnapping includes a description of how the abductor mingled with staff and patients in the newborn unit.

Loss of goodwill is a huge risk factor for hospitals, Mangels says. "What would this news do to your labor and delivery program? Nobody would want to deliver their babies there," he says. "The liability can be far greater than just a civil suit."

**A. Kevin Troutman**, JD, an attorney with the law firm of Fisher & Phillips in New Orleans, notes that such an incident also puts the hospital at risk for more lawsuits in the future. Even if no lawsuit arises from the off-the-premises abduction, the involvement and media exposure will create an atmosphere in which patients are more likely to sue, Troutman says.

It makes people more sensitive, he says. "People are looking more carefully, more skeptically and critically at anything that happens," Troutman says. "They've heard about the past incident, and it just encourages people to respond in a negative way to their own situation."

### *'Code Pink' drills a good idea*

To avoid that outcome, Mangels advises risk managers to ensure the hospital has a comprehensive program to prevent infant abductions. Security precautions should include high-tech solutions such as wrist or ankle bands on infants that set off alarms at exit points, as well as video cameras to monitor the unit, Mangels says. Another key element is the drill in which you rehearse how you would respond to an infant abduction. Often known as a "Code Pink," this scenario should be planned and practiced regularly, he says.

At Good Samaritan Hospital, the staff periodically runs a Code Pink drill by giving an infant-sized doll to someone posing as the kidnapper, and then — without any warning to the staff, even those on the neonatal unit — the facility's public address system announces the Code Pink. That alarm sends designated staff to all exits of the hospital, and their duty is to prevent anyone from leaving, especially with a child or anything that could conceivably conceal an infant.

"We once gave the doll to our CEO to see if they would challenge him," Mangels says. "He tried walking out with the doll in his big brief case, and they did stop him. A big part of the drill is convincing people to take this seriously, to challenge every person who could be taking that baby out of the hospital." ■

## Rider can help cover costs of infant abduction

A special rider available on some insurance coverage could help cover the costs associated with an infant abduction at your facility. The coverage sometimes is available at no extra cost, but only if you know to ask your insurance broker for it.

The company's "child abduction rider" is available as additional coverage on kidnapping and ransom policies, which many organizations buy to cover their senior executives, says **David Lattin**, director of specialty underwriting at Hartford, CT-based Travelers.

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Lattin suggests that the child abduction rider could provide invaluable aid in the event of an abduction at a health care facility.

When a child is missing, the rider pays for private detectives to supplement local law enforcement efforts, travel expenses to reunite parents and children, and any other reasonable expenses related to the abduction and efforts to find the child. The policy does not require any ransom demand to trigger coverage, unlike some other kidnapping policies. Lattin notes that is an important consideration considering that most infant abductions do not involve ransom demands.

"The most important benefit is not the expenses it covers but the resources that we make available in an abduction incident," Lattin says. "In an infant abduction, getting the child back quickly and safely is the primary goal, and unfortunately, your local authorities may be overburdened and unable to do everything they would like to do. A hospital with this rider will be able to use all our resources to supplement local law enforcement."

Those resources include a national network of

## SOURCE

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private investigators and the services of people such as Lattin, who is a trained hostage negotiator. St. Paul Travelers has offered the rider for two years but has not had a claim yet.

Lattin says kidnapping and ransom coverage is relatively low cost, as little as $800 annually for each $1 million in coverage. Most states require that the child abduction rider be provided at no additional cost for clients with the kidnapping and ransom policies, Lattin says. ■

# Engineers study design, hospital cuts falls 50%

Outside engineers can give risk managers a fresh perspective on design and procedures that affect the likelihood of patients falling, according to a team that was able to reduce falls in one hospital by more than 50% in fewer than two years.

After accumulating a higher-than-average number of patient falls in recent years, Our Lady of Lourdes Hospital in Pasco, WA, called in engineers from Pacific Northwest National Laboratory (PNNL), a division of Battelle, an engineering and consulting firm in Columbus, OH. The hospital's risk management staff asked the engineers to help in meeting new patient safety standards set by the Joint Commission on Accreditation of Healthcare Organizations, notes PNNL's **Jonathan Young**, a senior scientist who worked with the risk assessment team. The Joint Commission standards call for using failure mode analysis to analyze one high-risk process each year, Young says. **Anita Kongslie**, director of quality management at Lourdes, says she immediately knew that patient falls were the first topic to address.

Kongslie notes that the hospital's fall rate was excessive in part because it has a physical medicine rehab unit as well as an acute care hospital. That unit means there is a lot of therapy involving patients who are trying to regain the skills of daily living, in addition to the falls typical of any patient population. In addition, Kongslie noticed that rehab patients were having a lot of falls toward the end of their stay, as the staff encouraged them to become more independent.

"We believed our fall rate was a little high, but we weren't sure how to do failure mode analysis," she says. "That's why we called in outside engineers with experience in this method."

At the time, patient falls led to the highest payouts at Lourdes, Kongslie says. Now it has been about three years since the hospital had a fall that led to a significant payout. "It's totally dropped off the radar screen at this point, in terms of being a major expense for us," she says.

### New eyes see new things

The impressive results were brought about by having someone other than the risk management staff take a fresh look at the problem, Kongslie says.

"They see things that we have looked at for so many years that it just goes right by us. It doesn't register to us as a problem," she says. "But they come in with a fresh pair of eyes and say, 'Hey, what about that? Isn't that a problem?' And then we have to stop and say, 'Yes, that could really be something.'"

Young mentored Lourdes staff in the use of failure mode analysis, a common engineering tool in risk assessment, to examine the policy, procedures, and practices related to patient fall risk. The basic concept of the analysis is to identify the elements of the process, the failure modes of that process, and the effects of that failure on the organization. Then the analysis moves on to

## EXECUTIVE SUMMARY

When it comes to reducing patient falls, you may benefit by bringing in outside help with a fresh perspective. The consultants may spot problems that you have become accustomed to as the norm.

- Falls can be dramatically reduced if you find the key causes.
- Design elements in patient rooms can be big contributors.
- Make sure fall assessments are done on all patients.

## SOURCES

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trying to estimate the relative likelihood and severity of the consequences of each of the failure modes. Then that information is used to identify the most significant failure modes and how to address them.

The engineers also identified the safeguards in the current process, such as double-checking patient charts to make sure patients at risk of falling were properly identified when they were first admitted to the hospital. An algorithm was used to score the vulnerability in the system, and it categorized those failure modes as high, medium, or low risk.

Detailed data collection helped Kongslie and the PNNL engineers spot trends and possible problems with the physical surroundings. **(See article, this page, for more on the problems they found.)** In addition, Lourdes now implements an updated patient assessment of fall risk upon the patient's arrival at the hospital, holds staff refresher courses, uses bed alarm systems, color-codes charts of patients at risk of falling, and improved the Patient Fall Risk Care Plan process to allow hospital staff to provide the proper level of patient care.

### *Must work actively with consultants*

Fall prevention also is a bigger focus now in new staff orientation, Kongslie says. The hospital was going restraint-free at the same time, so that change brought an added challenge for fall reduction. One solution was to use more sitters for patients at high risk of falling, instead of restraints. The physical medicine rehab unit is now entirely restraint-free.

"We've done all the things that most facilities have done, like bed alarms, but the key for us was looking for trends in location of falls and taking an all-inclusive approach to fall assessment," she says. "We also revised our fall assessment to include the type of medications that patients are on and increased our education to staff."

Young notes that Lourdes was so successful in reducing falls partly because the risk management team was directly involved in the analysis and problem solving. While it can be useful to bring in outsiders to give you a fresh look, he says, the most success comes when risk managers work alongside those investigators.

"You get much better results that way than if you just wait for them to drop a report down on your desk," he suggests. ■

# Data help show fall risk with design, assessments

When Our Lady of Lourdes in Pasco, WA, brought in outside engineers to give them a fresh perspective on reducing falls, the team came up with several solutions. **Anita Kongslie**, director of quality management, notes these as two of the most significant findings:

• **The investigators found that the hospital had converted an acute care unit into a physical medicine rehab unit without designing in certain safeguards to reduce falls.** Toilet paper holders were placed in a position that required the patient to lean too far forward, then potentially lose their balance and fall. The toilets also were mounted on risers that made it difficult for some patients to use them without falling.

"So, some of the fixes were simple, such as moving the toilet paper holders and getting different toilets that didn't require risers," Kongslie says. "We also identified other measures we could improve, like monitoring medication and how often the staff was toileting patients so they wouldn't try to go on their own."

• **The analysis also revealed that observation patients had been overlooked in the Lourdes fall assessment and prevention program.**

"Here we had these patients in our hospital for 24 to 48 hours, and no fall assessment was done on them because they were considered outpatients," Kongslie says. It was a significant oversight, she said. "We needed to be all-inclusive with fall assessment and educate our staff more about what to do with those fall assessment results," says Kongslie, referring to the need for staff to act by implementing standard fall reduction strategies when an increased risk was revealed. ■

# Critical birth drills help prepare staff

You probably conduct fire drills, evacuation drills, infant abduction drills, and mass casualty drills, but there is one more you might want to add to the schedule: critical birth drills to help obstetric staff prepare for the high-risk emergent birth with the potential for a tragic outcome and major liability.

Fairview Southdale Hospital in Edina, MN, routinely conducts critical birth drills. They have greatly increased the staff's confidence in responding to high risk birth scenarios, says **David C. Seivert**, CPCU, ARM, senior director of risk management services at parent company Fairview Health Services in Minneapolis. The drills are an especially effective risk management strategy since obstetrics represents such a large liability risk for most health providers, he says. The drills focus on the key element that can make the most difference in a critical birth: communication.

"Our claims history tells us that it's not necessarily the skill sets or lack thereof with our clinicians that are the big issue in these incidents," he says. "It's primarily the breakdowns in sharing critical information between members of the team that contribute to bad outcomes."

The first drill was in January, and there have been 10 so far at Fairview Southdale, which is piloting the program. Soon, Seivert expects to start the same drills at the organization's other hospitals. The experience at Southdale has proven the value of the drills, he says.

## Realistic scenario for drill

The critical birth drills are made as realistic as possible by using a $30,000 doll that simulates a mother and newborn baby in distress, with cables running to a computer that can determine how the clinicians' actions would affect a real child, explains **Stanley Davis**, MD, an OB-GYN specialist in Minneapolis.

The "SimWoman and SimBaby" device is designed to test labor and delivery teams on every conceivable medical, biological, cultural, and logistical variable. The woman mannequin has a large belly containing a mannequin baby, and it even contains simulated bodily fluids and detailed anatomical features. The mannequin is a variation of the SimMan mannequin manufactured by Laerdal Medical Corp., a medical device manufacturer in Wappingers Falls, NY. **(For more information, see the company's web site at www.laerdal.com.)**

The drill uses a scenario that is realistic and creates a high-risk birth scenario. In a typical drill, a pregnant woman is in a car accident that leaves her bleeding internally. Her blood pressure is falling, and she goes into premature labor. To make things more difficult, the woman cannot speak English.

The woman, an actor, is rushed into an operating room for an emergency cesarean, which the mother initially refuses. Eventually the baby emerges blue and not breathing. The birthing team calls a Code Blue and begins to care for the dying baby. Davis uses a radio to talk with the lead physician through an earpiece, describing the scenario as it changes. He might radio the message, "The uterus has just ruptured," and the team must respond appropriately.

"The drill creates a stress dynamic so we can see where we might develop flaws in the process and team performance," he says. "We want to simulate a situation in which people are being pushed very hard so that we can see the weaknesses in our system."

## Post-drill review is vital

Each of the critical birth drills is videotaped, and the post-drill review of that tape is a crucial part of the experience, Seivert says. The participants learn some lessons in the midst of the drill, but some of the most valuable information is gleaned from watching the tape and discussing it with other team members to identify where performance was lacking and how it might be improved.

"The debriefing is where all the gold is," Davis says. "That's where you have time to look at it from the outside in and see things you were too

### EXECUTIVE SUMMARY

Critical birth drills can help hospital staff prepare for high risk emergent births and improve outcomes. The drills should be conducted regularly for all involved staff.

- Expect scheduling of drills to be difficult.
- Drills can be announced ahead of time.
- Reviewing the drill for lessons is a key element.

## SOURCES

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busy to think about at the time."

In addition to communication issues, the drills have revealed some practical ways to improve response during critical births, Seivert says. One drill revealed that the phone used to request blood during an emergency was not easily accessible to the anesthesiologist responsible for that request. If he or she could not leave the patient's side, the circulating nurse would be asked to go to the phone and request the blood. But there was at least one birth in which the request was not heard or the nurse was too busy, so the blood was not ordered. The phone was moved to a more convenient location so the anesthesiologist could request blood without leaving and without an intermediary. **(See article, this page, for more lessons learned from the drills.)**

The critical birth drills also led to a change in the way team leaders are identified during a critical birth. To facilitate better communication and leadership, physicians and certain other team members wear different colored scrub hats so that they are easily identified in a crowded, busy room.

"Some of the improvements are not that complicated, but the team members didn't even realize there was a problem to address until they went through the drill and analyzed it afterward," Seivert says. ■

# How to conduct critical birth drills

This advice for conducting critical birth drills comes from **Stanley Davis**, MD, an OB-GYN specialist at Fairview Health Services in Minneapolis:

- **Realize that a critical birth drill is difficult to organize.** Davis compares it to making a movie. You have to get a lot of people together in one place at one time, when most of them have other demands on their time. You have to set up a lot of equipment first, and you have to have a script that key people know ahead of time.
- **The drills cannot be a surprise.** Though it would be ideal to conduct the drills without warning, the way real high-risk births happen, it just isn't practical in most hospitals. Organizing the participants and choosing a time when all the key members can be there is difficult enough without trying to spring the drill on people without warning.
- **Encourage team members to react in realistic ways.** Brief the participants about the basics of how the drill will be run, such as the simulated baby and how it works. Then encourage them to take the drill very seriously and respond just as they would in true crisis.

Point out to the participants that the purpose of the drill is not to judge their individual skills and find cause for disciplinary action. Rather, the purpose is to improve team dynamics and the system for responding to critical births.

- **Alert ancillary departments to the drill.** For instance, you should let the blood bank know that the team may call to request blood. If they do, the bank should be prepared to send empty blood bags (with proper labels and coding, so you can check that part of the process) in the same manner it would deliver real blood.

The unexpected involvement of other departments can be revealing. In one Fairview drill, the physician called the main operating room for a pigtail catheter to use in an emergency hysterectomy, and the drill revealed a breakdown in communication. The nurses in the main OR were not sure exactly what he was requesting, and the two parties did not adequately converse to try to figure out what was needed for the emergency.

- **Try to conduct the drills at different times of day to involve staff from different shifts.** This step also can be a difficult part of scheduling a drill. At his hospital, most of the drills are conducted from 6 p.m. to 10 p.m. because that is the only time the anesthesiologists are free. Three of the drills were conducted from noon to 4 p.m. As much as possible, rotate staff from different shifts through the drills.
- **Always videotape the drill.** It's not enough to discuss the drill afterward without a videotape to watch. A critical birth drill should be high stress and fast paced, so it isn't possible for people to recognize and remember all the critical details.

• **Administration should respond quickly and visibly to the team findings.** When the drill revealed that the clinicians needed a phone at the patient's bed side, the hospital had the phone installed within a week. Davis says that signaled to the team that the drills were important to administration and their findings would be acted on quickly. ■

# Effort to cut errors works better than expected

The Institute for Healthcare Improvement (IHI) in Cambridge, MA, announced recently that U.S. hospitals taking part in an 18-month effort to prevent 100,000 unnecessary deaths by dramatically improving patient care have exceeded that goal. Hospitals enrolled in the 100,000 Lives Campaign have collectively prevented an estimated 122,300 avoidable deaths and have begun to institutionalize new standards of care to improve safety, the group reports.

Initiated by IHI in December 2004, the campaign has enrolled more than 3,000 hospitals — representing an estimated 75% of U.S. hospital beds and far surpassed the enrollment original goal of 2,000. The participating hospitals have pledged to implement up to six evidence-based and life-saving interventions. **Donald Berwick**, MD, president and CEO of IHI, announced the results at IHI's annual International Summit on Redesigning Hospital Care. He says the campaign has exceeded his highest expectations.

"The participating hospitals have not only prevented an estimated 122,300 unnecessary deaths, but they've also proven that it's possible for the health care community to come together voluntarily to rapidly make significant changes in patient care," he says. "I have never before witnessed such widespread collaboration and commitment on the part of health care leaders and front line staff to move the system giant steps forward."

More than 20 facilities have reported that they have gone more than a year without a case of ventilator-associated pneumonia, a leading killer among all hospital-acquired infections, which demonstrates that this sort of complication can be avoided, Berwick says. Hundreds of hospitals also have instituted rapid response teams, a relatively new concept that is saving lives. Participating hospitals also have made great headway in delivering reliable care for acute myocardial infarction, preventing adverse drug events, and preventing surgical site and central line infections.

Berwick says the campaign has led hospitals and health care systems to cooperate at unprecedented levels. Without regulatory mandates or financial incentives, groups of facilities on the regional, state, and community level have come together to exchange solutions and strategies to support improvement. Campaign participants are sharing ideas and examples of success on IHI's web site at www.ihi.org/IHI/Results/Success Headlines.

Hospitals that participated in the 100,000 Lives Campaign committed to implementing some or all of the following six quality improvement changes:

• **Activate a Rapid Response Team** at the first sign that a patient's condition is worsening and may lead to a more serious medical emergency. (There are 1,781 hospitals participating.)

• **Prevent patients from dying of heart attacks** by delivering evidence-based care, such as appropriate administration of aspirin and beta-blockers to prevent further heart muscle damage (2,288 hospitals participating).

• **Prevent medication errors** by ensuring that accurate and continually updated lists of patients' medications are reviewed and reconciled during their hospital stay, particularly at transition points (2,185 hospitals participating).

• **Prevent patients who are receiving medicines and fluids through central lines from developing infections** by following five steps, including proper hand washing and cleaning the patient's skin with chlorhexidine (1,925 hospitals participating).

• **Prevent patients undergoing surgery from developing infections** by following a series of steps, including the timely administration of antibiotics (2,133 hospitals participating).

• **Prevent patients on ventilators from developing pneumonia** by following four steps, including raising the head of the patient's bed between 30 and 45 degrees (1,982 hospitals participating). ■

## SOURCE

For more information on the 100,000 Lives Campaign, contact:

- **Donald Berwick**, MD, President, Institute for Healthcare Improvement, 20 University Road, Seventh Floor, Cambridge, MA 02138. Telephone: (617) 301-4800.

# JCAHO releases new goals, requires flu vaccine

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has announced the 2007 National Patient Safety Goals, and major changes include extending a requirement that accredited organizations define and communicate the means for patients and their families to report concerns about safety. This new goals applies to all organization accredited and certified by the Joint Commission.

The requirement — first applied to the home care, laboratory, assisted living, and disease-specific care programs in 2006 — is the central expectation of the goal: "Encourage patients' active involvement in their own care as a patient safety strategy."

In addition, a new requirement specifies that behavioral health care organizations and general acute care hospitals that treat patients for emotional or behavioral disorders identify patients at risk for suicide. This requirement is part of the goal: "The organization identifies safety risks inherent in its patient populations."

For home care organizations, a corresponding requirement under this goal stipulates that these organizations are to identify risks associated with long-term oxygen therapy such as home fires.

### *Provide patient with meds list*

Finally, new language in one of the two requirements under the existing medication reconciliation goal stipulates that a complete list of current medications be provided to the patient on discharge from care. This expectation is applicable to the ambulatory care, assisted living, behavioral health care, critical access hospital, disease-specific care, home care, hospital, long-term care, and office-based surgery programs.

The full text of the 2007 goals and requirements is posted on the Joint Commission web site at www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals.

In other developments, the Joint Commission made these announcements:

- A new infection control standard requires hospitals, critical access hospitals, and long-term care facilities to offer influenza vaccinations to staff, which include volunteers, and licensed independent practitioners. Currently, only about 35% of health care workers are vaccinated each year, the Joint Commission reports. The requirement is effective Jan. 1, 2007.
- Revised Standard EC.7.40 now requires organizations to test their emergency generators at least once every 36 months for a minimum of four continuous hours. This test is in addition to the current requirement to test emergency generators 12 times each year for 30 continuous minutes. The new requirement is effective Jan. 1, 2007, and organizations must have performed this test by July 1, 2007, to be in initial compliance. ■

# Americans favor liability reform legislation

More than three-fifths of Americans surveyed by the Health Coalition on Liability and Access (HCLA) support passage of comprehensive medical liability reform legislation. And 76% of those surveyed said they favor legally imposed reasonable limits on noneconomic pain and suffering awards.

According to the poll, 74% of Americans believe their access to quality health care is threatened because medical liability costs are driving doctors out of practice. And 64% said that medical lawsuit abuse is one of the primary causes of rising health care costs.

"It is clear that the medical liability crisis is an issue that deeply concerns Americans," said HCLA chairman **Christian Shalgian**. Shalgian called on Congress to enact "common-sense medical liability reforms to preserve patients' access to care and to allow doctors to provide quality medical services." ■

**COMING IN FUTURE MONTHS**

- Getting the most from legal counsel
- Insuring against cyber extortion
- Halloween horror room can educate staff
- Why visitor policies must be enforced

## 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 semester's activity with the **December** 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.

5. In the recent infant abduction involving a hospital in Lubbock, TX, why was it significant that the accused kidnaper wore scrubs in the hospital?
A. The mother assumed that the woman was on staff at the hospital because she was wearing scrubs.
B. It is illegal in Texas for unauthorized people to wear scrubs in a health care facility.
C. The nurses on the unit thought the woman was on staff because she wore scrubs.
D. The scrubs apparently helped the woman get out of the hospital while carrying the baby.

6. According to Barry Mangels, CPHRM, what is the Texas hospital's potential liability regarding the infant abduction?
A. There is no liability.
B. The hospital cannot be sued but it will suffer from the negative publicity.
C. The hospital could be sued and will suffer from the negative publicity.
D. The incident is a positive experience for the hospital because the kidnapping took place off the premises.

7. What does Anita Kongslie say is the main reason a fall reduction program involving outside engineers was successful?
A. The outside engineers provided a fresh perspective.
B. The consultants had more authority to make process changes.
C. The engineers worked on their own with no input from risk management.
D. The consultants had an unlimited budget.

8. According to David C. Seivert, CPCU, ARM, what is the root of most problems revealed during a critical birth drill?
A. Equipment problems
B. Insufficient training of staff
C. Judgment errors by physicians
D. Communication difficulties

**Answers: 5. A; 6. C; 7. A; 8. D.**

Healthcare Risk Management's

Legal Review & Commentary™

A Monthly Supplement

# $826,000 verdict after tuberculosis remains undiagnosed and untreated for more than 6 months

By **Blake J. Delaney**, Esq.
Buchanan Ingersoll
Tampa, FL

**News:** An elderly man suffering from a bloody cough did not receive a bronchoscopy to examine his lower airways until six months after initially visiting his primary care physician. When initial test results from the hospital-based lab showed that the man was suffering from tuberculosis, the hospital failed to communicate these results to the man's doctors or to the health department. When the tuberculosis finally was discovered, the disease was too advanced to allow for successful treatment, and the man died soon thereafter. A jury found that the hospital and primary care physician had acted negligently, which resulted in a verdict of $826,583.

**Background:** An 81-year-old man visited his primary care physician, complaining of a deep cough that was producing blood. The physician prescribed antibiotics, after which the man's symptoms ceased for a period of time. However, when the cough redeveloped four months later, the physician referred his patient to a pulmonologist. The pulmonologist examined the patient and instructed him to return for a follow-up in three or four more months. Two months later, however, the man's condition worsened, and he returned to his primary care physician for treatment. The doctor ordered the patient to return to the pulmonologist so that he could perform, on an outpatient basis at a nearby hospital, a bronchoscopy, wherein a hollow, flexible tube containing a viewing device would be inserted into the man's airways to allow the visual examination of his lower airways. The doctor did not tell the pulmonologist that the man's condition had worsened over the last few months.

The results of the bronchoscopy were interpreted to be positive for tuberculosis by the hospital-based lab based on a special DNA probe of the man's culture. Nevertheless, the hospital apparently did not communicate the results to the state health department within 72 hours, as required by law, or to the pulmonologist or the man's primary care physician. Three months later, the man returned to the hospital. He was admitted, and again tuberculosis was discovered. Unfortunately, the disease was in an advanced stage, rendering successful treatment extremely difficult. The man died two weeks later from tuberculosis pneumonia.

The man's 79-year-old wife filed suit against the primary care physician, the hospital, the pulmonologist, and the pulmonologist's professional association. She faulted the primary care physician for failing to timely refer the decedent to a pulmonologist and provide the pulmonologist with all of her husband's relevant medical history. She further claimed that the hospital had acted negligently in failing to advise of the bronchoscopy test results. Experts for the plaintiff testified that the man's life could have been saved if he had received immediate treatment following

the results of the bronchoscopy. The plaintiff sought damages for medical expenses, funeral expenses, pain and suffering, and loss of support and services, pointing to the fact that she had been married to the decedent for 57 years.

The defendants denied liability and claimed that the man died as the result of idiopathic pulmonary fibrosis, a disease of inflammation that results in scarring of the lungs and that has no known treatment. Although the plaintiff agreed that the man also was suffering from idiopathic pulmonary fibrosis, her experts opined that the actual cause of the man's death was the defendants' negligence.

The hospital maintained that it had, in fact, called the pulmonologist's office and communicated the results of the bronchoscopy to the office manager, but the plaintiff countered that the hospital should have insisted on speaking with a nurse. The hospital also maintained that it had reported the test results to the county health department, but the health department testified that it would have assigned a case manager to the decedent and sent a nurse to see him within 24 hours had it received such a report. Furthermore, the hospital could not submit any evidence showing that it had forwarded a written copy of the test results to the pulmonologist's office or to the county health department, as required by its own internal procedures.

During the first week of trial, the plaintiff settled with the pulmonologist and his professional association for an undisclosed amount. After trial, the jury returned a verdict in favor of the plaintiff for $826,583, including $720,000 for pain and suffering. The jury attributed 10% fault to the man's primary care physician, 75% fault to the hospital, and 15% fault to the pulmonologist's medical group, which was now a nonparty, resulting in a net award of $702,595.

**What this means to you:** "The verdict in the case, along with the pulmonologist's settlement, are indicative of a prevailing common denominator in adverse outcomes: failure to communicate," suggests **Cheryl Whiteman**, RN, MSN, HCRM, clinical risk manager for Baycare Health System in Clearwater, FL.

All of the parties involved in this scenario could have benefited from a risk manager ensuring that patient information was accurately and expediently communicated. For example, a risk manager responsible for office practices should have taken note of how the patient was bounced back and forth between the primary care physician and the specialist over six months. Indeed, the primary care physician complicated matters by failing to convey a worsening condition when he sent the patient to the pulmonologist the last time.

"Both physicians involved in this case failed to communicate the pertinent aspects in this patient's care to each other. Their communication should have included differential diagnoses, testing, follow-up, and a plan of care," notes Whiteman.

The hospital also exhibited signs of poor communication. In fact, it had little defense when it was unable to substantiate its claim that results were, in fact, communicated to the physicians and the health department, considering that it could not produce any supporting documentation. "The first step for a risk manager would be to review the process in which test results are reported," says Whiteman. She emphasizes the importance in determining the recipient of test results. In the physician office setting, it seems only reasonable that this information should go to a trained health care professional. If there is no licensed nurse in the office, it then would be necessary to report findings directly to a physician. "Clearly, an unlicensed person may not understand the importance of such information," recognizes Whiteman.

Whiteman suggests that all departments that report test results be involved in process improvement, including clear documentation of when and to whom test results were reported. Specifically, she recommends recording the name of the person to whom the results were reported and developing a monitor to determine the results of these changes. "Part of the monitor's responsibility should be to review the substantiating documentation and the time taken to report findings," notes Whiteman.

Even though a failure to communicate tests results has a serious potential for a delayed diagnosis or a missed diagnosis, as demonstrated by this case, Whiteman also acknowledges the serious concern raised by the failure to report this patient's diagnosis to the local health department. "In addition to providing another means of getting this patient treated, notification also begins a process to ensure that the community is protected from a treatable, but communicable disease," concludes Whiteman.

## Reference

• Palm Beach County (FL) Circuit Court, Case No. 50 2003 CA 011312. ■

# Overdose of aminophylline leads to $456,600 verdict

**News:** Upon the premature birth of a baby, a doctor recommended a dose of aminophylline to treat the brief pauses in the infant's breathing. However, nurses gave the baby 10 times the ordered dosage, and the infant immediately became agitated and began to experience an accumulation of fluid in his lungs. After the newborn was transferred to a nearby children's hospital, doctors conducted blood volume exchange transfusions to cleanse his bloodstream of the drug, and they drained the blood and excess fluids from the baby's brain. Although the doctors saved the baby's life, he now requires a permanent shunt to drain fluid from his brain, and the long-lasting effects of his injuries are unknown. Following a lawsuit alleging negligence against the first hospital, a jury awarded the baby and his family $456,600 in damages.

**Background:** During the last term of her pregnancy, a woman had been experiencing a variety of problems with her fetus, including in utero hemorrhage, fetal heart rate decelerations, and pre-eclampsia, a condition that was preventing the placenta from receiving enough blood. Six weeks before her due date, the woman rushed to the hospital in labor and prematurely gave birth to a baby boy weighing only 3½ pounds. Medical staff noted that the placenta exhibited localized areas of calcium deposition, known as infarcts, and doctors diagnosed the newborn with congenital heart disease.

Only five hours after birth, the baby developed apnea, a condition characterized by brief pauses in the infant's breathing pattern. The condition most likely occurred when the part of the baby's brain that controlled his breathing did not start, or failed to maintain, his breathing process properly. Recognizing that a few short apneas can be fairly common in premature infants due to the immaturity of their brain respiratory centers, the baby's physician took no chances. To stimulate respiration so that the baby would breathe normally, the doctor ordered an infusion of aminophylline, a bronchodilator drug that would attempt to open the infant's lung passages.

Unfortunately, the hospital staff gave the baby 10 times the amount of aminophylline ordered by the physician, and it was a highly toxic and potentially lethal dose. Although the drug should have been contained to a therapeutic range of 6 mcg to 13 mcg per ml, the overdosage subsequently raised the boy's blood serum levels of aminophylline to 77, and on recheck to 91.8. Within hours of the introduction of aminophylline, the baby became fussy and agitated, and he began grunting and flaring his nostrils. His breathing became labored, and he developed respiratory distress and pulmonary edema, characterized by swelling and an accumulation of fluid in his lungs.

Because no one at the hospital had any experience in treating a newborn baby with such a massive overdose of aminophylline or with such high blood serum levels of the drug, medical staff telephoned a poison control center to determine what they should do. Ultimately, the hospital intubated the baby and placed him on mechanical ventilation to breathe. The hospital then transferred the child on an emergency basis to a children's hospital 13 miles away.

The children's hospital administered an admission screening that determined that the baby's aminophylline blood serum levels had risen to 136, a lethal level. Doctors performed multiple blood volume exchange transfusions to cleanse the drug from the infant's bloodstream, but it took five days for the aminophylline levels to return to the therapeutic range. In the meantime, the infant suffered two intraventricular hemorrhages causing head bleeds, and he experienced hydrocephalus, a buildup of spinal fluid inside his brain.

The hospital treated the newborn for six weeks, during which period he underwent five neurosurgical procedures to drain the blood and excess fluids from the ventricles of his brain. Initially, the baby's doctors suspected that he would suffer permanent brain damage. However, the drains successfully alleviated the swelling in the baby's brain, and he currently is quite healthy. He is considered normal in function and above average developmentally. Nevertheless, he requires a permanent ventriculoperitoneal shunt to drain fluid from his brain to his abdominal area to prevent a future development of hydrocephalus, and doctors have diagnosed him with mild diffuse encephalopathy, a generalized slowing of cerebral functioning.

The baby, through his family, filed a lawsuit alleging negligence against the first hospital. The plaintiff relied on the testimony of five expert witnesses from across North America in the fields

of pediatric neurosurgery, pediatric neurology, pharmacology, neonatal-perinatal medicine, and pediatric head bleeds. Finding the testimony convincing, the court granted summary judgment in favor of the plaintiff on the issue of negligence, and that judgment left only the issues of causation and damages to be determined by a jury.

At trial, the defendant was forced to acknowledge its negligence in failing to properly dilute the dosage of aminophylline to the plaintiff, but it denied that its conduct caused any damages. Instead, the defendant argued that a variety of other factors caused the infant's brain hemorrhage, extended hospitalizations, surgeries, and his need for a permanent intraventricular shunt. Specifically, the defendant blamed the problems the mother had suffered before giving birth, the mother's smoking, the small size of the infant, and the premature gestation. The hospital did not present any testimony regarding the overdose of aminophylline, but the plaintiff pointed out that the hospital had never notified any regulatory authorities about the overdose and that neither federal nor state authorities had conducted an investigation of the hospital's error. After trial, the jury awarded $250,000 in damages to the baby for disfigurement, disability, and pain and suffering, $150,000 in damages to his mother for pain and suffering, and $56,600 for past and future medical expenses, for a total verdict of $456,600.

**. . . A poor system for dispensing medication can lead to situations such as this one. . . . work environments in which frequent interruptions lead a person to forget to . . . double-check dosage and packaging two drugs in similar containers so that one is easily mistaken for the other.**

**What this means to you:** Although the overdose in this case is potentially a one-time occurrence, **Tracey H. Dehm**, RRT, MHA, a risk management coordinator in Florida, suggests that undertaking a root-cause analysis of the problem will help to identify quality concerns and improve upon the processes needed to prevent similar medication errors in the future.

Quite often, a poor system for dispensing medication can lead to situations such as this one. Common problems include work environments in which frequent interruptions lead a person to forget to do something, such as double-check dosage, and packaging two drugs in similar containers so that one is easily mistaken for the other. But of particular note in this case is that the medication error did not prompt an immediate investigation at the time of the incident.

"Recognizing that the overdose of aminophylline was a definite threat to the child's life, a thorough investigation would uncover pertinent issues that need to be identified to reduce the risk of an adverse event like this happening again," Dehm says. In fact, she points out that because the incident was not reported to governmental agencies, it would appear that the hospital was covering up something that went badly wrong.

Dehm suggests several solutions for risk managers to avoid a situation such as the one described in this case. First, risk management departments need to develop protocols for checking high-risk medications that can be lethal to patients. Such protocols should be circulated, well understood, and checked for compliance from time to time. It may be prudent practice for two nurses to check potentially lethal medications prior to administration.

Furthermore, although all patients deserve attention while prescribing medications, the young, old, and pregnant require a particularly high level of scrutiny. The dosage of a drug for these patients should start at the lowest effective level until it is determined that the dosage can be increased appropriately.

Indeed, in this case, officials at the defendant hospital stated that several remedial steps were taken in the aftermath of this situation. The facility installed an electronically controlled medication dispensing system at an annual cost of $350,000, and it tightened procedures to ensure that medication is diluted properly for newborn infants. Such computerized systems can effectively provide alerts, monitor restrictions, and offer suggestions for safer substitutes.

But although an electronic system may be preferable, it may not be the most effective choice for many health care providers given its price tag. In fact, the development and implementation of manual checking procedures may just as effectively act as a solution to inadvertent overmedication.

## *Reference*


• Snohomish County (WA) Superior Court, Case No. 00-2-04355-2. ■