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Wide-scale suicide assessments needed to avoid tragedy and significant liability

New patient safety goal puts spotlight on difficult task

Patient suicides don't just happen on locked psychiatric wards. They can happen in your emergency department, your critical care unit, or virtually any area of any health care facility. That characteristic is what makes the suicidal patient so difficult to detect and protect: They could be anywhere.

With suicides distressingly common in health care, and the potential liability huge, the topic should be at the top of any risk manager's list of concerns, experts say.

Suicide prevention has always been important, but a new National Patient Safety Goal from the Joint Commission on Accreditation of Healthcare Organizations is putting a renewed emphasis on this important task. The National Patient Safety Goal, which became effective on Jan. 1, 2007, states that "the organization identifies safety risks inherent in its patient population," and "the organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]" **(For more information, go to www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/07_hap_cah_npsgs.htm.)**

EXECUTIVE SUMMARY

A new National Patient Safety Goal emphasizes the need to detect patients at risk of suicide and to protect them from harm. Risk managers must ensure that all patients are adequately screened and that proper policies and procedures are in place.

- The risk of suicide is not restricted to psychiatric care.
- Lawsuits involving patient suicide can be difficult to defend.
- Proper documentation can be the key to showing you took all reasonable precautions.

Unfortunately, patient suicide is not such a rare event. In fact, patient suicide is the No. 1 sentinel event reported to the Joint Commission, accounting for 13.2% of all sentinel events between Jan.1, 1995, and March 31, 2006. Those figures should prompt risk managers to take the National Patient Safety Goal quite seriously, says the immediate past president of ASHRM, **Peggy B. Martin**, ARM, MEd, DFASHRM, senior risk management coordinator with Lifespan Risk Services in Providence, RI.

Risk managers typically are not involved in the direct assessment of a patient for suicide risk, but they must ensure that proper policies and procedures are in place, Martin says. Exactly what policies and procedures are appropriate will vary from one facility to another, she notes, because the risk of suicide is so different depending on the patient population. A health care facility with a dedicated psychiatric or mental health service will have a higher risk of suicidal patients, but even acute care hospitals and virtually any other type of health care facility still must be on guard. **(See p. 4 for information on how clinicians can help detect suicidal intentions.)**

"People think of all the precautions that are necessary on a psychiatric unit, but it can actually be harder to implement safeguards on other units," Martin says. "On a psych unit, everyone knows there is a risk with a high percentage of patients and you can take some universal precautions with everyone to screen and prevent suicide. In other departments you have to know when to screen and who to screen, and that can be a challenge."

Martin says risk managers should conduct risk assessments on all units that may treat patients at risk for suicide, with psychiatric units being the most obvious example. In those units, the physical environment should be configured so as to reduce the opportunity for suicidal behavior, with locked doors, limited access to items that could be harmful, and clear lines of vision for staff. All of those safeguards can be good on other units where the risk is less severe, but the risk manager will have to make some judgment calls.

"You can't treat every unit in your facility like a lock-down psychiatric unit," Martin says. "The physical safeguards won't always be practical, so that's where you have to depend on the expertise of your staff."

That dependence means you should ascertain how well clinical staff members assess suicidal behavior in patients, Martin says. While all physicians and nurses are trained to recognize suicidal tendencies, they may not always take the time — or have the time — to screen patients properly. Martin suggests meeting with physician and nurse leaders in the departments where suicidal behavior is most likely to occur, emphasizing the risk and the need to have a proactive plan for screening. A good place to start is the emergency department, because the high percentage of patients with drug or alcohol problems increases the risk, Martin says.

"Do they have a policy on looking for these patients at risk, and do they do it systematically instead of just waiting for very obvious signs? There should be an assessment in the emergency

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Duty to warn related to suicide prevention

It is not uncommon for patients who want to die to say that they're going to take someone else with them. Once those words are uttered, a health care provider will have to decide whether to warn the other person, explains **Stephanie Resnick**, JD, a partner in the litigation group of the law firm Fox Rothschild in Princeton, NJ.

"The short answer is that whenever there is a definite statement that the person is going to cause harm to another, then the hospital has to go outside the privilege of the doctor/patient relationship and actually warn the intended victim," Resnick says. "We have faced this with a client, and we got an emergency order that allowed the hospital to disclose the information, and therefore there could be no allegation by the patient that there was a breach of privacy or the physician/patient privilege."

This obligation is generally called "the duty to warn." In situations where there is clear evidence of danger to the client or other people, the health care provider must determine the degree of seriousness of the threat and notify the person in danger and others who are in a position to protect that person from harm, Resnick says.

The legal precedent of this concept was set in the case of *Tarasoff v. Regents of the University of California* in 1976. In this case, Posenjit Poddar, a University of California student, was seeing a psychologist at the university's student health center because a young woman, Tatiana Tarasoff, had spurned his affections. When Poddar told the psychologist he intended to buy a gun, the psychologist notified the police verbally and in writing. The police questioned Poddar and found him to be rational; they made him promise to stay away from Tarasoff. Two months later, however, Poddar killed Tarasoff.

The Tarasoff family sued, asserting that the defendants had a duty to warn the victim or her family of the danger and that they should have persisted to ensure the man's confinement. The court held that the therapists did have a duty to warn Tarasoff. Resnick notes that the ruling means it is not enough to notify the police. The court imposed an affirmative duty on health care providers to warn a potential victim of intended harm by the client. ■

department and again if the patient is admitted," she says. Once a patient is found to be at risk of suicide, the provider is obligated to certain precautions such as putting him on suicide watch and taking away his belt and shoelaces, Martin says. "There must be clear policies that are triggered when a risk is detected."

Documentation could save the day

Documentation also is a major concern with patient suicides. Martin explains that if a patient does commit suicide, the liability will hinge on whether the provider knew or should have known about the risk and whether adequate precautions were taken. **(See p. 4 for resources to assist in suicide prevention.)**

"Sometimes if patients are really determined to kill themselves, they will find a way no matter what you do," she says. "It is critical that the documentation be good enough to prove in court that you did everything you could, that you detected the suicidal behavior and did everything reasonable to stop it. That's where a risk manager can have real influence, by requiring top-notch documentation in these cases."

Martin notes that a patient suicide can be devastating to the clinicians on the unit, with far-reaching consequences to the institution, so the policy should include assessment and counseling for any caregivers who might be affected.

Health care providers have a special obligation to protect suicidal patients, but only when they could reasonably have foreseen that the patient was at risk, explains **Stephanie Resnick**, JD, a partner in the litigation group of the law firm Fox Rothschild in Princeton, NJ. The simple fact that a patient commits suicide while under your care doesn't automatically make you liable.

"When you get into what the doctor should have reasonably foreseen, that is completely fact sensitive," Resnick says. There is no "hard-and-fast" rule, and jurisdictions are split on how they view the question, she says. "The court would look to see how many visits the patient had with the psychiatrist or psychologist, for instance."

The liability for such a case can be huge, she says, and the amount usually depends on how

obvious the risk of suicide should have been to the health care provider. Resnick also points out that the suicidal patient sometimes expresses a desire to harm others, which can create an obligation to warn the other party. **(See p. 3 for more on the duty to warn.)**

Martin emphasizes that suicide cases can be especially difficult to defend. Risk managers may understand how difficult it can be to protect someone determined to commit suicide, but juries see such cases more simply: The person was under your care, and you let the patient commit suicide.

"We count on documentation of the assessment and whether we followed our own policies, doing what we should have based on the assessment," Martin says. "How available were psychiatric experts to the emergency department staff and other units when a problem occurs? That can be a very big deal."

Other important questions for the defense may include:

- How recently did you conduct a safety assessment of the area in which the person died? What did you find, and did you correct any potential hazards?
- Do you have a safety committee on the unit that continuously oversees safety measures and conducts record reviews?
- Was information about the patient's suicide risk properly handed off from one clinician to another?

Resnick notes that the National Patient Safety Goal ups the ante in terms of the health care provider's obligation. The duty to protect the patient has been clear for some time, but the goal underscores the fact that good medical care requires screening for suicidal intentions. Courts generally will find that there is a lesser duty on nonpsychiatric units such as an emergency department, she says, but there still clearly is a duty.

How much of an assessment, and exactly what type, will depend on the situation and what is practical under the circumstances, Resnick says. In an ideal world, clinicians would have the time to ask all patients a few questions to assess suicide risk, and a good policy would be that you assess all patients for suicide, she says. In the real world, they should conduct at least a broad screening whenever possible, Resnick advises.

"Yes, that kind of assessment will impose a burden on the emergency room, but I think it's good practice," Resnick says. "That doesn't mean you have to do a full-scale psychiatric assessment on all patients, but you probably should observe for any warning signs, ask some general questions, and then follow up as necessary." ■

SOURCES/RESOURCES

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- **Stephanie Resnick**, JD, Fox Rothschild, 2000 Market St., 10th Floor, Philadelphia, PA 19103-3291. Telephone: (215) 299-2082. E-mail: Sresnick@foxrothschild.com.

- **A Quick Reference Guide to assessing suicidal behaviors** from the American Psychiatric Association is available at www.psych.org/psych_pract/treatg/quick_ref_guide/Suibehavs_QRG.pdf. The full guideline is available at www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf. The full guideline contains tables of suicide risk and protective factors as well as a list of example questions to ask suicidal patients in assessing their risk.
- **The New South Wales Australia suicide guidelines include information** on reviewing risk in the emergency department at www.health.nsw.gov.au/pubs/2005/pdf/emergency_dept.pdf.
- **The National Suicide Prevention Lifeline web site offers** resources and a national crisis phone number [(800) 273-TALK (-8255)]. Web: www.suicidepreventionlifeline.org.
- **The *Textbook of Suicide Assessment and Management* is available** from The American Psychiatric Publishing in Washington, DC. The book includes a chapter on emergency services. The cost of the book (item 62213) is $85 plus $9.95 for shipping and handling. To order, call (800) 368-5777 or go to appi.org. Under "Books," click on "Featured Titles" and then "The American Psychiatric Publishing Textbook of Suicide Assessment and Management."

Suicide check requires diligence from clinicians

As much as risk managers may worry about the risk of patient suicide, they have to trust that the frontline clinicians are sufficiently skilled and dedicated to spotting patients at risk. The

risk manager can, however, provide leadership and administrative support, according to suicide prevention experts.

A proper assessment of your current suicide screening and prevention is the best place to start when addressing the issue, suggests **John Draper**, PhD, director of the National Suicide Prevention Lifeline at the Mental Health Association of New York City.

Draper advises risk managers to get a clear picture of what your institution does and clinicians in various departments do to screen patients for suicide risk before trying to implement any radical improvements. The organization's history of patient suicides also is important, Draper says, because it can point to physical areas, certain scenarios, or certain patient populations that may need attention.

That assessment probably will reveal what the organization is doing right, but it might be harder to spot what is not being done, he says. For that task, Draper suggests consulting with a suicide prevention expert who can highlight any gaps in training and brief clinicians on the latest research. "The information on how to prevent suicide is not static, and what clinicians learned 10 years ago may not be all there is to know," Draper says. "For instance, there is some new research that shows a key way to know a person is serious about suicide is when they say they are a burden on others and the usual mitigating factors — children and other family members they want to live for — are in fact aggravating factors. They think that their living makes it harder on those loved ones."

Risk managers should ensure that nonmental health clinicians have adequate training in suicide prevention, says **Shara Sand**, PsyD, clinical assistant professor of psychology and assistant director of clinical training at the Ferkauf Graduate School of Psychology in the Albert Einstein College of Medicine at Yeshiva University in Bronx, NY. Because the risk of suicide is greater in the mental health field, administrators and clinical leaders sometimes focus exclusively on whether clinicians in those areas are adequately addressing suicide, she notes.

"We are really thoroughly trained in the social work, psychology, and psychiatry fields to recognize suicidal patients, but I would say that other physicians and nurses are often so focused on the physical body that this concern is overlooked," she says. "I don't say this to be critical, but my experience has been that primary care doctors often miss just basic depression, let alone suicidality."

SOURCES

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One out of every three people will suffer from a major depression at some time in their lives, Sand says, and that prevalence means that simply asking a few questions of patients could spot potential suicides long before that person volunteers any information. Sand cautions that if a risk manager urges clinicians to screen more for suicidal tendencies, one very common response is that asking may actually increase the possibility of suicide by introducing the idea. That concern can be a significant obstacle, she says.

"People genuinely worry that the patient will say he never thought of suicide, but now that you mention it, that's a great idea. That's really not the case," Sand says. "A person who has never considered it seriously isn't going to be driven to suicide by an innocent question. But one who has considered it can benefit from being allowed to talk openly about it, about how much they've thought about the idea and whether they've made any plans." ■

NQF updates list of safe practices, urges disclosure

Risk managers who have been pushing for more full disclosure of adverse events now have more backing and can argue that informing patients is a significant step closer to being considered the standard of care. Disclosure to patients and family was one of the more significant additions to the recently updated list of "safe practices" endorsed by the National Quality Forum (NQF) in Washington, DC.

EXECUTIVE SUMMARY

The National Quality Foundation has added disclosure of adverse events to its list of safe practices. Risk managers often use the list to set in-house goals for patient safety and other improvement.

- The safe practices require a multidisciplinary approach.
- Clinicians should be educated about how to disclose adverse events.
- Resources are available for help in implementing the safe practices.

In 2003, NQF endorsed 30 safe practices that should be universally utilized in applicable health care settings to reduce the risk of harm resulting from processes, systems, or environments of care. To ensure the practices reflected new evidence and innovation, NQF recently updated the list of practices, adding three new practices and materially changing 23 practices from the initial list. Another four practices remain unchanged. **(Detailed specifications and information on the recommendations may be found at www.qualityforum.org. Click on "News" and then the Oct. 16, 2006, announcement titled "NQF Updates Endorsement of Safe Practices for Better Healthcare.")**

The key change for risk managers is the addition of this safe practice: Following serious, unanticipated outcomes, the patient and, as appropriate, family should receive communication about the event.

Road map to quality

The NQF web site provides support for implementing the safe practices, including examples of effective strategies and tools for measuring success, notes **Melinda Murphy**, RN, MS, CNA, senior vice president of NQF. Some of the practices were changed to more accurately reflect the intent of the goal, plus current thinking on the topic, she says. For instance, one practice was changed to note that the health care provider should not just "create" a culture of safety but also "sustain" it once the change is made.

"The updated list makes it clear that none of this work is based in one person, which should resonate with risk managers," Murphy says. "There can be a tendency to say that this is all the responsibility of the risk manager or the quality manager, but this updated list should make it clear that this is the whole organization's responsibility. The risk manager and top administration play key roles."

Murphy says the list, even with the updates, should not come as any surprise to risk managers who already are addressing patient safety in a proactive, systematic manner. For many, the updated list may serve as reinforcement that you are doing the right thing, and it may provide backup if anyone doubts the necessity of a strategy you promote, she says. "If you are in an organization that is not so highly evolved, the list can be a road map of where you want to go," Murphy says. "It can help you make incremental changes and intervene, as well as how to make sure your intervention is working."

Disclosure a key change

The new safe practice regarding disclosure already is creating a sensation in the health care community, Murphy says. Many risk managers welcome the NQF's backing of an idea that sometimes meets resistance.

"With that safe practice there is the expectation that there will be education for clinicians on how to disclose, and that that support will be provided in a nonthreatening, nonpunitive way," Murphy says.

The American Society for Healthcare Risk Management (ASHRM) in Chicago was involved with updating the NQF list and encouraged the addition of the new practice on disclosure, says executive director **Elizabeth Summy**, CAE. "This is about the culture of organizations, and we support that," she says. "We commented on the proposed changes and communicated our position on these topics. Overall the tone and approach from the NQF was excellent, and we're glad to see this kind of support for the work of risk managers."

Summy directs risk managers to a useful ASHRM resource for encouraging full disclosure A "pearls" document outlining strategies and tips costs $20 for ASHRM members and $25 for nonmembers. For more information, go to www.ashrm.org. Choose "resources" and then "pearls." A free preview of the document is available on-line at www.ashrm.org/ashrm/resources/files/Pearls.Disclosure.TOC.pdf.

"That is a new resource that became available in just the past few months, and it has some ideas

SOURCES

For more information the updated list of safe practices, contact:

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- **Elizabeth Summy**, Executive Director, American Society for Healthcare Risk Management, One N. Franklin St., Chicago, IL 60606. Telephone: (312) 422-3989. E-mail: esummy@aha.org.

about how to structure the practices in your organization," Summy says. "We know that most organizations have a disclosure policy and are starting to move this issue forward, so we are looking at determining what are the best practices and how to disseminate those." **(For more on disclosure, see *Healthcare Risk Management*, November 2006, p. 121.)** ■

Nurses resist sharps program if not consulted

Most risk managers have attempted to reduce needlesticks and the associated costs, and there is no shortage of strategies and devices to aid in the effort. But commonly, the risk manager reviews the data after six months or a year and sees no significant improvement.

So what went wrong with a plan that looked so good on paper?

The answer, say those who have studied how sharps safety programs actually go over in the workplace, is that nurses and other clinicians often do not embrace a sharps program that was developed without their input. Their resistance is sometimes justified, the experts say, if the proposed solutions are not realistic in the day-to-day work environment. **(See article, p. 9, for statistics on needlestick injuries and staff perceptions.)**

In response to a rise in the number of needlestick injuries in its operating rooms, Hartford (CT) Hospital conducted a study to better understand why staff members sometimes resisted efforts to reduce sharps injuries. The study focused on the perceived barriers to safety, and the study leaders discovered that communication problems with physicians and feelings of powerlessness among nursing staff were lead factors, says **Andrea Hagstrom**, perioperative services nurse educator, who led the study. In the past year, the results of the study prompted the formation of a staff-led safety committee, made up of nurses and some technicians, and a physician-led initiative to gain practice change buy-in. **(See p. 8 for more on how Hagstrom worked with physicians.)**

The efforts have empowered nurses to enforce the new safety practices and improved the hospital's needlestick injury rates, Hagstrom says. Specific data on the number of needlesticks are not yet available, she says, but she already can tell the data will show a substantial decrease.

Staff members cite powerlessness as deterrent

Immediately following the passage of the Needlestick Safety and Prevention Act of 2000, Hartford Hospital updated its needlestick safety procedures and experienced a decrease in related injuries. However, needlestick injury rates began to worsen after the initial safety blitz, especially in the operating rooms, where 33% of hospitalwide needlestick injuries occurred in the first quarter of 2004, compared with 25% in 2002, Hagstrom says. In a continued effort to reduce needlestick injuries, Hartford in 2004 implemented a hospitalwide campaign to promote a newer type of safety needle, including inservices on how to use it.

"However, physician compliance with the new policy was lower in the OR than in other areas of the hospital, and nurses felt that surgeons were not aware that we were trying to implement a

EXECUTIVE SUMMARY

A recent study revealed the main reasons some clinicians resist efforts to reduce needlestick injuries. Staff members resist sharps safety programs when they feel they are imposed on them rather than being consulted for their opinions.

- The way a strategy is introduced can determine its success or failure.
- Physicians may be especially resistant to change.
- One solution is to have staff test new devices or policies before deciding what to implement.

new practice," Hagstrom says.

As a result, Hagstrom decided to study staff perceptions to pinpoint the reasons for the problem. Hagstrom gathered a group of five perioperative nurses and seven certified surgical technologists to participate in focus group discussions.[1] During four one-hour sessions, Hagstrom asked participants to describe their risk of exposure to needlestick injuries in the OR, their power to implement practice changes to prevent needlestick injuries, and their perceived barriers to successful practice changes. These are the barriers cited by the group:

- inadequate horizontal and vertical communication;
- powerlessness;
- resistance to change;
- intimidation;
- inconsistencies in practice;
- negative attitudes;
- inexperience of medical and nursing staff members;
- time constraints.

Investigate current culture first

Assessing the culture and how the staff members perceive their working environment is key to successfully reducing needlesticks, Hagstrom says.

"You can buy the latest toys and gadgets to reduce injuries, but if you don't assess the climate and how people work, you're just shooting in the dark," she says. "It can be hard for people who are enthusiastic about an initiative to understand why others aren't embracing it. The answer usually gets back to how you rolled in and started telling them how great this is without first asking them for their opinion."

Using what she learned from the study, Hagstrom recently had a smooth introduction of a strategy called the "neutral zone," which involves keeping an area free of hands-passing equipment. Building on the feedback about how staff sometimes felt toward a policy introduced without warning or their input, she started by first consulting them for their opinions and then introducing the idea itself to the staff in general.

"We started off with little information sessions and posters. Sending e-mails and hard copies doesn't work, so we had our print shop make posters that we plastered all over the place," she says. "When we actually had the inservice for the staff, it was a smooth implementation because they were ready for it."

Have staff test new devices

A risk manager with experience in needlestick prevention says Hagstrom's work is a valuable reminder about how the success of a safety program depends not just on the strategy itself but also how it is introduced. **Patricia Tydell**, MSN, BSN, MPH, accreditation facilitator and formerly the risk manager with North Chicago Veterans Administration (VA) Medical Center, has studied needlestick prevention for the VA from a risk management perspective.

"You can have the best program in the world, but people can be resistant to change," Tydell

Surgeon buy-in can be hard for needlestick effort

Surgeons don't want to be surprised, and buy-in from their leaders is essential to any needlestick prevent effort, says **Andrea Hagstrom**, perioperative services nurse educator at Hartford (CT) Hospital.

Hagstrom has targeted physicians' resistance to practice change with quantitative and qualitative reports to the hospital's largest physician group. Hagstrom notes that she did not gain much support when she first went to the group with needlestick injury data 1½ years ago; however, she persisted in bringing the compliance issue to the forefront of the physicians' agenda.

Once Hagstrom brought the results of her own research and an extensive literature search — including information from the Occupational Safety and Health Administration — the physicians heeded her call for change. The physicians group has since started needlestick safety education projects of its own, stressing the topic in mass communication to physicians and inviting Hagstrom to present more information almost quarterly.

Because these efforts were generated within their community, surgeons have increased compliance with safety procedures, Hagstrom says.

"It's a double-win, because not only do you get better compliance from the physicians and that reduces injuries, but then other staff [members] see that and take a cue that they should comply also," Hagstrom says. "Just like with other staff, maybe more so, physicians want to feel like they're doing something they had a role in deciding, rather than something they're just ordered to do." ■

SOURCES

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- **Patricia Tydell**, MSN, BSN, MPH, Accreditation Coordinator, North Chicago Veterans Administration Medical Center, 3001 Green Bay Road, North Chicago, IL 60064. Telephone: (847) 688-1900.

says. "We have a policy here at the VA that before we choose any device to prevent needlesticks, we have to have frontline input. They have to actually use the product for a certain amount of time and give us feedback."

Doing that kind of work up front yields less resistance when you make a decision later and introduce the new product or policy to the staff. You still may have to say the new procedure is mandatory, but you can note that most of the staff liked it in the test run or that the feedback was mostly positive, she says.

"All of this may be heightened when you're talking about surgery," Tydell notes. "They run a tight ship in the operating room, and nobody likes surprises; so if they open a pack and it has a device that is unfamiliar, people are going to be unhappy. You have to avoid giving the impression that you're walking on to their turf and telling them what to do, but that's easy to avoid if you solicit feedback."

Reference

1. Hagstrom AM. Perceived barriers to implementation of a successful sharps safety program. *AORN J* 2006; 83:391-397. ■

Study: Needlestick injuries still a major concern

A new study from Inviro Medical, an Atlanta-based maker of needlestick prevention devices, reveals that needlestick injuries affect the vast majority of nurses, and nearly half (47%) said they had been stuck by a contaminated needle. In addition, an overwhelming majority of infection control professionals and nurses believe current safety syringe designs need improving.

The 2006 Study of Needlestick Injuries and Safety Devices is an independent nationwide study of directors of infection control and nurses. The national study included two survey instruments. The first included responses from 147 directors of infection control, and the second survey consisted of responses from 188 nurses. **Mike Neumeier**, principal of Arketi Group, the Atlanta consulting firm that completed the study for Inviro Medical, says it is the first comprehensive survey of health care workers on this topic since the Needlestick Safety and Prevention Act became law in 2000.

Most nurses have been stuck

The study showed the majority of U.S. nurses (64%) had been accidentally stuck by a needle while working; nearly half (47%) of all nurses surveyed reported being accidentally stuck by a contaminated needle.

When asked if there was room for improvement in the design of current safety syringes, an overwhelming majority of infection control directors and nurses said yes (97% and 96%, respectively). Illustrating this belief, 70% of infection control professionals and 65% of nurses thought that safety syringes with retrofitted designs, which today account for 95% of the market, were not the most effective design to protect clinicians. Retrofitted safety syringes refer to nonsafety syringe designs that have been modified with an added shield, sheath, or cap to meet industry safety regulations. Inviro Medical makes a device with integrated safety features.

Gareth Clarke, CEO of Inviro Medical, notes that the study also found the overwhelming majority of infection control directors and nurses worry about accidental needlesticks. In fact, 82% of infection control directors believe needlesticks remain a significant hazard, and even more nurses (88%) cite them as a serious hazard.

The majority of infection control directors and nurses believe needlestick injuries are underreported (63% and 86% respectively), according to the survey. However, the two groups differ on the reasons why. Forty-five percent of infection control directors said the main reason is because clinicians are too busy to report them; 27% said the follow-up time takes too long; 11% believe clinicians may be afraid of workplace consequences associated with reporting needlesticks. Nurses, on the other hand, are more likely than

SOURCES

For more information the 2006 needlestick survey, contact:

- **Gareth Clarke**, CEO, Inviro Medical, 3235 Satellite Blvd., Building 400, Suite 300, Duluth, GA 30096. Telephone: (770) 291-2186.
- **Mike Neumeier**, Arketi Group, 1961 N. Druid Hills Road, Building B, Suite 101, Atlanta, GA 30329. Telephone: (404) 929-0091.

infection control directors to cite a concern for workplace consequences (23%) as the reason they believe needlestick injuries are underreported. **(Results of the study can be downloaded at: www.inviromedical.com. Select the pull-down menu from "About Us" on the home page, and then "2006 Needlestick Study.")** ■

Doctors who err are prone to burnout, more mistakes

Study: Perception, not actual error, is key

If a physician makes a significant error, it may be a good idea to keep an eye on him or her and watch for signs of serious burnout and more mistakes to come. That is the warning from a new study that says one error often is followed by another.

Interestingly, there doesn't even need to be an actual error for this pattern to start. Physicians who believe they have committed a major medical error in the previous three months, whether they really did or not, are more likely to report symptoms of burnout and depression, says **Tait Shanafelt**, MD, a physician at the Mayo Clinic in Rochester, MN, who led the study team. The burnout and worry over the previous error may also increase the risk of a future error, the study suggests.[1]

A 1999 Institute of Medicine report said as many as 100,000 patients die each year because of preventable medical errors. Since then, several studies of physicians in medical and surgical residency programs have found that a significant proportion of medical trainees make medical errors, Shanafelt notes. Previous studies asking residents about errors had taken a single snapshot in time or asked residents to look back on their entire residency and recollect whether they had made a serious error. The Mayo study is the first to follow a group of residents prospectively, which enabled researchers to examine the relationship between physician distress and the future likelihood of an error, Shanafelt says.

"We knew from previous studies some of the effects on physicians of making an error," Shanafelt explains. "This new study takes it a step further, enabling us to see the time relationship between errors and burnout, and vice versa."

The researchers followed 184 medical residents from 108 U.S. and international medical schools who were continuing their training in the Mayo Clinic Rochester Internal Medicine Residency program. Residents completed quarterly surveys asking, "Are you concerned you have made any major medical errors in the last three months?" They also completed validated survey instruments to measure quality of life and burnout and to screen for depression.

On average, 14.7% of the participants reported making an error in the previous three months on each quarterly survey. Those who reported an error experienced substantially higher levels of burnout and were more than three times more likely to have a screening test indicate possible depression.

Future errors more likely

The connection between errors and various measures of distress also operated in reverse; those who scored high on burnout measures were twice as likely to report an error in the next three months as those with low burnout. The study also found a trend toward increased future errors for physicians with symptoms of depression. "Not only are physicians who perceive they have made errors more likely to experience burnout and symptoms of depression, but those who are distressed appear more likely to make an error in the next three months," Shanafelt says.

Colin West, MD, PhD, another author of the study and a physician at the Mayo Clinic, says the study findings should be useful to risk managers. Much of the quality improvement movement has rightly focused on adjusting systems to prevent errors, he says, "but our study highlights the human dimension. If a physician is experiencing personal distress, it makes a future error more likely. Making an error also has a strong effect on burnout, empathy, and depression, and this

forms a vicious cycle that can negatively impact patient care."

Shanafelt and West urge risk managers to establish efforts to prevent, identify, and treat burnout in physicians, for the benefit of their patients. A good first step, they say, is to meet with department chairs and other physician leaders to discuss the risk and look for ways to intervene.

(Editor's note: A good resource for addressing physician burnout is the American College of Physicians web site at www.acponline.org. Enter "physician burnout" in the search box to find multiple sources of information.)

Reference

1. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy: A prospective longitudinal study. *JAMA* 2006; 296:1,071-1,078. ■

Cost of adverse events borne by provider

New report issued by AHRQ

Improving patient safety can have a direct effect on the bottom line, according to a new report from the Agency for Healthcare Research and Quality (AHRQ). The analysis reveals that though Medicare pays hospitals a substantial amount of money for adverse events that occur during hospitalization, providers are left holding the bag for even more.

The study found that Medicare paid an additional $300 million per year, or 0.3% of annual Medicare hospital spending, for five types of adverse events in hospitals in 2003.[1] However, these extra payments covered less than one-third of the additional costs that hospitals incurred in treating these adverse events.

Under Medicare's hospital payment system, hospitals are reimbursed a set amount for a patient's condition or diagnosis-related group (DRG), determined at admission. The study by AHRQ researcher **Chunliu Zhan**, MD, PhD, found the DRG changed only in a small number of cases. For example, the DRG changed in 1% of cases in which a patient had postoperative bloodstream infections, and it changed in 10% of cases for patients who experienced postoperative bleeding. Even if the DRG doesn't change, adverse events may result in additional costs, for example if the patient needs to spend more time in the hospital, Zhan says.

The study estimates that Medicare extra payments under the hospital prospective payment system (PPS) range from about $700 per case of decubitus ulcer to $9,000 per case of postoperative sepsis in the five types of adverse events identifiable in Medicare claims.

Zhan says, "We conclude that both Medicare and hospitals gain financially by improving patient safety."

Reference

1. Zhan C, Friedman B, Mosso A, et al. Medicare payment for selected adverse events: Building the business case for investing in patient safety. *Health Affairs* 2006; 25:1,386-1,392. ■

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. ■

COMING IN FUTURE MONTHS

- Lessons from auto industry reduce injuries
- Covert video surveillance: Pros and cons
- Limiting calls for critical lab results
- Creative safety program patterned on football

CNE 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 **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.

1. According to Peggy B. Martin, ARM, MEd, DFASHRM, how serious a problem is patient suicide?
A. Risk managers should take the problem quite seriously because it is the No. 1 reported sentinel event.
B. It is not a serious problem.
C. Patient suicide is a problem only in locked psychiatric units.
D. It is only a serious problem for patients younger than 25 years old.

2. What usually determines the amount of liability for a patient suicide, according to Stephanie Resnick, JD?
A. Age of the patient.
B. How obvious the risk of suicide should have been to the health care provider.
C. The time interval since admission.
D. Whether the physician had previously treated the patient.

3. According to Andrea Hagstrom, what is one key to successfully implementing a needlestick prevention program?
A. Solicit staff and physician input before implementing the change.
B. Introduce the change quickly, and emphasize that compliance is mandatory.
C. Inform only physician leaders beforehand and let them educate staff.
D. Impose a one-month moratorium on complaints.

4. According to Tait Shanafelt, MD, what is likely to happen within three months after a physician makes an error?
A. A lawsuit will be filed.
B. The physician will resign.
C. The physician will make another error.
D. Staff will complain about working with the physician.

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

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

Failure to diagnose large pleural abscess leads to $227,500 verdict

By **Blake J. Delaney**, Esq.
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News: A middle-aged woman went to the emergency department complaining of abdominal pains. After testing and evaluation indicated intestinal inflammation and a possible abdominal cyst along with diverticular disease, the hospital began the patient on a course of antibiotic therapy. Over the next three days at the hospital, the woman's health did not seem to improve. Nevertheless, her condition was characterized by her doctor as "stable," and she was discharged. After two days at home, the woman began gasping for breath and was rushed to another hospital's emergency department, where she ultimately died. An autopsy showed that the respiratory failure had been caused by a massive abscess in the woman's abdomen, itself possibly caused by diverticular disease. After a jury trial, a verdict of $227,500 was entered in favor of the decedent's husband.

Background: After experiencing abdominal pain and nausea for three days, a 55-year-old woman went to the emergency department. A trauma surgeon evaluated the woman and diagnosed her with a possible large abdominal mass or cyst. The surgeon ordered that the woman be admitted for further evaluation. The patient subsequently underwent a CT scan, the results of which showed possible diverticular disease, characterized by sacs having formed in the wall of the large intestine. Because the radiologist reviewing the CT scan also noted inflammation of the patient's distal colon and suspected that her large intestine may have been perforated, causing infection, he ordered immediate antibiotic therapy and an exploratory laparotomy to be conducted two days later to examine the patient's abdominal organs.

Later that day, the patient began feeling better, causing doctors to rethink the need for emergency surgery. But nurses noted that the woman was experiencing shortness of breath, and her blood work indicated a continuing infection. Even more, a subsequent chest X-ray indicated some difficulty with her lungs to the point that a follow-up X-ray was ordered.

On the woman's third day in the hospital, another CT scan was taken that showed increased inflammation around the woman's descending colon as well as new fluid around her stomach. The trauma surgeon concluded, however, that these changes were not significant enough to alter the patient's current course of antibiotic therapy treatment. The following day, the patient was noted to still be short of breath, her pulse oximeter readings were low, and her blood work showed a 12,600 white blood count with 82 segmentations. Nevertheless, the surgeon discharged the woman and claimed that his patient's condition was stable, even though he acknowledged a potential problem with her large intestine.

Once at home, the woman continued to endure

symptoms. She was confined to a wheelchair, needed help to get into the car, couldn't walk up a few stairs at the time without a good deal of distress, and was unable to lie down without feeling as if she was drowning. Consequently, she spent the following two nights and one day sitting in a chair.

The following day, her breathing became so labored that she called 911 for emergency assistance. She was rushed to a different hospital's emergency department, where she arrived gasping for breath. Shortly thereafter, the woman's pulse was lost, and immediate resuscitation was attempted. Following partial resuscitative success, the woman was taken to the intensive care unit, where a CT scan showed her left lung becoming opaque and a rightward shift of her heart, aorta, esophagus, and trachea. A pulmonologist at the second hospital concluded that the woman had suffered respiratory failure following a massive accumulation of fluid in an abscess on her left side. Hospital personnel worked quickly to drain 1,200 cc of fluid from the abscess, estimated to be 12 cm by 15 cm. The woman was placed on a ventilator to assist her with breathing.

Two days later, an electroencephalogram showed profound and irreversible brain damage. The woman was removed from the ventilator and subsequently died, with a final diagnosis of severe anoxic encephalopathy, cardiorespiratory arrest, unilateral pleural effusion, and left pericolic abscess. An autopsy showed no specific perforation site in her large intestine, but the abscess was thought to have formed due to such a perforation.

The woman's husband sued the trauma surgeon and the first hospital for negligence, and he claimed that the defendants failed to appreciate the woman's condition before discharging her. The plaintiff claimed that by failing to recognize that the blood work upon discharge clearly indicated a vigorous infection process at work, the defendants' conduct allowed the abscess to grow to the point of infecting his wife's lungs. The plaintiff maintained that had the trauma surgeon simply kept his wife in the hospital for a longer period of time, even just for observation, her infection never would have been able to spread such that it essentially asphyxiated her.

In their defense, the surgeon and the hospital insisted that administering the antibiotic therapy was all that should have been done for the woman and that the woman was not suffering from a lung infection when she presented to the hospital. The defendants also faulted the woman's failure to communicate fully and honestly regarding her condition — such as when she claimed she was feeling much better — as a major contributing factor to her damages. The defendants further deflected blame by faulting the ambulance service for its handling of the woman while taking her to the second hospital.

Leading up to trial, the plaintiff's final offer was $500,000, which the defendants failed to accept. A jury ultimately returned a verdict in favor of the plaintiff, finding the trauma surgeon to be 65% percent negligent and the plaintiff to be 35% at fault. The jury awarded a gross award of $350,000, representing $150,000 for pain and suffering and $200,000 for the husband's claim of loss of society and companionship. The award was reduced to $227,500 to account for the decedent's comparative negligence.

What this means to you: This case is unusual in that it appears that the emergency department's initial treatment of the decedent was appropriate. A trauma surgeon correctly diagnosed the woman with a possible large abdominal mass, ordered a CT scan, and admitted the woman and started her on IV antibiotic therapy with a plan to perform exploratory surgery. "Unfortunately, once admitted, appropriate care became compromised," says **Ellen L. Barton**, JD, CPCU, a risk management consultant in Phoenix, MD. "When the patient stated that she was feeling better, the physicians hesitated to execute the plan."

One of the major issues underlying this scenario is the lack of communication between the patient and the health care providers, and between the providers themselves. For example, Barton points out that the communication between the nurses and physicians was compromised. Although the nurses noted that the patient was experiencing shortness of breath and her blood work indicated a continuing infection, it does not appear that this information was appropriately communicated to the attending physicians. And even more, despite the test results and the continuing complaints from the patient regarding shortness of breath, the trauma surgeon then made a disastrous decision to discharge the patient.

"How he could have viewed this patient as stable is puzzling," says Barton. But Barton is quick to recognize that the information available in this scenario does not detail what other circumstances

may have been at work, including "payer pressure to discharge." And finally, Barton notes the question that is raised by the facts as to what kind of discharge instructions the patient was given. "The fact that she spent two nights and one day unable to leave a wheelchair indicates that the patient's condition was not only *not* improving, but was, in fact, deteriorating. The patient should have been given instructions to return to the hospital if her symptoms did not improve or got worse within hours . . . not days."

Barton suggests that this case puts a much-needed focus on communication in the health care setting and on the discharge planning process. The practitioners in this scenario, for example, could have improved their treatment in at least four ways. First, while the patient may have indicated that she was feeling better, the physicians had access to test results and observations from nursing staff that indicated that the patient still was compromised. Second, the nurses had an obligation to communicate concerns directly to the attending physicians and to intervene, if necessary. Third, even though the discharge planning process begins at admission, it involves a continuous evaluation of the patient, test results, nursing observations, and physician assessment. In this case, it appears that the process did not work as it should have. And fourth, this case emphasizes the need for personalized discharge instructions. Specifically, Barton notes, the patient must be provided with clear and understandable instructions that allow the patient to look for certain symptoms or conditions and then take appropriate actions on them. Also, health care facilities have to be aware of the "unspoken" communication that the very fact of discharge indicates to patients that they are better. "Otherwise," Barton questions, "Why would they still be discharged?"

Of course, as Barton is quick to point out, there is no question in this case that the patient did not act in her own best interest. She inappropriately delayed seeking further medical treatment, which contributed to her eventual death. Nevertheless, communication among her health care providers and with the woman herself undoubtedly would have increased her chances of survival.

"Although patients clearly have a role in their own health care, they are not professionals," Barton says. "That fact needs to be recognized in not only caring for them, but in asking patients to help care for themselves."

Reference

• Milwaukee County (WI) Circuit Court, Case No. 98 CV 007325. ■

OR fire breaks out, leads to $450,000 settlement

News: A man underwent surgery following a heart attack. During the procedure, the seal on the oxygen tube inserted in the patient's throat broke, causing the oxygen to catch on fire. The man suffered severe injuries and subsequently died. His estate sued the surgeon and the nurse anesthetist for negligence, but the defendants claimed that the decedent's death was due to his heart ailment — not the burns. The parties settled the case for $450,000.

Background: An 81-year-old retired teacher suffered a heart attack and was rushed to the hospital. After doctors decided to insert an oxygen tube in the man's windpipe to assist him with breathing, an otolaryngologist used an electrical surgical tool to seal off blood vessels in the man's throat. A nurse anesthetist then accidentally broke the seal on the oxygen tube, and the highly flammable oxygen caught fire, burning the man's mouth, trachea, and bronchial tubes, charring the inside of his windpipe, and melting the oxygen tube. The man died 19 days later.

The man's wife sued the otolaryngologist and the nurse anesthetist. She claimed that fire was a known risk and that when the seal broke, the defendants should have known that fire would result. The plaintiff also pointed out that the state had cited the hospital for "faulty practices" following the incident, causing the hospital to institute new operating room procedures and training programs.

The defendants acknowledged that the fire occurred but denied that it was anything other than a tragic accident. They claimed that the man's death resulted from his heart ailment and not the burns. Nevertheless, during the trial, the parties settled the case for $450,000. An informal poll of jurors following the settlement showed that they would have rendered a verdict in favor of the defendants. Apparently they thought that the defendants started the fire but that the burns did not cause the decedent's death.

What this means to you: The first issue raised by this scenario is what preventative measures could have been taken by the hospital to prevent the incident. Fires like these are simply not that common, says **Edward J. Carbone**, Esq., shareholder at Buchanan Ingersoll in Tampa, FL. Apart from the possibilities that the fire was the result of a defect in the operating equipment or a short circuit, the fire likely started as a result of the hospital's negligence. Carbone notes that nurses and medical staff members have a duty to know that electricity and oxygen are a dangerous combination. The oxygen supply must be kept as far away from the electricity as possible, and strict precautions must be followed during the procedure.

Accordingly, Carbone would not have been surprised if the jury had rendered a verdict in favor of the plaintiff. After all, he notes, the hospital's primary defensive tactic was to dispute causation, which is often not well regarded by juries. "A causation defense admits that the hospital engaged in negligent behavior, but disputes that the behavior was the legal cause of the plaintiff's injuries. Unless the plaintiff's theory on causation is entirely unrealistic, this is a hard argument to sell to a jury," he says.

When causation becomes the primary issue in a case, the plaintiff will argue that the patient would have lived for many more years in good health had the defendant not engaged in the negligent conduct, whereas the defendant will maintain that its conduct played no role in the plaintiff's ultimate injuries and that any bad outcome was simply the result of a natural course of events. In those cases, Carbone thinks that juries, more often than not, side with the plaintiff because "quite frankly, an injured patient is more sympathetic than an institution which has already admitted that it engaged in negligent conduct." For that reason, Carbone is not surprised that the hospital was anxious to settle the case. A settlement carries certainty, and there is probably no reason why the hospital should have suspected that the jury would have returned a defense verdict.

One final issue raised in this scenario is the hospital's choice to institute new operating room procedures and training programs following the incident. State evidence codes universally prohibit the admission of subsequent remedial measures as evidence of a defendant's negligence. The policy underlying this exclusionary rule is that a defendant should not be discouraged from implementing new procedures or training programs that might be able to prevent future injuries. Carbone points out, however, that a creative plaintiff's attorney usually will be able to find a way to admit such remedial measures into evidence, sometimes rendering the exclusionary rule useless. "Nevertheless," he advises, "a hospital should never think twice about changing certain policies and procedures if it means raising the overall standard of the care. Preventing evidence of liability from being established in one case cannot justify foregoing an overall improvement in patient care."

It is, of course, difficult to know whether the hospital's settlement for $450,000 was the best result in this case. Laws dictating what damages are compensable and how much a decedent's survivor may recover vary from state to state. Regardless of a facility's location, however, Carbone urges risk managers to constantly evaluate and update — if and when necessary — their policies and training programs relating to operating room procedures. A comprehensive policy will speak to the use of, and risks inherent in, all tools found in the OR. This scenario presents just one example of the potential dangers.

Reference

• Massachusetts Superior Court, Norfolk County, docket information withheld. ■

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Dear *Healthcare Risk Management* Subscriber:

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

Healthcare Risk Management, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help your staff make informed decisions concerning treatment options and administrative practices. Our intent is the same as yours — the best possible patient care.

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- **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 hopitalus, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice.

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You then can compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester, you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is health care risk managers and other professionals.

Those participants who earn nursing contact hours through this activity will note that the number of contact hours is decreasing to 15 annually. This change is due to the mandatory implementation of a 60-minute contact hour as dictated by the American Nurses Credentialing Center. Previously, a 50-minute contact hour was used. AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,

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