Healthcare Risk Management™

Celebrating our 28th year as your first source of risk management information
28th year

AHC Media LLC

IN THIS ISSUE

Financial Disclosure: Author Greg Freeman, Associate Publisher Coles McKagen, Senior Managing Editor Joy Dickinson, Nurse Planner Maureen Archambault, and Blake Delaney, author of *Legal Review & Commentary,* report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

MAY 2007
VOL. 29, NO. 5 • (pages 49-60)

Infant abduction raises questions about health care security and vigilance

Latest kidnapping shows familiar weaknesses and flaws in system

The community of Lubbock, TX, was shocked last year when a newborn baby was stolen from its mother, who had come to trust the accused kidnapper because she appeared to be on staff at the hospital. It would seem the community's hospitals would be on high alert for infant abduction after having seen firsthand how the crime can happen if staff is not vigilant.

But another Lubbock hospital recently was reminded that staff can never, ever let their guard down in the nursery unit.

The latest infant abduction occurred across town from another hospital that experienced a very similar incident in 2006. In that crime, a woman ingratiated herself with a mother by posing as a hospital employee and wearing scrubs that gave her the right look, and then she kidnapped the baby soon after the mother and child left the hospital. The baby was recovered unharmed. **(For more on that incident, see *Healthcare Risk Management*, August 2006, p. 85.)**

The most recent incident occurred across town in a very similar manner. On March 10, 2007, a woman posing as a medical worker walked out

EXECUTIVE SUMMARY

A recent infant abduction in Texas is focusing attention on whether health care providers are letting down their guards about this risk. The incident was carried out in a manner typical of most other abductions, yet it was not stopped by the security measures in place.

- The abductor posed as a hospital employee.
- The baby had an ankle bracelet that set off an exit alarm.
- Reports indicate the abductor was on the newborn unit for some time without being challenged.

of Covenant Lakeside Hospital in Lubbock with a 3-day-old baby in her purse. The newborn was found a day later unharmed in Clovis, NM, about 100 miles away, after a tip from someone who thought the woman matched the description of the abductor. Federal authorities charged her with kidnapping.

Similar strategy as other incidents

According to reports from the Lubbock Police Department, the kidnaper's strategy was virtually identical to the incident a year earlier in Lubbock and to many other incidents of infant abduction: A woman entered the nursery unit wearing surgical scrubs that gave her the appearance of being on staff at the hospital. She visited the mother's room several times looking for an opportunity, convinced the woman that the baby needed to be taken for tests, and then walked out of the hospital with the infant hidden in a large purse.

The infant was wearing a security tag on an ankle, but security cameras showed the woman exiting the hospital without being challenged. **Gwen Stafford**, a senior vice president at Covenant Health Systems, told the *Lubbock Avalanche-Journal* that the hospital's security measures did not malfunction, but she declined to say how the abductor beat the system. **John B. Rabun**, executive vice president and chief operating officer of The National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA, has investigated the incident and tells *Healthcare Risk Management* that the abductor removed the security tag before exiting the building. **(See p. 53 for more on the limitations of infant security tags.)**

Rabun says the woman took the infant out of the room in a bassinet and wheeled it past an unoccupied nurses' station to a utility closet at the end of the hall. She then removed the security tag, which was attached with Velcro. The abductor replaced the hospital's baby blanket with one she had brought and then took the baby down an elevator that is out of the line of sight of the nurses' station in the unit.

Removing the ankle bracelet activated it, Rabun says, but apparently the hospital programmed the bracelets with a delay timer so that the Velcro attachment could be adjusted without setting off the alarm. After a delay, the ankle bracelet set off the infant abduction alarm, but by then the woman had taken the baby downstairs to a building exit.

Rabun says the delay timers on the bracelets are a problem. He doesn't know how long the delay was set on this bracelet, but he says he has seen some set as long as three minutes — which gives an abductor a lot of time to escape with the child.

"There's also the question of whether everyone understood the system. Some hospital leaders have said they thought the alarm would automatically lock down the hospital, which it clearly did not," Rabun says. "The risk manager at that hospital has to get in there big time and say, 'What happened here?'"

A relative of the accused woman, Rayshaun Parson, told the *Associated Press* that the woman had recently experienced her second miscarriage.

Healthcare Risk Management® (ISSN 1081-6534), including **HRM Legal Review & Commentary**™, is published monthly by AHC Media, LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Healthcare Risk Management**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $495. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $545. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

Healthcare Risk Management® is intended for risk managers, health system administrators, and health care legal counsel.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Greg Freeman**, (770) 998-8455.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher, **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-5159, (joy.dickinson@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

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

Since being arrested, Parson has tried to kill herself several times, according to a statement from her attorney.

Healthcare Risk Management sought comment from the risk manager and other officials at Covenant Lakeside Hospital, but they declined. A hospital spokesman indicated that the officials were busy, not surprisingly, with a survey by The Joint Commission. It is common for The Joint Commission to immediately conduct a focused survey after such a sentinel event.

Infant abductions are not common, but they still occur with alarming frequency. Since 1983, there have been 248 infant abductions, according to the National Center for Missing and Exploited Children (NCMEC), in Alexandria, VA. This number includes abductions by nonfamily members from health care facilities, private homes, and other places. Of that number, 121 abductions, or 49%, were from health care facilities.

The Lubbock incident pushes Texas into a tie with California for the most infant abductions since 1983. Each state has 33.

Every infant abduction is frightening, but the latest Texas incident is disturbing in a different way, says **Barry Mangels**, CPHRM, director of risk management and compliance at Good Samaritan Hospital in Los Angeles. With each abduction that garners significant media attention and analysis within the health care industry, one would expect providers to take note and learn from the hardship of others, he says. But the publicly disclosed facts of the Covenant Lakeside abduction raise questions about whether risk managers really are taking the lessons to heart.

First, Mangels says, let's give credit to the hospital for having done some things right. The hospital did have an electronic monitoring system to alert staff when a baby is taken from the newborn area, and it had security cameras that captured good images of the woman leaving the hospital with the infant. But Mangels notes that the security camera footage shows the woman calmly walking out the hospital exit without being stopped.

Scrubs again play role in infant abduction

Scrubs were an issue in the latest Lubbock abduction, just as they were in the 2006 Lubbock incident and in other abductions nationwide. A simple of pair of scrubs can be purchased cheaply and easily by anyone, and they can be a surprisingly effective disguise, says **Barry Mangels**, CPHRM, director of risk management and compliance at Good Samaritan Hospital in Los Angeles.

Scrubs are the de facto "uniform" of many hospital staff, so anyone walking through the facility in scrubs automatically looks appropriate. "It's a simple but a very effective way to blend in, and that's what these people want. They want to blend in with all the other staff so no one questions them, including the parents," Mangels says. "It's like if anyone could buy a police uniform and have people just assume you're a police officer. But unlike police uniforms, anyone can buy a set of scrubs."

Curtailing the wearing of scrubs would be best, but that can be difficult to execute, Mangels notes. Some hospitals require staff in their newborn units to wear a distinctive color of scrubs or other uniform to make it clear that they are authorized to handle an infant, which Mangels says can be a good start. His facility uses a different color of scrubs and a distinctive-looking name badge for staff in the newborn unit.

Another possibility is to refuse entry to the hospital for anyone wearing scrubs but not showing staff identification — in effect, saying that only staff can wear scrubs. That would help avoid the problem of parents, if not staff, assuming that the scrubs mean a person is on staff even if the identification is not visible. "It's a good solution, but most risk managers will find it hard to implement," Mangels says. "With scrubs so common, you're going to turn away a lot of people. If you're in a big medical complex where people from other offices might be coming to the facility but aren't on staff, that would cause a lot of problems." ■

SOURCES

For more information on the Texas infant abduction, contact:

- **Barry Mangels**, CPHRM, Director of Risk Management and Compliance, Good Samaritan Hospital in Los Angeles, 1225 Wilshire Blvd., Los Angeles, CA 90017. Telephone: (213) 977-2121. E-mail: bmangels@goodsam.org.
- **John B. Rabun**, EVP & COO, National Center for Missing & Exploited Children, Charles B. Wang International Children's Building, 699 Prince St., Alexandria, VA 22314-3175. Telephone: (703) 837-6216. E-mail: jrabun@ncmec.org.
- **A. Kevin Troutman**, Fisher & Phillips, Suite 3710, 201 St. Charles Ave., New Orleans, LA 70170. Telephone: (504) 529-3856. E-mail: ktroutman@laborlawyers.com.

"I'm just baffled that the woman could get to the floor and get the baby out," he says. "It makes me wonder how much they depended on the alarm itself to stop the abduction, and whether everyone knew what to do when that alarm sounded." The alarm doesn't stop anything, he points out. "It just tells you that people need to spring into action," he says.

Mangels also is troubled by reports that the abductor was on the unit for some time before taking the baby and went into the patient's room several times, without being challenged by hospital staff. That strategy is standard for these crimes, he says: The abductor hangs around looking for an opportunity and getting friendly with the parents. "The question is, 'Why didn't the staff challenge this person?'" he says. "She didn't have proper identification, so someone — everyone — should have been asking who she was."

Hospital will suffer financially

A. Kevin Troutman, JD, an attorney with the law firm of Fisher & Phillips in New Orleans who assists hospitals with risk management projects, says he also was surprised by the videotape showing the woman walking out of the hospital with the baby. The incident is a reminder that infant abduction is a problem that requires constant attention, he says. Setting up a few safeguards and then thinking you've solved the problem isn't enough, he says.

The hospital could be sued by the parents for emotional distress and related claims, Troutman says. Mangels agrees, and he adds that the consequences for the hospital could be severe even if the parents do not file a lawsuit. "I would expect the hospital to suffer financially, not necessarily from a litigated claim, but from the people who say maybe they don't want to deliver their babies there," Mangels says. "Loss of good will is a huge risk factor for hospitals, and I guarantee you every single person in Lubbock, TX, knows there was a baby abducted from that hospital."

The negative publicity also can make the target a hospital for completely unrelated lawsuits in the future, Troutman says. The hospital's quality and attention to patient safety has been questioned, so that questioning may make people look at future incidents more skeptically and critically, he says. The negative image stemming from the abduction can spill over into unrelated cases, he explains.

Publicity surrounding the previous Lubbock incident may have spurred this latest attempt, and the current attention may prompt another abduction, Troutman says. People who are desperate for a child may hear about the incident and get the idea that such an abduction can be successful," he notes. This incident shows that these incidents continue no matter how much you prepare, but you can take steps to stop it all before the baby is gone," Troutman says. "There will be more of these, so the question is whether you're prepared and respond appropriately, or you're the next hospital that has to figure out what went wrong." ■

ID badges are key, staff must question everyone

No matter what other valid, necessary precautions you have in place, the effort to thwart infant abduction all centers on limiting access by people who shouldn't be on the newborn unit. Limiting access means checking identification and drilling for emergencies can be the most important prevention steps, say **Barry Mangels**, CPHRM, director of risk management and compliance at Good Samaritan Hospital in Los Angeles, and **A. Kevin Troutman**, JD, an attorney with the law firm of Fisher & Phillips LLP in New Orleans, who has worked on prevention efforts with hospitals.

"For years, I've seen a lackadaisical attitude where staff members say, 'Well, we all know each other, so there's no need to worry about name badges,'" Troutman says. "So people might wear their badge under a coat, inside their shirt, or they even wear it backward because they don't like people to see the picture. Cracking down on that behavior could make great strides toward stopping infant abductions."

Parents must be educated about requiring proper identification before handing over an infant, but Mangels notes that checking identification really is the staff's responsibility. Like many infant abductions, the latest incident in Texas might have been prevented if staff had challenged someone wearing scrubs without displaying identification — or anyone without a clear reason to be on the unit.

Troutman notes that the abductor in Lubbock wore a large overcoat that may have helped her hide the infant and provide an excuse for her identification not being visible.

"Hospitals just have to be very firm on this issue of identification being visible, especially on the unit with newborn infants," he says. "It can't ever be

Group issues warning on infant security tags

The National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA, has issued a special warning about infant abduction security tags: Don't rely on them too much, and act quickly if the alarm sounds, the group says.

The latest abduction in Lubbock, TX, is just another example of how security tags do not always thwart infant abduction, says **John B. Rabun**, executive vice president and chief operating officer of NCMEC. Rabun says the group's data show that there have been 10 infant abduction cases from health care arising from the criminal misuse of the attaching bands used with electronic tags. All types of attaching mechanisms have been involved in the 10 recorded cases, he says.

"The electronic tags and support systems themselves do not seem to be an issue. However, with the critical mass of these cases wherein the separation of the bands were successfully used in commission of the felony abduction of newborn babies, we feel it is time for a cautionary use advisory," he says.

The NCMEC released this advisory:

"No matter what form of attachment bands (or clamps) continue in use with the electronic tagging of infants, health care facilities should be very careful to ensure there is NEVER ANY DELAY in activation of the alarm function upon separation and perform frequent, ongoing testing in support of that guideline. Staff should be trained to respond IMMEDIATELY so there is no delay between detection of the alarm condition and generation of the alarm notification." ■

OK for someone to walk around with a heavy coat on that hides their badge, and it can't ever be OK for other staff to see that and not say anything."

Code Pink drills are vital

The hospital will be scrutinized to determine if it complied with the standard measures for preventing infant abduction, Mangels says.

"I'm sure the Joint Commission is looking right now at whether they had proper training for the staff and whether they carried out Code Pink drills, as well as other issues like what kind of physical security they had in place," Mangels says.

Infant abduction drills, often known as "Code Pink" drills, are used to practice how staff would respond to an infant abduction. At Good Samaritan Hospital, the staff periodically runs a Code Pink drill by giving an infant-sized doll to someone posing as the kidnapper. The facility's public address system announces the Code Pink.

"When they hear that alarm, staff have designated areas where they are to go and watch for the infant. That includes every exit from the building, and no one is allowed to leave without making sure they do not have the child," Mangels says. "Our staff take those duties very seriously. If this abductor was able to just leave the hospital once the alarm sounded, I have to wonder if the staff were really practicing this scenario and knew how to respond." ■

Stats show methods, profile of abductors

Infant abductions happen with enough regularity that the compiled statistics paint a clear picture of how the perpetrators typically commit the act and who they are.

The National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA, reports that since 1983, there have been 121 abductions from health care facilities. Within health care facilities, 56% are taken from the mother's room, 14% are taken from the nursery, 14% are taken from pediatrics, and 16% from elsewhere in the facility.

Texas and California have had the largest number of infant abductions, with 33 abductions each, notes **Ernie Allen**, president & CEO of NCMEC. The study of past incidents reveals not just the similarity of many of the acts but also the importance of responding properly, Allen says. "Any time a child is abducted, there is an immediacy to getting as many people looking for the child and/or the abductor as possible. We know the first hours are the most important in locating a missing infant and facilitating safe return," Allen says. "The news media play a critical role in working with law enforcement any time an abduction takes place. In the past 24 years, 95% of abducted infants and newborns have been recovered safely. Overwhelmingly, that success has been because of the power of the media to mobilize the eyes and ears of the public."

Based on analysis conducted by NCMEC of 248 cases between 1983 and 2007, the typical profile of an infant abductor includes the following:

- The abductor usually is female of childbearing

age (12 to 50), and is often overweight.

• The abductor usually is compulsive and frequently relies on manipulation, lying, and deception to gain access.

• The abductor usually states she has lost a baby or is incapable of having a child.

• The abductor is often married or is living with a male companion.

• Usually, the companion has a desire to have a child, or the abductor has a desire to provide her companion with "his" child. Often, that is the motivation for the abduction.

• Frequently, the abductor lives or is familiar with the community where the abduction takes place.

• The abductor usually visits the nursery or maternity ward at more than one health care facility prior to the abduction and has asked detailed questions about procedures and the maternity floor layout.

• The abductor frequently uses a fire exit stairwell for her escape. That person also may try to abduct from the home setting.

• While the abductor usually plans the abduction ahead of time, she does not necessarily target a specific infant and frequently seizes any opportunity present.

• The abductor frequently impersonates a nurse or other allied health care personnel.

• The abductor frequently becomes familiar with health care staff, staff work routines, and victim parents.

• The abductor demonstrates a capability to provide "good" care to the baby once the abduction occurs. ■

Center offers free help on site to stop abductions

If you're serious about assessing security and taking the right steps to thwart infant abductions, the National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA, offers direct assistance.

Since 1987, NCMEC has provided on-site security assessments to 940 hospitals and birthing centers throughout the United States and conducts nationally accredited training on infant security for health care professionals including nursing and security staff. The on-site assessment is completely free; even the visitor's travel costs are paid for by government grants and corporate donations.

To date, 61,000 health care personnel have been trained. The training is sponsored by Mead-Johnson Nutritionals in cooperation with the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN); the National Association of Neonatal Nurses (NANN); and International Association for Healthcare Security and Safety (IAHSS).

An on-site survey consists of the speaker, accompanied by appropriate management staff — such as the risk manager, nurse managers, and security directors — walking through different departments/locations of the hospital where infants may become victims of abduction. These areas usually are maternity, labor and delivery, nurseries, pediatrics, clinics, and in-house day-care centers. They make observations as to the state of the facility's access control, camera coverage, signage, etc. in reference to the NCMEC guidelines for protecting infants.

The on-site survey is considered confidential to the staff of that health care facility, and media are not allowed to accompany. The NCMEC representative does not provide written documentation to the facility, so the management staff accompanying him during this visit must take their own detailed notes. This procedure prevents as much as possible any vicarious liability for all parties.

In 2005, the eighth edition of "For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions" was released. (The first copy is free for individuals. The first 10 copies are free for facilities. Each additional copy is $3.) For more information on these products and services, go to the NCMEC web site at www.ncmec.org. On the home page, click on "Infant abduction prevention and resources." ■

Legal waivers under fire, have limited use

Local attorneys are criticizing a Pennsylvania hospital's use of a medical waiver that asks patients to sign away their right to a jury trial in the event of malpractice, but hospital officials remain steadfast in saying the waiver is voluntary and a good way to resolve claims more expediently.

Kindred Hospital — Wyoming Valley, a long-term acute care facility in Wilkes-Barre, PA, asks patients to sign a waiver that requires any claim

EXECUTIVE SUMMARY

A hospital in Pennsylvania is defending its use of medical waivers designed to limit lawsuits stemming from malpractice claims. Plaintiffs' attorneys say the waivers are unfair to patients, who may not realize they are signing away their rights.

- A hospital administrator says the waiver is strictly voluntary and does not diminish patient rights.
- The waiver requires that claims be handled through mediation or binding arbitration.
- Both parties can benefit from lower attorney's fees when a lawsuit is avoided.

for injuries to be handled through mediation or binding arbitration rather than a lawsuit. That route usually takes months to resolve a complaint, as opposed to the years it may take for a claim to make its way through the court system.

Attorneys criticize waivers

Plaintiffs' attorneys in the area are criticizing the waivers. They say the waivers unfairly restrict patients' right to sue and that people sign them without fully understanding what the waivers mean. **David Saba**, JD, an attorney with Hourigan and Kluger in Kingston, PA, told the *Times Leader* newspaper in Wilkes-Barre, PA, that "the circumstances hardly lend themselves to cool, rational thought."[1] Saba represents plaintiffs who have filed medical malpractice claims and says he has never seen a waiver like the one used by Kindred.

Concern was first raised by **Paul Lyon**, director of the Committee for Justice for All, a nonprofit group in Kingston, PA, that works to preserve plaintiff's rights. Lyon says he was appalled when he first heard of the waivers and calls them "absolutely outrageous." The hospital is taking advantage of people who are not in a position to carefully consider how the waiver affects their rights, he says.

Erin Pica, the administrator of Kindred Hospital, declined *Healthcare Risk Management*'s request for comment, but she told the *Times Leader* that the waivers are a fair alternative that offers benefits to the hospital and the patient. With mediation or arbitration, both parties benefit form lower attorneys' fees and the patient receives compensation much more quickly, she says. "It's binding arbitration on Kindred as well as the patient," she says. "If people don't want to sign it, they don't have to. It's not a condition of admission."

Can limit to clinics, not inpatient

Waivers that require mediation or arbitration can be an effective way to reduce lawsuits, but you should expect criticism from opponents, says **Harlan Hammond**, MBA, CPHRM, DFASHRM, ARM, HRM, assistant vice president for risk management services with Intermountain Health Care in Salt Lake City. A major malpractice insurer in Utah has been encouraging insureds to use arbitration agreements, he says, so he researched the pros and cons.

"We put together an arbitration agreement that we asked patients to sign. At the time, the state legislature allowed us to make that a condition for receiving nonemergent patient care," he says. "So we ran an experiment with that at one of our clinics, asking patients to sign it as they came in, and we had very favorable results with the trial period. So decided to expand it beyond that one clinic."

Local attorneys took exception to the idea and went on the offensive to disparage the agreements. They argued that Intermountain was strong-arming patients into signing away their rights. Partly as a result of those protests, the state legislature revised the law to say that mediation must be an option in addition to arbitration. Critics had complained that arbitration was costly to the plaintiff, who would share the cost equally with the hospital.

Because of the uproar from critics of the agreements, Intermountain decided to make the waiver voluntary, offering it to all patients in the physician clinics, but not in the inpatient setting. Hammond and other hospital leaders were worried about the ability to adequately convey the meaning of the agreement when a patient was being admitted to the hospital, which already involved a stack of paperwork.

Hammond says the legality of such waivers will always be questioned, and there will be plenty of attorneys to argue that the agreement cannot be enforced because people can be coerced into signing away their right to sue. The courts have determined that this is enforceable, and that the agreement to settle future disputes through mediation or arbitration is valid, Hammond says. That doesn't mean that people won't argue the point anyway, he says. "The question really comes down to whether the person understood what they were doing or whether they signed under duress, and that can be argued with many legal agreements," Hammond

SOURCES

For more information on medical waivers, contact:
- **Paul Lyon**, Director, Committee for Justice for All, 600 Third Ave., Suite 2, Kingston, PA 18704. Telephone: (570) 338-0158. E-mail: info@saynotocaps.org.
- **Erin Pica**, Administrator, Kindred Hospital — Wyoming Valley, 575 N. River St., Wilkes-Barre, PA 18764. Telephone: (570) 552-7620.
- **Harlan Hammond**, MBA, CPHRM, DFASHRM, ARM, HRM, Assistant Vice President, Risk Management Services, Intermountain Health Care, Holladay, UT. Telephone: (801) 442-3414. E-mail: harlan.hammond@Intermountainmail.org.

says. "It doesn't mean the whole concept of the agreement is invalid."

Useful, but benefits limited

Hammond says the agreement has been beneficial in the limited manner in which his organization uses it.

"It has had some impact for us, but not a significant effect. About 5% of our open claim files are working down an arbitration track," he says. "Financially so far, the impact has been negligible, but potentially it could be more significant in the future."

Hammond says he supports the idea of mediation and arbitration agreements, at least philosophically. The costs can be much lower for everyone, the process can be faster, and there is more predictability because the case is taken before a panel of three people versed in the issues rather than a randomly chosen jury. On a practical level, you have to expect resistance if you decide to do this, Hammond says. "It can be a fair, reasonable strategy, but you have to expect some in the community to disagree strongly," he says. "I would caution people that want to make this mandatory as a condition of care, because that will elicit a stronger level of push back than if you started out on a voluntary basis. Understand that it will receive some media attention, and you have to be ready for that."

Reference

1. "Hospital's waiver concerns lawyers." *Times Leader*, Kingston, PA. Feb. 26, 2007. Accessed at www.timesleader.com/mil/timesleader/16785513.htm. ■

Hospital, surgeon under fire after transplant death

Controversy has interrupted after an attempted organ transplant at a California hospital, with several groups investigating whether a doctor attempted to hasten a patient's death so that his organs could be harvested. The case already has prompted a clarification of national standards for transplant procedures, and criminal charges could be forthcoming.

At a meeting in Saint Louis, the board of the United Network for Organ Sharing (UNOS) said that all transplant hospitals must have policies preventing organ recovery teams from taking part in the care of a potential donor before a nontransplant doctor declares the patient dead. Members of the team are not allowed in the room when life support is withdrawn, according to the standards. Members of the board stated publicly that the clarification was prompted by the recent California case. **(For details, go to the UNOS web site at www.unos.org and select the "newsroom" tab at the top of the page. Click on "view all press releases," then look for the press release from March 23, 2007.)**

The case is unfolding in San Luis Obispo, CA, where a surgeon is accused of hastening the death of a donor who wasn't dying as quickly as expected. The case has prompted an investigation by the state medical board and may possibly lead to criminal charges. The attorney for the accused transplant surgeon says the doctor did nothing wrong during the case at Sierra Vista Regional Medical Center. Attorney **M. Gerald Schwartzbach**, JD, says Kaiser Permanente surgeon Hootan Roozrokh, MD, of San Francisco, did nothing to hasten the man's death.

EXECUTIVE SUMMARY

A failed effort to harvest organs for transplant has led to controversy and possible criminal charges. The transplant surgeon is accused of improperly attempting to hasten the patient's death.
- The case prompted a national transplant organization to clarify its standards.
- Local prosecutors are considering criminal charges against the clinicians involved.
- Evidence suggests the transplant surgeon violated hospital protocols.

The incident occurred on Feb. 3, 2006. Twenty-five-year old Ruben Navarro was on life support after being found unconscious at the residential care home where he lived. Navarro had a neurological disorder, and his mother agreed to donate his organs when it was clear he would not recover.

Navarro was taken into the operating room on a Friday evening and removed from life support, but he did not die immediately. According to the report of an investigation by the Centers for Medicare & Medicaid Services (CMS) obtained by the *Los Angeles Times*, a transplant surgeon ordered 100 mg of morphine and 40 mg of Ativan for Navarro.[1] The surgeon is not mentioned by name, but several sources told the newspaper it was Roozrokh.

The report notes that Roozrokh was not authorized to care for patients or order drugs at the hospital, according to the hospital's own policies. When Navarro's heart did not stop, the surgeon reportedly ordered another 100 mg morphine and 40 mg Ativan, which the ICU nurse administered.

Navarro still did not die. After about 30 minutes off life support — the time limit set to ensure the viability of the organs — the process was ended. Navarro was returned to the intensive care unit, where he died early the following morning. His organs were not retrieved.

A Sierra Vista spokesman, **Ron Yukelson**, confirms that on the following Monday, operating room nursing staff alerted hospital administrators that Roozrokh violated hospital policy during the attempted donation when "he entered the operating room prior to the death of the patient and started giving orders." State law prohibits transplant doctors from directing the treatment of a potential organ donor until the attending physician declares the patient dead.

The hospital reported the incident to the state Department of Health Services, the state Medical Board, the county coroner and CMS. In response, CMS, the state medical board, the San Luis Obispo County Sheriff's Department, and the San Luis Obispo police began an investigation.

The doctor's attorney says the surgeon did not order any drugs administered to hasten the man's death. San Luis Obispo police announced recently that they completed an investigation and turned over the case to the district attorney's office. Prosecutors are reviewing the case and will decide whether to press charges. The district attorney's office has declined to say how many people are being investigated and what the potential charges may be.

The case should raise serious questions for risk managers, says **Skip Freedman**, MD, an emergency physician and chief medical officer for AllMed Healthcare Management, an independent review organization serving insurance payers, providers, and claims managers nationwide. For starters, Freedman wonders if the hospital had an adequate peer review process to oversee physician credentialing and behavior.

"It is typical that a hospital asks physicians to do peer review on their friends, colleagues, and competitors, so I have to wonder how that played a role in this. And they also assert that the transplant doctor didn't even have staff privileges, so what is their internal policy for this kind of emergent procedure?" he says. "Do they have a policy for when a transplant surgeon comes in and needs privileges quickly? This all has to be lined up ahead of time."

The allegations in the case also raise questions about how quickly staff members reported their concerns about what happened during the procedure. If it's true that staff were slow to report their concerns, Freedman says that could signal a problem.

"There should be lines of confidential complaint within the hospital so that people can speak up with their concerns in a timely manner," he says. "What we don't know is whether that existed in the hospital, whether it had been used before, how people were treated when they used that system, or whether it existed but just wasn't well known to the staff."

SOURCES

For more information on the transplant controversy, contact:

- **Skip Freedman**, MD, Medical Director, AllMed Healthcare Management, 621 S.W. Alder St., Suite 740, Portland, OR 97205. Telephone: (503) 274-9916.
- **M. Gerald Schwartzbach**, JD, 655 Redwood Highway, Suite 277, Mill Valley, CA 94941. Telephone: (415) 388-2343.
- **Ron Yukelson**, Media Relations, Sierra Vista Regional Medical Center, 1010 Murray Ave., San Luis Obispo, CA 93405. Telephone: (805) 546-7600.

Reference

1. "Police probe death in organ donation case." *Los Angeles Times*, Feb. 28, 2007. Accessed at www.latimes.com/news/local/lametransplant28feb28,1,3711583.story?ctrack=1&cset=true. ■

Joint Commission warns on consent, literacy

The informed consent process is a linchpin of health care risk management, but even the most earnest efforts to fully detail the risks of treatment can be for naught if the patient simply can't understand what you're saying or what is written.

A new report from The Joint Commission says that is exactly what happens in many cases: The health care provider is trying to inform the patient, but the information just isn't getting through. The same thing happens in other key discussions, such as when explaining aftercare or medication use.

Whether the communication is oral or written, there sometimes is no real information exchange because the patient cannot understand medical jargon and unclear language. The Joint Commission recently released its newest public policy white paper, *"'What Did the Doctor Say?:' Improving Health Literacy to Protect Patient Safety."* The paper frames the existing communications gap between patients and caregivers as a series of challenges involving literacy, language, and culture, and suggests multiple steps that need to be taken to narrow or even close this gap.

Most risk managers know that written communications, such as the informed consent documents, can pose a challenge for patients with low literacy, and health care organizations have taken steps in recent years to simplify written communications or provide other assistance, such as explaining the documents verbally. But The Joint Commission is warning that low literacy also can affect comprehension during a spoken conversation. Addressing low literacy in the spoken conversation can be even more difficult, the group says, because it is difficult to determine if the patient really comprehends.

Patient safety threatened

Dennis S. O'Leary, MD, president of The Joint Commission, says the disconnect between highly educated clinicians and their patients can threaten patient safety. "If patients lack basic understanding of their conditions and the whats and whys of the treatments prescribed, therapeutic goals can never be realized, and patients may instead be placed in harm's way," he says. And of course, that lack of understanding means an increased liability risk as well.

Even patients who can read and write may be unable to understand much of what is conveyed to them during the informed consent process, says **Sunil Kripalani**, MD, MSc, assistant professor in the Division of General Medicine at the Emory University School of Medicine and internist at Grady Memorial Hospital, both in Atlanta.

"The average adult in the United States reads at the eighth-grade level," Kripalani says. "National studies have shown that, while only 1% of the U.S. population is illiterate, about 45% have difficulty reading and comprehending moderately difficult information like they find in the health care setting."

90 million adults at risk

A patient who is literate isn't necessarily health literate. Kripalani explains that health literacy is an individual's ability to read, understand, and act on health information. Kripalani notes that according to 2006 results of the National Assessment of Adult Literacy conducted by the U.S. Department of Education, more than 90 million adults lack the

EXECUTIVE SUMMARY

Low literacy can hamper efforts to communicate key information to patients, especially during the informed consent process. Failure to address this common problem can threaten patient safety and risk increased liability.

- Low literacy is common in all communities and patient populations.
- Even people who can read and write may have difficulty with health information.
- Asking patients to repeat information is a good test of understanding.

COMING IN FUTURE MONTHS

- Parking patients with EMS not allowed
- Check sheets help with transfer of care
- Protecting patient lists as trade secrets
- Bogus ED staffer caught in hospital

SOURCE

For more information on health literacy, contact:
- **Sunil Kripalani**, MD, Msc, Grady Memorial Hospital, GMH, Department of General Medicine, 69 Jessie Hill Jr. Drive, Atlanta, GA 30303. Telephone: (404) 727-5640. E-mail:skripal@emory.edu.

literacy skills needed to effectively function in the health care environment.

Low health literacy is associated with less medical knowledge, infrequent receipt of preventive services, increased hospitalization and use of emergency care, and worse control of chronic diseases. Kripalani's research has determined that some simple strategies, such as asking patients to repeat information back to the doctor or nurse, can help address low health literacy.

The Joint Commission called together a panel of experts to discuss the problem, and they offered detailed suggestions for making effective communications a priority in protecting the safety of patients. Failure to provide patients with information about their care in ways that they can understand will continue to undermine other efforts to improve patient safety, they said.

The Joint Commission already promotes the involvement of patients in their care through its ongoing Speak Up educational campaigns. In addition, expectations regarding patient engagement and involvement in care decisions are stipulated in Joint Commission accreditation standards and its National Patient Safety Goals.

The Joint Commission report on strategies for addressing health literacy and protecting patient safety contains 35 specific recommendations that cover a wide range of important improvement opportunities. Examples include the use of established patient communication methods such as "teach back" and the provision of medical liability insurance discounts for physicians who apply patient-centered communication techniques.

A complete copy of The Joint Commission white paper, *"'What Did the Doctor Say?:' Improving Health Literacy to Protect Patient Safety"* is available at www.jointcommission.org. The link to the report is on the home page. ■

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. ■

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.

17. According to police reports, what strategy was used in the most recent infant abduction in Lubbock, TX?
A. A woman entered the nursery unit wearing surgical scrubs that gave her the appearance of being on staff at the hospital. She visited the mother's room several times looking for an opportunity.
B. A woman obtained false credentials from human resources and posed as a nurse.
C. A woman posed as a social worker and showed a city issued identification badge.
D. A woman wore regular street clothing and violently took the child from its mother.

18. According to statistics from the National Center for Missing and Exploited Children, which of the following is typical of people who abduct infants?
A. The abductor usually is an older male (age 50 to 65).
B. The abductor is usually female of childbearing age (12 to 50) and is often overweight.
C. The abductor is usually a teenage male (12 to 19) who is trying to satisfy a female companion's desire for a child.
D. The abductor is usually an older female (age 50 to 65) who no longer can have children.

19. What does Harlan Hammond, MBA, CPHRM, DFASHRM, ARM, HRM, advise regarding the use of agreements that require mediation or arbitration for malpractice claims?
A. They can be a good idea, but you should expect criticism from the community.
B. They are never a good idea and offer no advantage to either party.
C. They are always a good idea and can be implemented without controversy.
D. They are a good idea only when imposed by a court order.

20. According to Sunil Kripalani, MD, MSc, what is the likelihood that health care professionals will encounter patients with low literacy?
A. It is rare to encounter patients with low literacy skills.
B. No matter where you live or work, a large percentage of patients will have limited literacy skills.
C. Patients with limited literacy skills are common only in urban communities.
D. Patients with limited literacy skills are common only in poor communities.

Answers: 17. A; 18. B; 19. A; 20. B.

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

Stent malfunction leads to $35,000 settlement with manufacturer, confidential settlement with hospital

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

News: During a routine visit to her primary care physician, a patient had abnormal EKG results and was sent to the emergency department. Interventional cardiologists admitted her and performed several procedures, one of which was a stent. At the time of the procedure, the physicians knew that there had been a malfunction in the materials used, but she was discharged with a normal EKG. Several months later, the woman suffered from a myocardial infarction and underwent bypass surgery. She subsequently brought suit against the manufacturer, hospital, and cardiologists. She successfully settled with the hospital and manufacturer; a defense verdict was rendered in favor of the cardiologists.

Background: In June 2000, a 59-year-old woman underwent an EKG in her primary care physician's office to evaluate a suspected heart-related problem. The results were abnormal and suggestive of a myocardial infarction, which is usually caused when an area of heart muscle dies or is permanently damaged because of an inadequate supply of oxygen to that area. She was sent to an emergency department, where an interventional cardiologist admitted her for telemetry to rule out myocardial infarction. The cardiologist's impression was that she had suffered a myocardial infarction four to five days earlier and was now experiencing recurrent chest pain.

Two days later, the cardiologist performed a cardiac catheterization via the right femoral arterial approach with selective coronary angiography. Single vessel coronary disease was disclosed. The cardiologist then recommended percutaneous transluminal coronary angioplasty (PTCA) and stenting of the left anterior descending artery (LAD). The patient consented, and a second interventional cardiologist performed the PTCA and stenting of the LAD using a guide wire catheter and stent provided by the hospital. When the second cardiologist withdrew the catheter at the end of the procedure, he noticed that the wire's distal tip had unraveled. Fluoroscopy revealed a portion of the guide wire had fractured and snagged a distal portion of the stent, causing the distal portion to become deformed.

After consultations, the first cardiologist performed a coronary angiogram, which revealed a patent proximal LAD with no compromise in the blood flow. It was determined that bypass surgery was not necessary, but the cardiologist decided to dilate the distal irregular portion of the stent with a balloon. Following the dilation, excellent angiographic results were obtained. The guide wire distributor's local representative recommended that the patient be placed on a specific anticoagulant for about six months to reduce the formation of blood clots in order to prevent any future heart attacks, strokes, or blockage of major veins and arteries. At discharge, the patient's EKG was normal.

Two months later, the patient was visiting in

California and suffered a myocardial infarction and underwent emergency bypass surgery. The fractured wire and stent were not removed, as doctors felt such an attempt would be too dangerous.

The woman and her husband brought suit against the manufacturer of the stent and the distributor on a products liability theory. They also sued the hospital and the doctors; they claimed the cardiologists were negligent in performing the PTCA procedure, in re-ballooning the deformed stent, and in failing to obtain the plaintiff's informed consent for the procedures. During discovery, re-examination of the lead wire showed that the wire broke because it was overloaded in tension with stresses exceeding its material strength. The plaintiffs settled their products liability suit with the manufacturer and distribution for a total of $35,000. The plaintiffs also settled with the hospital for an undisclosed amount. The cardiologists, however, were granted a defense verdict. The jury found that there was no negligence on the part of the doctors and that the subsequent myocardial infarction could have been the result of natural restenosis.

What this means to you: This scenario underscores the importance of implementing appropriate policies and procedures regarding defective medical equipment. It is simply an inevitable fact that medical equipment occasionally will exhibit a defect or otherwise break down. Having and following appropriate policies, though, will minimize any disruption to a patient's care and, therefore, risk of liability, says **Patricia S. Calhoun**, JD, RN, of Buchanan Ingersoll in Tampa.

It appears in this case that the hospital did have a policy regarding defective equipment and, just as importantly, it appears that all health care providers involved were aware of the policy. When the interventional cardiologist noticed that the guide wire's tip had unraveled and that a portion of the wire had fractured and snagged the stent, he consulted with the other health care providers about the prudent course of action: The insertion of a balloon rather than bypass surgery. And based on the jury's ultimate finding of non-negligence on the part of the doctors, it appears the doctors' decision was medically reasonable. In fact, further evidence of the appropriateness of the physician's actions, Calhoun notes, is that the California providers, two months later, similarly concluded that no attempt should be made to remove the fractured wire and stent from the patient. Although the California physicians were acting in the context of emergency bypass surgery, their choice to not remove the fractured wire was certainly helpful to the original cardiologists' defense of the plaintiffs' claims.

But although the jury found that the cardiologists did not act negligently in their treatment of this patient, risk managers still can learn from the scenario. As an initial matter, Calhoun is struck by the fact that the guide wire manufacturer's representative recommended that the cardiologists administer a particular brand of anticoagulant to the patient. Although manufacturers often inform physicians of known complications associated with their products, it is ultimately the physician's job to determine what medicine to prescribe.

Moreover, after the physicians had discovered the fractured guide wire and determined that a coronary angiogram and balloon were advisable, Calhoun notes that they should have secured informed consent for the additional procedure from the patient's husband before proceeding. Even though most informed consent forms ostensibly cover "any additional emergency procedures necessary," these savings clauses generally are regarded as weak. In a case such as this one, where a slight delay in obtaining the husband's consent to the additional procedure would not have adversely affected the patient's care, further consent should have been obtained. Calhoun stresses that obtaining extra consent, even to intraoperative changes, can reduce a hospital's exposure and eliminate claims.

Of course, obtaining informed consent is not effective unless the risks and benefits of the procedure are clearly explained to the patient and documented in the patient's record. In a stent procedure, for example, the physician should tell the patients that tearing is possible. "Although obtaining informed consent is generally the realm of physicians, the hospital can ensure that the doctor has obtained the patient's informed consent by implementing a comprehensive informed consent policy," says Calhoun. The policy should include, for example, guidelines on when extra consent needs to be obtained.

Calhoun notes that the modern trend seems to be obtaining informed consent at the doctor's office, with the doctor then forwarding the signed form to the hospital prior to the surgery. This procedure eliminates the chance that nurses will be left to explain risks and benefits to patients, and it ensures that the physician has performed his duty in this regard. A physician-obtained consent is also likely to be more specific than the usually generic nurse-obtained informed consent.

Calhoun recognizes that if the cardiologists had

obtained the additional informed consent from the patient's husband in this case, the only claim against the hospital would have been one for negligent credentialing relating to the doctors. A negligent credentialing claim is much easier to defend, especially when the underlying physicians are found to have acted non-negligently. In fact, given the jury's defense verdict as to the cardiologists in this case and that the plaintiffs' other claims were primarily against the catheter manufacturer, the hospital probably could have won this case had it not settled. Calhoun suspects, however, that the risk management team determined that incurring the cost of fighting the plaintiff, coupled with the risk (however minimal) of losing, was outweighed by the settlement offer.

"Whenever a facility learns of a situation like this, risk management should be involved as early as possible to facilitate communication with the patient and the patient's family," says Calhoun. "It is well documented that apologizing for a mistake — even if believed to not be the hospital's fault — and empathizing with the patient dramatically lowers the incidence of claims made against medical providers."

Reference

- Honolulu County (HI) Circuit Court, Case No. 012080. ■

Medication error results in brain injury, heart failure

News: A patient with pre-existing Addison's disease was admitted for the treatment and care of a fractured humerus. When the admitting physician tried to order hydrocortisone for the patient, the pharmacist erroneously transcribed the order as hydrochlorothiazide. After three days of receiving the wrong medication, the error was discovered when the patient was found unconscious. The patient had suffered anoxic brain injury and shock, and he was institutionalized for the remaining three years of his life. The patient brought suit against the hospital, and the jury awarded him $75,000.

Background: The patient was an 87-year-old man who had suffered from Addison's disease for 40 years. His condition, characterized by chronic insufficient function of the pituitary gland, necessitated that he take two doses of hydrocortisone daily, a course of treatment that had regulated the disease for decades. One day, the man sustained a humeral head fracture, and he was admitted to the hospital. His admitting physician subsequently wrote orders for the patient's care and treatment in the hospital medical chart. The doctor's medication orders included an order for hydrocortisone 25 mg by mouth twice a day. Hydrocortisone is a corticosteroid often used to replace a natural hormone produced by the adrenal glands when the body does not make enough of it.

Unfortunately, the pharmacist transcribed the physician's order for hydrocortisone as hydrochlorothiazide, a diuretic often used to treat high blood pressure and reduce the swelling and water retention caused by various medical conditions, such as heart, liver, or kidney disease. The incorrect medication was accordingly dispensed, and the plaintiff received 25 mg of the diuretic twice per day for three consecutive days. Three nights later, the effects of receiving the incorrect medication became apparent. The patient was found unconscious. He was hypotensive and went into heart failure with a blood pressure of 84/46. It was only then that the medication error was discovered.

The man was transferred to intensive care in a weakened condition requiring additional medical management, including placement of a Swan-Ganz catheter and continued cardiac monitoring. The plaintiff remained in the hospital for 10 days, at which time he was finally stabilized. The deprivation of oxygen to the man's brain caused anoxic brain injury, however, which resulted in diminished neurological function for the remainder of his life. He was discharged to a nursing home, where he died three years later with cardiac-related illnesses.

The plaintiff brought suit against the hospital for negligently dispensing medication and for failing to properly monitor the patient. By admitting negligence for dispensing the wrong medication, the hospital moved the focus of the lawsuit to the proximate cause of the patient's injuries and damages. The plaintiff claimed that abruptly stopping the hydrocortisone on which the man had been dependent increased the risk of severe hypotension and cardiovascular collapse. The plaintiff further maintained that the administration of hydrochlorothiazide for three days depleted the patient of appropriate fluid, which made him particularly susceptible to hypotensive crisis. The combination of these events caused the patient's physical systems to suffer from shock, resulting in subsequent hypotensive cardiovascular collapse, decreased oxygenation to the brain, and neurological sequelae.

The hospital countered that the injuries were the proximate result of the patient's age and the fractured humerus he had sustained. The jury sided with the plaintiff, but it awarded only $75,000 in damages against the hospital.

What this means to you: Medication error is a cause for concern for all health care facilities, and every risk manager should implement policies governing situations in which a provider's handwriting — such as for an order of medication — cannot be read, suggests **Patricia S. Calhoun**, JD, RN, Buchanan Ingersoll in Tampa. This case is a typical example of a pharmacist not being able to read the doctor's handwriting and yet guessing at the medication to be prescribed. While prescribing a diuretic for an elderly patient is certainly not uncommon, the pharmacist should have followed up with the physician.

Calhoun notes that many facilities are entering the modern age of technology by requiring medication orders to be entered electronically. Some physicians are able to remotely access their electronic patient medical records from the hospital where they have privileges, thereby allowing the hospital pharmacist to double-check a prescription against these records. "Electronic sharing of information between the physician and the hospital could have prevented this incident, or at the very least raised a red flag," notes Calhoun. "Of course, universal electronic medical records, shared among providers and pharmacies regardless of affiliation, is still a distant dream, due primarily to legitimate privacy and proprietary concerns."

Medication error also was the recent focus of The Joint Commission, which recently adopted Medication Management standard 4.10. That standard says that medication error should be a concern of every clinician, specifically including pharmacists. The standard outlines two keys to safe medicine management: knowing the medications that the patient is currently taking, and conducting a retrospective review of medications that have been ordered by the physician. Because the patient in this case had taken hydrocortisone for decades, Calhoun notes that there should have been no difficulty in learning what medications the man was currently taking, unless he was confused when he presented. Even then, it is likely that someone accompanied the man, given that he was 87 years old and had a broken arm.

Another risk management concern is the level of monitoring provided by the hospital nursing staff after administering the medication to the patient in this case. Calhoun stresses that with elderly patients, nurses must evaluate changes in mental state as well as vital signs. Hospitalization often leads to temporary changes in mentation for elderly patients, likely as a result of the patient being out of his or her traditional element. But when these changes are accompanied by changes in vital signs, nurses must take them seriously and communicate such changes to the physician. In this case, for example, Calhoun recognizes that 84/46 is hypotensive, but not to the point that one would expect the patient to faint. If the man's blood pressure had been gradually lowering, however, and been accompanied by mentation changes, the nurses should have notified the physician, which might have avoided any injury in this case, she says.

Reference

• Oakland County (MI) Circuit Court, Case No. 99-017950-NH. ■