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Hospital changes ID requirements after fake staffer works in the ED

Staff must be diligent, even when it's inconvenient

A Florida hospital has significantly strengthened its policies requiring proper identification for all staff in response a recent incident in which a woman was able to impersonate to an emergency department staff member. Risk managers and security experts suggest that other hospitals take the opportunity to reinforce the lessons learned from the incident before a similar incident happens again.

Spokeswoman **Lisa Patterson** at St. Joseph's Hospital in Tampa, FL, confirms that the woman escorted patients and visitors from one area of the department to another. She was asked to take a patient's blood pressure, but she was relieved from that responsibility when it became apparent that she was not accustomed to the equipment. She later was asked to prepare a patient for testing, but she also was unable to accomplish this task. Again, she was relieved from the duty.

"These observations led staff to believe the woman was too new at the job to be involved directly with patients, so she was then asked to simply observe a patient care technician at work," according to a statement released by the hospital. "Patient care was not compromised during this time. The woman made no medical decisions and had no access to computerized medical

EXECUTIVE SUMMARY

A woman pretended to be a temporary staffer at a Florida hospital and was allowed to work in the emergency department for an entire shift. The impostor had contact with patients, and staff did not realize her ruse until she confessed.

- The hospital has strengthened its identification requirements.
- Security experts say the case shows the importance of staff diligence.
- Such a breach risks patient safety and security of confidential data.

records or medications."

In response, the hospital has emphasized the importance of proper identification to staff members and encouraged them to question anyone who seems out of place.

"We revised our policy to include specific details about the process of obtaining a temporary badge and the consequences of not bringing your badge to work," Patterson says. The consequences include disciplinary action that can vary depending on the nature of the incident and how often the employee has violated the policy in the past. **(See p. 63 for more on how the hospital responded.)**

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The incident occurred March 5, 2007, when a woman who had been a patient in the ED at St. Joseph's returned there at 9 p.m. wearing scrubs and claiming to be a temporary worker. Although she had no ID badge, staff accepted her story that she had lost it and she was allowed to enter the ED and worked for 10 hours as a patient care technician. Apparently, her familiarity with ED lingo and the layout of the department helped convince the staff she was who she claimed to be.

The situation was absurd, says **Grena Porto**, RN, MS, ARM, CPHRM, senior vice president with Marsh, an insurance broker and risk management consulting company in Philadelphia, and past president of the American Society for Healthcare Risk Management (ASHRM). "This incident makes you think of a Marx Brothers movie," she says. "First of all, if you don't know someone you can't just say, 'Oh well, you lost your badge' — especially in the ED, where you have a lot of people coming and going."

You must be able to verify staff

Porto notes that it is not unusual for someone legitimate to show up and not be known to the staff — especially in a large hospital. "But having said all of that, you still have to have some process," she says. "We have to be able to verify who you are or send you home."

Photo ID is best, she says, because anyone can simply give the name of an employee. Anyone who shows up and does not have valid ID should be deemed not ready for work, Porto says. However, she concedes that there is no need to take that rule to a ridiculous extreme. "If one of my nurses I know on sight does not have their ID, and I am a nurse manager and need nurses, they might not go home," she concedes.

The issue of someone masquerading as a hospital employee is not unusual, Porto notes, which makes it even more important for ED managers to have strong policies in place. The biggest problem is doctors, who often do not have photo IDs, she says. They may walk in and start reading a patient's chart, but everyone is afraid to question them.

Emphasize training, not just technology

Tim Dimoff, a former police detective and SWAT team member who founded SACS Consulting, a security services company in Akron, OH, says the ED staff's quick acceptance of the impostor is

troubling. The bottom line, he says, is that no matter how elaborate your identification process, the whole effort comes to nothing when your staff are so nonchalant that they just wave a person through when she says she doesn't have her badge.

Staff must be trained to take a hard stance in such a situation, no matter how inconvenient it is to either party, and they must not be afraid of hurting someone's feelings, Dimoff says. The weak point in any security system always is the human being who doesn't follow policies and procedures, he says.

"You can put in the greatest technology in the world, and you can write policies and procedures that look absolutely foolproof on paper, but they always depend on someone doing the right thing," Dimoff says. "If that person decides at that moment that he or she can just forget it all and do what they think is OK, it all falls apart."

A hospital's badging process must be sacrosanct, says **Ron Morris**, senior director of Protective Services at Cincinnati Children's Hospital Medical Center. Hospital policy must require that identification badges be worn at all times, and there must be zero tolerance for those without badges, he says. At his hospital, a staff member who shows up without a badge is directed to the security office, where the identity is confirmed and another badge is issued. A $10 lost badge fee is charged to the employee. On evening shifts, the badge cannot be replaced immediately; thus, the staff person must have his or her

Hospital ramps up policies on ID after bogus ED worker

St. Joseph's Hospital in Tampa, FL, has significantly strengthened its policies requiring proper identification for all staff in response to a recent incident in which a woman was able to impersonate an emergency department staff member.

Hospital spokeswoman **Lisa Patterson** says the hospital's investigation determined that the impostor did not have a hospital badge, but she explained she had lost it and was replacing it the next morning. The impostor was familiar with the emergency department, aware of hospital processes, and wore scrubs, Patterson says.

In response to the incident, the hospital took these steps:

• Bolster the check-in process for new employees and temporary staff.

The more detailed procedure includes a requirement for management to personally confirm the identity of the new team member or float, Patterson says.

• Educate all staff about how to approach unfamiliar colleagues.

Patterson says discussions on the importance of badging have been included in the internal newsletter, placed on a meeting guideline that goes out to all departments, and addressed in leadership meetings. "The approach is that everyone is responsible for ensuring that all team members are properly identified and are empowered to be sure colleagues are wearing their badge," she says. "Some managers are 'secret shopping' departments, handing out small tokens of appreciation to team members who question them for not wearing a badge." For example, the small tokens of appreciation might include a gift certificate to the hospital cafeteria or gift shop.

• Investigate legal options for addressing health care impostors.

The impostor was trespassing and posed a threat to patient safety and confidentiality, Patterson notes. She says the hospital announced it was investigating legal options for prosecuting trespassers as a way to discourage anyone from trying to sneak in for media attention as a result of the impostor story. ■

SOURCES

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identity confirmed by managers on duty, and the incident will be reported to security the following day.

"Our badges can have cash value applied to them for use in the cafeteria and other areas in the hospital, and they are required for access to the parking garage as well," he says. "We've found that those features make the badge even more valuable to the staff member and encourage them to have it with them at all times." *(Editor's note: The badges are from Matrix Systems Integrated in Dayton, OH.)*

Personnel errors were root cause

As is so often the case in health care risk management, failures of corporate compliance are caused less often by policies than by people's failure to follow them, says **James M. Jacobson**, partner and co-chair of the health law and life sciences team at the law firm of Holland & Knight in Boston. This is a perfect example, he says.

"It appears that the hospital had appropriate security procedures and policies in place, such as a system of authentication, including badges and a procedure for checking them," Jacobson says. "Very likely, that system would have required reporting to a supervisor or administrator of the ED if a staff person did not meet security requirements. It appears that no one reported it."

The take-home lesson is that the best polices and procedures in the world aren't enough without ensuring that staff members adhere to them, Jacobson says. The solution is training, enforcement, and auditing. "First, hospital compliance officials should ensure that security is part of their corporate compliance training, and that training is repeated regularly and every time a new employee starts work," he says. "Second, when policies are not followed, there should be clear consequences for the staff who fail to follow them. In this case, that might be as simple as a

Liability mitigated when incident hard to predict

It appears no one was harmed by the bogus emergency department (ED) staffer at St. Joseph's Hospital in Tampa, FL, which means there may be no resulting lawsuit. But even if there were a plaintiff to sue the hospital, the potential liability might be reduced because the situation was so unusual, says **James M. Jacobson**, partner and co-chair of the health law and life sciences team at the law firm of Holland & Knight in Boston.

'Impostor . . . a rare bird'

Jacobson notes that while risk managers must prepare for even the extreme cases, the question of liability often comes down to whether the hospital could have foreseen the situation. "The impostor in this case is a very rare bird, and unless the hospital was aware that she wanted to crash the ED, it is very unlikely that her posing as a staffer was reasonably foreseeable," he says. "Mere errors in judgment or patient care, and even failures to follow corporate policy, are not necessarily legally actionable in a tort case when they are not reasonably foreseeable to the hospital."

Assuming the woman did not express an intention to breach security and was not known to have a disorder that would increase the risk of impersonation, Jacobson says he does not believe any jury would find that the hospital could have foreseen the woman's intrusion or that she would breach a duty to a patient. "Obviously, the impostor could have caused direct patient harm, whether by action or inaction," he says. "Fortunately, the staff recognized her limitations and forced her to shadow someone else. Even if she had caused patient harm, however, it is far from certain that a negligence lawsuit against the hospital would be appropriate or would succeed without foreseeability."

Finally, if the woman had access to protected health information, there could have been a violation of the Health Insurance Portability and Accountability Act, but Jacobson says it is very unlikely that the government would take action unless the data were further disclosed or the woman's use of the data caused harm to a patient. "Just as in medicine, the law expects people to look for horses, not zebras," Jacobson says. "This case is a zebra, something out of *Grey's Anatomy* or *ER*. Until this zebra becomes much more common, such that it is reasonably foreseeable, hospitals are unlikely to face liability for such mistakes." ■

weekend inservice training on hospital security policy, perhaps without pay."

In the most egregious cases, the response could be termination, Jacobson says.

No room for hurt feelings

A. Kevin Troutman, JD, an attorney with the law firm of Fisher & Phillips in New Orleans who assists hospitals with risk management projects, agrees that risk managers should clamp down on identification policies. Fortunately for St. Joseph's Hospital, the impostor apparently meant no harm, he says, but consider the ramifications if she wanted to gain access so she could harm patients or staff.

"The recent shootings at Virginia Tech remind us that we live in a society where security and controlled access can be paramount," Troutman says. "Safety and security is just not being emphasized enough, especially in these situations where you have the ability to stop people, check ID, and say, 'No, you can't come in.' When you have that process in place and people just don't follow it, that's inexcusable."

The St. Joseph's staff should have referred the woman to supervisors who could confirm that she was who she claimed to be, he says. "People have to be willing to act instead of just assuming someone else is handling it, or assuming that somebody knows what's going on," Troutman says. "You have to be willing to inconvenience that person, or inconvenience yourself if you need the employee working. If you're afraid to hurt someone's feelings or make them do what they should do, you're just asking for trouble." ■

Impostor incident could have led to ID theft

Any unauthorized person given access to patients and their records can steal confidential information and even assume someone's identity within the health care system, warns **Guillaume Deybach**, CEO of Worldwide Assistance Services, a provider of identity theft resolution services in Washington, DC.

The intruder at St. Joseph's Hospital in Tampa, FL, had ample access to information that could have led to medical identity theft, he says. Similar to identity theft in which a person's information is stolen for financial fraud, medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity — such as insurance information — without the person's knowledge or consent to obtain medical services or goods, or uses the person's identity information to make false claims for medical services or goods.

"Medical identity theft frequently results in erroneous entries being put into existing medical records and can involve the creation of fictitious medical records in the victim's name," Deybach says. "Medical identity theft can cause great harm to its victims. The extreme cases are where victims could be given the wrong treatment/surgery due to their medical records being compromised."

The more common consequences are that this type of theft leaves a trail of falsified information in medical records that can plague victims' medical and financial lives for years, he says. Deybach advises risk managers to consider the risk of medical identity theft when constructing security policies and identification procedures. ■

SOURCE

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Find out: Are your ED staff parking patients with EMS?

"Parking" patients with emergency medical services (EMS) crews still can happen even when the risk manager knows it is wrong and has taken an official stance against it, experts warn.

Risk managers may be aware that the Centers for Medicare & Medicaid Services (CMS) says emergency departments (EDs) may violate the Emergency Medical Treatment and Labor Act (EMTALA) by parking patients with EMS crews instead of officially taking charge of the patients in the ED, but that doesn't mean the practice isn't still going on in your ED.

ED staff sometimes resort to parking under the

EXECUTIVE SUMMARY

Experts caution that emergency department (ED) staff may continue "parking" patients with emergency medical services (EMS) crews even if you have told them not to. The Centers for Medicare & Medicaid Services has said parking patients may violate the Emergency Medical Treatment and Labor Act (EMTALA).

- ED staff may think the practice is acceptable as long as the EMS crew does not object.
- Risk managers should meet with ED staff to determine what really happens when the ED is overcrowded.
- As more hospitals back away from parking patients, any facility that continues to do so is at increased risk.

mistaken notion that patients are not covered by EMTALA as long they still are in the hands of the EMS crew, notes **Roberta Carroll**, a senior vice president for Aon Healthcare in Chicago. Even if the risk manager has told them not to park patients, ED staff still may think the practice is OK as long as the EMS crew doesn't complain, she says.

A cooperative EMS won't change the law

But a cooperative EMS crew can't change the EMTALA rules, Carroll says. "The hospital is still obligated to EMTALA," she explains. "Even if the EMS crew is trying to be helpful and offers to hold on to the patient for an hour, that doesn't relieve the hospital of its duty under EMTALA. This isn't just about avoiding strife between the hospital and the EMS crews."

Parking patients with EMS crews can happen even if it not sanctioned by the hospital as a coping strategy for an overcrowded ED, says **Mary Malone**, JD, of Hancock Daniel, a health law firm in Glen Allen, VA. Malone recommends that risk managers actively prohibit parking and make sure that ED staff do not see it as an acceptable option when the going gets tough.

"It can be something that people decide to do on the fly, but it's a really poorly thought-out solution," she says. It comes from having an essential misunderstanding of the EMTALA law, Malone says. Once that ambulance rolls onto your lot, the EMTALA obligation is triggered, she says. "So staff are just fooling themselves if they think they can let people stack up with EMS and they're off the hook," Malone says.

ED staff sometimes park patients with EMS crews as a way to cope with overcrowding and short staffing, notes **Mary Jean Geroulo**, JD, an attorney with the law firm of Stewart Stimmel in Dallas. Geroulo previously worked in health care administration for more than 15 years, including serving as a hospital CEO. She explains that parking patients with EMS crews has the potential for devastating effects on a hospital if CMS investigates. An EMTALA violation is bad enough, but this violation could even lead to a violation of the Medicare Conditions of Participation.

"This is something that should be on the top of the list for things you want to stop dead in their tracks," she says. The potential consequences are just too severe, Geroulo says. "The problem is that simply telling ED staff it is prohibited may not get that message across," she says. "It may take some face-to-face discussions to impress on them how important this is."

CMS: No parking

CMS clarified its position on July 13, 2006, with a letter to surveyors. **(To see the letter, go to www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter06-21.pdf.)** The letter pointed out that under EMTALA, hospitals have an obligation to assess the patient's condition once they "present" at a hospital's dedicated emergency department. An emergency medical condition triggers the obligation to provide the treatment necessary to stabilize the patient, but because the determination of an "emergency medical condition" is subjective, there is enough of a gray area that CMS concluded there "may" be a violation of the law.

After acknowledging that EDs are challenged by overcrowding, the letter stated that parking "is not a solution. 'Parking' patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of the EMS personnel to provide emergency services to the rest of the community."

Risk managers are unlikely to know that ED staff are parking patients with EMS crews until someone complains, and then it may be too late to prevent the damage, says **Sean P. Dwyer**, JD, a partner with the law firm of Havkins Rosenfeld in New York City. Once a complaint arises from and EMS crew or a patient, it will not be of much help to show that the risk manager sent a memo declaring parking patients is not acceptable.

SOURCES

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At that point, it could even come back to hurt you if you sent a memo and then didn't do anything to enforce it, he says. "It's like anything in risk management and liability," Dwyer says. "If you have a policy and you didn't follow it, that can be worse than not even having the right policy in place at all."

The 2006 letter has caused many hospitals to back down from using this strategy as a coping mechanism in the ED, Dwyer says. That means any hospital that continues to park patients with EMS crews is even more of an outlier now and will draw the attention of CMS surveyors, he says.

Dwyer recommends that risk managers meet with EMS managers in the community to come up with a solution that works on both sides of the equation. Complaints about parking may originate with EMS crews who feel they are being abused, so the potential risk and liability could be minimized by working more cooperatively with EMS providers, he says.

"The important lesson at this point is that you need to be proactive in doing something about this. Go down and meet with your ED manager, talk to them about what really goes on, find out what the reality is in the middle of the night," he says. "You can't fix it unless you know what really goes on." ■

CMS pushes for more in informed consent process

An interpretive guideline that calls for a more thorough informed consent process, whether the patient wants to hear the details or not, is causing consternation for physicians and risk managers across the country. The conflict is most pronounced in Oregon, where the instruction seems to contradict a state statute.

The issue is that the Centers for Medicare & Medicaid Services (CMS) has issued an interpretive guideline regarding a physician's requirement to gain an informed consent prior to any procedure, says **Paul Frisch**, JD, general counsel and director of medical legal affairs with the Oregon Medical Association (OMA) in Portland. The new guideline states that a comprehensive procedure, alternatives, and risks (PAR) conference with pre-procedure patients must be given even if the patient waives the right to or resists hearing all the risks and/or alternatives to the procedures the physician prescribes.

Legacy Emanuel Hospital & Health Center in Portland was sanctioned by CMS for failure to comply, he says. The hospital's policies said if a patient waived the right or resisted hearing the PAR details, the physician could note that in the chart, and it would be acceptable as a PAR conference in obtaining the informed consent. That wasn't sufficient for CMS, and the hospital changed its policies to comply with CMS interpretive guidelines. The hospital threatened to suspend privileges for physicians who failed to comply with the CMS guidelines.

Oregon leaves it to physician

The OMA is fighting CMS because the state has a statute that says a physician should judge the level of PAR given to a patient by the patient's response. The CMS guideline violates the Oregon

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is urging physicians to fully disclose all possible risks and alternatives to surgery, even if the patient does not want to hear the details. Some physicians resist the idea.

- An Oregon hospital was sanctioned for failing to comply.
- The CMS guideline contradicts an Oregon statute.
- Hospitals should comply unless CMS changes its position.

SOURCE

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statute and disregards patients' rights, Frisch says. OMA filed a lawsuit against CMS on Jan. 12, 2007. "If we're right and they're wrong, we'll have a judge at a district court level ruling that their interpretive guideline was improperly drawn," he explains. "Our objection is based on the fact that in 1977, the Oregon legislature passed an informed consent statute that was unique in that it said the physician and the patient have a conversation including the procedure, alternatives, and risks. The physician must ask if the patient wants to hear more, and if the patient says no, under Oregon law there is no further discussion."

Consent may scare elderly?

The Oregon law is premised on the idea that many patients, particularly the elderly, don't want to be unduly scared about possible risks, Frisch says. Forcing physicians to tell more after a patient says no may discourage some from seeking needed medical care, he says. "One of the plaintiffs in our lawsuit is an obstetrician who has women who need C-sections after laboring for several hours. If we follow the CMS guideline, he would have to go in there and detail all the risks and alternatives, even if she says she doesn't want to hear it," Frisch says. "That is really, really cruel and counterproductive to the clinical process.

Oregon is unusual in that it has a state law that contradicts the CMS guideline, and Frisch says most providers would be hard pressed to oppose CMS on this issue. A victory in Oregon could prompt CMS to change the guideline nationwide, but until then, he advises providers in Oregon and elsewhere to comply. "We're not going to back down, but until this is resolved, providers don't have much choice but to do what CMS says," Frisch explains. "Comply with the interpretive guideline. It is absolutely essential that you not put your hospital at risk by failing to comply." ■

Study looks at errors in labeling specimens

Risk managers know that communication errors often are a root cause of sentinel events in surgery, and a new study is reporting that specimen labeling is a common error that can threaten patient safety.[1]

In a six-month study of 21,351 surgical specimens, researchers from Johns Hopkins University School of Medicine in Baltimore found 91 labeling errors, for an annual rate of 182 errors. The five most common types of errors were specimen not labeled (18), empty specimen container (18), incorrect laterality (16), incorrect tissue site (14), and incorrect patient (11).

Breast procedures were the most common type of surgery to have an error. Nearly 60% of errors were associated with a biopsy procedure.

Reference

1. Makary MA, Epstein J, Pronovost PJ, et al. Surgical specimen identification errors: A new measure of quality in surgical care. *Surgery* 2007; 141:450-455. ■

Patient safety incidents up, big gap with best and worst

Patient safety incidents at the nation's hospitals rose over the years 2003 to 2005, but the nation's top-performing hospitals had a 40% lower rate of medical errors when compared with the poorest-performing hospitals, according to the results of a recent study.

The data come from the largest annual study of patient safety, conducted by HealthGrades, an independent health care ratings company in Golden, CO. The HealthGrades study of 40.56 million Medicare hospitalization records over the years 2003-2005 found that patient safety incidents continue to rise in American hospitals, with 1.16 million preventable patient safety incidents occurring over the three years studied among Medicare patients in the nation's hospitals, an incidence rate of 2.86%. The excess cost to hospitals was $8.6 billion over three years, with some of the most common incidents proving to be the most costly.

Patient safety incidents with the greatest increase in incident rates were postoperative sepsis (34.28%), postoperative respiratory failure (18.7%) and selected infections due to medical care (12.23%). Patient safety incidents with the highest incidence rates were decubitus ulcer, failure to rescue, and postoperative respiratory failure.

The top performers

Of the nearly 5,000 hospitals studied, the HealthGrades study identified 242 hospitals in the top 5% of all hospitals, says **Samantha Collier**, MD, HealthGrades' chief medical officer and the primary author of the study. Those hospitals — named Distinguished Hospitals for Patient Safety — were used as a benchmark against which other hospital efforts regarding patient safety could be evaluated.

On average, these hospitals had a 40% lower rate of patient safety incidents when compared with the poorest-performing hospitals, Collier says. If all hospitals performed at the level of the Distinguished Hospitals for Patient Safety, the study found that approximately 206,286 patient-safety incidents could have been avoided, 34,393 Medicare deaths could have been avoided, and $1.74 billion could have been saved.

"Despite the flurry of research, publications and process improvement activity that has occurred since the [Institute of Medicine] report there is a growing consensus that not much progress has been made leading to a visible national impact," the study says. "Our findings support this consensus. However, our findings also support that progress continues to be made at the top."

So what separates the best from the rest? The HealthGrades report says that "Distinguished Hospitals have deliberately chosen and maintained patient safety as a top priority."

For the full report, go to the company's web site at www.healthgrades.com. Under the subhead "HealthGrades Research," see "patient safety study." ■

Most drug side effects not due to error, study says

The vast majority of adverse drug events are side effects from a drug that was prescribed as intended, rather than being the result of a drug administration error, according to recent research.

In 2004, 1.2 million hospitalized patients experienced an adverse drug event, 90% of which were due to a side effect from a medication that was properly administered, according to the latest figures from the Agency for Healthcare Research and Quality in Rockville, MD.[1] AHRQ also found that just 8.6% of adverse drug events among hospitalized patients were because they were given the wrong drug or the wrong dose in the hospital or because they accidentally took an overdose or the wrong drug before entering the hospital.

Details of adverse events

These were some other findings:

- Average total hospital costs for patients who experienced drug side effects or other adverse drug events were $10,100, compared with an average cost of $7,600 for patients who didn't experience adverse drug events.
- The top three types of drugs involved in adverse drug events were corticosteroids, blood thinners, and anti-cancer drugs, mostly due to side effects from properly administered medications. For corticosteroids, 11.6% of hospital stays involved an adverse drug event, but just 0.4% of those events were due to wrong drugs or doses. For blood thinners, 9.4% of stays involved adverse drug events, 2.8% of which were due to wrong drugs of doses. For anti-cancer drugs and drugs used to prevent organ transplant rejection, 9.6% of stays involved adverse drugs events, 0.4% of which were due to wrong drugs or doses.
- Patients who suffered side effects from properly administered drugs tended to be older — an average of 64 years old — than patients who suffered from problems related to wrongly administered medication, who had an average age of 47. Nearly 60% of the patients who experienced an adverse drug event were women. **(The complete report can be found online at www.hcup-us.ahrq.gov/reports/statbriefs/sb29.pdf.)**

Reference

1. Elixhauser A, Owen P. Adverse Drug Events in U.S. Hospitals, 2004. *Statistical Brief #29*; April 2007:1-12. ■

Court decides if EMTALA should apply to inpatients

A 2003 Centers for Medicare & Medicaid Services (CMS) regulation that interpreted the Emergency Medical Treatment and Labor Act (EMTALA) does not apply to inpatients does not have the "force and effect of law," according to a recent decision by a U.S. District Court in Puerto Rico.

The court ruled that a mother could continue with her suit alleging that Hospital San Pablo del Este (HSPE) transferred her newborn child without providing stabilizing care while the infant was in a profoundly unstable condition. The judicial finding that the regulation only is an interpretation has the potential to bring up the issue on appeal in this or other cases, and perhaps ultimately return EMTALA to the Supreme Court for further clarification, says **Stephen A. Frew**, JD, a web site publisher and risk management specialist (www.medlaw.com) in Madison, WI.

The mother gave birth by cesarean at the HSPE, and the infant originally was taken to the hospital's newborn unit, according to a summary of the case. The child developed emergency conditions, including upper gastrointestinal bleeding, and was vomiting blood, the court opinion stated. The following day, the physician at HSPE ordered the infant transferred to Hospital Interamericano de Medicina Avanzada, where the child was described on arrival as being "critically ill." Medical records showed that the infant left HSPE "totally unstable" and with active upper gastrointestinal bleeding, the court noted. The child died two days later.

The hospital moved to dismiss the case on the grounds that under the 2003 CMS regulations, it was not bound by the stabilization and transfer rules of EMTALA because the infant was an inpatient. The court ruled that the 1998 *Lopez-Soto v. Jose Hawayek* case had previously held that EMTALA did apply in almost identical circumstances and emphasized that EMTALA's clear language is not limited to hospital emergency departments. The *Lopez-Soto* case is the only significant court of appeals case to interpret the Supreme Court ruling on EMTALA in the 1999 *Roberts v. Galen* case.

The judge refused to throw out the case because of the CMS interpretation not being binding on the court, and the judge stated that it would not apply in any case because the interpretation was issued after the child's death. The court noted that retroactive applications are not favored by law.

The decision allows the mother to proceed to trial, but she still must prove her allegations and that the conduct did violate EMTALA. Further appeal of the ruling is not likely to be allowed until a final verdict has been rendered in the case, Frew said.

"The original *Roberts* court clearly felt that EMTALA was not affected by what door the patient entered or what the patient's status in the hospital was, and applied it to an inpatient discharge situation," he notes. "The interpretation that EMTALA sections are to be read separately is also critical to the building debate over whether the CMS interpretation that 'EMTALA does not apply to inpatients' alters the requirements for hospitals with specialized capabilities to accept transfers under EMTALA." ■

SOURCE

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Spotlight is on awareness while under anesthesia

With National Public Radio, *Oprah*, and other media outlets covering patient awareness during anesthesia, many providers report an increasing number of questions about the issue from their patients.

Your surgeons and anesthetists should prepare for even more. This fall, a movie titled *Awake* will be released in which a man is awake but paralyzed during surgery. The movie is billed as doing for surgery what the movie *Jaws* did for swimming in the ocean, says **Richard J. Pollard**, MD, chief of neuro-anesthesia at Southeast Anesthesiology Consultants in Charlotte, NC. Pollard recently presented an audio conference titled *Awake During Surgery: A Patient's and Surgeon's Nightmare*, which was sponsored by AHC Media, publisher of *Healthcare Risk Management*. **(For information on ordering the CD, which includes tips for preventing awareness, see box in supplement, *Legal***

EXECUTIVE SUMMARY

A movie to be released this year about patient awareness, along with some well-publicized lawsuits, are bringing more attention to patient awareness.

- Muscle relaxants have no amnestic affect and can mask signs of awareness.
- Speeding patient extubation by five minutes per case may save 30-50 minutes a day, but it increases the potential for awareness and malpractice liability.

***Review & Commentary*, p. 4.)** Pollard and his peers just published a study on awareness in *Anesthesiology*.[1]

Recent cases of awareness have received national attention:

• One laparoscopic cholecystectomy patient received a large settlement after she reported being aware during surgery and hearing the surgeon call her a "fat whale," according to Pollard.

• In West Virginia, a Baptist minister had surgery to diagnose abdominal pain. The anesthesia providers gave him muscle relaxants but failed to give him general anesthesia until 16 minutes after the first cut. He was not told about the anesthesia incident, and he doubted his memories. After the procedure he was unable to sleep, he was afraid of being left alone, and he complained of people trying to bury him alive. Two weeks after the surgery, he committed suicide. A lawsuit has been filed by the family.

"This is outcome that can have a horrible devastating effect on your patient," Pollard says. "Even having it happen one time is too many."

There's an increased willingness to report awareness, he says. "So we will quite possibly see more of these patients on the front pages and come to the point we will meet them in the courtroom," he says.

Pollard's views are backed by the American Society of Anesthesiologist closed claims database, which indicates an increased number of claims for awareness. In addition, 78% of those cases received payment, Pollard says. The size of damages is increasing, with the highest award at $850,000, he says.

When looking at ways to avoid awareness, keep in mind that muscle relaxants have no amnestic affect, sources says.

Michael Rieker, DNP, CRNA, director of the Nurse Anesthesia Program at Wake Forest University Baptist Medical Center in Winston-Salem, NC, says, "In cases where muscle relaxants are used heavily or patients are on beta-blockers or other antihypertensives, some signs of awareness may be masked by these medications."

Also keep in mind that benzodiazepines have a drip half-life of only 1½ hours, Pollard says. "If the case is two hours, three hours, or longer, and you have only a single dose of benzodiazepines on board, the protective affects of that agent may be gone," he warns. All six cases of awareness in his study used Versed, he reports.

If the anesthetist feels compelled to run a "light" anesthetic to speed wake-up or avoid nausea, or to discontinue the anesthetic early,

CNE instructions/objectives

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. **The semester ends with this issue**. You must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

After reading this issue of *Healthcare Risk Management*, the CNE 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

■ Stroke care changed to reduce errors

■ Preserving e-mail for litigation

■ Protecting patient lists as trade secrets

■ Facility reduces falls to near zero

these actions could contribute to awareness, sources say. Speeding patient extubation by five minutes may save 30-50 minutes if you are performing six to 10 cases per day. "However, the tragedy of patient awareness, not to mention the potential malpractice liability, vastly overshadows the benefit of saving this time," Rieker says. "Economics are important, but with awareness occurring in 100 patients every day in the United States, cutting corners in the anesthetic is not a tenable risk."

CNE Questions

21. According to James M. Jacobson, how important is the performance of individual staff members in stopping hospital intruders?
A. The best polices and procedures in the world aren't enough without ensuring that staff adhere to them.
B. Policies and procedures should be constructed so that the effectiveness is not determined by how staff follow them.
C. Good technology is key, and the performance of staff is irrelevant.
D. Staff members cannot stop hospital intruders and should not try.

22. What does Jacobson say regarding the potential liability of a hospital where an intruder poses as a hospital worker?
A. The hospital is entirely responsible and would face huge liability.
B. Mere errors in judgment or patient care, and even failures to follow corporate policy are not necessarily legally actionable in a tort case when they are not reasonably foreseeable to the hospital.
C. The potential liability is minuscule even if the hospital could foresee the intrusion.
D. There is no liability for the hospital.

23. What does Mary Jean Geroulo, JD, say about "parking" patients with EMS crews?
A. The practice is fine and a good strategy for overcrowded emergency departments.
B. The practice has the potential to violate EMTALA and possibly hospitals' Medicare conditions of participation and is a very risky practice for hospitals to engage in.
C. The practice is allowable as long as patients are not parked longer than 30 minutes.
D. The practice is allowable only if the alternative is a hospital going on diversion.

24. According to Paul Frisch, JD, why are hospitals in Oregon resistant to the recent interpretive guideline from CMS regarding a physician's requirement to gain an informed consent prior to any procedure?
A. Hospitals in Oregon are especially overcrowded.
B. Hospitals in Oregon insist on providing a more thorough informed consent process than the one described in the guideline.
C. An Oregon state statute allows physicians to end the informed consent discussion if the patient asks not to hear further details of the procedure, alternatives, and risks.
D. The guideline is so vague that it is not clear what CMS is requiring of physicians.

Answers: 21. A; 22. B; 23. B; 24. C.

Reference

1. Pollard RJ, Coyle JP, Gilbert RL, et al. Intraoperative awareness in a regional medical system. *Anesthesiology* 2007; 106:269-274. ■

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

Hospital's delay in scheduling heart surgery due to inability to pay leads to $1.2 million verdict

By **Blake J. Delaney**, Esq.
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News: An uninsured man presented to the hospital complaining of chest pain. Doctors determined that he required heart-valve replacement surgery, but they discharged the patient until he could receive treatment for other conditions that could have complicated the heart surgery if left untreated. Six weeks later, the man returned to the hospital following treatment for his other conditions, and doctors cleared him for surgery. In the meantime, however, the man learned that he was ineligible for financial assistance from Medicaid to help pay for the heart surgery. A financial counselor from the hospital told the man that he should consult with an attorney to determine how to proceed. But before the man could finalize a plan to spend some of his retirement assets to pay for the surgery, he suffered a heart attack and died. The man's estate sued the hospital and two cardiologists. They claimed that delaying the surgery due to the decedent's financial condition violated the standard of care. A jury returned a $1.2 million verdict against the hospital, which represented $1 million in punitive damages and $168,400 in compensatory damages.

Background: An uninsured 62-year-old man experiencing symptoms of a heart attack was taken to the hospital for treatment. A cardiologist at the hospital diagnosed the man as suffering from critical aortic stenosis, and he transferred the patient to a nearby medical center for further treatment. Following testing at the medical center, doctors informed the man that he would need to undergo surgery to replace his aortic heart valve or else he would die. However, after learning that the patient had other health issues that could complicate the operation, such as dental disease and actively bleeding gastric ulcers, the man was discharged with instructions to first obtain treatment for those conditions before scheduling the open heart surgery.

At the time of the man's discharge, a financial counselor employed by the medical center assisted the patient with completing an application for financial assistance through Medicaid. The patient did not have medical insurance or a steady flow of income other than Social Security, but he did have equity in a home and $24,000 in a retirement account.

Over the course of the next six weeks, the man had nine infected teeth removed, leaving him with no teeth at all, and he received treatment for his ulcers. He then reported back to the medical center for an examination, at which point he was cleared for the heart-valve replacement surgery. In the meantime, however, Medicaid informed the man that he was ineligible for financial assistance due to his home equity and retirement account, and he was directed to meet with a financial counselor employed by the medical center. The financial counselor told the patient that he would need to spend some of his assets before he would be eligible

for assistance, and she urged him to confer with an attorney to determine how to proceed.

The patient became upset, left the hospital and, eight days later, consulted with an attorney. The attorney developed a plan for the man to use some of his retirement money to pay for the surgery and medical bills without having to sell his home. The surgery never was scheduled and, unfortunately, the man suffered a heart attack two days later and died.

The man's estate sued the medical center and two cardiologists for wrongful death and professional negligence. Claiming that the decedent had been told at his initial consult that he would receive the heart-valve replacement surgery regardless of his financial situation, the plaintiff asserted that delaying the surgery violated the applicable standard of care.

The plaintiff also retained a psychiatrist to conduct a psychological autopsy of the decedent. The psychiatrist gathered information about the decedent by collecting all manner of records and engaging in interviews with those who knew and communicated with him in an attempt to uncover the decedent's mental state during the last days of his life.

The psychiatrist testified that the stress of being told his life-saving surgery had to be delayed caused the man's condition to worsen and accelerated the heart attack that killed him.

Legal representatives of the medical center disputed liability and asserted that its counselor never informed the patient that his surgery would not be scheduled until the man determined how to pay for it. The hospital further argued that the man had made the decision himself to leave the hospital to get his financial affairs in order before surgery. The plaintiff responded that the financial counselor had implied that no surgery would be available until the man determined how to pay for it and that the defendants should have done more to make sure the man underwent surgery. After a trial, a jury absolved the cardiologists of any liability but returned a verdict against the medical center for $1.168 million, comprised of $1 million in punitive damages and $168,400 in compensatory damages. The award of punitive damages was predicated on a finding by the jury that the medical center's conduct was outrageous.

What this means to you: It is important to note at the outset that the cost of this claim far exceeded what the cost of the surgery and hospitalization would have been had the care been provided, says **Leilani Kicklighter**, RN, ARM, MBA, CPRHM, LHRM, consultant/principal at The Kicklighter Group in Tamarac, FL, and past president of the American Society of Healthcare Risk Management. "This was a very expensive lesson about drawing a line in the sand about obtaining payment without considering all of the alternatives," she says. Especially considering that the man had been advised that the heart-valve replacement surgery was a life-saving procedure, the plaintiff probably had no difficulty painting a picture for the jury that the medical center was more interested in money than saving a life. Kicklighter advises risk managers to keep in mind what kind of impression a scenario like this one will have on the community, regardless of how strong a legal defense is believed to exist. "The award of punitive damages in this case is the kind of thing that gives a marketing staff gray hair," she adds.

Kicklighter questions the knowledge base of the financial counselor at the medical center who assisted the patient in completing the Medicaid application. "Someone who is in such a position should know the criteria for eligibility for Medicaid, and one such criterion is the amount of money held by the patient in savings and the patient's home equity. The financial advisor should have advised the patient of these threshold criteria and begun to explore alternatives for payment," she says. Kicklighter also points out that the hospital already had the information regarding the financial assets of the patient and could have worked with the patient for a payment program after the surgery. In addition, because many, if not most, medical centers provide care at a discount or at no cost for the indigent population, the medical center should have been familiar with this patient's situation. If the medical center would not perform the surgery without payment, however, then Kicklighter suggests that the facility should have taken steps to refer the patient to a facility that did provide care to patients in financial need, such as a teaching or a tax-supported facility.

This scenario also illustrates that risks can arise from any department within a health care organization and that risk management efforts should not focus only on the clinical areas. "This patient was basically given a death sentence; he had symptoms of a heart attack and was found to require heart replacement valve surgery or he would die. This was apparently not an emergency, but clearly an urgently needed surgery," says Kicklighter. "A root-cause analysis of this situation might reveal aspects and attitudes or concepts that led to this sequence

of events and, if such factors were corrected, might prevent similar outcomes in the future."

Risk management should be sensitive to the role played by a facility's financial department, she says. "Because these personnel often give patients their first impression of the organization, the provider should undertake inservice of the staff, just as it does for others throughout the facility," says Kicklighter. She also advises the finance department's management to be sensitive to verifying the knowledge base of employees who serve in certain roles, such as those portrayed in this case. Management also should give due consideration to implementing a process that reviews each case with clinical input before a patient is denied care due to financial issues. "Such a procedure in this scenario might have prevented the patient's increased stress in an already clinically precarious situation," says Kicklighter. "Oversight by a supervisor might have recognized that arrangements for a payment program could be developed without the referral to legal counsel or referral to a different institution that would have enabled the center to perform the necessary surgery and deal with the payment issue afterward."

Reference

• Common Pleas Court, Dauphin County (PA), Case Nos. 1,270s-1,999 and 2,510s-1,999. ■

Woman's death leads to $602,800 verdict

News: A woman who required a feeding tube went to the hospital for a colonoscopy. Because of complications experienced during the procedure, doctors inserted a central line for intravenous fluid access. Upon her discharge from the hospital, a nurse attempted to restart the woman's feeding through her feeding tube, but she mistakenly connected the feeding pump to the patient's newly inserted central catheter line, which caused some of the feeding solution to infuse into the woman's system. Within 30 minutes, the woman began experiencing respiratory distress and was rushed to the intensive care unit, where she soon died. The patient's estate sued the hospital and its nurse. A jury awarded $602,800 in favor of the plaintiff and found that the hospital should be assessed punitive damages due to its grossly negligent conduct.

Background: A 62-year-old woman was developmentally challenged, blind, deaf, and nonverbal and had a history of mitral valve prolapse, high blood pressure, recurrent respiratory infections, and a mild stroke. With no close family relationships, she lived as a ward of the state in a group home for individuals with similar needs. She struggled to become a productive member of society, although she did have a job and had learned to communicate through body language, gestures, signs, vocalizations, and mannerisms.

In 1996, the woman underwent surgery to have a gastrostomy feeding tube (G tube) inserted to aid in her nutrition. Two years later, the woman went back to the hospital for a colonoscopy, but she experienced complications during the procedure. The woman was consequently hospitalized, and doctors inserted a central line for intravenous fluid access. Throughout her subsequent hospital stay, the woman experienced trouble with her G tube feedings. On the date of her discharge, nurses discussed the proper administration of her G tube feeding solution. One nurse ultimately attempted to restart the woman's feeding through her G tube but mistakenly connected the feeding pump to the patient's central line instead. The mistake caused 15 cc to 20 cc of the solution to infuse into the woman's system via the triple lumen central venous catheter.

Within 30 minutes, the woman began suffering from respiratory distress, and her skin and mucous membranes became bluish in color, a condition known as cyanosis, suggesting that her blood did not have enough oxygen. A Code Blue was called, and the woman was intubated and rushed to the intensive care unit. The patient's condition continued to deteriorate over the next several hours, and she died later that day, less than six hours after the feeding solution had been administered.

The woman's estate — distant relatives who did not know of the woman's existence until after her death — sued the hospital and its nursing staff for gross negligence. The plaintiff claimed that the woman had endured six hours of conscious pain and suffering, which was compounded by the fact that the decedent's hands were restrained during the incident, thereby preventing the woman from being able to "see." The hospital conceded that an error had occurred, but it disputed that its actions constituted gross negligence.

The hospital tried to minimize the plaintiff's damages, claiming that the woman was largely unresponsive during most of the time between the Code Blue and her death, suggesting that she did not suffer during that time. The hospital also

claimed that immediate steps were taken to avoid similar errors in the future. In response, however, the plaintiff introduced evidence of subsequent mistakes by the same nurse.

After a trial, the jury found that the defendant's actions had risen above mere simple negligence and classified them instead as gross negligence. The jury's damages award was consequently doubled, leading to an eventual judgment of $602,800, which included $250,000 in punitive damages.

What this means to you: "This is a sad, untoward outcome that could have been prevented," says **Leilani Kicklighter**, RN, ARM, MBA, CPRHM, LHRM, consultant/principal for The Kicklighter Group in Tamarac, FL, and past president of the American Society of Healthcare Risk Management. Significantly, this incident occurred in 1996, before the publication of the Institute of Medicine's report *To Err is Human*, which emphasized the prevention of medical error and the patient safety initiative. Kicklighter notes that many of the patient safety preventive goals that have been implemented as a result of the report are issues in this case scenario.

In this situation, the patient had a long-term G tube placed in the abdomen for feeding, which looks quite different from a central intravenous line. Nevertheless, this case illustrates that when a patient has more than one tube, the purpose of each tube should be labeled to prevent confusion. "This method would have probably prevented the infusion of the tube feeding into the central line in this scenario," says Kicklighter. A second preventive intervention that has been implemented since 1996 is the manner in which different tubes are connected. Kicklighter notes that if the feeding pump connectors not been compatible with the central line in-connector, this incident likely would not have happened.

Kicklighter questions the way the providers in this scenario handled the patient's situation. First, it is unclear whether the nurse who mistakenly connected the feeding pump to the central line was involved in the discussion among the nurses regarding the problems the woman had been having with her G tube. Because the problem with the G tube was known before the incident occurred, Kicklighter questions why the patient's physician did not call a consult or correct the problem with the G tube. "And if the patient had been having problems," says Kicklighter, "why did an attempt to give the tube feeding wait until the day of discharge?"

Another issue raised in this scenario is the restraint of a patient whose senses, hearing, seeing, and speaking were compromised. "It is unclear why the woman's hands, which she used to communicate, were restrained and taken from her in this case. Nowadays, the use of restraints is closely monitored and must be thoroughly documented," notes Kicklighter.

She notes in conclusion that disclosure is a requirement of The Joint Commission and in many states. "A root-cause analysis of this incident performed at the time of this unfortunate outcome might have shed more light on the situation, and addressing the issues identified in the root-cause analysis by implementing corrective action might have changed the reaction of the woman's distant relatives and might have prevented the alleged subsequent incidents involving the same nurse," Kicklighter concludes.

Reference

- Suffolk County (MA) Superior Court, Docket information withheld. ■