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Los Angeles hospital settles homeless 'dumping' case and avoids charges

New protocol makes Skid Row drop-off the last possible option

More than a year after an elderly hospital patient was found wandering a crime-ridden area in a hospital gown and slippers, the nation's largest HMO agreed in a settlement with the city to changes aimed at ending the dumping of homeless patients on streets. A civil lawsuit filed by the city also will be dismissed.

Kaiser Permanente, based in Oakland, CA, will create new protocols for discharging homeless patients in its chain of hospitals, train staff, and allow a retired U.S. district judge to monitor its progress, says Kaiser spokesman **Jim Anderson** in Los Angeles.

Carol Ann Reyes, 64, was discharged from Kaiser's Bellflower hospital in March 2006 and dropped off by a taxi outside the Union Rescue Mission in the city's notorious Skid Row area. She wandered around, apparently confused, for several minutes until mission staff took her in.

City Attorney **Rocky Delgadillo**, JD, filed charges of misdemeanor false imprisonment in November against Kaiser and said he wanted to

EXECUTIVE SUMMARY

A hospital in Los Angeles has agreed to a settlement that will end a criminal investigation regarding the "dumping" of homeless patients. The hospital will make large donations and implement a new protocol for discharging the homeless.

- While binding on only one hospital, the agreement is expected to influence how other hospitals discharge homeless patients.
- The agreement does not settle other investigations of similar conduct in Los Angeles.
- The settlement demonstrates how difficult it can be to discharge the homeless without incurring liability.

send a message to hospitals nationwide that engage in patient dumping. Los Angeles authorities are investigating allegations that a dozen area hospitals have dumped more than 50 homeless patients downtown. Kaiser also faced civil claims related to the mistreatment of Reyes.

As part of the settlement, Kaiser will pay $5,000 in civil penalties, $50,000 in investigative costs to the city attorney's office, and $500,000 to a charitable foundation benefiting local homeless programs. **(See p. 76 for details of the agreement.)**

Kaiser previously denied wrongdoing. Kaiser spokeswoman **Diana Bonta** said in November that hospital staff had called a taxi to take Reyes to Skid Row, but called ahead to the mission to let staff know she was on her way. **Benjamin Chu**, MD, president of Kaiser Permanente's Southern California region, released a statement saying the release of Reyes was a breakdown in hospital protocol and an aberration. "I don't think the policies and procedures were wrong," he said. "They just weren't as tight as we'd like them to be."

Other hospitals expected to follow

Other hospitals in the area have been accused of similar mistreatment of homeless patients, and risk managers across the country report that hospitals can find themselves in a no-win situation when discharged patients have nowhere to go. Many homeless patients resist attempts to discharge them in a more humane manner, risk managers report. **(For more on the difficulty of discharging homeless patients, see "'Patient dumping' charges in Los Angeles call attention to care of homeless," *Healthcare Risk Managememt*, June 2006, p. 61, and "Hospital vows changes after more patients 'dumped,'" April 2007, p. 45.)**

The agreement is binding only for Kaiser facilities, but most California hospitals with emergency departments plan to follow the Kaiser protocol, says **Jim Lott**, executive vice president of policy development and communications for the Hospital Association of Southern California. Delgadillo says his office has received 55 reports of homeless patient dumping on Skid Row over the last year, with one of the most notorious involving Hollywood Presbyterian Medical Center. In that February 2007 incident, hospital staff twice tried to deliver the paraplegic man to the Midnight Mission, which he had listed as his home address on hospital paperwork. On the first attempt security guards objected when the patient was brought into the mission courtyard on a gurney. Witnesses reported that a van returned later with the paraplegic man in a soiled hospital gown, a broken colostomy bag, and with no wheelchair or walker. The man hurled himself from the vehicle, crawled on the street, and dragged a bag of his belongings in his clenched teeth until the witnesses helped him.

According to the witnesses, the van driver ignored their cries for help and instead applied makeup and perfume before speeding off. Hospital spokesman Dan Springer issued a statement saying the hospital found the incident "extremely troubling and regrettable. The fact is,

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we would never condone leaving an individual at a location without his consent." He admitted that the hospital's procedures for discharging homeless and disabled patients were not followed.

After the Kaiser settlement, Hollywood Presbyterian Medical Center announced that it would adopt the new guidelines and better train its staff, but Delgadillo responded by saying, "This announcement by itself doesn't impact our investigation."

Settlement terms called reasonable

The Kaiser settlement was a good resolution of the dispute, says **Linda Stimmel**, JD, partner and co-founder of Stewart & Stimmel in Dallas, and **Mary Jean Geroulo**, JD, an attorney with the firm who previously was a hospital administrator for 10 years. The hospital was suffering extremely bad publicity from the controversy and did not handle the initial accusations well, they say.

The terms of the settlement essentially require the hospital to discharge homeless patients in a dignified manner, using a specific protocol that ensures the health provider has taken reasonable steps to find a safe way for the patient to re-enter the community, Geroulo says. The controversy in California involves accusations that hospital staff acted callously and treated patients with disrespect just because they were homeless, and Geroulo says the settlement provides a structured process to ensure that does not happen.

"These are processes that should be standard operating procedures for hospitals," she says. "This does not create any heightened level of responsibility, but rather it ensures that the hospital follows procedures it should have been following all along."

More allegations will come

The media attention to this issue increases the risk for all hospitals treating a high percentage of homeless patients, Stimmel cautions.

"We've seen this through the years. Once a case or an issue gets in the headlines, there are plaintiffs' attorneys who are looking for new avenues in which to pursue hospitals," Stimmel says. "We would be naive to think that plaintiffs' attorneys won't be on the lookout for this now, perhaps even having people stationed around hospitals looking for cases like this. Risk managers should be operating with an increased awareness of this issue, because we know the attorneys will be."

The counter to those charges will be a discharge process, carefully documented, that shows you did the best you could for a homeless patient, they say.

However, Geroulo and Stimmel emphasize that the Kaiser settlement does not impose any obligations on other facilities. Plaintiff's attorneys still will try to use the Kaiser settlement as a standard for other hospitals, they say, but standards of care are local rather than national.

"Will they try to use it against you? They absolutely will," Stimmel says. "But just because one hospital settled with these terms, that doesn't make it a rule. But plaintiffs' attorneys definitely will bring it up and use it as something to talk about."

Do what is reasonable

Even if you want to abide by the same terms as Kaiser, that does not mean you have to do anything beyond what is reasonable. Discharging homeless patients can be extremely difficult because ultimately the patient still will be homeless no matter how carefully you discharge him or her, they say. They caution against misinterpreting the Kaiser settlement to mean that hospitals are expected to find a perfect solution or just not discharge the patient. **(See p. 76 for more on why risk managers should not overreact to the Kaiser settlement.)**

SOURCES

For more information on appropriate discharge of homeless patients, contact:

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"Do not be afraid, risk managers, to send patients to a shelter. Do not let this settlement make you afraid," Stimmel says. "If you have to send the patient to a shelter because you've determined that is the best discharge option, then go ahead and do that. You only have to be reasonable. You don't have to solve the homeless problem." ■

Kaiser agrees to donate to shelters, change discharge

These are the details of the agreement reached between the Los Angeles City Attorney and Kaiser Permanente that will result in the dismissal of criminal charges brought in the case of Carol Ann Reyes, a homeless woman shown on videotape on Skid Row in Los Angeles in March 2006:

• Kaiser developed a discharge protocol specifically for homeless patients that declares the Skid Row area of Los Angeles a "destination of last resort." Homeless patients can be sent to Skid Row shelters or other agencies only if these conditions are met:

1) They live in the area already or specifically request services from a Skid Row shelter. Other options must be discussed.

2) The patient is able to handle the conditions on Skid Row.

3) The shelter has been contacted, and there is documented agreement to accept the homeless patient.

4) The patient is informed about other resources available there.

5) Transportation is provided in a van. Staff will assist the patient to enter the shelter or to find a place in the appropriate line if the shelter requires a line.

6) The top administrator (or designee) at the hospital has reviewed the discharge plan.

• Kaiser Permanente will pay $5,000 in civil penalties and also will pay the city attorney's legal expenses.

• Kaiser Permanente also has contributed $500,000 to a fund established in 2004 by California Community Foundation and Kaiser Permanente. It breaks down as follows: $25,000 to support a project to develop an electronic database that would link shelter providers and hospitals in Los Angeles County and share information about shelter availability, $25,000 to support the startup of a free legal clinic in the Skid Row area, and $450,000 to support the expansion of recuperative beds in Los Angeles County.

A court-appointed referee will oversee the agreement for the next three years. ■

Don't be afraid to discharge homeless patients, lawyers say

Discharging homeless patients can be tricky, but the recent controversy in California should not make risk managers so cautious that every homeless patient ready for discharge becomes a crisis, say **Linda Stimmel**, JD, partner and co-founder of Stewart & Stimmel in Dallas, and **Mary Jean Geroulo**, JD, an attorney with the firm.

Use the Kaiser settlement as a reason to review your discharge processes and meet with discharge planners to review how these difficult cases are handled, Stimmel and Geroulo advise. The purpose of the meeting should be twofold: to make sure that homeless patients are being discharged in a proper way, but also to make sure that discharge planners are not erring too far in the other way by "freezing up" when it seems a homeless shelter is the only option, they suggest.

"They need to understand that it can be reasonable, and they can't just hang on to those patients until something else comes up," Stimmel says. "This settlement does not require anything other than reasonable care in discharging the homeless, and we can't let people think it demands they perform miracles. When they think that, the whole system just comes to a stop."

Geroulo and Stimmel also urge risk managers not to become overly sensitive to the issue and create an atmosphere in which staff are afraid to discharge homeless patients. Even though Los Angeles hospitals are suffering from bad publicity related to the incidents, they say risk managers should strive for doing the right thing rather than pandering to critics.

"If you start trying to structure policies and procedures to avoid lawsuits and bad publicity, you're doing yourself a disservice," Stimmel says. "Sometimes you're going to get publicity, and sometimes you're going to get lawsuits you have to defend, but in the long run you're better off doing what you know is right and reasonable." ■

Center reduces falls with lift champion, ergonomics

A comprehensive program of education and changes in procedures has virtually eliminated falls at a surgery center in California. The leaders of the effort say their experience shows that reducing falls requires an approach that touches on all aspects of the problem.

The effort began in March 2006, with staff training started in June. There has been no patient fall in the year since the program began, says **Jeanne Linda**, RHIT, CPMSM, CPHQ, director of medical staff services/quality review at San Leandro (CA) Surgery Center. The falls at the surgery center never were higher than typically found in other surgery centers, but recent nationwide efforts at improving patient safety spurred staff at the center to look for ways to reduce injuries from falling, she says.

"Additionally, at the same time the staff was learning to reduce patient falls, they were also learning to protect themselves and avoid back injuries," Linda says. "Some of the resources we provided, like the transfer belts, helped make them more comfortable and confident that they could move patients without hurting themselves."

There has been no employee back injury since the program began, Linda says. She worked closely with **Carol Bowen**, RN, director of the center's post-anesthesia care unit (PACU) to investigate past falls at the facility and determine what might learned from them.

The investigation revealed a few intriguing points:

• New staff were involved with some of the falls. Was there a lack of orientation?

• All of the patients had a nerve block. Was there a lack education regarding numbness and difficulty in moving?

• All of the falls occurred in the PACU. Did the staff have the right training and tools? Were they communicating adequately with other team members?

Linda notes that leadership was involved in the investigation and supported the effort, including providing time and resources for those involved. "One of the things we realized was that we were not providing uniform training for all our staff on fall prevention. So leadership said maybe's time to go outside the organization to bring someone in to train the staff," she says. "Adding an ergonomic specialist from outside was a big part of the program."

Ergonomic specialist called in

This is what the surgery center did to reduce falls:

• An ergonomic specialist was hired to train all clinical staff in appropriate patient transfer. The training included classroom work on anatomy, body mechanics, safe transfer methods, and related topics. The specialist also conducted a hands-on lab where staff could practice safe

EXECUTIVE SUMMARY

A surgery center in California has practically eliminated falls with a comprehensive program that includes an ergonomic specialist to train staff. The program emphasizes staff recognition for practices that reduce falls.

- The center improved its efforts to track falls.
- Some policies and procedures were revised extensively.
- Individual staff members are rewarded for their efforts.

Fall prevention tips help keep post-op patients safe

These are some of the key fall prevention tips taught to the staff at San Leandro (CA) Surgery Center:

• Keep bed side rails up at all times. Never leave a patient unassisted with side rails down.

• Do not leave a patient unattended while dressing.

• Assume every patient will be weak and numb.

• To use a wheelchair, start with the wheelchair near the patient. Assist the patient directly to the wheelchair, position yourself in front of the patient, placing a hand in the axillary area, and guide the patient to a standing position. Then pivot to a sitting position in the wheelchair.

• Remember that moving a patient always will be more difficult than moving materials of a similar weight and size. The body is heavy, awkward, and delicate.

• Be prepared for the center of gravity to change during the handling activity. ■

SOURCES

For more information on the San Leandro effort to reduce falls, contact:

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transfers. **(See box, p. 77, for some of the fall prevention tips taught to the surgery center staff.)**

Staff were required to pass a competency examination in the appropriate skills. Training all of the staff took two days.

• Transfer aids were purchased for use by all staff. These included gait and transfer belts, transfer boards, slide boards, slippery sheets, and mechanical lifts.

• A "lift champion" was appointed to support staff in appropriate lift and transfer techniques. Bowen is one of the two lift champions; the other is in the operating room unit. The lift champion serves as a trainer during the clinical staff orientation process and mentors existing clinical staff. The champion also observes clinical staff during the patient transfer process and assists when necessary.

• Staff were encouraged to use "active communication" to prevent falls. With active communication, staff never hesitate to ask for assistance from team members and explains to the patient what he or she should do to assist.

• Discharge instructions were amended to include education to patients when nerve blocks have been administered. The warning begins with "You may have a block. This will cause numbness on the surgery side. Do not weight-bear until the block has fully worn off." The instructions are reviewed with the patient preoperatively and postoperatively, and then again with the patient's family member or other caregiver after discharge.

• The surgery center initiated a "Caught Being Good" program to recognize staff members who use proper techniques for avoiding falls. Any staff member can report someone performing well, or leaders like Linda and Bowen can catch them in the act. That person's name and sometimes a photo is posted on the "Caught Being Good" bulletin board with praise for following proper procedures in fall prevention.

"It's a small thing, but people think it's fun," Linda says. "It's a little way to let them know we've noticed they're doing the right thing, and we appreciate it." ■

Silicone implants are back, but little reason to fear

Silicone breast implants are now available for cosmetic purposes after a long hiatus, and chances are good that surgeons are using them in your operating rooms. But should you worry about a repeat of the lawsuit frenzy that led to the banishment of silicone implants years ago?

There is some need for caution, but not much reason to worry, says **Al Bixler**, JD, an attorney with the law firm of Eckert Seamans in Philadelphia. Bixler is experienced with defending medical malpractice cases and has studied the history of silicone implants and related lawsuits. A wave of lawsuits and intense media criticism in the 1990s led to the 14-year ban.

"The question everyone is asking is, 'Will that happen again?'" he says. "The answer is that it is very unlikely to be like what we say in the '90s. But that doesn't mean there won't be lawsuits."

Until the approval earlier this year, silicone implants were available in the United States only to women seeking breast reconstruction and revision surgery through clinical studies. After rigorous scientific review, the Food and Drug Administration (FDA) approved the marketing of silicone gel-filled

EXECUTIVE SUMMARY

The return of silicone breast implants, and their contentious malpractice history, raises questions about potential liability. One expert says some caution is needed, but the risk is low.

- There are substantially more clinical data now to prove the safety of silicone implants.
- Nuisance lawsuits still are possible, and the hospital or surgery center probably would be included.
- Patients should be educated during the informed consent process about the history of silicone implants.

SOURCE

For more information on the liability risk of silicone breast implants, contact:

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breast implants made by two companies for breast reconstruction in women of all ages and breast augmentation in women ages 22 and older. The products are manufactured by Allergan Corp. (formerly Inamed Corp.) of Irvine, CA, and Mentor Corp. of Santa Barbara, CA.

There still may be suits

As risk managers know, patients don't necessarily have to have a good case or a true injury in order to sue. So Bixler says it is possible that some patients will make unfounded claims related to silicone implants just because of the past controversy. Even with the lawsuits of the 1990s, there was little or no scientific basis for the claims of patient injury, Bixler says. Instead, the claims were the result of hysteria hyped by the media, he says.

If a patient sues after receiving silicone implants, the hospital or surgery center probably would be named as a defendant also, Bixler says. The difference this time around, unlike the 1990s, is that there is a wealth of scientific evidence showing the safety of the implants, he says.

"Even though the FDA has now approved silicone implants and even though the science behind the previous claims has been largely debunked, those two facts alone will not immunize a surgeon from potential claims," Bixler says. "You can see examples all the time of FDA-approved devices and pharmaceuticals that give rise to litigation."

More evidence to show safety

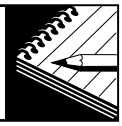
The FDA approved the wide use of silicone implants only after extensive clinical studies proved their safety, so Bixler says any health care provider would have a solid defense against claims that the implants themselves are unsafe.

"I don't see the plaintiff's bar being eager to take on a difficult case where the science is against them, because they are in business to make money like the rest of us, and that is just not good business sense," he says.

To reduce the chance of nuisance cases from patients who remember the previous lawsuit frenzy, Bixler suggests taking steps to makes sure that patients are well educated about not only the current scientific data regarding the safety of silicone implants, but also their controversial history. The informed consent process should include some discussion of how silicone implants were the subject of numerous lawsuits alleging patient harm, and the FDA's decision to restrict their use for many years, he says.

"You can't expect the patient to evaluate the epidemiology and the long scientific history, but you can be certain that the patient is aware of the history of this device," he says. "Full disclosure is always best in the informed consent process. You don't want someone claiming that she had no idea silicone implants were once criticized so harshly." ■

GUEST COLUMN



Patient lists can be trade secrets, need protection

By **Leila Narvid**, JD
Sideman & Bancroft
San Francisco

In today's competitive world of health care, lawsuits involving claims of misappropriation of trade secrets are becoming increasingly common among competitors. This trend can be seen in private medical practice, as health care practitioners are suing each other for what courts are now considering a valuable asset: patient lists.

What is a trade secret? The answer is largely the same in health care as in any other business. Courts analyze patient lists using the same legal standard applied to any other kind of customer list. Almost all states have adopted a portion of or modified version of the Uniform Trade Secrets Act (UTSA), which was drafted by the National Conference of Commissioners of Uniform State Laws in 1970 and amended in 1985. According to the UTSA, a trade secret has four characteristics: 1) information; 2) which derives independent economic value; 3) is not generally known or readily accessible by proper means or by other

EXECUTIVE SUMMARY

Patient lists and other information can qualify as trade secrets that can have substantial economic value for health care providers. Such trade secrets require special protection from risk managers.

- More lawsuits are being filed regarding health care trade secrets.
- Courts require that certain conditions be met before information is considered a trade secret.
- Access to trade secrets should be tightly restricted.

persons who can obtain economic benefit from its use; and 4) is the subject of efforts reasonable under the circumstances to maintain its secrecy.

As defined by the UTSA, "misappropriation" is the acquisition of a trade secret by "improper means" or disclosure of the trade secret without proper consent. Misappropriation can include "theft, bribery, misrepresentation, breach or inducement of a breach of a duty to maintain secrecy, or espionage through electronic or other means." Although an employee or independent contractor is free to leave a company and compete with his or her former company in the absence of a noncompete agreement, an employee or independent contractor is not permitted to misappropriate trade secrets.

Economic value is key

Trade secret law discourages employees and independent contractors from misappropriating confidential information. The laws are an effort to maintain and promote standards of business ethics and fair dealing in protecting those secrets.

Courts emphasize the economic value of patient lists in construing them as trade secrets. When disputes over patient lists arise, courts look to the conduct of each party and the particular information at issue. In *Pollack v. Skinsmart Dermatology & Aesthetic Center, PC* [68 Pa.D. & C.4th 417 (C.P. 2004)], the court of Common Pleas of Philadelphia held that a patient list taken by two physicians contained trade secrets protected under Pennsylvania law and that the defendants breached their duty of loyalty by using the list to solicit patients to their new practice. Defendants were independent contractors and were treating patients through the Philadelphia Institute of Dermatology (PID) owned by Andrew Pollack, MD. The patient list, containing 20,000 names, had been compiled by PID for over several years and was subjected to reasonable efforts to maintain its secrecy.

The case unfolded in October 2004, when Judge Gene Cohen of the Court of Common Pleas of Philadelphia ruled that Toby Shawe, MD, and Samy Badawy, MD, were liable to Pollack for misappropriation of trade secrets, breach of their duty of loyalty, and unjust enrichment. The court found that the defendants had improperly directed an employee to copy the patient list and then used the patient list to call to reschedule patients and to open their own practice. "The patient list was a trade secret, and defendants wrongfully acquired it," the judge said in his ruling. Shawe and Badawy settled with Pollack and agreed to pay more than $400,000 in damages.

Court records indicate that Shawe and Badawy worked for PID, but had no ownership interest in the practice. In June 2002, the three doctors reached a tentative agreement in which the majority of the practice would be sold to Shawe and Badawy. In early August 2002, Shawe and Badawy resigned from PID and on Sept. 3, 2002, opened their new practice, Skinsmart. The judge determined that prior to submitting their resignations, the doctors had directed PID staff members to make copies of the appointment books assigned to each of them and a printout of large portions of the patient list. The patient list was used to contact patients who had procedures scheduled at PID, to reschedule them to Skinsmart. Shawe and Badawy also contacted patients on the patient list as well as referring physicians via phone and mail to promote Skinsmart.

An important point is that neither defendant had access to the entire list. PID had taken significant steps to protect the list, such as investing in computers, software, and personnel to safeguard and maintain the list. The confidentiality of the patient list ensured that it remained unknown to those outside of PID. The patient list had tremendous economic value to the practice, which fulfilled the fourth major characteristic of trade secrets.

Efforts to keep confidential matter

In *Hoppens v. Haugen* (Nebraska Appeals Court, 1999) a Nebraska court used similar reasoning as the *Pollack* court in determining whether a list of dental patients could be considered a protected trade secret. Haugen shared a dental practice with Hoppens until they split up to practice separately. After the split, Haugen used patient lists and other

SOURCE

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records he obtained from Hoppens to contact Hoppens' former patients.

Hoppens sued for misappropriation of trade secrets. The court ruled in favor of Hoppens and held that the patient list, patient schedules, and office procedure documents Haugen used to set up his solo practice had significant economic value. While the court considered the security of the patient list and Hoppens' efforts to keep it confidential, the court's ruling focused on the economic value of the list.

Employers that fail to take adequate steps to protect the trade secret status of patient lists, patient schedules, and other office procedure documents may not be afforded the protection of the law. Health care employers should take precautions to make sure that they have met the requirements to protect the secrecy of patient lists:

- Limit access to patient lists only to those employees with a legitimate need to know.
- Use password-protected software to protect patient lists.
- Require employees and independent contractors to sign noncompete, nonsolicitation, or confidentiality agreements.
- When a practitioner is leaving a practice group, patients should be informed of the departure and that they will need to sign a release if they want their records to go with the departing provider.

By addressing the issues early on, companies may deter misconduct and avoid disclosure problems while the employee is employed and, more importantly, when the employee leaves. At the very least, such safeguards allow companies to arm themselves with the necessary tools to protect trade secrets and confidential information in the court system. ■

Hospital changes stroke care to improve safety

The quality and safety of stroke care in U.S. hospitals can be vastly improved if risk managers first understand how patients may be injured as a result of medical mishaps, according the experience of Strong Memorial Hospital in Rochester, NY. There has been plenty of attention to quality in stroke care, but not enough focus on safety issues, according to researchers there.

Strong Memorial revamped its stroke care after conducting a study that revealed an alarming number of medical errors in its stroke unit. The study looked 1,440 stroke patients hospitalized at Strong between July 1, 2001, and Dec. 31, 2004. By analyzing incidents reported by staff, the study details the frequency, types, and preventability of various adverse events.[1]

Associate professor of neurology and lead author **Robert G. Holloway,** MD, says he hopes that analyzing and sharing Strong's experience will prompt physicians and risk managers across the country to improve the safety of the care provided in their institutions.

"Learning about what caused these events in our stroke patients is the only way to keep them from happening again," Holloway says. "Over the last two decades, much attention has been given to improving the *quality* of stroke care in U.S. hospitals by establishing dedicated stroke centers and units, evidence-based guidelines, and performance measures. While these steps have been useful, most hospitals have yet to fully understand and address the *safety* of stroke patients."

12% of patients had adverse event

Over a 3½-year period, Holloway studied the experiences of patients who were treated for

EXECUTIVE SUMMARY

A hospital in Rochester, NY, has implemented several improvements intended to reduce medical errors and improve patient safety on its stroke care unit. The changes were prompted by a study that revealed a significant rate of errors.

- Twelve percent of the patients experienced a medical error.
- The hospital is using robotic dispensing systems to reduce medication mistakes.
- Stroke patients are being watched more carefully for falls.

strokes caused by blood clots or spontaneous bleeds in the brain. Of the 1,440 patients studied, 12% (173 patients) experienced an adverse event. A total of 201 events were reported for the 173 patients, although 18 events were considered "near misses," meaning that the error did not reach the patient. Of the 183 remaining adverse events, 86 were considered to be preventable, 37 were not preventable, and 60 were indeterminate. Preventable events included transcription/documentation errors, failure to perform a clinical task, communication/handoff errors between physicians and/or staff, and failed independent checks or wrong calculations.

"Although few patients who experienced a preventable adverse event were seriously harmed, adverse events do lead to temporary discomfort, longer hospital stays, and in some cases, serious injury or the potential for legal action," Holloway says. In the years since the study, Strong has concentrated on reducing medication errors and preventing complications such as blood clots and falls, he says.

Safety checks for meds

Strong has implemented a hospitalwide effort to reduce medication errors by implementing safety checks at the points that medications are prescribed, dispensed, and administered, says Strong Memorial chief quality officer **Robert Panzer**, MD. For example, computerized order entry systems have eliminated the need for handwritten prescriptions and screen medication orders for potential dosing errors, interactions, allergies, and more.

Robotic dispensing systems in the hospital's pharmacy ensure that the right medications are delivered to patient care units. Three years ago, Strong replaced all of its intravenous medication pumps with new smart-pump technology that checks the type and dosage of a drug just before it is administered.

Improved communication is a major focal point for reducing errors in the stroke care unit, Holloway and Panzer say. To improve communication, the hospital revised some policies and procedures to encourage staff to exchange information in a more organized, prescribed manner. At transfer points, such as when moving a patient in or out of the stroke care unit, staff are required to communicate in a systematic manner that ensures crucial information is conveyed correctly. For example, unit transfers include a check sheet that covers all important information. Supervisors hold staff accountable for following the procedures correctly and consistently, and failure to do so will affect their performance reviews.

"We're trying to improve the transfer of communication hospitalwide, using more systematic ways of transferring information from one person to another or one unit to another," Holloway says. "So what we're doing in the stroke care unit is consistent with what we're doing in a broader way to improve our culture of patient safety, but the study on this unit revealed some of the particular needs that could be addressed."

More attention to risk of falls

In addition, Strong has taken steps to prevent patients recovering from strokes from falling. This effort includes more consistent use of bed alarms on its inpatient stroke unit that alert staff when a patient who is unstable has gotten out of bed. Laminated signs hang outside of patient rooms to remind staff to check to make sure that alarms are always active and similar signs remind staff not to leave the patient alone in the bathroom.

"One way that stroke patients improve is by getting up and moving, so we have to balance that against wanting to reduce falls," Holloway says. "We want them up, but we also want to constantly remind staff to watch them and to use all the safeguards we have in place."

Though data on reduced falls are not yet available, Holloway says he is confident that the aggressive fall prevention measures are having a significant effect. The effort to reduce falls and adverse events dovetails well with Strong Memorial's overall efforts to use clinical best

practices for stroke care, such as for prevent hospitalized patients from developing blood clots (thrombosis), a complication to which stroke patients are particularly prone. Other efforts include getting patients up to walk whenever possible, using compression stockings or pads, and requiring the use of blood thinning drugs, such as heparin, at appropriate levels, Holloway explains.

Results from the improvements still are being compiled, but Holloway says it is clear that safety has been improved on the stroke care unit.

"Medication errors like heparin or insulin errors, the kind that we saw frequently in the beginning of this study, have essentially been eliminated," he says. "We're continuing to track our communication errors across transfer points and we think we're going to see excellent results there also."

Reference

1. Holloway RG, Tuttle D, Baird T, et al. The safety of hospital stroke care. *Neurology* 2007; 68:550-555. ■

CMS revises guidelines on informed consent

Under newly revised interpretive guidelines from the Centers for Medicare & Medicaid Services (CMS) for informed consent, hospitals are required to list all people performing "specific significant surgical tasks."

The previous interpretive guidelines had raised the ire of many providers because they required the listing of all persons performing parts of the procedure, including closing of a wound. This was problematic especially for teaching hospitals because residents sometimes are asked to close or do a portion of a procedure when they are available to participate, and they may not have been identified during the informed consent process.

The revised guidelines say significant tasks include "harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues," but wound closure is not listed and apparently is exempted.

The revised guidelines also include this statement that gives providers some leeway: "We recognize that at the time of the surgery, unforeseen circumstances may require changing which individual practitioners actually are involved in conducting the surgery." ■

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE objectives

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

- Studies without consent: Your risk
- Preserving e-mails during litigation
- Update on Katrina homicide cases
- Wristband inconsistency poses risk

CNE Questions

1. According to Mary Jean Geroulo, JD, how does the Kaiser settlement regarding the discharge of homeless patients affect other health care providers?
A. This does not create any heightened level of responsibility, but rather it ensures that the hospital follows procedures it should have been following all along.
B. The settlement creates an entirely new level of responsibility and will create a huge new burden for health care providers.
C. The settlement greatly decreases the level of responsibility and will make it far easier for providers to discharge the homeless.
D. The settlement completely absolves health care providers of any liability in discharging homeless patients.

2. Regarding whether plaintiffs' attorneys will try to use the Kaiser settlement as leverage against other hospitals accused of improperly discharging the homeless, what does Linda Stimmel, JD, predict?
A. They will not try to use the Kaiser settlement.
B. They will try to use the Kaiser settlement only in California.
C. It is possible but unlikely they will mention the settlement.
D. They absolutely will try to use the settlement. Plaintiffs' attorneys definitely will bring it up and use it as something to talk about.

3. What does Jeanne Linda, RHIT, CPMSM, CPHQ, say was one effect of the effort to reduce patient falls?
A. The training and lifting aids helped make them more comfortable and confident that they could move patients without hurting themselves.
B. Staff became more fearful about hurting themselves during patient lifts.
C. Staff back injuries rose sharply after the effort began.
D. Staff realized they can not be injured while moving patients.

4. According to Leila Narvid, JD, what is the obligation of employers to protect the trade secret status of patient lists and other information?
A. Employers that fail to take adequate steps to protect the trade secret status of patient lists, patient schedules, and other office procedure documents may not be afforded the protection of the law.
B. Employers are not obligated to protect the trade secret status to be afforded the protection of the law.
C. Employers are obligated to protect the trade secret status only when the potential loss would be significant.
D. Employers are obligated to protect the trade secret status only against infringement by other health care entities.

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

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- **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.

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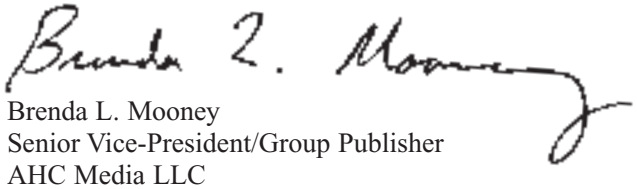

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A Monthly Supplement

Doctor's failure to monitor possible drug reaction leads to toxicity for child and $600,000 settlement

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

News: After receiving treatment at a hospital for an infection of his heel bone, a young boy was discharged with instructions for his mother to administer antibiotics several times a day for the next three weeks. Over the next few weeks, the boy exhibited severe symptoms, including a sustained fever and a rash, prompting her to return to the pediatrician's office several times. Upon each visit, the pediatrician ordered different treatments, but he insisted that the mother continue to administer antibiotics. The boy ultimately was referred to an infectious diseases specialist at the hospital, who concluded that the child had been experiencing an adverse reaction to the antibiotics. The boy underwent kidney and liver biopsies and exploratory laparotomies to address uncontrolled hemorrhaging. The boy's mother sued the pediatrician for negligence, alleging, among other things, that he failed to consider a drug reaction or drug toxicity as her son's symptoms progressed. The parties ultimately settled for $600,000.

Background: After sustaining a puncture wound to his right foot, a 4-year-old boy was sent to the hospital by his pediatrician for an X-ray and a bone scan. The X-ray was negative for a foreign body. But when the bone scan was interpreted as positive for an infection of the heel bone, the child came under the care of an infectious diseases specialist. During the course of the boy's two-day admission at the hospital, a peripherally inserted central-catheter line was inserted so that the mother could provide a three-week course of antibiotic therapy following discharge. Hospital staff instructed the mother on how to administer the drugs every several hours by means of an infusion pump, and she was told her to bring her son in for weekly blood work.

The mother never followed up on the blood work, but she did bring her son to the pediatrician for a follow-up appointment two weeks after his discharge. The doctor ordered another X-ray and told the mother to continue administering antibiotics. Two days later, the boy developed a fever, which the mother was told by the pediatrician to treat with acetaminophen. The fever continued over the next few days, however, and the boy became listless. The mother again called the pediatrician, and he ordered an immediate complete blood count. Although the results of the test were seemingly normal, the pediatrician instructed the mother to take her son back to the hospital because the boy's symptoms were progressing.

A surgeon at the hospital, concerned about a possible central-catheter line infection, replaced the existing line with a peripheral intravenous line. Upon the boy's discharge, the mother again was instructed to continue to administer the antibiotics and call if her son's symptoms lasted more than three days or became worse. The next day, the boy's temperature reached 104°, and the

mother returned to the pediatrician. A rash had developed all over the boy's body, and the doctor diagnosed him as suffering from a benign viral infection and mild dehydration. He ordered her to begin forcing fluids.

On the way home, the young child vomited, and the mother rushed him immediately to the emergency department. An infectious diseases consultant visited the boy for the first time since his discharge three weeks earlier and diagnosed him with complete liver and kidney failure, pancreatitis, hepatoxicity, nephrotoxicity, coagulopathies, and retroperitoneal bleeding. Recognizing that the child's liver enzymes and chemistries reflecting kidney function were markedly elevated, the infectious diseases consultant ordered that the antibiotics be immediately suspended.

The child was required to remain in the hospital's pediatric intensive care unit for 10 days, after which time doctors performed kidney and liver biopsies performed in tandem. Two exploratory laparotomies were subsequently performed to address the uncontrolled hemorrhaging that had resulted from clotting disorders caused by his liver failure. The surgeries caused permanent external scarring from the boy's breast bone down to his navel, and he remained at the hospital for four weeks. After discharge, the boy was kept on a special low-fat diet for months until his pancreatitis resolved. Doctors informed his mother that her son has the potential to develop a bowel obstruction secondary to his internal adhesions and scarring.

The boy's mother, on her own and her son's behalf, sued the pediatrician, the hospital, and other entities for medical malpractice. The plaintiff ultimately focused her lawsuit on the pediatrician and alleged that the doctor failed to consider a drug reaction or drug toxicity as his patient's symptoms progressed. The plaintiff also alleged that the doctor failed to properly monitor her son while he was receiving potent antibiotics at home known to have effects on the liver and kidneys, including hepatoxicity and nephrotoxicity, and she maintained that he failed to inquire of her — or anyone else — whether blood work was being performed. The plaintiff sought $73,000 in damages for her medical expenses and unspecified additional damages for pain and suffering.

In his defense, the doctor pointed out that he referred the boy to infectious diseases specialists at the outset because treatment of osteomyelitis and antibiotic toxicity were outside of his area of expertise. He also maintained that he was under no duty to monitor the child as an outpatient and that he had no knowledge of the discharge plan effectuated by the hospital. The doctor lastly argued that the boy's symptoms of rash, fever, and listlessness were more typical of a viral presentation rather than of any drug reaction or drug-toxicity reaction. After a jury trial, a verdict was returned in favor of the plaintiff for $1.073 million. The parties ultimately settled, however, for $600,000.

What this means to you: This case illustrates that when a child is the injured party, someone likely will bear the larger share of the blame, even if that individual had less than full liability in the grand scheme of the entire incident. "Juries are generally more sympathetic to child plaintiffs, as they see a child as more vulnerable and dependent on the professional accountability of the health care delivery system," notes **Lynn Rosenblatt**, CRRN, LHRM, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. "In this case, the pediatrician was the target of the jury's obvious disgust that such an egregious situation had occurred."

The pediatrician was the first provider that the child had contact with. "Once the pediatrician determined that the situation was beyond his expertise, he did the right thing in referring the case to an infectious diseases specialist. And from there, the treatment seemed appropriate," says Rosenblatt. In fact, it was at this juncture that the mother failed to follow instructions to return for blood monitoring, which prompts Rosenblatt to question what exactly the mother was told about the necessity of doing so. From a risk management perspective, there should have been some follow-up at this point by the infectious disease group to ensure the lab draws occurred as necessary to monitor the patient.

At the two-week interval, the pediatrician again was involved in the boy's care when he was consulted by the mother regarding the change in her son's condition. "The pediatrician should have collaborated with the specialist. The pediatrician was most likely aware that the child was on powerful antibiotics and, given the boy's age, there were certain risks to long-term treatment," says Rosenblatt. Rosenblatt notes that the pediatrician did not involve the infectious diseases team either because he did not question the mother sufficiently to know exactly what the course of treatment and follow-up had been or because he did not anticipate the possible signs of

drug toxicity.

In his argument at trial, the pediatrician used the defense that he had no knowledge of the care provided by the hospital and the infectious diseases specialist. He also contended that he had no obligation to monitor the child while receiving treatment from another professional. But Rosenblatt believes an argument can be made that the pediatrician had an obligation to follow up on the treatment that the infectious disease expert ordered. "The child remained his patient and was obviously under his care," she notes.

Rosenblatt thinks the pediatrician's argument completely disregards the concepts of "primary care provider" and "consulting physician." "While the consultant is managing a specific disease process according to his specialty training," she says, "the pediatrician still remains the primary attending following the patient." The pediatrician therefore is responsible for maintaining awareness of the patient's treatment by other providers and how that treatment affects the care the pediatrician is providing on an ongoing basis.

But Rosenblatt is quick to point out that this premise does not negate the obligation of the other providers to appropriately follow the patient and initiate appropriate interventions based on timely assessment and information from a coordinated network of care. Rosenblatt far too often has seen complex case management become segregated among specialties when no one identifies the role of case coordinator from the beginning. She thinks that this responsibility likely should have fallen by default to the pediatrician, as he was the primary practitioner and the others were brought in at his bequest. Because there was apparently no discussion between the various players as to the nature of the treatment, the appropriate follow-up, the effectiveness of the treatment over time, and the ongoing issues with the child, the obvious potential drug toxicity was overlooked until the child was in an advanced state of system failure. "All providers have some obligation to intervene at some point and come to this conclusion," she says. "Unfortunately, because they each were acting independent of the other providers, the child's condition went undetected until it was far advanced and life-threatening."

Reference

- Erie County (NY) Supreme Court. Case No. 99-7551. ■

Machine tips over while patient is asleep

Newly replaced knee is injured

News: A woman in therapy following knee replacement surgery was using a continuous passive motion machine to aid in strengthening her knee without her muscles being used. She fell asleep while using the machine, and it subsequently tipped over and twisted her knee. The woman sued the manufacturer of the machine and the hospital where she was undergoing therapy. A defense verdict was returned for the machine's manufacturer, but a jury awarded $206,000 in damages against the nurses.

Background: A 45-year-old woman underwent knee replacement surgery. Her post-surgery physical therapy at the hospital included the use of a continuous passive motion machine, designed to aid her recovery by gently bending and straightening her knee. Her doctors decided on the machine because attempts at joint motion in most patients following knee replacement surgery cause pain. The pain accordingly causes patients to not move their knee, which in turn allows the tissue around the joint to become stiff and scar tissue to form, resulting in a joint with a limited range of motion. The continuous passive motion machine moves the patient's joint without the patient's muscles being used, and it is often used for at least four hours during the day as well as all through the night.

While the patient was using the machine, she fell asleep. The machine subsequently tipped over, manipulated her knee joint at an odd angle, and damaged her knee replacement, which necessitated a second replacement procedure. The mishap also caused the woman to develop burning pain, stiffness, swelling, and discoloration in her joint.

The patient sued the hospital and the manufacturer of the machine. She claimed that the hospital's nurses had failed to properly set up the machine, which led to the tip-over, and that the machine should have had an automatic shut-off. The nurses claimed they used the machine as the physician had been and that the mishap was not why the woman required a second knee replacement.

A jury found that the machine manufacturer was not liable but that the hospital had acted

negligently in setting up the machine and supervising the woman. The woman was awarded $206,000 in damages.

What this means to you: "When patients are in a hospital setting undergoing treatment, no matter what that treatment is or whether the patient is an inpatient or an outpatient, the key responsibility of the hospital staff is one of supervised safety," says **Lynn Rosenblatt**, CRRN, LHRM, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. "The amount of supervision required is, of course, based on an accurate assessment of the patient, the nature of the treatment provided, and the conditions under which the treatment is provided."

Rosenblatt emphasizes the supervision required in a case such as this one. Given that joint replacement surgery is extremely painful, particularly in the first few days immediately following the procedure, many surgeons use patient control analgesic (PCA) pumps to allow the patient to adjust a continuous flow of an appropriate narcotic medication over the course of the first 24 hours postoperatively. This practice, together with post-residual anesthesia, can alter the patient's consciousness to the extent that she could drift in and out of a fairly deep drug-induced sleep. And even without the PCA pump, the patient is likely to take narcotic medications by mouth every three to four hours following a joint replacement surgery.

As the patient progresses toward post-surgical recovery and more strenuous rehabilitation and therapeutic modalities, narcotic pain medications generally are given orally at frequent intervals. Depending on the individual's pain tolerance and past medication usage, oral pain control can have varying effects upon patients. Accordingly, Rosenblatt cautions that any patient in this situation would be deemed unsafe for the use of a mechanized piece of equipment without some sort of staff oversight. "Nevertheless, because a CPM machine is generally ordered for extended periods over the course of the patient's day or even at night, it would be impractical to assume that continuous supervision could occur," she says.

Rosenblatt suggests that the more realistic alternative is to prevent such a mishap in the first place. The CPM unit is a heavy, bulky contraption that sits on the bed with an elevated leg rest that moves the patient's leg back and forth in a flexion and extension motion. It is electrically powered and usually not battery-operated. Ideally, the unit should be set up so that the bed rail on the side of the affected limb is in an "up" position. Also, in case the unit does tip over, the unit should not be so close to the side of the mattress that the incline is severe. And there should be enough slack in the electric cord so that there is no drag on the machine while it rests on the bed. These provisions offer some degree of safety that the unit will not fall off of the bed or fall over to distort the position of the limb. And in conjunction with the alarms that are equipped on many mechanical devices, preventing an accident from happening in the first place is an attainable goal.

"This accident speaks volumes to protocols that include assessment documentation of patients at the start of, conclusion of, and during the periods that equipment is utilized."

But Rosenblatt emphasizes that it is not sufficient for the nurses to merely set up the machine correctly without informing the patient about operating the machine. The patient should be fully instructed in the use of the equipment, its safety features, how to observe the equipment for safe and stable positioning, and how to quickly stop the operation and extract the limb safely. And if there is any reason to believe that the patient is sedated to a degree that he or she would not become aware or awaken should a problem with the machine occur, then the patient should not be left unattended.

"This accident speaks volumes to protocols that include assessment documentation of patients at the start of, conclusion of, and during the periods that equipment is utilized," says Rosenblatt. Flowcharts, for example, are an excellent way to maintain a running record of the treatment interval and to document the patient's tolerance to the process itself, and they are useful in establishing defenses in the case of a lawsuit. "Certainly a documented time line would have affirmed the assessment and oversight that would substantiate a reasonable and prudent standard of care," says Rosenblatt.

Reference

- United States District Court, Southern District at Huntington, WV. Case No. 3:03-2450. ■