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Cell phone cameras are creating liability risk for health care facilities

Cameras have been used by employees violating vulnerable patients

Nearly everyone carries a cell phone these days, and a large proportion of those phones include cameras that can be used to take photos quickly and quietly. But consider this: If you wouldn't allow employees or visitors to walk around a patient care area with big, traditional cameras hanging around their necks — and no risk manager would — then, why would you allow cell phone cameras?

Some risk managers are realizing that cell phone cameras should be restricted and closely monitored in a health care environment. Exactly how to restrict them can be a difficult decision because it is impractical to totally ban the presence of cell phones, but risk managers must take action, says **Raylene T. Filley**, JD, senior managing director of risk management at Rady Children's Hospital in San Diego. Filley knows the risk of cell phone cameras because an employee used one to record his sexual assaults on very young, unconscious patients at that facility. A second incident at Rady, involving sexual abuse of children and photos, also revealed weaknesses in protecting young patients from child predators.

EXECUTIVE SUMMARY

The proliferation of cell phone cameras is creating a liability risk for health care organizations. Employees and visitors can use the cameras surreptitiously to photograph patients and to record sexual assaults.

- It may not be practical to ban cell phone cameras completely.
- Some health care providers prohibit employees from carrying cell phone cameras.
- Existing camera policies may suffice, but employees must understand that cell phone cameras are included.

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(For the background on Filley's experience with this issue, see p. 99.)

"We have learned that any time you have kids present, and especially these kids who are the most vulnerable, you are going to have people try to gain access to them for the worst reasons," Filley says. "The presence of a cell phone camera just gives them one more way to commit their crimes and invade that child's privacy."

The hospital has lawsuits pending from the two cases, Filley says. Rady immediately reported the incidents to the California Department of Health Services and was cited for a deficiency. Filley notes that any incident of inappropriate touching automatically results in a citation.

Changes made to protect kids

In response to the sexual assaults involving cell phone cameras, Rady implemented strict controls on the devices, as well as making other changes to policies and procedures.

"We are probably way over the top in terms of standard practices on this issue. We wanted to set the bar very high," Filley says. "The fact that we had this happen twice, back to back, really drove home the point that there was more we could do to enhance the safety of our patients."

Filley says the hospital began making changes within two months of the first staff member's arrest. Hospital officials determined that it was impractical to prohibit visitors from bringing cell phones into the hospital, because that would require searching visitors at the door. But they decided that other changes were necessary, such as prohibiting staff from using their personal cell phones in patient areas. **(See p. 100 for the changes implemented at Rady.)** Rady has a zero-tolerance policy for violations and infractions could result in discipline, including dismissal, Filley says. Having good policies and procedures, and policing them strictly, can have a significant impact, Filley says.

"We learned from law enforcement that you will rarely catch a child abuser in the act. What you will find predators doing is violating policies in order to gain access," she says. "That's why we have tried to create an atmosphere here that is intolerant of people trying to violate patient safety policies."

Liability risk if you don't have policy

In another case, a staff member at a health care facility, did not sexually assault a patient but took a photo of a patient in "a very compromising situation, and this was a very vulnerable patient," says. **Bruce Cranner**, JD, chair of the Medical Liability and Health Care Law Committee of DRI — the Voice of the Defense Bar, a group based in Chicago that represents 22,000 defense counsel nationwide. Cranner defended the staff member, who had used a cell phone camera. "The person took the photo as a gag, but it ended up in a lawsuit," he says.

The hospital took the position that the act was committed without the hospital's knowledge and outside the scope of employment. The settlement

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

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Editorial Questions

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

eventually was made with the individual staffer and not the hospital, Cranner says. Nevertheless, the hospital suffered from the bad publicity surrounding the incident.

"There is exposure if the hospital has not established a policy and where the hospital is not taking reasonable steps to make sure the patient is protected," Cranner says. "Hospitals should have a policy prohibiting the use of cell phone cameras."

Cranner notes that most hospitals already have policies that restrict cell phone use because they may interfere with medical devices, so it may be simple to expand that policy to specify that the camera function also is prohibited. **(See p. 100 for the latest information on limiting cell phone use because of telemetry concerns.)**

Cranner recommends amending any existing policies on photography in the health care facility to include the use of cell phone cameras. He notes that people are so casual about using cell phone cameras, not even thinking of it as a "camera" so much, that some might argue they didn't think using the cell phone violated the prohibition on photography.

"I think a hospital that does not specifically include cell phone cameras in their policy on photography faces some exposure," he says.

HIPAA violation also possible

In addition to all the other reasons a cell phone camera can be dangerous in a health facility, a photo of a patient could be a violation of the Health Insurance Portability and Accountability Act (HIPAA), says **Meredith L. Borden**, JD, an attorney with the law firm of Venable in Baltimore.

"A photograph could reveal someone's protected health information — not just the fact that they're at the hospital, but their injury or what their particular illness might be," she says. There also can be criminal and civil claims for unauthorized photography, even if the patient is an adult and not nude, Borden says. Some states restrict the unauthorized photography of a person not in a public place, and the health care provider could be named in any lawsuit as well as the individual taking the photo, she says.

Sex assaults show risk of cell cameras

On July 25, 2007, a former respiratory therapist at Rady Children's Hospital in San Diego was sentenced to 45 years and eight months in prison for sexually abusing young patients and using his cell phone camera to record the crimes.

The case was one of two involving sexual assault on children that underscores the need to protect the youngest patients from predators and how they can use cell phones to surreptitiously record their acts. The first incident involved a respiratory therapist, 55-year-old Wayne Albert Bleyle, who pleaded guilty recently to molesting young, brain-damaged patients. He had worked at the hospital for 25 years, says **Raylene T. Filley**, JD, senior managing director of risk management at Rady. He admitted to eight counts of forcible lewd acts upon a child and four counts of exhibiting a minor in pornography, using pictures he took with his cell phone.

Bleyle was arrested in March 2006 after authorities traced child porn Internet traffic to his home computer. Prosecutor **Laura Gunn**, JD, told a judge then that Bleyle targeted children who were "the most brain-damaged, most comatose, most nonverbal — children who could never say anything about it." Bleyle admitted abusing four specific patients, including a 2-year-old girl, and he told investigators that he had abused so many children he had lost count.

Investigators reported to the court that they found images on Bleyle's computer and cell phone that he had created himself using children at the hospital.

A month after Bleyle's arrest, another Rady employee was charged with molesting a comatose toddler patient and transmitting child pornography on the Internet, Filley says. It was not proven that the images were of patients at Rady. Christopher Alan Irvin, a 32-year-old who had been a nurse at the hospital for a year and a half, pleaded guilty in September 2006 and was sentenced to 14 years and eight months in prison. ■

SOURCES

For more information on restricting cell phone cameras, contact:

- **Bruce Cranner**, JD, DRI — The Voice of the Defense Bar, 150 N. Michigan Ave., Suite 300, Chicago, IL 60601. Telephone: (312) 795-1101. E-mail: dri@dri.org.
- **Raylene T. Filley**, JD, Senior Managing Director, Risk Management, Rady Children's Hospital, 3020 Children's Way, San Diego, CA 92123. Telephone: (858) 966-4980. E-mail: rfilley@chsd.org.
- **Meredith L. Borden**, JD, Venable, Two Hopkins Plaza, Suite 1800, Baltimore, MD 21201. Telephone: (410) 528-2304. E-mail: mlborden@venable.com.

Hospital restricts cell phones after assaults

After two incidents of sexual assault on young patients, Rady Children's Hospital in San Diego implemented several changes to policies and procedures. These are the changes at Rady:

- **Staff are prohibited from using any cell phone in patient care areas unless they are hospital-issued phones.** Some staff, such as charge nurses, need to have cell phones at work, but the phones provided by the hospital do not have cameras, says **Raylene T. Filley**, JD, senior managing director of risk management. Staff are allowed to receive personal calls, within reason, on the unit's phone lines. They are allowed to bring their cell phones to work with them but they must be stored in their lockers and not taken on the patient care units. They may use their personal phones on breaks in public and in nonpatient areas of the hospital.
- **Personal cameras may not be brought onto hospital property by staff or physicians.** While it was considered impractical to prohibit staff and physicians from bringing cell phones to work, Rady officials decided they could completely ban any other type of camera. The hospital provides digital cameras for clinical use.
- **Standard privacy curtains in patient rooms were replaced with a type that has see-through mesh on the top third.** This type of curtain shields the patient in the bed from view, but any adult standing the room can be seen.
- **A new policy requires that privacy curtains in patient rooms be left open most of the time.** If the curtain must be closed, the policy requires that at least two adults be present behind the curtain. The adults can be any combination of physicians, staff, and parents. This policy not only protects the patient from harm, but protects the staff or physician from false accusations.
- **The hospital developed a child safety training program.** All staff and volunteers are required to complete a one-hour training program on child victimization and patient safety, developed with assistance from local child welfare agencies, the National Center for Missing and Exploited Children (www.ncmec.org), former Federal Bureau of Investigation agents with experience in investigating child predators, researchers from the Department of Justice and the National Institute of Justice, and clinicians with experience in treating child predators.

The material covers not only how to protect patients in the hospital, but also how to watch for signs of abuse in any child and how to respond. ■

"The risk to the employer in these situations is great," she says. "There are myriad ways that you can be penalized if someone takes an unauthorized photo of someone in your care."

Staff vigilance is important

The staff at Rady also were encouraged to monitor the use of cameras by parents. The use of cell phone cameras and other cameras is allowed, but staff watch for parents taking photographs of children not their own, Filley says.

Filley reports that the staff at Rady have accepted the cell phone restrictions well. They were so disturbed by the incidents that happened at the hospital that they were willing to do anything to prevent a recurrence, she says.

The vigilance of employees is a key part to making such a policy work, Filley says. Rady employees now know that anyone using a cell phone in a patient care area should be monitored, and violations of the hospital policy must be immediately reported.

"Our staff are the strongest part of this effort," Filley says. "They know what is at stake, and they will not just go about their business if they see someone using a personal phone around patients. They will speak up." ■

Cell phones don't interfere, report says

Many health care organizations routinely ban the use of cell phones because they can interfere with some medical equipment, but a new report says that fear is overblown. Other experts, however, say caution still is warranted.

In a study published in *Mayo Clinic Proceedings*, researchers say normal use of cell phones results in no noticeable interference with patient care equipment.[1] Three hundred tests were performed over a five-month period in 2006, without a single problem. Involved in the study were two cellular phones that used different technologies from different carriers and 192 medical devices. Tests were performed at Mayo Clinic campus in Rochester, MN.

The study's authors say the findings should prompt hospitals to alter or abandon their bans on cell phone use. Mayo Clinic leaders are reviewing the facility's cell phone ban because of the study's findings, says **David Hayes**, MD, a cardiologist in the Division of Cardiovascular Diseases and a study author.

But ECRI, a nonprofit health services research agency in Plymouth Meeting, PA, disagrees. In a February 2007 notice, ECRI continues to recommend against lifting cell phone restrictions completely in health care settings. In a recent report, ECRI noted that some news articles suggest that newer cell phones do not produce significant interference and that improvements to medical devices have reduced risks to the point where usage restrictions are unnecessary. "However, there is published evidence demonstrating that while risks may have diminished somewhat, they have not disappeared entirely, and well-documented cases of cell phones affecting medical equipment do exist," ECRI states.

For more on ECRI's research regarding cell phones, go to the ECRI web site at www.ecri.org and enter "cell phone" in the search box. *[Editor's note: Contact Hayes at the Division of Cardiovascular Diseases, Mayo Clinic, 200 First St. S.W., Rochester, MN 55905. Telephone: (507) 284-2511.]*

Reference

1. Tri JL, Severson RP, Hyberger LK, et al. Use of cellular telephones in the hospital environment. *Mayo Clin Proc* 2007; 82:282-285. ■

Grand jury saw Pou as hero, attorney says

A New Orleans grand jury's refusal to indict Anna Pou, MD, on murder charges stemming from several patients' deaths in the aftermath of Hurricane Katrina shows that the jurors understood "the difference between heroism and homicide," says an attorney who has represented several of the New Orleans health care facilities that were hardest hit by the disaster.

Lester Johnson, JD, an attorney with the law firm of McGlinchey Stafford in New Orleans, provided counsel to several New Orleans hospitals on regulatory and operational issues as they sought to reopen. He says the grand jury panelists "saw straight through Attorney General Charles Foti's reckless allegations and his underlying political/ego-driven motives." Johnson and the law firm have represented six of the leading health care institutions in New Orleans in recent years, and he says risk managers should be relieved that the grand jury did not comply with the efforts of state Attorney General **Charles Foti**, JD. Foti had sought to press criminal charges against the doctor at Memorial Medical Center in New Orleans and alleged she and others administered a "lethal cocktail" of drugs to end the lives of patients in the desperate days before help arrived. Foti had sought a 10-count indictment: one count of second-degree murder, and nine more counts of conspiracy to commit second-degree murder.

A New Orleans Parish grand jury issued a "no true bill" at Criminal District Court, which ended Pou's criminal saga. The second-degree murder cases against the two nurses, **Lori Budo**, RN, and **Cheri Landry**, RN, were dropped earlier this month after they were compelled to testify before a New Orleans grand jury.

Pou's Metairie attorney, **Richard T. Simmons**, JD, with the firm Hailey McNamara in Metairie, LA, issued a statement in which he said the grand jury's decision "fully and completely vindicates Dr. Pou of any criminal wrong doing in the wake of a miserably inept response by government at all levels to Hurricane Katrina." The decision brings to an end "23 months of pain and uncertainty, the hallmarks of which include suffering along with her colleagues, acutely ill patients, and far too many others in the sweltering heat and chaos of Memorial Hospital while local, state, and federal governments wrestled and wrangled and twiddled their thumbs as more than 40 people succumbed to third-world conditions inside the hospital." **(For more on the**

EXECUTIVE SUMMARY

Legal analysts say the grand jury's refusal to indict a doctor for murder in the aftermath of Hurricane Katrina shows that the public views her actions differently than prosecutors. Nevertheless, the case could have a chilling effect on health care providers.

- The doctor's attorney claims the charges were politically motivated.
- Similar criminal charges still are possible after a disaster.
- Good documentation may be the best defense.

conditions that led to the criminal charges, see *Healthcare Risk Management*, September 2006, pp. 97-103. See the article, below, for comments from Pou and medical organizations.)

Still some chilling effect

Johnson says the grand jury decision still may have a chilling effect on health care providers' willingness to serve in disaster situations.

"This case is a stark reminder that 'staying behind' can still result in them being subject to an unfair and ill-advised prosecution by authorities looking to further their own careers or political futures," he says. Foti's actions in this case were irresponsible and threatened to discourage physicians and nurses from making themselves available to provide care the next time a disaster strikes, Johnson says. "On the bright side, however, health care workers should take comfort in the fact that the public seems to be of the opinion that our medical professionals should be able to respond to emergency situations without the fear of being subjected to baseless criminal allegations," he says. **(For more on how risk managers can respond, see p. 103.)**

Johnson says what surprises him most about the case is how Foti, and even some of the expert witnesses, reacted to the grand jury's refusal to indict Pou. The day after the grand jury decision, Foti's office released a statement insisting that, despite the grand jury's findings, Pou did commit homicide.

Much of the attorney general's case relied on toxicology reports indicating the presence of morphine and Versed despite the fact that none of the patients received the drugs before Pou took over their care, Johnson notes. Such conclusions ignore the possibility that the patients' medical conditions worsened due to the unbearable conditions that existed at the hospital after Katrina's landfall, he says.

In particular, Johnson notes what he calls the absurdity of one report offered to the grand jury by the attorney general. In that report, a medical expert claimed that the administration of morphine and Versed shortened the lives of all nine patients.

"Our prisons would be filled with oncologists, hospice workers, and a host of other specialists if prosecutors charged physicians with homicide every time the administration of morphine and Versed shortens the life of a patient," Johnson says. "None of this has anything to do with Dr.

Pou says legal victory doesn't erase tragedy

Anna Pou, MD, the New Orleans physician accused of killing patients in the aftermath of Hurricane Katrina, says the grand jury's refusal to indict her on murder charges ends a 23-month ordeal. But she says, the legal victory should not overshadow the tragedy of what happened at Memorial Medical Center after the storm.

In a posting on the web site devoted to defending her against legal and civil claims (www.supportdrpou.com), Pou wrote that "this is not a moment of triumph, but a moment of remembrance for all those who lost their lives during the storm." She goes on to say, "We need to remember the magnitude of human suffering that occurred in the city of New Orleans in the wake of Hurricane Katrina so that we can ensure that this never happens again — and that no health care professional should ever go through this again."

Several health care organizations have expressed support for Pou, including the Orleans Parish Medical Society and the American Academy of Otolaryngology — Head and Neck Surgery (AAO-HNS). The Louisiana State Medical Society (LSMS) issued a statement praising the grand jury's decision and addressing concerns that her legal odyssey could dissuade some caregivers from risking a similar fate. "The LSMS strongly believes that Dr. Pou courageously performed her duties as a physician under the most challenging and horrific conditions. The decisions she made were in the best interests of the patients under her care," the group states. "We hope the grand jury's decision will remove the 'chilling effect' these charges have had and encourage physicians and other health care providers to continue to volunteer during disaster and emergency situations." ■

SOURCES

For more information about the grand jury's refusal to indict, contact:

- **Lester W. Johnson Jr.**, JD, McGlinchey Stafford, 643 Magazine St., New Orleans, LA 70130. Telephone: (504) 596-2782. E-mail: lwjohnson@mcglinchey.com.
- **Richard T. Simmons Jr.**, JD, Hailey, McNamara, Hall, Larmann & Papal, Suite 1400, One Galleria Boulevard, P.O. Box 8288, Metairie, LA 70011. Telephone: (504) 836-6500.

Pou's intent."

Pou also is suing the state of Louisiana and is asking a judge to force the state to pay for her legal representation against medical malpractice claims filed by the deceased patients' families.

Johnson says she should prevail. Pou is an employee of the state of Louisiana, and the state is responsible for defending its employed physicians from medical malpractice claims unless the physician's actions involve criminal conduct, he says. "It is preposterous the state can rely on the criminal acts exception when the state is the entity that brought the charges and in the end, it failed to prove that any criminal activities took place," Johnson says. "In any event, the intense involvement of the attorney general's office in this case should have disqualified it from making the decision on whether the state should defend Dr. Pou in civil suits." ■

Documentation must be good, even in crisis

The aftermath of Hurricane Katrina shows that health care providers risk criminal prosecution after making difficult decisions, says **Lester Johnson**, JD, an attorney with the law firm of McGlinchey Stafford in New Orleans.

The risk of prosecution should prompt special attention to risk management, Johnson says. Health care professionals working under emergency conditions should attempt to provide care under as normally as possible, he says. This would include documenting all patient care activities and the reasons as accurately and thoroughly as possible to prevent any subsequent investigations from drawing the wrong conclusions about why the treating professional chose to administer a particular medicine or perform one procedure over another.

For instance, Johnson points to the case of Anna Pou, MD, the New Orleans physician accused of killing patients in the aftermath of Katrina. The attorney general and some of the expert witnesses seemed to rely heavily on the fact that Pou and the two nurses administered morphine and Versed to several patients despite the fact that the patients did not receive those drugs prior to Hurricane Katrina, he notes. "It doesn't appear that the patient's medical records contained clear reasons why they felt the drugs were necessary, so the investigators were free to draw whatever conclusion they wanted in the absence of precise record keeping," he says.

The lack of adequate documentation allowed critics to claim that something nefarious was going on simply because the physician who took over the patient's care changed their medication, Johnson says. In Pou's case, the sweltering heat combined with the lack of food and water made it quite likely that a terminal patient's condition would take a turn for the worse, thereby necessitating a different approach to managing the patient's pain and comfort level, he says. Records showing that change in treatment and the reasoning behind it would have been helpful, he says.

Case shows risks for health workers

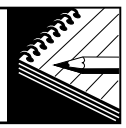
The Pou case illustrates some of the risks facing health care workers every day, says **Kathy Poppitt**, JD, a partner with the law firm of Thompson & Knight in Austin, TX. Her case may have been extreme, but it still holds everyday lessons, Poppitt says.

"I think the take-home lesson here is that with the current extensive regulation and oversight of health care workers and facilities, it is very easy for those workers and facilities to find themselves in unexpected trouble. Once a train such as this one starts to pick up steam, it can be very difficult to bring it to a stop," Poppitt says. "I see the same things almost daily in accusations of fraud and misconduct by civil regulatory agencies. Once the accusations start it can be very difficult, time-consuming, frustrating, and expensive to find a resolution."

Like some other observers, Poppitt says she thinks there could be some health care providers who are scared away from aiding in a disaster. While that may be an overreaction, Poppitt does say risk managers should advise care givers about the risk and how little protection there is against criminal charges.

"Most states have Good Samaritan laws that protect volunteer physicians from civil liability in most circumstances," she says. "Of course, there is no such similar protection for criminal charges. It is a good idea for providers to be familiar with the Good Samaritan laws that apply to them so they can have some comfort in knowing what protections they would have in such situations." *[Editor's note: Contact Poppitt at Thompson & Knight, 98 San Jacinto Blvd., Suite 1900, Austin, TX 78701. Telephone: (512) 469-6133. E-mail: Kathy.Poppitt@tklaw.com.]* ■

GUEST COLUMN



Develop plan for lawful management of data

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

With increasing frequency, health care providers confront the prospect of being involved in litigation or investigations by a regulatory body. While courts have always imposed a duty to preserve and produce documents and information relevant to a lawsuit or government investigation, the increased reliance on electronic communications and documents has altered traditional preservation and production practices.

Today, it is especially important that risk managers, with the assistance of legal counsel and information technology staff, develop a cohesive organizationwide protocol to manage electronic documents in the event of litigation or investigation.

The new Federal Rules of Civil Procedure, which govern civil procedure in the United States district courts, recognize that electronic evidence is on the same footing as printed, physical documents. The most drastic change in the federal rules is the emphasis on electronic data production. Rule 34 defines a new category of discoverable information known as "electronically stored information" (ESI).

EXECUTIVE SUMMARY

Health care providers have a duty to preserve electronic communications, such as e-mail, that may be pertinent to litigation. When faced with a malpractice lawsuit or action by a regulatory body, it is imperative that you have a plan of action regarding how to preserve those data.

- Failure to preserve data can result in stiff penalties.
- Risk managers should develop a "litigation hold" plan that facilitates the efficient preservation of data.
- Make sure information protected by attorney-client privilege is clearly marked.

ESI includes writings, drawings, graphs, charts, photographs, sound recordings, images, and other data stored in any medium from which information can be obtained or translated.

As with traditional physical documents, litigants are obligated to provide a copy, or description by category and location, of all ESI the litigants have in their possession, custody, or control that they may use to support their claims or defenses. The obligations are spelled out in Rule 26(a)(1)(B).

Failure to plan is major risk

Recent case law suggests that you can have disastrous consequence if you don't have a document retention policy or a plan for implementing a litigation hold, which is the process of notifying employees of their obligations to preserve all potentially relevant records while continuing the routine destruction of nonrelevant data. In *Zubalake v. UBS Warburg* (2004 U.S. Dist. LEXIS 13574), the plaintiff, Laura Zubalake, claimed that UBS Warburg fired her as an equities trader after she filed an Equal Employment Opportunity Commission charge alleging that she was denied promotion because of her gender. Early in the lawsuit, UBS's counsel instructed company employees to preserve ESI.

Despite these instructions, some employees deleted pertinent e-mails, and other employees did not turn over relevant e-mails. As a result, some discoverable e-mails were irretrievably lost, and others were not produced to the plaintiff for nearly two years.

Finding that UBS acted willfully in destroying potentially relevant information, the judge imposed sanctions against the company, including a negative jury instruction that would allow the jury to conclude that the destroyed e-mails contained information adverse to UBS. In determining whether UBS' conduct warranted sanctions, the court held that the employer has a duty to locate all relevant information and to ensure preservation of documents.

The *Zubalake* court advised that lawyers must start doing the following in order to make sure that their clients comply with discovery procedures:

- issue a litigation hold at the commencement of litigation or whenever it is anticipated, regardless of the format or location of the documents;
- communicate directly with the key players in the litigation;
- instruct all employees to produce electronic copies of their relevant files. **(See the article, p. 105, for tips on preserving ESI.)**

Retention policies are not just the province of

litigation. Federal and state statutes mandate certain data be retained for certain period of time. Statutes such as the Health Insurance Portability and Accountability Act and the Sarbanes-Oxley Act of 2002, which has a seven-year time period, as well as state data breach prevention statutes, require record retention protocols.

Because the employer in *Zubalake* failed to meet its discovery obligations, the court instructed the jury to presume that withheld documents were harmful to the employer's interests. The jury returned a verdict of $9 million in general damages and $20 million in punitive damages.

As shown in the *Zubalake* case, the cost of failing to produce relevant ESI when an organization is on notice of a potential claim or lawsuit can be catastrophic. Implementing protocols to address e-discovery and train employees on such protocols

6 tips for ensuring lawful data retention

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

The following tips are aimed at providing risk managers with a practical approach to readiness for the new Federal Rules of Civil Procedure.

• Develop a "litigation hold" plan.

A "litigation hold" plan is an important part of a general document retention policy, which lays out the types of documents that are routinely available and sets a schedule for destruction of such documents. Having such a plan in place and complying with it when litigation does arise evidences to the courts a company's good faith and reasonable efforts to comply with its discovery obligations. It is useful to prepare a generic litigation hold memorandum that can be quickly adapted to the particular needs of a litigation matter. **[Editor's note: A copy of this policy is available with the online version of *Healthcare Risk Management.* If you're accessing your online account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. If you already have an online subscription, go to www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." For assistance, call Customer Service at (800) 688-2421.]** When a lawsuit or investigation is imminent, work with counsel to prepare a litigation hold memorandum that describes: 1) the claims, or potential claims, involved in the lawsuit; 2) the data requested (or likely to be requested) in discovery requests; and 3) the types of data that must be retained. Failure to timely implement a litigation hold can lead to sanctions.

• Identify key witnesses.

Determine who within the company is a key witness in the litigation. Explain to these key players their obligations to preserve evidence.

• Facilitate easy preservation of evidence.

Work with information technology (IT) professionals or vendors to help employees preserve evidence. Be prepared to gather information maintained on network servers, desktop hard drives, laptops, removable storage media, personal digital assistants (PDAs), flash drives, and voicemail. IT professionals can create shared electronic folders to preserve newly created, discoverable documents.

• Work with counsel to make sure that attorney-client privileged documents are correctly marked.

The regular use of "privileged" banners on correspondence or in the subject line of e-mail messages will assist screening of privileged documents when key word searches are used to obtain relevant information once discovery begins. If practical, it may be helpful to store all potentially privileged documents on segregated or partitioned hard drives or servers.

• Advise employees that they should be judicious in the information that they create, receive, retain, or send.

They also must be ready to preserve and protect electronically stored information once they learn that litigation against the institution is likely or has begun. Include electronically stored information (ESI) retention policies in employee handbooks, and consider providing training specifically to address ESI policies.

• Remind employees that ESI is just as valid and important as hard copy documents.

Courts treat electronic documents no differently than any other documents. Advise employees to treat electronic materials as if they were printed, physical documents. ■

now will give companies the upper hand when faced with litigation or investigations. ■

Patient safety rounds called key strategy

Patient safety rounds can be an effective way to implement safety initiatives and assess ongoing efforts if the rounds are done properly, say those who have seen success with the strategy. Weekly rounds by administrators may not be enough, they say.

Health care providers implement safety rounds in different ways, but many use weekly or biweekly rounds in which the risk manager, department heads, and other hospital leaders visit various units in the facility to assess patient safety and get feedback from staff and physicians. That is the method has been employed for the past year at Holston Valley Medical Center in Kingsport, TN, explains **Tony Oliva**, MD, chief medical officer.

Oliva says a main benefit of patient safety rounds is simply having senior leadership out on the floors where they can be seen and can interact with others. But the strongest results come from focusing more frequent rounds on key patient safety initiatives, he says.

"We get the best results from having a lot of different people rounding very frequently, sometimes on a daily or hourly basis, and not just the weekly administrative rounding process that a lot of hospitals have set as patient safety rounds," he says.

In addition to the standard weekly patient safety rounds with administrators, the system also has used "leader rounding" for seven months and "nurse rounding" for five months. In leader rounding, the clinical leaders from each unit go to patient rooms and check for compliance with fall protocols, ask patients if they understand their medication regimens, and explore similar issues.

That leader rounding happens daily, but nurses conduct more focused rounding on an hourly basis. Every hour, nurses round specifically to assess patients identified at risk of falls, for instance. This rounding is in addition to the nurse's routine rounding for all patients.

"We've found we get more results from those rounds than from the weekly administrative rounds," Oliva says. "They both have their place, but when it comes to real results, the hourly rounds produce much more."

Fall prevention has been a primary patient safety focus for Holston Valley Medical Center, and Oliva says the intensive rounding has yielded a steady decrease. In March 2007, Holston's fall rate was 3.5 per 1,000 patient days and that rate fell to 2.1 in June and below 1 in July.

"We know that the hourly rounding and leader rounding has contributed to this trend," he says. "The reason it works is that you're getting information off the front line. The leader is out there seeing it for himself instead of calling in someone to the office to report what's going on."

University of Michigan reports good results

Patient safety rounds also were established in 2002 at the University of Michigan Medical Center in Ann Arbor to improve patient safety. The rounds have opened a new line of communication between the chief of staff and frontline caregivers. In a recent report on the hospital's experience with safety rounds, the medical center reports that patient safety rounds are biweekly, hourlong meetings between the chief of staff and caregivers on individual patient care units.[1]

In the past four years (2002-2006), 70 patient safety rounds have been conducted at the University of Michigan Medical Center, and more than 900 area staff members have participated, the hospital reports. Staff attendance averages about nine unit or area staff members per session.

"Patient safety rounds have proven to be a concrete, inexpensive mechanism to enhance patient safety," the report states. "Benefits have been documented in the improvement in the safety culture and development and implementation of preventive strategies to solve patient safety issues."

The Michigan hospital reports that the key

EXECUTIVE SUMMARY

More hospitals are employing patient safety rounds to improve safety and quality, using an approach similar to the rounds that physicians use to check on their patients. Risk managers and representatives of other departments usually go on the patient safety rounds together.

- Include a range of departments in the safety rounds.
- Act on the information discovered on rounds.
- Use the rounds to engage medical staff in patient safety efforts.

SOURCES

For more information on conducting patient safety rounds, contact:

- **Tony Oliva**, MD, Chief Medical Officer, Holston Valley Medical Center, 130 Ravine Road, Kingsport, TN 37660. Telephone: (423) 224-4000.
- **Deborah Morris Nadzam**, PhD, RN, FAAN, Joint Commission International, 1515 W. 22nd St., Suite 1300 W, Oak Brook, IL 60532.

components in the success of patient safety rounds are active medical staff leadership and the engagement of physicians and senior management in the process improvements that arise from the rounds.

The team members selected for the administrative patient safety rounds can be key to the success of the effort, says **Deborah Morris Nadzam**, PhD, RN, FAAN, a nurse and risk management consultant who previously served as executive director of The Quality Institute of the Cleveland Clinic health system. The risk manager or a representative from that department is a natural choice. The CEO or a similar top-level executive also is a great addition to the rounds.

"The presence of the CEO lends credibility to the effort and conveys that this is something the organization takes seriously at the highest level," Nadzam says. "The leader of the quality department also is a good choice because that person often is more familiar to the frontline staff. It's a good idea to always have someone the staff knows participating in the rounding. That can ease anxiety when they see executives coming down the hall."

Including the top-level executives not only sends the right message to the staff, but Nadzam says it produces a more fruitful and robust discussion of safety issues when the board meets. The executives have witnessed the problems themselves and heard from front line staff, instead of relying on information relayed to them. **(See article, right, for advice on including employee safety also.)**

Going on rounds isn't the final goal, Nadzam says. "You also need to be ready to act on what you find during the rounds," she says. "The rounds are really a data collection process, and then you have to do something with that information, rather than letting yourself think you've done your job by walking around the hospital."

Reference

1. Campbell DA, Thompson M. Patient safety rounds: Description of an inexpensive but important strategy to improve the safety culture. *Am J Med Qual* 2007; 22:26-33. ■

Employee safety also good for rounds

Don't forget to include employee safety issues in your rounding strategy, suggests **Steve Knowles**, safety officer at Women & Infants Hospital of Rhode Island in Providence.

Knowles and other safety officers conduct comprehensive safety rounds at the hospital at least twice a year to look specifically at employee safety and environment of care issues. They check for concerns such as fire doors are not blocked, evacuation plans are posted properly, electrical systems are not overloaded, fall and trip hazards are not present, and food is stored properly. In addition, two members of the safety department participate in weekly rounds with other hospital representatives.

"Each time we go out, we notice a decline in infractions," Knowles says. "Getting out there for

CE objectives

After reading this issue of *Healthcare Risk Management*, the CE participant should be able to:

- **Describe** legal, clinical, financial, and managerial issues pertinent to risk management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and other hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

COMING IN FUTURE MONTHS

■ 911 called for dying ED patient

■ Automation reduces drug errors

■ Time management for risk managers

■ Surgeons on the phone while operating?

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the weekly rounds seems to have made a big difference. It shows that the hospital is taking these issues seriously and reminds them that we'll be coming again next week, so we'll spot it again if the problem is not corrected." *[Editor's note: Contact Knowles at Women & Infants Hospital of Rhode Island, 101 Dudley St., Providence, RI 02905. Telephone: (401) 274-1100.]* ■

CNE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **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.

9. According to Raylene T. Filley, JD, how are health care providers likely to encounter child predators?
A. You will rarely catch a child abuser in the act. What you will find predators doing is violating policies to gain access.
B. Staff probably will discover them in the act of assaulting a patient.
C. They will be caught on surveillance video while committing the act.
D. The predator will accidentally admit to assaulting patients.

10. After the sexual assaults involving cell phone photos, what is the new rule at Rady?
A. Cell phones are completely prohibited in the hospital.
B. Staff are prohibited from using any cell phone in patient care areas unless they are hospital-issued phones.
C. Staff are prohibited from using cell phones at any time on hospital property, but visitors are not restricted.
D. Anyone can use their own cell phones anywhere at the hospital if they first register with the security department.

11. According to Leila Narvid, JD, what do the new Federal Rules of Civil Procedure say about electronic evidence?
A. It is exempt from rules of evidence and discovery.
B. It is exempt from rules of evidence and discovery unless there also is a hard copy of the same record.
C. It is on the same footing as printed, physical documents.
D. It is more important than printed, physical documents and must be protected more.

12. At Holston Valley Medical Center, what does Tony Oliva, MD, say produces the best results for patient safety?
A. Hourly and daily rounding by nurses and unit leaders
B. Weekly administrative rounding
C. Twice-yearly rounding by department heads
D. Annual rounding by the CEO

Answers: 9. A; 10. B; 11. C; 12. A.

Healthcare Risk Management's
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Unnecessary, unauthorized glaucoma surgery doesn't result in award of damages

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

News: An elderly man underwent cataract and glaucoma surgery in his left eye, after which he claimed his vision deteriorated. He sued the ophthalmologist. Although he signed a consent form, the man claimed that the physician did not explain the procedure to him, tell him that he suspected glaucoma, tell him that the glaucoma surgery and cataract surgery would be performed at the same time, or that there were any alternatives to surgery. A jury found that although the glaucoma surgery was likely unnecessary, the plaintiff did not suffer any damages.

Background: A 76-year-old man visited an ophthalmologist to treat a growing cataract in his left eye. Noting high intraocular pressures, the ophthalmologist suspected that the man was in the beginning stages of glaucoma, a disease of the optic nerve causing a loss of retinal ganglion cells. To treat the growing cataract, the ophthalmologist recommended cataract surgery. To treat the glaucoma, the physician recommended medication and monitoring of the intraocular pressure or, alternatively, glaucoma surgery, which would take only an additional 10 minutes if performed at the same time as the cataract surgery.

The patient agreed to the cataract and glaucoma surgery, with the surgery to be performed in two parts. First, the physician would perform a trabeculectomy to remove a piece of tissue in the drainage angle of the eye, which would allow fluid to drain out of the eye and bypass the clogged drainage channels of the trabecular meshwork. The doctor also would perform an iridectomy to remove a small piece of the iris to relieve pressure on the iris. The man signed a consent form indicating that cataract removal and a trabeculectomy would be performed.

After the surgery, the man claimed his vision had deteriorated, and he sued the ophthalmologist. The plaintiff maintained that the extra hole in his iris caused him to have a constant glare during the day and night that prevented him from engaging in his normal daily pursuits. He also claimed that he had constant headaches, double vision, shadow vision, floaters in his vision, and constant foreign body sensation. Even though he signed the consent form, the man argued that the doctor did not explain to him what a trabeculectomy was. He also claimed that the doctor did not tell him of the suspected glaucoma, that the glaucoma surgery and cataract surgery would be performed at the same time, or that he had been given any alternatives to surgery. The plaintiff's expert witness asserted that the man did not, in fact, have glaucoma and that the surgery was unnecessary.

The physician conceded that the patient did not have glaucoma, but he argued that the glaucoma surgery was advisable because the man showed indications of the initial stages of glaucoma and because the man's age and hyperten-

sion put him at risk for developing the disease. The defendant also maintained that the man's vision actually improved after the surgery (from 20/85 to 20/20) and that any visual complaints would be resolved if he would wear glasses.

After trial, the jury found that the ophthalmologist had acted negligently but awarded no damages. The jury apparently was influenced by the plaintiff's refusal to wear glasses even though his vision was correctable with glasses and by the plaintiff's failure to wear sunglasses or a hat when going outside even though he claimed that the glare from the sun made him virtually blind in his left eye.

An informed consent policy and procedure also should emphasize that a practitioner should not make any promises that he or she might not be able to keep.

What this means to you:
Informed consent is an integral component to the delivery of health care. It is the mechanism that ensures appropriate communication between the provider and their patient. "Informed consent is not merely a signed piece of paper, but is instead a process that relies upon clear communication," says **Cheryl Whiteman**, RN, MSN, HCRM, clinical risk manager for Baycare Health System in Clearwater, FL. As such, it generally is the physician's responsibility to describe various treatment options to his or her patients, complete with explanations of the risks and benefits associated with each. Informed consent cannot be delegated to nonmedical staff personnel and should not be delegated to one's partners. Hospitals should have policies and procedures in place that pertain to verification that informed consent had been obtained as well to verification of the surgical procedure. A physician also is required to provide information to his or her patient in terms that the patient can understand. "This case demonstrates an apparent breakdown in that communication," Whiteman says.

A facility's policy and procedure on informed consent should consider various issues. For example, important to this case — or to any case involving allegations of failure to provide informed consent — is documented indication that the physician explained to the patient these risks, benefits, and alternatives. And just as important is documentation showing that the patient *understood* this information and that all of his questions were answered. Whiteman notes that because the average patient may not have the knowledge to ask pertinent questions, the physician should attempt to anticipate questions and provide additional information to enhance the conversation regarding the recommended surgery and alternatives. It should also be recognized that despite documentation of a thorough informed consent process, a patient-turned-plaintiff may provide compelling testimony that a treatment or procedure was not fully explained.

The timing of obtaining informed consent also is important. For example, attempting to obtain informed consent from patient in severe pain might be insufficient if the patient is not able to make an informed decision. On the other hand, in nonemergent situations where the patient is competent — such as in this case, for example — a physician will be charged with having had plenty of time to explain the options to his or her patient. A finding of negligence is rendered more likely if such a physician doesn't take the time to confer with his partners and describe additional options as needed in nonemergent situations.

An informed consent policy and procedure also should emphasize that a practitioner should not make any promises that he or she might not be able to keep. In a 1997 case from Louisiana, for example, a surgeon promised he would use surgical mesh when he obtained the consent. The surgeon changed his mind during the operation, and as it turned out, things did not go well. The patient subsequently sued based on the lack of informed consent. A patient also cannot be lied to or misled about the procedure. Practitioners should inform their patients that unanticipated circumstances might arise, and they should prepare their patients for the planned course of action should any foreseeable changed circumstances come to fruition A health care practitioner simply cannot rely on a change in circumstances to negate his or her conversation with a patient, if the change was foreseeable. And finally, an informed consent process that includes material omissions is doomed from the beginning. Virtually every informed consent case is based on a failure to disclose something. A facility would do well to advise its practitioners that where there are doubts about whether to disclose a risk, err on the side of disclosure.

In this case, the physician's finding of high intraocular pressures, coupled with the aging patient's history of hypertension, clearly provided a firm framework for offering the trabeculectomy with an alternative plan to medicate and monitor. Also, the patient did not have glaucoma, even

though the patient apparently thought that he had been told that he did. "The informed consent process should have included discussing with the patient the risks and benefits of the surgical procedure as well as alternative therapies to the trabeculectomy," Whiteman advises.

The theory of liability under which a patient can sue a physician who failed to provide the patient with informed consent varies from state to state. Most states used to view such an action as premised on the unauthorized use of force on another person, which is known as a "battery." Because most surgical operations involve some use of force, a lack of authorization would result in a battery claim. Some states, however, have decided recently that the proper cause of action for an informed consent case is negligence. Although a battery claim still may exist if a physician performs an operation that is substantially different from what he or she was authorized to do, or where no consent exists at all, the failure to inform a patient of all the risks and benefits of, and alternatives to, a procedure now goes to whether the physician acted reasonably (i.e., non-negligently) in performing the procedure. This distinction might be important in some states, where a physician might be unable to procure insurance coverage for intentional torts such as battery and where a battery claim would more easily expose a physician to a punitive damage award.

An interesting aspect of this case is that the physician was found to be negligent, and yet the jury chose not to award any damages. Whiteman surmises that the finding of negligence was premised on the physician's office notes not clearly reflecting the informed consent process. And the scenario indicates that the jury's decision to award no damages was the result of the patient's unwillingness to comply with a remedy to his complaints, such as wearing glasses and a hat when outdoors. Thus, even though the hospital made the "correct" determination that the patient in this case was not entitled to any damages, the practical reality is that by being forced to defend a lawsuit all the way through trial and to verdict, the hospital certainly incurred substantial legal fees. "The parties' respective unreasonableness resulted in a 'no win' for both sides," concludes Whiteman.

Reference

• Macomb County (MI) Circuit Court, Case No. 04-1121-NH. ■

Newborn baby is burned in scalding water at hospital

News: A nurse at a hospital severely burned a newborn baby while giving her a bath. The parties reached a settlement shortly after the suit was filed, including periodic payments to a trust fund for the girl for 12 years.

Background: A 19-year-old woman gave birth to a healthy baby girl. Twelve hours after the delivery, the new mother was holding her baby. She handed the girl to a nurse for a bath, but the nurse placed the baby in water that was so hot that it caused first- and second-degree burns to the baby's back, buttocks, and toes.

The woman filed suit against the hospital and alleged negligence. Two days after the lawsuit was filed, the parties settled for $130,000, plus $62,000 in attorneys' fees, $1,400 in settlement expenses, and nearly $1,000 per month to be paid to a trust fund for the girl every year from her 18th birthday and continuing until age 30.

What this means to you: As sad as this scenario is, it is not as uncommon as one might think. In a 2006 case reported from England, for example, a 3-day-old baby had his foot burned after a nurse held it in scalding water for three minutes. The nurse, who was trying to soften the child's foot for a blood test, had failed to check the temperature of the water before immersing the boy's foot in the water. The nurse apparently did not realize that the baby was being burned because he was wearing gloves. The baby's foot was red, and the skin was peeling off. What made matters worse in that case was that the nurse apparently didn't even treat the horrific burn after realizing his mistake, instead proceeding with the blood test by switching to the other foot. The boy, whose wound was not dressed for two hours, luckily avoided any permanent scarring or other damage.

The case we are examining raises a couple of issues important for risk managers, the first of which is whether it was a nurse, a nursing assistant, or a medical assistant who bathed the infant. "Often we make references to nurse, when in fact it was an aide or medical assistant," says **Leilani Kicklighter**, RN, ARM, MBA, CPRHM, LHRM, consultant/principal with The Kicklighter Group, Tamarac, FL, and past president of the American

Society of Healthcare Risk Management. "The reason this is important is that there is a different standard of practice and expectations from each." A nurse, of course, is a licensed professional who has graduated from an accredited school of nursing, passed his or her state's board, and maintains his or her licensure through continuing education. A nurse's aide, however, does not have such stringent requirements. It used to be that nurse's aides required no special certification and that they would be trained on the job, although some states now give nurse's aides the option to become certified nursing assistant (CNA) by going through training and passing a CNA exam. Medical assistants also are usually not as highly trained as nurses. Depending on the state, they typically work as physicians' agents but are unlicensed. Because a medical assistant works under a physician, the physician would retain full liability and responsibility for the medical assistant's acts. Although some states do not license medical assistants, they can take the certification examination offered by the American Association of Medical Assistants to become a certified medical assistant or seek credentialing by American Medical Technologists to become a registered medical assistant.

Kicklighter would advise the risk management department of this facility to conduct a root cause analysis to assist in determining how this event happened and to prevent a recurrence. As part of this process, policies and procedures should be reviewed against *actual practice* related to bathing newborns, and it should be modified as needed. "Often times we assume that what we have written in the procedures is how things are actually being done," says Kicklighter. "Observing how processes are *actually* being done may reflect 'work-arounds' or error-prone deviations. On other hand, observation may reflect that the actual written procedure is error-prone, necessitating written procedure practice modifications."

Finally, Kicklighter notes that as part of the life safety code standards, hospitals have master mechanisms to monitor and control the temperature of water in the facility to prevent such a situation. She recommends that the organization's plant operations document periodic monitoring of the water temperature and that this information, along with other routine monitoring, should be reported to the Safety Committee on at least a quarterly basis. The bottom line, notes Kicklighter, is that this was a preventable event.

Because a baby's skin is so sensitive, it is important that any burns be treated immediately. Professionals recommend quickly cooling a mildly burned area by submerging it in cool water or applying cool compresses for 10-15 minutes, followed by drying the area with a clean towel and covering it with a sterile bandage. Burns that start to blister can be treated with an antiseptic ointment and covered loosely with a clean, nonstick bandage. In the health care setting, the physician should be contacted immediately and orders implemented. A prompt visit by the physician or a consultant ordered by the attending would be most prudent.

The only good news from this scenario is that the baby's first- and second-degree burns were not any worse. In a first-degree burn, the mildest kind of burn, only the outer layer of skin has been damaged, which results in redness and sometimes slight swelling. A second-degree burn is one in which the second layer of skin has been damaged, which results in blistering, swelling, and varying degrees of pain. A third-degree burn, which is the most serious, results in damaged skin well below the surface, and it may be characterized by skin that appears white or charred. Third-degree burns often are not painful because the nerves have been damaged. A first-degree burn may heal in a few days, but a second-degree burn can take a couple of weeks. If the burn damage in this case had been more severe, the settlement amount likely would have been even higher.

Reference

• Cameron County (TX) District Court, Case No. 04-10-5077-C. ■

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Sample Litigation Hold Memorandum

Attorney-Client Privileged Communication

As a result of certain claims that have been made against [Company], it is imperative that [Company] preserve ALL documents and electronic information that may be relevant to these claims. Neither [Company] nor any of its employees have been named as defendants in a legal proceeding, but [Company] has been apprised of claims that make it reasonably probable that litigation may be instituted against [Company]. This memorandum is being addressed to you because you have been identified as an individual who may have documents and electronic information that are related to these claims.

The claims appear to relate to the following issues: [Define Issues]

You are directed not to discuss the claims at issue, or the contents of this memorandum, without first discussing them with [Company's] legal counsel. Legal counsel can assist you with your duties to comply with the terms of this memorandum. This direction is made to ensure that the rights and interests of all individuals involved with these claims, including the right of privacy, are protected.

Because no legal proceeding has actually been filed, it is difficult at this time to narrow the scope of what categories and types of documents and electronic information must be retained. You should, therefore, err on the side of preservation. Further, you must undertake retention of this information regardless of [Company's] retention policies or any other policies applicable to the documents. You should also note that electronic information includes e-mails, voicemail messages, and all types of information that is commonly created, stored, and transferred by computer.

Please bear in mind that the [Company] has a legal obligation to preserve all records in the form in which they were created and maintained in the normal course of business. Therefore, it is not sufficient to simply print electronic records subject to this litigation hold for preservation, and then to alter or destroy the electronic copy.

[Company's] legal counsel assigned to assist in this matter will be in contact with you shortly to provide you with further guidance. In the meantime, if you have any questions concerning the scope of this litigation hold order, or whether any particular type of record is subject to it, please contact [Attorney X] in the Legal Department.

Source: Leila Narvid, JD, Sideman & Bancroft, San Francisco.