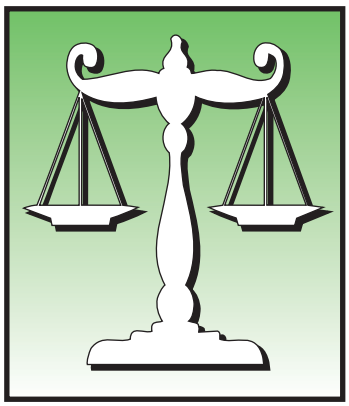

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IN THIS ISSUE

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911 call from emergency department shows the need for response teams

Family calling for help in ED was a last straw for troubled hospital

Many risk managers struggle to maintain high standards in overcrowded, understaffed emergency departments (EDs), and a recent case in California illustrates just how bad things can get when the system can't cope with the volume of patients. When a 43-year-old woman's family and a bystander had to call 911 to seek help for her as she was lying on the floor in the ED at Martin Luther King Jr. — Harbor Hospital in Los Angeles, it was the beginning of the end for the troubled hospital.

What happened to Edith Rodriquez may have been an aberration, an extreme case of a patient falling through the cracks, but risk managers say

HRM wins award for Katrina coverage

The Specialized Information Publishers Foundation (SIPF) has awarded the 2007 Award for Editorial Excellence to *Healthcare Risk Management* for its coverage of the criminal allegations against health care providers that arose after Hurricane Katrina. The SIPF awarded *HRM* Second Place for Best Interpretive or Analytical Reporting.

After surviving the hurricane, Anna Pou, MD, and three nurses were accused of conspiring to kill several patients with lethal injections — supposedly to get rid of patients who could not be evacuated, which would in turn free the staff to leave. The doctor and the nurses vehemently denied murdering anyone, but the local prosecutor pursued criminal charges before a grand jury. The grand jury recently refused to indict. The big lesson for risk managers was that, regardless of whether the allegations are proven, the situation at Memorial Medical Center forced the staff to make nearly impossible decisions as they valiantly tried to care for their patients.

To see the coverage that earned the award, see *HRM,* September 2006, pp. 98-102. ■

the incident holds lessons about how patient safety can spiral downward when a system is overburdened.

Rodriquez was on the floor throwing up blood when family members called 911 and told the dispatcher that the ED staff was ignoring her. According to a report in the *Los Angeles Times*, the 911 operator questioned why the ED staff was not helping her. Speaking from a pay phone outside the ED at 1:43 a.m. May 9, the woman's boyfriend, Jose Prado, responded by saying, "They're watching her, and they're not doing anything. Just watching her."

Eight minutes later, a bystander unrelated to Rodriquez called 911 with the same report. The 911 operator refused to send an ambulance to the ED and instead urged the caller to seek help from hospital staff. A half-hour after the first call, Rodriquez died of a perforated bowel, according to a report from the county coroner. Hospital security video shows the woman lying on the floor for 45 minutes, with staffers standing around and a janitor cleaning the floor around her.

The incident proved to be a final straw for the hospital. County supervisors recently voted unanimously to close the hospital. They released a 124-page report by federal inspectors that detailed dozens of significant problems found during a comprehensive review in July. Over the past four years, the hospital has been cited more than a dozen times for patient care lapses and blamed for a series of patient deaths. Inspectors concluded that there was no functioning quality improvement plan at the hospital.

Response teams can save the day

Grena Porto, RN, MS, ARM, CPHRM, senior vice president with Marsh, a consulting firm in Philadelphia, and past president of the American Society for Healthcare Risk Management (ASHRM), has heard of similar instances at other hospitals. Patients and family members have called 911 from inpatient units as well as EDs, she says. Wherever the call originates, it suggests a systemic problem in the health care organization, Porto says.

Rapid response teams (RRTs) may be one solution to the problem, Porto suggests. With RRTs, patients, family members, or even staff can call a designated phone number within the health care system when they think the immediate caregivers are not responding appropriately. The RRT is a team of clinicians who will respond to the patient immediately and intervene as necessary. **(For more on RRTs, see *Healthcare Risk Management*, February 2006, pp. 13-17.)**

"Anyone can call the number when they're desperate. That doesn't make it OK to neglect patients just because you have a response team as a backup, but it gives people a productive option when they really need help," she says. "I don't think what happened in Los Angeles is an isolated event, and calling the rapid response team is a far better option than calling 911."

A last-chance backup

The RRT is a fail-safe mechanism, a last chance backup when a patient may be near crisis, Porto

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EXECUTIVE SUMMARY

A dying woman's family and a bystander called 911 from a hospital's emergency department, desperate for help and saying the staff were ignoring the patient. The case may hold lessons for risk managers who want to avoid such a crisis in overcrowded departments.

- The incident occurred at a long-troubled hospital. The hospital has since closed.
- A rapid response team may help prevent such crises.

says. When there is no such option, people may believe they have no choice but to call 911. "Calling 911 is a bad option for the patient because they're in a facility where the best help is somewhere down the hall, if only they can get the right person's attention. 911 probably isn't going to send help at all," she says. "And when the incident becomes public, it's extremely embarrassing for the hospital that the patient felt that desperate for help."

The RRT system must be structured so that it is not seen as a replacement for quality care, and the criteria for calling the RRT must be explained to people well enough that the team is not called out for less-than-urgent needs, Porto says. Ideally, a RRT should be called upon infrequently. Frequent use of an RRT can signal systemic problems within the organization that must be addressed, she says.

Porto also suggests that the Rodriquez case should make risk managers wonder if their ED staff check on patients frequently enough to spot those who are suddenly getting worse. **(See p. 112 for more on that idea.)**

Resource allocation is important

A situation such as the one in Los Angeles can be the result of poor resource allocation in the ED and a staff that are focused on the wrong goals, says **Maurice A. Ramirez**, DO, BCEM, CNS, CMRO, an emergency physician at Pascoe Regional Medical Center and president of the consulting firm High Alert, both in Kissimmee, FL. Especially in an overcrowded, understaffed, and underfunded ED, he says, staff members can lose sight of their primary goal of providing the highest-quality care.

"If you don't plan for situations like the one in which a woman is lying on the floor dying, you get what happened in Los Angeles, where life-sustaining care took a back seat to some other objective," Ramirez says. "What was that other objective? We'll probably never know because it will end up in a sealed settlement, but some other objective ended up at the top of the list in that institutional culture."

Losing focus can be insidious, Ramirez warns. Even in a badly overstressed hospital ED, if you asked staff members what their primary objective is, they probably will say the right thing: providing quality care to patients. But in the heat of the moment, they may act quite differently, Ramirez says. "But if you went back and looked at how patients actually moved through the system, the goals probably were to move the highest number of patients through as quickly as possible, and that's not necessarily the same as providing the best care," he says. "The patients who are seriously ill get seen right away, and the ones who can be treated in five minutes might be moved through pretty quickly. But those who are in the middle might wait and wait."

Those patients aren't intentionally singled out for long waits, but competing interests and goals end up having that effect, Ramirez explains.

Watch for lost focus

ED management is tricky, and keeping patients moving is a valid goal, Ramirez says. But the way people are triaged is one indicator of what is really motivating ED staff, he says. Patients who are repeat visitors and known to be time-consuming also might be kept waiting too long, he says.

"When you're trying to get patients through your ED, sometimes it just seems to make sense to go ahead with these five other patients instead of spending time with that one patient you know is going to take up space for hours," he says. "You get so you can justify that decision in your head."

Ramirez suggests risk managers meet with ED

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managers, physicians, and staff to discuss some of these possible outcomes when they are pulled in too many directions. Be prepared to open a can of worms if you ask them to vent about all the competing priorities, but simply discussing the conflicts can help ED staff be more aware of the risks, he says.

"It seems obvious sometimes, but these people are being pulled in a lot of directions at once, so it can be good to remind them that true triage has to take precedence over moving bodies through the ED," he says. "No one wants someone to die of a hemorrhage in the waiting room while they're putting a [bandage] on a cut finger, so sometimes it is worthwhile to just remind them that they can practice good medicine, which is what they really want to do anyway." ■

Frequent checks can spot patients at risk

The recent case in which a woman died while awaiting care in a hospital emergency department (ED), while others called 911 for help, could be a reminder of the need for staff to check for updates on patients waiting for emergency treatment, says **Grena Porto**, RN, MS, ARM, CPHRM, senior vice president with Marsh, a consulting firm in Philadelphia, and past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

There has to be a mechanism for a regular rounding on patients, Porto says. Sometimes ED staff rely on phases of care to be triggered by some action, such as getting lab results back on the patient, she says. "Until that lab result comes back, the patient waits, and no one checks on him until the lab result triggers the next step," Porto says. "You assume he's in the same condition as the last time you saw him."

That assumption can be a recipe for disaster, Porto cautions. When lab results take a while, radiology is backed up, or a doctor takes longer than expected to arrive, the patient can fall by the wayside. The patient and family members may not recognize the signs of a worsening condition, or if they grow worried, they may not know the right words that would get a nurse's attention. Complaints that the patient is "still really sick" or "feeling worse" may not prompt much response if the care team is waiting for the next phase of care to be triggered.

"But if you have a better system in which you check back on that patient in a prescribed way, at routine intervals, there is less chance of the patient crashing without anyone noticing," she says.

Specific nurse can check on patients

The problem is addressed at the University of Michigan's ED by assigning a specific nurse to check back with patients who are waiting. A "waiting room" nurse reassesses all patients on an hourly basis, which includes checking lab results and standing orders, says **Lori Pelham**, RN, ED clinical nurse manager at University of Michigan in Ann Arbor. Experience is required: Nurses cannot be assigned to this role until they have been in the ED for six months and have completed a triage course.

Part of the waiting room nurse's job is to expedite care when necessary. If the patient's condition has changed such that he or she should be in a treatment room, the nurse works with the charge nurse to find a room. Abnormal blood work or lab results may spur intervention and expedited care, for example.

Because patients have ongoing contact with the waiting room nurse during reassessments, they are less likely to leave without treatment, Pelham says. The nurse's frequent contact also can help detect changes in more stoic patients, especially the elderly, who may be reluctant to volunteer that their symptoms are getting worse.

In many cases, the decision to change a patient's triage status is the result of not just one finding but a combination, Pelham says. Having a specific nurse assigned to this task helps ensure that the significance of those changes is not missed, she says. "This nurse is putting all the pieces together and seeing that the patient's condition has changed," she says. "It can help to have one person whose job is to make sure we don't miss how some of these facts come together." ■

SOURCE

For more information on monitoring patients waiting in the ED, contact:

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Taser use on father stuns some experts

A recent incident in which police officers used a stun gun to stop a man who was trying to leave a hospital with his own child has prompted concern among health care professionals who wonder if the action was justified, especially because the man was holding the infant at the time he was stunned. The media mostly portrayed the incident as an overreaction that could have harmed the child, and hospital security experts tell *Healthcare Risk Management* that they agree.

The case can be seen as an example of what can go wrong when a well-intended effort to stop infant abductions and to prevent violence in the hospital goes awry, suggests **Tony York**, CHPA, CPP, president of the International Association for Healthcare Security & Safety (IAHSS) in Glendale Heights, IL, the professional association for security professionals in health care. York also is senior vice president of Hospital Shared Services in Denver, which provides security to many Colorado hospitals.

Based on what he has learned from media reports of the incident, York says the stun gun use was "an inappropriate use of the device." **(For the background on the Houston incident, see article, right.)** "The officers used the Taser when they had control over the father," he explains. "It seems to me they pulled that Taser out because he was not cooperating with them, and they had not thought through this situation fully to think what they would do if someone was trying to leave with an infant."

EXECUTIVE SUMMARY

Police officers at a hospital in Texas used a stun gun to subdue an agitated father who was attempting to leave the hospital with his infant. The incident has raised questions about whether the use of force was appropriate.

- Security experts suggest there may have been alternatives to try before using force.
- Because the man was the child's father, the hospital may not have been empowered to stop him from leaving.
- The action was taken by Houston police officers, not hospital security guards, which could explain their decision making.

York says the incident illustrates a common dilemma that can occur when staff must confront people trying to take a baby. How far do you want them to go in trying to stop the person? A physical alteration must be avoided if at all possible because of the risk to the child, he says. But staff must be provided with practical guidelines for how to respond. **(See p. 114 for more on training staff.)**

York says a physical intervention — whether it is the use of a stun gun or wrestling with the person

Father stopped by wristband system

A surveillance videotape of the April 2007 incident at Woman's Hospital of Texas in Houston shows two police officers trying to stop a 30-year-old man, who was reportedly acting belligerent. Another patient and her husband told local reporters that they overheard the man threatening to create a hostage situation if the staff did not allow him to leave with the child.

Although the man was a custodial parent, the staff were trying to stop him because he was taking the baby without following hospital procedure. The staff summoned security, and two Houston police officers who had been in the building on other business arrived. The man was trying to leave via the elevator, but the infant's wristband caused the elevator to shut down. When he refused to comply with orders to calm down and hand over the baby, one of the officers used a stun gun on him, which caused him to fall to the ground. *(Editor's note: The surveillance video can be seen at http://abclocal.go.com/ktrk/story?section=local&id=5572678. The video has no sound, and the father is mostly out of the frame when the guard uses the stun gun on him.)*

When the man fell, the second officer picked up the baby and handed her to the mother. The father, William Lewis, told reporters that he was trying to leave with the baby because he and his wife felt mistreated by hospital staff. He says the girl landed on her head and suffered head injuries, but a medical examination revealed no harm.

The baby is in the custody of the local child welfare agency because of a history of domestic violence between Lewis and his wife. Lewis was charged with child endangerment, but a grand jury did not indict him. *Healthcare Risk Management* sought comment from Woman's Hospital of Texas, but our calls were not returned. ■

SOURCES

For more on the use of physical intervention in health care, contact:

- **Evelyn Meserve**, CHPA, Director of Security and Safety Services, CaroMont Health, P.O. Box 1747, Gastonia, NC 28053. Telephone: (704) 834-3575. E-mail: Meservee@gmh.org.
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— poses too much risk to the baby and therefore must be avoided unless necessary to stop immediate harm to the child. In most instances, the person is not harming the child, and staff can take time to talk and diffuse the situation, he says.

The key to understanding the Houston incident may be the fact that the stun gun was used by local law enforcement, not security guards employed by the hospital. "Nonhealth care law enforcement will readily admit to you that they don't understand infant abductions," York says. "They think of kidnapping, someone trying to do harm to a child, and they figure they have to do everything to stop and arrest that person. We know that it's more about someone trying to have a vicarious birth or a custody issue, and that has to be handled differently."

Evelyn Meserve, CHPA, president-elect of the IAHSS and director of security and safety services at CaroMont Health in Gastonia, NC, agrees that health care security professionals probably would have handled this situation differently. She agrees with York that the stun gun was unnecessary and dangerous, but she understands why the police officers were more prone to use that solution rather than de-escalating the situation. Police officers are obligated to intervene in the

Staff often don't know how to stop people

Even with drills on infant abductions and a heightened awareness of the risk with young patients, health care staff often don't know what to do when it appears someone is leaving with a child, says **Tony York**, CHPA, CPP, president of the International Association for Healthcare Security & Safety (IAHSS) in Glendale Heights, IL.

For instance, infant abduction drills usually involve sending staff members to designated exits to watch for someone who might be leaving with a child. The instruction usually is along the lines of "stop anyone who might have an infant." But York says his experience with hundreds of drills shows that when that moment comes, people freeze. "They see the person, but they don't know quite what to do. Many of the hospital policies don't clearly articulate what we want them to do," he says.

The policy should state that the staff member should not make physical contact unless there is imminent danger to the infant, York says. But at the same time, the policy should not just be "observe and report." Simply watching the person leave and then reporting to authorities is not enough. "We want the staff to engage that person. Talk to him or her," he says. "Get in the universal position that says 'stop,' with the hands up and palms out, and at the same time calling for assistance. There is strength in numbers."

A stranger trying to take an infant is not likely to be prone to violence, York notes. The profile of an infant abductor is a person with mental issues, but they do not typically have a record of violent crime. A parent trying to take a child in a custody dispute may be somewhat more prone to violence, but still the risk is low unless the staff escalates the situation with a physical intervention, York says.

When a staff member summons help, the hospital administration must be ready to respond with not just security guards, but others who might be able to end the crisis peacefully. Good candidates are nurse managers, the hospital chaplain, and other trained counselors, York says.

"The last thing you want is a violent fight over the baby," he says. "We witnessed this in a drill one time in which a nurse actually got into a tug-of-war with the doll representing the baby and the person playing the abductor. It was a wake-up call to us that we have to train people in crisis intervention if we're going to ask them to intervene." ■

way they see appropriate, and their perspective can be very different from that of security professionals who are oriented toward a health care environment, she says.

"I would want our security professionals to intervene very differently, with nonphysical interventions," she says. "This scenario might have played out very differently if hospital security had arrived on the scene before the local police officers."

The fact that the person trying to leave with the baby was the father further complicates the issue, Meserve says. Unless the hospital is aware of a custody dispute or verifiable risk to the child, there is little legal basis for stopping a parent from taking the child out of the hospital, she says. **(For more on the dilemma with parents, see article, below.)**

'Patience is a virtue'

Meserve and York concede that in some extreme cases, physical intervention can be necessary. If the person is harming the child or threatening to do so, the risk from physically intervening could be justified. But they emphasize that in most cases of infant abduction, the person is not likely to intentionally harm the child. "Patience is a virtue. Time is on your side in these cases," York says. "There's no harm in just talking, keeping the person there in the elevator lobby, talking as long as it takes to get that person to hand over the baby calmly and safely." ■

Hard to stop parents leaving with child

Infant abduction systems can help stop strangers from kidnapping a child and they also can slow down a parent trying to take a child against medical advice. But ultimately if the parent wants to leave with a child, there may be little you can do to stop them, says **Tony York**, CHPA, CPP, president of the International Association for Healthcare Security & Safety (IAHSS) in Glendale Heights, IL.

The recent case in Houston was just such a scenario. York says the hospital's infant tagging system worked properly by shutting down the elevator, which slowed the father down long enough for an intervention. Staff and security can talk to the parent in such a situation, but ultimately might have to let the person leave with the child, explains **Evelyn Meserve**, CHPA, president-elect of the IAHSS and director of security and safety services at CaroMont Health in Gastonia, NC.

"I would expect my officers to get physical in the sense of blocking the path of egress to slow the person down, to allow more time for a nonphysical intervention," Meserve says. "But I would not want to see a physical takedown, not knowing where the baby is going to end up in that pile, even if this is not a parent taking the child."

Without knowledge of imminent harm or legal disputes, hospital security probably does not have the authority to stop the parent from leaving, Meserve says. If the parent insists on leaving, staff should be trained to gather the same information they would if it were a stranger taking the child: a description of the person and the car, and the direction of travel. That information can be useful if it later turns out that there is concern over the child's welfare.

York and Meserve note that, even if the mother and father are in dispute, the hospital may have no authority to intervene. "There is not much we can do to stop parents from leaving unless we've been warned that there is a security risk or a restraining order against the other parent, for instance," York says. "If the parent just wants to go and the doctor doesn't want him to, we may not be able to stop him." ■

Pass the baton or NUTS for safer handoff

Pass the baton or pass the NUTS, but either way you're passing on vital patient information that can improve patient safety and reduce the risk of adverse events, say the risk managers who use these innovative patient handoff strategies.

Patient handoff is widely recognized as a point at which errors in communication are likely to jeopardize patient safety. In January 2007, The Joint Commission began requiring a standardized protocol for handoff communication (Patient Safety Goal 2E). *(Editor's note: For more on The Joint Commission's goal and its advice on how to improve handoffs, go to The Joint Commission site at www.jointcommission.org. Select the "Patient Safety" tab and then "National Patient Safety Goals.")*

Some hospitals are coming up with creative ways to make sure critical information gets from

EXECUTIVE SUMMARY

Hospitals are using innovative methods to improve patient handoff, a point known as high risk for errors. The strategies help ensure that critical information is passed in a consistent manner.

- One method involves passing information in an actual baton, like that used in relay races.
- Another method focuses mainly on staff education.
- The ideas are low tech and inexpensive.

one caregiver to another, whether the patient handoff happens at a shift change, when the patient is moving from one unit to another, or any other time important information might be lost along the way. One example is Trinity Medical Center in Rock Island, IL, where nurses and doctors actually "pass the baton." **Jennifer Dehlman**, RN, BSN, OCN, interim director of nursing, says the method grew out of a brainstorming session in which staff members were visualizing a relay race in which the runners must successfully pass a baton before the next runner can take over.

"We decided we could actually use a baton to accomplish the physical handoff. If the information were placed inside the baton and we handed that to the next person, that would be a way of getting the information across and a very visual, tactile way to make sure it happened," she says. "The batons are actually created for track teams to use in practice. They're bright yellow."

Baton used with SBAR

The baton is part of a larger patient handoff program that uses the popular "SBAR" format for recording and passing on patient information. SBAR stands for Situation, Background, Assessment, and Recommendation. **(See article, right, for background on the SBAR system.)** Trinity began using SBAR about four years ago but added the baton about a year and half ago.

The batons at Trinity are plastic, easily cleaned, and Trinity purchased hundreds of them from an athletic supply company for less than a dollar each. They are hollow and open on both ends. The batons are cleaned frequently with disinfectant wipes.

Staff and physicians roll up the SBAR form and place it in the baton, handing it to the next caregiver. The baton stays with the patient during any transit, Dehlman says. **(The system is modified for the emergency department. See p. 117 for more information.)**

"People are used to others walking by and asking, 'Do you have the SBAR?' or 'Can I see the baton?'" Dehlman says. "It's hard to miss that yellow baton, and we always have that SBAR information handy if something happens to the patient, like a code during transit."

Dehlman notes that the staff did not immediately embrace the baton concept once it was introduced, because it involved changing some of their reports to an SBAR-consistent report that could be used in the baton. But after using the system for months, staff members are enthusiastic about how much it streamlines communication while also improving patient safety, she says. "They don't circumvent the baton because they understand how important it is, and they appreciate having that information when a new patient is delivered to them," she says. "It's reciprocal."

Hospital uses NUTS

Another innovative strategy is used at Blount Memorial Hospital in Maryville, TN, where

SBAR offers way to better handoffs

SBAR stands for the key elements to be communicated in the patient handoff process: Situation, Background, Assessment, and Recommendation. The system was developed by Kaiser Permanente in Oakland, CA, and provides clinicians a framework for communicating effectively about a patient's condition and needs.

The checklist helps overcome a key cause of errors at patient handoff: the difference in how doctors and nurses communicate. Nurses tend to frame their comments in relation to a nursing plan, and physicians are more interested in whatever might be a problem at the moment and what they need to do to fix it, according to the SBAR developers.

The SBAR checklist is used throughout the Kaiser Permanente system and is spreading quickly to other providers. **(For more information on the SBAR program, see *Healthcare Risk Management*, September 2006, p. 102.)** ■

staff are encouraged to "Pass the NUTS." In this case, NUTS stands for some of the most vital information to be exchanged in the handoff: Name, Unusual factors, Tubes, and Safety concerns. **[The NUTS poster is available free online. If you're accessing your online account for the first time, go to www.ahcmedia.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an online subscription, go to www.ahcmedia.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose *"Healthcare Risk Management,"* and then click "Sign On" from the left-hand column. Once you're signed in, select "2007"and then select the October 2007 issue. For assistance, call Customer Service at (800) 688-2421.]**

Simple and easy to remember

The program began in March 2006 when the hospital did a mock survey and found inconsistencies in patient handoff, says **Susan L. Wood**, RN, the patient safety officer. To standardize the system, staff came up with an idea that is simple and easy to remember.

"We adopted the 'Pass the NUTS' idea and took it to our nursing division, where we came up with ways to educate the staff on how to do this," Wood says. "However, it's not just for nurses to use. This applied whenever a patient is handed off from one person to another, such as when a transporter arrives to take the patient for testing. The transporter needs to know, for instance, if that patient is at risk for falling."

NUTS passed verbally

The NUTS information is passed verbally. NUTS doesn't negate the need for any written communication, and in fact Blount uses SBAR for some nurse/physician communication. However, the verbal exchange allows the caregivers to ask questions of each other and to clarify any information that may not be clear in written communications, Woods says.

"When nurses are passing on information, such as at a shift change, they go to a quiet area and use the NUTS to discuss each patient so they are using the same format each time," she says. "They discuss more with some patients than with others, but the NUTS framework gives them a consistent format to start and makes sure they exchange the most vital information on each patient."

Blount was surveyed by The Joint Commission in October 2006, after the NUTS program was implemented, and Wood says the hospital received high marks for communication during patient handoffs. "They said it was consistent," she says. "Whenever they asked about a patient, the nurse used NUTS and the surveyor said the information flowed smoothly. They gave us very high marks for that." ■

SOURCES

For more information on the handoff strategies, contact:

- **Jennifer Dehlman**, RN, BSN, OCN, Interim Director of Nursing, Trinity Medical Center, 2701 17th St., Rock Island, IL 61201. Telephone: (309) 779-2255. E-mail: Dehlmanj@trinityqc.com.
- **Susan L. Wood**, RN, Patient Safety Officer, Quality Management, Blount Memorial Hospital, 907 E. Lamar Alexander Parkway, Maryville, TN 37804. Telephone: (865) 980-4903. E-mail: swood@bmnet.com.

Baton method can be altered for ED

Staff at Trinity Medical Center in Rock Island, IL, quickly realized that their system of passing the baton must be tweaked somewhat for transferring patients from the emergency department to the inpatient unit, because that transfer often involves numerous pages of information on a chart that cannot be distilled down to an SBAR form.

For those patients, the ED uses canary yellow folders that are the same color as the baton and they place a large sticker on the folder that "I am a yellow baton." It was a tongue-in-cheek solution that still strives for consistency, says **Jennifer Dehlman**, RN, BSN, OCN, interim director of nursing, at Trinity.

"The yellow baton is part of our culture now," she says. "That alone is an important part of the improvement, getting everyone on board to try to do the same thing in the same way." ■

Health system is first to automate drug info

Fauquier Health System of Warrenton, VA, has announced that it is the first health system in the nation to pilot a system that will improve patient safety by automatically incorporating a patient's current prescription information into the hospital environment.

While some hospitals are beginning to use internal electronic medical reconciliation, Fauquier will be the first to also track external records, says **Cathy Walsh**, RN, director of quality and risk management. She says the system should help reduce the risk from incomplete or inaccurate medication histories.

"Patients are not very good historians regarding their medications. They often say, 'I take one of the blue pills and two of the green pills,'" Walsh says. "That can lead to medication errors, and like many providers, medication errors were one of our most common incidents. From a risk perspective, the opportunity to collect better data and not rely on the patient's memory is really key."

Donna Staton, MS, chief information officer of Fauquier Health System, says she and her colleagues were looking for a way to improve medication reconciliation, partly in response to mandates by The Joint Commission, when they came upon this new approach. She was familiar with physicians using a similar concept in an outpatient setting but not for acute care.

Staton notes that inconsistent medication knowledge and record keeping threaten patient safety by causing up to 50% of all medication-related errors in hospitals and up to 20% of all adverse drug events. Beyond the toll on an individual's health, a 2006 Institute of Medicine study found that each preventable adverse drug event that took place in a hospital added $8,750 to the cost of a hospital stay.

"This is a very significant first as drug errors are causing a national health care challenge. When patients arrive in an emergency department they or their families often can't recall all the medications a patient is taking," she says. "This can open the door for drug interactions or duplicative prescriptions."

Fauquier is implementing the system in stages, beginning with scheduled surgery patients. The system begins when surgery is scheduled and a nurse preregisters the patient. The nurse collects medication information from the patient but also uses the automated system to look for current prescriptions. Information about a prescription can be used during the interview process. For example, the nurse might say, "We see a prescription for a statin here, one pill a day. Are you still taking that medication, and do you take it that way?"

Walsh and Staton say the new system is not a replacement for asking the patient about medication but it provides more information that can enhance the information. Fauquier Health System is working with DrFirst of Rockville, MD, to implement the patient safety initiative. **(See contact information in source box, p. 119.)** DrFirst has relationships with several pharmacy benefit management groups and pharmacy databases that allow it to compile information on most patients' medications. Walsh says there currently is about a 60% chance the patient's medication information will be in the system, but more databases are being added and that figure may rise to 90% by the end of 2007. Access to the information is allowed under the standard consent to treat, Walsh says.

Staton and Walsh approached the company with the idea of applying the medication reconciliation system to acute care, and then Fauquier worked closely with the company to develop the product and begin testing. DrFirst's Rcopia electronic Acute Care medication reconciliation (RcopiaAC) compiles a Fauquier patient's current prescriptions from various prescription history databases so that any potential new medications can be compared to limit drug interactions. Then, at the end of a patient's stay, this list is reviewed again to help ensure that any prescriptions made at the time of discharge are also without complications, such as duplicative therapy and interactive medications. The prescription information also is provided to the patient and can be electronically accessed by the patient's regular physician to ensure a continuum of care.

EXECUTIVE SUMMARY

A Virginia health system is the first to use an automated method that promises to improve patient safety by more effectively collecting data on patients' prescription drug use. The method is designed to reconcile information from a number of sources.

- The system is conducting a trial of the method.
- The new approach does not depend on patients remembering their medications.
- Users hope to reduce the number of adverse events related to drug interactions.

SOURCES

For more on the drug reconciliation system used by Fauquier Health System, contact:

- **Irene Froehlich**, Director of Marketing, DrFirst, Rockville, MD. Telephone: (240) 671-3320. E-mail: Ifroehlich@drfirst.com. Web: www.drfirst.com.
- **Donna Staton**, MS, Chief Information Officer, Fauquier Health System, Warrenton, VA. Telephone: (540) 349-5449. E-mail: StatonD@Fauquierhospital.org.
- **Cathy Walsh**, RN, Director of Quality and Risk Management, Fauquier Health System, Warrenton, VA. Telephone: (540) 349-3584. E-mail: WalshC@Fauquierhospital.org.

Another added safeguard through RcopiaAC is the e-prescribing feature that allows physicians to issue electronic prescriptions, thus avoiding yet another common source of drug errors: poor physician handwriting.

Fauquier first started talking about the concept last year and began the pilot program in June with a subset of patients: preoperative testing and scheduled surgery patients. Surgeons began participating in the process for discharging patients on Aug. 7. More patients will be folded into the system as the pilot program continues.

Because Fauquier helped develop the system with DrFirst and is piloting the program, the health system pays only a minimal fee. The pricing structure for other providers is in development, according to **Irene Froehlich**, director of marketing for DrFirst. The RcopiaAC drug reconciliation system can be used standalone or interfaced with the hospital's existing systems, she says.

"The price for electronic medication reconciliation depends upon the service package, and size of the hospital based upon the number of beds," she says.

Fauquier has not had enough time to compile hard data showing results of the pilot program, but Staton and Walsh say they expect to see measurable results.

The clinicians are excited about using the system and encouraged by the efficiencies it can bring, Walsh says. "Anything that helps them avoid these medication errors is going to be welcomed as long as it really works, and our first impression is that this does work," she says. ■

Joint Commission: Report concerns — no retaliation

Physicians and medical staff members who have concerns about the safety and quality of care at their hospital may report those concerns with the understanding that retaliatory disciplinary action is prohibited, according to explicit new rules announced by The Joint Commission. The accreditation participation requirement previously referred generally to hospital staff.

The revised requirement becomes effective Jan. 1, 2008. Accredited hospitals must educate staff and medical staff that any employee or any physician who has concerns about the safety or quality of care provided in the hospital may report those concerns to The Joint Commission and that no disciplinary action will be taken.

Anyone who has concerns about the safety or quality of care at an accredited organization may share those concerns with The Joint Commission Office of Quality Monitoring by phoning (800) 994-6610 or by sending an e-mail to complaint@jointcommission.org. ■

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

- ■ Transparency during a crisis
- ■ New liabilities in acute pain management
- ■ Fighter pilots teach risk management
- ■ Time management: How to juggle your duties

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.

13. According to Grena Porto, RN, MS, ARM, CPHRM, what does it mean if a hospital's rapid response team (RRT) is used very frequently?
A. Patient safety is extremely high.
B. The frequency of an RRT's use means nothing.
C. care provided by the RRT is of high quality.
D. Frequent use of an RRT can signal systemic problems within the organization that must be addressed.

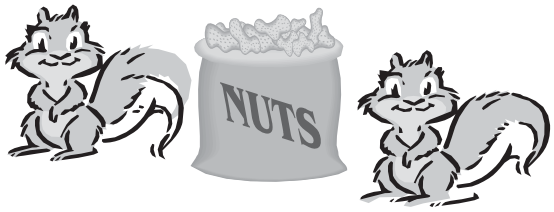
14. What does Maurice A. Ramirez, DO, BCEM, CNS, CMRO, say is one reason patients can be neglected in the ED?
A. ED staff members are not adequately trained in triage.
B. The goal probably was to move the highest number of patients through as quickly as possible.
C. Patients do not accurately report their symptoms.
D. Insurance approval can be delayed for hours when the ED is busy.

15. According to Tony York, CHPA, CPP, how should physical interaction be used when trying to stop someone trying to leave the hospital with a child?
A. A physical altercation must be avoided if at all possible because of the risk to the child.
B. A physical altercation is acceptable is the person does not comply with orders.
C. A physical altercation is acceptable if the person taking the child is a healthy adult.
D. A physical altercation can be reasonable as the first choice.

16. How did Trinity Medical Center alter its baton method for patient handoffs in the emergency department?
A. The hospital purchased larger batons that can hold more documents.
B. The hospital allowed the ED to opt out of the program entirely.
C. The hospital encouraged ED staff to use multiple batons for one patient.
D. The hospital allowed the ED to use canary yellow folders that hold more pages than the baton.

Answers: 13. D; 14. B; 15. A; 16. D.

WHEN "HANDING OFF" PATIENT INFORMATION



PASS THE *NUTS*

N – Name of patient, diagnosis, room #.

U – Unusual or Unique; Variances identified on the individual care plan including critical lab values, pain management, etc.

T – Tubes such as IVs, NG, catheters, drains, ostomies.

S – Safety concerns such as falls, POST, medication reconciliation.

Source: Blount Memorial Hospital, Maryville, TN.

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

Nursing home resident suffers head injuries when thrown to floor from wheelchair

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

News: A nursing home resident was thrown to the floor after her foot and leg became caught in her wheelchair. The employee pushing the woman's wheelchair had apparently disregarded warnings that the woman's foot and leg were caught and had continued pushing the chair, including giving it a hard lunge. The woman suffered severe injuries to her head and died 14 months later. Although the nursing home at first covered up the cause of the woman's injury, the family eventually found out what happened and sued the facility. A jury awarded the plaintiffs $417,461.39, finding that the nursing home employee had acted negligently but that she had not caused the patient's eventual death.

Background: An 87-year-old woman was a resident at a nursing home, where she required assistance with the basic activities of her daily living. One day while watching television sitting in her wheelchair, the woman was asked by one of the nursing home's employees whether she was ready for bed. When the woman indicated that she wanted to stay up for a short while longer, the employee became angry and insisted that she go to bed.

The employee began pushing the woman to her room in her wheelchair, but the patient's foot slipped underneath the wheelchair and became stuck. Although another employee notified the first employee that the woman's foot and leg were caught up under the wheelchair, the first employee kept pushing the woman forward and then gave the chair a hard lunge. The woman was subsequently thrown from her wheelchair, and the wheelchair flipped over on top of her. The woman's head was crushed against the concrete floor, and she began bleeding profusely from the head. She became totally unconscious for a time.

The nursing home informed the woman's six daughters and two sons of the injury, but it did not tell them the real reason the patient fell from the wheelchair. The nursing home apparently told the woman's family that their mother had fallen out of her wheelchair before an employee could catch her. The woman was sent to a hospital for treatment and then discharged to her family for home care, where she was confined to her bed. She developed pneumonia and then a sepsis infection that led to her death 14 months later.

The children later learned of the actual cause of the accident when the nursing home's nonoffending employee who witnessed the incident told them what really happened. The children filed suit against the nursing home and alleged causes of action for negligence and for violation of their mother's statutorily granted rights as a resident. The plaintiffs' witnesses included the nursing home's nonoffending employee and an expert witness who testified that the fall caused the decedent to suffer physical and mental deterioration

Florida lists rights for nursing home patients

In Florida, nursing home facilities must adopt and make public a statement of the rights and responsibilities of the residents of such facilities. The statement must assure each resident of the right to:

- civil and religious liberties;
- private and uncensored communication, including correspondence, telephone, and visitation;
- deny or withdraw consent to access by a provider of health, social, legal, or other services;
- present grievances on behalf of himself or herself or others to the facility, governmental officials, or any other person;
- recommend changes in policies and services to facility personnel;
- join with other residents or individuals to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal;
- organize and participate in resident groups in the facility and have the resident's family meet in the facility with the families of other residents;
- participate in social, religious, and community activities that do not interfere with the rights of other residents;
- examine, upon reasonable request, the results of the most recent inspection of the facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility;
- manage his or her own financial affairs;
- be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services;
- be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent;
- refuse medication or treatment;
- receive adequate and appropriate health care and protective and support services;
- have privacy in treatment and in caring for personal needs;
- be treated courteously, fairly, and with the fullest measure of dignity;
- be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and physical and chemical restraints;
- be transferred or discharged only for medical reasons or for the welfare of other residents;
- be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge;
- freedom of choice in selecting a personal physician;
- retain and use personal clothing and possessions as space permits;
- have copies of the rules and regulations of the facility;
- receive notice before the room of the resident in the facility is changed;
- be informed of the bed reservation policy for a hospitalization. ■

attributed to post-traumatic encephalopathy, which is a nonspecific diagnosis indicating that a person's brain has stopped functioning properly.

The nursing home defended the suit and claimed that the woman had been suffering from numerous pre-existing medical problems, including atherosclerotic heart disease, hypertension, and Alzheimer's-type dementia. The nursing home entered into evidence a CT scan performed after the fall showing no evidence of any acute internal damage and argued that the cause of death was atherosclerosis.

A jury found that the nursing home's employee had negligently injured the patient, but that the employee was not the cause of the patient's ultimate death. The jury also determined that the nursing home and its employees had not deprived or infringed upon the patient's rights as a resident in such a way as to cause her injury or death. The jury awarded the plaintiffs $417,461.39 in damages. The plaintiffs moved for a new trial with respect to the jury's finding as to cause of death, but the court denied the motion.

What this means to you: The actions of the nursing home may not have violated the patient's rights in a manner that caused her death, but it certainly was in the most egregious terms a violation of her right to receive compassionate care, says **Lynn Rosenblatt**, CRRN, LHRM, risk manager at

HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL.

The cause of death of elderly residents in nursing homes often is elusive. "They reside in such settings most often because of advanced age, frail health, and the inability to care for themselves," notes Rosenblatt. In this case, the patient's age and her Alzheimer's-type dementia most likely resulted in her need for custodial care. Her hypertension and atherosclerosis also contributed to her dementia and over time likely would have caused deterioration and other complications that eventually would have led to her death, had she not died from pneumonia and sepsis first.

The actions of the nursing home may not have violated the patient's rights in a manner that caused her death, but it certainly was in the most egregious terms a violation of her right to receive compassionate care.
— Lynn Rosenblatt, CRRN, LHRM, Risk Manager, HealthSouth Sea Pines Rehabilitation Hospital, Melbourne, FL

Rosenblatt questions whether the head injury was a direct cause of the patient's death. "That is a difficult question to answer, and this jury decided that it wasn't," observes Rosenblatt. "Another jury could have easily decided exactly the opposite." Although it is virtually impossible to separate the immediate cause of death from contributing factors, particularly in the elderly with significant end-of-life disease processes, it would be insensitive to say that the head injury that she sustained did not have some bearing on her rapid decline from her pre-incident condition.

By deciding that the injury was not a proximate cause of the patient's death, the jury then had to evaluate whether the resident's rights had been violated by the conduct. "Because the jury had not attributed the woman's death to the incident, the logical conclusion would be that any infringement upon the patient's rights also was not a direct cause of her death," says Rosenblatt. The jury's decision nevertheless did not fully exonerate the defendants. Rosenblatt notes that the verdict did spare the nursing home and its employee the possibility of criminal charges. In this case, those criminal charges could have included manslaughter, given that the scenario indicates that the employee acted vindictively and in wanton disregard of the resident's best interests.

One of the major issues present in this case is the course of conduct undertaken by the nonoffending employee who witnessed his or her colleague injure a resident. Many states have laws that protect the elderly from neglect and abuse, and reporting the abuse of children, dependent adults, and the elderly is considered a legal obligation, particularly for health care workers. In Florida, for example, where this case occurred, section 415.1034, Florida Statutes, mandates that any physician, nurse, paramedic, health professional, or nursing home staff, among others, who knows or has reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited, immediately report such knowledge or suspicion to the central abuse hotline. Rosenblatt notes that most states have 24-hour manned phone lines to accept such reports and channel them to the appropriate agencies for immediate investigation. "Had the individual who witnessed the scene between the resident and the offending employee reported the incident, the nursing home would have been investigated, and rightfully so," notes Rosenblatt. An angry health care worker had willfully taken retribution against a defenseless individual who was dependent upon that employee for compassionate care. The resident's refusal to go to bed at the request of the employee was within her rights. The fact that the nursing home employee thought otherwise and retaliated against her because she had exercised her choice was a violation of those rights, says Rosenblatt.

Most states also require that patient rights be posted in health care establishments so that patients, families, and visitors are aware of the expectations and available avenues of redress. And laws are also in place to require the prominent display and disclosure of the agencies to contact when abuse and/or neglect is perceived. "The individual reporting does not necessarily have to be a fact witness," says Rosenblatt. "The suspicion of abuse or neglect alone is sufficient to warrant a report." In Florida, for example, Section 400.022, Florida Statutes, mandates that all nursing home facilities adopt and make public a statement of the rights and responsibilities of the residents of such facilities and treat such residents in accordance with the provisions of that statement. Florida's statutorily mandated

rights might be more comprehensive than those present in other states, but it is an excellent model to which nursing homes outside of Florida can aspire.

Florida law further requires a nursing home to orally inform each resident of these rights and provide each resident with a written copy of these rights at or before the resident's admission to a facility. The resident's rights also must be made available to each staff member.

Rosenblatt further notes that health care providers must have policies in place to deal with grievances about care, and the patient and their representatives must be given information as to how to file a complaint. Florida law, for example, requires a nursing home to prepare a written plan and provide appropriate staff training to implement the policy. And as a condition of participation in the Medicare program, not to mention sound business practice, all complaints must be handled timely and without retribution. "If the nursing home in this case had informed the family truthfully of the situation, the home would have certainly met the most basic of its obligations," says Rosenblatt.

Another issue highlighted by this scenario is the type of training nursing homes need to be giving to their employees. Rosenblatt notes that all states mandate that nursing homes train their employees to deal in a productive, nonreactionary manner toward residents. Employees in these settings particularly must be given training on techniques that win the resident's confidence and cooperation and prevent such situations from getting out of control. Employees must undergo background checks to establish without doubt that nothing in their past might contribute to a pattern of abuse in the future. Employees must also be instructed to understand the difference between the resident's rights and the employee's responsibility.

"If the narrative is accurate, the employee showed wanton disregard for the resident's safety. One employee warned the other that the women was at risk for injury, but the employee pushing the wheelchair failed to heed the warning and continued forward," observes Rosenblatt. In what appeared to be a fit of anger, the employee then purposely displayed a violent response by lunging the wheelchair forward, which was the direct cause of the women's injury. "This was certainly abuse and most likely a battery," she notes.

Ensuring that situations such as the one described in this scenario do not happen is of paramount importance to nursing homes, but not just because of the potential money damages flowing from a lawsuit. Rosenblatt notes that had this incident been reported, as it should have been, the nursing home would have been sanctioned, and the employee would have been most likely the subject of a criminal investigation. This investigation likely would have resulted in the employee's removal from the facility and, perhaps, the health care industry. "Nursing homes need to be particularly careful about ensuring that their residents are not exposed to the uncertain frustrations of employees resulting from caring for demented patients whose behaviors can be trying and challenging," says Rosenblatt. The nursing home also would have been found deficient and been given guidance on improving its educational and support programs to ensure more appropriate responses in such situations. An investigation also could have led to the discovery of more issues that were covered up in the past, with the result being that the home might lose its license. After all, the failure of the home to disclose fully, accurately, and timely what had occurred to the patient's family might indicate knowledge of an ongoing pattern of abuse of the residents.

It is apparent that the nursing home in this case acted in bad faith as to its responsibility to disclose. It purposely covered up the willful actions of one of its employees and refused to acknowledge the role that the incident played in most likely hastening the woman's death. The home's obligation was to protect her, but in reality it caused her bodily harm. The jury acknowledged that fact with its finding of negligence. Indeed, Rosenblatt thinks that the $400,000 award was relatively generous. Although the woman's elderly age and her overall mortality were factors contributing to the amount of the award, Rosenblatt notes that it could have been substantially more. The resident had been relatively stable in terms of her overall health and was living out her life with some degree of quality. All of that was taken away as a result of the angry response of one individual. The home violated the trust that the state places in it by granting a license, and that violation resulted in the diminishment of an individual's quality of life, Rosenblatt concludes.

Reference

• Polk County (FL) Circuit Court, Case No. 53-1999CA-002950. ■