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# Healthcare Risk Management™

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## IN THIS ISSUE



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# Work with physicians to improve ED call coverage, avoid shortages

*Incentives may help, but also can take hard line with resistant doctors*

It's a constant worry for risk managers: Do you have enough physicians taking emergency department (ED) call duty? Will those on call actually respond when summoned? Are they taking ED calls from other hospitals at the same time?

Though it is a longstanding problem, risk managers must not let ED calls slip into the category of "just another worry with no solution," say the health care leaders who have addressed this potentially disastrous problem. Unless you come up with a way to ensure a good ED call response in your facility, you run the risk of huge liabilities every minute your ED is open for business, they say.

A confounding factor is that there is no single solution that will work for all hospitals, 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. Ramirez says risk managers must work with physician leaders to develop a solution that addresses the particular difficulties in your community or with your facility's ED call coverage. Failure to do so will likely result in violations of the Emergency

### EXECUTIVE SUMMARY

The resistance of physicians to take emergency department calls poses a significant threat to patient safety and exposes the organization to civil and regulatory penalties. Risk managers must develop effective strategies for improving the number of physicians who will respond to ED calls.

- There is no one solution that will work for all hospitals.
- On-call pay and other incentives may help.
- It may be necessary to penalize doctors who do not take calls.

Medical Treatment and Labor Act (EMTALA), in addition to various other regulations.

Any shortfall in coverage could be caused by a variety of factors, and often a combination, he says. Those problems include not having enough specialists to cover the entire month of calls, even when they take their obligated 10 days per month of call duty. Another factor might be that a physician takes calls at numerous hospitals, so he or she always is busy when your facility calls.

Or it could be that physicians are on call but just don't come in when summoned. That can be one of the most difficult issues to address, Ramirez says. When you face that problem, the best solution may be to play hardball. In most cases, he notes, the hospital must report the refusal.

"When you call a doctor on call and say the magic words, 'Doctor, I require your assistance to further evaluate this patient,' or words to that effect, and the doctor does not come in, you have no choice," Ramirez says. "You must report that doctor to the state agency that oversees EMTALA compliance. Depending on their guidance, you may or may not have to report it to the [Centers for Medicare & Medicaid Services] at the federal level."

In addition, the hospital should bring the physician before its medical staff and executive committees.

"That doctor has violated the federal law and created a violation of the federal law for your facility," Ramirez says.

## Fines fall on hospital, not doctor

Ramirez points out that physicians no longer are subject to personal fines on the federal level for refusing ED calls; the potential for fines falls solely on the institution.

"The American Medical Association and the specialty associations have made sure that their member physicians know this. The physicians know that it's not on their shoulders anymore," he says. "We used to be able to say, 'Doc, unless you want a $120,000 personal fine with 18% interest, you need to come see this person.' Now they know that's not the case, and it's the institution's problem."

That leaves the hospital with essentially two options: beg and plead, hoping the physicians will help you out, or get aggressive. Ramirez advocates the latter, at least when it is clear that the physician on call is shirking his or her duties. **(See p. 75 for more on how to get tough with physicians refusing ED calls.)**

For starters, he says, document the situation thoroughly so that if you have to self-report an EMTALA violation, you can show that the hospital did everything possible to get that physician to come in. Ramirez, an emergency physician who sometimes finds himself trying to coax reluctant physicians to come to the ED, says his protocol is to call the doctor every 30 minutes X 3, every 15 minutes X 2, and then every five minutes until they respond — all carefully documented. If the physician responds but refuses to come in, the documentation should clearly state what facts were conveyed to the doctor and his or her response.

Ramirez also urges risk managers to support

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the emergency physicians who report difficulty with getting other doctors to respond to calls. Too often, he says, administration grills the reporting emergency physician and puts him or her on the defensive, looking for a reason to let the on-call specialist off the hook by saying that the patient's condition was not clearly communicated.

"The clinicians need to know that when these situations occur, you want them to call the risk manager right away. The risk manager should be brought into the loop as soon as possible, while the dispute with the on-call physician is still happening," Ramirez says. "The risk manager should not only take the call but should come in and make sure that everything is being documented in real time. You want the chart to show that you were handling the problem in the best way, so that you might be able to avoid some or all of the fines."

There are other options for improving call coverage, such as paying physicians for ED calls, and Ramirez says it is up to the individual organization to find the right mix of strategies that address their unique situation. **(See article, p. 76, for more on paying physicians for call coverage.)**

Taking a hard line on call coverage still can have drawbacks. ED call coverage can become a negotiating point when physicians are choosing between treating patients at one hospital or another in a large community, notes **Ted McMurry**, MD, FACEP, medical director of the emergency trauma center at St. John's Regional Medical Center in Springfield, MO. If one hospital requires coverage and makes it clear that it will be tough on any evasion, the hospital across town with a different policy may look more appealing, he notes.

McMurry's own facility has experienced little difficulty with coverage because it employs a large number of physicians through the health system, making it easier to require call coverage and also to make clear that everyone is in the same boat when it comes to potential violations.

"It is important to have strong medical staff bylaws that clearly spell out what the responsibilities are in relation to coverage, but the second part of that is that you have to enforce it," McMurry says. "I would suspect that most hospitals have this responsibility in their bylaws, but if they don't enforce it, then the emergency department ends up having to transfer patients or spend hours trying to find someone."

With the potential liabilities so significant for

## Commit to treating all doctors the same

Convincing physicians not to evade their call obligations is best achieved by convincing them that they have a lot to lose. Risk managers should remind them that their careers could be at stake — and that the hospital isn't going to pussyfoot around, no matter who the physician is, 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.

"Educate them and remind them that they are going to lose their privileges over this. Be willing to make an example of that doctor who just refuses to come in when called," he says. "There has to be administrative commitment to this. You can't make empty threats."

The doctor doesn't necessarily have to lose privileges the first time, but there should be sanctions, which are reportable in most states, Ramirez says.

But remember that such a commitment has to apply across the board to any physician who evades call coverage — even that superstar cardiologist who is bringing in lots of patients for high-profit procedures, the one your facility has built an entire program around and who is featured in the marketing campaign. That is the only way to get serious about improving call coverage, and the only way to avoid a lawsuit charging discrimination against a doctor who lost privileges for the same misdeeds.

"That's how notoriously bad doctors keep skating by, because administration is not willing to take the risk that they would have to get rid of their favorite son if he commits the same malfeasance," Ramirez says. "Either you're committed to improving call coverage or you're not." ■

the hospital, **Philip L. Willman**, JD, a health care defense attorney with the Moser & Marsalek law firm in St. Louis, says it is well worth the risk manager's efforts to develop creative solutions. Some hospitals go beyond paying for ED calls and even subsidize the specialists' malpractice premiums, he says.

"I know of one hospital that did that to obtain neurosurgery coverage for trauma. They weren't able to get a neurosurgeon to cover the ED primarily because of liability exposure, so the hospital agreed to take on the malpractice cost for that surgeon," Willman says.

Malpractice concerns are reasonable for physicians taking ED calls, often with little or no compensation because the patients lack insurance, he says.

"There is no established physician/patient relationship, no history, and they're faced with treating a patient at 2 a.m. that they know nothing about," Willman says. "I can see why they would worry about the malpractice concerns there, and the risk manager will make the most headway by acknowledging that and coming up with a solution that addresses that concern." ■

## Keep the doctors' needs in mind, too

Understanding the physician's perspective may help risk managers improve call coverage, says **Joshua Kugler**, MD, FAAEM, FACEP, chief medical officer and senior vice president at South Nassau Communities Hospital in Oceanside, NY, who used to be the ED director. While there certainly are times when doctors just shirk their duties, it is important to remember that they may have justification for not wanting to take ED calls.

Most physicians respect the need to serve the community, but they also desire more uninterrupted time with family as they get older, he says. Plus, older and more successful physicians sometimes resent not being paid for their time spent on-call. In addition, late-night calls could impede a physician's ability to carry on with the following day's scheduled surgeries or other care.

When Kugler's facility was seeking to improve call coverage and keep physicians satisfied, the hospital brought together a number of physicians and asked them what would make the process better.

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"We tried to have an open dialogue about this. Trying to do it unilaterally is a great mistake, because it just alienates your medical staff," he says. "We tried to get their buy-in."

The hospital came up with a solution that includes a system for paying some physicians for responding to ED calls. For most physicians, the threshold is three calls per month without pay, and then the hospital pays for each ED call after that. The idea was to compensate those physicians who felt they were shouldering too much of the burden for call coverage.

"A mile away from us, another hospital pays the physician for every ED call, so we have to battle that," Kugler says. "That's fine if it works for them, but we felt we reached a good compromise considering our surgeons' needs and our economic reality." ■

## 'I'm not fallin' for that' reduces patient falls

Reducing falls is a constant worry for risk managers, and sometimes it seems there are no new ideas. But many health care providers are finding the most success with an approach that includes a wide range of efforts, everything from special equipment and monitoring systems to making sure every employee is empowered to prevent falls.

That all-encompassing approach has cut the incidence of falls in half at Briarwood Healthcare Center, a part of Friendship Village of Schaumburg in Illinois, a continuing care retirement center. The nursing home's fall prevention program was developed when **Rebecca Johnson**, senior vice president of human resources and quality improvement, was launching a new quality initiative program called, "Friendship Village's Spirit of Excellence." Johnson asked risk manager **Helene Corcoran** to participate

in evaluating a pilot falls prevention tool kit that was available from their insurance carrier.

Lynn Blakemore, the nursing home's administrator, was looking at the facility's fall data and wanting to control the number of repeat falls and related injuries. Finally, **Barbara Lopiccolo**, the nursing director, wanted Johnson to write a formal fall prevention program. They all approached **Valerie Bare**, RN, certified restorative nurse and rehabilitation coordinator, for help. That's when she realized that all the different parties were working toward the same goal.

So Bare suggested that they pull all the related projects together. The different perspectives should boost the chance of success, she thought.

"As a nurse, we have a scientific way of looking at things. We identify problems, establish time-limited measurable goals, and finally identify interventions," Bare says. "Rebecca explained that the quality improvement realm also had scientific methods to approach challenges as well. We then talked about how we would structure the project."

## Varied members on team

Bare says the composition of the team is critical. In addition to Corcoran, the risk manager, the team includes a housekeeper, certified nursing assistant, a staff nurse, the director of social services, MDS coordinator, therapy program manager, the director of nursing, assistant director of nursing, and Johnson, the senior vice president of human resources and quality improvement. Bare serves as the team leader.

The varied makeup of the team helped establish the project's importance and create a sense of ownership for all the staff, Bare says. It also promoted a wide range of ideas leading to creative solutions, she says.

The fall prevention team came up with a program called "I'm Not Fallin' for That." The name was meant to be catchy and memorable, Bare says. Friendship Village used the catchphrase on posters throughout the facility and in educational sessions for all staff.

"In our pilot program, we showed pictures to the staff of various dangerous situations for high-risk residents, such as trying to get out of bed unassisted, or going to the washroom by themselves. The pictures of those situations had the phrase, "I'm Not Fallin' for That" stamped across them. The idea was to cement in the staff's brains, at a glance, what was dangerous, so that as they passed the residents in their workdays — if they saw dangerous situations — they could identify them."

The team also provided staff with a process for intervention, beginning with approaching the resident and securing their safety. The hospital also uses a two-tiered wristband system that identifies those with the pieces in place to be at risk for falls and those who have distinguished themselves already by falling, maybe more than once.

"We had tried some other methods before like the 'Falling Star' symbols on beds or doorways, but the problem with that is that the resident changes rooms and the signage doesn't always get updated. And the signs don't help when the resident is in the dining room or in therapy," Lopiccolo says. "But the wristband is always with the resident. Everyone knows at a glance that this person is high risk."

## Empowerment is key

But most important, Bare says, is the empowerment of all staff to intervene in dangerous situations. Staff at Briarwood understand that preventing falls is the job of every employee, not just nurses, she says.

"We also have a Good Samaritan-type clause in place that allows anyone to intervene to prevent a fall, with the promise that we're never going to tell you that's not your job or you shouldn't get involved," Bare says. "As a result, we have had housekeepers, painters, and dishwashers prevent falls."

Corcoran says one important decision was to focus first on the nursing home portion of Friendship Village, excluding the assisted living and independent living facilities. The nursing home residents faced the highest risk, so the team decided to focus there first and then expand the program once all the kinks were worked out.

Over a period of three months, the incidence of falls decreased 50%, Bare says. Also, the number of injuries related to falls fell by 50%, she says.

"We had a decline in every area in which we collect data and measure falls," Bare says. "Whether you look at the number of falls or the injuries resulting from those falls, the numbers decreased across the board."

## Risk manager plays key role

Corcoran credits the multidisciplinary composition of the team, and Bare's leadership, for much of the success. Without the right team

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members and leadership, it will be difficult to achieve the all-important buy-in from the facility staff, she says.

The risk manager should play a substantial role in any fall prevention effort, Corcoran says.

"My experience as a nurse came into play, but I [also was there] to provide immediate answers to legal questions about the things we should or shouldn't do related to confidentiality, for instance," she says. "That helped the team move on efficiently, without having to wait for an answer from me, and I didn't have to wonder if the team's work was going to lead to a breach of confidentiality or requirements for reporting." ■

# 'TLC' program helps cut lifting injuries

Everyone can use a little TLC, and at Baptist Health, a multifacility health system based in Jacksonville, FL, staff get it from a program called "Transferring and Lifting with Care" or TLC.

The program is aimed at reducing the injuries that result from lifting, repositioning and transferring patients, daily events that put both health care workers and patients at risk. According to the United States Department of Labor, Bureau of Labor Statistics, nursing and personal care facilities rank highest in the incidence of non-fatal occupational injuries and illness, with 12.6 injuries per 100 full-time employees reported in 2002. The agency also reported that one-third of these injuries resulted in absence from work, and that nursing aides and orderlies were reported to have the highest number of absentee days (44,000) due to musculoskeletal disorders.

To prevent these types of injuries, Baptist Health developed a comprehensive program that uses assistive equipment and devices on nursing units and in clinical departments at every one of its five hospitals to help caregivers safely lift and move patients.

Injury prevention consultants are helping Baptist Health create a cultural change in how staff lift and move patients, says **Beth Mehaffey**, vice president of human resources for Baptist Health.

"This is being accomplished through the establishment of customized policies and procedures, ongoing clinical support, and formal training on assistive equipment for lifting, repositioning, and transferring patients," she says.

**Chris Olinski**, RN, MSN, COHN-S/CM, manager of employee health for Baptist Health, says programs addressing lifting injuries are increasingly needed as health care workers are aging.

"The average age of a nurse in the United States is 48 years old, and the average patient's weight is 250 lbs.," Olinski says. "That's 20-25 years of lifting, causing wear and tear on a caregiver's back. When you combine that with the average patient's weight, hospitals are losing caregivers from the bedside, and these are experienced employees."

Not only do the injuries result in significant liabilities from injuries to patients and staff, but they also produce costs related to bringing in additional staff to replace those taken off line by injuries, Olinski says. One of the first steps toward addressing lifting injuries at Baptist Health was hiring an employee injury specialist, **Holly Lemmons**, LPN, in the employee health department. She points out that the health care industry has long tolerated lifting injuries that would be cause for alarm in any other industry.

"Health care workers are the only laborers in this country who consider 100 lbs. light," Lemmons says. "In any other industry, such as UPS or the U.S. Postal Service, staff would enlist the use of a mechanical device to assist them with a load heavier than 50 lbs. As a result, bedside caregivers endure microtears to their muscles.

These microtears accumulate over years and years of undue stress on back muscles from lifting and moving patients, which could turn into a career-ending injury."

### Nurses involved in choosing devices

The hospital system formed a team to start looking at vendors to supply lifting devices and transfer aids, but then Olinski, Lemmons and the others involved realized from the start that equipment would be only part of the solution.

"The biggest challenge is the cultural change and changing the mindset of the staff on how to move and lift patients," Olinski says. "One of the things we knew would be important was having the nurses who would be using the equipment actually involved in selecting it."

To do that, Baptist Health organized vendor fairs at two of its facilities to allow nurses and other caregivers to see and try out some of the equipment offered by different suppliers. With their input, Baptist Health partnered with Arjo Inc., a company based in Roselle, IL, which manufactures lifts and other patient-transferring equipment. Arjo also is the parent company of Diligent, the consultative team that provides staff education and assists with implementation and ongoing support.

Baptist Health rolled out its TLC program first at Baptist Medical Center Downtown in October 2007. The other facilities have adopted the program gradually, with the last beginning the TLC effort in March 2008. In addition to widespread implementation of lifting devices, Baptist Health provided extensive training in using the new equipment and other methods for avoiding lift injuries. Those receiving training include nurses, physical therapists, occupational therapists, radiologic technologists, nurses' aides, patient transport staff, and any other employee who is responsible for lifting, moving or transferring patients.

More than 4,100 Baptist Health employees have been trained. In addition, a total of 225 "super users" have been trained systemwide to act as coaches for all other staff — about two per shift, per unit. They go through more intensive eight-hour training and they are responsible for confirming that other staff have completed two hours of staff training and are proficient in the proper techniques.

In addition to providing the assistive devices, the TLC program includes policies on how to lift and transfer patients, providing specific requirements rather than leaving it up to the individual staff member's judgment. The methods of lifting and transferring are based on best practices, but the TLC program creates a uniform, systemwide expectation of how to safely move patients, Olinski says.

The program also includes a signage system that allows staff to mark the patient's room with an indication of what type of assistive devices are needed for that individual.

**Cory Meyers**, RN, MN, LHRM, director of risk management and corporate compliance, and patient safety officer, points out that the TLC program was positioned as a benefit to staff, a way to help them avoid injuries and deal with the growing number of large patients, rather than just another set of rules they had to follow. She says that approach is proving key to how the staff are embracing the program.

The program is too new to yield much in measurable results, but Olinski says the initial indication is that lifting injuries are decreasing. The goal of the TLC program is to achieve a 70% reduction systemwide in employee injuries related to lifting and transferring patients, after one full year of using the new policies and equipment.

Baptist Health has long monitored falls and studied how they occur, and now that analysis will include an assessment of whether staff followed the new TLC policies and whether the lifting and transfer devices were used properly, Meyers says.

### SOURCES

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"Any time there is a fall, we have to see if the equipment was involved, and in the time since this program was begun, we have seen no incidents that were caused in any way by the equipment," she says. "So, a focus for us now is determining whether employees used the equipment and used it properly, and so far we are seeing satisfying results from that aspect also. We expect it to keep improving." ■

# ISMP warns of errors with ADCs

Automation and high-tech systems often are touted as the solution for medication errors, but the Institute for Safe Medication Practices (ISMP) in Horsham, PA, is warning that you could be substituting one type of medication error for another when you use automated dispensing cabinets (ADCs).

ADCs are widely used in many health care systems for the storage and dispensing of medications. In a statement issued recently by the ISMP, the group acknowledges that this technology may offer many benefits, but it cautions that design and use of the system must be carefully planned and implemented to ensure the safe use of medications. In addition, there must be collaboration on ADC use between the health care professions, especially pharmacy and nursing personnel, since each holds a large stake in the medication use process, the ISMP says.

"Despite the growing popularity of this technology, little formalized, truly interdisciplinary guidance exists to direct organizations in its safe use," ISMP wrote.

To address those concerns, ISMP recently released the first-ever interdisciplinary guidelines to promote safe practices with ADCs. *(Editor's note: For a copy of ISMP's Guidance on the Interdisciplinary Safe Use of Automated Dispensing Cabinets, visit www.ismp.org/Tools/guidelines/ADC_Guidelines_Final.pdf.)*

## Guidelines developed

To develop the guidelines, ISMP convened a national forum of stakeholders this spring that included pharmacists, nurses, and ADC vendor representatives with extensive operational knowledge of the technology.

The group developed guidelines for safe ADC use that focus on a collaborative approach and are based on these 12 core processes:

1. Provide ideal environmental conditions for the use of ADCs.
2. Ensure ADC system security.
3. Use pharmacy-profiled ADCs.
4. Identify information that should appear on the ADC screen.
5. Select and maintain proper ADC inventory.
6. Select appropriate ADC configuration.
7. Define safe ADC restocking processes.
8. Develop procedures to ensure the accurate withdrawal of medications from the ADC.
9. Establish criteria for ADC system overrides.
10. Standardize processes for transporting medications from the ADC to the patient's bedside.
11. Eliminate the process for returning medications directly to their original ADC location.
12. Provide staff education and competency validation.

The guidelines provide specific safe process recommendations for each of those core processes. They should bring welcome advice to risk managers and others who are worried about ADC safety, and apparently there is plenty of worry. A recent survey by ISMP shows that safety improvements with ADCs have not kept up with the growing popularity of the technology. Providers keep adopting the systems at a rapid pace even though there are known safety flaws.

According to the 800 respondents to the ISMP's 2007 ADC survey, 94% of the surveyed providers are using ADCs in their facilities. Of those, more than half (56%) are using the technology as the primary means of drug distribution. **(See article, below right, for more findings from that survey.)**

## Devices no good without training

**Crystal A. Riley**, PharmD, RPh, director of professional affairs for the National Community Pharmacists Association in Alexandria, VA, points out that automated dispensing cabinets were intended to create less risk of errors and greater efficiency in medication dispensing within healthcare facilities, but that is not always the result.

"Without proper training on use of the systems and practice guidelines to follow to ensure that each area of concern in the use of automated dispensing cabinets is addressed, there is little to no benefit to having these machines within a facility," Riley says. "In releasing guidelines for the

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safe use of automated dispensing cabinets, ISMP has brought forth a number of important considerations for their correct use and stressed the importance of pharmacist involvement, not only in the dispensing function, but in inventory control as well."

Riley says thorough training for pharmacists and other health care workers with access to automated dispensing cabinets will help in minimizing medication errors related to their use, and the ISMP guidelines provide a good basis for training.

**Jack E. Fincham**, PhD, RPh, professor of pharmacy practice and administration in the School of Pharmacy at the University of Misssouri-Kansas City, says the ISMP guidelines are a good step forward because they address many of what he considers the primary concerns with ADC safety.

"The guidelines are most definitely a good step in the right direction," Fincham says. "What I also like is the multidisciplinary and facilitative role that ISMP has played."

In addition to the ISMP guidelines, Fincham offers Healthcare Risk Management readers these key elements of an ADC safety plan:

**1.** Multidisciplinary assessment of needs, placement, utilization, policies, and procedures. This should include nursing, medical, pharmacy, technicians, and respiratory therapy staff input.

**2.** Failsafe, secure access and record keeping. Those goals can be achieved with passcode access, automated processes for medication reconciliation, and two-signature sign-off policies.

**3.** Allowing placement in a secure area, with a minimum amount of distractions preferable. There should be decreased foot traffic and ample room to open and analyze dispensing needs.

**4.** Allowance of a sufficient number of ADCs to minimize staff necessary travel to unit and distance to patient area.

**5.** Electronic monitoring as a necessary prerequisite, such as through automated medication administration records.

**6.** Drug references available and easily accessible.

**7.** Ample opportunity to contact pharmacists easily and quickly. This can be done by phone, e-mail, or any other reasonable means.

**8.** Adequate planning and procedure development in the case of an unforeseen emergency. Contingency plans may address power outages or a technical failure in the ADC itself, for instance.

**9.** Synchronicity with automated pharmacy systems.

**10.** Institution of regular pharmacy audits.

### Check actual use against policies

**Mary Beth Navarra-Sirio**, RN, MBA, vice president and patient safety officer for San Francisco-based McKesson, says all health care providers utilizing ADCs would be well served to have qualified staff members from the patient safety office, quality assurance, risk management, pharmacy, and nursing review the organization's policies around the use of ADCs.

"More importantly, they should conduct candid observations and interviews to determine how the devices are actually used in daily patient care activities," she says. "These findings should be compared with the ISMP guidelines, and a gap analysis should be conducted by the team. Identified gaps can be ranked and prioritized by risk and incorporated into a plan of action that may include creating new or modifying existing policies, reorienting pharmacy and nursing staff to proper ADC use and policy, developing reporting and monitoring functions, and scheduling equipment upgrades and modifications." ■

# ISMP survey shows risks of using ADCs

Problems related to automated dispensing cabinets (ADCs) include both product design flaws and human errors, according to the 2007 ADC Survey from the Institute for Safe Medication Practices (ISMP) in Horsham, PA. There has been some improvement since the first ADC survey in

1999, but not enough.

The survey found these common problems with ADCs:

• **Checking processes:** In both years, just 18% of respondents reported that another person verifies drug placement in the ADC. The ISMP says these manual checking processes are important to prevent stocking and/or wrong drug retrieval errors, similar to the events occurring in Indianapolis and Los Angeles that led to harmful 1,000-fold heparin overdoses in neonates.

• **Pharmacist review and overrides:** Just 59% of 2007 respondents reported that all ADCs in their facilities are capable of profiling, which provides a direct interface between the pharmacy information system and ADCs so that pharmacists can profile, screen, and approve medications before they are removed from the cabinet for administration.

• **Cabinet design:** Only 50% of respondents noted that individual compartments for each drug are always or frequently available in the ADC cabinets.

• **ADC stock:** In both 1999 and 2007, 35% of respondents reported that they always or frequently encounter multiple concentrations of medications in ADCs. In 2007, respondents also reported that they encounter fewer ready-to-administer medications in ADCs than reported in 1999. Almost a quarter (23%) of 2007 respondents reported that nonmedications are being stored in ADCs, a 15% increase from 1999.

• **Workflow and practice habits:** Only two-thirds (69%) of frontline nurses reported that they always or frequently remove just one patient's medication at a time, implying that multiple patients' medications are removed one-third of the time — a practice that is known to lead to drug administration errors.

The full *ISMP Medication Safety Alert!* newsletter article on the 2007 survey results is available online at http://www.ismp.org/Newsletters/acutecare/articles/20080117.asp. ■

# Man posed as ED doctor, used lost badge, police say

Police in Atlanta report they have arrested a man posing as an emergency physician in a hospital, and authorities in Jacksonville, FL, say they still are hunting for a man seen impersonating a doctor in a children's hospital.

The Atlanta Police Department released a statement saying Eric Perteet was arrested at Piedmont Hospital. Tammi Perteet, the man's wife, told WSB-TV in Atlanta that she had believed her husband was an emergency physician at the hospital, dropping him off at the hospital to go to work. She said he even called her frequently during the day to talk about the difficulties of being an emergency physician, even lamenting about the times he lost patients.

Mrs. Perteet told the television station that when he didn't call one evening, she telephoned the Piedmont Hospital emergency department and was surprised when staff said they had never heard of a "Dr. Perteet." The staff member asked if she was looking for the man who had the cell phone she called and, when she said yes, she was told that man had been arrested for impersonating a doctor.

Police report that Perteet was arrested on charges of identity fraud, receiving stolen property, and credit card theft. The police report says he was found at the hospital with a stolen Piedmont security badge and a vial of medicine. Hospital officials told police that the identification badge had been reported stolen by a physician at the facility, and that its electronic access had been deactivated. Perteet's wife told the television station that when he was arrested, Perteet and a nurse were transporting a patient from the emergency department to intensive care.

Piedmont Hospital issued a statement saying there was no evidence that Perteet interacted with patients and that it is cooperating with police.

In Jacksonville, FL, law enforcement authorities in May report that they are searching for a man seen in a children's hospital wearing a convincing imitation of a doctor's outfit, down to the stethoscope and an identification badge.

There was no report of harm to patients, staff, or visitors, and it appears nothing was stolen, says Jacksonville Sheriff's Office spokesman **Ken Jefferson**. But staff at Wolfson Children's Hospital staff noticed that the man was not known in the hospital, and subsequent review of security tapes show that he walked the halls unchecked for more than an hour.

Jefferson says the man wandered the corridors of the hospital from 5 a.m. to 6:10 a.m. that day wearing scrubs, a white coat, a stethoscope, and carrying a black bag. He fled after a hospital employee detected the odor of alcohol on his breath and stopped to question him. The staff notified hospital security at 10 a.m., according to the sheriff's office.

The sheriff's office obtained a photo of the man

from surveillance camera footage and sent it to local hospitals. A black computer bag was found later that day beneath a car in the parking garage containing the items the man used to blend in with the hospital staff, Jefferson says.

The scrubs were a generic type, not those used by the hospital. The badge was a Humana identification card from Shands Jacksonville Medical Center in Florida, but with a yearbook picture pasted on the front, Jefferson reports.

The sheriff's office is investigating whether the man might be responsible for recent thefts of laptops and purses from other hospitals. ■

# Hospital worker charged with stealing jewelry

Police say an employee of Grady Memorial Hospital in Atlanta stole jewelry from two patients in cases that garnered substantial media attention in the community.

Hospital social services worker Tacuma Jawara is facing two felony charges of theft by taking, according to a statement released by the Atlanta Police Department. The hospital announced Jawara's firing soon after he was charged in the first theft in May.

Local media covered the case extensively as Atlanta resident Alan Armstrong pleaded for help in recovering the wedding and engagement rings belonging to his wife, who recently died at Grady Memorial Hospital after a car accident. Armstrong's wife, a mother of two young children, had created the rings herself, so the unique design helped police detectives recover them.

Jawara was the hospital employee responsible for securing patients' belongings in the trauma unit, so police investigated his possible involvement, according to a report in *The Atlanta Journal-Constitution.*[1] Jawara's duties included taking patients' personal property, logging it into inventory and putting it in a safe. Police reports indicate that after several days, Jawara took detectives to a pawn shop to recover the rings. The wedding and engagement rings were valued at $5,000 and had been pawned for $650, according to Atlanta Police Detective P.J. Roberson.

Roberson told the newspaper that a video surveillance camera showed Jawara carrying a plastic bag believed to hold Armstrong's rings. Jawara turned himself in a day after police got a warrant for his arrest.

After the jewelry was returned to Armstrong, in an emotional exchange in front of news cameras, police investigated other reports of thefts at the hospital. They recovered a ring and gold chain worth $600 that was missing after Ron Goyette was treated following a car accident. Goyette's wife told the newspaper that she had noticed the missing jewelry as doctors worked to save her husband but never got an explanation.

When Melissa Goyette saw Jawara's picture on television in relation to the missing Armstrong jewelry, she realized he was the hospital worker who had first told her about her husband's condition and had even helped her look for the missing jewelry. Police report that they found Goyette's jewelry in a pawnshop, held under Jawara's name.

### Reference

1. Reid SA. Former Grady worker stole from another patient, police say. *The Atlanta Journal-Constitution.* May 20, 2008. Accessed at: http://www.ajc.com/metro/content/metro/atlanta/stories/2008/05/20/jewelry_0521.html?cxntlid=homepage_tab_newstab. ■

## 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 hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

## CNE Questions

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

1. According to Maurice A. Ramirez, DO, BCEM, CNS, CMRO, who is subject to fines for violating EMTALA by having insufficient physician coverage for ED calls?

A. Only the hospital.
B. Only the physician.
C. Both the hospital and the physician.
D. No one is subject to fines stemming from this EMTALA violation.

2. What does Joshua Kugler, MD, FAAEM, FACEP, say is the threshold after which physicians on call for his hospital will receive pay for ED calls?

A. All physicians are paid for all ED visits, except the first call per month.
B. For most physicians, the threshold is three calls per month without pay, and then the hospital pays for each ED call after that.
C. Physicians are paid for all ED calls.
D. If physicians complete six calls per month, they are paid for all of that month's calls.

3. What is significant about the guidelines for safe use of automated dispensing cabinets (ADCs) from the Institute for Safe Medication Practices (ISMP)?

A. They are the first information published on ADC safety.
B. They are the first interdisciplinary guidelines for ADC safety.
C. They reveal that there is little risk to patient safety from ADCs.
D. They indicate that the devices have never malfunctioned.

4. According to the 2007 ADC Survey from ISMP, which of the following is true regarding ADCs?

A. Just 18% of respondents reported that another person verifies drug placement in the ADC.
B. Nearly 90% of respondents reported that another person verifies drug placement in the ADC.
C. Respondents indicated that their policies and procedures prohibit another person verifying drug placement in the ADC.
D. Respondents indicated that the ADC systems usually make it physically impossible for another person to verify drug placement in the ADC.

**Answers: 1. A; 2. B; 3. B; 4. A.**

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

# Failure to transfer patient from hospital with inoperable CT scanner leads to death, $1.65 million verdict

By **Jon T. Gatto**, Esq.
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**News:** A man presented to the hospital complaining of a painful headache. A CT scan was ordered, but the CT scanner was not working properly. After an hour and a half of trying to repair the machine, staff made arrangements to use a backup CT scanner at an imaging center across the street, but that machine also was inoperable. The man eventually was transferred to another hospital for an immediate CT scan that showed a severe hydrocephalus and a colloid cyst. A neurosurgeon performed an emergency ventriculostomy, but the patient never regained consciousness and died three days later. The man's estate sued the hospital and the various physicians for medical professional liability. A jury awarded the plaintiff $1.65 million in damages, allocating 80% of the fault to the first hospital and 20% of the fault to the ED physician on duty at the first hospital.

**Background:** A 45-year-old shipping line worker took some over-the-counter medications after experiencing headaches. A few days later, he went to his family doctor, who diagnosed him with a sinus infection and prescribed him antibiotics and a nasal spray. Three days later, the man still was experiencing pain and he called his family doctor. He spoke with a medical assistant, whom he told that his headaches had worsened. The assistant passed the man's complaints on to another physician in the practice, who told her staff to telephone the man's pharmacy and order a prescription of tramadol, a narcotic-like pain reliever.

Two days later, the man awoke in the morning in serious pain. His wife drove him to the hospital, and the man vomited en route. Upon the man's admission to the ED at 9 a.m., the triage nurse reported that the patient had registered pain at 5 on a scale of 1 to 10 and later, at 3 out of 10. The man was seen within an hour by a physician's assistant (PA), who was working with the attending ED physician. The PA noted that the man's headache was moderate and not the worst headache he had ever had, but he nevertheless considered the possibility that the man could have had a brain hemorrhage or increasing intracranial pressure.

The PA consequently ordered a CT scan with the approval of the ED physician. But when the order for the CT scan was relayed to the radiology department a half-hour later, the ED unit secretary was told that the CT scan machine was out of order and that the technicians were working with maintenance personnel to repair it. It soon became clear that the CT scanner could not be rebooted remotely. Thus, radiology staff attempted to use a backup CT scanner that was located in an imaging center across the street. But when the staff went to use the second CT scan machine — about 90 minutes after they

determined that the primary CT scanner could not be repaired — they discovered that the backup CT scanner was inoperable as well.

Three hours after the man's initial admission, the man started demonstrating signs of disorientation and confusion. The ED physician was called to stabilize him and, about 20 minutes later, the man's pupils were dilated. The ED physician called for an immediate neurology consult because the man's deteriorating condition indicated that he may have been suffering from a brain injury. When the patient suddenly stopped breathing shortly thereafter, he was intubated.

When the man's condition finally stabilized, staff transferred him via ambulance to a second hospital for an immediate CT scan. The man, however, was in a coma upon his arrival at the second hospital. The CT scan displayed a severe hydrocephalus, or swelling of the ventricles of the brain, that was causing increased intracranial pressure. The CT scan also displayed a colloid cyst that was blocking fluid from leaving the ventricle and causing the hydrocephalus.

By the time the CT scan was performed at the second hospital, the pressure in the man's brain had become so severe that it caused a brain stem herniation. A neurosurgeon was called who performed an emergency ventriculostomy, consisting of the placing of a drain in the ventricle below the skull tap, in order to relieve the excess fluid causing the pressure.

The man never regained consciousness and died three days later. Claiming that the hospital and the various physicians involved in the man's care were liable for negligence that caused the wrongful death, the man's estate sued for medical professional liability.

As for the second family physician who evaluated the decedent's condition, the plaintiff argued that she was liable because she acted on an incomplete history when she addressed his phone call before he went to the hospital. The man's estate argued that had the physician spoken directly with the decedent, rather than through her medical assistant, she would have recognized that his headaches were more serious than she understood when she had her staff telephone his pharmacy to enter the pain reliever prescription. The plaintiff asserted that a complete history would have resulted in the family physician directing the man to either report to the ED immediately or come to her office for a consult.

As for the first hospital, ED physician, and PA, the plaintiff argued that the decedent's coma could have been avoided if the man had been transferred to another hospital in a more timely fashion. The plaintiff argued that the hospital failed to properly train its staff on procedures to follow when the CT scan machine was inoperable and that it was clear that any procedures the hospital did have in place were inadequate. A CT scan, the plaintiff argued, would have provided the hospital, physicians, and staff all of the information they needed regarding the man's urgent situation. The plaintiff also pointed out that the immediate concern should have been the increasing pressure from the hydrocephalus and that a CT scan was needed to diagnose that issue. And finally, the plaintiff argued that the underlying colloid cyst could have been addressed and surgically removed.

**As for the first hospital, ED physician, and PA, the plaintiff argued that the decedent's coma could have been avoided if the man had been transferred to another hospital in a more timely fashion.**

The man's estate also sued the attending radiologist, claiming he was liable for negligence by delaying the approval of the man's transfer. The plaintiff asserted that the combined negligence of all the parties led to the decedent's coma and subsequent death.

As for damages, the plaintiff sought compensation in an unspecified amount for the man's conscious pain and suffering leading up to his death. The plaintiff also sought pecuniary damages, as to which the plaintiff's economist estimated that the man's lost wages, based on his last annual income of $52,000, and household services amounted to $1.35 million when reduced to present value.

The family physician defended the claims by arguing that the patient had been seen just three days before he called her and that her partner had diagnosed him with a sinus infection. The physician maintained that it was reasonable to rely upon her partner's evaluation and that it was common for it to take longer than three days for patients to respond to antibiotics when they are prescribed for sinus headaches.

The hospital also defended the lawsuit, pointing out that most hospitals don't have any written policies to address inoperable equipment and that the man's situation required the parties to use common sense. To that end, the hospital maintained that it followed an appropriate procedure and, once the order was given to transfer the man, the staff took immediate steps to transfer him. The hospital also noted that this instance was the first and only time that the hospital's CT scan machines were both inoperable at the same time.

In their defense, the ED physician and his physician's assistant both argued that only the attending physician could order the transfer of a patient to another hospital and there was no need to transfer the man until he decompensated. They argued that the patient's condition was very rare and there was no way for either of them to determine that a colloid cyst was causing increasing pressure on the man's brain. Finally, they argued that the man was stable from a clinical standpoint, and while they realized he needed a CT scan, there was nothing about his condition that indicated the situation was urgent.

**Clearly, it was not inappropriate to order a CT scan. However, the focus on getting the CT scan obscured basic patient observation.**

The radiologist argued that he was never made aware that a transfer request was made for the man, and that there was no evidence to refute that assertion.

All of the defendants maintained that physicians and hospitals could not be held liable for sudden and unpredictable changes in patients' conditions. They also pointed out that the plaintiff's damages claim for both household services and loss of wages should be reduced to $740,000 given that the man's spouse had remarried since her husband's death and that the man had a serious pre-existing condition that would have inevitably affected his future earnings in an adverse manner.

At the close of evidence, the court granted the radiologist's motion for a directed verdict and dismissed him from the lawsuit. The jury then returned a $1.65 million verdict in favor of the plaintiff. Eighty percent of the award was attributed to the hospital, and 20% was allocated to the ED physician. The jury found that the physician's assistant was not negligent and that the family physician was negligent, but that her negligence did not contribute to the man's death.

**What this means to you:** "This is a very interesting case for several reasons," says **Ellen L. Barton**, JD, CPCU, a risk management consultant in Phoenix, MD, "First, while there clearly was negligence in this case on the part of more than one health care provider, the theories of liability asserted miss the mark. Second, this is a classic example of inappropriate reliance on technology. Third, some of the defenses offered were patently ridiculous."

When the patient first saw his family doctor, he presented with a headache. Considering the fact that 99% of headaches are benign, the family doctor's diagnosis of a sinus infection (while wrong) was not negligent given the patient's condition at the time of the visit. However, a small percentage of headaches may involve a lethal condition. Thus, when the patient called the physician's office and spoke to a medical assistant who relayed the conversation to a partner of the patient's family physician, the situation started to go off track. The second family physician should never have relied on her partner's diagnosis without seeing the patient, and she should never have prescribed medications for a patient she had never seen. It is possible that with an appropriate exam, a physician with the requisite skills could have determined that the situation was more than a "headache."

When the patient arrived at the ED, the PA apparently picked up on the fact that when a patient with a headache vomits, there is a possibility of increased intracranial pressure — it is precisely this symptom that needed attention. "However, here is where reliance on technology provides medical personnel with a false sense of security," says Barton.

Clearly, it was not inappropriate to order a CT scan. However, the focus on getting the CT scan obscured basic patient observation. Given the time the patient was in the ED — three hours — before losing consciousness, it is clearly possible that there were other signs that were ignored (or if they were observed, they were not understood). Such signs include abnormal respiratory pattern and dilated pupils. These signs (along with the history of vomiting on the way to the hospital) would have clearly indicated increased intracranial pressure and, more importantly, should have

signaled the need to institute measures to reduce intracranial pressure immediately. No CT scan was needed to make that diagnosis.

Given the inaction at the first sign of change in mental status, it is unlikely that anything done after that would have made any difference. What is tragic about this case is that it appears that the PA actually considered the correct issue but did not monitor the patient closely enough because of the distraction of the CT scanner. In Barton's opinion, the CT scan would not have made a difference in this case unless the patient had gotten the CT scan immediately upon arrival at the ED. The colloid cyst is a nonlethal problem that could have been dealt with. The real issue was that the patient was not monitored closely enough, she points out.

The plaintiff argued that the decedent's coma could have been avoided had he been transferred to another hospital in a more timely fashion. That argument would hold only if the second hospital had experienced providers capable of examining the patient to detect signs of change in mental status. Had the focus remained on getting a CT scan, it is unlikely that the outcome would have been different.

The argument regarding the equipment failure is interesting as it is uncertain that the CT scan alone would have made the difference without the understanding of the change in mental status. A CT scan was not at all necessary in diagnosing and treating an increase in intracranial pressure.

The delay in transfer further complicates the situation, again obscuring the need to diagnose the change in mental status as an increase in intracranial pressure.

Clearly, the second family physician was negligent for the reasons stated above. And, to argue that it was reasonable to rely on her partner's diagnosis without seeing the patient is at a minimum unprofessional. The second physician's conduct clearly violated the standard of care.

For the hospital to claim that "most hospitals don't have any written policies to address inoperable equipment" is ridiculous, Barton says. The standard is not what "most hospitals" do; it is what the reasonable course of action under the circumstances is. When equipment becomes inoperable, it is incumbent upon an organization to have backup plans and backup plans to the backup plans. When the main CT scanner went down, the alternate CT scanner should have been checked. This was not done. If it had been done, critical information would have been available much earlier. In this case, as soon as critical equipment becomes inoperable, all "emergency" cases need to be transferred if the patient's condition allows. If this patient had been transferred immediately, a different outcome could have been possible.

Furthermore, for the ED physician and his PA to argue about authorization for transfer misses the point. It was their responsibility to monitor the patient while he was in their care. This was not done. As a result, critical signs were missed which directly led to the patient's altered state of consciousness.

The directed verdict in favor of the radiologist seems appropriate. However, the allocation of the verdict between the hospital and ED physician does not. This appears to have been the result of the focus on the CT scanner rather than the physician's lack of understanding of the patient's deteriorating condition and thus his failure to act to reduce the intracranial pressure.

Finally, the PA does not appear to have been negligent and, in fact, appropriately recognized the possibility of increasing intracranial pressure. And, while the second family physician was clearly negligent, her negligence did not directly contribute to the patient's death.

Hospitals need to do everything they can to assure that equipment is adequate and operable; however, use of technology is not a very good substitute for medical expertise, Barton says.

## Reference


• Case No. MID-L-2447-04, Middlesex County (NJ) Superior Court. ■