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Reduce ED violence with training, diligent reporting to avoid harm

Don't let staff accept assaults as unavoidable part of the job

Violence in the emergency department (ED) is such a common occurrence that staff can become complacent about the risks they face daily. Nowhere else in your organization would employees accept the idea that they may be assaulted at any time, but that attitude can be common in the ED. Risk managers should emphasize to ED staff that violence does not have to be just a routine part of their work.

The Emergency Nurses Association (ENA) in Chicago recently surveyed 1,000 ENA members and found that 86% had been the victim of workplace violence in the past three years, with nearly 20% reporting that they experience workplace violence frequently. **(See p. 87 for more on a recent incident of ED violence.)** The potential for liability is enormous, not to mention the effect that ED violence has on employee morale and retention. Reducing the risk and effects from ED violence depends first on a good reporting system, says **Steve Albrecht**, PHR, CPP, a security consultant and expert on workplace violence based in San Diego.

"When it comes to health care violence, my biggest concern is that staff and physicians are reluctant to report threats or actual assaults, somehow thinking it is part of their jobs to take these behaviors," he says. "When I teach classes, the ED members all report being threatened or assaulted, because they work in the patient's intimate space, yet these are not reported."

EXECUTIVE SUMMARY

Violence in the emergency department continues to plague U.S. hospitals, with staff reporting frequent incidents. Risk managers must ensure staff have adequate training and resources to avoid harm.
- Encourage careful reporting of all violent incidents.
- Provide training in how to recognize and respond to potential violence.
- Do not hesitate to call local law enforcement for help.

Without knowledge of incidents, the leadership of the organization cannot respond effectively, write new policies or change existing ones, or create new protocols, Albrecht says.

"Without consequences for patient behaviors, we can expect more of the same," he says. "People who work with patients who often have high stress and high emotions, like in the ED and neonatal, tend to minimize patient actions even when it is quite severe. They get the idea that it is part of their job to be mistreated and assaulted."

Good reporting also can improve your threat analysis, says **Amit Gavish**, a security expert with SSC Inc., a security consulting company in Shelton, CT, who previously was deputy director of security for the office of the president of Israel. He says it is easy for people to focus almost exclusively on what they perceive as the big threat — a murder or rape in the ED — and devote little attention to preventing the far more common acts of violence.

"You have to categorize the different types of threats and plan a response for each threat," he says. "What you need to do to prevent a knife attack from a gang member is not the same thing you need to do to prevent a disgruntled former employee from walking into the ED and assaulting someone."

It is a mistake to be hasty in implementing security improvements without knowing what the real threats are, Gavish says. EDs are not all the same, and the type of potential violence will vary, he says. Urban EDs may have different concerns than rural facilities, and pediatric EDs may have their own concerns. Each will require an appropriate prevention and response plan.

When improving security in the ED, it is important to remember that fortifying the facility is not necessarily the answer, Gavish points out.

"A lot of times we see people say they're going to improve security, usually after a bad incident, and they spend a lot of money installing cameras and metal detectors and posting more guards," he says. "But if you haven't analyzed your risks and identified the threats, it can be a total waste of your money. You say you've increased security, but you really haven't done anything useful."

Promote zero tolerance

Risk managers can improve reporting by emphasizing that they want to hear about all incidents of ED violence and that those reports will not be viewed as whining or complaining, Albrecht says. Staff must understand that the hospital leadership

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Nurse saved from possible rapist

Police in Longview, WA, report that a nurse at St. John's Medical Center recently was saved from an apparent rape attempt by a hospital security guard who came to her defense.

Hospital officials reported that the incident began when a man walked into the hospital and asked for medical attention. He was taken to an exam room and asked to change into a gown. Then two nurses entered and began asking questions. That was when the man became violent, according to a statement from the hospital.

Police say the man jumped off the bed and attacked one of the nurses. He pinned her against the wall, ripped her shirt, and told her he was going to rape her, according to the police report. Hospital security guard Joel Reeder heard the nurses' screams and ran to the exam room. Reeder told police he saw the patient on the nurse and yelled at him to back up, and the man complied. The guard then called for more help and several guards took the man into custody.

A statement from the hospital noted that it had conducted a thorough review of security procedures and improved some measures about a year ago after someone entered the ED with a gun. Police say the man may be charged with attempted rape and assault, pending a mental evaluation. ■

does not consider ED violence an unavoidable job hazard. The relatively minor incidents can reveal security issues that can help prevent more serious incidents, he says.

"Don't wait until a nurse is beaten unconscious before you decide to act," Albrecht says. "No matter what you identify as why that happened, I can almost guarantee that you could have identified the same issues after previous, much less severe incidents took place."

Albrecht says ED staff also should be encouraged to call for help from the local police department whenever there is a threat of violence — without feeling as if they are being overly cautious.

"The police don't necessarily arrest anybody, but they show up and lower the emotional temperature of the situation," he says. "I would let ED staff know that hospital leadership will not frown upon staff calling for help when they feel threatened, before the violence occurs, whether that help comes from hospital security or the local police."

Hospitals can reinforce the safety culture in the ED by having a formal policy and reiterating the organization's zero tolerance for assaults on staff, says **Robert Siciliano**, CEO of NurseSecurity.com and a personal security expert in Boston. **(See article, below, for more on strategies you can employ to reduce ED violence.)**

"That policy should be posted, included in paycheck envelopes, handed out at safety and security meetings — any way you can get it in front of people repeatedly," he urges. "If they are continually reminded, there is a better chance that they will remember in the heat of moment, when they are faced with a potentially dangerous situation." ■

Training, buddy system can reduce ED violence

Angry, violent individuals need specialized attention, and improperly handling a crisis can mean years of litigation, warns **Robert Siciliano**, CEO of NurseSecurity.com and a personal security expert in Boston. Fail to act properly and you could face liability from either the injured staff member or the assailant who was injured by your intervention. Or both.

Siciliano offers this overview of the strategies that can reduce violence in the emergency department (ED) and ensure a proper response to incidents:

- **Create a safety culture for the ED.** Establish guidelines that include adaptable safety and security procedures customized to the limits of the facility. Create zero-tolerance policies for violence and threats for patients, staff, and visitors. Create reporting procedures and a filing system to evaluate and quantify progress.
- **Work together.** It is essential that management demonstrate organizational duties to ensure the ssafety and health of their employees. Managers should offer support and "be there" when employees are in crisis.
- **Educate employees about their responsibilities.** Staff are responsible for learning their assigned duties and complying with security program guidelines. They also must be involved in ongoing procedures, committees, inspections, reporting, and dissemination of information.
- **Know your risk factors.** Employees must know what elements increase the risk. Patients' families and friends bring in handguns, knives, and other weapons. An ED's 24-hour unrestricted access, long waits, disgruntled family or gang

members, and patients under the influence of drugs and alcohol all escalate the risk. Nurses are sometimes isolated in remote areas and are not trained to respond to physical threats.

• **Ensure premises security.** Options include security guards, metal detectors, pass keys, alarm systems, panic buttons, cell phones, proper lighting, and centralized radios. A central office to respond to distress calls is essential. Security cameras and curved mirrors assist in remote areas.

• **Coordinate with local law enforcement.** Although law enforcement usually responds after a crisis, it is important to create communications with local authorities and make them fully aware of the facility layout. Properly trained security guards usually can defuse violent situations whether by nonviolent means or with force.

• **Use nonviolent intervention.** Have systems in place to treat clients who are aggressive or acting out. Certified employee assistance professionals or social service staff should be on duty 24 hours a day to help calm angry patients.

• **Use a buddy system.** There is strength in numbers. To reduce potential threats, pairing staff can offset the chances of being overpowered. Elevators, stairwells, parking garages, home visits, and isolated areas are all potential threats.

• **Minimize jewelry and cash.** Not only is jewelry a potential target for thieves, it also can be a strangulation hazard during an attack. Carry only essential identification and cash. Beware of improvised weaponry in the form of surgical tools, keys, pens, or other items that could be used as a weapon.

• **Offer self-defense training.** Employees can be trained in assault response, avoiding assaults, personal safety, and self-defense. ■

Know what to do when faced with suit

It can be a common occurrence for risk managers, but it still makes your heart skip a little when you learn that there is a new claim or lawsuit against your facility. What do you do? Medical malpractice defense attorneys say what you do immediately after can make a big difference in how the case turns out further down the road — for better or worse.

Every defense attorney can tell stories about cases in which he or she wishes the defendant had done something — or not done something else — in those first hours, days, and weeks after learning of legal action. Risk managers should keep in mind that they will be the point person for making sure the response of many people throughout the organization is correct, says **Linda Stimmel**, JD, partner and co-founder of Stewart & Stimmel LLP in Dallas. **(See p. 89 for more on how to avoid the most common lawsuit traps.)**

The first rule is to stay calm, she says. You have to act, but in a deliberate, careful way. **Barbara A. Cotter**, JD, an attorney with Cook Brown in Sacramento, CA, points out that once a lawsuit is filed, the clock is ticking, and you must act. Most lawsuits require a response within 20-30 days, so you should quickly determine the deadline for your response.

Stimmel cautions that you must not let a lawsuit get bogged down in your organization's bureaucracy. If you miss a deadline, the court won't really care why.

"I've had cases where risk management took the lawsuit to the CEO's desk and it sat there on a stack of papers for weeks because he was on vacation, and it wasn't answered timely," Stimmel says. "The plaintiff can get a default judgment when that happens. The clock starts running from the date of service, so you need to make sure legal counsel know the time frame."

Get confirmation of coverage

Mina N. Sirkin, JD, LLM, an attorney with Sirkin & Sirkin in Woodland Hills, CA, says as soon as you know there may be a potential claim, you should write a certified letter to your E&O insurer, using the address provided on the claims instruction sheet of your policy. If you don't immediately report a potential claim, the E&O insurer

EXECUTIVE SUMMARY

What you do immediately after learning of a claim or a lawsuit can determine the eventual outcome of the case. You should have a plan beforehand so that you are not scrambling when the news comes.

- Ensure that involved staff do not try to improve the medical record.
- Preserve documents and evidence as soon as possible.
- Caution others not to create new evidence that may be damaging.

can deny your claim, she notes.

"Once you have been served, overnight copies of the malpractice complaint to your E&O insurance company, keeping a receipt of the package delivery," she says. "Immediately request defense in writing. Do not delay this step."

Cecile M. Loidolt, JD, an attorney with Meagher & Geer in Minneapolis, points out that timely notification is important, because your liability insurance requires you to cooperate in your defense and notify your insurance company if you are sued — or if you think you did something wrong with a patient's care.

Have the insurer provide written confirmation that a defense will be provided and who the attorney will be, says **Charles Holton**, JD, an attorney with Womble Carlyle in Research Triangle Park, NC. Communicate with the attorney promptly to confirm his or her involvement and what type of defense will be provided.

"I've seen cases over the years where there was a delay with the insurance company providing counsel, and that leads to real problems," he says.

Loose lips sink hospitals

The risk manager should determine right away whether there have been any previous investigations regarding the incident, says **Peter Hoffman**, JD, an attorney with Eckert Seamans in Philadelphia. If there has been a root cause analysis, for instance, that material should be obtained quickly and can form the basis of your own investigation, he says.

"From there you need to assess what you're looking at, whether you owe a defense to anyone, and whether there might be some competing interests," he says.

Loidolt says risk managers should remind physicians and staff to be careful who they talk to once a lawsuit is possible. **(See p. 90 for more on cautioning employees not to create new evidence.)**

"Discussions with colleagues are not protected by the attorney-client privilege," she says. "If you discuss your care with a colleague, and the colleague thinks you did something wrong, then this unfavorable opinion may come out during the lawsuit."

Stimmel says it also is important to track down clinicians who were involved in the patient's care but who no longer are employed with your organization. It may take some legwork to find them, but their professional organizations and friends at work usually can help, she says. Notify them of the plaintiff's potential legal action and remind them not to talk directly with the plaintiff or plaintiff's counsel.

"They track the nurse down and call her at home; if she's not been forewarned, the nurse can be caught off guard and start talking. They hear the phrase 'legal counsel' and their former employer's name and sometimes they think they're talking to the hospital's legal counsel," Stimmel explains. "They say things that are very damaging to your case."

Protect your privilege

Cotter points out that once a lawsuit is filed, all communication with the plaintiff must go through your own attorneys. Never break this

Avoid most common paths to litigation

The best way to avoid a claim or lawsuit is to keep the patient healthy and happy, of course. But even the best health care providers get sued, says **Cecile M. Loidolt**, JD, an attorney with Meagher & Geer in Minneapolis. You can lower your risk, she says, by avoiding the most common traps:

1. Failing to communicate test results.
2. Failing to follow up with patients. If you tell a patient he or she needs to follow up with you in six months, have a system in place for the follow-up. You cannot force patients to come and see you, but you can document that you communicated that they needed to be seen and that you sent a follow-up reminder card or used other means.
3. Failure to document communications with patients, including phone calls.
4. Blowing off informed consent discussions. If the physician does not agree with certain testing or treatment, but the standard in the community is to offer the testing or treatment, then the doctor should discuss it with the patient and document the discussion in the chart.
5. Lapses in record keeping. Ensure the typed dictation gets into the chart.
6. Delegating too much. For the most part, physicians should give patients informed consent, or explain to patients why they had a complication or bad outcome.
7. Inadequate communication by office personnel and failure to document what communication did occur. If a patient is told he or she needs to be seen because he or she is having chest pain but refused to come in, then whoever handled the call needs to document that the patient was told he or she needs to be seen, was told to come in, and refused. ■

Don't create new evidence for case

Don't let people involved in a legal action inadvertently create new evidence that can be used against you, warns **Linda Stimmel**, JD, partner and co-founder of Stewart & Stimmel LLP in Dallas. This includes any type of documentation not covered by attorney-client privilege.

"I had a case once where a nurse was upset after learning of a lawsuit and she went home and dictated a tape of everything she recalled, sort of to cover herself and get it all recorded. Once we learned of the tape's existence, we had to turn it over to the plaintiff," Stimmel says. "She later found out that a lot of what she said wasn't true, that she had misunderstood the actions of some people involved in the case, but she had to live with what she put on that tape. The hospital paid a lot of money to settle that case just because of that tape, and they didn't do anything wrong."

Charles Holton, JD, an attorney with Womble Carlyle in Research Triangle Park, NC, also has seen physicians make notes summarizing their actions or adding additional details they recalled after the fact, sometimes even questioning their own decisions in the patient's care.

"The doctor usually thinks these notes are just for his or her own use, but if they ever come to light, the plaintiff will find them useful," he says. "They're doing what comes naturally, jotting down some details while they still remember them, maybe second-guessing themselves about some decisions. But once it's on paper, it can be used against them." ■

rule, she warns.

"Do not call the plaintiff or plaintiff's counsel. Anything you say can and will be used against you. No conversation or communication is off the record," she says. "Don't risk it, even if you believe that a phone call will clear up all the evident misunderstandings."

Stimmel agrees, saying risk managers and other parties often have a hard time avoiding the plaintiff, not wanting to appear rude when the patient or family member calls with a question. A key concern must be protecting the attorney-client privilege, she says. Most state laws hold that if you have a good-faith belief that a lawsuit will ensue, you can begin talking to those involved and have those communications be protected, Stimmel adds.

Stimmel also cautions against being too quick to write off a bill as a conciliatory gesture toward the patient who has made a claim or is threatening a lawsuit. While dismissing the bill can be a fine negotiating tactic or goodwill gesture, Stimmel says it can be misinterpreted if you are too hasty with that step. The plaintiff can see it as an admission of guilt and be urged on to pursue the legal case.

Risk managers can suggest to the clinicians involved that they start thinking about how they will describe their actions to the plaintiff's counsel, and they should consider how to explain medical issues to a layman. You can provide the clinicians with a copy of the medical record that documents their care, Holton says, but be careful not to suggest any deception or effort to mislead.

Immediately collect all paperwork, files, correspondence, bills, e-mails, invoices, and other material regarding the subject matter of the lawsuit, and the plaintiff or plaintiffs who filed the action. Store all such information in a readily accessible place to turn over to your attorney. Holton points out that you also must keep those records secure, and that the filing cabinet in your office may not do the job.

"These records can be of interest to a lot of people with a great deal to lose or to gain, depending on the outcome of the case, and alterations can be made," he says. "I think it's a good idea to secure the original chart and related records, in a secure way. You might want to consider storing them off

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site in a more secure place."

Employees also must be cautioned to never destroy electronic files or e-mail records, Holton says. Plaintiffs often request electronic records routinely, and any indication of deletions or alterations will prompt a more thorough electronic investigation. **(See article, below, for more on the importance of not altering the record.)**

"The way we see cases get compromised the most is when the records are not secured in the best way possible. Slides are not included, tissue samples were not examined, and evidence was just lost," he says. "That happens most when a case is brought years after the incident, and no one knew how important that material might be. When you have the ability to collect all this information, make sure you get everything. Don't leave anything out." ■

Never alter chart to help lawsuit

Everyone knows you should never alter medical records after the fact, right? But if it is so clear to everyone, why do medical malpractice defense attorneys repeat that rule like a mantra, and why do they all have plenty of anecdotes about defendants trying to improve the medical record?

Never assume that everyone knows not to do this, says **Linda Stimmel**, JD, partner and co-founder of Stewart & Stimmel LLP in Dallas. Specifically remind those involved not to change the record.

"I had a case one time where the physician involved was looking at his notes and saw they were not written as clearly as they could be, so he tore up his progress note sheet and wrote a new one. He didn't put anything in there that was false. He just wrote them in a better, more detailed manner," Stimmel says. "When that is revealed, the judge tells the jury that they can assume whatever the defendant destroyed was hurtful to them. That can kill you in court, even when you know that the change wasn't anything deceptive or false."

It is possible to add late entries to the medical record, Stimmel says, but they should be entirely transparent. Do not delete anything from the original, but rather add another entry and clearly note that it is a late entry and the date on which it was entered. Once a lawsuit is filed, however, Stimmel advises against even that type of clear addition to the record.

Dick Wiles, JD, an attorney with Hiersche Hayward in Dallas-Ft. Worth, notes that physical security of the chart is paramount. Keep it separate from any records of communications with plaintiff's counsel, he suggests. He also says that, aside from the legal and ethical reasons not to alter the chart, any such deception probably will be detected.

"You never know when someone else has a copy of that original chart. You may think you know, but you don't," he says. "I've seen cases in which patients got their hands on records that you just could never imagine they would have. It's unsettling, to say the least, when the plaintiff's copy looks different than the one you're holding." ■

Hospital cuts injuries with 'falls cart'

Sometimes the most effective strategies for those problems that plague every health care facility are not high tech and don't require a highly paid consultant. Sometimes the solution can be deceptively simple — such as creating a "falls cart" to keep essential fall reduction tools handy for both patients and caregivers.

Another idea is to create one in a special inpatient room where patients at the highest risk for falls can receive special attention.

Both strategies are in use at Caritas Norwood (MA) Hospital, a 264-bed acute care facility where risk manager **Lynn Worley**, JD, RN, CPHRN, says it has been a simple and inexpensive strategy for improving patient safety. A falls cart or designated room will be only one part of a comprehensive fall

EXECUTIVE SUMMARY

A hospital is reporting success with using two relatively simple strategies for reducing patient falls. One is a special cart that keeps fall prevention tools handy, and the other is a special room designated for high-risk patients.

- The cart is a low-cost, practical way to address a common problem.
- A specially trained nurse's aide is assigned to the fall prevention room.
- The hospital also watches diabetic patients for fall risks.

SOURCES

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reduction plan, she says, but they are good examples of how seemingly basic suggestions from frontline clinicians can make a difference.

"Much of what we're doing to reduce falls was developed by working with the nurses who are out there every day working with these patients, listening to what they told us would work, in addition to consulting the literature and best practices," she says. "We now have a learning packet on our online network that has become an assigned competency for all of our nurses."

Mary McDougall, MSN, MPH, APRN, BC, a clinical nurse specialist at Caritas Norwood, was involved in developing the falls cart along with other aspects of the hospital's fall reduction program. She says the falls cart is part of a program that includes ongoing education for the staff about fall risks and the changes that come with aging. The hospital also created a high-risk fall room by remodeling an existing four-bed room.

One bed was removed so that there would be more space to move around, and the room was fitted with additional railings and hand holds throughout. Special care is devoted to avoiding any tripping or fall hazards in the room. The hospital uses common criteria for determining fall risk when assigning patients to the room. The typical patient assigned to the fall prevention room is more than 80 years old, with a history of falling, a history of confusion, and multiple medications.

The room is used only for female patients now, but there are plans to create another room for male patients at risk of falling. The room has been in use for only a few months, but there have been no falls in the room so far.

"Having this room doesn't mean that we don't practice fall prevention everywhere else in the hospital, but for this room we cherry-pick the patients who are at highest risk," McDougall says. "The room is staffed with a dedicated nurse's aide who has been through a special falls prevention program. In addition to that aide, the rest of the staff know to be extra vigilant with these patients."

McDougall says the team at Caritas Norwood is focusing more lately on diabetic patients, because recent literature shows that they are at increased risk of falls, even aside from any additional risk factors they may have. Their diabetes can lead to foot and circulation problems that impair walking, and difficulties with maintaining blood sugar levels also can make them unsteady.

"I teach our people to look for these patients who have these factors that make them a high risk for falls. They're on the lookout now, and we identify patients at risk. We sort of wave the red flag over these patients and make sure everyone knows there is a higher risk with this individual," McDougall says. "We can know ahead of time which patients are more likely to fall."

Worley says a retrospective review of falls data at the hospital confirmed that, in some cases, the patient's blood sugar level was one cause of the fall. **(See article, below, for more information on fall reduction strategies.)**

The falls carts are a particularly good idea when measured against the negligible cost and minimal work required, Worley says. McDougall explains that the falls carts are common rolling carts, the type used in many ways throughout any hospital, that are kept stocked with items that can help prevent falls. The items include Velcro belts and "busy aprons" for elderly patients who need something to occupy their hands, skin sleeves for intravenous lines, gait belts, minimal restraint devices, and various activities to keep patients busy.

"One cart is kept in the falls prevention room, and there are two more that are available on the units as needed," McDougall says. "It's a simple idea but it works." ■

Fall risk factors vary with groups

Risk managers should remember that the risk factors for falls are dependent on the situation, says **Alan M. Jette**, PT, PhD, FAPTA, professor of health policy and management at Boston University's School of Public Health and director of the university's Health & Disability Research Institute. The risk factors for an elderly patient

EXECUTIVE SUMMARY

It is crucial to assess patients' risk factors for falls early on, so that you can implement the correct prevention strategies.

- The setting can change the most important risk factors.
- A combination of risk factors can indicate higher risk.
- Home care and pediatric patients also must be assessed.

living at home will be quite different from the risk factors for a patient in a hospital setting, he says. Likewise, the risks may be different for a long-term care resident than for a short-term acute care patient, he notes.

"I think people sometimes look at the literature and compile risk factors without being careful to distinguish between the settings. It's tempting to generalize, and you can compromise the value of the data that way," he says. "One big difference between those living in the community and those in a long-term care setting, for instance, is the influence of the physical surroundings. The configuration of the room and other hazards in the area can be more influential in a long-term care setting, but they also can be controlled."

Jette also notes that there is no single risk factor that determines a patient's risk for falling. Even the most significant risks, such as the use of multiple psychotropic medications, may not be as important on their own as the presence of multiple risk factors, he says.

"There is no one magic bullet you can look at," Jette says. "It's really the number of them that come together. The literature shows that multiple risk factors greatly increase the possibility of falls, even if any one of those risk factors is not so big on its own."

Fear of falling also is often overlooked as a risk factor, Jette says. When people become fearful of falling, they may become overcautious and cut back on their physical activity, which actually can increase their risk of falling when they do move.

Don't forget home care

Fall management programs can extend to home care as well, says **Bridget Gallagher**, senior vice president of community services at Jewish Home Lifecare in New York. All patients receiving home care services undergo an assessment for fall risks, she says. The goal is to spot patients at risk and implement strategies to prevent falls, Gallagher says, so upfront assessment is crucial. The assessment also is repeated annually, regardless of previous scores.

Using an objective assessment can help identify patients who are reluctant to admit to past falls or a fear of falling, she says. Many elderly patients are hesitant to reveal such information, because they fear it will mean they can no longer live at home, Gallagher says. Patients who score high enough on the assessment are referred to the rehabilitation department, which sends someone to the home to evaluate the environmental risks.

"Those risks can include things like an upraised donut seat on the toilet, dim lighting, loose rugs," she says. "Once we identify those risks, we can offer ways to reduce that hazard."

Gallagher also points out that patients who have already fallen often become so afraid of falling again that they increase their risk through immobilization, so any patient who has fallen before is automatically referred to the fall management program when being discharged to home care.

"The clinician has to follow our protocol, so it is not up to their subjective judgment whether the patient needs fall management or not," Gallagher says. "We sometimes have clients who refuse, but in those cases we talk to them about why it is important, and in the majority of cases, we are able to have rehab go into their homes."

A social work referral often is necessary, because any necessary home modification can create tension between the client and the fall management specialist, Gallagher says. The social worker can help mollify the client and may be able to procure public funding for some of the necessary changes.

"It can be a delicate thing to go into someone's home and tell them to change it," Gallagher says. "We have to say, 'Yes, this throw rug is lovely and I'm sure you enjoy seeing it every day, but if it winds up killing you, it's not worth having on the floor.'"

Query parents about kids' risks

Pediatric patients also need attention when you are reducing falls, says **Eileen Mahler**, RNC, MSN, assistant director of nursing for women and children's services at South Nassau Communities Hospital in Oceanside, NY. Children's hospitals are familiar with the risk of children falling, but it can

SOURCES

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be easy for other facilities to focus so much on elderly patients that they overlook the risk with the youngest patients.

For instance, the admissions process for young children should include asking parents about the child's walking ability and what type of bed he or she sleeps in at home. Many pediatric units put young children in cribs for added safety, but a child who is mobile and not used to sleeping in a crib may attempt to crawl out, which could result in falls.

The usual environmental safeguards, such as avoiding slippery rugs, apply to children as well, but the pediatric environment must be even more secure. Medical equipment, for instance, can be tempting for children, so staff should avoid leaving items in areas that encourage the child to climb or reach for them.

"It's similar in the way you have to assess patients for their risks, but the risk factors are going to be different in some ways with children," she says. "It may be things like whether this child is a runner or a climber, or whether he's still learning to walk. These are things you have to ask the parents up front." ■

2009 safety goals address site marking

The Joint Commission's 2009 National Patient Safety Goals introduce some significant changes for hospitals related to multiple drug-resistant organisms (MDROs) and more stringent standards for how operative sites should be marked to avoid wrong-site errors.

Seen by many health care providers as the gold standard for policies and procedures, the 2009 National Patient Safety Goals promote specific improvements in patient safety by providing proven solutions to persistent patient safety problems. The goals apply to the more than 15,000 Joint Commission-accredited and -certified health care organizations and programs.

Changes for 2009

Much of the patient safety goals are carried over from 2008, but there are some noteworthy additions and changes for 2009. Major changes for 2009 include three new hospital and critical access hospital requirements related to preventing deadly health care-associated infections due to MDROs, central line-associated bloodstream infections, and surgical-site infections. Those additions build on an existing National Patient Safety Goal to reduce the risk of health care-associated infections, and recognize that patients continue to acquire preventable infections at an alarming rate within hospitals.

Announcing the 2009 goals, The Joint Commission president **Mark R. Chassin**, MD, MPP, MPH, said the new requirements related to central line-associated bloodstream infections also will take effect for ambulatory care facilities and office-based surgery practices, home care organizations, and long-term care organizations. In addition, prevention of surgical-site infections will be a new requirement for ambulatory care facilities and office-based surgery practices. These new infection-related requirements have a one-year phase-in period that includes defined milestones, with full implementation expected by Jan. 1, 2010.

A revision of the requirements for the existing medication reconciliation goal is based on feedback obtained from a Medication Reconciliation Summit convened in late 2007 and is included in the 2009 update, Chassin says. Other changes to the National Patient Safety Goals include a requirement to eliminate transfusion errors related to patient misidentification in hospitals, critical access hospitals, ambulatory care facilities, and office-based surgery practices. New requirements for several programs focus on engaging patients in their care regarding infection control, prevention of surgical adverse events, and the patient identification process.

The requirements associated with the existing

Universal Protocol, initiated to help prevent errors in surgical and noninvasive surgical procedures, also were improved for 2009. These changes, which address the topics of procedure verification, marking the procedure site, and conducting a "timeout" immediately prior to starting procedures, were based on feedback received at the Wrong Site Surgery Summit in 2007. The Universal Protocol is used by hospitals, critical access hospitals, disease-specific care organizations, ambulatory care facilities, and office-based surgery practices.

New protocols established

The Universal Protocol was changed to address some details about exactly how certain procedures are to be carried out. For instance, site-marking protocol for invasive procedures now requires that markings be performed by the licensed practitioner who will be involved directly in the procedure and who will be present at the time the procedure is performed. Such practitioners must mark surgical sites, preferably with their initials. That means it would no longer be compliant with the National Patient Safety Goals for a pre-op nurse, for example, to mark the site instead of the physician who will operate.

The goals also include additional requirements in medication reconciliation processes. Other changes include a requirement to eliminate transfusion errors related to patient misidentification in hospitals, critical access hospitals, ambulatory care facilities, and office-based surgery practices. New requirements for several programs focus on engaging patients in their care regarding infection control, prevention of surgical adverse events, and the patient identification process.

For the complete 2009 Patient Safety Goals, including details on what has changed from the 2008 goals, go to The Joint Commission's web site at www.jointcommission.org. Choose "Patient Safety" at the top of the home page and then "National Patient Safety Goals." ■

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. ■

$20 million verdict after liposuction death

A Pennsylvania jury has awarded $20 million to the family of an 18-year-old Newtown Square, PA, woman who died after a liposuction procedure.

The verdict came seven years ago to the day after Amy Fledderman had the cosmetic surgery that led to her death, according to a report by NBC-10 in Philadelphia.

The jury heard five weeks of testimony about Fledderman's death, who was an honors student at Pennsylvaina State University. In May 2001, she sought liposuction on her legs, stomach, and under her chin from King of Prussia, PA, plastic surgeon Richard Glunk, MD.

According to information presented by the plaintiff's attorney during the trial, Glunk's ambulatory surgical center was not licensed by the state for that type of liposuction procedure. During the surgery, Glunk hit a blood vessel but waited for 2½ hours to call for an ambulance, according to court records. Two days after surgery, Fledderman died of a fat embolism.

The defendant stated publicly that he will appeal and claimed there were many inaccuracies presented in court. In particular, the defendant said, he did not believe he needed a state license for his facility. ■

COMING IN FUTURE MONTHS

- RRTs cut peds codes
- Unlabeled syringes pose threat
- New genetic discrimination law
- Preventable birth injuries cut to zero

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.

5. According to Amit Gavish, which of the following is true?
A. EDs are not all the same, and the type of potential violence will vary.
B. EDs essentially are the same when it comes to the risk for violence.
C. There is no way to effectively improve security in an ED.
D. Added security cameras are the best way to improve ED security.

6. What should risk managers tell former employees about a legal case involving their past care for a patient?
A. Notify them of the plaintiff's potential legal action and remind them not to talk directly with the plaintiff or plaintiff's counsel.
B. Do not notify them of the legal action but ask if they have been contacted by an attorney.
C. Notify them of the plaintiff's potential legal action and tell them to get their own attorney.
D. Notify them of the plaintiff's potential legal action and tell them to contact the plaintiff's attorney and offer any information that might be helpful.

7. According to Dick Wiles, JD, what is true of medical records involved in litigation?
A. You can always safely assume that you have the only copy of the chart.
B. You never know when someone else has a copy of that original chart. You may think you know, but you don't.
C. If the primary clinicians involved say they did not copy the chart, you can safely assume that no one else did either.
D. It is not important whether the chart has been copied or altered.

8. What does Alan M. Jette, PT, PhD, FAPTA, say about fear of falling as a risk factor for patient falls?
A. Fear of falling is often overlooked as a risk factor.
B. Fear of falling is often overstated as a risk factor.
C. Fear of falling has no impact on a patient's risk of falling.
D. Fear of falling is extremely rare and only affects patients with dementia.

Answers: 5. A; 6. A; 7. B; 8. A.

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

Failure to diagnose fatal sepsis leads to $1.835 million verdict in New York

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News: A middle-aged man was taken to the hospital complaining of pain in his lower back and abdomen. The man was given pain medication and a muscle relaxant and discharged. After his pain persisted, the man went to another hospital, where he was given anti-inflammatory medications and discharged. A few days later, the man was taken by ambulance back to the first hospital, where he suffered cardiac arrest and died. A post-mortem work-up determined that the man had been suffering from septic shock. The man's estate sued the first hospital, and a jury eventually returned a verdict of $1.835 million in favor of the plaintiff.

Background: A 52-year-old heavy equipment operator was rushed to the hospital by ambulance after suffering severe pain in the right side of his lower back, radiating to his right lower abdomen. At the hospital, the man informed the triage nurse that he had a medical history of kidney infection and muscle spasms, and he provided his history to a second nurse about 30 minutes later.

An ED physician met with the patient and learned that he had a past history of hypertension. The physician then performed a back examination and noted that the "straight leg-raising" test was positive and that the man's pain was radiating down his left leg. The physician diagnosed the patient as suffering from lumbago with sciatica, and he prescribed pain medication and a muscle relaxant.

Five hours after getting the medication, the man continued to complain of pain and was medicated again. He was eventually discharged with two prescriptions and told to see his regular physician in two days or return to the hospital if he felt worse.

Later that day, the man returned to the ED, still complaining of back pain. He waited for some time after signing in, but when he was called about two hours later, he did not answer.

Two days later, the man went to another hospital for treatment, complaining that his severe back pain was worsening and that his joints were swelling. Blood work was ordered and completed, which showed an elevated white blood cell count, an abnormal erythrocyte sedimentation rate, and bandemia. The man's kidney function tests also were found to be abnormal, and the blood urea nitrogen and creatinine tests were found to be elevated. The physicians at the second hospital diagnosed the patient with gout, prescribed two anti-inflammatory medications, and discharged him home.

Three days later, the man was taken back to the first hospital by ambulance. He suffered a cardiac arrest and died three hours later. Doctors performed a thorough work-up and determined that

the man had been suffering from septic shock, brought on by urosepsis, which is sepsis resulting from the decomposition of extravasated urine.

The man was survived by a common-law wife and six children, three of whom were adults and three of whom were minors and still living at home. The man's estate sued the first hospital and the ED physicians working at the first hospital for negligence, alleging that the defendants failed to diagnose and treat the decedent's kidney problem and that this failure constituted malpractice. The ED physicians could not be identified, however, and were subsequently dismissed.

The plaintiff argued that the patient was suffering kidney pathology when he first presented to the first hospital and that the treating ED physician departed from good medical practice by failing to perform any laboratory testing. The plaintiff further contended that the physician failed to note the decedent's past medical history of kidney infection and that the man's condition could have been diagnosed if a simple urine analysis test had been performed. The plaintiff pointed out, in fact, that when the second hospital did blood work, the tests showed signs of an infectious or inflammatory process, and that if the original treating hospital had ordered blood work, the man's condition might have been identified.

The plaintiff relied on testimony from an expert in emergency medicine that given the man's history of kidney pathology and presentation of low back pain, the standard of care required that a urine analysis be performed. The expert opined that based upon the lab tests that were done at the second hospital two days after the man's initial visit to the first hospital — and based upon the consult reports and lab tests performed at the first hospital after the patient died — a urine analysis would have revealed abnormalities that, if treated, would have prevented the spread of the infection, as well as the man's pain and suffering and death.

The plaintiff sought damages for the decedent's five days of conscious pain and suffering as well as for the man's loss of earning and the estate's own loss of parental guidance and support.

The first hospital defended the lawsuit by arguing that the patient's history of kidney infection was too remote to be considered and that the ED physician's diagnosis of lumbago with sciatica was reasonable. The hospital also contended that there was no infection present when the man was seen on that first emergency admission. The first hospital also brought the second hospital into the case as a defendant, arguing that the second hospital was the one that departed from good practice by discharging the man while he was suffering an infection. Nevertheless, the second hospital was subsequently dismissed from the case based on the lack of expert testimony from the first hospital's experts as to there being any departures from the standard of care at the second hospital and as to there being any link between the treatment at the second hospital and the decedent's death.

After a trial, the jury found that the first hospital's staff departed from accepted standards of care and awarded the plaintiff $1.835 million in damages. Of the $750,000 awarded to the decedent's three minor children, the 6-year-old received $300,000, the 10-year-old received $250,000, and the 12-year-old received $200,000.

What this means to you: "The general public thinks of their local hospital's ED as the 'gold standard' in terms of urgent care," says **Lynn Rosenblatt**, CRRN, LHRN, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. "While the emergency room has long been the primary initial point of care destination for traumatic injuries, such is not always the case for medical emergencies," she adds. Many community-based hospitals actually operate trauma centers under contract with larger tertiary institutions such as teaching hospitals that oversee specially trained physicians and support staff. In such situations, the so-called trauma center actually is a subunit of the overall ED. Within the trauma center, the care is specific to traumatic injury and the urgent life-sustaining diagnostics and treatment such patients require.

Over the past two decades, hospitals have promoted the "other functions" that the ED can provide, such as urgent medical management for acute illness. Cardiac and Stroke Centers of Excellence designation is example of the application of the trauma approach to specific disease processes. In this manner, the ED is the point of entry for admission to the hospital for those patients who are in need of urgent care and cannot wait to see their primary care physician. In other cases, the ED is used as a substitute for a primary care visit, but in either case, the ED team of physicians and nurses needs to be just as astute as those who are responsible for trauma management.

The expectation would be that urgent medical

cases get the same intensity of services that a trauma emergency would require. The ED staff would, by necessity, require broad knowledge of internal medicine specific to a wide variable of signs and symptoms. In that case, that premise seems to be nearly nonexistent. Not only did the team not fully investigate the patient's vague complaint of "severe back pain," but it failed to consider the possible ramifications of that complaint in terms of an alternate diagnosis.

When a patient goes to his or her regular primary care provider, there is a safety net in the knowledge that the provider has the patient's past history on file or as an alternative has the time to develop a history and to fully investigate the current complaint in that light. The office visit allows for diagnosis and treatment "over time." Such is not the case when the patient presents to the ED.

Had the second hospital looked further at the lab values and proceeded with additional testing, one would hope that a diagnosis of systemic infection would have at least been raised and treated with appropriate antibiotics, which may have prevented this man's death.

This patient's primary complaint was back pain with radiating abdominal pain, which could be symptomatic of many internal problems. Such things as kidney infections and renal failure, appendicitis, urinary tract infection, gall bladder disease, musculoskeletal injury, and many other similar variables are certainly possible. Even with the patient's reported history of kidney infection, nothing other than muscular injury was apparently considered.

The categorization of a patient's complaint is extremely important as to how the case is managed in the initial evaluation stage. Just as a patient presents to his physician's office with a stated complaint and the physician considers a wide range of diagnostic approaches to rule out a variety of possibilities, the same holds true in the ED setting. In this case, the nurses taking the patient's history should have been alerted to the possibility of something other than a musculoskeletal problem and reported and documented the various other possibilities based on a more extensive questioning of the patient or family.

The narrative does not provide insight into what types of testing was accomplished at the first hospital, but it appears that there was no baseline blood drawn to rule out possible other acute internal medical problems. The physician either did not know or chose to disregard the patient's past history of kidney infection. Instead, he focused on the patient's occupation as a laborer and the closely related possibility of back strain. The test he did use also is very subjective and does not go beyond the functional issues, which in this case had a totally different etiology.

The man was given several doses of pain medication, which was effective in controlling his pain, but had no effect on the problem itself, as only the pain was addressed by the physician — not the etiology. Without a doubt, this physician violated the standard of care as he did not fully investigate the full range of possibilities of the actual cause of the patient's symptoms. He considered the complaint of back pain as the chief issue as opposed to viewing it as a symptom of something else.

The second hospital actually had an advantage, as two days had passed and the patient's symptoms were now evolving into a more defined clinical picture. While this hospital did secure appropriate lab work, it failed to investigate the full range of possibilities that the abnormal values raised. Instead, the second physician diagnosed the patient with gout and treated based on that assumption.

It is unknown whether the patient had a previous history of gout or whether there were any symptoms that would have been conclusive for that diagnosis. Obviously, the kidney function tests and elevated lab values were overlooked in terms of alternate possibilities. In this respect, the second hospital was just as liable in breaching the standard of care as the first, and was incredibly lucky that the expert testimony did not focus on this point as a matter of contributory negligence.

Had the second hospital looked further at the lab values and proceeded with additional testing, one would hope that a diagnosis of systemic infection would have at least been raised and treated with appropriate antibiotics, which may have prevented this man's death. The failure of the expert for the first hospital to link the second was a major tactical error in the defense of the case. While the second hospital would not have absorbed the full burden for the claim, any finding against the second facility would have reduced the final judgment against the first.

This was a preventable death. Both facilities failed in their diagnosis of a relatively common

ailment, which, if left untreated, can have dire consequences. As an urgent care provider, it is important to consider all possibilities, as there is neither the luxury of accurate past history or time to gradually rule out possible alternatives. Hospitals operating their EDs as urgent care response centers need to consider the educational scope of the staff, the informational accuracy provided by patients and families, and the need to assure that every possible consideration has not been overlooked.

Basic clinical decision making can go a long way to assist physicians in evaluating the most basic complaint of pain. If a lab panel had been initiated at the first facility, which would have most likely included blood work and a urinary specimen given the patient's history and complaint, the diagnosis would in all probability have been more accurate and the patient may have been spared. At the second hospital, the basic approach was undertaken, but it was not taken to the next level of inquiry — based on the results — to the next level of decision making.

Another problem was that the first hospital appeared greatly understaffed given the wait time when the patient returned that first day. Obviously, he became frustrated and left without additional evaluation, which could have possibly averted his death. Another indication of staffing inefficiency was the failure of the triage team to obtain a pertinent history and then convey that information to the physician. Clearly the patient informed two different nurses that he had a history of kidney infections in the past, but it is not clear as to how that information was documented and shared with the physician.

It would appear that any information the physician had was obtained directly from the patient at the time of the physical exam. The patient admitted to hypertension, but there was no indication that he told the physician about the past kidney infections. Had the physician consulted the triage team's documentation, if there was any, then he should have questioned the patient further.

The whole episode speaks to harried staff and an indifference to the demands of their individual jobs, as well as a failure to respond as a team. Without a doubt, each encounter lacked the detail and intensity that the ED setting commands. The second hospital was let off the hook, and the first paid a price for what is best described as incompetence.

Reference

• Case No. 24002/03, Kings County (NY) Supreme Court. ■

Brain-damaged child: $30 million malpractice verdict

After an extraordinary 14 years of litigation, a Broward County, FL, jury recently entered a $30 million verdict against a hospital and an obstetrician for damages arising out of the birth of a child with brain damage. The 36-year-old mother began seeing the obstetrician in October 1990. She had previously had a cesarean for her first child after she was in labor for 12 hours. The obstetrician recommended a vaginal birth for the second child, and the mother agreed. She presented at a Florida hospital for the birth of the second child in May 1991. She was in labor for nine hours before doctors performed a cesarean. The child was born oxygen-deprived and brain-damaged. Two years later, the son was diagnosed with cerebral palsy and mental retardation.

The parents sued on behalf of the child and themselves, and the case originally went to trial in 1998. The jury found for the defense. However, the Florida Supreme Court reversed the jury verdict, finding that the trial court had improperly excluded expert testimony from a neuropsychologist on brain damage and brain development. In 2003, the case was remanded for a second trial. The plaintiffs argued at trial that the defendants should have performed the cesarean earlier because of fetal heart monitoring strips, which showed that the child was not receiving enough blood and oxygen to his brain. They further argued that it should have been obvious to the defendants that the child could not be born through the birth canal. The defense denied that the fetal monitoring indicated any problems, and further argued that the child's brain injuries developed earlier in the pregnancy — not during the birth.

The trial lasted five weeks. After deliberating for three days, the jury awarded a total of $30 million to the child and both parents, finding the hospital 85% liable and the obstetrician 15% liable. The award included a total of $24.5 million for the child, including $8 million for medical expenses and lost earnings and $16.5 million for pain and suffering. The jury also awarded the parents a total of $5.5 million for loss of comfort. It was the largest medical malpractice verdict in the history of Broward County.

Reference

• *Tomlian v. Grenitz*, Case No. 94-08121, Broward (FL) County. ■