



Healthcare Risk Management™



Rapid response teams prove value for safety of your patients

Latest research suggests need for more implementation

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The evidence proving the value of rapid response teams (RRTs) continues to accumulate, with the latest research suggesting that this strategy can improve patient safety in a variety of clinical settings. Proponents of RRTs say risk managers may be missing an opportunity to improve outcomes if you are not using RRTs or formulating a plan to institute them in your own facilities.

Paul Sharek, MD, chief clinical patient safety officer at Lucile Packard Children’s Hospital in Stanford, CA, says the benefits from RRTs have been confirmed by the experience of many hospitals that were on the leading edge of this movement. Sharek and his colleagues at the hospital and the Stanford (CA) University School of Medicine recently published the latest research that confirms the value of RRTs.¹ In their case, the report showed significant benefits in a pediatric setting, complementing previous work that showed RRTs can be effective in adult populations.

The finding is the first to reveal lower death rates and cardiopulmonary arrest rates resulting from rapid response teams in a pediatric setting and could spark similar programs in children’s hospitals around the country.

EXECUTIVE SUMMARY

New research indicates that rapid response teams (RRTs) can improve patient safety in a variety of settings. Some advocates say risk managers should consider establishing RRTs in most health care institutions.

- RRTs can significantly reduce adverse events and preventable deaths.
- The staff education that comes with an RRT program does not account for all of the benefits.
- RRT members will be able to spend more time with patients if they have not been taken away from other patient care to respond.

Financial Disclosure: Author Greg Freeman, Associate Publisher Coles McKagen, Senior Managing Editor Joy Dickinson, Nurse Planner Maureen Archambault, Guest Columnist Leila Narvid, and *Legal Review & Commentary’s* authors Blake Delaney and Jon T. Gatto report no consultant, stockholder, speaker’s bureau, research, or other financial relationships with companies having ties to this field of study.

JANUARY 2008

VOL. 30, NO. 1 • (pages 1-12)

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Sharek, who also is an assistant professor of pediatrics at the medical school, estimated that 33 lives — equivalent to an 18% reduction in the monthly mortality rate — were saved during the 19-month study period by RRTs, trained to provide supportive care before a child's clinical condition becomes life-threatening.

"We previously had evidence that RRTs could be effective in an adult population," he says. "Now with this report, we have evidence that they should be implemented in hospitals that take care of children. The benefits are very clear."

So does this mean every hospital should have an RRT now? Sharek says the evidence suggests

the answer is yes, at least in terms of the potential benefits. The practicalities of implementing them, such as the costs involved with extra staffing, still have to be considered.

Good results in pediatric setting

Packard Children's hospital first considered establishing a rapid response team in December 2004 when the Institute for Healthcare Improvement recommended RRTs for adult U.S. patients as part of its 100,000 Lives Campaign. At the time, rapid response teams had been shown to be effective in adult care settings.

Packard Children's implemented the RRT program in 2005 to reduce the frequency of emergency codes occurring in children who are hospitalized but outside the intensive care unit. Although the most unstable children are kept in the intensive care unit, many young patients in non-ICU settings are very ill and can worsen rapidly.

"Once a child codes, the odds of long-term survival are pretty small," Sharek says. "However, there's often a period of about six to eight hours when a child who might later code begins to show subtle signs of distress. If we can intervene early in this process, the child is far more likely to improve than if we simply monitor and maintain the same approach to treatment."

Rapid response teams, made up of existing staff members, consist of a pediatric intensive care physician, an intensive care nurse, an intensive care respiratory therapist and a nursing supervisor. The teams, which are present at the hospital 24 hours a day, seven days a week, arrive at a child's bedside within five minutes after a summons to assess his or her condition. Interventions in addition to the medical management already under way include providing additional respiratory support, administering additional or different intravenous fluids or transferring the child to the intensive care unit for ongoing monitoring and more intensive therapy.

Nurses empowered to act

The researchers found that although many RRT calls were triggered by measurable changes in a patient's status — a change in breathing pattern, blood oxygen content or blood pressure — some occurred simply because the child's medical caretaker or parent felt that something just wasn't right.

"We empower the nursing staff to act on their

Healthcare Risk Management® (ISSN 1081-6534), including **HRM Legal Review & Commentary**™, is published monthly by AHC Media, LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Healthcare Risk Management**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), \$495. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, \$545. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues,** when available, are \$87 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

Healthcare Risk Management® is intended for risk managers, health system administrators, and health care legal counsel.

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Editorial Questions

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

expertise by calling for RRT involvement when they are concerned about a child's worsening clinical situation," Sharek says.

Aggressively empowering, and then supporting, the nursing staff may be one reason the RRT effort was so successful at Packard Children's, Sharek says. The researchers hypothesize that nurses at Packard Children's involved the RRT earlier in the time course of the child's deterioration than those at other pediatric institutions that have recently implemented RRTs. The fact that Packard Children's specializes in highly complex cases, which can result in a rapidly changing clinical status, may be another reason the RRT has been particularly successful at Packard Children's.

"The average level of illness at Packard Children's is substantially higher than the vast majority of other children's hospitals in North America," Sharek says. "Although the average child on our medical or surgical hospital units may not require the high nurse-to-patient ratio of the intensive care unit, he or she is still frequently quite ill."

The use of the RRT program at Packard Children's did not require any additional staffing or financial resources. The study authors added, however, that cost-effectiveness of the RRT program should be studied in more depth. (See p. 4 for case studies showing the benefits of RRTs at other hospitals.)

Don't stretch RRT members too thin

The way you structure an RRT can determine its effectiveness, notes **Cynthia Musetti, RN, CPHQ**, system director of quality management administration at New York Hospital Queens, which has seen good results from its own RRT program. The RRT was implemented in February 2006, first on two units and then adding additional units every couple of months until the whole hospital was covered by February 2007. As the RRT program grew, Musetti and **Elyse Goldberg, RN**, the hospital's RRT coordinator, realized that nurses assigned to the RRT were being pulled in too many directions because they had regular patient care duties that had to be put on hold when the RRT was called.

"So we went to administration and we asked for help. We were given two dedicated nurses, new staff positions, that are dedicated solely to the RRT," Musetti says. "That made a real difference in keeping the RRT effective without taking away from other patient care."

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The dedicated staff can stay with the patient much longer than nurses who must return to their regular patients soon, Goldberg says. The average time spent with patients by RRT nurses at New York Hospital Queens is about 75 minutes, which Goldberg says is at least three times longer than the average time spent when nurses must return to other patients.

RRT calls now average about 65 a month, she reports. The dedicated RRT nurses stay busy between calls by rounding on units to see if nurses need any special attention for patients and by providing ongoing education about assessment and critical care skills, she says.

The RRT members also use the surgery department's simulation lab to run RRT drills in which the team responds as if on a real call, with the response videotaped and critiqued afterward.

Go with your gut

Sharek agrees that exactly how RRTs are used can have a big impact on how effective they are. For instance, he says gut feelings can save lives. Deploying the hospital's RRTs proactively at the first inkling of trouble in hospitalized children, rather than taking the standard course of cautiously watching and waiting, can significantly reduce death rates, Sharek and his colleagues found.

Even in the hospital, sick children can deteriorate so quickly," Sharek says. "They don't have the energy reserves or muscle mass that most adult patients have."

Sharek notes that the researchers considered whether the additional staff education that came with implementing the RRT program could explain

the improvement in patient safety. As part of the program, clinical staff received training on how to spot a patient in decline, when to call for help from the RRT, and related issues.

“The literature is littered with studies showing that education alone doesn’t result in this kind of improvement,” he says. “Without the actual structure of having a team to call, we don’t believe the education is enough to make sure the deterioration phase is aborted.”

Reference

1. Sharek PJ, Parast LM, Leong K, et al. Effect of a rapid response team on hospital-wide mortality and code rates outside the ICU in a children’s hospital. *JAMA* 2007; 298:2,267-2,274. ■

There are many examples of RRTs improving safety

These are some examples of hospitals that have seen improvements in patient safety and outcomes from the use of rapid response teams (RRTs):

- Sutter Solano Medical Center in Vallejo, CA, implemented an RRT program on July 1, 2005, in which a hospitalist is the first responder, says **Susan Waters**, MD, medical director of the hospital medicine program. The team’s purpose is to provide immediate response required for a deterioration in status of patients who are not in the emergency department (ED) or intensive care unit (ICU). The hospitalist assumes responsibility for the situation and directs all personnel on the team. If the patient is transferred to the ICU, the hospitalist reports the patient’s status back to the staff member who activated the RRT. It is important to note that RRT members always defer to the attending physician when applicable, Waters says. Another important aspect of the program is that all Code Blues are reviewed by the Code Blue Committee to determine whether the RRT could have averted the code. During the first year of using the RRT, the number of Code Blue calls outside the ICU/ED declined 34%.

- VHA member hospitals that are using rapid response teams are rescuing patients earlier and faster, says **Veronica Hunt**, a spokeswoman for VHA in Chicago. In cases recently studied by VHA, RRTs helped hospital staff detect and treat patients before they experienced potentially fatal

SOURCES

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cardiac arrests. In 99 out of 150 cardiac arrest cases included in the unpublished study of RRTs in Alabama and Florida VHA facilities, the patients showed signs of deterioration during the six-hour period before the arrest, signs that were detected and acted upon by the rapid response teams. Since 2005, VHA has helped 800 hospitals nationwide implement rapid response teams. More than 75% of hospitals studied saw a decrease in mortality rates in one year, Hunt says. Hospitals saw a lower number of codes outside of the intensive care unit (ICU) and higher percentages of patients that coded or suffered a life-threatening incident and survived to discharge.

For instance, St. Vincent Hospital in Santa Fe, NM, has improved code blue survival rates as a result of implementing a RRT. Without a team, the hospital saw an initial survival rate of 64%. With a team in place, the survival rate increased to 100% during the study period. In addition, if a patient stops breathing for a second time, within 36 hours of their first event or episode, the survival rate is 94%. Without a team in place, the second episode usually resulted in a survival rate of 43%.

Hunt also cites Parkwest Medical Center in Knoxville, TN, which launched its program in January 2006, and in one year, it achieved a 40% reduction for in-patient, noncritical care codes. In addition, the hospital reduced the number of days that patients spend in the critical care unit and estimates it has avoided \$520,000 in costs.

- **Ali Farhat**, MD, chief of the hospitalist division at William Beaumont Hospital-Royal Oak in Michigan, says an RRT that began as a small project on a single unit in 2005 now is a leading hospitalwide patient safety operation. The team has provided more than 4,500 patient interventions

since 2005, and has contributed to saving many lives. Despite rising patient acuity, the hospital's code rates have declined by about 20% since 2005, Farhat says. The RRT is made up of a physician extender (physician assistant or nurse practitioner), ICU nurse, and a respiratory therapist. While any employee can initiate the RRT, the nurses providing care on the floors are primarily the ones who identify even the slightest changes in their patients' conditions and initiate the call to the RRT. The hospital uses the slogan "When in doubt, give a shout!" to encourage calling the RRT. The slogan is posted in patient care areas. ■

Shoulder dystocia drills can improve response

Shoulder dystocia drills should become a routine part of risk reduction in any hospital delivering babies, according to experts who say the drills can greatly improve how clinicians respond to this emergency.

The American College of Obstetricians and Gynecologists (ACOG) in Washington, DC, and other resources generally report the incidence of shoulder dystocia to be between 0.5% and 1.5%, but the true incidence of shoulder dystocia is unclear because the rate is dependent upon how this condition is defined and how accurately it is reported. Many obstetricians may be reluctant to document shoulder dystocia for fear that this will be a red flag attracting a malpractice suit if it turns out later that the baby has suffered an injury. Most sources estimate that about 20% of shoulder dystocia cases result in injury, such as brachial plexus

impairments and Erb's palsy, and the resulting malpractice cases often result in multimillion-dollar payouts. (Editor's note: For more information about shoulder dystocia and the consequences, see www.shoulderdystociainfo.com.)

A major risk management challenge

The relatively infrequent occurrence of shoulder dystocia and the potentially terrible consequences for all involved create a major risk management challenge, says **Sean Blackwell**, MD, associate professor of maternal fetal medicine at the University of Texas Health Science Center at Houston. When obstetrical teams don't see the condition often, they don't get much chance to practice a response, he says. Yet they must be able to respond quickly and correctly to avoid disaster. That is why shoulder dystocia drills should be as common as infant abduction drills and disaster drills, he says.

Unfortunately, they're not. Even at Blackwell's own hospital, shoulder dystocia drills are not performed regularly. A primary hurdle usually involves getting physicians to come to the hospital and participate, he says.

"Even for hospitals with a high volume of deliveries, most hospitals don't do the drills on a formal basis," Blackwell says. "There will be all sorts of informal training where physicians instruct residents and the obstetrics teams discuss it when they have a chance, but most do not do formal drills with instruction, observation, and a means to measure the performance."

Drills improve communication

Blackwell notes that there is not much evidence in the medical literature to prove that shoulder dystocia drills will reduce adverse outcomes. But he suggests the evidence is lacking simply because too few hospitals have implemented regular drills and even fewer have studied the results. The idea of drilling to practice a critical emergency response, however, makes sense no matter what the particular emergency is, he says. Hospitals more often perform drills to rehearse responses to emergency cesarean drills and hemorrhage.

The purpose of a shoulder dystocia drill is not necessarily to teach clinicians how to care for the condition, but rather the drill is designed to help them improve communication and coordinate their response, Blackwell says.

"One of the issues that comes up in medical/

EXECUTIVE SUMMARY

Shoulder dystocia drills can improve the response of obstetrical teams when faced with this potentially devastating complication. The improved outcomes can substantially reduce potential liability.

- Drills help clinicians improve communication skills in an emergency.
- Most hospitals do not conduct shoulder dystocia drills.
- A record of shoulder dystocia drills can be effective in defending a malpractice case.

SOURCES

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legal events is often communication — who said what, when they said it, and whether everyone communicated clearly and effectively,” he says. “This is what the shoulder dystocia drill can improve. The team needs to know not just what to do in a didactic sense but how to communicate and work with the other team members.”

Blackwell also points out that shoulder dystocia drills can be a real asset for the defense when litigating an injury resulting from dystocia.

“It’s a question that comes up very often in malpractice cases: Have you ever done a shoulder dystocia drill? How recently? Have you ever seen the ACOG video on shoulder dystocia?” he says. “Hospitals certainly have a self-interest in documenting the efforts to provide continuing training in this skill, and risk managers can champion this cause in the hospital just as they are doing for fetal heart rate monitoring.”

Underwriter endorses dystocia drills

The value of shoulder dystocia drills should not be underestimated, says **Susan R. Chmielecki**, APRN, FASHRM, JD, vice president, Risk Management and Client Services, Darwin Professional Underwriters in Farmington, CT. Her company recently introduced a new risk reduction program for obstetrical departments and policyholders receive a premium reduction for completing the educational modules. One element of the education involves the importance of shoulder dystocia drills.

“We developed these resources with an eye toward best practices and common issues,” she says. “We determined that shoulder dystocia drills represent an excellent opportunity to

improve patient safety and reduce the potential liability from this event.”

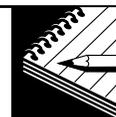
Use mannequins, simulators

A good shoulder dystocia drill should involve the use of medical mannequins and patient simulators that allow the obstetrics team to physically go through the different maneuvers necessary to alleviate dystocia, Chmielecki says.

“The purpose of the drill is to give the obstetrics team some experience, both for the individual and as they work as a team, in this emergency situation that they will not encounter with great frequency,” she says. “The risk manager is an ideal position to understand the potential consequences of not being able to respond effectively, and to convey the need for formal drills.”

(Editor’s note: Blackwell recommends a DVD on how to conduct shoulder dystocia drills that is available from ACOG. The ACOG DVD on shoulder dystocia drills is available at www.acog.org/bookstore/DVDs_Obstetrics_C70.cfm. The price is \$75 for nonmembers and \$49 for ACOG members.) ■

GUEST COLUMN



Feds focus on health care employers’ ADA compliance

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The Equal Employment Opportunity Commission (EEOC) has issued interpretive guidelines to help health care employers understand their obligations under the Americans with Disabilities Act (ADA), and the main message is that hospitals and other health care providers must proceed carefully when dealing with disabled employees.

Since the EEOC issued the guidelines, “Questions and Answers about Health Care Workers and the Americans with Disabilities Act” in

EXECUTIVE SUMMARY

Interpretive guidelines from the Equal Employment Opportunity Commission (EEOC) indicate that health care employers face substantial liability risks from the Americans with Disabilities Act (ADA). The EEOC recognizes that health care workers face unique physical challenges on the job.

- Health care workers are nearly twice as likely to be injured in the workplace as other workers.
- Employers may have to bear the costs of a reasonable accommodation.
- The EEOC urges health care employers to be judicious when assessing a disabled worker's potential threat to patient safety.

February 2007, risk managers and attorneys have been trying to understand its lessons. (The document can be found online at www.eeoc.gov/facts/health_care_workers.html.) One thing is clear: These interpretative guidelines and commentary reflect the EEOC's recognition that health care employees are uniquely susceptible to medical conditions and that health care employers must be particularly careful in handling disabled employees. Using examples from actual lawsuits, the EEOC analyzes key legal issues under the ADA as they apply to the health care sector. Risk managers should review the examples provided by the EEOC and its commentary, as they provide practical solutions for a variety of issues that occur in the health care employment setting on an almost daily basis.

Unique issues for health care

The health care industry is the largest industry in the U.S. economy and one with a high incidence of occupational injury. According to the EEOC, health care workers are nearly twice as likely to be injured in the workplace as in any other industry. The EEOC's fact sheet suggests increased scrutiny for health care employers with regard to ADA compliance. The EEOC will be paying particular attention to particular ADA topics in the years to come, according to the fact sheet, and reasonable accommodation is at the top of the list.

The EEOC points out that an employer does not need to provide reasonable accommodation unless asked. However, if a job applicant or employee does ask for an accommodation, it can

be an informal request, either written or oral, and it need not use the term "reasonable accommodation" to invoke protection under the ADA. Once an applicant or employee asks for accommodation, the employer is obligated to engage in an "interactive process" to elicit suggestions and discussion about how to best accommodate that employee.

For example, if a nurse has a lifting restriction, according to the EEOC, it may be a reasonable accommodation for a hospital to purchase a lifting device to allow the nurse to lift patients. In this example, the device would cost approximately \$1,500 and would require training to ensure it is used properly. The EEOC states that the cost of the device and training would *not* pose an undue hardship to the hospital.

The EEOC warns that health care employers should not rely only upon their own experiences, knowledge, and assumptions in determining whether to grant or deny an accommodation. They must request and assess medical documentation from the employee's own health care provider if the disability or need for accommodation is not obvious.

Careful with required medical examinations

The EEOC fact sheet suggests strong restrictions on when a health care employee may be required by her employer to undergo a "fitness for duty" medical examination. The EEOC provides the example of a diabetic anesthesiologist who uses an insulin pump and who has never exhibited performance problems at work. Despite the concern over whether he can perform lengthy surgeries due to a possible medical emergency, the EEOC states that requiring a "fitness for duty" examination would violate the ADA since there have been no prior incidents or problems with work performance.

Employers should take special care before requiring a fitness for duty examination to ensure that there are reasonable grounds, and that it is narrowly tailored to the particular situation. The EEOC considers a reasonable basis for belief to include such factors as evidence of current performance problems, complaints by co-workers or patients, or individualized medical information.

Threat to safety must be judged carefully

The EEOC fact sheet suggests that health care employers should not be overly zealous in

terminating employees on the basis of threat to public safety. The EEOC provides the example of a HIV-positive phlebotomist who works at a blood bank. The EEOC states that the phlebotomist does not pose a direct threat to the safety of patients and, as a result, his employer should not reassign him or terminate him on the basis of his medical condition.

Don't assume

The EEOC stresses the important of individualized assessments of a particular employee and the danger of categorically assuming that all employees with a certain type of disability are by definition ineligible for a particular job.

While the EEOC's fact sheet does not have force of law, health care employers should nonetheless assume that the EEOC will rely on its guidelines in its ADA enforcement efforts. Risk managers should take this opportunity to review their policies and procedures under the ADA and determine whether they are acting consistently with the statute and the EEOC's guidelines.

Risk managers need to make sure that job descriptions, employment ads, and interview questions will pass EEOC scrutiny. Also, in analyzing future disability accommodation requests, employers in the health care industry should consider any and all possible accommodations before denying a request as unreasonable or unduly burdensome.

[Editor's note: For more information on ADA compliance in health care, contact Narvid by phone at (415) 398-7860 or by e-mail at ln@paynefears.com.] ■

Health network launches effort to improve safety

Many health care providers are considering adopting the idea of a hotline that patients and family members can call when they think their concerns are being taken lightly by their immediate caregivers, but some risk managers might wonder if the phone will be ringing off the hook with trivial complaints and misunderstandings.

That has not been the case for the Community Health Network (CHN) in Indianapolis, which recently launched a new patient safety initiative in all of its hospitals, referred to as Call FIRST

EXECUTIVE SUMMARY

An Indiana health network has launched a patient safety initiative that encourages patients and family members to call a special telephone number for help. The hotline is intended to provide immediate access to input from outside the immediate care team.

- Nurses may not embrace the idea at first.
- The health network's initial experience shows no frivolous use of the hotline.
- The telephone number is part of an overall culture of safety.

(Family Initiated Rapid Screening Team). CHN has five hospitals in Indianapolis (Community Hospitals East, North, and South, Community Hospital Anderson, and The Indiana Heart Hospital) as well as almost 70 more facilities throughout the state. The Call FIRST effort encourages patients/and or families to make a simple phone call when there is a change in the patients' condition and they feel their concerns are not being addressed.

Internal phone lines designated

A designated internal phone line at each of CHN's hospitals has been established for this program, explains **Trudy Hill**, clinical patient safety officer for CHN. The hotline is part of an overall effort to create a culture of safety at the hospitals, she says, and it is intended as a safety net if all other efforts have failed up to that point.

When patients or families use Call FIRST, a nursing supervisor or consult nurse will provide help within 15 minutes at the bedside to evaluate and stabilize the situation. The program is not intended for routine questions or concerns; rather, it is intended for serious concerns in the change of a patient's condition. If the patient or family discusses the issue with the health care team and there is confusion about the condition or treatment plan, Call FIRST also can provide assistance.

"Call FIRST is an immediate response to any serious concerns about a patient's care in any one of our hospitals," Hill says. "By calling the designated Call FIRST line at each hospital, patients and families can receive a fast response about what is happening in the care process so that it

can be addressed in a very timely fashion.”

Call FIRST signs have been posted in rooms and other patient areas to make patients and families aware of the initiative, and patients are given a brochure describing the program on admission. (See excerpts from the brochure, below right.)

Skepticism not uncommon

CHN is not the first to use a patient hotline as a safety net, but its experience is helping dispel one of the common concerns about such programs. Nurses, in particular, tend to worry that patients will use the hotline to complain unnecessarily and they will be punished as a result. For instance, the web site www.allnurses.com includes a forum discussion of the CHN Call FIRST program in which nurses express skepticism. (Editor's note: See the discussion online at [allnurses.com/forums/f195/here-call-first-program-250768-2.html](http://www.allnurses.com/forums/f195/here-call-first-program-250768-2.html).)

One nurse posted a message with worries that the hotline will be used by people who “generally complain about little things” and patients who “complain about not important things.” Another writes with concern about “how many people will abuse this, and use it when they don't really need it. At our hospital, we've already had patients push the ‘code blue’ button to get a nurse to bring him/her water . . .” That nurse also said “there are very needy people out there that forget they are in a hospital and believe they are in a resort.”

None of those problems have occurred so far, says **Eleanore Wilson**, MA, BSN, RN, vice president of nursing at Community Hospital North. “We emphasize to them this is not to be used for routine calls or just complaints,” she says.

Community Hospital North began the Call FIRST program on Sept. 1, 2007, and through the end of November 2007, the hotline was used only two times, Wilson recalls. Community Hospital East received four hotline calls in a slightly longer time period, and the other hospitals have not received any, she says.

In the first case at Community Hospital North, a patient was concerned about a gurgling sound from a chest tube and did not understand the explanation from his nurse, so he called the hotline for help. The Call FIRST member responded right away and explained that the sound was normal, which satisfied the patient and his family.

In the second case, a diabetic patient was unhappy with a change in his usual medication and called the hotline for help. A nurse manager

explained why the medication was changed and gave him more detail than his nurse initially had provided. “I think he just wanted to hear it from someone else to make sure it was right,” Wilson says. “We consider both of those cases an appropriate use of the call. We don't want patients to feel uncertain about their care, but it doesn't necessarily mean anyone at the bedside did anything wrong either.”

Wilson says the nurses at her hospital were skeptical about misuse of the Call FIRST program initially, but then they attended an education session that included the story of Josie King, an 18-month-old girl who died in January 2001 at Johns Hopkins Hospital in Baltimore due to medical errors, along with the mother's inability to get staff and physicians to listen to her concerns. That death prompted the creation of the “Condition H” (for help) hotline at the University of Pittsburgh Medical Center Shadyside in Pennsylvania and similar projects at other facilities. (For more on Condition H and the Josie King story, see *Healthcare Risk Management*, February 2006, pp. 13-19.) “When we introduced this we really stressed to the staff that this was not about second-guessing them or trying to catch them in a mistake. Sometimes the patient just needs to hear from someone outside their immediate circle of care, and this number makes that possible,” she says. “The Josie King case really drove home how a resource like this can prevent a tragedy.” ■

Brochure describes how Call First works

All patients treated in the Community Health Network's hospitals in Indiana are given a brochure that describes the Call FIRST (Family Initiated Rapid Screening Team) that serves as a safety net when patients or family members think their concerns are not being addressed. These are some excerpts from the brochure:

When is Call FIRST appropriate?

Call FIRST provides patients and their families a way to call help to the bedside. As a partner in care, we encourage you to call in the following situations:

- *If there is a change in your condition and you feel your concerns are not being addressed.*
- *If after speaking with a member of the health care team there is confusion about your condition or your treatment.*

• Call FIRST should NOT be used for routine questions or complaints by patients or families.

How do I initiate Call FIRST?

Patient and families can call the FIRST team for help at each hospital by dialing (from a hospital phone): [internal numbers designated for Call FIRST at each hospital]

The person responding to the call will ask for your name and location and ask for a brief explanation of the situation.

A member of the FIRST team will then be dispatched and MUST be at the patient's bedside within 15 minutes.

Who will respond to Call FIRST?

The Family Initiated Rapid Screening Team is made up of nursing supervisors, who will come to the bedside to evaluate and stabilize the situation. The nurse caring for the patient and other members of the care team will also respond to Call FIRST. ■

Hospital fined \$50K for third wrong site

The Rhode Island Department of Health has issued a reprimand and a fine of \$50,000 to Rhode Island Hospital in Providence for its third wrong-site brain surgery in a year. The health department also issued a second compliance order due to this pattern.

On Nov. 23, 2007, the department was notified by the hospital that a wrong-site surgery had been performed, according to a statement released by the health department. Hospitals are required to report such events to the health department within

24 hours. The surgery follows a compliance order issued to the hospital on Aug. 2, 2007, for a pattern of wrong-site/-side surgery dating back to 2001. "This latest event is the hospital's fourth wrong-site surgery in six years," according to the health department statement. (Editor's note: The compliance orders are available on the health department's web site: www.health.ri.gov/hsr/facilities/hospitals/index.php.)

Director of health **David R. Gifford**, MD, MPH, said in the statement that "[w]e are extremely concerned about this continuing pattern. We have not seen an adequate response in the hospital's system and protocols since the last compliance order was issued. While the hospital has made improvements in the operating room, they have not extended these changes to the rest of the hospital."

The latest compliance order was issued as the result of preliminary findings from an unannounced inspection following the most recent report from Rhode Island Hospital. Several deficiencies were cited during the inspection, the health department reports. The compliance order requires these corrective actions:

- The facility must ensure that an unrestricted licensed physician attends all neurosurgical type procedures from beginning to end.
- For all neurosurgery procedures, the operating physician must complete a timeout checklist that at a minimum confirms the correct patient, procedure, and surgery site by reviewing imaging, consent forms, and medical records before proceeding with the procedure.
- The information must be verified by both the physician and a nurse or technician assisting with the procedure.
- The checklist to be used for this protocol must be approved by the health department.
- Emergency procedures that break from this protocol must be reported to the health department within 48 hours of the surgery.
- The hospital must submit a plan for ensuring that all licensed professionals receive training in this protocol and checklist.

As more information becomes available from the ongoing investigation, new requirements may be imposed on the hospital, Gifford said. The health department's Board of Medical Licensure and Discipline and Board of Nursing also will investigate whether any disciplinary action should be taken against the individual health care professionals involved in the Nov. 23 incident. "The repeated nature of these events suggests a systems problem with patient safety that needs to be addressed," the statement said.

EXECUTIVE SUMMARY

A Rhode Island hospital recently reported its third wrong-site neurosurgery in a year. The state health department has fined the hospital and issued a compliance order to reduce the risk of further wrong-site errors.

- The hospital has reported four wrong-site surgeries in six years.
- The compliance order requires better use of time out and data confirmation before surgery.
- The hospital already had pledged to improve policies and procedures after the previous incidents.

The most recent case happened when, according to the health department, the chief resident started brain surgery on the wrong side of an 82-year-old patient's head. In February 2007, a different doctor performed neurosurgery on the wrong side of another patient's head.

In August 2007, a patient died a few weeks after a third doctor performed brain surgery on the wrong side of his head. That surgery prompted the state to order the hospital to take a series of steps to ensure such a mistake would not happen again, including an independent review of its neurosurgery practices and better verification from doctors of surgery plans.

In a written statement, Rhode Island Hospital said it was working with the Department of Health to minimize the risk of medical errors. "We are committed to continuing to evaluate and implement changes to our policies to help ensure these human errors are caught before they reach the patient," the statement read.

The hospital said it was re-evaluating its training and policies, providing more oversight, giving nursing staff the power to ensure procedures are followed. ■

Little med-mal risk, psych drug maker says

With its best-selling antipsychotic drug Zyprexa the target of thousands of legal claims, Eli Lilly and Co., based in Indianapolis, is trying to reassure psychiatrists they face little malpractice risk for prescribing such drugs.

The company has hired a medical education company, Professional Risk Management Services of Arlington, VA, to help spread the message that psychiatrists can manage risk, according to a recent statement from both companies. Eli Lilly recently mailed a 14-page brochure to psychiatrists across the United States with the message that the best way to avoid malpractice claims is to provide good care and document it carefully. "Nothing will stop a malpractice lawyer dead in his or her tracks quicker than a well-documented chart," the brochure says.

The mailing also points out that psychiatrists have among the lowest number of malpractice claims of all medical specialists and most claims against them are closed without payment.

The drug maker has paid more than \$1 billion to settle tens of thousands of patient claims that it hid or downplayed the side effects of Zyprexa, according to the company. Many patients said the drug gave them diabetes symptoms, including weight gain and higher blood sugar levels. Lilly has consistently denied any culpability.

More information about Zyprexa is available at the Eli Lilly web site www.zyprexa.com. ■

AHRQ releases new patient safety toolkits

The Agency for Healthcare Research and Quality in Rockville, MD, recently released 17 new toolkits to help health care providers and patients prevent medical errors.

The toolkits focus on identifying high-risk practices and promote interventions to prevent errors and enhance communication among caregivers and with patients. Several of the patient toolkits address medication safety. For more information on the toolkits, go to www.ahrq.gov/qual/pips. ■

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. ■

COMING IN FUTURE MONTHS

■ Improving patient safety brochures

■ Nurse empowerment: Real or just talk?

■ Waiving charges for adverse events

■ Best response to patient falls

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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 **June** 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 Cynthia Musetti, RN, CPHQ, how did the hospital improve the performance of its rapid response team (RRT)?
 - A. The hospital provided two dedicated nurses, new staff positions, to work only on the RRT.
 - B. The hospital mandated that all nurses work overtime to staff the RRT.
 - C. The hospital required that RRT team members spend at least 30 minutes with the patient when called.
 - D. The hospital made the RRT available only during day-time hours.
2. According to Sean Blackwell, MD, what is the primary purpose of a shoulder dystocia drill?
 - A. To teach clinicians how to care for the condition.
 - B. To help clinicians improve communication and coordinate their response.
 - C. To assess the need for additional equipment.
 - D. To provide a baseline for measuring future response times.
3. According to Leila Narvid, JD, if a nurse has a lifting restriction and a reasonable accommodation would require purchasing a lifting device that costs \$1,500 and training, what does the EEOC say about this example?
 - A. The cost of the device and training would be an undue hardship to the hospital.
 - B. The cost of the device and training would *not* pose an undue hardship to the hospital.
 - C. The cost cannot be considered when determining an appropriate response.
 - D. The cost must not be revealed to the employee seeking accommodation.
4. According to Eleanore Wilson, MA, BSN, RN, what has been the initial experience with patients and family members using the Call FIRST hotline at her facility?
 - A. All of the calls were unnecessary and did not fit the intended use of the hotline.
 - B. All of the calls were legitimate and did fit the intended use of the hotline.
 - C. Most of the calls were legitimate and fit the intended use of the hotline, but some did not.
 - D. Most of the calls were unnecessary and did not fit the intended use of the hotline, but a few did.

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

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Unsupervised nursing home resident with dementia and dysphagia chokes to death — \$926,000 settlement

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

News: A nursing home resident with a history of difficulty in swallowing choked to death while eating a piece of brisket. Although staff attempted to perform the Heimlich maneuver and CPR on her, the woman died. The woman's family sued the nursing home and alleged failures in the type of food served to the woman, the manner in which it was served, the lack of supervision given to the patient while she ate, and the type of resuscitating procedures performed after the Heimlich maneuver was unsuccessful. The plaintiffs also sued two of the nursing home's board members under the theory that they could be held liable for a failure to adequately staff a nursing home. Before trial, the parties settled for \$926,000.

Background: A 65-year-old retired nurse with a documented history of dementia, stroke, and difficulty in swallowing lived at a nursing home that specialized in providing care for Alzheimer's patients and for the general elderly patient population. The woman, who lived on a hall for dependent residents with decreased mental capacity, was taking the prescription drug risperidone, which is an antipsychotic medication that interferes with the communication among nerves in the brain and, as a result, can decrease the amount of saliva able to be generated by the patient. One day, while eating a meal consisting of brisket with rolls and vegetables, the woman

choked on a piece of the brisket that was 4 inches by 6 inches. The staff attempted to perform the Heimlich maneuver on her, and when that failed, they placed her in a wheelchair, put her in bed, administered oxygen, and attempted CPR. The woman's extended inability to breathe led to cardiopulmonary arrest with severe anoxic brain injury, resulting in death.

The woman's family, who visited her often and had even brought her home for short periods of time, sued the nursing home. They alleged that their decedent should have been served a mechanical soft diet and that the meat should have been cut into small pieces. The plaintiffs also claimed that the facility should have supervised the woman while she ate and that it was on notice of the woman's dysphagia because of a prior choking incident at the nursing home. In fact, the plaintiffs maintained that the defendant should have seated the woman at a "feeder" table, where she would not receive a meal tray until a staff member was there to assist her. And finally, the plaintiffs alleged that the staff failed to provide proper care after its attempt at the Heimlich maneuver. The plaintiffs argued that the staff should have performed abdominal thrusts, back blows, and sweeps of the mouth with attempts to rescue breath, and that the CPR would have been more effective if the woman had been lying on a hard surface rather than in bed.

The plaintiff's speech pathologist expert testified during deposition about the physical pain and mental anguish suffered by the decedent while choking. She noted how horrific and frightening choking is while the individual attempts to breathe but is unable to, and then how the individual suffers extreme pain and suffering when she asphyxiates due to her airway being obstructed. Indeed, eyewitness accounts noted that while the woman was choking, she was panicking, fanning her hands on her neck and throat, and unable to make any noise before collapsing. The plaintiff's nursing expert opined that the facility was negligent in failing to develop appropriate assessments and in failing to generate a plan of care adequately addressing the woman's high degree of risk for aspiration and choking.

The plaintiffs also sued two of the nursing home's board members and alleged that those two individuals failed to ensure that the nursing home had sufficient staff to implement its policies regarding the management and operation of the facility. The plaintiffs relied on case law allowing individuals serving on a nursing home's governing body to be held individually liable for failing to adequately staff a facility. The plaintiffs maintained that of all the board members, these two individuals exercised the principal power and influence of the board and day-to-day operations of the facility.

Leaders of the nursing home apparently recognized the clear liability in the case and placed a \$1 million loss contingency in their budget shortly after the suit was filed. The defense did not dispute the alleged negligence as much as it contended that it had no liability insurance coverage and that it was in no position to respond to an adverse judgment should that contingency come to pass. While the case was pending, the Texas Department of Housing and Urban Development foreclosed on the facility. The home was sold to new ownership, and the sale resulted in a \$926,000 excess for the defendant. The parties accordingly settled for \$926,000, with \$700,000 payable immediately in cash and an additional \$226,000 payable if any of those funds still were in escrow after three years. The amount of the settlement, if any, attributable to the individual board members was not disclosed.

What this means to you: "This is clearly a case that should have been settled. There appears to be no question but that the nursing home knew that the patient had a documented history of dementia and difficulty in swallowing," says **Ellen L. Barton, JD, CPCU**, a risk management consultant in Phoenix, MD. Barton notes that the nursing home not only had knowledge of the resident's dysphagia due to medication, but they also were on notice that the risk was real based

on a prior choking incident at the nursing home. The resident should have been served a mechanical soft diet and been seated at a "feeder" table where she could have been supervised. Furthermore, a piece of brisket that is 4 inches by

6 inches could cause anyone to choke, especially an individual with documented swallowing problems. "Allowing the resident to be served such food while unsupervised borders on gross negligence," says Barton.

The volatile testimony of the plaintiff's speech pathologist clearly outlines the standard of care that should have been provided, which would include, at the least, an assessment of the resident's needs and a plan of care to address the resident's risk for aspiration and choking. According to Barton, however, there is a more basic issue at stake: lack of appropriately skilled and trained staff. Not only was the number of staff insufficient in this case, it appears that the staff was not adequately trained or skilled to manage what should have been a very manageable choking incident. A nursing home clearly has a responsibility to provide adequate numbers of appropriately trained and skilled staff, and it can be held liable for its failure to fulfill this responsibility.

Barton notes that the fact that two members of the board of directors of the nursing home were implicated in the lawsuit should serve as a notice that board members need to take their responsibilities seriously. Nursing home boards of directors should ensure that management hires appropriately skilled individuals and then provides those individuals appropriate training to manage residents with special needs.

Reference

- Hale County (TX) District Court, Case No. A32834-0305. ■

According to Barton, however, there is a more basic issue at stake: lack of appropriately skilled and trained staff.

Failure to administer medication leads to death

Prescription order sheet misplaced, \$976,784 verdict

News: An elderly man was transferred to a nursing home following a brief stay at another facility. Although the man was currently taking more than 20 medications, the second page of the two-page prescription order sheet somehow was misplaced during the transfer. The second nursing home did not realize the mistake and accordingly failed to give the patient all of his necessary medications. The man subsequently experienced acute renal failure and died. The man's estate sued the first facility, the second facility's medical director, and the employer of the second facility's nurses. A defense verdict was returned for the first facility, but a jury awarded the plaintiff \$976,784 against the other two defendants.

Background: A 70-year-old man underwent a bilateral below-knee amputation. Following his stay at the hospital, he was transferred to a nursing home with a list of more than 20 medications he was taking, including three customary immunosuppressants. After about a month at the nursing home, he was transferred to another long-term care facility. The first nursing home sent the hospital discharge summary and prescription order sheet to the second nursing home, but only the first page of the two-page prescription order sheet was received.

Despite a note at the bottom of the prescription order sheet to "see page 2," the second nursing home's medical director and one of its nurse practitioners failed to notice the discrepancy between the discharge summary medication list and the first page of the prescription order sheet. As a result, the second nursing home ordered only those medications listed on the first page of the sheet, including only one of the three immunosuppressant drugs. The other two immunosuppressants were necessary because the patient had undergone a kidney transplant 4½ years earlier.

Within 3½ months at the second nursing home, the man began rejecting his kidney, even though he had had excellent renal function at the hospital and at the first nursing home. He subsequently suffered acute renal failure requiring dialysis, and he ultimately died.

The man's estate sued the first nursing facility,

the second nursing facility's medical director, and the employer of the nurse practitioner employed by the second facility. The first facility defended the suit by arguing that both pages of the prescription order sheet had been sent to the second facility. The medical director argued that a nurse at the second facility should have followed up on the discrepancy. All defendants tried to limit their exposure by maintaining that the man would have died within one or two years even if all of the medications had been administered.

A jury found in favor of the first nursing facility but returned a verdict in favor of the plaintiff for \$976,784 against the medical director and the nurse practitioner's employer.

What this means to you: "One of The Joint Commission's National Patient Safety Goals for 2007 for all accreditation settings is medication reconciliation, which refers to the practice of comparing current and future medication orders against the patient's past dosing history," says **Lynn Rosenblatt**, CRRN, LHRM, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. Based on years of survey activity and data collection related to medication errors, The Joint Commission has focused on a very significant flaw in the ongoing care of patients.

No matter the setting — whether the physician's office, home health agency, ambulatory surgery, hospitals, nursing homes, and even in the emergency department — the need to know which medications the patient has been taking is an essential element for safe care. According to Rosenblatt, practitioners in all settings should question the patient and/or the patient's representative or family to establish a verifiable list of medications taken at home. The list should include not only daily prescription meds, but those taken infrequently and even over-the-counter and herbal remedies.

Providers should train the clinical staff to ask questions, but most importantly to think "out of the box." Frequently, it is not the medications that are normally associated with the admitting diagnosis, but those that are taken for a chronic condition that are not picked up when the patient is admitted or transferred between services or providers. This is particularly true for post-surgical patients where medications are stopped or held prior to surgery and never restarted.

In this case, the patient would most likely have been suffering from diabetes or peripheral vascular disease, or perhaps both, as these conditions

frequently result in amputations. An astute nurse also would consider such issues as dialysis or renal transplant. In this case, a patient being on one immunosuppressant should have triggered an inquiry about others, as transplant patients rarely take only one of these medications.

Second page apparently overlooked

According to Rosenblatt, another factor in this case was that the prescription order sheet directed the reader to a second page, which apparently was overlooked during the admission to the second nursing home. From that point forward, it appears that the patient received only a portion of his life-sustaining medications. This is just the issue that the National Patient Safety Goal addresses.

“Past history of serious adverse medication errors have prompted closer scrutiny of how medications are ordered, modified, and discontinued,” says Rosenblatt. In many health care facilities, particularly low profit-margin establishments such as long-term care homes, the act of transcribing orders is arduous and prone to error. Many smaller hospitals and nursing homes lack sophisticated computer software to reduce transcription error. There often is a single nurse who transcribes physician orders solely from a multi-form order sheet to a manually written Medication Administration Record (MAR).

When such problem-prone processes are combined with poor practice or, as in this case, negligence, the result is bound to pose a serious safety risk to the patient and a liability to the provider. The nurse practitioner admitting the patient at the second nursing home committed a major omission when he or she failed to reconcile all available information before writing orders. The medical director, who is the overseer of lower-tier practitioners such as advance practice nurses, was negligent because he or she failed to provide the supervision that his position requires.

It may be entirely possible that the admissions orders were transcribed by a desk nurse from the single prescription order sheet that was received. He or she in turn called the nurse practitioner and conveyed by phone the transcribed medication list. Any correlation to the discharge summary would have been moot at this point. The desk nurse then would have been given a verbal order to approve the list, and the orders then would have been transcribed to the MAR for administration.

Conceivably, it could have been some time

before the advanced practice nurse actually saw the patient. In fact, it appears doubtful if he or she ever compared the original transcribed orders to the prescription order sheet to assure accuracy. Taking that premise a step further, it is unlikely that the nurse practitioner ever compared the admission orders to the discharge summary.

It is for these reasons that The Joint Commission frowns on any medication ordering process that does not include the input of the patient and/or family and does not have system of checks and balances to assure greater accuracy. Asking a patient or family what a patient routinely takes is one way to ensure that a transfer medication packet is complete. While patients and families do not always know the exact names of medications that a patient takes, they frequently know that the patient takes something for one condition and something else for another.

Nurses admitting patients are another source of verification. Going over a patient’s past medical history is essential to a complete nursing assessment. It is good nursing practice. Had the staff nurse compared the discharge summary to the single-page order sheet, he/she would have realized that some medications were lacking. The patient’s previous transplant history should have triggered questions during the admission assessment. The nurse practitioner is equally as responsible for not reaching a similar conclusion during the visual history and physical.

Reference

- Tazewell County (IL) Circuit Court, Case No. 02-L-96. ■

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