IT TAKES A VILLAGE

JOSEPH HAASE, CPHRM, VP, Risk Management, HCI

For several years we have hosted and conducted quarterly orientation sessions for new risk managers from our affiliated hospitals and ambulatory centers. Some come with a glimpse of what to expect in their new jobs; most have only the Cliff notes version. The deer-in-the-headlight look is pretty much a guarantee at some point during the three days. These orientees consistently tell us they had little idea prior to coming to our session of the breadth of what was facing them, although they are oh so appreciative in the knowledge that resources are here to help.

Some of these orientation attendees are new to HCA; some are veterans; some have long term risk management experience elsewhere; some have none. (I’m tempted to add: “…and some cry wee, wee, wee all the way home!”). They hear about occurrence reporting, claims and litigation management. They learn about auto insurance and property coverage, just in case of that tropical storm. They are introduced to the nuances of claims-made versus occurrence coverage. They find out that an RCA isn’t your grandparents old console TV set. Speaking of acronyms, they are hypnotized with the likes of POA, TSG, SPAE, HRO and RIBs; and STARS is not just some cry we, we, we all the way home!”). They hear about occurrence reporting, claims and litigation management. They learn about auto insurance and property coverage, just in case of that tropical storm. They are introduced to the nuances of claims-made versus occurrence coverage. They find out that an RCA isn’t your grandparents old console TV set. Speaking of acronyms, they are hypnotized with the likes of POA, TSG, SPAE, HRO and RIBs; and STARS is not just what’s spinning in their heads. They may even come to understand why the term Safe Medical Devices is not an oxymoron.

And all of that is before we ever get around to the demands and expectations of the Premium Credit Program, Streetwise reporting or the Risk Metrics process. Of course there’s math too — the prerequisite to the Premium Credit discussion is grasping how the premium is determined in the first place, and what, if anything, a risk manager can do to impact it.

I’m exhausted just thinking about it!

So during one deer-in-the-headlights moment about a year and a half ago, I posed a question to the group of orientees…a question that I guess turned out to be a bit naïve based on the giggles it prompted. The discussion at the time was around the hiring process for risk managers, their selection for the job, the interview and on-site orientation process. I asked: "Didn't your boss sit you down on your first day and show you the ropes, tell you what was expected of you, fill you in on the status of all the premium credit work, tell you where things are, etc.?" That’s when the laughter erupted. Okay, maybe that was more than a bit naïve.

The reality of course is that typically "the boss" doesn't know all the things that are expected of facility risk managers. There’s only one person at that facility who’s walked in those shoes and that person is long gone.

It takes all of us to reach out to that new colleague. It takes a village to raise a risk manager! (Apologies to Hillary Rodham Clinton.) When you become aware of a new risk manager in your market or division, reach out to her or him. Offer your sage counsel and wisdom to help them through the details of risk management HCA-style. Help organize a buddy system for new risk managers in your division. Invite them to shadow you for a day (week?...month?...year?). Set a follow-up call during one of the crunch times when deadlines are looming for premium credit or metrics. Help pull them from the brink of overwhelmed-ness. You’ve been there. You’ve survived. You've lived to tell about it. By offering our experience, we can make a friend, we can save a risk manager, and most importantly, we can help our patients. It takes a village. And you are the village.
“ALL HAZARDS SUPPORT TEAM” IS TRAINED AS FIRST RESPONDERS BY FEMA

KATARINA KEMPER, Director of Risk Management and Safety, Rose Medical Center, Denver, CO

In January 2008, Rose Medical Center (RMC) developed an All Hazards Support Team in preparation for any biological or chemical event. This core group of qualified individuals was trained to respond to emergency events that may impact the operations of our facility. Twenty hospital staff, including a physician, volunteered to be part of the Team. These volunteers represented various departments including EMS, Medical Staff, Nursing, Respiratory Therapy, Physical Medicine & Rehab, PACU, Security, Risk and Safety.

Our hospital ramped up in preparations for the Democratic National Convention which was held in Denver this past summer. RMC was one of six Denver city and county hospitals that participated, and the Team was on-call during the week of the Convention. In the event of an influx of exposed patients (pepper/tear gas or any other biological/chemical) to Rose, the Team would be called into action.

In preparation for the Convention, RMC was awarded 20 slots from Homeland Security to attend an all inclusive training program (airfare, room, board) for one week in July. We were also awarded a $25,000 grant from the Urban Area Security Initiative to pay for backfill and overtime during the training. This opportunity enhanced our current training and provided our Team with additional tools and skills to be more competent and prepared.

Now that the Convention has concluded, the Team will continue their education to support the facility for any type of disaster (natural, epidemic & pandemic, or terrorist) with focus on detection, mitigation and recovery. Continued education includes support with the Code Lift Team, security lockdown and access control into the facility and evacuation.

Training Facility

The All Hazards Support Team trained at the nation's premier all-hazards training center at FEMA's Center for Domestic Preparedness (CDP), located in Anniston, Alabama. It is the United States Department of Homeland Security’s (DHS)’s only federally chartered Weapons of Mass Destruction (WMD) training center.

The CDP began operations in June 1998 as the only all-hazards training center, offering training on Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) weapons. While the training tempo has increased dramatically, the CDP’s training programs provide the very best in advanced hands-on training for America’s emergency responders. On March 31, 2007, the Noble Training Facility (NTF) was transferred to the CDP. NTF is the only hospital facility in the United States dedicated to training hospital and healthcare professionals in disaster preparedness and response. The CDP annually trains 5,500-7,000 responders.

Some other learning objectives included:

- Describe the threat to the community and potential targets,
- Identify chemical, biological, and radiological materials, and potential explosive devices,
- Identify protective measures, including downwind hazard analysis, confinement, and isolation,
- Work within Incident Command System,
- Select appropriate PPE,
- Perform decontamination procedures,

(Continued on Page 3)
ALL HAZARDS SUPPORT TEAM” IS TRAINED AS FIRST RESPONDERS BY FEMA, CONT’D.

- Perform triage and prioritize victims, and
- Conduct scene survey, aware of possible hazards at a CBRNE site.
  * Prerequisites are ICS-100, ICS-200 and ICS-700

The CDP believes in the phrase "Train like you fight." This training allowed our team members to build a level of confidence in their abilities and equipment that can't be grown through simulation alone. Because of this training, we are better equipped to meet the mission of our Team: To provide a safe and secure environment in which to give or receive care, exemplified by having a core group of qualified individuals trained to respond to emergency events that may impact the operations of Rose Medical Center.

If you are a state or local emergency responder, this training is completely funded by DHS at no cost to you or your jurisdiction. All airline and ground transportation, meals and lodging are provided. There are other Resident Programs that healthcare facilities would find interesting such as Hospital Emergency Response Training for Mass Casualty Incidents. You can find out more information from http://cdp.dhs.gov.

If you are interested in learning more about RMC’s experience and the CDP training, contact Katarina Kemper at Rose Medical Center.

WHAT YOU DON'T KNOW ABOUT MORPHINE CAN HARM YOUR PATIENT

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What You Already Know About Morphine

Morphine is an opioid that binds to opiate receptors in the Central Nervous System, inhibiting ascending pain pathways, thereby altering the perception and response to pain.1 It is included in the Institute for Safe Medication Practice’s list of high-alert medications.2 Not only is morphine associated with medication errors, it can also be responsible for multiple adverse drug reactions and/or events. Without proper monitoring and education, these error and events are potentially fatal.

What You Already Know About Morphine

One case study of a patient with mild renal insufficiency reports chronic nausea and an episode of confusion after receiving morphine. A M6G level was drawn revealing unusually high levels. The patient’s chronic nausea subsided as the level of morphine-6-glucuronide decreased.4

Another case report illustrates the prolonged effects of this active metabolite of morphine in a patient with acute kidney failure. The patient had been receiving morphine for eleven days before it was discontinued. After discontinuation, the patient received naloxone to prevent respiratory depression. However, morphine-6-glucuronide was found in the patient’s blood and cerebrospinal fluid days after the discontinuation of morphine. This explained the opioid effect seen in the patient after the morphine was stopped.5 Both of the case reports demonstrate the prolonged effects of M6G in patients with renal insufficiency.

In the early 1960s, it was suggested that morphine could cause hepatic encephalopathy in patients with liver cirrhosis.6 The mechanism of this effect is unknown, but it is suspected to be a result of either altered drug response or impaired hepatic drug metabolism. The elimination half-life of morphine is significantly prolonged in patients with liver cirrhosis when compared to patients with normal liver function.6,7

A small trial was conducted to evaluate the oral and intravenous kinetics of morphine in patients with liver cirrhosis who had a history of encephalopathy. The study found a significantly decreased blood concentration of morphine and a larger oral

What You Already Know About Morphine

Common Signs and Symptoms of Morphine Toxicities:

- CNS depression
- Drowsiness
- Dizziness
- Confusion
- Headache
- Respiratory depression
- Hypotension
- Bradycardia
- Pruritus
- Urinary retention
- Nausea/vomiting
- Constipation
- Weakness
- Injection site pain
- Fever2

Beware of What Lurks Inside

Morphine is metabolized to morphine-6-glucuronide (M6G) and morphine-3-glucuronide, which are renally eliminated. However, M6G has been found to accumulate in patients with renal insufficiency, increasing concentrations by ten-fold. This ten-fold increase raises a patient’s risk of developing morphine toxicities.3

(Continued on Page 4)
What You Don’t Know About Morphine Can Harm Your Patient, Cont’d.

bioavailability in the patients with liver cirrhosis when compared to those patients with normal liver function. This illustrates the importance to dose adjust morphine in patients with liver disease. Researchers also evaluated EEG patterns in those patients with liver cirrhosis receiving morphine, and found no detectable changes.

Morphine-3-glucuronide, the inactive metabolite of morphine, has potent neuroexcitatory activity. There have been several reports of neuroexcitatory side effects, including alldynia, myoclonic jerks, and seizures, associated with high doses of morphine due to this metabolite. A possible option for patients exhibiting these symptoms while on morphine includes changing the route of administration to intravenous or changing opioids.

What Should You Monitor

- Pain scores
- Blood pressure
- Level of sedation
- Heart rate
- Mental status/cognition
- Respiratory rate
- Renal function
- Pulse oximetry
- Liver function tests
- Capnography

Summary

Proper monitoring of patients receiving morphine is key. The most critical time to monitor patients is during the first 24 hours of administration and at night. It is also very important to educate nurses on all possible side effects of morphine. This includes knowing if patients have renal or liver insufficiency, as this may potentiate or prolong the effects of morphine.

References


So You Want to Submit, Reprint, or Comment on Articles from RiskWatch?

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■ Does your facility have a success story to tell? How about a risk event, solution, or process improvement you'd like to share? By doing so, you just might help other facilities avoid pitfalls you have encountered.

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Simply send us your thoughts. We'll put them in a "Letters to the Editor" column (and even make it anonymous if you prefer).

We want to hear from you; good, bad or ugly! This is your newsletter, so we encourage you to "participate." For questions, contact Dr. Ches Alper in the Risk Management Department at HCI.

Back issues of RiskWatch can be found on Atlas at http://atlas2.medcity.net/portal/site/risk. Click on "Publications" and then on "RiskWatch." From there, simply scroll down to find the issue you want.
A CASE FOR BLOOD RESPONSE PROTOCOL

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The patient was a 32 year-old Gravida 3, Para 2 at 27 5/7 weeks with known placenta previa who was admitted for evaluation of bleeding. On arrival to Labor and Delivery her bleeding was described as "scant." Uterine activity monitoring demonstrated some irregular contractions which resolved with hydration. She was transferred to the antepartum floor. Her past medical history included an uncomplicated pregnancy and delivery seven years ago of a normally grown infant and a "classical" Cesarean section at 32 weeks gestation fourteen months prior to this admission. An operative report of that delivery was not available.

So far, this pregnancy had been uncomplicated except for the sonographic diagnosis of placenta previa. On exam her uterus was soft and non-tender. Ultrasound examination demonstrated a single, viable intrauterine fetus in cephalic presentation that was appropriately grown. The amniotic fluid was normal. Complete anterior placenta previa was noted. The placenta had a "moth-eaten" appearance, and the interface with the uterine wall was "highly suggestive of placenta accreta."

Because her admission hemoglobin and hematocrit values were very low, she received a total of four units of packed red blood cells (PRBC's), which brought those values back to normal.

At 0639 in the morning of her fifth hospital day she had the sudden onset of heavy, bright red vaginal bleeding. She was taken immediately to the operating room by the "first available" obstetrician who made the first incision at 0650. Her BP was 134/69, and her pulse was 81. After vertical incisions were made in her abdomen and uterus, the fetus was delivered without difficulty at 0651. As the uterus contracted, the placenta delivered spontaneously and a small hematoma was noted in the left broad ligament. Otherwise, hemostasis was "adequate," and the uterine incision was closed.

Because the patient had previously requested sterilization and because there appeared to be little bleeding, her obstetrician performed bilateral tubal ligation at this time. Approximately 15 minutes after the initial incision, her BP was 80/48 with a pulse rate of 110. A large amount of blood was noted under the drapes with heavy ongoing vaginal bleeding. A Blood Response was called, and the decision was made to proceed with hysterectomy. Despite rapid infusion of two liters of lactated Ringer's solution and four units of packed red blood cells over the next 20 minutes, her BP dropped as low as 48/12 and her pulse increased to 140.

Surgical exploration during the hysterectomy demonstrated that what was thought to be a small broad ligament hematoma was actually placenta which had invaded through the lower uterine segment into the broad ligament as well as the lateral vaginal fornix. During the two-hour surgery to remove the uterus and resect the invasive placenta, she received 22 units of packed red blood cells, 32 units of platelets, four units of fresh frozen plasma and two units of cryoprecipitate. Calcium gluconate and bicarbonate were administered as needed to correct laboratory abnormalities.

She initially received volume expansion with rapid infusion of crystalloid and packed red blood cells. When initial laboratory evaluation at 0750 demonstrated borderline fibrinogen and moderate thrombocytopenia, in the face of ongoing bleeding, she received fresh frozen plasma as well as platelets. Packed red blood cell transfusion and crystalloid administration maintained adequate hemoglobin and circulating blood volume respectively. By 0910 her surgery was nearly complete, however she continued to have some oozing from cut surfaces. Her hemoglobin and volume status appeared appropriate so she was treated with cryoprecipitate and an additional infusion of platelets.

(Continued on Page 6)
A CASE FOR BLOOD RESPONSE PROTOCOL, CONT’D.

She was transferred to the surgical intensive care unit where her laboratory values continued to normalize. She developed mild ARDS but was extubated on post-operative day two and was discharged home on post-operative day five. It is clear to those who participated that, had she not been in a level III OB unit, and without the recently adopted Blood Response Protocol her chances of survival would have been slim.

The Blood Response Protocol was an idea initiated in the local Perinatal Safety Task Force. Considering the scope of the project it was referred to the Hospital Critical Care Committee. A multidisciplinary team was assembled which included representatives from Anesthesiology and Obstetrics, an ED Physician, Critical Care Intensivists, Surgeons and Hospitalists. Directors from the Operating Room, Emergency Room, Critical Care and Labor and Delivery also attended, as well as the Critical Care Clinical Nurse Specialist and Perinatal Clinical Nurse Specialist, the Director of the Lab and Blood Bank, and representatives from Respiratory Therapy and Pharmacy.

This team was tasked with developing a way to have access to emergency PRBC’s within minutes of calling a blood response. The protocol needed to be inclusive of all regulations for blood transfusion, storage, laboratory requirements, and the need for additional personnel. The final Protocol accomplished this and more:

- Streamlines the process to access emergency release blood without advance paperwork and then defines a process for completing the necessary paperwork after the emergent event has ended.
- Requires that four units of O negative blood are always available in the Blood Bank.
- Assists in getting blood drawn from the patient and processed quickly.
- Requires that a stand-by cooler be equipped with a thermometer to keep blood at appropriate temperature, as well as transfusion supplies, pressure bags and Lab supplies.
- Provides for hemorrhage supplies added to code Carts, or Hemorrhage Boxes/Carts developed on the units.
- Includes a list of personnel that are notified of Blood Response.
- Identifies the Team members: ED Physician, ICU nurse, Respiratory Therapist, Blood Bank Technologist, Nursing Supervisor (who notifies OR/OR call Team), Anesthesiologist, Pharmacy, House Officer, Pastoral Care (depending on shift) and Laboratory technician.

How did the Blood Response work in this case? Within five minutes, the four units of O negative blood had been delivered to the OB unit. Within another two minutes, the first unit was checked and infusing. With the extra personnel there were plenty of people with the right competencies to draw blood, courier it to the lab, assist with central line placement, take over as surgical assist and scrub for the hysterectomy.

Transfusion of blood products is integral to the comprehensive management of hemorrhagic shock in the postpartum woman. An efficient, measured response with frequent reassessment of effect is necessary to support the patient while the cause of hemorrhage is being addressed.

As the primary Cesarean rate increases in developed countries, there is likely to be an increase in severe obstetric hemorrhage related to placenta previa and placenta accreta in subsequent pregnancies. Because bleeding from placenta accreta can be catastrophic, all hospitals with obstetric services should be encouraged to develop policies and procedures to ensure the rapid availability of blood products and other necessary resources to all obstetric patients.
BEGINNING THE JOURNEY TOWARD HIGH RELIABILITY

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KATHY WILSON RN, AVP, HCA Clinical Services Group

During the last several months, HCA affiliated Ambulatory Surgery Centers (ASCs) across the country have been working to understand what defines a High Reliability Organization (HRO), what sets HROs apart from other organizations and how to embed those concepts into their respective cultures.

Spencer L. Byrum, Managing Partner of Convergent HRS, LLC., discussed key characteristics of a HRO in the July 2008 RiskWatch article, Taking the First Steps to Becoming Part of a High Reliability Organizations. Mr. Byrum wrote, "There are a number of key characteristics that High Reliability Organizations possess. First, there is a very high risk potential coupled with very high individual and organizational accountability. Second is a preoccupation with avoiding failures. Third is a broad knowledge base for all team members coupled with a high level of situational awareness (SA), a composite picture of what has happened, what is going on now and what might happen in the immediate future. The fourth characteristic is that HROs are able to rebound quickly after an undesired event. Finally, HROs are maniacal about accurately linking cause and effect with events and are continu-
ously "learning" how to improve the system from these experiences."

For the Ambulatory Surgery Division (ASD), planning began in late Spring 2007. Three surgery centers in Colorado were identified to participate in a pilot for this project: Lakewood Surgical Center, Midtown Surgical Center and Musculoskeletal Surgery Center. Work began that summer with our colleagues from Convergent and the three Centers to complete a formalized "Safety Survey." This survey identified opportunities for improvement that would lead to process as well as cultural changes impacting the safety of the patients and families served by those centers. The first opportunity on the list was pre-procedure time outs.

During the ASD Annual Leadership Conference held in September 2007, Lisa Cross, Administrator for Midtown summarized the pilot project the Colorado ASCs participated in for the Division's Administrators.

In October, Kevin Chilvers, Senior Vice President of the ASD - Central Region, along with the Vice Presidents of (Continued on Page 8)
BEGINNING THE JOURNEY TOWARD HIGH RELIABILITY, CONT’D.

Operations, the Central Region Administrators, Risk Managers, Sales Representatives and Gerry Bassell, MD, National Medical Director for the ASD met in Atlanta to learn more about HROs and how these concepts would be presented in each of the Central Region's Markets and ultimately in each of the 31 individual ASCs.

Work continued throughout the fall and winter of 2007, as Kathy Wilson, then VP Quality, Outpatient Services Group, Spencer Byrum and Lee Flowers, Managing Partners of Convergent HRS along with Cathy Stubbs of HCI Risk Management developed strategies to embed these cultural changes across the entire ASD — 17 Divisions and Markets, encompassing 107 Centers.

For these cultural changes to take place, leadership at all levels, partners and employees needed to have an understanding of what defines a high reliability organization and, as written by Mr. Byrum recently in RiskWatch, "...the most crucial part of becoming an HRO is effective communication. HROs focus on making every critical communication clear, timely and solution driven despite the inevitable chaos of daily events. ...Each and every member of the team is encouraged and, better yet, specifically trained on how to provide crucial information in a timely manner."

Every year in February, each ASC is represented by their Medical Director at the ASD Annual Medical Directors' Conference. This past February approximately 107 Medical Directors, 13 Vice Presidents of Operations, three Senior Vice Presidents and Division President Greg Beasley were engaged in a presentation introducing High Reliability Organizations by Mr. Byrum. For some of the attendees, this presentation was a repeat of information they had previously received, for others it was new and thought-provoking. The Medical Directors have been a key resource for the Centers in implementing the ASD plan.

During the following months, Market and Center Coordinators were identified across the country to assist with program roll outs. Each was tasked with tracking introductory education to all ASC employees and computer based pre-procedure time out education for all clinical staff members. The Coordinators were a pivotal resource for their colleagues. Without their dedication in moving their Markets and Centers toward embedding the concepts associated with becoming a high reliability organization, the Ambulatory Surgery Division would not succeed in meeting their educational goals for 2007.

John Schofield, Senior Associate, Convergent HRS provided support to the ASCs by facilitating web-based training and addressing issues as they arose. He was instrumental in providing alternative educational opportunities when web or computer based training was not an option. Mr. Schofield prepared "Safety Survey" reports and compiled information summarizing education completed electronically to assist Market and Center Coordinators with tracking.

By the beginning of September 2008, approximately 3200 surgery center employees had participated in introductory HRO training, and since May of this year approximately 2900 clinical staff members have completed pre-procedure time-out training.

Post HRO introductory follow up calls were arranged by Kathy Wilson as yet another mechanism for Senior Leadership, Administrators, Market and Center Coordinators to have an opportunity to discuss issues and concerns regarding next steps in the quest to embed cultural changes in the individual centers and implement strategies for successful pre-procedure timeouts. During these calls, Kathy, Lee Flowers and Cathy Stubbs reviewed how to gain access to web and computer based education, education tracking tools - both electronic and manual, monitoring tools and data collection strategies. Additionally, those participating on the calls shared ideas and thoughts with each other.

The numbers of wrong sites, wrong patients, or wrong procedures are not going to just stop overnight, and there are other measures which must be considered as barometers in determining the impact of the cultural changes taking place in the ASCs. One such indicator that must be considered is found in Close Calls reporting. For the ASD, 70% of the Close Calls reported for the surgery centers involve potential wrong site surgeries that were avoided. Of that 70%, communication was the primary factor identified in over half of the Close Calls reported. Additionally, each Center is now reporting the observation of 15 pre-procedure time outs per month. The ASD will be receiving reports for approximately 1600 pre-procedure time outs per month, which translates to over 19,000 pre-procedure timeouts per year. Capturing this data will provide valuable information for improvement opportunities.

Cultural change is occurring, but it takes time. It is not instant, nor is it automatic. It is a shift in one's thinking, followed by a change in one's actions. Embarking upon this journey would not be possible without the strong commitment from those working everyday in the Ambulatory Surgery Centers across the country and from those individuals in leadership roles who are committed to the prevention of events that cause harm to the patients seeking care in those very Centers.

For the Ambulatory Surgery Division, pre-procedure time outs are the beginning of the journey in becoming a high reliability organization.
THE UNDERUTILIZATION OF HOSPITAL ETHICS CONSULTATION: PROBLEM OR SYMPTOM? PART 2 (OF 2)

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(Editor's Note: This is the fourth in a series of articles addressing Clinical Ethics issues. We welcome your comments about the following article, as well as suggestions for future Clinical Ethics topics. Send those to Dr. Ches Alper at ches.alper@hcahealthcare.com. For additional clinical ethics resources, visit the Center for Clinical Ethics website at http://atlas2.medcity.net/portal/site/clinicalethics/)

In Part 1, I made three observations widely supported by the literature:
1. A substantial number of clinical ethics committees are greatly underutilized, especially with regard to case consultation.
2. Ethical dilemmas are perceived as common occurrences by hospital-based clinicians, especially with patients at the end of life.
3. Over 70% of reported dilemmas are resolved informally with no need for involvement by the whole committee.

But what should clinical ethics committees logically make of these three facts? That many committees are either overlooking or not productively addressing important institutional factors that may cause the majority of ethical dilemmas. In this article, I will explore one prominent institutional barrier and suggest some proactive ways to help remedy the situation.

Barrier: Poor communication with families of critically ill ICU patients

ICU's are not particularly family-friendly environments. Erratic rounding schedules by physicians, small rooms with limited seating, and restrictive visiting hours can all conspire to marginalize family involvement in the patient's care. Complicating matters, multiple family members often speak with various members of the health care team and frequently receive discordant information about the patient's condition and prognosis. All too often, attending physicians do very little to prevent this confusion.

Additionally, "... ICU clinicians, particularly physicians (often) wait until they have decided that life-sustaining treatments are no longer indicated before they initiate communication about end-of-life care with patients or families. Families may be just beginning to think about withdrawing life support while clinicians are feeling increasingly frustrated at providing the care they believe is no long indicated. Alternatively, sometimes the family is considering withdrawal of life-sustaining treatments well before the medical team. The ICU team itself may also vary in the timing which can be frustrating for some critical care nurses and a source of interdisciplinary conflict for physicians and nurses."

What proactive, procedural actions can be taken to address these all-too-common situations?

- **Identify the patient's surrogate.**
  Make a prominent note in the medical record (including a copy of any health care proxy document, when available) and encourage the attending physician to introduce himself/herself as soon as possible, by telephone if necessary. Such introductions provide an opportunity to clarify mutual expectations about ongoing communication and decision making.

- **Prepare the family for best-case and worst-case scenarios — sooner than later.**
  Bad news has been defined as any information that may adversely change one's view of the patient's future. Families certainly deserve the opportunity to deal with such news earlier rather than later during their loved one's medical crisis, and it is the responsibility of the attending physician to recognize (and resolve) any gap between the patient's or family's expectations and the realities of the patient's medical condition. This is best accomplished by early, ongoing, and predictable patterns of communication; ideally, daily check-ins between doctor and surrogate that are convenient for both parties' schedules, even when there is nothing new to report from the physician's standpoint.

Some physicians may object to this suggestion. Isn't it a waste of time, they say, to conjecture about outcomes early in the hospitalization and doesn't bringing up the possibility of a bad outcome unfairly rob the family of hope? Not according to most patients and families. Patient advocate Bart Windrum affirms that such 'forecasting' conversations constitute an essential form of advance planning - planning that all too often was never accomplished prior to the current hospitalization.

"If you don't conjecture and your loved one's condition worsens, s/he may languish while you and your family take in new, shocking information and then parse decisions. Having spent agonizing days parsing life-and-death decisions, I can tell you that I'd rather conjecture and be ready to move as soon as a choice point is reached, rather than subject my loved one to several more days of languishing...Forecasting is critical...it

(Continued on Page 10)
forms a baseline of care for the patient-family; without it, care is compromised and incomplete.""

Remember: the vast majority of patients and families don’t want to be in the hospital any longer than is absolutely necessary. It is in everybody’s interests to ensure that when decisions need to be made, ample time for preparation has already been given to the family.

- Develop an accountability checklist.
  In 1997, a Veterans Administration hospital in Richmond decided to conduct automatic, proactive ethics consultations on every ICU patient with four or more days of continuous mechanical ventilation. In particular, they checked for six items with the clinical team and the patient or family that composed a quality-of-communication index:
  1. Is there an advance directive, and if so, is it in the patient chart?
  2. Does the patient have decision-making capacity? If not, is proper surrogate identified?
  3. Has the surrogate been informed of diagnosis, prognosis, and various treatment options?
  4. Do any of the physicians on the case anticipate major obstacles to patient recovery, and if so, what are they?
  5. If patient’s current response to treatment is considered poor, has there been any documented discussion about withholding or withdrawing treatment?
  6. Are there any additional or unaddressed issues that require clarification?

The results of the study were noteworthy: length of stays for patients who ultimately died were significantly reduced, DNR orders for these patients nearly doubled, and ineffective life-sustaining treatments were substantially decreased. Additionally, the hospital had also developed an easy-to-use checklist — readily available in the medical record instead of spread throughout the progress notes and other various tabs — that could help care providers know the current level of doctor-patient communication and also be used to evaluate the effectiveness of individual physicians to pinpoint the need for further education. Thus the subjective notion of bedside manner was replaced by a specific set of actions that demonstrate the facility’s emphasis on good clinician-patient communication.

- Consider forming a separate ethics committee for ICU nurses and nurse managers.
  It is widely understood that nurses have a qualitatively different relationship with patients and families than doctors do. Because of their 24/7 presence at the bedside, they are uniquely positioned to identify communication gaps and report on important family dynamics and other institutional factors that may affect the care of their patients. However, nurses are often under-represented on clinical ethics committees, and some may feel uncomfortable speaking freely in such venues, especially when what they have to say may relate to specific cases, incidents or physicians.

  Providing a regular and confidential forum for these discussions can supply your ethics committee with valuable ‘front line’ information to improve care for ICU patients and families. Such meetings may also provide a much-needed space for nurses to cope with the residual stress generated from difficult cases and from the general pressures associated with working in an ICU environment. They also provide the opportunity for the clinical ethics committee to fulfill its responsibility to provide ongoing education to hospital staff.

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1. The Underutilization of Hospital Ethics Consultation: Problem or Symptom? Part 1. Huff, Ronn. RiskWatch, July 2008. (Contact Ches Alper, MD at 615.344.1144 for article reprint)
STAFF “SHINE” DURING HEALTHCARE RISK MANAGEMENT WEEK

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The Risk Management Department at CJW Medical Center in Richmond, Virginia celebrated the annual Healthcare Risk Management Week with a contest. Going along with this year's theme, "Safety in Numbers," we asked the various departments from both campuses to tell us about initiatives they had implemented in an effort to minimize the risk of harm within our organization. We encouraged everyone to take the opportunity to "shine" and share the innovative ways safety was being promoted through proactive and innovative programs. We were pleased with the response!

At CJW we define 'Healthcare Risk Management' as a system for identifying, managing and minimizing actual and potential sources of financial loss stemming from injury to the person, property or reputation of a patient, employee, credentialed provider, student, visitor or volunteer. Operating under that definition, we realize a department doesn't have to provide direct patient care in order to have a positive influence on managing risk and promoting safety.

Our Risk Management program is designed to identify risk exposures, allow appropriate implementation of loss control measures in an effort to reduce or prevent the exposures, and to monitor those results on an ongoing basis. The program strives to reduce both the frequency and severity of losses to the Medical Center through various risk control techniques employed by the individual departments.

The Contest

Employees, department leaders and volunteers were asked to complete an entry form outlining programs which significantly lowered risk of harm during the daily operation of business. Recognition was provided to the top three entries at each campus in the form of a trophy for display in their departments. Actual judging was difficult due to the number of entries and the positive efforts being made throughout the facility. While all entries were viewed as 'winners,' the following provides a brief description of the top three award-winning submissions we received from the various departments.

"The Envelopes, Please"

The third place Bronze Award went to the Maternal-Infant Units for the development of a new policy and implementation of new procedures for counting sponges during vaginal deliveries. This initiative to change current practice in an effort to reduce the risk of a retained foreign body became a reality due to collaboration between medicine and nursing.

Staff worked along side members of the medical staff to draft, approve and implement the new policy. One simple, but significant change was to switch from using the 10-count 4x4 sponges to the 5-count larger lap sponges for easier recognition and counting. The new process was disseminated through staff education efforts, physician service meetings, mass emails and poster presentations. Since implementing the new policy, there have been no instances of retained sponges.

The second place Silver Award went to the Blood Banks at each campus for initiating the second step in drawing blood samples to confirm a "match" in patients who have never been processed during prior hospitalizations. Anytime blood products are administered to patients, there is a significant risk. Many factors come into play when providing the correct product to the right patient. The process has inherent opportunities for error. While staff is cognizant of this fact, the need for improvement in the matching process was always at the forefront.

Misidentification or mislabeling of specimens increases the risk for a mismatch of the patient's real blood type. According to the College of American Pathologists, approximately 1 in 1000 specimens for pretransfusion testing are either misidentified or mislabeled. Since transfusion with the incorrect blood group is the leading cause of death from transfusion, the staff understood the need to develop a plan to minimize the associated risk.

Steps were taken to review existing policies and procedures to identify where errors in matching the right patient to the right blood type could occur. Staff realized patients who did not have a previous blood type recorded within the lab system database were at a higher risk for receiving the wrong blood type.

In an effort to decrease risk of errors with this specific patient population, the decision was made to mandate a second sample be collected at a different time from the first draw for comparison on patients with no previous blood bank history. A history check in the Meditech system is conducted by patient name and medical record number, which includes history in all HCA Richmond Market databases. If a patient has multiple medical record numbers, then all records are checked in the Patient Care Inquiry databases.

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Staff "Shine" During Healthcare Risk Management Week, Cont’d.

In cases where the patient has a historical blood type recorded within the HCA Richmond Market hospitals, the routine typing and screening procedure is done and results are compared to the historical type. If there is a discrepancy, a second confirmation specimen is obtained for appropriate testing. If the confirmation specimen matches the recent draw, then the supervisor is consulted regarding the need to amend the patient's history within Meditech.

The revised policy regarding confirmation of blood type was communicated to all staff and the appropriate upgrades were made within the Laboratory Information Systems to support the second draw. The new process was also communicated to the ED physicians and staff, Surgical Services, Pre-Admission Testing, and Nursing Services. Flyers were distributed to physician lounges and a mass mailing was sent to all hospital staff.

Delays resulting from the need for a second draw have been minimal and one error was detected prior to reaching the patient through the new process. All five HCA affiliated facilities within the Richmond Market have adopted and implemented this safety initiative.

Radiology Services was honored with the first place Gold Award for their efforts to reduce patient, staff and visitor injury within the MRI Suite. For example, there had been situations where patients with pacemakers were getting into the MRI suite before anyone realized the patients had pacemakers. Staff took the initiative to review current policies and procedures to make the necessary changes to improve safety not only in the clinical department, but for all individuals entering the area.

COULD THIS HAPPEN AT YOUR HOSPITAL?

REBECCA MANNEL, BS, IBCLC, Lactation Center Manager, OU Medical Center
Clinical Instructor, Dept of OB/Gyn, OU Health Sciences Center, Oklahoma City, OK

A new grandmother went in to check on her 3-day old grandson in order to let her daughter rest a bit longer. The baby "would not wake up." The family rushed the baby to the hospital of delivery, a level 1 community hospital. When urine cultures came back positive, the baby was transferred to our facility which is the children's hospital for Oklahoma. The baby was admitted through the emergency department and a full work up was done. The baby was so dehydrated that two spinal taps had to be performed to collect enough fluid for analysis. Since the baby was breastfeeding, a lactation consult was ordered on admission to the hospital infant unit.

When the International Board Certified Lactation Consultant (IBCLC) made first contact, the baby was on IV fluids, under photo therapy and being fed formula because the mother was unable to express any milk. The first-time mother had such painful breast engorgement that she could not even lie down. She could only rest by sitting up in the child bed in the room with pillows propped around her to support her painful breasts. She had been trying to pump with the hospital's electric pump without any success. The IBCLC immediately recommended ice packs to reduce the swelling and pain. After several hours of alternating ice pack treatment, the mother was finally able to begin expressing some milk. Once the breast engorgement was reduced, the IBCLC scheduled a visit to assist the mother and evaluate a breastfeeding session.

Initial test results indicated no infections, so the baby was treated for dehydration and an elevated bilirubin. Insuring adequate oral intake was a priority to prepare for discharge home. As the IBCLC gently questioned the traumatized mother about her recent breastfeeding history, she learned the following:

- The mother had an uncomplicated vaginal delivery, and

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the baby was born healthy at term.

- Breastfeeding was initiated after the baby stayed several hours under the warmer in the nursery.
- The baby stayed with the mother off and on during the day. The baby received some formula feedings while in the nursery.
- The mother reported some initial difficulty with getting her baby to latch on.
- The mother stated that the nursing staff tried to help and gave her two types of "nipple shields" to facilitate latch on, telling her she had "flat" nipples.
- The mother and baby were discharged home at 48 hours, breastfeeding with "nipple shields."
- The baby's first checkup with a physician was scheduled for two weeks.

When the mother reported that she thought the nipple shields helped and her baby sucked better with the "red one," the grandmother pulled both nipple shields out and discovered that the mother had been given a red, preterm bottle nipple to place over her own nipple for breastfeeding. It was now clear what had caused the baby to become so dehydrated and led to his hospital admission — inappropriate breastfeeding information and instruction. Bottle nipples are not nipple shields. A baby cannot transfer milk at the breast through a bottle nipple. So this baby was sent home basically nursing on a "pacifier." The mother also suffered severe, painful engorgement which could have led to mastitis and/or a breast abscess and a rapid, possibly irreversible decrease in milk production.¹

A closer look at this situation reveals several opportunities for implementing best practices which would have avoided this chain of events²-⁵:

- During the first hour of life, baby should have been placed skin to skin with the mother and given an opportunity to breastfeed. Many babies can latch on at this time with little to no help.
- Mother and baby should have been kept together 24 hours a day to allow for breastfeeding on cue of the baby.
- The baby should not have been supplemented with formula unless medically indicated.
- Hospital staff should have been trained and competent to provide basic breastfeeding support, including assisting with latch-on.
- Since they were experiencing difficulty with breastfeeding, mother and baby should have been seen by an IBCLC as soon as possible, ideally within 24 hours.
- A plan to insure adequate intake for baby and to protect mother's milk supply should have been developed and explained to the mother. (Early use of a real nipple shield should always include milk expression.)
- The mother should have been educated about breastfeeding with evidence-based information and given resources for skilled breastfeeding support after discharge.
- After discharge, a follow-up visit with an IBCLC should have been arranged for further evaluation of the baby's weight gain and mother's milk production.

Fortunately for this mother and baby, skilled support from an IBCLC and knowledgeable nursing staff and physicians insured that the mother's milk supply was not compromised, mastitis was avoided and the baby could latch effectively and transfer adequate quantities of milk at breast. The mother's nipples were also evaluated and found to be normally everted. The baby was discharged fully breastfeeding, the mother was thoroughly educated on signs of adequate intake for her baby, a follow-up weight check was scheduled for two days after discharge and the mother was offered post-discharge support from the hospital's lactation center.

Currently in the United States, breastfeeding initiation rates have reached an all-time high of 75% with many hospitals reporting initiation rates of 80-90%.⁶ While maternal/child health advocates celebrated the achievement of this first Healthy People 2010 breastfeeding goal, the reality is that duration rates, and in particular exclusive breastfeeding rates, have remained relatively flat. In fact, many babies leave the hospital not fully breastfeeding and thus are much more likely to be weaned in the first six weeks.⁷ The American Academy of

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PEDIATRICS and numerous other healthcare-related organizations recommend exclusive breastfeeding for six months with continued breastfeeding to at least the age of one year or more. The current national average for exclusive breastfeeding at six months is only 11%.

Because the care given to breastfeeding mothers and newborns in the hospital impacts breastfeeding duration rates, the US Centers for Disease Control conducted its first national survey of maternity hospitals and birthing centers. The goal of the CDC’s survey was to identify the number of Baby-Friendly practices occurring in U.S. hospitals. The World Health Organization’s Baby-Friendly Hospital Initiative (BFHI) is the model for evidence-based breastfeeding care. Hospitals that have achieved Baby-Friendly certification have well-trained staff, higher breastfeeding initiation rates, higher exclusive breastfeeding rates at hospital discharge and higher breastfeeding duration rates. CDC survey results indicate "substantial prevalences of maternity practices that are not evidence-based and are known to interfere with breastfeeding."9

Published in the CDC's June 2008 Morbidity and Mortality Weekly Report, results were tabulated on a 100-point scale, a report card on breastfeeding support in US hospitals. Grouped into seven main categories, from labor and delivery to breastfeeding support after discharge, the overall grade for US hospitals was an "F" with an average of 63 out of 100. The two categories with the absolute lowest scores were breastfeeding support after hospital discharge [40] and staff breastfeeding training and education [51]. When mothers receive optimal breastfeeding care in the hospital, they are eight times more likely to continue breastfeeding to at least six weeks.10 With adequately trained staff and referral to appropriate breastfeeding support after discharge, the unfortunate incident described here could have been avoided.

A universal complaint of breastfeeding mothers is the inconsistent information they receive. While many HCA affiliated hospitals may have one or more IBCLCs on staff, some IBCLCs are challenged to work with nurses and physicians that do not themselves have enough education and training to provide competent, basic breastfeeding support. Smaller hospitals without the volume to justify hiring an IBCLC are also challenged to provide consistent, evidence-based care to breastfeeding families. When hospital staff is well-trained, mothers and families are more likely to receive accurate, consistent information and support from the entire health care team. The IBCLCs on staff can also better utilize their expertise to focus on more complicated breastfeeding situations and even provide some of the needed staff education.

The CDC will soon be sending benchmark reports to individual hospitals that completed the maternity practices survey. Now that we have a national and state-by-state report, we will soon have a report card for individual hospitals, giving us an opportunity to identify areas for improvement.

HCA affiliates are in a unique position to make rapid and substantial improvement due to the work of HCA’s existing Lactation Consultant Workgroup.

Launched initially in 2004 to work on the Perinatal Safety Initiative on "Kernicterus As A Never Event," the Lactation Consultant Workgroup was continued due to the excellent, evidence-based work they had completed. Best practice policies have been recently updated and can serve as a guide to hospitals wanting to update or improve their own policies. Recommendations on various available offerings for quality staff education on breastfeeding are currently being developed. The Lactation Consultant Workgroup has also been used as an ongoing resource for all HCA affiliated hospitals whenever questions have arisen related to the care of breastfeeding mothers and children.

Moving a hospital to evidence-based breastfeeding care often requires more than just implementing a policy. It requires a culture change. The BFHI is the model for making that culture change. To date, Kaiser Permanente hospital system has the most Baby-Friendly certified hospitals in the United States. Currently there are no HCA affiliates that are Baby-Friendly certified. If HCA affiliated facilities took the lead on this initiative, we could have a major impact on breastfeeding rates around the country and thus improve maternal and child health far beyond the few days stay in the hospital. At the very least, we could avoid readmitting newborns who "wouldn't wake up."

References:
EMAR Optimization in periOperative Services

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National incident reporting data indicate that periOperative patients are at increased risk for medication errors, with five percent of errors resulting in harm. This is three times higher than the percent of errors in the rest of the data base! The study of the national literature shows that one in every 150 anesthetized patients is a victim of medication related harm. The operating room is the place in the hospital where the most potent drugs are given to patients. Combinations of drugs and gases are used to render patients unconscious so that surgical procedures can proceed without the patient being in pain or moving. As Surgical Services continues to address the elimination of surgical site infections, the use of antibiotics in particular has become an area of focus for the surgical team.

Safe medication administration practices contribute to positive outcomes for patients. Although current hospital processes could predispose patients to harm, opportunity exists to improve the quality of care, decrease cost of care, and prevent medication errors. HCA started its journey of using patient safety technology to prevent and detect errors in 2000, following the release of the landmark IOM report, To Err is Human, which reported that 98,000 patients die annually as a result of medical errors. HCA caregivers adopted a safe electronic medication administration process and acknowledge that eMAR incorporates the bar-code scanning technology. As of December 2006, all HCA affiliated hospitals are using this technology in the inpatient setting.

The 'Measuring and Monitoring' reports demonstrate that the use of eMAR and barcoding in the acute care setting enables caregivers to capture the most complex and severe adverse drug events. The use of health information technology (eMAR) paired with item specific identification (barcoding) enables the user to administer medications with general confirmation of allergies, interactions, expired medications, etc. The system provides caregivers with clinically significant warnings that prevent the caregiver from making an error. Many nurses, who once said that they felt confident that they did not make medication errors, became big fans of the eMAR and barcoding system once the system alerted them to an error they were about to commit.

Montgomery Regional Hospital in Blacksburg, VA initiated the process to extend this technology into the intraoperative arena. The Anesthesia Department, in collaboration with surgical leadership, approached the Clinical Services Group with the request to use eMAR and barcoding in surgery medication administration by nurses and by anesthesia. The team felt that it would be an achievable goal given the recent enhancements made to the eMAR functionality, the eMAR Desktop.

The journey started in May 2008 with a thorough evaluation of current medication management processes in the surgical area at Montgomery Regional, gap analysis and flowcharting of the future process. The team quickly realized that the benefits of using eMAR were:

- eMAR creates a single source of truth, through a comprehensive record of the medications administered to the patients throughout their care.
- The software provides lab values for review/verification before administration of medication based on set up of lab test view groups.
- Creates a consistent electronic method of hand off communication throughout the continuum of care.
- Allergy/Interaction checking is available if patient allergy information has been updated by pharmacy in the system at any point prior to or during the current visit.
- Verifies medication administered with the medication procured from an automated dispensing machine.
- Validates the med removed from the dispensing machine for the correct patient if using profile dispense.
- Aids in the use of billing on med administration that enables real time billing, thus improving the accuracy, timeliness and defensibility of the charges.

On the day of the 'go live,' two perioperative nurses and two anesthesiologists were identified as the alpha pilot group. It was agreed that one OR suite would use the eMAR Desktop for a series of ENT procedures. The use of eMAR in the OR by nursing was uneventful, and the staff described it as, "easy to use." Therefore, on day two, the entire OR nursing staff asked to implement the use of eMAR in all six ORs. Anesthesia use was expanded to two ORs. Daily assessment meetings were held during the first week to evaluate and

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EMAR Optimization in PeriOperative Services, Cont’d.

resolve any challenges that arose. At the end of the week, it was determined that the OR staff would continue using eMAR as would the rest of surgical services. The anesthesia use of eMAR, even though successful, was deferred until a later date in order to obtain a more optimal equipment setup for the anesthesia workspace. The piloting Anesthesiologists were disappointed and wanted their barcode scanner back!

HCA’s original focus for eMAR and barcoding was the inpatient setting. However, the tremendous improvements in medication safety that have resulted from eMAR use in the inpatient setting have prompted HCA leadership to commit to expanding this technology to all areas of the hospital, including surgical services.

Next steps:

- The Montgomery Regional Hospital team and HCA Clinical Services Group will share lessons learned from the pilot.
- An implementation toolkit will be posted to Atlas by the end of the year.
- A series of conference calls will be scheduled to demonstrate the new software functionality and answer questions about process changes in the operating room.

Perioperative eMAR and barcoding: Coming soon to an OR near you!

The authors want to thank the following for their assistance in conducting the pilot at Montgomery Regional:

- Scott Hill, CEO
- Loressa Cole, CNO
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- Sean Albert, Cindy Howlett and Vickie Tittemary, IT&S, Capital Division
- Teresa Sartain, IT&S Product Development, HCA
- Pamela Booker, Clinical Services Group, HCA

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2. Bowdle, TA: Drug Administration Errors from the ASA Closed claims Project, 2003

Cell Phone Technology Risk: Smile, You’re on Candid Camera!

BILL LAXTON, RN, Manager, Risk Management Consultative Services, HCI

The document, HCA Guidelines for the Use of Wireless Communication Devices in Healthcare Facilities, was posted on the HCA intranet in July 2007. Those guidelines advise facilities to restrict cell phone/wireless device use in the immediate vicinity of highly monitored patients. However, hand-held wireless devices now allow a user to not only have telephone access, but internet and satellite access as well. In addition, a high percentage of hand-held communication devices are capable of taking photographs and/or short video sequences. Advanced technology available to healthcare professionals provides faster communication, access to information and data, and electronic documentation alternatives. So how can a facility risk manager guide staff members in addressing the questions and concerns raised by "camera phones?"

The basic premise in restricting use in the immediate vicinity of highly monitored patients is to prevent electromagnetic interference (EMI) with the monitoring equipment. The new generation of hand-held devices has decreased most concerns around EMI; however, the technology brings on a number of new concerns about privacy and consent.

Facility policies currently address consent, use of the photograph/video, and documentation. Most policies addressing photography in the facility apply to certain areas and uses. For example, a number of invasive procedures are documented by video. In the same vein, some facilities augment documentation of skin condition through the use of photographs. The Health Insurance Portability and Accountability Act, enacted to assure the protection of an individual’s healthcare information, makes the issue of patient photography a major concern.

Camera phones are particularly problematic in that so many people have them. Most people don’t even notice cell phones anymore, and the camera phones are so small, a person would be unaware that their picture was being taken and sent by email almost immediately. Not only do visitors and patients have

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Often the staff is unfamiliar with pharmacokinetic and pharmacodynamic differences between children and adults. The report also addresses the lack of research in the area of pediatric medication errors, particularly in the Emergency Department, and the need for research in this area.

It is imperative that healthcare professionals in the emergency department develop an increased awareness of the challenges faced in delivering safe and effective care to both children and adults. It is also important to emphasize that there are relatively simple strategies available that can be implemented to help assure that the best care is being delivered to all patients, including the pediatric population.

**Review of the Literature**

Medication errors are the most common type of medical error to affect children. Indeed, when these errors occur, children run responsibilities relating to obtaining patient consent for photography and protecting patient privacy.

- Ensure the patient is provided information related to their privacy and understands how to address concerns related to unwanted photography.

Attempts to provide comprehensive guidance about this issue is prohibited due to space and time constraints; however, this article should help create an awareness of potential risk issues surrounding patient privacy and the proliferation of devices capable of photographing patients and staff.

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PREVENTING PEDIATRIC MEDICATION ERRORS IN THE EMERGENCY DEPARTMENT, Cont’d.

a much higher risk of death than adult patients. One of the particularly challenging factors involving children is the variability of their height and weight. This, coupled with the need for weight-based dosing, makes math errors a common occurrence. Posing a particular danger for children is the 10-fold error. In a small child, the 10-fold dose may be administered in a single syringe and may not provide the same visual cue to the person administering the medication as a 10-fold adult dose.

The necessity for nurses to do math to convert a dose in milligrams to milliliters is also a factor in medication errors in children. Sometimes, math errors may be due to poor math skills, and other times they may be due to the chaotic and hurried pace in an emergency department, making double checking of dose calculations very difficult.

Additional challenges in the emergency setting include off label use, meaning medications haven’t been subject to the same trials in pediatric patients that are required for Food and Drug Administration approval for use in adults. A medication may not be available in a form appropriate for dosing in small children. Even if available, appropriate formulations of the medication may not be stocked by the facility in an attempt to optimize the inventory. When the appropriate dosage forms are not available, manipulation of the product may be necessary prior to administration. Nurses have reported using an IV form of a medication mixed in cherry syrup and given orally, as well as using small pieces of a dissolvable tablet for administration in infants and toddlers. Such practices introduce additional risk of error and may alter the efficacy of the medication.

Strategies for Improving Pediatric Medication Safety

Culture change is the key for preventing medication errors and improving patient safety in the ED as well as in the rest of the facility. Included in this culture change are reporting systems that are non-punitive, critical assessments to uncover potential for risk in emergency departments, and improved communication (including handoffs) among team members. Key to all of these interventions is keeping the patient at the center of the process. Even then, culture change can be difficult and lengthy as we challenge our status quo and move forward to improve safety for our patients.

Throughout 2007 and 2008, the Clinical Services Group was involved in two observational studies involving 10 different emergency departments across HCA. The first study was conducted in order to assess the impact of a new medication administration system on preventing pediatric medication errors in the ED. The second study was completed in order to see if there are any low-cost, low-risk, high-reward ‘low hanging fruit’ that could be recommended to help our affiliated facilities reduce medication errors not only in pediatric patients, but in adult patients, as well.

Both studies illuminated the deviation from accepted practice in the medication administration process as outlined below. The following steps in the process could help staff detect potential errors before they occur. Process deviations include (data from both studies):

- **Failure to verify allergies prior to administration** of medications (38-31% of cases)
- **Failure to follow proper procedure for eMAR scanning** of the patient (25-60%)
- **Failure to identify the correct patient** (100% of patients had armbands) (16-76%)

Implications for Emergency Department Staff

Healthcare professionals in the ED are at the front line of preventing medication errors. The first step is to bring awareness to the problem. Most emergency department staff in HCA affiliated facilities do not work in pediatric emergency departments, and may not have specific pediatric training. HCA emergency departments treat over 1.2 million pediatric patients per year, according to the ED Dashboard. Despite that number, an individual nurse in an individual ED may rarely see a pediatric patient. Next, staff need to critically assess the medications administered routinely to children. In a recent sentinel event alert addressing pediatric medication errors, the Joint Commission highlights the need for standardization of concentrations and dose strengths of medications administered to children, as well as several other safety recommendations.

Finally, facilities need to look at both departmental medication preparation areas and medication administration process. Medications should be prepared in an area that is free from clutter and interruptions. Prior to administration, it is imperative that the patient be properly identified and that the patient’s allergy history is reviewed. **Focusing on the five rights of medication administration (right patient, right drug, right time, right dose, right route) can help reduce errors.**

References:

We want to congratulate the following who recently earned the designation of Certified Professional in Healthcare Risk Management (CPHRM) from the American Hospital Association Certification Center:

- **Dave Coughlin** — Gulf Coast Medical Center, Panama City, FL
- **Lynn Grace** — Specialty Hospital, Jacksonville, FL
- **Tori Howk** — TriStar Division, Brentwood, TN
- **Katarina Kemper** — Rose Medical Center, Denver, CO
- **Sharon Lapkin** — Henrico Doctor’s Hospital, Richmond, VA
- **Judy Richardson** — Parkridge East Hospital, Chattanooga, TN
- **Lisa Roberson** — Parkridge Medical Center, Chattanooga, TN
- **Tamara Winkler** — Southern Hills Hospital & Medical Center, Las Vegas, NV

According to the American Society for Healthcare Risk Management (ASHRM), the CPHRM designation "...provides a credential based on a solid assessment that verifies a broad-based knowledge of risk management. Certification elevates professionals in an increasingly competitive marketplace. This designation is awarded based on participants meeting eligibility requirements and passing an examination."

If you are interested in learning more about how you can achieve this designation, as well as how to access the Study Guide and Self-Assessment tool, visit [www.ashrm.org](http://www.ashrm.org) or call 312.422.3715.

And, if you have received your CPHRM designation, please let us know so we can share your good news in the next issue of RiskWatch! Contact Dr. Ches Alper at ches.alper@hcahealthcare.com.

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**Claims Free Discounts for Employed and Contracted Physicians/Extenders**

**DIANA TURNER**, Senior Underwriter, HCI

Beginning January 1, 2008, HCI offered claims free discounts to eligible employed physicians/extenders. HCI will now offer the same discount to eligible contracted physicians/extenders effective 1/1/2009. Eligibility criteria are as follows:

- Claims-free physicians/extenders who have been insured by HCI for at least five years will automatically receive a 20% discount.
- Claims-free physicians/extenders who have been insured by HCI for at least three years will automatically receive a 10% discount.
- All other physicians/extenders must submit claims history reports from prior insurance carrier(s) for a discount to be considered.
- Residents and part-time physicians/extenders are eligible, too.

As a reminder, the list of eligible physicians and extenders follows and a completed application is required for these categories:

- Physician and surgeon (MD, DO, DPM)
- Allied health professional (Extender)
  - Oral Surgeon
  - Dentist
  - Chiropractor
  - Optometrist
  - Nurse Practitioner
  - Physician Assistant
  - Nurse Midwife
  - Certified Registered Nurse Anesthetist
  - Surgical Assistant/Technician

As an added note, HCI has three new specialty classifications. They are surgical assistant/technician, bariatric surgery and pediatric surgery.

A copy of the Physician & Physician Extender Professional Liability Application, can be found at [http://atlas2.medcity.net/portal/site/icg/](http://atlas2.medcity.net/portal/site/icg/). And, if you should have any questions, feel free to contact Diana Turner at 615-344-2091.
Tim Morris recently joined the HCI Claims Department as the Claims Investigator for the East Florida Division. Tim has over 12 years of medical malpractice experience and comes to HCI from ProAssurance. Welcome aboard, Tim!

OCTOBER
15 The BIG DEADLINE DATE for most of the Premium Credit requirements
15 Sullivan Audit tool closes for 3Q data entry
31 HCI Annual Chili Cook-off (Look for the results in the January RiskWatch!)

NOVEMBER
5 Extended deadline for posting CPHRM documentation in facility TeamRoom
5-7 New Risk Manager Orientation; Contact: Ches Alper
15 Deadline for entering 3Q Metrics data in Streetwise
27-28 Thanksgiving Holiday: Corporate Offices Closed

DECEMBER
1 Due date for articles for January's RiskWatch
24-25 Christmas Holidays: Corporate Offices Closed

RiskWatch Distribution
The RiskWatch newsletter is distributed electronically to risk managers in HCA and Capella affiliated facilities, as well as to Group/Division Offices and Corporate personnel. The recipients of this newsletter should route it to others within their facilities in order to help distribute information more efficiently. This would include, at a minimum, the CEO, CFO, CNO, Quality Director and Safety Director, as well as any Department Director who would have an interest in a particular article.

Back issues of RiskWatch can be found on Atlas at http://atlas2.medcity.net/portal/site/risk. Click on "Publications" and then on "RiskWatch." From there, simply scroll down to find the issue you want.