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"Boston Med" show raises questions about media access in hospitals

Same issues at play on smaller scale with local television crews

Health care providers are becoming more open to the media and willing to comply with requests for access that in years past would never have been allowed, but a television series is raising questions about how much media access is too much. The ABC series "Boston Med" brings those issues to light as it depicts the physicians, staff, patients, and families who were filmed over a four-month period at Massachusetts General, Brigham and Women's, and Children's Hospital Boston.

The series has been lauded in the press as an educational and emotional glimpse into the everyday life of a hospital, but some legal and risk management experts are wary about the potential downside of such media exposure. They also point out that the concern is not just for the handful of hospitals that will ever be invited to participate in a prime time network television show, but also for health care providers who are approached by local news media for much smaller scale productions.

"Boston Med" is just an especially prominent example of how media access can create potential legal liabilities and ethical concerns, says plaintiff's attorney **Tanya Gendelman**, JD, in Brooklyn, NY. The same issues will arise when a small-town news crew asks for similar "behind the scenes" access to a health facility, she says.

EXECUTIVE SUMMARY

A television series that depicts three Boston hospitals is raising questions about allowing camera crews extensive access to patient areas. Some critics question whether the hospitals are violating patient privacy and risking legal liability.

- Previous participants report a good experience with such documentaries.
- Some attorneys and risk managers say the risk is too high.
- Camera crews were allowed to videotape patients before obtaining consent.

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'Disaster waiting to happen'

As a plaintiff's attorney, Gendelman sees plenty of opportunity for legal action and says the hospitals are foolish to expose themselves so much.

"The 'Boston Med' TV show is yet another example of a potentially huge legal and financial disaster waiting to happen," she says. "In the long run, open media coverage of everyday events at these hospitals could force the hospitals' closure due to major medical, legal, and financial liabilities."

Hospitals run the risk of compromising their mission, Gendelman says. Even if the media presence is thought to have a minimal effect on patient care, she asks why even the smallest impact is tolerated.

"A hospital is not a movie set. When it comes to saving people's lives, no reputable medical provider in his or her right mind would want this kind of notoriety, unless they are looking to switch careers from medicine to television and movies," Gendelman says. "For example, a doctor performing surgery on a patient under critical conditions, could be easily distracted by having a TV camera in his face. And it would take more of the medical staff's valuable time to prepare for surgeries, not to mention a much greater exposure to infectious diseases brought in from the outside by the TV crews and their equipment."

Informed consent problem

One major problem with such media access is the issue of informed consent, Gendelman says. Camera crews are allowed to film patients and distraught family members without asking their permission, and then the producers seek permission to air the footage. If the patient or family member says no, the footage is not used, according to the hospitals and ABC.

But Gendelman says that asking permission after the fact does not solve the problem. Even though the person can refuse permission later, that will not change the fact that a camera crew producing a commercial, for-profit product was allowed to film the patient's most difficult and private moments, she says. That dilemma was illustrated in the first episode of "Boston Med," which included a story line about a police officer being shot in the face. When he arrived for trauma care, the camera was looking over the shoulders of the trauma team, directly into his bloodied face. He could not possibly have given consent to be filmed at that moment, much less truly informed consent, Gendelman says. Even asking him at that time would be unreasonable, she says.

The result, Gendelman says, is a depiction of the hospital violating the man's right to privacy in a terrible moment.

"In our country's presently popular notion of

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transparency, this type of a TV show is a straight road not only to civil, but criminal liability, as well," Gendelman says. "Allowing wide access to doctors, staff, and their patients is simply a bad idea. There may be hundreds of various liability issues, each one coming down with a force of a lethal weapon against the very people who have brought additional troubles upon themselves in our already failing medical system."

Not the first series

"Boston Med" is not the first such series about hospital life. ABC broke new ground in this area with the 2000 show "Hopkins 24/7," by the same producer who did "Boston Med," Terence Wrong. (Wrong did not return phone calls by *HRM* seeking comment.) The same risk management issues were raised at that time, but a spokesman for The Johns Hopkins Hospital says none of the worries came to fruition, and the experience was positive for the hospital. *(See p. 88 for more on the Hopkins experience.)*

Some of the concerns over "Boston Med" involve the way the show was being advertised and comments made by the producer. Some television ads showed dramatic scenes of someone fighting in a hospital, a staff person carrying leather restraints, plus doctors and staff carousing after hours. Wrong was quoted in the *New York Daily News* as saying that the show would depict medical errors or other problems.

"In a few cases, it's due to the inexperience of residents," he told the *Daily News*. "In another case, which you'll see, it's a major error in a surgery."

Contract language important

Risk managers must be involved in the decision process when an organization considers special media access, says **Michelle Hoppes**, RN, MS, AHRMQR, DFASHRM, president-elect of the American Society for Healthcare Risk Management in Chicago, and president and CEO of Patient Safety and Risk Solutions in Grand Ledge, MI. The risk manager should weigh the risks and benefits, using an enterprise risk management approach, she says.

The enterprise risk management approach requires looking at the potential risks and the willingness of the organization to take on those risks in exchange for the expected benefits, she says. The evaluation should include the financial risk, the market share risk, the operational risk, and the reputation risk.

"I would assume that in this situation, the benefits would be to educate the public, help them understand the provider's role, and to gain public support and help advance the mission of health care," Hoppes says. "Then we have to look at the risks."

And there are definitely risks, Hoppes says. The first concern is patient privacy and whether people truly understand what they are getting into when they give consent for their images to be used in the television program, she says.

The issue of consent with camera crews is difficult, Hoppes says. Anyone agreeing to be on camera must truly understand what he or she is signing, or the consent is not valid, she says. The agreement with the media should state that the health care provider is in charge of determining what patients may be approached for consent and when, she says.

"There is a very fine line between trying to be transparent and increasing the public's awareness vs. respecting the patient's privacy at a very sensitive time" she says.

Public image at stake

Such a media event could have a positive or negative outcome, depending on how the program is portrayed. There is the risk that the hospital's public image could suffer from something shown on the program, she says. Hospitals may have little control, if any, over what is eventually shown. When asked about her thoughts of showing a medical error as part of the documentary, Hoppes indicated the depiction of a medical error on television is not necessarily a bad thing, if it is used as an opportunity to inform the public about the realities of health care and also the efforts towards patient safety.

"It potentially demonstrates that humans are fallible, but you also should show the many mechanisms in place, the checks and procedures, the safety net that is in place to ensure patient safety is a top priority," Hoppes says. "We'd want to promote our risk management profession's mission, safe and trusted health care, rather than causing concern and fear for our patients. This is certainly an area for caution."

Risk managers should require some degree of involvement regarding who is approached for

videotaping and what is shown on the program, Hoppes says. It is vital that the program be an honest, well-rounded depiction of the hospital — a documentary vs. a drama for ratings. The contract with the producers should stipulate that the show will provide that balanced approach, showing not only the mistakes, but also the system that prevents them, Hoppes says.

"If it is not a balanced approach, but just drama for a television show, then I would urge great caution there," Hoppes says. "I don't think that is promoting our mission of safe and trusted health care, and it could cause real concern among our patients. I would want to make sure that our message of dedication to patient safety comes through loud and clear."

Risk manager involved from start

The risk manager at two of the "Boston Med" hospitals — Massachusetts General Hospital and Brigham and Women's — was concerned about all those issues when she first heard of ABC's interest in filming at the hospital. **Marilyn A. McMahon**, JD, says most of those concerns were worked out in the contract with ABC before filming ever began, she says. The patient confidentiality issues, for instance, were addressed with the consent forms the crew used for any patients, family, or staff who appeared on camera. If someone was incidental to a scene, but did not want to be shown on television, that person's identity would be blurred.

The staff also were allowed to opt out of the filming, and some did so, McMahon says.

ABC had its own forms the network wanted to use, but McMahon insisted on reviewing them to ensure compliance with HIPAA and state laws. In addition, ABC agreed in the contract that the crew would stop filming any time a patient asked them to.

"Even though this was a crew that had worked in hospitals before, we put them all through the same HIPAA training that we put all our employees through," she says. "We figured, if nothing else, it wouldn't hurt for them to have a refresher."

McMahon says she also considered the impact on the hospital's reputation and how footage from the show might be used against the hospital in court. She says she was swayed by the fact that the health care industry is pushing for more openness and transparency, and the public expects it.

"That was my job to consider the risk and bring that to the senior people in the hospital who were trying to make the decision whether to do this," she says. "You have to have a lot of faith in the people who are doing this, and we had the benefit of knowing that they had a lot of experience doing this in a hospital before. We knew what their process was and what their product looked like."

The error in surgery discussed by the producer occurred at Massachusetts General, McMahon says. Because they were confident that ABC would depict the entire situation rather than focusing on the error itself and blaming individuals, McMahon says she was not overly concerned about the error being shown on television.

McMahon says she expects the experience to be positive, showcasing the hospital's physicians and staff, and also demystifying what goes on in a large hospital.

"I know there will be people who focus only on the negative, but I'm confident that the public will take away a positive image of the hospital from this," she says.

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Johns Hopkins says TV show worked well

Many people, including a lot of risk managers, thought The Johns Hopkins Hospital in Baltimore was taking a huge risk when it allowed ABC television crews extensive access to produce the groundbreaking series "Hopkins 24/7" in 2000. But the experience was overwhelmingly positive, says **Gary M. Stephenson**, MS, senior associate director for media relations and public affairs with Johns Hopkins Medicine.

The experience was so good that the hospital did another ABC series called "Hopkins" two

years ago, Stephenson says.

"We had very little negative experiences as a result of both experiences," he says. "There was some initial criticism of one scene when a large sea turtle from the Baltimore Aquarium was CT'ed to determine why the animal was not eating. The turtle had swallowed a large ball. A few viewers thought we were diverting resources and technologies to animals when they could be better used on human patients."

Hopkins explained that the physicians did the scanning on their own time using a CT unit that was being calibrated and was not yet used for human patients. Stephenson says there was also some minor concerns voiced regarding patient privacy, but he says those concerns were largely dispelled when Hopkins explained its protocols.

Advance consent was obtained in almost all cases, he says, and all ABC employees involved in the shoot were trained in HIPAA and hospital hygiene. Certain areas were off limits to filming, such as psychiatry, because obtaining informed consent was problematic.

"Patients filmed had the right to rescind their consent after filming also, but to my knowledge, no one did," Stephenson says. "There were no lawsuits or threat of lawsuits or any other legal actions. Patients who were included enjoyed the series and welcomed the opportunity to tell their stories."

Physicians and staff had the option of opting out of the filming, and a few exercised that option.

"We think the portrayal of Hopkins and its employees was accurate and honest. This was, after all, a documentary, and what viewers saw were the realities of a major, urban-based academic medical center," Stephenson says. "We had the confidence in our staff to know if their stories were portrayed objectively, there was little chance of problems. That turned out exactly to be the case."

For any hospital considering such an arrangement, even on a much smaller scale, Stephenson says the first step is to get leadership buy-in.

"Without the full support of top administrative and clinical leadership, it's difficult to move the process forward. Secondly, make sure all protocols are clearly articulated up front by all parties and become part of a formal memorandum of understanding between the two parties," he says. "Work closely with your legal and HIPAA staff to make sure the consent forms are appropriate and that all other legal and ethical issues are addressed. Have faith in your staff. Have fun."

SOURCE

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Violence on the rise, more attention needed

Health care facilities are being confronted with steadily increasing rates of crime, including assault, rape and murder, according to a new report from The Joint Commission (TJC) in Oakbrook Terrace, IL. Providers must devote more attention to protecting patients, visitors, and staff from violence, the report says.

The Sentinel Event Alert urges greater attention to the issue of violence and to controlling access to facilities to protect patients, staff, and visitors, noting that assault, rape, and homicide are consistently in the top 10 types of serious events reported to TJC. The alert cautions that the actual number of violent incidents is significantly underreported and advises organizations to mandate the reporting of all real or perceived threats.

To prevent violence in health care facilities, the alert newsletter suggests that facilities take a series of 13 specific steps, including the following:

- Evaluate the facility's risk for violence by examining the campus, reviewing crime rates, and surveying employees about their perceptions of risk.
- Take extra security precautions in the emergency department, especially if the facility is in an area with a high crime rate or gang activity. Precautions might include uniformed security guards, scanning people entering the building for weapons, and inspecting bags.
- Conduct thorough background checks of prospective employees and staff.
- Report crime to law enforcement.

Standards apply to violence

In addition to the specific recommendations

contained in the alert, TJC urges hospitals to comply with the requirements described in its accreditation standards to prevent violence. The standards require accredited health care facilities to have a security plan, as well as conduct violence risk assessments, develop strategies to prevent violence, and have a response plan when a violent episode occurs.

TJC standards also are clear that patients have a right to be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse. While there are many different types of crimes and instances of violence that take place in the health care setting, the alert specifically addresses assault, rape, or homicide of patients and visitors perpetrated by staff, visitors, other patients, and intruders to the institution. TJC's Sentinel Event Database includes a category of assault, rape, and homicide (combined), with 256 reports since 1995 – numbers that are believed to be significantly below the actual number of incidents, due to the belief that there is significant under-reporting of violent crimes in health care institutions, the report says. *(For the full text of the alert, go to http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_45.htm)*

"While not an accurate measure of incidence, it is noteworthy that the assault, rape, and homicide category of sentinel events is consistently among the top 10 types of sentinel events reported to The Joint Commission," the report says. "Since 2004, the Sentinel Event Database indicates significant increases in reports of assault, rape, and homicide, with the greatest number of reports in the last three years: 36 incidents in 2007, 41 in 2008 and 33 in 2009."

Top causes identified

The report says the following contributing causal factors were identified most frequently over the last five years:

- **Leadership** — Noted in 62% of the events, most notably problems in the areas of policy and procedure development and implementation.
- **Human resources-related factors** — Noted in 60% of the events, such as the increased need for staff education and competency assessment processes.
- **Assessment** — Noted in 58% of the events, particularly in the areas of flawed patient observation protocols, inadequate assessment tools, and lack of psychiatric assessment.
- **Communication failures** — Noted in 53% of the events, both among staff and with patients and family.
- **Physical environment** — Noted in 36% of the events, in terms of deficiencies in general safety of the environment and security procedures and practices.
- **Problems in care planning, information management, and patient education** — These causal factors were identified less frequently.

Must improve reporting

Hospitals have long tried to keep incidents of violence quiet, says **Tim Dimoff**, a former police detective and SWAT team member who founded SACS Consulting, a security services company in Akron, OH. They fear that patients will be driven to competing hospitals if word gets out about violence in the facility, Dimoff says.

"I do see hospitals recognizing that they need to be more proactive in preventing violence, rather than just hiding it," he says. "In the last five years, I've seen much more activity with hospitals conducting assessments, running drills and table-top exercises, planning for potential violence. Hospitals are finally realizing they need to have an organized system for preventing violence."

Risk managers should start by conducting an assessment of the hospital's security and vulnerability, Dimoff says. Determine the strengths and weaknesses of the facility, he says.

In addition, the hospital must train physicians, nurses, and other staff in how to deal with threats of violence, he says. Clinicians and other staff usually are the first to deal with a person who shows signs of potential violence, so they should know how to recognize those signs, how to de-escalate the situation, and how to respond if the person does get violent, he says.

Train staff to de-escalate

The hospital also must send the message to the community, and individuals in the hospital, that violence will not be tolerated, and that it will be met with swift and decisive action, he says. That doesn't mean turning the hospital into an armed camp or having guards run roughshod over people, but it does mean having trained security personnel respond quickly, he says. For instance, Dimoff says it can be a good idea for staff to call security when they are about to confront a person

they suspect may get violent.

"If the nurse is about to give some bad news to someone who already seems aggressive, there's nothing wrong with having a security guard stand nearby," he says. "It's not overbearing, but it gives the message that you're ready if the person decides to get violent and that it won't be tolerated."

The assistance doesn't have to come from a security guard, Dimoff explains. Another staff person can discourage violence simply by being present, he says.

"Why, as a nurse, would you go in a room alone with a person who is very upset and encounter him one-on-one?" he says. "You can go in the room to encounter the individual, but you have another person standing [in] the doorway. That is a de-escalation move. The person sees that there is another person watching and listening, and it discourages violence."

Staff also must be trained to call for help at the first sign of aggression, rather than brushing it aside and moving on. Too often, nurses let the person act out aggressively without calling for help, and each instance becomes more serious. By the time the nurse is concerned enough to call for assistance, the person has become violent, he says.

"That's the opposite of what we want to see with de-escalation," Dimoff says. "The longer you wait, the harder it is to stop it."

Code Orange brings help

Gang-related violence has become a bigger concern in recent years for **Georgene Saliba**, RN, HRM, CPHRM, FASHRM, administrator for risk management and patient safety at Lehigh Valley Hospital & Health Network in Allentown, PA, and 2009 president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. Lehigh Valley has recently improved its security by taking the steps outlined in the TJC alert, and she says other risk managers should take the issue seriously.

"Clearly, violence has increased," Saliba says. "The Joint Commission is trying to provide hospitals with guidance, and we should take advantage of what they're offering. They have seen the increase in violence in their own statistics, and I'm sure most facilities could look at their own data and find that you're seeing more violence than before."

Hospitals are always at risk of violence, because the doors are open to anyone who wants to come in, notes **Gerald Kresge**, CHS III, director of security at Lehigh Valley. And the nature of health care also means that people will be put in situations that may push them beyond their capacity for self-control, he says.

"A lot of times we think in terms of violence coming from the drug user or the gang member in the emergency room, and we build almost all of our plan around that kind of scenario. But what really happens in a hospital is that the person who was just told his child died can act out against staff, or the family member who is distraught about a loved one in surgery," Kresge says. "Remember that a person can be the most calm, level-headed, decent citizen, but if you call him at 4 a.m. and tell him his son was in an accident, that's not who shows up at the hospital. The person who shows up is scared, angry, anxious, and they can act out in unexpected ways. That is extremely dangerous if you don't handle that well."

Kresge says the current economic situation only increases the risk of violence, as many people already are stressed before their experience at the hospital.

One of Lehigh Valley's efforts is a "Code Orange" program, in which staff can call for help from other staff who are trained in de-escalation. Staff undergo a two-day program in verbal and physical de-escalation techniques. When the Code Orange call goes out, a minimum of five people respond, Kresge says.

Lehigh Valley's work in reducing violence has paid off. Kresge tracks intervention injuries, or those that occur when staff have to intervene with a violent patient, and the figures have dropped off sharply after the security assessment and training programs.

"We've gone three or four years now without a serious intervention injury," he says. "That's attributable to training and intervening early."

Must focus on prevention

Tony Kubica, a founding partner of Kubica Laforest Consulting in Warwick, RI, was vice president of hospital services, with responsibility for security, at an urban hospital in the Northeast in the early 1990s, when a rise in violence prompted concern. Violence and other crime at the hospital became known in the community, and media outlets covered the problem extensively, he says. That forced the hospital to confront the problem. *(For details on how Kubica's hospital addressed the*

problem, see "Seven steps," below.)

"The Joint Commission's Sentinel Event Alert raises an important issue for hospital executives — one that must be taken seriously," he says. "The alert outlines actions that should be taken to reduce the level of violence within and in the vicinity of the hospital."

Kubica says he learned that violence must be addressed as a primary concern for the hospital, not merely an afterthought. In particular, he says, someone in the organization must be solely responsible for security.

"Too often, this responsibility is tacked onto someone else's job duties, and it doesn't get the attention it deserves," Kubica says. "If you want to get serious about improving security and reducing violence, you have to devote the manpower and resources necessary for achieving that goal."

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Seven steps to reducing violence in hospitals

Violence can be reduced in hospitals only by addressing the issue head on, says **Tony Kubica**, a founding partner of Kubica Laforest Consulting in Warwick, RI, and formerly a hospital executive in charge of security.

Kubica makes the point that reducing violence in hospitals cannot be a piecemeal effort, but rather, it should be a focused effort with a specific goal. The first step in the effort should be hiring a director of security if you don't already have one, he says.

"This should not be a part-time job of the facility manager or anyone else," he says. "Also, this should not be a retirement job for someone in law enforcement unless the person has direct and relevant experience with security issues — the type of issues that are outlined in the alert."

If a security problem exists in the hospital, Kubica says, it is critically important to take decisive and visible action to improve security.

"In our case, we removed the incumbent security firm providing service to the hospital and hired another firm, making a visible transition to the hospital staff," he says. "This can be a challenge in a small community, because there could be an effort to influence board members to hire certain individuals or certain contractors. This should be avoided and the board educated on the need and the best approach to address security needs."

Kubica summarizes the steps he used to improve security at his hospital, steps he says can be applied to any facility:

1. Identify that you have a problem.
2. Acknowledge that problem publicly. (At Kubica's hospital, it was difficult not to acknowledge the problem, because it became a matter of discussion on local talk radio.)
3. Involve the hospital community in active discussions and communication on what is being done and by when. Include the hospital board of directors, because their support for a transition will be important.
4. Take visible and decisive action to improve security.
5. Communicate the plan and its execution thoroughly and often in the organization and to the community.
6. Monitor and report results.
7. Take action to improve. ■

Hospital develops early warning system

A scoring system designed to provide an early warning of patients who may need prompt care has helped a hospital decrease its code blue calls outside the intensive care unit (ICU) by 50% and increase rapid response team (RRT) calls by 110%.

EXECUTIVE SUMMARY

A hospital reports good results from a scoring system that is designed to make nurses aware of patients who need rapid intervention. The system rates patients on different factors and then produces a single score that may prompt action.

- Code blue calls were cut in half.
- Rapid response team calls more than doubled.
- Nurses are prompted to act earlier than they might have otherwise.

The Modified Early Warning System (MEWS) is a simple, validated physiological scoring system that identifies high-risk patients, says **Janice Maupin**, RN, MSN, CPHQ, director of quality and case management at Mercy Hospital Anderson in Cincinnati. The hospital began implementing the system in late 2008, because a review of code blue charts suggested that some of the cardiac arrests might have been prevented if nurses had intervened earlier.

Patients are scored on vital signs, and the higher the score, the higher the risk of mortality, Maupin says.

"We intended to pilot the program for three months, but the results were so good that we called off the pilot and went right away to implementing MEWS hospitalwide," Maupin says.

The score is calculated based on data already charted by nurses. The physiological parameters include heart rate; blood pressure; respiratory rate; temperature; and level of consciousness. Those values are measured routinely in hospitalized patients, and the score enables nurses and physicians to identify patients who are deteriorating and who need urgent intervention, Maupin explains. The MEWS score is also incorporated into existing protocols for utilizing the hospital's RRT.

The system was incorporated into the existing computer system for recording vital signs, minimizing the added work burden for nurses, Maupin says.

Director of risk management **Kristin Boggs**, RN, BSN, says MEWS has been a great tool for reducing the risks associated with codes and the subsequent administrative follow-up.

"That's been huge. When you have patients code in the hospital, it takes up a lot of time in terms of looking at the events, reviewing the processes, determining whether we're doing them appropriately," Boggs says. "MEWS has pretty much eliminated that for us. And from a patient safety perspective, we're just doing the right thing here. When patients do end up coding, we know that we didn't miss anything from a risk perspective."

Results good all over

The MEWS system has been used successfully in Britain and some other facilities in the United States, with users reporting significant decreases in cardiac arrests and crash team calls. A study of 2,974 patients over three years at the Royal Cornwall Hospital revealed a strong relationship between the probability of death and the MEWS score.[1] OSF St. Joseph Medical Center in Illinois reported that the average number of codes per month outside the ICU decreased from 2.2 in the first 12 months to 1.3 during the last 12 months. Total codes at the facility also decreased.[2] In Wales, the Ysbyty Glan Clwyd hospital decreased its crash call rate in half.

To determine how MEWS would have changed the treatment and outcome of patients, Maupin and her colleagues reviewed charts from 2007 of patients who had coded, applying the MEWS score retrospectively to the documented vital signs in the 24 hours prior to the code. They found that 60% of those patients could have possibly been identified an average of 6.6 hours earlier if the hospital had been using the scoring system at that time.

Part of the goal for MEWS is to reduce variability on when to call the RRT and to facilitate timelier nurse-physician communication, Maupin says.

"Nurses sometimes hesitate to call physicians at the first sign of deterioration, because they're just [not] sure; and they don't want to bother the physician unnecessarily," Maupin says. "We teach people that you should go ahead and call the RRT if you just feel like something isn't right. That's a valid reason to intervene, and a lot of RRTs report that that's the reason they're called in about 40% of the cases. MEWS helps people quantify when to call, but even if the MEWS score doesn't require a call, you should go ahead if something just doesn't feel right about your patient."

Prior to MEWS, the trigger for calling the RRT was based on a single parameter being so far off normal that intervention was required. For instance, a nurse would call the RRT if the heart rate was below 50, or if systolic blood pressure was above 200. With MEWs, Maupin explains, the nurse doesn't wait until one of those readings gets that severe. Rather, the combination of several

readings that are bad, but not critical, can add up to a MEWS score that signals intervention.

Deterioration can be seen

At the beginning of each 12-hour shift, or more frequently as indicated, the nurses calculate MEWS scores based on vital sign parameters. The nurse can refer to the MEWS score when describing the situation to a physician, using the score as an indicator of the patient's overall condition.

Maupin provides this example: The patient has a heart rate of 112, which scores a 1. The blood pressure is 98/70, which scores a 1. The respiration rate is 18, also scoring a 1. The temperature is 100.2, which gets a score of zero. On the central nervous system measure, the patient is alert, which also gets a score of zero.

So, the patient's total MEWS score is 4. The nurse can then refer to the MEWS action instructions and see that with a score of 0-2, the nurse should continue routine and ordered monitoring. With total score of 3, the nurse should increase vital signs frequency and inform the charge nurse. At a score of 4, the nurse must inform the physician, charge nurse, and clinical administrator to assess the patient. The nurse increases vital signs frequency and pulse oximetry, closely monitors urinary output, and calls the RRT if output is less than certain levels.

With a score of 5, the nurse calls the RRT and the physician. The nurse also increases vital signs frequency and pulse oximetry. If the patient remains at a 5 score for three consecutive readings, the nurse should request an order for possible transfer to a higher level of care and consider whether an end-of-life discussion is indicated for the patient and/or family.

At a score of 6, the nurse must call the RRT and physician STAT. The nurse should recommend transfer to a higher level of care and consider end-of-life discussions.

The hospital has seen RRT calls increase 110% after implementing MEWS, going from an average of 7.8 to 16.4 calls per 1,000 patient days, Maupin says. Code blues were cut in half, from an average of 0.77 to 0.39 per 1,000 patient days.

"MEWS helps us identify patients at the earliest signs of deterioration," Maupin says. "With earlier recognition, we intervene in the best way and avoid code blues."

REFERENCES

1. Carle C. et al. Use of a modified early warning system to predict outcome in patients admitted to a high dependency unit. *Critical Care* 2007, 11(Suppl 2):P479.
2. Whittington J. Using an automated risk assessment report to identify patients at risk for clinical deterioration. Joint Commission *Journal on Quality and Patient Safety* 2007; 33: 9.

SOURCES

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Nurses become quality, safety investigators

Quality and safety can be improved by providing special training to nurses and then making them the bedside champion for best practices, says **Liz Carlton**, RN, MSN, CCRN, director of quality, safety, and regulatory compliance at the University of Kansas Hospital (KUMED) in Kansas City, KS.

Carlton and her colleagues designed the hospital's Quality Safety Investigator program (QSI), with a designated QSI nurse on each unit.

"The goal was to improve quality and safety right at the bedside, the most direct contact we ever have with the patient," Carlton says. "We wanted the nurses to really own that safe, quality-based patient care."

Currently, there are 39 QSI nurses. Each nurse

EXECUTIVE SUMMARY

Nurses can be empowered to act as bedside safety investigators.
The nurses are given special training and agree to act as mentors and ensure safe patient care practices.
• Nurses must agree to be active participants.
• The nurses receive perks that encourage others to participate.
• Quality assurance experts serve as mentors for the nurses.

participating in the program is given dedicated time to focus on safety and quality initiatives specific to their unit, Carlton says. The nurses attend a monthly two-hour meeting, all paid time. The QSI nurses also undergo special training on topics such as medication safety, handoffs, and hand hygiene.

"We known that nurses don't receive a lot of training in quality issues as part of their nurse education, so we teach them some of the key concepts and techniques, such as the plan-do-check-act cycle and the difference between quality assurance and quality improvement," Carlton says. "We also spend a bit of time in the curriculum talking about having critical conversations. It may be difficult for a younger nurse to talk to a more seasoned nurse about doing the bedside safety check, for instance, so we go through some of those scenarios."

Must agree to be active

Not just anyone can become a QSI nurse, Carlton says. Nurses must go through an application process, and if selected, must sign a contract promising to actively participate. The nurse's manager also must sign a contract pledging to support the QSI nurse and encourage him or her to be active in the program.

"We didn't want anyone forced to do this, so we sent out a notice that asked if they wanted to help others understand and use information to improve quality of care for their patients," she says. "There are people out there who are dedicated to this kind of work, if you just ask them to participate."

Each QSI is paired with a mentor who can help them advance their skills in quality assurance. The QSI is seen as a leader on their unit and is considered part of the leadership team with the nurse manager, practice council representative, unit coordinator, and unit educator.

"Once they become a QSI nurse, they are responsible for helping their colleagues and peers on their unit understand the quality initiatives or create their own that are specific to the unit, and to really be the quality champion for that unit," she says.

There are perks to being a QSI nurse. In addition to receiving the tools necessary to promote quality and safety on their units, they get to wear distinct scrub tops and can go to outside conferences for training. Those benefits can encourage other nurses to join the QSI program, Carlton says.

The results are encouraging after one year of the program. Hand hygiene rates have improved significantly, and pre- and post-testing of the QSI nurses on quality issues shows a much greater understanding, Carlton says.

"We're beginning to see changes in communications patterns, which is kind of hard to track, but it is one of the more important improvements," Carlton says.

SOURCE

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CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- describe the legal, clinical, financial and managerial issues pertinent to risk management;
- explain the impact of risk management issues on patients, physicians, nurses, legal counsel and management;
- identify solutions to risk management problems in health care for hospital personnel to use in overcoming the challenges they encounter in daily practice. ■

COMING IN FUTURE MONTHS

- ■ Grants for reducing malpractice
- ■ Alarm fatigue can kill
- ■ Hospital sued over deaf interpreters
- ■ EMTALA: Refresher education

CNE QUESTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the December issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

5. According to plaintiff's attorney Tanya Gendelman, JD, what impact does extensive media access and participation in a network documentary have on a hospital's liability risk?
A. It greatly increases the exposure.
B. It greatly decreases the exposure.
C. It has no effect on liability risk.
D. It decreases the exposure slightly, and only for a short time.

6. What does Michelle Hoppes, RN, MS, AHRMQR, DFASHRM, say about the depiction of a medical error on a television program?
A. It is always a disaster, damaging the hospital's public image and resulting in a lawsuit.
B. It is not necessarily a bad thing, if it is used as an opportunity to inform the public about the realities of health care.
C. It should never be allowed.
D. A television network would never air the footage.

7. According to TJC's's sentinel event database, since 2004, what has happened to reports of assault, rape, and homicide in health care facilities?
A. There has been a significant increase.
B. There has been a minor and negligible increase
C. The number of reports has remained steady.
D. There has been a significant decrease.

8. When using the MEWS, a score of 5 means the nurse must call the RRT and the physician. The nurse also increases vital signs frequency and pulse oximetry. How is a score of 6 different?
A. There is no difference in what the nurse should do in response.
B. The nurse does increase vital signs frequency.
C. The nurse calls a code blue.
D. The nurse must call the RRT and the physician STAT.

Answers: 9. A; 10. B; 11. A; 12. D.

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

Abuse of Woman at Nursing Home not Investigated; $7.75 Million Jury Verdict

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News: An elderly woman was allegedly abused by employees at a nursing home. The woman's family repeatedly complained to management, who failed to investigate the issue. After more than a year of unaddressed complaints, the family installed a hidden camera in the room. Footage from the camera reveals multiple instances of staff abuse. A jury verdict was awarded in favor of the plaintiff in the amount of $7.75 million.

Background: In 2006, a 71-year-old woman, who, because of suffering a stroke, was unable to speak or walk, began receiving care at a nursing home. Upon visiting the elderly woman, the family noticed bruises on her face, arms, and legs. The family promptly reported these injuries to the management of the nursing home. In addition, the family of another resident residing across the hall similarly complained of alleged abuse by the staff. These complaints were not addressed by the nursing home's management for more than one year.

Frustrated by management's failure to investigate the suspected abuse, the woman's family installed a hidden camera in the room in an attempt to document the abuse. Upon reviewing the footage, the family watched as an employee of the nursing home slapped the woman in the face, pulled her by the hair, roughly handled her neck and hands, and treated her violently while in a shower seat. Management immediately terminated the employee upon viewing the footage.

With her husband of 45 years acting as the woman's guardian ad litem, the woman and her family brought suit against the employee, the nursing home, and the nursing home's owner for elder abuse, negligence, and violation of the woman's rights.

At trial, the plaintiffs showed that multiple families complained to the management about instances of suspected abuse. One of these submitted complaints specifically named the terminated employee. The terminated employee stated that, despite more than a year of notice, she was never interviewed or monitored with respect to the suspected patient abuse. The employee pled no contest to one count of simple battery for abuse on that specific day, and at the civil trial only admitted guilt pertaining to the one day of abuse.

The nursing home and its owner acknowledged that the employee's actions were reprehensible, but claimed that they were outside the scope of her employment. The nursing home further claimed that it had no reason to justifiably suspect the employee of abusing the residents.

The jury awarded the plaintiff $7.75 million, including $3 million in punitive damages against the nursing home's owner and $2 million in punitive damages against the nursing home.

What This Means To You: It is the moral and ethical responsibility of all of society to prevent abuse, neglect, and exploitation of vulnerable children, the mentally ill or impaired, and the elderly.

In most, if not all states, there are laws protecting those who fall into these categories. There are also federal laws that require immediate reporting of suspected abuse, neglect, and exploitation, usually through a state agency. Frontline health care professionals such as doctors, nurses, and home health care providers are referred to as mandated reporters.

The elderly are particularly vulnerable to bruising as a component of the aging process. All large or unusual bruising is not a result of abuse, if it can be explained. Many patients, residents, and clients are taking medications that make them susceptible to easy bruising. As we age, our skin becomes thinner and more vulnerable to a cut from a bump on a surface. Again, with an immediate investigation, many of these events can be explained away. In these instances the investigation results need to be documented in the medical record and the family or surrogate made aware of the condition and investigation results. Communication is imperative.

When suspected or actual abuse is recognized, it is required to be reported to the appropriate state and federal agency immediately and an internal investigation begun. Reports to the federal agency are required, as well. Some states require that the name and number of the abuse hotline be posted prominently throughout the facility. Depending on the state, the federal reports are made through the respective state. Usually within 24 hours of the report, a state investigator will interview the patient, resident, or client. If the investigation shows probable cause, law enforcement will be notified.

In the event of suspected or witnessed abuse, the involved employee or staff member should be immediately suspended until the investigation is complete. Human resources policies and procedures should be followed regarding whether the suspension is with or without pay. However, when the investigation by the authorities is complete, if the abuse is found to be unfounded, the employee should be returned to duty with back pay. Medical staff, vendors, and contracted workers are treated in the same way as an employee in the event of suspected or observed abuse.

Risk managers should be thoroughly familiar with their state and the federal laws regarding the reporting of abuse, neglect, and exploitation of children, the mentally ill and impaired, and the elderly. Systems should be set up to notify risk management immediately of any allegations, reports, suspicions or witnessed abuse, physical or psychological. Risk management should be the point person to coordinate with the state investigators and law enforcement, as well as the internal investigation.

Departmental and human resource (HR) policies and procedures should be developed and implemented regarding identification of and handling of reports or observed abuse and immediate state and federal reporting. Risk management should facilitate, with HR and management, the education of all new hires and annual updates to all employees on these policies and a zero tolerance philosophy of the organization. Regardless of whether a state law or regulation requires the state abuse reporting hotline be posted, risk management should advocate such a posting throughout the facility.

The legal doctrine *Respondeat Superior* comes into play in the situation of an employee involved in abuse of a patient, resident, or client. Simply stated, in these situations, the employer is responsible for the acts of the employee.

In almost all, if not all states, nursing home administrators are required to be licensed. A case such as this might be a trigger for an investigation into the actions of the facility administrator for not making the necessary reports of suspected abuse. It would behoove the risk management team to meet with the administrator to discuss the state and federal statutes, reporting requirements, and to reiterate the internal reporting system to make risk management aware of such family reports immediately.

In this sad case, the resident's family admitted their loved one into the care, control, and custody of this particular nursing home to care for her after a stroke that left her unable to speak or walk. The family's expectations were, as any family would assume, that their loved one would be cared for and protected in the facility. For whatever reason, the nursing assistant assigned to care for this patient abused her, on more than one occasion, reportedly. At no time did the facility undertake an investigation or make the required report to state or federal authorities. Even the corroborating reports made by the family of a resident across the hall from the resident failed to initiate an investigation or a report.

It is unknown if this facility had a risk manager, or if the risk manager was ever made aware of these multiple reports by the family of both of these residents of alleged abuse to administration. Risk managers, working with senior and middle management, particularly nursing management, should emphasize that suspicions, allegations/reports, or observed abuse should be immediately

reported to risk management. As is clearly recognized by this case, abuse is a significant risk exposure to a facility and should be handled as any other potentially compensable event (PCE.) From a potential claim view, failure to initiate an immediate investigation, and to comply with state and federal reporting requirements just makes a bad situation worse.

And of course, one cannot forget the potential of such a case triggering an inspection by the state licensing agency or accrediting body as a result of this kind of outcome.

REFERENCE

1. Superior Court, Ventura County, California, No. 56-2007-288161. ■

Failure to Confine Pregnant Woman: $24.1M Verdict

News: A pregnant woman exhibiting bleeding caused by placenta previa was hospitalized. Twelve days later, while walking to the bathroom, the woman experienced a massive hemorrhage, resulting in the premature birth of her twins. The hospital staff allegedly failed to adequately monitor the mother and confine her to bed, a necessity for women suffering from placenta previa. The resulting injuries to one of the infants have required multiple surgeries and rehabilitative sessions throughout her life, and she suffers from a continual debilitating condition.

Background: In July 1994, a pregnant woman suffering from bleeding caused by placenta previa was hospitalized. Prior to the birth of the twins, the mother had become severely constipated and was administered a laxative. Twelve days after the mother's hospitalization, while walking to the bathroom unattended, the placenta detached, resulting in a massive hemorrhage.

Because of the premature delivery caused by the hemorrhage, the female infant suffered from periventricular leukomalacia, a type of brain injury affecting infants, characterized by the death of small areas of the brain around the ventricles. This brain damage caused the infant to suffer from spastic triparesis, a partial paralysis of her legs and one arm. The resulting hospitalization of the infant lasted 12 weeks and included treatment for respiratory distress syndrome.

At the age of seven, the child underwent a rhizotomy, a procedure where nerve roots are selectively severed to release tension caused by neuromuscular conditions like spastic triparesis. The following year, the child again required surgery to remedy the chronic dislocation of one of her hips. These surgeries each required approximately 12 weeks of rehabilitative therapy.

With the assistance of a physical therapist, crutches, and a brace that covers most of her torso, the child is able to walk. The remainder of the time, however, the child is confined to a wheelchair. The child suffers atrophy of the leg muscles, and doctors doubt she will ever be able to walk independently.

The mother of the infant sued the hospital and several of its employees, alleging that the staff's failure to render proper care constituted medical malpractice. The hospital accepted responsibility for the actions of its staff, and the matter proceeded to trial. At trial, the plaintiff's counsel contended that the hospital staff was aware of uterine bleeding prior to, and during, the hospitalization. Because the hospital staff was cognizant of the bleeding, the plaintiff claims that every measure should have been taken to prolong the infant's gestation by restricting her movements. The plaintiff claimed that, while the bed was fitted with railings, the rails were not deployed at the time.

The plaintiff's counsel asserted that the hospital staff should never have allowed the pregnant woman to become severely constipated, and further, should not have administered a laxative to a woman who was confined to bed rest.

The defendant claimed that the hemorrhage occurred during an unapproved trip to the bathroom while the rails were properly deployed, and that the likely cause of the hemorrhage was engaging in sexual activity prior to hospitalization. The defense further claimed that the mother was not severely constipated and that administration of the laxative was an appropriate treatment. The defendant also contended that the child's current limitations on mobility were caused by unwillingness to rigorously follow the rehabilitative therapy.

A $24.1 million verdict was returned against the defendant-hospital.

What This Means To You: It appears there are many unanswered questions in this scenario. Even so, there are many risk management issues raised here.

A pregnancy with twins is a high-risk pregnancy. A pregnancy with a placenta previa is a high- risk pregnancy. Having both those high-risk issues present in the same pregnancy emphasizes the high level

of risk. A high-risk pregnancy is usually referred to a neonatologist and an obstetrician who specializes in such cases for prenatal care. In the facts given here, we have no reference to the physician's involvement. It is of interest that only the hospital was a defendant in this action.

This is a significant untoward outcome that should have been immediately reported to the risk manager. As a part of the investigation into the event, a root-cause analysis (RCA) should be initiated. Depending on the state, reports to the state may be required, and it may meet The Joint Commission definition of a reportable sentinel event. In addition, by the very nature of the event, it would be reportable to the hospital's liability insurance carrier (depending on whether the hospital is self-insured or commercially insured).

We have information that the patient was bleeding prior to admission and after. We don't know how long after admission the patient became constipated, when the laxative was administered, or what the laxative was. We do know that no medication may be administered to a patient without a doctor's order. The root-cause analysis of this sequence of events may peel back the layers of this onion to answer many of the questions this scenario raises.

Patient care is an all-encompassing process that involves the entire patient and his or her family. We work as a team to take care of patients and monitor all their systems. In this particular case, the patient's intake, nutrition, and fluids were as important as the elimination. While it is nursing staff who usually monitor and document the intake and output, it is also up to the physician to monitor and consider that information and act accordingly depending on that information. The medical record contains documentation of information and data that is to be reviewed and considered by all members of the patient care team, including the physician. One important piece of information we do not have is what documentation was in the record regarding the patient's output; was there documentation, or was it blank? Again, the root-cause analysis would address these questions. Another question this raises is why the physician didn't question the patient's output before the patient became severely constipated. We don't know the laxative ordered. Some laxatives are gentler than others. Was the choice of laxative ordered a factor in the hemorrhage? Was the laxative administered based on a standing order for all hospitalized prenatal patients, or specifically for this patient? This should be revisited with the obstetrical medical staff and as a part of the root-cause analysis.

Pregnancy is not an illness. In this case, the placenta previa and twins were a condition of the pregnancy. That means the staff was dealing with a healthy person who was on bed rest with the goal to control bleeding, prevent abruption of the placenta, and delay delivery as long as possible to provide the fetuses the opportunity to develop as long as possible before being brought into this world. That being said, a healthy pregnant woman would not have had the side rails up, as there was no need to restrain the patient, as having both side rails up would be considered a restraint. Again we don't have enough information here to know why the patient was walking to the bathroom. The root-cause analysis would identify whether the patient called for assistance that never arrived or never asked for assistance as she disregarded the instructions not to get out of bed. One might argue that even if the patient was being assisted to the bathroom whether that would have prevented the hemorrhage. Had the side rails been raised, that may have increased the danger if the patient climbed over the raised side rails or crawled out of the foot of the bed. Again, we don't have information to know if a bedside commode was ordered and at the patient's bedside, or if the patient was on strict bed rest, requiring the use of a bedpan, or if the order was for bed rest with assistance to the bathroom. Education is a part of the admission process of a patient ordered to be on bed rest. The physician is the first line of that education when the placenta previa is identified as a part of the patient care to inform of the potential complications and treatment. Nursing reinforces that education on admission, based on the admitting physician's orders. A part of that education is the reason and importance of the need for bed rest. A patient who disregards that bed rest order is a party to the untoward outcome. The patient could not be physically restrained in her bed. The root-cause analysis would identify the patient's compliance with the need for bed rest and the education and information provided the patient and her family in this regard by both nursing and the physician(s). Disclosure of the investigation into this unfortunate untoward outcome cannot be forgotten. This is an important step in the handling of this event and the support of the patient and her family. Risk management should facilitate the disclosure process.

Re-emphasis of the requirements of thorough documentation is imperative.

REFERENCE

1. Supreme Court, Second Judicial Circuit, Kings County, New York, No. 12356/04. ■