 Shootings, other violence on the rise and pose major liability risks

Hospital plans tested in lockdown with bank robber on the loose

It is never good news when your phone rings at 3 a.m. and the caller ID shows your hospital’s emergency operations center. Whatever is happening at work is bad, and you’re about to find out if you prepared adequately for it.

The risk manager and other hospital executives at Inova Fairfax Hospital in Falls Church, VA, received that call recently and were told there had been a shooting, with a bank robber loose in the hospital.

A convicted bank robber being treated at the hospital stole a guard’s gun, with a shot fired in the process, and held her hostage before fleeing. The incident prompted a five-hour lockdown of the facility.

The hospital’s preparations for such an event helped minimize the impact, says Greg Brison, the hospital’s director of emergency management and security.

A key part of that preparation was the workplace violence training required for employees at least once annually. That training includes information specific to responding to shots fired in the healthcare system.

Inova Fairfax also works closely with local law enforcement and other emergency responders. In fact, it allowed them to use a new patient care facility for training before the hospital moved in any patients, and they used a scenario very similar to what actually happened.

(For more on the incident at Inova Fairfax, see the story in this issue.)

“THIS IS THE KIND OF THING YOU HOPE NEVER HAPPENS, BUT IF IT DOES, YOU WANT YOUR PEOPLE TO KNOW WHAT TO DO AND HOW TO STAY SAFE.”

— GREG BRISON, INOVA FAIRFAX HOSPITAL

Financial Disclosure: Author Greg Freeman, Executive Editor Joy Daughtery Dickinson, and Nurse Planner Maureen Archambault report no consultant, stockholder, speaker’s bureau, research, or other financial relationships with companies having ties to this field of study.
The hospital had conducted full-scale drills as well as tabletop exercises to test its planning for an active shooter, including a meeting held just the day before the shooting. The Inova Fairfax incident illustrates how quickly a violent incident can put thousands of people in jeopardy and disrupt hospital operations, Brison notes.

No one was injured at the hospital during the incident, and patient care resumed as smoothly as could be expected after a long lockdown. (For more on the lessons highlighted by the Inova Fairfax incident, see the story in this issue.)

“There’s no question that our planning and the extensive training for our employees made a difference in the outcome,” Brison says. “This is the kind of thing you hope never happens, but if it does, you want your people to know what to do and how to stay safe.”

Increasing violence

Healthcare workers are increasingly at risk from violence at work, and their employers face the prospect of huge payouts if they are found negligent for failing to protect employees and patients. Violence in healthcare is not what it used to be, the experts say, and the typical precautions might no longer be enough.

Some level of violence has always been an unfortunate but seemingly unavoidable part of providing healthcare services, from psychiatric patients who attack nurses to irate family members going after a doctor. However, the type of violence facing healthcare organizations is changing, as evidenced by a recent report in the *The Journal of the American Medical Association (JAMA)*. The *JAMA* article indicates that hospital shootings are becoming increasingly prevalent, with “active shooter incidents” increasing from nine per year from 2000 to 2005, to an average of 16.7 per year from 2006 to 2011. (An abstract of the article is available online at http://tinyurl.com/q8xopyp2.)

When cardiothoracic surgeon Michael J. Davidson, MD, was fatally shot on the premises of the Brigham and Women’s Hospital in Boston on Jan. 20, 2015, there had been 14 active shooter incidents in U.S. hospitals in the previous year. Fifteen people died in those incidents.

“This reality and its potential amplification by copycats has reignited the debate over the adequacy of current and future hospital security arrangements,” the *JAMA* report says.
Bureau of Labor Statistics data show that healthcare workers are at higher risk of workplace violence than other American workers. The rate of workplace violence-related nonfatal occupational injuries and illnesses involving days away from work for healthcare and social assistance workers was 15.1 per 10,000 full-time workers in 2012, compared to 4.0 for private industry overall.

Common factors associated with violence in emergency departments include long wait times, psychiatric patients, patients who have a history of violence, and patients under the influence of drugs or alcohol, according to a recent study in the Journal of Emergency Nursing. (An abstract of the study is available online at http://tinyurl.com/ovyzluy. For information on federal guidelines to reduce workplace violence, see the story in this issue.)

Keep prisoners restrained

The increase in shooting incidents is prompting more hospitals to conduct active shooter drills, says Ben Scaglione, director of security in healthcare for G4S Secure Solutions, a security company based in Jupiter, FL. Inova Fairfax had conducted active shooter drills before its recent incident.

Hospitals also are seeing more violence from behavioral health patients and are developing better response plans, Scaglione says. Similarly, hospitals should reassess how they handle inmate prisoners, such as the one at Inova Fairfax, he says. Handcuffs and other restraints can be a thorny issue, with clinicians sometimes insisting that a patient be released at least temporarily during treatment.

“It’s a lack of understanding. Clinical staff want the best for their patient, but the bottom line is they are prisoners and they need to be shackled,” Scaglione says. “Clinical staff need to understand that a shackled prisoner needs to stay that way. I saw a case years ago where a prisoner should have been shackled and wasn’t, and he was able to leave his room and sexually assault a female patient down the hall.”

There has been a small increase in hospitals arming their in-house security officers, he says, but that issue is contentious. Some healthcare and security experts say armed security brings with it too much potential liability and responsibility for adequately training and certifying employees. Others say armed guards are necessary because a large amount of violence can take place before local police arrive.

Arming your security guards will get the attention of your insurers also, notes Sean Ahrens, CPP, BSCP, CSC, security consulting services practice leader for Aon Risk Solutions in Atlanta, the global risk management business arm of Aon. An insurer that might be responsible for paying claims related to an employee using a firearm will demand extensive documentation of the screening, training, and certification of those employees, he says. “It takes a significant effort to maintain those records, which you absolutely must have if an incident ever occurs,” Ahrens says.

The decision might come down to what sort of neighborhood the hospital is located in and what treatment is provided, says Allan Ridings, senior risk management and patient safety specialist with the Cooperative of American Physicians (CAP), a doctor-owned medical malpractice insurance organization in Los Angeles. An acute care hospital in a high crime area, with a busy emergency department, is more likely to need armed guards than a specialty facility in a low crime area, he says.

“When I worked for a large medical corporation, we had armed guards on campus, patrolling the parking lots, even in the facilities that were not in high crime areas,” Ridings says. “An important benefit is that it lets employees know you care enough to protect them.”

What are your options?

One option is to arm only one or two senior security personnel who are trained and experienced, and another is to hire off-duty police for high-risk areas such as the emergency department, he suggests. Both strategies would reduce the potential liability. (For information on a hospital that decided against arming its security guards, see the story in this issue.)

“I know a lot of hospitals that have had armed security for years and never had a bad shooting, but if your employee discharges that weapon and hurts someone, intentionally or by accident, your liability is through the roof,” Scaglione says.

In addition to potential civil liability from shootings, risk managers should remember the risk from running afoul of expectations from the Occupational Safety and Health Administration (OSHA) regarding workplace violence, says John Ivins, JD, a partner and leader of the Health Care Practice at the law firm Hirschler Fleischer in Richmond, VA. In 2011, OSHA issued Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents, document number CPL 02-01-052, to guide inspectors. Ivins suggests that risk managers should study the document to assess compliance with OSHA’s requirements. (The OSHA document is available online at http://tinyurl.com/q9npn3h.) Failure to protect employees from workplace
violence can result in a general duty clause citation from OSHA, which Ivins calls “serious, significant, and costly.”

**An “A” for anticipating**

Inova Fairfax did good job of anticipating and preparing for the violence, says R. Stephen Trosty, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management (AHRM).

“Risk management tries to be proactive, to determine actual or potential incidents that cause risk for people and facilities, and act accordingly,” he says. “To ignore the problem, and the increase in the problem, is not risk management, nor is being unprepared or incapable of responding to a potentially known risk. Safety should win out over appearance in the hospital.”

**SOURCES**

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**Escaped prisoner tests hospital security plans**

When a prisoner escaped from guards recently at Inova Fairfax Hospital in Falls Church, VA, staff and others in the facility were in jeopardy. The hospital’s security plan was activated and proved the value of planning for such an incident.

About 3 a.m. on March 31, convicted bank robber and federal prisoner Wossen Assaye, 42, was at the 833-bed hospital for treatment after a suicide attempt, accompanied by two guards from a security company contracted by the U.S. Marshals Service. The 42-year-old Assaye was restrained, but when one guard took a bathroom break, Assaye overpowered the second, explains **Greg Brison**, the hospital’s director of emergency management and security. The prisoner was able to get out of his restraints, but for security reasons Brison won’t say how or what type of restraints were used.

A shot was fired during the struggle, and Assaye was able to take the guard’s gun.

Shoeless and wearing only a hospital gown, he then held the female guard in front of him as a shield as he left the room. At this point the first guard returned and fired a shot at Assaye, who released the hostage and ran down a hallway and a stairwell. The guards lost sight of him at that point.

There were about 2,000 employees and 800 patients at the hospital.

Inova Fairfax employees immediately implemented their “Code Silver,” with several people calling the switchboard to activate it and many more calling 911. All staff are authorized to call the Code Silver without waiting for an administrator’s approval. Staff members started locking down the hospital. Staff, patients, and visitors were instructed by intercom and texts to stay where they were. Within minutes, managers on duty placed phone calls to key executives, including Brison.

Fairfax County police quickly established a security perimeter, which allowed access only to the hospital’s senior leaders. Police officers also entered the building to search for Assaye, who was suspected of robbing 12 banks and considered dangerous. Members of the hospital’s security staff were aided by the fact that, in the overnight hours, Inova Fairfax is always a controlled-access environment with exterior doors locked. The Code Silver further requires that many interior doors be locked or at least closed, which reduces opportunities for the shooter to move to different areas of the facility and encounter more potential victims.

The plan also calls for some additional defensive moves as necessary, such as turning out lights in some areas and barricading doors, but Brison says those details are being kept secret.

The lockdown was lifted after five hours when the police had completed a sweep of the entire campus and not found the gunman. Assaye is thought to have carjacked two vehicles after leaving the hospital, and he was captured in a Washington, DC, neighborhood after a nine-hour manhunt involving hundreds of officers.
Bank robber lockdown holds lessons for healthcare risk managers

Healthcare risk managers can work with their security directors to study the recent lockdown at Inova Fairfax Hospital in Falls Church, VA, for lessons that might improve their own emergency planning. The incident affirmed the value of much the hospital’s planning, but it also highlighted some needs that had not been considered, says Greg Brison, the hospital’s director of emergency management and security.

Hospital leaders conducted extensive debriefing sessions with everyone involved in the incident and spent many hours evaluating the response. The hospital is revising its active shooter response plan in light of some lessons learned and will conduct a drill in the fall of 2015 after staff have been educated on the changes. Brison notes that some of the lessons from the experience can apply to many emergency situations, not just an active shooter.

Brison offers this advice gleaned from the hospital’s experience with a shooting and five-hour lockdown:

• Provide access and information to local law enforcement ahead of time.
  During an emergency, it might be difficult for security officers or anyone else to meet police officers at the front door, let them in, and then guide them through the facility. Plan ahead by providing a way for police to gain entry on their own, such as keys or key cards, along with detailed floor plans they can use on arrival.

• Standardize how you name entryways.
  Inova Fairfax also has numbered all entry points, starting with the main entrance as Door 1 and then working around the building clockwise with sequential numbers. The number is marked prominently on the entryway. This system will improve communication with police who can be told to go to Door 5, for example, rather than having them struggle to find “the west wing entrance near radiology.”

• Hospital security should know where prisoner patients are at all times.

It is not enough for security to know that an inmate is in a certain unit. Security should know exactly what room, and staff members should notify security whenever the patient is moved somewhere else, such as being taken to another area for testing or therapy.

• Serve only finger food to prisoners.
  Even plastic eating utensils can become effective weapons, so prisoner patients should be designated for only meals that require no utensils, such as a sandwich rather than spaghetti. Any staff members delivering meals should know of this restriction so they don’t routinely include a utensil packet or comply when the prisoner asks for one. If you decide to provide utensils, you must have a strict accounting of them afterward.

• Use high visibility clothing for prisoners.
  As a result of the prisoner escape, Inova Fairfax will no longer provide standard hospital gowns for anyone under police custody. Those patients now wear bright orange gowns to make them easier to spot if they escape and also to serve as a warning to staff that this person could be hostile.

• Enable after-hours security officers to access security video.
  It is common for night-time security officers to be limited in their access to security camera recordings, and it frequently requires a manager to come in to the hospital and obtain them. When a violent person still might be on the campus, security officers must be able to gain access to those recordings without delay so they and local police can identify and track the person.

• Have backup command centers.
  For much of the lockdown, Inova Fairfax leaders could not get to their command center because it was in an area of the hospital not yet cleared by police. They now are establishing a backup command center on the opposite end of the building, with the same communication capabilities and resources such as job action sheets.

• Arrange police escorts for necessary clinical care.
  Even in a lockdown, babies can be born and patients can go into cardiac
arrest. The staff members responsible for those patients cannot remain in
place as they are supposed to during a lockdown, so police should be
prepared to escort them and guard them as they work. This system is best
accomplished by discussing the need with police ahead of time so they can
have adequate personnel on hand.

**Arrange for off-site parking.**
Parking might seem a mundane issue when people are in jeopardy,
but it quickly became a problem that threatened to hinder the response
of hospital staff and local law

- Prepare for media arriving at your campus and other areas.
The plan should call for public relations staff and security officers to
be on hand. Not just at the hospital campus, but also at any other area
where staff are likely to congregate after evacuation. Reporters will go
to those areas to interview staff, so public relations representatives
should be there also to help control the public message. Any designated
off-site parking area for incoming staff and patients must have media
relations and security present.

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**Hospital softens security image, staff rebels**

Despite a series of violent incidents that left the staff rattled, leaders at Erlanger Health System in Chattanooga, TN, recently decided to soften the image of its security guards to convey a more “family-friendly” environment, according to news reports and staff complaints.

The hospital was in the news in 2014 when police fought with a crowd of more than 40 people outside of the emergency department after a shooting victim was brought to the hospital. A woman also was assaulted in the parking deck that year.

Erlanger staff members expected the hospital to strengthen its security, according to a report by the Chattanooga Times Free Press. Instead, Erlanger recently decided to disarm its security guards and replace their police-style, tactical uniforms with blazers for a more approachable look.

Some staff members rebelled and circulated a petition calling for more security. “We cannot decrease our personal safety to increase the appearance of political correctness,” the petition said. “By pushing the security of Erlanger Health System to be unarmed, you are directly placing your employees, patients and visitors in danger.”

Officials at Erlanger declined requests to comment for this article. The newspaper report is available online at http://tinyurl.com/oe2un7q.

**OSHA underscores threat of healthcare violence**

Underscoring the threat in hospitals, the Occupational Safety and Health Administration (OSHA) has released updated Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.

The guidelines signal that OSHA officials take seriously the obligation of employers in healthcare and social service industries to minimize workplace violence. The report notes that of the 25,000 annual workplace assaults reported between 2011 and 2013, 70% to 74% of these occurred in healthcare and social service settings. The vast majority of job-related violence results in non-fatal, yet serious injuries, the agency reports.

OSHA notes several factors for workplace violence in healthcare, such as acute psychiatric services and geriatric long-term care settings, as well as some factors that can be controlled. Those include “poorly lit corridors, rooms, parking lots and other areas,” “lack of means of emergency communication,” and “lack of facility policies and staff training for recognizing and managing escalating hostile and assultive behaviors from patients, clients, visitors, or staff.”

Hospital managers should implement a written program for workplace violence prevention, which “should have clear goals and objectives for preventing workplace violence,” OSHA says. The document includes detailed advice on how to implement the program.

The updated guidelines are available online at http://tinyurl.com/ohwgnoe.
Video monitoring reduces falls as well as cutting costs for hospitals

Reducions also reported in number of days a patient requires constant visual observation

Hospitals that deploy remote video monitoring systems staffed with dedicated, trained observers can reduce patient falls significantly, with one reporting a reduction in patient falls and employee injuries, while also reducing associated costs.

Video monitoring is being employed by more hospitals seeking a way to prevent these non-reimbursable “never events.” Since 2008, Medicare has refused to pay the extra cost of treating a fall with injury, which averages $27,000. From 700,000 to one million patients suffer a fall in U.S. hospitals each year, according to the Agency for Healthcare Research and Quality.

At least 30% of inpatient falls result in moderate to severe injury, according to the Institute for Healthcare Improvement. Of those, 6% to 44% involve head injuries, serious fractures, subdural hematomas, and excessive bleeding. In 1% of falls with injury, or 11,000 times per year, the injuries result in death.

TIRR Memorial Hermann, a rehabilitation hospital in Houston, TX, introduced one video monitoring system, the AvaSys TeleSitter Solution, in July 2014. It is intended as the first line of defense for patients at risk, and it allows staff to immediately and directly intervene when a patient is at risk of falling, says DeAnne Roberts, RN, MSN, clinical effectiveness director of enterprise quality, patient safety, and infection control at TIRR.

The monitoring units at TIRR are portable, wireless units, but the same technology could be permanently installed in the ceiling. (See the story in this issue for more on how the remote monitoring system works.)

The hospital started by using the monitors on five units, and it added five more in December 2014. It is using all of the monitoring units primarily for brain-injured patients at risk of falling.

“WE HAVE A NICE TREND WITH THE CVO SITTER IN THE ROOM AND INTERACTING WITH THE PATIENT FOR A CERTAIN TIME, AND THEN WE CAN STEP THEM DOWN TO THE TELESITTER.”

Falls have been reduced 8.6%, Roberts says. TIRR previously used patient sitters for fall risk patients and has not eliminated them. At press time, the hospital had 10 patients monitored remotely by one person and 10 with sitters.

The system also contributed to an 18.6% reduction in the number of days a patient requires constant visual observation (CVO) by a sitter who is in the room. “We have a nice trend with the CVO sitter in the room and interacting with the patient for a certain time, and then we can step them down to the telesitter,” Roberts explains. “That is consistent with our goal of making them more independent. It lets us keep our eyes on them and gives them confidence while they move toward more independence.”

TIRR now has twice the number of brain injury patients the hospital could treat in the previous year because, in addition to reducing falls, the system made it possible for TIRR to admit more brain-injured patients because more could be monitored for falls, says Mary Ann Euliarte, RN, MSN, MBA, vice president of operations and chief nursing officer at TIRR. That increased admission helped TIRR’s referring centers but also complicated the calculation of cost savings from the remote video system.

However, from July 2014 to

EXECUTIVE SUMMARY

Video monitoring is proving to be a cost-effective way to reduce falls. Monitoring systems use cameras in patient rooms, with the video monitored by a trained employee.

• One hospital reduced falls 8.6% with a remote monitoring system.
• The video from the monitors is never recorded.
• The systems can be used to monitor other at-risk patients also.
December 2014, TIRR saw a 60% reduction in sitter costs, Euliarte says. A reduction in employee injuries during the same period also appears related to the use of the monitoring system, Euliarte says. Injuries for staff working with brain-injured patients have fallen 54% since the introduction of remote monitoring, Roberts says.

The cost of the system was recouped within the first six months, Euliarte estimates. (See the story in this issue for results from other hospitals using remote monitoring.)

Roberts notes that the two-way audio communication is useful with brain-injured patients because it allows nurses to redirect a patient rather than always intervening in person, which encourages the patient to be more cooperative while also gaining independence. The audio connection in the room isn’t always open, but the monitor can open it if patients or families wave or otherwise signal that they want to talk.

Not the only solution

As good as the results are with the video monitoring, it should not be introduced as a single solution to patient falls, notes Kerry Davis, BSN, RN, nurse manager on the brain injury and stroke team at TIRR and the project lead. A month before the video monitoring was introduced, a multidisciplinary TIRR team reassessed how the hospital identified patients who need a sitter and how staffs throughout the hospital communicate about fall risks.

“We needed everyone using the same terminology,” Davis explains. “A neuropsych doctor may have his own definition of what makes a patient impulsive or reckless; 200 nursing staff may describe it differently. So one shift might say the nurse can handle this reckless patient, while the next shift requires the CVO sitter.”

The hospital’s goal is for any patient with a CVO sitter to move to video monitoring before discharge. A patient who has a sitter throughout the entire stay is costing the hospital money and probably is not gaining the independence that is part of the clinical plan, Davis says.

“If the patient comes to us on a sitter, and after a week of our assessment and intervention, that patient is on a telemonitor, that’s where we see our savings,” Davis says. “We went from using a sitter one-to-one 24 hours a day to using a telemonitor who can watch 10 people.”

More information on the TIRR technology is available at http://avasure.com. Other vendors offering remote patient monitoring technology include Cisco (http://tinyurl.com/qhkn6ld) and Nexus (http://tinyurl.com/o53qscs).

SOURCES

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Fall-risk patients monitored continuously by video

When a fall-risk patient at TIRR Memorial Hermann in Houston, TX, is monitored remotely by video, the person watching is trained and ready to intervene if the patient is in danger.

The monitor is a hospital employee, either a certified nurse assistant or medical technician, says Mary Ann Euliarte, RN, MSN, MBA, vice president of operations and chief nursing officer at TIRR. A single monitor can oversee as many as 15 patients.

At the monitoring station, the patient is observed continuously, even at night when the lights are dim. If the patient begins to get out of bed, the staff member talks to the patient over the speaker. If the patient does not speak English, the system can issue pre-recorded simple commands in as many as 250 languages.

If the patient needs something such as water or to go to the bathroom, the staff member summons help, Euliarte explains.

Costs for the system will vary according to the number of units employed, but the maker of TIRR’s system says the video monitoring pays for itself in 3-6 months with reduced sitter costs and reduced fall rates.
Hospitals report success with video monitoring

Several hospitals have reported good experiences with video monitoring to reduce falls, including these two:

- **Rockford Memorial Hospital** in Illinois: In September 2011, administrators realized that certified nursing assistants (CNAs) were being pulled from the bedside to sit one-on-one with patients, which directly affected unit staffing. Patient falls were increasing due to lack of CNA staff for the units. On average 14.24 CNA positions were not available for staffing nursing units. In 2011 sitter utilization averaged 50 FTEs per pay period. The hospital began using a remote video monitoring system in November 2011 and increased its use through 2013. The falls rate decreased, and the overall sitter rate decreased. The average sitter FTE per pay period went from 42.8 in 2012 to 35 in 2014, with falls decreasing from 170 to 63 in that time period. The hospital used the AvaSys TeleSitter Solution, manufactured by AvaSure in Grand Rapids, MI.

- **Premier Health** in Dayton, OH: Over 15 months, the hospital used remote monitoring for an average of 6.5 patients per day, which resulted in $80,000 annualized savings from decreased use of sitters. Injury falls per 1,000 patient days in 2013-2014 went from 0.83 pre tele-sitter to 0.47 post tele-sitter. The hospital also used the AvaSys TeleSitter Solution.

Hospital joins plaintiff in suing scope maker

A hospital being sued for the death of patient related to a non-sterile duodenoscope is joining with the plaintiff to sue the scope manufacturer.

The patient, Richard Bigler, of Woodway, WA, was one of 39 patients at Seattle’s Virginia Mason Medical Center who were infected by carbapenem-resistant Enterobacteriaceae (CRE) between 2012 and 2014, according to a report in The Seattle Times. The outbreak was one of several nationwide since 2010 that have been linked to duodenoscopes manufactured primarily by Olympus, but also by Pentax Medical and Fujifilm, according to the Food and Drug Administration.

Known to be extremely difficult to clean, duodenoscopes are used in endoscopic retrograde cholangiopancreatography (ERCP) procedures. Olympus recently issued new reprocessing instructions for its TJF-Q180V scope. The instructions are available online at http://tinyurl.com/o75j7yn.

After being sued by Bigler’s widow, Virginia Mason filed a lawsuit against Olympus in a cross claim, according to the plaintiff’s attorney.

Hospital pays $18.8 million and admits to misconduct

A hospital in New York state has admitted to violating the Anti-Kickback Statute and the Stark Law and will pay $18.8 million to resolve liabilities.

The resolution was announced recently by Preet Bharara, JD, the U.S. attorney for the Southern District of New York. Westchester Medical Center (WMC) in Valhalla, NY, also admitted to submission of costs reports to Medicare seeking reimbursement for charges WMC did not incur.

Diego Rodriguez, assistant director-in-charge of the Federal Bureau of Investigation (FBI), says WMC participated in “a coordinated shakedown of Medicare and, by extension, taxpayers.”

According to the complaint-in-intervention filed in Manhattan federal court, WMC operates a tertiary and quaternary care hospital in Valhalla, NY, and serves as the primary clinical affiliate of New York Medical College. From approximately 2000 through 2007, WMC maintained a financial relationship with Cardiology Consultants of Westchester (CCW), a practice formerly operating on WMC’s Valhalla campus, which violated the Anti-Kickback Statute and the Stark Law, the FBI says.

In particular, the complaint-in-intervention alleges that WMC advanced monies to CCW to open a practice for the express purpose of generating referrals to the hospital. When CCW began making payments to WMC purportedly repaying the advances, WMC entered into retroactive, no-work consulting agreements under which it paid CCW tens of thousands of dollars.

The complaint-in-intervention alleges that around this same time, WMC began permitting CCW to use WMC’s fellows in CCW’s private office free of charge, contrary to
WMC’s historic practice. As a result, WMC’s submission of claims to the Medicare program for services rendered to patients referred to WMC by CCW’s shareholder physicians violated the False Claims Act.

Additionally, during the same time period, through cost reports filed with the Centers for Medicare and Medicaid Services, WMC wrongly sought and obtained reimbursement for certain costs that WMC did not incur and that were not reimbursable under the relevant cost-reporting rules.

During the period from approximately April 2003 through July 2005, CCW referred patients for hundreds of medical procedures at WMC. For certain years during the relevant period, WMC charged various physician practices for a portion of the salaries and expenses relating to residents and fellows who trained at WMC. During the relevant period, fellows in WMC’s cardiology fellowship program performed certain services within CCW’s private offices as part of their regular clinical rotation.

Pennsylvania sees dip in malpractice filings

The number of medical malpractice case filings in Pennsylvania dipped in 2014 to the lowest point since statewide tracking began in 2000. The latest available figures compiled by the Administrative Office of Pennsylvania Courts show there were 1,463 new cases filed in Pennsylvania’s civil courts in 2014, which marked the fewest ever recorded.

The latest filings represent a 46.5% decline from the number posted in the base years of 2000-2002. In Philadelphia, the state’s judicial district with the largest caseload, the decline has been 68.3% during the same period.

The base years are the period just prior to two significant rules changes made by the Supreme Court of Pennsylvania. The first change required attorneys to obtain from a medical professional a “certificate of merit” that establishes that the medical procedures in a case fall outside acceptable standards. A second change required medical malpractice actions to be brought only in the county where the cause of action took place, which was a move aimed at eliminating so-called “venue shopping.”

The number of jury verdicts grew slightly to 127 last year from 110 in 2013; however, that number is roughly a third of the 326 jury verdicts seen in 2000. It also was the third lowest number of jury verdicts in the 14-year reporting period.

The data also show slightly more than 81% of the verdicts in 2014 were for the defense. One of the only two reported nonjury verdicts during the year was for the defense.

OIG wants $6.4 million for overpayments

Northwestern Memorial Hospital in Chicago owes Medicare $6.4 million in alleged overpayments caused by billing errors, according to an audit by the Office of Inspector General (OIG) in the Department of Health and Human Services.

Hospital administrators aren’t reaching for the checkbook quite yet, and they are calling into question the methodology used to determine what is owed.

“OIG’s report in no way challenges the quality and medical necessity of the care provided,” Northwestern said in a statement.

“Rather, OIG concluded that most of these errors were because the claims should have been billed in an outpatient setting rather than an inpatient setting. Northwestern Memorial intends to appeal these findings, as it is our belief that OIG’s claims review process and statistical methodologies are flawed, resulting in a grossly overstated repayment amount.”

Jennifer Wooten Ierardi, JD, MPH, Northwestern chief integrity executive, wrote in a response to the OIG that many of the findings “reflect the vague and ambiguous CMS standards for inpatient Part A reimbursement and then extrapolates such findings in a manner that creates the appearance of abuse, when this is
The OIG’s audit determined that the 885-bed teaching hospital incorrectly billed Medicare Part A for patient stays that did not meet Medicare criteria for inpatient status and should have been billed instead as outpatient or outpatient with observation services. OIG also contends that the hospital incorrectly billed Medicare for observation hours that resulted in incorrect outlier payments, among other issues.

The $6.4 million bill was the result when OIG audited 171 sample inpatient and outpatient claims with payments totaling nearly $1.5 million submitted in 2011 and 2012. The OIG found that the hospital did not fully comply with Medicare billing requirements for 85 of the claims, which resulted in overpayments to the hospital totaling $272,181. The agency then extrapolated those results to estimate that the hospital was overpaid by $6.4 million in 2011 and 2012.

The OIG attributed the errors to the hospital’s lack of adequate controls to prevent them.

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### Quality reduces liability more than tort reform

Tort reform is often cited as the potential solution for the rising cost of medical malpractice claims, but a new study suggests that better results come from increasing quality of care.

Researchers from the Southern Illinois University School of Medicine in Springfield, IL, examined a single health system’s hospitals in Texas and another in Louisiana. They found that the number of lawsuits dropped in the Texas hospitals after the state implemented medical liability tort reform caps on noneconomic damages in 2003. But lawsuits also decreased at the Louisiana facilities, where the same malpractice caps do not apply. However, the Louisiana hospitals experienced an increase in quality scores, according to the study in the <i>American Journal of Medical Quality</i>.

“A significant correlation was found between the increase in mean Centers for Medicare & Medicaid Services performance score and the decrease in the frequency of claims observed in Louisiana,” the researchers reported. “Although tort reform caps on noneconomic damages in Texas caused the largest initial decrease, increasing quality improvement measures without increasing financial burden also decreased liability claims in Louisiana. Uniquely, this study showed that increasing patient quality resulted in decreased medical liability claims.”

An abstract is available at http://tinyurl.com/q6wv3hb.
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CNE QUESTIONS

1. What does Greg Brison, director of emergency management and security at Inova Fairfax Hospital, advise regarding clinical care that must go on during a lockdown?
   A. You should arrange in advance to have police officers available to escort and guard clinicians.
   B. The care should be provided only if staff do not have to move from their shelter-in-place position.
   C. Patients needing care should be transported out of the building.
   D. Clinicians should proceed with providing care and call for help if needed.

2. In the shooting incident that prompted a lockdown at Inova Fairfax, how did the prisoner escape?
   A. He was unrestrained and ran when his guards both stepped away.
   B. He was restrained but overpowered one guard when the other stepped away.
   C. A nurse insisted that his handcuffs be removed, after which he assaulted her and ran away.
   D. He stole an eating utensil from his food tray and attacked the guard.

3. With the remote video monitoring system in use at TIRR Memorial Herman, what is the patient to monitor ratio?
   A. 3:1
   B. 5:1
   C. 10:1
   D. 20:1

4. In the federal action involving Westchester Medical Center, what was one of the primary allegations?
   A. WMC advanced monies to cardiologists to open a practice for the express purpose of generating referrals to the hospital.
   B. WMC wrongly denied a group of cardiologists the right to participate in its network.
   C. WMC billed Medicare for patients who did not exist.
   D. WMC improperly unbundled Medicare bills to generate more revenue.
Allegedly botched and unnecessary surgery results in $4.25 million award for patient

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**Background:** In 2010, the plaintiff went to the hospital to obtain information on GBS. At that time, the plaintiff weighed 220 pounds and had a BMI above 40. The hospital, as part of its GBS program, recommended that the plaintiff enter into a preliminary program that provides education, support, and behavioral counseling with the GBS. Five months into the program, the plaintiff had lost 30 pounds, and her BMI dropped to 34. Nevertheless, the

**News:** The plaintiff, a female in her mid-30s, had been suffering a lengthy battle with being overweight. She thus sought out and was given the option of receiving gastric bypass surgery (GBS). This surgery rearranges the natural position of the stomach, which leaves the patient feeling full after consuming less food than previously was required. Prior to the surgery, the plaintiff lost 30 pounds in the GBS-preparation program at the hospital where she later received the surgery. At the time of the GBS, the plaintiff’s height was 5 feet 1 inch, and her weight was 189 pounds, with a body mass index (BMI) of 34. A BMI of 34 was high enough to qualify her as obese but not high enough to qualify her as a good candidate for GBS. The plaintiff proceeded with the GBS, and this surgery resulted in numerous complications, particularly fluid buildup and respiratory problems. The plaintiff made multiple trips to the emergency department and had multiple surgeries in the wake of the GBS. The plaintiff eventually received a diagnostic laparoscopy, which revealed severe adhesions on her abdomen, liver, diaphragm, gastric remnant, and gastric pouch. During an attempt to repair the gastric pouch, the patient’s esophagus and diaphragm were punctured. As a result of the GBS and ensuing difficulties, the plaintiff claimed she will suffer chronic pain, food intolerance, incontinence, and fatigue for the rest of her life. The plaintiff argued that the hospital, the hospital staff, and the hospital’s operating doctor deviated from the standard of care by performing the GBS surgery on her when she failed to meet medical guidelines for it. The jury agreed. It found the patient should not have been offered GBS and that she lacked informed consent regarding the procedure. As a result, the jury ruled against the doctor and hospital and ordered the U.S. government to pay $4.25 million to the plaintiff on their behalf. While the doctor and hospital were found liable here for their misconduct, the U.S. government paid the verdict because this facility was a federal hospital where the health center and its employees are considered federal employees and are individually immune from lawsuits.

A BMI OF 34 WAS HIGH ENOUGH TO QUALIFY HER AS OBESE BUT NOT HIGH ENOUGH TO QUALIFY HER AS A GOOD CANDIDATE FOR GBS.
doctor affiliated with the program and with whom she had been consulting recommended the plaintiff receive the GBS. One month later, when the 189-pound female plaintiff had a BMI of 34, she received the GBS. The resulting and numerous complications began one week later.

It was determined that the GBS caused adhesions on her abdomen, liver, diaphragm, gastric remnant, and gastric pouch. These complications led to fluid buildup and respiratory problems, for which the plaintiff received other surgeries. The GBS incident and subsequent surgeries, one of which punctured her esophagus and diaphragm, left the plaintiff with what she claimed are lifelong symptoms of chronic pain, food intolerance, incontinence, and fatigue. At one point after the surgery, and due to her alleged injuries, the plaintiff weighed as little as 103 pounds.

The plaintiff sued the operating doctor, the hospital, and hospital staff for her injuries. Specifically, the plaintiff alleged that the doctor failed to adequately warn of known dangers about the procedure and that the hospital fell below the duty of care by offering the surgery to her. The plaintiff pointed to the national eligibility criteria and with some irony as this was all part of the hospital’s own process, she should cancel or at least delay surgery. As such, the doctor claimed not to be obliged to inform her otherwise before the surgery.

The court, in a 13-day bench trial, agreed with plaintiff. The court said that the hospital breached the applicable standard of care by offering GBS when she didn’t meet the national eligibility criteria and the doctor failed to give the plaintiff sufficient and adequate information for her to give informed consent for the procedure. The court found the plaintiff was entitled to $4.25 million in total damages. The damages broke down as $1.87 million for future medical expenses, $891,000 for loss of current and future wages, and $1.38 million in pain and suffering.

What this means to you: This case illustrates the need to evaluate a patient’s circumstance at every step of the process. The physician began the GBS process with a candidate who met all the prerequisites and who, according to the national standard, likely would have benefitted from the procedure, or at least was situated such that the potential benefits outweighed the risks. However, and with some irony as this was all part of the hospital’s own process, the patient participated a pre-GBS program that led to weight loss. The patient no longer was a good candidate. A prudent doctor working with a patient ahead of surgery should evaluate the conditions of the patient at every step of the process and, if at any time the patient’s symptoms or circumstances change, the physician should re-evaluate the surgery in light of relevant changes. This situation is particularly the case, from a litigator’s perspective, when the patient is undergoing a high-risk surgery that has readily available
physician to inform the patient of risks using the patient’s current information and not when treatment first was sought. Providing this type of information will equip the patient with the tools necessary to make the best decision for himself or herself and, thus, can help to shield physicians and hospitals from liability. Finally, of critical importance for all physicians, is documentation of informed consent, including date and time discussed with the patient, and the patient’s understanding of what was discussed, within the body of the patient’s medical record. The medical record must accompany the patient to the surgical area so that staff can confirm the patient’s understanding of the procedure.

REFERENCE:
Case No. 112CV00527 (Hawaii Dist. Ct., Apr. 21, 2015).

Medication dosage error for infant patient leads to $17.8 million verdict for plaintiff

News: A 4-day-old infant had an aortic coarctation, a narrowing of the aorta, which is a relatively common and easily curable heart defect. While preparing for surgery to correct the condition, the doctor ordered the nurse to give the infant pre-surgery medication. The nurse then gave the infant that dosage of the medication. A few hours later, the nurses, allegedly with no order from the doctor, lowered the dosage of medication by half. This decrease caused the infant to go into cardiac arrest. It took doctors 33 minutes to get the infant’s heart beating. As a result, the infant has, among other things, a permanent brain injury and brain dysfunction that will require her to be cared for during the remainder of her life.

The plaintiff argued that the nurses, treating physician, and hospital where the incident occurred were negligent for administering an incorrect dosage of medication. The defense was that the hospital and its staff provided reasonable and appropriate care that comported with applicable standards of care and practice. The jury found the hospital staff was negligent and ordered the hospital to pay $17.8 million in damages to the plaintiff. The claims against the doctor had been resolved on unknown terms prior to trial.

Background: In 2008, the plaintiff was born with a genetic and entirely treatable heart problem called an aortic coarctation, which forces one’s heart to pump harder in order to pump blood through the narrow gap in the aorta. Four days later, the infant was scheduled to have the surgery that her physicians believed was very routine and would enable the infant to live an entirely normal life. In preparation for the surgery, and to help her condition, the plaintiff's physician ordered she be given Prostglandin (PG). The nurses followed the physician's order and administered PG at a dose of 0.025 mcg/kg/min and at a rate of 1.0 ml per hour. This dose was the one the physician believed would keep the patient stable prior to surgery.

Later that night, the nurses cut the plaintiff’s dose of PG to 0.0125 mcg/kg/min at a flow rate of 0.5 ml per hour, which was half the dose the doctor ordered. No physician's order requesting this drop in dosage could be found. The decrease of PG caused a pulmonary edema and constricted ductus arteriosus and coarctation, as well as cardiac arrest. Due to the constricted ducts, the resuscitation was difficult and lasted for 33 minutes before physicians were able to get oxygen back to the plaintiff’s brain.

The lack of oxygen to the plaintiff’s brain caused a hypoxic-ischemic brain injury. The plaintiff now suffers from significant intellectual disability, cognitive impairment, and motor skill impairment. At the time of trial, the plaintiff was 7 years old, but she had the cognitive and motor skills of a child half her age. The plaintiff is also physically disfigured and will require around-the-clock medical care for the remainder of life.

The plaintiff sued the hospital and its nurses as well as the treating physician for her injuries and the associated expenses. The plaintiff alleged that the dosage of PG being lowered without a physician’s order was negligent and failed to follow the rights and rules of medication administration that require the “right dose” be administered, and that the treating physician failed to maintain control over the case. Having a physician’s order to lower dosage is standard operating procedure. Additionally, the PG being lowered led to pulmonary edema and coarctation, which complicated the resuscitation and caused it to last 33 minutes. The plaintiff argued that this time period caused the brain damage and other injuries, and the plaintiff sought to hold the hospital liable through the work of its staff.

The defense denied any negligence on its part and contended its
treatment of the plaintiff was appropriate and comported with applicable standards of care. The defense also argued that there was an insufficient causal relationship between the plaintiff’s injuries and the conduct of the hospital and its staff. The claims against the doctor had been satisfied prior to trial on unknown terms.

The jury found the hospital liable for its nursing staff negligently allowing the dose of PG to be lowered without proper authorization from a physician. The jury also found this negligence to be the cause of the plaintiff’s physical and mental abnormalities, which will require extensive and continuing medical treatment. Accordingly, on March 31, 2015, the jury ordered the hospital to pay $17.8 million in damages to the plaintiff. Most of the damages, $12.2 million, are for future medical and health-related expenses. The remainder includes $2.5 million for current and past medical expenses, $2.1 million for lost future wages and earning capacity, and roughly $1 million for pain and suffering. The plaintiff’s attorney declared this verdict to be the largest medical malpractice jury award in the history of the state of Colorado.

What this means to you: The primary cause of liability from this case came from the PG being lowered without a written record of the physician’s order and the injuries that resulted. Injuries alone will not cause physicians or the hospitals for which they are working to face liability. Rather, the injuries must be related to a negligent act. Medicine is an uncertain practice in which a fairly routine procedure can become life-threatening or life-altering for the patient in an instant. A primary lesson to take from this case is not to become too comfortable or relaxed about meeting hospital and medical standards even when dealing with routine operations. In this matter, the negligence was significantly premised on lack of paperwork. Had the physicians and nurses kept prompt records or had the hospital staff remained hypervigilant in the face of this routine matter, the dosage would not have been lowered without adequate and liability-shielding paperwork. So, in addition to shelter from liability, remaining vigilant during routine procedures also can prevent an infant or other patient from suffering great hardship.

Another potential lesson here is the need to maintain and enforce the chain of command that most hospitals use. Regardless of whether hospitals and physicians practice the utmost standard of due care, a simple mistake or misunderstanding on the nurses’ part can lead to massive liability that affiliates the practicing physician and the hospital alike. That is not to say the nurses or hospital staff are to blame for this case. Rather, physicians and hospital administrators should work with all hospital staff to ensure guidelines are enforced and followed. Additionally, despite the pace at the hospital and burden of the physician being hectic at times, the physician who is giving orders must take the time to ensure his or her order is understood. The physician also should consider the nurse or hospital staff member might be equally mentally occupied at that moment. It is also essential that support staff understands the importance of, and feels enabled to seek, clarification regarding following the physician’s orders. Ensuring a well-oiled chain of command that is alert and has open lines of communication will better serve the interests of the physician, hospital, hospital staff, and, most importantly, the patient.

Also, if a nurse is not comfortable giving a certain dose of medication to a patient, he or she should consult with the hospital’s pharmacist. In these situations, the hospital pharmacist can give the nurse the order to change the patient’s medication dose. However, this process requires documentation at every step and for the pharmacist to have consulted with the physician before ordering the dosage change.

The significant amount of damages allotted for future medical expenses is illustrative of a lesson: The treatment of infants is a delicate practice, and an error can have long-term dire and costly consequences. A simple clerical error when dealing with an infant can be the foundation of negligence that holds a member or entity of the medical community liable for a lifetime of medical expenses. The necessity of following best practice guidelines and having all administrative considerations in order is amplified when dealing with an infant.

REFERENCE: