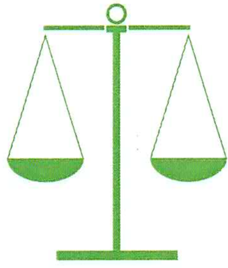

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Harsh claims as nurse sues hospital where she contracted Ebola

She alleges insufficient precautions, deceit by the hospital

In scathing allegations that paint a picture quite different than what the hospital has portrayed publicly, the nurse who was the first person to contract Ebola in the United States is suing her employer for thrusting her into danger without training or proper equipment. She also claims that the hospital lied about her volunteering to care for the patient and tried to use her to create positive press during the Ebola scare.

The hospital, of course, is at a disadvantage in defending itself publicly from the claims. Texas Health Presbyterian Hospital Dallas Spokesman **Wendell Watson** says that hospital officials still support 26-year -old Nina Pham but cannot comment on claims in the lawsuit.

"IT IS A PR NIGHTMARE. THE BIGGEST ISSUE FACING THAT HOSPITAL SYSTEM IS THAT IT WAS THE ONLY HOSPITAL WHERE A SECONDARY INFECTION OCCURRED." -- ROBERT FULLER, JD, NELSON HARDIMAN

"Nina Pham served very bravely during a most difficult time as we all struggled to deal with the first case of Ebola to arrive in a U.S. hospital's emergency room. Texas Health Resources has a strong culture of caring and compassion, and we view all our employees as part of our family," Watson says. "That's why we have continued to support Nina both during and after her illness, and it's why she is still a member of our team. As distressing as the lawsuit is to us, we remain optimistic that we can resolve this matter with Nina."

The lawsuit is indeed distressing. It claims Pham still has nightmares, body aches, and insomnia as a result of contracting the disease from Thomas Eric Duncan, the first person in the United States

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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.

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making sure those expenditures were approved, she says. Even simple items such as the socks must be kept in constant supply so that no patient is left at risk because the supply ran out.

In addition, Grady ensured that each patient room had a bedside commode. The paper signage previously used was changed for more durable, but more expensive, permanent signage that could be modified for the patient. Grady also mounted a white board in each room so that the nurse making rounds could check off that he or she asked if the patient needed assistance.

Much of the efforts were not innovative but rather the Grady team focused on ensuring strict compliance with the protocols that are known to reduce falls. That focus required staff education and also working with patients to encourage them to communicate their needs, Harris says.

"It took a host of different measures and interventions, and a very intense focus on them," Harris says. "The hardest thing was to stay focused and not let up. We wanted it to become second nature, and it did because we remained below the national benchmark for nine consecutive quarters, about 27 months."

As a result of the education, the tools provided, and the enhanced awareness, the recorded rate of falls decreased by more than 75% during the first quarter of 2014. The number of patient falls with injury per 1,000 patient days was 15% in 2011 and 28% in 2012. At the end of 2013, the rate was 0.5%. Grady has since had a steady rate of 0.7%.

Musheno notes that reduction in falls was well worth the investment in time and money, from a patient safety and a financial perspective. A fall with injury typically increases costs to the hospital by 60%, and the Centers for Medicare and Medicaid Services (CMS) limits reimbursement for fall-related injuries.

"From a human factor, taking care our patients and keeping them safe, reducing falls has to be a top priority," Musheno says. "From the standpoint of the resources that are devoted to caring for patients after a fall and the limited reimbursement from CMS, a fall reduction program like this is a huge opportunity for the organization." ■

Misplaced NG tubes a major patient safety risk

Every year, nearly 500,000 nasogastric (NG) and percutaneous endoscopic gastrostomy (PEG) tubes and suction tubes are misplaced, which result in severe complications or death, notes **Paul J. Gilbert**, MD, FACEP, an emergency physician who owns a private physician group of seven emergency department physicians in the Scottsdale, AZ, area.

After Gilbert lost a patient due to a misplaced tube, he realized something needed to be done to enhance patient safety. He now focuses on educating physicians and healthcare organizations about the risk of misplaced tubes, and along with colleagues, he has developed three new point-of-care diagnostic devices to provide safer NG tube placement and more accurate gastric acidity measures for critically ill patients. Gilbert's pH indicator tools, which are the RightSpot, RightLevel, and RightSpot Infant, are sold by RightBio Metrics in Scottsdale. Each device costs $10 or $13, depending on the purchase quantity.

RightSpot is a small, non-invasive in vitro diagnostic device that is used to verify gastric acidity to avoid misplacement of nasogastric feeding/suctions tubes and PEG tubes; the infant product serves the same purpose. The RightSpot indicator is placed on the tube and gastric fluid is aspirated; a pH below 4.5 would indicate gastric acidity. The RightLevel is similar but designed to facilitate proper treatment of gastric ulcers and bleeding, which involves administering medication in dosages appropriate for a specific stomach pH level.

Gilbert provides these facts:

- Studies show between 2% and 4% of all tubes are misplaced.
- Misplaced tubes are typically misguided into the lungs, which causes significant morbidity and mortality and costs medical providers millions of dollars.
- From 2001 to 2011, medical

EXECUTIVE SUMMARY

Misplaced nasogastric and percutaneous endoscopic gastrostomy tubes pose a serious threat to patient safety and a liability risk for hospitals. New technology might improve the detection of misplaced tubes.

- Half a million tubes are misplaced every year.
- Between 2% and 4% of tubes are misplaced.
- A misplaced tube can be deadly and can cost providers millions of dollars.

providers in the Chicago area alone paid more than $10 million to resolve lawsuits filed for injuries and deaths caused by misplaced NG feeding and suction tubes.

• Between 1993 and 2014 there were about 1,750 malpractice cases in the United States that were in some way related to placements of tubes; 412 of these cases directly stated that there was a misplacement issue.

• Of the 412 cases that related directly to the misplacement of NG, PEG, or suction tubes, 25 of them showed the settlement costs. NG tubes were involved in 173 settlements for tube misplacement, with an average cost of settlement being $1.07 million. For PEG tubes, there were 81 settlements for tube misplacement, with an average cost of settlement being $3.28 million. There were 119 settlements for suction tube misplacement, with an average settlement cost of about $1 million.

The common methods for checking tube placement involve X-rays or using pH paper to check the fluid in the tube, but Gilbert's devices provide what he says is a safer and easier way to check the pH of the fluids without removing them from the patient. The pH paper is contained in the plastic housing of the single-use device, so the fluid makes contact with the test strip there. "It's a very hot topic, especially with kids because we don't want to expose them to X-rays," Gilbert says. "There have been some very highly publicized cases of infant death, and that looks very bad for a hospital. It's a topic that risk managers should be involved in, so they can push for improvements on a problem that is occurring more often than they might realize."

Defending an NG tube misplacement malpractice case can be exceptionally difficult because it is widely recognized that the standard of care requires confirmation of proper NG tube placement in some manner, says **Edward McNabola**, JD, a partner with the McNabola Law Group in Chicago. The traditional approach of using auscultation to confirm placement is notoriously unreliable and, therefore, does not satisfy the standard of care, McNabola says.

"I have a vivid memory of a widow coming to speak with me about the tragic loss of her husband and father of her children. In short, the physician inserted the NG tube and assumed that it was in the stomach, based upon auscultation. However, the NG tube was actually in his lung, and they delivered charcoal and other substances into the lung, resulting in cardiopulmonary collapse, anoxic brain injury, and his eventual death," he says. "My firm filed a lawsuit against the healthcare providers and the hospital and successfully resolved the case for settlement in excess of $900,000." ■

$8.5 million verdict is first for concierge medicine

A Palm Beach County, FL, jury recently returned an $8.5 million malpractice verdict against MDVIP, the nation's largest concierge medicine practice company, which has 784 affiliated physicians in 41 states. The award is the first against MDVIP, and it is believed to be the first malpractice award against any concierge management firm.

Concierge practices offer patients who pay a membership fee faster access to a physician, more streamlined service, and higher quality care than practices that participate in managed care plans. A concierge practice is meant to appeal to those who can afford to pay extra in order to avoid some of the hassle typically associated with busy practices and third-party insurers.

The attorneys who won the case say it should signal caution for any hospital or health system that might align with a concierge service because the verdict casts doubt on the entire concierge concept. MDVIP was founded in 2000 to offer members such perks as same-day appointments and more personalized care in exchange for a $1,500 annual membership fee.

The jury found MDVIP liable for the negligence of one of its physicians, who was sued for misdiagnosing the cause of a patient's leg pain, which led to its amputation. The jury also found the firm had falsely advertised its exceptional doctors and patient care.

In 2008, Boca Raton resident Joan Beber, then a recent MDVIP member, sought medical attention for leg pain and was treated by MDVIP primary care physician Charles Metzger Jr., MD. Despite the progressive worsening of her condition, Beber was repeatedly misdiagnosed by Metzger and other MDVIP-affiliated staff members, according to her lawsuit. Orthopedists, to which Beber was referred by Metzger and with whom Metzger was supposed to be coordinating Beber's care, were never given medical records or informed of her worsening symptoms, she claimed. That information should have led to the discovery of a serious circulation problem in Beber's leg that eventually required the above-the-knee amputation. She spent the next four years dealing with serious phantom pain and struggling to learn