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Your Direct Link to Better Risk Management Practices

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In This Issue:

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Wrong Site Surgery

Mary Jane Shevlin, BSN, MA, CPHRM, CPHQ
Princeton Insurance Healthcare Risk Consultant

Despite years of patient-safety efforts, an increasing number of healthcare facilities have reported mistakenly removing the wrong limbs or organs, slicing into the wrong side of bodies and performing surgery on the wrong patients. The Joint Commission, in its September 7, 2007 publication of the Sentinel Event Statistics, indicates that wrong site surgery remains the highest reported event. Last year, healthcare facilities reported 94 operations to the commission that involved the wrong body part or the wrong patient. While some states, including New Jersey, require hospitals to report such slip-ups, many hospitals across the nation are not obligated to account for them publicly. Since the introduction of the Joint Commission's Sentinel Event Policy, the Joint Commission has reviewed numerous cases related to surgery and have identified several factors that may contribute to the increased risk of wrong site surgery. These risk factors include:

• more than one surgeon involved in the case, either because more than one surgery is contemplated or the care of the patient required more than one surgeon

• unusual time pressures, related to an unusual start time because of emergent situations or pressure to

Walking the Tightrope of the New Electronic Discovery Rules

James B. Couch, M.D., J.D., FACPE
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The November 2007 issue of *Risk Review* introduced the brave new world of electronic health records, including their various medical, legal and risk management benefits (as well as potential pitfalls to overcome). The January issue discussed how to ensure that electronic health records provide certain legal protections and are not used in such a manner which could actually increase medical legal risk.

This issue focuses on the new rules governing the discoverability in litigation of electronic health records (or, more accurately, electronic **medical** records since they will be assumed to meet the requirements discussed in the past two issues to be characterized as such).

An electronic **medical** record (EMR) constitutes a record in electronic medium which is completed in the ordinary course of business to reflect what occurred during a transaction which is central to that business, viz.

Another Article on Documentation?

By Donna Knight, CPHRM, CPHQ
Healthcare Risk Consultant

The topic of medical record documentation is about as exciting as watching paint dry. However, time after time we find that missing, incomplete, or illegible documentation seriously impedes safe patient care and the defense of malpractice claims, even when care was appropriate. The medical record is a legal document and, as such, demonstrates adherence to state and federal regulations, evidence-based practice guidelines as promulgated by professional organizations, and it provides the information necessary to support billing and reimbursement. It is also the provider's greatest defense in the event of a claim by providing a contemporaneously written record of the "what, when, why and hows" of the care provided.

The documentation elements that often lead to unanticipated outcomes, medical errors, and claims include:

- Missing documentation that leads to failure to diagnose, such as after hours telephone calls, a record of direct provider-to-provider communication, adherence to or reasons for not following evidence-based practice guidelines (e.g. rationale for choosing one particular course of treatment over another), and follow-up of ordered tests and consultations

- Unsafe medication documentation practices, such as utilization of trailing zeros and not utilizing leading zeros, or the use of abbreviations that lead to medical errors

Job Descriptions and Performance Evaluations for the Office Practice

By Amy Slufik,
Physician Risk Representative, Princeton Insurance

Patient dissatisfaction is a major contributor to malpractice claims, especially in the event that the patient experiences an adverse outcome. A cordial, caring and efficient staff, however, has a tremendous impact on patient satisfaction by setting the overall tone of the office culture. From the greeting at the window to the payment process after a visit, office practice employees contribute substantially to a patient's first and lasting impression of the practice and of the physicians, dentists or chiropractors who employ them. Good staff performance, whether through direct patient care or in the provision of administrative tasks, is essential to the safety of patients, efficiency in your business operations and overall patient satisfaction.

Yet, office practices often utilize a subjective method of evaluating new and existing staff performance. Well-crafted and detailed job descriptions and performance evaluations, on the other hand, are effective management tools that are important in supporting many employment actions such as hiring, compensation, promotion, discipline and termination. They provide the practice with an objective method of evaluating employees according to performance outcomes, and not on the subjective opinion of their abilities alone. Direct performance can be observed and measured, whereas the traits and attributes of employees (which may or may not contribute to performance) must be guessed at, or inferred. Whether a small office practice with few employees or a larger office practice with many employees, it is important to develop and utilize a consistent approach.

Job descriptions:

- Provide a basis to evaluate your employee's performance

- Clearly communicate to your employees what is expected of them, including the skills which are required for the position

- Provide a training outline

- Ensure an effective, consistent hiring process

- Assist in comparing the duties of the various positions within your office to establish relative pay rates

What should be included in a job description?

- Name of the office practice/employer

- Effective date

- Position title

- Name of employee

- Name of individual to whom employee reports

- Job summary (i.e. general overview of the position)

- General responsibilities for all employees (i.e. confidentiality, courtesy, etc.)

- Core competencies (i.e. specific duties/tasks for that position) listed in order of importance and/or frequency

- Working conditions (i.e. hours, health or safety hazards, physical requirements, etc.)

- Job requirements (i.e. education, special training, experience, abilities, certifications/licensing, clinical skills, technical skills, occupational skills, etc.)

If a job description is being created from an already existing position and it is unclear exactly what that individual does, simply ask the employee to explain what they do each day and select the key areas to establish a list of the specific duties/tasks. Next, have your employees assist in determining what measurable actions will help to gauge whether tasks are being performed satisfactorily, so that they may be incorporated into their performance evaluations.

Performance evaluations are based upon a direct comparison of the employee's job description to the employee's actual job performance during a specific time period to provide ongoing feedback and define concrete goals. They provide supportive written documentation for:

- Acknowledging an employee for exceptional performance

- Disciplinary action

- Identifying employees who need to improve

- Evaluating an employee's progress after training

Creating a performance evaluation from an existing job description is easy.

1. List the areas you want to evaluate from the identified general responsibilities and core competencies.

2. Develop criteria/standards for each general responsibility and core competency, indicating how you expect each to be done satisfactorily, but be careful not to establish an unrealistically high standard to meet. For example, one of the core competencies for a medical assistant may be to schedule appointments and tests. The criteria/standards defining that core competency may be to pre-certify

From The Hotline

In each publication of Risk Review, an outside guest or a member of our team of expert risk management and loss prevention consultants will answer a question from our Risk Hotline. If you are concerned about a risk management or safety issue at your practice or facility, let us know and we may answer it in a future issue. Our hotline number is 1.866.Rx4.RISK.

*By Russ Pride, MA, CPHRM
Princeton Insurance Healthcare
Risk Consultant*

A behavioral health provider asks: *Several of my patients recently asked me if it is okay for them to communicate using email. Are there any risk management issues that I should consider?*

Answer: Your inquiry raises the caution flag on several fronts that you will want to think through before you say "yes" or "no" to your patients.

The advantage to email is that it can be written and sent, or retrieved and read, anywhere at any time. You and your patient do not need to be available at the same time, thereby eliminating phone tag. Another plus is that emails automatically create a written, permanent record that may be referred to as needed by you or your patients.

But (and there is always a "but"), there are risks as well. Unless some type of encryption is used, email may not be as secure and confidential as you (or the patient) would like and expect it to be. Encryption is not easy to use, presuming a level of computer competence that many users do not have. Firewalls are another line of defense, but you must do your homework or consult with an information technology specialist to decide upon the firewall that is best suited for your practice and purposes.

There are other concerns, too. For example, many individuals don't wish their real identities to be known as they surf the internet. Screen names are a handy way to protect their identities to some extent. Patients using screen names when contacting you create the potential to jeopardize the confidentiality of the communication. You may not easily recognize or associate the screen name with that particular patient. We all are warned that if we do not recognize the identity of the sender, we should delete the email to protect our computers from illegal access by cyberspace predators or to prevent the introduction of a virus.

The likelihood is real that more than one patient may use similar screen names with slight variations (such as marathonman, marathon123man, marathonmate and so forth). Lessons learned from misadventures associated with look-alike/sound-alike drugs will encourage you to be careful with respect to look-alike/sound-alike screen names: be sure that the screen name you are responding to is the actual screen name for the patient you intend to provide with an email response.

What if you confuse screen names with your patients' identities and inadvertently respond to the wrong person with another patient's confidential information? A breech of confidentiality occurs at your hand, innocent and unintentional, but a violation nonetheless.

Or consider this possible scenario, an example provided by the American Psychiatric Association (APA) Council on Psychiatry and Law on its FAQ website: Your patient sends you an email in which he describes delusions of a political nature. Given the practice of randomly scrutinizing use of the internet for purposes of national security, it is plausible that an ISP (internet security provider) might take an interest in such confidential email content from your patient to you.

If you decide you will use email in some form to facilitate communication with your patients, here are some suggestions from the APA:

Use email only for established patients (not new ones) to…

- schedule or re-schedule appointments
- provide reminders of upcoming appointments
- respond to requests by patients for refills of prescriptions
- provide information of a general nature, such as appropriate time to take medication or the name of the provider covering for you in your absence.

Also recommended by the APA is the creation of an automatic computer-generated response to all incoming

Course Offerings

In Princeton Insurance's continuing effort to partner with our insureds, we are pleased to offer you an opportunity to improve your risk management practices and earn continuing education credit.

Several members of the Princeton Insurance Healthcare Risk Services Department are certified as instructors by the Institute for Healthcare Communication (IHC – formerly the Bayer Institute).

Currently, Princeton Insurance is offering two courses: **Clinician Patient Communication to Enhance Healthcare Outcomes** (CPC) and **Disclosing Unanticipated Outcomes and Medical Errors** (DUOME).

CPC is based on extensive research and the premise that the physician-patient interview is a procedure. Therefore, the basics of interviewing can be taught so that any physician may move from the fundamental "find it/fix it" model of diagnostics to a more in-depth paradigm of care. By including four elements of communication to find it/fix it, the physician will be able to improve their diagnostic ability and minimize liability.

DUOME is rooted in the current culture of dialogue between physician and patient/family at a most stressful time. The course takes into account that each participant works within different guidelines and with their own style of communication. The program uses guided practice, as does CPC. The strength of both courses lies in the fact that participants coach each other, and they are also coached by the instructor. This layering of experiences, coupled with less didactic learning than other courses may require, gives participants an in-depth learning experience.

These two continuing education activities meet the criteria set by the Institute for Healthcare Communication for both Category I of the Physician's Recognition Award of the American Medical Association and the Continuing Education for Professional Nursing. Credit hours will vary according to the different program lengths available.

If you are interested in taking these courses, contact Princeton Insurance through the Risk Management Line at 866-RX-4-Risk.❖

Electrical Safety

By Jim Echard
Princeton Insurance Healthcare Risk Consultant

Most individuals take electricity for granted. We walk into our offices in the morning, flip the switch and the lights come on. We sit down at our computers, go through the start-up routine, and the computer comes to life. Electricity is part of our everyday lives, but we sometimes forget that it can be a powerful energy source; an energy source that if not used properly or maintained can result in personal injury or death to us, our staff and our patients.

Electricity can also start fires. Electrical fires occur throughout the U.S. on a daily basis, resulting in destructive property losses.

Just a couple of proactive steps now can minimize the potential for an electrical hazard:

- Any piece of electrically powered equipment should have an Underwriter's Laboratory (UL) [i] label on the device or the power cord. If the device doesn't have a UL label, it shouldn't be used. All electrical cords should be inspected for fraying, cracks, or cuts and should never be placed under carpeting, rugs, or office furniture. Electrical cords also create trip-and-fall hazards for people, so try to keep them out of the normal paths of traffic.

- The use of extension cords in the office should be restricted. In addition, electrical cords should not be stapled or nailed to walls or floors. Sometimes when decorating for the holidays, office staff members use temporary extension cords; make sure that in this situation, the proper type of cord (indoor versus outdoor) is used for the job.

- If you need extra power, contact a registered electrician and have them install an additional circuit. Extension cords are often used in temporary situations which then become permanent, unsafe hazards. Note: Never use a cheater plug or three-prong to two- prong adapter. This eliminates the grounding properties of the circuit.

- Be sure to turn off any electrical device before you connect or disconnect it from an electrical outlet. Also, be sure to hold the electrical cord by the plug body and not by the cord itself. Using the cord will eventually damage the internal wiring.

- Don't handle any electrical device with wet hands or when standing on a wet floor. This may seem like common sense but remember, any liquid can conduct electricity, even your perspiration. Anyplace where electricity and water are within six feet of each other, install a Ground Fault Circuit Interrupter (GFCI) circuit for protection against an electrical shock. Note: On a monthly basis and after an electrical storm, trip any GFCI circuits to ensure that they will operate as designed.

- Don't use electrical tape to make splices in cords or to protect cut or frayed cords.

Remove the damaged cord from use. Repairing a cord by yourself can pose potential liability on your practice.

- The use of portable electrical space heaters should be discouraged since they can pose a potential source of ignition by generating resistance heating. Typical resistance heating is the process of running a normal household electrical current through high-resistance wires (called heating elements), thus generating heat, which can reach very high temperatures when operated. If a portable space heater must be used, we suggest that:

    - it is UL-listed

    - it is purchased with an automatic shut-off, should the heater be knocked over or overheats

    - at least three feet of open space is maintained in front of the heater

    - an extension cord is not used to power the heater

    - if the unit does not work as designed, it is immediately unplugged, remembering to shut-off the heater before doing so

- Wall receptacles may also become broken or loose through normal use. If you believe that a receptacle is broken or loose, unplug the device. Contact a licensed electrician and have them make any necessary adjustments or repairs to the receptacle. This might also be a good time to have all of your receptacles checked for plug tension and electrical polarity[ii]. Any wall receptacles in your office that could be exposed to children should have plastic inserts installed in any open receptacle slot to protect against exposure and electric shock.

    - When you turn on any electrical device and it begins to emit an odor, smoke, sparks or other strange noises (buzzing or sizzling), immediately shut the device off. Remove the power cord from the receptacle by using the plug body and not the cord. If the device still appears to be burning at this point, remove the patients from the room and contact the fire department. Remember, if you suspect an electrical fire, you may have other problems within the office wiring system that are not readily visible to you. This situation dictates an investigation by the fire department and most probably a call to your electrician for appropriate follow-up. Because your office wiring is concealed behind walls, a smell, visible smoke or sparks may be an indication of a more serious problem. Even a blown fuse or a tripped circuit breaker may also be a visual indicator of an electrical hazard.

- Other indicators of potential electrical trouble include lights that dim for no reason and discolored or warm switchplates/coverplates. Sometimes a tear-drop shape may be visible on the front of the switchplate or wall coverplate. These are also situations when a licensed electrician should be called.

- Illegibility

Documentation do's and don'ts

- Use permanent ink, not soft felt pens or lead pencils.

- Write legibly; print if your handwriting is indecipherable. The use of encounter forms, checklists, flow-sheets, and computer-assisted documentation for high-volume activities can save time and may also reduce communication problems and errors caused by illegible handwriting.

- Date, time and sign all entries, including your professional designation. Use precise time whenever possible. Precision contributes to an impression of thoroughness.

- Each entry should be in chronological order. Late entries and addendums should be identified as such. Document the date and time of all added note entries.

- Use only abbreviations approved by the facilities in which you have privileges and consider adopting these abbreviations at your
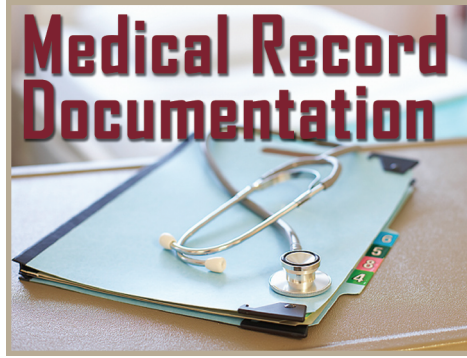
practice site (for the complete Joint Commission list of "Do Not Use" documentation go to http://www.jointcommission.org/PatientSafety/DoNotUseList/).

- When utilizing progress note style forms, do not leave blank lines between entries.

- Do not erase, use "whiteout" or obliterate a notation. Incorrect entries should be corrected by drawing a single straight line through the mistake, then write "mistaken entry" above or next to it. Include your initials and the date of the correction. ❖

- When replacing light bulbs or tubes, remember to use the wattage indicated on the fixture or lamp. Don't increase the wattage because you need more light.   Note: Halogen bulbs can produce high heat and should be placed away from combustible furnishings if used in your office.

- Know the location of your electrical panels before a problem develops. Label the circuits as to the area, room, or equipment that they control so that in an emergency situation you can shut off equipment or items quickly. Also make sure that any empty circuits are covered with a plate.

- If a fuse has blown or circuit breaker in an electrical panel has tripped, that is a good indication that a potential electrical hazard exists somewhere inside your office. At this point, your electrician should be called to investigate the problem. For those of us that are more mechanically/electrically inclined you may replace the fuse or attempt to reset the circuit breaker. If the problem reoccurs at this point, it is definitely time to call in the professionals. Don't ever increase the capacity of the blown fuse.

Electrical safety is common sense. If your

electrical system doesn't work or appears to be problematic, have a qualified licensed professional investigate and repair the problem. It's a good safety practice to have a member of your staff walk around the office and check the GFCI circuits for proper operation on a monthly basis. This is also a great opportunity to check electrical cords for fraying, cuts or breaks that could pose a potential electrical hazard. ❖

[i] Underwriters Laboratory is an independent testing laboratory that tests product samples from a manufacturer to meet national safety standards that focus on fire and electrical shock hazards.

[ii] Polarity is a term related to electrical systems. It means that one of the prongs of an electrical device is larger than the other prong. If the wiring is incorrectly installed, the equipment could malfunction and become a potential safety hazard. ❖

About Us

Princeton Insurance Healthcare Risk Services

Managing risk and preventing loss are concepts embraced by the Princeton Insurance mission of partnership, prevention and protection. Your success is our success. That's why the members of our Risk Services Department don't just work for you; they partner with you in reducing your liability.

It has been said that if you want to improve your future, you need to take a hard look at your past… and that is where the Risk Services Department begins. Through a process of claims review, onsite audits and system practice review, our risk services consultants provide insight on how to make improvements that are intended to reduce unwanted outcomes. And while it is recognized that all risk cannot be eliminated, it is well-recognized that the implementation of sound risk management practices have proven very successful in protecting your interests when an adverse event occurs.

Healthcare Risk Services Department - at a glance -

- The department includes data analysis, claim coverage verification for credentialing purposes, and risk / loss consultations

- 18 people dedicated to reducing liability exposure for physicians, dentists, chiropractors and various healthcare facilities

- Risk consultants have over 100 years' combined experience in healthcare, loss prevention and risk management

- Management/supervisory team possesses an average of over 20 years' experience in healthcare ❖

FTH, continued from page 3

emails to your practice, indicating that…

- you do not correspond on clinical matters by e-mail

- your response in no way creates a doctor-patient relationship between the sender and you

- they may not use email for any matter for which they cannot wait at least 72 hours to be addressed.

In other words, you need to ensure that the patient understands that any email to or from you or your practice does not constitute a medical/therapeutic intervention and is not intended to render any type of clinical service other than to provide a convenience for more routine matters. These communications are not a substitute for an in-person visit.

What other kinds of issues should be reserved for a face-to-face patient encounter rather than in an email?

- Concerns relative to one's intent to harm himself or another

- Emails that contain protected and sensitive personal patient information (such as HIV issues, Drug and Alcohol, names/identities of third-parties)

- Requests for a first or initial appointment

You will want to consider tracking the number and kinds of emails from your patients over a specific period of time for quality purposes. If it appears a patient is using internet services in lieu of face-to-face encounters for therapeutic or clinical purposes, you will want to counsel the individual that email is a convenience and privilege to foster timely communication, and is not to be regarded as a substitution for one-on-one appointments that promote a stronger therapeutic alliance.

To summarize:

- Be proactive and decide just what role email communications will have in your practice.

- Decide how you will educate your patients regarding appropriate use of email when communicating with you. When to provide this education is important – the initial patient encounter is recommended.

- Decide the means by which you will educate patients about your email policy, especially with respect to issues of confidentiality and privacy. Then have them demonstrate understanding and acceptance of your practice policy with respect to email.

- Determine what steps you must take to protect the information entrusted to you and how this information is stored, shared, utilized and, ultimately, destroyed.

For a better understanding of the far-reaching impact email can have on your practice, refer to the article *Walking the Tightrope of the New Electronic Discovery Rules* by James Couch, M.D. also appearing in this month's *Risk Review*.

Once you've established the criteria and have developed a policy addressing email use in your practice, determine how best to communicate this policy with your patients. Perhaps a statement on the back of your patient appointment card is best and most convenient. If you have a practice brochure, include your policy statement with regard to email use somewhere in this printed material. A simple, informed discussion, properly documented in the record, or a short form memorializing the discussion and acknowledged in writing by the patient, will help standardize your patients' expectations for the future. ❖

Coming by Mail

Dentists – Keep an eye out for the Princeton Insurance Dental Office Practice Toolkit, Princeton Insurance's latest risk management tool. Designed for individual office practices, the CD-ROM contains sample letters, forms, screenings and guidelines for policy development. Each document found on the CD-ROM is in Adobe (.pdf) format, but several forms are also available in Word for your customization. Documents are downloadable and reproducible on your office printer.

WRONG SITE SURGERY, continued from pg 1

speed up the pre-operative procedure

- incorrect site preparation by the staff and incorrect interpretation of X-rays

- unusual patient characteristics such as physical deformity or morbid obesity that might alter the usual process for equipment set-up or positioning of the patient

The root causes identified most often are related to the following major themes:

- incomplete or inaccurate communication among members of the surgical team

- inadequate pre-operative assessment of the patient and the procedure or lack of procedure to verify the correct surgical site

- the failure to engage the patient or family member in the procedure of identifying the correct surgery

The following graph published by the Joint Commission shows further breakdown.

Root Causes of Wrong Site Surgery (2006)
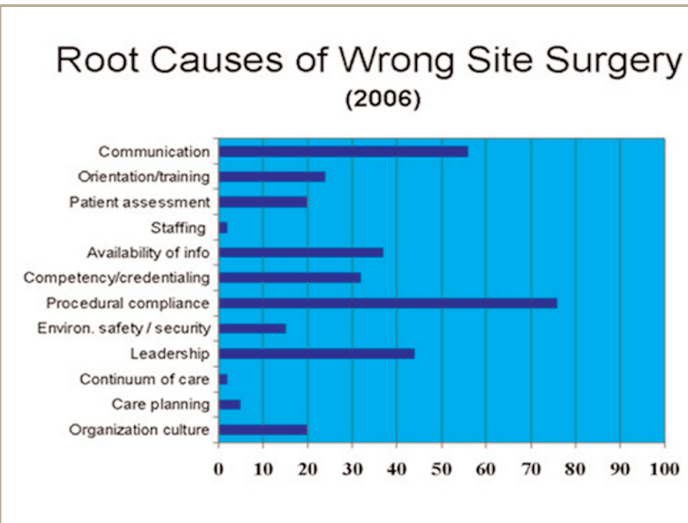
Furthermore, the Joint Commission's evaluation of 126 root cause analyses (RCAs) revealed the following specialties were the most commonly involved in the reported wrong site surgeries:

- Orthopedic/podiatric (41%)

- General Surgery (20%)

- Neurosurgery (14%)

- Urology (11%)

- Maxillofacial, cardiovascular, otorhinolaryngology, and ophthalmology (14%)

In New Jersey, the New Jersey Healthcare Quality Assessment and Patient Safety Initiative Summary Report does not break down the specialties involved in wrong site surgery; however, the report published in December 2007 indicates the following incidence of surgery-related events in the last two years:

Year	Wrong Body Part	Wrong Patient	Wrong Procedure
2005	10%	3%	3%
2006	20%	2%	4%

The study by Kwaan, Studert, et. al. of 2.8 million operations over a 20-year period, published in *Archives of Surgery*, suggests that the rate of "wrong site" surgery anywhere other than the spine is one in every 112,994 operations. According to the authors, the study excluded the spine because surgical sites on the spine are verified with x-rays. The study, which was funded by the Federal Agency for Health Care Research and Quality, concludes that the rate is "exceedingly rare" but "unacceptable."

The incidence of wrong site surgery has captured national attention, and current patient safety experts say more vigilance is needed. It is clear that the Joint Commission considers this of grave concern – it has convened two summits, one in May 2003 and a second one in February 2007.

After the first summit, the Universal Protocol for preventing wrong site surgery, wrong procedure and wrong person surgery was adapted. It gained wide support from numerous professional organizations such as the American College of Surgeons, the Agency for Healthcare Research and Quality, the American Academy of Orthopedic Surgeons and others who support the initiatives in patient safety. This protocol emphasizes three minimum requirements, namely: pre-operative site verification, marking and time-out.

Preoperative or Pre-procedure Verification

The preoperative or pre-procedural verification process starts at the time the surgery or invasive procedure is scheduled. The Operating Room (OR) schedule must include the exact site, digit, level laterality (including "left" or "right" and "bilateral") without using any abbreviations except in designating spinal levels such as C-Cervical, L-lumbar, S-sacral and T-thoracic - e.g. L-4-5.

Best practice models suggest that the staff responsible for accepting requests to schedule procedures must verify the information provided by the surgeon/physician either by read-back, fax or email as agreed upon by both institution and physician.

At the time of surgery, verification of the correct person, procedure site and side is carried out with the participation of the patient who is awake and aware, if possible. Any inconsistencies or discrepancies/uncertainties about proper site or procedure should be resolved by the surgeon with confirmation agreement by the patient and at least one of the inspecting caregivers. Protocols should explicitly address the manner in which inconsistencies are resolved.

The same procedure of verification is applicable in all clinical settings where invasive procedures are performed, including but not limited to endoscopy, cardiac catheterization and radiology interventional suites, emergency departments, and intensive care units.

Marking the Operative/Procedure Site

The intended site is marked so that the mark is visible after the patient is prepped and draped. The physician either marks the spot for surgery with his/her initials or the word "YES" - never with an "X". The mark must be made using an FDA-approved marker that is sufficiently permanent to remain visible after completion of the skin prep.

The Joint Commission also encourages patients to insist on such a mark. To support this requirement, the Joint Commission published a speak-up brochure for the patients, with tips on how they can help to prevent wrong site surgery.

If a smaller mark is necessary as in the pediatric ophthalmology cases, a dot near the eye may constitute the site marking. Some hospitals have adopted a special purpose wristband as an option.

Time Out

As doctors are required to mark the site, nurses are supposed to call a "time out," A "time out" provides the opportunity to call everyone's attention to a final safety check in an effort to ensure that the right procedure is performed on the right patient.

The New York State Surgical Invasive Protocol published in 2006 suggests that "time out" must be conducted in the location where the procedure will be done, after the patient is prepped and draped. This applies to all invasive procedures performed in all settings and must involve the entire operative/procedure team.

patients for insurance coverage, set up referral contacts, and review all requisitions for completeness.

3. Apply a rating scale to each general responsibility and core competency you are evaluating. The rating scale could be simple:
   (1) Did not meet standards
   (2) Met standards
   (3) Exceeded standards

   They can also be a little more complex:
   (1) Failed to develop as anticipated
   (2) Performance is below the standards set for the position, training is needed
   (3) Performance is satisfactory
   (4) Performance is consistently higher than the standards set for the position
   (5) Requirements and standards set for the position are always exceeded

In summary, performance evaluations should include the following:

• Name of the office practice/employer

• Position title

• Name of employee

• Period of time you are evaluating (i.e. 1/1/07 – 12/31/07)

• The general responsibilities and core competencies to be evaluated and the criteria/standards defining them

• A rating scale

• Specific acknowledgements/accomplishments

• Specific areas for improvement (be specific, i.e. training, certification, behavior change)

This is also a great opportunity to have an in-depth discussion with each employee in order to uncover areas in which the employee is having difficulty and to indicate ways to assist that individual, discuss their specific accomplishments and/or other job responsibilities they may be interested in, as well as develop goals for that employee for the upcoming year.

Remember that performance evaluations should be conducted at the end of an employee's probationary period, usually three months, and then at least annually thereafter. In addition, review the Employee Confidentiality Policy and Agreement with your employees and have them again sign and date it, as well as verify that their certifications and licensing requirements are up to date.

All employees should receive a copy of their job description upon hire. It is also a good idea to review the developed job descriptions on a periodic basis to ensure that they are being updated to include any technological changes (i.e. new equipment, including the skills required), as well as any changes to the office practice in general. Any changes made to the job description should be done with the agreement of the employee, and the employee should be given an updated copy for their records. All employment-related policies, procedures and forms should be reviewed by the practice's legal counsel with knowledge of employment practices liability. ❖

Job Description Form

On page 12 of this issue, we have included a sample **Job Description Form** for use in your office. This form can also be downloaded on the *RiskReviewOnline*.com site as well. (Look for the link within the *Job Descriptions and Performance Evaluations for the Office Practice* article in RiskReview, March 2008).

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Staff Job Composite: Medical Assistant (2007). Saint Louis University. Retrieved December 19, 2007 ❖

"Time out" using active communication techniques should include the following:

1. Identification of the patient using two identifiers

2. Identification of the correct site and laterality if applicable

3. Procedure to be performed and proper positioning of the patient

4. Availability of special equipment or implants

5. Radiological review, when applicable to the case and confirmation that the images displayed belong to the patient in the correct orientation

Other Protocols:

A vast array of intervention tools exist, and common strategies are evident in these protocols. What is evident in most of these protocols is the use of a standardized checklist to document information related to the site verification and the "time out" process. Monitoring compliance is another common element.

In conclusion, the incidence of wrong-site surgery must be viewed not as the failure of one individual but the failing of a complex system. Dr. Charles Chodroff, senior vice president of WellSpan Health, advises disciplinary action will not prevent systems errors but that "studying the psychology of errors will more effectively identify factors that can improve performance and detect systems breakdowns before they occur; and therefore improve safety."

Below is a list of organizations that have developed resources in doing the "right things to correct wrong site surgery." ❖

Resources

1. Joint Commission: www.jcaho.org - Sentinel Event Alert

2. Institute of Healthcare Improvement – through Collaboratives, www.ihi.org

3. American Academy of Orthopedic Surgeons

4. Association of periOperative Registered Nurses: www.aorn.org (for the AORN toolkit)

5. New York State Department of Health: http://www.health.state.ny.us/nysdoh/commish/2001/preop.htm

6. Agency for Healthcare Research and Quality: http://www.ahrq.gov/consumer/20tips.htm

7. The Institute for Clinical Systems Improvement

8. Veterans Administration, Department of Veterans Affairs: "Seven Absolutes to Avoid Surgical Site Errors"

9. National Patient Safety Agency (UK)

10. NASS - National Association of Spinal Surgery, SmaX Campaign (Sign, Mark and X-ray) ❖

the various aspects of the clinical encounter itself.

The New Electronic Discovery Rules

On April 13, 2006, the U.S. Supreme Court approved amendments to the Federal Rules of Civil Procedure aimed at the unique aspects of electronic discovery (e-discovery). These new rules took effect on December 1, 2006 and apply to cases in federal court, as opposed to state courts where most medical liability cases reside. However, New Jersey was one of the first states during 2007 to adopt e-discovery rules which mirror the federal rules as reported in the June 19, 2007 issue of the New Jersey Law Journal by Korin, JB, Quattrone, MS, *Electronic Health Records Raise New Risk of Malpractice Liability: http://www.law.com/jsp/legaltechnology/pubArticle LT.jsp?id=1182194746807*

The electronic information age has brought with it many changes regarding the gathering and use of electronic evidence in legal proceedings. The new rules related to e-discovery will dramatically affect how health care organizations manage their electronic data, and include changes that address characteristics distinguishing e-discovery from traditional paper discovery. E-discovery concerns the access, use, disclosure, preservation and handling of data, including e-mail and other computer-generated documents that are transmitted, stored, and backed-up electronically. In contrast to paper-based medical records, discovery of electronic records also extends to the following:

• Computer forensics (scientific methods that are employed to analyze sources of electronic data such as hard drives or servers to determine if evidence was accessed, altered, destroyed, or fabricated and/or to locate computer-generated evidence of which a layperson may be unaware)

• Searching, gathering, reviewing, analyzing, producing and using large amounts of relevant information in routine litigation (i.e. the equivalent to searching document storage facilities or warehouses, waste baskets, file cabinets, home offices and personal files for paper records)

• The focused search for electronically stored information relevant to the specific issues in a case such as cell phone or blackberry records and e-mail or instant messaging records (Rebelo, M. *E-Discovery in Health Care Litigation;* Physician's News Digest*: http://www.physiciansnews.com/law/207rebel o.html*).

In general, data loss or destruction, inappropriate corrections to the medical record, inaccurate data entry, unauthorized access and errors related to problems that arise during the transition to EMRs constitute potential liability issues. These concerns are not unique to EMRs—the same concerns exist with regard to paper medical records (Cf. Korin and Quattrone above at*:*

http://www.law.com/jsp/legaltechnology/pubArticle LT.jsp?id=1182194746807).

However, due to the intrinsic nature of electronic records, these same concerns may be even greater than with paper records.

Key Medical Recordkeeping Practices Impacted by the New Federal Rules

There are several key medical recordkeeping practices which will be impacted by the new federal rules, viz. disclosure processes, retention and destruction, litigation hold or preservation orders, spoliation and disaster recovery.

> *Discovery and Disclosure*
> Although an EMR may be regarded as a record completed in the "ordinary course of business," because of the privacy and confidentiality rules also imposed by HIPAA, there are certain

parts of records containing "personally identifiable medical information" which physicians and their staff must zealously protect from disclosure. This is especially true concerning content pertaining to HIV infection, mental health, substance abuse, and employee records.

Retention and Destruction
Organizations (including physician practices) must know where information is located (i.e. back-up tapes, instant messages, e-mail, word processing drafts) and establish a routine policy and practice for both retention and destruction which specifically identifies when the information's useful life is over, resulting in destruction. The new rules provide a safe harbor in circumstances where information cannot be produced because it was destroyed as a result of routine policy and practice.

Litigation Hold or Preservation Order
A litigation hold or preservation order in the context of e-discovery is the same concept as that applied to a paper-based record. It suspends the normal practice or disposition, including destruction, of paper *and* electronic records. Several courts have held that routine document destruction should be suspended once a party reasonably anticipates litigation - see *Heng Chan v. Triple 8 Palace, Inc., 206 U.S., Dist. Lexis 15780 (D.N.Y. 2006); Lewy v. Remington Arms Co., 836 F.2d 1104, 1112 (8th Cir. 1988) and Zubulake v. UBS Warburg LLC, 220 FRD 212 (S.S. N.Y. October 22, 2003).*

Spoliation
Spoliation is the legal term for intentional destruction, alteration, or concealment of evidence. Efforts to prevent spoliation should be tightly tied to an organization's policies and procedures for record retention and destruction, as well as to the policy and procedure for a litigation hold or preservation order.

Disaster Recovery
Disaster recovery seeks to preserve patient records in the event of a disaster (think Hurricane Katrina) and to return the organization to usual operations as quickly as possible. Although back-up processes are important to an organization's resumption of operations, they may also become a legal liability. Consideration of destruction of back-up tapes once their useful life is over should be addressed in the retention and destruction plan (Cf. Generally: Rebelo, M, above at: *http://www.physiciansnews.com/law/207 rebelo.html).*

Other Risk Management Issues

As covered in the November 2007 issue of *Risk Review*, along with the risk management benefits of EMRs' "baked in" clinical alerts, there are also medical legal pitfalls if they are not used (without defensible justification). In an effort to avoid disruption of the regular clinical process workflow, medical legal hazards may arise due to either the turning off, ignoring or active overriding of clinical alerts or practice guidelines. EMRs which require the user to generate an explanation for why an alert or guideline is being overridden are almost always preferred.

However, there is still the possibility that such an explanation could be discovered and used against a defendant physician. To what extent EMR vendors may become involved as co-defendants or even expert witnesses in the future is beyond the scope of this article, but still worth pondering.

An EMR also has the ability to create an electronically traceable path that a patient has followed throughout the care process for an episode of illness. This is especially true to the extent that embedded electronic data that is usually "hidden" from view of computer users (the so-called data about the data or "metadata") is also discoverable. This "metadata" is discoverable under the new federal rules and might well be in those jurisdictions such as New Jersey which have embraced these rules. Still, the extent of discoverability of "metadata" (which could be used to reconstruct a case's chronology and produce a record of when everybody may have accessed a particular patient's record) may ultimately be decided on a case-by-case basis.

Nevertheless, the new discovery rules may require that metadata created by computerized physician order entry (CPOE) systems be produced. This metadata may be discoverable even in situations for which hospital policy does not require the data to be integrated into a patient's permanent health record (e.g. where pursuant to hospital policy, the EMR system does not integrate clinical overrides made in the CPOE system into the EMR) (*Rollins, G. The Prompt, the Alert, and the Legal Record: Documenting Clinical Decision Support Systems, J. AHIMA, 2005; Feb; 76(2):24-8).* This discoverability of metadata may apply to physician office-based EMR systems, also.

Summary

All of the above is certainly not intended to provide yet another reason to avoid converting from paper to EMRs. As a matter of professional and economic survival in the next three to five years, physicians will need to undertake that transition in any event—voluntarily or involuntarily.

Rather, this article is intended to alert physicians and their staff of these new e-discovery rules. They need to be kept in mind when installing and using EMRs, to capitalize on their many clinical decision-making and economic benefits for physicians and patients alike, without falling into some of the traps which may prove costly should litigation involving the discovery of those electronic records ever arise.❖

New FDA alert service can help you improve patient safety and enhance your liability protection

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Protecting your practice means not only choosing a reliable medical professional liability provider but also remaining informed about the latest patient safety issues. Princeton Insurance recommends that its insureds enroll in a new, free service that will improve patient safety and liability protection.

Currently, important product-related patient safety alerts that have been mandated by the FDA are sent to you through the U.S. mail. The Health Care Notification Network (HCNN) is a new service that moves these alerts onto a secure, online network with the following benefits to you:

1. **It's free and only used for patient safety notices (i.e., no advertising or spam).**
2. **Faster and more efficient than current paper-based delivery of patient safety alerts.**
3. **Once enrolled, you will be able to designate staff members to receive the online alerts, if you wish.**
4. **You can opt out at any time.**

At Princeton Insurance, we believe that more rapid and focused delivery of FDA-mandated product recalls and warnings have the potential to reduce malpractice claims and, ultimately, to decrease malpractice insurance premiums. The FDA has contacted us asking for our help in enrolling our insured physicians into an online network for patient safety notices.

We are asking all of our insured physicians to enroll today in the HCNN and receive the FDA-related patient safety alerts online.

To enroll:

1. Complete the fax-back form (get the printable PDF).
2. Insert the email addresses you wish to use for these alerts (please print legibly). **You must provide your email address because your User ID will be the email address that you provide.**
3. **Fax the completed form to 1-866-539-6319.**
4. You will choose a password for your HCNN account when you receive your first email from the HCNN.

For more information, please email info@hcnn.net or call 1-866-925-5155. Thank you for enrolling in the HCNN to enhance patient safety and improve liability protection.

[Name & Address of Office Practice]

JOB DESCRIPTION

Effective Date:_____

Position/Title:_____ Name of Employee: _____

Name & Title To Whom Employee Reports: _____

Job Summary: _____
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General Responsibilities: _____
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Core Competencies: _____
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Working Conditions: _____
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Job Requirements: _____
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