# THE LNC NEWSLETTER

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## Letter from the Editor and Founder-Important Update on the Newsletter

**Pattie Patterson RN, LNCC, CLCP**

As many of you may have noticed there have been some changes within our group. Several members have left and we have been attempting to replace those members. Just as with many of your law firms, we are experiencing growing pains. Also, those of us who have been part of this team since its inception are playing a juggling act to keep all of our professional "balls" in the air.

The last few months have been especially trying for all of us on the team. That said, we hope, within the next few months to add several new writers to our team, and even invite some guest writers to add some fresh new ideas and topics. So, please bear with us and hope you will continue to enjoy our newsletter and hopefully you learn some things from our articles.

Also, if you have any particular topics you'd like to hear about, please let us know and we will happily try to either write on the topic or find someone who can speak to is with some semblance of authority.

Be advised, we are not leaving, just regrouping for the next four years or more.

## Joint Commission Announces 2006 National Patient Safety Goals for Hospitals and Critical Access Hospitals

The Joint Commission on Accreditation of Healthcare Organizations today announced the 2006 National Patient Safety Goals and related Requirements that will apply specifically to accredited hospitals and critical access hospitals. Major additions to this fourth annual issuance of National Patient Safety Goals, which were approved by the Joint Commission's Board of Commissioners, include a new Requirement that "hand-offs" of patients between caregivers be standardized, with particular attention to assuring the opportunity for asking and responding to questions. This requirement is part of the Goal: "Improve the effectiveness of communication among caregivers." In addition, a new Requirement applicable to all types of accredited organizations which provide surgical or other invasive services specifies that all medications, medication containers and other solutions used in perioperative settings are to be labeled. This Requirement is part of the Goal: "Improve the safety of using medications."

"The 2006 National Patient Safety Goals extend the Joint Commission's commitment to focusing attention on the greatest opportunities for improving patient safety," says Dennis S. O'Leary, M.D., president, Joint Commission. "We are confident that accredited organizations will integrate these requirements into their efforts to redesign internal systems to avoid unnecessary patient disabilities and loss of life."

The development and annual updating of the National Patient Safety Goals and Requirements continues to be overseen by an expert panel that includes widely-recognized patient safety experts, as well as nurses, physicians, pharmacists, risk managers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings. Each year, the Sentinel Event Advisory Group works with the Joint Commission to undertake a systematic review of the literature and available databases to identify candidate new Goals and Requirements. Following a solicitation of input from practitioners, provider organizations, purchasers, consumer groups, and other parties of interest, the Advisory Group determines the highest

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priority Goals and Requirement and makes its recommendations to the Joint Commission.

In order to maintain the focus of accredited organizations on the most critical patient safety issues, the Sentinel Event Advisory Group also recommends the retirement of selected Goals and Requirements each year. The following Requirements will be retired in 2006.

- Elimination of the Requirement to remove concentrated electrolytes (including but not limited to potassium chloride, potassium phosphate, sodium chloride greater than 0.9 percent) from patient care units. This Requirement will continue to exist in relevant accreditation manuals.
- Retirement of a Requirement to ensure free-flow protection on all general-use and patient-controlled analgesia intravenous infusion pumps used in an organization.

Compliance with this Requirement has been greater than 99 percent, and equipment manufacturing and availability issues for all health care settings have been satisfactorily resolved.

The net effect of these changes is that the total number of Goal-related Requirements for hospitals and critical access hospitals will remain unchanged, as has been true since 2004.

The Board of Commissioners also affirmed the six existing "do not use" abbreviations that constitute a single Requirement under the Goals: "Improve the effectiveness of communications among caregivers," but acted to delete a related stipulation that each organization also identify an additional three organization-specific "do not use" abbreviations that have been integral to this Requirement as well. Failure to substantially eliminate the utilization of "do not use" abbreviations in medication orders remains – at 27 percent – on of the most frequent non-compliance findings during the Joint Commission surveys.

The 2006 Hospital and Critical Access Hospital National Patient Safety Goals are:

**Improve the accuracy of patient identification**.

- Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

**Improve the effectiveness of communication among caregivers.**

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.

**Improve the safety of using medications.**

- Standardize and limit the number of drug concentrations available in the organization.
- Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization and take action to prevent errors involving the interchange of these drugs.
- Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.

**Reduce the risk of health care associated infections.**

- Comply with current U.S. Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with health-care associated infection.

**Accurately and completely reconcile medications across the continuum of care.**

Implement a process for obtaining and documenting a complete list of patient's Cont on p 3

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- current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

  A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

**Reduce the risk of patient harm resulting from falls.**

- Implement a fall reduction program and evaluate the effectiveness of the program.

The full text of the 2006 Goals and Requirements is posted on the Joint Commission website. Compliance with the Requirements or alternatives judged to be acceptable is a condition of continuing accreditation for Joint Commission-accredited hospitals and critical access hospitals.

# New Studies on Medical Malpractice Issues

**Pattie Patterson RN, LNCC, CLCP**

Over the past few weeks and months there have been several academic studies on medical malpractice, medical liability law and physician's reaction to the perceived threat of being sued.

Several questions were addressed in these studies. Theses are:

1. **What is the impact of Malpractice Reforms on the Supply of Physicians?**

One interesting point was that there was not a significant growth of practicing physicians to states that implemented the liability laws. This growth was only about 3.3%, according to the studies.

Nor was there a significant loss of physicians in states that did not implement these laws. In fact, what I found interesting that in California, where they have the strictest limits in malpractice awards, it was found that 43% of doctors there in 2001 planned to leave practice in three years.

Other medical liability law changes that states have made – that is, "indirect" changes that don't directly affect how much patients can be granted in damages – were associated with *smaller*, not larger, growth in physician supply. Such indirect changes include restricting patients' lawyers' fees or requiring that damages be paid over time.

2. **Have Caps on Malpractice Awards Increased the Supply of Physicians?**

This study found an even smaller correlation between the the malpractice restrictions and the number of doctors in these areas- only a 2.2 percent increase.

3. **Is there a Trend to Practice Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment?**

This survey was done based on a mailing, asking high risk practice area doctors is the anxiety of being sued causes them to practice defensive medicine. Of those surveyed ninety-three percent said they did. But whether this is an accurate count is questionable, as these physicians were all hand selected and were only practicing in Pennsylvania, which does not necessarily reflect the whole of the country. Also, the responses may have been self-serving, for political reasons, although it would be nice to thing that all physicians practiced defensive medicine.

These reports once again underscore the fact that lawsuits are not responsible for rising medical malpractice insurance costs and are not driving doctors away from any state. Like all Americans, doctors choose to live in a particular place because of such things as the quality of life, level of taxation and the quality of educational opportunities for themselves and their families. Caps punish the most severely injured patients and do nothing to reduce insurance rates.

A fourth study released this week shows the Growth of Physician Medical Malpractice Payments: cont on p 4

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Evidence from the National Practitioner Data Bank, also appearing in the June 1 issue of *Health Affairs*, says the growth of malpractice payments made on behalf of doctors is less than previously thought and is consistent with increases in the cost of health care itself. Focusing on courtroom judgments is misleading, because judgments – versus settlements between parties – account for fewer than 4 percent of cases, the study said. Malpractice payments as a fraction of national health care spending have not risen significantly, it said.

In April, Public Citizen released its report, "Medical Malpractice Payout Trends 1991-2004: Evidence Shows Lawsuits Haven't Caused Doctors' Insurance Woes." It found that malpractice payouts to patients have been flat since 1991 and show a significant decline since 2001, when the so-called "crisis" of escalating malpractice insurance rates began. It also found that the medical liability system is not one of "jackpot justice," in which patients go to court and score big awards based on flimsy claims. Instead, those with minor injuries receive little compensation, while the great bulk of malpractice awards are for cases involving major, debilitating injuries, or death.

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