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Killer practitioners: What can you do to stop them?

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Killer practitioners: What can you do to stop them?
Implement strategies to identify harmful scenarios

(Editor's note: This is the first in a two-part series on preventing employees from harming patients intentionally. This month, we cover how to track deaths and improve communication with human resources. Next month, we'll give step-by-step instructions to prevent problem employees from being hired and tips for encouraging staff to share their concerns.)

When a Pennsylvania nurse reported seeing potentially fatal drugs stuffed inside a disposal container for used needles, suspicion centered on one nurse in the cardiac care unit. When confronted with questions about dozens of patient deaths, the nurse refused to answer and instead, quit his job. Over the next few months, he worked at two other hospitals, with no system in place to alert employers about his past. He later admitted killing 30 to 40 patients during his 16-year nursing career.

This recent "killer nurse" story has sent chills up the spines of quality managers everywhere. The question is: What can you do to stop this nightmare from occurring at your organization?

"Quality managers, especially those of us who were nurses, are horrified," says **Angie King**, BSN, CPHQ, quality management director at Tift Regional Medical Center in Tifton, GA. "You can see how somebody very clever could do this."

Your focus must shift from a reactive patient safety approach to a proactive stance, by implementing effective strategies to identify potentially harmful scenarios in your midst, she emphasizes.

Hospital administrators, risk managers, and lawyers have scrambled to lay blame, with some pointing at the current nursing shortage for allowing incompetent or malevolent practitioners to slip through the cracks. "The need to protect patients from caregivers who might be killers is certainly real, but I do not believe the nursing shortage is relevant, nor is any particular environmental factor," contends **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, president of JB Quality Solutions Inc., a Pasadena, CA-based consulting firm. "We are dealing with persons who are aberrant to the norm."

Here are effective strategies recommended by quality management experts:

• Improve communication with human resources (HR).

Harmful or malevolent employees are able to elude detection in large part because of failure to share concerns, King explains. "Too often, hospital departments are like silos. Human resources and quality management should have a greater interaction." As a quality manager, if you notice any type of pattern in patient deaths, especially patterns involving personnel, it's your duty to share this information with HR leaders, she adds. "Likewise, HR should be informing quality managers, This is a troublesome employee, so be alert for any trends.'"

Don't be reluctant to freely exchange this kind of information, adds King, who also is a risk manager. "The quality setting is primarily peer-review protected, and it should not be an issue. If I see an issue that concerns me about narcotics, I will talk to pharmacy and also HR and share my concerns."

States do have different labor laws and levels of peer-review protection, so be familiar with yours. "In some cases, if somebody is being looked at, they may have to be notified," she says.

• Put reasonable barriers in place during the hiring process.

Those with patient safety responsibilities need to evaluate what barriers can be put in place to prevent the hiring of individuals with detectable psychological disturbances, Brown advises.

"These folks may be very competent and deliver care that is seen by their peers as genuine TLC but still euthanize patients, because of their aberrant mental processing. Others truly may be malevolent in intent." She recommends a basic uniform psychological screening process at point of hire, at least for all employees with direct patient contact. "Of course, there also must be the criminal background checks."

Honest responses to reference checks needed

In addition, there should be a system that allows former employers to respond honestly to reference checks, if well-documented negative information is relevant to patient safety, Brown says. "Former employers tend not to relate negative information, even though it is relevant and significant, due to fears of legal repercussions, such as slander, libel, or breach of confidentiality."

Each organization should solicit its own attorney's interpretation of state statutes, she recommends. "Perhaps more in-depth reference checks, using very specific questions with yes/no' options, might elicit enough information to provide the red flag."

• Implement a viable reporting system for suspicious behavior.

Brown points to her experience working with event reporting, beginning with California's Notification System in the 1980s, which allowed reporting to be anonymous if necessary, with convenient locked drop boxes. This clearly is the most effective way to get the necessary information to begin an investigation, she says. "If quality leaders encourage staff to express any patient safety concern, including suspicious behavior, and all concerns are investigated confidentially, then the system works."

• Find better ways to track and analyze all deaths over time.

The recent horror stories reveal the importance of reviewing all deaths, King advises. "Even a terminal patient can have an unexpected death, and patterns of mortality should be observed. Terminal patients may be actively dying or not. It depends on the individual patient, but they all have to be reviewed." A terminal patient's death is not unexpected at first glance, but the goal is to detect any patterns, she says.

King recommends tracking the time of death, type of patient, medications, systems involved, notification, comorbidities, and whether the death was unexpected.

Even expected deaths should be categorized and tracked in a database over time as part of mortality review, Brown advises. To find a pattern linking deaths with caregivers, individuals providing direct care during a specified time period preceding all deaths must be included in the database, she says.

"This might be considered a return to the old quality assurance days of looking at the who' — the practitioner — rather than the how' — the process — but it is not," says Brown. "Now we have the computer capability to screen both together as necessary, given the need."

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