

Strategies to Prove Risk Management = Value

In the two years that the *Healthcare Risk Control (HRC) System* has surveyed its members about the challenges in the year ahead, demonstrating risk management value has been among the top five concerns. In 2010, 48% of risk managers responding to *HRC's* survey chose demonstration of risk management value as among their top worries for the year ahead; in 2009, 44% of respondents identified it as a hurdle.

"It's an ongoing concern," says Georgene Saliba, R.N., B.S.N., M.B.A., CPHRM, FASHRM, administrator, risk management and patient safety, Lehigh Valley Health Network (LVHN) in Allentown, Pennsylvania. During her tenure as president of the American Society for Healthcare Risk Management (ASHRM) in 2009, the association launched a strategic initiative, called the Value Campaign, to raise the profile of the risk management profession. Today, the project remains a focus of ASHRM's strategic plan.

Some of the risk managers' worries are driven by budget cuts. As institutions make across-the-board cuts, "there's not always an appreciation that risk management should not be cut," says Saliba.

This concern is heightened by the fact that risk management departments are not revenue-generating departments of healthcare facilities in the way that, say, a cardiovascular service contributes to an organization's bottom line.

Compounding risk managers' concerns about demonstrating their value is the arrival of multiple patient safety and quality reporting requirements imposed by accrediting agencies, federal and state governments, and others. "Risk managers face an incredible challenge in establishing value for the organization in light of these other high-visibility initiatives, which could raise the value of others" in the organization, says Peggy Nakamura, R.N., M.B.A., J.D., DFASHRM, CPHRM,

assistant vice president, chief risk officer, and associate counsel at Adventist Health (Roseville, California). Unless risk managers are participating in these important projects, "there might be a tendency to relegate them to a lesser position," she warns.

The message for risk managers is that "we need to do a better job showing our value so senior leadership can understand and see the value of the programs we bring forward," says Edward Hall, M.S., CSP, senior director, risk management controls and education, Stanford (California) Hospital and Clinics Risk Consulting (SRC).

HRC spoke with several risk managers to learn about their strategies for demonstrating value to their

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► MORE EXPERTISE, AT-A-GLANCE DATA

Got a question you just can't get answered? Want at-a-glance data on topics important to you? Check out our columns on the home page of the *HRC* members' website. In *Ask HRC*, we answer members' tough questions—just e-mail hrc@ecri.org. We've helped members develop strategies to minimize workplace interruptions and address the discharge of a patient identified as a suicide risk, and we've provided advice on how hospital emergency departments and labor and delivery units can meet Emergency Medical Treatment and Labor Act requirements, to name a few topics. Data Snapshots offer at-a-glance data on the use of electronic medical records in physician offices, hospital stays related to pressure ulcers, and strategies used to promote staff flu vaccination, for example.

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▶ IN OUR VIEW

Celebrating Risk Management

Healthcare risk managers across the country have their ideological roots in one place: Missouri, the Show-Me State.

Since the healthcare risk management profession was founded more than 30 years ago, risk managers have sought to show the value of what they do for their organizations. Using data from events, claims, and settlements, they have demonstrated that risk management programs can make a difference. But as risk managers' roles in their organizations evolve, so, too, do their strategies to demonstrate their value. It is not surprising, therefore, that demonstrating the value of risk management remains an ongoing concern for risk management professionals.

In this issue of the *Risk Management Reporter*, we speak to risk managers about those strategies. They talk about networking with their colleagues, promoting what they do, measuring the impact of risk management and patient safety on patient outcomes and other benchmarks, and facilitating organizationwide planning to proactively apply their analytical skills to strategic decision making.

Today, there are even more opportunities for the profession. For example, risk managers will be called on to help identify and manage the risks of the many initiatives resulting from the Patient Protection and Affordable Care Act.

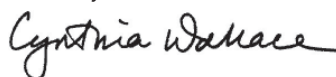
The American Society for Healthcare Risk Management (ASHRM) has established the third week in June as Healthcare Risk Management Week. This has become an annual event—an opportunity to celebrate what you do and to tell your story.

This year, Healthcare Risk Management Week is June 20 to 24. What are you planning for the occasion? Over the years, we've seen risk managers have fun with the event, planning risk management fairs, involving employees in games with a risk management theme, sending short daily messages to employees about risk management's role in the organization, and showing how everyone in the organization is the eyes and ears of the risk manager. ASHRM will provide tips and resources to help risk managers make the most of their week.

Whether you are working as a risk manager in Missouri, Maine, Montana, or anywhere else, Healthcare Risk Management Week should be a year-long celebration of risk management's essential role in healthcare.

Enjoy the spotlight.

Sincerely,



Cynthia Wallace, CPHRM
Senior Risk Management Analyst

▶ ON THE HRC MEMBERS' WEBSITE



Check out our new Alarm Management Resource Page! Alarm events continue to plague hospitals. It's no wonder that alarm hazards rank No. 2 in ECRI Institute's Top Ten List of Health Technology Hazards for 2011. Most reports seen by ECRI Institute are related to alarm problems with physiologic monitors (including telemetry) and ventilators. To help members improve alarm management, *Healthcare Risk Control (HRC)* has created an Alarm Management Resource Page with links to guidance, sample policies, educational materials, and other clinical alarm safety information from *HRC* and ECRI Institute. You can find it and other special resource pages on the *HRC* members' website by clicking Hot Topics on the left-hand menu.



Ask only the questions that matter to you. All of the Self-Assessment Questionnaires (SAQs) on the *HRC* Members' website are available as Microsoft Word® documents that you can customize to suit your facility's needs. Look for the "Microsoft Word® Version" link on every SAQ page, and add or delete questions to get the most out of every questionnaire.



Web-exclusive training tools. Looking for a new way to present information on healthcare technology? The *HRC* Members' website includes web-exclusive slide presentations, developed by ECRI Institute's Health Devices program, that you can use to provide basic information on topics like bar-coded medication administration systems, latex-free surgical gloves, methicillin-resistant *Staphylococcus aureus* testing, needleless catheters and catheter-related infections, and more. Find the slide shows in the Education and Training Tools section of the *HRC* members' website.



Stay up to date with HRC Alerts. *HRC Alerts* is the weekly e-news service that brings you the latest news and information in categories like patient safety, standards and guidelines, legal and regulatory, professional development, and more. If you don't receive *HRC Alerts* by e-mail each Wednesday, e-mail us at hrc@ecri.org.

Web-Exclusive Articles Updated Every Week



Risk Management Tips. "Combating Ventilator Alarm Problems" recommends steps that facilities can take to improve ventilator alarm safety.



Ask HRC. "Choosing a Defense Law Firm" provides questions to ask when selecting a law firm to defend a medical negligence case.



Data Snapshot. "U.S. Population and Hospital Discharges by Age" presents data indicating that in 2008, the oldest adults (i.e., age 85 and older) made up a large share of hospital discharges relative to their population size, accounting for only 1.8% of the U.S. population but 8% of all hospital discharges.

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organizations. They ranged from grassroots strategies—such as being a visible resource for staff, senior leaders, and clinicians—to more proactive approaches, such as applying risk managers’ analytical skills to organizationwide planning and activities.

The risk manager’s role is evolving, and there will be “more opportunities for the profession,” says Michelle Hoppes, R.N., M.S., AHRMQR, DFASHRM, senior vice president and national director for healthcare risk management and patient safety at Sedgwick Claims Management Services Inc. (Grand Ledge, Michigan) and ASHRM’s 2011 president.

PERCEPTIONS OF RISK MANAGEMENT

As part of its Value Campaign, ASHRM has conducted focus groups and one-on-one interviews with senior leaders of healthcare employers to assess their perceptions

of risk management. “Employers use a wide variety of words and phrases to describe risk management,” says Kara Clark, FSA, MAAA, ASHRM’s former executive director. Some of the words they commonly associate with risk management are “proactive,” “reactive,” “loss prevention,” “patient safety,” and “underappreciated,” she says. Although the perceptions are “generally positive,” says Clark, there are times when the word “obstructionist” is used to describe risk managers.

While some may view being obstructionist as part of a risk manager’s job to protect the assets of the organization, others advise countering this perception by telling risk managers to help their organizations explore both the upside and the downside of risk. The approach, discussed in more detail in “The Upside and the Downside of Risk,” evaluates both the risks and the opportunities that new initiatives bring to organizations.

ASHRM also tested key messages about risk management to determine how they resonate best with senior

The Upside and the Downside of Risk

At ASHRM’s 2011 annual conference in Tampa, Florida, Jeff Driver, J.D., chief risk officer and executive vice president of Stanford (California) University Medical Center, recounted the first time he heard the term “upside of risk.” Introducing an ASHRM session called Articulating the Value of Risk Programs, Driver said hearing the phrase “was an eye opener” because it is “all about strategy and bringing value to an organization instead of just a downside focus on risk.”

Speaking later with HRC, Edward Hall elaborated on the concept and the risk management department’s approach at Stanford. “Risk managers do a good job preventing losses and preventing an exposure from expanding,” he explains. “But we can apply a similar focus to the upside of risk and assist an organization with decisions that need to be made . . . and help to quantify the uncertainties by looking at the upsides and downsides.”

As an example, he described SRC’s input in helping the medical center cost justify an overhead patient lift system. While the lift system could help minimize risks to the organization by reducing worker injuries and workers’ compensation claims, the lift system could also bring value to the medical center by increasing patient satisfaction—influencing a patient’s choice to return to the medical center if future care is needed—helping patients ambulate sooner, and increasing worker satisfaction, which also has an impact on staff retention. Using analytical approaches, Hall and others were able to quantify these and other

values that an overhead patient lift system brought to the organization and obtained the necessary approval from the medical center’s capital committee for funding to proceed with the project. Although the medical center also considered floor-based patient lifts, the committee approved the more costly overhead lift system because of the analysis that Hall and others provided. Their decision-making methodology is described in more detail in a monograph on value creation and value protection, available from ASHRM’s website at http://www.ashrm.org/ashrm/education/development/monographs/Monograph_ERM2010.pdf.

SRC’s next step is to open a risk analytics division that will apply similar decision analyses to other medical center projects, says Driver. “In our organization, we’re trying to be a resource on more fronts than the traditional risk role,” he explains. Driver says he is aware of other healthcare systems’ risk management departments that participate in similar analytical approaches to decision making.

“If we can get risk managers to promote the idea of the upside of risk and implement appropriate measures to manage the risk, that’s how you establish value,” says Peggy Nakamura of Adventist Health.

SRC, Stanford University’s Center for Professional Development, and the consulting firm Strategic Decisions Group in Palo Alto, California, now offer a course in strategic decision making with an emphasis on managing risks in healthcare organizations. The course was offered for the first time in March 2011 in collaboration with ASHRM.

leaders. One key message describes risk managers as a “strategic investment” who deliver organizational value by protecting patients, as well as the organization’s balance sheet and reputation. ASHRM is using this message to educate employers and the public about what risk managers do.

But ASHRM also wants to enlist its members’ help in raising awareness about the healthcare risk management profession. Employers indicate that they form their perceptions of risk management during their personal interactions with risk managers, says Clark. Based on that finding, she underscores the need for risk managers “to tell their own story.” It needs to be a grassroots effort, she says. ASHRM will develop resources and tools to help members “advocate for themselves” in time for Healthcare Risk Management Week, June 20 to June 24, 2011.

BE VISIBLE

A grassroots effort starts with the risk manager being visible to staff and clinicians at the healthcare facility. “If you’re sitting in your office, you’ll never get that seat at the table,” says Saliba. She remembers that when she was starting as a risk manager, she would forward interesting articles to senior managers with a note about their relevance to risks that the organization faced. Or, if she identified a particular trend—for example, from a medical record review—she would summarize the issue for senior managers and provide a list of recommendations. Today, overseeing LVHN’s risk management and patient safety department, Saliba says she has the “luxury” of being at an organization that is committed to risk management and patient safety.

When Denise Myers, R.N., B.S.N., M.S., CNAA, CPHRM, was hired as director of risk management to establish the risk management department at Monongalia Health System (Morgantown, West Virginia), her boss, the chief legal officer, gave her a goal to “make risk management such an integral part of everything we do that [the health system] can’t imagine not including me in the future.” She met one on one with department managers to promote risk management’s purpose, prepared short newsletter articles about “things you never knew about risk management,” and provided feedback to staff about improvements in patient care based on information from event reports. She continues these efforts today and participates on various Monongalia committees to provide risk management input.

“There’s no magic solution,” Myers acknowledges. “It’s being out there and promoting what it is that you are doing and the good things that we’re learning” from risk management activities.

BE ACCESSIBLE

In addition to being visible, risk managers must be accessible to staff at their organizations. For example, when she started in risk management, Nakamura established monthly meetings with the healthcare facility’s administrative team to discuss “risk management issues I was seeing.” From those meetings, she developed a good rapport with team members. “It was amazing to see the kind of communication that developed.” Additionally, Nakamura scheduled regular meetings with the medical staff and the quality improvement department and met every year with department directors to review their top risk issues. “I’d work on strategies they could implement,” and, with administration’s permission, she had each department head establish one risk management goal for the department as part of that individual’s performance goals for the year.

To be accessible, most risk managers have established a process to be available to hospital staff and clinicians after hours. Saliba, for example, is on call at all times, unless she is out of the country—in which case someone else from the department is available. “It’s important for staff to know that someone is there in case there is a patient care issue. . . . With technology and cell phones, it’s easy to be reached, so I don’t have any problem with taking calls.”

Myers ensures that information from her risk management program is available to all staff. To do so, she has established a risk management web portal on the organization’s intranet site and posted relevant information, such as risk management policies, presentations she has given, and the organization’s response for implementing recommendations from the Joint Commission’s sentinel event alerts.

“If you make yourself available, invite yourself to meetings, and use e-mail, you can get risk management information out there,” says Myers.

TEACH RISK MANAGEMENT 101

Educating staff about the role of risk management is essential for risk managers to develop positive relationships with their colleagues, says Marcie Williams, R.N.,

M.S., FASHRM, CPHRM, CHSP, CLNC, vice president, safety and risk management, Texas Health Resources (THR), Arlington, Texas. During an orientation program that her department conducts for THR's new risk managers at the system's 24 acute-care and short-stay hospitals, Williams underscores the importance of providing a risk management overview for new physicians and staff. "People will see you as the greatest cheerleader for patient safety who can help them be better care providers and make their jobs safer," she says. If risk managers are not proactive in building their relationships, there is a danger that they will be viewed as "the person you don't see until something goes bad," she warns.

Providing staff education on risk management and patient safety "is how you build your credibility so that they come to you," says Saliba, whose department provides ongoing risk management education for residents, medical staff, nurses, and department staff. "They are your eyes and ears. [Through education] they'll recognize you as a person to talk to when dealing with a difficult patient or situation."

At staff orientation for Monongalia Health System, Myers introduces new staff to risk management by telling them that their "second job" is that of a risk manager. "I tell them, 'I can't be everywhere at all times. . . . It is your job to work with me and identify risks and try to fix them.'"

COMMUNICATE ACHIEVEMENTS

To track the accomplishments of THR's hospital risk managers, Williams requires them to report each quarter on their success in meeting 15 metrics, which the hospital and corporate risk managers select and revise each year. The reports "help risk managers demonstrate their individual value" to the facility because they are reviewed by the hospital president, she says. Using red, yellow, and green markings, a report shows how a risk manager met each metric. Williams reports hospitals' risk management achievements at meetings of the THR's quality performance committee of its board of directors. A sample scorecard from 2008, "Patient Safety/Risk Management Scorecard," is available in the Sample Policies and Tools section of the *HRC* members' website.

In 2010, the scorecard included goals such as updating the annual patient safety and risk management plan, completing a root-cause analysis on a timely basis for sentinel and catastrophic events, investigating and closing most event reports within 30 days, and monitoring

use of the hospital's smart infusion pumps with dose-calculation software.

While risk managers at stand-alone hospitals may not have the advantage of working with a system that measures their achievements, they can still communicate the successes of their risk management efforts. "I play up our proactive success stories where we had a problem, we looked into it, and we fixed it," says Myers. If appropriate, she will share the story with her boss, the health system's chief executive officer (CEO), who sometimes shares the information with the health system board.

Communicate with Organization Leaders

Of course, having access to an organization's senior leaders allows risk managers to communicate their efforts and successes. Like Myers, about 31% of top risk managers report to the organization's CEO, and another 51% report to a senior leader who is one level below the CEO, according to ASHRM's 2009 survey on risk management staffing.

Many of the risk managers interviewed for this article also report to the organization's board. "It's good visibility for the risk manager to present to the board," says Saliba, who presents quarterly patient safety and grievance trends to LVHN's board. She also prepares an annual risk management and patient safety report for senior management's performance improvement council.

When Williams's department staff conduct orientations for THR's new risk managers, they underscore the importance of reporting to the board and the need to keep the information simple. The health system has developed a template patient safety and risk management summary board report that risk managers use to present annual data on events and trends in a one-page, easy-to-read format. A sample report, "Board Report on Hospital Patient Safety and Risk Management Data," prepared by THR for *HRC* using fictitious data, is available in the Sample Policies and Tools section of the *HRC* members' website.

The report presents the top 10 frequently occurring events at the hospital, identifies the number of catastrophic events by department, and provides a monthly summary of catastrophic and major events at the hospital and the system level. At the board meeting, the risk manager may also report on root-cause analyses that the hospital conducted and improvement initiatives put in place as a result of the findings. The board report should "show trending—that you're watching events,

and if you've seen trends, you've put a performance improvement plan in place to prevent future errors," says Williams.

SHOW THE DATA

To quantify their risk management efforts, risk managers traditionally provide their senior leaders with reports on events, claims, and lawsuits. "Numbers talk," says Myers, who provides a year-end report on events and claims to Monongalia Health System's senior leaders and its board quality council committee.

"Risk managers should continue to measure where they have traditionally done so," says Hoppes. Nevertheless, she believes there are other opportunities to mine data to demonstrate risk management value. Hoppes provides case studies that use data to quantify risk management initiatives in the chapter "Using Data as a Risk Management Tool" in the sixth edition of the *Risk Management Handbook for Healthcare Organizations*. She is a coauthor of the chapter.

Risk management program assessment. An assessment of the risk management program—whether conducted in-house or by a third party, such as the organization's insurer—"is key to demonstrating value to the organization," says Hoppes. She describes a system that did a risk management program assessment of each of its hospitals using 200 indicators. Once a baseline assessment of each hospital was completed, the system put in place a process to measure each hospital's risk management program "to see if its risk profile score is improving." Further, the system was "beginning to connect" each hospital's risk score to other outcomes, such as number of events and their severity, to measure risk management's contribution "to overall improvement in safety and a decrease in financial losses." While Hoppes acknowledges that it is helpful for a system to be able to compare the risk management programs of its various hospitals, "it's equally important to look at who you are." Even a stand-alone hospital can benefit from a risk management program assessment because it measures "the status of your overall process" and provides a comparison to evaluate how the program is evolving over time, she says.

Return on investment. Hoppes encourages risk managers to show the return on investment (ROI) for an organization's risk management and patient safety efforts. "We can do a better job of measuring ROI," she says. In their *Risk Management Handbook* chapter, Hoppes and

her coauthors give an example of one hospital's falls prevention initiative that collected the necessary data to compare the organization's investment of \$26,700 in falls prevention resources, such as hip pads and floor mats, with the amount it spends to treat a hip fracture from a fall—about \$22,000 per fall. The hospital was able to reduce the number of falls that resulted in fractures from seven to two per year and avoided spending about \$110,000 by preventing the five fractures each year. The hospital calculated a benefit-cost ratio for the initiative (total savings by preventing five fractures/total cost of the falls prevention) of 4, meaning it saved \$4 for every \$1 invested in the program and achieved an overall ROI of \$3 for every \$1 spent.

Clinical Metrics

In Texas, where tort reform has reduced the number of lawsuits against healthcare organizations, Williams has identified the need to use clinical metrics to demonstrate risk management's contribution to the organization. "In the past, we could always demonstrate risk management value with data on claims and litigation," she says. "Since we're not spending as much in litigation . . . , we're turning to other metrics." She lists these as follows:

- ▶ Track THR hospitals' progress in perinatal safety by participating in Premier Inc.'s perinatal safety initiative, which enables the system to compare its birth injuries experience with a national database.
- ▶ Monitor hospitals' emergency care efforts by participating in another Premier initiative to implement care bundles for managing the chest and abdominal pain of emergency department patients. Again, the system can compare its success in implementing the bundles with that of all the other hospitals in the initiative.
- ▶ Use tools similar to the Institute for Healthcare Improvement's global trigger tool to monitor the effectiveness of hospitals' event reporting programs. (For information on trigger tools, see "Warning: Patient Safety Under Construction," in the April 2011 issue of *HRC's Risk Management Reporter*.)
- ▶ Participate in the American Nurses Association's National Database of Nursing Quality Indicators to compare a hospital's experience with patient falls with that of other hospitals in the database.
- ▶ Conduct the Agency for Healthcare Research and Quality's (AHRQ) hospital culture survey to biannually assess individual hospitals' safety culture and

compare results with AHRQ's national database of survey results.

- ▶ Monitor medication administration practices with infusion pumps by using pumps with dose-calculation software, which alerts users to pump settings that do not match the facility's preset drug administration guidelines. Not only can THR track whether its infusion pumps are used appropriately, it also receives quarterly data from the manufacturer to compare its experience with that of more than 100 other hospitals that use the same infusion pump model.

In the future, Williams predicts that more healthcare providers will participate in patient safety organizations (PSOs), enabling risk managers to compare their healthcare organization's risk management data to other providers in the PSO. In anticipation of someday joining a PSO, THR hospitals are incorporating the common formats used by PSOs for collecting and reporting risk management information into THR's in-house event reporting system.

Other Data Sources: Billable Hours and Customer Surveys

Nakamura applied her previous experience tracking billable hours as a defense attorney to her risk management activities. "That experience taught me the value of being able to quantify how much time I spent on various projects." Consequently she has a process to capture, in 15-minute increments, the amount of time she spends on various activities, such as contract review and negotiations, education, and formal risk management opinions. She tracks her time spent on both system-level and hospital activities and summarizes the information in her annual risk management report for the system's senior leaders and board members. "Risk managers at the hospital level could also pull this type of information together," Nakamura says.

At LVHN, Saliba asks department directors, managers, medical staff, and the system's medical practices to complete an annual customer survey of the risk management department. For information about the survey and sample questions, see "Customer Service Survey Used to Evaluate Department Value."

BREAK DOWN SILOS

With so much emphasis on patient safety, Williams encourages risk managers to get involved in their organizations' patient safety efforts if they have not done so already. With the drop in the number of lawsuits against Texas healthcare providers as a result of tort

Customer Service Survey Used to Evaluate Department Value

Every year, the risk management/patient safety and service excellence departments at LVHN ask clinical department directors and medical staff about the department's performance in a customer service survey. The survey, which is also sent to LVHN's physician practices, covers 17 specific questions about the department and 3 open-ended questions to solicit feedback. "You need to know what your customers think," says Georgene Saliba of LVHN. The department provides the results to the healthcare system's senior management.

Saliba shared the customer service survey with HRC so that other risk managers might try something similar in their efforts to demonstrate the value of their efforts. Sample questions, which are scored on a five-point Likert scale to evaluate how strongly the respondent agrees or disagrees with a statement, are reprinted below. The full survey, "Risk Management, Patient Safety and Service Excellence Departments Customer Service Survey," is available in the Sample Policies and Tools section of the HRC members' website.

- Risk Management/Patient Safety/Service Excellence employees are identifiable and easily approachable.
- When solving your problems or concerns, Risk Management/Patient Safety/Service Excellence employees are empathetic and reassuring.
- Risk Management/Patient Safety/Service Excellence employees keep private and sensitive information confidential.
- Employees of Risk Management/Patient Safety/Service Excellence respond to customers' requests promptly.
- Risk Management/Patient Safety/Service Excellence employees have the knowledge to answer my questions.
- Risk Management/Patient Safety/Service Excellence offers operating hours/availability convenient to all their customers.

reform, risk management departments that are focused on claims management activities could see a reduction in staff. THR's hospital risk managers have avoided this scenario because risk management at the corporate and hospital levels is aligned with patient safety activities, which are garnering increased attention, says Williams. "Without a doubt, more patient safety initiatives will be mandated," she says. "It will be good for improving patient care and outcomes."

Saliba also encourages risk managers to "break down the silos" that may exist between the risk management

and quality departments. In 2003, restructuring at LVHN resulted in the risk management and patient safety department reporting to a new senior vice president of quality and patient safety—a position held by a physician. “Having a physician champion broke down the silos between quality and risk management,” she says. “We now have a seat at the table of quality committees, which we didn’t have before.” As a result, risk management is more engaged in quality issues such as reducing ventilator-associated pneumonia, preventing hospital-associated infections, and implementing measures to prevent deep vein thrombosis, she says. “We’re all here to improve the care we deliver to our patients. It’s important for risk management to hear what is happening in the quality arena . . . because we see the risks associated with these events.”

Even more broadly, Nakamura recommends that risk managers get involved in enterprisewide initiatives. “Although risk managers are burdened already with many things that they need to do in their day, we still have to try to see opportunities for expanding our influence in the organization.” As Adventist’s chief risk officer, Nakamura is an advocate of the enterprise risk management model, which examines risks to an organization in various domains such as operations, human resources, and finance. Risk managers can enhance their value to an organization by applying the principles of enterprise risk management without having a formal program in place, she says.

To do so, risk managers should bring together the various domains of an organization “to brainstorm about organization activities, prioritize efforts, manage the risks, and identify the benefits of whatever that initiative is,” says Nakamura. Risk managers who have not tried this approach should start slowly by taking on one project that can be completed in about six months. “It doesn’t need to be world hunger,” she cautions, advising that the project should be manageable. “If you can show success with a process, you’re more apt to get the attention of other people in the organization.”

Nakamura encourages risk managers at Adventist Health’s 17 hospitals to consider a similar approach. Although Adventist Health has adopted an enterprise risk management approach at the corporate level, it does not expect the same of its individual hospitals. “I’m not asking that they have their own enterprise risk management program, but I do promote an expanded approach to risk throughout the hospital,” she says.

“We should get rid of the idea that risk managers are only dealing with lawsuits and malpractice claims,”

says Nakamura. “They can bring such value to the organization with their skills in assessing risk.”

BE FACILITATORS

In line with getting more involved in enterprisewide activities, risk managers can demonstrate their value by “serving as facilitators . . . and asking the right questions” to help their organizations identify and manage the risks that arise from implementing activities related to strategic goals, says Hoppes.

Saliba agrees. “Our role is to be facilitators, not to have knee-jerk reactions by saying, ‘You shouldn’t do that because the risks outweigh the benefits.’ Clearly, whatever the issue is, an organization is pursuing it because it sees a benefit.” As an example, Saliba describes the risk manager’s proactive role in helping a facility consider whether to implement a bariatric surgery program for which “the risks are real.” She warns, “Don’t take the attitude, ‘We will be subject to claims, and we can’t get into this.’” Instead, the risk manager can guide the process by helping the organization accomplish its goals to meet the needs of the community while minimizing its liability. The risk manager, says Saliba, should be asking about the infrastructure to support the program, procedures for evaluating patients, processes to credential and monitor surgeons, measures to acquire the right equipment for the service, and more.

“Next Big Thing”

An important area where risk managers can serve as facilitators is helping their organizations address initiatives that must be put in place as a result of healthcare reform legislation, say Williams and others. “The next big thing immediately on the horizon is accountable care organizations [ACOs],” she says. Although the details of operating ACOs must be finalized in federal regulations, the healthcare reform package enables providers to form arrangements to care for patients and to receive a percentage of any cost savings to Medicare from the new model. Risk managers, says Williams, should be helping their organizations ask, “How do we make the transition to an ACO? What are the new risks? How do we deal with any exposures across the continuum, including care delivered outside the hospital?” Be the content expert, she advises, and help the organization “prepare for a different set of risks if it becomes an ACO.”

▶ IN REVIEW

Study Assesses Ventilator-Associated Pneumonia Prevention

A patient-to-nurse ratio greater than 1 to 1 is not associated with an increased likelihood that patients receiving mechanical ventilation will develop ventilator-associated pneumonia (VAP), concludes a study published December 31, 2010, in the *American Journal of Critical Care*. Although a patient-to-nurse ratio of 1 to 1 appears to be associated with a lower risk for VAP, the difference is not significant after adjustments are made for confounding variables.

The study includes data from an observational survey conducted in 27 intensive care units in nine European countries: Belgium, France, Germany, Greece, Italy, Ireland, Portugal, Spain, and Turkey. VAP occurred in 393 of the 1,658 patients (23.7%) who had mechanical ventilation for at least 48 hours.

Initial findings indicated that rates of VAP were significantly lower in units with a ratio of 1 patient to 1 nurse (9.3%) than in units with a ratio of more than 1 to 1 (24.4%). However, after adjustments were made for multiple variables, ratios of more than 1 patient to 1 nurse were no longer associated with increased risk for VAP.

Researchers found that factors such as admission because of trauma rather than elective surgery, number of days at risk, and severity of acute illness (as measured by the Simplified Acute Physiology Score II) were stronger determinants of VAP. Therefore, efforts to prevent VAP should focus on reducing the number of days patients are at risk, such as by using a proactive extubation policy with a “sedation vacation” consistent with current guidelines. Healthcare facilities should ensure that staff comply with evidence-based recommendations and care bundles to prevent VAP.

The authors note that other studies have associated higher staffing levels with improved outcomes and survival rates but that those results were not duplicated in the current study.

Tests Ordered in the ED: Liability Risks of Failure to Follow Up

Failure of emergency physicians to follow up on tests ordered in the emergency department (ED) exposes physicians and healthcare organizations to significant liability, reports an article in the February 2011 *Journal*

of Emergency Medicine (Moore). The article reviews legal cases, potential defenses, and recommendations to reduce liability.

If the patient bears at least some fault in the matter (e.g., by failing to follow directions, by providing erroneous contact information), the concepts of contributory negligence or comparative fault may apply. Contributory negligence, recognized by only a few jurisdictions, entirely bars recovery if the patient had any degree of fault in the matter. Comparative fault allows plaintiffs to recover some damages but reduces them by the percentage of fault the patient bears.

The ED, patient, and follow-up physician are the three points in a “triangle of communication,” according to the article. Thus, hospitals, EDs, laboratories, and radiology departments must institute and ensure provider adherence to protocols for communicating abnormal results and discrepancies.

Communicating with the patient. If abnormal results or discrepancies are returned while the patient is still in the ED, the article suggests the following:

- ▶ Verbally tell the patient about the results, emphasizing the need for follow-up.
 - Explain why follow-up is important and the potential consequences of failing to follow up.
 - Suggest a possible diagnostic plan so that the patient knows what to expect and ask for.
- ▶ Document this discussion in the medical record.
- ▶ In written discharge instructions, include language such as “see your physician to follow up on discrepancy as soon as possible” and “return or contact me if you are unable to get follow-up.”

If abnormal results or discrepancies are returned after the patient has been discharged, the article suggests the following:

- ▶ Inform the patient in writing, electronically, or by phone.
- ▶ Clearly document this contact; consider using certified mail.
- ▶ Document unsuccessful attempts to contact the patient, especially if he or she is unreachable.
 - To mitigate the risk of clerical or transcription errors, check a phone book or other such sources before labeling a phone number or address as nonvalid.

Communicating with the patient’s private physician. It is vital to communicate abnormal results and discrepancies to the

patient's physician and to document the communication. Whenever possible, avoid performing in the ED tests that are not necessary for ED evaluation (e.g., tests requested by consulting physicians or patients), the author recommends.

Facility Complexity Influences Staff's Perception of Safety

A healthcare facility's level of complexity influences staff's perception of patient safety, states an article published in the November/December 2010 *American Journal of Medical Quality*. Operating room (OR) caregivers at highly complex facilities reported that while they are familiar with their organization's safety procedures, medical errors are typically handled poorly within their workplaces compared with less complex facilities.

Facility complexity was rated based on patient volume, patient risk, teaching status, and intensive care unit capabilities. The study includes more than 1,600 OR caregivers at 34 Veterans Affairs clinics who

responded to a questionnaire designed to assess staff attitudes about safety.

Researchers found that caregivers at high-complexity facilities were more likely than those at medium-complexity facilities to agree with the statement, "I know the proper channels to direct questions regarding patient safety in the ORs here." However, caregivers at high-complexity facilities were significantly less likely to agree that "medical errors are handled appropriately" in their facilities than staff at medium-complexity facilities.

The findings reinforce the importance of communicating directly with staff about an organization's plans to implement quality and safety initiatives, state the authors, who recommend using face-to-face training sessions when possible.

The study authors state that larger organizations typically have clearly defined hierarchies and policies, which may account for the high level of familiarity with safety procedures in highly complex facilities. "On the other hand," speculate the authors, "everyone

Managing Conflict among Leadership Groups: A Strategic Approach

A well-designed conflict management program retains the benefits of constructive conflict while minimizing risks that conflict may pose to patient care, states a pair of articles in the February 2011 *Joint Commission Journal on Quality and Patient Safety* (Scott and Gerardi). The authors describe how hospitals can develop a process for managing conflict among senior administration, the governing body, and leaders of the organized medical staff.

Joint Commission standard LD.02.04.01 requires hospitals to "[manage] conflict between leadership groups to protect the quality and safety of care." One Element of Performance for the standard stipulates that the process for managing conflict should include meeting with the parties "as soon as possible," gathering information, working with the parties, and protecting safety and quality.

However, conflict avoidance reigns in healthcare, state the authors. Potential consequences are unprofessional behavior, lack of leadership support, poor teamwork, mistrust, personal stress, and a higher risk of future conflicts.

By contrast, conflict engagement is proactive and collaborative; the concept views conflict as natural and as an opportunity to improve operations.

A well-designed conflict management process focuses on the interests of the parties, rather than rights or power, while restoring trust and mending relationships, the authors note. They suggest implementing a process, such as the following, that gradually moves from low-cost,

informal, collaborative methods to more rights-based methods as necessary but allows participants to return to more informal methods at any phase:

- A leader experiencing a conflict with another leader seeks informal, individual coaching or feedback from a peer coach.
- The parties in conflict have an informal face-to-face meeting.
- The parties have an informal meeting aided by an internal facilitator.
- The parties have an informal meeting aided by an outside conflict management specialist.
- If these collaborative, interest-based approaches do not prompt resolution, rights- and power-based approaches (e.g., evaluative mediation, resolution by the governing body, arbitration, litigation) may be used.

The authors recommend evaluating the conflict management process and the participants' progress after every instance of its use, regardless of the stage at which the conflict was resolved. Organizations can adapt the process for use not just among leadership groups but throughout the hospital.

The articles provide several useful tools, including a strategic framework for developing a conflict management program, case studies, sample conflict assessment questions, and lists of conflict competencies for leaders and characteristics of potential conflict specialists.

in high-complexity facilities may think someone else is handling a problem, so no one resolves the issue.” Meanwhile, the authors state that caregivers in smaller facilities are more likely to know each other and work better as a team.

Healthcare administrators should consider facility complexity when making organizational changes. Interventions may be modified based on the facility’s complexity. Smaller facilities must ensure that policies and responsibilities are sufficiently detailed, and larger facilities may consider ways to increase face-to-face and team training. The authors recommend assessing whether staff know the appropriate channels to direct questions related to patient safety and how effectively medical errors are handled.

Rating Preparedness of Medical Trauma Directors

Level-1 trauma hospitals in Canada can do more to prepare for mass casualty events, states an article in the February 2011 issue of *Canadian Medical Association* (Gomez et al.). U.S.-based trauma hospitals may also find the article helpful in reviewing their emergency preparedness plans. The authors evaluated facility preparedness by surveying medical trauma directors on the following critical emergency preparedness characteristics:

1. Leadership
2. Hazard planning
3. Communication
4. Sustainability of peak operations
5. Education
6. Interagency cooperation

While 83% of facilities had a disaster preparedness committee, many respondents indicated that it was not made up of appropriate stakeholders. The authors state that medical directors of trauma units should be involved in these committees, but only half the respondents said they were. The authors noted that some recent mass casualty events were greatly aided by surgeons; however, unfamiliarity with hospital disaster plans was an issue.

Plans were widely available for chemical, biological, and radiation threats, but only half of facilities had an all-hazards plan. The authors speculate that hospitals may have focused planning on specific hazards (e.g., pandemics), but ideally an all-hazards plan should be developed. Additionally, almost half the hospitals had not performed a disaster drill within the past two years.

Most respondents (61%) reported plans to increase capacity to deal with patient surges during these situations, but 57% were unsure whether surge capacity had been evaluated. The majority of respondents (59%) were unsure if their facility could sustain operations at maximum occupancy for 72 hours; of those who believed their facility was sustainable, most stockpiled water, food, and fuel, something that the authors recommend.

While 70% of facilities had a communications plan for these types of events, most indicated that landline and cell phones would be used—methods proved to be unreliable in recent disasters. The authors state that it is imperative that communication strategies be improved to avoid isolation during these events. Only five respondents (22%) have facilities with real-time monitoring systems to assess regional resources.

Education and interagency cooperation are also important components in responding to a mass casualty event. Only 39% of survey respondents indicated that physicians, nurses, and allied health professionals were required to be trained for these kinds of emergencies. Finally, only 22% of facilities possess mutual aid agreements or memoranda of understanding with other healthcare facilities, military and government agencies, or nongovernmental agencies for disaster planning or cooperative efforts. Working with other organizations by establishing agreements can strengthen the disaster response.

Study Identifies Factors Associated with Missed Laboratory Test Results

To reduce the risk that clinicians will fail to follow up on patients’ laboratory test results, facilities must pay attention to the integration of information technology solutions into clinical work practices, concludes a study published in the February 2011 issue of *BMJ Quality & Safety* (Callen et al.). The researchers performed a literature review of studies that quantified rates of follow-up for diagnostic tests and found that these rates varied substantially. Data indicated that lack of follow-up on test results for inpatients occurred at a rate of 20% to 62%, while for patients treated in the emergency department the rate ranged from 1% to 75%. The analysis confirmed that lack of follow-up can result in serious patient outcomes, including missed cancer diagnoses, and identified three main factors associated with missed results.

Systems and practices used for following up on test results. The researchers found no direct link between the type of test management system used (e.g., electronic, paper,

Preventing MRSA Infections: A Look at the Evidence

More evidence and strategies to prevent community- and healthcare-associated methicillin-resistant *Staphylococcus aureus* (MRSA) are required, as the current evidence on prevention strategies is “very limited,” states an article in the January 2011 *Infectious Diseases in Clinical Practice* (Miller). However, the article reviews the available evidence and identifies strategies that it best supports.

Community-associated MRSA. According to the author, while no strategies have proved effective at preventing community-associated MRSA infection, the best approach appears to be decolonizing the body using both the nasal topical antibiotic mupirocin and chlorhexidine body washes. For patients who experience repeated infections (studies have observed rates of community-associated MRSA reinfection ranging from 15% to 31% in different populations), eliminating MRSA in the environment may also help.

Although the role of colonization in the development of community-associated MRSA infection is poorly understood, the following are some decolonization methods that have been studied:

- Nasal topical antibiotics
 - Nasal decolonization does not always reduce MRSA infection rates, and colonization often recurs after treatment ends.
 - Mupirocin is the best studied, but it is unclear whether the drug is effective as a monotherapy in eliminating colonization.
- Systemic antibiotics
 - Rifampin is associated with toxicities and development of drug resistance.

- Clindamycin is little studied.

- Body decolonization

- Chlorhexidine is well studied, effective, and well tolerated.
- Hexachlorophene can be absorbed through the skin, especially with repeated use, and can cause neurotoxicity.

MRSA can remain on surfaces for weeks. Environmental decolonization strategies include wiping surfaces with diluted bleach (1 tablespoon per quart of water) or alcohol spray, washing linens and clothes in hot water, and decolonizing pets.

Healthcare-associated MRSA. MRSA colonization is common in patients admitted to the hospital, and many patients acquire a MRSA infection during a hospital or nursing home stay.

Although MRSA screening and decolonization may benefit some patient populations and organizations, the risks and benefits of universal MRSA screening must be studied further, states the article. Studies of universal screening have had conflicting results, and in many studies conducted in hospital settings, nasal decolonization using mupirocin did not prevent MRSA infection.

The article further notes that the risks and benefits of isolation are not well understood. Isolated patients are more likely to experience potentially preventable adverse events (e.g., falls, fluid or electrolyte disorders), complain about their care, and be depressed, anxious, or angry. They are less likely to be seen by clinicians and have their vital signs checked.

combination) and the extent of missed test results; however, the rates were high for all three types. The researchers argue that advances in the functionality of these systems alone are not sufficient to solve the problem. They add that the complexity of the test management process necessitates significant review and reform of work practices for systems to be flexible enough to adapt to various requirements.

Critical test result reporting. Breakdowns in the communication process, including documentation of actions, were particularly evident in situations involving reporting of critical test results. The authors suggest that the traditional telephone practices of laboratories can cause errors in the communication of urgent results. To reduce the potential for error, they recommend examining the information transfer between laboratory staff and clinicians to devise technological, work practice, and policy

solutions that address the specific aspects of urgent test results. The authors stress the importance of selecting a test management system with “active notification,” because those with “passive retrieval systems” have been shown to reduce productivity when clinicians waste time continually checking for results.

Test results for patients transferred between settings. Situations in which patients are transferred between care settings, such as from inpatient to outpatient services, were associated with higher instances of missed test results. The study’s review highlighted the need for systems, policies, and practices that facilitate communication across multiple settings. To facilitate follow-up of test results pending at discharge, the authors recommend developing an electronic test management and discharge summary system with secure access for healthcare professionals from both the hospital and the community.

Guidelines Finalized for Radiopharmaceuticals in Pediatrics

While overuse of computed tomography in the pediatric population has garnered much attention, exposure to the radiopharmaceuticals used to enhance imaging is equally concerning. Nuclear medicine physicians, technologists, and physicists in North America have addressed this issue by publishing consensus guidelines to limit radiopharmaceutical radiation exposure in children. The recently finalized guidelines are now available for nuclear medicine professionals on several professional society websites.*

Guideline development began in 2008 after findings from a survey conducted at 13 premier pediatric hospitals in North America indicated that administered radiopharmaceutical activities in children varied widely and that the greatest variability in administered dose existed among the youngest, smallest, and most vulnerable patients. According to S. Ted Treves, M.D., chief of nuclear medicine and molecular imaging at Children's Hospital (Boston, Massachusetts), and colleagues, dose administration is generally based on the recommended adult dose adjusted for body mass.

"Of concern is that the minimum administered activity varied on average by a factor of 10 and as much as a factor of 20 for one procedure," according to Treves, who cochaired the Pediatric Dose Reduction Workgroup with Michael J. Gelfand, M.D., chief of nuclear medicine at Cincinnati Children's Hospital Medical Center (Cincinnati, Ohio), and Marguerite T. Parisi, M.D., associate professor of pediatric radiology at the University of Washington, Seattle. A total of 20 pediatric radiology professionals participated in the effort.

The workgroup's efforts, supported by the Society of Nuclear Medicine's (SNM) Pediatric Imaging Council, the Society for Pediatric Radiology, and the American College of Radiology, took place during three consensus sessions in 2009 and 2010. SNM will further disseminate the guidelines as it incorporates them into an ongoing update of its guidelines for radiopharmaceutical doses, said Dominique Delbeke, M.D., Ph.D., SNM president and director of nuclear medicine and director of positron emission tomography (PET) at Vanderbilt University Medical Center (Nashville, Tennessee).

* This article originally appeared in the February 2011 issue of ECRI Institute's *Health Technology Trends*. Learn more at https://www.ecri.org/Products/Pages/Trends_Newsletter.aspx or contact clientservices@ecri.org.

Avoid Compromise of Physician Integrity by Patient Autonomy: Set Limits

When weighing a patient's special request against one's integrity and ethics as a physician, there is no simple answer. The physician and, by extension, the hospital leadership must address each situation separately and carefully. An article in the February 2, 2011, *Journal of the American Medical Association* guides clinicians through such delicate situations (Lantos et al).

Key points to remember in such circumstances are to always respect the right of the patient to make a request, even if the physician disagrees with the request, and to carefully weigh all options available to the patient and clinicians. Taking the matter before an ethics committee or bioethics consultant can provide a third party's perspective. Certain limits can also help set standards by which to judge patients' requests.

When a patient requests a certain type of treatment, the benefits of the treatment must be measured against additional risks it incurs for the patient. "It is rare for a patient to request a treatment that has absolutely no chance of benefit," say the authors. However, the benefit of the treatment may be unclear. When a treatment has no chance of success, then it becomes a case of futility, which is more clear-cut; clinicians are not obligated to provide care if there is no chance of success. When a treatment is suboptimal, however, it falls into a gray area where there is a need for guidance.

Clinicians should always promote the best possible care for patients and should engage in respectful discussion with patients who request an option that clinicians consider less than ideal. Patient autonomy does not preclude such discussion, say the authors; rather, such dialogue reinforces and supports patient autonomy by according the patient respect and the ability to participate in his or her own care plan. Coercion of a patient, however, is unethical.

Set limits can help hospital staff handle frequent or clearly unreasonable requests. These limits can be based in efficiency, fairness, and cost-efficacy, which would create a set range of choices for patients to discuss. Patients do not have the right to request a specific treatment because it requires the participation of a clinician, whose moral standard must also be met.

Therefore, the authors conclude, respect for patient autonomy is critical, but limits are necessary to prevent patient autonomy from overriding patient safety.

"North American Consensus Guidelines for Administered Radiopharmaceutical Activities in Children and Adolescents," finalized in October 2010, addresses radiopharmaceutical doses for 11 radiopharmaceuticals commonly used in pediatric single photon computed

emission tomography and PET imaging. The guidelines specify that dose determination should be based on body weight alone (not body surface area or other methods), except for nuclear cystogram and gastric emptying studies. The guidelines state that they differ significantly from the European Association for Nuclear Medicine Pediatric Dose Card issued in 2007. Differences, as stated in the new guidelines, are as follows:

1. The administered activities are slightly lower for infants and small children.
2. Administered activities for technetium-99m-labeled dimercaptosuccinic acid and 18F-fluoride are considerably lower.
3. Administered activities for orally administered technetium-99m-labeled radiopharmaceuticals and for radionuclide cystography provide a range for each type of study rather than an administered activity per kilogram.
4. The consensus guidelines are intended to more closely represent clinical practice in North American pediatric centers.

OB Patient Safety Program Reduces Sentinel Events, Liability Payments

A New York medical center reports that its comprehensive obstetrics patient safety program eliminated the occurrence of sentinel events over time and significantly reduced indemnity payments. The program, initiated in 2003 by the facility's professional liability insurance carrier, resulted in a steady decline in sentinel events as measured from 2000, when 1.04 sentinel events per 1,000 deliveries occurred, to zero sentinel events in 2008 and 2009. In 2009, the average payment for an obstetrics liability claim dropped 99.1% to \$250,000, whereas the average annual payment was more than \$27 million from 2003 to 2006. The result was an annual savings of more than \$25 million in indemnity payments for the last three years reported.

Elements of the program were implemented incrementally, over a period of years, in the facility's labor and delivery unit that performs 5,200 deliveries per year. The program's components are described in an article in the February 11, 2011, issue of the *American Journal of Obstetrics and Gynecology* (Grunebaum et al.) and are summarized as follows:

- ▶ Requiring interdisciplinary team training for attending physicians, nurses, residents, and clerical staff

- ▶ Implementing electronic medical records for antepartum, labor, and delivery patients and electronic templates for shoulder dystocia and operative deliveries
- ▶ Implementing a chain of communication policy
- ▶ Creating a dedicated gynecology attending on-call schedule separate from obstetrics coverage
- ▶ Limiting use of misoprostol to induction of labor or cervical ripening only for a nonviable fetus
- ▶ Standardizing oxytocin labor induction and stimulation protocol
- ▶ Using premixed and safety color-coded labeled magnesium sulfate and oxytocin solutions
- ▶ Identifying potential liability cases for possible early settlement
- ▶ Creating a full-time hospital-employed dedicated obstetrics patient safety nurse position, funded by the liability insurer
- ▶ Implementing a secure, interactive, Internet-accessible whiteboard as a hub for situational awareness
- ▶ Adding three obstetric physician assistants for labor and delivery triage and cesarean deliveries
- ▶ Requiring certification in electronic fetal monitor interpretation by attending physicians, residents, physician assistants, and nurses
- ▶ Routinely applying lower extremity pneumatic compression devices intermittently for cesarean deliveries as thromboembolism prophylaxis
- ▶ Conducting periodic drills for maternal cardiac arrest, shoulder dystocia, emergency cesarean section, and maternal hemorrhage with participation by obstetricians, anesthesiologists, neonatologists, nurses, residents, fellows, and physician assistants
- ▶ Employing a laborist on nights and weekends
- ▶ Implementing an oxytocin checklist
- ▶ Providing a postpartum hemorrhage kit with the four most important drugs
- ▶ Assigning literature to attending physicians and residents and requiring reading and testing.

The facility's shoulder dystocia documentation template and chain of communication policy are reproduced in the article.

▶ IN PRACTICE

U.K. National Patient Safety Agency Provides Guidance for Postfall Care

The U.K. National Patient Safety Agency (NPSA) receives nearly 282,000 reports of patient falls each year, with a significant number of the falls resulting in death and serious injuries. In a January 13, 2011, Rapid Response Report (available online at <http://www.nrls.npsa.nhs.uk/alerts/?entryid45=94033>), NPSA details failures in postfall care among 200 patients who experienced fractures or intracranial injuries following in-hospital falls.

Common shortcomings included delayed diagnosis of fracture, delayed diagnosis of intracranial bleeding due to missing or inconsistent documentation of neurological observations, use of sling hoists to move patients despite signs or symptoms of fractures or spinal injuries, and delayed access to urgent investigations or surgery.

To limit the risk of inappropriate postfall care and subsequent patient harm, NPSA recommends that acute care hospitals and mental health facilities with inpatient beds ensure that five key elements are in place:

1. A postfall protocol should be adopted that includes checks by nursing staff for signs or symptoms of fracture or potential for spinal injury before the patient is moved; safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury; frequency and duration of neurological observations for all patients in whom head injury has occurred or cannot be excluded (e.g., unwitnessed falls) based on clinical practice guidelines; and timescales for medical examination following a fall (including fast-track assessment for patients with signs of serious injury or high vulnerability to injury or who have been immobilized).
2. The postfall protocol should be easily accessible (e.g., laminated versions at nursing stations).
3. Staff should have access to clear guidance and formats for recording neurological observations using a 15-point version of the Glasgow Coma Scale (GCS); changes in the GCS that should trigger urgent medical review should be highlighted.
4. Special equipment (e.g., hard collars, flat-lifting equipment, scoops) should be accessible by staff at all times for use with patients having a suspected

fracture or potential for spinal injury, and colleagues with the expertise to use it should be available.

5. Systems should be in place giving inpatients who are injured in a fall access to investigation and specialist treatment equal in speed and quality to that provided in emergency departments.

▶ ON THE ROAD

Webinar: Prepare for ACOs by Understanding Areas of Risk

Participants in an accountable care organization (ACO) must understand the additional risks assumed in a shift to this patient care model, said panelists in a February 3, 2011, webinar sponsored by Lexington Insurance Company. Panelists Diane C. Pinakiewicz, president of the National Patient Safety Foundation; James J. Kennedy III, partner in the Carlton Fields law firm; and Bradley Cox, senior vice president of Lexington Insurance and division executive of Lexington's healthcare division, discussed the possible effects of ACO formation on the healthcare industry.

Right now, Cox noted, the major effect of ACO formation is the consolidation of medical groups, and he explained that such consolidation might create some gray areas in insurance coverage that will need to be addressed by the industry. "This movement toward consolidation is affecting caregivers," he said. "There will be fundamental changes to business operation." He also stressed that contractual arrangements between ACO participants need to be clear and understood by all participants, as well as their insurance coverage providers.

Pinakiewicz further explained that the formation of an ACO will change the way all participating healthcare providers view the risk they assume. "In an ACO, the provider network will assume risk and manage care across a continuum," she said. "But, it will inherently require that there be recording of outcomes and performance measures." The interprofessional relationships and individual risk profiles are going to change, she said.

According to Cox, risk managers need to understand how to identify, manage, and reduce risk in key areas; however, until ACOs are more clearly defined, along with the additional protections (if any) such an entity

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▶ ABOUT YOUR COLLEAGUES

“Management’ Is Not a Primary Focus”

Jennifer Bentley, R.N., J.D., CPHQ, of Parkland Hospital, in Dallas, Texas, is the Director of Patient Safety and Risk. There’s no “management” in the department’s title. “We don’t have those titles,” says Bentley. “It’s not a primary focus. We’re really more focused on patient safety.”

In many settings, Bentley says, the phrase “risk management” can convey false impressions. “If we’re following up on an event, we’ll just say we’re from ‘Patient Safety.’ The staff has seen a difference since this change in address happened. Our goal is to prevent harm to patients, but things happen, and when they do, we’re here. We’ll figure out how it happened, why it happened, and how to prevent it from happening again.”

Bentley’s path to patient safety was literally thousands of miles long. In 1990, she was a pediatric nurse who traveled the United States. Beginning in 1995 she spent four years in Saudi Arabia, where she met her husband, a military contractor from Texas. Back in the States in 2000, she worked as a legal nurse consultant doing research and summaries for defense cases. “I felt very comfortable in the defense environment,” she says.

Next, Bentley and her husband went to South Korea, where she volunteered in the military health facility’s risk management department. “That was my first real experience, in 2001 and 2002. I did a lot of HIPAA [Health Insurance Portability and Accountability Act] education, worked with the National Patient Safety Goals, and created a database for the incident reporting system.”

Bentley and her family next moved to Omaha, Nebraska, where Bentley began law school. “I just knew that this was meant to be,” she says. “I took health law classes and mediation classes, and I was very interested in mediation for medical malpractice.” Right after graduation, her husband’s job moved them back to Texas, where she had difficulty finding work in the legal field. Bentley went back to bedside nursing. “I was thinking of things differently,” she says. “I was so much more aware of the implications of what I was doing.”

Then, three years ago, a job opened up at Parkland. A patient safety analyst was needed to do root-cause analysis. Once on board at Parkland, Bentley found that communication could be improved. “There had been bad experiences,” she explains. “[The system] was extraordinarily commanding and punitive, not collaborative and proactive. We had a lot of hurdles to overcome. We had to build relationships and trust. About a year and a half ago, we reorganized the entire division. There are still some growing pains, but we are far better able to communicate and build.”



Jennifer Bentley, R.N., J.D., CPHQ
Director of Patient Safety and Risk
Parkland Hospital

“Patient Safety adjusted the best,” jokes Bentley. “We’ve had a lot to learn; we try to be patient safety focused, rather than working under the old-fashioned model of documentation and coverage. I had a lot to learn. My experience with the military was all I had with risk management. I joined ASHRM [the American Society for Healthcare Risk Management] and took courses.” Bentley also notes that Parkland’s Medical Director/Patient Safety Officer has been a great resource. “She’s been instrumental in the success of the program and has been a great mentor to me from the patient safety side,” explains Bentley.

One challenge for Bentley and her staff has been to improve the visibility of and reliance on the patient safety department. “We offer disclosure training and videos for physicians, and we have a person on call 24 hours a day.” The staff has responded well to the changes in patient safety. Doctors call Bentley’s staff proactively, she says, and their other services, such as the 24-hour phone access, are also being utilized. “We have so much more communication now,” she says. “So many physicians call us to ‘give us a heads up’ about something, or just to update the department.”

Bentley has helped her staff move to a proactive point of view. “I tell my staff all the time—and I firmly believe this—there’s no such thing as a risk management emergency,” she says. “To move away from ‘reactionary mode’ to proactive, we need to set our priorities. We can review an incident, but it does no good if we don’t share the information and make improvements based on what we learned. Even the action plan of a root-cause analysis probably only affects the area where the error occurred. So, we really try to identify the areas where we can do the most to make it safer for patients. If we treat patients well, with respect, and by utilizing best practices, then we’ll be successful.”

(continued from page 16)

will be afforded, possible risk exposures are difficult to measure or quantify, said Kennedy.

The panelists all suggested that healthcare professionals looking to enter into an ACO examine the risk factors likely to be involved in the organization, work with insurance providers to eliminate any coverage gaps as they are found, and be ready to respond to risk exposures as best they can.

A recording of the webinar is available online at <http://www3.ambest.com/ambv/displaycontent/MediaArchive.aspx?RC=182897>.

▶ IN COMPLIANCE

Tips to Reduce Financial and Legal Risks of RAC Audits

Getting caught off guard by an audit for potential overpayment from Medicare, Medicaid, and other government-funded healthcare programs can result in financial and legal peril to a provider. The Recovery Audit Contractor (RAC) program initiated by the Centers for Medicare and Medicaid Services (CMS) began as a three-year pilot program to identify and recoup overpayments by Medicare and Medicaid and to detect fraudulent billing practices. The program has gone nationwide, and all providers are subject to audit. The RAC program uses private auditors, contracted on a contingency fee basis with CMS, to audit Parts A, B, and C claims submitted to Medicare. Audits involve sophisticated computerized analyses of claims and coding practices to identify incomplete documentation, duplicate billing, incorrectly coded services, lack of medical necessity based on Medicare guidelines, and inappropriate bundling or unbundling of claims. A more complex audit involves review of medical records.

RACs inform providers of any “improper payment” to be recouped and may make referrals to law enforcement for suspected violations of the False Claims Act, a law that requires providers to return any identified overpayments within 60 days.

The best defense to a RAC audit is to be prepared, according to attorneys writing in the January 2011 issue of *HFM Magazine* (Swichar and Walworth). To minimize financial and legal risk, the authors make the following suggestions:

▶ Consider performing a self-assessment to uncover, report, and resolve potential overpayments.

- ▶ Consider setting a reserve from which to pay potential overpayments that the provider identifies for reporting and resolution.
- ▶ Identify and rectify problems with document retention and access to ensure adequate and timely responses to RAC auditors’ requests for records.
- ▶ Audit records dated October 1, 2007, and onward.
- ▶ Identify all key record custodians.
- ▶ Create a clear “map” of the location of all records.
- ▶ Ensure that all off-site medical records and documents are indexed and accessible.
- ▶ Develop and implement a protocol for responding to a RAC request record.
- ▶ Assemble a RAC response team, and train and designate a RAC point person.

In light of the potential legal pitfalls for providers who fail to reconcile overpayments properly and expeditiously, the authors suggest that providers involve outside legal counsel to determine the scope and extent of a self-assessment.

▶ IN THE COURTS

In the Courts features summaries of recent court decisions affecting healthcare facilities and their risk management programs. When reviewing these abstracts, keep in mind that laws and court decisions vary among jurisdictions and that decisions of lower courts may be overturned on appeal. For specific legal guidance regarding the significance or applicability of these decisions, contact legal counsel.

ADA: Failure to Provide Interpreter May Be Discrimination, Regardless of Intent

The U.S. District Court of the Western District of Washington denied a hospital’s request for summary judgment in a case in which a deaf patient alleged unlawful discrimination because the hospital neglected to provide her with a requested American Sign Language (ASL) interpreter during her hospital visits.

The patient alleged discrimination under the Americans with Disabilities Act, the Rehabilitation Act, and the Washington State Law Against Discrimination when the hospital failed to provide her with an ASL interpreter on three occasions. The hospital requested summary judgment because the patient’s complaint was allegedly defective in that it contained references

to incorrect dates of her appointments, and the hospital asserted that the lack of an interpreter was due to an “administrative error,” not an effort to unlawfully discriminate against the patient because she is deaf. Considering the hospital’s defense that its failure to provide an interpreter was unintentional, the court found that the hospital misinterpreted the legal element of causation in regard to discrimination laws—the test for discrimination is whether discrimination was the effect of something the defendant has done, not the defendant’s intent. Therefore, the court noted, whether the inability to provide an interpreter was the result of an administrative error is irrelevant.

For the court to consider the charge of discrimination, the plaintiff must show that the defendants exhibited “deliberate indifference.” The court concluded that a jury could reasonably determine that such behavior occurred because the plaintiff notified the hospital numerous times that she needed an interpreter at her appointments. This information would have put the hospital on notice that the patient requires accommodation for proper care, the court wrote. The plaintiff must also establish that the defendant failed to act in light of the requested accommodation, a fact that is undisputed by the hospital.

The hospital claimed that the patient’s physician did not believe that communication was a problem during visits with the patient and that many different forms of communication were used during the visit (e.g., writing notes, lip reading). The patient, however, stated that she can write in English only with difficulty and that she had a difficult time understanding the notes written to her. Further, she can only understand about 5% of what a person is saying through lip reading. In light of the factual allegations, the court concluded that a reasonable jury could find that the patient did not receive the same treatment that others would have received, potentially indicating discrimination.

Considering the alleged defects in the complaint, the court found that the typographical errors related to the dates in the patient’s complaint could be amended to the correct dates, as the defendants acknowledged that the visits she incorrectly referenced in her complaint had occurred. The court thus denied the hospital’s motion for summary judgment and granted the plaintiff’s request to amend the complaint. (*Adamski-Thorpe v. Stevens Memorial Hospital*, No. C09-1302, U.S. Dist. Ct. Wash., LEXIS 128288 [Dec. 3, 2010].)

Contract: Hospital Had Right to Dismiss Emergency Physician without Due Process

A U.S. Court of Appeals for the Eighth Circuit affirmed a summary judgment in favor of a defendant hospital that allegedly violated an emergency physician’s due process rights and wrongfully interfered with business expectancy when it fired the physician because of patient complaints about his services.

In 2002, the hospital entered into a contract for emergency medical services with another physician, which included a provision that the hospital could remove “any physician at any time.” The plaintiff contracted with the physician that was the exclusive provider of emergency services for the hospital in 2003; the contract for these services stated “either party may terminate this Agreement...with reasonable cause.” Each contract had a term of one year, with automatic renewal.

In 2007, the physician who had contracted directly with the hospital informed the plaintiff that he was dismissed based on a request made by the hospital in response to patient complaints about him.

The plaintiff contended that he had an expectation of continued employment at the hospital through the emergency services and independent contractor agreements and that the hospital violated his constitutional rights under the Fourteenth Amendment by failing to provide him due process of law. However, the court found that the hospital had a contractual right to dismiss the physician at any time, and thus he had no legitimate expectation of continued employment. Further, there was no agreement between the plaintiff and the hospital regarding his services. The court also denied this claim of wrongful interference with a business relationship because the terms of the independent contractor agreement specifically authorized the hospital to dismiss the physician, and thus there was no “improper” interference with a contractual relationship.

The court therefore upheld the district court’s grant of summary judgment in favor of the defendants. (*Schueller v. Goddard*, No. 09-3047, U.S. Ct. App. 8th Circ. [Nov. 15, 2010].)

Discovery: Court Orders Internal Review of Quality Database

An appellate court in Washington ruled that a hospital must provide redacted patient records that could be identified by an internal search of its quality assurance committee database to a plaintiff in a lawsuit alleging

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The Patient Safety and Quality Improvement Act of 2005 laid the groundwork for the first-ever national system that allows providers to voluntarily report medical errors, near misses, and other patient safety events to designated patient safety organizations (PSOs) while knowing that the information will be protected from legal discovery and kept confidential. ECRI Institute PSO, one of the first designated by the federal government, works with hundreds of providers from around the country to collect patient safety work product, learn about events that lead to patient harm, and offer expert guidance to improve patient care. Learn more about how ECRI Institute PSO can help your organization by contacting us at pso@ecri.org.

corporate negligence. The plaintiff claimed to have suffered a permanent neurological injury allegedly as a result of negligently administered intravenous (IV) therapy at the hospital. The decision reversed a lower court's ruling that the records were protected from disclosure by state law privilege for hospital quality improvement records.

The plaintiff, a former staff physician at the hospital, requested information describing instances of IV infusion complications or injuries at the hospital from 2000 to 2008. The court determined that the information requested was relevant to the claims asserted and that the hospital was capable of producing the requested information by performing a search of the quality assurance committee database, which would generate a list of cases involving complications with IV infusions, indexed by date and identification number. The only other way to retrieve this information would be to manually review patient records, a process that already had been deemed an undue burden to the facility.

The hospital resisted discovery on grounds that using the database to identify the requested information is prohibited by state law, which provides a privilege from disclosure to all information and documents created for and collected and maintained by the quality assurance committee. The court found that the requested medical charts were not created specifically for the quality assurance committee, are maintained outside the committee files, are relevant, and thus are discoverable.

In providing the requested records, the hospital would not be compelled to identify participants in the review process, identify cases flagged as relevant or important, or indicate how the committee sorted,

grouped, or organized the events. Further, no analysis, discussion, or communication related to the quality assurance committee would be included in the information provided to the plaintiff.

The appellate court determined that the state statute protecting the work of a hospital's quality assurance committee from review and disclosure is meant to prevent review of the records by persons outside the hospital in order to preserve the confidentiality of the documents and to ensure that the quality process is not inhibited by external review. The statute does not prohibit the internal review of records to identify information available elsewhere in the hospital. The court concluded that the hospital cannot hide information contained in ordinary medical records through inclusion in the quality assurance database, and thus it granted the plaintiff's discovery request. (*Lowy v. PeaceHealth*, No. 63866-1-I, Wash. App. LEXIS 310 [Jan. 31, 2011].)

HRC Commentary: It is interesting to speculate whether a court would order a hospital to search a quality assurance database that is a part of a patient safety evaluation system (PSES) established under the federal Patient Safety and Quality Improvement Act (PSQIA). PSQIA provides that "patient safety work product" is not subject to discovery in civil litigation and that the privilege attaches from the time that data is collected into a PSES for reporting to a patient safety organization. Arguably, the privilege should attach to a quality committee's database that is part of a PSES. However, PSQIA does not provide a privilege from discovery to medical records, or to "information that is collected, maintained, or developed separately or exists separately from a patient safety evaluation system." How courts will interpret the privilege protections of PSQIA will depend on the facts and circumstances unique to each case.

EMTALA: Court Allows Claim that Hospitals Failed to Follow Their Own Policies

The U.S. District Court in Nevada has allowed an Emergency Medical Treatment and Labor Act (EMTALA) lawsuit alleging disparate medical screening by two healthcare facilities to proceed, denying their motions for summary judgment and describing the claims as a "heart-wrenching story."

The plaintiffs alleged the following. The patient arrived at an ambulatory care facility with her fiancé, complaining of severe abdominal pain and vaginal bleeding. After evaluating the patient, the physician recommended "higher care" at a university medical center.

On arrival at the university medical center's emergency department (ED), the patient and her fiancé told staff that the patient might be pregnant and was experiencing the worst pain in her life. When the patient's fiancé attempted to summon staff, security arrived and "made it clear" that there was no certain time when the patient would be seen by a physician. The couple waited in the ED for more than five hours, during which time nursing staff allegedly berated, belittled, and embarrassed them. They left and drove to another hospital. After the couple informed the registration clerk about their five-hour wait at the medical center, the clerk allegedly asked the patient why she believed she would be seen any sooner at this hospital. The couple then returned home, where the patient's amniotic sac broke and she "felt feet hanging from her vagina." Her fiancé called 911 and followed instructions until the paramedics arrived and delivered the infant in breech position. The infant went into distress nearly immediately and was transported to the university medical center, where she was pronounced dead. A nurse there told the plaintiffs that the infant had been born pre-viable, and nothing could have been done to save her. The plaintiffs requested an autopsy by the coroner, on the basis of which they claimed the infant's gestational age was approximately 26 weeks, indicating a potentially viable fetus.

The plaintiffs sued both facilities, alleging that each failed to screen and treat the patient as required by EMTALA and alleging that the university medical center failed to screen and treat the newborn infant. Each plaintiff sought damages for negligent infliction of emotional distress.

To support its motion for summary judgment, the university medical center contended that the plaintiffs failed to provide expert medical opinion testimony to substantiate their claims; failed to show "personal harm" as direct result of the defendants' conduct, as required by EMTALA; and failed to show that the infant died as a result of an untreatable infection of the placenta, not as a direct result of failing to follow screening procedures. The second hospital contended that the plaintiffs left the ED before a screening examination could be completed.

Ruling on their summary judgment motions, the court commented that EMTALA does not define "an appropriate medical screening examination" other than to state that its purpose is to identify an emergency medical condition. Citing court opinions from other circuits, the court stated that EMTALA requires that a

Discovery: Hospital Must Produce Nurse's Note, Not Part of Quality System

The U.S. district court for Western Pennsylvania ruled that a hospital must produce a nurse practitioner's note detailing the care the plaintiffs' son received during a transfer from a Pennsylvania hospital to a New York hospital, after finding that quality assurance protection restrictions provided by Pennsylvania and New York laws did not protect the note from discovery.

The plaintiffs requested the handwritten note regarding the treatment of their son during his hospital transfer; however, the hospital asserted that the note was protected from discovery under both Pennsylvania and New York laws because it was created as part of the peer review/quality assurance process. The nurse practitioner who wrote the note testified that she was part of the Pennsylvania hospital's peer review/quality assurance committee and that the note was created as part of the quality assurance review.

The Pennsylvania statute does not protect "information, documents, and records otherwise available from an original source," or "non-peer reviewed business records, even if used by the peer review committee." The New York law states that protection is provided for documents that are related to proceedings and records for medical or quality assurance review function or a medical malpractice prevention program, or incident reports prepared according to incident reporting laws.

The court reviewed the note and found that it did not meet the protections of either state's privilege law. The note was not derived from an evaluation or review by a peer review committee, and it resembled an incident report or log prepared during treatment of the patient. Further, the note was never used as a quality assurance document, nor was it prepared or produced by an established quality assurance communication or as part of mandatory reporting provisions. Finding that the note is not privileged under either state law, the court granted the plaintiff's motion to compel the hospital to produce the note. (*Ellison v. Women and Children's Hospital of Buffalo*, No. 08-313, Erie U.S. Dist. Ct. Pa., LEXIS 130828 [Dec. 10, 2010].)

screening procedure within the hospital's capability is in place and is administered to patients evenhandedly (i.e., similar screening procedures must be administered to similarly situated patients). Disparate screening claims are not judged according to a professional negligence standard, it wrote, and thus the plaintiffs did not need an expert to testify about the accepted standard of care. Instead, evidence that a hospital did not follow its own screening procedures can support a finding of EMTALA liability for disparate treatment.

The court observed that EMTALA does not define the “personal harm” that a plaintiff must directly incur to state a legally recognizable claim. It found that the plaintiffs’ claims of suffering as a result of the defendants’ alleged conduct was enough to create a genuine issue of material fact that should be decided by a jury.

To succeed on their disparate screening claim with regard to the infant’s death, the court wrote, the plaintiffs must provide enough evidence to support a finding that the patient received a “materially different screening” than that provided to others “in the same condition”; they were not required to prove that the infant died as a direct result of the facility’s failure to follow its screening procedures.

The court gave no weight to the expert witness opinion offered by a physician retained by the university medical center because the witness expressed no opinion about whether the plaintiffs received a materially different screening than that provided to others.

The court denied the second hospital’s motion for summary judgment, finding the plaintiffs provided sufficient evidence to show that the facility failed to observe requirements of its own EMTALA policy—

that a representative from the admitting department “immediately notify the triage nurse of any individual presenting for treatment” and that its “quick patient identification process” is to be used to obtain basic demographic information from the patient or a relative, if time permits. The plaintiffs claimed that the registration clerk also refused to permit any type of screening to occur without her completing “some type of admitting paperwork” and that they left the hospital on the basis of the registration clerk’s inappropriate comment and conduct, which amounted to a constructive refusal to treat the patient.

The court also permitted both plaintiffs’ emotional distress claims to proceed, finding that the woman’s claim of severe depression could be properly decided by a jury. It found that the fiancé’s claim of emotional distress met the legal requirements for “bystander liability” under Nevada tort law, concluding that a jury could assess his claims that after having witnessed the infant’s traumatic emergency delivery, he experienced emotional pain that caused him to attempt suicide. (*Abney v. University Medical Center of Southern Nevada, et al.*, 2:09-cv-02418-RHL-PAL [D. Nev. Feb. 4, 2011].)

Adverse Events Happen.

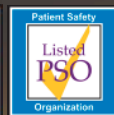
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