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Letter from the Chair

By Renee G. Wenger, JD, RPLU, CPHRM

Renee G. Wenger
JD, RPLU, CPHRM

All Sentinel Events must be reviewed by the hospital and are subject to review by the Joint Commission. The Joint Commission adopted a formal Sentinel Event Policy in 1996 and, January 2015, the Commission issued a revised Sentinel Event definition, which is **"any patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, or severe temporary harm."**[1] The Joint Commission considers **"severe temporary harm"** to be any **"critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure or treatment to resolve the condition."**[2]

New or more defined examples of events now considered "sentinel" by the Joint Commission include:

1. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department;
2. Any elopement (e.g., unauthorized departure of a patient from a staffed around-the-clock care setting including the ED) leading to death, permanent harm or severe temporary harm to the patient;
3. Rape, assault (leading to death, permanent harm or severe temporary harm) or homicide of any patient receiving care, treatment and services while on-site at the hospital or any staff member, licensed independent practitioner, visitor or vendor while on-site at the hospital;
4. Invasive procedure, including surgery, on the wrong patient, at the wrong site or that is the wrong (unintended) procedure;
5. Fire, flame or unanticipated smoke, heat or flashes occurring during an episode of patient care;
6. Any intrapartum (related to the birth process) maternal death or severe maternal morbidity.

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Member Profile
Ann Gaffey, RN, MSN, CPHRM, DFASHRM

By Renee G. Wenger, J.D., RPLU, CPHRM

ASHRM has the good luck this year to be led by Ann Gaffey, current senior vice president of Healthcare Risk Management and Patient Safety for the Professional Liability Division of Sedgwick. I thoroughly enjoyed my interview with her for this article and anticipate that she will be a personable powerhouse for our organization.

Ann Gaffey
RN, MSN, CPHRM, DFASHRM
ASHRM President

Gaffey earned a Bachelor of Science in Nursing from the University of Virginia and a Master of Science in Nursing Leadership and Management from George Washington University. She is currently a Board Member of the National Perinatal Information Center, vice chair of the National Coordinating Council for Medication Error Reporting and Prevention and past president of the Virginia Association for Healthcare Risk Management. Gaffey serves as adjunct faculty at George Washington University in Washington D.C.

She has an industry-recognized career in risk management, quality and patient safety with more than 29 years of experience in healthcare. As senior vice president of Sedgwick, she has responsibility for overseeing and providing innovative consultative services to improve and enhance risk management and patient safety programs with an emphasis on risk identification, assessment, analysis and prevention as well as risk management and patient safety education. Her experience includes managing self-insurance and captive insurance programs; insurance purchasing; claims management; and traditional risk assessment and mitigation activities. She has worked with Risk Managers across the continuum of care across the country and around the world, giving her a strong, broad knowledge base.

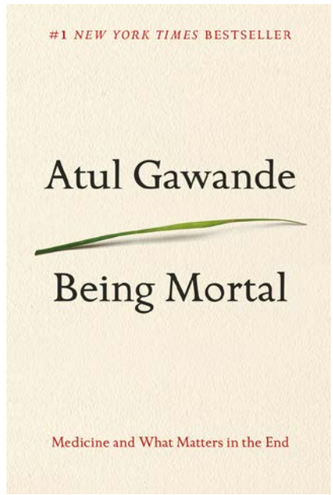
On the ASHRM Board from 2008-2010, she is now president-elect for the term of 2015-2017. She says she plans to continue to advance the organization's Strategic Plan. Her passions are to assist members in moving forward on Enterprise Risk Management and to engage new members and attract a new generation. The current average age of ASHRM's membership is 53 and she stresses that it is important for new professionals to be able to find their peer group and have good mentors. We with ASHRM need to create our own succession plan. Overall, she says that this will be a great year and is honored to be leading the way.

On a personal note, Gaffey and her husband are empty nesters with two children in college and an adored dog named Daisy.

Book Review
Atul Gawande's Being Mortal

By Margaret Curtin, MPA, HCA, CPHRM, DFASHRM, CPCU

Many of us have experienced death in some fashion. Some reading this review will have cared for someone who was dying with memories of some deaths that were peaceful and others that were fraught with suffering. *Being Mortal* suggests that there is a better way to provide care for terminally ill patients so that suffering is decreased and the patient's wishes are central to the care provided. *Being Mortal* can teach us about, well… being mortal and importantly how we can improve end-of-life care by teaching clinicians of the importance of communication and decision making when medicine can't "fix" a patient's problem.



"What drops through the cracks for providers who care for people with terminal illness or serious infirmity is being able to take good care of patients whose problems you are not going to be able to make go away, such as patients at the end of life or with increasing problems due to frailty as they age." *Dr. Gawande, AHA Leadership Summit*, 2015.

Through his interviews of more than 200 patients and family members about their experiences with death and dying, Dr. Gawande found that there are some clinicians who do a superb job with caring for these patients. He found that these really good clinicians recognized that people have priorities in their lives besides just living longer and the only way to know what those priorities are is to ask – and he says "we are not asking them."

Being Mortal challenges clinicians and healthcare leaders to shift their thinking on the provision of healthcare from one of delivering "stuff" (pills, surgery and specialists) to delivering outcomes. End-of-life care needs to be a team approach where talking to the patient about their wants, fears, and wishes becomes what sets the plan of treatment, rather than the single clinician's decisions on treatment options.

Dr. Gawande explains that there must be an emphasis on questioning and listening skills at several points during the remaining living period of a patient's life. He advocates that clinicians, and includes himself in this statement, must change their approach to discussions and routine office visits where the clinician talks 95 percent of the time, gives the patient lots of facts and presents the treatment options with all the risks and benefits… leaving patient asking, "So what should I do doctor?" There is an obvious lack of clarity about how to answer that question on the clinician's part.

To remedy this situation, Dr. Gawande encourages a different kind of conversation one where the clinician asks the patient: *What is your understanding about where you are with your condition? What are your fears and worries for the future? What are your goals and priorities if your health worsens? What are you willing to go through and what are you not willing to go through for the sake of more time?* This type of conversation helps the clinician determine what treatment choices to offer the patient that would allow him or her to have the best chance at a life that still has value as well as what treatments won't provide that. These questions make up the core discussions taught in palliative care.

A goal of *Being Mortal* is to help clinicians realize a transformation in thinking about what their job is for the dying patient. Once the clinician understands how to answer the question of "What should I do," It will change and improve the way care proceeds for patients as well as for the family members.

The six aims for healthcare improvement from the IOM, Crossing the Quality Chasm, references delivering care that is safe, timely, effective, equitable, efficient and patient-centered. Focusing on effective, efficient and patient-centered, we find the following guiding points for healthcare at the end of life:

Effective - provide services based on scientific knowledge to all who could benefit, and **refrain from providing services to those not likely to benefit**

Efficient - **Avoid waste**, including waste of equipment, supplies, ideas and energy

Patient-centered - Provide care that is **respectful of and responsive to individual patient preferences, needs and values;** ensuring that patient values guide all clinical decisions

Being Mortal speaks to a care model that has its base in palliative care, ensuring that clinicians have conversations with their patients that include the core palliative questions before the patient is referred to them when it is often too late to truly

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Patient Safety/Clinical Care

Code Carts – Do You Really Know All Your Equipment?

By David J. Murray, MS, BS, CCEP, CHPC

The patient was being transferred from PACU to the floor after surgery. A portable monitor was on the gurney but wasn't attached to the patient. The patient went into sudden cardiac arrest. The nurse called the code and the rapid response team swarmed around the patient as the nurse went to retrieve the closest defibrillator. The defibrillator was fired up, the patient was cleared, paddles applied – and nothing! She tried again – nothing! The RRT seemed disorganized, and no one took charge of the situation.

The nurse ran to the next unit, grabbed that code cart while the rapid response team worked manually on the patient. She fired the defibrillator up, the patient was cleared, and the patient was shocked back into normal sinus rhythm. The group then hooked the portable monitor up to the patient and diverted off to ICU.

Fist Report

Later that day, one of the nurses wrote up a risk report that the equipment failed and that it didn't seem like the rapid response team was comfortable with running a code – and no one took charge. The Risk Manager called a Root Cause Analysis meeting, bringing all parties involved to the table. Through the process, the following was determined:

- The nurse who grabbed the first defibrillator stated the machine didn't work. She was asked if biomedical engineering was called. She didn't know – so the risk manager called biomed and found that they weren't called – and were dispatched to assess the machine. **Initial Issue:** When a piece of equipment fails or breaks, the policy is to report it immediately to biomed and take it out of service until it is repaired or cleared.
- Because the patient seemed fine on leaving PACU, the portable monitor wasn't hooked up. On review of the history and physical, the patient had a history of cardiac issues. **Second Issue:** Based on the patient's history, he should have been on a monitor per policy.
- Because codes happen infrequently, it was agreed that the hospital would bring in a trainer over the next several months and run frequent code exercises around the facility at random in order to allow staff to be comfortable with running a code at any time. **Third Issue:** Staff needed adjunctive training to maintain skills in running a code.

Machine Function

The meeting was adjourned while biomed was contacted to address the defibrillator. On follow up, Biomed reported that nothing was wrong with the machine – after repeated testing, it functioned as it was supposed to. The group was insistent that something had to have been wrong because the second machine worked and "they're all the same." The risk manager asked if that was true, and everyone agreed. The risk manager stated he'd check and the meeting was adjourned.

On follow up, the group was informed that while all of the machines were made by the same manufacturer, they did not work the same. The nurse was unfamiliar with the first machine she pulled and tried to operate it just like the one in her unit. The second machine she pulled was just like the one she had in PACU, which she was familiar with – and it worked for her. The group realized that their assumption about the defibrillators was wrong and that they needed to know how each of the machines worked in the event a code was called. Training was implemented.

In your facility, assess like-functional equipment for differences operation and ensure that staff understand how the equipment actually works and demonstrate competency in that understanding.

Enterprise Risk Management

Protecting Your Employees: Fleet Safety Program

By Tina Tucciarone, RN, MSN, CPHRM

At any point of time, your fleet program is vulnerable. "Every 12 minutes someone dies in a motor vehicle crash, every 10 seconds an injury occurs and every 5 seconds a crash occurs."[1] Our employees are our most valuable asset. Motor vehicle crashes are the leading cause of death among workers in the United States with a total of 18,716 work-related crash fatalities between 2003-2012.[2] As risk managers we can proactively manage, monitor and mitigate the fleet program. This includes reducing the risk of potential legal fault that can apply to an employer such as negligent hiring/retention, negligent supervision, negligent training and owner liability. The Centers for Disease Control and Prevention recently published a white paper, "Preventing work-related motor vehicle crashes" with evidence-based intervention strategies to consider when developing a fleet safety program.[2]

Creating a Shared Need

In order to align stakeholders to begin building a safe driving culture that listens, empowers, trains and rewards, begin the journey by encouraging leaders and employees to understand the needs of all stakeholders.[3] At a minimum, include the following stakeholders – risk management, executive leadership, human resources, security, department leaders of drivers, drivers and claims managers or coordinators.

Communication

Create a standard communication tool leaders will use as they set the tone for the safe driving culture. Focus on road safety as a priority and stress that all employees are expected to drive in a safe and responsible way.[2]

Developing a Fleet Safety Policy

Build effective policies, procedures and strategies to mitigate and manage the fleet safety program. Elements to consider when developing the fleet safety policy include:

1. Purpose
2. Scope
3. Driver selection - make sure every driver has a valid state drivers license and consider annual motor vehicle record reviews[2]
4. Vehicle maintenance[2]
    a. Daily inspections – develop a vehicle safety checklist to inspect the vehicle before driving.
    b. Regular maintenance per manufacturers' recommendations
5. Driver safety rules -includes topics such as:[1]
    a. Cell phones and other distractions
    b. Seat belts
    c. Fatigued driving/driving under the influence
    d. Severe weather
    e. Radar detectors
6. Traffic violations, citations and accident investigation[1]
    a. Occurrence reports
        i. You may want to explore the Innovation Series 2011 Institute for Healthcare Improvement's "Respectful Management of Serious Clinical Adverse Events."[4] This white paper has best practice tools leaders could use as a guide to respectful adverse event investigation as well as responses and the use of appreciative inquiry when speaking with employees.
7. Driver training upon hire and annual[1,2]
8. Periodic program review - define who will oversee the periodic program review
9. Record retention
    a. Driver list (with date of last MVR check- outcome and drivers license expiration)
    b. Vehicle maintenance
    c. Vehicle self-inspection report, if vehicle is pulled out of service
    d. Driver training record

Periodic program review

Do you have a comprehensive tool to manage your fleet safety program smoothly and efficiently? Consider creating a dashboard to access critical data and reports so you can create and manage custom risk plans. Loss run reports; tracking driver accidents by age; trends in types of accidents or multiple accidents by the same driver, as they may signal the need for additional training or changes to driver selection procedures; and occurrence report trends regarding the fleet program will provide you with information to make sound risk management decisions.

Incorporate safety rounds utilizing appreciative inquiry[5] when speaking directly with employees, allowing the employee to have a voice in shaping fleet safety and keeping the cycle of learning going.[6] Rounds can be utilized as an opportunity to recognize

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Behavioral Health
A Nursing Perspective on Workplace Assaults

By Kathleen Barton, RN, MS

Acts of violence by patients toward nurses are becoming more and more frequent. When a patient is verbally or physically assaultive, it can be traumatic to the nurse regardless whether a physical injury occurs. Administrators need to be sensitive to this and provide nurses a safe environment to care for their patients. Nurses and the entire healthcare staff need to be offered education on how to manage the assaultive patient as well as given support and the opportunity to debrief and process after an assaultive event.

As our culture continues to change, the healthcare industry is experiencing a significant shift in how it addresses and manages patient and staff safety. Healthcare facility administrators, risk managers, safety managers and human resource staff continually assess, implement and monitor safety initiatives to ensure a safe environment for patients and staff. It is acknowledged that nurses are continually at risk of being verbally or physically assaulted by a patient, a patient's family member or visitors. As we strive to improve customer satisfaction and the patient care experience, we must remember to set limits and to maintain professional boundaries particularly when dealing with a difficult, angry, or demanding patients, family members or visitors. We must inform patients of their right to be cared for and treated with dignity and respect. We must also send a clear message to our patients that we have zero tolerance for verbal or physical threats made against staff. Behaviors such as yelling, screaming, profanity and prejudicial remarks are unacceptable and are not to be tolerated. In extreme situations, the healthcare facility public safety team might need to notify law enforcement.

Demands on Staff

Patients, family members, their friends and visitors have become increasingly demanding of nurses and other healthcare providers. Sometimes patients make unreasonable demands. If the healthcare provider is not trained in de-escalation techniques, the situation could ramp up with the patient becoming loud, verbally threatening and causing physical harm.

Types of verbal and physical assaultive behaviors include verbal threats, shouting, yelling, screaming, spitting, hitting, kicking, scratching, biting, grabbing, shoving and punching. Healthcare providers who were physically assaulted typically report injuries to the head, neck, torso and extremities. Some healthcare providers describe such patient behaviors as "acting out" or "attention seeking" but that minimizes the seriousness of the situations and ignores the potential for violence or physical harm. Staff and administration must be trained to recognize patient verbal, non-verbal and physical behavior that could quickly escalate so nurses and others can be prepared to respond and manage the situation.

Ideally, staff should work as a team to prevent a situation from escalating or respond should assaultive behavior occur. Training staff how to recognize, respond and manage patient assaultive behavior keeps the patient and healthcare team safe. Healthcare facility administrators, risk managers, safety managers and human resource staff should review current policies for responding to assaultive patients and consider including notification of local law enforcement if necessary.

CPI Training

Staff at Linden Oaks Behavioral Health Hospital in Naperville, Illinois is trained in nonviolent crisis intervention following Crisis Prevention Institute guidelines. CPI is an international training organization that specializes in the safe management of disruptive and assaultive behavior.

Particularly vulnerable to verbally threatening or physically assaultive behavior is the staff in behavioral health hospitals, psychiatric inpatient units, public safety, the emergency department, Intensive Care Unit and physician offices. By educating nurses and all staff in the principles of CPI, including the verbal escalation model and de-escalation technique, they are better equipped to prevent a potentially volatile situation from erupting.

There are situations when the assaultive person is not responsive to de-escalation and physically assaults a staff member. When this occurs, the healthcare provider is presented with a professional and ethical dilemma. There is the option of contacting the police department and filing a report about the attack. Whether the patient exhibited intent to harm vs. being in an altered state (psychosis, hallucinating, etc.) could influence the decision on whether or not to file a law enforcement report. Some choose not to press charges after evaluating the patient's psychological state at the time of the assault and whether the patient knowingly meant to harm the staff member; or if the assault was due to the patient being cognitively impaired such as having a diagnosis of dementia, traumatic brain injury or other neurological condition causing the patient's behavior to unintentionally result in a physical assault.

Over the years, particularly in psychiatric facilities, healthcare

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providers report that attitudes still exist that patient assaultive behavior "is to be expected" and "part of the job." Staff members who still embrace this mindset should go through training including a discussion of patient and staff safety including additional education to ensure that all staff is informed of the right to work in a safe environment.

Certainly traumatic for the person who is assaulted, it can be also traumatic to the patient who commits the assault. Some patients express remorse for harming the staff member. The patient's sense of remorse could also influence the decision about whether or not to file a police report.

Responding to growing violence, risk managers should consider the following recommendations to address and manage patient potential assaultive behavior toward staff:

1. Educate your staff in CPI nonviolent crisis intervention
2. Conduct a risk assessment of your facility's inpatient units, outpatient programs and physician offices including the waiting areas to determine how staff is to respond if confronted with an assaultive patient including how to secure the area
3. Ensure you have the means for staff to communicate in emergency situations including the use of walkie-talkies or other electronics such as a panic button or paging system

Resources

New OSHA guidelines recommend the following five components for establishing violence-prevention program in the workplace:

1. Leadership commitment and employee participation
2. Worksite analysis and hazard identification
3. Hazard prevention and control
4. Safety and health training
5. Record keeping and program evaluation

There is also an online Workplace Violence Prevention for Nurses course through the Centers for Disease Control. It includes scenarios seen at hospitals including bullying, troublesome visitors, sexual advances and emotional distress on staff. It takes about 1.5 to 2 hours to complete.

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provide care that is patient centered, efficient or effective. According to Dr. Gawande, the outcomes that are reported from programs where early engagement of palliative care is utilized show that often a choice to stop aggressive therapy is made sooner, the patients have more days at home, less days in the hospital, they have less suffering at the end of life and have been found to live longer on average.

Dr. Gawande has consistently been a change agent for healthcare leaders and clinicians. Again with *Being Mortal* we must listen. Change is coming to how healthcare supports end-of-life care. Clinicians are being taught how to have these conversations. Medicare is again considering paying clinicians for these discussions; it was part of the original legislation of the Affordable Care Act back in 2009. Private insurance companies are already starting to reimburse for these conversations. End-of-life counseling sessions often delve into treatment options and legal documents, such as advance directives and living wills. Many Risk Managers have had an opportunity to be involved in situations where a family is in dispute over end-of-life-care decision making for a loved one. These disputes often require legal resources as well as ethics reviews which require the Risk Manager's involvement to varying degrees. If end-of-life discussions were to become a routine part of the care process for the terminally ill and aged, we would truly be providing patient-centered care while also achieving efficiency by reducing the costs associated with end-of-life care.

It's what we all want when we are dying-to retain some control over what remains of our life, to ensure that our life has value as we define it, and to avoid suffering if that is what we choose. *Being Mortal* has opened the door for discussion and adoption of this model of care that will make a difference by helping clinicians to avoid the question "What should I do doctor?" when faced with discussions.

Sources: Foden-Vencil, Kristian and O'Neill, Stephanie. (2015, August 18). Medicare Says Doctors Should Get Paid To Discuss End-Of-Life Issues, 8/18/2015, online at: http://www.npr.org/sections/health-shots/2015/08/18/427041879/medicare-says-doctors-should-get-paid-to-discuss-end-of-life-issues

Emergency Preparedness
Tested by Amtrak Train Derailment

By Charles B. Conklin, BS, MBA

"On May 12, 2015, an Amtrak Northeast Regional train from Washington, D.C., bound for New York City, derailed and crashed on the Northeast Corridor in the Port Richmond neighborhood of Philadelphia, Pennsylvania. Of the 238 passengers and 5 crew on board, 8 were killed and over 200 injured, 11 critically."[1]

Philadelphia area hospitals and first responders were immediately engaged and responded heroically in treating and caring for these injured passengers. At Temple University Hospital, our Emergency Preparedness program was put to the test. Temple received more than 50 of the injured passengers. Twenty-three of those patients were considered traumas, requiring the highest levels of care.

Throughout the year our Emergency Preparedness Committee had conducted several tabletop exercises and ongoing training of our Emergency Department personnel involving mass casualty topics. It is very humbling and quite remarkable when an actual event such as this occurs and you put your training and planned actions into motion.

Immediately we activated our Emergency Command Center and called a Code White Level IV which evoked a cascade of both personnel and services that were set up. Our chief medical officer took the role of incident commander, taking charge of all response and recovery efforts at Temple University Hospital. Patient triaging, identification and leveling of injured passengers were the first priorities for staff and physicians. Additional physicians, nurses and technicians arrived at the hospital within 30 to 60 minutes of the code notification.

Our staff at all levels performed admirably. It was amazing to see and hear how triage was established, patients were evaluated, treatment plans determined and then carried out. A steady stream of patients arrived over the course of several hours and, within three hours, we had triaged and treated 57 patients. Every level of injury was seen, some minor, some major. What is equally remarkable is that our census that day was already at close to full capacity both on the inpatient side and in the Emergency Department.

When a tragedy such as this happens, of course your immediate attention goes to those injured and in need of treatment and care. However, as we learned, there is so much more that must be managed during these events. While you have called staff in to cover your needs for caring for the patients, preparing for and dealing with family members and friends looking for their loved ones; responding to reporters and the media; and coordinating with the authorities and other hospitals who are also dealing with the event are just a few of the many considerations with which you must be prepared to deal.

Overall, we feel that not only our facility but the entire Philadelphia medical community responded admirably to this tragic event. On June 23, 2015, Pennsylvania Secretary of Health Dr. Karen Murphy visited Temple University Hospital to present Certificates of Recognition to Temple and other area hospitals for the care, dedication and compassion we provided to the victims of the May 12 incident. Secretary Murphy offered commendation to the Temple University Hospital Main and Episcopal Campuses, as well as 11 other area hospitals for our roles in treating patients injured in the disaster.[2]

While we were pleased with the overall response and that our Emergency Preparedness training and exercises contributed to our success, there is always room for improvement. In the days following the incident, we began to meet in groups to debrief on what went well and what could have gone better.

What Went Well

- Triage set-up by the clinicians facilitated rapid assessment and assignment of care
- Response by physician, nursing, patient care assistants and other technicians to the Code call provided adequate staffing at all levels
- Leveling and movement of patients through the Emergency Department and into the hospital
- Triaging of family members and loved ones to a central location with continuous communication

Lessons Learned

Registration and patient identification is very important. First, it is vital to have patients registered to allow ordering of basic tests and medications. **Rapid registration techniques** help reduce bottlenecks in the patient care process. Second, developing patient rosters is vital for connecting patients with loved ones. In a mass casualty incident, family members may be transported to different facilities. Having a patient list and providing that list to the local emergency management agency will help unify families quickly.

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Incident Command Center

Lead personnel should wear identification vests delineating roles and follow the Hospital Incident Command System (HICS). Some are intimidated by HICS, however, the intuitive roles, job action sheets and forms make response easier than "winging it." Hospital leadership will continue to practice disaster situations using HICS to engrain the system in the culture of the organization. Exercising and educating leadership on HICS ensures its use in planned or unplanned events. A great way to start is through the use of tabletop exercises in which leadership can practice and discuss in an open environment.

Leadership should also take advantage of free education offered by the Federal Emergency Management Agency. The FEMA independent study program is a great place to start. (www.training.fema.gov/nims) The free, online program offers classes on HICS and other Emergency Management topics. FEMA offers free, in-person classes at their Center for Domestic Preparedness (https://cdp.dhs.gov/). The Healthcare Leadership for Mass Casually Incidents provides hospital leaders with practical, hands-on leadership training in a realistic atmosphere.

Decompression in the Emergency Department is vital. It is important to make room for inbound mass casualty patients and to ensure that the critical patients have inpatient beds available when needed. Leadership should do whatever possible to keep others out of the area by locking down the Emergency Department and by creating congregation spaces for friends and family in other areas of the facility. Having a space designated for these well-wishers also helps disseminate timely information and updates.

Mental and spiritual support for victims, families and staff is very important. Mass casualty incidents result in horrible physical traumas. However, the psychological traumas can last a lifetime. It is essential to have psychosocial support and interventions for the victims of mass casualty events. Leadership would be remiss to forget the staff and physicians caring for mass casualty victims. Support for staff should be provided well after an incident to assure the emotional needs of staff are met.

Having a mass casualty incident or any type of hospital emergency reminds us of the **importance of communication.** In terms of internal notifications, notify stakeholders as quickly as possible. Mass notification systems fill this need, but can be imperfect as many are passive notification systems. During off hours, a mass text may go unseen to leaders attempting a peaceful night's sleep. Mass notifications should be less passive and do as much as possible to get the attention of recipients. It is a great idea to conduct regular audits of the notification systems to make sure the right people are on the list. Besides the "who," regularly audit the "how" inventory of all of the forms of communication available to the organization. Some forms of communication you may want to inventory include:

- Emergency phone lines/phone systems
- Handheld transceiver (walkie talkie) system for backup communication
- Satellite phones
- Web-based communications
- Government Emergency Telecommunications System (GETS)
- Wireless Priority System (WPS)

We truly believe that Emergency Preparedness holds a vital role for every healthcare institution. The success or failure of your preparedness plan is in how seriously the institution embraces the notion of planning, training and arming with the necessary resources. At Temple, we believe that our training and preparation clearly contributed to the success of how we handled this tragedy. We also believe that it is imperative to address the lessons learned and re-train and prepare for the next time.

Resources

1 https://en.widipedia.org/wiki/2015_Philadelphia_train_derailment

2 Temple Talk Newsletter, Temple University Hospital, August 2015

Legal & Regulatory
Managing Risk in the Practice of Physical Therapy

By Peter Chidichimo, MS, PT

The Physical Therapy profession is not immune from claims and lawsuits arising from unwanted or unfortunate outcomes. The purpose of this article is to discuss these risks and to highlight real cases of recently filed claims and lawsuits.

Physical therapists are healthcare professionals who are dedicated to relieving pain, improving function and treating a variety of injuries through modalities, therapeutic activities, education and manual therapy. Today's PTs are also capable of and legally empowered to perform physical assessments on patients and arrive at a diagnostic impression, which forms the basis of an individually designed treatment plan. Physical therapists practice in hospitals, rehabilitation facilities, nursing homes, private offices, veterans hospitals, military installations, schools and patients homes. There are several specialties including cardiac rehabilitation, orthopedics and pediatrics.

Physical therapists are highly trained to deliver physical agents, which can include heat or cold, electrical stimulation, ultrasound, iontophoresis (the process of delivering a medicinal agent such as cortisone through the skin via an electrical current), light therapy (known as cold laser), traction and others. Since these applications are forms of energy coming in direct contact with a patient's skin, therapists must be acutely knowledgeable as to the risks of applying these physical agents, the correct technical application and, perhaps most important, the correct explanation to the patient (known as informed consent) and proper monitoring.

The use of thermal agents in physical therapy has existed since the early 1900s. Heat or cold applications can improve circulation, provide pain relief and reduce inflammation. However, the use of heat therapy carries the risk of a burn and caution is indicated. Therapists should be aware of any loss of sensation to the patient's skin before applying a thermal agent. In addition close supervision and even physical inspection are important for mitigation of risk when applying heat or cold therapy.

In a recent claim filed against a New York Hospital, the claimant is alleging she received second-degree burns after receiving physical therapy treatment. The patient claims she received electrical stimulation, followed by a cold pack and then an application of Biofreeze, which is a common pain relieving gel, containing camphor and menthol. The patient says she experienced a "burning and stinging" sensation immediately after the Biofreeze was applied, but the therapist ignored her. She went home and then to the Emergency Department, where she was diagnosed with a burn injury. This matter is currently pending.

The use of iontophoresis carries the specific risk of a chemical burn. This is because the medicinal agents used, be it cortisone, lidocaine, acidic acid and others, are transmitted transdermally via a direct current (DC), which is necessary to push the charged ions through the skin to the peripheral circulation. Iontophoresis is an excellent modality as a pain reliever or anti-inflammatory, but special caution is necessary to monitor the skin closely, usually through visual inspection mid-way through the treatment, which is typically 15-20 minutes duration. Additionally, patients should be instructed to report any sense of irritation immediately to the clinician.

Any person who has visited a PT or received physical therapy is fully aware of the use of therapeutic exercises, as part of an overall rehabilitation program. These programs are designed to achieve individualized goals, which may include muscle strengthening, improving ROM (range of motion), flexibility, balance, coordination or even sports specific programs, such as improving a golf swing or the ability of a receiver in football to leap when catching a pass. These programs are necessary to enable patients to return to work, sports or a specific activity of daily living (ADL). There is risk when patients are performing exercises as part of a PT program because PTs are licensed professionals and, unlike at the local fitness club, patients are under the care and supervision of a PT and therefore a legal standard exists. Patients should be properly screened to perform the program and correctly instructed including demonstration by the therapist or PT assistant, when indicated. When performing an exercise, patients should be closely monitored, which may include recording vital signs and observing for difficulty or fatigue. Simply watching and questioning the patient is usually sufficient. However, some patients hide their discomfort in an effort to be stoic. In addition, special populations, such as the elderly, the disabled and children, require special attention due to their inability to report their status accurately.

In one particular lawsuit filed in a New York State Supreme Court, the therapist was treating a patient who was recovering from a mild CVA with residual ankle weakness. The therapeutic exercise consisted of the patient standing on a balance board while playing catch with a 6-pound ball. On the third session of this activity, the patient failed to catch the ball cleanly, thus injuring her pinky finger. The injury turned out to be a fracture. A suit filed alleges the patient was improperly instructed and improperly supervised. The lawsuit remains pending.

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It is interesting to note several things when evaluating the above suit. First, the actual exercise was conducted under the supervision of a PT assistant, not the PT. This is perfectly acceptable as PTAs have two-year degrees and are trained to work under the supervision of licensed physical therapists. In these situations, the PT would have evaluated the patient and designed a treatment plan with specific goals. The PTA would then implement the program and manage the day-to-day care of the patient, under the supervision of the PT. That is what was done in this case. It is similar to the Physician/ PA relationship.

The second issue to consider is whether this treatment constitutes medical malpractice. When reviewing the records, we were able to glean that the patient was properly evaluated by the PT, had shown competency to perform this exercise in previous sessions and was being properly monitored by the PTA. It was a judgment call to choose this particular activity and justifiable in accordance with the patient's current condition and abilities. Based on the above, it would appear liability is not evident. However, once a suit is served, it must be defended and defending any lawsuit is expensive and time consuming. Many suits are settled before trial to control litigations costs.

Physical therapists that practice in the home care setting are responsible for teaching therapeutic exercises, transfers and ambulation to home bound patients. Instructions to the patient, family or caregiver should be clear, so the patient performs only activities previously practiced and approved by the PT, to avoid any confusion. It is usually best for the family or caregiver to practice an activity in the presence of the PT, before attempting an activity independently.

Another example of claims and suits that appear quite frequently are falls. Many such cases involve inpatients who attempt to transfer out of bed, or even ambulate, despite the fact they are on fall precautions. However, falls can also occur during physical therapy sessions involving transfer and ambulation training. Again, it is important to understand the patient's current condition, including medical history, prior function, body habitus, mental status, and compliance. Once the above factors are taken into account, the PT can begin the activity, using any available resources deemed appropriate, such as an assistant, safety belt, proper footwear for the patient, or an assistive device (walker or crutches). Patient tolerance should be taken into account. If a fall does occur, prompt assessment by nursing and a physician is indicated. Then the therapist should document the incident thoroughly, and cooperate with superiors as to any incident follow up management. The caregiver involved should not discuss the incident, or attempt to alter the record in any way. Risk management should contact the caregiver, and counsel them that a claim or lawsuit could be filed, and the caregiver possibly named and served. If that occurs, the caregiver should immediately contact risk management and arrange for representation. If the therapist is privately employed, he or she should immediately contact their carrier and report that a claim or suit has been filed. Having a suit or claim filed against you, whether named or not, is not in itself a declaration of liability, it is merely the opening volley that a plaintiff (patient) is of the opinion that something unfortunate or unexpected, has occurred, and they are seeking to be appropriately compensated. However, these suits and claims also serve a function for risk management, as a means to improve quality of care, and act preventively and proactively to mitigate risk and avoid costly litigation.

Physical therapists, who work in hospitals and nursing homes, frequently perform bedside therapeutic exercises to patients who are unable to transfer safely out of bed, and attend their sessions in the PT department. Usually this is due to some serious illness or disability. Treating these patients poses the inherent risk that these patients may be frail, may have joint contractures, may have metastatic disease, may be uncooperative, may be on isolation precautions, or even comatose. Therefore, as noted previously, careful chart review is indicated, to avoid the possibility of a pathologic fracture, infection or other unwanted event.

Perhaps the most common treatment performed by PTs is manual therapy, the hands-on component of what therapists do. Manuel therapy can include joint and spinal manipulation, soft tissue mobilization, stretching, massage and traction. It is considered the most skill oriented facet of PT practice, as it takes years of practice and continuing educations to become competent, or even certified, to perform it. Fortunately, this is not an area that seems vulnerable to unwanted events, although it is not without risk. Since manual therapy involves direct patient contact, it is somewhat intimate, and not all patients are amenable to direct contact. Like the above procedures, patients should be fully informed as to what to expect, whether they have received and tolerated manual therapy previously, and what the PT is attempting to accomplish. Another risk with manual therapy is joint damage or a fracture, which could occur if the therapy is applied incorrectly or with excessive force. Particular attention should be paid to cervical manipulation, where the nerves and blood vessels to the brain are somewhat superficial. However, when applied properly, the benefits of MT are significant, and the risks minimal.

The final areas to be discussed are privacy and documentation. The HIPAA (Health Insurance Portability and Accountability Act) applies to Physical Therapy practices, just as it does any other medical practice or facility. Practitioners and owners are

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ASHRM 2015 Annual Conference Notes

This year's Annual American Society for Healthcare Risk Management Conference was held in Indianapolis, Indiana, Oct. 18-21. Home of the legendary race track, it was an ideal location to spotlight the ASHRM 2015 Theme: Celebrating 35 Years of Driving Safe and Trusted Healthcare. Hospital Risk Management professionals from across the nation came together to immerse in the expertise and innovation of renowned keynote speakers and more than 70 education sessions led by the best in the business. As always it was an opportunity to network with colleagues and meet new RMs who share the same passion and dedication to patient safety. Here are a few reviews by those professionals who attended ASHRM 2015.

ERM Pre-conference
By Victoria Wiley – Pruitt, RN, MS, LHCRM, CPHRM

"Awesome, exciting, stimulating, knowledgeable, academic, professional, inspiring, fantastic, visionary, teamwork, collaboration, guidance" are just a few of the words to describe the Enterprise Risk Management Pre-conference.

Wow, what an awesome three-day experience! Each speaker was an expert in her or his field and all shared a broad and longitudinal base of knowledge and practice. The excitement and anticipation for the next speaker was always apparent as discussions about risk management transition, creating value, risk tolerance, risk appetite, collaboration and team communication dominated the room in discussion and interactive projects.

And wait, the session did not stop after three days, we have assignments to work on and submit in 30 days. Our group (each table was a designated group) decided to continue our projects as a team and we will be conferring with each other to discuss the progression of our assignments. Several days into the conference as our team met in the hallways going to our designated sessions, we smiled and greeted each other acknowledging our new friendships. I think this is the outcome the ASHRM leaders had in mind when developing the construct and the sessions for the conference. Looking forward to the next conference in Orlando, Florida, Sept. 25-28.

Keynote Panel – Preparing for What's Around the Next Bend
By Renee G. Wenger, JD, RPLU, CPHRM

The questions for the ASHRM Conference attendees prior to the Keynote Panel were: Why does one organization successfully withstand a crisis while another organization, facing the same calamity, is unable to weather the storm? And, how can risk managers help their own organizations overcome the inevitable crises in healthcare today?

In the keynote panel moderated by Ellen Grady Venditti, ASHRM President, the answers from the panel members were consistent: it takes preparation, collaboration, cooperation, communication and coordination.

Theresa Anderson was the senior vice president/chief nursing officer at West Jefferson Medical Center, Louisiana, when New Orleans and the surrounding towns flooded after Hurricane Katrina. Anderson shared how the staff cared for the patients and each other when there was no power, no water, no phone service and ultimately no access to supplies. The hospital employees lost loved ones, their homes and communication with their families but did not lose their will to care for the more than 300 patients in their hospital. Even after a decade, it was clear that the experience still evokes strong emotions from her.

Barry Wante, director of Emergency Management, Brigham and Women's Health Care, Boston, shared how the preparation and emergency response drills for the Boston Marathon saved lives. He added that there is community commitment to prepare for what's around the bend. While Boston still mourns the loss of three bystanders when the bombs exploded at the Boston Marathon in April 2013, none of the 264 injured lost their lives in the aftermath of the explosions. Unanticipated were the logistical challenges and the need to clarify expectations when Boston was put on lockdown while law enforcement searched for the bombing suspects.

Dr. Ramanathan Raju is the president and CEO of the New York City Health and Hospitals Corporation, the largest municipal healthcare system in the nation. Dr. Raju spoke of his strategies to address the politics, media response and community reaction to a patient with Ebola at one of the New York City hospitals. He provided a picture of the fears in the community and the challenges of providing transparency with information to dispel fear and anxiety while respecting patient privacy. With the patient's permission, Dr. Raju continually shared information with the multiple involved and interested constituencies. He was emphatic that science is not trumped by politics, and stressed the importance of internal communication and the value of visible leadership in times of crisis.

Michelle Hoppes, CEO, Michigan Professional Insurance Exchange and chair of the ASHRM ERM Committee, and Barbara McCarthy, enterprise risk officer, Beverly Hospital - a

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member of Lahey Health, ASHRM Board member and member of the ASHRM ERM Advisory Committee, provided insight on how the Enterprise Risk Management framework applies in preparing for what's around the bend. They stressed involving all levels of the organization when conducting an annual hazardous vulnerability assessment, using the risk ranking process to prioritize potential risks and thinking outside the box for potential vulnerabilities to be prepared for the unexpected.

All the panelists emphasized how critical visible leadership is; how risk managers need to be present and available, especially with crisis situations; how staff support after the initial crisis is critical for recovery; how you can never over communicate with all levels of staff; and how it is important to look out for each other. A cautionary note with internal debriefing is to not over debrief to protect staff from internalizing the experiences.

Other lessons learned shared by the panelists included the need to speak with one voice to provide consistent messaging and to minimize panic; to prioritize vulnerability hazards to include velocity, which is the speed of impact, as evidenced in the three situations faced by the panelists; and to employ enterprise risk management as a strategic thought process and tool to anticipate and prepare for the unexpected.

The final message expressed by each of the panelists is that we need to be prepared for a "new normal." We may not always know what's around the bend but through collaboration, communication, coordination and cooperation, we as Risk Managers WILL be prepared to help our organizations overcome the inevitable crises in healthcare today.

Conference Session - Increasing Accountability to Ensure Patient Safety
By Kelly J. Cameron, BSN, CPHRM
Clinical Risk Manager

The ASHRM 2015 conference, in the Hoosier State of Indiana, was a moment for Healthcare Risk Managers of all kinds to take a moment to enjoy a sense of camaraderie, while taking the opportunity to gain exposure to the rapidly changing business of Healthcare Risk Management. There were many excellent sessions at the conference. The following is a review of session M-12: Increasing Accountability to Ensure Patient Safety. The speaker, Emily Hoffman, MD, MBA, is the vice president of development and delivery for Vital Smarts.

The basis for this presentation is the assumption that professional work that centers on human error and patient safety looks continually at the gap between expected performance and actual performance. The presenter identified these seven crucial confrontations as the most common concerns people have about their colleagues: Competence, Poor Teamwork, Lack of Support, Disrespect, Micromanagement, Broken Rules and Mistakes. Increasing accountability to ensure patient safety was presented as a navigation tool that focuses on people's behavior rather than systems, processes or strategy.

Accountability
Influencing human behavior is a difficult undertaking. The chance of failure is high and patient safety can remain compromised. Effective influences don't zero in on outcomes but instead on the behaviors that enable or impair the desired outcome. Standard approaches to changing behaviors such as ignoring, intimidating, coercing, threatening or compelling are minimally affective. The first step in changing behaviors is accountability. Accountability for a performance can begin with a conversation that addresses the gap between expected performance and actual performance. The gap conversation can often create regret and defensiveness because people can feel unsafe about the intent of the conversation. People innately sense intent as well as a lack of respect. Hoffman presented the idea that people do not become defensive about what you're saying but why they think you are saying it; the intent of the message not the content. Influencing behavior change requires aligning the content with the intent of the message. Contrasting is a conversational technique used to establish this alignment. It involves describing the gap first (what you were expecting and what you are getting) and then asking what happened. This technique establishes a safe place for the person to speak about the gap in performance. Once the situation is discussed, then you can say what behavior you are expecting.

Influences
Influences are change strategies that can be utilized to change behavior to improve performance. There are a set of six influences that can be manipulated to affect behavioral changes. Hoffman explained that these influences can be used in all situations and are most effective if used congruently and in multiples. In fact, she presented data that reflected that if four or more influences were used at the same time, there could be an increase of 10 times the chance of success. The first four influences – values, skills, support and teamwork – all focus on individual behavior. The final two influences – incentives and structural ability (space, data, cues, tools and processes) – change the environment surrounding the person with the behavior. Interestingly enough, it is common to utilize incentives and structural ability influences independently to improve performance, leaving leadership wondering why the gap continues. Hoffman emphasized that the maximizing the effectiveness of influences relies heavily on using many of them at the same time, not sequentially.

Conclusion
Humans error and performance gaps will always exist. Healthcare Risk Managers have the opportunity to enlist some of the strategies and concept of behavioral science to get to the core of the undesired behaviors and decrease their occurrence. Many of these concepts fit nicely into corrective action plans following Root Cause Analysis where performance deviation played a strong role in the event. Hoffman did a wonderful job of presenting some insights into this body of knowledge that was both practical and, with some practice, relatively easy to master.

ASHRM Update

Valuable educational offerings, networking venues, exclusive patient safety publications, social media connections and exciting industry events are some of the benefits enjoyed by members of the American Society of Hospital Risk Management. Take a look at recent accomplishments and make note of upcoming opportunities.

ASHRM Academy 2016 – April 18-21, San Antonio, TX
Join healthcare risk management colleagues for a springtime retreat in the scenic hills of San Antonio. ASHRM Academy combines four days of educational activities with a rejuvenating getaway.

Build your expertise and work on healthcare risk management credentials in courses led by the most experienced and influential risk managers in healthcare. At the 2016 ASHRM Academy, the AHA Certification Center is partnering with ASHRM to offer a special administration of the Certified Professional in Healthcare Risk Management (CPHRM) certification examination. Find out more at the AHA Certification Center.

Rejuvenate your spirit the AAA Four Diamond award-winning La Cantera Hill Country Resort, a scenic vacation destination atop one of the highest points the San Antonio. When you're not in stimulating educational sessions, enjoy gourmet dining, five shimmering pools, the Castle Rock Spa, running trails and 36 holes of championship golf. You'll return to work refreshed and motivated with innovative ideas and an enhanced patient safety toolkit.

Monthly Webinars
ASHRM presents a live webinar each month. The final quarters of 2015 featured:

- August - Emergency Medical Treatment and Active Labor Act (EMTALA) Update 2015
- September- Dealing with Difficult People
- October - The Art of Consent Communication
- November - The Clinician and Staff Support Toolkit: Navigating your way to developing a Clinician and Staff Support Program
- December Moral Issues with Risk Management Implications

For information about the Jan. 14 webinar, Risky Contracts, featuring Alumine Bellone, MMHC, LHRM, CPHRM, CPHQ, ACA, director, Risk and Insurance Services, Broward Health. Feb. 27 is a sponsored webinar – Inspiration, Ideation, Action! An introduction to Design Thinking for Risk Managers by Simon Mawer, LLB, GCLP, assistant vice president, Risk Strategy & Design, The Risk Authority.

Mark your schedule for the Feb.12 webinar - Not Too Quick, Not Quick Enough: Getting Cesarean Delivery Safety Right and the March 10 webinar - How to Keep Lawyers from Circling Your Health System. Find out more at learning.ashrm.org.

ASHRM UNIVERSITY

New courses are continually added creating a growing resource of expertise and the latest information about timely topics of importance to risk managers and patient safety professionals. Monthly featured courses offer savings. ASHRM members get $30 off of the January Course of the Month – Emergency Medical Treatment and Labor Act (EMTALA) – 2015 Update. February's featured Course of the Month is Risk Management and Sleep Apnea in the Hospitalized Patient and March's is Neuroeconomics and Communication Science is Your "Secret Sauce" for Success with the C-Suite. For more information and to purchase a course of study, go to learning.ashrm.org.

ASHRM EXCHANGE

The ASHRM Exchange is a lively and important private forum for members to ask questions, share policies, recommend procedures, build a professional network of contacts, connect with others who share their specialties and plug into an entire healthcare risk management community. From policy queries to recommendations for products, what's on the minds of risk managers is available in this web-based forum exclusively for ASHRM members to connect and share resources and expertise with other healthcare risk management professionals. To access the Exchange, you must be:

- An active member of ASHRM
- Registered for the ASHRM website
- Logged in with an account that includes your member ID.

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ASHRM Career Connections
This online job source is exclusively dedicated to positions in patient safety and risk management fields. As hundreds of job opportunities are posted, potential employees and employers connect. New and highlighted positions are communicated to members weekly through an eblast.

Publications
To keep members up-to-date on industry trends, policies and techniques, ASHRM regularly adds new publications and revises Pearls and other vital sources of patient safety information. Here are a few of the organization's recent publications.

- Enterprise Risk Management Playbook
  Whether your organization has just begun the journey into Enterprise Risk Management or you wish to improve an established ERM program, ASHRM's new resource will prove indispensable to your success.

- Patient Safety Risk Management Playbook
  Gain the knowledge to promote an enterprise risk management program that enhances patient safety and demonstrates added value.

- Root Cause Analysis Playbook
  This playbook includes all of the leading RCA tools in one place, and instructions on the essential steps for responding to sentinel events.

- Risk Management Pearls: Insidious Intimidation
  Insidious intimidation is a subtle behavior that can lead to breakdowns in communication and actions, threatening patient safety.

- Risk Management Pearls: Informed Consent
  This Pearls edition will help risk managers communicate to risk partners the process, legal doctrine and regulations of informed consent.

- Now Available – the Updated CPHRM Exam Preparation Guide

ASHRM's CPHRM Exam Preparation Guide is updated and organized according to the most current Certification Exam Content Outline.

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advised to understand the law, to protect the patient's healthcare information, and maintain the appropriate documentation that the patient was advised that the HIPAA policy is in force. If information is to be released, then to whom and under what circumstances should be outlined. Business partners should be identified. Also, how and by what means patients are contacted is equally important. For example, leaving a voice mail message at a patient's home regarding MRI results may not be an acceptable means of communicating with some patients. How records are stored, physical or cloud based, should also be noted.

PT practices are governed by state statutes as to maintenance of records, including adult and children's records. Since PT patients are generally seen two or even three times per week, a note should be written for each encounter, and the patient re-evaluated on a regular bases. Medicare has been known to request progress notes on a patient, as do commercial insurers, including carriers who process workers compensation and no fault claims. This is due to the large incidence of fraud that occurs with these types of claims. This is equally true with Medicare and Medicaid claims. Writing a concise yet thorough note for every patient encounter, and maintaining and protecting the patient's privacy, will go a long way toward mitigation any risk in these areas. It is important to document a patient's measurable progress.

Canceled appointments and no-show visits should also be recorded, as this demonstrates patient compliance.

Physical therapists are valued members of the medical community, providing care to patients in need of pain relief, and rehabilitation, in a wide range of healthcare settings. However, PTs owe it to themselves, and their patients, to assess the risks associated with a particular practice and take the proper care to minimize these risks.

Peter Chidichimo is a Professional Liability Claims Specialist at Sedgwick, and a former PT who practiced for 28 years on Long Island, New York.

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The term "Sentinel Event" is not synonymous with medical error. Not all Sentinel Events arise from an error, and not all errors lead to Sentinel Events. Accredited healthcare organizations are required to define a Sentinel Event in a way consistent with The Joint Commission's definition. In cases in which the hospital is uncertain that there has been a Sentinel Event as defined by the Joint Commission, the event will be **presumed** to be a Sentinel Event.

For obstetrics, The Joint Commission considers "*severe maternal morbidity*" a Sentinel Event only if the outcome was unexpected in relation to the condition being treated. However, the definition of "severe maternal morbidity" has changed. The new definition from the American College of Obstetrics and Gynecology, the United State Centers for Disease Control and Prevention, and the Society of Maternal and Fetal Medicine replaced "*blood products*" with "RBCs."[3]

"*A patient safety event that occurs intrapartum through the immediate postpartum period (24 hours) that requires the transfusion of 4 or more units of RBCs (previously defined as blood products, such as fresh frozen plasma, packed red blood cells, whole blood, platelets) and/or admission to the ICU.*"[4]

There is some concern that defining giving blood or sending a patient to the ICU as a Sentinel Event will have a negative impact on reporting and patient care. However, the American College of Obstetrics and Gynecology, among others, has noted that the purpose of reviewing adverse outcomes is to learn and improve rather than to be punitive:

"*A culture of learning from adverse events, rather than a culture of blame and punishment, is critical to improving patient outcomes. We strongly encourage that all cases of severe maternal morbidity, whether Sentinel Events or not, undergo a thorough and credible multidisciplinary comprehensive review and analysis, resulting in an action plan for improvement, when appropriate.*"[5]

A reduction in maternal mortality has traditionally been used as a critical measure of progress in improving maternal health.[6] Yet maternal deaths have been described as the tip of the iceberg and maternal morbidity as the base.[7] For every woman who dies of pregnancy-related causes, 20 or 30 others experience acute or chronic morbidity, often with permanent sequelae that undermine their normal functioning. These sequelae can affect women's physical, mental or sexual health, their ability to function in certain domains…, their body image and their social and economic status. The true burden of maternal morbidity is still not known.[8] Perhaps changing the definition of a Sentinel Event will not only reflect our focus on patient safety and just culture, but also substantially contribute to the improvement of maternal health.

1 The Joint Commission. (2015, January). Comprehensive Accreditation Manual for Hospitals, Update 2. Sentinel Events. SE-1.

2 Id.

3 J. Habib. (2015, February 12). Sentinel Events and Severe Maternal Morbidity. ObGyn.net.

4 Id.

5 Severe Maternal Morbidity: Clarification of the New Joint Commission Sentinel Event Policy. (2015, January 28). ACOG News Releases.

6 Bulletin of the World Health Organization. (2013_. 91, 794-796

7 Id.

8 Id.

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drivers with a long record of crash-free driving and employees who report potential or actual driver safety issues.

Driver Training

There are several resources for driver education. Collaborate with your fleet insurance company for free or discounted education programs, such as defensive driving courses. Some elements to consider when evaluating or developing fleet education courses:

- ✓ clearly articulates "why" fleet safety is important
- ✓ defines your safe-driving culture
- ✓ offers tips on how to stay safe, stay focused and avoid aggressive driving[7]
- ✓ describes "what if strategy"
- ✓ defines following distance[8]
- ✓ defines delayed acceleration technique[8]
- ✓ describes how to avoid head on collisions using the National Safety Council's The four R's when trying to avoid a head-on collision[9]
- ✓ points out dangers of distracted driving[8,10]
- ✓ discusses determining tire pressure and how to avoid a tire blowout[8,11]

Summary

Building a comprehensive fleet safety program will help protect your organization value more than just insurance coverage and enhance your safety culture.

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