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Hospital Professional Liability
Claim Report 2015

STEPPING UP TO QUALITY HEALTHCARE AND PATIENT SAFETY

Part One Overview

Introduction

We at CNA are pleased to present our first hospital professional liability claim report. The report examines professional liability claims that closed over the 10-year period from January 1, 2005 through December 31, 2014. These closed claims were paid by CNA on behalf of organizations with professional liability coverage insured through the primary hospital program. Limiting the analysis to closed claims with significant indemnity payments permits us to highlight the types of serious adverse events that result in patient harm.

While the report derives certain lessons from the dataset, it is not intended to provide comprehensive risk management guidelines. CNA and professional organizations have published a wide variety of materials discussing various patient safety issues and related risk management recommendations. Professionals seeking detailed information on specific issues should refer to these publications.

Following this introduction and executive summary, Part Two focuses on the frequency and severity of various claim characteristics, including clinical service, location of the event, allegation, injury and related outcome. Part Three examines the 20 claims that incurred a $1 million indemnity payment. More in-depth analysis of selected topics and risk control recommendations are included in Parts Four and Five. We conclude with a brief discussion of emerging industry challenges and a self-assessment checklist to help organizations assess their strengths and identify opportunities for improvement.

Our objective is to enhance quality and patient safety by helping the industry understand and respond to current sources of risk exposures.

2015 Executive Summary

Actuarial projections indicate that the frequency of claims is remaining constant, based upon all claims incurring indemnity and/or expense payments in the CNA primary hospital program. While indemnity and expense payments have fluctuated over time, the ultimate severity of indemnity payments trended upward between 2005 and 2014, from an average of approximately $87,000 to $136,000.

The 591 closed professional liability claims included in this report incurred an average total paid amount (indemnity and expense) of $250,970. Most of the claims occurred on an inpatient medical unit, in the emergency department, or in surgical and invasive procedure areas. The most frequent allegations are related to treatment and care rather than assessment, monitoring or governance. In general, the allegations that incur the highest costs have low frequency. For example, while claims related to assessment, monitoring and governance are less common, their average total amount paid (i.e., overall cost) significantly exceeds the average total paid for other allegation classes. As anticipated, perinatal closed claims incurred the highest average indemnity and expense payments. Emergency department claims range considerably in terms of severity, with half of the claims having a paid indemnity under $100,000. Perinatal and emergency medicine clinical services are each associated with six of the 20 closed claims that incurred a $1 million indemnity payment.

Close examination of specific allegations reveals the continuing need for vigorous attention to such issues as communication, credentialing and privileging, medication safety, patient falls and pressure ulcers. As noted in Part Six, many industry challenges outside the scope of this claim report are emerging and creating new demands on leadership and providers.

Part Two General Review and Analysis of Closed Claims

Dataset and Methodology

The dataset was limited to professional liability claims that met the following criteria:

- The claim involved care that was provided in a hospital and/or its affiliated ambulatory care facilities.
- The claim closed between January 1, 2005 and December 31, 2014, regardless of when the claim was first reported or initiated.
- The claim resulted in an indemnity payment between $10,000 and $1 million, which was paid by CNA on behalf of a client.

These criteria produce a dataset of 591 closed claims with an average total paid amount of $250,970. Unless otherwise specified, the denominator in graphs and charts is 591.

The dataset excludes closed claims with an indemnity payment of less than $10,000, as well as claims from long term acute care hospitals (LTACHs), home health services and hospital-affiliated aging services communities. Also excluded were other claims that would not fall under hospital professional liability.

The following chart summarizes the claims occurring during the indicated 10-year period that are not included in the dataset:

1

EXCLUDED CLAIMS BY CATEGORY

* These include the non-hospital claims noted above.

Category of excluded claims	Number of excluded claims	Percentage of excluded claims	Total paid by CNA
Indemnity of > $1M	5	0.1%	$10,541,263
No payment	7,421	79.6%	$0
Paid expense only	1,111	11.9%	$21,878,320
Indemnity of < $10,000	556	6.0%	$2,798,235
Other excluded claims*	222	2.4%	$32,855,415
Total	9,315	100.0%	$68,073,233

The following inherent limitations to the dataset should be noted:

- The dataset includes only CNA-insured hospitals and affiliated ambulatory care facilities.
- All claims were paid under a primary professional liability policy.
- Indemnity and expense payments include only monies paid by CNA on behalf of its insureds. Self-insured retentions and other possible sources of payment in response to a claim cannot be determined, and therefore, are not included in this report.
- In general, the per-claim limit of liability for CNA primary professional liability is $1 million, which is why this figure serves as the upper limit of the dataset. Note that payments may exceed $1 million for clients who purchase both primary and excess coverage.
- Resolving malpractice claims may take many years. For this reason, inclusion criteria is based upon when the claim closed, regardless of when the incident occurred.

Definitions

The following terms are defined as they are utilized specifically for the purposes of this report:

- **Average total paid:** Indemnity plus expense costs, divided by the number of closed claims.
- **Book of business:** The number of insured beds.
- **Clinical service of the patient:** The discipline primarily responsible for the care and treatment of the patient. For example, if the patient is admitted to the medicine service and the event involves radiology staff or providers, it is categorized as the medicine service.
- **Emotional distress/pain and suffering:** Injuries that produce psychological rather than physical harm or impairment, such as an allegation of inappropriate contact by a provider.
- **Expense payment:** Monies paid by CNA in the investigation, management and/or defense of a claim.
- **Frequency/distribution:** The percentage of closed claims with a common attribute, such as a specific allegation or injury.
- **Improper care/treatment:** Failure to follow an established plan, reasonable standard of care, or organizational policy and procedure.
- **Indemnity payment:** Monies paid by CNA on behalf of an insured to resolve a claim.
- **Location:** The healthcare setting or unit where an event occurs.
- **Patient:** A person receiving care in a hospital or affiliated ambulatory care facility.
- **Permanent injury:** An irreversible change in the patient's health status or ability to function. For example, emotional distress is frequently considered to be a permanent injury.
- **Severity:** The amount paid by CNA for a closed claim.
- **Temporary injury:** Pain or impairment that lasts a limited period of time, after which the patient returns to baseline functioning.

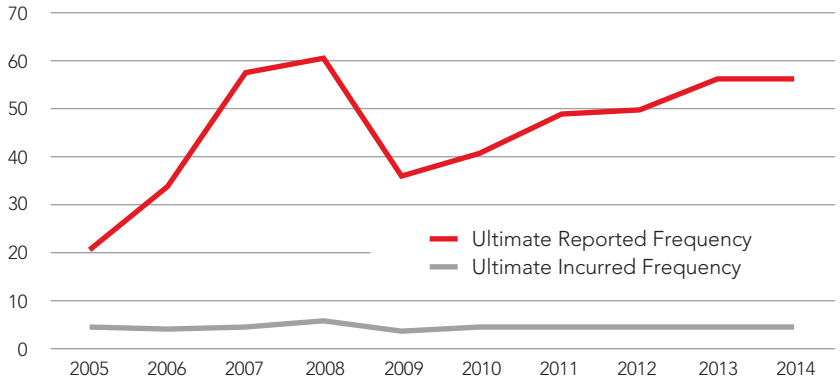
Distribution of Closed Claims

In order to more clearly capture trends in severity, the following discussion uses its own, distinct dataset, which includes a 10-year timeframe and no minimum value for claims. *Reported* claims are all claims reported to CNA, including those that result in no payment. *Incurred* claims are only those reported claims that result in an indemnity and/or expense payment. Ultimate claim counts and ultimate severity are projected using actuarial methods based upon historical development patterns.

- The ultimate *reported* frequency has fluctuated between 21 and 56 claims per thousand beds, while the ultimate *incurred* frequency has remained constant over the past 10 years. This difference reflects the fact that many reported incidents never develop into claims (see Figure 2).
- Both indemnity and expense payments have fluctuated in terms of ultimate severity over the past 10 years. Ultimate indemnity payments, on average, have trended upward from approximately $87,000 to $136,000 (see Figure 3).
- Of the 591 closed claims in the dataset, almost half (48.2 percent) have indemnity payments under $100,000 (see Figure 4).
- Only a small proportion of the claims (7.0 percent) have an indemnity payment at the upper end of the scale, between $750,000 and $1 million (see Figure 4).

2

DISTRIBUTION OF CLAIMS PER THOUSAND BEDS BY ACCIDENT YEAR



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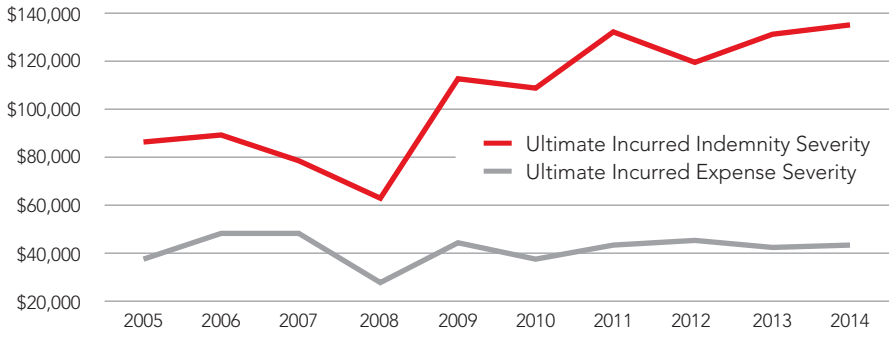
DISTRIBUTION OF CLAIMS ULTIMATE AVERAGE SEVERITY BY ACCIDENT YEAR



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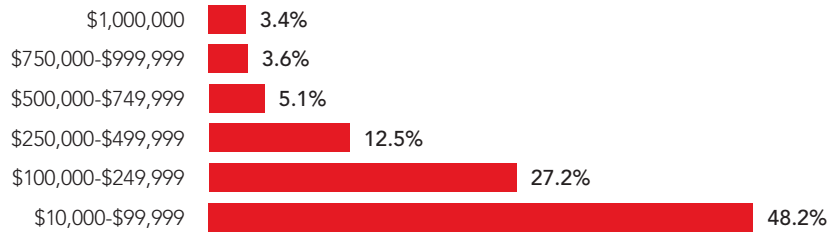
FREQUENCY OF CLOSED CLAIMS BY PAID INDEMNITY



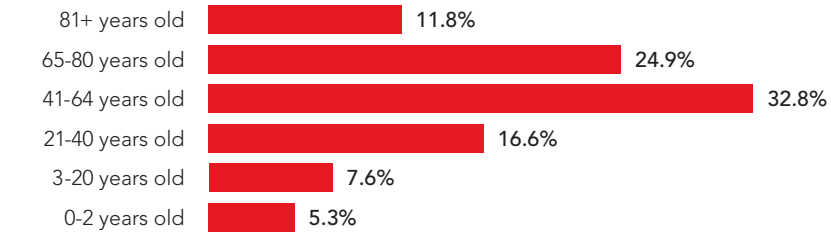
Claimant Age

- Claimants between 41 and 64 years of age incur the highest percentage of claims.
- The costliest claims involve children from birth to 2 years of age.

5

FREQUENCY OF CLOSED CLAIMS BY CLAIMANT AGE*

* The graph excludes the 1 percent of claims with no age-related information.



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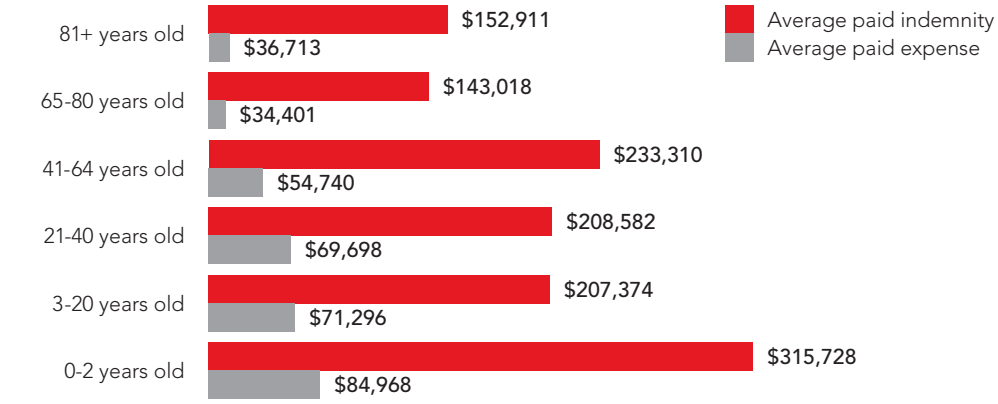
AVERAGE PAID FOR CLOSED CLAIMS BY CLAIMANT AGE*

* The graph excludes the 1 percent of claims with no age-related information.



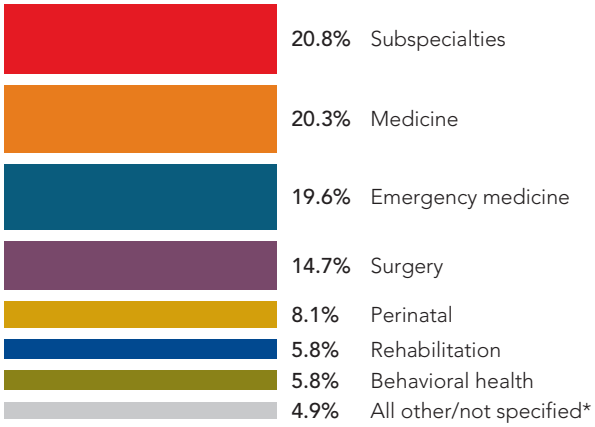
Clinical Service

- *Subspecialties* refer to a cluster of clinical services, including cardiology, gastroenterology, gynecology, hospice, neurology/neurosurgery, oncology, orthopedic surgery, otolaryngology, pediatric, plastic/reconstructive surgery, radiology and urology/nephrology.
- Subspecialties, medicine and emergency medicine comprise the highest percentage of claims in the report.
- Claims involving perinatal or behavioral health patients have a significantly greater average total paid than the overall dataset average.
- Rehabilitation services demonstrate relatively low frequency and severity.

7

FREQUENCY OF CLOSED CLAIMS BY CLINICAL SERVICE

* "All other/not specified" includes sleep study and critical care claims, as well as claims with no specified clinical service.



8

AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY CLINICAL SERVICE

* "All other/not specified" includes sleep study and critical care claims, as well as claims with no specified clinical service.

Clinical service	Average paid expense	Average paid indemnity	Average total paid
Perinatal	$95,382	$320,097	$415,479
Behavioral health	$67,636	$232,520	$300,156
Surgery	$42,193	$222,205	$264,398
Medicine	$51,297	$212,160	$263,457
Emergency medicine	$69,816	$190,238	$260,054
Critical care	$34,697	$169,357	$204,054
Subspecialties	$39,118	$158,397	$197,515
Rehabilitation	$28,066	$125,694	$153,760
All other/not specified*	$11,515	$99,438	$110,953
Overall	$52,563	$198,407	$250,970

Location

For the purposes of this report, the location identifies the setting or unit where the event occurred.

- In most cases, clinical services are consistent with locations. For example, 96.7 percent of medicine patients are located on the inpatient medical unit or in ambulatory care - nonsurgical at the time of the event.
- Analysis of exceptions reveals only one claim where location may have played a significant role in the serious adverse event.
- The most frequent locations where events occur include inpatient medical units, emergency departments and perioperative areas. Perioperative locations include pre-operative/pre-procedure areas, operating suites, invasive procedure rooms, post-anesthesia care units and ambulatory surgery centers.
- Perinatal units (including antepartum, labor and delivery, and postpartum), critical care units, and inpatient behavioral health hospitals or units have significantly higher average total payments in comparison with the overall average.

9

FREQUENCY OF CLOSED CLAIMS BY LOCATION

* "All other" includes subacute care hospital units, internal hallways, patient rooms, nurseries and pediatric units, as well as claims with no distinguishing location.

Location	Percentage of closed claims
Inpatient medical unit	18.8%
Emergency department	18.1%
Perioperative areas	15.7%
Inpatient surgical unit	10.0%
Perinatal unit	7.6%
All other*	6.8%
Ambulatory care - nonsurgical	4.6%
Radiology/laboratory/therapy	4.4%
Inpatient behavioral health hospital/unit	4.2%
Outdoor space	3.5%
Rehabilitation hospital/unit	3.4%
Critical care units	2.9%
Total	100.0%

10

AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY LOCATION

* "All other" includes subacute care hospital units, internal hallways, patient rooms, nurseries and pediatric units, as well as claims with no distinguishing location.

Location	Average paid expense	Average paid indemnity	Average total paid
Perinatal unit	$101,708	$338,097	$439,805
Critical care units	$59,818	$290,222	$350,039
Inpatient behavioral health hospital/unit	$71,091	$242,987	$314,077
Inpatient surgical unit	$49,851	$233,959	$283,810
Emergency department	$75,310	$201,569	$276,879
Ambulatory care - nonsurgical	$41,347	$225,907	$267,254
Inpatient medical unit	$55,106	$202,513	$257,619
Perioperative areas	$30,521	$162,361	$192,882
All other*	$35,630	$147,793	$183,423
Radiology/laboratory/therapy	$21,657	$123,415	$145,071
Rehabilitation hospital/unit	$20,045	$92,450	$112,495
Outdoor space	$11,136	$48,417	$59,553
Overall	$52,563	$198,407	$250,970

By knowing the events most commonly associated with professional liability claims, providers and leadership teams can implement more effective preventive measures.

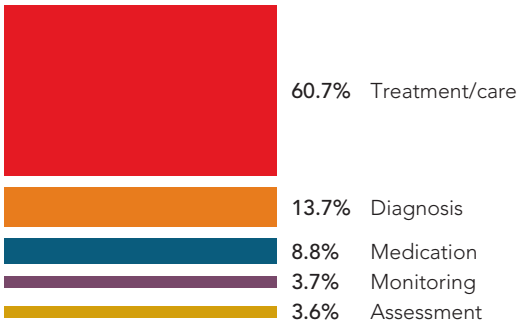
Allegation

Hospitals, like all other healthcare entities, face ongoing challenges in providing high-quality, cost-effective care. By knowing the events most commonly associated with professional liability claims, providers and leadership teams can implement more effective preventive measures.

- For the purposes of this report, *allegation* refers to the primary reason that the plaintiff brought legal action against the insured. *Diagnosis* is defined as a conclusion based upon information compiled during assessments. Diagnosis-related allegations include delay in diagnosis, misdiagnosis or failure to diagnose. *Monitoring* allegations include events where the staff failed to watch for changes for an identified condition. *Treatment/care* allegations refer to negligence in performing specific interventions and/or failure to appropriately manage patient services. *Governance* allegations include issues related to credentialing, privileging and supervision.
- Treatment/care allegations are the most frequent.
- Assessment allegations experienced the highest severity, due in part to one claim with an unusually high expense payment.

11

MOST FREQUENT CLOSED CLAIMS BY ALLEGATION CLASS



12

HIGHEST AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY ALLEGATION CLASS

Allegation class	Average paid expense	Average paid indemnity	Average total paid
Assessment	$165,387	$365,087	$530,474
Monitoring	$60,710	$374,774	$435,485
Governance	$58,545	$282,955	$341,499
Diagnosis	$76,189	$243,900	$320,089
Communication	$40,349	$231,178	$271,527

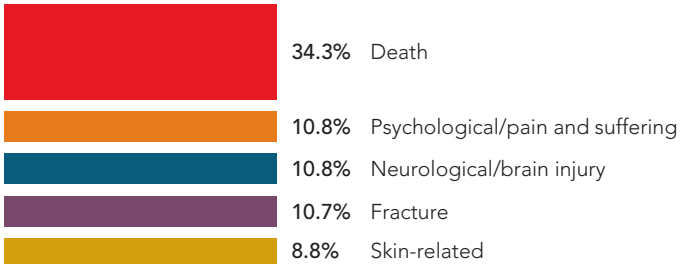
Injury

As with allegations, knowledge of common and high-severity injuries can help providers and leadership identify areas of greatest exposure and enhance the effectiveness of quality, patient safety and risk management programs.

- Death is the most common injury, accounting for 34.3 percent of all closed claims.
- On average, neurological injuries are significantly costlier than the claim dataset as a whole.
- Laceration includes cuts, tears, abrasions and perforations. The average total paid reflects more serious injuries, including lacerations to arteries, tendons and organs.
- Skin-related injuries include bruises, burns, pressure ulcers and other wounds.

13

MOST FREQUENT CLOSED CLAIMS BY INJURY



14

HIGHEST AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY INJURY

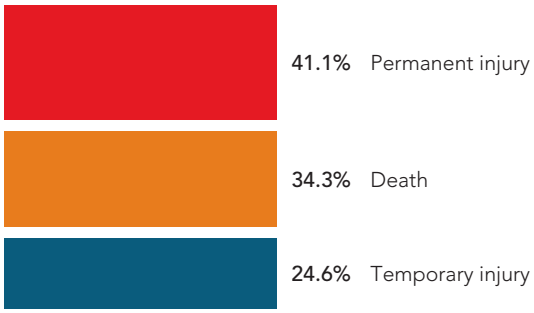
Injuries	Average paid expense	Average paid indemnity	Average total paid
Neurological/brain injury	$109,498	$442,031	$551,529
Death	$66,266	$254,709	$320,975
Loss/use of organ	$81,178	$188,962	$270,139
Laceration	$59,951	$145,974	$205,925
Infection	$42,585	$139,338	$181,923

Outcome of Injury

Analysis of outcomes illustrates the impact of injuries on patients and families, which in turn influences indemnity payments.

- Permanent injury is the most common outcome, comprising 41.1 percent of all closed claims.
- Death has the highest average total paid.
- The average total paid for permanent injury is influenced by the wide range of disabilities that may result from an injury, including significant emotional distress and neurological deficits.

15
FREQUENCY OF CLOSED CLAIMS BY OUTCOME OF INJURY



16
AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome	Average paid expense	Average paid indemnity	Average total paid
Death	$66,266	$254,709	$320,975
Permanent injury	$59,867	$211,534	$271,401
Temporary injury	$21,141	$97,585	$118,726
Overall	$52,563	$198,407	$250,970

Permanent injury is the most common outcome, comprising 41.1 percent of all closed claims, while death has the highest average total paid.

Allegations Related to Patient Death

- Overall improper care allegations represent 23.6 percent of patient deaths. These allegations include delay in treatment; delay in transfer or failure to transfer the patient to a higher level of care, either internally or externally; failure to follow clinical pathway or treatment protocol; failure to follow organizational policy and procedure; failure to invoke chain of command; hospital-acquired pressure ulcers; and multiple issues with the provision of care.
- Credentialing and privileging allegations have the highest average total payment. These allegations include issues with impaired providers, qualifications for specific surgical procedures and general competency of providers.

17

MOST FREQUENT CLOSED CLAIMS BY ALLEGATIONS RELATED TO PATIENT DEATH

Percentage of 203 death-related closed claims

23.6%	Overall improper care
15.8%	Diagnosis
12.3%	Medication
11.8%	Assessment and monitoring
9.9%	Patient falls

18

HIGHEST AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY ALLEGATION RELATED TO PATIENT DEATH

Allegation	Average paid expense	Average paid indemnity	Average total paid
Credentialing and privileging	$20,569	$568,750	$589,319
Assessment and monitoring	$95,308	$363,265	$458,573
Nursing-related care	$78,538	$346,815	$425,353
Perioperative event	$63,563	$293,211	$356,774
Medication	$68,601	$267,455	$336,056

Cause of Death

- Cardiopulmonary arrest includes acute myocardial infarctions and medication-related cardiopulmonary arrests, as well as other deaths for which details could not be verified.
- Comorbidities refer to pre-existing health issues that contributed to the patient's death.
- One claim, which incurred a $1 million indemnity payment, involves death resulting from trauma sustained in a motor vehicle accident.
- The most frequent locations where the arrest occurred are emergency department examination rooms, labor and delivery units, inpatient medical units, critical care units and inpatient surgical units.

19

MOST FREQUENT CLOSED CLAIMS BY CAUSE OF DEATH

Percentage of 203 death-related closed claims

35.5%	Cardiopulmonary arrest
16.7%	Infection/sepsis
13.3%	Comorbidities
10.3%	Internal bleed/hemorrhage
6.9%	Head injury

20

HIGHEST AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY CAUSE OF DEATH

Cause of death	Average paid expense	Average paid indemnity	Average total paid
Trauma	$74,093	$1,000,000	$1,074,093
Anaphylactic shock	$20,514	$725,000	$745,514
Fracture	$101,588	$332,500	$434,088
Aspiration pneumonia	$24,850	$387,500	$412,350
Internal bleed/hemorrhage	$86,325	$306,357	$392,681

21

MOST FREQUENT CLOSED CLAIMS BY LOCATION OF CARDIOPULMONARY ARRESTS

Percentage of 72 closed claims

22.2%	Emergency department - examination room
16.7%	Labor and delivery unit
15.3%	Inpatient medical unit
8.3%	Critical care units
8.3%	Inpatient surgical unit

Part Three Analysis of Closed Claims with $1 Million Indemnity Payment

Summary	Allegation Class	Injury	Clinical Service
1. A patient presented to the hospital's crisis center, after which the physician recommended that she be admitted to an inpatient behavioral health hospital. Neither the staff nor the physician assessment revealed signs of lithium toxicity. Therefore, lab tests were ordered as routine. Admission to the behavioral health hospital was delayed due to lack of inpatient beds. While awaiting admission, the patient was monitored appropriately, based upon initial assessments. The critical issue is related to staff failure to detect lithium toxicity, even as the patient's neurological status was deteriorating. After being admitted to the behavioral health hospital, her condition was diagnosed and she was transferred to an acute medical hospital. The lithium toxicity resulted in toxic encephalopathy.	Assessment	Brain injury	Behavioral health
2. The patient was evaluated in the ED three separate times and discharged home after complaints of progressive back pain. Later, at another facility, she was diagnosed with a spinal epidural abscess and underwent surgical intervention. The ultimate outcome was paraplegia.	Diagnosis	Paralysis	Emergency medicine
3. During hip surgery, the patient experienced a cardiac arrest and was resuscitated. An endotracheal tube was inserted. In the ICU, poor oxygenation was noted and a chest X-ray was ordered. There was a delay in performing and reviewing the chest X-ray, which revealed that the endotracheal tube had been positioned incorrectly. The patient sustained anoxic brain damage and is permanently disabled.	Treatment/care	Brain injury	Subspecialties
4. A newborn was identified as at high risk for hyperbilirubinemia. The physician ordered additional diagnostic tests and was notified of the positive test result, but took no action prior to discharging the newborn home. The infant returned to the hospital with symptoms of bilirubin toxicity and was diagnosed with kernicterus, resulting in cerebral palsy.	Treatment/care	Brain injury	Perinatal
5. After a lengthy hip revision procedure, the patient experienced decreased perfusion to his leg. A Doppler study was ordered stat, but it was not performed for several hours. The patient developed compartment syndrome, resulting in an above-the-knee amputation.	Treatment/care	Amputation	Subspecialties
6. The physician did not appropriately follow up with the patient after receiving a CT scan report. The delay in diagnosis resulted in a worse prognosis, and the patient required additional surgery and chemotherapy.	Diagnosis	Increase or exacerbation of illness	Emergency medicine
7. During a laparoscopic cholecystectomy, the patient suffered an injury to an artery, resulting in extensive bleeding, multiple gastrointestinal complications and additional surgeries.	Treatment/care	Laceration/ tear/abrasion	Surgery
8. The patient arrested and died after a ventral hernia repair. The autopsy revealed a titanium clip in the pericardium.	Treatment/care	Death	Surgery
9. The patient was evaluated in the ED and determined to meet the criteria for involuntary commitment. While waiting for admission, she eloped and could not be found. Soon after, she was struck by a car and sustained fatal injuries.	Monitoring	Death	Emergency medicine
10. The patient was admitted for induction of labor and placed on electronic fetal monitoring. As labor progressed, hyperstimulation and several episodes of late decelerations were observed. However, nurses did not document that they notified the physician of these findings. The baby was delivered by Cesarean section and diagnosed with hypoxic brain injury.	Communication	Fetal/infant birth-related brain injury	Perinatal

Summary	Allegation Class	Injury	Clinical Service
11. The patient presented to the ED with a life-threatening traumatic chest injury. He arrested, was intubated and later died. Autopsy results revealed improper endotracheal tube placement in the esophagus.	Treatment/care	Death	Emergency medicine
12. The patient was admitted for induction of labor. As labor progressed, nurses observed late decelerations and notified the physician, who took no action. There is no indication that the chain of command was invoked. An emergent Cesarean section was performed, revealing a complete abruption and uterine rupture. The baby was diagnosed with hypoxic ischemic encephalopathy.	Treatment/care	Fetal/infant birth-related brain injury	Perinatal
13. The patient experienced bleeding following thyroglossal tumor surgery. She was evaluated in the ED by a mid-level provider, who discharged her home with pain medicine. Shortly afterward, she returned to the ED in respiratory distress, was resuscitated and taken to surgery for control of active bleeding. The patient sustained significant brain injury.	Diagnosis	Brain injury	Emergency medicine
14. A patient presented for a sleep study. Contrary to protocol, the technician failed to notify the physician of the patient's abnormal vital signs and low oxygen saturation levels. The patient was given Ambien. As a result of this failure to follow protocol, the patient later experienced a cardiac arrest. Following resuscitation, she was diagnosed with a stroke. During the discovery process, it was revealed that the sleep study videotape had been erased, leading to a claim of spoliation of evidence.	Treatment/care	Stroke	Other
15. The patient presented to the ED with complaints of respiratory distress, heaviness in his arms and stress at home. Following a chest X-ray, the patient was incorrectly diagnosed with pneumonia and discharged home. The patient returned to the ED a few hours later in cardiac arrest and died.	Diagnosis	Death	Emergency medicine
16. After an uneventful labor and vaginal delivery, the nurse noted that the baby was not breathing and initiated resuscitation efforts. However, as there was no process for calling a neonatal resuscitation team, the nursing staff had to call for anesthesia, respiratory and other providers individually. The baby was transferred to another hospital, having been diagnosed with brain damage and seizures.	Treatment/care	Brain injury	Perinatal
17. The patient was admitted for a scheduled delivery and was administered epidural anesthesia. Afterward, the patient experienced respiratory distress, which the staff failed to recognize in a timely manner. An emergency Cesarean section was performed. The infant was diagnosed with hypoxic ischemic encephalopathy and spastic cerebral palsy.	Monitoring	Fetal/infant birth-related brain injury	Perinatal
18. A patient who was a poor historian presented to the ED for treatment of an infection and was admitted to the hospital. His history of allergies was discussed. Based on his statement that he was not allergic to a specific antibiotic, the reference to the allergy was removed from the electronic medical record. The antibiotic was prescribed, dispensed and administered, resulting in a fatal anaphylactic reaction.	Medication-related	Death	Medicine
19. The patient called the labor and delivery unit multiple times to report decreased fetal movement, but staff failed to tell her to come immediately to the hospital. After the patient was admitted, the nurses observed non-reassuring fetal heart rate tracings, but they neglected to promptly notify the physician of the need to assess the patient. Several hours later, the physician determined that a Cesarean section should be performed, but did not assess the situation as emergent. The delayed diagnosis of placental abruption resulted in the infant having cerebral palsy.	Diagnosis	Fetal/infant birth-related brain injury	Perinatal
20. The patient underwent spine surgery, which resulted in partial paralysis. The primary allegation in the lawsuit was "malicious credentialing," based upon prior acts of the surgeon.	Governance - credentialing	Paralysis	Surgery

Part Four Analysis of Clinical Services and Locations

Perinatal Closed Claims

There are 48 perinatal closed claims, with an average total paid of $415,479. Minimizing perinatal harm should remain an area of emphasis for providers and hospital leadership.

Perinatal Allegations

In order to highlight significant exposures and facilitate analysis, the perinatal allegations are grouped into four categories:

Category 1: Failure to Intervene

- Category 1 represents the large majority of perinatal claims, resulting from failure to intervene or take action during the labor process or immediate postpartum period. Failure to intervene includes both general and specific allegations, which are enumerated because they illustrate key problems in providing perinatal care. The treatment/care - other allegation reflects two claims so unusual that providing any detail may breach confidentiality.
- Of the specific allegations in category 1, mismanagement of labor - other comprises the highest frequency. These claims involve multiple serious adverse events, such as multiple delays and/or failures by both nursing and medical staff, assessment and communication issues, inappropriate use of forceps or vacuum, and/or improper use of induction.
- Of the specific allegations in category 1, delay in treatment reflects the highest severity. Delay in treatment allegations include failure to perform neonatal resuscitation when respiratory distress was assessed.

Category 2: Failure to Identify or Diagnose Condition

- Category 2 represents the highest severity. It includes allegations of delay in identification of fetal distress, delay in diagnosis of placental abruption and failure to diagnose/misdiagnosis.
- The specific allegation in category 2 with the highest frequency and severity is delay in identification of fetal distress.

Category 3: Quality of Care and Category 4: Other

- The percentage of claims in categories 3 and 4 is small, and the severity is significantly lower compared with other categories.
- Category 3 includes improper technique or negligent performance of an obstetrical treatment or intervention by a provider, as well as improper nursing technique or performance of care.
- Category 4 includes three allegations involving specimen management, informed consent, and failure to follow policy and procedure.

22

FREQUENCY OF CLOSED CLAIMS BY CATEGORY OF PERINATAL ALLEGATIONS

Percentage of 48 perinatal closed claims

70.8% Category 1: failure to intervene

14.6% Category 2: failure to identify or diagnose condition

8.3% Category 3: quality of care

6.3% Category 4: other

23

AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY CATEGORY OF PERINATAL ALLEGATIONS

Allegation category	Average paid expense	Average paid indemnity	Average total paid
Category 2: failure to identify or diagnose condition	$70,925	$555,714	$626,640
Category 1: failure to intervene	$117,022	$328,158	$445,180
Category 3: quality of care	$25,562	$53,750	$79,312
Category 4: other	$285	$34,103	$34,388
Overall	$95,382	$320,097	$415,479

Minimizing perinatal harm should remain an area of emphasis for providers and hospital leadership.

24
FREQUENCY OF CLOSED CLAIMS BY CATEGORY 1: FAILURE TO INTERVENE

Allegation	Percentage of 48 perinatal closed claims
Mismanagement of labor - other	33.3%
Delay in delivery of fetus	10.3%
Improper/untimely management of obstetrical patient	8.3%
Failure to timely report complication of pregnancy/labor	4.2%
Treatment/care - other	4.2%
Failure to maintain infection control	4.2%
Failure to invoke chain of command	2.1%
Delay in treatment of neonate	2.1%
Delay in managing change in maternal condition	2.1%
Category total	70.8%

25
AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY CATEGORY 1: FAILURE TO INTERVENE

Allegation	Average paid expense	Average paid indemnity	Average total paid
Delay in treatment of neonate	$15,416	$1,000,000	$1,015,416
Failure to timely report complication of pregnancy/labor	$30,686	$725,000	$755,686
Delay in delivery of fetus	$194,686	$426,038	$620,724
Mismanagement of labor - other	$133,395	$308,438	$441,833
Failure to invoke chain of command	$94,834	$325,000	$419,834
Improper/untimely management of obstetrical patient	$138,268	$195,417	$333,684
Treatment/care - other	$49,142	$187,750	$236,892
Delay in managing change in maternal condition	$38,569	$125,000	$163,569
Failure to maintain infection control	$4,728	$17,506	$22,233
Category overall	$117,022	$328,158	$445,180

26
FREQUENCY OF CLOSED CLAIMS BY CATEGORY 2: FAILURE TO IDENTIFY OR DIAGNOSE CONDITION

Allegation	Percentage of 48 perinatal closed claims
Delay in identification of fetal distress	8.3%
Delay in diagnosis of placental abruption	4.2%
Failure to diagnose or misdiagnosis	2.1%
Category total	14.6%

27
AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY CATEGORY 2: FAILURE TO IDENTIFY OR DIAGNOSE CONDITION

Allegation	Average paid expense	Average paid indemnity	Average total paid
Delay in identification of fetal distress	$106,511	$657,500	$764,011
Delay in diagnosis of placental abruption	$35,218	$600,000	$635,218
Failure to diagnose or misdiagnosis	$0	$60,000	$60,000
Category overall	$70,925	$555,714	$626,640

28
FREQUENCY OF CLOSED CLAIMS BY CATEGORY 3: QUALITY OF CARE PROVIDED

Allegation	Percentage of 48 perinatal closed claims
Improper technique/performance obstetrical care	6.2%
Improper nursing technique/performance of care	2.1%
Category total	8.3%

29
AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY CATEGORY 3: QUALITY OF CARE PROVIDED

Allegation	Average paid expense	Average paid indemnity	Average total paid
Improper technique/performance obstetrical care	$34,082	$68,333	$102,415
Improper nursing technique/performance of care	$0	$10,000	$10,000
Category overall	$25,562	$53,750	$79,312

30
FREQUENCY OF CLOSED CLAIMS BY CATEGORY 4: OTHER ISSUES

Allegation	Percentage of 48 perinatal closed claims
Specimen issue	2.1%
Lack of informed consent	2.1%
Failure to follow policy and procedure	2.1%
Category total	6.3%

31
AVERAGE TOTAL PAID FOR CLOSED CLAIMS BY CATEGORY 4: OTHER ISSUES

Allegation	Average paid expense	Average paid indemnity	Average total paid
Lack of informed consent	$0	$80,308	$80,308
Failure to follow policy and procedure	$855	$12,000	$12,855
Specimen issue	$0	$10,000	$10,000
Category overall	$285	$34,103	$34,388

Permanent injury is the outcome with the highest frequency and severity across all perinatal categories.

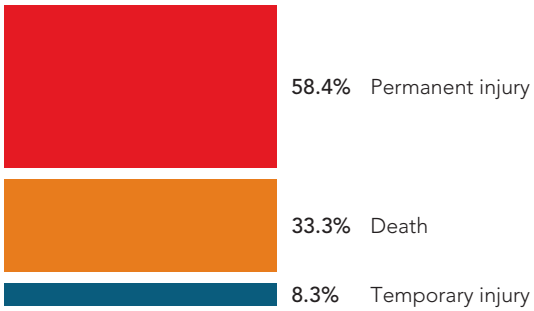
Outcome of Perinatal Injury

- Permanent injury is the outcome with the highest frequency and severity across all categories.
- The 16 perinatal deaths include 13 fetal deaths, which occurred during labor or immediately thereafter. The three maternal deaths involved postpartum hemorrhage, postpartum infection and pulmonary edema.

32

FREQUENCY OF PERINATAL CLOSED CLAIMS BY OUTCOME OF INJURY

Percentage of 48 perinatal closed claims



33

AVERAGE TOTAL PAID FOR PERINATAL CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Permanent injury	$128,719	$397,601	$526,320
Death	$58,442	$238,553	$296,995
Temporary injury	$9,785	$103,750	$113,535
Overall	$95,382	$320,097	$415,479

Risk Control Recommendations

Establish a Perinatal Committee that oversees all aspects of perinatal services, including specific issues noted in the following recommendations:

Category 1: Failure to intervene or take action

- **Clearly establish criteria and enforce accountability for intervening and/or taking action** when the patient experiences a potentially problematic change in condition.
- **Regularly review patient care protocols and related policies and procedures** to ensure that they are current and reflect the care being provided.
- **As part of the unit's patient safety program, conduct obstetrical emergency drills and simulations** for such situations as emergency Cesarean delivery, shoulder dystocia, postpartum hemorrhage, eclampsia, and maternal and neonatal resuscitation.
- **Require that providers be able to perform an emergent Cesarean delivery in not more than 30 minutes from "decision to incision,"** in accordance with American College of Obstetrics and Gynecology (ACOG) clinical guidelines.
- **Develop and implement a perinatal department chain of command** policy and procedure.
- **Implement an induction protocol** based upon uterine activity and fetal response, in accordance with ACOG clinical guidelines.
- **Provide guidelines that address all aspects of operative vaginal delivery,** including indications and contraindications, as well as management of interventions and documentation.
- **Designate a code response team** as part of the process for managing neonatal codes.

Category 2: Failure to identify or diagnose

- **Base electronic fetal heart rate monitoring training on current standard nomenclature** developed by the National Institute of Child Health and Human Development (See http://www.nichd.nih.gov/.)
- **Provide team training in fetal monitor interpretation** and obstetrical emergency response.
- **Ensure that all perinatal staff are competent in managing placental abruption**, including understanding the signs and symptoms, as well as performing appropriate interventions.
- **Implement an emergency response team** to respond to perinatal events occurring outside perinatal patient care units, including the emergency department.
- **Establish perinatal quality metrics that are consistent with industry standards,** including those of ACOG, the Association of Women's Health, Obstetric and Neonatal Nurses, and the American Academy of Pediatrics. Monitor outcomes for trends and opportunities for further review, analysis and improvement.

Claim Scenario: Failure to Intervene

Allegations

Failure to diagnose and timely manage persistent fetal distress and high risk for uterine rupture; delay in performing an emergency Cesarean section (c-section) resulting in uterine rupture, with intra-abdominal death of a 36-week fetus.

Summary of Findings

The patient presented to the emergency department two weeks before her scheduled repeat c-section with complaints of severe abdominal pain and urinary retention. Her obstetrical history was notable for a previous uterine rupture, emergency c-section and death of a 23-week fetus, which occurred just 10 months prior. Upon arrival, she was at 36 weeks gestation and not in labor. Fetal monitoring was initiated, a urinary catheter was inserted and attempts were made to contact the obstetrician. After the patient was placed on a fetal monitor, the nurse noted decelerations but deemed the heart rate to be reassuring.

The physician responded one hour and 20 minutes after the patient arrived in the emergency department and provided telephone orders for the patient to be admitted to the hospital, started on oral antibiotics and given intramuscular pain medication. One hour and 30 minutes after the patient arrived at the hospital, the shift changed, and the new day nurse assigned to the patient was immediately concerned about the fetal heart tracings during the night. She also was concerned about what she believed were recurring decelerations and signs of fetal distress. She notified the physician who came and examined the patient for the first time, two hours and 15 minutes after her arrival. The physician ordered a uterine ultrasound on a stat basis, but it was not completed until two hours and 50 minutes after her arrival. The ultrasound was interpreted as normal and revealed positive fetal motion and no placental abruption.

However, shortly after the ultrasound, the patient reported a sharp sensation of something "snapping" in her abdomen with an increase in pain, accompanied by a decrease in the fetal heart rate to 90 beats per minute. The nurse initiated oxygen per mask, repositioned the patient and again contacted the physician. Hospital policy called for transfer of stable patients for delivery at less than 38 weeks gestation. Rather than declare an obstetrical emergency, the physician first attempted to contact the nearby regional hospital to arrange for transfer. The regional hospital refused the transfer as the fetus was unstable. At that time (three hours and 36 minutes after her arrival), the physician ordered that an emergency c-section be performed.

The patient was disconnected from fetal monitoring for transport to the operating suite and was unmonitored for approximately 30 minutes prior to initiation of anesthesia. During transport, the patient was highly agitated and complained of unremitting and unbearable pain. There is conflicting information regarding the arrival times of the operating room technician and the anesthesiologist, and documentation is unclear regarding the exact time of the induction of anesthesia. The time-out was documented 24 minutes after the c-section decision. Notes indicate that anesthesia was induced simultaneously with the time-out. A question arises, however, as there was a 14-minute delay between the time-out and the time of the initial incision, which took place 38 minutes after the decision was made.

The fetus was found to be in the abdominal cavity, the uterus was ruptured and there was significant intra-abdominal bleeding that required transfusion. Approximately four hours and 20 minutes after the patient's arrival at the hospital, a six-pound, four-ounce unresponsive male infant was delivered via c-section. Resuscitation was immediate and briefly successful, but the heartbeat could not be sustained and the infant was pronounced dead. The placenta was delivered, the uterine rupture was repaired and the incision closed.

Expert Findings

Multiple nursing and medical experts were retained and all were critical of both the medical and nursing care in the following areas:

The night nurse failed to recognize and report troubling decelerations in the fetal heart rate. The day nurse recognized the signs of maternal and fetal distress, but failed to invoke the chain of command for emergency treatment when the physician delayed calling for an emergency c-section. Fetal monitoring was discontinued during the time the patient was transported to the operating room. Given the patient's severe pain and agitation, experts believe the evolving uterine rupture occurred during transfer to the operating suite.

The physician did not timely evaluate the patient and failed to recognize fetal distress and the possibility of uterine rupture after the patient reported a snapping sensation in her abdomen with increasing pain and depressed fetal heart rate. The physician delayed the initiation of an emergency c-section by attempting to arrange for an inappropriate transfer of an unstable obstetrical patient.

There is conflicting documentation regarding the arrival times of the surgical team members, the time-out, induction of anesthesia and the initial incision. Regardless, the c-section decision was formally called at 8:06 a.m., and the time-out was documented at 8:30 a.m., but the initial incision was made at 8:44 a.m. At best, the surgery was initiated 38 minutes after the decision, which exceeds the ACOG guideline of 30 minutes from decision to incision.

Resolution

Given the devastating nature of the patient's outcome, multiple negative expert opinions and documentation discrepancies, the decision was made to use a structured settlement in securing a resolution in the mid-six figures.

Behavioral Health Closed Claims

This section reviews the 34 behavioral health closed claims, which have an average total payment of $300,156.

- Behavioral health-related claims are relatively uncommon, accounting for 5.8 percent of the dataset, but they tend to be costly.
- Patient abuse/professional conduct and patient falls are the behavioral health allegations with the highest frequency.
- Four behavioral health patient fall claims resulted in death, with three of these falls occurring on a geriatric behavioral health unit.
- Assessment and monitoring allegations incur the highest severity among behavioral health closed claims, with most resulting in permanent injury or death.
- The majority of claims occur on a behavioral health unit of a hospital or a specialty behavioral health hospital.
- Permanent injury is the most frequent outcome and death the costliest, with suicide as the cause of death in four of the closed claims.

34

MOST FREQUENT BEHAVIORAL HEALTH CLOSED CLAIMS BY ALLEGATION

Percentage of 34 behavioral health closed claims

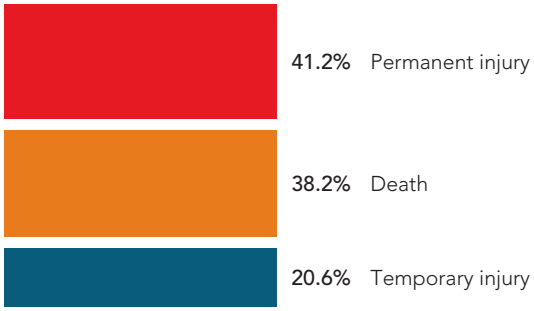
26.5%	Patient abuse/professional conduct
26.5%	Patient falls
17.6%	Assessment and monitoring
8.8%	Nursing-related care
8.8%	Overall improper care

35

HIGHEST AVERAGE TOTAL PAID FOR BEHAVIORAL HEALTH CLOSED CLAIMS BY ALLEGATION

Allegation	Average paid expense	Average paid indemnity	Average total paid
Assessment and monitoring	$86,806	$445,833	$532,639
Nursing-related care	$187,034	$300,000	$487,034
Patient abuse/professional conduct	$53,668	$279,444	$333,113
Credentialing	$27,404	$200,000	$227,404
Medication	$29,088	$155,834	$184,921

36
FREQUENCY OF BEHAVIORAL HEALTH CLOSED CLAIMS BY OUTCOME OF INJURY
Percentage of 34 behavioral health closed claims

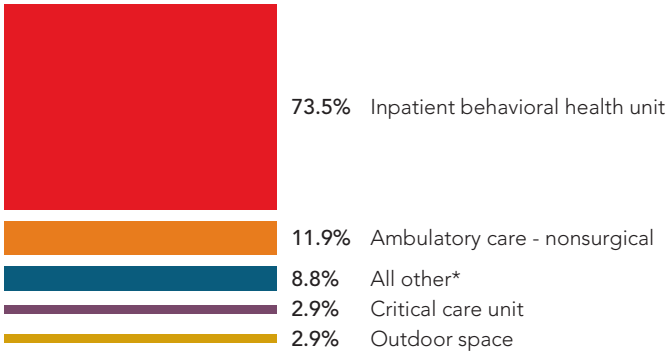


37
AVERAGE TOTAL PAID FOR BEHAVIORAL HEALTH CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Death	$99,831	$271,154	$370,985
Permanent injury	$57,642	$246,976	$304,619
Temporary injury	$27,834	$131,857	$159,691
Overall	$67,636	$232,520	$300,156

38
FREQUENCY OF BEHAVIORAL HEALTH CLOSED CLAIMS BY LOCATION
Percentage of 34 behavioral health closed claims

* "All other" includes claims involving incidents in the dining room and lobby, as well as claims with no distinguishing location.



39
AVERAGE TOTAL PAID FOR BEHAVIORAL HEALTH CLOSED CLAIMS BY LOCATION

* "All other" includes claims involving incidents in the dining room and lobby, as well as claims with no distinguishing location.

Location	Average paid expense	Average paid indemnity	Average total paid
Critical care unit	$137,276	$475,000	$612,276
Ambulatory care - nonsurgical	$86,305	$292,500	$378,805
Inpatient behavioral health unit	$71,091	$242,987	$314,077
All other*	$13,289	$58,333	$71,622
Outdoor space	$0	$11,000	$11,000
Overall average	$67,636	$232,520	$300,156

Risk Control Recommendations

Assessment and Monitoring:

- **Establish policies and procedures for suicide prevention**, including utilization of a comprehensive suicide risk assessment tool.
- **Implement formal policies and procedures** addressing medical management of acute and chronic conditions for patients on the behavioral health unit.
- **Assess behavioral health patients in all units of the hospital for suicidal ideation** and monitor them per organization protocol.
- **Ensure that unit safety and security policies are in place**, enforced and well-documented.
- **Implement hospital-wide protocols to prevent patient elopement** and regularly conduct hospital-wide elopement drills.

Patient Falls:

- **Review and revise fall risk assessment and fall prevention policy and procedures**, addressing the specific needs of patients in the behavioral health setting.
- **Perform a root cause analysis (RCA) whenever patients experience multiple falls** or falls with significant injuries.

(See the discussion of patient falls in Part Five for additional recommendations.)

Patient Abuse and Professional Conduct:

- **Strictly and consistently enforce human resources policies and procedures,** as well as the employee code of conduct.
- **Perform employee background checks and pre-employment screening**, including verification of references, criminal records and registered sex-offender status.
- **Using role-playing techniques, train staff to manage and de-escalate aggressive patient behavior**. Document this training and review competency on an annual basis.
- **Establish a procedure for investigating and documenting all acts of real or threatened violence, abuse, harassment or assault**. Ensure that the procedure is compliant with applicable statutes and regulations.

Nursing-related Care:

- **Ensure that nursing staff who care for and treat behavioral health patients meet industry guidelines** regarding training and competence.
- **As part of the unit or organization quality program, conduct routine health record audits** to ensure that observation checks, suicide assessments, restraint and seclusion monitoring, and other nursing-related interventions are completed and documented.
- **Perform RCAs following serious adverse events**, including (but not limited to) self-harm or harm to others, attempted suicide, suicide, seclusion- or restraint-related injuries or deaths, and patient abuse.

Surgical and Invasive Procedure Closed Claims

This section reviews the 123 perioperative closed claims, which have an average total paid of $250,983. The closed claims include procedures performed in ambulatory settings, invasive procedure rooms, and operating suites comprising pre-operative areas, operating rooms and post-anesthesia care units.

- The most common cluster of allegations involves a serious adverse event occurring during a surgical/invasive procedure. These allegations include unintended retained foreign objects, wrong site/side surgery, improper technique or negligent performance of a treatment or test, improper administration and/or management of anesthesia outside of the operative suite, improper positioning and intraoperative fire.
- Assessment and monitoring and credentialing allegations represent low frequency, but incur the highest average severity for this group.
- Permanent injury comprises the most frequent outcome, while death is the most costly.

40

MOST FREQUENT PERIOPERATIVE CLOSED CLAIMS BY ALLEGATION

Percentage of 123 perioperative closed claims

55.3% Perioperative event
10.6% Overall improper care
8.1% Medication
7.3% Patient falls
4.1% Nursing-related care
4.1% Diagnosis

41

HIGHEST AVERAGE TOTAL PAID FOR PERIOPERATIVE CLOSED CLAIMS BY ALLEGATION

Allegation	Average paid expense	Average paid indemnity	Average total paid
Assessment and monitoring	$19,409	$672,500	$691,909
Credentialing	$76,366	$565,625	$641,991
Medication	$37,748	$217,781	$255,529
Overall improper care	$44,779	$199,385	$244,163
Nursing-related care	$23,701	$210,500	$234,201

42

FREQUENCY OF PERIOPERATIVE CLOSED CLAIMS BY OUTCOME OF INJURY

Percentage of 123 perioperative closed claims

37.4% Permanent injury

31.7% Temporary injury

30.9% Death

43

AVERAGE TOTAL PAID FOR PERIOPERATIVE CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Death	$64,759	$315,311	$380,070
Permanent injury	$37,520	$206,821	$244,341
Temporary injury	$21,497	$111,543	$133,040
Overall	$40,855	$210,128	$250,983

The most common cluster of allegations involves a serious adverse event occurring during a surgical or invasive procedure.

Risk Control Recommendations

Serious adverse event during a surgical or invasive procedure:

- **Create a quality committee for perioperative services** to encourage and monitor a culture of safety.
- **Utilize a pre-operative checklist** that includes patient identification, verification of signed informed consent form(s), current history and physical, site/side marking, review of laboratory and diagnostic test results, and administration of pre-operative medication(s).
- **Establish and enforce policies and procedures regarding correct-site/side surgery** and monitor staff compliance.
- **Provide multidisciplinary simulation drills for difficult intubation and/or airway emergencies,** documenting staff and provider participation.
- **Implement policies and procedures to prevent unintended retained foreign objects,** including a standardized counting method, documentation protocol and formal process to address a count discrepancy.
- **Maintain a surgical fire prevention and response program,** including regular fire drills and ongoing staff education and training.
- **Consistently apply surgical safety practices throughout all areas of the hospital** where invasive procedures are performed.

Assessment and Monitoring:

- **Remind nursing staff of the need to comply with post-procedure orders** regarding notification of clinical signs and symptoms, as well as changes in condition.
- **Encourage staff to listen and respond to concerns** expressed by the patient or family.
- **Incorporate best practices and evidence-based guidelines** when establishing post-surgical and post-procedure monitoring parameters and protocols.
- **Investigate all incidents in which staff fail to notify the provider or the provider fails to respond to calls or pages**. Utilize both hospital investigation processes and peer review to evaluate instances where the provider does not respond appropriately. Track and trend such incidents for practice patterns and possible behavioral issues.
- **Provide support to nursing staff who invoke the chain of command appropriately**, especially when working with novice staff.
- **Audit health records to identify quality issues**, such as failure to complete an assessment, obtain vital signs and/or respond to clinical alarms.

(See Part Five for analysis of claims related to credentialing and privileging.)

Emergency Department Closed Claims

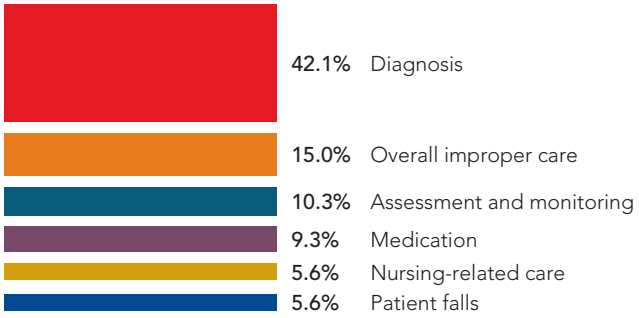
The dataset includes 107 closed claims involving the emergency department, with an average total payment of $276,879. Distribution and severity in the following charts are based upon these 107 claims.

- The most common emergency department allegations involve diagnosis. Examples of allegations related to diagnosis include delay in establishing a diagnosis, failure to or delay in obtaining/addressing diagnostic test results, failure to diagnose and misdiagnosis.
- The percentage of diagnosis-related claims in the emergency department is significantly higher than the percentage of assessment and monitoring-related claims.
- Emergency department claims range considerably in terms of severity, with many of these claims having a paid indemnity under $100,000. At the opposite end of the spectrum, six of the 20 $1 million paid indemnity claims involve the emergency department. (See Part Three.)
- Assessment and monitoring-related allegations include failure to properly or fully complete a patient assessment, failure to assess the patient's concerns or symptoms, delayed or untimely patient assessment, failure to monitor patients who are identified as an elopement risk, failure to monitor and address vital signs, and failure to monitor per order or protocol. These allegations have the highest average severity.
- Death has the highest frequency and severity.

44

MOST FREQUENT EMERGENCY DEPARTMENT CLOSED CLAIMS BY ALLEGATION

Percentage of 107 emergency department closed claims



45

HIGHEST AVERAGE TOTAL PAID FOR EMERGENCY DEPARTMENT CLOSED CLAIMS BY ALLEGATION

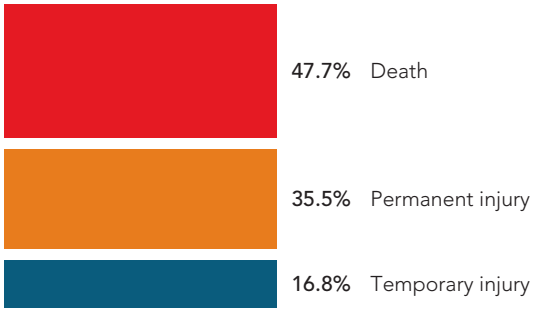
* These claims involve failure to have policies and procedures in place for credentialing and/or supervising mid-level providers.

Allegation	Average paid expense	Average paid indemnity	Average total paid
Assessment and monitoring	$195,391	$378,500	$573,891
Perioperative event	$33,841	$537,500	$571,341
Diagnosis	$76,153	$234,233	$310,386
Governance*	$16,271	$200,000	$216,271
Patient falls	$70,493	$145,337	$215,830

46

FREQUENCY OF EMERGENCY DEPARTMENT CLOSED CLAIMS BY OUTCOME OF INJURY

Percentage of 107 emergency department closed claims



47

AVERAGE TOTAL PAID FOR EMERGENCY DEPARTMENT CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Death	$78,638	$242,782	$321,419
Permanent injury	$87,606	$198,777	$286,383
Temporary injury	$39,921	$90,694	$130,615
Overall	$75,310	$201,569	$276,879

Risk Control Recommendations

Assessment and Monitoring:

- **Develop and implement triage staffing in accordance with historical patterns of patient flow into the emergency department**, in order to reduce the likelihood of patients leaving prior to triage or medical screening evaluation.
- **Ensure that patients in the waiting room are reassessed on a regular basis**, assigning this responsibility to a qualified healthcare provider.
- **Implement protocols to ensure a safe environment for behavioral health patients in the emergency department**, including frequent monitoring of patients who are awaiting treatment and/or admission.
- **Consider patients who are experiencing acute, significant alterations in mental status to be at high risk** for elopement and/or causing harm to self or others while in the emergency department.

Diagnosis-related:

- **Comply with all EMTALA requirements** regarding access to medical screening evaluation and appropriate interventions.
- **Remind staff to document patient and/or family concerns**, as well as symptoms and changes in condition.
- **Encourage providers to obtain assessment and diagnostic input from consultants or specialists**, and to document these discussions.
- **Ensure consistency in the management of radiology over-reads** to minimize errors.
- **Establish a process for communicating and documenting test results post-discharge**, in collaboration with laboratory and/or diagnostic testing departments.

Claim Scenario: Failure to Diagnose

Allegations

Alleged failure to diagnose and treat meningitis resulting in stroke and permanent, severe neurological deficits.

Summary of Findings

A 54-year-old man presented to the emergency department complaining of headache, neck pain and vomiting. He had visited his primary care physician on each of the prior two days, initially for sinusitis and then because of a ruptured ear drum. He stated that his primary care doctor had prescribed antibiotics for his sinus problem.

Upon examination, the patient was alert and oriented, had normal vital signs, no elevation in temperature and no signs of nuchal rigidity. After the patient related a history of degenerative disease in his cervical spine, he was given intravenous fluids and medication for his pain and vomiting, which provided some relief. Blood samples were obtained, revealing a significantly elevated white blood cell count. The physician documented his differential diagnosis as viral syndrome, sinusitis and cervical strain. No explanation was provided for the elevated white blood cell count. The patient was discharged home with a final diagnosis of sinusitis and cervical strain, and was given prescriptions to relieve his pain and vomiting. In addition, he was told to continue the treatment prescribed by his primary care physician.

The next morning, the patient's wife was unable to rouse her husband. She called an ambulance, which transported him back to the emergency room. He was unresponsive and was admitted to the hospital, intubated and underwent a lumbar puncture that revealed purulent spinal fluid. The diagnosis of bacterial meningitis was made.

The patient was treated with intravenous antibiotics and improved. He was extubated three days later and remained in the hospital for further intravenous antibiotic treatment. During the evening, he suffered a severe stroke, resulting in permanent disability, which included gross and fine motor deficiencies, speech impairment, incontinence and limited mobility. Due to this outcome, his wife had to leave her job in order to care for him full-time.

Additional Factors for Consideration

Sometime after the patient's discharge from the initial emergency department visit, the emergency physician added "meningitis" to his differential diagnosis documentation. The notation was readily identifiable as having been added after the fact, creating a major problem for the defense.

Expert Findings

There was general agreement among the experts that, due to the absence of nuchal rigidity, the patient likely did not have meningitis at the time of his initial emergency department visit. The experts further suggested that the rupture of his eardrum one day prior was the likely source of the bacterial infection that led over time to the development of meningitis.

Experts agreed that given the patient's history and physical examination findings, bloodwork had not been indicated at the time of the initial visit. However, once the requested blood work was performed and the significantly elevated white blood cell count was known, it was incumbent upon the physician to investigate the source of the infection, as the high white blood cell count could not have been due to viral sinusitis. An infectious disease consultation, lumbar puncture and/or CT scan should have been considered and, at a minimum, discussed with the patient. Also, upon discharge, the patient should have been given specific instructions to return to the emergency department if he developed neck rigidity, a fever or worsening of his symptoms.

The physician's addition of "meningitis" to his differential diagnosis after the patient was discharged was improper, constituted tampering with the clinical record and rendered the likelihood of a defense verdict for the hospital extremely unlikely.

The development of stroke after meningitis is a known complication of the infection and resulting vasculitis. Experts could not offer an opinion as to whether any change in treatment at either episode of care would have changed the outcome.

Resolution

The patient suffered both economic and non-economic damages. He is severely and permanently disabled and will require lifelong care. The physician, the emergency department physician group practice and the hospital were all named as co-defendants in the claim.

Defense counsel and the hospital determined that given the alteration of the record and the patient's need for lifetime care, it would be necessary to attempt to settle the matter. A settlement in the high six-figure range was paid on behalf of the hospital. The physician and the physician group practice also settled with the patient for a confidential amount.

Medicine Inpatient and Ambulatory Care Closed Claims

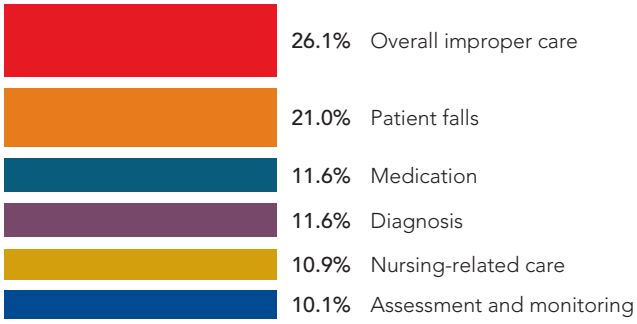
There are 138 closed claims relating to medicine clinical service and/or medical units, with an average total paid of $263,821. Of the 138 claims, 116 occurred on the medical unit. Therefore, location data are listed only by severity.

- The most frequent allegations are improper care and patient falls, while the most severe relate to diagnosis.
- More than half of the injuries resulted in death. These claims are also the costliest.

48

MOST FREQUENT MEDICINE INPATIENT AND AMBULATORY CARE CLOSED CLAIMS BY ALLEGATION

Percentage of 138 medicine inpatient/ambulatory care closed claims



49

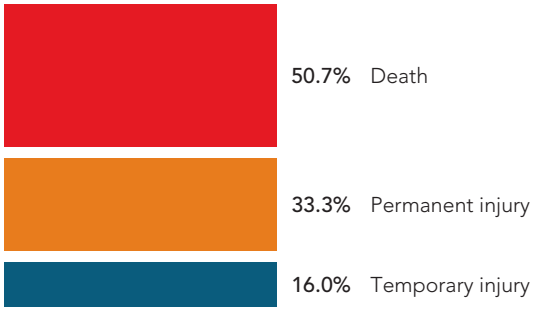
HIGHEST AVERAGE TOTAL PAID FOR MEDICINE INPATIENT AND AMBULATORY CARE CLOSED CLAIMS BY ALLEGATION

Allegation	Average paid expense	Average paid indemnity	Average total paid
Diagnosis	$105,838	$341,442	$447,280
Medication	$68,901	$254,724	$323,625
Assessment and monitoring	$102,328	$200,538	$302,867
Nursing-related care	$24,029	$240,699	$264,728
Equipment	$11,894	$235,543	$247,437

50

FREQUENCY OF MEDICINE INPATIENT AND AMBULATORY CARE CLOSED CLAIMS BY OUTCOME OF INJURY

Percentage of 138 medicine inpatient/ambulatory care closed claims



51

AVERAGE TOTAL PAID FOR MEDICINE INPATIENT AND AMBULATORY CARE CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Death	$52,166	$242,935	$295,101
Permanent injury	$67,211	$191,365	$258,575
Temporary injury	$22,023	$153,237	$175,260
Overall	$52,376	$211,445	$263,821

52

HIGHEST AVERAGE TOTAL PAID FOR MEDICINE INPATIENT AND AMBULATORY CARE CLOSED CLAIMS BY LOCATION

* "All other" claims include two that took place on telemetry units and three claims with no distinguishing location.

Location	Average paid expense	Average paid indemnity	Average total paid
Ambulatory care - nonsurgical	$51,051	$409,167	$460,218
Critical care unit	$61,445	$354,500	$415,945
Radiology/laboratory/therapy	$74,789	$305,996	$380,785
Inpatient medical unit	$54,215	$206,545	$260,760
All other*	$36,221	$127,747	$163,967

Risk Control Recommendations

Overall improper care:

- **Conduct Patient Safety Leadership walk-rounds** on a routine basis and provide feedback to staff about the concerns presented during the walk-rounds.
- **Perform daily safety briefings** or daily safety huddles.
- **Reinforce with staff the importance of documentation compliant** with the organization's protocols and policies.
- **Audit events in which there was a delay in transferring or failure to transfer the patient to a higher level of care**, either internally or externally.
- **Consider implementing rapid response teams** activated by staff, patients or family members.
- **Train staff to comply with infection control and prevention requirements** when providing treatments and interventions.
- **Emphasize the importance of complete, timely, legible and accurate documentation**, and provide staff with educational programs designed to reinforce these requirements.
- **Ensure that staff understand the organization's chain of command policy** and know how and when to invoke it.

Assessment and Monitoring:

- **Perform a complete assessment of the patient**, identifying any risk factors that require immediate attention or escalation of care.
- **Instruct providers to reconcile patient information** and address any inconsistencies.
- **Communicate any changes in patient condition to the provider**, documenting the discussion and intervention(s) performed.
- **Evaluate and document concerns expressed by the patient and/or family**, as well as perceived changes in the patient's condition.
- **Provide ongoing staff education**, evaluating their knowledge and skills at least annually.

Diagnosis:

- **Develop a process for tracking, reporting and following up on diagnostic and laboratory test results** at outpatient and physician offices.
- **Establish a mechanism for notifying patients of test results in a timely manner** and ensuring appropriate follow-up.
- **Clearly delineate the responsibilities of all providers**, including primary care physicians, specialists and radiologists.
- **Collaborate with electronic medical record vendors in implementing a user-friendly system** that prominently displays and promptly notifies providers of new, abnormal and/or critical test results.
- **At discharge, inform patients of any pending test results**, tell them when to anticipate follow-up by a provider and explain the next steps in their care.
- **Remind staff to perform read-back and verification** to ensure accuracy when communicating test results.
- **Audit health records to ensure that ordered tests are performed**, and that results are reviewed and documented in the health record.

(See Part Five for risk control recommendations regarding medication errors and patient falls.)

Part Five Analysis of Selected Allegations

Communication

The dataset includes 11 claims (1.9 percent of the total) in which the primary allegation relates to communication. Specific allegations include failure to report or delay in reporting a test result, failure to inform or notify the provider of a change in condition or new condition, failure to timely report a postoperative complication or change in condition, handoff issues, and incorrect information provided or recorded regarding patient communications with staff.

While the relative frequency and severity of these claims are low, effective communication among healthcare providers, within patient care teams and with the patient remains a patient safety priority. Research has demonstrated that ineffective communication is a major factor in errors and near-misses, which may increase the likelihood of litigation. In today's complex healthcare environment, inadequate communication is always a risk, especially during handoffs and other transitions in care.

Risk Control Recommendations

- **Instill a culture of safety**, training staff to utilize language triggers when necessary, such as "I am concerned about …" or "I am uncomfortable with …."
- **Train staff to use structured formats for exchanging information**, such as the "**S**ituation, **B**ackground, **A**ssessment and **R**ecommendation" (SBAR) method.
- **Utilize the Agency for Healthcare Research & Quality (AHRQ) *Team Strategies and Tools to Enhance Performance and Patient Safety* (TeamSTEPPS®) or similar training resources** to enhance staff communication skills. (See http://teamstepps.ahrq.gov/.)
- **Encourage use of the chain of command**, prohibiting any retaliation on the part of colleagues or supervisors.
- **Develop an effective procedure to manage diagnostic test result reporting and follow-up,** as well as to monitor provider compliance.

Credentialing and Privileging

Healthcare organizations are responsible for ensuring that providers are competent and qualified. By developing and consistently implementing a comprehensive credentialing and privileging process, hospitals can minimize liability exposure and enhance legal defensibility.

The primary allegation for eight claims in the dataset is negligent credentialing and/or privileging, which includes failure to:

- Verify that the physician had the proper training and experience to perform the procedure.
- Properly monitor an impaired physician and take necessary administrative action.
- Identify and investigate provider-related incidents.
- Perform external, independent peer review after the organization's medical director had identified concerns.
- Investigate the validity of a procedure and representations regarding its risks and benefits.

Although the frequency of closed claims alleging negligent credentialing and/or privileging is low in our dataset, the average paid indemnity is high. Most claims resulted in either death or permanent injury (e.g., paralysis or neurological deficit).

Risk Control Recommendations

- **Establish and consistently utilize an effective credentialing and privileging process**, investigate "red flags" in applicants' employment history and document actions taken.
- **Collect and systemically analyze performance data at established intervals**. Key metrics include, but are not limited to, morbidity and mortality data, complaints, practice patterns (e.g., length of stay, readmissions, and prescribing patterns), peer review recommendations and patient satisfaction surveys.
- **Provide staff with sufficient resources** to conduct thorough credentialing and privileging processes.
- **Develop a list of common privileges and the resources required to support each one**, including the organization's license capacity and availability of equipment, personnel and services.
- **Ensure that hospital and medical staff bylaws define a formal framework for peer review** that meets government and accreditation organization requirements.
- **Implement external peer review whenever a potential conflict of interest arises** or other situation occurs that may compromise objectivity.
- **Exercise proper oversight of the credentialing process** through the governing board.

Claim Scenario: Negligent Credentialing and Surgical Misadventure

Allegations

Allegations were made against the hospital's previous chief executive officer (CEO) and an employed surgeon. Allegations included wrongful death resulting from improper surgery performed by an impaired physician, negligent credentialing of a surgeon with a history of substance abuse, failure to medically supervise the surgeon and failure to monitor the surgeon for possible substance abuse.

Summary of Findings

The patient was a 65-year-old woman with complaints of intractable abdominal pain, progressive malnutrition and weight loss, as well as a long history of peptic ulcers, cardiovascular disease, congestive heart failure and chronic obstructive pulmonary disease. The involved surgeon, who was employed by the hospital, performed an exploratory laparotomy, identifying a gastric outlet obstruction. The surgeon then obtained multiple biopsies and performed a gastric bypass. During the procedure, the certified registered nurse anesthetist (CRNA) deemed the surgeon to be impaired, as he exhibited loss of fine motor skills and drowsiness to the point of nearly falling asleep. She offered to call another surgeon for assistance, but the surgeon declined and continued the operation. Concerned, the CRNA fruitlessly attempted to obtain the assistance of another surgeon. During the prolonged surgery, the patient suffered intraoperative hypotension with evidence of a myocardial infarction. Afterward, the patient was transferred to the intensive care unit where she had a cardiopulmonary arrest. Despite advanced cardiac life support efforts, she could not be resuscitated and died.

Liability Assessment

The patient's adult son initiated the lawsuit against both the surgeon and the hospital's CEO. Investigation revealed that when the CRNA contacted another surgeon for assistance, that surgeon contacted the chief of surgery. According to hospital policy, only the chief of surgery or hospital CEO was authorized to halt a surgical procedure and/or obtain an alternative surgeon. The chief of surgery contacted the hospital's CEO, who went to the operating suite and observed the surgeon through a window. Notwithstanding the report of the surgeon's impairment and the patient's intraoperative complications, the CEO neither halted the procedure nor obtained another surgeon.

It was widely known that the surgeon had a prior substance abuse problem. Despite knowing about the impairment, the CEO had granted the surgeon privileges and provided him with a contract to perform surgery for hospital patients without the approval of the hospital or medical boards – a violation of the hospital's policies. The CEO was aware that the surgeon had not performed any surgery for more than a year, but did not impose conditions regarding supervision or assessment of the surgeon or monitor the surgeon for possible substance abuse.

The biopsies revealed that the patient was suffering from cancer of the pancreas, which would have limited her life expectancy. However, the decision was made to attempt to promptly settle the matter, due to the fact that the surgeon had a history of substance abuse, had been improperly credentialed and had exhibited signs of impairment during the patient's procedure. The settlement was coordinated with a second insurance carrier that provided the hospital's directors and officers (D&O) liability insurance coverage.

Resolution

Both the surgeon and the CEO left the hospital, and the matter was reported to the state's malpractice review body and the medical licensing board. The claims against the surgeon and hospital CEO were resolved in the high six-figure range.

Medication Errors

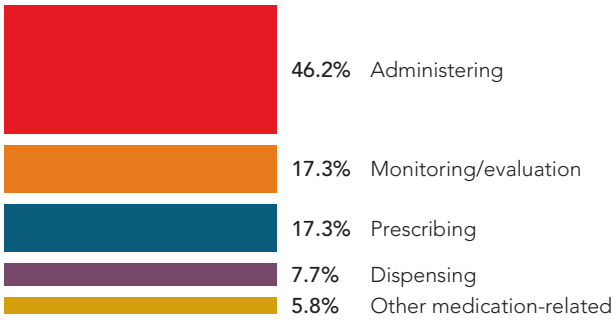
Medication errors are the primary allegation for 52 of the 591 closed claims in the dataset (8.8 percent), with an average total paid of $250,953. Although the industry has launched many initiatives to decrease medication-related errors over the years, such incidents continue to occur.

- Administration errors represent the largest group of medication-related claims.
- No significant patterns or trends were detected in terms of clinical service or location for medication-related claims.
- The medication error - other claim involves a patient who gave incorrect information to staff about a documented allergy to an antibiotic. Based upon this misinformation, the patient received a contraindicated antibiotic and died of anaphylactic shock.
- Omission of a medication order involved an anticoagulant, which resulted in the patient experiencing a myocardial infarction.
- Other medication-related events included:
  - Administration of a lethal dose of the wrong medication, due to an error in the electronic health record software.
  - Failure to remove medications brought from the patient's home, resulting in over-medication and death.
  - Adverse drug reaction.
- The drug class medication - all other includes drug classes such as antihypertensives and antipsychotics.
- Anticoagulants constitute the drug class with the highest severity.

53

MOST FREQUENT MEDICATION ERROR CLOSED CLAIMS BY ALLEGATION

Percentage of 52 medication-related closed claims



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HIGHEST AVERAGE TOTAL PAID FOR MEDICATION ERROR CLOSED CLAIMS BY ALLEGATION

Allegation	Average paid expense	Average paid indemnity	Average total paid
Medication error - other	$7,684	$1,000,000	$1,007,684
Omission	$9,158	$625,000	$634,158
Other medication-related	$71,275	$329,333	$400,609
Monitoring/evaluation	$54,359	$262,109	$316,468
Administering	$50,372	$168,994	$219,367

55
FREQUENCY OF MEDICATION ERROR CLOSED CLAIMS BY DRUG CLASS
Percentage of 52 medication-related closed claims

40.4% Medication - all other
26.9% Narcotic/opioid
11.5% Antibiotic
9.6% Anesthetic agent
5.8% Anticoagulant
3.9% Neuromuscular agent
1.9% Steroid

56
AVERAGE TOTAL PAID FOR MEDICATION ERROR CLOSED CLAIMS BY DRUG CLASS

Drug class involved in the event	Average paid expense	Average paid indemnity	Average total paid
Anticoagulant	$24,003	$515,000	$539,003
Antibiotic	$13,482	$270,000	$283,482
Narcotic/opioid	$64,793	$206,276	$271,069
Medication - all other	$56,870	$177,127	$233,997
Anesthetic agent	$31,996	$119,062	$151,058
Neuromuscular agent	$33,077	$95,000	$128,077
Steroid	$1,294	$10,000	$11,294
Overall	$47,725	$203,228	$250,953

57
FREQUENCY OF MEDICATION ERROR CLOSED CLAIMS BY OUTCOME OF INJURY
Percentage of 52 medication-related closed claims

48.1% Death
30.8% Permanent injury
21.1% Temporary injury

58
AVERAGE TOTAL PAID FOR MEDICATION ERROR CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Death	$68,601	$267,455	$336,056
Permanent injury	$36,467	$191,780	$228,247
Temporary injury	$16,652	$73,909	$90,562
Overall	$47,725	$203,228	$250,953

Risk Control Recommendations

General safe practices:

- **Utilize error-reduction strategies throughout the medication-use process**, such as checklists, protocols, forcing functions, and automation.
- **Develop clinical protocols for prescribing, dispensing and administering medications to pediatric and geriatric patients**, and document compliance.
- **Evaluate staff competency** upon hire and annually thereafter.
- **Implement a collaborative, multidisciplinary approach to medication reconciliation** across the continuum of care.
- **Maintain current drug reference materials** and ensure that they are readily accessible to clinicians.
- **Implement an antibiotic stewardship program** to ensure optimal prescribing and limit overuse and misuse of antibiotics. (Information is available from the Centers for Disease Control and Prevention at http://www.cdc.gov/getsmart/healthcare/pdfs/checklist.pdf.)
- **Encourage staff to report medication-related events**, such as adverse drug reactions, prescription or administration errors, and especially near-misses.
- **Report serious drug side effects to MedWatch**, the FDA's safety information and adverse event reporting program. (See www.fda.gov/Safety/MedWatch/default.htm.)

Prescribing recommendations:

- **Consult with pharmacists or evidence-based resources as needed to avoid drug interactions or contraindications,** and to reduce the risk of prescribing the wrong medication, dosage or frequency.
- **Establish a defined process for noting and modifying patient allergies and reactions** in the health record. Specify who is permitted to change the health record and how such changes should be made.

Administration recommendations:

- **Implement a "no interruption zone" during medication preparation, dispensing and administration** to minimize distractions and reduce the possibility of error.
- **Establish a double-check procedure for high-risk medications**, including (but not limited to) anticoagulants, chemotherapeutic agents, insulin and narcotics/opioids.

Monitoring recommendations:

- **Conduct and document ongoing pain assessments**, using standardized tools.
- **Develop protocols and order sets to monitor and determine the therapeutic effectiveness of specific drug-classes**, such as anticoagulants, antibiotics and antipsychotic medications.
- **Clearly identify patients who are at risk for respiratory depression** and potential opioid tolerance or intolerance.

Claim Scenario: Medication Error and Communication Issues

Allegations

The patient mistakenly was given Coumadin, allegedly causing a hemorrhagic stroke that resulted in permanent physical and emotional deterioration, as well as significant pain and suffering.

Summary of Findings

The patient was a 72-year-old man who had been living and ambulating independently despite an extensive history of problems, including lower extremity weakness, hypertension, renal insufficiency, cardiovascular disease, hyperlipidemia, peptic ulcer, Type II diabetes, two prior strokes and several episodes of transient ischemic episodes. He had suffered a fall two months earlier, but the CT scan of his head was normal at that time.

On the day of admission, he fell at his home and became unresponsive with evidence of slurred speech and right-side weakness. He was admitted to the hospital with significant loss of movement of the right arm, weakness of both lower extremities and fluctuating cognition with aphasia. A head CT scan confirmed a left frontal parietal intracranial hemorrhage of unknown cause. The differential diagnosis was possible hypertensive hemorrhagic stroke, tumor, trauma or amyloid angiopathy. His clotting studies and INR were noted to be normal, and he was started on sequential compression device therapy and compression stockings for prevention of deep vein thrombosis. The patient received medication for his chronic and acute conditions. Because of the location of the brain hemorrhage, he also was started on anti-epileptic medication to prevent seizures. Two days after admission, the patient suffered a seizure with decreased consciousness, and the anti-epileptic medication dosage was increased. The patient began physical, occupational and speech therapy and made slow progress.

Eight days after his hospital admission, the patient was deemed medically stable and transferred for acute inpatient rehabilitation. Doppler studies of both carotid arteries revealed no significant abnormality. The head CT scan was repeated and the hemorrhagic area was described as subacute and slightly smaller. The patient continued the same medications and treatment, eventually regaining the ability to ambulate with a rolling walker and support. However, he frequently refused to eat and drink and required intravenous fluids when dehydrated.

On the tenth day of his rehabilitation, he became increasingly confused, lethargic, difficult to rouse and uncooperative. A repeat head CT scan was ordered that day, but was not performed until the next day. It revealed the subacute left frontal parietal hemorrhage, as well as a new hemorrhage in the left frontal area. A subsequent brain MRI showed the prior subacute hemorrhage, the new left frontal hemorrhage and an additional small intraventricular hemorrhage of the right lateral ventricle. The patient was transferred to the intensive care unit for coagulopathy treatment with Aqua-Mephyton and recombinant Factor 7. The patient's PT and PTT remained elevated, and his INR remained low. The treatment was repeated over four days until the levels normalized.

Following resolution of the coagulopathy, the patient was unable to achieve his previous level of functioning, despite ongoing supportive therapies. He was subsequently transferred to an extended care facility for ongoing skilled nursing care.

The patient's health record and pharmacy records were examined to discover the cause of the new hemorrhage. The review revealed that, without any physician order, the pharmacy had dispensed Coumadin 5 mg daily for this patient, entering this drug on his electronic medication administration record. Three different nurses had administered four doses of Coumadin 5 mg, with one dose given on each of the four days immediately preceding the patient's decline and the diagnosis of the new hemorrhage areas.

Root cause analysis revealed that the pharmacist had confused the orders for two different patients due to frequent interruptions while entering prescription data into the patient's electronic health record. Another problem was poor communication. None of the involved nurses questioned the presence of the new medication on the electronic medication administration record, contacted the pharmacist or the physician to clarify the new drug, or challenged the use of Coumadin for a patient with a known history of hemorrhagic stroke. Finally, physicians failed to note the pharmacy list of the patient's medications and the nursing documentation regarding the Coumadin.

Liability Assessment

One expert indicated that the amount of Coumadin administered and the fact that the second hemorrhage was separate from the first made it highly unlikely that it was caused by the Coumadin. However, other experts – including those from hematology, pharmacy and nursing – opined that the administration of any Coumadin was a departure from the standard of care and could have resulted in the second hemorrhagic event.

Resolution

Given the departures from the standard of care by the pharmacist and the nursing staff, as well as the patient's poor outcome, the decision was made to settle the claim. Settlement was achieved in the high six-figure range.

Patient Falls

Patient falls are the primary allegation for 106 of the 591 closed claims in the dataset (17.9 percent) with an average total paid of $133,349. The closed claim data indicate that falls occur in both inpatient and outpatient settings, including outdoor environments. Patient falls are a common source of both injury and litigation.

Many of the falls in the dataset involve improper care, including failure to follow an established treatment plan, organizational policy and procedure, or reasonable standard of care. Additional falls are due to unsafe environmental conditions in well-traveled indoor and outdoor areas, such as cracked or uneven sidewalks and walkways, ice-or snow-covered surfaces, and exposed cords or tubing. Fall-related incidents for which details could not be verified are included in patient fall - other.

- Approximately two-thirds of the patient fall claims involve allegations of improper care by staff.
- The most common location for patient falls is inpatient medical unit, followed by outdoor settings, such as sidewalks and parking lots.
- The costliest claim involves a patient who sustained a brain injury, with a resultant indemnity payment in the mid-six figures.
- The overall total average paid for fall-related claims is significantly below the average for all claims in the dataset.

59

FREQUENCY OF PATIENT FALL-RELATED CLOSED CLAIMS BY ALLEGATION

Percentage of 106 fall-related closed claims

66.0% Patient fall - improper care

29.3% Patient fall - unsafe environment

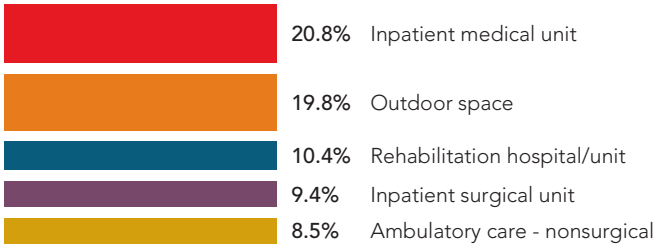
4.7% Patient fall - other

60

AVERAGE TOTAL PAID FOR PATIENT FALL-RELATED CLOSED CLAIMS BY ALLEGATION

Allegation	Average paid expense	Average paid indemnity	Average total paid
Patient fall - improper care	$30,298	$136,495	$166,793
Patient fall - other	$21,355	$127,500	$148,855
Patient fall - unsafe environment	$7,609	$47,720	$55,329
Overall	$23,241	$110,108	$133,349

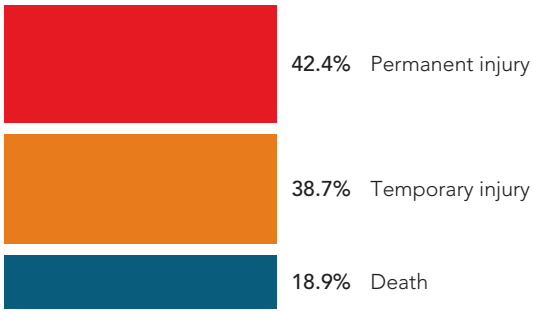
61
MOST FREQUENT PATIENT FALL-RELATED CLOSED CLAIMS BY LOCATION
Percentage of 106 fall-related closed claims



62
HIGHEST AVERAGE TOTAL PAID FOR PATIENT FALL-RELATED CLOSED CLAIMS BY LOCATION

Location	Average paid expense	Average paid indemnity	Average total paid
Inpatient behavioral health hospital/unit	$92,995	$154,667	$247,661
Emergency department	$70,493	$145,337	$215,830
Inpatient surgical unit	$32,334	$175,728	$208,062
Inpatient medical unit	$21,888	$178,237	$200,125

63
FREQUENCY OF PATIENT FALL-RELATED CLOSED CLAIMS BY OUTCOME OF INJURY
Percentage of 106 fall-related closed claims



64
AVERAGE TOTAL PAID FOR PATIENT FALL-RELATED CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of Injury	Average paid expense	Average paid indemnity	Average total paid
Death	$35,820	$174,300	$210,120
Permanent injury	$26,541	$113,355	$139,896
Temporary injury	$13,482	$75,231	$88,714
Overall	$23,241	$110,108	$133,349

Risk Control Recommendations

Improper Care:

- **Promote a multidisciplinary approach to fall assessment and prevention**, seeking input from providers, rehabilitation services, dietary and pharmacy, at a minimum.
- **Implement a fall prevention program** that includes:
  - Tools for assessing patient risk for falls.
  - Interventions to help minimize patient falls and injuries.
  - Safe patient-handling guidelines, including patient lifts, sliding boards, gait belts or other assistive devices.
  - Post-fall procedures, including root cause analysis, when appropriate.
  - Documentation guidelines.
  - Ongoing staff training and competency evaluation.
- **Utilize published resources, such as AHRQ's Fall Prevention Tool Kit,** to evaluate the current fall prevention programs. (See www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtoolkit.pdf.)
- **Consider performing hourly rounding** to proactively identify changing patient needs and risk factors.
- **Establish a process for tracking and documenting falls** and fall-related injury rates.

Environment of Care:

- **Check that floors are flat,** dry and have nonslip surfaces.
- **Regularly inspect sidewalks, driveways, walkways, parking lots and other paved areas** to ensure that they are well-lit and well-maintained.
- **Institute daily environmental safety rounds**, assigning this responsibility to specific staff members and documenting completion.

Promote a multidisciplinary approach to fall risk assessment and prevention, seeking input from providers, rehabilitation services, dietary and pharmacy, at a minimum.

Claim Scenario: Patient Fall Related to Improper Care

Allegations

Alleged negligence resulted in a fall, skull fracture, subdural hematoma, craniotomy, severe physical and neurological disabilities, and subsequent death.

Summary of Findings

A 72-year-old man was brought to the hospital via ambulance after being found on the floor of his home. His wife reported that for the three days prior to admission, he had fallen repeatedly and had been suffering from increasing weakness and confusion.

He had a complex history of chronic pain and multiple chronic cardiac, pulmonary, metabolic, neurological, musculoskeletal and psychological conditions. He was receiving medications for all of these conditions, but was known by his physician to be frequently noncompliant with his medical regimen.

Upon admission, he was found to have abnormal cardiac laboratory values, severe hyponatremia and hypotension. After being admitted for care and observation into the room closest to the nursing station, he was placed on a high risk fall prevention protocol and given a bed motion monitor. Although he and family members were told to press his call light for assistance with physical needs, and he was warned repeatedly not to leave the bed unattended, the patient continued to get out of bed by himself, experiencing four falls in his first six days. In addition, despite staff admonitions and warnings about the risk of serious injury, he and/or his relatives had disabled his bed alarm and had refused any further form of restraint or warning mechanism.

On the day of the incident, the patient had suffered his fourth fall, after which he was administered pain medication and reminded again to use his call light for assistance. Two hours later during the shift change report, the patient put on his call light, and the nurse immediately responded. The patient, who was standing at the bedside, refused the nurse's offer to use the urinal and insisted that the nurse assist him to the bathroom. While in the bathroom, the patient suddenly dropped the urinal and fell straight back into the nurse who caught him under his arms. Although the nurse partially broke his fall, he struck his head on the floor, lost consciousness and developed seizure-like activity. The nurse, who was also injured, called for help. The rapid assessment team responded, returned the patient to bed, started oxygen and notified the physician, who came to see the patient within minutes. The patient was transferred to the telemetry unit, where he was observed to have seizure-like activity and unequal-sized pupils.

The patient was transported to the nearest trauma center, where a craniotomy was performed. He was found to have a depressed skull fracture and very large subdural and scalp hematomas. The damaged portion of the patient's skull was removed, the hematomas were evacuated and the scalp closed. Following hospital care, he was discharged for rehabilitation with a plan for subsequent implantation of a metal plate to repair the skull defect, and he was advised to wear a helmet until the repair was made. The patient never returned for insertion of the advised metal plate and was not observed to wear the recommended safety helmet.

Additional Factors for Consideration

The patient's wife left her job to care full-time for her husband. The patient never regained his former level of functioning, remained fully disabled and was unable to communicate effectively or care for himself. He died approximately two years after his craniotomy.

Expert Findings

Experts were critical of the hospital's policy regarding patients at high risk for falls. Although the patient had suffered four falls, nursing staff had neither initiated additional care planning nor sought physician orders to address his continuing high risk for falls. They were specifically critical of the nurse for allowing the patient to go to the bathroom with just her in attendance. The nurse failed to consider that he had suffered four prior falls (including a fall two hours before the event), that he had received pain medication at that time and that he had severe hyponatremia, which increases fall risk. In addition, the nurse did not seat him on the commode, instead allowing him to stand unaided, and so was unable to prevent his injury when he suddenly fell.

Resolution

Despite the noncompliance of the patient and his family, the nurse was deemed to have failed to meet the standard of care in permitting the patient to go to the bathroom. Given his devastating outcome and his two subsequent years of total care, defense counsel believed there would be significant jury sympathy for the patient. The decision was made to settle the claim in the mid six-figure range.

Pressure Ulcers

This section reviews the 31 pressure ulcer closed claims, which have an average total paid of $191,632. Pressure ulcers represent a significant issue for hospitals, potentially affecting patients' overall health and quality of life, patient and family satisfaction, reputation and reimbursement. An organization-wide commitment to skin integrity can help reduce both their incidence and seriousness.

- Most of the pressure ulcer claims occur on general medical and surgical units.
- Claims involving inpatient surgical patients reflect the highest severity.
- In more than 80 percent of pressure ulcer claims, the patient's outcome was death or permanent harm.

65

FREQUENCY OF PRESSURE ULCER CLOSED CLAIMS BY LOCATION

Percentage of 31 pressure ulcer closed claims

*All other includes claims with no distinguishing location.

54.8% Inpatient medical unit

35.5% Inpatient surgical unit

6.5% All other*

3.2% Rehabilitation hospital/unit

66

AVERAGE TOTAL PAID FOR PRESSURE ULCER CLOSED CLAIMS BY LOCATION

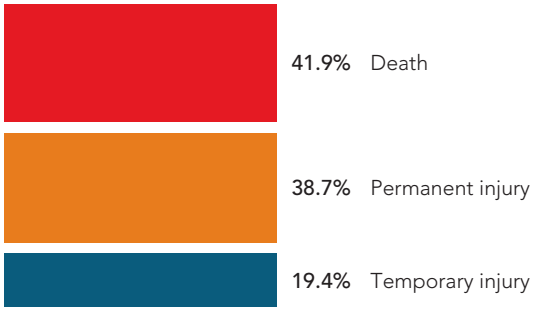
*All other includes claims with no distinguishing location.

Location	Average paid expense	Average paid indemnity	Average total paid
Inpatient surgical unit	$31,623	$216,909	$248,533
Inpatient medical unit	$51,441	$128,975	$180,416
Rehabilitation hospital/unit	$24,511	$40,000	$64,511
All other*	$18,549	$19,017	$37,565
Overall	$41,418	$150,213	$191,632

67

FREQUENCY OF PRESSURE ULCER CLOSED CLAIMS BY OUTCOME OF INJURY

Percentage of 31 pressure ulcer closed claims



68

AVERAGE TOTAL PAID FOR PRESSURE ULCER CLOSED CLAIMS BY OUTCOME OF INJURY

Outcome of injury	Average paid expense	Average paid indemnity	Average total paid
Death	$63,456	$167,823	$231,279
Permanent injury	$29,360	$192,365	$221,724
Temporary injury	$17,788	$27,756	$45,544
Overall	$41,418	$150,213	$191,632

Risk Control Recommendations

- **Institute a formal staff training program regarding pressure ulcer prevention and treatment**, and evaluate the program at regular intervals.
- **Ensure that skin integrity protocols address key issues**, such as pressure ulcer prevention, skin assessments, appropriate interventions and documentation.
- **Perform risk and skin assessments upon admission**, utilizing standardized assessment tools and documentation formats, as well as industry-specific terminology.
- **Implement a turn/reposition schedule** that reflects individual patient needs.
- **Encourage staff to perform pressure relief/redistribution interventions** when providing other treatments.
- **Consult with registered dietitians for nutrition and hydration recommendations** to facilitate wound healing.
- **Promptly inform the patient and family of pressure ulcers** or other significant skin condition changes.
- **Instruct staff to strictly follow protocols regarding photographing wounds,** if the organization chooses to photograph wounds.
- **For more detailed skin integrity guidelines, refer to the AHRQ's "Preventing Pressure Ulcers in Hospitals, A Toolkit for Improving Quality of Care."** (See http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putoolkit.pdf.)

Part Six Closing Comments

Many of the risk control recommendations in this document address basic issues such as establishing policies and procedures, training and orienting newly hired employees, and reviewing staff competence. While analyzing the data, it became clear that these foundational processes, although integral to the delivery of safe, quality care, are not always formulated and consistently followed. Many organizations continue to find it a challenge not only to develop and implement effective protocols, but also to create a culture of safety.

Research recently published by the Mayo Clinic reveals that overcoming human error remains a key challenge as the industry strives to reduce preventable harm.[1] Adoption of human-factor principles such as redundancies, use of checklists and automation minimizes the opportunity for human error. However, while augmented use of information technology may decrease certain types of mistakes, it also introduces new sources of risk. For example, use of the copy-and-paste feature in electronic medical records may result in perpetuating inaccurate information. This misinformation may then become the basis for a misdiagnosis. Although these risks are not yet reflected in CNA professional liability claims, technological innovation presents the possibility of unintended consequences.

Some leaders have achieved good results in reducing human error and enhancing quality and patient safety by applying the concepts and principles of "high reliability organizations" (HROs). Such organizations have systems in place that encourage consistent staff performance and can help prevent potentially catastrophic errors. Weick and Sutcliffe[2] have identified five principles that can help healthcare entities provide exceptionally safe, consistently high-quality care:

1. **Sensitivity to operations**: Leadership, management and staff at HROs are mindful of the systems in place, as well as of the situation, environment and issues that can affect patient care.
2. **Reluctance to simplify**: HRO leaders and staff refuse to accept simplistic explanations for failures. Rather, they acknowledge complexity and consider the full range of possible reasons for error.
3. **Preoccupation with anticipating and avoiding failure**: HROs focus on identifying and eliminating potential failures, not simply reacting to them. For example, near-miss events are perceived as opportunities to identify system vulnerabilities and make improvements, rather than taking refuge in the idea that "the system worked."
4. **Deference to expertise**: HROs foster a culture where leadership and staff defer to the individual with the most knowledge, regardless of rank.
5. **Resilience**: HROs adopt and implement procedures and systems to facilitate continued functioning even under unexpected situations. Conducting regular emergency drills is an example of a strategy to promote resilience.

Leaders are confronting significant changes in the delivery and reimbursement of healthcare. By applying the principles of high reliability organizations, they may be better positioned to address these fundamental shifts. As the healthcare industry continues to evolve, enhanced patient safety remains a key to success.

1 Cornelius, A. et al. "Surgical Never Events and Contributing Human Factors." *Surgery*, published online May 29, 2015. Available at http://www.surgjournal.com/article/S0039-6060(15)00315-3/abstract; also see http://newsnetwork.mayoclinic.org/discussion/how-does-human-behavior-lead-to-surgical-errors-mayo-clinic-researchers-count-the-ways/.

2 Weick, K.E. and Sutcliffe, K.M. *Managing the Unexpected: Assuring High Performance in an Age of Complexity*. San Francisco: Jossey-Bass, 2001.

Industry Challenges

The Institute for Healthcare Improvement (IHI) Triple Aim Initiative[1] calls for the simultaneous pursuit of three goals: enhancing the patient experience of care, improving the health of populations and reducing the per-capita cost of health care.

This report has focused on enhancing quality and patient safety, which is central to achieving any and all of these goals. However, many other challenges outside the scope of this claim report are emerging and creating new demands on leadership, including the following:

- **Shifting from volume-based to value-based reimbursement.** Organizations are under strong financial pressure to eliminate unnecessary care, improve quality and performance, and partner with public and private payers. One response to changes in reimbursement is new care delivery models, such as accountable care organizations. The new paradigm will affect many areas of hospital operations, requiring long-term strategic planning and a commitment to measuring outcomes and analyzing utilization patterns.
- **Integrating physicians and provider practices.** More hospitals and health systems are directly employing physicians, in order to enhance efficiency and create synergies. However, this model may have significant liability and insurance implications, which must be considered when formulating enterprise risk management strategies.
- **Enhancing transitions and preventing readmissions.** Facilitating safe discharges and improving care coordination is a complex process requiring open, ongoing communication between the provider and patient/family; attention to patients' psychosocial, environmental and economic factors; and access to numerous resources within the home and community. At a time when the Centers for Medicare and Medicaid Services are assessing monetary penalties for preventable readmissions, hospitals as well as other care settings need to implement innovative programs to enhance patient safety and minimize risks.
- **Managing population health.** Due to changing incentives and healthcare delivery models, hospitals and healthcare systems are launching large-scale, coordinated initiatives to enhance wellness, prevent readmissions, retain patients in the network, and identify and manage new patient safety risks. For population health efforts to succeed, leadership must work closely with government agencies and community organizations to address complex public health problems.
- **Strengthening and connecting health information systems.** As episodes of care grow shorter in duration and more varied in terms of type of setting and provider, the ability to transfer relevant and accurate health information in real time becomes more essential. Interconnected provider and hospital information systems, bolstered by data analytics, may facilitate better patient outcomes and help leaders identify and address loss drivers. One of the major challenges today is to make full use of evolving information technology (IT) to support the needs of a more complex and integrated healthcare delivery system.
- **Improving patient satisfaction and increasing patient engagement.** The healthcare marketplace is becoming increasingly competitive, with patients having access to an expanding array of choices regarding both providers and settings. In this environment, healthcare providers are encouraged to listen to patients, providing them with the resources and support they need to make well-informed decisions and become active partners in the care team.
- **Reducing cyber liabilities and protecting patient privacy.** This is an era of electronic health records, telemedicine, social media and ever-expanding utilization of IT systems. Online communication and electronic care documentation create new categories of liability exposures, including data breaches and cyber attacks, which can lead to compromised patient information, disrupted operations, negative publicity and regulatory sanctions. IT security measures have thus become vital components of healthcare risk management programs.

1 Whittington, J., et al. "Pursuing the Triple Aim: The First 7 Years." The *Milbank Quarterly*, 2015, Vol. 93:2, pp. 263-300. Available at http://www.milbank.org/uploads/documents/featured-articles/pdf/Milbank_Quarterly_Vol-93_No-_2_Pursuing_the_Triple_Aim_The_First_7_Years.pdf.

Concluding Remarks

The healthcare industry is undergoing a dramatic transformation, as incentives shift and transparency increases. The evolution from a volume-based to a value-based paradigm reinforces the central and strategic importance of enhancing quality and patient safety. The process of improving outcomes and reducing errors begins with awareness of current risks and issues.

We are proud to share our claim data and analysis in the hope that it will inspire our insureds and the industry as a whole to examine patient care philosophies and practices, as well as to initiate constructive, evidence-based change. In the end, systemic improvement requires more than revised policies and procedures. It also demands a patient-centered, staff-empowered culture of safety that starts with the leadership and governing board and permeates every discipline and department. As always, we at CNA remain committed to supporting our partners and colleagues in the vital task of eliminating preventable patient harm and minimizing exposure to litigation and loss.

Part Seven Risk Control Self-assessment Checklist for Hospitals

This checklist is designed to help hospital leadership and management evaluate liability exposures, enhance patient safety and minimize potential loss. While not all-inclusive, this self-assessment tool addresses many of the sources of risk noted in the preceding claim analysis. For additional risk control resources, please visit **www.cna.com/riskcontrol**.

Leadership/Governance	Not started	Beginning stages	Partially implemented	Fully implemented
We have an enterprise risk management plan, which is reviewed and revised annually.				
We consistently communicate and model the organization's values, mission and vision, especially as they relate to patient safety.				
We conduct Patient Safety Leadership walk-rounds on a regular basis and provide feedback to staff about the concerns presented during the walk-rounds.				
We uphold the ideal of a fair and just culture and seek to propagate this concept throughout the organization.				
We have a process in place to hold individuals accountable for their actions and performance, and to evaluate compliance with designated responsibilities, scope of practice and organizational values.				
We perform daily safety briefings or huddles.				
We embrace patient- and family-centered care practices, and commit adequate resources and effort to implement these practices.				
We have a formal process to identify and respond to serious adverse events and medical errors.				
We are honest and transparent with patients and families when serious adverse events and medical errors occur.				
We have an established process for disclosing errors to patients and family members, and we specify who should participate in these discussions.				
We monitor patient satisfaction survey results and take prompt action when we become aware of adverse trends and issues.				
We provide the governing board with quarterly reports on patient safety and risk management initiatives.				
We have a thorough, well-documented process for credentialing, privileging and reappointing members of the medical staff.				
We involve the governing board in overseeing the credentialing process.				
We have a process in place for verifying the education, training and credentials of advanced practice nurses and mid-level providers.				
We conduct employee surveys to assess attitudes and reveal potential problems regarding patient safety.				
We actively encourage communication and collaboration among risk management, quality and patient safety departments.				

Medical Staff	Not started	Beginning stages	Partially implemented	Fully implemented
We have a formalized peer review process, which is governed by hospital and medical staff bylaws.				
Our peer review process is in accordance with the requirements of relevant government and accrediting organizations.				
We collect and systemically analyze provider performance data, including morbidity and mortality rates, patient satisfaction results, complaints, peer review recommendations and practice patterns (e.g., length of stay, readmissions, prescribing patterns).				
We follow Accreditation Council for Graduate Medical Education requirements regarding the supervision of residents.				
We have a formalized process in place addressing disruptive, abusive and/or impaired providers.				

Human Resources	Not started	Beginning stages	Partially implemented	Fully implemented
We include Office of Inspector General, criminal and registered sex offender background checks in our hiring process.				
We have anti-discriminatory hiring, promotion and termination policies in place.				
We evaluate core competencies upon hire, at the end of the probationary period and annually thereafter.				
We do not tolerate intimidating, disrespectful or disruptive behavior at any level, and respond to incidents swiftly and consistently.				
We watch staff for signs of substance abuse or other impairments that could affect job performance.				
We promote use of our employee assistance program.				
We have a social media policy that complies with privacy/confidentiality requirements and is designed to maintain professional boundaries.				

Perinatal	Not started	Beginning stages	Partially implemented	Fully implemented
We have a telephone log and formal process for replying to patients who call the labor and delivery unit for medical advice.				
We follow a protocol that provides for timely triage of patients who present to the labor and delivery unit.				
We have on-call schedules for obstetric and anesthesia providers to ensure that one is always available if needed.				
We have a departmental chain of command, and we are accountable to use it.				
We utilize structured communication tactics, such as SBAR (**S**ituation, **B**ackground, **A**ssessment and **R**ecommendations).				
We require that all staff who interpret electronic fetal monitoring (EFM) demonstrate competence on an annual basis.				
We require nursing and medical staff to utilize National Institute of Child Health and Human Development terminology for fetal monitoring tracing interpretation.				

Perinatal (continued)	Not started	Beginning stages	Partially implemented	Fully implemented
We follow relevant guidelines for the identification, storage and retention of EFM tracings.				
We follow a protocol regarding elective inductions before 39 weeks gestational age.				
We follow a protocol for induction of labor that is consistent with current American College of Obstetrics and Gynecology (ACOG) clinical guidelines.				
We follow monitoring guidelines for patients who receive epidural infusions.				
We have a process and train staff for emergency deliveries prior to the arrival of a physician.				
We follow a protocol for operative vaginal deliveries.				
We follow a protocol for vaginal birth after previous Cesarean delivery that is in accordance with current ACOG clinical guidelines.				
We monitor for compliance with "decision-to-incision" timeliness for emergent Cesarean sections.				
We follow a shoulder dystocia protocol that is in accordance with current ACOG clinical guidelines.				
We have emergency obstetric medications readily available on the unit.				
We have written maternal and neonatal resuscitation guidelines and the necessary equipment on hand.				
We routinely conduct obstetrical emergency drills and simulations.				
We have an infant identification policy.				
We have a written infant abduction prevention and response plan, and we conduct regular drills.				
We follow a hyperbilirubinemia protocol that addresses assessment, laboratory testing and reporting of results.				
We assess the skills and competency of all perinatal staff and providers at least annually.				
We have a process in place for situations where a provider may be acting outside of his/her scope of practice.				
We utilize perinatal quality metrics that are consistent with industry standards.				
We monitor for compliance with established perinatal protocols, guidelines, and policies and procedures.				
We have multidisciplinary perinatal patient safety meetings to evaluate trends and opportunities for improvement.				
We perform root cause analyses (RCA) on sentinel and/or serious reportable events.				

Perioperative	Not started	Beginning stages	Partially implemented	Fully implemented
We follow a screening checklist for all procedures performed in ambulatory surgical centers.				
We participate in training and exercises to improve teamwork and communication within the perioperative and ambulatory surgical care settings.				
We institute and enforce a policy regarding the presence of healthcare industry representatives and/or observers.				
We utilize a pre-operative checklist covering such areas as patient identification, informed consent, current history and physical, site/side marking, review of diagnostic test results and administration of pre-operative medications.				
We require that anesthesia providers complete a pre-operative equipment safety checklist.				
We follow a protocol for managing unexpectedly difficult intubations and/or airway emergencies.				
We require staff to document critical information – such as pre- and post-surgery skin assessments; skin preparation; patient positioning; and use of any padding, supports or restraints – in a specific section of the perioperative record.				
We implement the Universal Protocol, which includes a pre-operative verification process, operative site marking and a final time-out.				
We implement the same assessments, treatment and monitoring protocols wherever anesthesia is administered, including locations other than the operating room.				
We follow industry standards for labeling medicines in syringes, cups and basins.				
We have emergency medications readily available and properly secured on the unit.				
We have a departmental chain of command, and we are accountable to use it.				
We comply with industry guidelines for the prevention and detection of unintended retained foreign objects.				
We have a surgical fire prevention and response program in place, which includes staff training and the performance of drills on a regular basis.				
We have a protocol addressing clinical alarm management in the perioperative setting, which ensures that alarms remain on, are audible at all times, and undergo preventive and routine maintenance.				
We follow protocols for the assessment and management of patients with sleep apnea.				
We have a malignant hyperthermia rapid response protocol.				
We require all providers to comply with an established process for obtaining approval of new technology or revised procedures.				
We train staff and verify their ability to safely use all relevant equipment and technology.				
We have specific equipment sterilization guidelines, and regularly monitor staff compliance.				

Perioperative (continued)	Not started	Beginning stages	Partially implemented	Fully implemented
We follow an established process for credentialing physicians who perform laparoscopic or robotic procedures.				
We comply with manufacturer guidelines regarding the use of equipment with bariatric patients.				
We utilize established perioperative quality metrics, and confirm that they are consistent with industry standards.				
We monitor for compliance with established perioperative protocols, guidelines, and policies and procedures.				
We have multidisciplinary perioperative patient safety meetings to evaluate trends and opportunities for improvement.				
We perform RCA on sentinel and/or serious reportable events.				

Behavioral Health	Not started	Beginning stages	Partially implemented	Fully implemented
We maintain a secure environment of care and utilize products that are safe for behavioral health patients.				
We respect and safeguard patient rights.				
We follow a formalized process for conducting searches of patients, belongings and rooms.				
We conduct a comprehensive suicide risk assessment on every patient upon admission and comply with protocols regarding reassessment, intervention and monitoring.				
We have policies and procedures for the safe use of seclusion, restraints and one-to-one observation.				
We have a policy concerning assessment and management of patients who have comorbidities or are medically unstable.				
We have a fall prevention program reflecting the specific risk factors and needs of the patient population (e.g., geriatric behavioral health).				
We conduct elopement drills and debrief as a team.				
We train staff in crisis intervention and de-escalation, using established programs and techniques.				
We comply with applicable statutes and regulations for the investigation and reporting of violence, abuse, harassment and assault.				
We monitor for compliance with established behavioral health protocols, guidelines, and policies and procedures.				
We establish patient safety goals and utilize standard quality metrics.				
We perform RCA on sentinel and/or serious reportable events.				

Emergency Department	Not started	Beginning stages	Partially implemented	Fully implemented
We use a reliable, valid triage scale (such as the Emergency Severity Index).				
We have a protocol for replying to patients who contact the emergency department for medical advice.				
We establish staffing schedules based on historical patient flow.				
We follow a formal process to increase staffing during peak times and when patient flow exceeds normal capacity.				
We collaborate with the admissions department regarding patient flow and decompression procedures to minimize overcrowding and boarding.				
We assign a qualified healthcare provider to monitor and reassess patients in the waiting room.				
We have protocols in place for the transfer of trauma, obstetric, pediatric and behavioral health patients to other facilities, when necessary.				
We follow a formal process for responding to emergent obstetrical events.				
We provide a safe environment for patients who have altered mental status or who are identified as being at risk for harm to self or others.				
We have a guideline for the administration and monitoring of procedural sedation and analgesia in the emergency department.				
We follow established guidelines and recommendations for opioid prescriptions in the emergency department.				
We follow established protocols when diagnosing and treating patients who present with symptoms that are known indicators of high-risk conditions, such as (but not limited to) aneurysm, heart attack, stroke, meningitis and ectopic pregnancy.				
We encourage providers to conduct handoff discussions at the patient's bedside.				
We monitor, track and trend wait times, as well as the number of patients who leave without being seen or against medical advice.				
We have a procedure for managing radiology over-reads.				
We follow a standardized process for communicating diagnostic and test results to patients post-discharge.				
We comply with the Emergency Medical Treatment and Labor Act.				
We adopt standard patient safety goals and quality metrics.				
We monitor for compliance with established emergency services protocols, guidelines, and policies and procedures.				
We perform RCA on sentinel and/or serious reportable events.				

General Treatment and Care	Not started	Beginning stages	Partially implemented	Fully implemented
We utilize guidelines to assist staff and providers in complying with documentation protocols, policies and procedures.				
We consistently include and educate the patient and family about treatments and interventions.				
We monitor for compliance with hand-hygiene guidelines.				
We collaborate with the infection control and prevention department when analyzing trends and patterns of healthcare-associated infections.				
We have a chain of command policy, and we are accountable to use it.				
We audit events involving an unexpected transfer to a higher level of care.				
We have a system in place to identify readmissions within 30 days of discharge and to initiate a record review.				
We monitor and review all hospital-acquired conditions.				
We have a process for tracking, reporting and following through on all diagnostic test results.				
We perform RCA on sentinel and/or serious reportable events.				

Communication	Not started	Beginning stages	Partially implemented	Fully implemented
We train staff in effective communication strategies and tactics, such as TeamSTEPPS®.				
We support staff members who use the chain of command appropriately and protect them against possible retaliation.				
We limit verbal orders to emergent situations only.				
We require verification of telephone/verbal orders and test results, using a read-back technique and two unique patient identifiers.				
We provide staff with language interpretation tools and translation services when needed.				

Medication Safety	Not started	Beginning stages	Partially implemented	Fully implemented
We implement appropriate technology – such as automation, forcing functions, robotics, e-prescribing and bar-code medication administration – in order to reduce medication errors.				
We use standard concentrations, in order to minimize or eliminate multiple strengths.				
We provide easy access to current drug reference materials.				
We judiciously use electronic alerts and review alert override data.				
We obtain and record all patient weights in kilograms.				
We have a process for questioning patient allergies and reactions listed in the health record and modifying allergy notations.				
We have a medication reconciliation process that clearly outlines provider/department responsibilities during transitions of care.				
We perform independent double-checks for selected high-alert medications.				
We designate a "no interruption zone" during medication preparation, dispensing and administration.				
We follow a standardized protocol for managing and monitoring patients who are prescribed anticoagulants.				
We have a comprehensive pain management program, which includes age-appropriate pain assessment tools and resources, and which encourages consultation with a pain specialist when necessary.				
We follow established protocols for prescribing, dispensing and administering medications to pediatric and geriatric patients.				
We make relevant laboratory data and test results available to all those involved in prescribing or administering medications.				
We monitor patients who are identified as being at risk for respiratory depression or opioid tolerance.				
We evaluate staff competencies annually.				
We review adverse drug events, close calls and near-misses.				
We track and trend medication errors and identify opportunities for improvement.				
We perform RCA on sentinel and/or serious reportable medication-related events.				

Patient Falls	Not started	Beginning stages	Partially implemented	Fully implemented
We promote a multidisciplinary approach to fall assessment and prevention.	☐	☐	☐	☐
We utilize an evidence-based fall assessment tool.	☐	☐	☐	☐
We implement standardized fall prevention interventions.	☐	☐	☐	☐
We conduct hourly rounding to proactively identify patient needs.	☐	☐	☐	☐
We have a safe patient-handling program, which includes use of patient lifts and regular evaluation of staff competency.	☐	☐	☐	☐
We perform internal and external environment-of-care rounds to identify hazards and risk factors.	☐	☐	☐	☐
We follow standardized post-fall procedures.	☐	☐	☐	☐
We measure, track and trend patient falls and fall-related injuries.	☐	☐	☐	☐
We perform RCA on sentinel and/or serious reportable fall-related events.	☐	☐	☐	☐

Pressure Ulcers	Not started	Beginning stages	Partially implemented	Fully implemented
We have a formal staff training program for pressure ulcer prevention and intervention.	☐	☐	☐	☐
We have a policy addressing the frequency of skin and risk assessments.	☐	☐	☐	☐
We utilize a standardized documentation tool or form.	☐	☐	☐	☐
We use the National Pressure Ulcer Advisory Panel's definitions of pressure ulcer stages/categories.	☐	☐	☐	☐
We follow established industry clinical practice guidelines for the prevention and treatment of pressure ulcers.	☐	☐	☐	☐
We adhere to recommended best practices for the prevention of medical-device related pressure ulcers.	☐	☐	☐	☐
We establish turn/reposition schedules tailored to every patient's needs, and we document this activity.	☐	☐	☐	☐
If wounds are photographed, we follow a standard protocol to assure image consistency, quality and retention.	☐	☐	☐	☐
We measure, track and trend both community- and hospital-acquired pressure ulcers.	☐	☐	☐	☐
We perform RCA on sentinel and/or serious reportable pressure ulcer-related events.	☐	☐	☐	☐

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