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Emergency department triage: Reducing risks at the front door

An interview with Robert Schafermeyer, MD, FACEP, FIFEM, FAAP
by Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM

Knowing where your greatest risks to patient safety and liability lie is the first step in reducing those risks. Analysis of adverse events and liability actions arising from the emergency department (ED) can help direct successful risk reduction and patient safety improvements. This includes triage staffing and design, as well as physician-approved rapid triage protocols for high-risk conditions.

Common high-risk conditions in ED liability claims against hospitals and physicians include chest pain, stroke, sepsis, and trauma. Factors contributing to adverse events and patient harm in the ED that can lead to allegations of malpractice liability include errors, delays, and missed diagnoses.

Sedgwick healthcare risk management and patient safety consultants have a proven record of successful partnerships and collaboratives in conducting comprehensive risk assessments of emergency services with prioritization and support for implementing improvements. In the following interview, Kathy Shostek, lead consultant for a number of emergency department risk and safety improvement projects, sat down with Robert Schafermeyer, Sedgwick ED physician consultant and emergency medicine expert (Professor Emeritus, Immediate Past Chief and Associate Chair, Department of Emergency Medicine, Carolinas Medical Center, Charlotte, NC; Past President, American College of Emergency Physicians), to discuss pitfalls in the ED triage process that can result in delays in patient diagnosis and treatment. The two summarized strategies for overcoming delays and system issues to improve timeliness of treatment.

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The following is a step-by-step approach to improving triage and other emergency care processes:

1. Identify your ED's top 5-10 chief complaints by volume and include high-risk diseases and injuries.
2. Decide if a clinical protocol will expedite care, improve safety, and/or reduce costs. Identify the resources available for protocol development and implementation. For example, the evidence for using protocols for early identification and intervention of sepsis is clear and sample sepsis protocols are available.
3. Using an interdisciplinary task force or committee, develop and implement the protocols. Involve the clinical staff and provide education about, and rationale for, using the protocols. Memorize the protocols and practice using them. Post protocol algorithms in ED treatment rooms. Care should be bundled to promote compliance.
4. Monitor compliance with the protocols. Conduct chart audits using screening tools or use your electronic health record (EHR) if it has documentation monitoring features available.
5. Analyze the data and determine if the protocol reduced delays and improved patient throughput times while maintaining or improving treatment of high-risk conditions. If the answer is yes, imbed the protocols in your EHR and the workflow. If the answer is no, reevaluate the protocol and revise as necessary, implement changes, and continue to monitor.

Kathy: Robert, we know from a review of ED claims in the Sedgwick database that diagnostic failures, delays and failures in patient assessments, complaints regarding treatment, and quality concerns are among contributing factors to these claims. Can you summarize your experience with these issues in the ED?

Robert: Missed and delayed diagnoses in the ED are often the result of multiple breakdowns in the diagnostic process, beginning with triage assessment. This results in delays and includes other factors, such as inadequate handoffs that can lead to the wrong disposition or follow-up care for the patient. Focusing on high-risk conditions, putting in place protocols for identification at triage, and implementing rapid care and treatment procedures can help get the patient's evaluation and subsequent treatment correct from the beginning – right at the front door.

Kathy: During our ED risk assessments, we focus on evaluation and management of clinical conditions that comprise the top diagnoses involved in hospital and physician ED claims. They include pain, sepsis, myocardial infarction (MI), and stroke (CVA), among others – all of which require accurate assessment at initial triage. Please comment on these conditions as patient safety and risk management priorities.

Robert: Delayed recognition of sepsis, MI, CVA, or deterioration leading to cardiac arrest is a patient safety issue because delays increase morbidity and mortality. A delay is a risk management issue because it places the physician and the hospital at risk of liability. Because patients with these conditions are usually already very ill requiring immediate attention, it is necessary to treat the patient at the same time as confirming the diagnosis – this should begin at triage. Rapid and accurate triage is a primary goal for ED patient safety and risk management.

Kathy: With the ED being the front door to the hospital, and the higher acuity of patients coming in that door, the failure to identify those who are really sick is a huge patient safety risk. So the place for the best and brightest emergency staff is triage. However, when we are conducting ED risk and safety assessments around the country, we don't always find that to be the case. Unfortunately, all too often there are new graduates or nurses with six months or less of experience assigned to triage, particularly during the night. What approaches can improve staff effectiveness in triage?

Robert: Without a doubt, triage nurses should be well-trained with demonstrated competence; the Emergency Nurses Association has established minimum qualifications for triage nurses that include advanced training, experience, and education. But it is important to remember that triage is a process, not a place, and that it should be a team effort. This includes high-functioning critical thinking, as well as interpersonal skills such as teamwork and communication that support a culture of safety. Nurses, physicians, and other providers and staff in the ED need to be able to work well together and communicate effectively. These skills can impact timely intervention and a patient's ultimate outcome. Team triage models have been successfully used to reduce delays, as well as improve patient and staff satisfaction.

Kathy: What are common things that you see causing delays during triage or reducing the effectiveness of triage?

Robert: The top things that impact effective triage and can result in delays include:

- Processes that take too long to identify time-sensitive illness or injury
- Inadequate resources, space, and equipment available for triage
- Lack of a plan to deal with the "rush hour" – peak volume times
- Asking the wrong questions or not enough key questions to get an accurate history

  - Failure to ask about comorbidities
  - Failure to ask about medications, especially anti-coagulants, beta blockers, and medications that affect vital signs and mental status
  - Not believing the patient in pain or a frequent ED user
- Failure to re-evaluate the EMS patient
- Failure to know and recognize atypical presentations of critical illnesses
- Failure to communicate important information to the physician and care team

Kathy: Can you describe an approach for reducing delays and improving the triage process?

Robert: Hospitals and physicians need to collaborate to improve safety and reduce the risks of triage. A continuous process of assessing the current state, planning for improvements, implementing changes, measuring them, and then reassessment should be followed. Clinicians are motivated to improve when presented with accurate and clinically relevant data *(see step-by-step approach on page 2)*.

Kathy: Thank you Dr. Schafermeyer. Hospitals and emergency providers can benefit from lessons learned when serious safety events and liability claims arise from delays and failures that can be prevented as part of a robust triage function. The high-level overview provided here can jump start an evaluation of the triage process in any emergency care setting.

Kathleen Shostek is a senior healthcare risk management consultant for Sedgwick.

Pediatric safety in the emergency department: Reducing the risk of liability claims

By Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM

Providing safe care to children and avoiding liability is a top concern for most emergency department (ED) providers and facilities. ED use by children under age six is frequent, accounting for more than 30 million encounters and 24 percent of annual ED visits in the U.S., according to a 2012 National Report on Health Statistics.[1] Three quarters of pediatric emergency visits are to hospitals that are not children's hospitals.[2] Recognizing this, the American College of Emergency Physicians (ACEP) currently offers its members an online course, culled from its 2013 scientific assembly entitled, "The Pediatric "Risk-Free" Emergency Department: Reducing Malpractice Exposure" (http://virtual.acep.org/common/presentations.aspx/4/18/390).

Indeed, ACEP, along with the Emergency Nurses Association (ENA) and the American Academy of Pediatrics (AAP) published a Joint Policy Statement setting forth guidelines and the resources necessary for EDs to serve pediatric patients.[3] According to the joint guidelines, the first essential for managing pediatric emergency care is to appoint physician and nurse coordinators for the care of children in the department. Having these coordinators in place supports responsibility for ensuring provider and staff competencies in pediatric care, implementation of risk management/patient safety/quality improvement activities, and development of appropriate policies and procedures for pediatric emergency care.

A useful self-assessment checklist to assess ED readiness to safely care for children has been developed based on the

joint guidelines. The checklist is available online at the ENA website: http://www.ena.org/about/position/jointstatements/Documents/GuidelinesfortheCareofChildreninED2010.pdf.

Top areas of risk for pediatric emergency care include communication breakdowns during transitions of care and handoffs, barriers to obtaining adequate histories and presenting problems, and challenges with ensuring safe medication prescribing and administration. These areas are compounded when the culture in the ED is not conducive to teamwork and the work environment does not allow staff to speak up when there are concerns about safety and quality.

Strategies to address these top areas for pediatric safety improvement in the ED center on enhancing teamwork, implementing standardized communication tools, and using evidence-based safe practices. Resources to implement these strategies include the following:

- ✓ **TeamSTEPPS®** – an evidence-based teamwork system to improve communication and teamwork skills in support of a culture of safety. Higher hospital patient safety culture survey scores have been associated with lower adverse event rates.[4] TeamSTEPPS is freely available from the Agency for Healthcare Research and Quality. See http://teamstepps.ahrq.gov/.
- ✓ **ED "Safer Sign Out" protocol** – this team-based intervention to improve safety and prevent communication failures during shift changes and care transitions that can lead to patient harm and liability is promoted by and readily accessible through The Emergency Medicine Patient Safety Foundation. See http://safersignout.com/.
- ✓ **Joint Commission Sentinel Event Alert: Preventing pediatric medication errors** – this literature contains guidance on pediatric medication safety in the emergency department.[5] See: http://www.jointcommission.org/sentinel_event_alert_issue_39_preventing_pediatric_medication_errors/.

There is increasing evidence of a significant correlation between the frequency of adverse events and malpractice claims.[6] Examination of serious safety events and liability claims can also reveal high-risk areas and diagnoses or conditions ripe for risk prevention efforts. Diagnostic error is a frequent allegation in claims involving pediatric patients,[7] and conditions related to these errors include infections such as meningitis, appendicitis, and sepsis. Both cognitive and system factors contribute to diagnostic error.

Analysis of a high-profile ED case involving the death of a 12-year-old in New York from streptococcal toxic shock in 2012 revealed several possible cognitive and system factors leading to error in diagnosis. Possible contributing cognitive factors include:[8]

- ✓ Availability bias: Gastroenteritis was prevalent at the time
- ✓ Received diagnosis: Reliance on diagnosis from referring provider
- ✓ Premature closure: Assuming first diagnosis is accurate without considering another
- ✓ Anchoring bias: Not considering new information/not listening to the patient

Possible contributing system and communication factors include:

- ✓ Initial vital signs lacked a temperature
- ✓ Discharge vital signs not reviewed by the physician
- ✓ Abnormal labs not reviewed or not acted on

Strategies for mitigating these cognitive and system/communication factors and reducing risk of diagnostic errors that can result in patient harm and expose ED providers to liability include:

- ✓ Awareness of cognitive factors by ED providers, deliberate self-assessment, and cross monitoring with peers
- ✓ Use of algorithms and screening tools for high-risk conditions such as sepsis and abdominal pain
- ✓ Implementing decision support systems that prompt considerations of alternative diagnoses
- ✓ Auditing compliance with patient intake, assessment, and discharge procedures and correcting noncompliance
- ✓ Establishing protocols for communicating and acting on diagnostic results and assigning accountability for carrying out the protocols
- ✓ Ongoing training and education in the care of children – ACEP, ENA, AAP, and other professional societies provide clinical education programs to develop and maintain pediatric competencies and skills

References

1. National Center for Health Statistics. Health, United States, 2012: With Special Feature on Emergency Care. Hyattsville, MD. 2013.
2. Schappert SM, Bhuiya F. Availability of pediatric services and equipment in emergency departments: United States, 2006. National health statistics reports; no 47. Hyattsville, MD: National Center for Health Statistics. 2012.
3. AAP Joint policy statement—guidelines for care of children in the emergency department. Pediatrics 2009 Oct;124(4):1233-43. http://pediatrics.aappublications.org/content/124/4/1233.full.html.
4. Mardon, et al. Exploring Relationships Between Hospital Patient Safety Culture and Adverse Events. Journal of Patient Safety, 2010. Vol. 6 (4) 226-32.
5. Cadwell S. Pediatric medication safety in the emergency department. J Emerg Nurs 2008;34:375-7.
6. Greenberg MD, Haviland AM, Ashwood JS, Main R. Is better patient safety associated with less malpractice activity? RAND Institute for Civil Justice, 2010. Available at http://www.rand.org/pubs/technical_reports/2010/RAND_TR824.pdf.
7. Data Sharing Project 1985-2010. Physician Insurance Association of America (PIAA), Rockville, MD.
8. Ryan R and Fischer S. Risk and Claims in Pediatrics: A case study in sepsis. Available online at: http://www.isabelhealthcare.com/pdf/Monograph_Pediatrics_2012_Final.pdf.

Safe management of mental health patients in the emergency department

By Monica Cooke BSN, MA, RNC, CPHQ, CPHRM, FASHRM

Emergency departments (ED) have rapidly become the primary care providers for persons with mental health or substance abuse disorders. The 2011 Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS), recently published by the Agency for Healthcare Research & Quality (AHRQ), reports that 5.5 million, or 4 percent, of all emergency room visits were for a mental health/substance abuse diagnosis. (https://www.hcup-us.ahrq.gov/nedsoverview.jsp). Even more significant, there were 43 million, or 33 percent, of patients that presented with either a primary or secondary mental health/substance abuse diagnosis. This indicates that one in three emergency department visits involve a patient with a significant mental health condition. Because of dwindling community resources and fewer inpatient treatment settings, emergency departments have become the "de facto" care provider for the mentally ill.

Caring for mental health patients often affects timely throughput of patients in the ED and they present many other risks in the emergency care setting. The future of rapid improvement in access to appropriate treatment settings and care providers is uncertain. Therefore, organizations must identify and implement strategies to mitigate risk and improve patient safety.

The major high-risk conditions for emergency departments caring for mental health patients include: suicidality, aggression, and elopement. Adverse outcomes involving these conditions have led to legal claims with the most frequent allegations including inadequate risk assessments, lack of a safe treatment environment, and lack of staff competencies. These deficiencies can lead to a variety of exposures such as regulatory risk, healthcare professional liability risk, and reputational risk from adverse media attention – none of which will fare well for organizations.

It is not an impossible challenge for emergency departments to provide safe care to mental health patients. The first step in identifying risk is to conduct an assessment of the treatment setting. Once completed, this assessment can yield valuable information to set priorities for improvements and develop strategies to improve safe care and prevent adverse events.

The following are three common risk assessment findings that are high liability areas ripe for risk mitigation strategies.

1. Insufficient initial and routine assessment for patients that demonstrate high risk behaviors

The lack of screening, assessment, and documentation of assessments opens the door to liability for the facility.

Risk management strategies:

- Identify patients "at risk" during the initial triage assessment to be followed by a comprehensive assessment by a mental health clinician.
- Implement frequent assessment (every one to two hours) and document patient contact by care providers. Note: anxiety/agitation are usually the first signs of increasing risk and contact with staff helps to minimize this symptom.
- Perform reassessment at critical junctures and transitions in care: change in level of functioning, change in observation level, and at discharge.
- Assign the appropriate level of observation to the patient based on the risk assessment. Staff providing the monitoring should have documented competencies to provide this intervention.
- Based on the risk assessment, medication management should be instituted promptly to manage symptoms.

Note: for the assessment of suicidality, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed the Suicide Assessment Five Step Evaluation and Triage – "SAFE-T" assessment tool – which can be utilized by professionals with limited competencies in suicide risk assessment (http://www.integration.samhsa.gov/images/res/SAFE_T.pdf).

2. The lack of a safe treatment setting

Given the high rate of mental health patients presenting to emergency departments, it is essential that there are safely designed treatment areas to minimize the risk of suicide, aggression, and elopement.

Risk management strategies:

- Escort patients presenting with a mental health complaint into the exam room. Do not have them wait in the patient waiting area.
- Conduct an initial search of the patient for any items of potential harm. These items should be secured in a locked cabinet in the room or another safe location.
- Establish "safe" rooms close to the central nursing area – not near the ambulance bay. These rooms can be a permanent design or able to be converted for use in a medical situation.
- Design a large room for two or more patients and provide recliners instead of beds for patient comfort. This can optimize staff resources for observation of patients.
- Provide diversions such as a television, magazines, music, and food/fluids.
- Conduct routine surveillance and searches of the designated

treatment area for potentially dangerous items (plastic bags, sharps, ropes, strings, etc.).

- Ensure that the bathroom used by patients is safely designed or provides for constant supervision of high-risk patients.
- Consider the use of a different color gown or scrubs for easy identification of mental health patients or those at risk for elopement.

Note: the Joint Commission published Sentinel Event Alert Issue 46 (accessible at www.jointcommission.org), which provides recommendations for the assessment and management of behavioral health patients in non-behavioral health settings and is a useful reference. Additionally, the National Association for Psychiatric Health Systems (NAPHS) has the "Design Guide for the Built Environment of Behavioral Health Facilities" reference available at www.naphs.org, considered the standard in the industry.

3. Insufficient staff competencies

Considering that the emergency room is often the first stop for patients having a mental health crisis, it is imperative that the staff treating them have competencies in managing their behaviors and symptoms in a safe, therapeutic manner.

Risk management strategies:

- Provide education/training in assessment, de-escalation, and non-violent management of aggressive behaviors. Security personnel should also be trained in de-escalation and safe management of patients.
- Ensure that staff members are knowledgeable about the federal guidelines surrounding the use of restraint and seclusion.
- Provide adequate mental health professional support to allow for timely and comprehensive assessment. Crisis counselors, social workers, or advance practice nurses are invaluable to assist in assessment and discharge planning. Psychiatrist consultation should also be available for evaluation.
- Hire trained behavioral health technicians to provide routine monitoring and management of these patients. These staff members can be cross-trained to function as ED technicians should the volume of mental health patients be low.
- Provide patient companions or "sitters" that function as observers and document their competencies.
- Tele-psychiatry can be useful in providing timely assessment and disposition of patients. Note: barriers for tele-psychiatry can include reimbursement methods, clinician licensing, and credentialing.

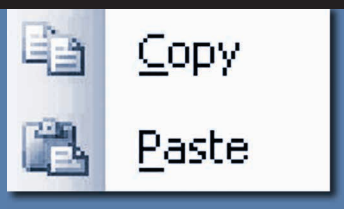
Safer care for mental health patients is possible in the emergency department. A focus on these three high risk areas in the management of mental health patients can greatly assist in reducing risk and improving patient safety.

Sedgwick thanks Monica Cooke of Quality Plus Solutions LLC - A Behavioral Risk Consulting Firm for contributing this article. Monica is a Sedgwick partner consultant.

TechnologyBytes

BY ANN GAFFEY RN, MSN, CPHRM, DFASHRM

Copy and paste: Time saver or trouble in the making?



As the Meaningful Use incentive program forges ahead, the tide has shifted for electronic health record (EHR) adoption in both acute care and outpatient settings. According to a recent CDC report, in 2013, 78 percent of office-based physicians used any type of electronic health record (EHR) system, up from 18% in 2001.[1] More than 83 percent of hospitals are at Stage 3 or higher in electronic medical record (EMR) adoption, based on the Healthcare Information and Management Systems Society (HIMSS) EMR Adoption Model.[2] Those who have successfully navigated through "go live" have improved their efficiency in using the technology, and have likely learned some of the shortcuts to get around the system they are using.

One of the more common shortcuts is "copy and paste." As reported in the September 2013 American Health Information Management Association (AHIMA) report, "74 to 90 percent of physicians use the copy/paste function in their EHRs, and between 20 to 78 percent of physician notes are copied text."[3] Statistics like this beg the question if providers and nurses are actually listening to what a patient is saying and memorializing the conversation in a clearly unique note, or if they are just trying to get through their day efficiently, and using copy/paste computer functions to document what, to them, may sound like similar patient complaints and plans of care.

Risk managers shudder when they think about the potential fallout from this practice. First and foremost, the opportunities to negatively impact patient care and cause harm are increased. Copy and paste can contribute to incorrect or inaccurate information being relayed in the patient's record or important information being left out. Information may not be updated with the most current data, information could be redundant, making it difficult to determine the patient's current state, or there could be over-documentation because the note that was copied was not reviewed completely. Furthermore, risk managers must consider potential privacy breach – records of one patient may be cut into the records of another and then improperly disclosed in a medical record request. For providers who work in more than one EHR system, some are able to copy information from one system (for example, the office practice EHR) into another system (such as the hospital EHR). In addition, it can leave the question of authorship up for grabs. When was the original entry actually made, and by whom? As noted by AHIMA, "In some settings, copy and paste may be acceptable for legal record purposes but not for others (clinical trials data, quality assurance data, pay-for-performance data). In the hybrid environment, audit tracking of copy and paste may not be available because it involves different systems."[4]

Beyond patient safety concerns, the Office of the Inspector General has noted copy and paste as one of the two most common documentation practices to commit fraud.[5] Multiple encounters using the same documentation, as well as the potential for over-documentation previously mentioned, has the potential to create the appearance of support for billing higher level services with the irrelevant documentation that was brought forth from a record of another patient or another encounter of the same patient. This false documentation places an organization or individual provider at high risk for trouble.

What mitigation efforts should we consider? Realistically, turning copy and paste functionality "off" would be difficult in many organizations, and likely met with significant resistance. However, certain boundaries still must be set, with the creation of an approach that can be used to consistently manage clinical content, and outlining what is acceptable and what is not. In addition, limitations on copy and paste for legal record purposes may need to be outlined, such as for documentation in clinical trials data, and pay-for-performance data.[6] A reliable chart audit function must be established and should contemplate an audit of a representative number of records by specialty and provider on a monthly basis; this could be centered around certain diagnoses or treatments, which is where copy and paste activity is typically found.

As we move toward achieving a fully electronic documentation system across the country – a goal of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 – we must continue to evaluate the impact of EHRs in the patient care environment, how this form of documentation may be affecting patient safety for the better and the worse, and continually work to make EHR technology a valuable tool in support of safe patient care.

Ann Gaffey is SVP, Healthcare Risk Management and Patient Safety for Sedgwick.

References:

1. Hsiao C-J, Hing E. Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001–2013. NCHS data brief, no 143. Hyattsville, MD: National Center for Health Statistics. 2014.
2. HIMSS Analytics: EMR Adoption Model, found at: https://www.himssanalytics.org/emram/emram.aspx

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3. Bowman, S. (2013). Impact of Electronic Health Record Systems on Information Integrity: Quality and Safety Implications. Perspectives in Health Information Management. Available at: http://perspectives.ahima.org/impact-of-electronic-health-record-systems-on-information-integrity-quality-and-safety-implications/#.UxaIuD9dUed
4. Amatayakul, M., Brandt, M. and Dougherty, M. (2003) Cut, Copy, Paste: EHR Guidelines. Journal of AHIMA,74, (9), 72–74.
5. Healthcare IT News, January 9, 2014. CMS called out for EHR fraud failings. Available at: http://www.healthcareitnews.com/news/cms-called-out-ehr-fraud-failings
6. Ibid.

Additional Resource

✓ Health Information Technology Patient Safety Action & Surveillance Plan, Office of the National Coordinator for Health Information Technology, available at: http://www.healthit.gov/sites/default/files/safety_plan_master.pdf.

Upcoming events

Visit the Sedgwick professional liability and healthcare risk management team at these upcoming conferences:

- **VASHRM Spring Program**
  May 1 | Virginia Beach, VA
  - *Hospital-Physician Integration: Steps for Successful Collaboration (panel discussion) – Ann Gaffey*
- **Emergency Department Practice Management Association Solutions Summit** – *Visit Sedgwick in the exhibit hall*
  May 4–7 | New Orleans, LA
- **NNESHRM New England Regional Conference for Healthcare Risk Management**
  May 4–6 | Mystic, CT
  - *Visit Sedgwick in the exhibit hall*
  - *A Risk Manager's Nightmare (panel discussion) – Sue Wilson*
- **ASHRM Academy**
  May 5–8 | Oak Brook, IL
  - *Educational luncheon with Ann Gaffey, sponsored by Sedgwick*
  - *HRM Module 2: Applications in HRM – Ann Gaffey, Faculty*
- **SCAHRM Annual Educational Conference**
  May 7–9 | Rancho Mirage, CA
  - *Visit Sedgwick in the exhibit hall*
  - *Tackling the Top 10: Driving Down Claims – Ann Gaffey and Jayme Vaccaro*
- **NPSF Patient Safety Congress** – *Booth 223*
  May 14–16 | Orlando, FL
- **ALFA** – *Booth 935*
  May 19–22 | Phoenix, AZ
- **RL Solutions RL Palooza User Group Conference**
  June 3–6 | San Diego, CA
  - *Using Data for ACTION! – Ann Gaffey and Lynn Gmeiner*
  - *Using Technology for Care Transitions – Ann Gaffey*

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