A H R M N Y

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Editor's Corner

AHRMNY's Risk Management Journal (RMJ) is the official journal of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) and is published several times a year.

RMJ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulation, as well as other relevant information of interest to risk managers. The articles are usually written by AHRMNY members, so the journal serves as an opportunity for members to showcase their writing talents.

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Article Requirements: Maximum article length 3,500 words. Photos should be high-resolution JPEGs (at least 300 dpi). AHRMNY will not publish articles promoting products or services.

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Questions or comments to editors may be sent to ahrmny@gmail.com

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PRESIDENT'S MESSAGE

As we close out another remarkable year, I am reminded of the proud history and enduring purpose of the Association of Healthcare Risk Management of New York (AHRMNY). For decades, AHRMNY has stood as a cornerstone of professional excellence–advancing risk management practice, promoting patient safety, empowering healthcare leaders, and fostering a collaborative community committed to improving outcomes across New York State. Our legacy is built on service, education, and the shared belief that safer, more equitable care is achievable when we work together.

I want to extend heartfelt appreciation to our past Co-Presidents, Carolyn Wolf and Robert Martin, whose leadership, vision, and unwavering commitment helped strengthen the foundation on which we continue to build.

This year has been one of tremendous engagement for AHRMNY. We kicked off 2025 with a successful half-day conference at The DeMatteis Center in Long Island in March, celebrating Patient Safety Week with an energizing and insightful program. In June, we hosted yet again, another sold-out conference at the City Winery, featuring dynamic speakers who challenged, inspired, and educated attendees. Also in June, AHRMNY conducted a free and very well attended learning webinar during Risk Management week. We continued our upward trajectory with our Third Annual Upstate Conference in Binghamton, affirming our commitment to reaching risk management professionals across all regions of New York. We then concluded the year with a highly relevant webinar on Countering Bias in Healthcare Risk management Investigations, reinforcing our focus on meaningful contemporary issues in the field.

Our efforts to expand into the upstate region have been met with a lot of enthusiasm and participation. We are especially proud to have now, two board members representing the upstate community, a milestone that reflects our belief that AHRMNY should be a truly statewide organization that engages with and serves all healthcare risk management professionals across New York.

AHRMNY extends its sincere gratitude to the Chairs of our Publications Committee, Sharon Scheuermann and Melissa Bedward, along with every member of the committee, for their hard work and dedication in producing this exceptional edition of our journal.

I would also like to recognize the outstanding work of our Education Committee Co-Chairs, Stephanie Campbell and Gina Kittek, and the entire committee. Their commitment has been instrumental in delivering the high-quality programs we offered throughout the year.

Similarly, we express our deep appreciation to our Fundraising Committee Chair, Lesli Giglio, and the members of her committee for their tireless efforts in securing sponsorships that make our programming possible.

A heartfelt thank you to all our committee chairs, committee members, volunteers, and contributors. Your time, energy, and passion are what keep AHRMNY thriving, and we are truly grateful for all that you do. I would also like to extend our sincere appreciation to AHRMNY's Executive Director, Kisha Wright, for her unwavering dedication and steadfast commitment to our organization.

Finally, we extend our deepest gratitude to our sponsors, whose generosity and partnership make it possible for us to deliver high-quality educational events, networking opportunities, and professional resources throughout the year. Your support allows AHRMNY to grow, innovate, and continue to fulfill our mission.

As we look ahead to the New Year, I am inspired by all we have accomplished together and excited for the opportunities on the horizon. On behalf of the AHRMNY Board of Directors, I wish you and your families a joyful holiday season and a healthy, peaceful, and prosperous New Year.

Wilhemina Nyarko, President

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Top Risk Management Issues Facing Healthcare Providers[1]

Susan Briones, Paige Lueking, and Karen Garvey

While there are many different Risk Management issues facing heath care providers, this article will focus on four:

1. Liability
2. Medication Errors
3. Use of Social Media
4. Workplace Violence

I. Liability

A provider's care is scrutinized in liability situations like medical malpractice cases, professional licensing board investigations, and peer reviews. While "perfect care" is important to aspire to, what is legally required is "reasonable care." To help understand what is "reasonable" and how care is evaluated in liability situations, we will provide a quick primer on healthcare liability law.

Law 101

When a plaintiff sues a healthcare provider, there are four elements they need to show: **Duty, Negligence, Causation,** and **Damages**. All healthcare providers have a duty to provide reasonable care to their patients, so the "**Duty**" element is often easy to establish and rarely challenged.[2, 3]

Negligence means failing to meet the standard of care, which is defined as what a reasonably prudent provider would do in the same or similar circumstances.

That standard will be specific to the situation. For example, if the issue is whether a patient was appropriately cared for in the PACU, then the standard of care would be what a reasonable PACU nurse would have done in the same or similar circumstances. Those circumstances can vary. For example, what is reasonable will depend on the type of patient, their age, their comorbidities, the type of surgery performed, the physician's orders, hospital policies, and other factors.

The next element is **Causation**. If duty and negligence have been established, the plaintiff must show that the outcome or injury would not have happened "but for" the negligence—in other words, that the alleged negligence caused the damages.

The plaintiff also needs to show that the outcome was foreseeable based upon the negligent act or omission. Take our PACU nurse example: If the post-op patient is awake and alert but struggles to meet the expected threshold of O^2 saturation on room air, there are several things a reasonably prudent PACU nurse would do, such as instituting nursing interventions like assessing the airway, administering supplemental oxygen, or repositioning. The PACU nurse might review the physician's orders for guidance, call respiratory, or contact the physician. But if the PACU nurse does not do any of those things and discharges the patient, the plaintiff will argue it was reasonably foreseeable that the patient would decompensate and suffer respiratory arrest. The foreseeability question would be examined by attorneys on both sides, with the defense looking to identify other potential causes that removes the PACU nurse from the "but for" equation.

The final element of a medical malpractice case is **Damages**. The Plaintiff has to show that the negligence caused the injury, and that this injury can be compensated. The damages claimed can include pain and suffering, lost wages, and the cost of past or future medical care.

The plaintiff's case may often focus on damages, the financial component to the case. Causation issues are argued by medical experts. The area that can be most successfully controlled by the providers *before* there is a lawsuit, is the element of negligence. To assess whether a provider is negligent, the evidence examined includes: medical records; testimony of the patient/family, the defendant provider, other providers, and medical experts; written policies and procedures, statutes, or guidelines; and medical literature. The one piece of evidence providers have the most control over is the medical records.

Common Liability Issues

- Failure to Monitor
- Failure to follow orders
- Failure to report significant change in condition
- Failure to advocate
- Failure to document all of the above

In a lawsuit, any of these issues could be present. Lack of documentation is one of the primary issues in lawsuits. It is not that the failure to document itself is a causal factor, although it can be, but it is more often the missing piece of evidence that could be used to defend the provider. We will use real case studies to provide examples of situations faced by health care providers, lessons learned, and recommendations to mitigate future issues.

Case Study – failure to monitor:

- History: Resident in a Memory Care Unit of an Assisted Living Facility has a documented history of wandering and attempts to escape the building (elope).
- Injury: Resident elopes in the middle of the night and is lost for six hours. She is found on the floor of an apartment building two blocks away, unresponsive, with injuries consistent with a fall.
- Contentions: Staff failed to timely: respond to a door alarm, conduct room checks, initiate an outdoor search, and notify police.
- Causal chain to be proven: The alleged failures permitted the resident to escape, which led to her fall and injuries.

Was the resident's elopement and subsequent injuries foreseeable? The evidence revealed that the staff were on notice that she would try to escape from the building. During the resident's 10 months at the facility, there were four documented elopement incidents and eleven documented wandering incidents. The records contained a Care Plan addressing wandering and exit seeking, and the attending physician's progress note, written two days before the elopement, noted the resident was "wandering day and night" and "exit seeking." Based upon the records, it was reasonably foreseeable that the resident would elope. Another question in the case was whether the staff followed the Care Plan and facility policies aimed at preventing exit seeking. Unfortunately, there was little documentation to show that the resident had been closely monitored. Also because of a lack of documentation, it was argued the staff failed to follow a facility policy requiring immediate outdoor search when no one was found near the door after the alarm sounded.

Lessons & Mitigations

- Institute procedures that provide evidence of monitoring
- Electronic tracking of resident room doors opening
- Cameras outside the building
- Timely documentation of actions taken once resident is found missing

Case Study – failure to follow orders:

- History: 75-year-old male with history of uncontrolled diabetes and cardiac stents. Admitted to hospital through ER with a severely infected arm wound. Plan for surgery in AM. General Surgeon orders chest x-ray and EKG "now."
- Injury: Sudden cardiac arrest in the middle of the night.
- Contentions: Failure to follow orders.
- Causal chain to be proven: Had the chest x-ray and EKG been performed, an impending cardiac event would have been recognized and averted.

The physician's orders included that the patient be NPO after midnight and that a chest x-ray and an EKG be performed "now." The orders were written while the patient was still in the ER, before transfer to the floor.

The floor nurse documented she received the patient at 9:00 PM, 45 minutes after the orders were written. At 10:00 PM nurse notes indicate family was at the bedside and the patient was fine. At 11:00 PM, the nurse documents the patient's vitals are checked, his medications are reviewed, and he is resting. At 12:30 AM, the nurse documents the patient is resting with no distress. The nurse also notes the patient asked for a snack and was given a sandwich. This is the first

evidence that the orders were not reviewed by the floor nurse since those orders included that the patient should take nothing by mouth after midnight. The next nurse note is at 2:00 AM and describes finding the patient on the floor of the bathroom, unresponsive. The code sheet states the patient was pronounced dead at 2:45 AM.

Although no autopsy was performed to confirm cause of death, factoring in the patient's age and preexisting cardiac condition, the plaintiff argued it was more likely than not a sudden, but preventable, cardiac event. It was easy to point to the failure to perform an EKG and chest x-ray as an important link in the causal chain. While the defense could argue it was speculation to say the cause of death was cardiac related and that performing a chest x-ray or EKG would have averted the outcome, the clear failure to follow orders rendered the case difficult to defend.

Lessons & Mitigations

- Strengthen training, policies, and procedures surrounding orders written in the ER before patient transfers to floor.
- Institute Electronic Medical Record safeguards that trigger and mark locating, identifying, acknowledging, and completing orders.

Case Study – failure to report/advocate:

- History: 45-year-old male on floor following anterior cervical spine surgery.
- Injury: Asphyxia due to compression from retropharyngeal hematoma.
- Contentions: Failure to recognize and address respiratory distress, failure to timely report to surgeon/anesthesiologist, failure to advocate when attending physician interventions not successful.
- Causal chain to be proven: Had the floor nurse timely advocated, the appropriate physicians could have intervened and prevented asphyxia/death.

The floor nurse records show that upon arrival from PACU, the patient was reporting 10/10 pain but was not in distress. 20 minutes later, the patient was "screaming" he could not breathe. The attending physician (Internal Medicine) was notified, who ordered anxiety and pain medications. One hour and 15 minutes later, the nurse documents the patient is again complaining he cannot breathe. The attending is notified, and she calls the surgeon, who orders a CT of the neck. The attending gives floor nurse the verbal order, who enters it as "routine." The surgeon documents later that his order had been "stat." Before the CT is performed, a code blue is called, but the patient does not survive.[4] An autopsy revealed a retropharyngeal hematoma had compressed the patient's airway.

The floor nurse's actions, at least initially, were reasonable. He reported the patient's complaints to the attending physician, who promptly ordered interventions. However, were the interventions appropriate for the complaints? Of course, a nurse is not a medical doctor, but close monitoring after administration of the medications would have been appropriate, and may have occurred, but were not documented. It was argued by the plaintiff that the nurse should have immediately gone up the chain of command to advocate for a patient who was screaming that he could not breathe and should have called the surgeon or anesthesiologist instead of relying on the attending. Lack of documentation and confusion about whether the order for the CT was "routine" or "stat" and assertions that the nurse should have advocated for a "stat" CT further complicated the nurse's defense.

Lessons & Mitigations

- Have clear protocols for reporting up the chain of command.
- Make sure all communications between nurses and physicians are documented, including phone calls, voice mails, and text messages.
- Follow-up assessments must be conducted and documented.
- Address culture of fear of going over a physician's head or tendency to defer to physicians, especially when patient is not responding to ordered interventions.

Case Study – Documenting contact with provider:

- History: Patient on the floor following surgery.
- Injury: Post op epidural hematoma.

- Contentions: Failure to timely notify provider and provider's failure to act.
- Causal chain to be proven: Timely intervention would have prevented adverse outcome.

This was a case where the floor nurse and attending physician were pitted against each other. The nurse's position was that she timely notified the provider, where the physician tried to argue he was not made aware of the situation.

The nurse's documentation showed she had been monitoring the patient throughout the night and involved several physicians at the first sign of problems. The nurse documented she saw Dr. A rounding on other patients and asked him to see this patient. She further documented that Dr. A texted Dr. B, the patient's physician, of the findings and interventions provided so far. The documentation not only described what Dr. A did at the bedside, but also his contact to Dr. B, the method of contact, and the content. The nursing notes documented multiple subsequent attempts to contact the Dr. B via cell phone, leaving messages, and paging his service.

Lessons & Mitigations

- The quality of the nursing notes left no openings to attack the care.
- The detail in the note led to Dr. B deferring to the note's version of events.
- Document involvement of any and all physicians, no matter how limited.
- Document all attempts at contacting physicians, even if unsuccessful.

Case Study – Importance of contemporaneous documentation

- History: Patient in PACU following surgery, discharged home.
- Injury: Respiratory arrest.
- Contentions: PACU nurse's failure to timely notify provider of inadequate oxygen, decreased Aldrete score, and elevated pain at time of discharge.
- Causal chain to be proven: That admitting rather than discharging patient would have averted the outcome.

This was another case where the nurse and attending physician were pitted against each other. The PACU nurse contended she had consulted with the physician and advocated admission to the floor, but the physician declined. The physician contended the nurse never notified him of the patient's change in condition. Unfortunately, the only documentation supporting the nurse's contention was contained in a late entry, handwritten after the patient had already died. In her deposition, the floor nurse testified that she opened the record to enter her late note because she suspected her initial narrative nursing notes were missing. The physician testified he had never been contacted, and the nurse had to answer difficult questions about whether the physician was lying in his testimony.

Lessons & Mitigations

- The late note gave the lawyer the opportunity to question the nurse's truthfulness.
- Lack of contemporaneous documentation led to a "he said/she said" argument with the physician.
- The timelier the documentation, the less likely it will be called into question.
- Confirm that entries into the electronic medical record are saved and recorded appropriately before leaving your shift.

II. Medication Errors

Medication errors continue to be one of the biggest concerns for hospitals and health systems. In recent years, medication errors have become more widely publicized, particularly due to some cases resulting in the criminal conviction of providers whose medication error caused a death and was determined to reach the level of criminal negligence.[5]

The reported incidence of medication errors in acute hospitals is approximately 6.5 per 100 admissions. Globally, medication-related errors are responsible for 5% to 41.3% of all hospital admissions and 22% of readmissions after discharge. Medication errors is 30% higher in patients who are prescribed five or more drugs and 38% higher in those 75 years or older. Patients 65 years or above experience nearly double the medication-related admissions compared to their younger counterparts.

The most common medication errors are:

1. Administering the wrong drug or dose
2. Using the wrong route
3. Administering it incorrectly
4. Giving medication to the wrong patient

Once a medication error occurs, what is the next step? Once a provider recognizes the error, it must be reported to the supervisor. Pursuant to hospital policies and procedures, the error should be disclosed to the patient and family so they understand what has happened, and the harm caused, if any. They should also be informed of the measures taken to minimize the harm, if possible. The patient and their family should be allowed to ask questions. Hospital committees will then perform the investigations necessary to comply with healthcare regulations and disclosure to regulatory agencies.

Prevention of medication errors requires implementation of system wide processes and training. Consider implementing barcode scanning, methods for limiting distractions and multitasking during medication administration, addressing system failures, and creating a just culture where providers feel safe disclosing errors to their supervisors.

III. Social Media

In today's world, many of us live online and we are all used to sharing (or over sharing) the minutiae of our daily lives on social media. It takes strict and repetitive training, particularly for younger generations, to prevent potentially disastrous disclosures of a patient's protected health information on social media. Health systems must educate on the boundaries between professional and personal lives and establish policies on appropriate social media use.

Making posts about patients on social media without obtaining their authorization is a serious breach of patient privacy and is a violation of most state privacy laws and the federal Health Insurance Portability and Accountability Act ("HIPAA"). If you don't have written consent to share information about a patient, even if the post does not mention the patient's name, do not post it. In fact, it is recommended that even when you have a patient's consent, do not post it. Patients can change their minds, but once something is on social media, it is virtually impossible to remove it.

HIPAA violations affect both healthcare professionals and organizations, resulting in hefty fines and job termination. There are numerous cases of providers losing their jobs due to inappropriate social media posts. For example, in 2021, a Florida nurse was terminated for posting photos of newborns with birth defects on Instagram and mocking them. The nurse was immediately put on leave and then terminated following an investigation of privacy violations related to HIPAA. In 2018, a Texas nurse was terminated for posting on a Facebook anti-vaccination group about a young patient who contracted measles. In the post, the nurse posted a series of comments about a rare case of measles at the hospital and her reaction of seeing the boy at the hospital suffering from the disease. The nurse was suspended and fired four days later for the HIPAA violation.

The goal is to prevent boundary violations that could harm patients and breach ethical or legal standards. Policies should educate employees as follows:

- Never identify a patient or post information about them.
- A patient does not need to be mentioned by name for them to be identified.
- Maintain professional boundaries online. Work and private lives should be kept separate, and information about patients or work in the healthcare space should not be posted.
- Avoid making disparaging, discriminatory, or offensive posts (even without naming the patient/family).
- Adhere to all employer policies and legal standards when using social media.
- Promptly report any breaches of confidentiality or inappropriate online conduct.

IV. Workplace Violence

Workplace violence is a national epidemic and an increasing issue in the healthcare space. There are endless headlines reporting attacks against hospital staff from physical assault, to stabbing, to gun violence. Sadly, many healthcare providers have lost their lives while in the process of caring for others. These events are costing health systems billions of dollars each year which encompass management of physical injuries but has have yet to capture losses due to psychological injury, absenteeism, recruitment

efforts and turnover. Health systems have legal and ethical obligations to keep employees, patients, and visitors safe.

The Occupational Health & Safety Administration (OSHA) mandates that employers assure safe and healthful working conditions. OSHA's general duty clause requires an employer to furnish to its employees "employment and a place of employment which are free from recognized hazards that are causing or likely to cause death or serious physical harm to (his) employees."[6] CMS and the Joint Commission also impose regulatory and accreditation requirements relating to workplace safety.[7] For example, the Joint Commission mandates annual worksite analysis on workplace violence prevention programs, review and investigation of all incidents of staff, patient, and visitor harm, ongoing education and training for staff, and the establishment of a workplace violence program comprised of an interdisciplinary team that develops policies and reporting procedures.[8]

At this time, every state in the U.S. has active laws or pending legislation to address violence against healthcare providers, with some increasing criminal penalties for violence committed against healthcare workers.[9] Nationally, the Safety from Violence for Healthcare Employee Act (SAVE ACT) would have provided health care workers same legal protections against assault and intimidation that flight crews and airline workers have under federal laws and federal grant funding through Department of Justice to augment hospital efforts to reduce violence by funding violence prevention programs, coordination of state/local law enforcement, and physical plant improvements (metal detectors, panic buttons). The legislation was introduced during the 2023-2024 legislative session and passed the House but did not become law. At this time, there is no action being taken on this bill in Congress, but advocates for stronger legislation to protect healthcare workers continue to lobby for passage of this law. Additionally, with the Accreditation 360 changes with The Joint Commission, compliance with the standards and elements of performance will be required.

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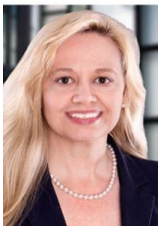
About the Authors



Susan Briones is a Partner in the Dallas, Texas office of Lewis Brisbois Bisgaard & Smith and a member of the firm's Healthcare practice. Susan has been advocating on behalf of healthcare providers for over 20 years, defending them in medical malpractice lawsuits and licensing board investigations as well as handling peer review and compliance matters. She represents hospitals, free standing emergency rooms and urgent care centers, skilled nursing and long-term care facilities, physician clinics and ambulatory surgical centers as well as individual practitioners including physicians, PAs, Nurse Practitioners, RNs, radiology technicians, and others. Susan is a proud member of ASHRM and active in local chapters.

Paige Lueking is Associate General Counsel at Dallas County Hospital District – Parkland in Dallas, Texas, and has been practicing healthcare law for over 30 years. Before coming to Parkland in 2020, Paige was a law firm partner representing individual healthcare providers and their employers in litigation, regulatory investigations, and board proceedings. At Parkland, Paige provides strategic legal guidance in the areas of patient safety, nursing and medical liability, medical staff governance, credentialing, peer review, and board licensure investigations. She also advises hospital leadership, peer review committees, and graduate medical education teams on managing risk, navigating regulatory frameworks, and addressing sensitive matters to minimize liability exposure and maintain quality standards for patient care.

Karen Garvey, MPA/HCA, BSN, DFASHRM, CPHRM is Vice President of Safety & Clinical Risk Management at Dallas County Hospital-Parkland Health in Dallas, Texas. Her current responsibilities include health system oversight of Regulatory and Accreditation, Patient Safety and Clinical Risk Management, Quality & Safety Education. She is the executive sponsor for the SPARKs (Supporting Parkland Staff) Peer Support Program and the chairperson for enterprise Workforce Safety Initiatives, which works proactively to develop strategies to decrease violence in the workforce. Karen is active in ASHRM, having served two terms on the ASHRM Advisory Board, and is also a faculty member for the CPHRM Review Course and national teaching faculty for the IHI certification in Patient Safety credential.

Patient Suffers Aortic Dissection While Waiting for Emergency Care

Theodore Passineau

Introduction

When medical risk management professionals analyze cases with poor outcomes, they can sometimes identify what is referred to as the "Swiss cheese" effect. This describes a situation in which several failures have occurred that individually would likely not result in patient injury; however, when the "holes" align, a major failure in patient care can occur. This interesting case capably illustrates this phenomenon.

Facts

The case occurred at a small, rural hospital outside a major city. The hospital did not contract directly with an emergency medicine group; rather, they contracted with an emergency medicine staffing agency. The agency contracted directly with emergency physicians and assigned them to their various hospitals' emergency departments (EDs). MedPro insured the staffing agency. The patient in this case was a 45-year-old Caucasian female who had a medical history of obesity, hypertension, and hyperlipidemia. She previously had been prescribed metoprolol and lisinopril but was not taking either medication because she "didn't like to take pills." She had visited the hospital's ED in November of Year 1 due to vaginal/abdominal pain. At that time, her blood pressure (BP) was 175/111 mmHg. She was discharged without treatment and advised to contact her primary care physician regarding her elevated BP. She again presented to the ED in April of Year 2 due to left-sided back pain. At that time, her BP was 155/99 mmHg. After being evaluated, she was discharged with pain medication. She returned 6 days later at 9:20 p.m. with chest pain (which had commenced that day). She also had back and lower abdominal pain, which had increased in severity over the week. Her BP was 225/124 mmHg.

A physician assistant (PA) who was the ED's triage officer promptly saw the patient. After doing an initial assessment, the PA ordered an ECG and appropriate lab studies and assigned the patient an acuity level of 2. As was normal, the PA had no further involvement in the case, including not ordering any medications or discussing this patient with either of the two physicians staffing the ED at that time (Dr. G and Dr. M). The patient was promptly placed in a treatment room, and Nurse B (the charge nurse) assigned her to Nurse S. The ECG was performed at 9:56 p.m. and reported to Dr. G. He did not order further cardiac testing, as he was satisfied that the patient was not suffering from a cardiac event at that time. He also did not feel that a physician needed to see the patient immediately. Because of the rotation of physicians in the ED, patients were not assigned to a specific doctor; the assigned nurse was expected to bring any abnormalities to a physician's attention. At 11 p.m., the patient continued to report 8/10 pain and had a BP of 231/128 mmHg. She was alert and oriented. At that time, Dr. M went off duty and Dr. H arrived for an 11 p.m. to 7 a.m. shift. Dr. H was a family physician who had previously practiced family medicine for several years; subsequently, he had completed an emergency medicine residency and recently had begun practicing emergency medicine. This was Dr. H's first shift at this hospital, where he would be the only physician from 3 a.m. to 7 a.m. When Dr. H came on duty, Nurse S discussed the patient with him. She explained that she was uncomfortable with the patient's BP. Dr. H acknowledged this information but did not immediately see the patient. Because of this, Nurse S also discussed her discomfort with Nurse B, who said he would do what he could to have the patient evaluated. After that, Nurse B asked Dr. H to see the patient and was told that he would. At 1 a.m., Dr. H still had not seen the patient. After being updated by Nurse S, he ordered metoprolol (5 mg) and potassium, which was administered at 1:15 a.m. Nurse S never reported back to Nurse B about the effects of the medications, whether Dr. H had seen the patient, or anything else. Nurse B had noted that the ED was very busy. Nurse S continued to document the patient as stable but remained concerned about her BP, which was 223/138 mmHg at 2:25 a.m. The patient's BP

lowered to 195/121 mmHg by 3:15 a.m. but elevated to 205/126 mmHg by 4:50 a.m. Nurse S documented that she had advised Dr. H, who had no new orders and still had not seen the patient. Nurse S also did not update Nurse B further. At 5:00 a.m., the patient suffered a grand mal seizure, which progressed to a full cardiac arrest. Resuscitation commenced but was unsuccessful, and she was pronounced dead at 5:38 a.m. A subsequent autopsy stated that the cause of death was a ruptured aortic aneurysm, but both plaintiff and defense cardiothoracic experts opined that she had actually died from an aortic dissection (an important distinction because dissection has a better chance for survival if treated promptly and appropriately). A malpractice lawsuit commenced against Dr. G, Dr. H, the hospital, and the staffing company (for their direct liability and their vicarious liability for their employee physicians). The hospital and the staffing company settled the case by each making a payment in the midrange. The physicians were dismissed as a result of these payments. Defense costs for the staffing company were in the high range.

Discussion

A review of this case shows that several factors contributed to the unfortunate outcome — some circumstantial and some related to performance. The staffing agency was criticized for placing a largely inexperienced physician on his own for several hours in an ED where he had never worked previously. Although it is unknown if Dr. H expressed any reservations about this assignment to the agency, he testified in his deposition that he was uncomfortable with being alone on his first night at this facility. The agency did not have any sort of orientation protocol in place, either for new physicians or physicians commencing a new assignment. The agency also did not do any monitoring of patient volumes at their client locations to ensure they were providing adequate physician coverage. As mentioned previously, this was a busy night in the ED (73 patients were there at 11 p.m., followed by another 18 between 11:00 p.m. and 3 a.m.). The hospital was also criticized for this failure (however, nothing indicates that the nursing staff was inadequate). Both parties were also criticized for their failure to have a surge protocol in place, which would provide additional physician resources if circumstances required them. A plaintiff's expert testified that, at a minimum, Dr. H saw 16 patients during his 8-hour shift (presumably the most acutely ill). The expert speculated that part of the reason Dr. H never saw this patient was that he was simply overwhelmed by these 16 patients and the others who were waiting. The nurses' actions were also criticized. The plaintiff's nursing expert felt that Nurse S's communication with both Dr. H and Nurse B was inadequate given her well-founded concerns. The nursing expert also felt that after Nurse S alerted Nurse B, he should have been more aggressive in his communication with Dr. H — and Nurse B should have elevated the matter through the chain of command if he did not receive an appropriate response. The criticism of Dr. G was less severe. He assumed the care of the patient when she came in at 9:20 p.m. and had been triaged. He reviewed the ECG shortly after its completion and was satisfied that the patient's condition was not an ST-segment elevation myocardial infarction. Therefore, additional cardiac testing was not indicated at that time. However, he never laid eyes on the patient while she was under his care, and no handoff communication occurred when Dr. H assumed her care at 11 p.m. Similarly, the direct criticism of Dr. H was modest. However, his failure to see a patient with these symptoms for over 6 hours in the ED was not excusable. Further, one dose of metoprolol was ordered and administered, but when Nurse S requested a second dose, it was not ordered because Dr. H said he would see the patient. He never did. In general, it was observed that the communication among Nurse S, Nurse B, and Dr. H was clearly short of optimal. It is noteworthy that the likelihood of the patient having an aortic dissection was extremely remote; a study of 9.5 million ED visits found that aortic dissections occur in about 1 out of every 12,200 visits.[1] One could argue that even if either physician had seen and thoroughly worked up the patient, an aortic dissection would have been — at best — at the bottom of a differential diagnosis, thereby offering some justification for missing it. However, that argument is largely neutralized by the fact that neither physician ever laid eyes on the patient. In the end, the cardiovascular surgery experts generally agreed that if the patient had been evaluated, she could have been in surgery by 3:30 a.m. They also agreed that if she had been promptly and properly diagnosed, and her BP brought under control, she had as high as a 90 percent chance of surviving the surgery and a 52 percent chance of surviving for 5 years.

Summary Discussion

The following suggestions may be helpful for healthcare organizations and staffing agencies that support patient care in busy ED settings:

- Carefully monitor patient volume trends to ensure that adequate physician to patient ratios are maintained. In this case, the plaintiff and defense experts generally agreed that for patients who are assigned a Level 2 acuity, 2.5 patients per physician per hour would be on the high end of what is considered reasonable.
- Provide orientation and appropriate training for new physicians or physicians new to the ED before they are left solely in charge.
- Make sure ED surge protocols are in place to respond to acute large influxes of patients or patient volumes that exceed appropriate ratios.
- Empower direct care nurses to elevate patient care issues when they perceive a threat to patient safety. Develop thorough chain-of-command protocols and ensure that nurses know when and how to activate them.
- Foster and facilitate strong communication between direct care nurses and collaborating physicians and providers. Include communication and teamwork concepts as part of training exercises and drills.
- Develop patient handoff policies and protocols (including expectations for verbal and written communication) and ensure that appropriate handoffs occur during shift changes.

Conclusion

The practice of emergency medicine is challenging because of some of its unique characteristics — a fact that will not change. The proper deployment and support of ED personnel is essential to maximize patient outcomes. This is accomplished through careful planning, the provision of adequate resources, and an institutional commitment to the highest levels of efficacy and patient safety.

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About the Author

Ted Passineau, JD, HRM, RPLU, FASHRM, has worked in medical professional liability for almost four decades, building a distinguished career as a medical malpractice defense attorney, risk management consultant, and director of risk management and continuing medical education for both doctor-owned and commercial insurers. He has trained thousands of physicians, dentists, and hospital staff across the U.S. and internationally, and authored numerous articles on professional liability topics. Ted retired from MedPro Group several years ago but still consults with the company to develop case studies and malpractice insights.

Disclaimer

Enhancing Safety Culture as Part of Fall Prevention Initiatives in Hospitals

Laura M. Cascella

Patient falls are a common risk management and safety concern in various healthcare settings, but particularly in hospitals where patients might be at increased risk of falling due to an "unfamiliar environment, acute illness, surgery, bed rest, medications, treatments, and the placement of various tubes and catheters."[1] The Agency for Healthcare Research and Quality (AHRQ) estimates that between 700,000 and 1 million hospitalized patients in the United States fall each year.[2]

Although some patient falls result in minimal or no harm, other falls can have severe consequences. MedPro closed claims data over a 10-year period show that more than half of inpatient falls (55 percent) result in clinically severe outcomes, such as death, fractures, head trauma, lacerations, or internal bleeding.[3] Patient falls also can have negative ramifications for hospitals and healthcare staff, including increased workload (both in relation to patient care and documentation), financial burden, poor satisfaction survey results, and liability exposure.

Various patient safety strategies and initiatives are available to help hospitals reduce patient falls. However, successful implementation of these strategies can hinge on each organization's commitment to a culture of safety and transparency. AHRQ notes that "Achieving a culture of safety requires an understanding of the values, beliefs, and norms about what is important in an organization and what patient safety attitudes and behaviors are expected and appropriate."[4]

Hospital leaders, providers, and staff members should consider the following characteristics of a robust safety culture to identify ways in which their organization is succeeding as well as areas for improvement:

- The organization has well-defined and documented safety protocols. These protocols are reviewed and updated periodically and when changes occur in workflows, systems, staffing, etc.
- The organization's safety protocols clearly outline the types of incidents that require reporting and the appropriate reporting method.
- The organization's leaders support safety initiatives — including fall prevention programs — through goal setting, resource allocation, and training opportunities.
- The organization has a code of conduct/ethics statement that promotes professionalism and encourages respectful and courteous communication.
- The organization promotes psychological safety and supports a nonpunitive approach to staff feedback and risk identification. Speaking up behavior is encouraged, and providers and staff members do not fear retaliation when reporting safety issues.
- Safety incidents are viewed as learning opportunities. When an incident occurs, the problem — not the individual(s) involved — is the focus of investigation and corrective actions.
- A system is in place to evaluate corrective actions and their effectiveness as well as to provide feedback to providers and staff about the results of these actions.
- The organization's leaders empower providers and staff to make decisions and changes that support quality improvement.
- The organization supports truthful and transparent communication with all healthcare providers and staff members.
- The organization measures performance and quality indicators and educates providers and staff members about data trends.
- Hospital units work individually and collectively to improve care coordination and identify potential gaps in communication and information transfer. Unit staff have input into tailoring fall prevention strategies for their units.
- The organization has a designated fall prevention team to evaluate fall risks, review incidents of falls, implement safety protocols, and monitor results.

- The fall prevention team includes appropriate representatives from across the organization, such as physicians, nurses, nursing assistants, physical therapists, occupational therapists, risk managers, facility engineers, and environmental services staff.
- The organization provides training that raises awareness about patient falls, their potential adverse outcomes, and the organization's commitment to fall prevention.

The basis of a successful fall prevention program is a robust culture of safety that prioritizes risk identification, resource allocation, thorough safety protocols, transparent communication, and quality improvement.

For more information about enhancing safety culture and improving your hospital's fall prevention program, see AHRQ's comprehensive resource titled Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care. For curated resources on this topic, see MedPro's *Risk Resources: Fall Prevention in Hospitals*.

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About the Author

Laura M. Cascella, MA, CPHRM, is the medical writing and publication management lead at MedPro Group. She has more than 20 years of experience in health communications and content development and has authored and contributed to numerous print and digital publications and health education programs.

How Medical Misconduct Disciplinary Actions Can Affect Your Malpractice Case

Rafi Cheema

Various types of evidence can be used in medical malpractice litigation – plaintiff or defendant. One notable type of evidence is evidence arising from professional misconduct proceedings.

Professional misconduct findings arising from negligent medical care allegations may influence the outcome of a medical malpractice lawsuit. In very limited circumstances, professional misconduct *findings* may be admissible as evidence of negligence in a medical malpractice lawsuit.

Understanding Professional Misconduct Complaints

Understanding the impact of professional misconduct findings on a medical malpractice lawsuit would not only help you protect your license but your reputation as well. In order to understand the impact of professional misconduct findings on medical malpractice lawsuits, we first need to understand the nature of professional misconduct proceedings. **Professional misconduct complaints** can range from a documentation issue to a physician engaging in sexual misconduct against a patient or providing negligent medical care. One need not be a former patient to file a complaint; rather, a family member can file a **professional misconduct complaint**.

The **Office of Professional Medical Conduct** (OPMC) reviews complaints against physicians, physician assistants and specialist assistants, and determines whether an investigation is warranted. If an investigation finds evidence of professional misconduct, charges may be filed and a hearing scheduled. A committee for the State Board for Professional Misconduct conducts the hearing, makes findings, and imposes penalties, if appropriate. **Penalties** can include revoking, suspending or limiting a physician's license, issuing a censure and reprimand, ordering education and/or retraining, levying a fine, or requiring community service.

While the **Board** can impose a fine if you are found to have engaged in professional misconduct, compensation of a claimant alleging medical malpractice is not within its purview. An aggrieved patient who is seeking financial compensation can file a lawsuit in the court system.

Relationship Between Professional Misconduct Proceedings and Malpractice Lawsuits

The use of a professional misconduct finding arising from instances of negligent care or medical malpractice can be an indicator of the claim's success in a civil court. A finding of professional misconduct arising from a complaint of malpractice or negligent care does not necessarily mean that a jury would also deem you to have committed malpractice. Each proceeding has different elements, with different rules of evidence and different factfinders.

Professional misconduct is defined by statute and includes "negligence on multiple occasions," as well as a long list of other acts or omissions constituting professional misconduct. Findings against a physician are determined by the Board after a hearing. Medical malpractice requires proof of medical negligence elements (duty and breach) in addition to two elements never required for professional misconduct, causation, and damages. Also, the rules of evidence, civil procedure, and the factfinder in a medical malpractice action differ from professional misconduct matters. As a consequence, findings arising from the same incident may yield different outcomes in these distinctly different forums.

Any **adverse finding** is public record and a savvy plaintiff's attorney may bring it up during the discovery process of a lawsuit. Thus, all misconduct matters involving a defendant physician should be reviewed and discussed before the physician's deposition is conducted.

As is evident from the foregoing, the impact of professional misconduct complaints on medical malpractice lawsuits cannot and should not be overlooked, especially when the professional misconduct complaint has the potential to be admissible in a civil lawsuit. An adverse finding can change the course of a civil malpractice lawsuit. So, determining admissibility is key when defending a civil lawsuit following an OPMC finding.

Can OPMC Findings be used against you in Court? Admissibility as Evidence

Admissibility of professional misconduct findings as evidence in medical malpractice cases in Court is very limited. It is worth noting that although the same "preponderance of the evidence" standard is applied in OPMC disciplinary hearings as in a civil lawsuit, there is no guarantee that a Court would admit the OPMC findings into evidence. In fact, Courts may decline to admit OPMC findings into evidence on the grounds that it could prejudice a jury, depending on the specific circumstances of the case.

As a general rule, **admissibility** of evidence depends on whether evidence is relevant and whether its probative value outweighs the risk of undue prejudice. While this same **standard** applies to the admissibility of professional misconduct findings as evidence, the courts narrowly read the relevance requirement and broadly protect against the prejudicial impact of this type of evidence.

Relevance limits admissibility to findings specifically addressing care of the plaintiff seeking admission and addressing only the care alleged to be negligent in the action. Findings unrelated to the pending medical malpractice allegations or the plaintiff seeking admission are **inadmissible** as they are both marginally relevant at best and highly prejudicial. Thus, even though findings or consent agreements may be publicly available, admissibility in medical malpractice cases is very limited. If you are facing a professional misconduct complaint you should consult with an attorney as soon as possible and always before making any statements to an investigator. This is particularly important if the allegations of professional misconduct arise from medical care that has or may result in a medical malpractice lawsuit. An attorney can assist you in knowing the process and your rights when dealing with this stressful situation.

Likewise, if you have been involved in a professional misconduct proceeding and are also defending a medical malpractice claim, speak with your attorney about the impact findings may have in your case.

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About the Author

Rafi Cheema is an attorney with the MLMIC Legal Department. Mr. Cheema is an experienced litigator, representing physicians, dentists, healthcare professionals, and hospitals in the defense of malpractice. This includes representing and defending physicians, dentists, and healthcare professionals in professional malpractice and negligence litigation from claim status through trial. He provides legal advice to healthcare providers, dentists, and medical facilities on risk management issues, healthcare law, and professional liability.

As a member of the editorial board of MLMIC Insurance Company's issues of Dateline/The Scope, Mr. Cheema has also been a contributing author for those publications. Mr. Cheema is admitted to the New York State Bar and received his Juris Doctor from the Hofstra University School of Law and his Bachelor of Arts from City University of New York.

The Patient Safety Structural Measure: A Turning Point for Risk Management

Dan Corcoran

The Centers for Medicare & Medicaid Services (CMS) is gradually reshaping how the healthcare industry measures safety. Beginning in Spring 2026, hospitals will attest to their performance and culture alignment under the **Patient Safety Structural Measure (PSSM),** a new standard for patient safety and quality systems for acute care. Each hospital's score will be made public the following October.

For risk managers in both hospitals and insurance companies, the implications are enormous. The PSSM isn't just another compliance task; it's a public reflection of how effectively a health system manages risk.

A New Kind of Measure

Unlike process or outcome metrics, the PSSM examines the *structure* behind patient safety, the leadership, systems, and accountability mechanisms that drive every root-cause analysis, event report, and improvement effort. It looks at whether hospitals have coordinated systems that truly link safety, quality, and risk management under one framework.

The measure is part of the **Hospital Inpatient Quality Reporting (IQR) Program** and will start with a mild influence in the **Hospital Value-Based Purchasing Program** starting in fiscal year 2027, in the form of a revenue calibrated penalty if they fail to provide compliance attestations the prior Spring.

Impacting Old Measures

In addition, the Centers for Medicare & Medicaid Services (CMS) is seeking public comment on incorporating PSSM scores into the **Hospital Star Rating** system, replacing one or more existing metrics. At the same time, CMS is requesting feedback on giving patient safety greater weight in the ratings including a proposal to **subtract a star** for hospitals or health systems that perform in the bottom quartile on current patient-safety measures. For example, a five-star hospital would become four stars, a four-star would drop to three, and so on. If both proposals advance, the PSSM component could become a direct factor shaping the existing Hospital Star Rating system.

A Shared Challenge for Providers and Insurers

For hospital risk leaders, PSSM presents both challenge and opportunity. The challenge lies in overstating readiness. Attesting "yes" without the policies, staffing, or documentation to support it creates exposure not only with regulators but also in litigation.

The opportunity is equally significant: a chance to demonstrate real maturity in safety culture, risk reduction, and learning systems. Hospitals that can show verifiable processes and culture will not only perform better on PSSM but also earn greater confidence from insurers and accrediting bodies.

For malpractice carriers, the PSSM introduces a national benchmark for organizational risk maturity. Underwriting has long relied heavily on claims history; structural safety data now provides a forward-looking lens to assess and support clients' risk profiles.

Avoiding the Attestation Trap

Some voices are already downplaying the effort required, suggesting hospitals can "check yes" on PSSM attestations without changing much internally. That's a dangerous mindset. Incomplete or inaccurate attestations create a false sense of security and undermine trust, culture, and credibility.

Hospitals that take the time to align their policies, reporting tools, and governance structures to the PSSM framework will earn reputational benefits through stronger scores and visible commitment to transparency. Those that improve their culture and quality systems in response to PSSM will be better positioned for malpractice claims that arise months or years after care and, more importantly, will reduce preventable harm from the outset.

A Moment for Collaboration

For hospital risk and quality leaders, the PSSM is both a mirror and a roadmap. It reflects whether leadership commitment, governance, policy alignment, and learning systems are in place to reduce risk, and provides a structured path to strengthen them.

At the same time, PSSM attestations can become a common language for providers to credibly communicate safety infrastructure investments to insurers, shifting discussions from retrospective loss to demonstrated organizational readiness.

About the Author

Dan Corcoran, HACP, is the Founder and CEO of SafeQual, a New York based enterprise software company that unites patient safety, clinical quality, and risk management in one platform. A longtime ASHRM member, he has served on three committees including as Chair of the Education Development Content Committee and currently serves on the board and Publications Committee of our chapter. Dan holds an HACP certification in CMS Compliance, volunteers with Patients for Patient Safety US, and leads software initiatives that reduce the complexity of CMS PSSM compliance. He also teaches CE-accredited courses and writes on PSSM, artificial intelligence, and risk management at **safequal.net/resources**.

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

HIGHLIGHTS FROM THE ASHRM ANNUAL CONFERENCE

The American Society for Health Care Risk Management (ASHRM) successfully hosted its 2025 annual healthcare conference in Charlotte, North Carolina, from September 28–30.

This year's event brought together healthcare leaders, risk management professionals, and industry experts from across the country to share insights, explore emerging trends, and strengthen best practices in patient safety and risk management.

The program proudly featured several members of the New York Chapter of AHRMNY, who distinguished themselves through thought-provoking presentations and recognition for their professional achievements.

Presentations:

- Anne Huben-Kearney and Josh Hyatt presented Risk Management Professional 411: Cases, Conversations, and Critical Thinking
- Anne Huben-Kearney presented Save Time and Money: Use ACAs-A Cost-effective Patient Safety Strategy
- Gina Kittek and Melissa Dziak presented Navigating the Digital Shift: Balancing the Benefits and Legal Risks of Patient Portals
- Gina Kittek presented the "What" Collapsed? Lessons Learned from a Building Collapse
- Gina Kittek presented Risk and Reward: The Essentials of Health Care Contracts and Risk Management
- Dr. Victor Klein, Melissa Bedward, and Adriann Combs presented Hiding in Plain Sight: Strategies to Decrease Risk and Improve Patient Safety Obstetrics
- Chris Allman presented Resilience Under Pressure: Operations and Risk in a Shifting Political Climate
- Chris Allman presented an annual review of Cases that have been handed down by courts across the United States

Awards and Recognitions:

Mike Midgley was the recipient of the 2025 Distinguished Service Award, (ASHRM)'s highest individual honor. This prestigious award recognizes either a single outstanding achievement or a lifetime of contributions to the field of healthcare risk management—and Mike's impact exemplifies both.

Marco Tomakin was selected as this year's ASHRM Ray Rozovsky Scholarship Program. This prestigious award supports emerging leaders in healthcare risk management, and Marco was able to attend the conference as part of this honor.

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

2025 CONFERENCE HIGHLIGHTS

ASHRM hosted its Annual Conference on September 28-30, in Charlotte, North Carolina, at the Charlotte Convention Center. This premier national gathering for healthcare risk management professionals featured actionable sessions, expert speakers, networking opportunities, peer-to-peer knowledge sharing, and hands-on vendor solutions.

Here are a few session summaries brought to you by Stephanie Campbell, Edward Nicholson, Suhlail Villa, and John Barous of Schiavetti Corgan DiEdwards Weinberg & Nicholson:

Program Title: The Toolbox You Need to Survive a High-Risk Venue
Presenters: Dianne Salter; Lisa Ramthun, MSN, RN, CPHRM, DFASRM, CPHQ; Clare Bello, BA, JD

Synopsis: Focusing on "judicial hellholes" and the implicit biases that favor plaintiff's in such venues, the speakers discussed how the judiciary in certain venues have stacked the deck against the defendants. Citing to the overwhelming majority of plaintiff-friendly rulings in both aspects of discovery and at the stage of dispositive motion practice, the presentation offered guidance as to how to combat these circumstances utilizing examples such as developing a personal rapport with the judiciary; building a reputation of honesty and integrity with opposing counsel; and bringing to trial those cases/claims which ought to have been dismissed or resolved but for the unfair actions or practices of either the Courts or plaintiff's bar. The presentation next highlighted what they believed was a central tenet in maintaining costs in an unfavorable venue, that being attempts to resolve potential cases even before they may be filed with the court. In this respect, it was detailed that the earlier a healthcare provider or facility realizes that a potential lawsuit could be forthcoming, and undertakes steps to address the concerns or complaints of the patient, the greater likelihood that prolonged and disadvantageous litigation can be avoided. Taking into account the personal level on which all prospective plaintiffs have in relation to their care and treatment, the presentation delved into how to address such patients after an adverse event so as to mitigate feelings of anger or betrayal. In this same vein, the presentation concluded with how defendant providers or health care associations can create a system by which all potential claims can be systemically addressed, investigated, and brought to the proper professionals to determine the appropriate course of action to include prospective early resolution of a claim.

Program Title: Expectations Management and the Medically Unpreventable Pressure Ulcer
Presenters: Caroline E. Fife, MD, and Monica Chadwick, BSN, RN, LNCC, CPHRM

Synopsis: This session focused on risk mitigation strategies, identifying the contributing factors involved in severe pressure injury malpractice claims, as well as understanding the psychological mechanisms by which wounds evolve over time. Some of the risk mitigation strategies include communicating effectively with a patient and his or her family, expectation management discussions, medical chart documentation (including documenting "medical unpreventability "and patient co-morbidities), and photos of the wound(s). In defending a pressure injury case it is important to understand that a pressure injury can occur even with the best of care, the wound(s) may be medically unpreventable, and a physician expert is needed to opine on the standard of care and causation. Importantly, because something may not be documented in the medical chart does not mean it was not done.

Program Title: Anesthesia Liability: Provider Scope of Practice and Impact of Regulations
Presenters: Jeannette Domask, MPH, CPHRM, RPLU, CPCU and Marta Garrett, JD, RN

Synopsis: The aim of this session was to learn the legal framework and regulations that govern the scope of practice of anesthesia providers in the ambulatory and office settings; understand liability risks involving anesthesia administration in ambulatory surgery centers and office-based surgery settings; and develop risk management mitigation strategies to ensure anesthesia practices and providers followed best practice to help reduce or eliminate liability exposure.

Some cases that were discussed during the presentation included:

- The death of 40-year-old plaintiff following a colonoscopy at an ambulatory surgery center. Allegations included failure to react to the patient's crashing vital signs and failure to resuscitate. The patient had a history of sleep apnea which warranted that the procedure be performed in a hospital. Further, it was discovered the providers at the ambulatory surgery center did not receive training on how to timely and appropriately respond to an emergency which resulted in the patient being without oxygen for approximately 22 minutes. The state had a wrongful death cap of 500k so the verdict is currently being challenged in court as unconstitutional. Questions to consider, are we obtaining adequate medical history of patients, particularly those on the younger side? Risk recommendations included patient selection criteria, anesthesia credentialing, improved communication and emergency drills.

- A patient suffered 2nd degree burns to her face during a facelift procedure when the electrocautery device malfunctioned and ignited the surgical drapes. Contributing factors to the event included lack of communication among the surgical team; use of 100% alcohol preparation and failure to allow it to dry; use of 100% oxygen; poor training and failure to use proper precautions when employing the electrosurgical devices. Risk recommendations included: inclusion of fire safety in briefs and huddles; implementation of protocols; stopping oxygen before using the electrocautery device; education of staff about the fire triangle and conduct fire drills.

- A 72-year-old female underwent cataract surgery on her left eye. A CRNA administered a retrobulbar block (local anesthesia) which should have been injected behind the globe of the eye but was accidentally injected into the eye causing nerve damage and vision loss. It was alleged that the CRNA lacked the required level of training and competence to safely administer a retrobulbar block. Contributing factors included failure of the ASC to ensure anesthesia providers are properly privileged and credentialed; consideration of safter alternatives; and the failure of the ophthalmologist to administer the block instead of the CRNA. Risk recommendations included consider safer alternatives with risky blocks; recognition of potential complications of retrobulbar blocks.




Article References

Top Risk Management Issues from page 5

[1] This article has been adapted from the seminar "Top Five Risk Management Issues Facing Nurses and Allied Health Professionals" presented at the ASHRM 2025 Conference in Charlotte, North Carolina on September 29, 2025 and at the ASHRM 2025 Virtual Conference on November 7, 2025.
[2] A defendant healthcare provider might argue she did not owe a duty to the patient if she was only peripherally involved in the care, such as a physician providing a one-time phone consultation with the primary provider.
[3] Reviewer's footnote - This article addresses these principles in general. There may be variations from state to state.
[4] The attending was unable to intubate the patient during the code.
[5] Nurse RaDonda Vaught, Tennessee; Paramedics Peter Cichuniec and Jeremy Cooper, Colorado.
[6] OSHA 5(A)(1).
[7] See November 28, 2022 CMS Directive, QSO-23-04-Hospitals addressing workplace violence in Hospitals and the June 18, 2021 R[3] Report from the Joint Commission publishing revised workplace violation prevention standards going into effect on January 1, 2022 for all Joint Commission accredited hospitals.
[8] See Joint Commission Standards and Elements of Performance, EC 09.01.01, EC 04.01.01, HR 01.05.03, and LD 03.01.01.
[9] Ninan, RJ, Cohen, IG, Adashi, EY. State Approaches to Stopping Violence Against Health Care Workers. *JAMA*. 2024;331;(10):825-826. doi:10.1001/jama.2024.1140

Aortic Dissection from page 11

[1] Alter, S. M., Eskin, B., & Allegra, J. R. (2015). Diagnosis of aortic dissection in emergency department patients is rare. The Western Journal of Emergency Medicine, 16(5), 629–631. doi: https://doi.org/10.5811/westjem.2015.6.25752

Enhancing Safety Culture from page 14

[1] Dykes, P. C., Carroll, D. L., Hurley, A. C., Benoit, A., & Middleton, B. (2009). Why do patients in acute care hospitals fall? Can falls be prevented? *The Journal of Nursing Administration, 39*(6), 299–304. doi: https://doi.org/10.1097/NNA.0b013e3181a7788a
[2] Agency for Healthcare Research and Quality. (2019, September 7). *Patient safety primer: Falls.* Retrieved from https://psnet.ahrq.gov/primer/falls
[3] MedPro Group closed cases, 2013–2022, inpatient fall allegations.
[4] Agency for Healthcare Research and Quality. (2013, January). *Preventing falls in hospitals: A toolkit for improving quality of care. Tool 1A: Hospital survey on patient safety culture.* Retrieved from www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/hospital-survey.html

Medical Misconduct from page 16

[1] Understanding New York's medical Conduct Program – Physician discipline. (n.d.). https://www.health.ny.gov/publications/1445/#:~:text=The%20New%20York%20State%20Health,assistant%20and%20unlicensed%20resident%20physician.
[2] NYS Professional Misconduct Enforcement – Discipline Complaint Form. (n.d.). https://www.op.nysed.gov/enforcement/discipline-complaint-form#:~:text=For%20information%20on%20filing%20a,New%20York's%20professional%20discipline%20system.
[3] New York State Education Law 6530 Definitions of Professional Misconduct. (n.d.). https://www.health.ny.gov/professionals/office-based_surgery/law/6530.htm
[4] Mazella v. Beals, 27 N.Y.3d 694 (2016), https://casetext.com/case/mazella-v-beals-22
[5] Maraziti v Weber, 185 Misc. 2d 624, 626, https://casetext.com/case/maraziti-v-weber-1
[6] In the Matter of Mahender Goriganti, M.D., No. BPMC 14-303, 2014 WL 12979603, at *6 (Dec. 18, 2014)

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