personality conflicts between co-workers, bringing weapons onto a work site or drug or alcohol use on the job. Problematic behavior might consist of increased belligerence, threats, outbursts of anger, extreme disorganization, noticeable changes in behavior, or homicidal or suicidal comments or threats.[9]

When individuals are diagnosed with a serious mental illness, their willingness to comply with treatment is adversely affected by the stigma associated with having a serious mental illness. The problem is not gun control, but rather a lack of "viable affordable options for successfully treating mental illness".[10] Society's prejudice against those suffering from a mental illness "clouds logic and stigmatizes a significant portion of the American populace".[11]

Unfortunately, the most recent tragic events at the Washington D.C. Navy Yard perpetuate the stigma that individuals with mental health issues are violent. The truth is that while Aaron Alexis did become violent, most people suffering from behavioral health issues are more often the victims of violence rather than the perpetrators. Violence in the workplace, whether it is perpetrated by someone with mental health issues or not, can be dealt with proactively by consulting a mental health legal expert and having a Behavioral Intervention Team ready in advance to tackle the issues.

References Listed on page 29

About the author

Carolyn Reinach Wolf, Esq., is an Executive Partner in the law firm Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Einiger, LLP and Director of the Firm's Mental Health Law practice. Ms. Wolf's practice concentrates in the areas of mental health and health care law, representing mental health and health care professionals, major hospital systems and community hospitals, institutional and community outpatient programs, skilled nursing facilities, higher education institutions, individuals and families. The New York Times Sunday Edition (February 8, 2013) ran a front page story in the Metro section on Carolyn Reinach Wolf and her unique mental health law practice as it impacts the lives of people with serious mental health issues and their families.[12]

MANAGING RISK AND REDUCING READMISSIONS: NEW SAFETY RECOMMENDATIONS PREVENT VENOUS THROMBOEMBOLISM IN MATERNAL PATIENTS

By Michael Wong, JD and
Lynn Razzano, RN MSN ONCC

OB VTE safety recommendations have recently been developed to prevent venous thromboembolism (VTE) in maternal patients. These VTE Safety Recommendations provide the concise and considered recommendations of a **panel of national and international health experts**.*

For pregnant women, the **risk of VTE*** is 4-5 times higher than women who are not pregnant. Moreover, this risk is at least twice as much following cesarean delivery.

The importance of addressing VTE risk in maternal patients has been emphasized by many healthcare organizations. In 2011, The Partnership for Patient announced the Patient Safety goal for Health and Safety of Maternal Patients: 40% of all adverse events/risk occurring in pregnant women will be decreased by 30% by the end of 2013. Focus of VTE prevention was one of the key areas of focus-there was difficulty attaining this goal. In 2014, The Maternal Harm Prevention Initiative was dually developed by ACOG and Society of Maternal Fetal Medicine, both organizations clearly continuing to identify preventable harm events occurring in pregnant women. Patients undergoing general surgery overall are at high risk to develop DVT. It has been reported that the **cost*** associated with a thromboembolic event averages $10,804 for a DVT and $16,644 for a pulmonary embolism (PE). The CDC includes reduction in DVT as one of ten major factors for reducing adverse events.

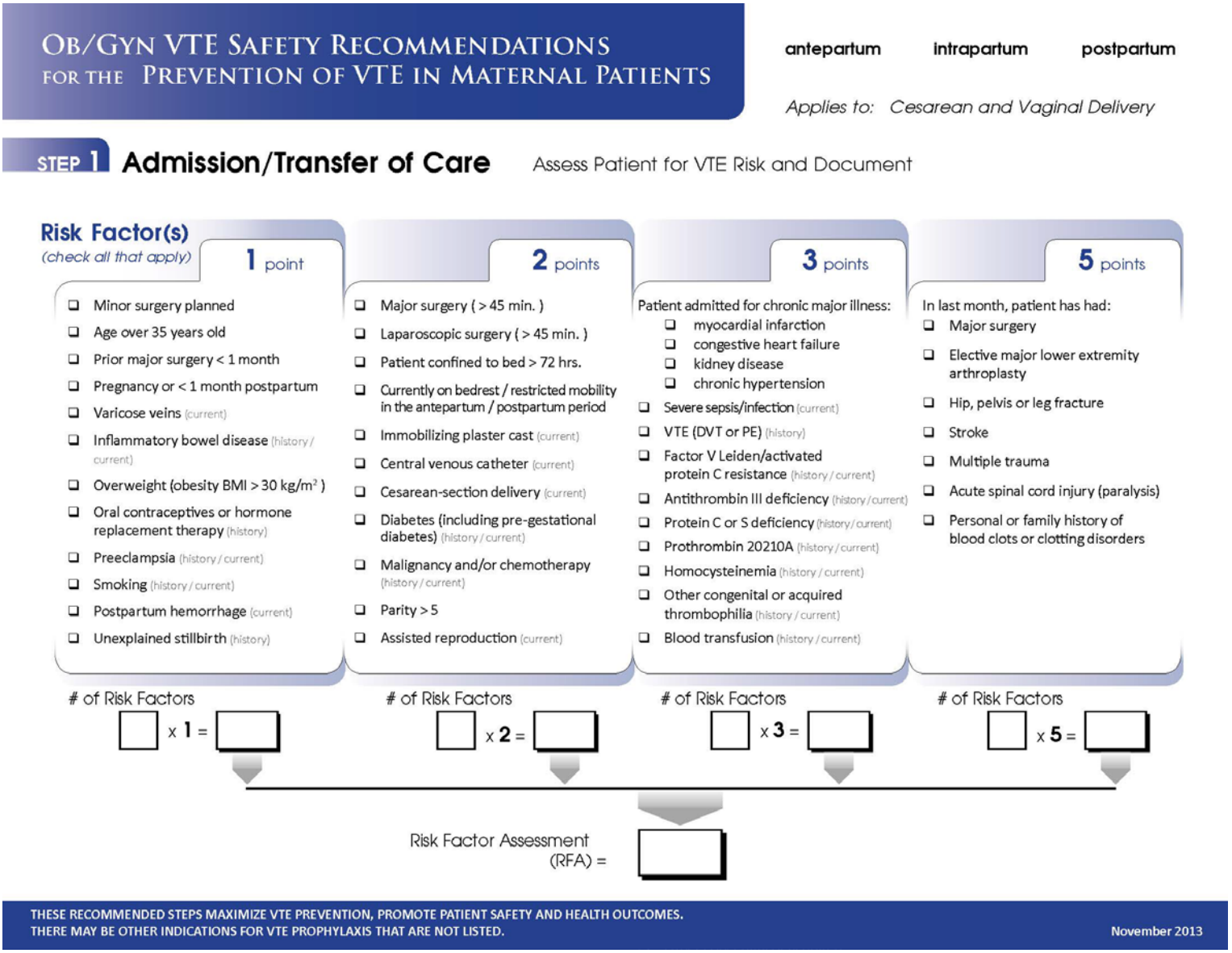
What is the clinical answer and what are the needs of clinicians working in the OB scope of practice?

The identification of a succinct tool that would guide clinicians to utilize a well-established VTE risk assessment was developed with specifically identified OB experts from the United States and internationally that expressed a passion for developing VTE recommendations. The group of health experts that reviewed the checklist consisted of almost 25 members, including those from or represent organizations such as American Congress of Obstetricians and Gynecologists, Centers for Disease Control and Prevention, Institute for Healthcare Improvement, The Joint Commission, and Society for Maternal-Fetal Medicine, as well as well-respected hospitals from Australia, Canada, and the United States.

Initially it was felt this would be in the form of a safety checklist, but as the development progressed, the experts felt concise statement of recommendations best expressed the needed tool to be used for consistent VTE risk assessment along the continuum of care for the OB patient.

The result is a four-step recommendation process developed for the prevention of VTE in maternal patients (antepartum/intrapartum/postpartum) that provides recommended steps to be considered regarding risk factors, preventative measures, and discharge procedures:

Step One consists of a OB VTE Risk factor which provides a baseline risk assessment conducted on all patients on admission for any reason and at the time there is a transfer of care. It is a cumulative point system that assigns VTE risk level from one to five points for both historical and current patient conditions and procedures. This step provides a baseline risk of VTE and determines what VTE prophylaxis needs to be ordered. In terms of practice impact, this lends a consistent approach to patients VTE risk and determines the treatment clinical path.



Step Two sets forth the prophylaxis regime that needs to be ordered on the basis of the risk level score determined in Step One. It describes the parameters for both mechanical and pharmacological treatment interventions that need to be instituted both antepartum and postpartum. It serves as a consistent safety reminder to provide the clinician a decision tool that allows for maximum VTE prevention in all maternal phases and assurance of safe practice adherence. As well, this step reminds clinicians to initiate discharge planning process, which need to be started early after the patient's admission.

Step Three recommends periodic reassessment of the patient. Risk factor reassessment is commonly overlooked and this step consequently serves a reminder of the criteria for timing of the reassessment: repeat the risk factor assessment in Step One if the patient is hospitalized longer than 24 hours, before surgery or with any significant change in patient condition. This is a crucial step that promotes continued patient assessment and validation of the correct risk and associated prophylaxis regime as set forth in Step Two. The effect on clinical practice is a continuous check on the patients VTE status and assurance of prophylaxis maintenance.

Step Four identifies the patient discharge protocols. The value of this step is to ensure all necessary patient education, engagement tools are provided to the patient for a smooth transition to home post discharge. It also looks to possible prevention of VTE readmission for the patient, which would be detrimental to the safe practice standards and harm.

The OB VTE Safety Recommendations focus on the consistent reduction of VTE risk, the risk of any long-term complications of VTE development, and the application of prevention measures principally through mechanical and pharmacological prophylaxis. Use of these recommendations in providing the optimally maintained prophylaxis along with incorporating in patient safety rounds also allows for double-checking to ensure all prophylaxis is being properly measured, maintained and adhered to. It ensures that the patient is prescribed compression devices and taking pharmacological prophylaxis as required. Moreover, these recommendations help to proactively interact with patients to engage and collaborate with the common goal on VTE prevention and ensure consistent hand off communications with clinicians along the care spectrum.

The OB VTE Safety Recommendations also address areas that may not have been previously considered:

Admission for Other Than Delivery: A newly published study shows that VTE risk is also increased for any **non-delivery admission**.* These recommendations are to be used every time a maternal patient is admitted or transferred for care.

OB/GYN VTE SAFETY RECOMMENDATIONS FOR THE PREVENTION OF VTE IN MATERNAL PATIENTS

STEP 3 Patient Reassessment

Repeat assessment if Patient hospitalized longer than 24 hrs., before surgery or with any significant change in patient condition.

- ❑ Assess Patient for VTE Risk and Document **(see step 1)**
- ❑ Pharmacological prophylaxis:
  - ❑ continued as prescribed
  - ❑ not ordered
    (*why?* _____)
- ❑ Mechanical prophylaxis:
  - ❑ not prescribed
  - ❑ graduated compression stockings
    or ❑ intermittent pneumatic compression
    or ❑ venous foot pump
- ❑ Mechanical prophylaxis, if prescribed:
  - ❑ on patient
  - ❑ properly worn
  - ❑ patient provided with information on proper use and wearing
- ❑ Initiate discharge planning:
  - ❑ discussed with patient/family
  - ❑ anticipated discharge date determined
  - ❑ evaluate patient for home use of:
    - ❑ intermittent pneumatic compression (IPC)
      or ❑ venous foot pump (VFP)
      or ❑ no IPC/VFP
  - ❑ if evaluated for IPC/VFP, initiate availability on discharge

STEP 4 Patient Discharge

- ❑ Discharge instructions include:
  - ❑ healthcare provider contact information
  - ❑ signs and symptoms of DVT and PE
  - ❑ evaluate patient for home use of:
    - ❑ intermittent pneumatic compression (IPC)
      or ❑ venous foot pump (VFP)
      or ❑ no IPC/VFP
- ❑ Discharge instructions:
  - ❑ reviewed with patient and read back
  - ❑ received by patient
- ❑ Patient understands DVT/PE risk factors and how to prevent in postpartum period
- ❑ Follow up appointment made
- ❑ If immobility or bedrest required in antepartum period or extending 6 weeks postpartum:
  - ❑ healthcare provider orders completed, including:
    - ❑ evaluated patient for home use of:
      - ❑ intermittent pneumatic compression (IPC)
        or ❑ venous foot pump (VFP)
    - ❑ length of IPC/VFP treatment
    - ❑ durable medical equipment unit notified of start date of IPC/VFP treatment
    - ❑ patient provided with information on:
      - ❑ purpose of IPC/VFP
      - ❑ proper use and wearing
      - ❑ importance on maintaining use at home until MD discontinues
      - ❑ removed for ambulation and skin inspections (every 8 hrs)
      - ❑ worn minimally 18- 20 hours per day

THESE RECOMMENDED STEPS MAXIMIZE VTE PREVENTION, PROMOTE PATIENT SAFETY AND HEALTH OUTCOMES.
THERE MAY BE OTHER INDICATIONS FOR VTE PROPHYLAXIS THAT ARE NOT LISTED.

November 2013

Patient Education: Another commonly overlooked step in the risk reduction process for VTE prevention in the maternal patient is patient education, engagement and collaborative discussion on why VTE prevention matters and why they need to wear mechanical devices is a crucial part of compliance and empowering the patient for her own self care management. VTE risk remains even after the patient is discharged and in OB the risk window remains up to one month post-partum. Education of and the provision of necessary information to the patient is therefore essential post-discharge.

Taking these extra clinical actions allows for successful transition of care/discharge planning and further helps to prevent unnecessary and costly readmissions which have an impact on hospitals' transparency of adverse events and cause negative scrutiny in the public's view. As a result of lack of a consistent method of VTE risk assessment of the maternal patient, maternal patient's risk may be overlooked and result in harm. This is demonstrated in the potential oversight of high risk pregnant women being admitted for delivery or other diagnosis during the course of pregnancy that are truly at high risk for the development of VTE.

* Blue color texts are hyperlinks to supplemental reading material.

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