

Washington State Department of Labor and Industries' SHARP program

Implementation of Safe Patient Handling in Washington State Hospitals



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Implementation of Safe Patient Handling Legislation in Washington Acute Care Hospitals

Final Report to the Legislature

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HIGHLIGHTS

Washington State was the first state to implement safe patient handling (SPH) legislation for all acute care hospitals.

The voluntary Washington State Safe Patient Handling Steering Committee facilitated implementation of the legislation through a website, webinars and conferences.

Incentives for implementation included a Business and Occupations Tax Credit of \$1,000 per acute care bed for all hospitals and a reduced workers compensation premium classification for State Fund hospitals that implemented SPH.

Compared to nursing homes, hospitals had a somewhat greater reduction in compensable claims rates over the study period

Hospitals doubled their use of ceiling lifts per acute care bed to reduce manual handling

Ambulance and paramedic workers (no SPH legislation) continue to have very high compensable claims rates

Sustainability in the face of competing pressures for health care institutions and workers will be an on-going challenge

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OVERVIEW

Washington State was the first state in the nation to enact Safe Patient Handling legislation for 96 acute care hospitals in the state, effective January 2007. The legislation mandated the following:

- By January 1, 2007, L&I must develop rules to provide a reduced workers' compensation premium for hospitals that implement a safe patient handling program.
- By February 1, 2007, each hospital must establish a safe patient handling committee.
- By December 1, 2007, each hospital must establish a safe patient handling program with specific criteria.
- By January 30, 2010, each hospital must purchase equipment in line with criteria laid out in the legislation
- By December 1, 2010 and December 1, 2012, L&I shall complete an evaluation of the results of the reduced premium, including changes in claim frequency and costs, and shall report to the appropriate committees of the legislature.
- A Business & Occupational tax credit of a maximum of \$1,000 per acute bed was established.

An active voluntary "safe patient handling (SPH) steering committee" was established by stakeholders to assist hospitals in implementation of the legislation. It originally consisted of representatives from the Washington State Hospital Association (Brenda Suiter), Washington State Nurses Association (Ann Tan Piazza), Service Employees International Union 1199 (Chris Barton), United Food and Commercial Workers International Union 141 (Sharon Ness), Department of Labor and Industries SHARP Program (Barbara Silverstein and Ninica Howard), Swedish Medical Center (Leslie Pickett), St. Peter's Hospital (Dan Donahue), St. Luke's Medical Center (Jeannette Murphy), Lynn LaSalle (Multicare Health System) Regional Hospital for Respiratory and Complex Care (Donavan Knight). This committee was dedicated to getting out the information needed to establish SPH programs, policies and support, in a systematic fashion, as hospitals began to implement the legislation. A website was developed and maintained by the SHARP Program to assist hospitals in the implementation and sustainability of these efforts (www.Washingtonsafepatienthandling.org).

INTRODUCTION

The manual handling of patients is a well-recognized hazard for health care workers and patients. One in ten serious work-related back injuries involves nursing personnel and about 12% leave the profession because of back injuries (Goldsmith, 2001). Back and shoulder disorders are common with an annual incidence of more than 30% related to reaching, pushing and pulling patients while repositioning (Smedley, 2003, Silverstein 2012). Safe patient handling includes lifting, turning, and repositioning patients in a way that is safe for patients and for staff. For non-weight-bearing patients, manual handling of patients is physically stressful for staff and often for patients.

Recognizing these issues, Safe Patient Handling (SPH) legislation, Engrossed Substitute House Bill (ESHB) 1672, was passed in Washington State in 2006:

Intent

- Reduce injuries to patients and health care staff resulting from patient lifting and transfers.

Scope

- Washington acute care hospitals, roughly 95 facilities and 11,400 acute care beds.

Incentives

- A Business and Occupations (B&O) tax credit from the Department of Revenue was authorized for purchase of patient handling equipment (\$1,000 per acute care bed).
- A special reduced workers compensation premium risk class, established by the Department of Labor and Industries (L&I) for those State Fund hospitals with fully implemented SPH programs (roughly a 16% discount).

Enforcement

- The Department of Health (DOH) is responsible for ensuring that hospitals implement the components of the legislation, including having a SPH committee and provision of equipment and training.

This report is the final evaluation of the impact of the SPH legislation including results of the reduced premiums (change in frequency and costs) for State Fund hospitals, the B&O tax credit of \$1,000 per acute care bed, and activities initiated by hospitals and other stakeholders.

Evaluation Methods

Mixed methods were used to assess the impact of this legislation: a) compensable workers' compensation claims incidence rates for hospitals (with legislation) and nursing homes (without legislation) over time including all compensable claims, compensable claims for work related musculoskeletal disorders (WMSDs), WMSDs of the back, those associated with another

person (presumably a patient or resident) at those of other health care types [e.g, ambulance , b) manager focus groups at Washington State hospitals (with SPH legislation) matched on size and geographic location (east vs. west sides of the state), c) surveys of SPH coordinators at hospitals regarding implementation successes and barriers, d) WC premium discount for Washington State Fund hospitals who applied for discount class, and e) Department of Health surveys of hospitals including SPH programs.

RESULTS

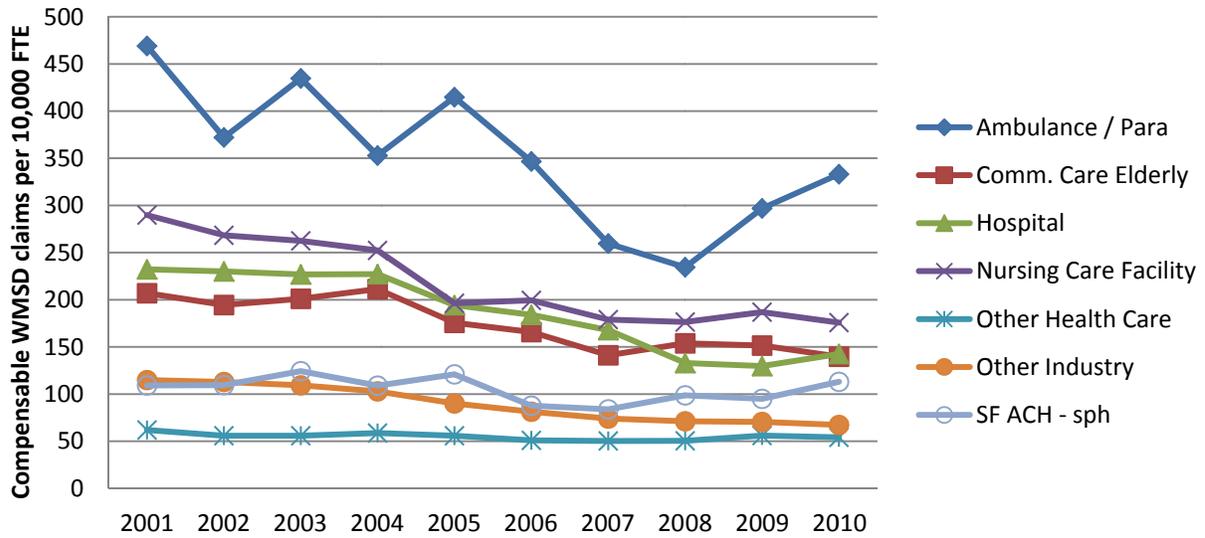
A. Compensable Workers Compensation Claims Rates for Hospitals Compared to Nursing Homes

Figure 1 shows compensable (3+ days of lost work time) claims rates (Self-Insured and State Fund) for several fields of the health care sector and then all industry from 2001-2010.

Ambulance and paramedic services have consistently had the highest compensable claims rates, followed by nursing homes (nursing care services). For acute care hospitals, the rate decreased from 2007 to 2009, the first two years of legislation implementation, and then began to increase again. For nursing homes, the rate decreased pretty consistently through 2005 and then became relatively stable. There are a variety of possible external reasons for this relatively slow decrease in incidence rates for hospitals: 1) higher acuity of patients, 2) increasing morbid obesity among patients, 3) increasing age of nursing staff, 4) increasing overtime or long shifts among nursing staff, 5) increasing turnover of nursing staff, and 6) the return of retired nurses to the professional. A related risk on the horizon is the shortage of nursing faculty thereby affecting the training of nurses.

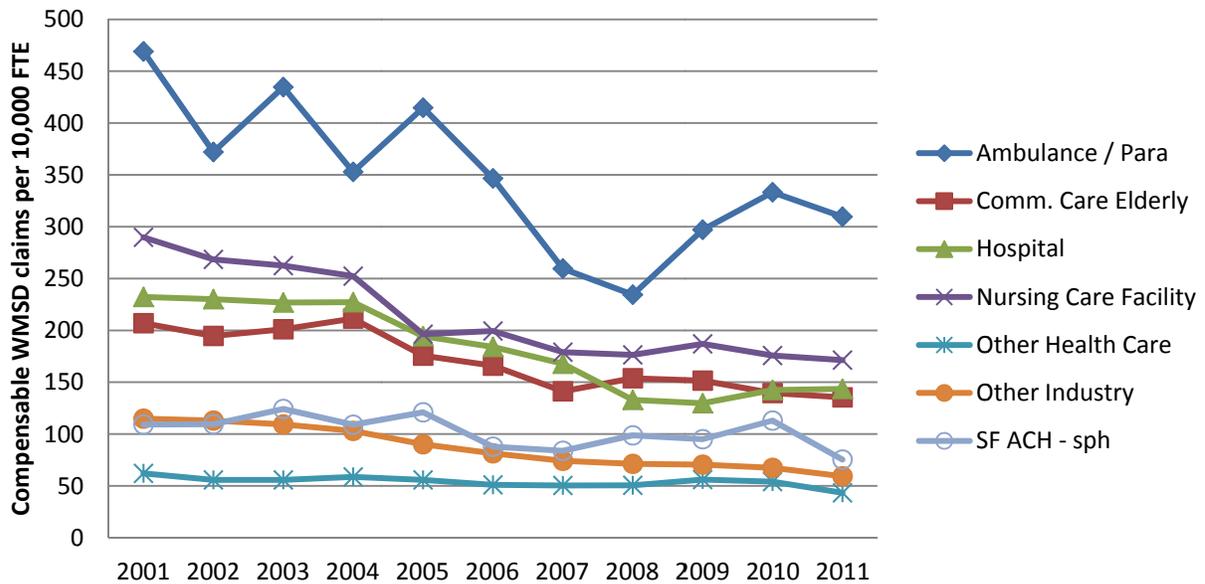
Among State Fund acute care hospitals, the increase in rates may reflect the entrance of a number of critical access hospitals into the State Fund. Figure 2 shows the same data but extended through 2011. This data is tentative because claims may not have matured sufficiently. Nonetheless, this data is showing the same trends as seen in Figure 1, although the rate for ambulance/paramedics is somewhat more hopeful.

Figure 1. Washington Workers' Compensation
Compensable WMSD Claims Rate (risk class based)



SF ACH-sph = State fund acute care hospitals with sph programs

Figure 2. Washington Workers' Compensation
Compensable WMSD Claims Rate (risk class based)



SF ACH-sph = State fund acute care hospitals with sph programs

B. Manager Focus Groups at a Sample of Washington Hospitals

To obtain a more in-depth understanding of successes and barriers in the implementation and management of Safe Patient Handling programs in hospitals, manager focus groups were conducted in 4 Washington hospitals (1 large and 1 small in Eastern and Western Washington) in 2007 (baseline) and 2011 (closure). Participants for these focus groups included directors of nursing services, employee health and unit managers from units that regularly handled, moved, transferred or repositioned patients including the emergency, medical/surgery, surgery, birthing, radiology, rehabilitation.

Manager focus groups addressed two general issues:

- Successes within the safe patient handling program
- Barriers staff face when trying to handle patients safely

The baseline focus groups were conducted in 2007, one year after the passage of the SPH Law. At baseline, focus groups identified barriers associated with the introduction and integration of a safe patient handling program. Newly implemented safety programs can typically expect to encounter difficulties involving the lack of adequate numbers of safety equipment, unclear or misunderstood procedures, and inconsistent use of the procedures. The barriers identified by the focus group reflected this and included:

- The lack of storage space for the lift equipment,
- The difficulty in determining the point at which the use of lift equipment is limiting the patient's independence
- The inadequacy of staffing numbers needed to use the equipment properly. One manager indicated that the acuity system did not account for the number of staff needed to handle patients.
- The inconsistency of the equipment. The types, manufacturers and storage location of the lift equipment differed between units.
- The staff losing their competency on the equipment because they didn't use it enough.
- The patients' mistrust of the lift equipment and their refusal to be moved by one.
- Not knowing when to trust patients when they describe their weight-bearing capabilities.

Successes identified by the manager focus groups at baseline included the decline of patient and staff injuries, the use of the Business & Occupation Tax credit to purchase equipment and the acknowledgement by the legislature that funding was necessary, and the eventual buy-in by staff of the SPH program.

In the final focus groups, held 2 years after the full implementation of the law, the barriers identified raises concerns about the sustainability of the program as well as the inability to overcome certain challenges. One manager described that after an initial decrease in patient-handling related injuries, the numbers are beginning to increase again because of the lack of sustained momentum. Another focus group attendee described the aging of the lift equipment and the lack of on-going funding to replace them. Other difficulties that were identified by the focus group that might negatively impact sustainability were the struggle to maintain awareness and the lack of consistent training or the difficulty in finding to time train.

Barriers to handling patients safely that were identified both at baseline and at closure included:

- Rooms and bathrooms too small to easily maneuver equipment. This was exacerbated with bariatric equipment such as wheelchairs and beds.
- The perceived increase in time to use the appropriate equipment by patient care staff.
- The lack of easy access to the appropriate equipment.

These same challenges were also identified in the surveys administered to the Safe Patient Handling Committees.

C. Survey of Safe Patient Handling Committees Functioning in Hospitals

The Safe Patient Handling Committee Survey has been administered to Washington State hospitals three times, in 2006/2007 (baseline), 2009/2010 (interim) and 2011/2012 (closure). To date, 13 hospitals have completed both the baseline and final survey. The 2011/2012 Safe Patient Handling Committee Survey is still continuing at the time of writing this report. For this analysis, only those hospitals that completed a baseline survey and a final survey were analyzed. Seven of these same hospitals completed the interim survey.

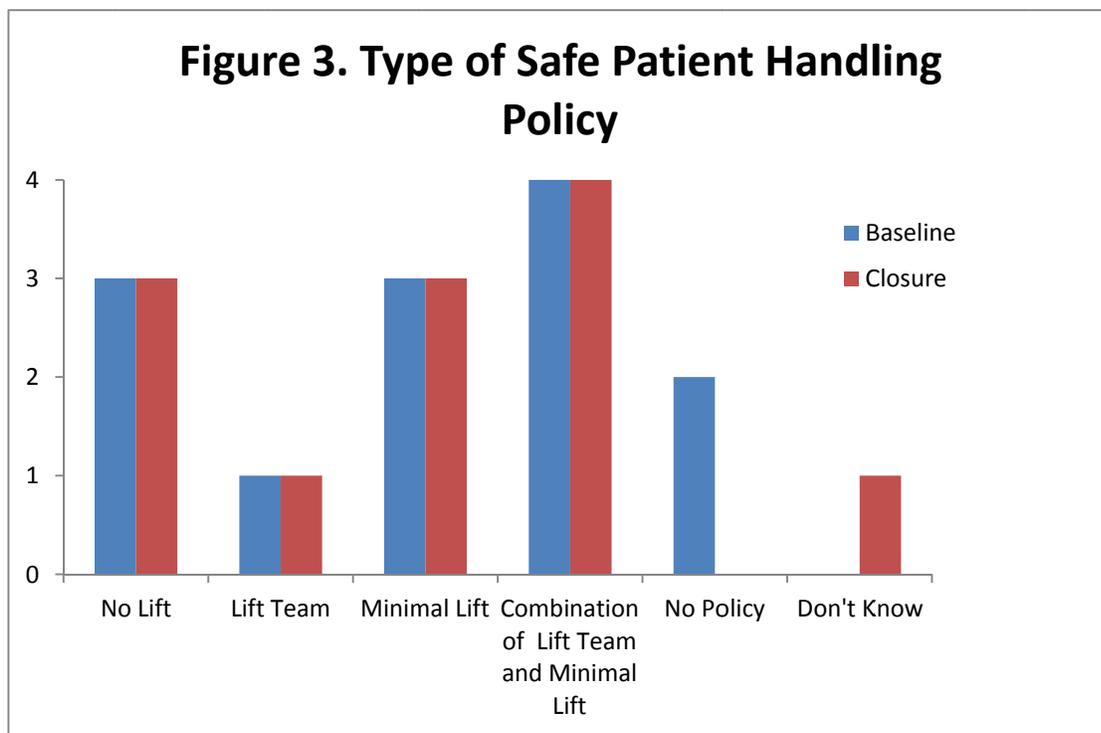
D. Safe Patient Handling Committee Membership/Sustainability:

ESHB1672 states that hospitals must have established a safe patient handling (SPH) committee and at least half of the members must be frontline, non-managerial direct care providers. At baseline, 4 hospitals (36%) had fewer than half direct care staff on their SPH committees. At closure, only 1 hospital had an SPH committee with less than 50% direct care staff. Most of the SPH committees have retained 45% of their original members since the formation of the SPH committee. At baseline, most SPH committees met either monthly or every 2 months. At closure, 40% of the SPH committees had decreased the frequency at which the committee meets, with most of these meeting quarterly. The law did not establish a minimum meeting frequency. Of the hospitals who provided a committee size at baseline and closure, 67% either had the same number of members or more.

Hospitals must take care that as they shift priorities, safe patient handling does not lose its significance. As the staff struggles to handle multiple responsibilities, there is a risk that frequency of the committee meetings, committee size, the continuity of committee members, the participation in meetings, and the appropriate balance of managerial and non-managerial staff will decrease or worsen.

E. Hospitals' Safe Patient Handling Policy

At baseline, 10 of the 13 hospitals reported to have a written safe patient handling policy. By the final survey, of the three hospitals that did not have a policy at baseline, 2 did not respond to the question on the final survey and 1 respondent stated no knowledge of the policy, despite being at the facility for more than 6 years. At baseline, 3 hospitals described their policy as a “no-lift” policy, 1 as a team lift policy, 3 as a minimal lift policy and 4 as a combination of a minimal and a team lift policy. Two hospitals claimed to have no policy. By closure in 2011, although the types of policies maintained the same proportion, 9 of the 13 hospitals have changed the description of their policy. This may be an indication of a change in SPH procedures over time (e.g. eliminated lift teams and adopted a minimal lift policy) or ill-defined policies.



Mechanical Devices in Hospitals

a) Lift Equipment in Hospitals (Table 1)

Ceiling lifts had the highest equipment-to-licensed bed ratio, increasing from the baseline survey to the final survey. This suggests that hospitals were investing in ceilings over other types of equipment over time. Total body lifts were the second most common mechanical transfer device. However, the ratio decreased between baseline and final, most likely because hospitals were removing outdated total lifts and possibly replacing them with ceiling lifts. Sit-to-Stand lifts had the lowest equipment-to-licensed bed ratio, indicating this type of equipment was not as preferred as others.

Table 1. Equipment Available per Bed

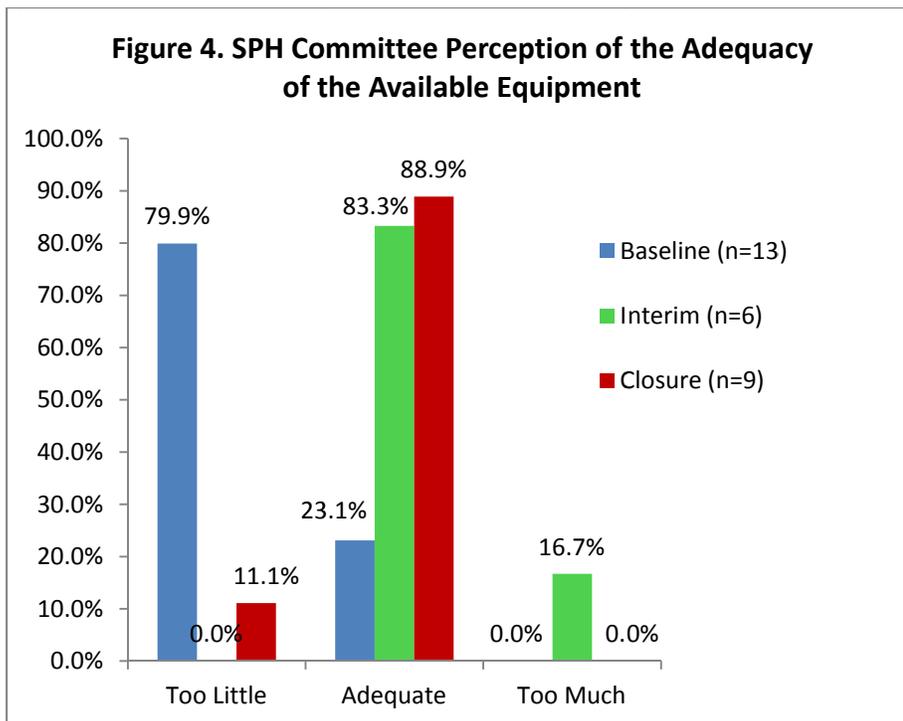
Equipment	Average Equipment-to-Licensed Beds Ratio	
	Baseline Survey	Final Survey
Ceiling Lifts	0.03 (0-0.2)	0.06 (0-0.14)
Sit-To-Stand Lifts	0.01 (0-0.04)	0.02 (0-0.08)
Total Body Lifts	0.04 (0-0.11)	0.03 (0-0.11)

b) SPH Construction and Renovations

The legislation mandates that when hospitals are developing architectural plans for construction or remodeling, the feasibility of incorporating SPH equipment must be considered (Sec 2.3.e). In the interim survey, 3 hospitals indicated that renovations had incorporated the needs of ceiling lift installation and storage. However, it was 3 different hospitals that indicated the same at closure. At baseline, no hospital indicated any SPH renovations.

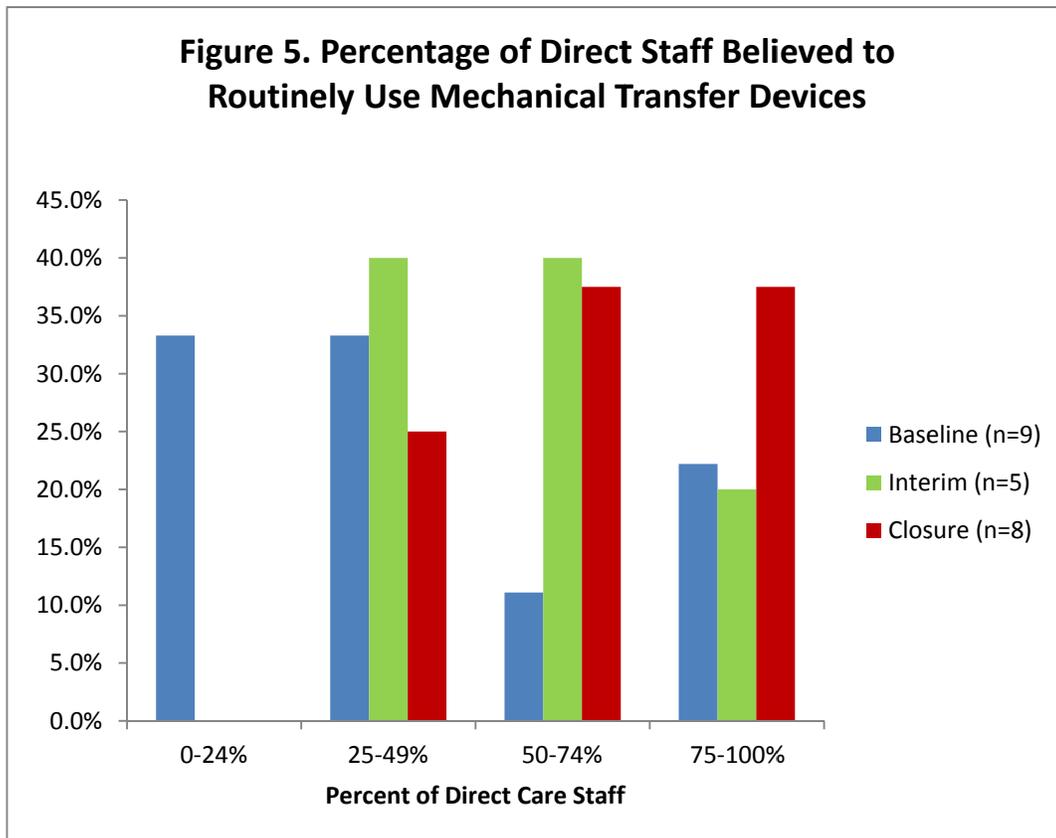
c) Perception of Availability of Equipment (Figure 4)

When asked whether the amount of equipment was adequate, at baseline, the majority of the hospitals considered the amount too little; 11% continued to consider the amount to be too little at closure. There was a distinct change in staff perception of the adequacy of equipment with the vast majority (89%) believing they had adequate equipment by closure. No hospital felt they had too much equipment.



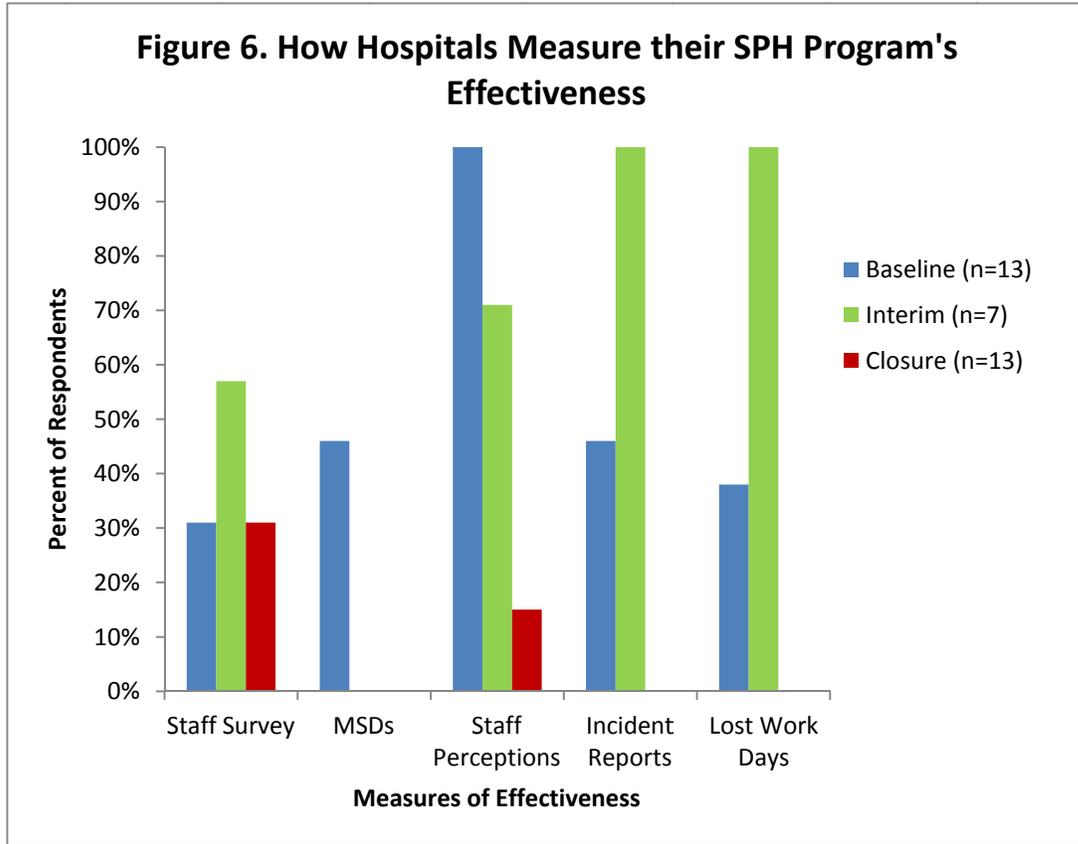
d) Routine Use of Mechanical Transfer Devices (Figure 5)

Over time, the SPH Committee believed that more of the direct staff used the available mechanical transfer devices. At baseline the majority of hospitals believed that less than half of the direct care staff routinely used the mechanical transfer devices. At interim, the majority of hospitals (80%) believed that 25-75% of direct care staff used transfer devices. At closure, most hospitals (75%) thought that over 50% of their direct care staff used the equipment.



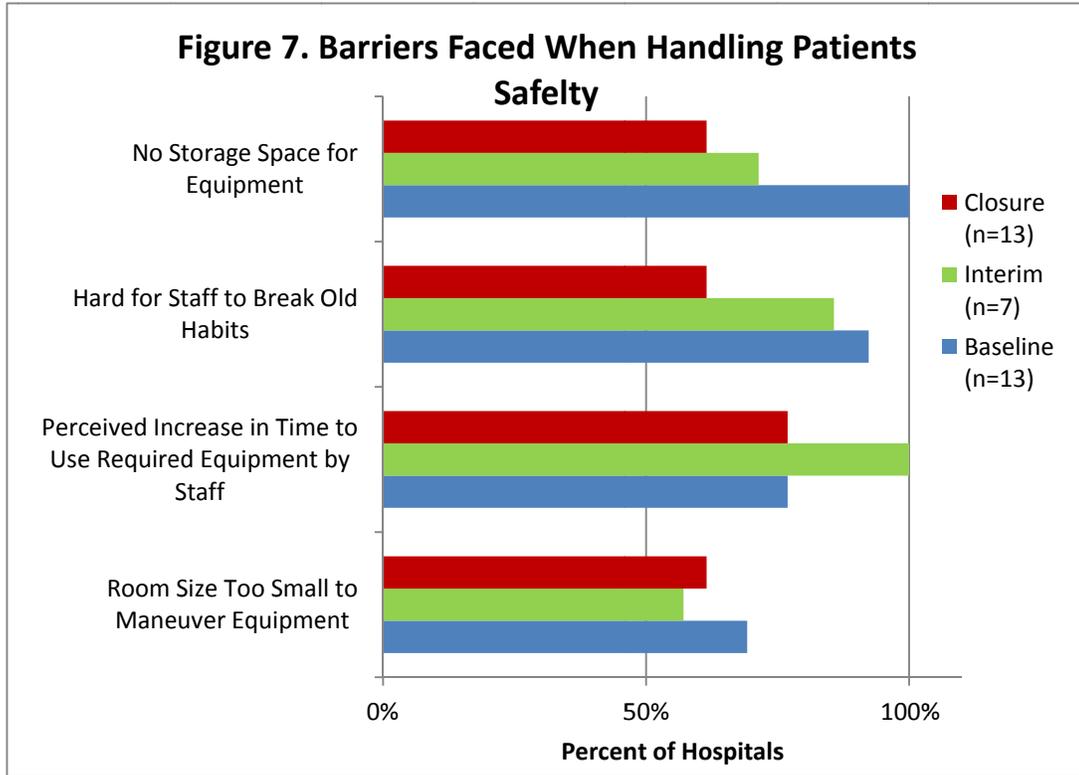
e) Evaluation of the SPH Program Effectiveness (Figure 6)

At baseline, survey hospitals evaluated their SPH program using staff perceptions. At interim, all reporting hospitals used incident reports and lost work days. However, at survey closure, these SPH evaluation methods were not reported. Over time, it appears that hospitals used fewer methods, relying on only 1 or 2 measures to determine the effectiveness.



f) Barriers Faced When Handling Patients Safely (Figure 7).

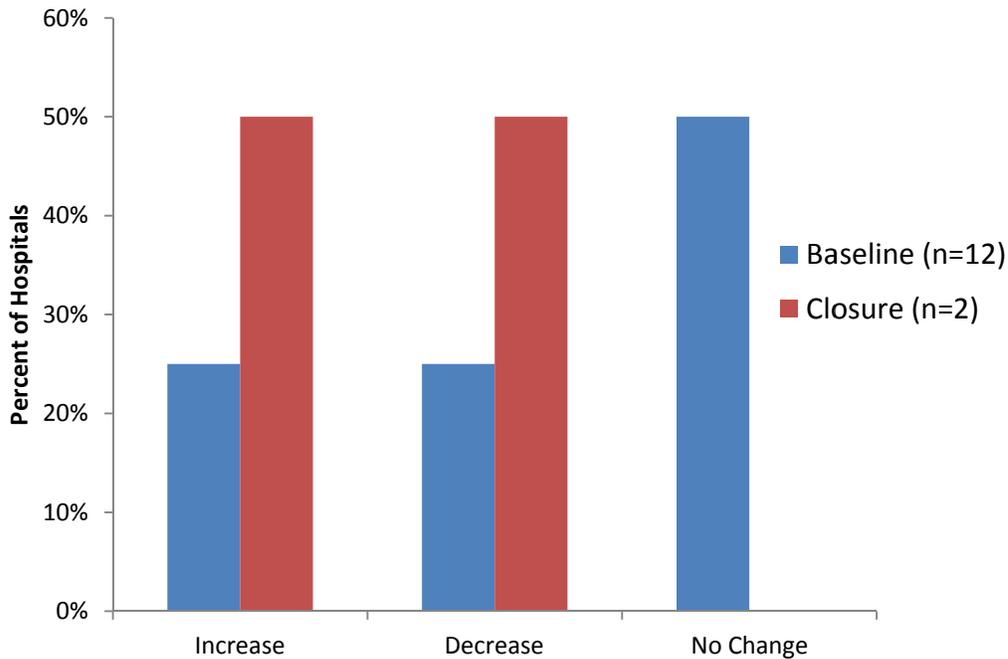
Over the survey years, it appears that hospitals are struggling with the same barriers to handling patients safely, although the order of their significance varied across the years. The top four barriers to handling patients safely identified by the SPH Committees are 1) no storage space for the equipment, 2) difficulty in breaking old habits by the staff, 3) a perceived increase in time by staff to use the require equipment and 4) room sizes are too small to maneuver equipment.



g) Perceived Staff Retention (Figure 8)

When asked whether nurse turnover had changed, more hospitals at closure than at baseline felt that registered nurse (RN) retention had improved over the past 2 years. When asked the same question for direct care staff, at baseline, most SPH Committees felt there was no change in direct care staff retention. However, at closure, half the hospitals felt that retention had improved while the other half believed it had worsened.

Figure 8. SPH Committee Perceived Change in Direct Care Staff Turnover Over the Past 2 Years



D. Workers' Compensation Premium Discount for Washington State Fund Hospitals who applied for the discount class.

Premium Year	2007	2008	2009	2010	2011	2012	2013
Washington State Fund Premium Discount – Acute Care Hospitals with Safe Patient Handling *2013 Rates not final	18.0%	17.8%	20.0%	17.2%	15.8%	10.9%	10.8%*

Based on preliminary actuarial analysis, it appears that the premium discount for acute care hospitals with fully implemented safe patient handling programs is sustainable, at least for the near future. See appendix A.

E. Department of Health Surveys of Hospitals' SPH programs.

The Department of Health (DOH) Investigation and Inspection Office has the responsibility to inspect hospitals for compliance with the Safe Patient Handling legislation. DOH conducts annual inspections of hospitals for a variety of issues and has included safe patient handling

requirements as part of the routine inspection. In general, DOH has found that the vast majority of hospitals are in compliance with Safe Patient Handling requirements. In 2011, six citations and in the first half of 2012, 2 citations were written and corrected.

F. Voluntary Efforts to Promote Implementation of Washington State’s Safe Patient Handling Legislation

The Washington State Safe Patient Handling Steering Committee continues to organize and discuss patient handling issues and to educate others, meeting on a quarterly basis. Although representatives from the Washington State Hospital Association (WSHA), Washington State Nurses Association (WNSD), Service Employees International Union 1199NW (SEIU1199-NW) and L&I’s Safety and Health Assessment and Research for Prevention (SHARP) Program continue to sit on the steering committee, new members have become involved. The current membership of the Washington State Safe Patient Handling Steering Committee is listed in Table 1.

Member Name	Organization	Role
Chris Barton	SEIU 1199NW	Secretary-Treasurer, SPH Steering Committee Chairperson
Annie Bruck	Department of Environmental and Occupational Health Science, University of Washington	Asst. Director, Continuing Education, NW Center for Occupational Health Service, UW
Nancy Clark-Sumara	St. Joseph Hospital, Franciscan Health System	Clinical Manager, Rehabilitation
Mary-Clayton Enderlein	Seattle Children's Hospital and Medical Center	Director, Occupational Health Services
Richard Goggins	Department of Labor and Industries	Ergonomics Technical Supervisor, DOSH
Anne Grimes	Valley Medical	Director of Wellness Services
Ninica Howard	Department of Labor and Industries	Research Ergonomist, SHARP Program; SPH Steering Committee Coordinator
Lynn LaSalle	Multicare Health System	Ergonomist
Tony Melessa	Madigan Army Medical Center(MAMC)	SPH Program Manager

Suzanne Metz	Washington State Hospital Association	Safety Coordinator, WA Hospitals Self Insured WC Programs
Leslie Pickett	Swedish Medical Center	PT/Ergonomics Clinical Coordinator
Jaime Sifre-Collazo	VA Puget Sound Health Care System	SPH Coordinator
Barbara Silverstein	Department of Labor and Industries	Research Director, SHARP Program
Carol Velasquez	Lake Chelan Community Hospital	Chief Nursing Officer
Sally Watkins	Washington State Nurses Association	Asst. Executive Dir, Nursing Practice, Education and Research
Lori Wilkinson	PeaceHealth St. Joseph Medical Center	Employee Health Manager
Teka Zamora	Central Washington Hospital	Safe Patient Handling Coordinator

At its inception, the goal of the committee was to assist hospitals in the successful implementation of the SPH legislation in order to reduce patient handling related injuries. However, since the law has been fully implemented in Washington acute care hospitals by January 30, 2010, the steering committee has adopted a more comprehensive focus on SPH. From the steering committee meetings, the biggest challenge facing those responsible for the SPH programs in their facilities is program sustainability. Committee members have expressed concern that safe patient handling is no longer a primary concern for hospitals. Evidence of this includes a reduction in hours allowed for SPH training or retraining. Additionally, after the initial outlay of funds to meet the equipment requirements set by the law, obtaining additional funds to replace out-dated or worn equipment or to expand the program is more difficult.

Consequently, current SPH Steering Committee priorities include:

- The promotion of the message of “continuous improvement” and growth within an SPH program and dispel the belief of some hospitals that their SPH program is “done” now that the law is fully implemented.
- The promotion and education about the issue of sustainability of SPH programs including the need for continuous funding, continued adequate allocation of resources and staff and continued support by management.
- The promotion and education of hospitals on the development of comprehensive program evaluations that include injury investigation, tracking SPH injuries, and the safety climate.

Outreach and Education

Significant resources have been devoted to insure knowledge of the legislation, provide assistance in implementation, and evaluation of the ongoing efforts.

a) Safe Patient Handling Conference

A third SPH Northwest Conference is being organized for June 2013. This conference will act as a companion to the two previous SPH Northwest Conferences which were held in 2008 and 2011 and focused on the implementation and integration of a SPH program. This third conference will focus on the challenges to a safe patient handling environment, including sustainability, special populations, cultural competency and continuous quality improvement. This conference is being organized by the University of Washington Northwest Center for Occupational Health and Safety and the Washington State Safe Patient Handling Steering Committee.

b) The Washington Safe Patient Handling Website

The website (<http://www.washingtonsafepatienthandling.org>), developed by the Washington State Safe Patient Handling Steering Committee, still continues to provide important and educational materials concerning safe patient handling. Over the past 2 years (Jan 01/2010 – Sep 30/2012), the website pages have had over 46,000 visits. The website is being updated to reflect the new focus and direction of the steering committee and will continue to be an important resource for hospitals within Washington State and beyond.

c) On-line Safe Patient Handling Discussion Group

An on-line discussion group, Washington Safe Patient Handling Committee, has been created (https://groups.google.com/forum/?fromgroups#!forum/wa_sph_committee). The intent of this discussion group is to provide an ideas and problem-solving forum – an opportunity for the sharing of ideas, best practices and hazard resolution involving patient handling.

Conclusions

Safe patient handling legislation has been implemented in all acute care hospitals in Washington. Regulatory and voluntary efforts to improve implementation have been innovative and cooperative. The role of the voluntary efforts has helped to institutionalize the importance of safe patient handling. However, as new challenges affect hospitals and other health care settings (including increased patient morbidity and obesity, as well as an aging health care staff), sustainability of safe patient handling will be critical to improved patient outcomes and retention of staff. As more acutely ill patients are transferred as residents to nursing homes, greater attention may need to assist nursing homes with the increased acuity burden.



Appendix A – Actuarial Review.

Process and data collected by SHARP have been briefly reviewed regarding the experience of Risk Class 6120 Acute Care Hospitals with Safe Patient Handling. No attempt was made to verify the data. The selection and sort bases used seem reasonable. The data, analysis and conclusions are reasonable. Recent changes in claim frequency are unexplained so far. There remains some uncertainty as to the future rates and rate relativities. On a purely technical basis; however, it is nearly impossible that the rate differential between Classes 6120, Acute Care Hospitals with Safe Patient Handling, and 6121, Acute Care Hospitals without Safe Patient Handling will disappear as Class 6121 is depopulated. Furthermore, a 24% difference in rates between Class 6120, Acute Care Hospitals with Safe Patient Handling, and 6105, Hospitals: N.O.C. would take several years of continued converging experience to eliminate the rate differential.

Review of experience and rating, Classes 6120, Acute Care Hospitals with Safe Patient Handling, and 6121, Acute Care Hospitals without Safe Patient Handling.

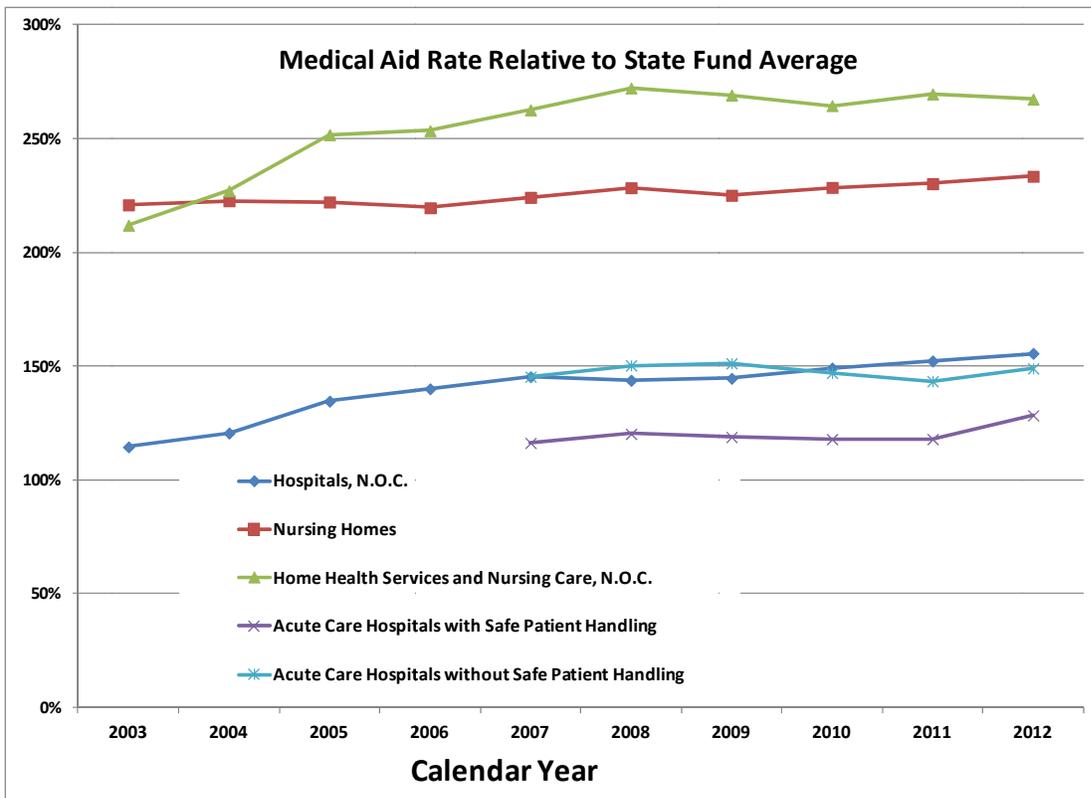
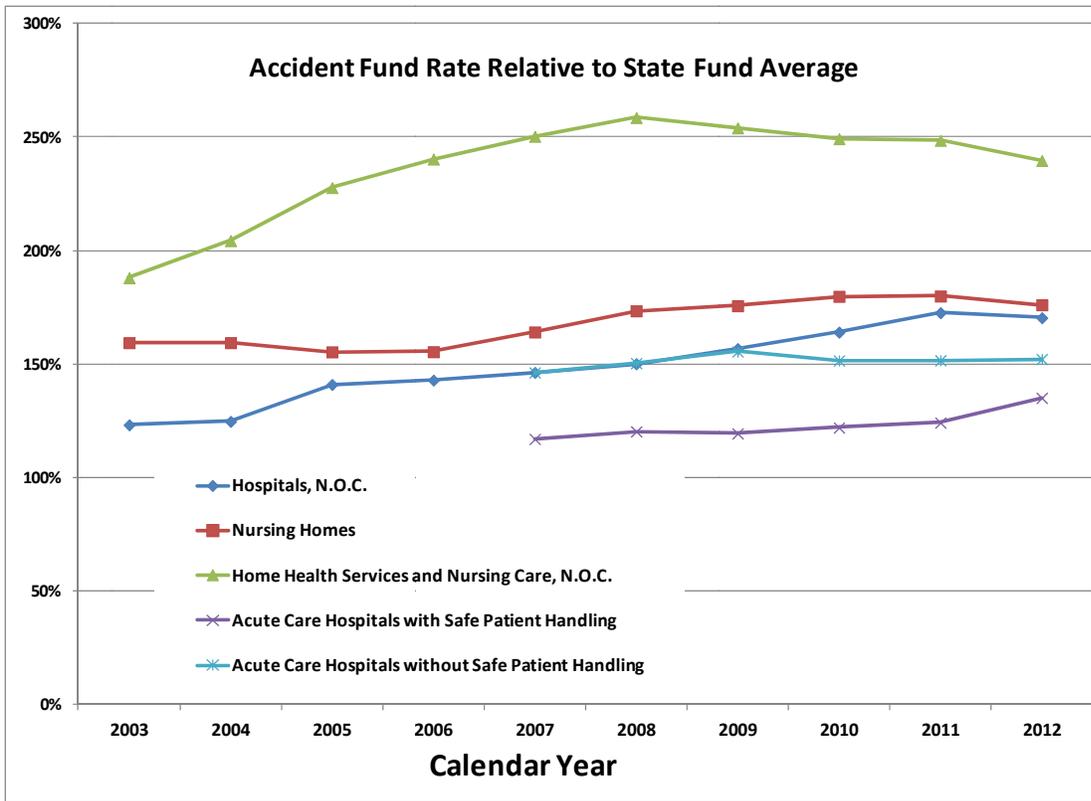
Class 6121, Acute Care Hospitals without Safe Patient Handling, is effectively depopulated. There continues to be historical experience on which to base a rate; however, it has very little credibility. The proposed rates for 2013 are based on experience from the period 7/1/2006 through 6/30/2011. The following exhibit illustrates the differences between classes 6120 and 6121, acute care hospitals (ACH) with and without safe patient handling.

Comparison of Pure Premiums		
	Class	
	6120	6121
Underlying	0.5509	0.6294
Indicated	0.4611	0.7177
Formula	0.5435	0.6205
Credibility	41%	11%

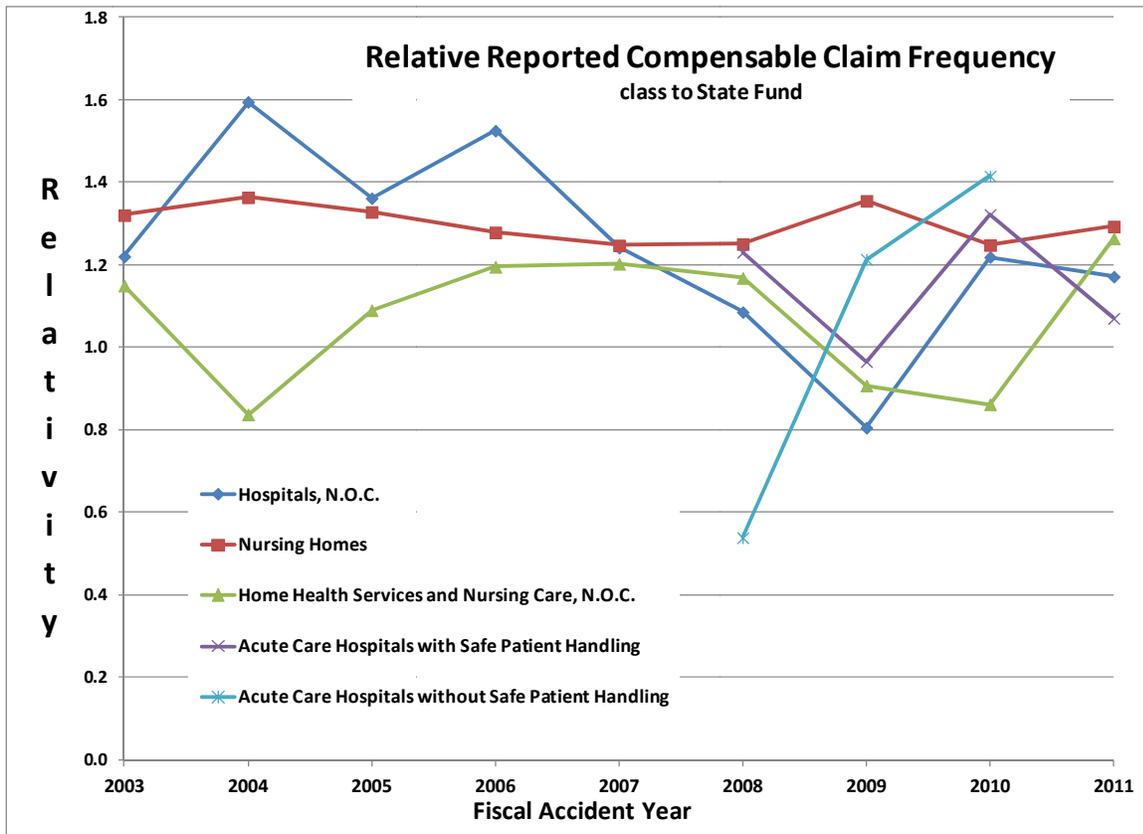
Pure premium is a measure of the expected benefit costs per hour. The underlying pure premiums are based on prior estimates. The indicated pure premium is the measure of the costs observed in the current rating period. The formula pure premium is a credibility-weighted average of the underlying and indicated pure premiums. The credibility is based on the costs that were expected to emerge in the rating period. The credibility of Class 6120 is 41%, giving it a ranking in the top 1/3 of all classes. The credibility of Class 6121 is 11% and falling, and ranking it in the lowest ¼ of all classes. Given the difference between the indicated pure premiums and the wide differences in credibility, the rate differences are unlikely to close.

The rates for these (and related) classes is compared to the state fund overall rates to get a rate relativity. This provides a sense as to the experience of these classes relative to the average experience of the state fund.

The accident fund rate relativities expose an increasing trend in class 6120, flat trend in class 6121 and recently decreasing trends for Home Health Care and Nursing Homes. Hospitals N.O.C also shows an increasing trend except for 2012. The medical aid fund rate relativities show class 6120 decreasing except for 2012, closing back towards an increasing relativity for Hospitals N.O.C. The rate differential between Hospitals N.O.C and Acute Care Hospitals with Safe Patient Handling closed somewhat in 2012.



Another comparative measure of the relative experience of classes is the compensable claim frequency of a class relative to the compensable claim frequency of the state fund as a whole. The reported numbers of compensable claims by class, by year, are compared to the on-level premium for matching periods. Those frequencies are then compared to the state fund compensable claim frequency to get an indication of the relative performance of a class.



Class 6120, Acute Care Hospitals with Safe Patient Handling, demonstrates a very similar pattern to Hospitals not otherwise classified (N.O.C.) except for the most recent fiscal-accident year, where the compensable claim relativity for Class 6120 dips below the larger Hospitals N.O.C. class.

In reviewing the Pure Premium Review Spreadsheet, Fiscal-Accident Year 2010 was a particularly bad year, compared to the other years in the rate review. Fiscal-Accident year 2011 is slightly worse than the average year, but contributes much less to the indicated rate than the experience from 2010.

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