CNA HEALTHPRO NURSE CLAIMS STUDY

AN ANALYSIS OF CLAIMS WITH RISK MANAGEMENT RECOMMENDATIONS 1997-2007

For more information about Professional Liability coverage, **click here**.

Study provided by:

nso
nurses service organization℠

NURSING HAS A DISTINGUISHED HISTORY OF CONCERN FOR THE WELFARE OF THE SICK, INJURED, AND VULNERABLE AND FOR SOCIAL JUSTICE.

CNA

NURSING ENCOMPASSES THE PREVENTION OF

CONTENTS

PREFACE

We at CNA, in collaboration with our business partners at Nurses Service Organization (NSO), are dedicated to improving the risk awareness of our insured nurses. In this study, we use CNA/NSO-insured nurse claim data to identify high-risk areas for nurses. Associated risk management recommendations also are included to suggest various strategies to reduce potential liability.

The study is divided into three major sections: claim data and analysis, examination of the overall nursing litigation environment and risk control recommendations. A glossary at the end of the document defines key terms.

Please note that the study does not include data for nursing assistants, nurse aides or nursing students. It also excludes data addressing advanced practice nurses, such as nurse practitioners, certified registered nurse anesthetists and certified nurse midwives.

CNA has provided professional liability insurance to nurses since 1984. We currently insure more than 650,000 nurses in the United States. Approximately 58 percent of all nurses insured by CNA work in adult medical/surgical care specialties. The remainder pursues other clinical specialties, including gerontology, women's health (obstetrics and gynecology), pediatrics and psychiatry.

In preparing this claim study, we sought to share our risk management knowledge related to current claim trends in order to better enable nurses to recognize and manage the risks and challenges they face on a daily basis in their nursing practice. We hope you find this study a valuable educational resource.

NURSE CLAIMS REVIEW AND ANALYSIS

DATABASE AND METHODOLOGY

The data for this study were derived from a sample of 8,151 professional liability claims from the CNA/NSO nurses insurance program related to events that occurred between January 1, 1997 and December 31, 2007.

In order to focus on the most significant nurse claims and to manage the aggregated data from a reporting and analysis perspective, **the study was limited to professional liability claims involving licensed nurses with indemnity payments or reserves equal to or greater than $10,000.**

Claims that met one or more of the following criteria were excluded:

- The event occurred before January 1, 1997 or after December 31, 2007.
- The claim closed with an indemnity payment by CNA of less than $10,000.
- The claim remains open and incurred reserves and/or expenses are less than $10,000.
- The claim was instituted solely against a nursing assistant, nurse aide or nursing student.
- The claim was instituted solely against an advanced practice nurse.
- The only claim service provided was either legal assistance for protection of the nurse's license or deposition assistance.

UNDERSTANDING AND USING THE DATA

Frequency and severity. In this study, the frequency figures include both open and closed claims. However, only closed claims with an indemnity payment of $10,000 or more are used to determine severity. Smaller claims were excluded to enhance the usefulness of the severity analysis.

Patients. For the purposes of this study, *patient* refers to any person receiving nursing care in a hospital, aging services or long term care facility, behavioral health facility, physician office or other healthcare delivery setting.

Limitations of the data and analysis. The study database, related analysis and risk management recommendations have some inherent limitations, reflecting the following parameters:

- *The database includes only CNA-insured nurses,* which may not necessarily represent the spectrum of nurse activities and claims.
- *Noted indemnity and expense payments are only those paid by CNA on behalf of its insured nurses* and do not represent amounts paid by employers, other insurers, insureds or other parties in the form of deductibles or self-insured retentions.
- *CNA nurse professional liability insurance coverage is typically provided on an "occurrence" basis,* which means a claim may occur, be reported and resolved over a period of years.

Specific information related to an open or closed claim may be lacking for many reasons, including, but not limited to, the following:

- *The claim is open,* the investigation is ongoing, and a specific data element is not yet reported in the claim management database.
- *Responsibility for the claim has been assumed by a third party,* now managing all investigative findings. For example, when the claim involves the actions of a hospital or one of its employees, and the hospital subsequently agrees to take responsibility for defense of the claim, the insurer is not responsible for the claim handling.
- *The claim is open but dormant,* and no further information is available.
- *Some or all of the patient's health information record is not available,* or record requests are pending.
- *Information is not yet available* pending depositions and the discovery process.
- *The claim was settled/resolved* before a full investigation was completed.
- *The nurse named in the suit was dismissed from the claim* or otherwise deemed not liable, and additional investigation was not required.
- *Some data elements cannot yet be determined,* such as the final outcome of injury.

Please note that data in this study are not intended to be compared with findings in the CNA Nurse Practitioner Claims Study or any other previously published CNA healthcare professional liability claims study. It should be emphasized that the liability experience within specific professional groups varies widely.

REVIEW OF NURSING CLAIMS DATA

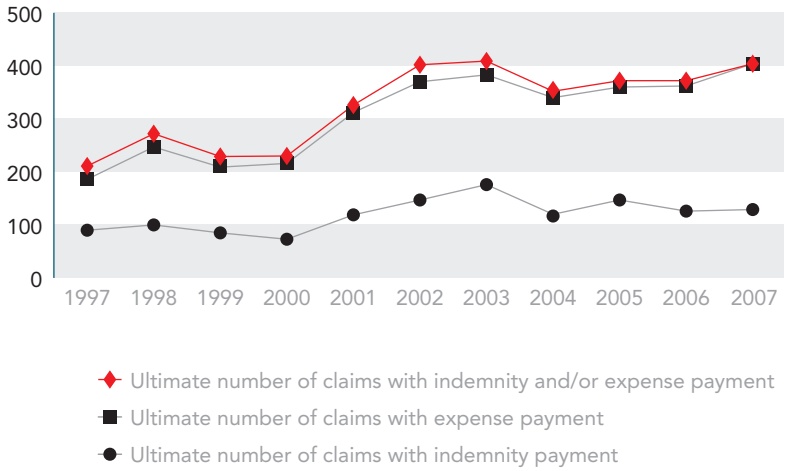
ULTIMATE FREQUENCY AND SEVERITY OF CLAIMS BY YEAR OF LOSS

Statistically, the most revealing financial analysis of claims is determined via specialized actuarial calculations called *ultimate projections*. Ultimate projections are based on historical patterns and incorporate predictive factors for frequency and severity in a specific loss year. The following ultimate values represent reported losses to date, with a provision for future loss development. As no model can predict claims or their settlements with absolute precision, ultimate values may increase or decrease throughout the course of claim development.

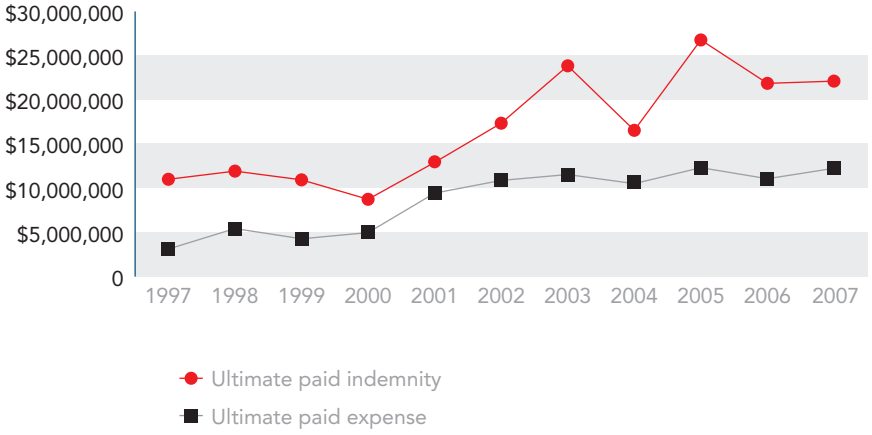
In order to establish the ultimate loss information for the CNA nurse claims database, the actuarial ultimate loss projection process was applied to the database of 8,151 claims. Of these claims, 1,260 are currently projected to ultimately result in an indemnity payment, while 2,253 are projected to close with an expense payment only. The remaining 4,638 are projected to close with no indemnity or expense payment.

As reflected in Figures 1a and 1b, the ultimate frequency and severity (total paid indemnity) generally increase each loss year. The trend in ultimate average indemnity (Figure 1c) also increases over time.

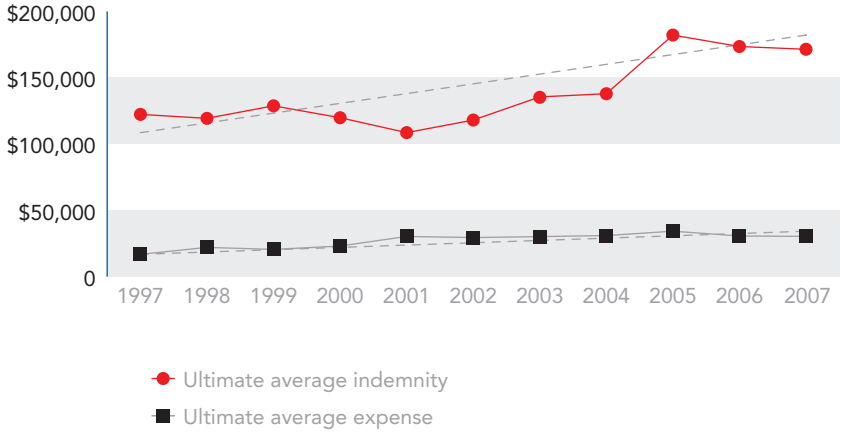
Ultimate Number of Claims by Year of Loss 1a



1b Ultimate Total Paid by Year of Loss



1c Ultimate Severity (Average Paid) by Year of Loss



ANALYSIS OF CLAIMS BY CLAIM STATUS AND LICENSURE TYPE

Claim status refers to whether the claim is open (active or inactive) or closed (via settlement, judgment, award, arbitrated agreement or dismissal). The status of claims becomes important when determining patterns and trends related to claim frequency and severity. The frequency is reported as percentages of open and closed claims. The measure of severity is defined as the average paid indemnity for all closed claims with an indemnity payment equal to or greater than $10,000.

As indicated in Figure 2, the study's final database of open and closed claims includes open claims with reserves equal to or greater than $10,000, and closed claims with an indemnity payment equal to or greater than $10,000. These figures also include the amount of indemnity, reserves and/or expense that has been paid by CNA for each status type. A total of $137,221,576 has been incurred by CNA for open and closed claims. Please note that this is the *only* figure that includes reserves for open claims. Indemnity payments for open claims are not included in other charts or in the descriptions of claim severity.

If indemnity monies have been paid by CNA on an open claim, the payment may indicate one or more of the following situations:

- *Closure is imminent,* and partial indemnity payment has been made.
- *The claims professional has not yet completed the claim closure procedure,* although monies already have been paid.
- *A component of the indemnity payment – such as medical costs – has been paid,* but the claim has not yet been fully resolved.

Approximately 86 percent of the total indemnity paid by CNA HealthPro was for claims involving registered nurses, and 14 percent was for claims involving licensed practical nurses, as shown in Figure 3. However, average paid indemnity was higher for licensed practical nurse claims than for registered nurse claims.

Claims by Claim Status 2

Claim status type	Percentage of total claims	Total paid indemnity	Total paid expense	Case reserve	Total paid indemnity, expense and reserves
Closed with indemnity payment of ≥ $10,000	57%	$68,880,309	$16,855,652	$0	$85,735,961
Open with reserves of ≥ $10,000	43%	$1,553,998	$6,881,842	$43,049,775	$51,485,615
TOTAL	100.0%	$70,434,307	$23,737,494	$43,049,775	$137,221,576

Claims by Licensure Type (Closed Claims with Paid Indemnity of ≥ $10,000) 3

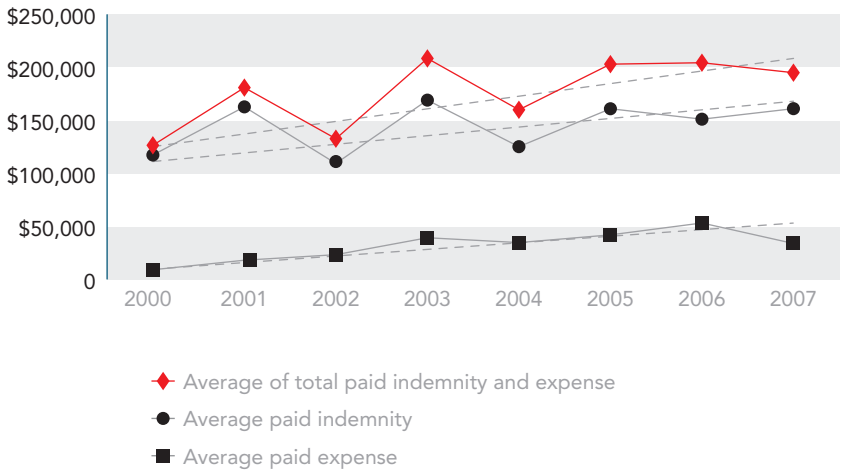
Licensure type	Total paid indemnity	Average paid indemnity
Licensed practical nurse	$9,477,929	$163,413
Registered nurse	$59,402,380	$149,252
Overall	$68,880,309	$151,053

ANALYSIS OF SEVERITY BY YEAR

As noted earlier, CNA typically provides professional liability insurance to nurses on an *occurrence* coverage basis. Occurrence coverage protects the insured against any claim that occurs during the year the policy is in effect, regardless of when the claim is reported. For example, if a nurse has a 2007 policy, that policy will respond to any covered event that occurs in 2007, even if the event is not reported until years later. Loss experience for occurrence policies continues to develop as claims are reported and throughout the timeframe within which they are investigated and resolved.

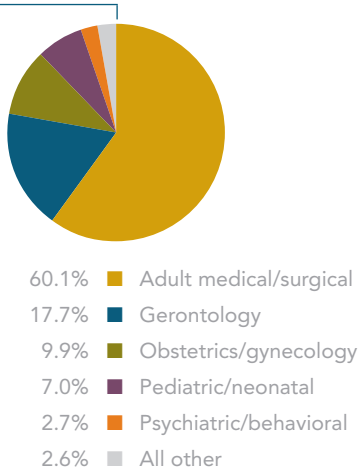
Figure 4 displays the severity trend for claims by the year the claim was closed. The information includes average paid indemnity and average paid expense in each year. The top line represents the average of total paid indemnity and expense. The data demonstrate a trend toward greater average paid indemnity and expenses.

4 Severity Trends by Year Closed (Closed Claims with Paid Indemnity of ≥ $10,000)



5 Frequency by Nurse Specialty (Open and Closed Claims)

Nurse specialty	Percentage of total claims
Adult medical/surgical	60.1%
Gerontology	17.7%
Obstetrics/gynecology	9.9%
Pediatric/neonatal	7.0%
Psychiatric/behavioral	2.7%
Adolescent	1.4%
Urology/renal	0.6%
Public/community health	0.3%
Clinical research	0.1%
Other	0.1%
Total	100%



ANALYSIS OF FREQUENCY AND SEVERITY BY NURSE SPECIALTY

The data in Figure 5 indicate that 60.1 percent of CNA open and closed claims involved nurses within the adult/medical surgical specialty, while gerontology accounted for 17.7 percent of the claims. As noted in Figure 6a, claims involving nurses in obstetrics/gynecology had an average paid indemnity of $335,375, the highest for all specialties. As nurses are directly involved in the decision-making process when providing labor and delivery services, they may have greater liability exposure. Neonatal injuries are associated with high severity, as they often result in the need for complex medical and support services for prolonged periods. The severity of obstetrics/gynecology specialty claims is detailed in Figure 6b. Further detail regarding birth-related trauma is provided in Figures 6c and 6d.

Severity by Nurse Specialty
(Closed Claims with Paid Indemnity of ≥ $10,000) 6a

Nurse specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Obstetrics/gynecology	10.3%	$15,762,609	$335,375
Pediatric/neonatal	9.2%	$10,436,416	$248,486
Adolescent	1.8%	$1,810,000	$226,250
Urology/renal	1.1%	$935,000	$187,000
Psychiatric/behavioral	2.4%	$1,804,310	$164,028
Adult medical/surgical	56.4%	$29,333,731	$114,139
Gerontology	18.2%	$8,601,927	$103,638
Public/community health	0.4%	$171,316	$85,658
Other	0.2%	$25,000	$25,000
Overall	100%	$68,880,309	$151,053

Severity for Obstetrics/Gynecology by Allegation
(Closed Claims with Paid Indemnity of ≥ $10,000) 6b

Allegation related to	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Scope of practice	2.1%	$970,000	$970,000
Assessment	8.5%	$2,550,000	$637,500
Monitoring	10.6%	$2,851,667	$570,333
Treatment and care management	76.6%	$9,366,042	$260,168
Medication administration	2.1%	$24,900	$24,900
Overall	100%	$15,762,609	$335,375

ACTIVELY PROMOTE THE COLLABORATIVE

OF THE NURSE SPECIALTIES,

OBSTETRICS/GYNECOLOGY

HAD THE HIGHEST

AVERAGE PAID INDEMNITY.

6c Frequency of Claims Related to Fetal Birth Trauma by Injury (Open and Closed Claims)

Injury	Percentage of fetal birth trauma claims
Birth-related brain damage	63.3%
Fetal death	30.0%
Other birth trauma	5.7%
Total	100%

6d Severity of Claims Related to Fetal Birth Trauma by Injury (Closed Claims with Paid Indemnity of ≥ $10,000)

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Birth-related brain damage	65.2%	$12,978,031	$432,601
Other fetal birth trauma	30.4%	$2,564,167	$183,155
Fetal death	4.3%	$158,000	$79,000
Overall	100%	$15,700,198	$341,309

MULTI-DISCIPLINARY PLANNING REQUIRED TO ENSURE TH

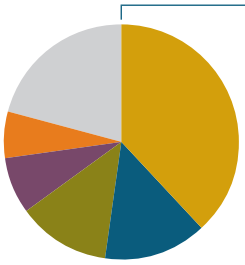
ANALYSIS OF FREQUENCY AND SEVERITY BY LOCATION

Emergency department, inpatient perinatal services, dialysis, radiology and behavioral health are noted as separate locations. All other hospital services are included in either hospital-inpatient or hospital-outpatient services.

The largest percentage of claims occurred in the hospital inpatient setting. The second most frequent location was aging services residential facilities. These findings are consistent with the fact that the majority of our insured nurses work in adult and geriatric specialties.

The claim locations with the highest severity did not have the highest frequency. The location with the highest average paid indemnity was hospital-inpatient perinatal services, reflecting the fact that injuries during birth can result in costly life care plans or death.

Frequency by Location (Open and Closed Claims) 7



38.2% Hospital–inpatient
14.2% Aging services residential facility
12.7% Patient's home
7.8% Hospital emergency department
6.4% Physician office
20.7% All other

Location	Percentage of total claims
Hospital–inpatient	38.2%
Aging services residential facility	14.2%
Patient's home	12.7%
Hospital emergency department	7.8%
Physician office	6.4%
Hospital–inpatient perinatal	5.4%
Prison	4.9%
Ambulatory surgical center	2.8%
Pediatric long term care residential facility	1.6%
Hospital–outpatient	1.1%
Psychiatric/behavioral	1.0%
Clinic–outpatient	0.8%
Nurse private practice	0.5%
School (nursery school through college)	0.5%
Dialysis	0.4%
Radiology	0.4%
Other physician/licensed independent practitioner office	0.4%
Methadone clinic	0.3%
Clinical research facility	0.1%
Retail healthcare delivery sites	0.1%
Military facilities	0.1%
Urgent care or walk-in care center	0.1%
Other	0.1%
Total	100%

Practice in psychiatric/behavioral health locations also resulted in high-severity claims. In one such location, an employee with 20 years' experience monitored a 40-year-old man who had been admitted to the facility for treatment of injuries suffered as a result of severe schizophrenia. The patient had a history of gastroesophageal reflux disease with mild swallowing weakness and hypertension. Although these conditions were controlled by medication, the patient's excessive water drinking, together with his habits of eating too rapidly and not chewing his food, caused frequent vomiting. When the patient complained one day of abdominal pain, fever and vomiting, he was evaluated by the facility nurse, who believed the patient was suffering from pneumonia. He died soon after. It was later determined that the patient had developed sepsis after an acute appendicitis attack. Among the many allegations against the nurse were failure to monitor and assess the patient and failure to notify physicians of the patient's condition in a timely manner.

Locations with high frequency are the most predictive of future nurse claims. Based upon the data, we can expect that a nurse claim occurring in an inpatient hospital setting will have an average indemnity payment of $163,436. Due to the frequency of such claims, we can better estimate the potential average cost of a nurse inpatient hospital claim than a nurse prison claim. While lower frequency locations are less predictive, claims with significant indemnity payments can occur in any location where nurses care for patients.

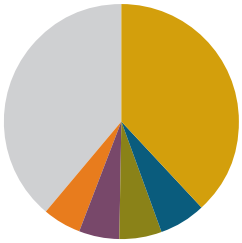
8 Severity by Location (Closed Claims with Paid Indemnity of ≥ $10,000)

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Hospital–inpatient perinatal services	6.4%	$7,984,376	$275,323
Psychiatric/behavioral	1.1%	$1,342,500	$268,500
Hospital–outpatient	1.8%	$2,067,500	$258,438
Dialysis	0.7%	$700,000	$233,333
Radiology	0.4%	$462,500	$231,250
Methadone clinic	0.4%	$375,000	$187,500
Patient's home	16.0%	$13,156,724	$180,229
Hospital–inpatient	33.8%	$25,169,094	$163,436
Prison	4.2%	$2,629,125	$138,375
Hospital emergency department	7.0%	$3,615,136	$112,973
Physician office	9.4%	$4,221,750	$98,180
Pediatric long term care residential facility	2.6%	$1,151,987	$95,999
Urgent care or walk-in care center	0.2%	$93,750	$93,750
Aging services residential facility	12.7%	$5,246,617	$90,459
Ambulatory surgical center	2.0%	$521,750	$57,972
Other physician/licensed independent practitioner office	0.7%	$90,000	$30,000
Clinic–outpatient	0.2%	$17,500	$17,500
Nurse private practice	0.4%	$35,000	$17,500
Overall	100%	$68,880,309	$151,053

ANALYSIS OF FREQUENCY AND SEVERITY BY INJURY

For purposes of this study only, the term *injury* is expanded to include the unanticipated patient harm, injury, illness, diagnosis, symptoms or disease that led to the initiation of the claim.

Frequency by Injury (Open and Closed Claims) 9



38.2% Death (other than fetal or maternal death)
6.5% Infection/abscess/sepsis
5.7% Birth-related brain damage
5.5% Fracture
5.3% Brain damage other than birth-related
38.8% All other

Injury	Percentage of total claims
Death (other than fetal or maternal death)	38.2%
Infection/abscess/sepsis	6.5%
Birth-related brain damage	5.7%
Fracture	5.5%
Brain damage other than birth-related	5.3%
Burn	4.2%
Pressure ulcer	4.0%
Pain and suffering	3.0%
Emotional/psychological damage/distress	2.8%
Fetal death	2.6%
Cardiac condition including MI, angina, coronary artery disease	2.4%
Bleeding/hemorrhage	2.0%
Loss of organ or organ function	1.6%
Loss of limb or use of limb	1.6%
Paralysis	1.5%
Neurological deficit/damage	1.5%
Abuse/patient's rights/professional misconduct	1.5%
Amputation	1.4%
Allergic reaction/anaphylaxis	1.3%
Fall	0.9%
Laceration/tear/abrasion	0.8%
Cerebral vascular accident/stroke	0.6%
Compartment syndrome	0.6%
Peripheral vascular ulcer	0.6%
Other	0.6%
Other birth trauma	0.5%
Eye injury/vision loss	0.5%
Wound (other than pressure ulcer)	0.4%
Pneumonia/respiratory infection	0.4%
Maternal death	0.3%
Back injury	0.3%
Cancer	0.1%
Head injury	0.1%
Coma	0.1%
Ear injury/hearing loss	0.1%
Embolism	0.1%
Bruise/contusion	0.1%
Appendicitis	0.1%
Total	100%

NEEDS FOR HEALTH CARE. THE NURSE PROMOTES,

As noted in Figure 9, death was the most frequently reported injury (38.2 percent). Infection/abscess/sepsis accounted for 6.5 percent of the claims. Infections arose from varied sources, including intravenous lines, retained medical sponge/equipment after surgery, improper wound care, and skin ulcers or bedsores. Re-use of needles and syringes was another observed risk factor.

Figure 10 indicates that the most severe closed claims involved birth-related brain damage, brain damage related to events other than the birthing process, and paralysis. Brain injury claims generally have high severity due to the potentially devastating impact on the patient and family.

10 Severity by Injury (Closed Claims with Paid Indemnity of ≥ $10,000)

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Birth-related brain damage	6.6%	$12,978,031	$432,601
Brain damage other than birth-related	6.6%	$9,220,500	$307,350
Paralysis	0.2%	$250,000	$250,000
Amputation	2.0%	$2,226,250	$247,361
Allergic reaction/anaphylaxis	1.3%	$1,133,175	$188,863
Fetal death	3.1%	$2,564,167	$183,155
Cerebral vascular accident/stroke	0.4%	$325,000	$162,500
Death (other than fetal or maternal death)	37.3%	$25,326,452	$148,979
Eye injury/vision loss	0.7%	$427,500	$142,500
Cardiac condition including MI, angina, coronary artery disease	2.9%	$1,573,436	$121,034
Bleeding/hemorrhage	2.6%	$1,382,679	$115,223
Loss of limb or use of limb	2.4%	$1,137,500	$103,409
Pneumonia/respiratory infection	0.4%	$180,000	$90,000
Other birth trauma	0.4%	$158,000	$79,000
Pain and suffering	2.9%	$1,009,375	$77,644
Fracture	5.3%	$1,860,870	$77,536
Burn	6.4%	$2,217,000	$76,448
Infection/abscess/sepsis	6.6%	$2,129,750	$70,992
Pressure ulcer	1.5%	$465,000	$66,429
Loss of organ or organ function	1.3%	$397,500	$66,250
Emotional/psychological damage/distress	3.3%	$837,224	$55,815
Abuse/patient's rights/professional misconduct	1.5%	$347,500	$49,643
Compartment syndrome	0.7%	$143,750	$47,917
Neurological deficit/damage	1.5%	$334,750	$47,821
Coma	0.2%	$40,000	$40,000
Embolism	0.2%	$37,500	$37,500
Fall	0.4%	$65,000	$32,500
Other	0.2%	$24,900	$24,900
Back injury	0.2%	$22,500	$22,500
Wound (other than pressure ulcer)	0.2%	$20,000	$20,000
Laceration/tear/abrasion	0.2%	$15,000	$15,000
Peripheral vascular ulcer	0.4%	$30,000	$15,000
Overall	100%	$68,880,309	$151,053

ANALYSIS OF SEVERITY BY INJURY OUTCOME

Claims with outcomes involving permanent total disability had the highest severity, relating to the ongoing cost of supporting the needs of disabled claimants. Death and permanent partial disability also have average paid indemnity over $100,000.

Severity of Injury Outcome (Closed Claims with Paid Indemnity of ≥ $10,000) 11

Injury outcome	Percentage of closed claims	Average paid indemnity
Permanent total disability from injury/illness	12.9%	$360,694
Death	47.4%	$153,160
Permanent partial disability from injury/illness	19.5%	$104,000
Temporary partial disability from injury/illness	9.6%	$64,870
No injury	2.2%	$57,550
Severity and/or patient outcome not indicated	2.6%	$51,042
Temporary total disability from injury/illness	5.7%	$46,868
Overall	100%	$151,053

ANALYSIS OF FREQUENCY AND SEVERITY BY ALLEGATION CATEGORY

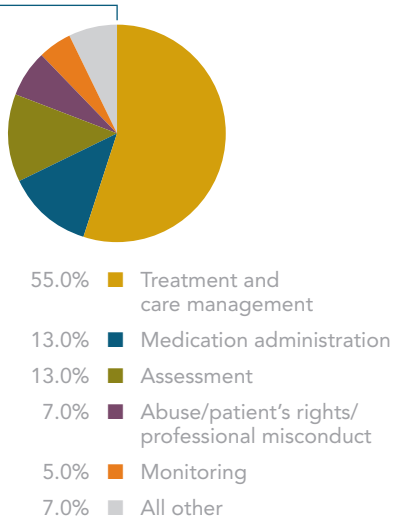
Allegation categories with the highest frequency (Figure 12) were those relating to treatment and care management, medication administration and assessment. These three categories comprised 81 percent of allegations. The treatment and care management-related category represents 55 percent of the claims. The prevalence of allegations in this category may indicate that patients and their families hold nurses responsible for the delivery of patient care and treatment, whether or not the nurse has direct authority to create, monitor and/or change the medical treatment plan. It may also reflect the fact that most patient interactions with healthcare staff involve nurses.

Figure 13 shows the average severity of closed claims by allegation. The allegation category with the highest severity of closed claims was scope of practice, with an average CNA indemnity payment of $440,854. These claims typically involve procedures, actions and processes that are not recognized within the nursing scope of practice statutes and by the licensing bodies in the state where professional services were provided. Claims related to monitoring also had high severity, with an average CNA-paid indemnity of $303,570. These categories encompassed relatively few closed claims. Nevertheless, even these less frequent allegations are potentially severe.

SCOPE OF PRACTICE ALLEGATIONS HAD THE HIGHEST AVERAGE PAID INDEMNITY.

12 Frequency by Allegation Category (Open and Closed Claims)

Allegation category related to	Percentage of total claims
Treatment and care management	55.0%
Medication administration	13.0%
Assessment	13.0%
Abuse/patient's rights/professional misconduct	7.0%
Monitoring	5.0%
Equipment	3.0%
Diagnosis	2.0%
Scope of practice	1.0%
Other	1.0%
Total	100%



13 Severity by Allegation Category (Closed Claims with Paid Indemnity of ≥ $10,000)

Allegation category related to	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Scope of practice	1.3%	$2,645,125	$440,854
Monitoring	5.7%	$7,892,817	$303,570
Equipment	2.9%	$2,954,992	$227,307
Assessment	12.3%	$9,620,862	$171,801
Treatment and care management	55.0%	$35,070,311	$139,722
Medication administration	15.6%	$8,723,203	$122,862
Abuse/patient's rights/professional misconduct	4.4%	$1,457,999	$72,900
Documentation	0.4%	$111,250	$55,625
Nurse and patient communication	0.2%	$50,000	$50,000
Diagnosis	1.3%	$251,250	$41,875
Other	0.2%	$37,500	$37,500
Confidentiality	0.7%	$65,000	$21,667
Overall	100%	$68,880,309	$151,053

THE SAME DUTIES TO SELF AS TO OTHERS, INCLUDING THE

ANALYSIS OF SEVERITY OF ALLEGATIONS RELATED TO TREATMENT

The average paid indemnity for closed claims related to treatment was $139,722. The most severe treatment allegation was failure to timely treat symptoms/illness/disease in accordance with established standards/protocols/pathways, with an average paid indemnity of $337,500. The second most severe allegation was failure to timely report complications of pregnancy, labor or delivery to a physician/licensed independent practitioner, with an average paid indemnity of $274,017. The third most severe allegation was failure to timely implement established treatment protocols or established critical pathways, with an average paid indemnity of $263,333.

Severity of Allegations Related to Treatment (Closed Claims with Paid Indemnity of ≥ $10,000) 14

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to timely treat symptoms/illness/disease in accordance with established standards/ protocols/pathways	1.2%	$1,012,500	$337,500
Failure to timely report complications of pregnancy, labor or delivery to physician/ licensed independent practitioner	12.7%	$8,768,542	$274,017
Failure to timely implement established treatment protocols or established critical pathways	3.6%	$2,370,000	$263,333
Failure to timely respond to patient's concerns related to the treatment plan	2.8%	$1,552,500	$221,786
Abandonment of patient, including checking patient's status at appropriate intervals	6.4%	$3,040,400	$190,025
Failure to timely notify physician/licensed independent practitioner of patient's condition and/or lack of response to treatment	6.4%	$2,649,071	$165,567
Improper/untimely nursing management of patient or medical complication	15.1%	$4,843,708	$127,466
Delay in implementing ordered, appropriate treatment	1.6%	$502,500	$125,625
Improper/untimely nursing technique or negligent performance of treatment resulting in injury	27.9%	$7,047,922	$100,685
Premature cessation of treatment	0.8%	$190,000	$95,000
Failure to timely report complication of post-operative care to physician/licensed independent practitioner	1.6%	$280,000	$70,000
Improper/untimely nursing management of pre-operative, peri-operative, or post-operative treatment or complication	15.5%	$2,375,708	$60,916
Improper/untimely application, ordering or management of physical or chemical restraints, and/or failure to remove restraints at proper increments of time	0.8%	$120,000	$60,000
Improper/untimely nursing management of behavioral health/mental health patient or behavioral health complication	0.8%	$97,500	$48,750
Improper/untimely nursing management of patients in need of physical restraints, including 1:1 supervision, timed release, comfort breaks, fluids and nourishment	2.0%	$166,210	$33,242
Failure to timely obtain physician/licensed independent practitioner orders to perform necessary additional treatment(s)	0.8%	$53,750	$26,875
Overall	100%	$35,070,311	$139,722

OF THE MEDICATION ERROR CLAIMS, THOSE ALLEGING THAT MEDICATIONS HAD BEEN ADMINISTERED BY THE *WRONG ROUTE* PRODUCED THE HIGHEST SEVERITY.

ANALYSIS OF SEVERITY OF ALLEGATIONS RELATED TO MEDICATION ADMINISTRATION

One claim involved a nurse who was floated to the neurology floor, where she was assigned seven patients. Among them was a 19-year-old man recovering from a frontal craniotomy. She was instructed by the head nurse to administer a new order for Dilantin oral elixir through the patient's feeding tube. The nurse mistakenly gave this medication through the patient's triple lumen catheter. The patient reportedly gasped and coded within seconds. This incorrect administration triggered anaphylaxis and respiratory arrest resulting in a severe non-recoverable anoxic brain injury.

Claims alleging wrong medication route, such as the one described above, have the highest average paid indemnity of all medication error claims. Claims alleging issues related to wrong medication, wrong rate, intravenous infiltration with tissue and/or sensory injury, and wrong dose also had average paid indemnity amounts greater than $100,000. Many of the claims involving medications noted problems during administration of chemotherapy, including overdose and extravasation.

15 Severity of Allegations Related to Medication Administration (Closed Claims with Paid Indemnity of ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Wrong route	14.1%	$2,142,500	$214,250
Wrong medication	15.5%	$1,785,340	$162,304
Wrong rate	1.4%	$125,000	$125,000
Infiltration of intravenous medication with tissue and/or sensory injury	16.9%	$1,382,500	$115,208
Wrong dose	29.6%	$2,226,613	$106,029
Not covered under state scope of practice	4.2%	$240,000	$80,000
Failure to immediately report and record the incorrect or improper administration of medication/prescription	4.2%	$240,000	$80,000
Wrong patient	7.0%	$338,750	$67,750
Wrong/delayed time	2.8%	$130,000	$65,000
Missed dose	4.2%	$112,500	$37,500
Overall	100%	$8,723,203	$122,862

CLAIMS AGAINST THE DIRECTOR OF NURSING (DON)

It is no longer unusual for the most senior nurse, with overall responsibility for nursing care provided to patients/residents, to be individually named as a defendant in a lawsuit. Referred to within this study as the Director of Nursing (DON), this category includes nurse supervisors, assisted living facility managers, or other healthcare facility nurse administrators or managers who are perceived by the public as being ultimately responsible for the nursing care rendered.

While DONs do not always provide direct patient care, they may be held vicariously liable for the actions of the entire nursing care staff. DONs may also be held responsible for errors in the development and implementation of facility standards and procedures including hiring, training and quality management/improvement.

A recent example of this trend involves a DON at a nursing home who, along with staff nurses and the facility, was named as a defendant in a lawsuit for failure to monitor and delay in treatment of an 81-year-old resident suffering from dementia, congestive heart failure, seizure disorder and other ailments at the time of her admission. In this situation, the resident was experiencing abdominal pain and was taken to the facility's x-ray services. While waiting, she became unusually quiet. It was noted that the resident had aspirated after vomiting, was having difficulty breathing and died before emergency services arrived. Fecal impaction was noted in the autopsy. While named in the lawsuit, this DON was not responsible for daily hands-on care. Rather, the DON's duties included participating in various facility committees, including quality improvement, risk management and infection control. The DON also prepared staffing, census, infection control and pressure ulcer reports. Finally, she was in close communication with the facility medical director and participated in care planning meetings with families of the facility's residents. The family asserted, in this case, that the resident suffered a decline as a resident of the facility and held the DON responsible for the care provided by the facility's staff.

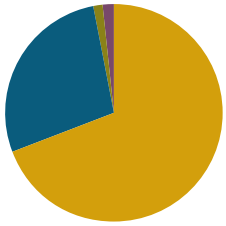
DON claims most frequently arise in the gerontology specialty, followed by adult medical/surgical care. The most common injury associated with these claims was death.

The most frequent allegation for DON claims was treatment and care management. Other common allegations were related to abuse/patient's rights/professional misconduct and patient/resident assessment. The most common locations for DON claims were aging services residential facilities, followed by prisons and inpatient hospital units.

DIRECTOR OF NURSING CLAIMS MOST FREQUENTLY ARISE IN THE GERONTOLOGY SPECIALTY, FOLLOWED BY ADULT MEDICAL/SURGICAL CARE.

16a Frequency of DON claims by Nurse Specialty (Open and Closed Claims)

Nurse specialty	Percentage of total claims
Gerontology	69.2%
Adult medical/surgical	27.7%
Psychiatric/behavioral	1.5%
Pediatric/neonatal	1.5%
Total	100%



69.2% Gerontology
27.7% Adult medical/surgical
1.5% Psychiatric/behavioral
1.5% Pediatric/neonatal

16b Severity of DON Claims by Nurse Specialty (Closed Claims with Paid Indemnity of ≥ $10,000)

Nurse Specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Gerontology	66.7%	$1,061,553	$66,347
Adult medical/surgical	33.3%	$468,500	$58,563
Overall	100%	$1,530,053	$63,752

RESPECT ACCORDS MORAL WORTH AND DI

Frequency of DON Claims by Injury (Open and Closed Claims) 17a

Injury	Percentage of total claims
Death (other than fetal death)	40.0%
Pressure ulcer	10.8%
Fracture	10.8%
Emotional/psychological damage/distress	7.7%
Infection/abscess/sepsis	7.7%
Abuse/patient's rights/professional misconduct	4.6%
Pain and suffering	3.1%
Bleeding/hemorrhage	3.1%
Bruise/contusion	1.5%
Appendicitis	1.5%
Fall	1.5%
Fetal death	1.5%
Head injury	1.5%
Loss of limb or use of limb	1.5%
Ear injury/hearing loss	1.5%
Other	1.5%
Total	100%

Severity of DON Claims by Injury (Closed Claims with Paid Indemnity of ≥ $10,000) 17b

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Fetal death	4.2%	$200,000	$200,000
Emotional/psychological damage/distress	16.7%	$409,999	$102,500
Fracture	8.3%	$200,000	$100,000
Pain and suffering	4.2%	$70,125	$70,125
Abuse/patient's rights/professional misconduct	8.3%	$137,500	$68,750
Bleeding/hemorrhage	8.3%	$106,429	$53,215
Infection/abscess/sepsis	4.1%	$36,000	$36,000
Death (other than fetal death)	25.0%	$215,000	$35,833
Pressure ulcer	12.5%	$100,000	$33,333
Loss of limb or use of limb	4.2%	$30,000	$30,000
Fall	4.2%	$25,000	$25,000
Overall	100%	$1,530,053	$63,752

18a Frequency of DON Claims by Allegation (Open and Closed Claims)

Allegation related to	Percentage of total claims
Treatment and care management	43.1%
Abuse/patient's rights/professional misconduct	23.1%
Assessment	18.5%
Monitoring	6.2%
Medication administration	3.1%
Scope of practice	1.5%
Equipment	1.5%
Documentation	1.5%
Confidentiality	1.5%
Total	100%

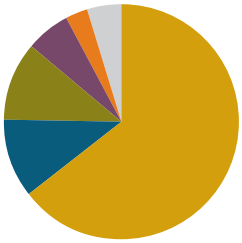
18b Severity of DON Claims by Allegation (Closed Claims with Paid Indemnity of ≥ $10,000)

Allegation related to	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Abuse/patient's rights/professional misconduct	25.0%	$562,499	$93,750
Monitoring	4.2%	$72,500	$72,500
Scope of practice	4.2%	$70,125	$70,125
Assessment	20.8%	$315,000	$63,000
Treatment and care management	33.3%	$426,000	$53,250
Medication administration	4.2%	$40,000	$40,000
Equipment	4.1%	$33,929	$33,929
Confidentiality	4.2%	$10,000	$10,000
Overall	100%	$1,530,053	$63,752

RSONAL ATTRIBUTES OR LIFE SITUATION. CONTINUAL PROFESSIONAL

THE MOST COMMON LOCATIONS FOR *DIRECTOR OF NURSING CLAIMS* WERE AGING SERVICES RESIDENTIAL FACILITIES, FOLLOWED BY PRISONS AND INPATIENT HOSPITAL UNITS.

Frequency of DON Claims by Location (Open and Closed Claims) 19a



64.6% Aging services residential facility
10.8% Prison
10.8% Hospital–inpatient
6.1% Pediatric long term care residential facility
3.1% Patient's home
4.6% All other

Location	Percentage of total claims
Aging services residential facility	64.6%
Prison	10.8%
Hospital–inpatient	10.8%
Pediatric long term care residential facility	6.1%
Patient's home	3.1%
Hospital emergency department	3.1%
Psychiatric/behavioral	1.5%
Total	100%

Severity of DON Claims by Location (Closed Claims with Paid Indemnity of ≥ $10,000) 19b

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Pediatric long term care residential facility	16.6%	$449,999	$112,500
Hospital–inpatient	12.5%	$312,500	$104,167
Aging services residential facility	54.2%	$647,554	$49,812
Prison	12.5%	$90,000	$30,000
Patient's home	4.2%	$30,000	$30,000
Overall	100%	$1,530,053	$63,752

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GROWTH, PARTICULARLY IN KNOWLEDGE AND

CLAIMS RELATED TO AGENCY NURSES

Healthcare organizations and facilities of every size and description may utilize the services of contracted or agency-provided nurses on an as-needed basis. Agency nurses are thus providing services in prisons, hospitals, aging services facilities and home healthcare agencies.

Of all open and closed claims reviewed within this study, approximately 20 percent were determined to involve an agency or contracted nurse. The most common agency nurse specialty claim was adult medical/surgical, followed by pediatric/neonatal and gerontology.

The average severity for all nurse claims (Figure 6a) was $151,053, which is approximately the same as the average severity for agency nurse claims ($153,355). However, this pattern does not apply to specialties with fewer claims. For example, agency obstetrical nurse claims had an average paid indemnity of $478,317, whereas the average paid indemnity for claims in the same specialty that did not involve an agency nurse was $335,375.

The most common injury was death, followed by infection/abscess/sepsis, and fracture. The most common allegation related to treatment and care management, followed by assessment and medication administration.

The largest category of claims (42.5 percent) attributed to agency nurses arose from services provided in the patient's home. In one claim, a home healthcare agency nurse went to a lung transplant patient's home to administer antibiotics to prevent bacterial infection. A new antibiotic was prescribed for this visit because the patient previously had an adverse reaction to the antibiotic initially prescribed. The insured administered the newly ordered medication by IV push, and the patient quickly showed signs of anaphylactic reaction. The nurse immediately stopped the administration of the drug and called 911. The nurse administered CPR until emergency medical service personnel arrived. Further attempts to revive the patient failed. An anaphylactic kit, containing an ampule of epinephrine and a vial of Benadryl, was found unused on the patient's dresser.

While frequency for claims in the patient's home is relatively high, severity tends to be lower than for claims in other locations, such as a hospital or physician office.

THE *OBSTETRICS/GYNECOLOGY* SPECIALTY HAD THE HIGHEST AVERAGE SEVERITY FOR CLOSED CLAIMS INVOLVING AGENCY NURSES.

Frequency of Agency Nurse Claims by Nurse Specialty (Open and Closed Claims) 20

Nurse specialty	Percentage of total claims
Adult medical/surgical	62.1%
Pediatric/neonatal	13.8%
Gerontology	13.2%
Obstetrics/gynecology	5.2%
Psychiatric/behavioral	1.7%
Adolescent	1.7%
Urology/renal	1.1%
Public/community health	1.1%
Total	100%

Severity of Agency Nurse Claims by Nurse Specialty (Closed Claims with Paid Indemnity of ≥ $10,000) 21

Nurse specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Obstetrics/gynecology	5.4%	$2,869,900	$478,317
Pediatric/neonatal	16.2%	$4,373,833	$242,991
Adolescent	2.7%	$652,500	$217,500
Urology/renal	1.8%	$325,000	$162,500
Adult medical/surgical	55.0%	$6,661,025	$109,197
Gerontology	16.2%	$1,908,821	$106,046
Public/community health	1.8%	$171,316	$85,658
Psychiatric/behavioral	0.9%	$60,000	$60,000
Overall	100%	$17,022,395	$153,355

LIFELONG LEARNING. THE NURSE PARTICIPATES IN EST

22 Frequency of Agency Nurse Claims by Injury (Open and Closed Claims)

Injury	Percentage of total claims
Death (other than fetal or maternal death)	40.8%
Infection/abscess/sepsis	6.9%
Fracture	6.9%
Brain damage other than birth-related	5.7%
Pain and suffering	4.6%
Burn	4.0%
Pressure ulcer	2.9%
Cardiac condition including MI, angina, coronary artery disease	2.9%
Loss of organ or organ function	2.9%
Cerebral vascular accident/stroke	2.3%
Birth-related brain damage	2.3%
Neurological deficit/damage	2.3%
Bleeding/hemorrhage	1.7%
Paralysis	1.7%
Peripheral vascular ulcer	1.7%
Abuse/patient's rights/professional misconduct	1.1%
Amputation	1.1%
Emotional/psychological damage/distress	1.1%
Loss of limb or use of limb	1.1%
Allergic reaction/anaphylaxis	0.6%
Cancer	0.6%
Coma	0.6%
Compartment syndrome	0.6%
Embolism	0.6%
Eye injury/vision loss	0.6%
Fetal death	0.6%
Laceration/tear/abrasion	0.6%
Maternal death	0.6%
Other	0.6%
Total	100%

AGENCY NURSE CLAIMS INVOLVING *BIRTH-RELATED BRAIN DAMAGE* INJURIES HAD THE HIGHEST AVERAGE SEVERITY.

Severity of Agency Nurse Claims by Injury (Closed Claims with Paid Indemnity of ≥ $10,000) 23

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Birth-related brain damage	3.6%	$2,495,000	$623,750
Brain damage other than birth-related	7.2%	$2,135,000	$266,875
Loss of limb or use of limb	1.8%	$425,000	$212,500
Pressure ulcer	0.9%	$200,000	$200,000
Death	42.3%	$8,353,245	$177,729
Burn	5.4%	$660,000	$110,000
Compartment syndrome	0.9%	$100,000	$100,000
Pain and suffering	3.6%	$390,500	$97,625
Fracture	7.2%	$737,500	$92,188
Amputation	1.8%	$180,000	$90,000
Eye injury/vision loss	0.9%	$85,000	$85,000
Loss of organ or organ function	2.7%	$225,000	$75,000
Cerebral vascular accident/stroke	0.9%	$75,000	$75,000
Cardiac condition including MI, angina, coronary artery disease	2.7%	$174,000	$58,000
Infection/abscess/sepsis	6.3%	$400,000	$57,143
Neurological deficit/damage	2.7%	$128,500	$42,833
Coma	0.9%	$40,000	$40,000
Embolism	0.9%	$37,500	$37,500
Abuse/patient's rights/professional misconduct	1.8%	$57,500	$28,750
Other	0.9%	$24,900	$24,900
Bleeding/hemorrhage	2.7%	$68,750	$22,917
Peripheral vascular ulcer	0.9%	$15,000	$15,000
Emotional/psychological damage/distress	0.9%	$15,000	$15,000
Overall	100%	$17,022,395	$153,355

AMONG AGENCY NURSE CLAIMS, *SCOPE OF PRACTICE* ALLEGATIONS HAD THE HIGHEST AVERAGE SEVERITY.

24 Frequency of Agency Nurse Claims by Allegation (Open and Closed Claims)

Allegation related to	Percentage of total claims
Treatment and care management	52.3%
Assessment	14.9%
Medication administration	14.4%
Diagnosis	4.6%
Abuse/patient's rights/professional misconduct	4.0%
Equipment	3.4%
Monitoring	2.9%
Scope of practice	1.7%
Documentation	1.1%
Nurse and patient communication	0.6%
Total	100%

25 Severity of Agency Nurse Claims by Allegation (Closed Claims with Paid Indemnity of ≥ $10,000)

Allegation related to	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Scope of practice	2.7%	$1,470,000	$490,000
Equipment	3.6%	$880,000	$220,000
Monitoring	3.6%	$651,400	$162,850
Assessment	10.8%	$1,913,816	$159,485
Treatment and care management	56.8%	$9,380,779	$148,901
Medication administration	15.3%	$2,397,150	$141,009
Nurse and patient communication	0.9%	$50,000	$50,000
Abuse/patient's rights/professional misconduct	3.6%	$165,500	$41,375
Diagnosis	2.7%	$113,750	$37,917
Overall	100%	$17,022,395	$153,355

Frequency of Agency Nurse Claims by Location (Open and Closed Claims) 26

Location	Percentage of total claims
Patient's home	42.5%
Hospital–inpatient	28.2%
Prison	10.9%
Aging services residential facility	5.7%
Hospital emergency department	5.2%
Pediatric long term care residential facility	2.3%
Hospital–inpatient perinatal	1.7%
School (nursery school through college)	1.1%
Retail healthcare delivery	0.6%
Physician office	0.6%
Hospital–outpatient	0.6%
Ambulatory surgical center	0.6%
Total	100%

Severity of Agency Nurse Claims by Location (Closed Claims with Paid Indemnity of ≥ $10,000) 27

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Hospital–inpatient perinatal	1.8%	$1,175,000	$587,500
Hospital–outpatient	0.9%	$570,000	$570,000
Physician office	0.9%	$500,000	$500,000
Patient's home	48.6%	$9,036,649	$167,345
Prison	7.2%	$1,296,875	$162,109
Aging services residential facility	6.3%	$991,000	$141,571
Hospital–inpatient	27.0%	$2,815,050	$93,835
Pediatric long term care residential facility	3.6%	$367,821	$91,955
Hospital emergency department	3.6%	$270,000	$67,500
Overall	100%	$17,022,395	$153,355

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CLOSED CLAIMS WITH NO INDEMNITY PAYMENT AND INCURRED EXPENSE PAYMENTS EQUAL TO OR GREATER THAN $10,000

There were 275 closed claims without indemnity payment, but with expense payments equal to or greater than $10,000. No indemnity payment was made because the nurse was successfully defended or dismissed as a named party to the complaint. Indemnity payments also were not made where professional liability coverage responsibilities were transferred to the insurance of the employer or another third party. For these 275 claims, legal defense expenses totaled $7,786,965, with an average paid expense of $28,316. Thus, claim expenses can be financially catastrophic for an uninsured individual even when no indemnity is paid.

License protection claims were excluded from the overall study, but are included in this section because they demonstrate typical legal costs associated with license protection.

Location

The six most common locations were

- Hospital-inpatient
- Prison
- Aging services long term care facility
- Hospital-emergency department
- Patient's home
- Hospital-inpatient perinatal services

Allegation

The five most common allegations were related to

- Treatment and care management
- Assessment
- Medication administration
- Abuse/patient's rights/professional misconduct
- Monitoring

Injury

The six most common injuries were

- Death
- Infection/abscess/sepsis
- Fracture
- Birth-related brain damage
- Brain damage other than birth-related
- Pain and suffering

Severity by Location of Closed Claims with No Indemnity Paid and Expenses of ≥ $10,000 28

Location	Percentage of closed claims	Total paid expense	Average paid expense
Urgent care or walk-in care center	0.4%	$192,542	$192,542
Retail healthcare delivery site	0.4%	$83,068	$83,068
Hospital–outpatient	0.7%	$159,594	$79,797
Hospital–inpatient perinatal services	5.8%	$841,214	$52,576
Clinic–outpatient	1.8%	$217,132	$43,426
Pediatric long term care residential facility	0.4%	$41,877	$41,877
Physician office	2.4%	$267,520	$38,217
Prison	14.2%	$1,263,757	$32,404
Patient's home	5.8%	$507,745	$31,734
Hospital–inpatient	31.2%	$2,548,804	$29,637
Insurance companies	0.4%	$27,722	$27,722
Psychiatric/behavioral	1.5%	$91,425	$22,856
Hospital-emergency department	6.5%	$390,089	$21,672
Aging services residential care facility	11.3%	$661,733	$21,346
Laboratory or specimen collection	0.4%	$14,057	$14,057
Other physician/licensed independent practitioner office	0.4%	$13,644	$13,644
Nurse private practice	0.4%	$13,451	$13,451
Dialysis	1.1%	$39,822	$13,274
Ambulatory surgical center	0.4%	$11,769	$11,769
License protection (various locations)	14.5%	$400,000	$10,000
Overall	100%	$7,786,965	$28,316

Severity by Allegation of Closed Claims with No Indemnity Paid and Expenses of ≥ $10,000 29

Allegation related to	Percentage of closed claims	Total paid expense	Average paid expense
Medication administration	8.4%	$952,359	$41,407
Diagnosis	0.7%	$78,652	$39,326
Assessment	9.1%	$927,296	$37,092
Treatment and care management	51.6%	$4,530,003	$31,901
Documentation	0.7%	$59,866	$29,933
Equipment	0.4%	$27,799	$27,799
Monitoring	5.1%	$307,415	$21,958
Scope of practice	1.8%	$101,795	$20,359
Abuse/patient's rights/professional misconduct	7.3%	$384,766	$19,238
Nurse and patient communication	0.4%	$17,014	$17,014
License protection (various allegations)	14.5%	$400,000	$10,000
Overall	100%	$7,786,965	$28,316

30 Severity by Injury of Closed Claims with No Indemnity Paid and Expenses of ≥ $10,000

Injury	Percentage of closed claims	Total paid expense	Average paid expense
Back injury	0.4%	$107,446	$107,446
Other birth trauma	0.7%	$117,890	$58,945
Birth-related brain damage	6.9%	$1,034,825	$54,464
Bruise/contusion	1.1%	$152,387	$50,796
Allergic reaction/anaphylaxis	0.7%	$97,252	$48,626
Amputation	2.2%	$278,202	$46,367
Brain damage other than birth-related	3.6%	$345,978	$34,598
Neurological deficit/damage	1.8%	$169,919	$33,984
Pressure ulcer	2.5%	$230,585	$32,941
Death (other than fetal death)	27.3%	$2,460,718	$32,810
Loss of organ or organ function	1.8%	$156,633	$31,327
Abuse/patient's rights/professional misconduct	1.8%	$149,664	$29,933
Paralysis	0.7%	$54,027	$27,014
Pain and suffering	3.6%	$259,852	$25,985
Fetal death	1.8%	$125,269	$25,054
Cardiac condition including MI, angina, coronary artery disease	1.8%	$123,304	$24,661
Laceration/tear/abrasion	2.2%	$146,163	$24,361
Bleeding/hemorrhage	2.9%	$188,229	$23,529
Infection/abscess/sepsis	7.6%	$489,576	$23,313
Loss of limb or use of limb	0.4%	$23,201	$23,201
Emotional/psychological damage/distress	0.4%	$22,195	$22,195
Eye injury/vision loss	0.7%	$43,318	$21,659
Fracture	7.3%	$417,960	$20,898
Ear injury/hearing loss	0.4%	$16,082	$16,082
Aneurysm	0.4%	$15,479	$15,479
Embolism	0.7%	$30,048	$15,024
Burn	1.8%	$70,676	$14,135
Fall	0.4%	$12,848	$12,848
Other	1.1%	$36,852	$12,284
Seizure	0.4%	$10,387	$10,387
License protection (various injuries)	14.5%	$400,000	$10,000
Overall	100%	$7,786,965	$28,316

TRENDS IN THE NURSING LITIGATION ENVIRONMENT

TRENDS IN THE NURSING LITIGATION ENVIRONMENT

The role of the nurse in medical malpractice litigation has experienced a paradigm shift over the last several years. In the past, nurses were considered by many plaintiffs' lawyers and some judges to be mere "functionaries" or "custodians" who played a limited role in the care and treatment of patients. Not surprisingly, medical malpractice lawsuits typically did not name individual nurses as party defendants. When nurses were specifically named, it was for perceived mistakes made by nurses acting in a "functionary" or "custodial" role. The following examples demonstrate the claims that emanated from services performed in the more traditional custodial capacity:

- A patient with gait difficulties falls due to the nurse's failure to respond to the call bell in a timely fashion.
- A mother in labor has a difficult delivery because the nurse neglected to advise the physician of obvious changes in the mother's condition.
- A bedridden patient experiences skin breakdown because of the nurse's failure to turn and reposition the patient.
- A patient suffers a drug interaction due to the nurse's error in administering medication.
- A patient in the emergency department experiences serious complications due to the nurse's failure to perform timely triage.

These examples focus on obvious mistakes that nurses may make while carrying out the orders of physicians or licensed independent practitioners.

THE ROLE OF THE NURSE IN MEDICAL MALPRACTICE LITIGATION HAS EXPERIENCED A *PARADIGM SHIFT* IN THE LAST SEVERAL YEARS.

NURSE AS CLINICIAN

While *nurse-as-custodian* claims continue to be asserted, plaintiff's lawyers have now begun to pursue claims that focus on the *nurse as a clinician,* responsible for using professional judgment in the course of treatment.

In these claims, nurses are perceived as highly skilled and educated professionals who are charged with making clinical observations, exercising discretion and taking appropriate treatment actions based upon a patient's changing clinical picture. This shift reflects, to some extent, the increasing number and importance of specialties and areas of expertise within the profession. The following are examples of the new paradigm of nursing claims:

- Following a fall by a geriatric patient, the nurse is sued for failure to change the service plan despite increasing problems with gait and behavior.
- A child is born with profound brain damage, and the nurse is alleged to have failed to properly interpret fetal monitoring strips.
- A lawsuit charges the nurse with failure to appreciate a patient's risk for skin breakdown and to take appropriate preventive measures.
- After a patient experiences adverse drug reactions, the family alleges that the nurse failed to properly administer and provide the correct dosage.
- A patient in the emergency department has a cardiac arrest, and a lawsuit is filed alleging that the triage nurse failed to appreciate acute cardiac symptomatology.

This shift has afforded increasing opportunities for plaintiff's attorneys to name nurses as defendants in medical malpractice lawsuits. Mistakes made by nurses in their role as "custodian" were infrequent, and such mistakes led to easily understood claims that could be resolved without resorting to litigation. However, the new generation of "clinician" claims permits nurses to be included in any case in which a patient receiving complex treatment has a poor outcome.

Risk Exposure	Prior risks for nurse as custodian	Potential risks for nurse as clinician
Assessment	✓	✓
Communicating change in patient condition	✓	✓
Initial and subsequent nursing diagnoses		✓
Interpretation of diagnostic findings		✓
Treatment		✓
Change in treatment plan		✓
Medication administration and dosing		✓

CONTROLLED MEDICATIONS

Another area of evolving nursing liability involves the documentation and administration of controlled medications. Today, many plaintiff's attorneys analyze medication administration records (MARs) routinely in all cases, including those that do not initially appear related to medication error or improper pain control. The increased scrutiny of MARs, especially in the area of aging care, sometimes reveals discrepancies in the medical record between the amount of a controlled drug released by the pharmacy and the dosage actually administered and documented in the patient's MAR. These discrepancies, often inadvertent, may be presented by plaintiff's attorneys in a manner that suggests the nurse is diverting medications for personal use or sale. This issue relates to both professional discipline and malpractice.

For example, plaintiff's attorneys have asserted that nurses bear responsibility for "putting drugs on the streets and into the schoolyards of our children." Alternatively, plaintiff's attorneys may contend that nurses failed to provide the pain control their patients desperately needed due to indolence or indifference to human suffering. Discrepancies in MARs also may be used to create the false impression that "lazy" nurses are overmedicating their patients to restrain them chemically or even to silence them permanently. Thus, professional liability claims may be brought against nurses via allegations of under- or over-medication.

In the current litigation environment, nurses and healthcare institutions must scrupulously retain and maintain all records relating to the prescription, administration and destruction of narcotic-based medications.

CONCLUSION

Nurses play a critical role in delivering healthcare in a wide range of clinical settings. They are often the member of the healthcare team best known to the patient and family. The nurse's responsibilities include administration of powerful medications, performance of complex patient/resident assessments, development and implementation of appropriate nursing care plans, and provision of therapeutic and comfort measures. Each of these services carries inherent risks. By knowing the areas within their own daily practice that present the highest degree of risk exposure, nurses can act more effectively to prevent or minimize patient injury and financial loss.

The risk management recommendations outlined in the next section of this study are designed to help nurses develop their own proactive approach to providing quality patient/resident care in a safe environment. These efforts must be coordinated with the overall risk management program in the nurse's work setting, whether it is a hospital, physician office, aging services care facility or other healthcare delivery milieu.

Because patient and community expectations of nursing care are constantly evolving, nurse liability patterns will also change. However, the strongest defense against litigation remains an unwavering commitment to the health and safety of the vulnerable human beings under one's care.

ADDITIONAL RESOURCES

CNA HealthPro has produced numerous studies and articles that provide useful risk management information on topics relevant to nurses. These publications are available at **www.cna.com**.

RISK MANAGEMENT RECOMMENDATIONS

RISK MANAGEMENT RECOMMENDATIONS

Because the claims in this study involve nurses from a wide variety of training levels, specialties and clinical settings, the risk management recommendations included in this resource may not apply equally to all readers. Scope of practice as set forth in state nurse practice acts and other regulatory guidelines varies by educational level, licensure, and facility policies and procedures. Yet every nurse must act within a defined scope of practice.

SCOPE OF PRACTICE: RISK MANAGEMENT RECOMMENDATIONS

Review at least annually and comply with the relevant state nurse practice act as it defines the nurse's scope of practice, as well as any applicable regulatory authority requirements. Nursing care standards also may be defined by professional associations, regional practices, organization-specific policies and procedures, clinical protocols, practice parameters, guidelines, treatment standards and critical pathways. The following guidelines can assist in minimizing related exposures:

- *Maintain professional communication skills* in order to interact effectively with all levels of healthcare workers involved in the provision of nursing services.
- *Verify, to the extent possible, that your employer(s), medical staff members and contracted healthcare co-workers maintain appropriate professional liability insurance limits* as may be required by the practice setting, state law or regulations.
- *Immediately report any allegation or notice of pending professional or legal action* related to professional scope of practice to your insurance company, if you purchase your own professional liability insurance.

NURSING COMPETENCIES: RISK MANAGEMENT RECOMMENDATIONS

Regardless of clinical specialty, there are certain core competencies required for all nurses at a given level of training/education. Nurses must take responsibility for acquiring the ongoing education and experience needed to maintain and improve their basic nursing skills, as well as those competencies specific to their specialty. The following guidelines can help reduce competency-associated risks:

- *Maintain clinical nursing competencies* through continuing education.
- *Obtain additional education, mentoring, supervision or assistance as needed* from professional organizations and internal resources, including written, electronic and long-distance learning tools.
- *Prepare to undergo an annual skills assessment* and demonstrate required competencies.
- *Collaborate with other healthcare professionals* to ensure continuing education opportunities in the clinical setting.
- *Inform appropriate managers, supervisors and nurse educators of your educational needs and goals* in order to strengthen your nursing competencies.

PATIENT HEALTH INFORMATION RECORDS: RISK MANAGEMENT RECOMMENDATIONS

While individual nurses may not be directly responsible for implementing the following recommendations, they should be cognizant of risk exposures and understand the risk management activities appropriate to their setting. Nurses are frequently included in the development of policies and procedures related to the patient health information record. In that capacity, they can increase awareness of areas of risk and promote measures to manage these risks.

Paper health information records remain the most common form of documentation of nursing care services, but many organizations are adopting or incrementally implementing electronic medical record (EMR) systems. The recommendations below focus on paper recordkeeping, with additional general suggestions for EMR systems.

Patient Health Information Records – General Principles

- *Ensure that entries are legible* and written in ink.
- *Sign, date and time all entries*, using either the a.m./p.m. designation or military time.
- *Obtain required countersignatures,* as specified by organizational policy.
- *Avoid subjective comments* regarding the patient, family or other healthcare providers.
- *Document actions and patient discussions as soon as possible* after the event.
- *Never leave blanks or unfilled data spaces* on forms.
- *Avoid late entries, if possible.* If a late entry must be made, ensure that it is noted as such and dated and timed contemporaneously.
- *Do not insert late entries for any reason after a lawsuit has been initiated,* to avoid the appearance of tampering.
- *Contact the risk manager, your professional liability insurer and/or legal counsel for advice about properly drafting a written addendum,* if there is a legitimate need to create one.
- *Use only approved methods for correction* of documentation error(s).
- *Never alter a patient healthcare information record for any reason.* This includes erasing, scratching out or using correction fluid on the record.
- *Use only approved abbreviations,* and write out words fully if there is any possibility of confusion.
- *Maintain patient health information records in a confidential manner,* consistent with the Health Insurance Portability and Accountability Act (HIPAA) requirements, other pertinent state and federal regulations, and organization/facility policies.
- *Retain patient health information records as long as reasonably possible,* and minimally in accordance with state and federal record retention laws.
- *Use binders or closed-type patient health information records* that protect against the loss of pages.
- *Develop and adhere to a standard format and order* for every patient health information record.
- *Perform periodic audits of patient health information records* to identify departures from appropriate practice and opportunities for education/training and future improvement.
- *Ensure that effective safeguards and firewalls* are built into electronic medical record systems.
- *Ensure that staff members receive sufficient training and support* before, during and after the implementation of electronic medical record systems.

Patient Health Information Records – Contents

- *Record the patient's name and record number on every page of the patient health information record.* Healthcare records should include, but not be limited to, the following contents:
  - admission sheet
  - history and physical
  - advance directives, where permissible
  - consent for treatment
  - consent for invasive procedures
  - physician orders
  - physician notes
  - nursing notes
  - laboratory and radiology reports
  - progress notes and reports documenting other therapies or services (e.g., physical therapy, occupational therapy, etc.)
  - miscellaneous information

- *Document nursing actions in accordance with facility requirements,* capturing, at a minimum, the following information:
  - results of each and every nursing assessment
  - nursing observations
  - patient complaints or concerns
  - significant changes in the patient's condition
  - any change in the patient's care plan
  - every monitoring finding, treatment or episode of care, as well as the patient's response to that care
  - facts relating to any patient accident or incident, including evidence of any injury, all parties notified, nursing care provided and patient's condition after care is rendered
  - laboratory and diagnostic test results
  - referral and consultation requests and results
  - telephone, face-to-face and electronic contacts with other members of the healthcare team, including the content of discussions and agreed-upon follow-up

Patient Health Information Records – Release of Patient Health Information

As noted above, nurses may not be directly responsible for implementing the following recommendations, but should be aware of them and encourage their implementation in the workplace.

- *Maintain patient information in a confidential manner,* as required by law.
- *Discuss patient information only with healthcare providers who are involved in the patient's care* and never in public areas, such as elevators, hallways and cafeterias/lounges.
- *Release medical and health information only with written permission of the patient/authorized agent* or as medically necessary in a medical emergency for continuity of care purposes, in accordance with HIPAA and state legal requirements.
- *Obtain special written authorization* before releasing patient medical information related to treatment of HIV or AIDS, alcohol or other substance abuse, and mental/behavioral illness.
- *Do not use postcards or telephone answering machines* to communicate health information, including test results, unless the patient has given consent to use the answering machine.
- *Never respond directly to legal demands for patient health information,* including a subpoena, summons and complaint, or court order. Immediately refer all such requests to an authorized individual or to the facility administration.

DOCUMENTATION: RISK MANAGEMENT RECOMMENDATIONS

Maintaining a consistent, professional patient health information record is essential to providing quality patient care, ensuring consistent communication among all professionals caring for the patient, and establishing the basis for an effective defense should litigation arise. The following guidelines can help reduce risk:

Documentation – Clinical Content

The following measures, among others, can enhance documentation of the patient health information record:

- *Enter the patient's chief complaint* or current healthcare concerns.
- *Mark any allergies* in a conspicuous manner.
- *Include vaccine tracking information* for all vaccines administered.
- *Indicate current and past medications* and whether the patient has deviated from the current prescribed medication regimen.
- *Incorporate nursing risk assessments* including, but not limited to, the following areas:
  - ambulation status
  - need for help with activities of daily living
  - bowel and bladder function
  - mental status (i.e., emotional and cognitive functioning)
  - elopement risk (for higher-risk individuals, including, among others, children, the aged, and behavioral health and developmentally disabled patients)
  - fall risk
  - nutritional status
  - pain management
  - skin and wound condition
- *Document discussions with the patient* about medical issues that require additional explanation by the physician/licensed independent practitioner or other healthcare provider.
- *Record medications administered,* including injections, ointments and infusions, as well as a description of the patient's response.
- *Detail nursing observations* during patient contacts.
- *Specify patient's questions and answers given* regarding the nursing care/service plan, as well as the goals and methods of treatment.
- *Describe patient's response* to nursing care.
- *Note the review of current problems* or symptoms.

- *Assess skin and wound condition,* including clinical findings and observations, the nursing care/service plan and the patient's response to treatment.
- *Summarize communications with practitioners,* including those via telephone, facsimile and e-mail, and note any subsequent nursing actions taken.
- *Note use of an interpreter,* including the interpreter's contact information.

Documentation – Diagnostic Tests, Referrals, Consultations

- *Contact the patient's healthcare provider to report abnormal test results* and any provider orders for additional testing or follow-up and document the interaction.
- *Contact consulting physicians/licensed independent practitioners* to confirm that the consulting provider was notified of the consultation request and to facilitate the timely provision of the consultation and receipt of the results. Document these actions in the patient's health information record.
- *Utilize the chain of command to report abnormal laboratory results and the results of consultations* if the ordering/primary care physician is not available or does not respond to messages.
- *Initiate additional steps, if necessary, to ensure timely patient care.* These may include reporting to the supervisor/nurse manager, administrators, attending or covering physician, licensed independent practitioner and/or medical staff leadership until the abnormal result is addressed.

Documentation – Medications and Prescriptions

- *Review and update the current medication list* and patient's reported compliance with prescribing orders.
- *Perform the appropriate medication reconciliation process* following patient admission, changes in care or treatment, transfer from one service to another (e.g., after surgery or delivery), or post-discharge return to care.
- *Notify the physician/licensed independent practitioner of the need for medication order changes* or prescription renewals.
- *Clearly describe patient responses to medications,* positive or negative.
- *Document signs or symptoms of adverse drug reactions,* contact with physicians/licensed independent practitioners and subsequent follow-up.

Documentation – Patient Education

- *Describe patient and family healthcare education encounters,* listing the presence of specific family members and their relationship to the patient.
- *Provide a written assessment of the patient's ability to comprehend and repeat information provided,* both immediately and after three or more minutes have elapsed.
- *Maintain a copy of written materials provided* and document references to standard educational tools.
- *Retain patient-signed receipts* for any educational materials provided.
- *Document the use of interpreters,* if needed, and include the interpreter's contact information.

INFORMED CONSENT: RISK MANAGEMENT RECOMMENDATIONS

Verifying that the patient has had an informed consent discussion with the physician/licensed independent practitioner and anesthetist for higher-risk activities and invasive tests and procedures represents an important risk management practice.

Nurses should provide the informed consent discussion only in the case of nurse-performed procedures, such as permanent lip coloring or eyeliner and laser hair removal. In such cases, comply with all state laws related to the informed consent process and include, at a minimum, the following steps:

- *Provide a clear description of the patient's current medical/emotional condition* and the clinical reason for the proposed procedure/treatment.
- *Describe the procedure in detail* and determine whether the patient still wishes to undergo it.
- *Discuss the risks and benefits of the procedure,* alternatives to the recommended procedure and the risks of *not* performing the recommended procedure.
- *Encourage the patient to ask questions* until he or she can repeat the information correctly.
- *Document the complete informed consent discussion* and the patient's acceptance or refusal of the procedure.
- *Obtain the patient's witnessed signature* for informed consent or refusal of the recommended treatment and retain it in the patient's health information record.

DIAGNOSIS: RISK MANAGEMENT RECOMMENDATIONS

Nurses have a high degree of responsibility for assisting patients in obtaining necessary information related to diagnostic procedures and consultations.

Tests, Referrals, Consultations

There are many instances where the nurse will be required and/or requested to assist patients in securing test appointments, referrals or consultations, often pursuant to physician orders. The following guidelines can help minimize the associated risks:

- *Aid the patient in scheduling appropriate diagnostic tests, procedures and/or referrals as ordered by the physician.* Enlist the assistance of family or friends for minors and for patients whose language skills or mental competency may raise concerns.
- *Notify the physician of any delays* in availability or access to tests, referrals or consultations.
- *Document efforts to obtain test results* if there is a delay.
- *Notify the physician of any significant abnormal findings* from test results or consultations and document the notification.

Patient Communication

- *Utilize proper therapeutic and listening skills* to elicit the patient's vital information and concerns.
- *Obtain an interpreter if necessary* and document the interpreter's contact information.
- *Help the patient understand what will occur* during ordered tests/procedures.
- *Continue to ask questions* until it is clear that the patient comprehends the information.

Continuum of Care

- *Notify the physician of the receipt of significant diagnostic test, consultation and referral results* and document when the notification occurred.
- *Recognize safe nurse-to-patient staffing ratios* based on the patient's diagnosis and/or acuity and comply with any state-specific staffing requirements.

ADVANCE DIRECTIVES: RISK MANAGEMENT RECOMMENDATIONS

Advance directives, including living wills and durable powers of attorney for healthcare, enable patients and residents to exercise control over their treatment even if they become incapacitated. Such directives are legally binding documents that, if ignored, can result in allegations of lack of informed consent, battery, wrongful death and/or wrongful life. The following guidelines can help ensure that advance directives are properly executed and followed:

- *Ask patients if they have executed a living will* or other form of advance directive.
- *Provide patients with basic information about the purpose and process of an advance directive* and, if necessary, obtain assistance for patients who require help in completing the document.
- *Ensure that a copy of any valid advance directive* is in the patient's health information record where it can be easily located.
- *Document all discussions and actions* related to advance directives.
- *Know and comply with state law* and regulations whenever executing an advance directive.

CANCER SCREENING AND DIAGNOSIS: RISK MANAGEMENT RECOMMENDATIONS

- *Ask patients whether they have undergone appropriate cancer screening tests* and, if not, explain how to obtain them.
- *Encourage patients to discuss with the physician* any questions or concerns they may have about cancer screening.
- *Help patients understand what to expect* when undergoing physician-ordered screening tests.

TREATMENT ACTIVITIES: RISK MANAGEMENT RECOMMENDATIONS

For purposes of this study, *treatment* includes any therapy, procedure or administration of medication, blood or blood product, which has been ordered for the patient's disease, condition, illness or injury. The physician/licensed independent practitioner is responsible for ordering tests and obtaining informed consent for any procedure that involves significant risk of injury.

- *Provide additional explanation* of the treatment process, if necessary.
- *Refer to the patient's physician/licensed independent practitioner any patient questions* regarding the risks, benefits and alternatives of a proposed treatment.
- *Decline to provide nursing services or other forms of assistance that are beyond your scope of practice and current competencies* or that would otherwise unduly endanger the patient.
- *Note and document the objective, clinical signs of the patient's response to the treatment,* as well as the patient's subjective comments.
- *Include nursing observations and the nursing decision-making process* regarding patient treatment in the patient's health information record.

MEDICATIONS: RISK MANAGEMENT RECOMMENDATIONS

It is essential to remain current and in compliance with state laws and regulations and the state nurse practice act regarding administration of medications. The following guidelines can help reduce medication-related risks:

Administration of Medications

- *Familiarize yourself and comply with all requirements* regarding medication administration, reconciliation and documentation practices.
- *Recognize the appropriate indications, dosage range, route(s) of administration, contraindications, side effects and warnings* related to commonly prescribed drugs, obtaining this information prior to administration of any new or unfamiliar drug.
- *Know how to obtain current drug reference materials,* and refer to them when administering a drug that is not frequently prescribed or whenever questions arise regarding a drug.
- *Contact the patient's prescribing physician or a pharmacist* should a question arise relating to an unfamiliar drug/medication.
- *Consult with physicians/licensed independent practitioners and pharmacists to identify potential drug interactions and/or contraindications with a patient's existing drug intake,* including over-the-counter medications, supplements, and herbal and homeopathic remedies.
- *Ensure and document that the patient or a designated representative understands the purpose, dosage, frequency and potential side effects of prescribed medications* and can repeat this information back to you.
- *Document all instructions and warnings provided to the patient* regarding unplanned discontinuation of medication or an unauthorized increase or decrease in dosage.
- *Describe the patient's response to prescribed medications* and notify the physician immediately of any adverse reaction.

Medication Consent Process and Continuum of Care

- *Confirm that the patient has fully discussed the risks, benefits and alternatives of the medications prescribed with the physician/licensed independent healthcare practitioner,* in order to ascertain the patient's competency to consent to or refuse medications as part of the plan of care.
- *Ensure that the patient has fully discussed the risks, benefits and alternatives of* failing *to take the medication* with the physician/licensed independent practitioner, as well as the risks of taking more or less than the prescribed amount.
- *Encourage the patient to ask questions* to ensure understanding of instructions.
- *Ask the patient to repeat the medication-related information* and periodically recheck the patient's level of understanding.
- *Notify the prescribing physician/licensed independent practitioner if the patient has continuing questions about risks, benefits or alternatives,* or does not appear to understand the potential consequences of noncompliance, and document the notification.
- *Maintain accurate allergy information* in the patient's health information record and query patients regarding allergies whenever administering a new drug.
- *Maintain a current drug list for each patient* and query the patient at each encounter regarding any changes that may have occurred. Include in the drug list any over-the-counter medications, supplements, and herbal or homeopathic remedies.
- *Reconcile medications when appropriate,* such as following surgery, transfer and post-discharge readmission.
- *Document any wasted or destroyed medications* in compliance with organizational policy and all applicable laws.

- *Describe any medications administered to a patient on the medication administration record (MAR)* and include the following information:
  - drug name
  - expiration date, vaccine lot and serial number of vaccinations
  - expiration date, lot and serial number of medication samples provided to the patient by the physician/licensed independent practitioner
  - dose
  - route and site
  - diluent or solution, if applicable
  - infusion pump information, such as the serial and model numbers, which become important in the event of device malfunction
  - rate of administration
  - time administered
  - duration of administration, if given over a period of time
  - reaction to medication, if any
  - vital signs, when appropriate
  - length of time patient was observed
  - any signs of reaction or distress
  - status of injection or intravenous site
- *Maintain precise documentation of controlled drugs* to protect against allegations of drug diversion.

EQUIPMENT: RISK MANAGEMENT RECOMMENDATIONS

Medical equipment defects and misuse represent a significant liability exposure. Whether you or your employer is primarily responsible for managing, monitoring and calibrating these devices, the following guidelines can help reduce equipment-related risks:

- *Maintain all manuals and instructional materials* that are provided with equipment at the time of purchase or lease.
- *Inspect all equipment for defects* and remove any damaged or broken equipment from use.
- *Do not discard equipment that has been the source of any patient injury,* including devices involved in a current lawsuit.
- *Inquire whether the workplace has an inventory of its equipment,* including serial and model numbers. This information will be helpful if an adverse event or patient injury occurs due to mechanical failure or equipment-user error.
- *Look for tags, labels or other evidence of preventive maintenance and/or ongoing maintenance* of clinical equipment.
- *Utilize equipment in accordance with manufacturer's recommendations* and request orientation prior to using new or unfamiliar clinical equipment.
- *Know and comply with the U.S. Food and Drug Administration reporting requirements* for adverse equipment-related events, as mandated by the Safe Medical Devices Act.
- *Maintain written documentation of requested equipment inspections, preventive maintenance and repairs,* as well as nurse training and patient/family education in the use of medical equipment.

NURSING SPECIALTIES: RISK MANAGEMENT RECOMMENDATIONS

Some specialty areas involve unique nursing skills and additional risks. The following risk management recommendations, and the general strategies previously discussed, apply to nurses working in higher-risk areas:

Nursing Specialties – Obstetrics

- *Follow established policies, procedures and clinical protocols* regarding the assessment and management of each patient's labor and delivery.
- *Attain and maintain up-to-date knowledge of and skills in* the interpretation of electronic fetal monitoring tracings.
- *Agree upon and utilize common language and interpretation of electronic fetal monitoring tracings* among all members of the patient care team, including, among others, physicians, nurses and technicians.
- *Maintain fetal and maternal monitoring* during transport to diagnostic test locations or operating room and during the patient's preparation for a Cesarean section.
- *Document communication with other members of the healthcare team* throughout the patient's labor and delivery.
- *Understand and follow the nursing scope of practice requirements* related to management of medications for cervical ripening and labor induction or augmentation.
- *Know and follow the chain of command,* as needed, to ensure timely and appropriate nursing and medical care.
- *Utilize the chain of command to address medical orders outside the standard of care* as defined by nursing and medical staff policies and protocols, professional guidelines and/or the state nurse practice act.
- *Participate in drills for the management of obstetrical emergencies,* including uterine hemorrhage.
- *Document in a timely manner all patient assessments, fetal monitoring tracing assessments, patient care services and contacts with other healthcare professionals,* as well as the patient's symptoms, response to treatment and complaints.

Nursing Specialties – Emergency Medicine

- *Consistently comply with facility-specific triage policies,* procedures and protocols.
- *Deliver nursing services in accordance with established clinical pathways and protocols,* as well as nursing policies and procedures.
- *Document the patient's/family's reasons for coming to the emergency department,* and establish the patient's chief complaint(s).
- *Promptly notify appropriate medical and facility personnel of changes in the patient's condition,* results of tests and the patient's response to treatment.
- *Utilize chain of command, as necessary,* to ensure patients receive timely nursing and medical care.
- *Maintain ongoing monitoring and care, as needed,* while the patient is awaiting testing, treatment, admission and discharge.
- *Document all patient care services,* notification to the physician of the patient's emergency and communication with family members/significant others, as authorized by the patient.
- *Maintain competencies in interpretation of cardiac monitoring tracings,* utilizing a common language to describe cardiac monitoring findings.

Nursing Specialties – Gerontology

- *Assess the patient's/resident's mental and emotional status, hydration needs and overall functional level,* as well as the specific risk for falls, pressure ulcers, elopement and abuse.
- *Discuss the plan of care with patients/residents* and determine if they are able to accurately repeat the plan. Elicit and answer questions until patients/residents can demonstrate understanding by correctly repeating the information.
- *Document patient's/resident's refusal of any medication and/or prescribed treatment.* In addition, notify the physician of the refusal and document the interactions with the patient and physician.
- *Establish who may be given health-related information* to ensure compliance with applicable HIPAA privacy regulations.
- *Ensure that the patient's/resident's care/service plan is consistently followed by all team members* and report deviations to supervisors.
- *Review and revise the patient's/resident's care/service plan on a continuous basis* and notify management if the patient's/resident's safety appears threatened at the current level of care.
- *Notify the patient's/resident's family of any changes in the patient's/resident's condition* and encourage family participation in care/service plan meetings.

Nursing Specialties – Cosmetic Services

- *Ensure that procedures are within the nursing scope of practice,* as defined by the applicable state nurse practice act.
- *Refer patients to a physician/licensed independent practitioner or other healthcare provider* for complaints of unexpected pain and/or discomfort.
- *Provide patients with a clear and realistic description of the procedure, treatment experience, probable results and possible complications* during the informed consent process.

Nursing Specialties – Home Care

- *Ensure that home care assignments are within the nursing scope of practice,* as defined by the applicable state nurse practice act.
- *Verify that home care assignments are in accordance with your clinical specialty/experience.* Consider the patient's clinical diagnosis and age, as well as the specific care and treatment prescribed, e.g., respirator care, home dialysis, intravenous and central line management, and management of total parenteral nutrition.
- *Provide patients with a clear and realistic description of the care and services that will be provided,* clarify any unrealistic expectations identified and document the patient's ability to correctly repeat appropriate expectations.
- *Evaluate family members' and other home-based caregivers' ability to support the patient's needs,* especially during times when trained and professional staff are not present.
- *Carefully examine the patient for signs of neglect, abuse or lack of continuity of care by other caregivers,* including family members and other contracted or employed persons.
- *Continually assess the home for ongoing suitability in meeting the patient's needs.* Examine such environmental factors as adequacy of living and storage space, availability of adequate electrical outlets for equipment, water supply, lighting, cleanliness, accessibility of food and water, stairway safety, bathing and grooming facilities, and climate control (both heat and cold). Also, consider general safety measures, such as removal of throw rugs, re-arrangement of furniture, and clearing of hallways and passages for unobstructed ambulation.
- *Regularly complete risk assessments regarding falls, pressure ulcers and nutritional needs,* in addition to general assessments of behavioral, mental, emotional and functional status.
- *Establish who may be given health-related information* to ensure compliance with HIPAA privacy requirements.
- *Review and revise the patient's care/service plan on a continuous basis* and notify the patient, family and physician if it appears that a patient would benefit from additional treatment or services, is not responding to treatment or is no longer safe in the home setting.
- *Collect samples for any ordered diagnostic tests.* In addition, follow up on receipt of findings, inform the physician of any delays in obtaining samples and/or reports, and ensure that the physician is aware of abnormal values, especially critical ones.
- *Inform the physician of changes in the patient's condition.* If necessary, call emergency services (911) to transport the patient to an emergency room for immediate medical assessment and treatment.
- *Notify the physician of patient noncompliance with care and treatment regimes* and ascertain if additional orders are needed or transfer to a higher level of care is required.
- *Provide supervision for home health assistants* and monitor their performance related to the implementation of the patient's care plan.
- *Continuously educate the patient, family members and other caregivers regarding the patient's condition.* Discuss with them the expected results of treatment and answer any questions about meeting the patient's daily care needs, maintaining patient safety, responding to emergencies, enhancing the patient's quality of life, monitoring for signs of abuse or neglect, and managing clinical equipment, including proper use, maintenance and safe handling.
- *Confirm that the home care agency maintains adequate professional liability and general liability insurance.* Ascertain how that insurance can protect you and how it will interact with your own coverage if a patient of the home care agency includes you as a named individual in a claim or defendant in a lawsuit.

Additional Nursing Groups – Agency-based, Traveling and Contracted (Other than Home Care)

- *Ensure that clinical work assignments are within the nursing scope of practice,* as defined by the applicable state nurse practice act.
- *Verify that assignments match your clinical specialty and experience.* Before accepting specialty-specific clinical assignments, consider the age of the patient and the specific care and treatment prescribed, e.g., respirator care, dialysis, intravenous and central line management.
- *Refuse traveling or agency nurse assignments outside of or incompatible with your training and experience.* Examples include an obstetrics nurse asked to accept an adult emergency department assignment, a neonatal ICU nurse asked to accept an acute psychiatric department assignment, or an aging services nurse asked to accept an NICU assignment. (However, some crossover of specialty may be appropriate. For example, an agency nurse with unique experience in wound care may deem it appropriate to accept an assignment as the wound care nurse in an aging services unit or facility.)
- *Request orientation to the facility and unit and read the nursing and administrative policy and procedure manuals.* Familiarize yourself with essential policies and procedures, including emergency and disaster plans, documentation requirements, use of electronic medical records, medication dispensing systems, and test result retrieval and physician order management systems. Also, locate the unit's emergency exits.
- *Determine your responsibilities in the event of a medical or non-medical emergency.* In addition, know the name, title, location and contact information of the person to whom you would report in an emergency situation.
- *Ascertain the knowledge and experience necessary to perform the tasks for which you are responsible.* Consult with the pharmacist before administering an uncommon or unknown medication, and seek out instruction about any other unfamiliar tasks.
- *Determine the process for requesting a preceptor or speaking with a nurse manager or administrator* whenever you are confronted with clinical or systems issues beyond your expertise.
- *Arrange to attend a general orientation session* at any facility where you intend to be available for contracted assignments on a regular basis.
- *Regularly assess patients for both their general condition and specific response to the clinical treatment course.* Carefully document assessment results, subsequent follow-up with other healthcare professionals, and any changes in care and treatment.
- *Establish who may be given reports on a patient's health-related information* to ensure compliance with facility policies and HIPAA privacy regulations.
- *Review and assess the patient's care/service plan on a continuous basis* and notify the physician if it appears that a patient is not responding to treatment or would benefit from additional treatment or service.
- *Collect samples for any ordered diagnostic tests.* In addition, follow up on receipt of findings, inform the physician of any delays in obtaining samples and/or reports, and ensure that the physician is aware of abnormal values, especially critical ones.
- *Notify the physician of changes in the patient's condition,* and, if necessary, follow the facility's emergency services plan to transport the patient to an emergency room for immediate medical assessment and treatment.
- *Notify the physician of patient noncompliance with care and treatment regimes* and ascertain if additional orders are needed or transfer to a higher level of care is required.
- *Continuously educate the patient, family members and other caregivers regarding the patient's condition.* Discuss with them the expected results of treatment, and answer any questions they may have about meeting the patient's daily care needs, maintaining patient safety, responding to emergencies, enhancing the patient's quality of life, monitoring for signs of abuse or neglect, and managing clinical equipment, including proper use, maintenance and safe handling.
- *Confirm that the agency maintains adequate professional and general liability insurance.* Ascertain how that insurance can protect you and how it will interact with your own coverage in the event that a patient of the agency includes you as a named individual in a claim or defendant in a lawsuit.

Additional Nursing Groups – Per Diem or "Float" Nursing

Working in a per diem or "float" capacity is not a clinical specialty. However, such working arrangements may result in additional risks, as nursing staff will be working with unfamiliar patients and potentially unfamiliar clinical situations.

As with agency/contracted nurses, per diem or "float" nurses may have little control of the assignments they are given by their facility/supervisor. Ideally, per diem and float nurses would be utilized only in areas where they have clinical expertise and experience. As this is not always the case, nurses in this situation may wish to consider some of the following risk management measures:

- *Ask to work on unfamiliar specialty units during times of adequate staffing.* Avail yourself of the opportunity for a preceptorship by an experienced nurse or "shadow" a nurse knowledgeable about the unit and the clinical specialty.
- *Request assistance and/or direct supervision from nursing managers* when asked to provide care outside of your clinical expertise/experience.
- *Ask regular staff members to provide an orientation to the unit, when arriving on an unfamiliar unit.* Discuss with them your lack of familiarity with the situation and ask them to be available for assistance.
- *Work with nursing leadership and nursing management to establish a staffing system that accommodates fluctuations in patient numbers and acuity* without requiring the floating of nurses outside their areas of expertise and experience.
- *Encourage systematic cross-training in specialties where expertise requirements are related* and limit floating to those areas where staff is routinely cross-trained. Possible examples include cross-training between nurses in obstetrics and surgery for Cesarean sections, obstetrics and neonatal intensive care or nursery, operating room and recovery room, and emergency room telemetry unit and intensive care or cardiac care units.
- *Consider requesting permanent assignment to a specified unit on a part-time or on-call basis only.* Or, if necessary, consider finding employment with an organization that appropriately utilizes your experience and expertise.

EXPLANATION OF TERMS

For purposes of this study, terms are defined as follows:

ABUSE Physical, sexual, emotional and/or verbal mistreatment of a patient.

ALLEGATION A statement asserting as a fact that the nurse has done something wrong or illegal, typically arising in the context of a pleading, but which has not yet been proven in a court of law.

CLAIM Legal action or proceeding, and/or a demand for money or services, against a CNA-insured nurse involving an allegation of professional negligence resulting in patient harm or injury.

CLOSED CLAIM A legal action/proceeding where financial compensation has been sought based on the legal liability of the nurse pursuant to error, omission or negligence in the performance of professional services, and the matter has been resolved through a judgment, settlement or verdict with or without payment of a monetary/damages award.

DEATH Patient demise occurring as a result of factors other than the natural/expected course of the patient's disease or illness.

EXPENSE PAYMENT Monies paid in the investigation, management or defense of a claim.

FAILURE TO MONITOR Harm or injury to a patient when the nurse should have known about evolving or pre-existing patient conditions, and failed to adapt the care/service plan to the patient's medical condition/illness in order to identify, report or prevent a decline in the patient's condition.

FAILURE TO TREAT Failure of the nurse to follow a medical order or otherwise provide appropriate nursing care to the patient.

FREQUENCY The number of open and closed claims with the specified attribute.

IMPROPER MANAGEMENT Failure of the nurse to provide appropriate nursing care, coordinate diagnostic tests, consultations and referrals, or to administer medication as ordered for the patient.

INDEMNITY PAYMENT Monies paid in the settlement or judgment of a claim.

INJURY The unanticipated damage, illness, diagnosis, symptoms or disease that results in a claim, generally involving bodily harm, sickness, death, and mental or emotional distress sustained by a patient/resident.

LACK OF INFORMED CONSENT Failure of a physician/licensed independent practitioner to provide the patient/legal representative with a clear description of the following: the diagnosis or condition; the proposed treatment (including diagnostic procedures and medications); risks, benefits and alternatives to the proposed treatment; reasonable expectations regarding the desired effect/result; and the risks and benefits of failing to obtain treatment. Also included is the failure to offer the patient/representative the opportunity to ask questions and achieve full understanding.

MEDICATION EVENT Encompasses any drug-related incident, including administration and documentation.

OPEN CLAIM A legal action/proceeding that has been asserted against a claimant alleging damages for personal injuries claimed to have been caused by an error, omission or negligence in the performance of professional services, where financial compensation has been sought, but which remains unresolved.

PATIENT Any person receiving nursing care in a hospital, aging services or long term care facility, behavioral health center or other healthcare delivery setting.

SEVERITY The average paid indemnity for closed claims with indemnity payments resulting from a claim settlement or verdict. (Only nurse claims with paid indemnity of $10,000 or greater were included in the calculation of severity.)

VIOLATION OF PATIENT RIGHTS Purposeful or inadvertent infringement upon a patient's legal prerogatives.

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