Understanding Nurse Liability, 2006 – 2010: A Three-part Approach

CNA HEALTHPRO AND NURSES SERVICE ORGANIZATION

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Nurse Professional Liability Exposures: CNA HealthPro Five-year Closed Claims Analysis (January 1, 2006 – December 31, 2010) and Risk Control Self-assessment

Part 1: Introduction

In collaboration with our business partners at Nurses Service Organization (NSO), we at CNA are dedicated to educating nurses about risk. As part of that effort, we have created this report focusing on *nurse closed claims* over a five-year period. This emphasis is intended to assist nurses in identifying and managing the risk exposures most likely to affect their own practice.

Through the NSO program, CNA continues to be the nation's largest underwriter of professional liability insurance coverage for individual nurses, with more than 600,000 policies in force. CNA/NSO nurses work in a wide and growing array of specialties and locations, including hospitals, nursing homes, outpatient and ambulatory care centers, practitioner offices, schools, community and retail health settings, spas and aesthetic/cosmetic centers. We believe that nurses in every type of setting will find this report a valuable educational resource.

Purpose

Our objective is to utilize CNA's considerable pool of nurse closed claims from the NSO program to identify current liability patterns and trends. By limiting the study to closed claims resulting in significant financial loss, we highlight the types of situations most likely to have serious adverse consequences for both patients and nurses. Using this report, nurses can examine their current practices in relation to the claims and losses experienced by their peers, in order to better understand the risks and challenges they encounter on a daily basis.

In addition, this study contains several high-level risk control recommendations regarding delivery of care and documentation which, if implemented, can help enhance patient safety and minimize liability exposure. A self-assessment checklist is included to assist nurses in reviewing their custom and practice in relation to the risks identified in the report and determining whether they are in compliance with recommended standards.

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Database and Methodology

In this report, we analyze nurse closed claims that

- involved a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN)
- closed between January 1, 2006 and December 31, 2010
- resulted in an indemnity payment of $10,000 or greater

The database for this report was derived by applying specific exclusion criteria to the 3,222 closed claims attributed to CNA-insured nurses from the NSO program between January 1, 2006 and December 31, 2010.

In order to focus the analysis on nurse closed claims involving significant patient injury and financial loss, the 3,222 closed claims were carefully reviewed to determine whether they met one or more of the following exclusion criteria:

- The claim closed before January 1, 2006 or after December 31, 2010.
- The closed claim was reported as an incident, never rose to the level of a legal action and did not result in a payment by CNA.
- The claim closed with an indemnity payment by CNA on behalf of the insured nurse of less than $10,000. (Closed claims with indemnity payments of less than $10,000 were excluded for many reasons, including the fact that they typically reflected less severe injuries and resolved without extensive discovery actions, such as obtaining and assessing clinical records, expert opinions and sworn depositions.)
- The closed claim involved an advanced practice nurse (i.e., nurse practitioner, clinical nurse specialist, certified nurse midwife or certified registered nurse anesthetist).
- The closed claim involved a nursing assistant, nurse aide or nursing student.
- The closed claim involved only legal representation for nurse deposition assistance.

These exclusion criteria narrowed the database to *516 closed nurse claims*, which were subsequently reviewed and analyzed.

Note that claim-related expenses (including expert witness expenses, attorney fees, court costs and record duplication expenditures) are *not* included in the total or average paid indemnity amounts reflected in the report. Expenses resulting from nurse closed claims are addressed in Figures 2 and 3 on pages 10 and 11.

As this report uses different data inclusion criteria than do past CNA/NSO nurse claims studies or claims studies from other organizations, readers should exercise caution about comparing the findings.

Scope

The focus of the analysis is on the *severity* of nurse closed claims. Claim characteristics analyzed within the report include location of the event, nurse specialty, allegation, injury and related disability, among other factors.

Unless specifically noted, the tables and charts in Part I of this report include both registered nurse and licensed practical nurse/licensed vocational nurse closed claims. See Figure 20 on page 31 for a comparative analysis of RN and LPN/LVN closed claims.

Terms

For purposes of *this report only,* please refer to the terms and explanations below:

- **Aging services** – Specialized facilities or organizations that provide healthcare to a senior population. Sometimes also referred to as *long term care facilities*, aging services settings include, but are not limited to, nursing homes, assisted living centers and independent living facilities.
- **Expense payment** – Monies paid in the investigation, management and/or defense of a claim.
- **Incurred payment** – The costs or financial obligations, including indemnity and expenses, resulting from the resolution of a claim.
- **Indemnity payment** – Monies paid on behalf of an insured nurse in the settlement or judgment of a claim.
- **Patient** – Any person receiving nursing care in a hospital, aging services/long term care facility, private home, behavioral health facility, prison, clinic, community health facility, practitioner office, retail health setting or other healthcare delivery setting where a nurse practices.
- **Practitioner** – A licensed independent healthcare provider such as a physician, dentist, advanced practice nurse or physician assistant.
- **Severity** – The average paid indemnity for those nurse claims that closed with an indemnity payment of $10,000 or greater.

Limitations

The data analysis within this report is subject to the following limitations and conditions:

- The database includes only closed claims against nurses insured by CNA through the NSO program, which does not necessarily represent the entire spectrum of nurse activities and nurse closed claims.
- Noted indemnity payments are only those paid by CNA on behalf of its insured nurses through the NSO program and do not represent additional amounts paid by employers, other insurers, or other parties in the form of direct or insurance payments.
- The process of resolving a professional liability claim may take many years. Therefore, claims included in this report may have arisen from an event that occurred prior to 2006, yet closed during the period of the study.

General Data Analysis

ANALYSIS OF CLAIMS BY LICENSURE TYPE

- Of the 516 nurse closed claims, 91.9 percent involved RNs and 8.1 percent involved LPNs/LVNs. These percentages vary from the overall proportion of CNA-insured RNs and LPNs/LVNs – a proportion that changes somewhat over time, but approximates 85 percent RNs and 15 percent LPNs/LVNs.
- These data suggest that LPNs/LVNs tend to have fewer and less severe claims than do RNs, possibly due to RNs' higher level of responsibility and the greater probability that RNs work in an acute care setting.

1

Closed Claims by Nurse Licensure Type
(Indemnity and Expenses for Closed Claims with Paid Indemnity ≥ $10,000)

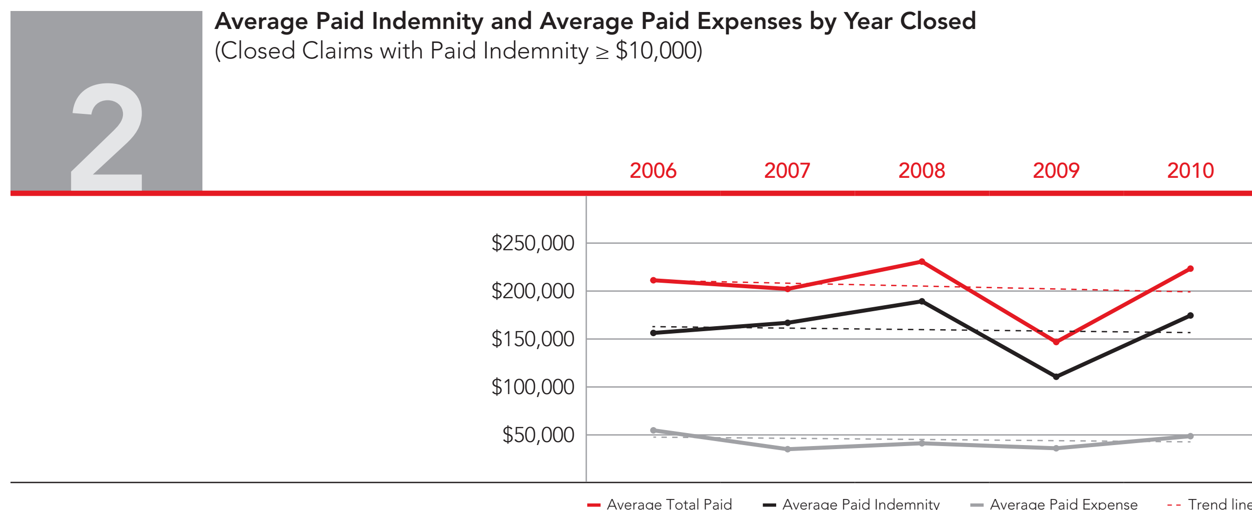
Licensure type	Percentage of closed claims	Total paid indemnity	Average paid indemnity	Average paid expense	Average total incurred
Registered nurse	91.9%	$79,839,387	$168,438	$43,051	$211,489
Licensed practical/vocational nurse	8.1%	$3,494,965	$83,213	$43,570	$126,784
Overall	**100.0%**	**$83,334,352**	**$161,501**	**$43,093**	**$204,594**

ANALYSIS OF SEVERITY BY YEAR

- Figure 2 displays average paid indemnity and average paid expense for nurse closed claims with an indemnity payment of $10,000 or greater in each of the five years included in the analysis. The year of highest severity was 2008.
- From 2006 through 2010, losses for individual years vary. The overall pattern of indemnity payments for closed claims with an indemnity payment of $10,000 or greater and their accompanying expenses suggests a leveling trend.
- Year-to-year figures fluctuate, but the overall stability in liability costs over the past five years reflects progress in managing and defending nurse claims. The moderating trend may be at least partially due to research and educational efforts by CNA, NSO, the NSO Nurses Advisory Board, nurse educators and nurse professional organizations. These groups have shared their findings and recommendations with nurses and healthcare organizations regarding the need to implement effective quality improvement, patient safety and risk control initiatives. Another possible factor is the ongoing implementation of innovative claims management strategies and litigation best practices by CNA Claim professionals and defense counsel.

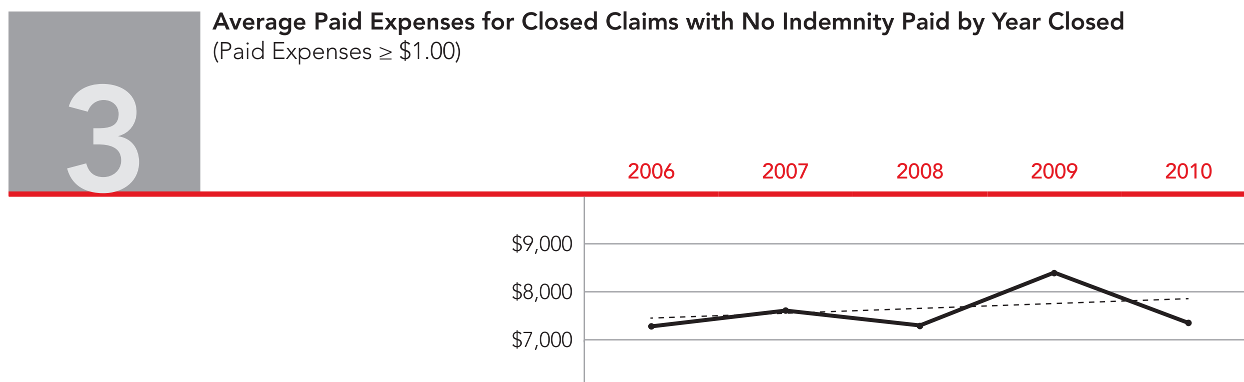
2

Average Paid Indemnity and Average Paid Expenses by Year Closed
(Closed Claims with Paid Indemnity ≥ $10,000)



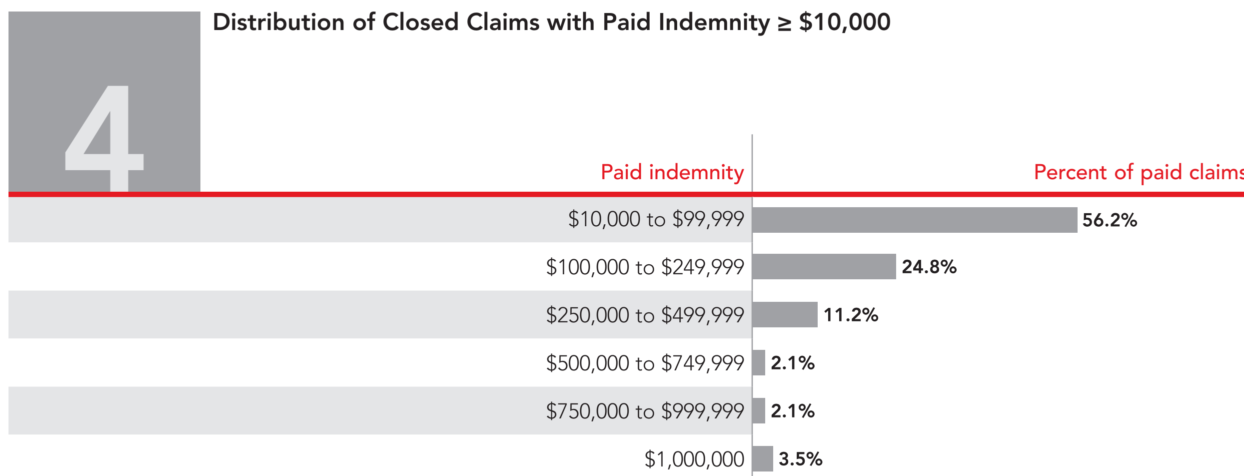
NURSE CLOSED CLAIMS WITH EXPENSE PAYMENTS ONLY

- Figure 3 displays average paid expenses for nurse closed claims with no indemnity payment and paid expenses of one dollar or greater in each of the five years included in the analysis. The highest average paid expenses between 2006 and 2010 occurred in 2009, a year that included one successfully defended claim which resulted in over $500,000 in expenses, an unusually large sum. This claim is discussed on page 29.
- Nurse closed claims in Figure 3 included those that were
  - successfully defended on behalf of the nurse (i.e., resulted in a favorable jury verdict)
  - dismissed or abandoned by the plaintiff during the investigative or discovery process
  - terminated in favor of the defendant by the court prior to trial
- Expenses varied widely for nurse claims that closed without an indemnity payment during the five-year period of this study. In general, expenses for managing nurse professional liability claims showed a gradual rise, as identified by the dotted black trend line.



DISTRIBUTION OF THE CLOSED CLAIMS

An indemnity payment of $100,000 or greater was made in 43.7 percent of the 516 closed claims.



4 Distribution of Closed Claims with Paid Indemnity ≥ $10,000

Paid indemnity	Percent of paid claims
$10,000 to $99,999	56.2%
$100,000 to $249,999	24.8%
$250,000 to $499,999	11.2%
$500,000 to $749,999	2.1%
$750,000 to $999,999	2.1%
$1,000,000	3.5%

ANALYSIS OF SEVERITY BY NURSE SPECIALTY

- The specialties with the highest average paid indemnities were obstetrics, neurology/neuro-surgery and plastic/reconstructive surgery.
- A possible emerging trend involved aesthetic services. Such procedures are most often provided by nurses under the direction of a licensed independent practitioner in the practitioner's office or clinic, or in a spa. The scope of aesthetic services provided by nurses varies based on the governing state nurse practice act. Risks associated with such patient procedures include
  - burns and/or scarring from laser hair removal
  - burns and/or scarring from laser tattoo removal
  - scarring, disfigurement and/or infection from injections of tissue "fillers" and/or Botox for purely aesthetic purposes
- The highest percentages of closed claims occurred in the adult medical/surgical, gerontology and obstetrics specialties.
- The finding that 40.1 percent of closed claims were in the adult medical/surgical specialty indicates that a large proportion of nurses insured through the NSO program works in these specialties. It does not necessarily mean that such nurses are more likely to be sued. More predictive is the severity of such claims, which indicates that an adult medical/surgical indemnity payment will average approximately $144,000.
- As the population of experienced nurses continues to age, it will be of interest to observe whether experienced nurses migrate toward non-hospital-based specialties and work in locations that offer defined work hours and possibly make fewer physical demands on the nurse.

5

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

Nurse specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Obstetrics	10.3%	$20,264,713	$382,353
Neurology/neurosurgery	0.6%	$1,137,000	$379,000
Plastic/reconstructive surgery	0.8%	$1,297,500	$324,375
Pediatric/adolescent	2.7%	$3,486,250	$249,018
Behavioral health	1.7%	$1,367,500	$151,944
Correctional health	3.1%	$2,315,208	$144,701
Adult medical/surgical	40.1%	$29,801,615	$143,969
Emergency/urgent care	9.7%	$7,091,584	$141,832
Public/community health/hospice	8.9%	$6,368,790	$138,452
Gerontology - in aging services facility	18.0%	$9,327,317	$100,294
Aesthetic/cosmetic	3.7%	$821,875	$43,257
*Other	0.4%	$55,000	$27,500
Overall	**100.0%**	**$83,334,352**	**$161,501**

*"Other" specialties included a certified insulin pump trainer and a county-employed administrative nurse who reviewed state Department of Health nursing home recommendations.

ANALYSIS OF SEVERITY BY LOCATION

- The location with the highest average paid indemnity was the hospital post-anesthesia care unit (PACU). Most of the closed claims in this location involved deaths or permanent neurological damage and resolved for full policy limits.
- Obstetrics closed claims are analyzed in Figure 15 on page 25.
- The high average paid indemnity for "Clinic – hospital outpatient" was affected by one closed claim that was resolved for the full policy limit.
- Locations accounting for 10 percent or more of the closed claims included hospital inpatient medical services, aging services and hospital inpatient surgical unit.

6

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

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Hospital - PACU	1.2%	$4,692,115	$782,019
Obstetrics - outpatient services	1.0%	$3,206,250	$641,250
Clinic - hospital outpatient	0.6%	$1,212,500	$404,167
Obstetrics - inpatient perinatal services	8.1%	$14,299,813	$340,472
*Other	0.6%	$878,750	$292,917
Dialysis - freestanding	0.6%	$576,250	$192,083
Hospital - inpatient surgical unit	10.3%	$10,143,846	$191,393
School (preschool through university)	0.6%	$482,000	$160,667
Behavioral/psychiatric health	1.7%	$1,367,500	$151,944
Emergency department - hospital-related	9.3%	$7,096,584	$147,846
Correctional health - inpatient or outpatient	3.7%	$2,676,208	$140,853
Hospital - inpatient medical	20.2%	$14,490,654	$139,333
Patient's home	8.9%	$6,362,765	$138,321
Hospital - operating room/operating suite	2.1%	$1,204,275	$109,480
Ambulatory surgery	3.9%	$2,154,625	$107,731
Aging services	18.4%	$9,436,092	$99,327
Clinic/outpatient - nonhospital	1.7%	$815,750	$90,639
Nurse private practice/office	0.6%	$222,500	$74,167
Spa	0.6%	$208,000	$69,333
Radiology	0.6%	$200,000	$66,667
Practitioner office other than physician	0.2%	$60,000	$60,000
Physician office practice	5.0%	$1,497,875	$57,611
Long term residential facility - pediatric/adolescent	0.2%	$50,000	$50,000
Overall	100.0%	$83,334,352	$161,501

*"Other" claim locations included a children's camp, cruise ship and nurse's home.

Severity by Allegation

The analysis of allegations begins with Figure 7, which examines the broad allegation categories and reflects 100 percent of allegations and average and total paid indemnities for all allegation categories. Additional review of allegation sub-categories follows in Figures 8-12.

ALLEGATION BY CATEGORY

- Claims involving scope of practice had the highest average paid indemnity, perhaps because practicing outside the scope of one's professional license is perceived as egregious misconduct. Claims with allegations relating to scope of practice are thus difficult to defend successfully, as illustrated by the following examples:
  - An RN instructed an LPN to administer medication via intravenous bolus injection, which was outside the LPN's scope of practice and facility policy. The patient suffered a stroke as the bolus was being administered, resulting in irreversible neurological damage and permanent right-sided hemiparesis.
  - A nurse removed and replaced an aging services resident's gastric tube without practitioner orders and without notifying the practitioner. The patient suffered severe infection, sepsis and subsequent death from respiratory arrest.
- Allegations related to patient assessment and monitoring were relatively common and resulted in high average paid indemnity.
- Allegations related to treatment/care accounted for the highest percentage of closed claims.
- The average paid indemnity for closed claims involving medication administration is lower than allegations related to scope of practice, patient assessment, monitoring and treatment/care.
- Documentation deficiencies are contributing factors in many nurse professional liability claims, but documentation was the *primary* allegation in one closed claim. The documentation claim included in Figure 7 resulted from the complete absence of any form of documentation for an incident in which a nurse removed a tick from the patient's skin in a hospital emergency department. The nurse did not register the patient and created no records regarding the patient's treatment. This absence of documentation was a causative factor in the patient's subsequent death, as no practitioner was aware that the patient had undergone a tick removal. The diagnosis and treatment of the infection resulting from the tick bite were delayed, resulting in unsuccessful treatment.

7

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

Allegation category related to	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Scope of practice	1.7%	$2,664,100	$296,011
Assessment	12.6%	$14,867,925	$228,737
Monitoring	6.8%	$7,814,875	$223,282
Treatment/care	58.5%	$47,370,806	$156,857
Medication administration	14.7%	$8,593,330	$113,070
Patients' rights/patient abuse/professional conduct	5.4%	$1,992,066	$71,145
Documentation	0.2%	$31,250	$31,250
Overall	**100.0%**	**$83,334,352**	**$161,501**

Figures 8-12 examine the delineated allegation sub-categories in greater detail. Percentages and average and total paid indemnities in Figures 8-12 reflect only those allegations within the specified sub-category.

ALLEGATIONS RELATED TO SUB-CATEGORY ASSESSMENT

- The highest average paid indemnity involved delayed or untimely patient assessment.
- The high average paid indemnity for closed claims related to failure to reassess the patient after a change in condition underscores the fact that nurses are responsible for performing comprehensive patient assessments across the continuum of care and for reporting assessment results.
- Of the closed claims with allegations involving assessment, 70.8 percent related to the nurse's failure to properly or fully complete the patient assessment or to assess the need for medical intervention. The high average paid indemnity for these closed claims indicates the critical importance of nurses' assessments in establishing the patient's clinical, psychosocial and safety needs.

8

Severity by Allegations Related to Assessment
(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Delayed or untimely patient assessment	4.6%	$1,291,250	$430,417
Failure to reassess patient after any change in medical condition	10.8%	$2,457,500	$351,071
Failure to properly or fully complete the patient assessment	40.0%	$6,898,950	$265,344
Failure to assess the need for medical intervention	30.8%	$3,800,350	$190,018
Failure to document results of assessment or reassessment	1.5%	$56,000	$56,000
Failure to consider/assess patient's expressed complaints/symptoms	12.3%	$363,875	$45,484
Overall	100.0%	$14,867,925	$228,737

ALLEGATIONS RELATED TO SUB-CATEGORY MONITORING

- Failure to monitor and timely report blood test results had the highest average paid indemnity; however, there was only one claim in this category. The claim involved the nurse's failure to monitor the results of the patient's PTT blood test, which revealed an abnormal blood clotting time. Having not seen the PTT results, the practitioner ordered resumption of the patient's Heparin. The nurse did not question the order and restarted the Heparin. The patient suffered significant brain hemorrhage with permanent total disability.
- The allegation with the highest percentage of closed claims, as well as a high average paid indemnity, was failure of the nurse to monitor and report changes in the patient's medical and/or emotional condition to the practitioner.
- Assessing and monitoring patients, as well as reporting findings to the practitioner and health-care team, are integral to the nurse's role. The difficulty defending nurses who fail to perform and document actions related to these core competencies is reflected in the high average paid indemnity for these closed claims.

9

Severity by Allegations Related to Monitoring
(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to monitor and timely report blood test results	2.9%	$1,000,000	$1,000,000
Failure to monitor/report changes in the patient's medical/emotional condition to practitioner	74.3%	$6,265,875	$240,995
Failure to monitor and timely report patient vital signs	22.8%	$549,000	$68,625
Overall	**100.0%**	**$7,814,875**	**$223,282**

ALLEGATIONS RELATED TO SUB-CATEGORY TREATMENT AND CARE

Because of the size and diversity of the treatment and care allegation category, *Figure 10 is limited to specific allegations that had an average paid indemnity of $50,000 or greater.* Thus, there are no totals at the bottom of the table.

- The closed claims with the highest average paid indemnity included allegations that were relatively infrequent, and were typically associated with failure to fulfill core responsibilities, duties and expectations of licensed nurses.
- The closed claim categories with the highest average indemnity were failure to timely respond to patient's concerns related to the treatment plan, failure to respond to equipment warning alarms, failure to invoke or utilize the chain of command, and delay in implementing practitioner orders.
- Closed claims involving the failure to invoke or utilize the chain of command represented 5.6 percent of the treatment and care closed claims, and had a high average paid indemnity. Clearly, the attention of all nurses must be directed to this protocol. Nurses are responsible for invoking the chain of command in order to obtain appropriate services and practitioner intervention for the patient. Our review of chain-of-command closed claims revealed that all patients in this group either died or sustained permanent total disability. Half of these claims occurred in the labor and delivery specialty.

- Several categories of high-indemnity closed claims related to the nurse's failure to timely obtain and/or carry out practitioner orders and failure to notify the practitioner of changes in the patient's condition. These closed claims reflect the need for ongoing, effective communication between the nurse and practitioner, as well as prompt and precise implementation of practitioner orders.
- The variety of allegations related to equipment issues demonstrates that nurses are responsible for determining that the equipment needed for each patient is readily available and checked before each use. Nurses must ensure that emergency equipment is accessible and ready for immediate use.

10

Severity by Allegations Related to Treatment and Care
(Closed Claims with Paid Indemnity ≥ $50,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to timely respond to patient's concerns related to the treatment plan	0.3%	$375,000	$375,000
Failure to respond to equipment warning alarms	0.3%	$372,500	$372,500
Failure to invoke/utilize chain of command	5.6%	$5,959,480	$350,558
Delay in implementing practitioner orders	0.7%	$700,000	$350,000
Improper or untimely nursing management of obstetrical patient/complication	7.0%	$6,590,417	$313,829
Failure to timely obtain practitioner orders to perform necessary additional treatment(s)	1.3%	$1,216,666	$304,167
Failure to carry out practitioner orders for care and treatment	3.0%	$2,655,416	$295,046
Failure to notify practitioner of patient's condition	10.6%	$7,436,046	$232,376
Failure to timely transfuse ordered blood/blood product	0.3%	$218,750	$218,750
Equipment not available	0.7%	$346,500	$173,250
Failure to timely implement established treatment protocols	3.6%	$1,746,250	$158,750
Equipment malfunction	0.3%	$150,000	$150,000
Improper or untimely nursing management of surgical or anesthesia complication	6.3%	$2,663,092	$140,163
Failure to supervise	3.6%	$1,522,500	$138,409
Abandonment of patient	1.7%	$633,427	$126,685
Failure to identify transfusion reaction	0.3%	$125,000	$125,000
Improper nursing technique or negligent performance of treatment resulting in injury	6.3%	$2,166,417	$114,022
Improper or untimely nursing management of medical patient or medical complication	15.9%	$5,185,416	$108,030
Improper or untimely management of aging services resident	16.2%	$4,461,124	$91,043
Improper or untimely nursing management of behavioral health patient	1.7%	$455,000	$91,000
Equipment user error	5.6%	$1,482,125	$87,184
Failure to adequately train nurse in proper use of equipment	0.7%	$100,000	$50,000

ALLEGATIONS RELATED TO SUB-CATEGORY MEDICATION ADMINISTRATION

- Nurses are responsible for providing the correct medication, in the correct dose, to the correct patient, via the correct route and at the correct time – and for remaining constantly vigilant about preventing medication errors. Of the medication-related allegations, administration of the wrong medication had the highest average paid indemnity. Administration of the wrong dose resulted in the highest percentage of medication-related closed claims, and also had a relatively high average paid indemnity.
- Medication safety has become a more prominent issue, in part due to the occurrence of widely publicized drug-related errors. In response, national patient safety initiatives have focused providers' attention on the need to reduce medication administration errors by improving medication management and error reporting processes.
- Medication safety initiatives may partially account for the fact that medication closed claims had a significantly lower overall average paid indemnity ($113,070) than the average paid indemnity for allegations related to assessment ($228,737), monitoring ($223,282), and treatment and care ($156,857).
- The fact that many claims involved a failure to understand, clarify or properly implement practitioner orders again underscores the critical importance of ongoing, two-way communication between practitioners and nurses.

11

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

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Wrong medication	18.4%	$2,119,400	$151,386
Failure to immediately report/record improper administration of medication	2.6%	$276,000	$138,000
Wrong dose	26.3%	$2,738,580	$136,929
Wrong patient	2.6%	$217,500	$108,750
Improper technique	19.7%	$1,579,350	$105,290
Wrong/delayed time	1.3%	$100,000	$100,000
Wrong rate of flow	2.6%	$200,000	$100,000
Failure to properly monitor and maintain infusion site	13.2%	$960,000	$96,000
Wrong route	2.6%	$175,000	$87,500
Wrong information provided or recorded	1.3%	$35,000	$35,000
Failure to notify patient's practitioner	2.6%	$67,500	$33,750
Failure to resolve medication question with pharmacist and/or practitioner prior to administration	1.3%	$25,000	$25,000
Failure to recognize contraindication and/or known adverse interaction between/among ordered medications	5.3%	$100,000	$25,000
Overall	**100.0%**	**$8,593,330**	**$113,070**

ALLEGATIONS RELATED TO SUB-CATEGORY PATIENTS' RIGHTS, PATIENT ABUSE AND PROFESSIONAL CONDUCT

- Patients have the right to receive care from a nurse who is properly trained, experienced and competent to provide patient care. The costliest single closed claim involved the death of a patient under the care of a nurse who was abusing illegal substances.
- Closed claims alleging violation of the patient's right to receive care in a safe environment included instances where the nurse did not take necessary action to prevent falls, ensure clear hallways, perform pre-employment screening or ensure that patients were at the appropriate level of care.
- The closed claims alleging violations of the patient's right to privacy involved the unauthorized release of protected patient information.
- Allegations related to abuse included patient-to-patient abuse as well as physical, sexual and verbal abuse of the patient by the nurse.

12

Severity by Allegations Related to Patients' Rights, Patient Abuse and Professional Conduct
(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Substance abuse by nurse	3.6%	$141,667	$141,667
Violation of patient's right to care in a safe environment	35.7%	$1,060,400	$106,040
Patient-to-patient abuse	25.0%	$502,499	$71,786
Physical abuse by nurse	7.1%	$77,500	$38,750
Sexual abuse by nurse	14.3%	$120,000	$30,000
Violation of patient's right to privacy	7.1%	$52,500	$26,250
*Other inappropriate nurse behavior/action	3.6%	$22,500	$22,500
Verbal abuse by nurse	3.6%	$15,000	$15,000
Overall	100.0%	$1,992,066	$71,145

*The "other inappropriate nurse behavior/action" allegation involved a nurse who, acting outside of facility policy, left a female patient alone in the building with a male clinician. The patient was sexually assaulted.

Severity by Injury

INJURY BY CATEGORY

- Other maternal obstetrics-related injury closed claims had the highest average paid indemnity. These injuries included permanent brain damage and permanent seizure disorder, as well as complications resulting from a retained IV catheter tip and a retained surgical sponge.
- Death (other than maternal or fetal) was the most common injury, accounting for 45 percent of the closed claims. When maternal and fetal mortality were included, 48.5 percent of all closed claims involved a patient death.
- Maternal deaths accounted for the second-highest average paid indemnity.
- Fetal/infant birth-related brain injury had the third-highest average paid indemnity, reflecting the expected cost of care for such infants.

Death (other than maternal or fetal) was the most common injury, accounting for 45 percent of closed claims. When maternal and fetal mortality were included, 48.5 percent of all closed claims involved a patient death.

13 Severity by Injury Category

(Closed Claims with Paid Indemnity ≥ $10,000)

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Other maternal obstetrics-related injury	0.8%	$2,046,500	$511,625
Maternal death	1.4%	$3,525,000	$503,571
Fetal/infant birth-related brain injury	5.8%	$13,796,646	$459,888
Paralysis	1.6%	$3,163,750	$395,469
Brain injury other than birth-related brain injury	5.2%	$10,673,750	$395,324
Genetic defect (OB-related)	0.6%	$950,000	$316,667
Cardiopulmonary arrest	1.0%	$1,352,500	$270,500
CVA/stroke	1.0%	$1,250,000	$250,000
Dehydration/malnutrition	0.2%	$175,000	$175,000
Neurological deficit/damage	1.7%	$1,529,642	$169,960
Eye/ear injury or sensory loss	0.6%	$465,833	$155,278
Erb's/brachial plexus palsy	0.2%	$147,500	$147,500
Amputation	1.9%	$1,440,000	$144,000
Death (other than maternal or fetal death)	45.0%	$31,108,096	$134,087
Compartment syndrome	0.4%	$225,000	$112,500
Pain and suffering	3.1%	$1,567,475	$97,967
Fetal death	2.1%	$1,009,367	$91,761
Heart attack/myocardial infarction	0.6%	$250,000	$83,333
Abuse	2.9%	$1,202,399	$80,160
Loss of organ or organ function	1.0%	$362,000	$72,400
Burn	5.2%	$1,847,500	$68,426
Abrasion/bruise/contusion/laceration	1.9%	$683,000	$68,300
Scar(s)/scarring	1.7%	$596,250	$66,250
Fracture	4.7%	$1,485,042	$61,877
Allergic reaction/anaphylaxis	0.8%	$237,500	$59,375
Infection/abscess/sepsis	2.3%	$694,927	$57,911
Pressure ulcer	2.7%	$755,025	$53,930
Increase or exacerbation of illness	1.9%	$517,250	$51,725
OB medication errors - extended treatment only	0.6%	$149,900	$49,967
Bleeding/hemorrhage	0.8%	$87,500	$21,875
Swelling/edema	0.4%	$40,000	$20,000
Overall	100.0%	$83,334,352	$161,501

As noted above, 48.5 percent of all injuries were fatalities. Figure 14 provides additional insight into the causes of those deaths.

ANALYSIS OF SEVERITY BY CAUSE OF DEATH

- The three causes of death with the highest average paid indemnity (cardiac injury, loss of organ function and embolism) included a small number of closed claims with extenuating clinical circumstances. These included failure to diagnose and properly manage co-morbidities; failure to properly and timely assess, monitor and report the patient's condition; failure to invoke the chain of command to the point of resolution; and patient assault.
- In some of the closed claims, patient death was associated with a single injury or acute illness. However, of the 44 percent of closed claims where cardiopulmonary arrest was the ultimate cause of death, many involved patients whose clinical course included a series of illnesses, injuries and symptoms occurring over a period of time, which contributed in varying degree to the patient's overall decline. This pattern of multiple adverse patient events and injuries leading to eventual cardiopulmonary arrest was most common in aging services settings, but it also occurred in acute care, home care, and other locations and specialties. The box below contains a closed claim scenario illustrating this type of claim.

CLAIM SCENARIO: CARDIOPULMONARY ARREST AS THE CAUSE OF DEATH

Following an elective hip replacement, an elderly woman was discharged from the hospital to a nursing home for skilled nursing care and rehabilitation. Upon admission to the nursing home, she was observed to have skin tears on her extremities and postoperative hip. The resident also suffered from dementia, prior stroke, coronary artery disease and chronic obstructive pulmonary disease. Several skin tears healed, but the hip skin tear became infected, and the resident developed a pressure sore.

Several weeks after admission, the resident was found on the floor of her room, complaining of pain in her shoulder. She was diagnosed with a fracture of the shoulder and was placed in a shoulder immobilizer. She continued to develop and receive treatment for pressure ulcers and skin tears, several of which became infected.

Subsequently, the resident fell again and suffered swelling and discoloration of the previously affected arm and fingers. A wrist fracture was diagnosed, after which surgery was performed and a cast applied. The resident then returned to the nursing home, having acquired additional pressure sores during her hospital stay.

Her symptoms worsened and her downward course continued. The family initiated hospice care and the resident later died from cardiac arrest. The family sued the director of nursing, the nursing home and other healthcare providers, alleging that multiple failures in care over time precipitated the resident's death. The claim was settled in the mid-six-figure range.

14 Severity by Identified Cause of Death

(Closed Claims with Paid Indemnity ≥ $10,000)

Identified cause of death	Percentage of closed claims	Total paid indemnity	Average paid indemnity
*Cardiac injury (excluding heart attack or myocardial infarction)	0.4%	$725,000	$725,000
Loss of organ or organ function	0.4%	$300,000	$300,000
Embolism	2.4%	$1,365,715	$227,619
Bleeding/hemorrhage	12.4%	$6,543,450	$211,079
Brain injury other than birth-related brain injury	0.8%	$401,316	$200,658
Suicide	1.6%	$685,000	$171,250
Cardiopulmonary arrest	44.0%	$17,434,648	$158,497
Heart attack/myocardial infarction	3.2%	$1,265,950	$158,244
Pressure ulcer	2.0%	$534,500	$106,900
Infection/abscess/sepsis	16.4%	$4,299,525	$104,866
Aspiration	1.6%	$384,167	$96,042
Seizure	0.4%	$90,000	$90,000
Increase or exacerbation of illness	0.4%	$75,000	$75,000
Dehydration/malnutrition	0.4%	$75,000	$75,000
Allergic reaction/anaphylaxis	1.6%	$285,000	$71,250
Fall	1.6%	$240,000	$60,000
Injury resulting from elopement	0.4%	$50,000	$50,000
CVA/stroke	3.6%	$433,525	$48,169
Fetal/infant birth-related brain injury	0.4%	$42,500	$42,500
Pneumonia/respiratory infection	4.0%	$307,750	$30,775
Fracture	1.2%	$68,750	$22,917
Fetal distress not otherwise specified	0.8%	$35,667	$17,834
Overall	**100.0%**	**$35,642,463**	**$142,570**

*The cardiac injury claim involved a patient with longstanding cardiac disease who was struck in the chest area with a pillow and suffered cardiac failure and death.

ANALYSIS OF OBSTETRICS-RELATED INJURIES

- It is important to note that not all obstetrics-related closed claims occurred in obstetrics-specific locations. Injuries to the mother or fetus/neonate also occurred in the emergency department, adult medical/surgical units, post-anesthesia care unit, critical care unit, outpatient care locations and the patient's home.
- The obstetrics-related injuries with the highest average paid indemnity were maternal obstetrics-related injuries with 6.8 percent of the closed claims and maternal deaths with 11.9 percent. These maternal obstetrics-related injury closed claims involved
  - a cardiac arrest resulting in anoxic brain damage
  - complications from a retained sponge following Caesarean section delivery
  - complications from a retained arterial catheter tip
  - septic shock resulting in a seizure disorder
- The maternal deaths resulted from complications – including bleeding and hemorrhage – following Caesarean section delivery.
- The fetal/infant birth-related brain injury closed claims involved failure to
  - properly monitor the fetus during labor
  - recognize signs of fetal distress
  - notify the practitioner of fetal distress
  - invoke the chain of command to obtain appropriate practitioner intervention and care during labor
- The genetic defect injuries emanated from failure to pursue appropriate professional services. One claim involved a patient, whose nurse did not obtain diagnostic prenatal genetic screening in accordance with facility protocol. The infant was born with severe genetic defects.
- The obstetric medication errors involved a newborn receiving an incorrect medication in the delivery room, an incident that required transfer and observation but resulted in no injury. A second claim alleged maternal cardiac injury from receiving a wrong medication. Experts deemed the mother's condition to be pre-existing and unrelated to the medication error. Since neither patient suffered an injury as a result of the medication error, the only "injury" suffered in each of these claims was an extension of care and treatment.
- The obstetrics-related closed claim average paid indemnity of $366,524 was more than double the average paid indemnity for all nurse closed claims of $161,501.
- The box on page 25 contains a case scenario of a maternal death obstetrics claim.

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

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Maternal obstetrics-related injury	6.8%	$2,046,500	$511,625
Maternal death	11.9%	$3,525,000	$503,571
Fetal/infant birth-related brain injury	50.8%	$13,796,646	$459,888
Genetic defect (OB-related)	5.1%	$950,000	$316,667
*Erb's/brachial plexus palsy	1.7%	$147,500	$147,500
Fetal death	18.6%	$1,009,367	$91,761
Obstetric medication errors - extended treatment only	5.1%	$149,900	$49,967
Overall	**100.0%**	**$21,624,913**	**$366,524**

*The Erb's/brachial plexus palsy injury involved a nurse who failed to apply supra-pubic pressure when directed to do so by the obstetrician while assisting in the delivery of an infant with unanticipated shoulder dystocia.

CLAIM SCENARIO: OBSTETRICS CHAIN OF COMMAND

A 21-year-old woman delivered a healthy male infant via Caesarean section and was transferred from the recovery room to the obstetrical postpartum unit, where she was placed under the care of an appropriately trained and experienced temporary staffing agency obstetrics nurse. The nurse rapidly identified and reported a rising pulse and dropping blood pressure, the absence of urine output and increasing complaints of abdominal pain. The obstetrician responded and saw the patient briefly, then attended another delivery. The nurse made frequent calls to the obstetrician over the next four hours and received telephone orders that included frequent checks for vaginal bleeding, pain medication, IV fluids and blood transfusion.

Approximately five hours after delivery, the nurse notified the obstetrician that the patient was experiencing difficulty breathing and had a rash on her arm, indicating a possible transfusion reaction. The obstetrician provided telephone orders to stop the transfusion, administer oxygen and obtain an abdominal ultrasound, which revealed blood in the abdomen. The patient arrested, and the obstetrician performed emergency surgery to stop the uterine hemorrhage. The patient survived the surgery but was diagnosed with severe anoxic encephalopathy, coagulopathy, post-partum hemorrhage and cardiopulmonary arrest. She died the following day.

Although the nurse had identified the clinical problems, closely monitored the patient, and reported and documented the signs of hemorrhage and respiratory distress, the nurse was deemed liable for failing to invoke the chain of command to obtain more aggressive practitioner care. The fact that the nurse was on temporary assignment may have affected the nurse's knowledge of the chain of command process and/or the nurse's willingness to invoke that process.

Disability Outcome

ANALYSIS OF SEVERITY BY DISABILITY OUTCOME

- The level of disability with the highest average paid indemnity was permanent total disability. This is to be expected, as permanently disabled individuals require significant medical and social support for the remainder of their lives.
- Closed claims involving patient deaths had the second highest average paid indemnity. The relatively high average paid indemnity for closed claims where the patient died may be associated with compensation to survivors and/or aggravating circumstances, such as nurse failure to follow practitioner orders or abandonment of the patient.
- The claims involving permanent total disability were associated with the following allegation categories:
  - 72.7 percent, treatment and care
  - 14.3 percent, assessment
  - 7.8 percent, monitoring
  - 1.3 percent, medication administration
  - 3.9 percent, all other categories

16 **Severity by Disability**
(Closed Claims with Paid Indemnity ≥ $10,000)

Disability	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Permanent total disability	14.9%	$32,699,979	$424,675
Death	48.4%	$35,642,463	$142,570
Permanent partial disability	14.3%	$7,877,312	$106,450
Temporary total disability	4.1%	$1,370,775	$65,275
Temporary partial disability	18.0%	$5,706,323	$61,358
*No disability	0.2%	$37,500	$37,500
Overall	**100.0%**	**$83,334,352**	**$161,501**

*This closed claim involved a HIPAA violation that did not result in any patient disability.

Director of Nursing Claims

ANALYSIS OF DIRECTOR OF NURSING (DON) CLOSED CLAIMS

Of the total nurse closed claims, 8.5 percent involved a director of nursing, mostly in aging services settings.

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

Nurse specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Public/community health/hospice	2.3%	$310,000	$ 310,000
Adult medical/surgical	4.5%	$400,000	$ 200,000
Gerontology - in aging services facility	93.2%	$3,854,151	$94,004
Overall	**100.0%**	**$4,564,151**	**$103,731**

The average paid indemnity of $103,731 for DON closed claims was significantly less than the overall average paid indemnity for the 516 closed claims analyzed in this report ($161,501).

18

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

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Pain and suffering	4.5%	$485,000	$242,500
Dehydration/malnutrition	2.3%	$175,000	$175,000
Death	68.2%	$3,108,766	$103,626
Abrasion/bruise/contusion/laceration	2.3%	$100,000	$100,000
Fracture	9.1%	$343,000	$85,750
Abuse - all forms	4.5%	$153,333	$76,667
Infection/abscess/sepsis	2.3%	$54,052	$54,052
Pressure ulcer	6.8%	$145,000	$48,333
Overall	**100.0%**	**$4,564,151**	**$103,731**

MANAGEMENT OF DIRECTOR OF NURSING CLAIMS

Some closed claims against directors of nursing (DONs) involved injuries alleged to have occurred as a result of direct patient care services provided by the DON. Those claims were managed as typical professional liability claims.

Additionally, over the past several years, CNA Claim has identified a number of claims where the DON was personally named in a professional liability lawsuit, despite not having provided direct care or services to the patient. These claims were directed toward the DONs' actions in delivering managerial and/or administrative services, based upon the assumption that the DON was personally responsible for the actions of the members of the nursing care staff and for the care of each patient within the organization. Many of these claims involved DONs working in aging services facilities, often in states where practitioners carry lower professional liability coverage limits or where the healthcare organization employing the DON was underinsured or uninsured. CNA legal counsel has developed aggressive litigation management strategies to defend against such claims.

Agency Nurse Claims

CLAIMS RELATED TO AGENCY NURSES

- For the purposes of this report, the term "agency nurse" means an RN or LPN/LVN who provided nursing services as an independent contractor or as an employee of a staffing or placement service.
- Agency nurses were involved in 25.4 percent of the closed claims.
- The average paid indemnity was $170,564 for agency nurse closed claims. For purposes of comparison, the average paid indemnity for all non-agency nurse closed claims was $158,417, while the average paid indemnity for all nurse closed claims included in the study was $161,501.

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

Agency type	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Independent contracted nurse	13.0%	$4,974,375	$292,610
Temporary staffing agency	57.3%	$11,952,973	$159,373
Home care agency	23.7%	$4,812,515	$155,242
*Other	2.3%	$310,000	$103,333
Hospice care agency	3.8%	$294,000	$58,800
Overall	**100.0%**	**$22,343,863**	**$170,564**

*"Other" agency nurse closed claims included a nurse who was placed by an agency that staffed only contracted prison health facilities, a nurse placed by a blood bank to provide a home-based transfusion and a nurse placed by an agency that staffed a telephone nurse advice service.

CLAIM SCENARIO: SUCCESSFUL DEFENSE OF AN EMERGENCY DEPARTMENT NURSE

It is CNA Claim policy to pay covered claims fairly and promptly, while aggressively defending unsubstantiated claims. The following claim scenario represents an example of an aggressive defense of a CNA/NSO-insured nurse, which was successful despite patient injuries including pain, suffering, disfigurement and permanent total disability.

The patient, who was well-known to the emergency department staff, arrived at the emergency department intoxicated, agitated and aggressive. His condition limited our insured nurse's ability to complete an initial assessment. For the patient's safety, the nurse requested that security staff place him into four-point restraints per hospital protocol. According to hospital policy, the restraint procedure should have included a security check of the patient's person for contraband.

As another patient was being monitored in the psychiatric observation room, the nurse placed the intoxicated patient in a quiet single room where he could sleep and calm down sufficiently to undergo a more thorough admission assessment. The nurse performed patient monitoring checks every 15 minutes as ordered, missing only one patient check in order to care for a critically ill patient. The exception was clearly documented, including the nurse's findings at each of the completed patient checks.

Shortly after the nurse performed a 15-minute check, during which the patient was observed to be resting more comfortably in four-point restraints, the patient attempted to burn off his restraints with a cigarette lighter, igniting his bed linens and clothing. In those few minutes, the patient suffered severe burns, causing him to lose his fingers on one hand, scarring his other hand and resulting in burns over 25 percent of his body, which required multiple surgeries and left him permanently disabled.

Experts were retained who determined that the nurse had acted within her scope of practice and in compliance with both the standard of care and hospital policy. Documentation supported the nurse's frequent checks of the patient and the reasons for the one missed check, which did not occur at the time of the fire. The case against the insured nurse was defended successfully at trial, with the jury determining that the patient was responsible for his own injuries. The verdict was appealed on two narrow issues, leading to a second successful defense of the nurse.

The claim took 12 years to resolve, with total expenses of over $500,000. While it might have been less expensive to settle the claim, the nurse's proper care of the patient and complete documentation made an aggressive defense possible and ultimately successful.

LPN/LVN Claims

COMPARISON OF RN AND LPN/LVN CLOSED CLAIMS

The previous charts in the report combine RN and LPN/LVN closed claims data. To help LPNs/LVNs better understand their unique risk exposures, we compared the 43 closed claims where the defendant was an LPN or LVN with the 473 RN closed claims. The top three results for each of the claim characteristics analyzed are presented below:

- LPNs/LVNs were defendants in 8.1 percent of the closed nurse claims. The distribution of CNA/NSO-insured nurses, while fluid, is about 15 percent LPNs/LVNs and 85 percent RNs.
- The average paid indemnity for LPN/LVN closed claims of $83,213 was approximately half the average paid indemnity for RN closed claims of $168,438.
- The specialty with the highest average paid indemnity for LPNs/LVNs was surgery and for RNs was neurology/neurosurgery.
- The top three locations with the highest average paid indemnity differed for LPN/LVN and RN claims.
- The allegation with the highest average paid indemnity differed for LPNs/LVNs and RNs, but for both groups, assessment and monitoring were among the top three allegations.
- The injuries with the highest average paid indemnity differed for LPNs/LVNs and RNs.
- The causes of death with the highest average paid indemnity differed for LPNs/LVNs and RNs.
- Permanent total disability and death had the highest average paid indemnity for both LPNs/LVNs and RNs.

The average paid indemnity for licensed practical nurse/licensed vocational nurse closed claims of $83,213 was approximately half the average paid indemnity for registered nurse closed claims of $168,438.

20 LPN/LVN and RN Closed Claim Comparison – Top Three Elements by Severity Criteria

(Closed Claims with Paid Indemnity ≥ $10,000)

Topic	LPN/LVN	RN
Percent of claims	8.1%	91.9%
Average paid indemnity	$83,213	$168,438
Specialties	- Surgery - Home care - Hospice	- Neurology/neurosurgery - Obstetrics - Plastic/reconstructive
Location	- Hospital – inpatient surgical service - Patient's home - Hospital – inpatient medical service	- Hospital PACU - OB outpatient services - Clinic – hospital outpatient
Allegations	- Medication administration - Assessment - Monitoring	- Scope of practice - Assessment - Monitoring
Injury	- Fetal death (occurred on surgical unit) - Brain injury (not birth-related) - Death (other than maternal or fetal death)	- Respiratory arrest* - Maternal obstetrics-related injury - Maternal death
Cause of death	- Fall - Cardiac arrest - Respiratory arrest	- Cardiac injury - Brain injury (other than birth-related) - Loss of organ or organ function
Disability	- Permanent total disability - Death - Temporary total disability	- Permanent total disability - Death - Permanent partial disability

*Respiratory arrest with delayed resuscitation resulted in permanent physical and emotional injuries.

Risk Control Recommendations

While rare events may be difficult to prevent, the nurse closed claims data suggest that many errors are both predictable and preventable. Therefore, ongoing attention to developing and enhancing core competencies can increase patient safety while minimizing nurses' liability exposure. Compliance with critical processes, such as careful documentation and understanding and invoking the chain of command, is essential in every nursing setting, clinical specialty and position. The following basic strategies can serve as a starting point for nurses seeking to assess and enhance their safety practices:

Know and comply with your state scope of practice, nurse practice act, and facility policies, procedures and protocols.

Nurse employers are required to establish position descriptions and policies in compliance with state regulations. If regulatory requirements and organizational scope of practice and/or policies differ, comply with the most stringent of the applicable regulations or policies. If in doubt, contact your state Board of Nursing or specialty professional nursing association for clarification. The following additional strategies can help reduce the likelihood of scope-of-practice allegations:

- If a job description, contract, or set of policies and procedures appears to violate the legal scope of practice, bring this discrepancy to the organization's attention.
- State clearly that you are unwilling to risk revocation of your license and possible legal action by failing to comply with the state scope of practice/nurse practice act.
- Know the organization's policies and procedures related to clinical practices, documentation and steps to take if given an assignment beyond your scope of practice or experience.

Follow documentation standards established by professional nursing organizations and comply with your employer's standards.

The importance of complete, appropriate, timely, legible and accurate documentation cannot be overstated. Whether patient records are in paper or electronic form, the following information, at a minimum, should be included:

- patient's presenting complaints and ongoing concerns
- results of initial and ongoing patient assessment findings
- changes in the patient's condition and date/time of practitioner notification
- results of ongoing patient monitoring and date/time of practitioner notification, if applicable
- results of diagnostic procedures and laboratory testing, as well as date/time of practitioner notification
- referral and consultation requests and results, including scheduling efforts and notification to the practitioner of any delays in completing the request or reporting the results
- content of relevant discussions with the patient and members of the healthcare team, as well as patient-authorized discussions with family members and support system
- patient education and discharge instructions, including the patient's ability to demonstrate self-care and/or correctly repeat instructions
- objective facts related to any patient accident, injury or adverse outcome

The following additional documentation strategies can help enhance defensibility in the event of litigation:

- Comply with organizational policy and protocol related to correction of documentation errors and/or late entries.
- Refrain from documenting subjective opinions or conclusions and from placing blame or making any accusatory or derogatory statements.

- Never alter a clinical record for any reason. When using paper records, do not write over or obliterate an entry, squeeze an entry into existing documentation or remove any document from the record. Remember that electronic records identify electronic deletions and automatically date and time each entry, making an attempt to alter the record apparent.
- Contact the risk manager for assistance with documentation concerns or questions related to possible liability or regulatory compliance.

Develop, maintain and practice professional written and spoken communication skills.

Effective communication – which involves the exchange of accurate, timely, complete and appropriate information – is essential to working with patients, families, administrators, practitioners and other members of the patient care team in an efficient and appropriate manner. The following communication strategies can enhance information flow and help create a more patient-centered and caring atmosphere:

- Always consider what information to share, when to share it, how to share it (e.g., written versus spoken or in-person vs. telephone) and with whom it should be shared.
- Ensure that communication among caregivers, and between caregivers and patients, is professional, respectful and inclusive. As the caregiver with the most access to the patient, the nurse is often the individual who ascertains the patient's needs and wishes and conveys them to others. Include family members or significant others in discussions only if the patient or designated legal representative has given authorization.
- Determine the patient's primary language, follow organizational procedures to obtain translation/interpreter services, and ensure that the patient receives information regarding condition and treatment in the primary language.
- Carefully communicate patient assessments and observations to other members of the healthcare team, in order to develop and modify the plan of treatment and care as necessary.
- Utilize sound hand-off methods, as failure to adequately communicate during patient hand-offs is a common contributing factor to delays or errors. It is essential to convey key information related to acute and/or chronic conditions, including allergies and special needs. Ensure that critical information has been shared whenever the patient is transferred to another caregiver or environment.

Emphasize ongoing patient assessment and monitoring.

Thorough, accurate and timely patient assessment and monitoring are core nursing functions. The healthcare team relies upon nurses to communicate in a timely and accurate manner both initial and ongoing findings regarding patient status and response to treatment. As nurse practice acts vary regarding conditions under which LPNs or LVNs may perform patient assessments, it is essential to understand the scope of practice in your state for each license type.

Maintain clinical competencies relevant to the patient population and healthcare specialty.

Nurses have a duty to proactively obtain the professional information, education and training needed to remain current regarding clinical practice, medications, biologics and equipment utilized for treatment of acute and chronic illnesses and conditions related to their specialty. Continuing nursing education programs represent an important mechanism for meeting this responsibility. If such programs are not routinely provided by the employer, contact state and local nurse associations for information about reputable educational and training offerings.

Invoke the chain of command when necessary to focus attention on the patient's status and/or any change in condition.

Nurses are the patient's advocate, ensuring that the patient receives appropriate care when needed. Advocacy includes the duty of invoking both the nursing and medical staff chains of command to ensure timely attention to the needs of every patient, and persisting to the point of satisfactory resolution. Nurses must be comfortable with utilizing the medical chain of command whenever a practitioner does not respond to calls for assistance, fails to appreciate the seriousness of a situation or neglects to initiate appropriate intervention. The following strategies can help reduce apprehension regarding chain of command issues:

- Address communication issues between nursing and medical staffs, and identify instances of intimidation, bullying, retaliation or other deterrents to invoking the chain of command.
- Notify leadership of individuals or areas that prevent nursing staff from invoking the chain of command or punish them for doing so.
- If the organization's current culture does not support invoking the chain of command, explain the risks posed to patients, staff, practitioners and the organization, and initiate discussions regarding the need for a cultural shift.

For additional nurse-oriented risk control tools and information, visit **www.cna.com** and **www.nso.com/nurseclaimreport2011**.

Conclusion

Our analysis of nurse professional liability closed claims reveals that nurses continue to be held strictly accountable for acting within their scope of practice according to their license, as well as within the policies and procedures of their place of employment. Many claims develop due to a failure involving core competencies, such as patient assessment, monitoring, treatment and care, practitioner and patient communication, timely and complete documentation, and invocation of the chain of command – all of which are essential to ensure quality patient care in a safe environment. The claims also demonstrate that nurses are expected to serve as the patient's advocate and are responsible for obtaining alternative practitioner intervention if the initial practitioner does not respond appropriately to the patient's medical needs.

Another lesson reinforced by the data is the need for timely, ongoing, two-way communication between the nurse and other members of the healthcare team. All communication, either spoken or written, must be fully documented in the patient's health information record, providing the information needed to make sound clinical decisions. Documentation should clarify the decision-making process and support discharge planning and other activities implemented on behalf of the patient by nurses, practitioners and other professionals. As illustrated in the scenario on page 29, strong documentation is a pillar of risk management, often delineating the difference between successful and unsuccessful legal defense of nurse professional liability claims.

Knowing the risks that confront today's nurses is the first step in protecting patients and reducing liability exposure. We anticipate that the data, analysis and risk control recommendations contained in this resource will inspire nurses nationwide to examine their practices carefully and focus their risk control efforts on the areas of statistically demonstrated error and loss.

Risk Control Self-assessment Checklist for Nurses

Self-assessment Criteria	Yes	No	Action(s) I Need to Implement to Reduce Risks
Self-assessment Related to My Clinical Specialty			
I work in an area that is consistent with my training and experience.			
My competencies (including experience, training, education and skills) are consistent with the needs of my assigned patients and/or patient care unit.			
I understand the risk of caring for patients within my clinical specialty.			
When I am floated or asked to cross-cover, I ensure that my competencies and experience are appropriate for the assignment.			
I am provided with or request orientation whenever I am assigned to a different clinical care unit or different level of care.			
I obtain education and training on an ongoing basis to maintain my competencies in my clinical specialty.			
I decline an assignment if my competencies are not consistent with patient needs.			
Self-assessment Related to Scope of Practice			
I know my Nurse Practice Act and read it at least annually to ensure I understand the legal scope of practice in my state.			
I decline to perform a requested service that is outside my legal scope of practice and immediately notify my supervisor or the director of nursing.			
I contact the risk management department or the legal department regarding patient or practice issues, if necessary.			
I contact the Board of Nursing and request an opinion or position statement on nursing practice issues, if necessary.			
Self-assessment Related to Patient Assessment			
I assess and **document** the following upon admission, with a change in treatment, or with a change in a patient's condition or response to treatment:			
- Presenting problem(s)			
- Fall risk			
- Co-morbidities affecting the patient's status			
- Patient's understanding of his/her condition and plan of treatment/care			
- Mobility status, including the use of mobility aids			
- Medications			
- Elopement/abduction risk			
- Skin/wound status including any wounds or lesions			
- Pain management			
- Restraint use			
- Behaviors			
- Cognition			
- Nutrition/hydration			
- Vital signs			
- Lab values			
I notify all appropriate parties of assessment results.			

Self-assessment Criteria	Yes	No	Action(s) I Need to Implement to Reduce Risks
Self-assessment Related to Patient Monitoring			
I perform and **document** the results of specific patient-monitoring activities according to practitioner orders and as indicated by the patient's condition, including:			
- Vital signs, blood pressure, oxygen saturation			
- Blood sugar			
- INR/clotting times/bruising			
- Blood and diagnostic test results (notifing the practitioner of abnormal results)			
- Clinical signs of bleeding or hemorrhage			
- Effectiveness of pain management			
- Signs of infection and/or inflammation			
- Restraint protocol compliance			
- Nutritional intake			
- Oral and intravenous fluid intake and output			
- Output – urine, stool, wound drainage			
- Wound status – measurement, treatment and response to treatment			
- Behaviors			
- Cognition			
- Patient concerns/complaints			
- Change in condition			
- Response to medication/treatment, including change in behavior, cognition and potential increased risk for falls			
- Patient safety – current environment			
I notify all appropriate parties of findings from monitoring activities.			
Self-assessment Related to Treatment and Care			
I provide and **document** patient treatment and care, including:			
- Timely implementation of approved/standardized protocols			
- Timely contacting the practitioner to obtain orders			
- Timely implementation of practitioner orders			
- Medication administration, as ordered (i.e., ensuring correct medication, patient, dose, route, and time; checking the reason for administering medication; and noting if the problem was lessened or alleviated, etc.)			
- Patient/family education related to treatment and verification of their understanding			
- Practitioner notification of change in condition/symptoms/patient concerns and practitioner's response and/or orders			
- Practitioner notification of complications and adverse response to medication or treatment and practitioner's response and/or orders			
- Supervision of non-professional caregivers			
- Provision of nutrition and hydration (assisting patient as needed)			
- Oversight/scheduling of referrals/tests/diagnostic procedures			
- Tracking of test results/consultation reports			
- Practitioner notification of test/consultation results and practitioner's response and/or orders			
- Participation in accurate and complete hand-offs between assigned caregivers, units and shifts			
- Practitioner notification of delays and issues encountered in carrying out orders			

Self-assessment Criteria	Yes	No	Action(s) I Need to Implement to Reduce Risks
- Follow-up on delays and issues in obtaining test or test results			
- Invoking of nursing and medical chains of command if there is a delay in response from practitioner or significant concern with practitioner action taken			
- Practitioner notification of patient refusal of recommended healthcare (e.g., assessments, diagnosis and/or treatment interventions including medications)			
- Reporting of any patient incident, injury or adverse outcome and subsequent treatment/response			
Self-assessment Related to Patient Care Equipment and Supplies			
I ensure that emergency and required patient care equipment is readily available and in good working order.			
I check all equipment before each use to ensure that it functions properly.			
I report broken/malfunctioning equipment, remove it from patient care use and obtain an appropriate replacement.			
I sequester broken/malfunctioning equipment that was involved in a patient incident to preserve its condition at the time of the event.			
I provide oral and written reports of broken/malfunctioning equipment to all appropriate parties.			
I perform all required monitoring, assessment and reporting activities.			
Self-assessment Related to Professional Conduct			
I speak to patients, families and staff in a respectful and dignified manner.			
I refrain from personal relationships with patients/families.			
I explain procedures and treatments to patients, including what touching they can anticipate during assessment, monitoring and treatment.			
I include a chaperone when indicated if intimate touching is required for the patient's treatment.			
I honor the patient's rights throughout the episode of care.			
I refrain from harsh physical touching or movement with patients at all times.			
I monitor the patient care environment to ensure patient safety.			
I remain aware of the need for ensuring a safe patient care environment, including unobstructed hallways, properly secured entrances and exits, and restricted access to hazardous substances.			
Self-assessment Related to Documentation Practices			
I document contemporaneously and never make a late entry unless it is appropriately labeled and is necessary for safe continued patient care.			
I never remove any portion of the patient's health information record.			
I never alter a record in any way.			
I refrain from subjective comments, including comments about colleagues and other members of the patient care team.			
I do not remove patient health records (paper or electronic) from the patient care unit, nor do I make entries from home or other inappropriate locations.			
If provided with a laptop, electronic pad or electronic PDA, I do not permit any other person access to that equipment and never share my passwords/ access codes.			
If I have documentation concerns, I contact the risk manager or legal counsel for assistance prior to making an entry about which I am unsure.			

This checklist is also available at **www.cna.com** and **www.nso.com**.

CLAIM TIPS

Below are some proactive concepts and behaviors to include in your nursing custom and practice, as well as steps to take if you believe you may be involved in a legal matter related to your practice of nursing:

- Practice within the requirements of your state Nurse Practice Act, in compliance with organizational policies and procedures, and within the national standard of care.
- Document your patient care assessments, observations, communications and actions in an objective, timely, accurate, complete, appropriate and legible manner. Never alter a record for any reason or add anything to a record after the fact unless it is necessary for the patient's care. If it is essential to add information into the record, properly label the delayed entry as a late entry, but never add any documentation to a record for any reason after a claim has been made. If additional information related to the patient's care emerges after you become aware that legal action is pending, discuss the need for additional documentation with your manager, the organization's risk manager and legal counsel to determine appropriate actions.
- Immediately contact your personal insurance carrier if
  - you become aware of a filed or potential professional liability claim against you
  - you receive a subpoena to testify in a deposition or trial
  - you have any reason to believe that there may be a potential threat to your license to practice nursing
- If you carry your own professional liability insurance, report such matters to your insurance carrier, even if your employer advises you that it will provide you with an attorney and/or that it will cover you for a professional liability settlement or verdict amount.
- Refrain from discussing the matter with anyone other than your defense attorney or the claim professionals who are managing your claim.
- Promptly return calls from your defense attorney and the claim professionals assigned by your insurance carrier. Contact your attorney or claim professional before responding to calls, e-mail messages or requests for documents from any other party.
- Provide your insurance carrier with as much information as you can when reporting such matters, but at a minimum, include contact information for your organization's risk manager and the attorney assigned to the litigation by your employer.
- Never testify in a deposition without first consulting your insurance carrier or, if you do not carry individual liability insurance, without first consulting the organization's risk manager or legal counsel.
- Copy and retain the Summons & Complaint, subpoena and attorney letter(s) for your records.
- Maintain signed and dated copies of any employer contracts.

Nurses Service Organization's Analysis of Nurse License Protection Paid Claims

(January 1, 2006 – December 31, 2010)

Part 2: Introduction

An action taken against a nurse's license to practice nursing differs from a professional liability claim in that it may or may not involve allegations related to patient care and treatment provided by the nurse. Another difference is that amounts paid in response to license protection claims represent the cost of providing legal representation to the nurse in defending such actions, rather than indemnity or settlement payments to a plaintiff.

License Defense Paid Claims

During the period of this report (January 1, 2006 through December 31, 2010), there were 1,127 license defense paid claims, in which legal counsel defended nurses against allegations that could potentially have led to revocation of their license. License defense paid claims involved both medical and non-medical regulatory board complaints against nurses.

ANALYSIS OF CLAIMS BY LICENSURE TYPE

The percentage of license defense paid claims was 84.5 percent for RNs and 15.5 percent for LPNs/LVNs, which correlates with the proportion of RNs and LPNs/LVNs in the overall CNA/NSO-insured nurse population.

1 **License Defense Paid Claims by Licensure Type**

Licensure type	RN	LPN/LVN	Total
License defense paid claims	962	165	1,127
Percent of defense actions by licensure type	84.5%	15.5%	100.0%
Total Payments	**$3,280,568**	**$498,561**	**$3,779,129**

ANALYSIS OF CLAIMS BY LOCATION

- RNs who experienced a license defense paid claim worked most often in a hospital setting (57.3 percent) followed by aging services facilities and home health services.
- LPNs/LVNs who experienced a license defense paid claim were most likely to have worked in an aging services settings (56.0 percent), followed by a hospitals and home health services.
- Other practice locations include schools, prisons, practitioner offices, community health centers and group homes.

2 Practice Locations by Nursing Licensure

RN		LPN/LVN	
Hospital	57.3%	Nursing home	56.0%
Aging services facility	19.6%	Hospital	27.8%
Home health	7.9%	Home health	6.6%
All other	15.2%	All other	9.6%
Total	**100.0%**	**Total**	**100.0%**

The percentage indicated for RNs is based upon the 962 paid claims for RNs. The percentage for LPNs/LVNs is based upon the 165 paid claims for LPNs/LVNs.

ANALYSIS OF CLAIMS BY ALLEGATION CLASS

- The four allegation classes with the highest percentage of license defense paid claims were the same for both RNs and LPNs/LVNs, although the order of prevalence differed.
- For RNs, the most common allegation was professional conduct (23.5 percent); however, this was only the fourth most common allegations among LPNs/LVNs.
- The top allegation for LPNs/LVNs was medication administration errors at 25.4 percent. Medication administration errors ranked third for RNs at 19.7 percent.

3 Primary Allegation Classes by Nursing Licensure

RN		LPN/LVN	
Professional conduct	23.5%	Medication administration errors	25.4%
Improper treatment/care	21.1%	Abuse/patients' rights	22.4%
Medication administration errors	19.7%	Improper treatment/care	19.4%
Abuse/patients' rights	13.7%	Professional conduct	15.2%
Documentation error or omission	8.2%	Assessment	5.5%
Scope of practice	6.1%	Monitoring	4.9%
Assessment	5.1%	Documentation error or omission	4.2%
Monitoring	2.6%	Scope of practice	3.0%
Total	**100.0%**	**Total**	**100.0%**

The percentage indicated for RNs is based upon the 962 paid claims for RNs. The percentage for LPNs/LVNs is based upon the 165 paid claims for LPNs/LVNs.

Exhibits 4 through 7 provide additional information regarding the most frequent and severe allegation sub-categories. Note that the percentages are calculated based on the total paid claims by licensure type, with 962 closed claims for RNs and 165 closed claims for LPNs/LVNs.

ALLEGATIONS RELATED TO SUB-CATEGORY PROFESSIONAL CONDUCT

- Within the professional conduct category, drug diversion and/or substance abuse was the top allegation for both RNs and LPNs/LVNs.
- Drug diversion or substance abuse allegations included such acts as diverting medication for self or others, neglecting to document proper disposal of narcotics, inaccurate medication counts not reported/detected, and apparent intoxication from alcohol or drugs while on duty.
- Criminal acts involved shoplifting, driving under the influence and other off-duty conduct.
- Nursing professionals must recognize the stress factors that may lead to unprofessional conduct, and should be proactive in seeking support to manage challenging situations or circumstances.

4

Detailed View of Allegation Sub-category Related to Professional Conduct

RN		LPN/LVN	
Drug diversion and/or substance abuse	18.7%	Drug diversion and/or substance abuse	10.4%
Criminal act or conduct	2.4%	Other inappropriate behavior	2.4%
Suspended or revoked license	1.4%	Criminal act or conduct	1.8%
Other inappropriate behavior	1.0%	Professional misconduct as defined by the state	0.6%
Total	**23.5%**	**Total**	**15.2%**

The percentage indicated for RNs is based upon the 962 paid claims for RNs. The percentage for LPNs/LVNs is based upon the 165 paid claims for LPNs/LVNs.

ALLEGATIONS RELATED TO SUB-CATEGORY PATIENTS' RIGHTS AND PATIENT ABUSE

- Patients' rights and patient abuse allegations constituted 13.7 percent of total allegations for RNs and 22.4 percent for LPNs/LVNs.
- Physical abuse allegations ranked highest for both RNs at 4.7 percent and 12.1 percent for LPNs/LVNs.
- The ability to manage difficult patient situations is a core nursing competency. Developing communication and relationship skills for a diverse patient population qualifies as an essential risk control tool for nurses, minimizing exposure to allegations of abuse/violation of patients' rights.

5 Detailed View of Allegation Sub-category Related to Patients' Rights and Patient Abuse

RN		LPN/LVN	
Physical abuse	4.7%	Physical abuse	12.1%
Sexual abuse	2.5%	Violation of patients' rights	4.3%
Verbal abuse	2.2%	Verbal abuse	3.6%
Failure to provide a safe environment	1.6%	Confidentiality	1.2%
Violation of patients' rights	1.1%	Emotional abuse	0.6%
Confidentiality	0.8%	Sexual abuse	0.6%
Emotional abuse	0.4%	**Total**	**22.4%**
Inappropriate communication	0.4%		
Total	**13.7%**		

The percentage indicated for RNs is based upon the 962 paid claims for RNs. The percentage for LPNs/LVNs is based upon the 165 paid claims for LPNs/LVNs.

ALLEGATIONS RELATED TO SUB-CATEGORY IMPROPER TREATMENT AND CARE

- Allegations related to improper treatment and care were comparable for RNs and LPNs/LVNs. These allegations included failure to implement established treatment protocol, improper technique/negligently performed treatment, and abandonment of the patient.
- Allegations often reflect miscommunication or lack of communication with a physician or another nurse, or inadequate hand-off of a patient to another practitioner.
- Allegations for failure to implement established treatment protocols are effectively minimized when nurses ensure that they are fully conversant with facility policies and protocols.
- Another key risk control measure is to document any information shared with patients or other members of the care team.

6 Detailed View of Allegation Sub-category Related to Improper Treatment and Care

RN		LPN/LVN	
Failure to implement established treatment protocol	10.4%	Failure to implement established treatment protocol	7.9%
Improper technique/negligently performed treatment with injury	3.4%	Improper technique/negligently performed treatment with injury	2.4%
Abandonment of patient	1.9%	Abandonment of patient	2.4%
Failure to carry out physician orders for care and treatment	1.1%	Failure to carry out physician orders for care and treatment	1.2%
Failure to notify physician of patient's condition	0.8%	Failure to notify physician of patient's condition	1.2%
*All other	3.5%	Failure to respond timely to patient's concerns	1.2%
Total	**21.1%**	*All other	3.1%
		Total	**19.4%**

The percentage indicated for RNs is based upon the 962 paid claims for RNs. The percentage for LPNs/LVNs is based upon the 165 paid claims for LPNs/LVNs.

*"All other" includes allegations that individually represent less than 0.4 percent of the paid claims. These include failure to respond timely to patient's concerns, improper nursing management of patients in need of physical restraints, premature cessation of treatment and improper nursing management of a medical complication.

ALLEGATIONS RELATED TO SUB-CATEGORY MEDICATION ADMINISTRATION

- Medication administration issues represented 19.7 percent of RN paid claims and 25.4 percent of LPN/LVN paid claims.
- The specific allegations related to medication administration were similar for both groups but the percentage of errors differed significantly.

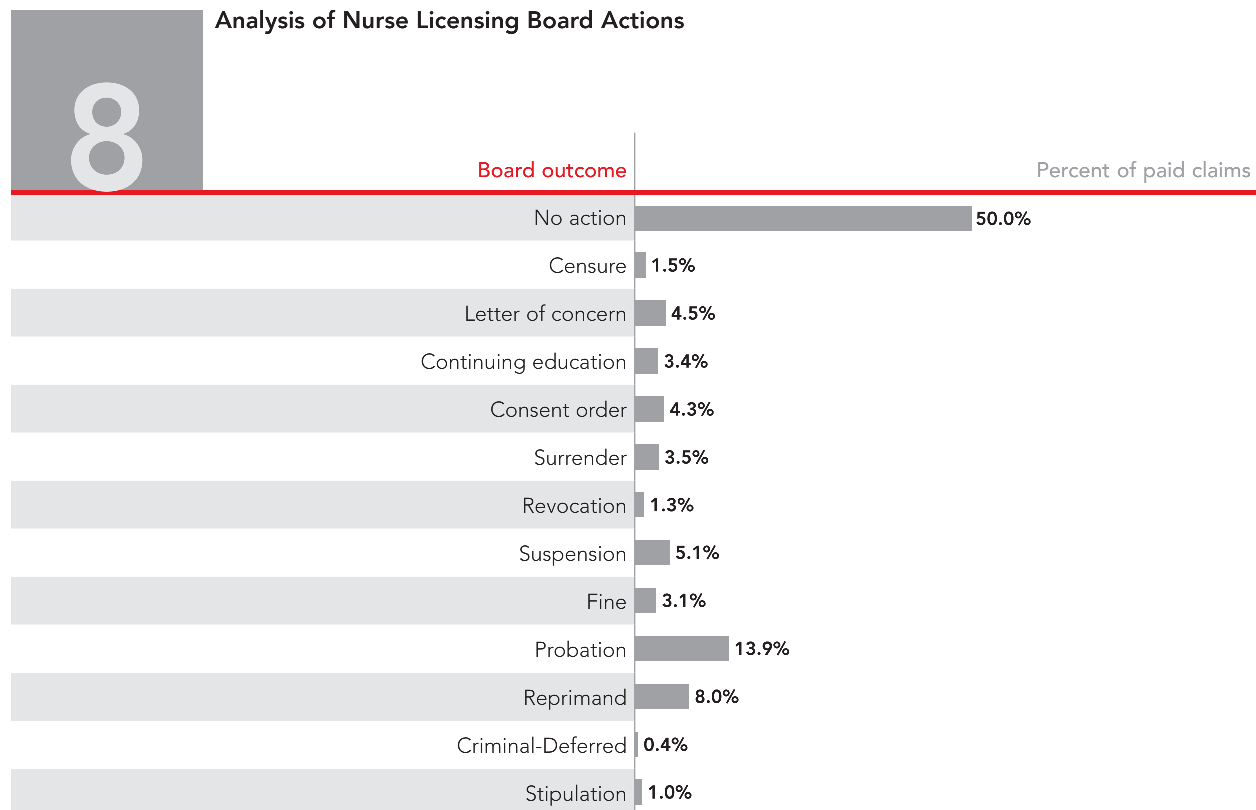
7 Detailed View of Allegation Sub-category Related to Medication Administration

RN		LPN/LVN	
Wrong Dose	3.0%	Wrong medication	5.6%
Improper technique	2.4%	Wrong route	3.6%
IV administration	1.8%	Missed dose	2.4%
Missed dose	1.5%	IV administration	1.8%
Wrong medication	1.5%	Failure to notify patient's physician	1.8%
Wrong/incorrect information provided or recorded	1.4%	Improper technique	1.8%
Failure to document medication administration	1.4%	Wrong/incorrect information provided or recorded	1.8%
All other	6.7%	Wrong patient	1.2%
Total	**19.7%**	Wrong time	1.2%
		Failure to immediately report/record improper administration of medication	1.2%
		Failure to document medication administration	1.2%
		All other	1.8%
		Total	**25.4%**

The percentage indicated for RNs is based upon the 962 paid claims for RNs. The percentage for LPNs/LVNs is based upon the 165 paid claims for LPNs/LVNs.

Licensing Board Actions

ANALYSIS OF NURSE LICENSING BOARD ACTIONS



Explanation of terms:

- Letter of concern – a communication from the Board of Nursing expressing concern that the nurse may have engaged in questionable conduct
- Consent order – a stipulation of a condition or conditions that must be met in order for the nurse to continue to practice
- Stipulation – a condition or limitation on the nurse's practice
- Censure – a public written reprimand regarding a violation of the Nurse Practice Act, which does not impose any conditions on the nurse's professional license
- Criminal-Deferred – a pending Board of Nursing action, awaiting the results of a criminal action against the nurse

Conclusion

Any complaint filed against a nursing license can have career-altering consequences, such as suspension, probation, license surrender or license revocation.

When considering board complaint outcomes for paid license defense claims, half the board's final decisions resulted in no action, while 45.2 of the outcomes involved monitoring the nurse's practice, requiring further education or issuing a caution. In addition, 4.8 percent of the decisions involved license surrender or revocation, terminating the careers of these nurses.

A nursing board complaint can be filed against a nursing license by a patient, patient's family member, colleague or employer. By knowing the most common types of allegations filed, nurses can identify their vulnerabilities and take appropriate action to protect their licenses. Effective risk control strategies include

- working to improve communication and interpersonal skills
- knowing and adhering closely to facility policies
- maintaining nursing skills/competencies through continuing education efforts
- ensuring thorough and accurate documentation in patient care records

Highlights from Nurses Service Organization's 2011 Qualitative Nurse Work Profile Survey

Part 3: Introduction

CNA and NSO are committed to providing nurses with useful information to assist them in caring for patients in a safe manner. In 2011, CNA and NSO conducted three separate studies in order to analyze nurse closed professional liability claims (Part I), review nurse license protection closed claims (Part II), and survey nurse insureds about a range of professional and risk issues (Part III).

Part III differs significantly from the closed claims analyses in Parts I and II, as it presents selected highlights from the Nurses Service Organization's 2011 Qualitative Nurse Work Profile Survey. (The complete results of the survey may be accessed on the NSO Web site at **www.nso.com/nurseclaimreport2011**.*) It reflects direct feedback from two subsets of our insured nurses – one group of nurses who had a claim filed against them, and a demographically similar group of insured nurses with no claims. Both groups of respondents electively opted to complete the 2011 NSO survey tool. (In this survey, the term *respondent* refers to those NSO-insured registered nurses, licensed practical nurses and licensed vocational nurses who voluntarily replied to the NSO survey.)

This survey was performed at the request of NSO insureds, the NSO's Nurses Advisory Board, professional nurse organizations and nurse educators who sought to compile data from nurses about issues that are not addressed by the analysis of closed claims. It should be noted that the findings in Part III are derived only from those nurses who responded to the 2011 NSO nurse survey, and do not reflect all NSO-insured nurses or all nurses in general.

The survey approach enabled us to compare several variables that influence professional liability exposure, including

- the effect of having a mentor/preceptor versus not having a mentor/preceptor
- the relationship between varying levels of continuing education credits and average paid indemnity amounts
- the results of interacting and not interacting with management when an incident occurs
- the consequences of differing nurse workplace policies and procedures regarding the disclosure of mistakes

NSO engaged Wolters Kluwer Health, Lippincott Williams & Wilkins to survey nurses on these and associated issues. The survey participants included registered nurses, licensed practical nurses and licensed vocational nurses who participated in the NSO insurance program between January 1, 2006 and December 31, 2010.

*Note that the numbering of the figures in Part III is not sequential because they have been excerpted from the full survey results posted on the NSO Web site in a somewhat different order.

Survey Background and Methodology

The purpose of this survey was to examine the relationship between professional liability exposure and a variety of demographic and workplace factors. To that end, the responding nurses were divided into two groups: those who had experienced a professional liability claim resulting in loss that had closed between 2006 and 2010, and those who had never experienced a claim.

Two similar survey instruments were distributed to NSO-insured nurses with and without claims. The first sample group consisted of 1,617 nurses who had a claim close between January 1, 2006 and December 31, 2010. The non-claims sample included a randomized sample of current insureds, approximately matching the demographic characteristics of the closed claims group.

The survey was available in both printed and online form. To ensure that nurses did not complete the survey twice, each nurse was sent either a printed or e-mailed invitation. Those receiving the printed version were informed that they could take the survey online, if they preferred, via an Internet link. Each survey was labeled with a unique identifier to prevent the possibility of duplication by any respondent.

Please note that the survey findings are based on self-reported information and thus may be skewed due to the respondents' personal perceptions and recollections of the requested information. The qualitative NSO survey results are not comparable to the quantitative CNA nurse closed claims data in Part I or the nurse license protection closed claims data in Part II, and are not representative of all NSO-insured nurse paid claims or nurse paid claims in general.

Summary of Survey Response Rates

	Claims			Non-claims		
	Print	Online	Total	Print	Online	Total
Initial sample size	1,003	614	1,617	975	6,500	7,475
Undeliverable/opt out	64	107	171	89	513	602
Usable sample	939	507	1,446	886	5,987	6,873
Number of respondents	222	72	294	101	719	820
Response rate	**24%**	**14%**	**20%**	**11%**	**12%**	**12%**

Within this document, results are based on overall responses for respondents both with and without claims. The margin of error at the 95 percent confidence level for the claims portion of the survey was ±5.2 percent. The margin of error for the non-claims portion was ±3.4 percent. In other words, we can be confident 95 percent of the time that percentages in the actual population would not vary by more than this percentage in either direction.

Some figures and narrative findings in Part III include a reference to the average paid indemnity of the respondents' closed claims. It is important to remember that *the average paid indemnity in this section reflects only those indemnity payments made on behalf of NSO-insured RNs and LPNs/LVNs who had a closed claim and who responded to the survey.* Therefore, average paid indemnity findings in Part III should not be compared with average paid indemnity findings in Part I.

Summary of Findings

- The longer respondents worked as nurses, the greater the number of claims. The highest percentage of closed claims involved respondents who had worked more than 21 years as a nurse. In addition, there was a correlation between the average paid indemnity and the number of years in the profession.
- Education contributed to the average paid indemnity amount. Indemnity payments were higher for claims from respondents who had completed a nursing diploma program than for respondents with a bachelor's or associate's degree.
- Respondents who did not have a mentor or preceptor during their first two years as a nurse experienced higher average paid indemnities than those who did.
- Continuing education was associated with decreased average paid indemnity. As the number of required credits for such programs increased, the average paid indemnity decreased.
- The existence of an organization/facility policy for disclosing mistakes resulted in a 50 percent decrease in the average paid indemnity. A quarter of respondents stated their facility did not have a policy in place for disclosing mistakes, and a third stated they did not know if such a policy existed.
- Average paid indemnity decreased when electronic medical records were used exclusively.
- Interaction with management was associated with decreased average paid indemnity. Respondents who noted they felt comfortable turning to management for help had a lower average paid indemnity than those who did not.

Topic 1: Respondent Demographics

NURSING LICENSURE

Although the percentage of registered nurse respondents was slightly higher in the claims group, the overall distribution of nursing licensures for respondents with claims and those without claims was similar.

1

Nursing Licensure
Q: Please indicate your current nursing licensure.

	Non-claims	Claims
Registered nurse	93.1%	94.9%
Licensed practical nurse/vocational nurse	6.9%	5.1%

YEARS AS A LICENSED NURSE

The majority (69.2 percent) of respondents with claims had been a licensed nurse for 21 years or more.

3

Years as a Licensed Nurse
How many years have you been a licensed nurse?

	Non-claims	Claims
Less than 1 year	11.0%	0.0%
1 to 2 years	7.3%	0.0%
3 to 5 years	13.8%	0.7%
6 to 10 years	11.0%	3.8%
11 to 15 years	9.3%	13.4%
16 to 20 years	7.4%	13.0%
21 years or more	40.2%	69.2%

GENDER

The two groups did not differ significantly in terms of gender.

4

Gender
Q: What is your gender?

	Non-claims	Claims
Female	92.9%	91.3%
Male	7.1%	8.7%

AGE

The data were weighted heavily toward nurses with claims who were 51 years or older (66.9 percent). This group comprised two-thirds of respondents with claims, compared with 41.3 percent of respondents without claims. Respondents under the age of 30 had rarely experienced a claim.

5

Age
Q: What is your age?

	Non-claims	Claims
30 years or younger	17.7%	0.3%
31 to 35 years	8.4%	2.4%
36 to 40 years	11.2%	5.9%
41 to 45 years	8.4%	9.7%
46 to 50 years	13.2%	14.8%
51 to 60 years	28.6%	37.2%
61 years or older	12.7%	29.7%

HIGHEST LEVEL OF EDUCATION

The two groups varied somewhat, but the highest proportion of respondents with claims earned bachelor degrees, followed by those with associate degrees, those from diploma programs, those with master's degrees and those with doctorate degrees.

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Highest Level of Education

Q: What is your highest level of education completed?

	Non-claims	Claims
Diploma program	12.9%	18.0%
Associate's degree	26.4%	31.1%
Bachelor's degree	45.8%	38.1%
Master's degree	13.6%	11.4%
Doctorate degree	1.3%	1.4%

LOCATION OF PRACTICE

Respondents who worked in suburban locations had significantly more claims (56.5 percent) than their non-claim counterparts (43.9 percent).

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Location of Practice

Q: Which of the following best describes the location of your practice?

	Non-claims	Claims
Suburban	43.9%	56.5%
Urban	36.2%	24.4%
Rural	19.9%	19.1%

Topic 2: Respondent Practice Profile

Practice profile findings include both the non-claims and claims percentages for each response and the average paid indemnity. The average paid indemnity reflects only the payments made on behalf of NSO-insured RNs and LPNs/LVNs who had a closed claim and who responded to the survey. Therefore, as noted earlier, average paid indemnity findings in Part III should not be compared to average paid indemnity findings in Part I of this document.

MENTOR OR PRECEPTOR

There was no difference between claims and non-claims respondents in terms of whether they had a mentor or preceptor during their first two years as a nurse. Respondents without a mentor or preceptor had a higher average paid indemnity.

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Mentor or Preceptor
Q: During your first two years of working as a nurse, did you have a mentor or preceptor?

	Non-claims	Claims	Average paid indemnity
Yes	51.0%	51.0%	$14,511
No	49.0%	49.0%	$26,301

POSITION OF MENTOR OR PRECEPTOR

Most respondents with a mentor/preceptor indicated that their mentor or preceptor was a nurse colleague/staff nurse. Respondents who had a nurse manager/director as a mentor experienced the highest average paid indemnity. Respondents mentored by a nurse practitioner (NP), clinical nurse specialist (CNS) or physician had the lowest average indemnity payments.

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Position of Mentor or Preceptor
Q: Who was the mentor or preceptor?

	Non-claims	Claims	Average paid indemnity
Nurse colleague/staff nurse	84.0%	84.1%	$17,554
Nurse manager/director	9.3%	8.5%	$22,647
Nurse practitioner/clinical nurse specialist	4.7%	3.7%	$14,467
Physician	2.0%	3.7%	$14,292

NUMBER OF ANNUAL CONTINUING EDUCATION (CE) CREDITS REQUIRED

While each state mandates its own required number of annual CE credits, about 8 percent more respondents with claims (38.2 percent) reported needing 30 to 60 credits annually to retain their nursing licensure, compared with those without claims. Importantly, as the total number of required CE credits increased, the average paid indemnity decreased.

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Number of Annual CE Credits Required
Q: According to your State Licensing Board, how many CE credits are you required to complete annually to retain your nursing licensure?

	Non-claims	Claims	Average paid indemnity
None	28.0%	21.4%	$24,851
Less than 30	41.9%	40.2%	$17,491
30 to 60	30.1%	38.2%	$15,623

Topic 3: Information About the Claim Submitted

YEARS OF PRACTICE AT TIME OF INCIDENT

The majority of respondents with claims had engaged in nursing practice for 16 or more years at the time of the incident that resulted in a claim.

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Years of Practice at Time of Incident
Q: At the time of the incident, how many years had you practiced nursing?

	Claims	Average paid indemnity
Less than 1 year	0.4%	$5,631
1 to 2 years	3.3%	$7,048
3 to 5 years	5.4%	$11,456
6 to 10 years	12.3%	$16,602
11 to 15 years	9.4%	$19,994
16 to 20 years	22.5%	$19,947
21 years or more	46.7%	$16,938

YEARS IN POSITION AT TIME OF INCIDENT

At the time of the incident, 45.8 percent of respondents had held their position for three to 10 years. Respondents who had been in their position less than one year experienced the lowest average paid indemnity. Average paid indemnity rose for respondents working in their position three to five years and peaked for those who had served in their position 11 to 15 years.

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Years in Position at Time of Incident
Q: At the time of the incident, how many years had you worked in this particular position?

	Claims	Average paid indemnity
Less than 1 year	6.5%	$12,490
1 to 2 years	12.7%	$17,554
3 to 5 years	22.9%	$26,900
6 to 10 years	22.9%	$15,120
11 to 15 years	12.7%	$27,977
16 to 20 years	10.9%	$21,310
21 years or more	11.3%	$18,049

CERTIFICATION IN PRACTICING SPECIALTY

More than half of the respondents who experienced claims did not have certification in their practicing specialty. Those nurses who were certified in their practicing specialty experienced higher average indemnity payments. Generally, nurses who were unclear about their specialty status were in practice for less than a year.

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Certification in Practicing Specialty
Claims Q: At the time of the incident, were you certified in the specialty area in which you were practicing?
Non-claims Q: Are you certified in the specialty area in which you are currently practicing?

	Non-claims	Claims	Average paid indemnity
Yes	37.3%	41.9%	$23,082
No	59.8%	53.3%	$16,249
Specialty certification status unclear	2.9%	4.8%	$23,741

WORKING WITHIN TRAINED ABILITY

Nearly all respondents who had experienced a claim believed they were fully trained in the patient care services they were providing when the incident occurred. Respondents who believed they were fully trained to work within their specialty had the highest average paid indemnity.

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Working Within Trained Ability
Q: Were you providing services in an area where you believe you were fully trained to provide clinical services?

	Claims	Average paid indemnity
Yes	91.3%	$21,747
No	7.3%	$15,796
Training level unclear	1.4%	$16,506

PRACTICING OUTSIDE OF SCOPE

Only 3.6 percent of respondents with claims believed they were working outside their scope of practice at the time of the incident, or were not sure. Most respondents – especially those who had experienced a claim – believed they were working within their scope of practice.

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Practice Outside of Scope
Claims Q: Were you working outside of your scope of practice?
Non-claims Q: Do you ever work outside of your scope of practice?

	Non-claims	Claims	Average paid indemnity
Yes	7.1%	1.4%	$8,178
No	90.0%	96.4%	$21,801
Not sure	2.9%	2.2%	$7,057

AWARENESS OF WORKING OUTSIDE OF SCOPE OF PRACTICE

Nearly two-thirds (63.7 percent) of respondents who experienced claims were not aware they were practicing outside of their scope of practice. These respondents also experienced the highest average paid indemnity. Respondents who were not sure whether they were practicing outside of their scope of practice experienced the lowest average paid indemnity.

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Awareness of Practicing Outside of Scope
Q: Did you know you were working outside of your scope of practice?

	Claims	Average paid indemnity
Yes	1.7%	$10,583
No	63.7%	$24,012
Not sure	34.6%	$9,719

AWARENESS OF WORKING OUTSIDE OF FACILITY POLICY

More than 70 percent of respondents who experienced claims were not aware they were working outside of facility policy, and their claims resulted in the highest average paid indemnity. Only 1.6 percent of respondents reported they knew they were working outside of facility policy, and their claims had the lowest average paid indemnity.

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Awareness of Working Outside of Facility Policy
Q: Did you know you were working outside of your facility's policies?

	Claims	Average paid indemnity
Yes	1.6%	$8,604
No	70.3%	$22,803
Not sure	28.1%	$12,110

POLICY ON DISCLOSURE OF MISTAKES

One-quarter of nurses surveyed who experienced claims responded that their facility had no policy for disclosing mistakes. These respondents had the highest average paid indemnity. More importantly, respondents working in a facility where such a policy was in place had average indemnity payments that were 50 percent lower.

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Policy on Disclosure of Mistakes
Claims Q: At the time of the incident, did your employer have a policy regarding disclosure of mistakes?
Non-claims Q: Does your employer have a policy regarding the disclosure of mistakes?

	Non-claims	Claims	Average paid indemnity
Yes	63.6%	42.2%	$17,255
No	11.1%	25.7%	$34,707
Not sure	25.3%	32.1%	$16,204

Topic 4: Facility Profile When Claim Was Submitted

TYPE OF MEDICAL RECORDS

While use of electronic medical records is increasing, the majority of respondents who experienced claims used handwritten records at the time of the incident. One respondent answered that no type of medical record had been created at the time of the incident.

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Type of Medical Record
Q: At the time of the incident, did your facility:

	Non-claims	Claims	Average paid indemnity
Use handwritten records	18.0%	64.6%	$23,585
Use a combination	49.4%	25.3%	$16,836
Use electronic records	28.3%	9.1%	$12,726
Other	4.3%	1.1%	$39,544

Respondents were directed to indicate the type of patient records utilized in their workplace.

CONTACTING MANAGEMENT FOR HELP

Most respondents indicated they invoked the chain of command to obtain management help when experiencing a problem. This action significantly lowered the average paid indemnity. Those who responded that they were afraid to contact management concerning the incident had the highest average paid indemnity.

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Contacting Management for Help
Q: Describe your level of interaction with your manager/supervisor when you experienced a problem at work. In other words, did you feel comfortable asking for help?

	Non-claims	Claims	Average paid indemnity
No, I was afraid to contact management	5.7%	3.1%	$42,276
No, I did not contact management	8.3%	8.8%	$16,735
Yes, I used the chain of command	86.0%	88.2%	$15,181

For More Information

The entire NSO 2011 nurse survey may be viewed at **www.nso.com/nurseclaimreport2011**. For additional information, please contact NSO at 1-800-247-1500.

In addition to this publication, CNA HealthPro has produced numerous studies and articles that provide useful risk control information on topics relevant to nurses. These publications are available by contacting CNA HealthPro at 1-888-600-4776 or at **www.cna.com**. Nurses Service Organization (NSO) also maintains a variety of online materials for nurses, including nurse survey results, articles, and useful clinical and risk control resources, as well as information relating to nurse professional liability insurance, at **www.nso.com**.

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