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Nurse Professional Liability Exposures: 2015 Claim Report Executive Summary

A COMPARATIVE ANALYSIS FROM
CNA AND NURSES SERVICE ORGANIZATION

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PART 1 Nurse Professional Liability Exposures

CNA Five-year Closed Claims Analysis (January 1, 2010-December 31, 2014) and Risk Control Self-assessment for Nurses

Introduction

For over 30 years, CNA and our business partners at Nurses Service Organization (NSO) have been committed to helping nurses insure themselves against loss by providing specialized insurance coverage and working to enhance their risk awareness. Our joint professional program is the nation's largest underwriter of professional liability insurance for individual nursing professionals, with more than 550,000 policies in force.

Executive Summary

In collaboration with NSO, we are pleased to provide readers with an executive summary taken from our third report on nurses' risk exposures. This executive summary provides a brief glimpse of closed claims analysis regarding:

- Nurse specialties
- Healthcare delivery setting
- Allegations against the nurse
- Patients' injuries associated with the claim
- License defense paid claims
- Highlights from NSO's 2015 Qualitative Nurse Work Profile Survey

This summary provides selected findings from the 2015 nurse closed claim report and the reader will notice that charts are not numbered consecutively. To review the results of the complete report and all the accompanying charts visit www.cna.com/healthcare and www.nso.com.

Database and Methodology

The report includes only those CNA professional liability closed claims that:

- Involved a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN).
- Closed between January 1, 2010 and December 31, 2014 (although they may have been reported earlier).
- Resulted in an indemnity payment of $10,000 or greater.

These inclusion criteria were applied to 10,639 reported adverse incidents and claims that closed during the designated time period. The final primary database comprises 549 nurse closed claims, which were subsequently reviewed and analyzed.

In addition to the primary dataset of claims that closed from January 1, 2010 to December 31, 2014 (the 2015 dataset), a dataset consisting of claims that closed between January 1, 2006 and December 31, 2010 (the 2011 dataset) was utilized in this report to draw comparisons and identify trends. Since both of these datasets include closed claims from 2010, it is important to note that the two datasets are not fully independent. Nevertheless, by comparing the two datasets we can see how the average paid indemnity amounts associated with various claim characteristics are changing over time and better identify patterns in nurse claim activity and litigation. The 2011 dataset includes 516 professional liability claims, while the 2015 dataset includes 549 professional liability claims.

As this report has unique data inclusion criteria, readers should exercise caution about comparing the findings with similar publications from other sources.

Data Analysis

Analysis of claims by licensure type

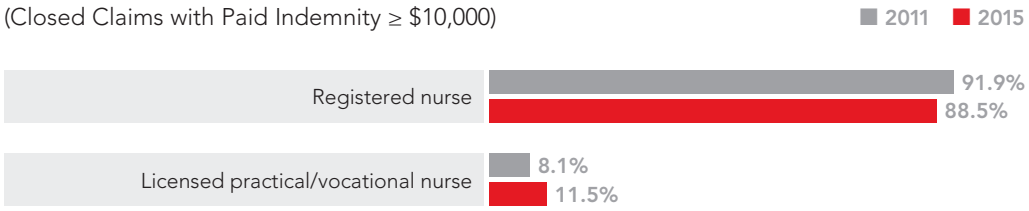
1A CLOSED CLAIMS BY NURSE LICENSURE TYPE

(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	88.5%	$80,428,847	$165,491	$36,424	$201,916
Licensed practical/ vocational nurse	11.5%	$9,928,686	$157,598	$42,173	$199,771
Overall	100.0%	$90,357,533	$164,586	$37,084	$201,670

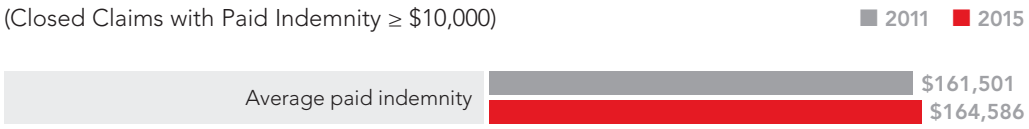
1B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY NURSE LICENSURE TYPE

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



4B COMPARISON OF 2011 AND 2015 AVERAGE PAID INDEMNITY

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



Analysis of severity by nurse specialty

The adult medical/surgical specialty continues to represent the highest percentage of closed claims. However, as predicted in the 2011 claim report, claim frequency has increased in non-hospital-based specialties such as home health/hospice.

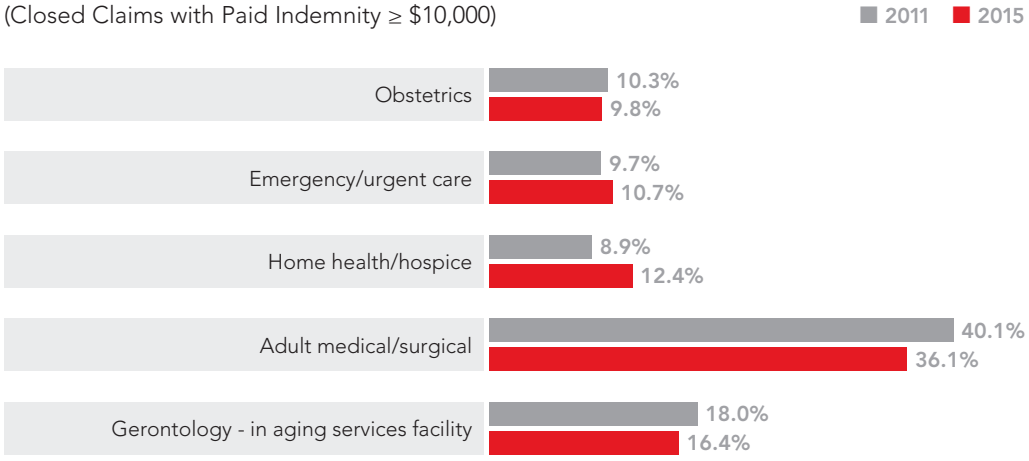
5A SEVERITY BY NURSE SPECIALTY

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

Nurse specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Neurology/neurosurgery	0.4%	$1,077,000	$538,500
Occupational/employee health	0.4%	$827,980	$413,990
Obstetrics	9.8%	$21,441,467	$397,064
Neonatal/nursery - well baby	1.1%	$1,325,000	$220,833
Plastic/reconstructive surgery	1.6%	$1,752,332	$194,704
Emergency/urgent care	10.7%	$10,750,689	$182,215
Home health/hospice	12.4%	$11,794,067	$173,442
Pediatric/adolescent	2.0%	$1,710,250	$155,477
Behavioral health	2.4%	$1,850,249	$142,327
Adult medical/surgical	36.1%	$27,392,453	$138,346
Wound care in an office setting	0.7%	$435,250	$108,813
Gerontology - in aging services facility	16.4%	$7,736,782	$85,964
Correctional health	3.6%	$1,501,639	$75,082
Aesthetic/cosmetic	2.4%	$762,375	$58,644
Overall	100.00%	$90,357,533	$164,586

5B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY NURSE SPECIALTY

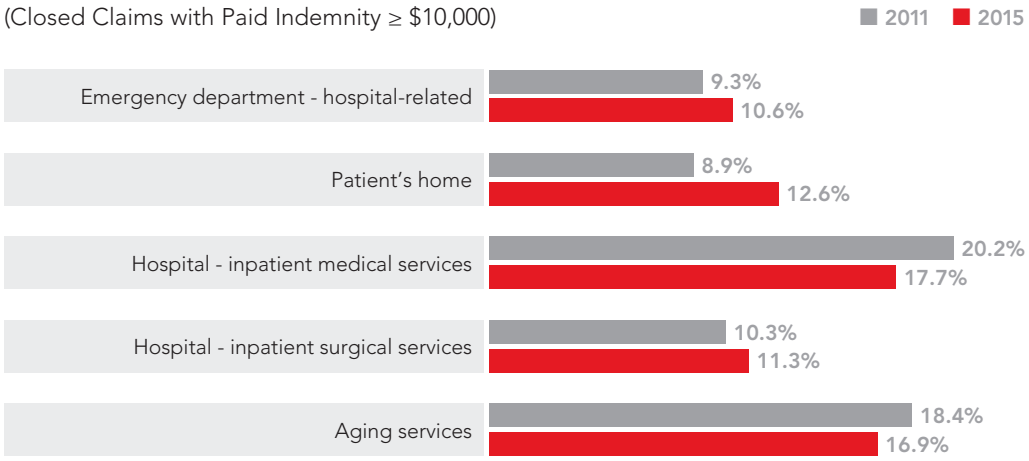
(Closed Claims with Paid Indemnity ≥ $10,000)



Analysis of severity by location

Figure 6B contains the highest percentage of distribution of closed claims by location from the 2011 and 2015 closed claim reports.

6B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY LOCATION
(Closed Claims with Paid Indemnity ≥ $10,000)



Analysis of Severity by Allegation

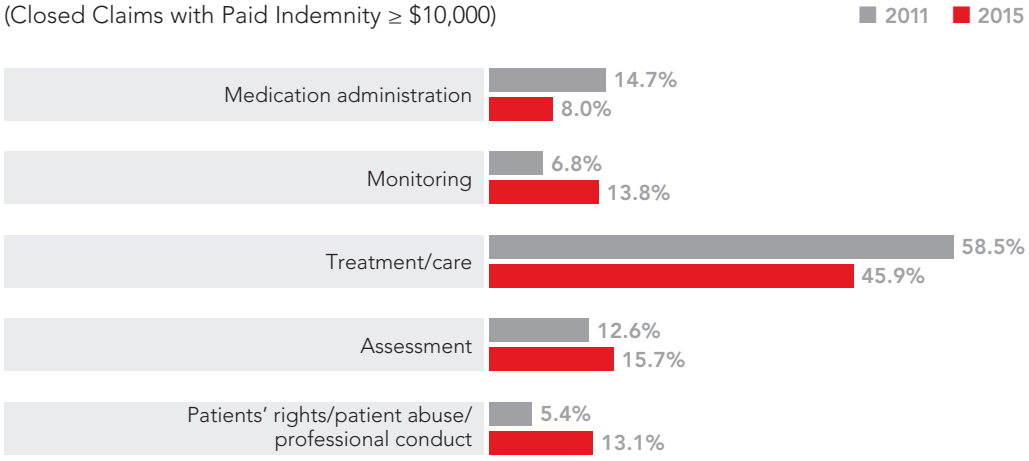
Allegation by category

Figures 7A and 7B contain the average and total paid indemnities for all allegation categories.

7A SEVERITY BY ALLEGATION CATEGORY
(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Medication administration	8.0%	$9,372,227	$213,005
Monitoring	13.8%	$13,977,772	$183,918
Treatment/care	45.9%	$45,053,823	$178,785
Scope of practice	2.9%	$2,458,777	$153,674
Assessment	15.7%	$11,099,510	$129,064
Documentation	0.5%	$368,334	$122,778
Patients' rights/patient abuse/ professional conduct	13.1%	$8,027,090	$111,487
Overall	100.0%	$90,357,533	$164,586

7B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY ALLEGATIONS
(Closed Claims with Paid Indemnity ≥ $10,000)



Analysis of Allegation Sub-categories

Allegations related to assessment

Most of the assessment-related closed claims involve a failure to asses the need for medical intervention. These closed claims often involve nurses failing to identify the worsening of a pressure ulcer or contact the treating practitioner for additional medical treatment.

Allegations related to monitoring

Failure to monitor and timely report patient vital signs represents the highest severity in the monitoring sub-category, including two claims that closed at policy limits. Closed claims included nurses who failed to monitor vital signs after patients returned from surgery.

Allegations related to treatment and care

Allegations related to treatment and care continue to represent the highest percentage of closed claims. Claims in this category occur in all specialties and locations, but the highest percentage of closed claims involve adult/medical surgical, gerontology, home health/hospice and obstetrics.

Allegations related to medication administration

The percentage of closed claims involving medication administration has declined by half since the 2011 claim report, while severity has approximately doubled. This decrease in frequency correlates with recent technological advances and error-reduction initiatives, such as bar-coding of medications and computerized order entry.

Allegations related to patients' rights, patient abuse and professional conduct

Many of the closed claims in the patients' rights/patient abuse/professional conduct category involve falls, which occurred because a nurse failed to follow fall-prevention policies polices, thereby violating the patient's right to a safe environment.

Analysis of Severity by Injury

- The review of claims in this report reveals that comas, which were often due to medication administration errors, have the highest severity among patient injuries. The high severity reflects the lifelong medical cost for patients in a persistent vegetative state who require 24-hour nursing care.
- Death (other than maternal or fetal) is the most common injury, accounting for 42.8 percent of the closed claims. When maternal and fetal mortality are included, 44.3 percent of all closed claims involve a patient death.
- Seizures have the second highest severity. Closed claims in this category involve allegations of failure to properly complete a patient assessment, invoke the medical chain of command and monitor/report changes in the patient's condition.

13 SEVERITY BY INJURY

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

To view the full listing of severity by injury, see the full report at www.cna.com/healthcare and www.nso.com.

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Coma	0.5%	$1,862,500	$620,833
Seizure	0.7%	$2,300,000	$575,000
Neurological deficit/damage	1.3%	$3,874,792	$553,542
Fetal/infant birth-related brain injury	5.3%	$14,638,551	$504,778
Maternal death	0.4%	$900,000	$450,000
Spinal pain/injury - cervical spine and neck	0.2%	$375,000	$375,000
Brain injury other than birth-related	1.8%	$3,629,167	$362,917
Paralysis	1.8%	$3,464,701	$346,470
Cerebrovascular accident (CVA)/stroke	1.3%	$2,355,064	$336,438
Bleeding/hemorrhage	0.7%	$1,261,250	$315,313
Cardiopulmonary arrest	1.6%	$2,429,001	$269,889
Fetal death	1.1%	$1,592,450	$265,408
Loss of limb or use of limb	4.4%	$5,364,333	$223,514
Death (other than maternal or fetal)	42.8%	$32,649,771	$138,935
Head injury	0.7%	$475,000	$118,750

Conclusion

The first step in the process of protecting patients and reducing liability exposure is to learn about the risks that confront today's nurses. The claims data and analysis contained in this resource are presented in an effort to inspire nurses nationwide to examine their practice, dedicate themselves to patient safety, and direct risk control efforts toward areas of statistically demonstrated error and loss.

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

Claim Scenario: Successful Defense of a Nurse

It is CNA's claim policy to pay covered claims involving actual liability fairly and promptly, while aggressively defending unsubstantiated claims. The following claim scenario demonstrates our aggressive defense of a CNA/NSO-insured nurse, which succeeded despite the seriousness of the patient's injuries, including pain, suffering and death.

A registered nurse with 19 years of experience as an emergency nurse (including 15 as a certified emergency nurse) was working in the triage area of the emergency department. A 34-year-old female patient was sent to the emergency department from the local dialysis clinic to have her hemodialysis catheter, which was bleeding around the insertion area, examined by the emergency department practitioner. The patient was accompanied by her mother and son, who appeared to be about 10 years old. The nurse noted in the triage portion of the medical record that the patient appeared ill and disheveled, and she allowed her mother to answer all the medical questions.

During the 15-minute triage process, the nurse noted that the patient's vital signs were normal, she had plus 2 pitting edema in her lower extremities and her catheter seemed intact with a small amount of dried blood, but no active bleeding at the insertion site. On a five-level emergency department triage scale, the nurse rated the patient as a "3-urgent," meaning that the patient should be seen by a practitioner within 15 to 60 minutes following triage. As there were no available beds in the treatment area of the emergency department, the nurse asked the patient and her family to take a seat near the triage area to facilitate monitoring.

Shortly after the nurse performed the triage on the patient, she was relieved for her lunch break. She gave a report to the new nurse on all the patients in the waiting area, advising him that the last patient she triaged should be the next patient to be taken to an available treatment bed. Thirty minutes later, the CNA-insured nurse arrived back at the triage area and noticed that the patient was still in the waiting area. The nurse re-evaluated the patient per hospital protocol, noting that the patient's status remained unchanged.

Ninety minutes after her initial triage, the patient was taken to the emergency department treatment area. The nurse had no additional contact with the patient. The patient was examined by the emergency department practitioner and had sutures placed around the catheter site. She was discharged home moments after the sutures were completed and told to follow up with the dialysis clinic the next day.

The next morning, the patient was found unresponsive and pronounced dead.

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 not triaging the patient at a higher acuity level. The case against the nurse was defended successfully at trial, with the jury determining that the nurse was not responsible for the patient's untimely death.

The claim took four years and more than $165,000 in expenses to resolve. While it may have been less expensive to settle the claim, the nurse's proper care of the patient and complete documentation made an aggressive defense not only possible, but ultimately successful.

Risk Control Self-assessment Checklist for Nurses

Scope of Practice	Yes	No	Actions needed to reduce risks
I read my nurse practice act at least annually to ensure that I understand the legal scope of practice in my state.			
If a job description, contract, or set of policies and procedures appears to violate my state's laws and regulations, I bring this discrepancy to the organization's attention and refuse to practice in violation of these laws and regulations.			
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 or legal department regarding patient and practice issues, if necessary.			
If necessary, I contact the board of nursing and request an opinion or position statement on nursing practice issues.			
If necessary, I use the chain of command or the legal department regarding patient care or practice issues.			

Patient Safety: Falls	Yes	No	Actions needed to reduce risks
I evaluate every patient for risk of falling, utilizing a fall-assessment tool that considers the following factors, among others: - Previous fall history and associated injuries. - Gait and balance disturbances. - Foot and leg problems. - Reduced vision. - Medical conditions and disabilities. - Cognitive impairment. - Bowel and bladder dysfunction. - Special toileting requirements. - Use of both prescription and over-the-counter medications. - Need for mechanical and/or human assistance. - Environmental hazards.			
I identify higher-risk patients, including those who experience recurrent falls or have multiple risk factors.			
For home health/hospice patients, I conduct a home safety check prior to commencement of services.			
If I detect safety problems in the home, I recommend that corrective actions be taken as part of the patient service agreement.			
I regularly assess patients and modify the health record in response to changes in their condition.			
I inform patients and families of salient risk factors, as well as basic safety strategies.			
I document all assessment findings and incorporate them into the patient service plan.			
I document the patient's condition at each visit, and also: - Report any changes to the supervisor and family in a clear and timely manner. - Perform frequent home safety checks, as appropriate. - Reinforce fall-reduction tactics with patients and family. - Encourage patients to ask for assistance with risky tasks. - Keep accurate, detailed records of patient encounters.			
After a fall, I offer emotional support to the patent and the caregiver			
I review patient falls for quality assurance purposes, including analysis of root causes and tracking of trend.			

Patient Safety: Falls (continued)	Yes	No	Actions needed to reduce risks
I perform post-fall analysis, describing the circumstances of the fall and also: - Identifying major causal factors, both personal and environmental. - Indicating the patient's functional status before and after the fall. - Noting medical comorbidities. - Listing witnesses to the fall. - Intervening to prevent or mitigate future falls.			
I conduct a thorough post-fall analysis and incorporate findings into quality assurance and/or incident reporting programs.			

Patient Safety: Medication	Yes	No	Actions needed to reduce risks
I complete a patient drug history, including current prescription medications; over-the-counter drugs and supplements; alternative therapies; and alcohol, tobacco and illicit drug use.			
I utilize electronic or hard-copy medication profiles when readily available at the point of care.			
I review allergy notations on medication profiles prior to administering any medications.			
I record patient's weight and height measurements in metric units to avoid possible confusion.			
I review laboratory values and diagnostic reports prior to administering medications, and make practitioners aware of any abnormalities.			
I utilize machine-readable coding to check patient identity and drug data prior to administration of drugs or, if this is not possible, I verify patient identity using two patient identifiers (such as patient ID number and birthdate) from the original prescription.			
I document simultaneously with medication administration to prevent critical gaps or oversights.			
I utilize only medication containers prepared in advance, ensuring that intravenous and oral syringes, vials, bowls and basins are appropriately labeled with the name of the patient and the drug's name, strength and dosage.			
I store unit doses of medications in packaged form up to the point of handoff/administration, in order to facilitate a final check of the medication administration record.			
I accept verbal drug orders from practitioners only during emergencies or sterile procedures, and before transcribing the order, I read it back to the prescriber and document the read-back for verification.			
I communicate potential drug side effects at points of transition and document them on accompanying patient care plans and/or handoff reports.			
I include patients in the handoff dialogue, when possible, in order to prevent errors, reinforce their awareness of the medication regimen and strengthen post-discharge compliance.			
I follow procedures to prevent wrong dosages or concentrations of identified high-alert drugs (e.g., anti-coagulants, muscle relaxants, insulin, potassium chloride, opioids, adrenergic agents, dextrose solutions and chemotherapeutic agents).			
I ensure that high-alert medications are always accompanied by standardized orders and/or computerized safe-dosing guidelines, and are verified by two persons before administration.			
I ensure that pediatric medications are accompanied by standardized orders and/or computerized dosing guidelines.			
I follow my employer's guidelines for both adult and pediatric patients' dosages, formulations and concentrations of drugs.			
I seek out education about minimizing the risks associated with look-alike and sound-alike products, and I document my training.			
I follow my employer's policies and procedures to keep drugs with look-alike and sound-alike names separate.			
I receive notification when medication stock is relocated or storage areas are reorganized, in order to reduce the likelihood of confusion or error.			
I have pharmacists available on-site or by telephone to consult regarding prescribed medications.			

PART 2 Nurses Service Organization's Analysis of License Protection Paid Claims

(January 1, 2010-December 31, 2014)

Introduction

An action taken against a nurse's license to practice differs from a professional liability claim in that it may or may not involve allegations related to patient care and treatment. In addition, license protection claims involve only the cost of providing legal representation to defend the nurse before a regulatory or licensing board, whereas professional liability claims also may include an indemnity payment.

License Defense Paid Claims

License defense paid claims involving medical or non-medical allegations made to a regulatory or licensing body have increased 15.4 percent since the 2011 claim report, which had 1,127 license defense paid claims. While the cost of defending a license protection claim is typically less than that associated with resolving a professional liability claim, the consequences for the nurse can be severe.

Analysis of claims by licensure type

The percentage of license defense paid claims correlates to the proportion of RNs and LPNs/LVNs within the overall CNA/NSO-insured nurse population. Total paid increased by 37.3 percent since the prior report, and the average payment for a license protection closed claim increased by 18.9 percent.

1 LICENSE DEFENSE PAID CLAIMS BY LICENSURE TYPE

License type	RN	LPN/LVN	Total
License defense paid claims	1,127	174	1,301
Percentage of defense actions by license type	86.6%	13.4%	100.0%
Total payments	$4,554,539	$634,445	$5,188,984
Average payment	$4,041	$3,646	$3,988

Analysis of claims by allegation class

Additional review of allegation sub-categories can be found in the full report.

- For RNs, professional conduct complaints account for the highest percentage of license defense claims, at 24.2 percent of all allegations. Such complaints include professional misconduct for a nursing professional as defined by state statute, criminal acts/behaviors and substance abuse, including drug diversion while on duty and driving under the influence while off duty.
- For LPNs/LVNs, medication administration errors and improper treatment and care account for the highest percentage of license defense paid claims.

3 PRIMARY ALLEGATION CLASSES BY NURSING LICENSURE

Note: The percentages indicated for RNs are based upon the 1,127 paid claims for RNs. The percentages for LPNs/LVNs are based upon the 174 paid claims for LPNs/LVNs.

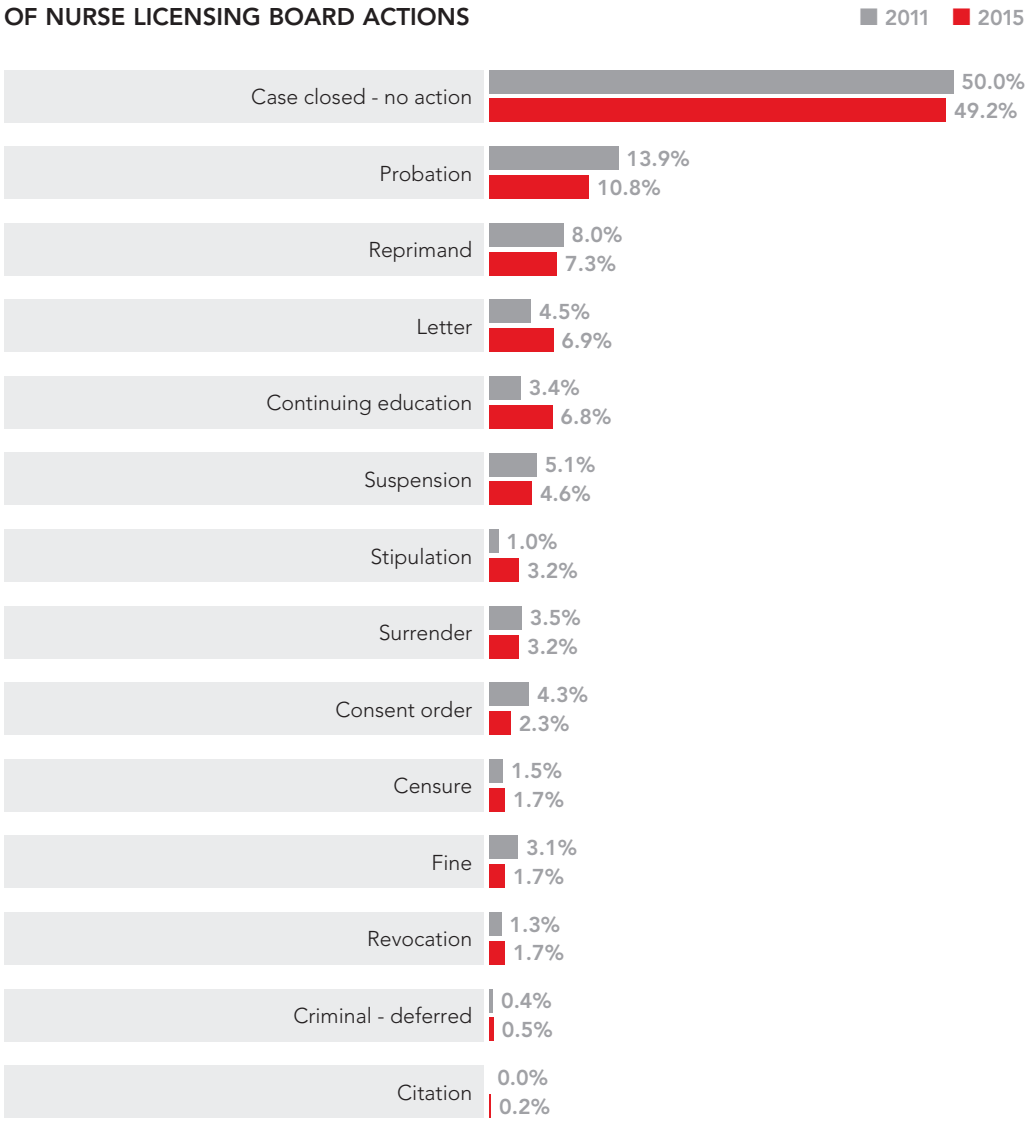
	RN
Professional conduct	24.2%
Medication administration	18.6%
Improper treatment/care	18.5%
Patients' rights/patient abuse	11.0%
Scope of practice	9.4%
Documentation error or omission	9.1%
Assessment	5.0%
Monitoring	4.0%
Breach of confidentiality	0.1%
Total	100.0%

	LPN/LVN
Medication administration	22.4%
Improper treatment/care	22.4%
Patients' rights/patient abuse	21.3%
Professional conduct	12.6%
Assessment	6.3%
Scope of practice	6.3%
Documentation error or omission	4.6%
Monitoring	4.0%
Total	100.0%

Licensing Board Actions

Comparison of 2011 and 2015 distribution of licensing board actions

9 COMPARISON OF 2011 AND 2015 DISTRIBUTION OF NURSE LICENSING BOARD ACTIONS



Conclusion

A board complaint can be filed against a nurse by a patient, patient's family member or employer. Once filed, a license complaint takes an average of two years to achieve resolution, and can have career-altering consequences. In 4.9 percent of the cases in the dataset, the nurse's license was either surrendered or revoked, effectively ending the individual's nursing career.

PART 3 Highlights from Nurses Service Organization's 2015 Qualitative Nurse Work Profile Survey

Introduction

CNA and NSO are committed to informing nurses of the risks they may encounter in their daily practice. This section of the report presents selected highlights from the NSO 2015 Qualitative Nurse Work Profile Survey, which examines nurses' professional liability closed claims in relation to various demographic factors and workplace.

Summary of Findings

Origin of training

Nurses trained outside of the United States are more likely to experience a claim than nurses trained in the United States. However, the average paid indemnity for this group is about one half the average indemnity of those trained domestically.

Managing of technology and time

While technology is intended to drive efficiency, 69.1 percent of those experiencing a claim noted that it takes more time to manage the technology system.

Usage of electronic patient notes

Respondents who reported that patient notes were unnoticed or underutilized had a higher level of liability, with 41.5 percent of this group having experienced a claim.

Access to evidence-based data

Evidence-based practice is becoming the standard for patient care. Those who lacked access to evidence-based information had an average indemnity payment 66 percent higher than those who had access to this information at their place of employment.

Staff development opportunities

Offering development opportunities to staff has a positive effect on liability claims and payments. Under-trained nurses have a higher likelihood of experiencing a claim.

Rapid response team

Nurses at organizations without a rapid response team were more likely to experience a claim. This group also experienced the highest average payment.

The complete results of the survey may be accessed on the NSO website at www.nso.com/nurseclaimreport2015.*

Topic 3: About the Claim Submitted

Years in practice at the time of the incident

Nurses who have been in practice for 11 years or longer are most likely to experience a closed claim.

29 YEARS IN PRACTICE AT THE TIME OF THE INCIDENT

Q: At the time of the incident, how many years have/had you practiced nursing?

	Claims	Average paid indemnity
Less than 1 year	1.7%	$3,921
1 to 2 years	0.8%	$343
3 to 5 years	6.6%	$12,220
6 to 10 years	11.6%	$21,050
11 to 15 years	11.6%	$48,627
16 to 20 years	21.5%	$21,592
21 years or more	46.3%	$53,752

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