

nso *Risk Advisor*

For Nurse Practitioners.....

WHAT'S INSIDE

Retail clinics bring new opportunities—and risks

The next time you're at a Target store, CVS pharmacy, or Cub Foods store, take a good look around. You may find a medical clinic, along with the merchandise.

In 2002, a firm called MinuteClinic began launching mini practices in suburban retail stores near Minneapolis and several other cities. Since then, at least half a dozen eager competitors, including Aurora Quick Care, Take Care Health Systems and QuickClinic, have either joined the party or plan to during 2006.¹ Currently, California, Indiana, Oregon, Maryland and Wisconsin, as well as Minnesota, are among the states in which in-store clinics can be found, and in Arkansas, Wal-Mart is testing a clinic in one of its stores.

The bare-bones clinics usually have no waiting rooms or support staff. They also have no on-site physicians. Instead, nurse practitioners are hired to diagnose and treat patients. Using practice guidelines and treatment protocols, available on computer software, the NPs address a limited range of common ailments, such as ear or bladder infections, flu and strep throat. The NPs give routine vaccinations, conduct basic lab tests, and run simple screens like those for diabetes or cholesterol. They handle all office chores, from greeting patients and taking their histories to collecting fees. An off-site physician supervises them in states where supervision is required, and is available for consultation as needed. When patients present with problems

beyond the practice's scope, the NPs refer them to primary care practitioners (PCPs).

The speedy care and convenience attract plenty of business. Most visits last no more than 15 minutes, and patients can walk in without an appointment.



Reduced costs add appeal; many local health plans cover clinic visits, so patients often are responsible for only a co-pay.

For NPs, rewards and risks

This growing trend offers some enticing benefits to NPs, such as a flexible work schedule and more autonomy, including the opportunity to manage the business aspects of their own practices. Moreover,

they're presented as key players in primary care, rather than as support staff for physicians. So they can enjoy more visibility and potentially earn greater respect as patients learn that NPs are skilled and knowledgeable providers.

The benefits come with an equal measure of risk. With limited time for diagnosis and assessment, NPs may miss a sign or symptom, resulting in a misdiagnosis. The clinics attempt to ensure quality of care by providing the patient's PCP with information about the visit (or by helping the patient without a PCP to find one), but patients do not always follow up in a timely fashion, enhancing the risk of missing the diagnosis of a potentially important underlying condition.

Before signing on to work for an in-store clinic, you need to evaluate the practice carefully and to protect yourself against potential liability, Melanie Balestra, JD, NP, an attorney and pediatric nurse practitioner in Irvine, CA, warns. Check out:

► **The parent company.** Make sure it has the necessary licenses and a sound reputation. Find out if any lawsuits have been filed against it; if necessary, hire an attorney to help.

► **The malpractice policy.** Request a copy from the company and read it carefully to make sure you'd be adequately covered. It's wise, of course, to maintain your own professional liability coverage, as well.

► **Treatment protocols.** Review the clinic's policies and protocols and meet with

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NSO's professional liability insurance is endorsed by the California Association for Nurse Practitioners, the National Conference of Gerontological Nurse Practitioners and the American College of Nurse Practitioners.

Retail clinics bring new opportunities—and risks

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the supervising or collaborating physician to make sure you have a similar approach to patient care.

Know the law, and keep detailed records

The clinics get very busy, said Balestra, but for your own protection you can't afford sloppy paperwork. "You need to keep careful documentation on each patient." If a patient needs a referral or follow-up care, write that down, she advises, and do all you can to ensure that the patient follows through.

Knowing your state's Nurse Practice Act will also help you avoid problems. Since the laws vary from state to state, you must be clear on guidelines in the jurisdiction in which you're practicing and adhere to them.

"If your state has protocols and the clinic isn't following them or you notice that it's

not using the right billing codes, report the problems and get out of the practice. No job is worth that kind of risk," Balestra said. As always, it's your responsibility to find out what the law requires and make sure you're adequately insured.

By offering good basic care and patient education at a lower cost, NPs can provide optimal affordable care for individuals who otherwise might not access the healthcare system, while carving out a satisfying niche for themselves. "Because of their clinical and teaching skills, NPs are well-suited to work in these clinics," says Balestra, "and they can enjoy a sense of pride in giving back to the community, since the clinics are affordable." Just don't neglect to protect yourself against the potential risks by adhering to the law and your state practice act.

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Coverage Corner

News about your Professional Liability Insurance

Going before the board can cost you if you don't call NSO first

Every year, thousands of nurses face charges of professional misconduct. Although most complaints against nurses originate with their employer, the complaints can come from almost anyone—patients, colleagues, supervisors or physicians you work with—for anything from alleged theft to abusive behavior, substance abuse, insubordination or negligence.

Often, the charges are investigated and dismissed with no action taken.

Sometimes, other disciplinary action results and, in some cases, a nurse faces either license suspension or revocation of his or her license. Without your license, you lose your ability to work, which can be devastating—professionally, financially and emotionally. An accusation of professional misconduct should never be taken lightly. Even when you are certain that you have done nothing to warrant such an allegation, never attempt to face the

charges alone. A lawyer who specializes in disciplinary defense can prepare you to face the questions about the relevant issues and help ensure that you don't unintentionally incriminate yourself.

If you are summoned to appear before a licensing or disciplinary board regarding your professional activities or conduct arising out of a covered medical or non-medical incident, your coverage through NSO will provide you with a means to secure experienced legal representation and reimbursement for out-of-pocket expenses. Employers rarely provide license protection; however, NSO will provide up to \$10,000 per proceeding, for your legal defense coverage. Just be sure to contact us right away!

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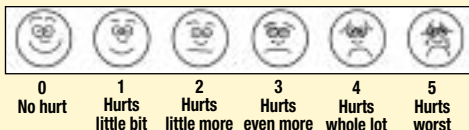
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PAIN MANAGEMENT: RESPONSIBILITIES AND RISK

In 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented pain management standards calling for the recognition of patients' right to pain relief. According to JCAHO, pain is to be treated

Wong-Baker FACES Pain Rating Scale



From Hockenberry MJ, Wilson D, Winkelstein ML: *Wong's Essentials of Pediatric Nursing*, ed. 7, St. Louis, 2005, p. 1259. Used with permission. ©Mosby.

as a fifth vital sign, evaluated along with the patient's pulse, blood pressure, core temperature and respiration.

While caring for your patient, you're responsible for educating him or her about your facility's pain management policies, the pain assessment process, and ways of providing pain relief. To assess for pain, you should use a method that is suitable for the patient's age and abilities. Adolescents or adults may be able to describe their pain and to rate its intensity, using a scale from one to 10 in which 10 represents the worst pain imaginable. For pediatric patients, you might use the FACES scale. Ask a child to show you how much he or she hurts by pointing to one of its six cartoon images, which range from a happy, smiling face to a tearful, sad face. In older adults with cognitive changes, look for signs of pain such as grimaces, agitation, restlessness, inability to sleep, depression or withdrawal.

Once you have identified the level of pain, managing it should become part of the plan of care. Become familiar with the analgesics administered to the patient, including the dose

and dosing interval, duration of action, time of onset and peak effect, and any side effects or contraindications. To ensure the appropriate use of the pain medication, document the patient's response to the drugs and the findings of any follow-up assessments. It's crucial, too, to notify the primary care provider if the pain continues unabated, both to help the patient and to avoid a malpractice charge for undertreatment of pain.

REPORTING ON-THE-JOB INJURIES

In 2003, nurses suffered from more than 20,000 injuries that resulted in missed work, the Bureau of Labor Statistics reports. Needlesticks and musculoskeletal injuries were particularly common. If you are injured at work, be sure to report the injury to your supervisor. Fill out an incident report that includes a description of the accident and resulting injury and its time and date. If you are in an employee-employer relationship, also complete a workers' compensation claim form. Independent contractors and private duty or per diem nurses may not be covered by workers' comp.



Laws vary by state, but workers' comp generally covers medical and hospital bills and provides a percentage of lost pay. Permanent disability usually results in a flat monetary award. But to get any of these benefits, you must complete the workers' comp claim form and submit it within the time specified by law. Be truthful and thorough when answering questions about your claim. The workers' comp carrier will use this information to determine your benefits.

Lessons from Court

⋮ Restraining a patient—carefully

Were these nurses negligent in restraining—or failing to monitor—this patient?

A blind amputee with diabetes was admitted to the hospital, disoriented and confused. Three days later, he was diagnosed with a cerebral stroke. That night, when he tried to get out of bed, the nurses applied a Posey vest. Three hours later, the patient was found, wedged between the mattress and bed rail and unresponsive. Although he was briefly revived, the patient died two hours later.

His estate sued the hospital, claiming that the nurses failed to monitor the patient after restraining him. The defen-

dant denied any negligence and claimed that the death was caused by the stroke. The jury found in favor of the defense.

Staff. (2005). Medical Malpractice Verdicts, Settlements & Experts, 21(7), 17.

Advice from the expert:

Restraining a patient should be a last resort, after other interventions have failed. Nonetheless, cases like these can easily be defended if healthcare providers take precautions whenever they restrain a patient. Restraints, such as the Posey vest, are medical devices regulated by the FDA, and their use requires a clinician's order. The most common mistakes associated with restraints are applying them incorrectly, using the wrong size device, not securing the

restraint to the bed correctly, not checking on the patient frequently and using the restraint for convenience rather than medical necessity. These mistakes can be prevented by educating staff in the proper use of restraints and their application. Nurses should ensure that they follow their facility's protocols for using restraints.

Bottom line: Properly applied and used only as needed, these devices can increase a feeling of safety and greatly reduce the risk of patient injury. Use a restraint only as a last resort—document other interventions that were tried first—and be sure to check on the patient frequently.

Melanie Balestra, JD, MN, NP
Irvine, CA

End-of-life care:

Most patients who die in hospitals spend time in an ICU receiving aggressive, high-tech, costly care. As the widely acclaimed SUPPORT study of some 9,000 hospitalized patients found, however, these final days of life are often filled with unnecessary suffering.¹ The alternative to this scenario is palliative care, which concentrates not on prolonging life but on providing supportive care that promotes patients' comfort and dignity.

Nurses can make a major contribution in easing the transition from aggressive treatment to palliative care, regardless of the setting. To do so, they must be prepared to make ethical and humane decisions and at the same time consider ways to avoid liability.

Who receives palliative care?

The World Health Organization defines palliative care as the "active, total care of patients whose disease no longer responds to curative treatment.... (It) affirms life and regards dying as a normal process...neither hastens nor postpones death... (and) provides relief from pain and other distressing symptoms."² While the precepts of palliative care are rooted in the hospice movement, its delivery need not be limited to patients who are expected to die within six months, as originally conceived by Medicare. Nor should it be offered only to patients enrolled in hospice.

Nursing responsibilities

If your patient is receiving palliative care, you may be part of a healthcare team—and a central player. The makeup of the team varies, but may include—in addition to one or more nurses and the patient's primary care practitioner (PCP)—a social worker, chaplain, pharmacist, dietitian, physical and occupational therapists and other allied health workers.

Nursing tasks include assessing for pain and other distressing symptoms, providing evidence-based interventions to alleviate them, and preventing initiation of interventions that may not improve comfort and quality of life. Nurses also work with team members to attend to the psychological and spiritual dimensions of terminal illness. Finally, nurses must work with family members as they also shift their focus from curing the patient to palliative care. The commitment to family members should continue after the patient's death, with support and referral for counseling, if indicated.

Making choices

End-of-life care is full of choices: Should pneumonia be treated with antibiotics? Would a ventilator alleviate respiratory distress? Should tube feeding be started? Should dialysis be continued? According to the precepts of palliative care, the patient should be at the center of these choices. But what happens if the patient is unconscious, unable to speak or senile and cannot make these choices? That's where the Terri Schiavo case becomes relevant.

To many observers, the lesson of this case—in which the husband and parents battled for years over what kind of care



their loved one should have—is that decisions would have been vastly easier if Ms. Schiavo, despite her youth, had an advanced directive. It could have specified her wishes regarding interventions like the artificial nutrition that kept her alive for all those years. Terri Schiavo might also have had a healthcare proxy (a durable power of attorney for healthcare), clearly defining whom she wished to speak for her when she could not speak for herself. Yet even when such documents are executed and in the medical record, they don't always guarantee that the patient's wishes will be carried out.

Sally Okun, RN, an experienced hospice nurse with the nonprofit Center

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Responsibilities and risks

for Life Care Planning and Support, Hyannis, MA, has developed a more comprehensive solution she calls Advanced Care Planning (ACP), which many hospices have adopted.³ ACP, a type of anticipatory guidance introduced early in the patient's illness, involves both the family members and the patient. "If we can improve communication and lifecare planning earlier in the lifespan [of the patient], each one of us will become more experienced with balancing important health-related decisions, including those near the end of life," Okun believes. In what she calls "lifecare conversations," the patient and family members, working with the interdisciplinary team, discuss the likely course of the illness, and the benefits and drawbacks of available interventions. They work together to define the patient's goals and choose the best means to attain them. Writing an advanced directive, which should be reevaluated periodically, is often a part of this comprehensive process.

What about DNR orders?

Even when the patient has an advanced directive or has clearly said he or she does not wish to receive CPR in a life-threatening situation, CPR is mandatory for respiratory or cardiac arrest—unless the chart contains a PCP's DNR order. It's vital for nurses to help patients and families understand this, to provide information about the odds that the resuscitation efforts will succeed, to find out whether the patient or the designated surrogate wants a DNR order and, if so, to request the order from a PCP.

Risks and ethical dilemmas

End-of-life care often involves choices that are ethically difficult and give rise to fears of potential liability. Withdrawal of life-sustaining treatment such as dialysis or a feeding tube and the need for large or escalating doses of opioids (which can lead to serious adverse effects or even be lethal) or sedatives are particularly troubling issues.

Here's what the ANA says about opioids: "Nurses must use effective doses of medications prescribed for symptom control and nurses have a moral obligation to advocate on behalf of the patient when prescribed medication is insufficiently managing pain and other distressing symptoms. The increasing titration of medication to achieve adequate symptom control is ethically justified."⁴

The Hospice and Palliative Nursing Association takes a similar position regarding the use of potentially lethal sedatives—a practice sometimes called terminal sedation: "For imminently dying patients... whose suffering is unrelenting and unendurable," its position statement says, "... medications intended to induce varying degrees of unconsciousness but not death... may offer relief."⁵

Actions based on these principles are not the same as

euthanasia or assisted suicide, which are not sanctioned by nursing codes of conduct and are illegal in almost every state.

Withholding and withdrawing life-sustaining therapy is also legally and ethically permissible if it is the patient's fully informed and freely made wish—or if the therapy is causing or will cause harm to the patient or offers no benefit to the patient. Artificial nutrition and hydration may be withheld or withdrawn on the same grounds. To avoid liability, however, it is essential to follow your institution's guidelines on these issues, as well as your state's law.

Your role, regardless of the circumstances, is to advocate for the patient's wishes, as expressed in an advanced directive or an advance planning conversation or by the patient's chosen surrogate. The family may want to consult with a psychiatrist, ethicist, chaplain, social worker, pharmacist or palliative care specialist in making an end-of-life care decision. Judy Lentz, RN, CEO of the Hospice and Palliative Nurses Association, noted, "Decisions based on the known desires of the patient and family, as the unit of care, are the guiding directives for the patient plan of care."

If you find yourself in a position where a patient's desire to end life-sustaining interventions conflicts with your own belief system, request that his or her care be transferred to a colleague. As always, thoroughly document any conversations you have with the patient, family or other professionals about end-of-life decisions to protect yourself against potential liability.

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End-of-life care often involves choices that are ethically difficult and give rise to fears of potential liability.”

To read more...

about the expanded role of palliative care in patients with certain chronic illnesses, see the Web Flash in the Newsletter section of www.nso.com.

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Occurrence vs. claims-made: What are the differences?

In the world of professional liability insurance, there are two types of policies, occurrence and claims-made. It's important to understand the difference between the two coverages.

An occurrence policy, like the one currently offered by Nurses Service Organization (NSO), covers you for any incident that occurs during the policy term, regardless of when the claim is filed. As long as the incident occurred during the term that the policy was active, regardless of when you were named in a lawsuit, you are covered.

A claims-made policy also provides coverage for an incident that occurs during an active policy period, but only if the claim is also reported to the insurance company while the policy remains in force or during any applicable extended reporting period (also known as "tail"

coverage). In other words, if you are named in a lawsuit, claims-made coverage will respond only if the date of the incident and the date of the claim are subsequent to your prior acts date and while you have a claims-made policy in force or applicable tail coverage.

What's key with a claims-made policy is that you run the risk of not being covered for a claim discovered after the policy has expired. Therefore, if you decide to terminate a claims-made policy, you will need to purchase tail coverage to continue to protect yourself. This will extend the time that a claim can be reported, but the incident still needs to occur while the policy was active, or you won't be covered.

The bottom line is, learn the details of your coverage so you are not caught unawares. You may be shocked how policies differ from one another.

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Understanding—and preventing—medication errors

A patient who suffers permanent injury from being given the wrong drug is obviously the victim of a medication error. But even when no negative effect results, giving the right drug at the wrong time or via the wrong route constitutes a medication error. So does administering the wrong drug or the wrong dose of the right drug. And, any med error can jeopardize patient safety and increase your risk of liability.

The best way to prevent medication errors is to recognize when they're most likely to happen. If a staffing shortage leaves you busier than usual, for example, you are more likely to make a mistake because you feel rushed. But take the appropriate amount of time to read medication labels—and read those that you're not familiar with twice. Converting milligrams to micrograms and calculating a pediatric dose from an adult dose are also potential pitfalls. So take extra time when you perform these tasks and ask another nurse to check your math.

Unclear orders are another problem. Verbal orders are particularly risky, especially when drugs have sound-alike names, such as Advair and Advicor. Prepare yourself by consulting the U.S. Pharmacopeia's list of commonly confused drugs at

www.usp.org/patientSafety/newsletters/qualityReview/qr7920-04-04-01.html. Consider posting the list so every nurse on your unit can refer to it. Written orders can be safer, but watch for illegible handwriting, misplaced zeros or decimal points, and frequently misread abbreviations. A list of such abbreviations (again, consider posting it) is available from the Institute for Safe Medication Practices, at www.ismp.org/msaarticles/specialissuetable.html. Of all written forms, electronic order entry is safest, but don't let your guard down. Electronic prescribing cannot detect all human error.



The bottom line? If the order doesn't make sense or is unclear, don't administer the drug. Ask the prescriber for clarification. If he or she is not available, speak to your supervisor and document your actions, including the date and time of your conversation, to whom you spoke and the outcome.

Finally, always review *all* of the five rights—right drug, right patient, right dose, right route and right time—before administering any drug. This helps avoid medication errors, enhances your patients' well being and reduces your risk of liability.

NSO Continues to Support NPs

For over 30 years, Nurses Service Organization (NSO) has been an advocate for nurses and nurse practitioners. NSO works hard at being the nation's largest provider of professional liability insurance for nurses and NPs, and through research and communication we strive to stay ahead of your needs, providing you with essential insurance and risk management products.

This commitment to learning, especially through open dialogue with the nursing community, helps NSO understand current trends, as well as the struggles and risks that you face on the job, so that we can continue our campaign to educate both nurses and NPs by making risk management information available. We accomplish this through our newsletters, numerous published on-line articles and our on-line continuing education modules. Recently, we have increased our educational efforts due to the rise in malpractice lawsuits against nurse practitioners.

In late 2004, NSO worked closely with our underwriter, CNA, investing in a

claim data study to focus solely on NPs. The study was developed to create awareness of professional liability claims brought against NPs, identify the areas of greatest risk for NPs, and outline risk management strategies to help reduce those risks. To read more about this claim data study, turn to page 8.

Because of NSO's dedication to advocacy for NPs, the California Association for Nurse Practitioners (CANP), one of our endorsing associations, recently awarded Michael J. Loughran, executive vice president of NSO, with its Nurse Practitioner Advocate of the Year award. Mr. Loughran has spearheaded many of NSO's educational efforts by attending

many NP association conferences to expand members' knowledge on the importance of purchasing their own professional liability insurance policy, to answer questions about malpractice allegations, and to offer risk management recommendations to help NPs avoid lawsuits.

We consider it a privilege that the CANP recognizes NSO, CNA and Mr. Loughran's commitment to preserve coverage currently offered to you, as well as to help safeguard your practice against potential risks by focusing on current claims issues. Thank you for helping us to create a program of which we can all be proud.

NSO Earns Endorsement from the ACNP

The American College of Nurse Practitioners (ACNP) has recently chosen to endorse NSO! This endorsement is an honor to NSO because of the important work the ACNP does for NPs. The ACNP is a national nonprofit membership-directed organization for nurse practitioners, headquartered in Washington, DC. The college is focused on advocacy and keeping NPs current on legislative, regulatory and clinical practice issues that affect NPs in the rapidly changing healthcare arena. To learn more about the ACNP, including information on its upcoming conference, go to www.nurse.org/acnp.

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⋮ Nurse practitioner claims study update

In late 2004, NSO and the CNA Risk Management Staff invested in a claim data study to focus solely on nurse practitioners. You may have read about this study in last year's NSO Risk Advisor. The recently published study by CNA analyzes a database of 841 open and closed claims brought against CNA-insured nurse practitioners between January 1, 1994 and December 21, 2004. The study is an educational resource intended to help NPs identify and manage risk.

"Nurse practitioners, like other healthcare providers, are vulnerable to professional liability claims," said Michael Scott, assistant vice president, underwriting, CNA HealthPro. "As a leading provider of liability insurance for nurse practitioners, CNA is in a unique position to analyze the areas of risk and improve risk awareness for nurse practitioners, enabling them to focus on patient safety and improve their loss experience."

By reading this study, you will review the expanded role of the NP in today's healthcare environment, and learn about the impact that expansion has made with respect to the rise of professional liability claims against nurse practitioners. You will explore areas analyzed in the study, which include severity by practice location, injury and state, as well as frequency and severity by clinical specialty and allegation.

Using the analysis of the claim data, risk management recommendations were developed to focus on patient safety and improvements of nurse practitioner practice patterns. These

recommendations include strategies for managing patient health information records and ensuring that nurse practitioners work within the scope of their abilities and responsibilities. Additional recommendations focus on identifying and managing diagnosis-related, treatment-related and medication-related risks.

To read the 2005 nurse practitioner Risk Advisor article "Reacting to Rising Malpractice Claims," go to www.nso.com/npclaims. Copies of the claim data study results are now available from CNA by going to www.nso.com/npclaimstudy or by calling CNA directly at 1-888-600-4776.

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