

Protect your professional license, protect your livelihood

At a time when the increased demands of nursing seem overwhelming, it's good to know that you made a wise decision to purchase your own professional liability insurance policy through Nurses Service Organization (NSO). You have peace of mind knowing that you have the resources available to protect you and your interests in a covered malpractice allegation or disciplinary proceeding.

The truth is, relying solely on an employer's policy is risky. An employer's policy is usually designed to protect your employer first. Further, it will only provide protection to you for incidents that occur at work. Also, it is not likely that an employer's policy will have any protection for you if the Board of Nursing (BON) is investigating you. And, let's face it; your license is one of your most valuable assets. You need to protect your license and your right to practice as best as you can.

If you are called before the BON, the policy you purchased through NSO will reimburse you up to \$10,000 per proceeding for legal expenses for the defense of disciplinary allegation and investigation. There are other covered expenses too, such as lost wages, travel and/or lodging that arise out of a covered license protection incident. But, to take advantage of this benefit, you need to contact NSO.

The value of license protection coverage

An accusation of professional misconduct should never be taken lightly. Even when you are certain that you have done nothing to warrant such allegations, never attempt to face the charges alone. Doing so could leave you unprepared to answer questions, which could leave you vulnerable to being deemed culpable.

Like the nurses in these two case studies below, you can learn how imperative it is to notify NSO immediately if you are ever called before your state board.

Case study: Medication error

A nurse, practicing for 13 years, was reported to the state BON by her employer for unprofessional conduct—failure to meet or departure from minimal standards of acceptable and prevail-

ing nursing practice—after administering the wrong medication to an infant patient.

The infant had been diagnosed with an acute middle ear infection and acute bronchitis and was prescribed Rocephin 500 mg. IV and a Zithromax suspension for home use. The nurse administered Zithromax 500 mg. IV, instead of Rocephin 500 mg. IV. The infant developed cardiac arrest and was resuscitated. She was later transferred to another hospital.

Soon after, the hospital reported the nurse to the BON, giving her 20 days to respond. Just shy of the 20-day requirement, the nurse called NSO to report the complaint. NSO provided her with all the necessary information and referred her to The American Association of Nurse Attorneys (TAANA) so she could select a nurse attorney in her state who would be experienced and qualified to defend her against the hospital's allegations.

Because the deadline-to-respond requirement was approaching, the attorney had to file an extension so she could review the case. During the hearing, the nurse's attorney was able to secure a settlement in which the BON stated, "Respondent neither admits nor denies the factual allegations in the Administrative Complaint." Further, the attorney resolved that the nurse's license was only reprimanded, instead of being suspended or revoked as was recommended in the original complaint. Due to the extra time involved in filing an extension and the time it took to investigate the case, the legal fees and other expenses exceeded the policy limits. A total of \$10,000 was reimbursed to the nurse at the closing of the case.

Case study: Traveling nurse

A nurse with 19 years of experience and excellent performance appraisals took a short-term nursing assignment in order to work in an area that was near where her husband was working. She worked the 3-11 p.m. shift. On the last night of her contract term, patient A who was complaining of chest pains arrived in the nurse's assigned unit from the ER at 6 p.m. for overnight observation on a telemetry monitor after all initial tests were

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reported as normal. The nurse was also responsible for supervising a certified nursing assistant (CNA). Since she was told that the CNA had advanced training in several areas, the nurse instructed the CNA to connect the unit to patient A. At 10 p.m., while assisting patient B, several staff members called the nurse back to patient A's room where it was discovered that the monitoring unit had no batteries and no one had called to verify that the signal was being received. Batteries were inserted that night and patient A was discharged without any complications the following day.

When the family of patient A complained to the hospital CEO about how care was managed, the hospital brought a complaint against the nurse to the state board, claiming that she engaged in unprofessional conduct by failing to properly supervise the CNA, failing to check the telemetry unit for batteries, and failing to check the telemetry unit to verify that the signal was being received by the central monitoring section.

In a letter notifying the nurse of the complaint, the BON said she would need to speak with an investigator. The nurse did so without calling NSO or seeking counsel. During the interview, the investigator went beyond his usual role, suggesting that the nurse hire an attorney. Realizing that the situation was more serious than she initially thought, the nurse called NSO and a TAANA attorney who specializes in professional misconduct complaints.

The attorney contacted the board to call attention to information relevant to the nurse's defense and was successful in getting the case reconsidered. In the original complaint, the nurse's supervisor claimed no one was aware that patient A wasn't monitored for the entire shift, even though the CNA was qualified to set up the telemetry unit and observe and report any changes with patient A while the nurse tended to other patients. The attorney pointed out that the nurse did what any reasonable nurse would do by expecting the CNA to perform her assigned task without constant, direct supervision.

The Probable Cause Panel for the BON made the determination that there was no probable cause after reviewing the file and hearing a detailed response from the nurse, which was prepared with the guidance of her attorney. The case was

closed, no action was taken against the nurse and all attorney fees amounting to \$2,600 were reimbursed by NSO. If the nurse had continued without calling NSO and securing an attorney, it is likely that the case would not have concluded with this favorable outcome.

Other great NSO benefits

License Protection is just one of the many benefits that you get with the professional liability insurance policy you purchased through NSO. Your policy covers you if you are sued for malpractice, and it covers defense expenses that are paid in addition to your limits of liability. It also covers you for costs associated with a trial such as loss of wages.* Plus, you never share limits with other employees because the policy is yours.

As always, all of these policy benefits are offered at a competitive rate. You may notice on your next renewal that your premium was increased from \$89 to \$98** per year, but keep in mind that it has been nine years since NSO increased the price of this insurance. You will still enjoy all of the superior benefits that you have come to rely on through NSO. To read more about the benefits of having a policy through NSO, go to www.nso.com/benefits.

Conclusion

Both cases described here demonstrate the importance of always calling NSO and an attorney right away when you face professional misconduct charges. Not doing so can leave you unprepared and vulnerable to large fines and possibly losing your license. Never agree to attend a hearing unless your attorney advises you to do so—and prepares you for the hearing.

Remember, if a patient perceives she has been injured as a result of a nurse providing, or failing to provide, professional services, that patient could sue. This doesn't mean you have been negligent. It means that the patient perceives negligence, so being protected by a policy, like the one offered through NSO, is one of the most important purchases you'll ever make. You should maintain the policy as long as you keep your license active.

*Defense expenses and lost wage costs are subject to the license protection limit of liability.

**New rates apply to individual, employed nurses. Self-employed nurse rates have not increased.

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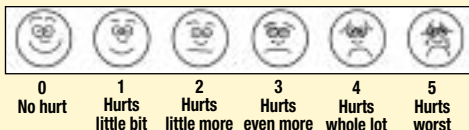
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PAIN MANAGEMENT: RESPONSIBILITIES AND RISK

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.

The risks of correctional nursing are not what you might think

What are the biggest concerns of nurses in correctional institutions? Their physical safety? The possibility of contracting an infectious disease? Experts say that such nurses are far more likely to be hit by a lawsuit than by an inmate or an illness transmitted by a prisoner.

Communicable diseases are indeed common in the correctional setting. Because inmates are subjected to a thorough health screening when they are incarcerated, those risks are known up front, said Joseph Paris, MD, Medical Director for the Georgia Department of Corrections. And the risk of contracting other infections is also not high because “the correctional facility is a very controlled environment,” he said.

Officers are nearby during exams so being assaulted is likewise unlikely. On the other hand, said William Rold, JD, a member of the National Commission on Correctional Health Care, correctional nurses are more likely than their counterparts on the outside to be the target of a malpractice suit because the nurse is the first practitioner the inmate sees.

An inmate who believes he has received inadequate care may also decide to file a federal case: The Eighth Amendment bans the use of cruel and unusual punishment, and indifference to healthcare needs constitutes such punishment, according to the Supreme Court. Also, case law supports prisoners' right to access care and receive treatment ordered by a healthcare provider.

One way to protect against liability is to always follow the institution's policies and protocols, including when to refer the patient to a PCP—who often is not on site. Also, spend enough time with the patient to answer questions; this can help to avoid misunderstandings.

Because of socioeconomic and lifestyle factors, many prisoners do not seek healthcare before being incarcerated. The prison nurse may be the first real healthcare professional a patient meets, which can make this work especially rewarding. Correctional nursing also has many challenges—including avoiding liability. Knowing the legal pitfalls is your first step towards protecting yourself against a lawsuit.

have questions or an idea?

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ICN 501347

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Nurses Ask

Answering your questions

Q. Because my unit is often short-staffed, I must prioritize which patients I see first. At times, that leads to lengthy delays in assessing newly admitted patients. What can I do to reduce my risk when this happens? K.M., Spokane, Washington

A. Delayed assessments are common when the nursing staff is overwhelmed because of a staff shortage. You are handling this the right way by determining which patients need your attention first. Be aware, however, that you can still be held accountable for your decision to delay an assessment, even if short-staffing is to blame.

To reduce your risk, make your supervisor or someone higher up on the chain of command aware of the problem. Fill out an incident report as well, and note the circumstances that led to the delayed assessment. This ensures that management is aware of the short-staffing and should prompt some action that will help reduce the liability risks that you and your facility could face because of delayed assessments.

Q. I am an RN and an NP student. Can I still apply for professional liability coverage as a student? V.B., Baltimore, Maryland

A. Yes. Actually, you must apply as an NP student. To be eligible in any NP program as an NP student, you must first be a licensed RN. As a student pursuing an advanced practice nursing degree, you face greater liability exposure than you did as an RN. Because your risk is greater, it is important that your policy reflects that you are pursuing this form of advanced practice nursing. But, be sure to include that you are an RN, listing it as a secondary profession. Anyone who lists himself or herself as an NP student can be covered as an RN at no extra charge.*

For more information about coverage for an RN who is pursuing an advanced practice nursing degree, please call us at our new number, 1-866-216-8080, and one of our licensed service associates devoted to NPs will be happy to assist you.

*Please note this does not apply if you are a self-employed RN.