

## Does multistate licensure increase your liability risk?

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Even though the multistate Nurse Licensure Compact has been in place since 2000, it is still causing much controversy in the nursing community. So far it has been implemented in 20 states and is being considered in another three, but not without opposition. Why?

Opponents of the compact, which include the American Nurses Association (ANA) and nurses' organizations in California and Oregon, believe the compact raises serious liability and disciplinary issues.

The National Council of State Boards of Nursing (NCSBN) and the Association of Compact Administrators, on the other hand, say the predicted problems have not materialized and are not likely to. So, if you have a license in one compact state and also practice in another, should you be concerned about increased liability?

### The compact's promise

The idea behind the Nurse Licensure Compact was to facilitate a nurse's ability to practice across state lines by making a practice license work the same way as a driver's license. Just as licensed motorists must obey the laws of the state in which they're driving, so too must nurses obey the rules and regulations in the state in which they provide nursing care. Nurses could practice in more than one state without going to the trouble and expense of applying for multiple licenses. Proponents of the compact believe that freer movement of nurses would ease the nursing shortage. They also believe that telehealth services could be provided across state lines without fear of heightened liability risk.

Critics of the compact dispute every point of this rationale. According to Susan King, RN, MS, executive director of the

Oregon Nurses Association, the number of nurses practicing in more than one state is actually quite small, and nurses have few problems obtaining additional licenses. The telenursing rationale doesn't hold water either, King contends. A nurse providing advice by phone to a patient in another state is subject to the jurisdiction of the state where the nurse is located, not the state she is phoning.

But, the most basic objection to the compact relates to

standards for nurse licensure, which differ from one state to another. Participation in the compact means accepting what King calls "the lowest common denominator" for nurses coming from out of state.

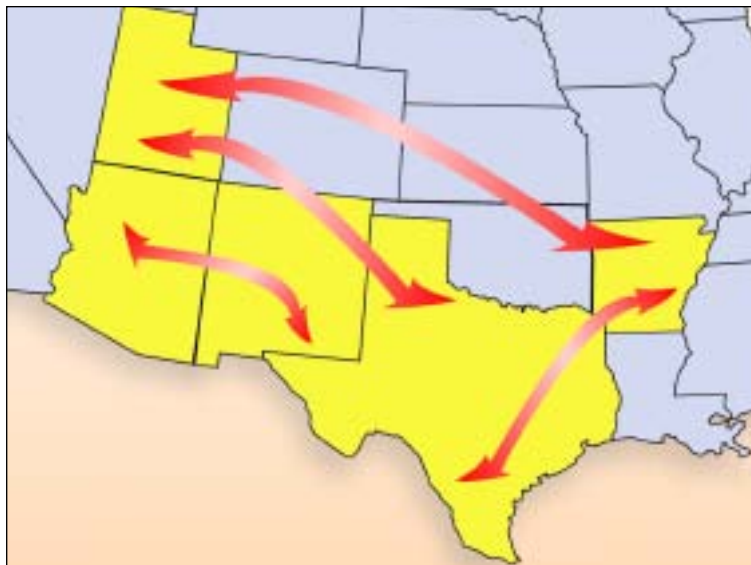
Compact challengers fear that the compact makes it easier for a nurse who has a black mark on her record in one jurisdiction to practice undetected in another. NURSIS, the national nursing database, "is a useful step toward preventing this," said Rose Gonzales, RN, of the ANA's department of govern-

mental affairs, but it is far from infallible; there is no way of knowing what is and is not reported to the database. Nurses' malpractice liability has increased, critics assert, as out-of-state nurses are held to definitions and standards with which they are not familiar. Finally, compact opponents say, nurses will find it more difficult to protect their licenses in a disciplinary action for an incident in a state that is different from the one where they are licensed.<sup>1,2</sup>

### So, are there problems?

NCSBN does not believe the problems foreseen by compact challengers have actually come to pass. Though the rumor

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mill has been active, “there aren’t any facts to substantiate the rumors,” according to Kristin Hellquist, director of policy and government relations for the NCSBN.

Gloria Damgaard, RN, chair of the compact administrators’ organization that oversees the day-to-day functioning of the compact, concurs, noting the absence of compact-related malpractice issues.

“Disciplinary problems have surfaced from time to time,” she said, “but have been resolved cooperatively by the states concerned.” In Damgaard’s view, telenursing does continue to raise a real liability risk for nurses practicing from noncompact states who may not know what standards they must meet in compact states.

According to Gonzales, the difference of opinion on the compact is fundamental and irreconcilable. The ANA believes that “a nurse should be licensed in the place where he or she practices. The compact licenses people in the state where

they live. That’s basic and it’s not going to change. The ANA Board has agreed to disagree with the NCSBN, and that’s how it stands.”

So should you be worried about increased liability if you have a license in one compact state and practice in another? The answer to this question is not clear. To protect yourself until more data are available, you should be especially diligent about state rules and regulations. If, for example, you leave Texas to work in New Mexico, both compact states, it is up to you to learn and follow the practice standards of the state to which you are moving, including getting any additional required education. Not doing so could put patients and your license in jeopardy.

### REFERENCES

1. Position statement of the ANA Board of Directors on the Nurse Licensure Compact. [www.nursingworld.org/ojin/tplcg/leg\\_7f.htm](http://www.nursingworld.org/ojin/tplcg/leg_7f.htm) (September 18, 2006).
2. ANA Multistate Licensing Compact: Areas of Concern. [www.nursingworld.org/gova/concerns.htm](http://www.nursingworld.org/gova/concerns.htm) (September 18, 2006).

## Lessons from Court

### ⋮ Fatal overdose of anti-seizure medication

#### Was the label ambiguous, the nurse negligent, or both?

A 6-year-old had a skull fracture after falling through the bleachers at an ice hockey game. When the child had a slight seizure in the emergency room, the ER physician ordered 300 mg of Cerebyx, an anti-seizure medication. The largest print on the label of the Cerebyx vial, other than the brand name, said “fifty mg PE (phenytoin equivalent)/mL.” A notation at the bottom of the vial said “10 mL.” Assuming that the vial contained 50 mg of Cerebyx, a nurse administered six vials, a 3,000 mg dose 10 times what had been ordered. The child died.

Plaintiff sued the nurse for negligent administration of the drug as well as the municipality for allowing gaps in the bleachers, the hospital, and the manufacturer, for faulty labeling. The action was settled for a confidential amount, said to be the largest in the history of the state for the wrongful death of a child.

Staff. (2002). *Medical Malpractice Verdicts, Settlements & Experts*, 18(10), 26.

#### Advice from the expert:

*The nurse who administered the drug was negligent, although the other defendants in the case contributed to the child’s death.*

*The nurse’s actions did not meet the standard of care for administering medication, which requires reading all the print on the label, never making assumptions, and double-checking orders. This procedure is particularly crucial when the patient is a child, as children are more vulnerable to an overdose than adults, and when the nurse is not completely familiar with the medication and how it is supplied. A dose of six vials of medication is highly unusual and should have been a red flag in itself.*

*The nurse could have avoided the dosage error if she had checked with the hospital pharmacist or looked up the drug on the Internet or on her PDA. This case is an ideal illustration of a fundamental risk management rule of thumb: Never be complacent.*

Melanie L. Balestra, JD, MN, NP  
Irvine, CA

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## BEWARE THE PERILS OF LOOK-ALIKE, SOUND-ALIKE DRUGS

The problem of look-alike, sound-alike drugs, which accounts for about 10% of all medication errors, has attracted the attention of stakeholders across the healthcare system—so much so that some drug companies have voluntarily changed product names. Prilosec, for example, originally was named Losec but was renamed to avoid being confused with Lasix.

For their part, hospitals are investing in computerized physician order entry (CPOE) and pharmacy information systems (PISs) that include alerts to notify providers when a drug or dosage may not be the one they intend. Institutions, as well as drug manufacturers, are adopting “tall man lettering”—use of capital letters to differentiate certain letters in words with similar spellings.



But, technology is no substitute for human care and good judgment. If a drug order is illegible

or if a practitioner speaks too quickly, always ask for clarification or have the drug name spelled out. Never guess which drug or dosage the provider intended. If you are unfamiliar with a drug or proper dosage, investigate before administering it. Above all, if the drug or the dosage doesn't seem right, speak up.

No system is foolproof. But, learning more about the most common look-alike, sound-alike drugs and carefully reviewing medication orders can go a long way toward preventing errors and avoiding potential liability.

## Legal Lookout

Stay up-to-date on safe practices, legal trends and more.



### SERVING AS AN EXPERT WITNESS? PROTECT YOURSELF!

When a nurse takes the stand as an expert witness, he or she can play an important role in educating attorneys and, potentially, a judge and jury about nursing issues in a case. But not everyone is cut out to be an expert witness. Before agreeing to serve, know what will be expected. Determine if you have the necessary qualifications, which differ from state to state and may vary with the nature of the case. If you choose to serve, review everything you've said or written that may be relevant to the case and notify the attorney about your past statements, as any inconsistencies could damage your testimony. Study the medical record for the case but consult the attorney with whom you are working before doing additional research.

When you take the stand in court, avoid using jargon. Speak confidently and pause before answering questions so the attorney with whom you are working can voice an objection to the question if necessary. Stay within the bounds of your knowledge base. If you don't know the answer to a question, simply say so. Finally, make sure your professional liability insurance includes a consulting services endorsement so you are protected for any expert witness services you provide. If you need to add this endorsement to your policy, call NSO at 800-247-1500 or visit [www.nso.com](http://www.nso.com) to fill out a request.



## Employed, self-employed, or LLC—Are you underinsured?

Theoretically, the difference between working for yourself and working for someone else is huge. In reality, some circumstances blur those lines. And, being classified as employed, self-employed, or limited liability company (LLC) affects the kind of professional liability insurance you need.

If you draw a salary from an employer or leave your full-time job to practice on your own, your status seems obvious. But what if you're employed during the day and provide services elsewhere as an independent contractor in the evening? What if you incor-

porate yourself but are a single-person practice, are you still self-employed?

NSO has a solution to meet these different needs. If you work exclusively for a facility, you need a basic individual professional liability insurance policy for employed healthcare professionals. If you perform professional services for at least 120 hours a year as a consultant, or work as an independent contractor, you need the comprehensive coverage of a self-employed policy, which provides protection for your professional services at your employer's workplace, as well as to your own con-

sulting clients.

Starting a new business? Even if you don't plan to hire employees, you have created a new entity, and it's important to keep you and the business separate. If you are ever sued, you and your business can be named as two individuals, so you need to make sure you are both covered with a policy designed for the small business owner.

If you practice on your own, or expect to, you may need to change your NSO policy. E-mail us at [service@nso.com](mailto:service@nso.com) or call 800-247-1500. Small businesses can call 888-288-3534.

## NSO News

Keeping you informed of what we're doing.



# Keeping Up with Technology:

Information technology is constantly evolving. Among the most common types are electronic health records (EHRs) and computerized physician order entry systems (CPOEs). Though these and other information technologies offer advantages, they also pose new challenges and potential risks.

When properly implemented, information technology can simplify information retrieval, reduce medical errors, and improve communication, among other pluses. But information technology doesn't eliminate the need for professional judgment. "People are not infallible. Neither are computers—but we tend to think they are," said Melanie Balestra, JD, MN, NP, a California-based attorney. Always keep this warning in mind to protect your patients' health and minimize your professional liability risk.

## Some potential pitfalls of EHRs

If your facility doesn't already use an EHR, eventually it will. Compared with paper records, an EHR can store more information for longer periods. Also, an EHR is accessible concurrently from many workstations and can provide medical alerts and reminders. Despite these and other advantages, an EHR can make one of your key responsibilities—documenting patient care—more difficult. "Traditional paper charting is free-form," noted Leslie Nicoll, PhD, RN, MBA, editor-in-chief of the journal *CIN: Computers, Informatics, Nursing*.

"EHR charting is more structured; you're forced to choose from various options in multiple lists. You have to change your thinking about charting."

That doesn't lessen your responsibility to document thoroughly and accurately, so you must understand how the system works and use it properly. "For instance, what if you enter something into the wrong patient's chart?" asked Diane Kjervik, JD, RN, editor-in-chief, *Journal of Nursing Law*. "How do you correct that? On paper you'd line through the entry once and initial or sign it, but you can't do that in an EHR. And, if you are able to make a correction, will the system still save the mistake?"

Another potential hitch is redundant charting, Kjervik noted. If you record the information in two different places and make a mistake in one of them, you introduce a conflict. Whether you can correct charting mistakes easily or at all may depend on the safeguards built into the system.

If the EHR's limitations cause documentation problems,

tell your risk manager promptly. "Later it'll be harder to prove what happened," said Balestra. Remember, if medical errors cause a patient harm and the patient later sues, inadequate documentation will come back to haunt you.

Sometimes busy nurses find risky ways to work around EHR hassles. They may take notes on paper during the day and update the EHR when their shifts end. Or rather than give temporary nurses system passwords, they have temporary nurses document on paper and a staff nurse transcribes the notes later—which is false documentation and hence repre-



sents potential liability. Both scenarios can lead to charting errors, noted Nicoll. Even worse, other healthcare providers may base patient-care decisions on outdated data.

## Be cautious, too, about CPOEs

CPOEs, another up-and-coming technology, can eliminate illegible orders, check for inappropriate drugs, and prompt healthcare providers to get informed consent. But a study that evaluated systems in the United States, the Netherlands, and Australia found that they can also facilitate errors. The study revealed that a practitioner faced with endless lines of similar-looking text on a computer screen may click on the wrong line and select an inappropriate test, order the wrong drug, or enter instructions for the wrong patient.<sup>1</sup>

The study also found that trouble can result in emergency situations—for example, a physician tells a nurse to administer a drug immediately but enters the order into the system

# Your Risks and Responsibilities

later. If that nurse isn't around when the order shows up in the system, another nurse could give the patient an extra dose.

Overdependence on the system is another potential drawback. NPs, RNs, and other practitioners may accept the system's output without question. Or they may not communicate directly with the patient's other caregivers, incorrectly assuming that the system has done it for them.

As with EHRs, you need to understand the shortfalls as well as the advantages of a CPOE system and watch for trouble, especially if the system has just been introduced. Blindly following an unproven system could have lethal consequences. A case in point: According to a recent review of records at an academic tertiary-care children's hospital, the mortality rate among children admitted for specialized care rose by 3.77% instead of dropping, 18 months after the rapid implementation of a new CPOE.<sup>2</sup>

## Don't throw out the pen and paper!

While technology has made tremendous inroads when it comes to patient records and physicians' orders, many things still are done on paper. Informed consent is one process that still uses paper, even though there may be a small electronic component: CPOE systems alert providers to get consent. Even with this electronic prompt, "the division of responsibility remains the same," said Tina Gerardi, RN, MS, CAE, deputy executive director of the New York State Nurses Association. A practitioner performing the procedure must explain the proposed treatment plan and get the patient's consent; an RN can witness a patient's signature but should not obtain the consent. Still, an RN must make sure a patient understands the PCP's explanations and instructions, and tell the provider if the patient seems confused or has questions.

Incident reporting is also still done on paper, though online reporting systems are available and may be incorporated into EHRs. Online systems can be undermined, however, if they alert practitioners about every report filed, regardless of severity. This can make practitioners complacent. That's why it's important to understand the system's ranking system—if it has one. Whether you do your incident reporting online or on paper, one thing remains clear: Your most important duty is to file reports promptly, while you still remember the details.

## What records are legally valid?

Remember that reports or other documents transmitted via "low-tech" e-mail or fax can be just as legally valid as paper originals or records stored in an EHR. "They'll generally hold up in court as long as automatic date stamps or other systems are in place to prove they're authentic and weren't altered," said Balestra. A court may still require the original

of a faxed document as additional backup, though. To protect yourself, keep copies of all electronic communications you send or receive.

## High-tech or low, remember security

With all patient-related documents, whether paper or electronic, taking appropriate security measures to protect privacy remains a top priority. To comply with the regulations of the Health Insurance Portability and Accountability Act (HIPAA), you must do everything possible to prevent unauthorized people from viewing patients' health information. Don't leave printed documents lying around for others to see. If you input or transmit information electronically, keep the computer screen turned away from prying eyes and don't walk away from the computer without signing off first. Never share your user ID and password. If you're faxing or e-mailing information to patients, get their permission for doing so, and follow up to make sure they received it.

When it comes to information technologies, learn what these systems can and can't do and how to use them properly, so you can give patients the best possible care and minimize potential for professional liability. You must also scrupulously follow all policies and procedures outlined by your facility and ask about your potential professional liability for information-related errors. Technologic ignorance isn't a valid defense. "Nurses are ultimately responsible for the patient outcome," said Gerardi. "Using technology doesn't usurp your accountability."

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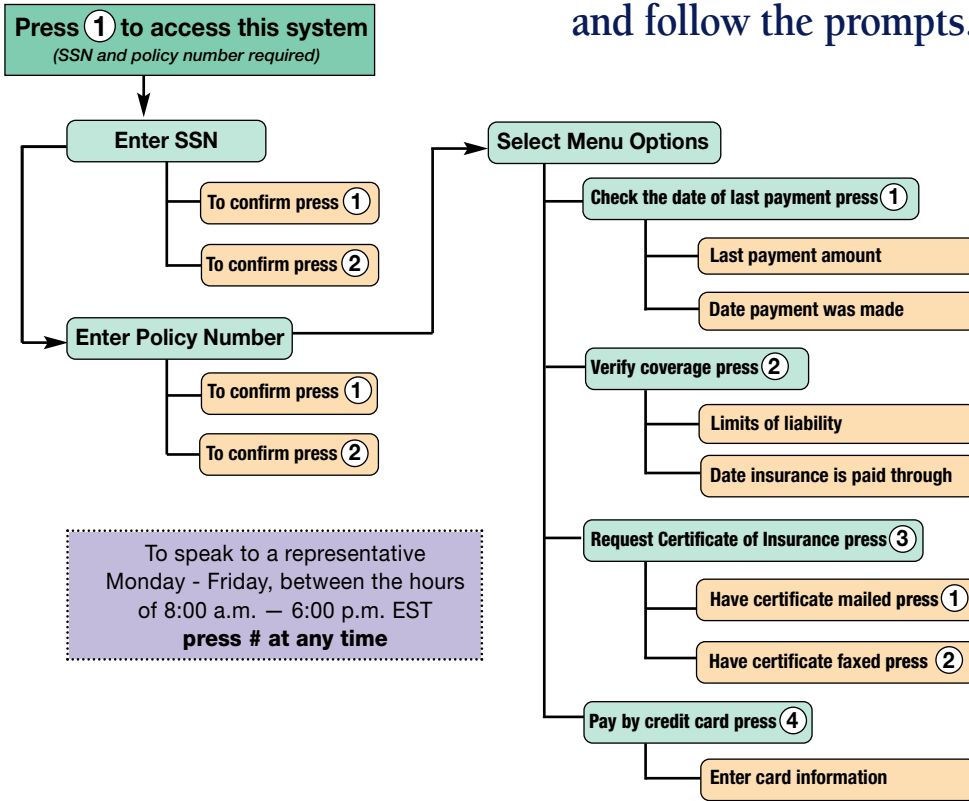
“  
...information  
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professional  
judgment.”

## For an update...

on the uses, limitations, and potential liabilities associated with medical technologies, see the Web Flash in the Newsletter section of [www.nso.com/webflash2007](http://www.nso.com/webflash2007)



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## NEEDLE AND SYRINGE REUSE= INFECTION RISK

Most nursing professionals know that needles and syringes generally are *not* reusable because they can transmit bloodborne pathogens (including HIV and hepatitis), potentially endangering patients, residents, and staff. Reusing needles and syringes to administer parenteral substances on multiple patients or residents is strictly prohibited by the infection control guidelines of the Centers for Disease Control and Prevention (CDC) and the practice standards of various professional associations. Studies demonstrate that compliance problems persist, however, especially in physician offices and among anesthesiologists.

CNA, the underwriter of the professional liability insurance policy available through NSO, highlights common causes of needle/syringe reuse and multidose vial contamination and offers practical risk management strategies to enhance patient/resident safety and minimize liability in its *ALERT Bulletin*—available at [www.nso.com/needles](http://www.nso.com/needles).

## ⋮ Facing a frivolous lawsuit

Being accused of negligence can be a devastating experience. Even if you're sure the claim is baseless you should not ignore the investigation or handle things on your own.

"Take seriously any legal action, no matter how implausible it seems," said Melanie Balestra, JD, MN, NP. "Immediately call your professional liability insurer and your employer's risk manager." Your insurer will ask for crucial information about the claim and will provide you with information that will assist you through its claims process. Response time is critical. Also, failure to meet filing deadlines can lead to a default judgment against you.

Although frivolous lawsuits may have no legal basis, they're not uncommon. Often the plaintiff hopes the defendant will settle to avoid litigation costs and a lengthy trial. A vigorous defense against such a case requires your active participation. Provide a complete factual narrative of the incident to your attorney or with your attorney's advice. Make sure he or she receives all necessary records and medical charts. And, because your

conversations can be used as evidence, don't discuss the case with anyone else.

Your employer's insurance may cover you whether you are the only party or one of many named in a suit. But, to minimize the employer's liability, he may include you in a settlement without your consent or regard for your innocence and consequences to your career. Having your own professional liability insurance, however, provides you with your own defense to fight for your best interests.

You can also bolster your protection in any liability situation with a few routine measures:

- ▶ Document all professional encounters accurately and objectively, including dates and times. Write clearly in ink.
- ▶ Keep up-to-date with your education.
- ▶ If you have access to your employer's policy, read it. If you change jobs, check your coverage.
- ▶ Stay current on national and state laws, as well as your state Board of Nursing policies.
- ▶ Report concerns to a supervisor or risk manager.

Ultimately, though, a quick response and adequate preparation are your best defense against frivolous allegations.



# Are you and your facility prepared for a flu pandemic?

Each year, the Centers for Disease Control and Prevention (CDC) advises nurses and other healthcare professionals to get influenza vaccinations because their exposure to the disease threatens their own health, as well as that of their patients. The World Health Organization (WHO) believes that the world is closer to an influenza pandemic than at any time since 1968, which gives this recommendation added weight.

As the United States government agency responsible for pandemic influenza planning, the Department of Health & Human Services (HHS) strongly promotes flu vaccinations for healthcare workers and advises facilities to document vaccination of healthcare personnel. Some facilities have responded by attempting to make flu shots a condition of employment. Although the American Nurses Association (ANA) also strongly encourages nurses to become immunized

against the flu, it opposes healthcare facilities threatening to fire those who do not submit to mandatory vaccination, especially in the absence of a declared public health emergency.

Vaccinating healthcare personnel is, of course, just one component of the healthcare community's preparedness efforts. According to the CDC, in a pandemic the United States healthcare system could be called on to treat about 50 million people. To prepare for this possibility, healthcare facilities should follow HHS recommendations, available at [www.pandemicflu.gov](http://www.pandemicflu.gov). The "healthcare planning recommendations" section of the site offers a toolkit and checklists for home health services, clinics, hospitals, residential facilities, and others. The hospital preparedness checklist, for example, covers the creation of a structure for planning and decision making; development of a written pandemic influenza plan; commu-

nication; triage and admission; facility access; and vaccine and antiviral drug use.

A facility's written pandemic influenza plan should specify the circumstances under which the plan will be activated and describe the organizational structure that will be used to put the plan into operation, as well as the responsibilities of key personnel for executing the plan. A simulation exercise should be developed and performed to test the effectiveness of the plan. The written plan also should have a surveillance element that establishes syndromic surveillance in the emergency room and criteria for recognizing pandemic influenza.

Everyone must do their part to prepare for a possible pandemic. Encourage your superiors to make the most of the resources that the government offers, but don't rely on them. It is up to you to educate yourself. And, at the very least, set an example by getting a flu shot every year.

## ARE YOU CONSULTING, TEACHING, OR TRAINING?

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## Understanding the importance of an A.M. Best rating

NSO customers often wonder and ask what a rating from A.M. Best means. You often see us state that “NSO is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA Company. CNA has earned an A (Excellent) rating from A.M. Best (as of 10/11/06), the nation’s leading authority on the financial well-being of insurance companies.” But have you thought about what it means?

First, it is important to know that an A.M. Best Rating is an independent third-party evaluation that subjects all insurers to the same criteria and provides a benchmark for comparing insurers. The rating is used as a tool that can enhance consumer confidence in an organization’s stability.

Insurance companies, like CNA, depend on an A.M. Best Rating to analyze the financial strength and operation of specific insurers, to evaluate prospective reinsurance accounts, to compare company performance and financial condition, and more.

Ratings have also become an increasingly important factor for consumers so they can make educated buying decisions. Because of this, NSO knows how important it is to work with a company like CNA, one of the 10 largest commercial insurers in the United States with over \$60 billion of assets, to bring you products tailored to your needs, at affordable rates.

Now that you understand what the A (Excellent) rating from A.M. Best means, you can have confidence that the policy you purchased through NSO is a wise and secure investment.

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