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Nurse Practitioner
Claim Report: 4th Edition

A Guide to Identifying and Addressing Professional Liability Exposures

The Institute for Safe Medication Practices (ISMP) is pleased to have provided input into the development of the *Nurse Practitioner Claim Report*. ISMP's commitment to advancing medication safety means we recognize how essential collaboration within the healthcare community is for error prevention. Our collaboration with CNA and Nurses Service Organization (NSO) provides valuable medication safety content designed to help healthcare professionals follow safe medication practices and keep patients safe. We thank CNA/NSO for their work, and we believe that this report will assist nurse practitioners in enhancing their risk management practices.

Michael R. Cohen, RPh, MS, ScD (hon.), DPS (hon.), FASHP
President, ISMP

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

Part 1: Professional Liability Data and Risk Control Strategies

Introduction

In collaboration with our partners at Nurses Service Organization (NSO), we at CNA insure over 26,000 nurse practitioners (NPs) in a wide variety of settings, including acute care, home health, hospice, aesthetic medicine, behavioral health, geriatrics and primary care.

As part of our mission to educate our insureds and the healthcare field at large about risk-related issues, we are pleased to present our fourth nurse practitioner closed claim report. Our goal is to help nurse practitioners enhance patient safety and minimize liability exposure by providing up-to-date information on professional liability claim and licensing board complaint patterns and trends, as well as related risk management information and guidance. We believe that all NPs, regardless of practice setting, will find this detailed, fact-based report useful.

As with prior reports, we include a range of risk control recommendations, as well as a self-assessment checklist at the end of Part 1. The suggestions and self-evaluation questions contained in this report complement similar tools from prior reports and together offer a comprehensive NP risk management guide.

Database and Methodology

Two datasets are utilized in both Parts 1 and 2 of this report. The 2017 claim dataset utilized in Part 1 is based upon 2,236 reported total adverse incidents and claims involving NPs that closed between January 1, 2012 and December 31, 2016. The 2012 claim dataset draws upon a grand total of 1,880 reported adverse incidents and claims affecting NPs that closed between January 1, 2007 and December 31, 2011. For the 2017 dataset, only those professional liability closed claims that met the following criteria were included:

- The claim involved an NP, NP practice or NP student.
- Closed between January 1, 2012 and December 31, 2016, regardless of when the claim was initiated or first reported.
- The claim resulted in an indemnity payment of $10,000 or greater.

These criteria, applied to the total number of reported NP claims and adverse incidents, create a 2017 claim dataset consisting of 287 closed claims. Similar criteria produced a 2012 claim dataset comprising 200 closed claims.

Part 2 of the report relies upon two additional datasets of license protection incidents or claims affecting CNA/NSO-insured NPs. These datasets are described in detail on page 75.

As the inclusion criteria in this report may differ from those of prior CNA/NSO nurse practitioner claim analyses and claim studies from other organizations, readers should exercise caution about comparing these findings with other reviews, unless the comparison is made within this report.

Scope

The report focuses upon the *severity* (see Definitions, below) of nurse practitioner closed claims that satisfy the inclusion criteria detailed above. Claim characteristics analyzed within the report include location of the event, NP specialty, type of allegation, resulting injury and level of patient disability.

Limitations

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

- **The database includes only closed claims made against NPs, NP practices or student NPs insured by CNA through the NSO program,** and does not necessarily represent the complete spectrum of nurse practitioner activities and nurse practitioner closed claims.
- **Noted indemnity payments are only those paid by CNA on behalf of its insured NP healthcare businesses, individual NPs or NP students through the NSO program** and exclude additional amounts paid by employers, other insurers or other parties in the form of direct or insurance payments.
- **The process of resolving a professional liability claim may take many years.** Therefore, while claims included in this report closed during the period of January 1, 2012 through December 31, 2016, some may have arisen from an event that occurred prior to 2012.

Definitions

The following definitions are valid within the context of this report:

- **2009 claim report –** A reference to an earlier CNA study, titled "Understanding Nurse Practitioner Liability: CNA HealthPro Nurse Practitioner Claim Analysis 1998-2008, Risk Management Strategies and Highlights of the 2009 NSO Survey."
- **2012 claim report –** A reference to the previous CNA study, titled "Understanding Nurse Practitioner Liability, 2007-2011: A Three-part Approach."
- **Aging services –** Specialized facilities or organizations that provide care to a senior population. Sometimes also referred to as *long term care*, aging services settings include, but are not limited to, nursing homes, skilled nursing facilities, assisted living centers and independent living communities.
- **Average total paid –** Refers to indemnity or settlement plus associated expenses, divided by the number of closed claims.
- **Expense payment –** Monies paid in the investigation, management or defense of a claim, including but not limited to expert witness expenses, attorney fees, court costs and record duplication expenditures.
- **Incurred payment –** The total costs or financial obligations, including both indemnity and expenses, resulting from the resolution of a claim.
- **Indemnity payment –** Monies paid on behalf of an insured nurse practitioner in the settlement or judgment of a claim.
- **Location –** The healthcare setting where the nurse practitioner provided professional services.

- **Medical malpractice –** A civil action based on tort law that involves a healthcare provider whose care deviates from the accepted standard of care, causing patient injury or death. (Also known as *professional liability*.) In a medical malpractice lawsuit, the plaintiff must prove the following four elements to obtain a favorable judicial outcome: first, a duty of care was owed by the health-care provider to the patient; second, the duty was breached; third, the breach was the proximate cause of the injury; and fourth, damages flowed from the injury.
- **Medical negligence –** The failure of a healthcare professional to exercise the relevant standard of care.
- **Practitioner –** A licensed independent healthcare provider such as a physician, nurse practitioner or advanced practice registered nurse.
- **Settlement –** An alternative in civil lawsuits to pursuing litigation through trial, in which typically the defendant agrees to some or all of the plaintiff's claims and decides not to pursue the matter in court. Usually, the arrangement requires the defendant to pay the plaintiff an agreed-upon sum.
- **Severity –** The average paid indemnity for nurse practitioner claims that closed with an indemnity payment of $10,000 or greater.
- **Standard of care –** The degree of care that a reasonably prudent or similarly qualified practitioner in the community would have exercised under the same or similar circumstances. Considered beyond the knowledge of lay jurors, it is most often established by the testimony of medical experts conversant with standards of practice in a particular community and/or in the same medical specialty.
- **Vicarious liability –** A legal principle that assigns responsibility not solely to the individual whose negligent act or omission caused an injury (such as a nurse practitioner, student or aide), but also to that person's employer or supervisor if the act or omission occurred during the course and scope of employment or supervision.

Standard of care is most often established by the testimony of medical experts conversant with standards of practice in a particular community and/or in the same medical specialty.

Analysis of Claims by Insurance Type

- Of the nurse practitioner closed claims, 97.6 percent involve individually insured nurse practitioners.
- The data suggest that nurse practitioners receiving professional liability coverage through a CNA-insured healthcare business have a higher average paid expense. This result is expected, inasmuch as NP practice coverage is the primary source of insurance coverage for multiple parties, including the corporation as well as its employees and independent contractors. Conversely, individually insured NPs may share financial responsibility for claim-related losses with their employer.
- The average paid indemnity for closed claims with an indemnity payment of $10,000 or greater is $240,471. In the 2009 and 2012 CNA/NSO nurse practitioner claim analyses, which used the same criteria, the average paid indemnity is $221,852 and $186,282, respectively. This indicates an average annual paid indemnity growth rate of +6 percent between the 2009 and 2012 claim reports and a +2 percent annual growth rate between the 2012 and 2017 report periods.

1 Closed Claims by Licensure and Insurance Type

Licensure and insurance type	Percentage of closed claims	Total paid indemnity	Total paid expense	Average paid indemnity	Average paid expense	Average total incurred
Nurse practitioner, individually insured	97.6%	$68,300,261	$16,877,292	$243,930	$60,276	$304,206
Student nurse practitioner, individually insured	1.0%	$380,000	$65,712	$126,667	$21,904	$148,571
Nurse practitioner receiving coverage through a CNA-insured healthcare business	1.4%	$335,000	$286,869	$83,750	$71,717	$155,467
Overall	100%	$69,015,261	$17,229,873	$240,471	$60,034	$300,506

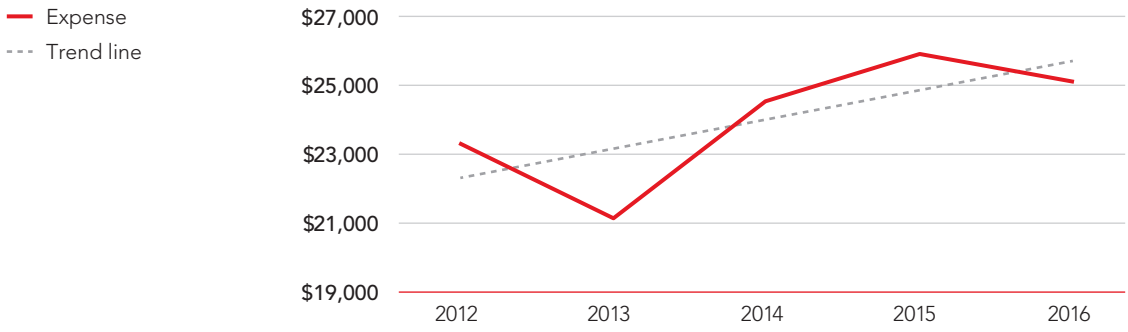
Closed Claims with Expense Payments but No Indemnity Payment

Claims may resolve without an indemnity payment for various reasons. For example, such a claim may be …

- **Successfully defended on behalf of the NP,** resulting in a favorable jury verdict.
- **Withdrawn by the plaintiff** during the investigation or discovery process.
- **Dismissed in favor of the defendant NP** by the court prior to trial.

Claims that resolve without an indemnity payment may nevertheless incur costs. Known as expense payments, these expenditures can include attorney fees, expert witness fees and costs involved in investigating the claim. Claim expenses can vary widely due to the unique circumstances of every case. Over the five-year period, expense costs arising from claims with no indemnity payment total over $10.7 million. Figure 2 displays average paid expenses per year for NP claims that closed with no indemnity payment.

2 Closed Claims with Expense Payments but No Indemnity Payment



Over the **five-year period,**
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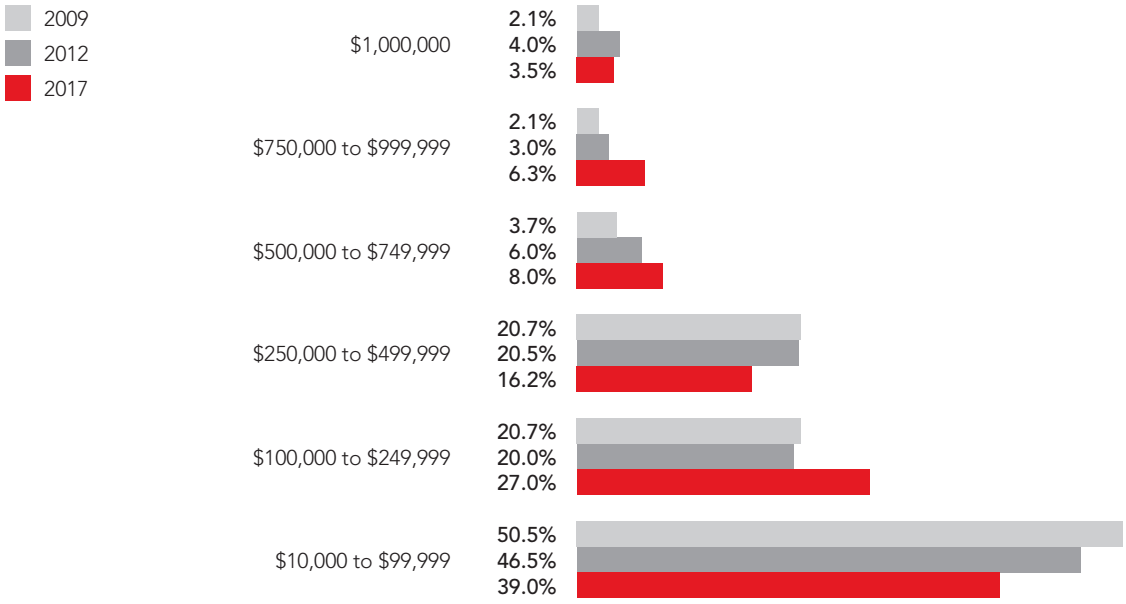
total **over $10.7 million.**

Comparison of Average Paid Indemnity: 2009, 2012 and 2017

Of closed claims with paid indemnity above $10,000, the largest group has continued to resolve between $10,000 and $99,999. However, as the average paid indemnity of claims above $10,000 continues to rise, this group declined from 46.5 percent of closed claims in the 2012 dataset to 39.0 percent in 2017. The number of claims that resolved between $100,000 and $249,999 correspondingly rose from 20 percent in 2012 to 27.0 percent in 2017.

3 Comparison of Average Paid Indemnity: 2009, 2012 and 2017



Analysis of Frequency and Severity by Nurse Practitioner Specialty

- The three specialties with the highest average paid indemnities are **neonatal, women's health (obstetrics)** and **emergency medicine.** Many of the neonatal and women's health (obstetrics) closed claims have indemnity payments in the mid-to-high six-figure range.
- The proportion of **emergency medicine** claims has increased from 3.5 percent in the 2012 report to 5.7 percent in the 2017 report.
- Four specialties account for 80.9 percent of all closed claims:
  - **Adult medical/primary care** and **family practice** account for 53.7 percent of all closed claims. Most of these claims occurred in a physician's or nurse practitioner's office, and many involve failure to order diagnostic tests or obtain/address diagnostic test results, as in the following case:
    - A nurse practitioner and owner of a primary care practice treated a patient for two years and failed to appreciate the significance of elevated creatinine levels and worsening symptoms of benign prostatic hyperplasia, which resulted in an acute episode of urinary obstruction, catheterization and post-obstructive dialysis. The patient suffered acute renal failure and must undergo dialysis three times per week. The claim settled in the low six-figure range.
  - **Behavioral health** accounts for 15.3 percent of the closed claims in the current report, compared with 6.5 percent in the 2012 report. However, the average paid indemnity has remained relatively consistent, despite some high-severity claims involving improper prescribing of medications and failure to address a behavioral health condition in a timely manner, as in the following scenario:
    - An insured NP certified in child and adolescent psychiatry began treating a 16-year-old patient for anxiety and depression. The patient had a medical history significant for fibromyalgia and a history of attempting suicide. After six months of therapy and medication treatment, the patient overdosed on oxycodone pills belonging to her stepfather. The patient suffered brain hypoxia and currently resides in a residential healthcare facility. Allegations included negligence in managing the patient's depression and anxiety and failure to recognize the patient's risk for suicide. The claim settled in the high six figures. (See page 58 for risk control recommendations and additional resources relating to patient suicide prevention.)
  - **Gerontology** accounts for 11.9 percent of the closed claims, up from 10.5 percent in the 2012 report. Many of the claims, which typically occurred in a skilled nursing facility setting, involve the death of the patient/resident, as seen in the following case:
    - An NP working at a skilled nursing facility was responsible for adjusting anticoagulation medications of a recently admitted resident on warfarin who had undergone a right total hip arthroplasty. There was a three-day delay before anticoagulant therapy was initiated. Once therapy began, the NP had difficulty getting the patient's INR to a therapeutic level. She discussed the patient's INR levels with her collaborating physician, who advised her to keep the patient on the current regimen. Several days after this consultation, the patient suffered a fatal pulmonary embolism. The claim against the NP resolved in the low-to-mid six-figure range.
- **Aesthetics/cosmetics** as a specialty account for 3.1 percent of the closed claims, a slight decrease from the prior report (4.5 percent). However, the average paid indemnity has increased significantly, rising from $51,944 in the 2012 report to $205,278. This increase is largely driven by one claim where a nurse practitioner working in a cosmetic dermatology office failed to follow up with a patient for more than a year regarding a pathology test result that concluded the patient had squamous cell carcinoma via shave biopsy. The patient was on immunosuppressive drugs for a recent liver transplant, which allowed the cancer to advance rapidly. The claim settled in the high six-figure range.

- **Hospitalists,** included in the 2017 report for the first time, account for 1.0 percent of the closed claims. This specialty, which is growing due to the effects of healthcare reform and changing reimbursement patterns, warrants attention from a liability perspective. The following closed claims involve problems in diagnosis and care:
  - A 41-year-old female was admitted into an intensive care unit after having a seizure and becoming unconscious at a music festival. The patient was treated by the insured hospitalist NP for hyponatremia. Over the course of 12 hours, she repeatedly complained of numbness and loss of feeling in her legs. The day after admission, the nurse practitioner consulted with a neurologist. The neurologist gave orders for the patient to have an MRI scan, leading to a diagnosis of an unstable burst fracture of L1 secondary to falling after experiencing seizure activity. The patient was transferred to a secondary hospital for emergent surgery but was left permanently disabled and in need of a walker. Many of the defense experts opined that had the NP diagnosed the L1 fracture sooner, the patient's injuries would have been less severe. The claim settled in the low-to-mid six-figure range.
  - A 37-year-old male sustained a chemical burn at his place of employment. He was admitted to a burn unit for treatment, where he was listed as at high risk for deep vein thrombosis (DVT), according to the hospital's DVT protocol. The insured NP, a hospitalist working in the burn unit, failed to place the patient on anticoagulation therapy. Two days after the patient received a skin graft, the insured ordered physical therapy. The patient complained of shortness of breath and weakness when the physical therapist eased him out of bed, then took a couple of steps and collapsed to the floor. He went into cardiac and respiratory arrest and never regained consciousness. An autopsy revealed the cause of death to be pulmonary embolus. The claim was settled in the low six-figure range.

4 Analysis of Frequency and Severity by Nurse Practitioner Specialty

Nurse practitioner specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Neonatal	1.0%	$1,891,232	$630,411
Women's health (obstetrics)	2.1%	$2,505,000	$417,500
Emergency medicine	5.7%	$4,444,995	$277,812
Adult medical/primary care	41.2%	$31,562,191	$267,476
Pediatric	3.1%	$2,270,000	$252,222
Family practice	12.5%	$9,066,525	$251,848
Aesthetics/cosmetics	3.1%	$1,847,500	$205,278
Behavioral health	15.3%	$8,984,000	$204,182
Women's health (gynecology)	3.1%	$1,666,000	$185,111
Gerontology	11.9%	$4,391,568	$129,164
Hospitalist	1.0%	$386,250	$128,750
Overall	100%	$69,015,261	$240,471

Analysis of Frequency and Severity by Location

- The three locations with the highest frequency of closed claims – which together account for 65.1 percent of all closed claims – are **physician office practice** (35.7 percent), **NP office practice** (16.4 percent) and **aging services facility, skilled nursing** (13.0 percent).
- Both the frequency and severity of NP office practice setting closed claims have increased significantly since the 2012 report. In 2012, this setting accounted for 7.0 percent of the closed claims, with an average paid indemnity of $45,750. In 2017, this setting accounts for 16.4 percent of the closed claims, with an average paid indemnity of $158,611, which is three times greater than in the 2012 report. For a detailed analysis of closed claims involving this location, see pages 36-37.
- As in the 2012 report, closed claims occurring in physician offices have an average paid indemnity higher than the overall average. The majority of the closed claims in this location involve allegations of improper medication prescribing or failure to diagnose, as in the following scenario:
  - A nurse practitioner was the primary treating provider of a 45-year-old female with a history of benign hypertensive heart disease without congestive heart failure. She saw the patient six times over eight months for what seemed to be issues related to hypertension. The symptoms – including mild headaches, tinnitus and double vision – were escalating. One week after the last appointment with the practitioner, the patient suffered from a seizure while at work. The patient was taken to the emergency department where she underwent a CT scan and was diagnosed with a large brain tumor. Medical experts opined that, although the patient had a rapid-growth type of cancer, the tumor should have been detected earlier. The claim was resolved in the mid-six-figure range.
- While infrequent, claims occurring in hospital nurseries, schools, inpatient behavioral health settings and long-term acute care hospitals (LTACHs) have the highest severity. Claims in these locations include the following:
  - An insured neonatal nurse practitioner (NNP) failed to transfer a newborn with a complicated birth and low APGAR score to the neonatal intensive care unit immediately after birth. Instead, she allowed the mother to hold the infant and left the room. While the mother was holding the infant, he stopped breathing and needed resuscitation. The insured, who was responsible for the overall care of the infant, waited two hours before testing the newborn's blood glucose, despite hospital policy requiring glucose testing within 30 minutes of birth. The glucose level was reported as critical at less than 20 mg/dl. The NNP ordered glucose replenishment, but the course she ordered did not achieve normal glucose levels until four to six hours later. The infant is permanently incapacitated, with spastic quadriplegia, seizure disorder, microcephaly, and profound motor and mental retardation. The claim settled for policy limits.

- An insured nurse practitioner, working at a college infirmary, was asked by a maintenance employee at the clinic for a terbinafine prescription for fungal toe infection. The nurse practitioner advised him to see his primary care provider for the prescription, but the employee explained that his primary care provider would not see him because of money owed. The insured reluctantly agreed to a one-time prescription but informed the employee that he would need to arrange with his regular practitioner for any further treatment. Later that day, the pharmacy contacted the nurse practitioner about changing the prescription from terbinafine ($400) to ketoconazole ($40). The insured agreed to the medication change but told the pharmacist that the employee would need bloodwork prior to beginning the prescription. The following day the nurse practitioner ordered baseline serum liver enzymes, which were normal. She then verbally instructed the employee to avoid alcohol and contact his primary care provider for monitoring and follow-up. A month later, the nurse practitioner left her employment at the college and had no further contact with the employee, who never followed up with his primary provider. He eventually suffered liver failure and needed an organ transplant due to acute hepatotoxicity. When the lawsuit was filed against the insured, she stated she never thought of the employee as a patient and had only prescribed him the medication as a favor. An indemnity payment in the high six-figure range was made on behalf of the nurse practitioner due to her failure to monitor the patient.
- A 59-year-old male was admitted after open-heart surgery to a long-term acute care hospital for recovery purposes, including weaning from mechanical ventilation. One week after admission to the LTACH, a respiratory therapist notified the nurse practitioner that the patient's partial pressure of carbon dioxide (PaCO2) level was dangerously high. He recommended that the patient, who was on a trans-tracheal augmented ventilator machine, be placed on a different ventilator to improve his PaCO2 level, but the NP did not do so. The following day, the patient was found unresponsive and could not be revived. The claim settled in the mid-six-figure range.

The three locations with the **highest frequency** of closed claims are **physician office practice, NP office practice** and **aging services facility, skilled nursing**.

5 Severity by Location

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Hospital, nursery	0.7%	$1,500,000	$750,000
School	1.0%	$1,160,000	$386,667
Behavioral health/psychiatric, inpatient	1.0%	$1,114,500	$371,500
Inpatient rehabilitation at hospital or long-term acute care hospital	0.7%	$735,000	$367,500
Emergency or urgent care walk-in center, freestanding	3.8%	$3,754,995	$341,363
Physician office practice	35.9%	$32,600,883	$319,617
Hospital, labor and delivery	1.7%	$1,516,232	$303,246
Patient's home	1.0%	$877,500	$292,500
Hospital, emergency department	4.6%	$3,465,000	$266,539
Hospital, adult critical care unit	0.3%	$250,000	$250,000
Behavioral health/psychiatric, outpatient	3.1%	$2,156,500	$239,611
Prison health service, inpatient or outpatient	3.1%	$1,933,100	$214,789
Hospital, inpatient surgical service	2.1%	$1,246,250	$207,708
Hospital-based outpatient clinic	1.7%	$991,000	$198,200
Aging services, subacute care	1.4%	$757,500	$189,375
Hospital, inpatient medical service	1.0%	$555,000	$185,000
Aging services, assisted living	1.4%	$650,000	$162,500
Nurse practitioner office practice	16.4%	$7,454,733	$158,611
Aging services, skilled nursing	13.0%	$4,849,068	$131,056
Radiology, outpatient intervention/invasive	0.3%	$130,000	$130,000
Substance abuse, short-term inpatient	1.4%	$497,500	$124,375
Hospice	1.0%	$317,500	$105,833
Hospital, operating room or suite	0.3%	$100,000	$100,000
Spa/medispa	1.7%	$255,000	$51,000
Dialysis, freestanding	0.7%	$95,000	$47,500
Practitioner office other than physician or nurse practitioner	0.7%	$53,000	$26,500
Overall	100%	$69,015,261	$240,471

Analysis of Frequency and Severity by Allegation Category

Figures 6 and 7 depict the average and total paid indemnities for all allegation categories. **Diagnosis, medication** and **treatment/care management** allegations account for 84.5 percent of all the closed claims in the dataset. These allegations are analyzed in more detail in Figures 8-13.

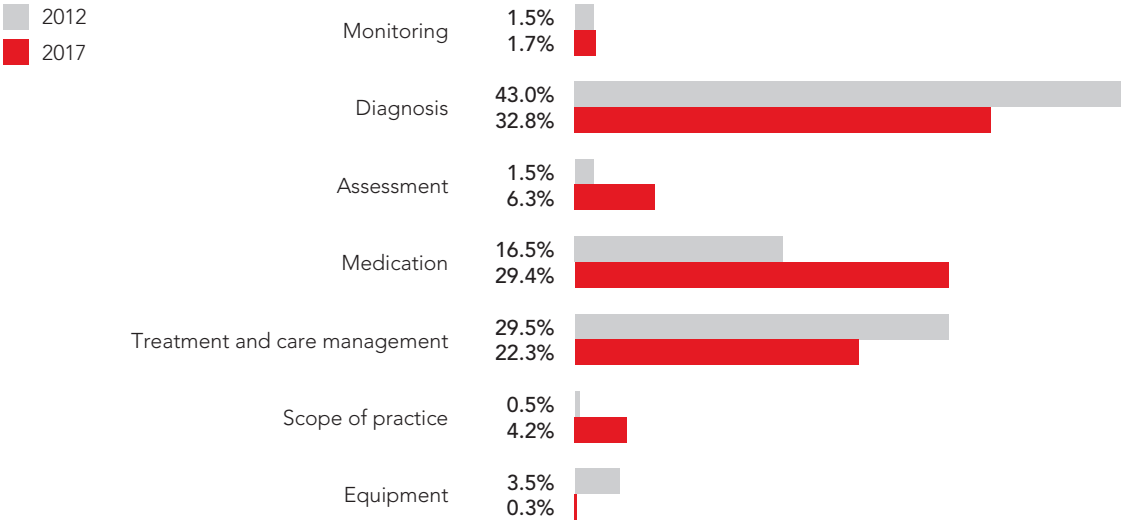
- **Monitoring** closed claims, while infrequent, have the highest severity. Monitoring claims include failure to monitor or timely address blood levels related to medications, as seen in the following case:
  - A woman fell, suffering a fracture to her tibia and fibula. After undergoing surgery to repair the fractures, she was sent to a rehabilitation facility for occupational and physical therapy. Upon admission, a basic metabolic profile was ordered, which showed a significantly elevated potassium level. The treating nurse practitioner was notified and ordered Kayexalate™ to counteract the effects of the potassium. When asked by staff whether the patient should be placed on a cardiac monitor within the facility, the NP stated that this was not necessary. During the night, the patient complained of chest pains but was kept at the facility. The plaintiff was found unresponsive the following morning and was pronounced dead shortly afterward. The patient's family alleged that the NP failed to order that the patient be placed on a cardiac monitor, despite knowing of the elevated potassium level. The claim resolved in the low six-figure range.
- **Assessment** closed claims accounted for 6.3 percent of all claims and have a higher-than-average severity. This category includes failure to complete a patient assessment or perform/document a complete history and physical, as in the following example:
  - A nurse practitioner was working in a small rural emergency department when she was approached by local law enforcement officers. The police officers told her that they had an intoxicated male in their car and asked if she could offer the man any medical assistance for his intoxication. She informed them that while she could order intravenous fluids, the only cure for intoxication is time. The officers decided against having the man treated, instead taking him home and laying him on the floor of his living room. The NP neither assessed nor treated the man. When the man's wife came home later that evening, she found him lying on the floor in emesis and not breathing. He was later pronounced dead at the same emergency department. Because the man was brought to the hospital by the police, the NP should have performed an assessment prior to advising the officers. The claim settled against the NP in the low-to-mid six-figure range.
- **Scope of practice** claims are relatively infrequent but can have serious consequences. The following scenarios involve moments when the nurse practitioner should have advocated for the safety of the patient but failed to do so, leading to patient injury:
  - A 16-year-old male with a known history of substance abuse, depression and psychiatric difficulties claimed to have been involved in a motor vehicle accident. A nurse practitioner failed to contact the parents despite knowing the patient's substance abuse history and prescribed narcotics at discharge. Soon after, the boy's parents found their child dead in their home. The family claimed the NP had failed to inform them of the accident and to educate the patient and parents on the risks of the medications prescribed. This claim was additionally hard to defend as the insured admitted to altering the health information record after she learned of the patient's death. The claim resolved in the low six-figure range.
  - A surgeon was called in late one evening for an emergent spinal surgery. Several of the operating room staff noticed a strong smell of alcohol, and a nurse practitioner assisting the surgeon found that he was acting strangely. A surgical complication ensued, leaving the patient permanently partially disabled. A lawsuit was filed, alleging that the insured had failed to report that the surgeon was not performing his duties appropriately and appeared

to be under the influence of alcohol. The lawsuit further stated that the NP failed to warn and prevent injury to the patient. In deposition, many staff members testified that this was not the first time the surgeon had exhibited this type of behavior. In addition to being sued, the NP was reported to the state board of nursing and was subject to an investigation that lasted three years and incurred legal expenses of more than $20,000. The claim settled in the low six-figure range.

6 Severity of Allegations

Allegation category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Monitoring	1.7%	$2,247,500	$449,500
Diagnosis	32.8%	$26,626,755	$283,263
Assessment	6.3%	$4,456,275	$247,571
Medication	29.4%	$19,602,274	$233,360
Treatment and care management	22.3%	$13,397,457	$209,335
Communication	0.3%	$200,000	$200,000
Scope of practice	4.2%	$1,755,000	$146,250
Abuse/patient rights/professional conduct	1.8%	$560,000	$112,000
Equipment	0.3%	$70,000	$70,000
Documentation	0.3%	$50,000	$50,000
Supervision of others	0.3%	$40,000	$40,000
Confidentiality	0.3%	$10,000	$10,000
Overall	100%	$69,015,261	$240,471

7 Comparison of 2012 and 2017 Claim Distribution by Allegation Category



CASE SCENARIO: Failure to Diagnose

A 9-year-old female presented to the emergency department (ED) accompanied by her mother. The patient was triaged and noted to be ambulatory, with a chief complaint of abdominal aching/cramping, vomiting and diarrhea for five days. Her vital signs were recorded as follows: oral temperature 98.2 degrees Fahrenheit, pulse 116 beats per minute (bpm), unlabored respiratory rate 22 breaths per minute and blood pressure 110/64 mmHg. The patient reported her pain level to be four on a 10-point pain scale. The symptoms the child was experiencing were described by the triage nurse as mild, and the patient was taken to a fast-track (non-urgent) treatment area of the emergency department.

The registered nurse assigned to the patient in the fast-track area assessed the patient, obtained her history from her mother and noted that the onset of symptoms began five days prior to her presentation to the emergency department. At the time of the nurse's assessment, the symptoms were present but had decreased in intensity. The nurse's documented assessment noted that the patient's pain was generalized and described as a dull ache. Bowel sounds in all four quadrants were normal, her abdomen appeared normal and palpation of the abdomen did not elicit tenderness.

The patient reported that the pain, which was located in her abdomen and head, remained at four. The patient's mother stated that the child had diarrhea early that morning and that nothing seemed to either exacerbate or relieve the pain. The mother also noted no decrease in activity, fluid or food intake. Finally, she told the nurse that the patient's brother had had the same symptoms the prior week.

The ED nurse practitioner reviewed and verified with the mother and patient the information gathered by both the ED triage nurse and the fast-track nurse. He noted that the patient was well-developed and well-nourished, was not in acute distress or taking any medications, and had no previous medical history or allergies. Furthermore, his physical assessment noted that the patient's abdomen was flat, non-tender and without palpable masses. The only order the nurse practitioner gave was for the child to receive an oral electrolyte fluid challenge of one milliliter/kilogram (approximately 35 milliliters) every 10 minutes for three hours. The child was monitored during the fluid challenge and experienced neither vomiting nor diarrhea.

When the fast-track nurse reassessed the patient after the fluid challenge, she found the child to be alert and oriented, with warm and dry skin and regular and unlabored respirations. Upon readying her for discharge, the nurse reassessed the patient's vital signs: oral temperature 98.3 degrees Fahrenheit, pulse 103 bpm, regular unlabored respiratory rate 22 breaths per minute, blood pressure 112/65 mmHg and oxygen saturation 98 percent on room air. As the patient was leaving the ED, she began vomiting, but how much or how many times was not documented. The nurse practitioner was notified and, without reassessing the patient, ordered an anti-nausea medication suppository. After the order was completed, the patient was discharged home.

The discharge instructions given to the mother were for the child to have "Clear liquids for the next 24 hours, no dairy products, advance to a BRAT (bananas, rice, applesauce and toast) diet after 24 hours and anti-nausea medication by mouth. Follow up the next day with a pediatrician and return to the ED immediately if symptoms worsen or fail to improve."

According to the child's mother, the child complained of not feeling well all night and began vomiting black emesis when she awoke the next morning. A few minutes after vomiting the last time, the child passed out and her mother could not revive her.

An ambulance was dispatched to the patient's home, and the paramedics found the child unresponsive. At the time of the initial assessment, the child's pupils were fixed, dilated and non-reactive; her skin was cold and dry; her mucosa ashen; and her capillary refill greater than two seconds. Her vital signs were blood pressure 66/44 mmHg, pulse 100 bpm, respiratory rate 8 breaths per minute, and oxygenation saturation 74 percent. Pediatric advance life support was initiated and the child was taken to the nearest ED.

When the ambulance arrived at the ED, the patient was in asystole, her pupils were fixed and dilated, and her extremities were cool and stiff. The child never regained any heartbeat or pulse, despite resuscitation efforts. An autopsy was ordered and the cause of death was ruled acute peritonitis and septicemia due to infection with Shigella sonnei. Urine cultures revealed heavy group B Streptococcus and Escherichia coli (E.coli).

The lawsuit alleged that the NP had misled the mother to believe he was a physician, failed to perform proper physical assessment, failed to order appropriate diagnostic testing (i.e., urine analysis or bloodwork), and failed to correctly diagnose and treat the patient, resulting in her death.

Several experts were asked to review the claim and had mixed comments about the nurse practitioner's documentation and treatment. Some felt that when the child vomited on discharge, she should have been reassessed. Concern was also expressed that the NP's assessment in the electronic health record appeared copied and pasted from the triage and fast-track nurses' documentation, giving the impression that no hands-on assessment had been completed.

The defense counsel felt that a jury would find the nurse practitioner's documentation and diagnostic practices inadequate. Although the patient's death was ultimately due to a type of infection rarely seen in developed countries, a jury could find the NP responsible for the child's death. The decision was made to settle the claim prior to trial.

An indemnity payment in excess of $345,000 was made on behalf of the nurse practitioner, along with expense payments of over $140,000.

Risk control recommendations:

- **Reassess patients when indicated,** e.g., following treatment or a change in condition.
- **After reassessing patients, document key clinical information,** including …
  - Patient's relevant medical history and allergies.
  - Nature of the patient's symptoms and associated complaints.
  - Aggravating and relieving factors.
- **When using an electronic health record system, document clinical encounters and communications with care,** always noting …
  - Date and time of the encounter or discussion.
  - Patient's name and date of birth.
  - Identity of other parties in addition to the patient.
  - Subject of the discussion.
  - Advice given and recommended follow-up.
- **Avoid repetitive copying and pasting,** especially when documenting problem lists, diagnoses, allergies, current medications and history.
- **Be mindful of gender-related perceptions,** e.g., that all men are physicians and all women are nurses.
- **Display name and credentials when speaking with patients/families** and introduce oneself fully, e.g., "Hello, my name is John Doe. I am a nurse practitioner and will be treating you today."

Analysis of Allegation: Diagnosis

- Of all closed claims, **diagnosis-related** ones are the most frequent and have the second-highest average severity at $283,263.
- Although diagnostic claims occurred in many locations, the most common settings are **physician and nurse practitioner offices**.
- The sub-category **failure to identify and report observations, findings or changes in condition** has the highest severity. The single claim of this type has an indemnity payment double the overall average paid indemnity. It involves a nurse practitioner's waiting 11 months to order a PSA level on a patient receiving testosterone injections, although the NP knew the patient had not made follow-up appointments with a urologist. The patient was diagnosed with prostate cancer, which metastasized during the nearly yearlong delay.
- Diagnosis-related closed claims are further divided into five sub-categories, as noted in Figure 8, with **failure to diagnose** having the highest frequency. This sub-category is explored in more depth in Figures 9 and 10.
- A common thread running through diagnosis-related closed claims is lack of sound documentation supporting the decision-making process of the treating practitioner or other staff members under the supervision of the nurse practitioner. In many cases, inadequate documentation hindered legal defense. Common missing or incomplete documentation includes …
  - A thorough history and physical assessment.
  - A current medication list and problem list.
  - Records of the patient missing appointments, failing to complete ordered diagnostic tests and/or neglecting to take prescribed medications.
  - Notification of diagnostic test results and any further treatment or testing needed.
  - Reminders to patients to seek emergency treatment if a condition worsens.
  - Patient education efforts and materials.

(See the risk control recommendations on pages 41-63 and self-assessment checklist on pages 64-71 for strategies on improving documentation. In addition, the Pennsylvania Patient Safety Authority has posted online publications on the subject of diagnostic errors in acute care. Finally, the National Quality Forum has a web page on improving diagnostic quality and safety.)

8 Frequency and Severity of Diagnosis-related Allegations

Allegation sub-category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to identify and report observations, findings or change in condition	0.3%	$500,000	$500,000
Failure to order appropriate tests to establish diagnosis	6.3%	$5,397,664	$299,870
Delay in establishing diagnosis	2.0%	$1,709,733	$284,956
Failure to diagnose	20.7%	$16,680,875	$282,727
Failure or delay in obtaining/addressing diagnostic test results	3.5%	$2,338,483	$233,848
Overall	32.8%	$26,626,755	$283,263

Analysis of Allegation: Illnesses/Injuries Related to Failure to Diagnose

As noted in Figure 8, 20.7 percent of all the closed claims in this dataset involve failure to diagnose. Figures 9 and 10 examine these allegations in greater detail.

- As with the 2012 report, **failure to diagnose infection/abscess/sepsis** and **failure to diagnose cancer and benign tumors** account for more than half of the failure to diagnose closed claims.
- **Failure to diagnose infection** is less frequent than in the 2012 report, although the severity increased by approximately 25 percent. Appendicitis, sepsis and osteomyelitis are the injuries/illnesses most often associated with this category. Legal defensibility was frequently impaired due to inadequate medical documentation.
- **Failure to diagnose cancer and benign tumors** accounts for 8.5 percent of all closed claims in the dataset, a slight increase from 2012 (7.5 percent). The severity is similar to the 2012 report ($242,719). Multiple types of cancers are found in the dataset, but the most common are lung, breast and pelvic. As noted earlier, a common thread in failure to diagnose cancer claims is lack of consistent, thorough documentation of the nurse practitioner's clinical decision-making process.

9 Frequency and Severity of Failure to Diagnose Claims by Illness/Injury

Illness/injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Testicular torsion	0.3%	$800,000	$800,000
Pulmonary embolism	0.7%	$1,100,000	$550,000
Cerebrovascular accident	2.2%	$2,642,500	$440,417
Myocardial infarction	1.0%	$1,140,875	$380,292
Cardiac condition (excludes myocardial infarction)	0.3%	$300,000	$300,000
Infection/abscess/sepsis	5.8%	$4,163,500	$260,219
Laceration/tear/abrasion	0.3%	$250,000	$250,000
Cancer and benign tumors	8.5%	$5,797,750	$241,573
Renal failure	1.0%	$455,250	$151,750
Pregnancy complication	0.3%	$21,000	$21,000
Fracture/dislocation	0.3%	$10,000	$10,000
Overall	20.7%	$16,680,875	$282,727

- Among the failure to diagnose claims, **failure to consider/assess a patient's complaints** has the highest severity, as the plaintiffs in both cases suffered permanent total or partial disability. One of these scenarios follows:
  - A nurse practitioner working in a primary care office had been treating a 30-year-old patient for three years. The patient had a medical history of diabetes, diabetic ketoacidosis, multiple lower lumbar and abdominal surgeries, chronic pain, and drug and alcohol abuse. The patient also had a pattern of reporting his pain medications as lost or stolen. He was noncompliant with his diabetes treatment, and when he received diabetes education, he would comment, "It's not that I'm uneducated [regarding diabetes], it's just that I don't care." The insured saw the patient three weeks in a row for upper thoracic back pain. On his last visit, the patient was in tears and had chills and shaky hands. He stated his pain was very different; it was now an extremely painful burning sensation in his upper back and between his shoulder blades, as if his body were on fire. The patient alleged that the insured did not take his reporting seriously or believe his claims of pain, and interrupted him repeatedly. The patient also claimed that the nurse practitioner refused to order further diagnostic imaging, stating she had enough imaging. The NP prescribed muscle relaxers for the pain and told him to go to the emergency department if his pain worsened. Five days later the patient was unable to get out of bed. He called an ambulance to take him to the emergency department, where he was diagnosed with spinal stroke resulting in paralysis. The claim settled for policy limits.
- **Failure to timely or properly establish and/or order appropriate treatment** has the highest frequency and an average paid indemnity of $253,344.
- **Failure to order appropriate tests to establish a diagnosis** has the second highest frequency and an average paid indemnity significantly higher than the overall average paid indemnity. These claims were often difficult to defend due to lack of documentation supporting the nurse practitioner's treatment of the patient.
  - One claim involves an 11-month-old child in mild distress with a two-day history of fever, vomiting and diarrhea. The mother stated that the child's older siblings had had a stomach virus earlier that week, but the symptoms lasted only hours. The nurse practitioner diagnosed the child with pharyngitis and acute gastritis. The insured instructed the mother to give the child small amounts of fluids every 15 minutes for the next few hours and return if the child's condition worsened. Eight hours later, the child was brought to the emergency department in cardiac and respiratory arrest and never regained consciousness, despite resuscitative measures. According to the autopsy report, the child died of sepsis related to Beta strep, Group B and Klebsiella. A review of the patient healthcare record revealed little to no supportive documentation regarding the nurse practitioner's differential diagnosis. Worse, a chart notation suggested that at the previous office visit two weeks earlier, the child had a complete blood count, showing he was anemic. A notation on the laboratory report from the pediatrician requested that the NP recheck the complete blood count at the next office visit. The insured saw the note from the pediatrician, but could not explain why he had not ordered the blood test. Defense experts stated that had the blood test been performed, the outcome might have been different. The claim settled in the mid-to-low six-figure range.

10 Frequency and Severity of Failure to Diagnose Claims by Cause of Failure

Cause of failure to diagnose	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to consider/assess patient's expressed complaints/symptoms	0.7%	$1,500,000	$750,000
Failure to perform and/or document a timely and complete history and physical examination	0.7%	$825,000	$412,500
Failure to diagnose	0.7%	$777,750	$388,875
Failure to order appropriate tests to establish a diagnosis	4.3%	$4,612,500	$384,375
Failure to obtain consultations to establish a diagnosis	1.0%	$1,025,000	$341,667
Failure to obtain physician consultation for assistance/clarification/collaboration/supervision	0.7%	$625,000	$312,500
Failure to timely/properly establish and/or order appropriate treatment	5.8%	$4,053,500	$253,344
Failure to timely order/obtain diagnostic test/consultation at patient's request due to insurance/affordability issues	0.3%	$250,000	$250,000
Improper or untimely management of medical patient or medical complication	0.3%	$250,000	$250,000
Failure to properly or fully complete patient assessment	1.0%	$573,375	$191,125
Failure to timely/properly address medical complication or change in condition	0.3%	$175,000	$175,000
Failure to enlist assistance from collaborating or supervising physician to establish diagnosis	0.7%	$349,000	$174,500
Delay in obtaining/addressing diagnostic test results or failure to do so	2.9%	$1,373,750	$171,719
Failure to obtain/refer to immediate emergency treatment	0.3%	$125,000	$125,000
Failure to timely address/manage complication or change in post-surgical patient	0.3%	$100,000	$100,000
Improper management of medications	0.3%	$45,000	$45,000
Failure to timely manage complication of pregnancy/labor or report it to physician	0.3%	$21,000	$21,000
Overall	20.7%	$16,680,875	$282,727

Analysis of Allegation: Medication Prescribing

- The average paid indemnity for **medication** closed claims is close to the overall average paid indemnity ($240,471). However, the overall frequency of medication allegations in the current report (29.4 percent) has increased significantly since the 2012 report (16.5 percent).
- **Failure to properly instruct patient regarding medication** has the highest severity among the medication-related allegations, as resultant injuries include death, brain damage and seizures. An example follows:
  - An infant diagnosed with panhypopituitarism was taking Cortef®. The insured NP failed to advise and instruct the mother about the risk of hypoglycemia associated with the medication and the need to monitor her baby's blood glucose level. The infant suffered seizures due to hypoglycemia, leading to delays in motor and social skills, as well as speech. The claim settled in the mid-six-figure range.
- The increased frequency of medication-related allegations is due in part to the allegation of **improper prescribing/managing of controlled drugs,** including schedule II and schedule III opioids such as methadone, oxycodone, fentanyl and hydrocodone. Many times the patient had a history of drug/alcohol abuse and was currently using or abusing schedule IV controlled substances. The injuries associated with this category include addiction and fatal overdose. (Information on prescribing practices can be found on pages 59-61.)

11 Frequency and Severity of Allegations Related to Medication Prescribing

Allegation sub-category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to properly instruct patient regarding medication	1.0%	$2,385,000	$795,000
Failure to recognize contraindication and/or known adverse interaction between ordered medications	4.3%	$5,533,750	$461,146
Improper management of medications	3.9%	$4,212,000	$382,909
Improper prescribing/management of anticoagulant	3.2%	$2,085,024	$231,669
Prescribing error, wrong dose	2.4%	$1,169,000	$167,000
Prescribing/administering error, intravenous fluids and/or medication	0.7%	$310,000	$155,000
Prescribing error, wrong route	0.3%	$100,000	$100,000
Improper prescribing/managing of controlled drugs	12.9%	$3,687,500	$99,662
Prescribing error, wrong medication	0.7%	$120,000	$60,000
Overall	29.4%	$19,602,274	$233,360

Analysis of Allegation: Medication Claims by Illness/Injury

- **Ear injury/hearing loss** is the costliest medication-related injury. The details of this single closed claim can be found on page 26.
- **Death** and **addiction** are the most common medication-related injuries, together accounting for 19.6 percent of all the claims in this subset. As noted in Figure 11, **improper prescribing/managing of controlled drugs** is by far the most frequent medication-related allegation.

12 Frequency and Severity of Medication Claims by Illness/Injury

Illness/injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Ear injury/hearing loss	0.3%	$925,000	$925,000
Brain injury (other than birth-related brain injury)	0.7%	$1,141,250	$570,625
Emotional /psychological harm/distress	0.7%	$997,000	$498,500
Allergic reaction/anaphylaxis	1.0%	$1,394,000	$464,667
Eye injury/vision loss	0.7%	$925,000	$462,500
Steroid-induced psychosis	0.7%	$900,000	$450,000
Cardiac condition (excludes myocardial infarction)	0.7%	$650,000	$325,000
Paralysis	0.3%	$312,500	$312,500
Cerebrovascular accident	1.0%	$875,000	$291,667
Death	9.9%	$7,990,024	$285,358
Loss of organ or organ function	1.0%	$765,000	$255,000
Neurological deficit/damage	1.4%	$742,500	$185,625
Infection/abscess/sepsis	1.0%	$205,000	$68,333
Addiction	9.7%	$1,750,000	$64,815
Pulmonary/respiratory failure	0.3%	$30,000	$30,000
Overall	29.4%	$19,602,274	$233,360

CASE SCENARIO: Improper Management of Medication

A nurse practitioner employed by a rural family practice began treating the 78-year-old mother of a co-worker. The patient presented at the first office visit with a six-month history of difficulty swallowing due to throat swelling and soreness, as well as a persistent cough. She also complained of a pimple-like sore in her right nostril. The patient's prior medical history was positive for coronary artery disease, atrial fibrillation, chronic obstructive pulmonary disease, hyperlipidemia and arthritis.

The insured nurse practitioner prescribed a broad-spectrum antibiotic and a prednisone dose pack, while scheduling the patient for a barium swallow and bloodwork. She also ordered a culture of the patient's throat and the pimple in her nasal passage. Several laboratory values were abnormal, including a decreased white blood cell count, low red blood cell count, low hematocrit, low lymphocytes, low sodium, low chloride, high glucose, high SGOT, low total protein and low albumen. The cultures indicated a positive result for Staphylococcus aureus and Pseudomonas aeruginosa.

The NP prescribed 350mg Gentamicin every day for 10 days to be administered intravenously, advising the patient to have the antibiotic administered at the hospital. The patient refused to receive treatment at the hospital, requesting that the drug be administered at home. The insured verbally informed the patient and her daughter of the medication's potential side effects – such as progressive kidney failure, blurred vision, permanent hearing loss and nerve damage – but did not document the conversation.

The following day the patient started a 10-day regimen of the antibiotic. On the second day of treatment, she fell due to weakness and was taken to the emergency department, where she was diagnosed with a right hip contusion and dehydration. She received intravenous hydration before being discharged home.

The next day the patient came to see the insured. She stated that the antibiotic was making her feel "very woozy" and causing her to fall. Her daughter, angry with the home health nurses, fired the agency and pressured the insured to allow the patient to receive the antibiotic in the office. The insured reluctantly agreed to the request, as she would be in the office the next several days and could oversee the infusions. The insured documented, "Reviewed sputum culture again with patient and daughter, reviewed susceptibility of meds, encouraged hospitalization, patient refuses, already fired home health, patient will come to office, order antibiotic Gentamicin."

After administering the fourth dose of antibiotic on a Friday afternoon, the insured gave a verbal order to a medical assistant to obtain a serum gentamicin level from the patient and to perform several other laboratory tests. The assistant obtained the requested laboratory specimens but not the gentamicin level. The office was closed on weekends, so a medical assistant administered the antibiotic both days at the patient's home, with no NP or physician present.

On Monday morning, the nurse practitioner received a telephone call from the patient's daughter, who was concerned about her mother's condition and asked the NP to see the patient at her home. When she arrived, the patient complained of dizziness and was unable to get out of bed without assistance. Once the insured NP saw how weak the patient was, she called the office to ascertain the gentamicin level. Learning that no sample had been obtained, she drew one herself and discussed the patient with her collaborating physician. The physician advised starting the patient on intravenous fluids, but did not recommend hospitalization.

Later that day, the gentamicin level results were called in to the office. They were critically high. The insured instructed the patient's daughter to take her to the emergency department for treatment of gentamicin toxicity.

The patient suffered complete loss of hearing in both ears and acute renal failure, which has since resolved. She has been in and out of a nursing home for therapy. Her daughter has had to quit work to take care of her mother.

The claim settled in the high six-figure range, with expense costs of slightly less than $50,000.

Risk control recommendations:

- **Discuss the patient's condition, medications and care needs with the collaborating or supervising physician as needed,** and document these discussions.
- **Use caution when prescribing anticoagulants, antibiotics and psychoactive medications,** as well as other known toxicity-prone drugs.
- **Order and follow up with all indicated monitoring tests,** documenting results in the patient healthcare information record.
- **Avoid verbal orders** except in emergency situations.
- **Consult with a pharmacist as needed,** documenting all communications.
- **Remain current regarding clinical practice, medications, biologics and equipment** related to the diagnosis and treatment of illnesses and conditions encountered in one's specialty.
- **Prior to delegating patient care services,** ensure that the assigned services are within the scope of practice or work of the individual.
- **Be cautious about treating or providing care to family, friends or co-workers.** While it is not always easy to say no to requests from relatives and friends, the situation may cloud professional judgment and lead to ethical lapses.
- **Politely decline any suggestions or recommendations from patients that could jeopardize their safety** or lead to later questions about one's clinical expertise and/or judgment.
- **Refrain from initiating personal relationships outside of the care setting** with patients and their family members.

Analysis of Allegation: Treatment and Care Management

- Treatment and care management allegations have decreased slightly in terms of both frequency and severity since the 2012 report, at 29.5 percent (2012) versus 22.3 percent (2017) and $220,431 (2012) versus $209,335 (2017).
- In both the 2012 and 2017 reports, the allegation in this category with the highest severity is **failure to respond to patient's concerns related to the treatment plan.** The two claims proved difficult to defend due to the gravity of the patients' injuries and the lack of response by the practitioners, as seen in the following example:
  - An independent contractor nurse practitioner was on call for medical services at a detention center. The insured received a call from the detention center's medical staff regarding an incarcerated 26-year-old female seeking treatment for thigh pain, low-grade fever and a large abscess on her left thigh. The patient had a long history of intravenous drug use and Hepatitis C. The insured ordered an X-ray, which was normal, as well as over-the-counter pain medication for the patient. A day later, the patient returned to the medical staff with a baseball-sized abscess on her thigh and increased fever. The medical staff could not immediately reach the insured, but when contact was made the nurse practitioner requested that the patient's abscess be cultured and ordered a broad-spectrum antibiotic. This was the last time the insured had any dealings with the patient. However, the next day the medical staff noted that the patient's abscess was approximately the size of a basketball and the patient could not bear weight on the affected leg. The patient was sent to the local emergency department where she was diagnosed with severe sepsis. The claim settled in the low-to-mid-six-figure range.
- **Improper/untimely treatment/management of a pressure injury** has the highest frequency in this category. Typically, these claims occur in a skilled nursing facility and have a relatively low average paid indemnity. In several of the claims, the nurse practitioner was not informed of the severity of the pressure injury. However, as the primary care provider, the NP should have taken a more active role in the patient's/resident's treatment, as seen in the following example:
  - A nurse practitioner with independent contractor status was the primary care provider of a resident with a worsening pressure injury and declining nutritional status. The NP was not asked to address these problems until several weeks had passed. When laboratory test results for a possible infection were received, the nurse responsible for the resident waited several hours before notifying the nurse practitioner of the critical laboratory results. By the time the insured NP reviewed the results, the resident's condition had deteriorated greatly and the resident had to be transferred to a hospital. The claim resolved in the mid-five-figure range.

(For more information on pressure injuries, see the Pennsylvania Patient Safety Authority's resources on hospital-acquired pressure injury and skin integrity in class III obese patients.)

13 Frequency and Severity of Allegations Related to Treatment and Care Management

Allegation sub-category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to timely respond to patient's concerns related to the treatment plan	0.7%	$1,225,000	$612,500
Premature cessation of treatment	0.3%	$425,000	$425,000
Improper or untimely management of medical patient or medical complication	1.5%	$1,650,000	$412,500
Abandonment of patient	0.3%	$400,000	$400,000
Improper/untimely management of aging services resident	1.0%	$895,000	$298,333
Failure to timely/properly establish and/or order appropriate treatment	3.4%	$2,277,500	$253,056
Improper or untimely management of obstetrical patient/complication	1.0%	$749,500	$249,833
Failure to timely address behavioral health condition/complication	2.4%	$1,635,000	$233,571
Failure to obtain/refer to immediate emergency treatment	2.4%	$1,350,600	$192,943
Failure to timely/properly address medical complication or change in condition	1.0%	$540,000	$180,000
Improper technique or negligent performance of treatment or test	1.8%	$834,232	$166,846
Failure to contact patient's physician	1.0%	$465,000	$155,000
Failure to timely manage or report complication of pregnancy/labor to physician	0.3%	$150,500	$150,500
Failure to timely address/manage complication or change in surgical patient	0.3%	$106,250	$106,250
Retained foreign body	0.3%	$60,000	$60,000
Improper or untimely treatment/management of pressure injury or other non-surgical wound	4.3%	$591,375	$49,281
Failure to supervise others when appropriate	0.3%	$42,500	$42,500
Overall	22.3%	$13,397,457	$209,335

Injuries

- **Death** remains the most common injury, accounting for 44.9 percent of claims in 2017 versus 45.0 percent in 2012. The average paid indemnity for death-related claims ($232,277) is slightly less than the overall average paid indemnity ($240,471).
- **Addiction** claims grew almost tenfold between 2012 and 2017, from 1.0 percent to 9.5 percent of all the closed claims in the dataset. Average paid indemnity of addiction claims is relatively low at $64,815. All of these claims occurred in a physician office practice or clinic and involved allegations that the nurse practitioner prescribed excessive amounts of medications, including opioids, antianxiety drugs and/or muscle relaxants. While this injury directly relates to the overprescribing of highly addictive medications, it does not include all injuries associated with prescribing of schedule II and III drugs. For additional information, see pages 60-61.
- The claim involving **embolism** as the primary injury is discussed on page 11.
- **Ear injury/hearing loss** and **eye injury/vision loss** claims were relatively infrequent but had high severity due to the permanence of the injury.
- The **wrongful life** claim involves a nurse practitioner working in a high-risk maternal-fetal practice:
  - The insured nurse practitioner saw a patient who was 18 weeks pregnant for a regularly scheduled appointment. She was considered a high-risk pregnancy due to her age (44). The patient had a language barrier but was always accompanied by a family member to interpret. The nurse practitioner informed the patient that all genetic screening was normal but encouraged her to undergo amniocentesis to officially rule out any genetic concerns. The patient declined the recommendation. Her infant daughter was born with a chromosomal defect that would have been detected if an amniocentesis had been performed. She is severely disabled. Shortly after the birth, a lawsuit was filed against the nurse practitioner and her employer. During the discovery phase, the patient and interpreter testified that they had no recollection of ever discussing amniocentesis. The patient felt that she had not been properly informed, asserting that no one had told her that the genetic testing already performed was not 100 percent effective in screening for genetic defects. The NP made an excellent witness in deposition, but a review of the medical record revealed minimal documentation of the visit. In fact, the NP had been employed for only a few weeks when she saw the patient and had no subsequent contact. The claim settled for a high amount due to the child's need for lifelong 24-hour care. For risk control recommendations regarding informed consent and use of interpreters, see pages 51-57 and 68-69.

14 Frequency and Severity by Injury

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Embolism	0.3%	$1,000,000	$1,000,000
Ear injury/hearing loss	0.3%	$925,000	$925,000
Wrongful life	0.3%	$630,000	$630,000
Eye injury/vision loss	1.0%	$1,675,000	$558,333
Suicide	0.7%	$1,102,500	$551,250
Glycemic events	0.7%	$1,025,000	$512,500
Allergic reaction/anaphylaxis	1.0%	$1,394,000	$464,667
Brain injury (other than birth-related brain injury)	1.0%	$1,391,250	$463,750
Medication-related injury not otherwise classified	0.7%	$900,000	$450,000
Fetal/infant birth-related brain injury	1.8%	$2,166,232	$433,246
Loss of organ or organ function	2.8%	$3,118,233	$389,779
Cerebrovascular accident	2.8%	$2,845,000	$355,625
Cardiac condition (excludes myocardial infarction)	1.4%	$1,350,000	$337,500
Paralysis	2.8%	$2,397,500	$299,688
Increase or exacerbation of illness	0.7%	$550,000	$275,000
Pulmonary/respiratory failure	1.7%	$1,318,000	$263,600
Amputation	2.8%	$1,999,500	$249,938
Infection/abscess/sepsis	4.5%	$3,150,275	$242,329
Cancer	3.6%	$2,393,750	$239,375
Death	44.9%	$29,963,663	$232,277
Autoimmune disease	0.7%	$424,500	$212,250
Neurological deficit/damage	2.1%	$1,167,500	$194,583
Emotional/psychological harm/distress	3.8%	$2,054,500	$186,773
Bleeding/hemorrhage	0.7%	$370,000	$185,000
Myocardial infarction	0.7%	$310,000	$155,000
Appendicitis	1.8%	$762,500	$152,500
Fracture	0.3%	$100,000	$100,000
Meningitis	0.3%	$100,000	$100,000
Renal/kidney failure	0.7%	$172,483	$86,242
Addiction	9.5%	$1,750,000	$64,815
Retained foreign body	0.3%	$60,000	$60,000
Burn	1.8%	$282,500	$56,500
Spinal pain/injury, lumbar, coccyx	1.0%	$140,000	$46,667
Pressure injury	0.3%	$26,375	$26,375
Overall	100%	$69,015,261	$240,471

Causes of Death

- Five causes of **death** (**infection/abscess/sepsis, cancer, respiratory arrest, suicide** and **cardiac arrest**) account for 26.6 percent of all closed claims. The average paid indemnities for cancer and respiratory arrest resulting in death are higher than the overall average paid indemnity.
- **Death caused by infection/abscess/sepsis** accounts for 9.9 percent of all closed claims in the analysis, with an average paid indemnity of $191,429. The frequency has remained relatively flat since the 2012 report (10.0 percent), but average paid indemnity has risen by $37,830. The majority of infection/abscess/sepsis deaths occurred in aging service facilities.
- **Cancer** has the second-highest frequency at 6.7 percent of closed claims. Often the nurse practitioner would fail to follow up with the patient after an abnormal diagnostic test. The patient's cancer may have been treatable at the time of the test, but it metastasized due to the delay in diagnosis, resulting in death, as in the following example:
  - A 49-year-old man presented to a physician office practice for a single visit, complaining of abdominal pain, fever, chills and sweats of two weeks' duration. The insured nurse practitioner diagnosed the patient with probable diverticulitis, prescribed medications and referred him for a diagnostic CT scan of the abdomen/pelvis with contrast to confirm the diagnosis. The CT scan confirmed the diagnosis of diverticulitis. Additionally, and quite significantly, it also revealed a 3.5 cm left renal lesion measuring higher in density that was suspected to be a simple cyst, as well as a 6 mm liver lesion that also looked like a cyst. A follow-up CT scan or MRI with or without contrast was suggested for further evaluation. The radiology report notes that the findings were discussed with the insured. The patient health information record shows that the insured attempted to telephone the patient on three occasions without success. No further attempts were made to communicate the above findings to the patient either by way of one of the numerous other telephone numbers listed in the health information record or by certified letter. The insured testified that after making the aforementioned attempts to contact the patient, he placed the chart on his desk as a visual reminder to attempt to call the patient again in a week or so. The patient never returned to the practice. However, he called the office two weeks after his CT scan, requesting the results. When the insured received the message, he requested that the office staff schedule an appointment with the patient to discuss the results. The staff scheduled an appointment with the patient for the following week. When the office staff called the patient to confirm his appointment, the patient advised that he was canceling the visit and that he had found a new practitioner because no one from the practice called him back regarding his test results. The conversation was communicated to the office manager in memo form. The insured testified that he never saw the message and wished it had been brought to the attention of one of the medical practitioners. Six months later, the patient sought treatment from a second practitioner with complaints of continued weight loss, fever and no appetite. He was sent for a chest X-ray and CT scan of the abdomen. The chest X-ray revealed moderate-sized pleural effusion associated with lower lobe consolidation, which was presumed to be pneumonia. Follow-up was recommended to check on progress and ensure that there was no underlying mass. A new CT scan was performed and compared to the first CT study, revealing an expanding mass in the anterior mid-pole left kidney that was felt to be compatible with renal cell carcinoma. A previously observed 6 mm hypodensity located centrally in the liver was felt to be stable, but a new 3 mm hypodensity was now observed inferiorly within the right hepatic lobe. Additionally, the scan suggested a malignant process within the chest. The patient was diagnosed with stage IV renal cell carcinoma, which had metastasized to his lungs and liver and later to his brain. The patient had multiple hospitalizations, treatments and surgical procedures – including bronchoscopy, exploratory thoracoscopy, right pleural effusion drainage, right pleural biopsies, craniotomy with resection of a brain tumor and chemotherapy – but died at the age of 51. The claim settled in the high six figures.

- **Fatal allergic/anaphylactic reaction,** while infrequent, has the highest average paid indemnity of all death-related claims. These closed claims involve a nurse practitioner who knew or should have known of a patient's allergy to a specific class of antibiotics, yet prescribed a drug within that class, as in the following example:
  - A 55-year-old female presented to an urgent care facility for treatment of a sinus infection and upper respiratory problem that had been present for over two weeks. The patient was treated by a nurse practitioner, who diagnosed bronchitis and ordered ceftriaxone and steroid intramuscular (IM) injections. The patient's health information record noted an allergy to cephalosporin. The insured NP questioned the allergy during the assessment and the patient replied that she had suffered a rash several years ago, but the last two times she had taken a cephalosporin antibiotic it caused no problems. The patient received the two IM injections and, without being monitored for any length of time, left the facility. She then walked to a restaurant across the street and, while ordering her meal, went into respiratory distress. The restaurant called 911, summoning an emergency management team, which gave the patient 0.5 mg of epinephrine IM. Upon arrival at the hospital, the patient was intubated, became unresponsive and died soon after. The cause of death was ruled as anaphylaxis. During deposition, a nurse employed by the urgent care center blamed the NP for the incident and mentioned several other medication-related near-misses. This finger-pointing eliminated any chance to defend this claim, which settled in the high six figures.

Fatal allergic/anaphylactic reaction, while infrequent, has the highest average indemnity of all death-related claims.

15 Frequency and Severity by Cause of Death

Selected cause of death	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Allergic reaction/anaphylaxis	1.0%	$2,012,500	$670,833
Aneurysm	0.7%	$800,000	$400,000
Cerebrovascular accident	2.1%	$2,242,500	$373,750
Cardiac condition (excludes myocardial infarction)	2.9%	$2,920,000	$365,000
Cancer	6.7%	$5,857,750	$308,303
Respiratory arrest	3.6%	$2,937,500	$293,750
Myocardial infarction	1.0%	$745,000	$248,333
Renal/kidney failure	1.0%	$677,500	$225,833
Bleeding/hemorrhage	0.7%	$420,024	$210,012
Pneumonia/respiratory infection	2.1%	$1,200,769	$200,128
Infection/abscess/sepsis	9.9%	$5,360,000	$191,429
Embolism	2.4%	$1,248,750	$178,393
Seizure	0.7%	$310,000	$155,000
Cardiac arrest	3.2%	$1,540,000	$154,000
Fetal death	0.3%	$150,500	$150,500
Suicide	3.2%	$980,000	$108,889
Glycemic event	1.0%	$304,995	$101,665
Overdose	1.4%	$205,000	$51,250
Injury resulting from elopement	0.3%	$25,000	$25,000
Graves' disease	0.3%	$15,875	$15,875
Cervical spine injury	0.3%	$10,000	$10,000
Overall	44.9%	$29,963,663	$232,277

Disability Outcome

- **Permanent total disability** accounts for 5.6 percent of all the closed claims, compared with 13 percent in the 2012 report. Due to the medical and social support that such patients will need for the rest of their lives the average paid indemnity for permanent total disability claims is more than twice as high as for death-related claims, which are, however, more frequent.
- **Temporary partial disability frequency** has doubled since the 2012 report, and severity has more than tripled. Within this disability outcome are allegations of improper prescribing/managing of controlled drugs, with addiction as the most commonly cited injury.

16 Frequency and Severity by Disability Outcome

Disability outcome	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Permanent total disability	5.6%	$7,950,732	$496,921
Permanent partial disability	27.8%	$23,980,241	$299,753
Death	44.9%	$29,963,663	$232,277
Temporary partial disability	21.7%	$7,120,625	$114,849
Overall	100%	$69,015,261	$240,471

The average paid indemnity for **permanent total disability** claims is more than **twice as high as** for **death-related claims**.

Analysis of Nurse Practitioner Office Practice Closed Claims

- While the most common office-related claims involve medication, the costliest closed claims relate to **diagnosis,** with an average paid indemnity of $548,244. This high severity is driven by the following two closed claims:
  - One claim that closed at policy limits involves a nurse practitioner who failed to diagnose a patient with a recurrent spinal abscess, even though the patient had a history of this condition. The claim was difficult to defend due to the perception that the NP had altered the patient healthcare information record after the claim was filed against him.
  - Another high-indemnity claim is discussed on page 22. It involves the nurse practitioner's **failure to identify and report observations, findings or changes in condition** in relation to a noncompliant patient.
- The majority of medication-related allegations related to prescribing involve the **improper prescribing/management of controlled drugs.**
  - Many of these claims were challenging to defend based on the excessive amounts of controlled medications prescribed and the paucity of supportive documentation. See page 59-61 for prescription-related risk control recommendations.
  - Several closed claims involve criminal charges and actions taken against the NP's license to practice. For additional information on license protection claims involving medication-related complaints, see pages 81-82.

17 Frequency and Severity of Nurse Practitioner Office Practice Claims by Allegation Type

Allegation type	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Diagnosis	1.0%	$1,644,733	$548,244
Treatment and care management	1.4%	$1,175,000	$293,750
Medication	12.4%	$4,515,000	$129,000
Documentation	0.3%	$50,000	$50,000
Scope of practice	0.3%	$37,500	$37,500
Abuse/patient's rights/professional conduct	0.7%	$22,500	$11,250
Confidentiality	0.3%	$10,000	$10,000
Overall	16.4%	$7,454,733	$158,611

- The costliest office-related closed claim has **infection/abscess/sepsis** as the injury. It closed at policy limits and is described on page 36.
- **Addiction** is the most frequent NP office claim injury. As already mentioned, such claims are difficult to defend whenever the insured nurse practitioner is shown to have failed to meet fundamental prescribing and documentation standards.
- **Death** is the second most frequent injury in this claim category. The majority of claims involve nurse practitioners who over-prescribe controlled medications, leading to unintentional overdose.

18 Frequency and Severity of Nurse Practitioner Office Practice Claims by Injury

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Infection/abscess/sepsis	0.3%	$1,000,000	$1,000,000
Increase or exacerbation of illness	0.3%	$500,000	$500,000
Neurological deficit/damage	0.3%	$400,000	$400,000
Death	3.9%	$3,005,000	$273,182
Loss of organ or organ function	0.7%	$344,733	$172,367
Cerebrovascular accident	0.3%	$125,000	$125,000
Emotional/psychological harm/distress	1.8%	$470,000	$94,000
Addiction	8.8%	$1,610,000	$64,400
Overall	16.4%	$7,454,733	$158,611

CASE SCENARIO: Failure to Diagnose Allegation – a Success Story

CNA vigorously defends insureds against unsubstantiated allegations. The following claim scenario exemplifies a successful defense of a CNA/NSO-insured nurse practitioner:

A 43-year-old male had been a patient of a family practice for over five years, making many office visits during that time. He had a medical history of hypertension, anxiety disorder, depression, back pain and frequent upper respiratory infections, and a social history of a pack-a-day smoking and minimal use of alcohol. The patient's blood pressure was often in the 130-140/80-100 mmHg range, consistent with stage I hypertension. Blood testing revealed high triglycerides (219 mg/dL) and elevated calcium levels, while pulmonary function testing showed moderately severe obstruction, a sign of possible emphysema. Although the patient's hypertension was recognized, his principal medical challenge appears to have been his pulmonary status.

The patient typically presented with respiratory illnesses, including sinusitis, bronchitis, ear infections and upper respiratory infections, with occasional complaints of back pain. He was regularly medicated for hypertension, as well as respiratory infections, nicotine addiction, acid reflux disease, anxiety and depression. Based upon the health information record, smoking, stress and diminished physical activity appear to have contributed to his hypertension. He was prescribed anti-hypertensives, antibiotics for his respiratory infections and a nicotine patch, but he was consistently noncompliant for financial reasons. He was also urged repeatedly to stop smoking.

The insured nurse practitioner was employed by the family practice and treated the patient, as did all members of the medical group, which included physicians, nurse practitioners and physician assistants. The patient called the office and requested an appointment due to cough, chest congestion and a sore throat. Later that day, the patient presented to the nurse practitioner with complaints of upper back pain/spasm, a cough, chest congestion and a sore throat. His blood pressure was very low (95/58 mmHg), and a repeat blood pressure remained low at 100/68 mmHg. A spirometry (i.e., pulmonary function) test revealed moderate to severe obstruction. The insured diagnosed him with bronchitis, upper respiratory infection with cough, pharyngitis (ruling out streptococcal pharyngitis), and thoracic pain secondary to muscle spasm. She prescribed an antibiotic, a cough suppressant and an anti-inflammatory medication; wrote an order for an X-ray of the thoracic spine; and again advised him to stop smoking. It appears that the thoracic X-ray was never done.

Two days later, the patient returned to the office and was seen by a physician, who recorded the visit as a "Follow up for bronchitis, still sick." The patient's blood pressure had risen to 141/86 mmHg and upper respiratory symptoms had improved only 50 percent. Spirometry testing continued to show moderate obstruction with low vital capacity and auscultation of his lungs revealed bilateral wheezing and rhonchi.

A blood sample was drawn in the office, revealing an elevated white blood cell count and decreased volume. The physician's differential diagnosis was bronchitis versus possible pneumonia. The patient was given an intramuscular injection of corticosteroid and instructed to continue his antibiotic therapy. The physician also prescribed a bronchodilator and a corticosteroid and ordered a stat chest X-ray.

After leaving the medical office, the patient proceeded to an outpatient diagnostic imaging center for the chest X-ray. The radiologist read the film as: "Compatible with pneumonia, due to patchy bilateral lower lobe infiltrates. Cardiac silhouette not enlarged. The pulmonary vessels are normal." However, the aorta was not described. The results of the X-ray were reported to the ordering physician by telephone and the dictated report was mailed two days later.

The morning after the physician office visit, the patient was found unconscious at home. He was taken by ambulance to a local emergency department (ED), where he was found asystolic and not breathing, according to the healthcare informational records. He was pronounced dead on arrival at the ED. A postmortem autopsy recorded the cause of death as cardiac tamponade due to ruptured aortic dissection.

The widow filed a lawsuit against several treating providers, including the insured nurse practitioner. The chief allegation against the NP and her collaborating physician was failure to diagnose an acute aortic dissection based upon the signs and symptoms presented in the days before the patient's death. The claim averred that the providers' mismanagement prevented medical and surgical interventions which could have saved the patient's life.

Defense experts found that the nurse practitioner's actions were within the standard of care. The experts stated that the patient's back pain was consistent with prior complaints and, in any event, it was not the type of severe pain usually associated with an aortic dissection. The experts also testified that the patient's low blood pressure at the time of his office visit was more than likely a result of his respiratory illness and not the aortic dissection.

There were several codefendants in the case, including the radiologist, the last treating physician, the physician practice that employed the nurse practitioner and the nurse practitioner. Given the positive expert opinions, CNA filed a motion for partial summary judgment on behalf of the nurse practitioner. However, the motion was denied by the court. CNA then defended the nurse practitioner in court, and the codefendants also took their respective cases to trial.

At the end of the trial, the plaintiff demanded that the jury consider an award of $6,437,404, including $1,187,404 in lost earnings, $5 million for loss of parental guidance for the couple's two children and $250,000 for pre-death pain and suffering. After more than two weeks of trial testimony, the jury returned a defense verdict. Due to the successful legal defense, no indemnity payment was made on behalf of the nurse practitioner, although expenses exceeded $350,000 over the nine years of litigation.

Risk control recommendations:
A complete and accurate healthcare information record is the best legal defense. If a patient is chronically noncompliant, providers should protect themselves against potential liability by documenting these behaviors and demonstrating the patient's pattern of resisting medical advice.

The following measures can help enhance both patient compliance and legal defensibility in the event of a claim:

- **Document all patient-related discussions, consultations, clinical information, treatment orders made and other actions taken,** including the supporting rationale and decision-making process.
- **Adhere to relevant documentation standards,** including state and local regulations, professional association guidelines and employer protocols. If these differ, follow the stricter requirements.
- **Review the recommended care plan with patients** and have them confirm in writing that they agree to the plan and understand their responsibilities.
- **Discuss potential barriers to compliance with treatment recommendations,** including financial/insurance concerns and logistical issues.
- **Talk to patients about the importance of compliance,** and document this discussion in the healthcare information record.
- **If noncompliance continues, provide a written description of the potential harmful consequences.** Ask patients to sign the document, then give them a copy and place the original in the healthcare information record.
- **Assess the risk involved in continuing to provide care to chronically noncompliant patients.** In some cases, it may be necessary to suspend or terminate the practitioner-patient relationship in accordance with written practice policies.
- **If patients are noncompliant for financial reasons, discuss available options,** including manufacturer drug-provision arrangements, state and local agencies, and federal assistance programs.

Summary of Closed Claims with Indemnity Payment of $1 Million

The closed claims in Figure 19 resolved with an indemnity payment of $1 million. Note that the CNA/NSO professional liability insurance indemnity limit is $1 million per claim, although judgments against a defendant may be higher. Half of the highest-severity closed claims involve diagnosis.

19 Closed Claims with Paid Indemnity of $1 Million

Summary	Allegation	Injury	Specialty	Location
Failed to properly diagnose and treat influenza.	Diagnosis	Respiratory failure	Adult medical/ primary care	Hospital, emergency department
Failed to diagnosis a spinal tumor after patient was seen with abnormal gait and severe back pain.	Diagnosis	Paralysis	Adult medical/ primary care	Physician office practice
Failed to diagnose and treat necrotizing fasciitis, leading to amputation.	Diagnosis	Amputation	Adult medical/ primary care	Hospital, emergency department
Failed to diagnose spinal abscess, even though patient had history of same.	Diagnosis	Paralysis	Family practice	Nurse practitioner office practice
Failed to respond to patient's complaint of calf pain, leading to a deep vein thrombosis.	Treatment/care	Pulmonary embolism	Adult medical/ primary care	Physician office practice
Failed to care for newborn in the neonatal intensive care unit.	Treatment/care	Glycemic event resulting in permanent disability	Obstetrics-postpartum	Hospital, nursery
Failed to recognize hypersensitivity syndrome to a prescribed medication.	Medication	Allergic/ anaphylactic reaction	Behavioral health	Behavioral health/ psychiatric, outpatient
Failed to contact patient's prescribing practitioner prior to twice refilling an antiarrhythmic medication.	Medication	Death	Adult medical/ primary care	Nurse practitioner office practice
Improperly prescribed an antibiotic to a patient with a known history of allergy to this drug class.	Medication	Death	Adult medical/ primary care	Physician office practice
Failed to diagnose a myocardial infarction even though patient had a history of heart disease.	Diagnosis	Death	Adult medical/ primary care	Physician office practice

Risk Control Recommendations

The following risk control recommendations, which complement and supplement the strategies included in the preceding section, can serve as a starting point for nurse practitioners seeking to assess and enhance their patient safety and risk management practices.

Scope of Practice

Nurse practitioners are required to practice within the scope of their state's practice act, as well as their employer's policies and procedures and their own job descriptions. Practicing outside these applicable regulations or policies can jeopardize patient safety and lead to a lawsuit or a board complaint. The following strategies can help reduce the likelihood of scope of practice-related allegations:

- **Annually review the state nurse practitioner practice act,** job description or contract, and organizational policies and procedures.
- **Know the organization's policies and procedures** related to clinical practice, documentation, and appropriate responses to assignments beyond one's current scope of practice and experience.
- **Contact organizational leadership** if a job description, contract, or set of policies and procedures appears to violate one's legal scope of practice.
- **Clearly state one's unwillingness to risk license revocation and potential legal action** by failing to comply with the scope of practice delineated within the state nurse practitioner act.

Annually review the state nurse practitioner practice act, job description or contract, and organizational policies and procedures.

Disrespectful Behavior

Bullying, harassment, intimidation and other forms of disrespectful behavior in healthcare have been linked to medical errors, provider burnout and lost work days. Such conduct may also lead to complaints and civil lawsuits, as well as poor morale and high staff turnover. The Joint Commission refers to workplace bullying and intimidation as either *lateral* (i.e., nurse on nurse) or *horizontal* (i.e., physician on nurse) violence. Both types of aggression can occur in every type of healthcare setting.

As owners of healthcare practices and leaders in organizations, nurse practitioners play a critical role in battling bullying and harassment. The following strategies can help maintain a respectful, humane workplace:

- **Establish a "no retribution" policy for those who report disrespectful behavior.** This policy must be established at the very onset of organizational anti-bullying efforts and be communicated to all staff.
- **Create an interdisciplinary code of professional conduct** designed to encourage collegiality, collaboration, mutual trust and respect. (See Kramer, M. and Schmalenberg, C. "Securing 'Good' Nurse Physician Relationships." *Nursing Management*, July 2003, volume 34:7, pages 34-38.)
- **Clearly articulate both desired and unacceptable behavior.** Do not assume that staff already understand and accept basic behavioral expectations. (See Porto, G. and Deen, J. "Drawing the Line: Effective Management Strategies for Disruptive Behavior." *Patient Safety & Quality Healthcare*, November/December 2008.)
- **With leadership support, develop an intervention policy for unacceptable behavior** that encompasses fairness to all parties, consistency in enforcement, a tiered response to infractions, regular performance evaluations and a restorative process to help people change their behavior. (See Leape, L. et al. "Perspective: A Culture of Respect, Part 2: Creating a Culture of Respect." *Academic Medicine*, July 2012, volume 87:7, pages 853-8.)
- **Emphasize that there is zero tolerance for disrespectful behavior,** regardless of the offender's standing in the organization.
- **Communicate to staff that no one deserves to be treated less than respectfully,** even in the wake of an error. If those who generate the most revenue are excused from responsibility for their actions, the code of conduct will have little impact on anyone else's behavior.
- **Consider providing additional and separate education to practitioners and hospital leaders** who set the organizational tone and must model respectful behavior to others.

The following resources offer additional information on curbing disrespectful and abusive behavior in healthcare settings:

- From the Institute for Safe Medication Practices (ISMP), see the *Nurse Advise-ERR*® article "Unresolved Disrespectful Behavior in Healthcare," Part I and Part II.
- From The Joint Commission's *Quick Safety* online bulletin, see "Bullying Has No Place in Health Care."
- From the National Institute for Occupational Health and Safety, see the online course "Workplace Violence Prevention for Nurses."

Records Management

The paper or electronic patient healthcare information record serves two major purposes: communicating information both within and outside the practice and creating a written history in the event of later questions or challenges. It serves as objective documentation of all phases of medical treatment, including the care plan, laboratory and diagnostic testing, procedures performed and medication provided.

Because complete, accurate and legible health records are such an essential risk management measure, every practice needs a written policy governing documentation issues, and all staff members should be trained in proper documentation practices. The policy should address, among other issues, healthcare information record contents, patient confidentiality, and the release and retention of patient healthcare information records.

Patient Healthcare Information Records

The patient healthcare information record should contain a complete picture of the patient's entire course of treatment. At a minimum, the record should include the following components:

- Identifiable patient information.
- An accurate and current problem list.
- A medication list updated at each patient visit.
- Patient weight in metric units and pounds with units clearly indicated (e.g., 68 kg or 150 lbs).
- A highly visible, front-of-the-healthcare-record listing of food, medication and environmental allergies and known reactions.
- Laboratory and other diagnostic test results.
- Opioid status (i.e., naïve or tolerant).
- Advance directives.
- Consents and authorizations.

In addition, the record should contain a complete history and physical that addresses …

- The chief complaint(s).
- A review of symptoms.
- Past medical history.
- Screening and/or diagnostic test results with associated analysis and treatment recommendations.
- Family history.

At a minimum, the following facts, events and interactions also should be documented:

- **A current summary of the patient's condition,** including but not limited to presenting problems, clinical findings, assessment, treatment plan and the outcome of the prescribed treatment.
- **Any and all advice and instructions** provided to the patient, together with patient responses.
- **Patient education provided, both spoken and written,** noting pamphlet title(s) and the patient's ability to comprehend the information given.
- **Instructions for return visits to the office** for follow-up testing, treatment or consultation.
- **Referrals to other providers,** tests or therapies.
- **Missed or canceled appointments,** along with efforts to contact the patient.
- **Receipt of test results and subsequent actions taken,** as well as receipt of results of referral procedures and consultations, which should be signed or initialed by the practitioner before filing.
- **Discussions with patients regarding abnormal test results,** including recommendations for treatment and the patient's response.
- **Informed consent discussion** or informed refusal of treatment.
- **Prescription refills,** including the name of the pharmacy and pharmacist.
- **Documentation of medications prescribed, administered or distributed** (e.g., sample medications), along with corresponding discussion of potential side effects and other instructions.
- **Notations of patient noncompliance and/or failure to follow through** on recommended return visits or outside referrals.
- **Discussions with patient/family regarding noncompliance** and its potential consequences.
- **Termination of the practitioner-patient relationship,** where applicable, including copies of all pertinent correspondence.

General Documentation Guidelines

The following general principles of documentation can help the practice maintain a consistent, professional patient healthcare information record:

- **Ensure that hard-copy notes are legible** and written and signed in ink, and also that they include the date and time of entry.
- **Avoid subjective comments** about the patient or other healthcare providers.
- **Correct errors clearly** by drawing a single line through the entry to be changed.
- **Sign and date the correction,** as well as the notation giving the reason for the change.
- **Do not erase or obliterate notes in any way.** Erasing or using correction fluid or black markers on notes may suggest an attempt to purposefully conceal an error in patient care.
- **Document actions and patient discussions as soon as possible after the event.** If it is necessary to make a late entry, the entry should include the date and time, along with the statement, "late entry for _____" (i.e., the date the entry should have been made).
- **When dictating notes, include all vital information,** such as date of dictation and transcription. Sign transcriptions and write the date of approval or review.
- **Never alter a record or write a late entry after a claim has been filed,** as this may seriously compromise legal defense.
- **Develop a list of approved abbreviations for documentation purposes.** Review and revise the list as necessary and at least annually. In addition, maintain a list of error-prone abbreviations that should never be used, such as the one from the ISMP.
- **If using a form, complete every field.** Do not leave any lines blank.

Release of Healthcare Information Records

The following general principles can help reduce liability associated with the release of confidential patient information:

- **Remember that while the patient has the legal right of access to all information in the record, it is the provider who owns the healthcare record** and all associated diagnostic information.
- **Never release original records or radiographs,** only copies.
- **Respond to patient requests for healthcare informational records in a professional manner and in a reasonable time frame.** Refusing to transfer records because of unpaid bills is a violation of the law in most states. While the federal government requires that healthcare providers act within 30 days after receiving a request for records, some states call for a quicker response. Check with an attorney conversant in healthcare record law to determine applicable state requirements.
- **Do not overcharge for copying medical records.** If unsure of what constitutes a reasonable charge, ask a copying or duplicating service. Note that some states have adopted specific requirements and limitations on such charges. Consult an attorney with relevant expertise to confirm state-specific rules.
- **Document the request and the date the copy was sent or picked up** in the patient healthcare information record. Failure to make such a notation could prove embarrassing later if a lawsuit is filed, and a copy of the patient record surfaces containing information that differs from what is on file in the office.
- **File all original patient authorizations and receipts in the healthcare information record.** If records are sent by post, utilize certified, registered mail with a required return receipt, which should be placed in the patient's records. If records are picked up by the patient, ask that he or she sign and date a receipt.
- **Release only the records specifically requested.** Have staff members check with the provider before mailing paper records or sending electronic records, in order to verify that all relevant information – and only relevant information – is included. Electronic records should be sent only in an encrypted manner, as outlined in greater detail below.
- **Assign a specific individual or department to process information release requests,** including associated documentation.
- **Retain signed authorization forms in the patient's healthcare informational record,** with a note specifying what information was released and to whom. The form should include …
  - The name of the releasing office and the receiving facility.
  - The patient's full name, address and date of birth.
  - The extent or nature of the information to be released, with specific reference to treatment date, event and/or condition.
  - The date the consent was signed and the date the authorization will expire.
  - The notarized signature of the patient or legal representative.

Electronic Healthcare Records

Electronic healthcare records (EHRs) have revolutionized the practice of medicine, creating the potential for significant improvements in patient safety, clinical teamwork and operational efficiency. However, the effectiveness of EHRs depends upon many factors, both technical and human. The risk of error and other unintended consequences is especially acute during the period of transition from a familiar paper-based record to a new, multipurpose electronic system.

EHR documentation strategies. Whatever medium is used to store the patient's healthcare information record, the same basic risk management principles apply: the record must be thorough and accurate, and the patient's privacy must be protected. Utilization of EHR technology makes effective security and confidentiality measures even more critical.

The following measures can help reduce liability risks associated with EHR use:

- **Establish a policy regarding electronic copying, cutting and pasting.** To this end, consider limiting or deactivating the copy, cut and paste function of the electronic health record software. (For guidelines, see the American Health Information Management Association's statement on "Auditing Copy and Paste.")
- **Avoid copying and pasting when documenting high-risk items,** such as laboratory results, radiology reports and drug formulations. (See CNA *Vantage Point*® 2015 – issue 1, "Electronic Healthcare Records: Maximize Benefits, Minimize Risks.")
- **Review and update information found elsewhere in the EHR before pasting it into current entries,** especially problem lists, diagnoses, allergies, current medications and history.
- **Expressly prohibit copying and pasting text from another clinician's note without proper attribution,** which may constitute medical plagiarism and lead to allegations of billing fraud.
- **Do not delete original source text or data and insert it elsewhere in the record,** thus altering the initial entry and compromising documentation integrity.
- **Discourage staff from "carrying forward" information (such as allergies, prior medical history or diagnostic results) that is readily available elsewhere in the EHR,** as this creates clutter and may adversely affect the record's reliability and usefulness.
- **Ensure that key patient identifiers are accurate,** in order to effectively link records within and across systems.
- **Determine what changes can be made in records,** as well as who can make them, when they can be made, and how they are tracked and monitored.
- **Remember that most pharmacies cannot process electronic discontinue/change orders,** although many EHR prescribing systems offer this capability to prescribers. Always check with the pharmacy to see if it has received discontinue/change orders, in order to prevent duplicate or prolonged therapy.

EHR system design and selection. EHR vendors offer various tools – including template documentation and population via default – designed to make writing notes easier, while minimizing the hazards of duplication. Templates feature predefined text options targeted to specific conditions and procedures, while populating via default involves one-click data entry to indicate normal status.

When using these forms of notation, providers must enter negative or out-of-the-ordinary findings manually, a practice known as documentation by exception (DBE). Both options carry a high risk for "cloned" documentation, which can render the record of a 70-year-old patient similar in content and appearance to that of a 20-year-old. Such generic records can lead to allegations of deficient care and may be difficult to defend in the event of litigation.

Consider the following interventions:

- **Assess whether vendor-developed templates adequately support recommended work practices.** If they do not, adjust them to accurately reflect current protocols, standards and regulations.
- **Include a variety of input controls** to facilitate the capture of all relevant findings, both normal and abnormal. Possibilities include right-left-bilateral confirmation, positive/negative notation, and multiple-choice text and number features.
- **Incorporate voice recognition and text-entry tools** to document subjective observations and to help locate specific EHR entries in the event a malpractice action is filed years after the date of care.
- **Create a section within templates for relevant past medical history, positive findings on exams and answers to "red flag" questions.** For example, on a strep throat template, include prominent prompts for fever, headache, rash, and a history of heart valve or kidney problems.
- **Perform quality audits to track incidence of "scribing,"** i.e., the overwriting of one practitioner's authenticating notes by another. Audits also should identify clutter-prone templates and DBE practices (e.g., when routine patient encounters produce more than one to two pages of documentation).
- **Prohibit staff from tampering with the EHR audit trail capability.** Explain that the function is necessary and does not significantly slow down the system.

Generic records can lead to allegations of deficient care.

Patient Problem List Maintenance

Accurate patient problem lists are essential to effectively manage patient populations and provide care across multiple sites. However, keeping problem list data relevant and up-to-date can be a challenge due to the large number of disciplines and services – ranging from health IT, medical staff and nursing to billing, quality management and clinical departments – involved in the compilation process.

Because of the many contributors, problem lists tend to accumulate a wide variety of symptoms, health factors, diagnoses and ICD code descriptors. If not reviewed and updated on a routine basis, lists may become riddled with obsolete and irrelevant information, potentially compromising quality and continuity of care.

To avoid this situation, it is important to clearly define the purpose and scope of the problem list, focusing on these critical functions, among others:

- **Facilitating continuity of care** between patient visits.
- **Recording medical conditions** for treatment and reporting purposes.
- **Coordinating communication during patient transitions** between settings and care providers.

The following measures can help ensure that problem lists do not themselves become a problem:

- **Create a written procedure for developing, updating and reconciling problem lists** in the following medical situations, among others:
  - **Primary care –** at the end of each episode of care and annually, at a minimum.
  - **Internists and specialists –** at the end of each episode of care.
  - **Attending practitioner –** upon discharge from an inpatient or outpatient setting.
- **Ensure that only designated individuals make or change entries in patient problem lists,** and instruct them to use an approved standard vocabulary for problem list notation.
- **Strictly prohibit the use of problem lists as a source of billing data,** a tool for revenue management or a substitute for a final diagnosis list in discharge summaries.
- **Establish timeliness requirements for problem list entries and audit activities.** See AHIMA's "Standardizing the Problem List in the Ambulatory Electronic Health Record to Improve Patient Care," from Qualis Health.

Electronic Technology and Social Media

Electronic technology and social media – including email, blogs, social networking platforms, websites, texting and instant messaging – have become a primary means of self-expression and communication for many individuals, including practitioners and other healthcare personnel.

Documentation of Electronic Communications

The increasing volume of electronic communication between patients and providers has created a stronger sense of connection, as well as new risk management issues, including documentation of the many different types of patient contacts. The substance of all electronic communication related to patient care – whether by telephone text, email or instant messaging – should be documented. If an electronic communication cannot be saved directly into the patient healthcare information record, it should be documented in a log.

At a minimum, the following information should be included when documenting any electronic communication:

- Date and time of the conversation.
- Patient's name and date of birth.
- Identity of other parties in addition to the patient.
- Identity of the staff member taking the call.
- Subject of the discussion.
- Advice given and recommended follow-up.

Also be sure to include the following clinical information:

- Patient's relevant medical history and allergies.
- Nature of the patient's symptoms and associated complaints.
- Aggravating and relieving factors.

Social Media Risks

Social media platforms may pose significant privacy risks, as seen in the following scenario examples:

- A group of "friends," having entered the hospital room of a boy who just died of an overdose, took pictures and posted them on Snapchat.
- A nurse took a picture of a man getting an EKG and posted it on Facebook.
- A nurse sent text messages to another nurse and a physician portraying a sick child and his mother in an unfavorable light.
- A certified nursing assistant at an aging services facility went into labor. Other staff members videotaped and photographed the event while allegedly mocking the plaintiff, and posted pictures of the plaintiff's vaginal area on various social media sites.

In light of these disturbing incidents and others, every practice should develop and enforce strict policies in regard to inappropriate use of social media. Consult the following resources for additional information:

- The National Counsel of State Boards of Nursing's white paper, "A Nurse's Guide to the Use of Social Media." All nurses should be aware of and comply with these guidelines.
- In addition, see the American Nurses Association's poster, "Six Tips for Nurses Using Social Media."

Other Electronic Media Exposures

The risks associated with electronic media continue to evolve and expand with increased usage. For example, nurse practitioners should be aware that litigation discovery requests may go well beyond patient treatment and financial records, potentially encompassing text messages, blog entries and social media postings. Consequently, nurse practitioners must understand the exposures associated with these media, and practices must create policies that recognize their benefits while minimizing the possibility of carelessness or misuse.

The use of social media and electronic devices by medical personnel may result in the following additional risk exposures, among others:

Patient confidentiality lapses. Workplace emailing or text messaging may violate privacy and security requirements imposed under HIPAA and the HITECH Act, as protected health information may be inadvertently transmitted to an unauthorized third party. Every practice should consider implementing a HIPAA compliance program, featuring ongoing staff training, review of protocols and technical upgrades, including use of a HIPAA-compliant encrypted email system. A wide range of resources and tools are available to aid healthcare practices in this effort.

Improper texting. Harassing, threatening or otherwise inappropriate messages posted by employees from workplace computers or texted from employer-issued mobile telephones can create vicarious liability exposure for a practice, and improper litigation-related postings and text messages can undermine legal defense efforts.

Overuse of electronic devices. Texting and conversing on cellular telephones in patient care areas may decrease staff efficiency and lead to distraction and error, thereby endangering patients. Even the use of MP3 players and other headphone devices can create a sense of disconnection from the environment, impairing communication and slowing response time.

Network security issues. Unregulated web browsing and emailing on networked computers can introduce viruses or spyware into the system, resulting in possible data loss, theft or damage. In addition, sharing of passwords and other security lapses can compromise confidential information, with potentially serious regulatory and liability implications.

Evidence-based Management

In today's evolving practice environment, nurse practitioners must stay abreast not only of the latest information on treatment and patient management, but also of the applicable standard of care.

The professional obligation to remain current involves awareness, evaluation and application of current knowledge – i.e., taking an evidence-based approach to clinical practice. Staying up-to-date with medical knowledge, standards and best practices requires a well-defined and consistent procedure to search for the most current guidelines and warnings from recognized organizations and websites. In addition to actively searching for clinical guidelines, nurse practitioners should utilize "push" technologies to receive automatic updates from key medical sources. A strategy combining both of these elements will reduce the possibility of overlooking important research findings and practice advances.

Evidence-based practice and clinical guidelines are designed to enhance patient outcomes by strengthening the clinical decision-making process. They should not be followed blindly or rigidly. However, if a treatment decision is made that deviates from an established guideline, the rationale must be carefully documented and explained to the patient, a practice that can help reduce risk and strengthen the practitioner-patient relationship.

Informed Consent/Informed Refusal

Informed consent is the process of providing patients with sufficient information to make a reasoned decision regarding proposed treatment. The consent must be given without coercion or fraud, based upon the patient's reasonably accurate and complete understanding of what will take place. Refer to state statutes for guidance on the informed consent process, as there is considerable variance among states.

Fundamentals of Informed Consent

Nurse practitioners who ignore the wishes of a patient and proceed with treatment without the necessary consent may be subject to malpractice litigation, whether or not the NP considered the treatment to be in the best interest of the patient. If the treatment can be characterized as an unauthorized touching of the patient, the nurse practitioner also may have committed the criminal offense of battery. Most patients have a reasonable idea of procedures that occur during routine examinations or treatment. Thus, patients are sometimes considered to give implied permission for treatment when they visit an office for routine care. Implied consent, however, has serious limits as a legal defense.

The informed consent process involves two main components:

- **Discussion,** including risk disclosure and patient education.
- **Documentation in the healthcare information record,** which often includes the use of a written informed consent form.

Although some nurse practitioners may consider the informed consent process burdensome and time-consuming, it is critical to effective risk management. The informed consent discussion represents the first step in managing patient expectations, thus reducing the possibility of a misunderstanding and consequent lawsuit. In addition, documentation of the informed consent process provides the best defense against a patient's subsequent allegation that the proposed treatment, other options and the potential for injury were not adequately explained.

Many claims of professional negligence are accompanied by an allegation of lack of informed consent. In such an action, patients may assert that had they known in advance that a bad result was possible, they would not have agreed to the treatment. Rarely do claims solely allege lack of informed consent without other claimed damages.

In many lawsuits, the nurse practitioner met the standard of care, but the patient was nevertheless dissatisfied, often due to a lack of communication. A sound informed consent process can enhance patient management and education, thus reducing risk.

Informed consent is a process, not a specific document. The process requires a verbal component, regardless of whether a written form is used. In most jurisdictions, a patient can give an oral informed consent. However, informed consent requirements vary among states, and conceivably a written form may be required in addition to discussion with the patient. Whether the patient's permission is spoken or written, the goal of the informed consent process remains the same: to ensure that the patient has an adequate understanding of the proposed treatment prior to giving consent.

The doctrine of informed consent requires that the patient be given sufficient information about and time to consider three major subjects:

1. **The nature of the proposed treatment,** including rationale, anticipated benefits and prognosis.
2. **Alternatives to the proposed treatment,** including specialty referral options and no treatment at all, with an explanation of why, in one's professional judgment, the recommended treatment is preferable to the alternatives.
3. **Foreseeable risks,** including potential complications of the proposed treatment and the risks of refusing it. As with the discussion of alternative treatments, the list of foreseeable risks need not be all-inclusive, but it should reflect the patient's condition and overall health status. Following full discussion of these questions, the patient then states his/her desire to either pursue or decline the proposed treatment.

Note that the practitioner who will perform the treatment or procedure must conduct the informed consent discussion. **It cannot be delegated.** Healthcare staff, such as registered nurses, may witness a patient's signature on a consent form, but they are not permitted to conduct the informed consent discussion.

Informed consent is a **process,**
not a specific document.

The informed consent discussion. The following measures can help enhance the informed consent process:

- **Tailor discussions to the needs of each patient,** as well as the patient's level of health literacy.
- **Use basic, uncomplicated language** that the patient can understand, defining any technical terms that must be used.
- **Present the informed consent requirement as a benefit to the patient,** rather than a burden.
- **Consider the complexity of the proposed treatment and its degree of risk** when conducting the informed consent discussion with the patient.
- **Utilize educational materials as needed,** including pamphlets, models and online resources.
- **Give the patient every opportunity to ask questions,** and answer them as clearly and comprehensively as possible.
- **Ask the patient to describe the proposed plan of treatment** in his or her own words.
- **Encourage the patient to have a family member present in the room** during the informed consent discussion to make the patient feel more at ease.
- **Have a staff member present during the informed consent discussion** to serve as witness.
- **Always ask the patient, "Do you have any questions about the information you have been given or about the proposed treatment?"** and document the answer.
- **If necessary, use a qualified interpreter,** and include the translator's name, address and telephone number in the body of the progress note for that day. If many patients speak the same foreign language, consider having consent forms translated into that language. The use of family members – especially children – as interpreters is discouraged.
- **Conduct and document the informed consent process whenever the course of therapy changes** or a new medication is prescribed.
- **Proceed only after obtaining the patient's approval.** Any treatment rendered without the patient's consent may result in malpractice allegations or even charges of battery.

Informed consent documentation. The patient's informed consent must be documented in the healthcare information record, along with evidence that the patient understands and agrees to the proposed treatment. A written description of the informed consent discussion, signed and dated by the patient, effectively demonstrates that the process has been conducted in full. Consult state laws and regulations to determine whether a written informed consent document is required. Even if it is not mandatory, a written form serves as valuable documentation.

Regardless of whether a written informed consent form is used, write a progress note that reflects the specific consent process for the patient, including questions asked and answers given, staff and/or family members present, educational materials provided, and of course whether the patient agreed to or declined the recommended treatment.

Fundamentals of Informed Refusal

An informed refusal is essentially the opposite of an informed consent, in that the patient has refused the suggested procedure rather than accepting it. From the moment a patient declines a recommendation, the practitioner is required to provide more information and explanation to the patient and to carefully document warnings given and patient response.

The patient has the legal right to decline treatment recommendations and refuse care. If this occurs, explain to the patient the consequences and foreseeable risks of refusing treatment and ask the patient's reasons for doing so. If the refusal reflects a lack of understanding, re-explain the rationale for the procedure or treatment, emphasizing the probable consequences of the refusal. If the patient again refuses to accept treatment recommendations after the risks of refusing treatment have been explained, then the patient has given an *informed refusal*.

Informed refusal risks and continuing responsibilities. Patients who suffer a serious injury after refusing care sometimes claim that they did not understand the potential consequences of such refusal and that the healthcare provider was negligent in not fully disclosing the risks of forgoing treatment. The patient may further assert that had the risks of refusal been properly and completely explained by the provider, he or she would have consented to the procedure or treatment.

For this reason, disclosure of the likely consequences of declining treatment recommendations is central to the informed refusal process. The nurse practitioner who continues caring for a refusing patient must be aware of several consequent responsibilities relating to the informed refusal, which include …

- **A continued duty to examine and diagnose the patient** for the duration of the practitioner-patient relationship and as long as the patient continues to refuse treatment.
- **A continued duty to inform the patient about the condition and its associated risks** while the practitioner-patient relationship is in place, the condition exists and the patient continues to refuse treatment.
- **A heightened duty to tell the patient how refusal of treatment may affect treatment of other conditions or problems** when discussing these conditions.

The documentation process for informed refusal does not end after the first refusal. Continue to assess the patient's condition and health status, update the patient on changes and needed treatment, and state the patient's refusal of care in the progress note as appropriate. Neglecting to fulfill these obligations has resulted in numerous *failure to diagnose* and *failure to inform* allegations.

Informed refusal documentation. Refusal of care increases liability exposure, which can be minimized by thoroughly documenting the informed refusal process and emphasizing that the patient understood and acknowledged the risks of rejecting recommended care.

Techniques for documenting informed refusals are similar to, but go beyond, those for informed consent. After discussing the potential consequences of refusal with the patient, write a comprehensive progress note and document the refusal using a written form, which should be incorporated into the patient healthcare information record.

Progress notes should document …

- Those present during the discussion.
- The treatment discussed.
- The risks of not following treatment recommendations, listing the specific risks mentioned.
- The brochures and other educational resources provided.
- The questions asked and answers given by both parties.
- The patient's refusal of the recommended care.
- The patient's reasons for refusal.
- The fact that the patient continues to refuse the recommended treatment.

Few patients remember all that they were told during the informed consent/refusal discussion, making written forms a valuable reminder. A written form also helps manage patient expectations, provides further documentation of the disclosure of information and may deter negligence claims.

The informed refusal form. Complete the Discussion and Refusal of Treatment Form. Patients may reconsider when presented with a written document to sign. Although the informed refusal documentation process is not primarily designed to persuade reluctant patients to accept needed treatment, it may have this beneficial effect on some. Of the patients who persist in refusing recommended treatment, some will sign the form and others will not. While it is preferable to have the patient's signature, other documentation strategies may be pursued. For example, the nurse practitioner may sign the form and also have the staff member who witnessed the discussion and disclosure sign it as well. If the patient will not sign, write "Patient refuses to sign this form" on the patient signature line. Whether or not the patient signs the form, place the original in the patient's healthcare information record and provide a copy to the patient. The signatures on the form, as well as the progress note, will demonstrate that a discussion took place and an informed refusal was given.

Special Issues in Informed Consent

The informed consent process includes special provisions for minors, cognitively impaired patients and emergency situations.

Consent for minors. As a general rule, unemancipated minors cannot consent to treatment. The informed consent of a parent or legal guardian must be obtained before treatment is rendered. Adult siblings, grandparents and other adult caretakers may not be legally authorized to provide consent unless they have been granted legal guardianship by the court. Sometimes the adult party who brought the child is not authorized to grant consent. If the parent or legal guardian cannot be contacted by telephone, consider the presenting signs and symptoms, and determine whether to proceed or defer treatment until consent can be obtained.

From a liability perspective, treating a minor without consent of a parent or legal guardian is a gray area. However, considering the frequency of lack of informed consent allegations, proceeding without consent may increase risk by creating conflict between the nurse practitioner and the child's parents. By establishing and communicating an office policy on consent for both accompanied and unaccompanied minor patients, medical practices can prevent misunderstandings. If an unemancipated minor, unaccompanied by a parent or legal guardian, asks for care, the following steps can help minimize potential conflict and reduce liability exposure:

- **Determine whether, in light of the patient's presenting condition, it is in the patient's best interest to proceed with the treatment immediately,** or whether treatment can wait until a parent or legal guardian can be contacted.
- **Make a reasonable effort to contact the parent or legal guardian.** To that end, maintain up-to-date cellular telephone numbers and other contact information. Document all attempts to communicate with a parent or guardian. (See page 57 for more information about obtaining remote consent.)
- **If a parent or legal guardian cannot be contacted, defer routine treatment** until the informed consent of a parent or guardian can be obtained.
- **Generally, it is acceptable to intervene without parental consent when immediate intervention is warranted** due to traumatic injury or other truly emergent conditions.

The age of majority varies by jurisdiction, as do laws about emancipation of minors. For clarification of these issues, contact an attorney in the area who specializes in medical malpractice defense.

Diminished mental capacity. Nurse practitioners confront a range of medical, ethical and legal questions when treating patients who are mentally incapacitated due to injury, congenital condition, aging or disease. Healthcare decisions, including informed consent and refusal matters, are valid only when patients have the capacity to comprehend the issues at stake. It is the nurse practitioner's responsibility to assess patients' decision-making capacity, which is not always an easy task. Consider the following tenets when mental capacity is at issue:

1. **All adult patients are assumed to be capable of consent** unless proven otherwise.
2. **Competency is a legal status,** and only a court can officially designate someone as legally incapacitated.
3. **Emergency procedures may be completed regardless of mental capacity,** provided that the urgent need for intervention is clear and well-documented.

The following questions may assist a nurse practitioner in determining and documenting a patient's capacity to understand information, deliberate about choices and consent to treatment. Ask the patient to …

- **Describe the reason for the visit** to the medical office.
- **Repeat back the information** given him or her about treatment needs.
- **List basic personal information,** such as age, birth date, current address and the name of the emergency contact person.

Patients who can correctly and fully answer these questions may be considered of adequate mental capacity to proceed with the informed consent discussion and subsequent treatment. Treatment of patients who do not fully comprehend the questions or do not provide cogent answers should be deferred until mental capacity is more fully investigated.

Remote consent for minors or the cognitively impaired. Consent should be obtained by telephone or other electronic means only if the patient's legal surrogate is not otherwise available. The following guidelines can help reduce risk in this situation:

- **Clearly explain why consent was obtained in this manner** in the patient healthcare information record.
- **Ensure that consent by telephone is witnessed by a third party,** who remains on the line during the entire consent discussion between the healthcare surrogate and the practitioner.
- **Document all elements of the informed consent discussion,** i.e., description of the recommended procedure and its material risks and benefits, risks and benefits of alternative treatments, risks associated with treatment refusal, name of the consenting party, relationship to the patient, nature of the consent given, and date and time.
- **Have the witness time, date and countersign the entries** in the patient healthcare information record.
- **Print or scan all emails involving patient consent** and include them in the patient healthcare information record.

Exceptional informed consent situations. States generally recognize special circumstances where delaying treatment in order to obtain informed consent could be detrimental to the patient. These include emergency or life-threatening situations when the patient is unable to consent and diligent efforts to contact the appropriate family member or guardian have been unsuccessful. In addition, the informed consent process can be modified if, in the nurse practitioner's medical opinion, the disclosure of risks would have a serious adverse effect on the patient or the therapeutic process. Such exceptional situations must be well-documented in the patient's healthcare information record. Legal counsel should be sought regarding specific state statutes.

Suicide Risks and Prevention

According to the Centers for Disease Control and Prevention (CDC), suicide is one of the top ten causes of death for all ages, and is the second leading cause of death for those between 10 and 24 years of age.

Unfortunately, suicidal individuals are often unwilling or unable to seek help because of the stigma attached to mental health and substance abuse disorders or barriers blocking access to needed care. For this reason, nurse practitioners must be on the alert for the following suicide risk factors, as noted by the CDC:

- Family history of suicide.
- Family history of child abuse or mistreatment.
- Previous suicide attempt(s).
- History of mental disorders, particularly clinical depression.
- History of alcohol/substance abuse.
- Feelings of hopelessness.
- Impulsive or aggressive tendencies.
- Predisposing cultural beliefs (e.g., the idea that suicide is a noble resolution of personal dilemmas).
- Local epidemics of suicide.
- Feelings of being cut off from other people.
- Loss (e.g., familial, occupational, financial).
- Chronic or terminal illness.
- Easy access to potentially lethal drugs or weapons.

The following resources provide information on caring for patients with suicidal thoughts or behavior:

- American Psychiatric Nurses Association, "Psychiatric-Mental Health Nursing Resources."
- CNA *Vantage Point*® 2016 – issue 3, "Behavioral Health Patients: A Risk Management Overview."
- Scottish Government Social Research, *Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review*.
- U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, *National Strategy for Suicide Prevention: Goals and Objectives for Action*.
- U.S. Public Health Service, "The Surgeon General's Call to Action to Prevent Suicide."
- World Health Organization's *World Report on Violence and Health*, chapter 7, "Self-directed Violence."

Medication Management

Sound medication prescribing involves more than selecting the right dose of the right drug for the right person by the right route at the right times. It also means staying current with literature; guarding against patient allergies, side effects and adverse interactions; and educating patients about drug regimens and related risks.

Prescribing Recommendations

Prescribing is not a responsibility to be taken lightly. By prescribing a drug to any person – even as a "one-time favor" for a co-worker, relative, friend or neighbor – the practitioner has established a patient-practitioner relationship. The following strategies can help NPs avoid errors and minimize risk exposure:

- **Review current allergy information,** including descriptions of reactions, when ordering medications. In addition, ensure that such information is available to all prescribers in the practice. (See the Pennsylvania Patient Safety Advisory's "Medication Errors Associated with Documented Allergies.")
- **Learn about medication allergies, side effects and interactions,** including how to screen patients for potential allergic or other adverse reactions, recognize an allergic response and treat serious reactions. (See the above-listed resource for more information.)
- **Review previous medication orders alongside new orders and care plans,** and resolve any discrepancies each time a patient moves from one care setting to another. (See *ISMP Medication Safety Alert!®*, "Building a Case for Medication Reconciliation.")
- **Use developed standard order sets to minimize incorrect or incomplete prescribing,** standardize patient care and clarify medication orders. (See *ISMP Medication Safety Alert!®*, "ISMP Develops Guidelines for Standard Order Sets.")
- **When prescribing opioid drugs, use an appropriate opioid dose** based on patient age and opioid tolerance. (See *ISMP Medication Safety Alert!®*, "Beware of Basal Opioid Infusions with PCA Therapy.")
- **When reconciling medications, talk to patients and other practitioners** who may know more than what is written in the record. (See "The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles." Chicago: American Medical Association, 2007)
- **Emphasize the importance of keeping follow-up appointments,** especially when the patient is discharged on warfarin or direct oral anticoagulation therapy and there is a transition of care process. When necessary, verify that the patient has a confirmed, scheduled appointment with the laboratory, practitioner or anticoagulant clinic. (See the "2017 ISMP Medication Safety Self Assessment® for Antithrombotic Therapy.")
- **Consider integrating medical office electronic health record systems with inpatient systems,** thus permitting prescribers to view a more complete patient profile. It also facilitates medication reconciliation by comparing what the patient is taking at the time of the office visit with what was prescribed upon discharge. (See the Institute of Medicine [now the National Academy of Medicine] publication, *Preventing Medication Errors: Quality Chasm Series*, 2007.)
- **Develop a comprehensive medication patient education program** that includes both general written materials and specific spoken advice, and which is presented at an appropriate level for each patient. Copies of medication-related materials provided to patients should be retained in the healthcare information record. (See Shrank, W. and Avorn, J. "Educating Patients About Their Medications: The Potential And Limitations Of Written Drug Information." *Health Affairs*, May 2007, volume 26:3, pages 731-740.)

Opioid Risk Evaluation

All patients suffering pain should be given a thorough physical and have a history taken, including an assessment of psychosocial factors and family history. Reevaluate the level of pain and the efficacy of the treatment plan at every visit.

To minimize the risk of abuse, conduct an opioid risk assessment and depression scale test before prescribing opioids and perform periodic screening thereafter. Major risk factors of opioid abuse include, but are not limited to, family history of alcohol or drug use, history of physical or sexual abuse, and certain psychiatric conditions.

Many nurse practitioners perform random urine drug screens and regular pill counts on patients at risk of opioid overuse or abuse. Some other commonly used screening tools include …

- Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain.
- Diagnosis, Intractability, Risk, Efficacy (DIRE) tool.
- DIRE Score for Appropriate Opioid Use.
- Screening Instrument for Substance Abuse Potential (SISAP) Assessment Instrument, which evaluates the potential for misuse at every visit.

Remember that nurse practitioners, like all healthcare providers, have the right to determine whom they will treat, but discharging a patient in chronic pain may lead to complaints or legal action. Providers can help protect themselves against allegations of abandonment by rigorously documenting instances of noncompliance, communicating clearly and straightforwardly with patients, and establishing and consistently implementing formal policies and procedures.

Pain Treatment Agreements

A pain treatment agreement is a means of contractually defining the responsibilities of patient and provider, thus potentially reducing conflict and liability, while enhancing patient understanding and continuity of care. Such an agreement should address both prescription refill parameters (e.g., one provider, one pharmacy, refills only as scheduled, no early refills) and the repercussions of noncompliance, which may include discharging patients who repeatedly violate practice policies and procedures. Once the agreement is in place, it must be strictly enforced. Violations should be clearly communicated to the patient and documented in the patient healthcare information record.

Always seek legal counsel when drafting and revising pain agreements, and remember to update them regularly so that they reflect changes in level of pain, health status and medication dosages.

Prescription Drug Monitoring Programs

A prescription drug monitoring program (PDMP) is an electronic database that collects selected information on substances dispensed in the state. According to the Drug Enforcement Administration (DEA), the database serves a range of purposes, including the following:

- Supporting access to legitimate medical use of controlled substances.
- Deterring drug abuse, addiction and diversion.
- Identifying individuals addicted to prescription drugs and facilitating interventions.
- Strengthening public health initiatives by documenting drug use and abuse trends.
- Educating the public about the use, abuse and diversion of prescription drugs.

For additional information on state PDMPs, visit the U.S. Department of Justice's and DEA's Diversion Control Division's State Prescription Drug Monitoring Programs website.

Additional Medication-related Information and Resources:

The *ISMP Medication Safety Alert*!® article "Reducing Patient Harm from Opiates" makes the following safety-related points:

- **When appropriate, consider non-opioid medications and non-pharmacological therapies for pain.** Do not prescribe more or longer than necessary.
- **Review an equianalgesic chart** for different opioid products.
- **Establish protocols for pain management** depending on the severity of pain.
- **Incorporate prompts in electronic prescribing systems** to verify past opioid use.
- **Provide direct counseling,** including written instruction and information, to all patients receiving opioid products and/or their caregivers.
- **Advise caregivers about the need to monitor patients who are taking opioids.** Include information about contacting the prescriber regarding uncontrolled pain prior to taking more of the same or different pain-relieving medications, including over-the-counter products.

The ISMP also produces a set of High Alert Medication Learning Guides designed to promote discussion and counseling about higher-risk pharmaceuticals.

The Pennsylvania Hospital Engagement Network's "Organization Assessment of Safe Opioid Practices" advises that when prescribing an opioid, prescribers should first review the patient's active medication list and limit the number and variety of concurrent opioid orders. It also recommends screening patients for factors – such as allergies, presence of obstructive sleep apnea, advanced age, other sedating agents and opioid status (i.e., naïve versus tolerant) – that might affect the dose, monitoring parameters or appropriateness of opioid use.

The "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016" is a standard reference tool for all prescribers.

Diagnostic Test Result Management/Serial Testing

By consistently reviewing and following up on outpatient test results in a timely manner, nurse practitioners can both enhance patient safety and reduce potential liability. Consistent routines, reliable backup systems and thorough documentation are key to effective tracking of test results and patient notification.

Tracking and Reviewing Diagnostic Information

Most liability claims associated with outpatient tests ordered in the office setting involve allegations of negligence in either diagnosis (e.g., failure to diagnose or delay in diagnosis) or treatment (e.g., failure to treat, delay in treatment or premature end of treatment. In order to reduce risk, increase patient satisfaction and improve quality in this critical area, practices should draft a written practice policy that clarifies practitioner and staff responsibilities in regard to clinical tests, including ordering tests, reviewing results and notifying patients of findings.

Sending out tests and receiving results. Most practices already have a system in place for sending specimens to reference laboratories and ordering tests. It is equally important to ensure that test results are reported back to the office for timely review. Consider implementing the following practices:

- **Utilize a paper or electronic test order log.** Record the date the specimen was sent or the test was ordered, the patient's name and unique identifier, the name of the test and the expected date of return.
- **Indicate the results of returned tests by using the designated notation** or, in a computerized system, by highlighting the entry with a color marker or color filler.
- **Consider acquiring an effective test management system** based on the telephone, computer software or the Internet. Most electronic health record systems include a built-in test management component.
- **Place paper healthcare information records awaiting test results in a designated area,** arranged in chronological order. Assign a staff member to review these records daily and follow up on outstanding tests.

Reviewing test results. All tests results, no matter how they are reported, should be reviewed and signed by the practitioner prior to filing them in the patient's paper or electronic healthcare information record. If an electronic signature is utilized, the system should permit only one authorized user. If the ordering practitioner is unavailable, refer test results to another practitioner (in accordance with written policy) to ensure prompt review.

Critical test results received by telephone should be reported immediately to the practitioner who ordered the test, or, if the provider is unavailable, to another individual designated by written policy. When documenting a test-related call, consider using a form designed to capture the following information:

- Date and time of call.
- Name of individual taking the call.
- Patient's name and unique identifier.
- Test name and critical test value.
- First name, last name and location of caller/sender (e.g., John Doe, Acme Diagnostics).
- Acknowledgment that the information has been read back and confirmed.

When handing off the results to another practitioner, document the practitioner/individual notified (e.g., John Smith, D.O. or Jane Doe, APRN), indicate that the test results are of crucial importance, and note the date and time of the interaction. Consider providing patients with all test results through an electronic patient portal. Information on patient access to test results can be found at The Office of National Coordinator for Health Information Technology.

Serial Testing

Certain drugs and conditions require serial monitoring and close clinical observation. In these situations, failure to order tests at recommended intervals may compromise the patient's health and lead to a lawsuit. Consider implementing the following risk-reduction measures:

- **List the drugs requiring a laboratory baseline value and periodic reassessment** (e.g., Lipitor®/liver enzymes). Review and update the list annually.
- **Identify the conditions requiring periodic reassessment** (e.g., chronic lymphatic leukemia). This list too should be reviewed and updated annually.
- **Develop and implement an alert system** to ensure that patients are notified and serial tests ordered at appropriate intervals.
- **Engage in an informed consent discussion with the patient regarding the drug or condition and the need for serial follow-up.** Include signs and symptoms that should prompt a call to the doctor.

Review the patient healthcare information record and any information received since the last patient visit to determine if a diagnostic test should be ordered. Failure to do so can lead to poor patient outcomes and a possible lawsuit.

Additional Diagnostic Resources

For more information on enhancing diagnostic processes, see the Pennsylvania Patient Safety Authority's advisory on diagnostic error in acute care and its overview of diagnostic errors. In addition, the National Quality Forum sponsors an effort to improve diagnostic quality and safety.

Consider providing patients with all test results through an electronic patient portal.

Risk Control Self-assessment Checklist for Nurse Practitioners

This resource is designed to help nurse practitioners evaluate risk exposures associated with their current practice. For additional risk control tools and information geared to the needs of NPs, visit www.cna.com and www.nso.com.

Scope of Practice	Yes	No	Comments/Action Plan
I read my state nurse practice act at least once per year to ensure that I understand and provide care within the legal scope of practice in my state.			
I know and comply with the requirements of my state regarding physician collaborative or supervisory agreements, and I review and renew my agreements at least annually.			
I collaborate with or obtain supervision from a physician as defined by my state laws and/or regulations and as required by the needs of my patients.			
I seek alternative physician consultation if I am not provided with appropriate support from my collaborating/supervising/employing physician(s), and modify my agreements accordingly.			
I decline to perform requested actions if they are outside of my legal scope of practice as defined by my state nurse practice act.			

Nurse Practitioner-Patient Relationship	Yes	No	Comments/Action Plan
Are problems clearly conveyed to patients, including the specific risks associated with not carrying out instructions? For example, *"Your wound must be cleaned three times a day in the first week after surgery, in order to avoid hard-to-treat infections and permanent scarring. What questions do you have about dressing changes?"*			
Are patients told that they must take some responsibility for the outcome of their care or treatment? For example, *"We both want you to benefit from treatment, but the results depend upon the effort you make."*			
Do practitioners relate personally to patients, in order to build a stronger therapeutic partnership? For example, *"Tell me, what can I do differently to better help you meet your personal health goals?"*			
Are staff trained to communicate with difficult patients, using workshops and role-playing scenarios?			
Are patients encouraged to identify goals and preferences on their own? For example, *"Let's talk about what you wish to accomplish and what you think is a suitable approach."*			
Do patient encounters begin with a discussion of the patient's personal concerns, rather than a recap of laboratory or diagnostic workups? For example, *"First, tell me what concerns you most, and then we'll discuss test results."*			
Does each encounter end with the patient verbalizing at least one self-management goal in a clear and specific manner? For example, *"I will monitor blood glucose levels before meals and at bedtime between now and my next appointment."*			

Documenting Patient Healthcare Information	Yes	No	Comments/Action Plan
Are all written entries in the healthcare information record legible and signed in ink, and do they include the date and time of entry?			
Are healthcare information records free of subjective comments about the patient or other healthcare providers?			
Is there a formal procedure for compiling patient healthcare information, as well as for handling and accessing patient healthcare information records?			
Is the filing system logical, making it easy to locate and hard to misplace patient healthcare information records?			
Does the record-keeping system deter staff from making unauthorized entries in patient healthcare information records?			
Are computerized records backed up daily, and is backup information stored off-site?			
Is a system in place for training new employees in office record-keeping methods, including electronic healthcare records and computerized physician order entry systems, as appropriate?			
Does the office have a system in place for record review/quality assurance, and are record audits performed on a regular basis?			
Are healthcare information record audit findings discussed with staff, including such areas as …			
- Patient ledger?			
- Referral forms?			
- Consultation letters?			
- Patient correspondence?			
- Telephone communications?			
Is a comprehensive medical history taken on every new patient?			
Are the patient's current prescription medications and over-the-counter remedies documented and checked for potential interactions at every encounter (e.g., by calling the patient's pharmacist, if necessary) before additional drugs are prescribed?			
Is critical medical information prominently displayed inside the healthcare information record, including drug allergies, chronic conditions, major procedures undergone, medication regimens, etc.?			
Is the patient's medical history reviewed and updated at every consultation or treatment visit?			

Documenting Patient Healthcare Information (continued)	Yes	No	Comments/Action Plan
Is every visit documented in the patient healthcare information record, and are the following actions and information noted:			
- Date in full (month/day/year) of examination or treatment?			
- Review of medical and medication history?			
- Chief patient complaint?			
- Clinical findings and observations, both normal and abnormal?			
- Diagnosis?			
- Receipt of informed consent?			
- Referral, if necessary?			
- Prescriptions and over-the-counter medications?			
- Postoperative and follow-up instructions?			
- Plans for next visit?			
Does the patient healthcare information record note the rationale for not following a previously documented plan of care and other important medical decisions?			
Are canceled appointments and no-shows documented in the patient health-care information record, as well as attempts to contact the patient and reschedule appointments?			
Is evidence of patient satisfaction or dissatisfaction documented, including specific complaints and concerns, as well as favorable comments?			
Are instances of noncompliance documented, as well as discussions with patients regarding consequent risks?			
Are treatment complications documented, as well as unusual occurrences and corrective actions taken?			
Are all pertinent discussions documented, whether in person or by telephone?			
Are all referrals to specialists and consultants documented in the patient healthcare information record?			
Is the patient given written, customized postoperative instructions, and are these instructions documented?			
Are telephone consultations documented in the patient healthcare information record, including both the consultant's name and the information received?			
Are specialists asked to submit a written report following consultations, using a standard referral form that is retained in the patient healthcare information record?			
Does the referral form include space for the following basic information, at a minimum:			
- The patient's name?			
- The diagnostics offered to the specialist and the date they were collected?			
- The primary practitioner's diagnosis?			
- The treatment completed to date?			
- The test or procedure the specialist is expected to complete?			
- The information needed from the specialist?			

Documenting Patient Healthcare Information (continued)	Yes	No	Comments/Action Plan
Is a follow-up call made to all consulting providers, and are these calls documented?			
Do staff check with patients to determine if referral recommendations have been followed, and are these calls and patient responses documented?			
Is the patient informed of potential consequences of refusing to follow through on a referral, and is this action documented in the patient healthcare information record?			
Is a written referral form required from all outside providers who refer patients to one's practice?			
Are practitioners alerted to after-hours calls from patients needing emergency care or information?			
Are all attempts to reach a patient by telephone noted, including the number called and message left?			
Are all patient telephone calls documented by practitioners and staff?			
Is a system in place for documenting follow-up appointment reminders, with visit notifications recorded in the patient healthcare information record or in a follow-up visit log?			
Are canceled and missed follow-up appointments monitored and noted in the patient healthcare information record?			
Is there a written policy addressing patients who miss scheduled follow-up appointments on a routine basis, and are patients informed of this policy?			

Informed Consent/Informed Refusal	Yes	No	Comments/Action Plan
Do nurse practitioners know the basic elements of informed consent, as well as informed refusal?			
Do nurse practitioners know when an informed consent discussion is necessary, as well as the special circumstances in which it may be omitted?			
Do nurse practitioners conduct a face-to-face discussion with the patient, allotting as much time as is needed to ask and answer questions?			
Do nurse practitioners answer all questions to the patient's satisfaction?			
Is informed consent documented in the patient healthcare information record as soon as it is obtained?			
Are written informed consent forms utilized, and if so, do they …			
- Have a patient-friendly and easy-to-understand title?			
- Describe the nature of the proposed treatment and its likely benefits?			
- List possible alternative treatments as well as their risks and benefits?			
- Note potential complications/risks?			
- Use the simplest language possible?			
- Allow for customization as necessary?			
When possible, do nurse practitioners give the informed consent form to the patient prior to the beginning of treatment, so the patient has time to think about the decision?			
Is the signed informed consent form placed in the healthcare information record, and is a copy given to the patient?			
If a patient declines recommendations, is this refusal documented in the healthcare information record?			
Are the risks and potential consequences of refusal to follow recommendations explained to reluctant patients in writing and documented in the healthcare information record?			

Patient Education	Yes	No	Comments/Action Plan
Are barriers to communication assessed and documented in the patient healthcare information record, including low health literacy, cognitive impairment and limited English proficiency?			
Are qualified and credentialed interpreters available when required?			
Is the "teach-back" technique used to ensure understanding of proposed treatments, services and procedures – e.g., not only asking patients if they have any questions about their medications, but also requesting that they describe in their own words how to take them?			
Is use of the teach-back technique documented in the patient healthcare information record?			
Are patients asked to explain in everyday language the medical information they have been given, including:			
- Diagnosis or health problem?			
- Recommended treatment or procedure?			
- Risks and benefits of the recommended treatment or procedure, as well as alternative measures?			
- Patient responsibilities associated with the recommended treatment?			
Are patients asked to repeat back critical instructions, and is their response noted in the patient healthcare information record? For example, *"It is important that we remain on the same page regarding your recovery. Can you tell me in your own words what an infected wound looks like and what you would do if you observed signs of infection?"*			

Barriers To Compliance	Yes	No	Comments/Action Plan
Are underlying factors affecting compliance explored with patients in a nonjudgmental manner? For example, *"It sounds as if you may be concerned about the medication's possible side effects. Is that why you have not taken it as prescribed?"*			
Do providers strive to achieve a mutually acceptable plan of care with hesitant patients, using the following strategies:			
- Identifying and recognizing specific patient concerns, such as the out-of-pocket costs of a procedure?			
- Identifying practical or logistical difficulties that may hinder compliance, such as lack of reliable transportation to and from the practice?			
- Encouraging patients to get a second opinion, if desired?			
- Taking the time to explain the potential consequences of not complying with recommendations?			

Patient Management	Yes	No	Comments/Action Plan
Do patient healthcare information records note the individuals whom patients rely upon to meet their general healthcare needs (e.g., spouse, relatives, paid caregivers, friends, etc.)?			
Are written protocols established and implemented for patient management issues, including …			
- Narcotic use and general pain management in drug-seeking patients?			
- Appointment or procedure cancellations?			
- Unacceptable behavior, such as belligerent voice-mail messages, yelling or cursing at staff?			
- After-hours patient management?			
- Refusal to consent to recommended treatment?			
- Noncompliance with recommendations regarding medications or lifestyle changes?			
Are patients reminded of upcoming appointments, including referrals and laboratory visits, and are reminders documented in the patient care record?			
Are electronic alerts used to remind patients with a history of noncompliance about follow-up and monitoring requirements?			
Are blind or otherwise impaired patients informed of subscription services that, via wireless devices, deliver reminders to take medications or perform other self-care activities?			
Are follow-up and referral appointments scheduled and entered in the computer system before patients leave the facility?			
Does written policy require documentation of no-shows, as well as appropriate follow-up?			
Is there a written policy for terminating the provider-patient relationship if the patient is chronically noncompliant?			

Medication Safety*	Yes	No	Comments/Action Plan
Are all patient/caregiver concerns and questions about a prescribed medication addressed by the NP, including the drug's appearance, as well as the patient's ability to afford and swallow it and follow drug administration directions?			
Is all necessary patient identification information entered into the system before any medications are prescribed, including …			
- Full name (including preferred prefix)?			
- Gender?			
- Date of birth?			
- Weight?			
- Allergies?			
- Physical address?			
- All telephone numbers (e.g., home, cell, business)?			
- Alternate means of contact (e.g., email address, emergency contact person)?			
Is the current medications list reviewed, entered into the computer system and updated at each encounter, and does it include …			
- Prescriptions, including dose, frequency and route?			
- Over-the-counter products?			
- Immunizations, including vaccination dates?			
- Vitamins and other dietary supplements?			
- Homeopathic remedies, herbal products and other alternative medicines?			
Are telephone orders read back to the nurse practitioner by the pharmacist to confirm their accuracy?			
Is opioid prescribing strictly supervised, in compliance with the state's prescription drug monitoring program?			
Are allergies documented, including a description of past reactions?			
Are NPs and others in the practice trained to prevent medical errors by applying continuous quality improvement techniques?			
Are NPs and others in the practice trained to report adverse drug reactions to the U.S. Food and Drug Administration, as well as to follow internal reporting protocols?			

* Additional medication safety-related risk control self-assessment questions can be found in the "2017 ISMP Medication Safety Self Assessment for Community/Ambulatory Pharmacy."

This tool provides a reference for nurse practitioners seeking to evaluate basic risk exposures. The content is not intended to be a complete listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient/client needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. The statements expressed do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation encompassing a review of relevant laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

Minimizing Risk/Responding to Claims

The following recommendations are divided into two groups: proactive risk control measures for normal practice and advice for responding to a real or potential malpractice claim or other legal action. Together, these suggestions can help nurse practitioners both reduce their liability exposure and increase legal defensibility in the event of a lawsuit or complaint.

Everyday practice strategies:

- **Practice within the requirements of your state nurse practice act,** in compliance with organizational policies and procedures, and within the national standard of care. If regulatory requirements and organizational scope of practice differ, comply with the most stringent of the applicable regulations or policy. If in doubt, contact your state board of nursing or specialty professional association for clarification.
- **Document your patient care assessments, observations, communications and actions** in an objective, timely, accurate, complete, appropriate and legible manner.
- **Never alter a record for any reason or add anything to a record after the fact** unless it is necessary for the patient's care. If it is essential to add information to the record, properly label and date the delayed entry.

Actions to take after becoming aware of a real or potential claim:

- **Contact your insurance provider, even if your employer advises you that the practice or organization will represent you in the matter.** Take action immediately should you become aware of a filed or potential professional liability claim against you, receive a subpoena to testify in a deposition or trial, or have any reason to believe that there may be a potential threat to your license to practice.
- **Refrain from discussing the matter with anyone** other than your defense attorney or the claim professionals managing your claim.
- **Promptly return calls from your defense attorney** and the claim professionals assigned by your insurance carrier.
- **Contact your attorney or claim professional before responding to claim-related calls,** e-mail messages or requests for documents from any other party.
- **Provide your insurance carrier with as much information as you can when reporting claims and related matters,** including contact information for your organization's risk manager and employer-assigned attorney.
- **Never testify in a deposition without first consulting your insurance carrier** or, if you do not carry individual liability insurance, the organization's risk manager or legal counsel.
- **Copy all legal documents and retain them in your records,** including the summons and complaint, subpoenas, attorney letters and other legal documents pertaining to the claim.
- **Never add any documentation to a record for any reason after a claim is filed.** If additional information about the patient's care emerges after you become aware that legal action is pending, discuss the need for additional documentation with your manager, the organization's risk manager and legal counsel.

Part 2: Nurses Service Organization's Analysis of Nurse Practitioner License Protection Paid Claims

(JANUARY 1, 2012 THROUGH DECEMBER 31, 2016)

Introduction

A licensing board complaint can be filed against a nurse practitioner by a patient, colleague, employer and/or regulatory agency. Such complaints are subsequently investigated by the board, with results ranging in seriousness from no action taken to license revocation. The majority of these complaints are unsubstantiated and the regulatory body closes the case without disciplinary action. But regardless of the outcome, board investigations are a serious matter, requiring legal assistance and involving a significant amount of time and effort on the NP's part.

License protection claims differ from professional liability claims in that they may extend beyond matters of professional negligence and involve allegations of a personal, non-clinical nature, such as substance or physical abuse. Another key difference is that the amounts paid for license protection claims represent only the cost of providing legal defense for the nurse practitioner, as there is no plaintiff and therefore no indemnity or settlement payment.

This section highlights the most common types of license protection claims. It is intended to assist nurse practitioners in identifying potential vulnerabilities and taking focused, proactive action to minimize risk.

Definitions

- **Consent agreement –** A stipulation of a condition or conditions that must be met in order for a nurse practitioner to continue to practice.
- **Letter of concern/guidance/admonishment –** A communication from the regulatory board noting that the nurse practitioner may have engaged in questionable conduct.
- **Probation –** A decision by the state board of nursing that the nurse practitioner in question can continue to practice subject to specified conditions, including monitoring.
- **Public censure/censure/reprimand –** A public, written statement regarding a nurse practitioner's violation of the Nurse Practice Act, which does not impose any conditions on the NP's professional licensure.*
- **Revocation –** The withdrawal of the nurse practitioner's license by state board of nursing action.
- **Surrender –** A voluntary relinquishment of a license that has the force and effect of revocation.
- **Suspension –** The temporary withdrawal of the nurse practitioner's license by state board of nursing action.

* Note: The definitions of these actions may differ slightly from state to state. For the purposes of this section, each of these terms are counted separately, as that is how these data are reported to CNA/NSO.

Database and Methodology

As noted in the introduction, two datasets are utilized in Parts 1 and 2 of this report. The 2012 dataset drew upon a total of 504 reported license protection incidents or claims affecting nurse practitioners insured through the CNA/NSO insurance program that closed between January 1, 2007 and December 31, 2011.

The 2017 dataset for this section is based upon 404 reported license protection claims affecting CNA/NSO-insured nurse practitioners. Only those license protection closed claims that met the following criteria were included:

- The claim involved an NP, NP practice or NP student insured through the CNA/NSO insurance program.
- Closed between January 1, 2012 and December 31, 2016, regardless of when the claim was initiated or first reported.
- The claim resulted in a license protection defense cost (i.e., a payment).

These criteria, applied to the total number of reported nurse practitioner license defense claims, create a 2017 dataset consisting of 240 closed claims. Similar criteria produced a 2012 dataset comprising 133 closed claims.

- Incident reports are filed when an insured has been notified by a regulatory board that a complaint has been filed and an investigation is pending, or when the insured anticipates that an incident may lead to a regulatory board investigation.
- Of the 404 total incidents, 240 or 59.4 percent resulted in a payment.
- The average payment – comprising legal expenses, associated travel costs and wage loss reimbursable under the policy – is $5,987.
- The average payment amount may not reflect the total expense paid by the nurse practitioner for the license protection defense.
- Although incidents decreased from the 2012 report to the 2017 report (from 504 to 404), the number of paid claims rose by 80.5 percent, from 133 to 240. The average payment also increased, from $4,441 to $5,987.

1 2012 and 2017 License Defense Claim Data Comparison

	2017 report	2012 report	Variance (numerical)	Variance (percentage)
Incidents	404	504	(100)	-19.8%
Average number of incidents per year	81.0	100.8	(20)	-19.6%
Paid claims	240	133	107	80.5%
Average number of paid claims per year	48.0	26.6	21	80.5%
Paid claims as percentage of total incidents	59.4%	26.4%		33.0%
Average payment	$5,987	$4,441	1,546	34.8%

License Protection Defense Paid Claims

As previously noted, license protection defense paid claims involve both medical and non-medical allegations against nurse practitioners.

Analysis of License Protection Claims by Insurance Type

The 2017 dataset includes 240 paid claims, resulting in a total paid of $1,436,876. Of these paid claims, 96.7 percent involve nurse practitioners who are individually insured in the CNA/NSO program, and 3.3 percent involve employees or independent contractors providing professional services on behalf of a nurse practitioner group practice insured by CNA.

2 Severity by Insurance Type

Insurance type	Percentage of paid claims	Total paid	Average payment
Nurse practitioner, individually insured	96.7%	$1,371,240	$5,911
Nurse practitioner receiving coverage through a CNA-insured healthcare business	3.3%	$65,636	$8,205
Total	100.0%	$1,436,876	$5,987
Total	100%	$1,436,876	$5,987

Analysis of Severity by Location

- The locations accounting for the majority of closed claims are **office practice** settings (81.7 percent), **hospitals** (10.0 percent), **aging services** (4.6 percent) and the **patient's home** (1.7 percent).
- **Prison health** settings, **nurse practitioners' homes**, **schools** and **spas/medispas** each accounted for less than 1 percent of paid claims. **Spa/medispa** locations, which are new to the 2017 report, have an average payment more than double the overall average.
- The **office practice** setting has by far the highest frequency, at 81.7 percent.
- **Spas/medispas** ($12,170), **patient homes** ($8,562) and **aging services** ($7,335) have a higher-than-average payment.
- A common thread among license protection complaints is the need for nurse practitioners to clearly document treatment given and follow-up, whether they directly deliver care or supervise others who carry out instructions.
- The following claim took place at a **spa/medispa**:
  - A nurse practitioner worked for a salon advertised as a "medispa," where she administered Botox® and Restalyne® injections. The NP's name was included in the salon's advertisements. After a board of barbering and cosmetology search did not yield a physician affiliated with the medispa, a complaint was filed against the salon and the NP with the board of nursing. The complaint alleged that the NP aided and abetted the unauthorized practice of medicine by cooperating with the salon in advertising and procuring clients, to whom she prescribed and administered Botox® and Restylane® without an order from a physician. An investigation confirmed that the nurse practitioner did in fact have a collaborating agreement with a physician. While the complaint was subsequently closed with no further action taken by the board, it cost over $12,000 to defend.

- Most of the complaints stemming from incidents that occurred at a **patient's home** involve medication issues, such as inappropriately leaving medications at the patient's home, resulting in overdose and death, or improperly administering medications, as in the following scenario:
  - An insured nurse practitioner believed that one of her patients could benefit from clonidine, but she was concerned about the patient's financial situation. She provided the patient with clonidine 0.1mg samples in a plastic bag marked with "Clonidine 0.1mg" written with a marking pen. The home health agency filed a complaint with the state alleging that the nurse practitioner improperly labeled and packaged medication at the home of a patient and that the patient was not provided with written instructions, violating the health and safety code. After review, the board of nursing handed down a reprimand with stipulations and fines. The claim cost over $5,000 to defend.
- **Aging services** complaints include failure to properly treat by failing to replace a feeding tube, failing to diagnose a urinary tract infection and failing to call 911, as well as medication errors, scope of practice violations and breach of confidentiality. One such claim is described below:
  - The family of a resident at an aging services facility filed several complaints against a nurse practitioner, including failure to maintain the standard of care, billing fraud involving a private pay arrangement between the practitioner and the resident's family, administration of a medication the resident was known to be allergic to, and alteration and destruction of resident healthcare information records. The cost to defend the nurse practitioner before the board was higher than average.

3 Severity by Location

* Percentage is calculated against the total number of paid license protection claims.

Location	Percent of paid claims*	Total paid	Average payment
Spa/medispa	0.4%	$12,170	$12,170
Patient's home	1.7%	$34,249	$8,562
Aging services	4.6%	$80,690	$7,335
Office practice	81.7%	$1,171,912	$5,979
Hospital	10.0%	$129,468	$5,395
Prison health services	0.8%	$6,298	$3,149
Nurse practitioner's home	0.4%	$1,147	$1,147
School	0.4%	$942	$942
Total	100%	$1,436,876	$5,987

Analysis of Severity by Allegation Category

This section examines primary allegation categories and highlights the top three allegation classes: **medication** (27.1 percent), **scope of practice** (22.1 percent), and **treatment and care management** (13.3 percent).

- The four most frequent license protection allegations represent 71.3 percent of all complaints filed against nurse practitioners. These allegations include **medication** (27.1 percent), **scope of practice** (22.1 percent), **treatment and care management** (13.3 percent), and **professional conduct** (8.8 percent).
- Allegation classes that exceed the overall average payment ($5,987) include **patient rights** ($8,413), **confidentiality** ($7,425), **documentation** ($6,782), **scope of practice** ($6,687) and **medication** ($6,627).
- It is the nurse practitioner's responsibility to maintain a safe practice environment for staff and patients, and also to respect patients' rights, including privacy and consent – rights violated in the following scenario:
  - An insured nurse practitioner was working in a home health setting with a medical assistant present. The nurse practitioner failed to ask the patient's permission to perform a physical examination of her breast wound. The patient alleged that her privacy was violated, as she would never have wanted the male medical assistant in the room while a physical examination was performed. The cost to defend the nurse practitioner's license was in excess of $12,000.
- While not one of the most frequent complaints made against nurse practitioners, breach of confidentiality allegations affect both the patient and the NP's professional reputation. Claims include failure to obtain the patient's permission to copy and release healthcare information records and failure to secure patient healthcare information records, as in the following claim:
  - A patient's healthcare record was left unsecured in a public area. The cost to defend the nurse practitioner's license exceeded $13,000, and the investigation resulted in a one-year license suspension.
- Breach of confidentiality complaints also may involve failure to maintain boundaries, as exemplified by the following claim:
  - A patient who had once been treated by an insured nurse practitioner later became the NP's co-worker. The nurse practitioner shared private health information about the former patient with another co-worker, and the former patient filed a complaint. The board of nursing determined that there was insufficient evidence and closed the complaint without taking action against the nurse practitioner's license. However, it cost over $10,000 to defend the nurse practitioner's license.

4 Severity by Allegation Category

* Percentage of all license defense closed claims.
** This category includes allegations where the final order from the board of nursing, including the attorney's fees was sufficient to settle a license protection claim.

Allegation category	Percentage of closed claims*	Total paid	Percentage of total paid	Average payment
Patient rights	6.3%	$119,614	8.3%	$8,413
Confidentiality	3.8%	$66,825	4.7%	$7,425
Documentation	6.3%	$101,735	7.1%	$6,782
Scope of practice	22.1%	$354,417	24.7%	$6,687
Medication	27.1%	$430,731	30.0%	$6,627
Professional conduct	8.8%	$120,489	8.4%	$5,738
Monitoring	0.8%	$9,647	0.7%	$4,824
Diagnosis	5.0%	$51,988	3.6%	$4,332
Treatment and care management	13.3%	$128,219	8.9%	$4,007
Assessment	3.3%	$27,593	1.9%	$3,449
Details of allegation unavailable**	3.2%	$25,618	1.7%	$3,202
Total	100%	$1,436,876	100%	$5,987

The top three allegation classes are medication, scope of practice, and treatment and care management.

Comparison of 2012 and 2017 Allegation Categories

- Since the 2012 report, there have been some significant shifts in allegation class frequency. The allegation class that showed the biggest change is **scope of practice,** which more than doubled as a percentage of total claims, from 9.0 percent in the 2012 report to 22.1 percent in the 2017 report.
- **Medication** allegations increased from 20.3 percent in the 2012 report to 27.1 percent in the 2017 dataset. Complaints typically involve over-prescribing, especially of controlled substances, as well as failure to explain potential drug side effects. Of the total medication complaints, 67 percent closed with no board action taken.
- **Documentation** allegations more than quadrupled as a proportion of total claims, from 1.5 to 6.3 percent.
- The incidence of **professional conduct** and **treatment and care management** claims decreased significantly.
- **Scope of practice** includes complaints against NPs who were alleged to have prescribed controlled substances, although they were not authorized to do so. Injuries include patient addiction, as well as two instances of patient death. More than half (57 percent) of scope of practice allegations were closed without disciplinary action taken.
- The remaining 43 percent of scope of practice allegations resulted in a variety of sanctions, including **probation, continuing education, fines** and **letters of concern.** Less common resolutions include **civil penalty, consent agreement, reprimand, suspension,** and **license surrender** or **revocation.**

5 Comparison of 2012 and 2017 Allegation Categories

**This category includes allegation where the final order from the board of nursing, including the attorney's fees was sufficient to settle a license protection claim.

Allegation category	2017 report	2012 report	Variance
Medication	27.1%	20.3%	6.8%
Scope of practice	22.1%	9.0%	13.1%
Professional conduct	8.8%	23.3%	-14.5%
Treatment and care management	13.3%	25.6%	-12.3%
Documentation	6.3%	1.5%	4.7%
Diagnosis	5.0%	6.0%	-1.0%
Patient rights	6.3%	9.0%	-2.7%
Confidentiality	3.8%	2.3%	1.5%
Assessment	3.3%	1.5%	1.8%
Monitoring	0.8%	1.5%	-0.7%
Billing practices	0.0%	0.0%	0.0%
Details of allegation unavailable**	3.2%	0.0%	3.2%
Total	100%	100%	

Top Allegations for License Protection Defense Paid Claims

This section examines the top three allegation classes – **medication** (27.1 percent), **scope of practice** (22.1 percent), and **treatment and care management** (13.3 percent) – in more detail. Together, three classes account for the majority of allegations made against nurse practitioners.

Medication

Medication prescribing/management is both a key nurse practitioner responsibility and a major source of liability.

Within the **medication** allegation class, the most frequent allegations are **improper prescribing or management of controlled drugs** (27.7 percent), **improper management of medication** (24.7 percent) and **wrong dose** (15.4 percent).

Considering the high level of public concern regarding opioid overuse and abuse, it is more important than ever that nurse practitioners prescribe with care, document the rationale behind prescription decisions, monitor patients taking multiple medications, and cooperate with other healthcare providers in managing and tracking drug regimens. Related claims include the following:

- A patient's husband alleged that his wife was improperly prescribed controlled substances for a period of one year, resulting in her addiction to pain medications. The nurse practitioner was alleged to have failed to explore other treatment modalities besides pain medication and to have continued prescribing oxycodone despite the addictive nature of the drug. An investigation determined that on seven occasions, the NP failed to personally examine the patient prior to renewing her narcotic pain medication, instead relying inappropriately upon physical examinations delegated to an unlicensed medical assistant. The insured signed a board consent order, which involved accepting a reprimand and agreeing to pay a civil penalty of $2,000. The cost to defend the nurse practitioner's license was $11,660.
- A pharmacist filed a complaint against an insured nurse practitioner working at a pain management clinic, stating that she had grown concerned about both the number of pills being prescribed to patients and the duration of the prescriptions. The pharmacist also stated that she had tried to contact the clinic where the nurse practitioner worked a number of times regarding her concerns, but never received a call back. An investigation found that the nurse practitioner had engaged in unsafe prescribing practices, breached the standard of care for prescribing narcotics while working at a pain clinic, and had copied and pasted portions of patient records. The board issued a letter of reprimand with monitoring requirements. The NP was ordered to complete mandatory training and placed on probation for 18 months. The cost to defend the nurse practitioner's license was over $9,900.

6 Detailed View of Medication-related Allegations

** This category includes situations where the final order from the board of nursing, along with the attorney's bill, was sufficient to settle a license protection claim.

Allegation detail	Percentage of total within allegation class	Total paid	Average payment
Improper prescribing/management of anticoagulant	1.5%	$17,154	$17,154
Prescribing practice not included within state scope of practice	10.8%	$58,528	$8,361
Improper management of medications	24.7%	$133,095	$8,318
Failure to recognize contraindication and/or known adverse interaction between/among ordered medications	7.7%	$35,963	$7,193
Wrong dose	15.4%	$60,800	$6,080
Improper prescribing/management of controlled drugs	27.7%	$106,624	$5,924
Wrong medication	4.6%	$9,181	$3,060
Failure to properly instruct patient regarding medication	3.1%	$4,191	$2,095
Failure to notify patient's healthcare team of prescribing/administration error	1.5%	$1,785	$1,785
Wrong time	1.5%	$1,760	$1,760
Details of allegation unavailable**	1.5%	$1,650	$1,650
Total	100%	$430,731	$6,627

Medication prescribing/ management is both a key nurse practitioner responsibility and a major **source of liability**.

Scope of practice

Nurse practitioners must work to their full practice authority, while being mindful of state regulations and limitations.

The most frequent allegation within the **scope of practice** allegation class is **practice violates scope of practice and standards of care,** at 60.3 percent of claims. In terms of severity, the average defense cost is $7,030, which is greater than the average cost of the allegation class ($6,687) and the total license protection dataset ($5,987).

However, it should be noted that of the scope of practice complaints investigated by the various boards of nursing, 57.4 percent of the final decisions resulted in no disciplinary action.

- Several scope of practice allegations involve prescribing. The majority of these complaints were closed without the regulatory body handing down any disciplinary action.
- In a few cases, the nurse practitioner was required to complete continuing education course-work on documentation practices. Other, more serious cases of practicing beyond or outside the scope of practice resulted in nurse practitioners being placed on probation or losing their license.
- As practice authority and scope of practice continue to evolve, it is imperative that nurse practitioners exercise caution when prescribing to avoid board allegations.
- Nurse practitioners must know what medications are outside of their prescribing scope of practice. When necessary, consult with another practitioner or one's consulting physician to mitigate the risk of prescribing the wrong medication or dosage.
- Additionally, it is important to be clear with patients, their family members and other practitioners about one's level of prescriptive authority. In order to keep their license safe, NPs must maintain up-to-date documentation of physician agreements.
- To minimize the risk of complaints, investigations and board actions in this area, nurse practitioners must adhere to both state/local regulations and organizational protocols. If these are in conflict, the stricter rule must be followed.

7 Detailed View of Scope of Practice Allegations

Allegation detail	Percentage of total within allegation class	Total paid	Average payment
Improper prescribing of controlled substances (i.e., beyond scope of practice)	3.8%	$19,209	$9,605
Practice violates scope of practice and standard of care	60.3%	$224,949	$7,030
Practice violates the state's nurse practice act	32.1%	$106,400	$6,259
Failure to communicate with collaborating or supervising physician/practitioner	1.9%	$2,437	$2,437
Failure to consult with collaborating physician/practitioner in order to obtain assistance/clarification	1.9%	$1,422	$1,422
Total	100%	$354,417	$6,687

Treatment and Care Management

For nurse practitioners, **assessment, diagnosis,** and **treatment and care management** are three of the core elements of care. Complaints in this area comprise 13.3 percent of the total allegations made. While these allegations are not as frequent or costly as **medication error** or **scope of practice** complaints, they can have equally serious consequences for nurse practitioners' careers and must be vigorously defended against.

- Of the complaints in this allegation class that were defended before a board of nursing, 87.5 percent resulted in no findings by the board and therefore no disciplinary action against the nurse practitioner, as in the following case:
  - A patient had been prescribed oxycodone (45mg once every four hours) for chronic pain by a physician before he left the practice. The insured nurse practitioner took over the patient's care. The patient alleged that the NP failed to physically examine him during an appointment and accused him of selling and/or abusing his pain medications. The complaint also alleged that the NP declined to refill his prescription for oxycodone, forcing him to manage his pain in other ways. The board of nursing reviewed the complaint and dismissed the case.
- The following case did result in disciplinary action:
  - A patient filed a complaint with the state, alleging that during a follow-up appointment after a recent hospital stay, the insured nurse practitioner spent 20 minutes discussing current social events and 45 minutes discussing the patient's spiritual beliefs and her need to join a local church. Additionally, the patient alleged that the NP did not review recent test results with her and refused to complete the patient's disability and leave-of-absence paperwork. The nurse practitioner's unprofessional activity so concerned the patient that she canceled her future appointments with the practice. The state board of nursing reviewed the complaint and issued a letter of concern.
- A common theme in these allegations is inadequate communication with patients and other providers. Effective preventive measures for complaints of this type include establishing proper documentation and filing procedures, maintaining appropriate professional boundaries, conducting a thorough informed consent discussion with patients prior to treatment, using signed informed consent forms and implementing other risk control recommendations included in Part 1 of this report.

8 Detailed View of Treatment and Care Management Allegation Class

Allegation	Percentage of total within allegation class	Total paid	Average payment
Premature cessation of treatment	3.1%	$2,300	$2,300
Patient abandonment	15.6%	$12,895	$2,579
Failure to timely respond to patient's concerns related to the treatment plan	15.6%	$16,841	$3,368
Failure to timely implement/order established treatment protocols	15.6%	$17,274	$3,455
Failure to timely/properly address medical complication or change in condition	6.3%	$7,088	$3,544
Failure to correctly place nasogastric tube	3.1%	$3,660	$3,660
Improper technique or negligent performance of treatment or test	9.4%	$12,842	$4,281
Failure to notify patient/family/healthcare team of patient's condition	9.4%	$13,857	$4,619
Improper or untimely management of medical patient or medical complication	18.8%	$33,452	$5,575
Failure to obtain/refer to emergency treatment	3.1%	$8,010	$8,010
Total	100%	$128,219	$4,007

A common theme in these allegations is inadequate communication with patients and other providers.

Licensing Board Decisions

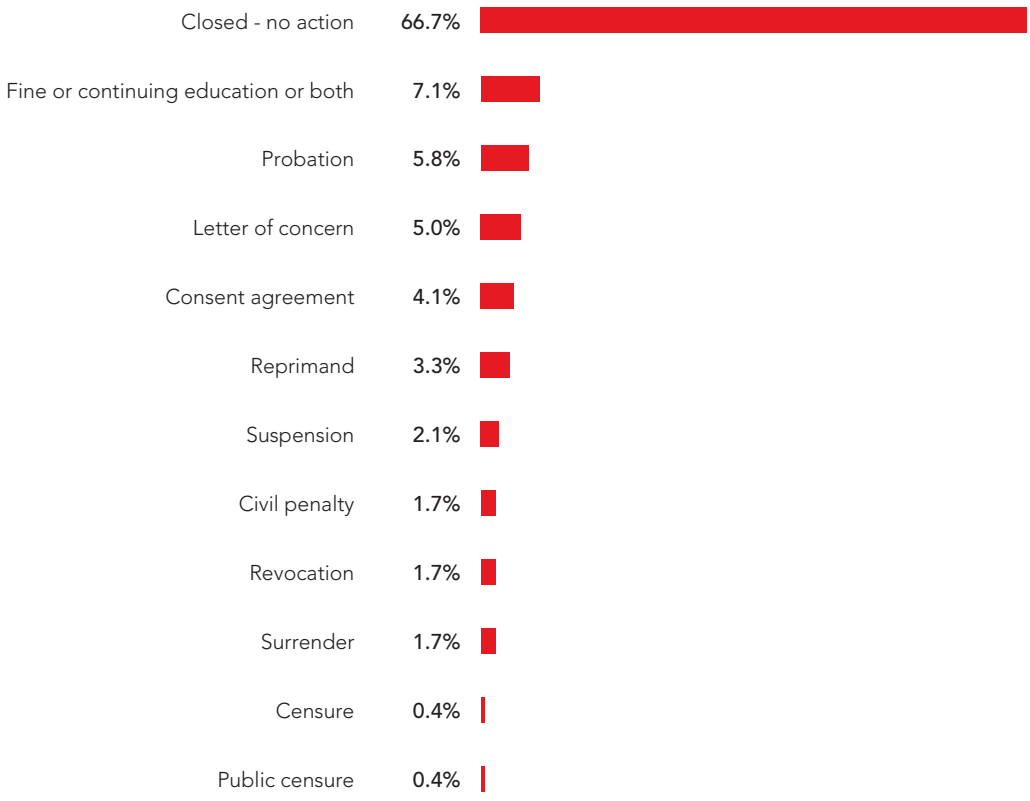
The average time from the nurse practitioner's reporting of the incident to CNA/NSO to the final board decision is 15 months.

Two-thirds of the total complaints in the licensing protection defense dataset were closed with no action taken against the nurse practitioner. The remaining one-third resulted in some level of discipline, ranging from fines, required continuing education coursework, letters of concern and reprimands, to more serious decisions, such as probation and license surrender or revocation.

The more serious board decisions, while less common, are career-altering or even career-ending. But even the complaints resulting in less serious decisions have a significant impact on nurse practitioners, who must devote time and energy to their defense while awaiting the board's decision.

- Many of the issues mentioned in the professional liability section of this report are equally relevant to licensing board complaints.
- By reviewing and complying with state practice authority regulations, and working to maintain and enhance skills in such areas as medication management, patient assessment, documentation, informed consent and communication, nurse practitioners can significantly reduce the likelihood of lawsuits, complaints and board actions.

9 Frequency of Board Decisions



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