Risk Control Self-assessment Checklist for Nurse Practitioners

This resource is designated 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 (CPOE) 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?			
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?			

Documenting Patient Healthcare Information (continued)	Yes	No	Comments/Action Plan
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?			
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?			

Documenting Patient Healthcare Information (continued)	Yes	No	Comments/Action Plan
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, benefits, and alternatives pertaining to the recommended treatment or procedure?			
- 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 screening 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 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."

1100 Virginia Drive, Suite 250
Fort Washington, PA 19034
1.800.247.1500 www.nso.com

333 South Wabash Avenue
Chicago, IL 60604
1.888.600.4776 www.cna.com

In addition to this publication, CNA and Nurses Service Or ganization (NSO) have produced numerous studies and articles that provide useful risk control information on topics relevant to nurse practitioners, as well as information relating to nurse practitioner professional liability insurance, at www.nso.com. These publications are also available by contacting CNA at 1.888.600.4776 or at www.cna.com.

Nurses Service Organization (NSO) is the nation's largest administrator of professional liability insurance coverage to individual nursing professionals. Nurses Service Organization is a registered trade name of Affinity Insurance Services, Inc., an affiliate of Aon Corporation. For more information about NSO, or to inquire about professional liability insurance for nursing professionals, please contact NSO at 1.800.247.1500 or visit NSO online at www.nso.com.

Nurses Service Organization is a registered trade name of Affinity Insurance Services, Inc. (TX 13695); (AR 100106022); in CA, MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services, Inc.; in CA, Aon Affinity Insurance Services, Inc. (CA 0G94493); Aon Direct Insurance Administrators and Berkely Insurance Agency; and in NY, AIS Affinity Insurance Agency.

X-12916-1017