# Nursing Liability Update

## Professional Liability Claim & Licensing Board Metrics and Case Studies

CNA



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# Objectives

- Analyze the leading allegations made against nurses in medical malpractice claims and State Board of Nursing matters.
- Define the average incurred costs related to a malpractice claim, lawsuit or State Board of Nursing matter.
- Identify key risk management tools nurses can incorporate into their practice.

# Professional Liability Case Study

# Case Study

- The two insureds in this case were registered nurses employed by a community hospital.
- The primary RN had been a nurse for 10 years and had been working on the telemetry unit of this hospital for two years.
- The charge nurse had been an RN for 20 years and had been a charge nurse at the hospital for 10 years.
- Both nurses were working on the evening shift on the second day of the patient's admission.

# Case Study

- The patient was a 66-year-old married female who presented to the emergency department (ED) with complaints of left-sided back pain radiating to the chest and shortness of breath.
- The patient had a past medical history of aortic valve replacement, diabetes, coronary artery disease, hypertension, peripheral vascular disease, obesity and chronic obstructive pulmonary disease. Diagnostic testing ruled out acute cardiac findings and she was diagnosed with atypical pneumonia, treated with antibiotics and discharged  home.
- About two weeks later, the patient returned to the ED complaining of shortness of breath and abdominal pain. The patient was tachycardic and had an oxygen saturation of 94 percent on four liters of oxygen.

# Case Study

- Coagulation studies revealed that her INR level was elevated at 5.1, so the anticoagulant medication was held.
- A chest x-ray was performed which revealed a large pleural effusion.
- The patient was admitted to the hospitalist service with an admitting diagnosis of “rule out C. Difficile”, based upon the patient’s gastrointestinal complaints (C. Difficile cultures were subsequently negative)

# Case Study

- The admitting hospitalist was working on a locum tenens basis and was covering the weekend 7 a.m. to 7 p.m. shifts. He was employed full-time at another area hospital.
- The patient was admitted to the telemetry unit at 6 p.m. with orders for intravenous (IV) fluids and pain medication.
- Diagnostic imaging orders included a cardiac echocardiogram and a chest CT to be performed on a routine basis.
- There was also an order for nursing to report a heartrate above 130 beats per minute (bpm) or if the patient's oxygen saturation level fell below 90 percent.

# Case Study

- The patient was stable overnight. However, the following day, the patient complained of increasing abdominal pain.
- She was evaluated by the hospitalist at 9:00 a.m. The physical exam revealed tachycardia and diminished lower left lobe breath sounds. The hospitalist documented that the tachycardia was likely related to volume depletion and dehydration.
- The clinical plan included pain medication, volume replacement, lung CT scan with a “possible” thoracentesis to drain the pleural effusion.

# Case Study

- At 11:20 a.m., an echocardiogram was performed which revealed **a large left pleural effusion** as well as moderate to severe left ventricular hypertrophy. The hospitalist was aware of this result.
- The insured RN (primary RN) began her shift at 3:00 p.m. and conducted an initial patient assessment at 3:30 p.m. The patient's condition was unchanged from the previous shift.

# Case Study

- The primary RN reviewed the results of the chest CT performed at 2:30 p.m. that day, which stated, “Large left pleural effusion which is inverting the left hemidiaphragm and causing inferior and medial displacement of the structures in the left upper quadrant of the abdomen, as well as near complete collapse of the entire left lung and mediastinal shift to the left.  Findings suggest that the pleural fluid is under significant pressure and is likely either infectious or malignant in etiology rather than simple effusion.”
- She immediately reported the abnormal CT findings to the hospitalist and asked him if the patient should be transferred to the ICU.
- The hospitalist stated that he was comfortable with the patient remaining on the telemetry unit and that he would order a pulmonary consult.

# Case Study

- The primary RN inquired as to whether the pulmonary consult order should be placed as a **STAT** order versus a “routine” order.
- The hospitalist stated that a routine order would be “fine.” The hospitalist mistakenly believed that consults would be performed the same day as they were ordered, but this assumption was based on the protocols in place at the other hospital where he was on staff.
- The primary RN informed him, “we may not get those results today”, but the order was kept as “routine”.

# Case Study

- The primary RN remained concerned about the patient's CT results and was not satisfied with the plan for a "routine" pulmonary consult.
- She reported her concerns to the charge nurse who agreed that this matter warranted further escalation of the chain of command.
- The charge nurse contacted the chief medical officer (CMO), who was a cardiologist, and informed her about the patient's CT results. The CMO advised the charge nurse to contact a pulmonologist directly to request a STAT consult.

# Case Study

- The charge nurse immediately called the pulmonary service and left a message at 5:15 p.m. requesting a STAT consult. The pulmonologist called back at 5:30 p.m. and the charge nurse reported the CT results verbatim to him.
- The pulmonologist ordered a Vitamin K injection to treat the patient's elevated INR, in anticipation of performing a thoracentesis the following day, if the patient's condition warranted.
- The phone consultation was not documented by the pulmonologist; however, it was documented in detail by the charge nurse.

# Case Study

- The charge nurse then notified the hospitalist that she had spoken with the pulmonologist and that she had administered Vitamin K in response to the pulmonologist's verbal order.
- The hospitalist agreed with the pulmonologist's plan to consider performing a thoracentesis the following day.
- The charge nurse continued to keep the nursing supervisor apprised of the situation. The supervisor advised her to keep in close contact with the treating physicians to ensure that they were aware of any changes in the patient's condition and to document all conversations, which was done.

# Case Study

- At 6:30 p.m., the primary RN documented that the patient was complaining of increased abdominal pain and nausea. She administered Zofran 4 mg and Morphine 2mg intravenously, as ordered.
- She again contacted the hospitalist to inform him of the patient's continued complaints of pain, despite receiving pain medication, as well as to alert him to the patient's decrease in oxygen saturation to 78 percent.
- The hospitalist did not see the patient at this time. However, he ordered the RN to increase the patient's oxygen from 2 liters per minute to 4 liters per minute and to request that respiratory therapy provide a nebulizer treatment.

# Case Study

- At 7:00 p.m., a nebulizer treatment was performed by respiratory therapy, and the patient's oxygen saturation level increased to 96 percent. However, her heartrate remained elevated at 134 bpm.
- The hospitalist was preparing to end his shift at 7:15 p.m. and was on the unit speaking with the patient and her husband about the plan of care. The RN interrupted him to inform him that the patient was having a sustained heart rate in the130s.
- The hospitalist advised the primary RN that he believed that the tachycardia was related to pain gave a verbal order for a STAT one-time dose of Dilaudid 2mg, which was administered at 7:30 p.m.

# Case Study

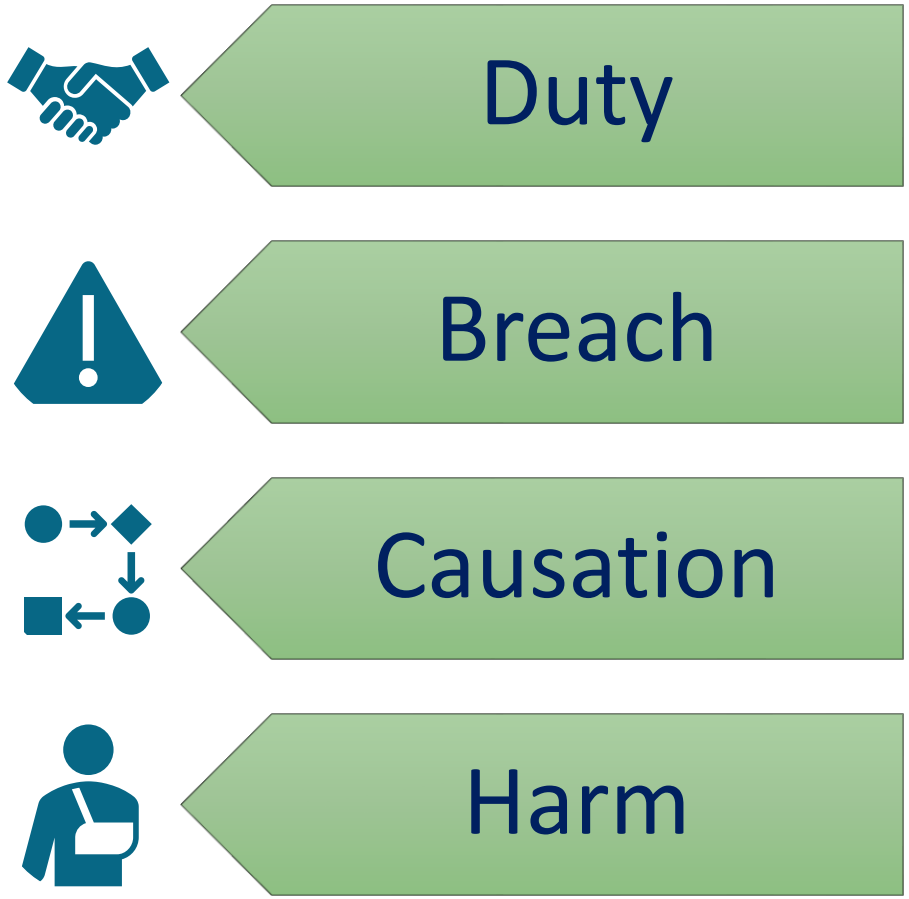
- At 8:00 p.m., a new hospitalist was on duty and received report from the previous hospitalist. The primary RN updated him about her concerns regarding the CT results.
- The incoming hospitalist stated that he did not need to see the patient at this time, as the previous hospitalist examined the patient shortly before the shift change and reported that her condition was stable.
- At 8:45 p.m. the primary RN again contacted the hospitalist stating that she believed that the patient needed a higher level of care.
- The  hospitalist advised that the patient could remain on the telemetry unit as her oxygen saturations were within normal limits.

# Case Study

- Approximately 30 minutes later, the patient became unresponsive, and a code was called.
- Resuscitative measures were initiated including emergent drainage of the pleural effusion, yielding several hundred milliliters of serosanguineous fluid.
- The code was unsuccessful, and the patient expired. The cause of death was cardiac arrest due to a left pleural effusion.

# Consider

- Do you believe that the primary RN was negligent?
- Do you believe that the charge nurse adhered to the standard of care?
- Do you believe that any other parties were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the nurse?
  - If yes, how much?



# Case Study-Allegations

- One year following the patient's death, the patient's husband (plaintiff) filed a lawsuit naming the hospital, the treating physicians, the charge nurse and the primary RN.
- The plaintiff asserted that the treating physicians failed to perform an emergent thoracentesis of the large pleural effusion which was the direct cause of the patient's death.
- Plaintiff further asserted that the primary RN and the charge nurse failed to use critical thinking skills to recognize that the patient's symptoms required emergent treatment.

# Plaintiff's Experts

- The plaintiff's expert in pulmonary medicine opined that the hospitalist should have ordered a STAT pulmonary consult and Vitamin K to proactively prepare the patient for a thoracentesis upon learning of the large pleural effusion.
- This expert criticized all the physicians for disregarding the nurses' concern that the patient needed a higher level of care based upon the persisting tachycardia and abnormal CT results.
- The plaintiff's nursing expert opined that the primary RN deviated from the standard of care by failing to conduct ongoing nursing assessments and failing to communicate with the physicians regarding the patient's respiratory status.

# Defense Experts

- Both defense experts-- an RN and a board certified pulmonary critical care physician-- were supportive of the nursing care provided.
- They testified that the primary RN documented frequent assessments and ongoing communications with the treating physicians. The experts opined that both nurses appropriately invoked the chain of command to advocate for the wellbeing of the patient.
- The nursing documentation demonstrated that the primary RN kept the hospitalist apprised of all changes in the patient's condition including questions about the patient needing a higher level of care.

# Defense Experts

- The defense experts also refuted the plaintiff's assertion that the primary RN failed to utilize critical thinking skills. They testified that her knowledge was demonstrated by her attention to detail and concerns regarding the CT results.
- The defense RN expert concluded that the ultimate care was governed by decisions that could only be made by the treating physicians and that nurses cannot render clinical decisions regarding whether a thoracentesis was indicated.

# Defense Challenges

- The most significant challenge for the defense was the finger-pointing amongst the co-defendants.
- The pulmonologist testified that he was not informed about CT scan details and the extent of the pleural effusion. He stated that he relied on the primary RN's report and did not review the CT results in the electronic healthcare information record.
- The night shift hospitalist admitted that the primary RN asked him to see the patient at the start of his shift, but denied being informed about the patient's tachycardia, shortness of breath or CT results. He testified that they only discussed whether the patient met the criteria to be transferred to the ICU.

# Supportive Defense Testimony

- The primary RN's testimony that she notified the night shift hospitalist about the CT results was supported by her documented note which read, "explained patient's condition--CT results and ongoing pain, to night hospitalist and requested that he come up to the floor to see the patient, and physician said he would…"
- In further support of the RN's credibility, the defense attorney obtained an audit trail of the electronic medical record which revealed that the night shift hospitalist viewed the patient's CT scan results at 8:45 p.m.
- The day shift hospitalist was not critical of the nursing care. He testified that he was distracted with an emergency in the ICU and that he did not acknowledge the severity of the patient's condition. He stated the primary RN informed him that the pulmonologist had been called so he believed that the patient's care was being managed. He also agreed that he received multiple calls from the primary RN regarding the patient's condition and confirmed that the primary nurse's notes about the call were accurate.

# Resolution

- The nurses' defense team concluded that, based upon the supportive expert opinions, both nurses acted within the standard of care.
- The defense team was able to successfully obtain a dismissal for both RNs in exchange for a nominal settlement to avert the nurses having to experience a lengthy trial.
- The successful outcome of this case was based upon tireless efforts of the nurses to advocate for the patient, as well as their complete, detailed documentation in the healthcare information record.

# Resolution

**Total Incurred:** More than **$30,000 on behalf of each nurse.**

Proprietary & Confidential-*Figures represent only the payments made on behalf of the insured RN and do not include any payments that may have been made by or on behalf of other involved providers or companies.*

# Risk Control Recommendations for Nurses

- ***Ensure that the patient receives appropriate and timely care,*** as nurses are the patient's advocate.
- ***Maintain clinical competencies*** aligned with the relevant healthcare specialty of nursing practice.
- ***Report all significant information*** regarding the patient's condition, including test results, medications, and outstanding orders, to the treating providers, and document this action in the healthcare information record.
- ***Conduct comprehensive nursing assessments to identify patients requiring close monitoring*** to recognize early signs and symptoms of changes in the patient's condition, and advocate for patients requiring additional treatment.

# Risk Control Recommendations for Nurses

- ***Utilize effective communication techniques*** to avoid misunderstandings amongst the healthcare team.

- ***Consider using an evidence-based tool*** to ensure consistent communication of critical patient information. The Agency for Healthcare Research and Quality (AHRQ) offers several tools for effective hand-off communication, including:
  - Team Strategies and Tools to enhance Performance and Patient Safety (TeamSTEPPS)
  - Illness severity, Patient summary, Action List, Situation awareness & contingency planning and Synthesis by receiver (I-PASS)
  - Situation, Background, Assessment and Recommendations (SBAR).

# Risk Control Recommendations for Nurses

- ***Invoke the organization's chain of command*** when leadership support is needed to advocate for patients at risk.

- ***Know and comply with your state scope of practice requirements,*** nurse practice act and organizational policies.

- ***Follow documentation standards*** established by professional nursing organizations and your employer's policies. Document any changes in the patient's condition and/or response to treatment in the healthcare information record, as well as all patient-related discussions and actions taken.

# Risk Control Recommendations for Charge Nurses

- ***Monitor patient acuity and staffing*** to proactively manage patient safety issues.
- ***Engage in continuing education*** to maintain clinical competencies as well as leadership skills**.**
- ***Adhere to organizational policies regarding*** *the roles and responsibilities of a charge nurse*, including but not limited to the following:
  - Ensuring that all nursing functions within the department run efficiently.
  - Supervising and assisting staff nurses with patient-related questions.
  - Providing patient care as needed to support staff nurses.
  - Monitoring patient care and invoking the chain of command, when indicated.
  - Acting as a liaison and resolving conflicts between nurses and other members of the healthcare team.
  - Delegating staff assignments based upon staff members' competencies**.**

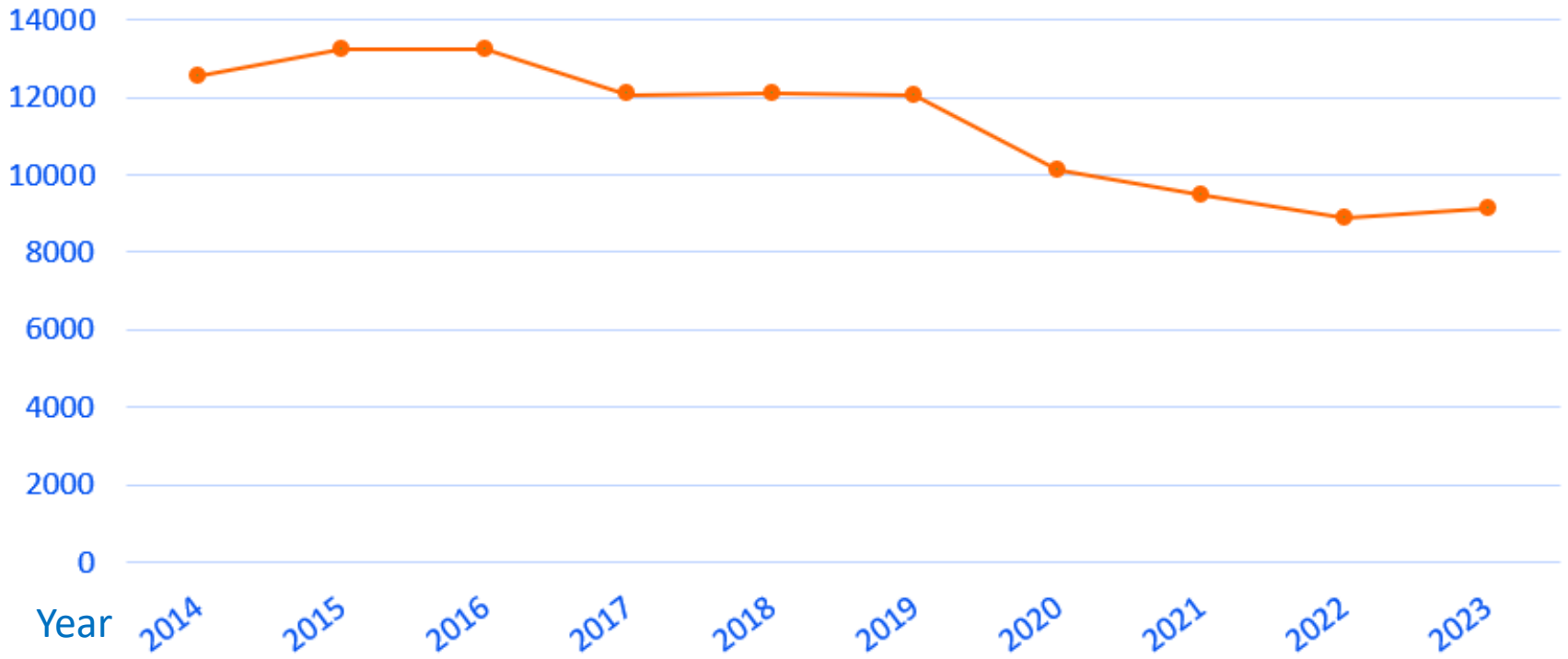
# License Protection

## Metrics & Case Study

# License Protection: Overview

- License protection matters involve the defense of the insured nursing professional during a regulatory agency or State Board of Nursing (SBON) investigation.
- The total incurred expenses include the cost of providing legal representation to defend the insured nursing professional.
- Any average or total incurred expense payment discussed is not necessarily indicative of the severity of the matter or allegation.
- *Investigations may or may not involve allegations directly related to patient care.*

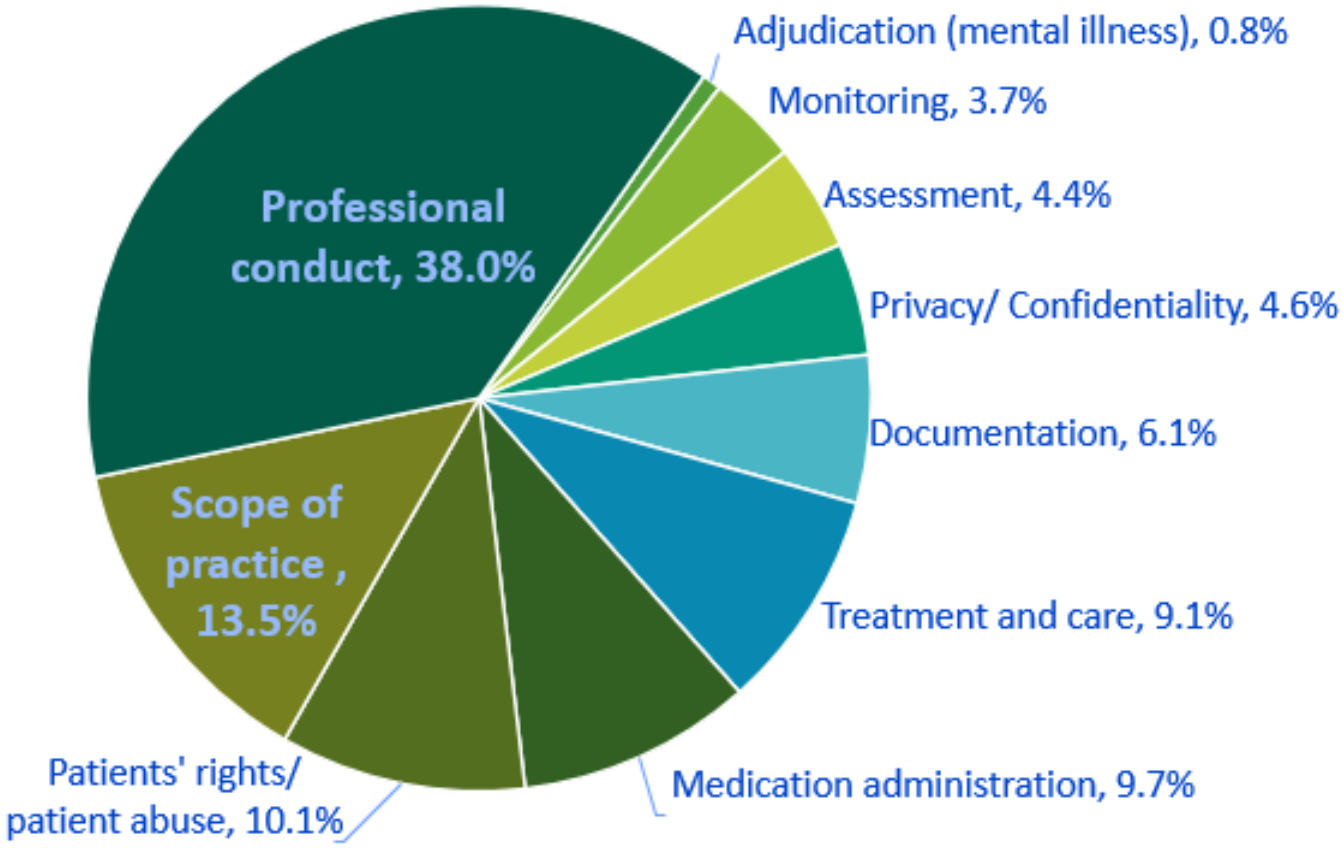
# National Practitioner Data Bank: Reported SBON Disciplinary Actions Against RNs by Year






Division of Practitioner Data Bank, Bureau of Health Workforce, Health Resources and Services Administration. Generated September 13, 2024 using the Data Analysis Tool at https://www.npdb.hrsa.gov/analysistool.

# Allegation Categories

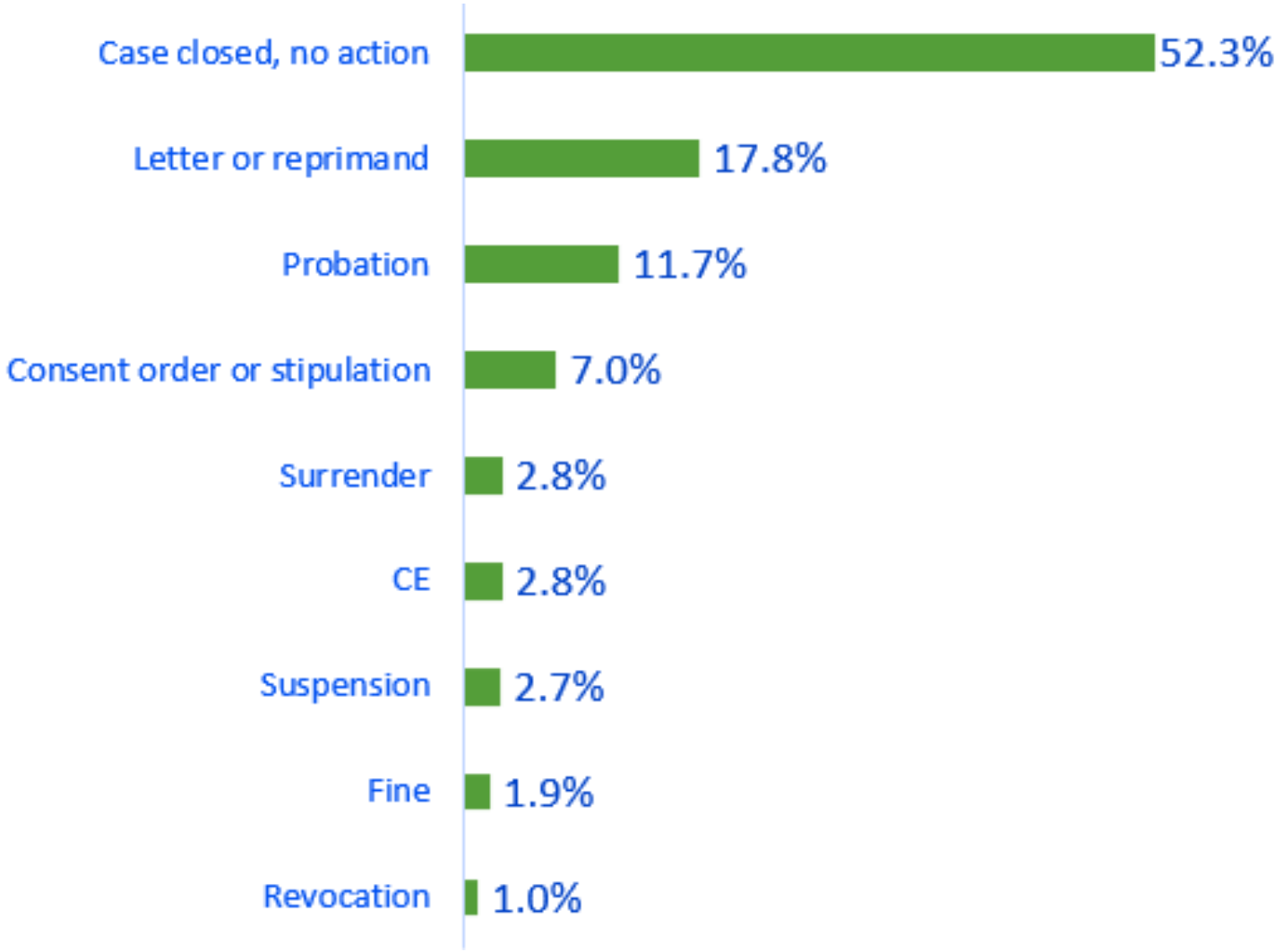


# Top 10 License Protection Allegations

| **Allegation** – *Primary allegation against insured nurse involved in License Protection matter* | **Percent of All LP Matters** | **Allegation Category** |
|---|---|---|
| **Drug diversion and/or substance abuse** | 13.4% | Professional Conduct |
| **Professional misconduct as defined by the state** | 9.0% | Professional Conduct |
| **Failure to maintain minimum standards of nursing practice** | 6.5% | Scope of Practice |
| **Provision of services beyond scope of practice** | 5.6% | Scope of Practice |
| **Criminal act or conduct** | 4.7% | Professional Conduct |
| **Fraudulent/falsified patient care or billing records** | 4.2% | Documentation |
| **Violation of patients' rights** | 2.7% | Patients' Rights/Patient Abuse |
| **Overriding medication safety policies and procedures** | 2.6% | Medication Administration |
| **Abandonment of patient** | 2.6% | Treatment and Care |
| **Physical abuse** | 2.6% | Patients' Rights/Patient Abuse |

# Outcomes

- Slightly more than half of all matters closed with the SBON deciding against taking disciplinary action against the RN or LPN/LVN
- Matters that did not result in Board action incurred an average expense of **$4,272**
- Matters that resulted in a Board action incurred an average expense of **$7,628**



# License Protection Case Study

Failure to accept only those nursing assignments that are commensurate with the nurse's education, experience, knowledge, and abilities

# License Protection Case Study

- The insured RN had been working as a private-duty home health nurse for approximately eight months when she was assigned to an overnight shift caring for a new patient.
- The patient, a ten-year-old female patient who had been paralyzed in a vegetative state since an acute brain injury sustained in infancy, could not move or breathe on her own, and she was ventilator-dependent with a permanent trach.
- The patient's treatment plan included:
  - Continual monitoring of the patient's respiratory status via pulse oximeter
  - Tracheostomy care including emergency measures if the trach became obstructed or dislodged
  - Intrapulmonary percussive ventilation (IPV) treatments three times per day, as needed
  - If the patient did not tolerate the IPV treatments, nebulizer treatments were to be given instead.

# License Protection Case Study

- Typically, the RN would receive at least several hours of orientation during her first shift working with a new patient.
- However, in this instance, the LPN who had worked the day shift caring for the patient only provided the RN a 20-minute orientation before leaving.
- The RN's nursing notes reflected that she assessed the patient at the start of her shift, shortly after 7:30 p.m., and the patient's heart rate was 102 BPM and her oxygen saturation was 98%.
- The patient's vital signs remained stable for the next several hours as the RN administered medications, repositioned the patient, changed her diaper, and administered a tube feeding.

# License Protection Case Study

- Around 11:00 p.m., the RN noted that the patient's vital signs were still within normal limits, though the patient was having "a lot" of secretions despite the RN having just recently suctioned her mouth and nose.
- Shortly after midnight, the RN administered an IPV treatment with albuterol. Her notes stated "IPV was not functioning correctly" and after she administered the IPV treatment, the patient's heart rate and pulse oxygen dropped to 64 BPM and 72%.
- The RN then administered supplemental oxygen, and the patient's heart rate and pulse oxygen returned to a normal range.

# License Protection Case Study

- Then, rather than switching to the patient's nebulizer to administer medication, the RN next tried to administer budesonide, an alternative breathing treatment, with the IPV machine.
- As the budesonide was administered, the patient's heart rate and pulse oxygen fell again to 74 BPM and 60%.
- This again prompted the RN to administer supplemental oxygen to try to raise the patient's heart rate and pulse oxygen. The RN then disconnected the IPV machine.
- The RN said that she remained next to the patient for 2-3 minutes after reconnecting the ventilator, and that she thought the patient appeared fine after the two desaturation events.
- The RN then left the patient's bedside to clean the IPV equipment in the adjacent bathroom.

# License Protection Case Study

- While cleaning the IPV equipment, the patient's pulse oximeter began alarming, indicating that no pulse was registering on the device.
- The RN returned to the patient and saw secretions coming from the patient's mouth and nose and tried to suction them.
- She then moved the pulse oximeter sensor from the patient's left leg to her right leg, and then to both thumbs, but could not get a reading on any of the patient's extremities.
- The RN tried to check the patient's pulse manually and thought she detected a weak pulse on the patient's wrist, even though nothing was registering on the pulse oximeter.
- The RN went upstairs to get help from the patient's parents because she suspected that the pulse oximeter's sensor might be defective, and she hoped they had an alternate.
- Both parents later told investigators that the RN did not appear panicked when she awoke them and she reported only that "the machine was not working."

# License Protection Case Study

- The patient's father ran downstairs, arriving at the patient's beside first.
- Seeing that the patient was turning blue, the father told the RN to get the patient's mother while he called an ambulance.
- While waiting for the ambulance, the father tried to change the patient's trach tube using spare equipment by the patient's bedside, thinking it had become dislodged.
  (*Note: It was never determined whether the patient's trach tube was, in fact, dislodged, or whether something else caused the patient to stop breathing*).
- Meanwhile, the patient's mother found a replacement sensor for the pulse oximeter and confirmed it was working by testing it on herself. However, she could not get a reading from the patient.
- When the ambulance arrived, the EMTs tried to use their own equipment to detect a pulse but found none. The mother told the EMTs that the patient had a DNR order, and she turned off the patient's ventilator.

# License Protection Case Study: The Investigation

- That same night, police and Child Protective Services were called to investigate the patient's death, and the RN and the patient's parents were all interviewed for several hours.
- The patient's parents both told investigators that they did not think the RN had been properly trained to care for the patient.
- The patient's death was also investigated by the state Department of Health and Human Services.
- The RN's employer was cited for numerous violations of state regulations, including failing to ensure that the RN received adequate orientation and training prior to working with new equipment and technology or in an unfamiliar care situation.

# License Protection Case Study: The Investigation

An investigation into the RN's conduct in this matter was also initiated by the SBON, with allegations against the RN including:

- Failure to accept only those nursing assignments that are commensurate with the nurse's education, experience, knowledge, and abilities.
- Failure to conform with the standards of minimum acceptable levels of nursing practice.
- Failure to implement measures to promote a safe environment for patients and others.

# License Protection Case Study: The Investigation

The SBON investigators considered several mitigating factors in this case:

- The RN had only been licensed for eight months when she was assigned to work with this patient. Prior to this incident, she had specifically asked her employer, in writing, for additional training on trach patients before being assigned to care for one independently.
- Despite her concerns about being left alone with the patient, the RN testified that she felt she had no choice at the time but to stay. Her employer's offices were already closed when her shift began, and the RN doubted that anyone would be available to help even if she called to raise concerns.
- Additionally, the RN testified that she felt pressured to accept the assignment because her employer had previously told her she would not be scheduled for regular shifts until she completed enough PRN shifts.

# What potential consequence(s) should the nurse face for their actions in this case?

- *Case dismissed – no action*
- *Warning letter*
- *Formal reprimand*
- *Fine*
- *Continuing education*
- *Consent order or stipulation agreement*
- *Probation*
- *License suspension*
- *License surrender*
- *License revocation*

# License Protection Case Study: Outcome

- SBON experts who evaluated the matter were sympathetic to the difficult position that the RN found herself in when she realized she was undertrained to care for the patient.
- Still, the SBON experts emphasized that nurses must act as patient advocates, and an advocate would not accept an assignment that they could not adequately and completely fulfill.
- Under these circumstances, the RN was required to call her supervisor and voice her concerns. Even if the RN was correct in assuming that the supervisor would not be happy to hear from her after hours, as her patient's advocate, the RN was nonetheless required to insist on having a conversation to determine what could be done to ensure the patient's safe provision of care.

# License Protection Case Study: Outcome

- After reviewing the facts of this case, SBON staff concluded that disciplinary action was warranted.
- The SBON decided to place the RN on **probation for two years** and ordered her to **complete at least 45 hours of Board-approved continuing education** on nursing jurisprudence and ethics, patient assessment, documentation, and critical thinking.

- The total incurred to defend the RN in this matter exceeded **$16,000**.

*(Note: Figure represents only the total defense expense payments made on behalf of the insured nurse.)*

# Risk Management Recommendations

## For RNs and LPNs/LVNs

- **Accept only those nursing assignments that are commensurate with your education, experience, knowledge, abilities, and scope of practice**. This is even more critical when private duty nurses are assigned a new patient.
- **Be conversant with organizational policies**, including the process for invoking the chain of command for patient safety concerns, before agreeing to provide private duty nursing services.
- **Serve as the patient's advocate in ensuring patient safety and the quality of care delivered.** Initiate additional steps, as necessary, to ensure safe, timely patient care.
- **Routinely engage in continuing education** for your nursing specialty to ensure competency.

# Risk Management Recommendations

## For RNs and LPNs/LVNs

- **Know your State Nurse Practice Act and employer's policies and procedures related to clinical practices.** Lack of knowledge about established regulations, standards, and policies and protocols is not a defense.
- **Always conduct yourself in an ethical and professional manner.** Avoid any activities that may jeopardize, or raise questions concerning, your ability to perform safe and competent practice.
- **Immediately contact your professional liability insurer** if you have any reason to believe that there may be a potential threat to your license to practice nursing. Provide as much information as you can when reporting such matters, including up-to-date contact information.
- **Maintain files that can be helpful with respect to your character.** Retain copies of letters of recommendation, performance evaluations, thank-you letters from patients, awards, volunteer records, and CE certificates.

# Thoughts?

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