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Nurse Practitioner
Claim Report: 4th Edition
Executive Summary

A Guide to Identifying and Addressing Professional Liability Exposures

Part 1: Professional Liability Data and Risk Control Strategies

(January 1, 2012 through December 31, 2016)

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.

In collaboration with NSO, we are proud to present the *Nurse Practitioner Claim Report: 4th Edition*, designed to help nurse practitioners enhance patient safety and minimize liability exposure by providing up-to-date information on professional liability claims and licensing board complaints, as well as related risk management information and guidance.

Executive Summary

In addition to the full-length report, we are pleased to provide readers with this executive summary, which provides a brief glimpse of trends and patterns in NP liability. In concise fashion, the summary analyzes the frequency and severity of professional liability and license defense closed claims in relation to such factors as specialty, location, allegation and patient injury/outcome.

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.

Because this executive summary excerpts findings from the 2017 nurse practitioner closed claim report, the reader will notice that charts are not numbered consecutively. To view the complete report, including all charts, visit www.cna.com/healthcare and www.nso.com.

Database and Methodology

The report includes only those CNA professional liability closed claims that …

- 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.
- Resulted in an indemnity payment of $10,000 or greater.

In addition to the 2017 dataset, a dataset consisting of claims that closed between January 1, 2007 and December 31, 2011 (the 2012 dataset) is utilized in this report to draw comparisons and identify trends. Due to possible differences in database criteria, readers should exercise caution when comparing these findings with those of other reports, unless the comparison is made herein.

Data Analysis

Analysis of Claims by Insurance Type

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

1a Comparison of Average Paid Indemnity in 2009, 2012 and 2017

Analysis of Frequency and Severity by Nurse Practitioner Specialty

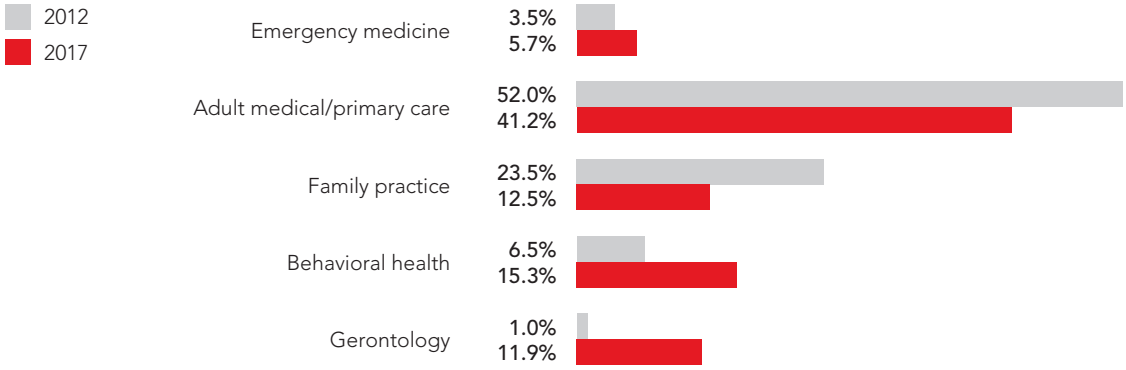
Four specialties – adult medical/primary care, family practice, behavioral health and gerontology – account for 80.9 percent of all closed claims.

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

Figure 4a highlights the specialties with the highest percentage of closed claims from the 2012 and 2017 closed claim reports.

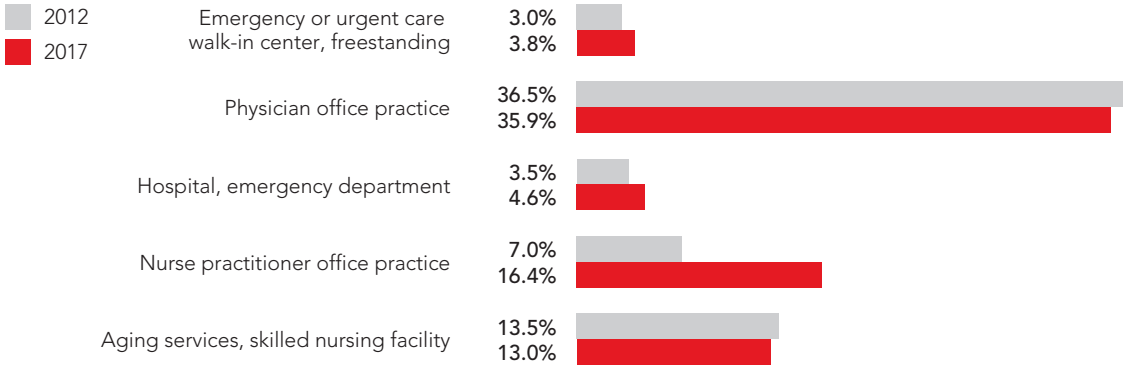
4a Comparison of 2012 and 2017 Claim Distribution by Nurse Practitioner Specialty



Analysis of Frequency and Severity by Location

Figure 5a highlights the locations with the highest percentage of closed claims from the 2012 and 2017 closed claim reports.

5a Comparison of 2012 and 2017 Claim Distribution by Location



Analysis of Frequency and Severity by Allegation Category

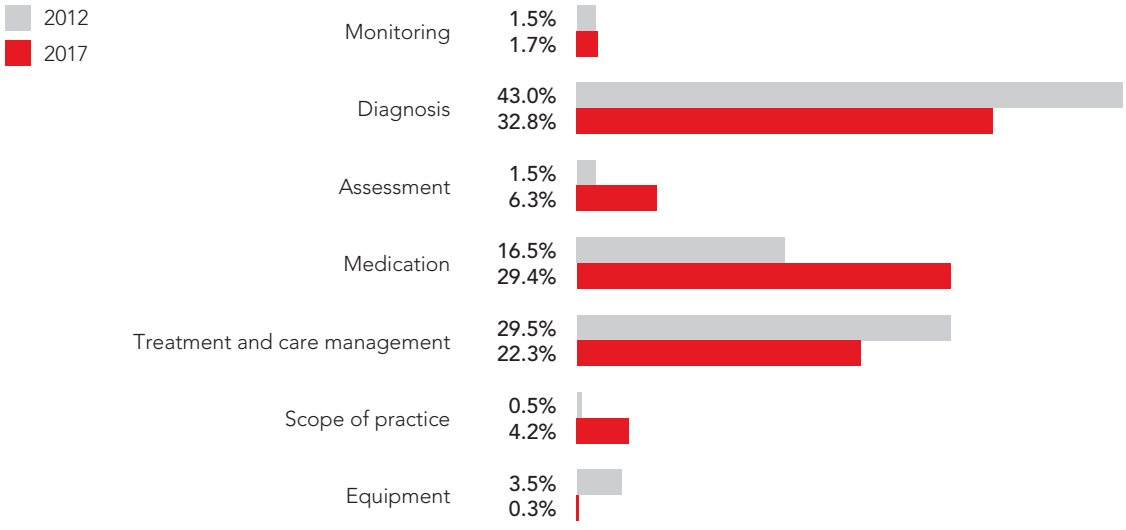
Diagnosis, medication and **treatment/care management** allegations account for 84.5 percent of all the closed claims in the dataset.

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

Figure 7 highlights the allegation categories with the highest percentage of closed claims from the 2012 and 2017 closed claim reports.

7 Comparison of 2012 and 2017 Claim Distribution by Allegation Category



Analysis of Allegation: Medication Prescribing

- **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.
- 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.

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

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.

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.

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.

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. 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.

Database and Methodology

The 2017 dataset for this section is based upon only those license protection closed claims that …

- 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.
- Resulted in a license protection defense cost (i.e., 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.

Summary of Findings

- 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). (See page 18, chart 3.)
- 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. (See page 18, chart 5a.)
- 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. (See page 19, chart 9a.)

License Protection Defense Paid Claims

Analysis of Severity by Location

3 Severity by Location

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

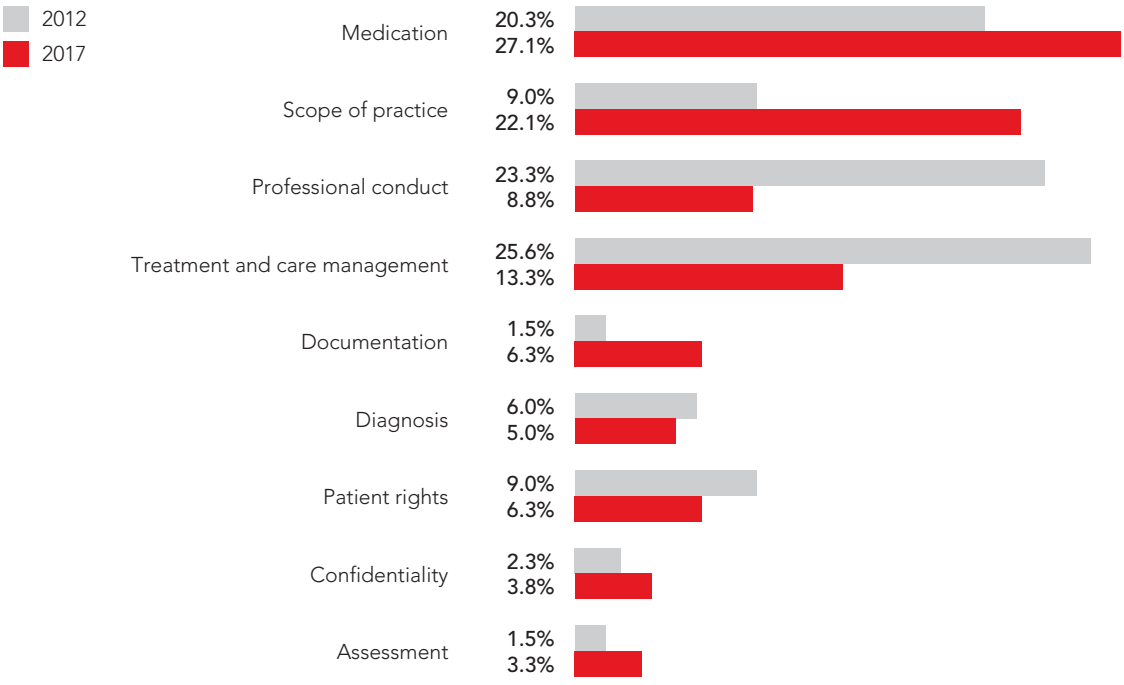
Location	Percent of paid claims*	Total paid	Average payment
Spa/medispa	0.4%	$12,170	$12,170
Patient's home	1.7%	$34,249	$8,562
Aging services	4.6%	$80,690	$7,335
Office practice	81.7%	$1,171,912	$5,979
Hospital	10.0%	$129,468	$5,395
Prison health services	0.8%	$6,298	$3,149
Nurse practitioner's home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

Analysis of Allegations

Analysis of Severity by Allegation Category

Figure 5a highlights the allegation categories with the highest percentage of closed claims from the 2012 and 2017 reports.

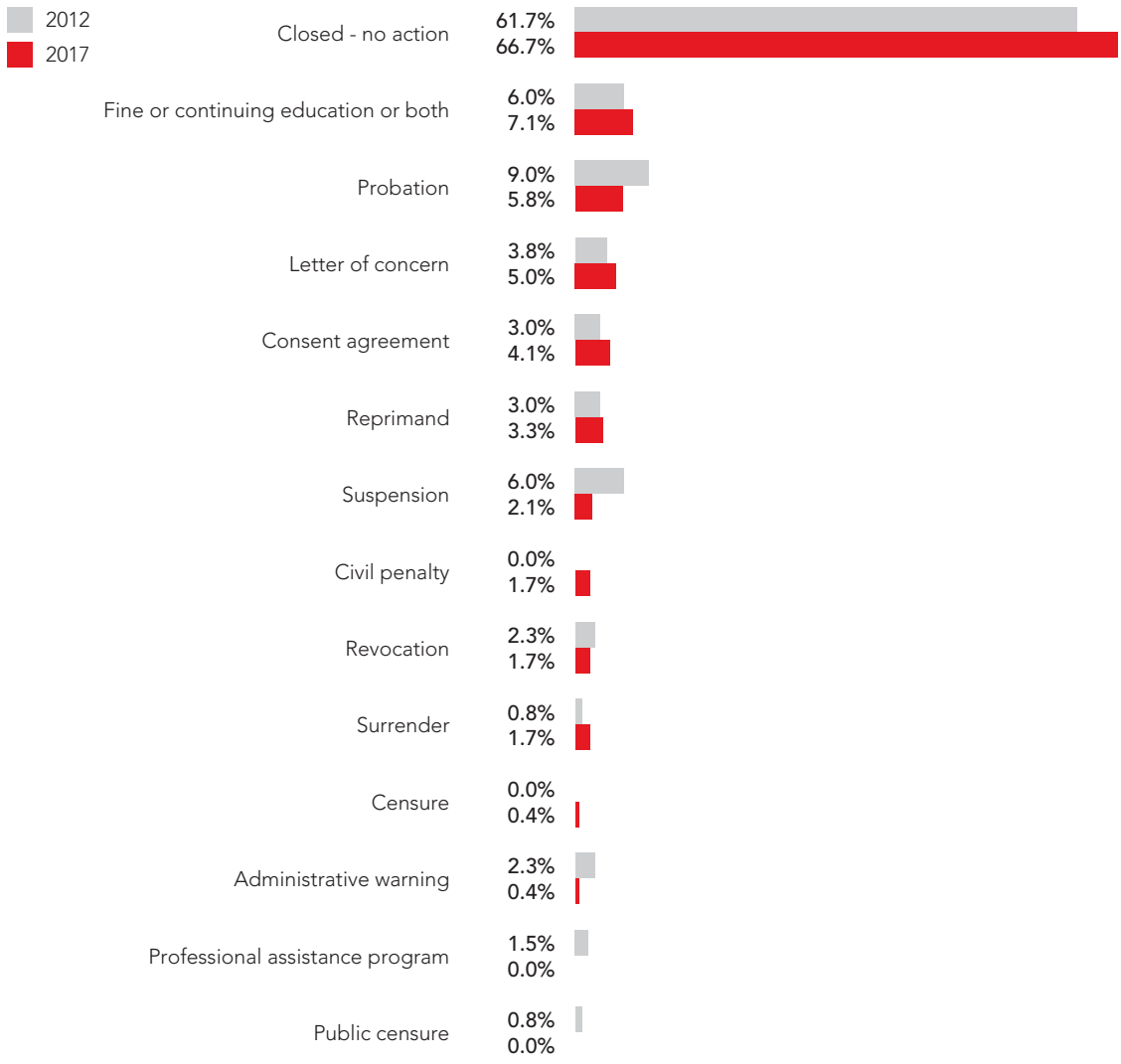
5a Comparison of Allegation Categories, 2012 and 2017



Licensing Board Decisions

Figure 9a presents the outcomes (i.e., board actions taken) of license protection closed claims from the 2012 and 2017 reports.

9a Comparison of Licensing Board Actions, 2012 and 2017



Conclusion

The first step in the process of protecting patients and reducing liability exposure is to learn about the risks that confront today's nurse practitioners. We hope that the closed claims data and analysis contained in this resource inspire nurse practitioners nationwide to examine their practice, dedicate themselves to patient safety, and direct their risk control efforts toward the areas of statistically demonstrated error and loss.

For additional nurse practitioner-oriented risk control tools and information, visit www.cna.com/healthcare and www.nso.com.

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.

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In addition to this publication, CNA and Nurses Service Organization (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.

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