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Nurse Professional Liability Exposures: 2015 Claim Report Update

A COMPARATIVE ANALYSIS FROM
CNA AND NURSES SERVICE ORGANIZATION

PART 1 Nurse Professional Liability Exposures

CNA Five-year Closed Claims Analysis
(January 1, 2010-December 31, 2014)
and Risk Control Self-assessment for Nurses

Introduction

For over 30 years, CNA and our business partners at Nurses Service Organization (NSO) have been committed to helping nurses insure themselves against loss by providing specialized insurance coverage and working to enhance their risk awareness. Our joint professional program is the nation's largest underwriter of professional liability insurance for individual nursing professionals, with more than 550,000 policies in force. CNA/NSO-insured nurses provide healthcare in an increasingly broad array of locations and specialties, including hospitals, aging services facilities, outpatient and ambulatory centers, practitioner offices, schools, community and retail health settings, spas and aesthetic/cosmetic centers.

Purpose

In collaboration with NSO, we are pleased to present our third report on nurses' risk exposures, which examines CNA nurse claims that closed between January 1, 2010 and December 31, 2014. Our goal is to identify liability patterns and trends in order to help nurses understand their areas of greatest vulnerability, in order to take appropriate action to protect patients from harm and reduce the risk of potential litigation.

When possible, this report compares CNA/NSO nurse professional liability closed claims that occurred between January 1, 2006 and December 31, 2010 with the corresponding set of closed claims dating from January 1, 2010 through December 31, 2014. The two groups of closed claims are referred to as the 2011 and 2015 closed claim reports, respectively. This comparison provides a broader historical perspective on claim characteristics, including trends in exposures and severity.

The report also summarizes individual claims with settlements or judgment awards equal to or greater than $1 million. Detailed case studies illustrate failure to comply with professional standards of care, resulting in patient injury and consequent claims of negligence. Finally, risk control recommendations and a self-assessment checklist are included to assist nurses in reviewing their custom and practice in relation to the risks identified in the report.

Database and Methodology

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

- Involved a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN).
- Closed between January 1, 2010 and December 31, 2014 (although they may have been reported earlier).
- Resulted in an indemnity payment of $10,000 or greater.

These inclusion criteria were applied to 10,639 reported adverse incidents and claims that closed during the designated time period. The final primary database comprises 549 nurse closed claims, which were subsequently reviewed and analyzed.

In addition to the primary dataset of claims that closed from January 1, 2010 to December 31, 2014 (the 2015 dataset), a dataset consisting of claims that closed between January 1, 2006 and December 31, 2010 (the 2011 dataset) was utilized in this report to draw comparisons and identify trends. Since both of these datasets include closed claims from 2010, it is important to note that the two datasets are not fully independent. Nevertheless, by comparing the two datasets we can see how the average paid indemnity amounts associated with various claim characteristics are changing over time and better identify patterns in nurse claim activity and litigation. The 2011 dataset includes 516 professional liability claims, while the 2015 dataset includes 549 professional liability claims.

As this report has unique data inclusion criteria, readers should exercise caution about comparing the findings with similar publications from other sources.

Scope

The focus of the analysis is on the *severity* of nurse closed claims that satisfied the inclusion criteria described above. Claim characteristics examined within the report include location of the event, nurse specialty, type of allegation, and harm or injury.

Unless specifically noted, the tables and charts in Part I of this report include both RN and LPN nurses closed claims. See Figure 20 on page 38 for a comparative analysis of RN and LPN/LVN closed claims.

Terms

For purposes of *this report only*, please refer to the terms and explanations below:

2011 claim report – A reference to the prior CNA study, titled "Understanding Nurse Liability, 2006-2010: A Three-part Approach," www.cna.com/healthcare.

Agency nurse – Any RN or LPN/LVN who provides nursing services as an independent contractor or as an employee of a staffing or placement service.

Aging services – Specialized facilities or organizations that provide healthcare to a senior population. Aging services facilities, which also may be referred to as long term care, include but are not limited to nursing homes, assisted living centers and independent living facilities.

Average total incurred – Indemnity plus expense costs paid by CNA, divided by the number of closed claims.

Expense payment – Monies paid in the investigation, management and/or defense of a claim.

Incurred payment – The costs or financial obligations, including indemnity and expenses, resulting from the resolution of a claim.

Indemnity payment – Monies paid on behalf of an insured nurse in the settlement or judgment of a claim.

Practitioner – A licensed independent healthcare provider such as a physician, dentist, advanced practice nurse or physician assistant.

Severity – The average indemnity amount of CNA nurse closed claims included within the dataset.

Limitations

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

- The database includes only closed claims against nurses insured by CNA through the NSO program, which does not necessarily represent the entire spectrum of nurse activities and nurse closed claims.
- Noted indemnity payments are only those paid by CNA on behalf of its insured nurses through the NSO program and do not reflect 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, claims included in this report may have arisen from an event that occurred prior to 2010, yet closed during the period of the report.

Data Analysis

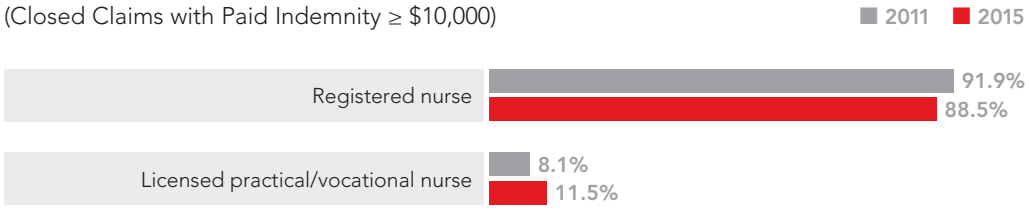
Analysis of claims by licensure type

- Of the 549 nurse closed claims, 88.5 percent involve RNs and 11.5 percent involve LPNs/LVNs. These percentages reflect the overall proportion of CNA/NSO-insured nurses. While the distribution of licensure types within the CNA/NSO book of business varies somewhat over time, the current ratio of our in force business represents 89 percent RNs to 11 percent LPNs/LVNs.
- Claims asserted against LPNs/LVNs resulted in a 58 percent increase in average total incurred, compared with the 2011 closed claim report. The higher severity was driven by several closed claims that settled for $250,000 or more, involving infant and pediatric patients with tracheostomies who suffered adverse outcomes in their homes, as illustrated by the following examples:
  - An LPN with significant geriatric experience accepted a weekend position as a home health nurse to earn extra income. The home health agency requested that the nurse take an assignment providing one-on-one care to a two-year-old child on a ventilator. The LPN told the agency that the only experience she had with ventilators was assisting geriatric patients with tracheotomy care. The agency told the nurse to meet the child and "give caring for the child a try." On the second visit, the child suffered an apneic episode. The nurse called 911 but then panicked and could not remember the proper procedure for removing the child from the ventilator. Manual resuscitation was initiated using a bag valve mask. The patient experienced an anoxic brain injury and suffers from seizures.
  - An experienced pediatric home health LVN arrived at the home of a ventilator-dependent one-year-old girl and found the child to be playful but not quite herself. The health record notes indicated that the child was cranky, her color was not normal and her oxygen saturations were between 91 and 93 percent. Eventually, the child was placed in the crib for a nap. When she woke up, the ventilator alarm sounded. The child was suctioned and some material was retrieved, but the child continued to exhibit respiratory difficulties. The nurse removed the tracheostomy tube and passed a suction catheter through the tracheostomy, encountering no obstruction or material. She reinserted the tracheostomy tube and suctioned again, but nothing was retrieved. Via ambulance, the patient was taken to the emergency department, where eventually the tracheostomy tube was reinserted correctly. Due to the lack of sufficient oxygen during the nurse's attempt to reinsert the tracheostomy tube and the delay in recognizing the child's respiratory difficulties, the child suffered profound neurological brain damage. The patient's experts testified that according to the documentation, the child was already having respiratory difficulty prior to the nap. Therefore, the nurse should have been more proactive.
- For additional analysis of LPN/LVN closed claims, see Figure 20 on page 38.

1A CLOSED CLAIMS BY NURSE LICENSURE TYPE
(Indemnity and Expenses for Closed Claims with Paid Indemnity ≥ $10,000)

Licensure type	Percentage of closed claims	Total paid indemnity	Average paid indemnity	Average paid expense	Average total incurred
Registered nurse	88.5%	$80,428,847	$165,491	$36,424	$201,916
Licensed practical/ vocational nurse	11.5%	$9,928,686	$157,598	$42,173	$199,771
Overall	100.0%	$90,357,533	$164,586	$37,084	$201,670

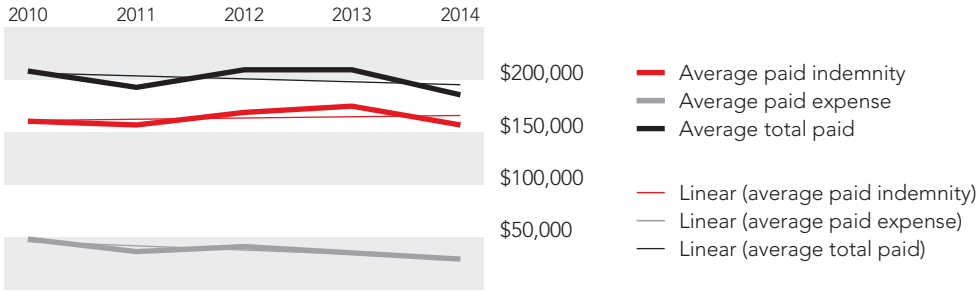
1B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY NURSE LICENSURE TYPE
(Closed Claims with Paid Indemnity ≥ $10,000)



Analysis of severity by year

- Figure 2 displays severity and average paid expense for nurse closed claims from 2010-2014 with an indemnity payment of $10,000 or greater. The year with the highest severity was 2013, during which 17 claims (10.4 percent) resulted in an indemnity payment of $500,000 or above.
- Although the graph lines fluctuate throughout the noted time period, the overall cost of managing and defending a nurse claim over the past five years appears to be stable.

2 SEVERITY AND AVERAGE PAID EXPENSES BY YEAR CLOSED
(Closed Claims with Paid Indemnity ≥ $10,000)



Nurse closed claims with expense payments only

- Figure 3 displays average paid expenses for nurse closed claims with no indemnity payment and paid expenses of one dollar or greater over five years, with the highest average paid expense occurring in 2013 and 2014.
- The chart depicts closed claims that were successfully defended on behalf of the nurse, dismissed or withdrawn by the plaintiff during the investigative or discovery process, or terminated by the court in favor of the defendant prior to trial. An example of a successful defense against a nurse resulting in no indemnity payment can be found on page 37.

3 AVERAGE PAID EXPENSE FOR CLOSED CLAIMS
(No Indemnity Paid by Year Closed with Paid Expenses ≥ $1.00)

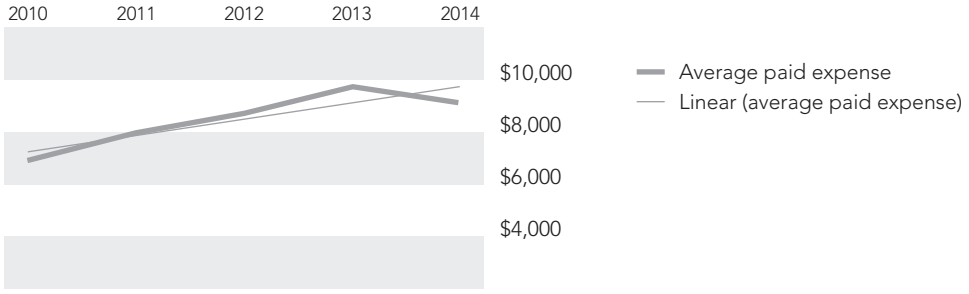
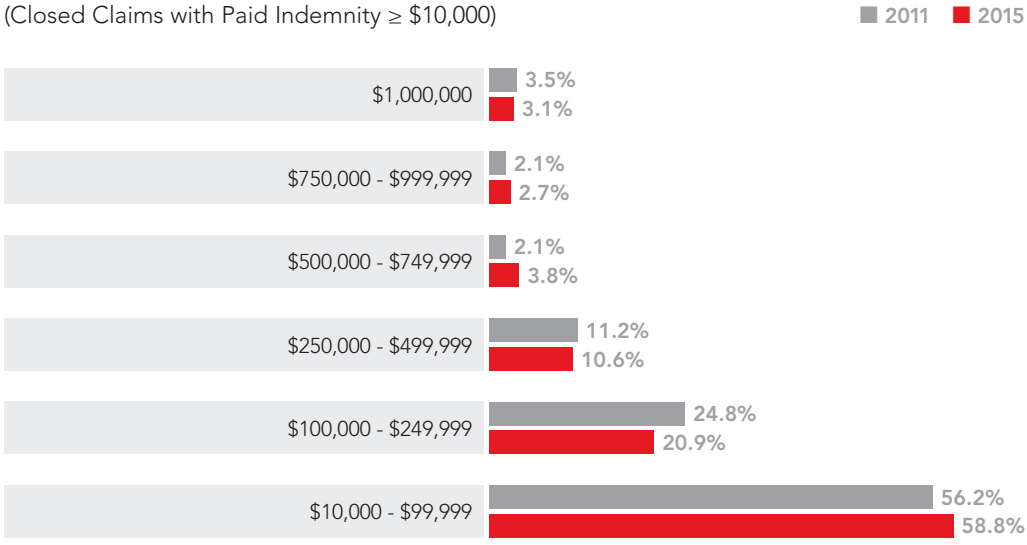
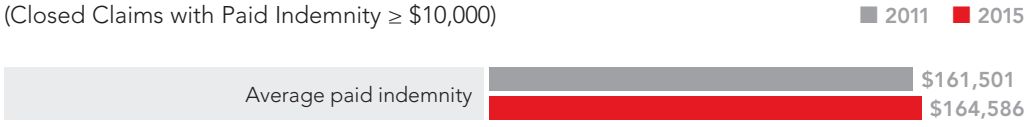


Figure 4 reveals that for both the 2011 and 2015 claim analyses, the highest percentage of closed claims have a paid indemnity between $10,000 and $99,999. The two analyses show similar percentages of closed claims in the $750,000-$999,999 and $1,000,000 paid indemnity categories.

4A COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION
(Closed Claims with Paid Indemnity ≥ $10,000)



4B COMPARISON OF 2011 AND 2015 AVERAGE PAID INDEMNITY
(Closed Claims with Paid Indemnity ≥ $10,000)



Analysis of severity by nurse specialty

- The nurse specialties consistently experiencing the highest severity in both past and present CNA/NSO closed claim reports are neurology and obstetrics, due to the cost of lifelong, one-on-one nursing care required by the injured party. Examples of these closed claims include:
  - Failure of a nurse to monitor and timely report blood levels on a 30-year-old patient receiving anticoagulation therapy. The patient suffered an eight-centimeter hematoma within the right frontal lobe of her brain due to the delay, leaving her permanently and totally disabled.
  - Improper management of an obstetrical patient by a nurse who attempted to reinsert a prolapsed umbilical cord prior to delivery.
- The adult medical/surgical specialty continues to represent the highest percentage of closed claims. However, as predicted in the 2011 claim report, claim frequency has increased in non-hospital-based specialties such as home health/hospice, reflecting the overall migration of healthcare toward outpatient settings. One consequence of this shift is that, more than ever, home health/hospice nurses must be in frequent communication with the patient's practitioner, as illustrated by the following closed claims:
  - The home health nurse failed to notify the practitioner of the patient's medical decline. The patient was on intravenous antibiotics for bacterial endocarditis, and on two visits to the patient's house, the nurse failed to notify the referring cardiologist of the patient's extremely abnormal vital signs.
  - Against practitioner orders, the nurse delayed administering pain medication to a hospice patient, resulting in unnecessary suffering.
- There were two occupational/employee health closed claims:
  - One closed claim involves failure to properly assess and advise an employee with a history of uncontrolled high blood pressure and a severe headache to seek medical treatment. The nurse instructed the employee to go home, take over-the-counter pain medications and rest. Later that night the patient suffered a severe cardiovascular accident.
  - The second closed claim involves the nurse's failure to properly maintain correct infection prevention practices while administering an influenza intramuscular injection, causing an employee to suffer from cellulitis. The nurse neither cleaned the injection site nor used gloves during the injection.

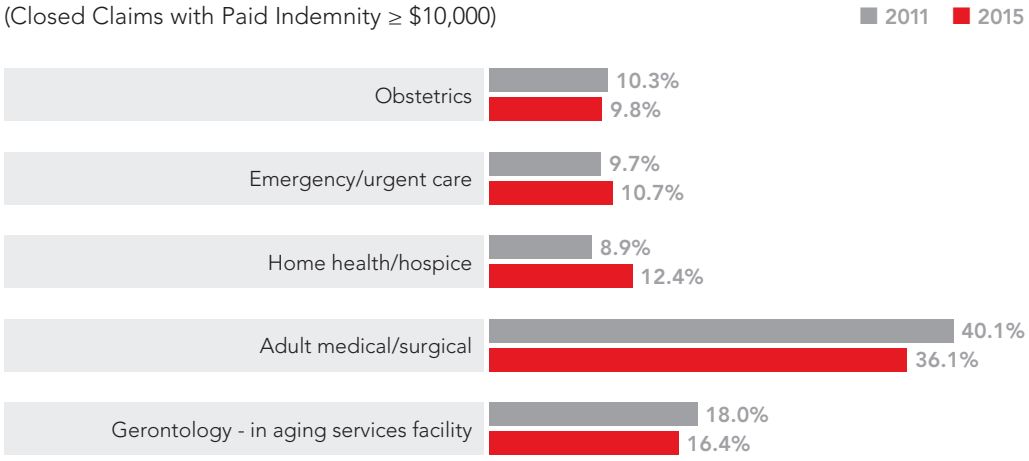
5A SEVERITY BY NURSE SPECIALTY

(Closed Claims with Paid Indemnity ≥ $10,000)

Nurse specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Neurology/neurosurgery	0.4%	$1,077,000	$538,500
Occupational/employee health	0.4%	$827,980	$413,990
Obstetrics	9.8%	$21,441,467	$397,064
Neonatal/nursery - well baby	1.1%	$1,325,000	$220,833
Plastic/reconstructive surgery	1.6%	$1,752,332	$194,704
Emergency/urgent care	10.7%	$10,750,689	$182,215
Home health/hospice	12.4%	$11,794,067	$173,442
Pediatric/adolescent	2.0%	$1,710,250	$155,477
Behavioral health	2.4%	$1,850,249	$142,327
Adult medical/surgical	36.1%	$27,392,453	$138,346
Wound care in an office setting	0.7%	$435,250	$108,813
Gerontology - in aging services facility	16.4%	$7,736,782	$85,964
Correctional health	3.6%	$1,501,639	$75,082
Aesthetic/cosmetic	2.4%	$762,375	$58,644
Overall	100.00%	$90,357,533	$164,586

5B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY NURSE SPECIALTY

(Closed Claims with Paid Indemnity ≥ $10,000)



Analysis of severity by location

- The locations with the highest distribution of closed claims, accounting for 58.5 percent of all closed claims, are hospital-inpatient medical, aging services, patient's home and hospital – inpatient surgical service-related. These findings are consistent with the 2011 claim report.
- The closed claims with the highest severity, excluding obstetrics - inpatient perinatal services, tend to be relatively infrequent. Several claims arose from services provided in non-traditional settings, such as the nurse's residence or a hotel. These closed claims usually involve failure to fulfill the core responsibilities, duties and/or expectations of licensed nurses, as the following examples illustrate:
  - A patient underwent several plastic surgeries in one day. After more than 12 hours of surgery, the patient was released to the care of a nurse, who tended to her in a local hotel room. The nurse stayed with the patient overnight, but failed to notify the attending practitioner and family members of meaningful changes in her condition and failed to react to emergent conditions requiring timely transfer of the patient to an acute care facility. The nurse's delay in care and failure to recognize changes in the patient's medical condition was the ultimate cause of the patient's death.
  - A registered nurse was hired by a not-for-profit organization to train patient care technicians to care for disabled children participating in an overnight field trip. The nurse failed to explain to the patient care technicians how to properly set up the continuous positive airway pressure machine for one child, who died in her sleep.
- Many of the closed claims in the obstetrics location involve permanent neurological damage, resulting in an indemnity payment at full policy limits. Additional obstetrics-related closed claims are analyzed in Figure 15 on page 33.

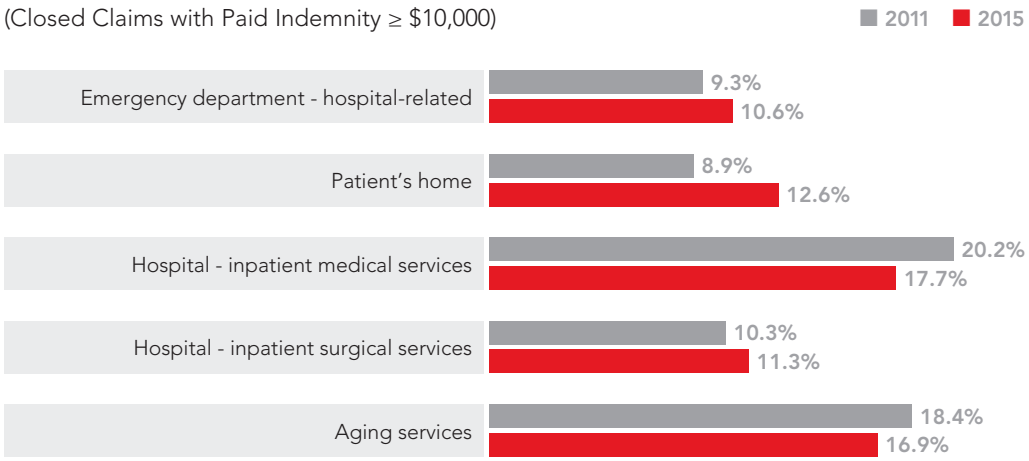
6A ANALYSIS OF SEVERITY BY LOCATION
(Closed Claims with Paid Indemnity ≥ $10,000)

* "Other" claim locations include working as an independent contractor for a patient recuperating in a hotel following extensive plastic surgery, and working as a consultant for a not-for-profit organization.

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Occupational health center	0.4%	$827,980	$413,990
Obstetrics - inpatient perinatal services	8.2%	$17,993,967	$399,866
Nurse residence/home	0.5%	$1,040,000	$346,667
Hospital - obstetrics (Cesarean suite or PACU)	1.1%	$1,772,500	$295,417
*Other	0.4%	$550,000	$275,000
Telemetry unit - hospital-based	0.2%	$218,750	$218,750
Hospital - (PACU)	1.3%	$1,372,500	$196,071
Hospital - nursery	0.9%	$925,000	$185,000
Emergency department - hospital-related	10.6%	$10,725,689	$184,926
Radiology - inpatient diagnostic	0.4%	$330,000	$165,000
Transport services	0.2%	$162,500	$162,500
Patient's home	12.6%	$10,970,067	$158,986
Hospital - inpatient medical services	17.7%	$15,336,650	$158,110
Hospital - inpatient surgical services	11.3%	$9,508,085	$153,356
Behavioral/psychiatric health	2.4%	$1,850,249	$142,327
Spa	0.7%	$460,000	$115,000
Aging services	16.9%	$9,735,782	$104,686
Practitioner office practice	4.6%	$2,579,677	$103,187
Correctional health - inpatient or outpatient	3.8%	$1,812,639	$86,316
Ambulatory surgery	2.9%	$1,169,498	$73,094
School (preschool through university)	1.1%	$407,000	$67,833
Hospital - operating room/suite	1.5%	$490,000	$61,250
Dialysis - freestanding	0.2%	$50,000	$50,000
Clinic - hospital outpatient	0.2%	$45,000	$45,000
Freestanding specialty care facility (non-ambulatory)	0.2%	$24,000	$24,000
Overall	100.0%	$90,357,533	$164,586

6B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY LOCATION

(Closed Claims with Paid Indemnity ≥ $10,000)



The percentage of closed claims involving medication administration has declined by half since the 2011 claim report, while severity has approximately doubled.

Analysis of Severity by Allegation

Figures 7A and 7B contain the average and total paid indemnities for all allegation categories. Allegation subcategories are listed in Figures 8-12.

Allegation by category

- The percentage of closed claims involving medication administration has declined by half since the 2011 claim report, while severity has approximately doubled. This decrease in frequency correlates with recent technological advances and error-reduction initiatives, such as bar-coding of medications and computerized order entry. However, the existence of these highly publicized drug safety efforts may make it more difficult to defend medication administration-related claims where nurses bypassed such controls, as illustrated by the following examples:
  - An agency nurse working in an emergency department gave 16 milligrams of undiluted hydromorphone in three minutes by intravenous push instead of an intravenous drip over several hours. When the nurse returned 30 minutes after giving the hydromorphone, the patient, who was not on a cardiac monitor, was pulseless and not breathing. Despite resuscitation efforts, the patient died. The nurse testified that she was unfamiliar with the potency of hydromorphone and misread the practitioner's orders.
  - A geriatric nurse working in an aging services setting ignored the facility's policies and procedures on medication administration and gave a methadone injection to the wrong patient, which caused fatal respiratory arrest.
- Allegations related to treatment and care continue to represent the highest percentage of closed claims. Claims in this category occur in all specialties and locations, but the highest percentage of closed claims involve adult/medical surgical, gerontology, home health/hospice and obstetrics.
  - During the evening shift, an intensive care unit (ICU) patient being weaned off the ventilator became agitated and had difficulty maintaining her oxygen saturation levels. The nurse spent most of his time caring for the patient, making several telephone calls throughout his shift to the practitioner for additional orders. The nurse administered a sedative, per practitioner orders, and stepped away from the patient to attend a meeting in the unit's conference room. As a result, the cardiac monitor alarm sounded for eight minutes before the nurse heard it. When he returned, the patient was in asystole and later died.
  - A 38-year-old female patient was admitted to the medical intensive care unit with a diagnosis of pneumonia and an extensive and complicated history of cardiac illness, including endocarditis. She was receiving a large amount of diuretics for fluid retention. Her practitioner, believing she was stable, allowed her to use a bedside commode while on a cardiac monitor. When the patient ambulated to use the commode, the cardiac monitor would indicate the patient was in ventricular tachycardia, but when the nurse checked on the patient, she appeared fine. The nurse discussed the rhythm with her charge nurse, and both agreed that the change in the cardiac rhythm was associated with patient movement rather than ventricular tachycardia. However, a few hours later, the patient's cardiac monitor indicated the patient was in ventricular fibrillation. When the nurse went to check, the patient was observed to be cyanotic, with distended neck veins. A code team was called, but the patient expired.
- Many of the closed claims in the patients' rights/patient abuse/professional conduct category involve falls, which occurred because a nurse failed to follow fall-prevention policies polices, thereby violating the patient's right to a safe environment.

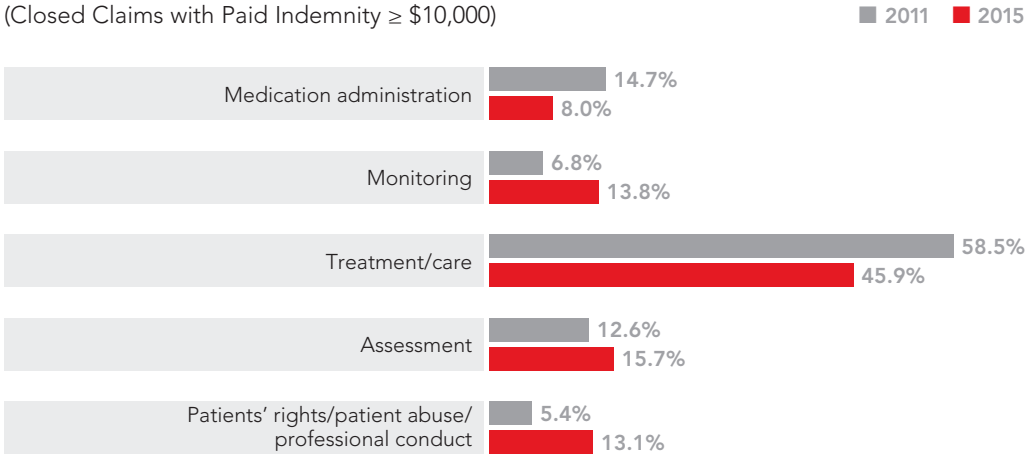
7A SEVERITY BY ALLEGATION CATEGORY

(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Medication administration	8.0%	$9,372,227	$213,005
Monitoring	13.8%	$13,977,772	$183,918
Treatment/care	45.9%	$45,053,823	$178,785
Scope of practice	2.9%	$2,458,777	$153,674
Assessment	15.7%	$11,099,510	$129,064
Documentation	0.5%	$368,334	$122,778
Patients' rights/patient abuse/ professional conduct	13.1%	$8,027,090	$111,487
Overall	100.0%	$90,357,533	$164,586

7B COMPARISON OF 2011 AND 2015 CLAIM DISTRIBUTION BY ALLEGATIONS

(Closed Claims with Paid Indemnity ≥ $10,000)



Assessment-related closed claims often involve nurses failing to identify the worsening of a pressure ulcer or contact the treating practitioner for additional medical treatment.

Analysis of Allegation Sub-categories

Figures 8-12 examine allegation sub-categories in greater detail. Percentages in Figures 8-12 relate to the indicated allegation category, rather than the overall dataset.

Allegations related to assessment

- Closed claims alleging failure to properly or fully complete the patient assessment reflect the highest severity.
- Over one-third of the closed claims in this category allege a failure to adequately assess inmates in a correctional facility, as illustrated in the following case scenarios:
  - The patient had an extensive personal and family history of high blood pressure. After an altercation with other inmates and correctional staff, he complained of a headache, was drowsy and had slurred speech. The correctional nurse was called to evaluate the patient and did so hurriedly, because the patient was in a secured area. The nurse obtained orders for a baby aspirin from the facility's medical director and had the patient transferred to the infirmary. Thirty minutes later, the patient was unable to follow commands or open his mouth, and his movements were spastic with weakness in both hands. He was sent to the local emergency department and was diagnosed with a large left basal ganglia bleed due to uncontrolled hypertension. The patient is now in a permanent vegetative state.
  - The insured was an admission nurse working in a correctional facility, where she would see up to 400 patients a month. Her responsibilities included obtaining information from patients by conducting a brief medical assessment and then referring patients to the medical director for any medication needs and follow-up. One patient complained of leg weakness upon admission, but the nurse failed to document his statement. Two days later, the patient claimed that he could not walk. When he was examined by the facility medical director, the patient was found to have a spinal abscess requiring immediate medical intervention.
- Most of the assessment-related closed claims involve a failure to asses the need for medical intervention. These closed claims often involve nurses failing to identify the worsening of a pressure ulcer or contact the treating practitioner for additional medical treatment.

8 SEVERITY OF ALLEGATIONS RELATED TO ASSESSMENT
(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to properly or fully complete the patient assessment	19.8%	$4,454,555	$262,033
Delayed or untimely patient assessment	3.5%	$380,000	$126,667
Failure to assess the need for medical intervention	60.5%	$5,656,080	$108,771
Failure to consider/assess patient's expressed complaints/symptoms	11.6%	$482,375	$48,238
Failure to reassess patient after any change in medical condition	4.7%	$126,500	$31,625
Overall	100.0%	$11,099,510	$129,064

Allegations related to monitoring

- Failure to monitor and timely report patient vital signs represents the highest severity in the monitoring sub-category, including two claims that closed at policy limits. Both closed claims involve nurses who failed to monitor vital signs after patients returned from surgery, as described below:
  - A nurse cared for a patient who had an emergent appendectomy and coded afterward in the PACU. The patient was admitted to a regular unmonitored hospital bed during the evening hours and was not placed on any cardiac or pulse oximetry monitoring. The nurse made few entries during the night regarding the patient and failed to record any vital signs. The patient coded again and the family insisted the patient be transferred to another hospital to recover.
  - A nurse failed to request a continuous pulse oximetry monitor for the patient after surgery. The patient was at high risk for decreased oxygen levels related to surgery, increased hydromorphone levels and a self-reported history of sleep apnea. The nurse assessed the patient every 15 minutes for the first hour, per organizational policy, without any problems. However, after the nurse switched to every-30-minute assessment, the patient was found pulseless and unresponsive. He later died in the ICU due to complications of anoxic brain injury.
- Claims alleging failure to monitor and timely report blood levels for medications involve nurses who neglected to properly watch patients on high-risk drugs such as insulin and anticoagulants, as described below:
  - A critically ill, intubated, diabetic patient was admitted to the ICU on a glycemic control insulin infusion protocol. The nurse signed the orders, but failed to check the patient's blood glucose level every two hours per protocol. Four hours elapsed before the nurse realized that she had not performed a finger-stick blood sugar test on the patient. When the levels were checked, the patient's glucose was 11 mg/dl and emergency hypoglycemic measures were initiated. The patient, who suffered from metabolic encephalopathy secondary to hypoglycemia, later died.
  - A patient in an acute care rehabilitation facility following knee replacement surgery was placed on Coumadin® as a result of her immobilization, as well as Septra® to treat a urinary tract infection. The nurse was responsible for monitoring the INR levels but was unfamiliar with the interaction of Septra® and Coumadin®. She neither monitored the blood levels nor contacted the prescribing practitioner to obtain an order for a new antibiotic for the patient. The patient was given each medication for three days when the patient's daughter noted a change in her mental status. Suffering from an intracranial hemorrhage, the patient was transferred to the nearest medical center and died two days later.

9 SEVERITY OF ALLEGATIONS RELATED TO MONITORING

(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to monitor and timely report patient vital signs	11.8%	$3,395,000	$377,222
Failure to monitor and timely report blood levels for medications	11.8%	$2,254,833	$250,537
Failure to monitor/report changes in the patient's condition for high-risk patient care areas	52.6%	$6,291,231	$157,281
Failure to monitor/report changes in the patient's medical/emotional condition to practitioner	21.1%	$1,903,375	$118,961
Failure to monitor results of ordered tests, consultations or referrals, or report them to practitioner	2.6%	$133,333	$66,667
Overall	100.0%	$13,977,772	$183,918

Closed claims involving the failure to invoke or utilize the chain of command account for **7.5%** of the treatment and care closed claims, and have a higher average severity.

Allegations related to treatment and care

- Closed claims relating to pregnancy or obstetrical complications collectively comprise 19.0 percent of all treatment and care allegations. While the majority of these closed claims involve nurses working in labor and delivery units within hospitals, some incidents occurred in practitioner offices, emergency departments, ICUs and correctional facilities, where nurses failed to manage pregnancy or obstetrical complications due to lack of training in obstetrical emergencies. (Obstetrics closed claims are analyzed in Figure 15 on page 33.)
- Nurses are responsible for invoking the medical chain of command when necessary, in order to trigger a practitioner's intervention for the patient. Closed claims involving the failure to invoke or utilize the chain of command account for 7.5 percent of the treatment and care closed claims, and reflect a high average severity. Both the frequency and severity of this subcategory have increased slightly since the 2011 claim report. Approximately half of the chain of command closed claims occurred in labor and delivery units, with nearly all injured patients either dying or sustaining permanent total disability.
- In the 2011 claim report, retained foreign body closed claims had an overall severity of less than $40,000 and represented less than 4 percent of the total treatment and care allegations. In the current report, retained foreign body closed claims comprise 5.2 percent of the total treatment and care allegations, and severity has grown to more than $60,000. Retained objects included intravenous catheters, sponges and gauze.

Because of the size and diversity of the treatment and care allegation category, *this chart is limited to allegations with a severity of $50,000 or greater.* Thus, there are no totals at the bottom of the table.

10 SEVERITY OF ALLEGATIONS RELATED TO TREATMENT AND CARE

(Closed Claims with Paid Indemnity ≥ $50,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to timely report complication of pregnancy/labor to practitioner	4.4%	$6,354,950	$577,723
Failure to identify and report observations, findings or change in condition	1.6%	$1,487,500	$371,875
Failure to invoke/utilize chain of command	7.5%	$6,698,551	$352,555
Delay in implementing practitioner orders	0.8%	$690,000	$345,000
Improper or untimely nursing management of obstetrical patient/complication	7.9%	$6,257,916	$312,896
Improper management of assaultive/ abusive/aggressive patient	0.8%	$500,000	$250,000
Failure to timely transfuse ordered blood/blood product	0.4%	$218,750	$218,750
Abandonment of patient	1.2%	$585,000	$195,000
Failure to timely obtain practitioner orders to perform necessary additional treatment(s)	0.4%	$187,500	$187,500
Failure to notify practitioner of patient's condition	5.6%	$2,573,557	$183,826
Improper or untimely nursing management of medical patient or medical complication	11.9%	$5,394,475	$179,816
Improper or untimely nursing management of behavioral health patient	4.8%	$2,041,667	$170,139
Treatment and care provided to the wrong patient	0.4%	$160,000	$160,000
Failure to document observations, treatment or practitioner contact	0.4%	$140,000	$140,000
Improper or untimely nursing management of surgical or anesthesia complication	4.0%	$1,294,667	$129,467
Failure to carry out practitioner orders for care and treatment	4.4%	$1,323,500	$120,318
Improper nursing technique or negligent performance of treatment, resulting in injury	11.5%	$3,363,000	$115,966
Equipment user error	5.6%	$1,621,457	$115,818
Failure to report medical complication or change in medical patient's condition	1.2%	$273,500	$91,167
Failure to follow critical pathways	2.4%	$524,741	$87,457
Failure to timely report behavioral health complication/change	0.4%	$86,000	$86,000
Improper or untimely management of aging services resident	5.6%	$1,196,349	$85,454
Failure to respond to equipment warning alarms	0.4%	$66,660	$66,660
Failure to timely implement established treatment protocols	0.4%	$66,500	$66,500
Retained foreign body	5.2%	$784,166	$60,320

Claim Scenario: Delay in Implementing Provider Orders

The patient was a 38-year-old female admitted for a Cesarean delivery of twins. The babies were delivered without incident, but the patient experienced excessive post-operative vaginal bleeding attributed to placental accreta.

An emergency total abdominal hysterectomy was performed in an attempt to control the bleeding. After surgery, the patient, who appeared stable, was transferred to the ICU with blood pressure of 110/60 mmHG. The receiving ICU nurse had orders to transfuse the patient with two units of fresh frozen plasma and monitor vital signs every 30 minutes. After the first unit of plasma was given, the patient's blood pressure was 108/59 mmHG. She was assessed by the attending ICU practitioner, who ordered a complete blood count to be conducted after the second unit of fresh frozen plasma. The ICU practitioner noted that the patient post-surgical hemoglobin and hematocrit levels were 7.4 gm/dL and 22 percent respectively. However, one hour after the second unit of plasma was given, the patient's hemoglobin was 5.9 gm/dL, and hematocrit was 17.7 percent. The nurse documented the results in the health record, but did not notify the ICU practitioner because he assumed the practitioner was returning to the unit to reassess the patient. Two hours after the second unit of plasma, the patient's blood pressure was reported as 63/21 mmHG. The nurse notified the on-call resident of the blood pressure and received an order for stat transfusion of two units of packed red blood cells. The blood bank records indicated that the blood was available 20 minutes after stat order was received.

One hour later, upon arrival of the oncoming shift, the ICU nurse reported to the oncoming nurse that the blood had still not been delivered. Even though both nurses were concerned about the situation, neither nurse called to ascertain the blood's location. Fifteen minutes into the oncoming nurse's shift, the administration of one unit of packed red blood cells was started. While the blood was transfusing, the patient went into respiratory distress, and the admitting ICU practitioner was notified.

Later that evening, the patient underwent a second abdominal surgery. Due to her extensive hypovolemia, she slipped into a coma post-operatively and currently remains in a vegetative state. During deposition, the admitting ICU practitioner testified that he was not informed of the second laboratory results or the patient's vital signs until the patient went into respiratory distress. The claim asserted against our nurse settled for greater than $600,000. Several other healthcare practitioners were also included in the lawsuit, but their settlement amounts were not available.

Allegations related to medication administration

Significant improvements in medication administration technology have occurred since 1999, when the Institute of Medicine released its groundbreaking report, "*To Err is Human: Building a Safer Health System*," http://iom.nationalacademies.org/reports/1999/to-err-is-human-building-a-safer-health-system.aspx. This publication created widespread awareness of drug administration errors. While the percentage of closed claims involving this allegation has gradually decreased, severity continues to rise.

- Errors such as wrong rate of flow, wrong route, wrong dose, wrong medication and wrong patient are often caused by poor communication with the pharmacist and/or prescribing practitioner, failure to clarify the medication order, excessive workload or preoccupation/distraction.
- Of the 44 medication administration-related closed claims in the dataset, 16 (36 percent) involve narcotics, as in the following examples:
  - During a busy evening shift, a nurse administered hydromorphone to the patient intravenously instead of by mouth, as the practitioner had ordered. The patient went into respiratory arrest minutes after receiving the medication.
  - A patient in an aging services facility was receiving hospice care and died after receiving a methadone injection intended for another hospice patient.
- Many of the medication administration errors involve nurses using "work-arounds" to bypass the facility's established safety procedures, such as medication bar-coding or other automated processes. Bypassing safety systems or failing to follow established facility policies and procedures makes claims difficult to defend, especially when high-risk drugs are involved.

Many of the medication administration errors involve nurses using "work-arounds" to bypass the facility's established safety procedures.

11 SEVERITY OF ALLEGATIONS RELATED TO MEDICATION ADMINISTRATION

(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Wrong rate of flow	6.8%	$2,033,480	$677,827
Provision of services beyond scope of practice	2.3%	$500,000	$500,000
Wrong route	15.9%	$1,898,000	$271,143
Failure to immediately report/record improper administration of medication	4.5%	$538,500	$269,250
Wrong dose	18.2%	$1,674,667	$209,333
Failure to properly monitor or maintain intramuscular, subcutaneous, or gastric tube site	2.3%	$200,000	$200,000
Failure to recognize contraindication and/or known adverse interaction between/among ordered medications	9.1%	$781,250	$195,313
Wrong patient	9.1%	$655,000	$163,750
Wrong information provided or recorded	2.3%	$121,250	$121,250
Wrong medication	11.4%	$457,750	$91,550
Failure to properly monitor and maintain infusion site	2.3%	$90,000	$90,000
Missed dose	6.8%	$246,500	$82,167
Failure to resolve medication question with pharmacist and/or practitioner prior to administration	6.8%	$155,830	$51,943
Improper technique	2.3%	$20,000	$20,000
Overall	100.0%	$9,372,227	$213,005

Claim Scenario: Medication Error Resulting in Death

Following a recent hospitalization for complications of metastatic ovarian cancer, an elderly woman with an extensive history of bipolar disorder was discharged to an aging services facility due to her family's inability to care for her at home. Throughout her stay, her family made several complaints to the administration regarding the care the patient was receiving and requested that the patient be transferred to another facility on numerous occasions.

The LPN on duty the evening of the incident was an agency nurse who had worked at the facility previously and was aware of the facility's policies and procedures in regard to medication administration. During the scheduled evening medication administration round, the nurse was in the patient's room when she became distracted by a patient from another room requesting assistance. When the nurse returned to the patient's room, she gave the patient her nightly medications. The patient questioned the number of pills the nurse was giving her, stating that she had never taken "purple pills." The nurse assured the patient that the medication was correct and continued with the administration.

An hour later, a certified nursing assistant notified the nurse that one of her patients was unresponsive. The LPN found the patient to have a thready pulse and shallow respirations. The facility called 911, and when the paramedics arrived they administered Narcan® intravenously, which instantly revived the patient. On the way to the hospital, the patient told the paramedics that the nurse had given her four "purple pills" earlier that evening, which immediately put her to sleep.

On admission into the hospital, the patient was responsive when receiving Narcan®, but as soon as the medication wore off, she suffered from shallow respirations and became unresponsive. By day two of the hospitalization, the patient appeared to be less responsive, but was able to respond to the voices of family members. On day three, she was unresponsive to painful stimuli, was found without a pulse or heart rate, and pronounced dead. An autopsy was performed, which indicated that the primary cause of death was an overdose of morphine.

When the patient was transferred to the hospital, an investigation at the aging services facility revealed that the nurse had made a medication administration error. The morphine given was prescribed for another patient. Because the nurse became distracted in the middle of the medication administration process, the morphine had been entered into the correct patient's medication record but given to another patient. Although there was no record of the patient receiving morphine, the patient's reaction to Narcan®, as well as the results of the urine and blood analysis completed at the hospital where the patient was transferred, left little doubt as to the medication administration error. The claim resolved for greater than $350,000.

Allegations related to patients' rights, patient abuse and professional conduct

- Closed claims alleging inappropriate nurse supervision have the highest severity. These closed claims asserted against directors of nursing involve hiring practices related to clinical staff. (See Figures 17-18 on page 35 for more information about director of nursing claims.)
- Closed claims alleging violation of patients' rights include unauthorized release of protected patient information, as well as denial of care to inmates requesting medical treatment.
- Closed claims alleging violation of patients' rights to care in a safe environment include failure to take necessary action to prevent falls, maintain clear hallways, perform pre-employment screening or ensure that patients were treated with the appropriate level of care. For additional analysis of fall-related closed claims, see Figure 12B.
- In general, abuse allegations against nurses reflect a relatively low frequency and severity, in comparison to the overall dataset.
- The average paid indemnity for falls ($81,972) is less than the overall average paid indemnity for nurse closed claims.
- Closed claims alleging injury due to a failure to take necessary action to prevent falls was a recurring theme, as in the following examples:
  - A resident fell down a flight of stairs because a fire door had been propped open. The charge nurse was responsible for ensuring that all doors to the unit were closed.
  - While in an acute medical center, an elderly patient was given a sedative prescribed by his practitioner. The nurse failed to engage the bed alarm and shut the door of the patient's room. During nursing rounds, the patient was found on the floor, where he apparently had been lying for several hours.

12A SEVERITY OF ALLEGATIONS RELATED TO PATIENTS' RIGHTS, PATIENT ABUSE AND PROFESSIONAL CONDUCT

(Closed Claims with Paid Indemnity ≥ $10,000)

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Inappropriate nurse supervision	2.8%	$1,080,000	$540,000
Violation of patients' rights	5.6%	$1,159,167	$289,792
Violation of patients' rights to care in a safe environment	75.0%	$5,412,832	$100,238
Sexual abuse by nurse	6.9%	$192,591	$38,518
Verbal abuse by nurse	2.8%	$55,000	$27,500
Physical abuse by nurse	6.9%	$127,500	$25,500
Overall	100.0%	$8,027,090	$111,487

12B SEVERITY AND FREQUENCY OF FALLS

(Closed Claims with Paid Indemnity ≥ $10,000)

Falls	Percentage of closed claims	Total paid indemnity	Average paid indemnity
No	88.0%	$84,994,659	$175,972
Yes	12.0%	$5,362,874	$81,256
Overall	100.0%	$90,357,533	$164,586

Analysis of Severity by Injury

- The review of claims in this report reveals that comas, which were often due to medication administration errors, have the highest severity among patient injuries. The high severity reflects the lifelong medical cost for patients in a persistent vegetative state who require 24-hour nursing care. Examples include the following:
  - An elderly patient admitted to a medical center for generalized weakness was given 80 milligrams of oxycodone, although the drug had not been ordered for her. The nurse reported the medication administration error immediately to the practitioner and was told to monitor the patient for a few hours. One hour later, the patient was discovered to be in respiratory distress. She suffered a left sub-acute cerebrovascular accident, leaving her in a permanent vegetative state.
  - A 29-year-old woman was admitted to a behavioral health unit for an apparent attempted suicide by insulin overdose. The admitting practitioner ordered blood sugar checks every four hours. However, the nurse was distracted by several additional admissions and failed to perform the checks during the evening hours. The patient was found unresponsive and suffered anoxic brain injury from remaining in a hypoglycemic state for an extended period of time.
- Death (other than maternal or fetal) is the most common injury, accounting for 42.8 percent of the closed claims. When maternal and fetal mortality are included, 44.3 percent of all closed claims involve a patient death. (Injuries involving death are analyzed in Figure 14 on page 32.)
- Seizures have the second highest severity, driven by two claims that settled at policy limits. Closed claims in this category involve allegations of failure to properly complete a patient assessment, invoke the medical chain of command and monitor/report changes in the patient's condition.
- Fractures and pressure ulcers are the second and third most common injuries, together accounting for 12.6 percent of closed claims. Their frequency has increased significantly since the 2011 claim report. These injuries occur in a variety of locations, especially aging services and hospital settings.
- Other maternal birth-related injuries include an emergency delivery due to premature labor and complications resulting from the retention of a sponge during an unplanned Cesarean section.
- In this report, "pain and suffering"are defined as injuries of an emotional nature, such as depression, anxiety or embarrassment. They may involve temporary or permanent disabilities, which are discussed in greater detail in Figure 16 on page 34.

13 SEVERITY BY INJURY

(Closed Claims with Paid Indemnity ≥ $10,000)

* "Other maternal obstetrics-related injury" claims include the failure to identify premature labor and retained foreign body during a Cesarean section.

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Coma	0.5%	$1,862,500	$620,833
Seizure	0.7%	$2,300,000	$575,000
Neurological deficit/damage	1.3%	$3,874,792	$553,542
Fetal/infant birth-related brain injury	5.3%	$14,638,551	$504,778
Maternal death	0.4%	$900,000	$450,000
Spinal pain/injury - cervical spine and neck	0.2%	$375,000	$375,000
Brain injury other than birth-related	1.8%	$3,629,167	$362,917
Paralysis	1.8%	$3,464,701	$346,470
Cerebrovascular accident (CVA)/stroke	1.3%	$2,355,064	$336,438
Bleeding/hemorrhage	0.7%	$1,261,250	$315,313
Cardiopulmonary arrest	1.6%	$2,429,001	$269,889
Fetal death	1.1%	$1,592,450	$265,408
Loss of limb or use of limb	4.4%	$5,364,333	$223,514
Death (other than maternal or fetal)	42.8%	$32,649,771	$138,935
Head injury	0.7%	$475,000	$118,750
Loss of organ or organ function	2.2%	$1,314,750	$109,563
Burn	4.0%	$2,284,582	$103,845
Infection/abscess/sepsis	5.1%	$2,297,188	$82,042
Eye/ear injury or sensory loss	0.9%	$391,667	$78,333
Pain and suffering	3.1%	$1,162,001	$68,353
Fracture	6.6%	$2,452,166	$68,116
Abrasion/bruise/contusion/laceration	1.3%	$446,000	$63,714
Allergic reaction/anaphylaxis	0.7%	$250,750	$62,688
No injury specific to nurse care, but nurse is named	0.2%	$55,000	$55,000
Scar(s)/scarring	1.1%	$326,500	$54,417
Other maternal obstetrics-related injury*	0.5%	$162,500	$54,167
Peripheral vascular ulcer/wound	0.2%	$46,250	$46,250
Compartment syndrome	0.9%	$214,750	$42,950
Pressure ulcer	6.0%	$1,395,509	$42,288
Increase or exacerbation of illness	0.2%	$40,000	$40,000
Cardiac injury (excludes heart attack)	0.4%	$65,000	$32,500
Abuse	0.7%	$123,090	$30,773
Chest pain/angina	0.5%	$75,500	$25,167
Medication-related injury not otherwise classified	0.2%	$25,000	$25,000
Heart attack/myocardial infarction	0.2%	$25,000	$25,000
Sprain/strain	0.2%	$20,000	$20,000
Embolism	0.2%	$12,750	$12,750
Overall	100.0%	$90,357,533	$164,586

Analysis of fatal injuries by underlying cause of death

As previously noted, 44.3 percent of all injuries were fatal. Figure 14 provides additional insight into the causes of these deaths.

Analysis of severity by cause of death

- Allergic reaction/anaphylaxis represented the highest severity of all fatal injuries. The three closed claims involve administration of a higher-than-prescribed dose of Narcan® or failure to recognize the patient's drug allergies prior to administering an antibiotic.
- The three most common causes of death are cardiopulmonary arrest, pressure ulcer and bleeding/hemorrhage. These results are similar but not identical to the 2011 claim report, in which the three most frequent causes of death were cardiopulmonary arrest, infection/abscess/sepsis and bleeding/hemorrhage. Pressure ulcers as a cause of death occur more often in aging services facilities, where the patient's comorbidities may impede recovery.
- Suicide as a cause of death is four times more common in the claims reviewed in this report than in the 2011 claim report. All closed claims involve improper nursing management of a behavioral health patient in a variety of settings, from behavioral health and correctional facilities to emergency departments and patients' homes. Most patients in this category were on facility-established suicide precautions but were allowed to retain unsafe items (such as plastic bags, combs or pens) or were left in high-risk areas (such as bathrooms and public lobbies) without supervision. The following suicide-related closed claim is just one of several:
  - The patient was brought to the emergency department by police and family because of suicidal ideation. On arrival, he was placed in an observation room outfitted with two video cameras, which had a live feed to a monitor at the nurses' station. While in the observation room, he hanged himself with a sheet and died.

The three most common causes of death are cardiopulmonary arrest, pressure ulcer and bleeding/hemorrhage.

14 IDENTIFIED CAUSE OF DEATH

(Closed Claims with Paid Indemnity ≥ $10,000)

Identified cause of death	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Allergic reaction/anaphylaxis	1.2%	$925,000	$308,333
Brain injury other than birth-related	0.4%	$262,500	$262,500
Fetal death	3.3%	$2,092,916	$261,615
Congestive heart failure	0.4%	$250,000	$250,000
Aneurysm	0.8%	$480,000	$240,000
Cardiopulmonary arrest	25.5%	$14,301,670	$230,672
Embolism	2.5%	$1,147,600	$191,267
Aspiration	3.7%	$1,601,000	$177,889
Suicide	6.6%	$2,693,583	$168,349
Meningitis	1.2%	$500,000	$166,667
Injury resulting from elopement	1.2%	$456,667	$152,222
Cardiac injury	1.6%	$572,500	$143,125
Bleeding/hemorrhage	11.9%	$4,107,200	$141,628
Abrasion/bruise/contusion/laceration	0.8%	$250,000	$125,000
Maternal death	0.8%	$242,500	$121,250
Heart attack/myocardial infarction	0.8%	$170,950	$85,475
Medication-related injury not otherwise classified	0.8%	$163,330	$81,665
Fracture	4.1%	$692,150	$69,215
Infection/abscess/sepsis	7.8%	$1,195,740	$62,934
Cancer	0.4%	$60,000	$60,000
Hypothermia	0.4%	$58,250	$58,250
Fetal/infant birth-related brain injury	0.8%	$112,500	$56,250
Pressure ulcer	13.6%	$1,847,999	$56,000
Dehydration/malnutrition	0.8%	$103,333	$51,667
CVA/stroke	2.1%	$255,000	$51,000
Pneumonia/respiratory infection	3.3%	$360,833	$45,104
Loss of organ or organ function	1.2%	$125,000	$41,667
Coma	0.4%	$37,500	$37,500
Head injury	0.4%	$26,500	$26,500
Increase or exacerbation of illness	0.8%	$50,000	$25,000
Overall	100.0%	$35,142,221	$144,618

Analysis of obstetrics-related injuries

Not all birth-related closed claims occurred in obstetrical locations. Injuries to the mother or baby also occurred in the emergency department, adult medical/surgical units, post-anesthesia care units, critical care units, outpatient care locations and patients' homes.

- Of all obstetrical injuries, fetal/birth-related brain injuries demonstrate both the highest percentage of closed claims and the highest severity. In a number of closed claims, the baby suffered permanent disability, requiring lifelong ongoing nursing care. These obstetrics-related closed claims involve one or more of the following nursing errors:
  - Failure to invoke the chain of command.
  - Failure to timely report complication of pregnancy/labor to a practitioner.
  - Failure to monitor and timely report the mother's and/or baby's vital signs.
  - Failure to identify and report observations, findings or changes in condition.
  - Improper or untimely nursing management of an obstetrical patient/complication.
- The maternal deaths resulted from complications, as in the following claim:
  - A patient with a history of chronic hypertension, preeclampsia and HELLP syndrome delivered a child via Cesarean section. While in the recovery room, she developed new symptoms, became unresponsive, and demonstrated decreased saturation levels and shallow respiration. The nurse responsible for the patient's care failed to timely and appropriately respond to this change, which resulted in the patient's death.
- Of the three maternal obstetrics-related injuries, one occurred in an obstetrician's office and two occurred in the labor and delivery departments. These closed claims primarily involve:
  - Sepsis due to an untreated bladder infection.
  - Complications from a retained sponge following a Cesarean section.
  - Complications during delivery following premature labor.
- The average obstetrics-related closed claim severity of $432,338 is more than twice the dataset's overall average severity of $164,586.
- Page 24 contains a more detailed obstetric case scenario.

15 SEVERITY OF OBSTETRICS CLAIMS BY INJURY
(Closed Claims with Paid Indemnity ≥ $10,000)

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Fetal/infant birth-related brain injury	72.5%	$14,638,551	$504,778
Maternal death	5.0%	$900,000	$450,000
Fetal death	15.0%	$1,592,450	$265,408
Maternal obstetrics-related injury	7.5%	$162,500	$54,167
Overall	100.0%	$17,293,501	$432,338

Analysis of severity by disability outcome

- Permanent total disability is the outcome with the highest severity. This result is expected, as permanently disabled individuals require significant medical and social support for the remainder of their lives. This finding is consistent with the 2011 claim report.
- Closed claims involving patient deaths have the second highest severity, which remains consistent with the 2011 claim report. The relatively high severity for closed claims where the patient died may be associated with compensation to survivors and/or aggravating circumstances, such as allegations that the nurse abandoned the patient or failed to follow practitioner orders.
- Injuries associated with permanent total disability include brain injuries (both non-birth and birth-related), paralysis, loss of limb or use of limb, and cardiovascular accident/stroke. The permanent total disability claims were included in the following allegation categories:
  - Treatment and care: 50.6 percent
  - Monitoring: 16.5 percent
  - Assessment: 11.4 percent
  - Medication administration: 8.9 percent
  - All other categories: 12.7 percent

16 SEVERITY BY DISABILITY
(Closed Claims with Paid Indemnity ≥ $10,000)

Disability	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Permanent total disability	14.4%	$33,264,933	$421,075
Death	44.3%	$35,142,221	$144,618
Temporary total disability	3.3%	$2,218,250	$123,236
Permanent partial disability	22.6%	$13,310,830	$107,345
Temporary partial disability	15.5%	$6,421,299	$75,545
Overall	100.0%	$90,357,533	$164,586

Analysis of director of nursing (DON) closed claims

The majority of DON professional liability closed claims involve performance of managerial and/or administrative services, such as hiring. These allegations are based upon the assumption that the DON is personally responsible for the actions of the members of the nursing care staff and for the care of each patient or resident. Of the total nurse closed claims, 5.7 percent involve a director of nursing, mostly in aging services settings.

- The severity of DON closed claims ($96,371) is significantly lower than the dataset's overall severity ($164,586).
- DON claims involving death are both relatively common (67.7 percent) and costly ($115,275), which is consistent with the 2011 claim report.

17 SEVERITY OF DIRECTOR OF NURSING CLAIMS BY NURSE SPECIALTY

(Closed Claims with Paid Indemnity ≥ $10,000)

Nurse specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Adult medical/surgical	3.2%	$1,000,000	$1,000,000
Gerontology (in aging services facility)	96.8%	$1,987,516	$66,251
Overall	100.0%	$2,987,516	$96,371

18 SEVERITY OF DIRECTOR OF NURSING CLAIMS BY INJURY

(Closed Claims with Paid Indemnity ≥ $10,000)

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Death	67.7%	$2,420,766	$115,275
Loss of limb or use of limb	3.2%	$112,500	$112,500
Fracture	9.7%	$249,250	$83,083
Pressure ulcer	6.5%	$80,000	$40,000
Infection/abscess/sepsis	6.5%	$80,000	$40,000
Abrasion/bruise/contusion/laceration	3.2%	$25,000	$25,000
Abuse	3.2%	$20,000	$20,000
Overall	100.0%	$2,987,516	$96,371

Claims related to agency nurses

- Agency nurses are involved in 23.9 percent of the closed claims.
- The severity for agency nurse closed claims is $186,430. For purposes of comparison, the severity for all non-agency nurse closed claims is $157,740, while the severity for all nurse closed claims included in the report is $164,586.

19 SEVERITY OF AGENCY NURSE CLAIMS BY AGENCY TYPE
(Closed Claims with Paid Indemnity ≥ $10,000)

Agency type	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Temporary staffing agency	7.7%	$9,034,244	$215,101
Individually contracted nurse	4.6%	$4,712,959	$188,518
Home care agency	11.1%	$10,195,067	$167,132
Hospice care agency	0.5%	$480,000	$160,000
Total agency	**23.9%**	**$24,422,270**	**$186,430**
Total non-agency	**76.1%**	**$65,935,263**	**$157,740**
Overall	100.0%	$90,357,533	$164,586

Agency nurses are involved in **23.9%** of closed claims, and the severity for agency nurse closed claims is $186,430.

Claim Scenario: Successful Defense of a Nurse

It is CNA's claim policy to pay covered claims involving actual liability fairly and promptly, while aggressively defending unsubstantiated claims. The following claim scenario demonstrates our aggressive defense of a CNA/NSO-insured nurse, which succeeded despite the seriousness of the patient's injuries, including pain, suffering and death.

A registered nurse with 19 years of experience as an emergency nurse (including 15 as a certified emergency nurse) was working in the triage area of the emergency department. A 34-year-old female patient was sent to the emergency department from the local dialysis clinic to have her hemodialysis catheter, which was bleeding around the insertion area, examined by the emergency department practitioner. The patient was accompanied by her mother and son, who appeared to be about 10 years old. The nurse noted in the triage portion of the medical record that the patient appeared ill and disheveled, and she allowed her mother to answer all the medical questions.

During the 15-minute triage process, the nurse noted that the patient's vital signs were normal, she had plus 2 pitting edema in her lower extremities and her catheter seemed intact with a small amount of dried blood, but no active bleeding at the insertion site. On a five-level emergency department triage scale, the nurse rated the patient as a "3-urgent," meaning that the patient should be seen by a practitioner within 15 to 60 minutes following triage. As there were no available beds in the treatment area of the emergency department, the nurse asked the patient and her family to take a seat near the triage area to facilitate monitoring.

Shortly after the nurse performed the triage on the patient, she was relieved for her lunch break. She gave a report to the new nurse on all the patients in the waiting area, advising him that the last patient she triaged should be the next patient to be taken to an available treatment bed. Thirty minutes later, the CNA-insured nurse arrived back at the triage area and noticed that the patient was still in the waiting area. The nurse re-evaluated the patient per hospital protocol, noting that the patient's status remained unchanged.

Ninety minutes after her initial triage, the patient was taken to the emergency department treatment area. The nurse had no additional contact with the patient. The patient was examined by the emergency department practitioner and had sutures placed around the catheter site. She was discharged home moments after the sutures were completed and told to follow up with the dialysis clinic the next day.

The next morning, the patient was found unresponsive and pronounced dead.

Experts were retained, who determined that the nurse had acted within her scope of practice and in compliance with both the standard of care and hospital policy. Documentation supported the nurse's frequent checks of the patient and the reasons for not triaging the patient at a higher acuity level. The case against the nurse was defended successfully at trial, with the jury determining that the nurse was not responsible for the patient's untimely death.

The claim took four years and more than $165,000 in expenses to resolve. While it may have been less expensive to settle the claim, the nurse's proper care of the patient and complete documentation made an aggressive defense not only possible, but ultimately successful.

Licensed practical/licensed vocational nurse closed claims

The previous charts in the report combine RN and LPN/LVN closed claims data. To help LPNs/LVNs better understand their unique risk exposures, this section compares the 63 closed claims where the defendant was an LPN or LVN with the 486 RN closed claims. The top three results for each of the claim characteristics analyzed are presented in Figure 20, below.

- LPNs/LVNs are defendants in 11.5 percent of the closed nurse claims. The distribution of CNA/NSO-insured nurses, while fluid, is approximately 11 percent LPNs/LVNs and 89 percent RNs.
- The severity for LPN/LVN closed claims of $157,598 is similar to the severity for RN closed claims of $165,491.
- The LPN/LVN specialty representing the highest severity is obstetrics, while for RNs the highest severity specialty is occupational health.
- Treatment/care and medication administration are among the costliest allegations for both RNs and LPNs/LVNs.
- Permanent total disability had the highest severity for both LPNs/LVNs and RNs.

20 TOP THREE HIGH-SEVERITY CLAIM ELEMENTS FOR RNs AND LPNs/LVNs
(Closed Claims with Paid Indemnity ≥ $10,000)

Professional Designation	RN	LPN/LVN
Percent of closed claims	88.5%	11.5%
Severity	$165,491	$157,598
Specialties	Occupational health Neurology Obstetrics	Obstetrics Home care Occupational health
Locations	Occupational health center Obstetrics - inpatient perinatal services Nurse residence	Practitioner's office Patient's home Occupational health center
Allegations	Medication administration Monitoring Treatment and care	Patients' rights Treatment and care Medication administration
Injuries	Coma Neurological deficit/damage Seizure	Fetal/infant birth-related brain injury Cardiopulmonary arrest Coma
Causes of death	Brain injury (other than birth-related) Fetal death Congestive heart failure	Allergic reaction/anaphylaxis Cardiopulmonary arrest Injury resulting from elopement
Disabilities	Permanent total disability Death Temporary total disability	Permanent total disability Permanent partial disability Death

Summary of Closed Claims with a Minimum Indemnity Payment of $1 Million

The closed claims in Figure 21 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 awarded against a defendant may be higher. The highest-severity closed claims most frequently involve treatment and care, such as failure to comply with facility policies or operate within the nurse's appropriate scope of practice. These actions render the claims difficult to defend.

21 CLOSED CLAIMS WITH PAID INDEMNITY OF $1 MILLION

Summary	Allegation	Injury	Licensure type	Specialty	Location
A nurse caring for a patient in a hotel room failed to assess patient for dehydration and hypovolemia following multiple facial procedures.	Assessment	Death	RN	Plastic surgery/ reconstruction	Practitioner's office
A nurse failed both to complete a full assessment and to notice that the patient was pre-eclamptic.	Assessment	Seizure	RN	Obstetrics - prenatal	Hospital - obstetrics, C-section suite
A nurse failed to monitor labs, advocate for patient and restart heparin according to practitioner order.	Monitoring	Brain injury other than birth-related	RN	Neurology	Hospital - inpatient surgical
A nurse asked a mother to hold her child's head while she left to obtain tape for the child's tracheostomy tube. The child's tracheostomy tube became dislodged, and when the nurse returned, the child was blue and unable to re-intubate until 20 minutes later.	Monitoring	Neurological deficit/damage	RN	Pediatric	Pediatric intensive care unit
A nurse failed to request a continuous pulse oximetry monitor for patient after surgery. The patient was at high risk for decreased oxygen levels related to surgery, increase of hydromorphone and patient's self-proclaimed sleep apnea.	Monitoring	Neurological deficit/damage	RN	Adult medical/ surgical	Hospital - inpatient surgical
A nurse failed to initiate policy for treatment of non-reassuring fetal distress.	Treatment/care	Fetal/infant birth-related brain injury	RN	Obstetrics - labor and delivery	Hospital - obstetrics, labor and delivery
A nurse failed to monitor vital signs after patient was given high doses of narcotics while in the PACU.	Monitoring	Death	RN	Adult medical/ surgical	Hospital - inpatient surgical
The director of obstetrical nursing failed to provide proper administrative and supervisory support when nurse caring for patient was having difficulty obtaining practitioner response.	Treatment/care	Loss of limb	RN	Obstetrics - postpartum	Hospital - obstetrics, postpartum care

21 CLOSED CLAIMS WITH PAID INDEMNITY OF $1 MILLION (CONTINUED)

Summary	Allegation	Injury	Licensure type	Specialty	Location
A claim was filed against a nurse in her role as manager of patient care. The patient was left in deplorable conditions at home and was not given seizure medication. In addition, the patient's pressure ulcer was left untreated, leading to sepsis.	Abuse/ patients' rights	Seizure/sepsis	RN	Home health	Patient's home
A claim was filed against director of nursing in her role as supervisor of patient care. A patient given a narcotic to keep him quiet, later died of overdose.	Abuse/ patients' rights	Death	RN	Home health	Patient's home
A labor and delivery unit nurse identified fetal distress on the fetal heart monitor, but did not timely report concerns to practitioner.	Treatment/care	Fetal/infant birth-related brain injury	RN	Obstetrics - labor and delivery	Hospital - obstetrics, labor and delivery
The nurse gave undiluted hydromorphone in three minutes by intravenous push instead of intravenously over several hours.	Medical administration	Coma	RN	Emergency and urgent care	Hospital - emergency department
A labor and delivery unit nurse failed to identify fetal distress on the fetal heart monitor.	Diagnosis	Fetal/infant birth-related brain injury	RN	Obstetrics - labor and delivery	Hospital - obstetrics, labor and delivery
A nurse working in an obstetrics/ gynecology office communicated a message to practitioner that a patient was having problems, but failed to explain that the problems were emergent.	Treatment/care	Fetal/infant birth-related brain injury	LPN/LVN	Obstetrics - prenatal	Practitioner's office
A nurse failed to initiate the chain of command when practitioner would not respond to her concerns of identified non-reassuring fetal distress.	Treatment/care	Fetal/infant birth-related brain injury	RN	Obstetrics - labor and delivery	Hospital - obstetrics, labor and delivery

The highest-severity closed claims most frequently involve treatment and care, such as failure to comply with facility policies or operate within the nurse's appropriate scope of practice.

Risk Control Recommendations

The following risk control recommendations are designed to serve as a starting point for nurses seeking to assess and enhance their patient safety risk control practices:

Patient safety

Falls are a common yet largely avoidable source of both patient harm and litigation. While eliminating falls may not be a realistic goal, decreasing falls and mitigating the severity of fall-related injuries should remain a top priority for nurses in any healthcare setting. Fall-related injuries include head trauma, broken bones and death, with losses ranging into six figures. Over half of the falls in the dataset occurred in either the patient's home or an aging services facility, when an unattended patient failed to comply with caregiver instructions, attempted to self-transfer or self-ambulate, rejected assistance from staff or maneuvered into a wheelchair without assistance.

Nurses can help minimize falls and fall-related liability by following sound operational policies, environmental precautions and documentation practices, especially with respect to describing the patient's condition and the specific circumstances of the fall. The following suggested actions can assist in reducing the liability associated with patient falls:

- Focus fall prevention programs and care plans on the locations of greatest risk, such as bedside, bathrooms and hallways.
- Encourage teamwork in the care-planning process. Include certified nursing assistants in order to benefit from their unique knowledge of patients and families.
- Assess the environment for potential hazards, make patients and families aware of any dangers and encourage environmental modifications, as necessary.
- Educate patients and families about fall-related risks and preventive measures. Encourage patients and families to mitigate fall risks by addressing such issues as hydration, medication management and environmental safety.

The following organizational and agency websites provide a wide range of information on fall prevention and gerontological health:

- American Academy of Family Physicians at www.aafp.org.
- American Geriatrics Society at www.americangeriatrics.org.
- Centers for Disease Control and Prevention (CDC), fall prevention information for older adults, at http://www.cdc.gov/HomeandRecreationalSafety/Falls/index.html.
- Fall Prevention Center of Excellence at www.stopfalls.org.
- National Council on Aging at www.ncoa.org.
- National Institute on Aging, one of the National Institutes of Health, at www.nia.nih.gov.
- American Physical Therapy Association at www.apta.org/BalanceFalls/.

Medication safety has become a more prominent issue in recent years, as national patient safety initiatives have focused practitioners' attention on the need to improve medication management and error reporting processes. However, dispensing and administration lapses, which are often difficult to defend in the event of a malpractice claim, continue to occur. By following the suggested actions, nurses can assist in reducing the liability associated with medication errors:

- Follow established medication protocols. If "work-arounds" persist, consult with the facility's nursing leadership about methods to enhance staff monitoring and compliance.
- Understand that while bar-coding scanning of the patient's armband to confirm identity can reduce medication errors, this method is not foolproof. Consistently use the "six rights" when administering medications to patients:
  - Right patient
  - Right drug
  - Right dose
  - Right route
  - Right time
  - Right documentation
- Know the medication(s) being administered to the patient. While nurses do not prescribe and only rarely dispense medications, they are responsible for administering drugs. Therefore they must understand why the patient is taking a particular medication as well as interactions, side effects or adverse reactions that may occur.

Environmental safety is another major area of concern, especially as home-based medical care continues to expand. Whether in an acute care facility or their own home, patients have the right to receive care in a safe environment. For this reason, nurses must be cognizant of patients' surroundings and know how to keep them out of harm's way.

Assessment and monitoring

Accurate and timely assessment of patients and careful monitoring can mean the difference between a favorable and unfavorable outcome. The following strategies can help nurses improve their performance of these core nursing duties:

- Perform a timely head-to-toe assessment of patients. If an assessment cannot be completed, document the interventions taken.
- Accurately communicate patient assessments and observations to other members of the healthcare team and convey any changes in the patient's condition.
- Listen to and consider patients' complaints/concerns regarding their healthcare. If necessary, report complaints/concerns to members of the healthcare team and the patient's practitioner.
- Recognize and report any change in a patient's condition to the appropriate practitioner.
- Document patient complaints/concerns in the healthcare record and all steps taken to resolve them.

Treatment and care

The most common allegations in this report are associated with treatment and care of patients. Specific issues included:

- Failure to report patient complications to a practitioner.
- Improper nursing management of a medical patient.
- Improper performance of a nursing technique.
- Failure to invoke the medical chain of command.

As a valuable member of the healthcare team and, in most situations, the only member that the patient interacts with on a regular basis, nurses can do much to reduce the risk of treatment and care allegations. The following measures apply to nurses in every setting:

- Implement and document approved/standardized protocols in a timely manner. If orders cannot be followed, notify the practitioner of the delay.
- Track test results and consultation reports, ensuring that findings are promptly communicated and acknowledged.
- Maintain basic clinical and specialty competencies, thus considering the responsibility to proactively obtain the professional information, education and training needed to remain current regarding nursing techniques, clinical practice, biologics and equipment utilized for treatment of acute and chronic illnesses and conditions related to one's specialty. Continuing nursing education programs represent an important means to fulfill this responsibility. If such programs are not routinely provided by one's employer, contact state and local nurse associations for information about reputable educational and training offerings.
- Report any patient incident, injury or adverse outcome and subsequent treatment/response.

Chain of command

Nurses are the patient's advocate, ensuring that the patient receives safe and appropriate care when needed. Advocacy includes the duty to invoke both the nursing and medical staff chains of command to ensure timely attention to the needs of every patient, and persisting to the point of satisfactory resolution. Nurses must be comfortable with utilizing the medical chain of command whenever a practitioner does not respond to calls for assistance, fails to appreciate the seriousness of a situation or neglects to initiate an appropriate intervention. The following strategies can help reduce apprehension regarding chain of command issues:

- Proactively address communication issues between nursing and medical staffs, and identify instances of intimidation, bullying, retaliation or other deterrents to invoking the chain of command.
- Notify leadership of individuals or areas that prevent nursing staff from invoking the chain of command or impose punitive actions for doing so.
- If the organization's current culture does not support invoking the chain of command, explain the risks posed to patients, staff, practitioners and the organization, and initiate discussions regarding the need for a shift in organizational culture.

Scope of practice

Nurses are required to practice within their states' scope-of-practice act, as well as their employers' policies and procedures and their own job descriptions. Practicing outside these applicable regulations or policies can jeopardize patient safety and result in liability either from a lawsuit or a board complaint. The following strategies can help reduce the likelihood of scope-of-practice allegations:

- Annually review the state scope of practice/nurse practice act, job description or contract, and organizational policies and procedures.
- Know the organization's policies and procedures related to clinical practices, documentation, and appropriate responses to assignments beyond one's current scope of practice and experience.
- If a job description, contract, or set of policies and procedures appears to violate one's legal scope of practice, bring this discrepancy to the organization's attention.
- Clearly state one's unwillingness to risk license revocation and potential legal action by failing to comply with the state scope of practice/nurse practice act.

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

Conclusion

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

Risk Control Self-assessment Checklist for Nurses

Scope of Practice	Yes	No	Actions needed to reduce risks
I read my nurse practice act at least annually to ensure that I understand the legal scope of practice in my state.			
If a job description, contract, or set of policies and procedures appears to violate my state's laws and regulations, I bring this discrepancy to the organization's attention and refuse to practice in violation of these laws and regulations.			
I decline to perform a requested service that is outside my legal scope of practice and immediately notify my supervisor or the director of nursing.			
I contact the risk management or legal department regarding patient and practice issues, if necessary.			
If necessary, I contact the board of nursing and request an opinion or position statement on nursing practice issues.			
If necessary, I use the chain of command or the legal department regarding patient care or practice issues.			

Patient Safety: Falls	Yes	No	Actions needed to reduce risks
I evaluate every patient for risk of falling, utilizing a fall-assessment tool that considers the following factors, among others: - Previous fall history and associated injuries. - Gait and balance disturbances. - Foot and leg problems. - Reduced vision. - Medical conditions and disabilities. - Cognitive impairment. - Bowel and bladder dysfunction. - Special toileting requirements. - Use of both prescription and over-the-counter medications. - Need for mechanical and/or human assistance. - Environmental hazards.			
I identify higher-risk patients, including those who experience recurrent falls or have multiple risk factors.			
For home health/hospice patients, I conduct a home safety check prior to commencement of services.			
If I detect safety problems in the home, I recommend that corrective actions be taken as part of the patient service agreement.			
I regularly assess patients and modify the health record in response to changes in their condition.			
I inform patients and families of salient risk factors, as well as basic safety strategies.			
I document all assessment findings and incorporate them into the patient service plan.			

Patient Safety: Falls (continued)	Yes	No	Actions needed to reduce risks
I document the patient's condition at each visit, and also: - Report any changes to the supervisor and family in a clear and timely manner. - Perform frequent home safety checks, as appropriate. - Reinforce fall-reduction tactics with patients and family. - Encourage patients to ask for assistance with risky tasks. - Keep accurate, detailed records of patient encounters.			
After a fall, I offer emotional support to the patent and the caregiver			
I review patient falls for quality assurance purposes, including analysis of root causes and tracking of trend.			
I perform post-fall analysis, describing the circumstances of the fall and also: - Identifying major causal factors, both personal and environmental. - Indicating the patient's functional status before and after the fall. - Noting medical comorbidities. - Listing witnesses to the fall. - Intervening to prevent or mitigate future falls.			
I conduct a thorough post-fall analysis and incorporate findings into quality assurance and/or incident reporting programs.			

Patient Safety: Medication	Yes	No	Actions needed to reduce risks
I complete a patient drug history, including current prescription medications; over-the-counter drugs and supplements; alternative therapies; and alcohol, tobacco and illicit drug use.			
I utilize electronic or hard-copy medication profiles when readily available at the point of care.			
I review allergy notations on medication profiles prior to administering any medications.			
I record patient's weight and height measurements in metric units to avoid possible confusion.			
I review laboratory values and diagnostic reports prior to administering medications, and make practitioners aware of any abnormalities.			
I utilize machine-readable coding to check patient identity and drug data prior to administration of drugs or, if this is not possible, I verify patient identity using two patient identifiers (such as patient ID number and birthdate) from the original prescription.			
I document simultaneously with medication administration to prevent critical gaps or oversights.			
I utilize only medication containers prepared in advance, ensuring that intravenous and oral syringes, vials, bowls and basins are appropriately labeled with the name of the patient and the drug's name, strength and dosage.			
I store unit doses of medications in packaged form up to the point of handoff/administration, in order to facilitate a final check of the medication administration record.			
I accept verbal drug orders from practitioners only during emergencies or sterile procedures, and before transcribing the order, I read it back to the prescriber and document the read-back for verification.			

Patient Safety: Medication (continued)	Yes	No	Actions needed to reduce risks
I communicate potential drug side effects at points of transition and document them on accompanying patient care plans and/or handoff reports.			
I include patients in the handoff dialogue, when possible, in order to prevent errors, reinforce their awareness of the medication regimen and strengthen post-discharge compliance.			
I follow procedures to prevent wrong dosages or concentrations of identified high-alert drugs (e.g., anti-coagulants, muscle relaxants, insulin, potassium chloride, opioids, adrenergic agents, dextrose solutions and chemotherapeutic agents).			
I ensure that high-alert medications are always accompanied by standardized orders and/or computerized safe-dosing guidelines, and are verified by two persons before administration.			
I ensure that pediatric medications are accompanied by standardized orders and/or computerized dosing guidelines.			
I follow my employer's guidelines for both adult and pediatric patients' dosages, formulations and concentrations of drugs.			
I seek out education about minimizing the risks associated with look-alike and sound-alike products, and I document my training.			
I follow my employer's policies and procedures to keep drugs with look-alike and sound-alike names separate.			
I receive notification when medication stock is relocated or storage areas are reorganized, in order to reduce the likelihood of confusion or error.			
I have pharmacists available on-site or by telephone to consult regarding prescribed medications.			

Claim Tips

Below are some proactive concepts and behaviors to include in your nursing custom and practice, as well as steps to take if you believe you may be involved in a legal matter related to your practice of nursing:

Everyday practice

- 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 nursing 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 the delayed entry, but never add any documentation to a record for any reason after a claim has been made. If additional information related to 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.

Once you become aware of a claim or potential claim

- Immediately contact your personal insurance carrier if you:
  - Become aware of a filed or potential professional liability claim against you.
  - Receive a subpoena to testify in a deposition or trial.
  - Have any reason to believe that there may be a potential threat to your license to practice nursing.
- If you carry your own professional liability insurance, report claims or potential claims to your insurance carrier, even if your employer advises you that it will provide you with an attorney and/or cover you for a professional liability settlement or verdict amount.
- 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 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 such 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 and retain all legal documents for your records, including:
  - The summons and complaint
  - The subpoena
  - Attorney letter(s)
  - Any other legal documents pertaining to the claim

PART 2 Nurses Service Organization's Analysis of License Protection Paid Claims

(January 1, 2010-December 31, 2014)

Introduction

An action taken against a nurse's license to practice differs from a professional liability claim in that it may or may not involve allegations related to patient care and treatment. In addition, license protection claims involve only the cost of providing legal representation to defend the nurse before a regulatory or licensing board, whereas professional liability claims also may include an indemnity payment.

License Defense Paid Claims

Between January 1, 2010 and December 31, 2014, there were 1,301 license defense paid claims in which legal counsel defended nurses against allegations that could potentially have led to license revocation. License defense paid claims involving medical or non-medical allegations made to a regulatory or licensing body have increased 15.4 percent since the 2011 claim report, which had 1,127 license defense paid claims. While the cost of defending a license protection claim is typically less than that associated with resolving a professional liability claim, the consequences for the nurse can be severe. The regulatory or licensing body has the authority to issue letters of concern, warnings or reprimands, or to suspend or revoke the nurse's license to practice.

Analysis of claims by licensure type

The percentage of license defense paid claims correlates to the proportion of RNs and LPNs/LVNs within the overall CNA/NSO-insured nurse population. Total paid increased by 37.3 percent since the prior report, and the average payment for a license protection closed claim increased by 18.9 percent.

1 LICENSE DEFENSE PAID CLAIMS BY LICENSURE TYPE

License type	RN	LPN/LVN	Total
License defense paid claims	1,127	174	1,301
Percentage of defense actions by license type	86.6%	13.4%	100.0%
Total payments	$4,554,539	$634,445	$5,188,984
Average payment	$4,041	$3,646	$3,988

Analysis of claims by location

Registered nurses with a license defense paid claim most often work in a hospital setting (60.0 percent). LPNs/LVNs, however, are most likely to work in an aging services setting (57.5 percent).

Other practice locations include schools, correctional facilities, community health centers and group homes.

2 PRACTICE LOCATIONS BY NURSING LICENSE

Note: The percentages indicated for RNs are based upon the 1,127 paid claims for RNs. The percentages for LPNs/LVNs are based upon the 174 paid claims for LPNs/LVNs.

	RN
Hospital	60.0%
Aging services facility	18.2%
Practitioner office	6.9%
Home health/hospice	5.9%
All other settings	9.0%
Total	100.0%

	LPN/LVN
Aging services facility	57.5%
Hospital	19.0%
Home health/hospice	10.3%
Practitioner office	6.3%
All other settings	6.9%
Total	100.0%

License defense paid claims involving medical or non-medical allegations made to a regulatory or licensing body have increased **15.4%** since the 2011 claim report.

Analysis of claims by allegation class

Additional review of allegation sub-categories follows in Figures 5-8.

- For RNs, professional conduct complaints account for the highest percentage of license defense claims, at 24.2 percent of all allegations. Such complaints include professional misconduct for a nursing professional as defined by state statute, criminal acts/behaviors and substance abuse, including drug diversion while on duty and driving under the influence while off duty.
- For LPNs/LVNs, medication administration errors and improper treatment and care account for the highest percentage of license defense paid claims, comprising 44.8 percent of paid LPN/LVN claims.

3 PRIMARY ALLEGATION CLASSES BY NURSING LICENSURE

Note: The percentages indicated for RNs are based upon the 1,127 paid claims for RNs. The percentages for LPNs/LVNs are based upon the 174 paid claims for LPNs/LVNs.

	RN
Professional conduct	24.2%
Medication administration	18.6%
Improper treatment/care	18.5%
Patients' rights/patient abuse	11.0%
Scope of practice	9.4%
Documentation error or omission	9.1%
Assessment	5.0%
Monitoring	4.0%
Breach of confidentiality	0.1%
Total	100.0%

	LPN/LVN
Medication administration	22.4%
Improper treatment/care	22.4%
Patients' rights/patient abuse	21.3%
Professional conduct	12.6%
Assessment	6.3%
Scope of practice	6.3%
Documentation error or omission	4.6%
Monitoring	4.0%
Total	100.0%

Average payment by allegation class

Professional conduct, abuse/violation of patients' rights and documentation error/omission allegations have an average payment higher than the overall average license protection payment of $3,988.

4 DETAILED VIEW OF AVERAGE PAYMENT BY SUB-CATEGORY

Allegation class	Average payment
Professional conduct	$4,545.69
Patients' rights/patient abuse	$4,137.72
Documentation error/omission	$4,124.29
Medication administration errors	$3,933.25
Improper treatment/care	$3,777.65
Monitoring	$3,758.17
Scope of practice	$3,332.61
Assessment	$3,128.40

Claims by Allegation Class Sub-Categories

Exhibits 5 through 8 provide additional information regarding the most frequent and severe allegation sub-categories. Note that the percentages are calculated based upon the total paid claims by licensure type, with 1,127 closed claims for RNs and 174 closed claims for LPNs/LVNs.

Allegations related to sub-category of professional conduct

- Drug diversion and/or substance abuse remain the top allegations for both RNs and LPNs/LVNs. Examples of such activities include:
  - Diverting medications for oneself or others.
  - Neglecting to document proper disposal of narcotics.
  - Neglecting to perform or incorrectly performing accurate medication counts.
  - Apparent intoxication from alcohol or drugs while on duty.
- Criminal acts involve off-duty misbehavior, such as shoplifting, driving under the influence and other violations.

5 DETAILED VIEW OF ALLEGATION SUB-CATEGORY RELATED TO PROFESSIONAL CONDUCT

Note: The percentages indicated for RNs are based upon the 1,127 paid claims for RNs. The percentages for LPNs/LVNs are based upon the 174 paid claims for LPNs/LVNs.

	RN
Drug diversion and/or substance abuse	15.3%
Professional misconduct as defined by the state	3.8%
Other inappropriate behavior	3.2%
Criminal act or conduct	1.9%
Suspended or revoked license	0.1%
Total	24.2%

	LPN/LVN
Drug diversion and/or substance abuse	8.6%
Professional misconduct as defined by the state	2.3%
Criminal act or conduct	1.1%
Other inappropriate conduct	0.6%
Total	12.6%

Allegations related to sub-category of patients' rights and patient abuse

- Abuse/patients' rights allegations constitute 11.0 percent of all RN allegations and 21.3 percent of all LPN/LVN allegations. These proportions are similar to the 2011 claim report.
- Physical abuse is the most common allegation for both RNs and LPNs/LVNs.
- Verbal abuse allegations more than doubled for LPNs/LVNs since the 2011 claim report.

6 DETAILED VIEW OF ALLEGATION SUB-CATEGORY RELATED TO PATIENTS' RIGHTS AND PATIENT ABUSE

Note: The percentages indicated for RNs are based upon the 1,127 paid claims for RNs. The percentages for LPNs/LVNs are based upon the 174 paid claims for LPNs/LVNs.

	RN
Physical abuse	5.6%
Sexual abuse	1.2%
Verbal abuse	2.9%
Failure to provide a safe environment	0.8%
Violation of patients' rights	0.4%
Emotional abuse	0.1%
Total	11.0%

	LPN/LVN
Physical abuse	12.1%
Verbal abuse	7.5%
Sexual abuse	1.1%
Failure to provide a safe environment	0.6%
Total	21.3%

Allegations related to sub-category of improper treatment and care

- RNs and LPNs/LVNs have many of the same allegations relating to improper treatment/care. These include:
  - Failure to implement established treatment protocols.
  - Abandonment of the patient.
  - Failure to follow and implement practitioner orders regarding care and treatment.
  - Failure to the notify primary care practitioner of the patient's condition.
- Nurses can minimize the likelihood of allegations of failure to implement established treatment protocols by regularly reviewing facility policies and protocols.

Allegations also can result from miscommunication or lack of communication with a practitioner or nurse or from inadequate handoff of a patient to another practitioner. By carefully documenting the information shared with the patient and/or other members of the patient's care team, nurses can significantly reduce communication-related risks.

7 DETAILED VIEW OF ALLEGATION SUB-CATEGORY RELATED TO IMPROPER TREATMENT AND CARE

Note: The percentages indicated for RNs are based upon the 1,127 paid claims for RNs. The percentages for LPNs/LVNs are based upon the 174 paid claims for LPNs/LVNs.

* "All other" includes allegations that individually represent less than 0.8 percent of the paid claims, such as failure to respond in a timely manner to patient concerns, improper nursing management of patients in need of physical restraints, premature cessation of treatment and improper nursing management of a medical complication.

	RN
Failure to timely implement established treatment protocol	9.9%
Abandonment of patient	2.0%
Failure to carry out practitioner orders for care and treatment	2.0%
Failure to notify practitioner of patient's condition	1.8%
Failure to timely obtain practitioner orders to perform necessary additional treatment	0.7%
Wrong/incorrect information provided or recorded	0.5%
Delay in implementing practitioner orders	0.4%
Improper nursing technique or negligent performance of treatment resulting in injury	0.4%
All other*	0.8%
Total	18.5%

	LPN/LVN
Failure to implement established treatment protocol	8.6%
Abandonment of patient	4.0%
Failure to notify practitioner of patient's condition	2.9%
Failure to carry out practitioner orders for care and treatment	2.3%
Improper or untimely nursing management of patient condition	1.7%
Improper nursing technique/ negligently performed treatment with injury	1.1%
Failure to timely obtain practitioner orders to perform necessary additional treatment	1.1%
Wrong/incorrect information provided or recorded	0.6%
Total	22.4%

Allegations related to sub-category of medication administration

- Medication administration issues accounted for 18.6 percent of RN paid claims and 22.4 percent of LPN/LVN paid claims. There has been a modest reduction in frequency since the 2011 report, in which 19.7 percent of RN paid claims and 25.4 percent of LPN/LVN paid claims involved administration of medications.
- While medication administration-related allegations were similar for all nurses, the frequency of specific allegations differed slightly for the two licensure types.

8 DETAILED VIEW OF ALLEGATION SUB-CATEGORY RELATED TO MEDICATION ADMINISTRATION

Note: The percentages indicated for RNs are based upon the 1,127 paid claims for RNs. The percentages for LPNs/LVNs are based upon the 174 paid claims for LPNs/LVNs.

	RN
Failure to notify primary care practitioner	2.8%
Wrong dose	2.5%
Wrong information provided or recorded	2.3%
Missed dose	2.1%
Wrong medication	1.6%
Failure to document medication administration	1.6%
Wrong patient	1.1%
Improper technique	0.5%
All other	4.1%
Total	18.6%

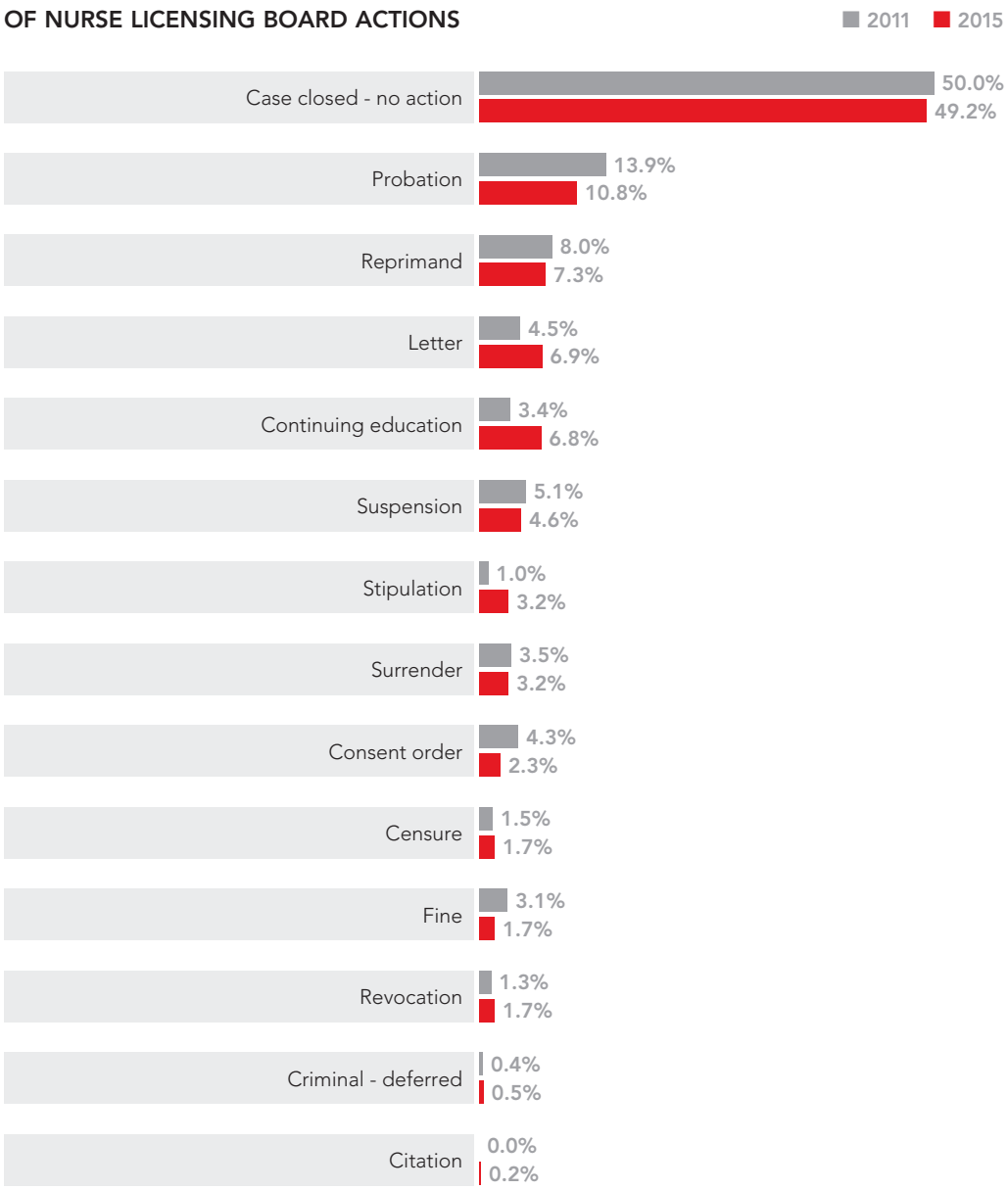
	LPN/LVN
Missed dose	5.2%
Failure to notify primary care practitioner	2.9%
Wrong information provided or recorded	2.3%
Wrong dose	1.7%
Wrong medication	1.1%
Improper technique	0.6%
Wrong patient	0.6%
Wrong time	0.6%
Failure to immediately report/ record improper administration of medication	0.6%
Failure to document medication administration	0.6%
All other	6.3%
Total	22.4%

Medication administration issues account for **18.6%** of RN paid claims and **22.4%** of LPN/LVN paid claims.

Licensing Board Actions

Comparison of 2011 and 2015 distribution of licensing board actions

9 COMPARISON OF 2011 AND 2015 DISTRIBUTION OF NURSE LICENSING BOARD ACTIONS



Explanation of Terms

Case closed - no action – A decision by the board of nursing or other regulatory body not to impose discipline, reflecting a successful defense of the nursing professional.

Censure – A public written reprimand regarding a violation of the Nurse Practice Act, which does not impose any conditions on the nurse's professional license.

Citation – A disciplinary notice that is more formal than a letter of warning, concern or guidance.

Consent order – A stipulation of a condition or conditions that must be fulfilled before the nurse can continue to practice.

Criminal - deferred – A notice of a pending board of nursing action, while the board awaits the results of a criminal action against the nurse.

Letter of concern (includes warning, admonition and guidance letters) – A communication from the Board of Nursing expressing concern that the nurse may have engaged in questionable conduct.

Letter of reprimand – A communication stating that probable cause of an infraction has been found, and that disciplinary action will be implemented if any further problems arise. A letter of reprimand is more serious than a letter of concern.

Revocation of license – A decision by a board of nursing prohibiting the nurse from practicing.

Stipulation – A condition or limitation on the nurse's practice.

Surrender of license – A decision by the nurse to cease professional practice.

General Recommendations

- Nurses must educate themselves on an ongoing basis about quality of care issues and strategies, and focus on mastering and reinforcing key competencies. The importance of maintaining documentation skills cannot be overemphasized.
- As nursing professionals are asked to deliver care to diverse patient populations, managing difficult patient situations is a core competency for all nurses. By enhancing their communication skills and reviewing established policies and protocols, nurses can minimize the risk of claims or complaints alleging patient abuse or violation of patients' rights.
- Nursing professionals must be aware of the stress factors that may lead to unprofessional conduct, and be proactive in seeking support to manage the situations or circumstances that can make them vulnerable.

Conclusion

A board complaint can be filed against a nurse by a patient, patient's family member or employer. Once filed, a license complaint takes an average of two years to achieve resolution, and can have career-altering consequences. In 4.9 percent of the cases in the dataset, the nurse's license was either surrendered or revoked, effectively ending the individual's nursing career.

By becoming aware of the most common complaints, nurses can identify potential vulnerabilities in their own practice and take measures to protect their patients and themselves. Basic risk control strategies for every nurse include:

- Enhancing communication and interpersonal skills to prevent potential errors.
- Adhering to facility policies and procedures.
- Maintaining nursing skills/competencies through continuing education.
- Paying careful attention to documentation requirements.

PART 3 Highlights from Nurses Service Organization's 2015 Qualitative Nurse Work Profile Survey

Introduction

CNA and NSO are committed to informing nurses of the risks they may encounter in their daily practice. This section of the report presents selected highlights from the NSO 2015 Qualitative Nurse Work Profile Survey, which examines nurses' professional liability closed claims in relation to various demographic factors and workplace attributes not addressed in Parts 1 and 2 of the report.

The survey enables us to compare several workplace variables which may influence professional liability exposure, including:

- The effect of using information technology versus not using such technology.
- The relationship between varying levels of employment training programs and periodic checks, and average paid indemnity amounts.
- The liability consequences of having or not having a rapid response team when an incident occurs.
- The effect of having access to evidence-based information versus not having access.

Methodology

This survey was undertaken in order to examine the relationship between professional liability exposures and a variety of demographic factors and workplace attributes. The survey looks specifically at a sample of CNA/NSO program nurses who had a closed professional liability claim between January 1, 2010 and December 31, 2014, and compares their responses with a sample of insureds who did not experience a claim during that time period.

Two similar survey instruments were distributed to NSO-insured nurses with and without claims. The first group consisted of 738 nurses who were identified as having had a claim close between January 1, 2010 and December 31, 2014. The second, non-claims group of NSO nurses consisted of a randomized sample of 5,000 current insureds, which approximately matched the geographic distribution of the closed claims group. In this survey, "respondent" refers to those NSO-insured registered nurses, licensed practical nurses and licensed vocational nurses who voluntarily replied to the NSO survey.

A hybrid methodology was used, comprised of a printed mail survey, including an email invitation to complete an online version of the survey. Each participant was sent the print version and, if an email address was available, the online invitation as well. Those receiving the print version were invited to take the online survey via a generic link. Each survey was labeled with a unique identifier to prevent multiple responses. Sample members were sent reminder notifications to encourage study participation.

Survey findings are based on self-reported information and thus may be skewed due to memory lapses and personal biases. The qualitative NSO survey results are not comparable to the CNA nurse closed claims data in Part I or the nurse license protection closed claims data in Part II, and are not representative of all NSO-insured nurse paid claims or nurse paid claims in general.

The following chart summarizes the response rates for the survey.

SURVEY RESPONSE RATES

	Claims	Non-claims
	Total	Total
Initial deployment	7/16/15	7/16/15
Reminder #1 sent	7/28/15	—
Field closed		8/21/15
Initial sample size	738	5,000
Undeliverable/opt out	17	283
Usable sample	721	4,717
Number of respondents	134	593
Response rate	18.5%	12.5%

Within the report, results are reported on overall responses for both the claims and non-claims segments. The margin of error at the 95 percent confidence level for the claims portion of the study was ±7.3 percent. In addition, the corresponding mark for the non-claims version was ±3.7 percent. In either case, a 95 percent confidence level has enabled us to conclude that percentages in the actual population would not vary by more than this in either direction.

Some figures and narrative findings include a reference to the average paid indemnity of the respondents' closed claims. It is important to remember that this refers only to indemnity payments made on behalf of NSO-insured RNs and LPNs/LVNs who experienced a closed claim and who responded to the survey.

Offering development opportunities to staff has a positive effect on liability claims and payments. Under-trained nurses have a higher likelihood of experiencing a claim.

Summary of Findings

- Nurses trained outside of the United States are more likely to experience a claim than nurses trained in the United States. However, the average paid indemnity for this group is about one half the average indemnity of those trained domestically.
- The majority of nurses (85.0 percent) who experienced a claim have been in practice for at least 16 years. However, the largest average indemnity payments ($70,171) were made to practitioners working as a nurse for three to five years.
- The majority of nurses reported that they have technology in their place of employment that allows rapid access to clinical information. Those without rapid access to information experienced a higher indemnity payment.
- While technology is intended to drive efficiency, 69.1 percent of those experiencing a claim noted that it takes more time to manage the technology system.
- Respondents who reported that patient notes were unnoticed or underutilized had a higher level of liability, with 41.5 percent of this group having experienced a claim. Average indemnity payments, however, were similar for all respondents..
- Evidence-based practice is becoming the standard for patient care. Those who lacked access to evidence-based information had an average indemnity payment 66 percent higher than those who had access to this information at their place of employment.
- Offering development opportunities to staff has a positive effect on liability claims and payments. Under-trained nurses have a higher likelihood of experiencing a claim.
- Nurses at organizations without a rapid response team were more likely to experience a claim. This group also experienced the highest average payment.

The complete results of the survey may be accessed on the NSO website at www.nso.com/nurseclaimreport2015.*

* Note that the numbering of the figures in this section of the report is not sequential because they have been excerpted from the full survey results posted on the NSO website.

Topic 1: Respondent Demographics

Nursing licensure

The majority of respondents who experienced a claim were licensed registered nurses. The overall distribution of nursing licensure for respondents with claims and those without claims was similar. As reported in Part 1, the overall proportion of the CNA/NSO-insured nurses within the CNA/NSO book of business varies somewhat over time, but the distribution here basically mirrors the in force ratio of 89 percent RNs to 11 percent LPNs/LVNs.

1 NURSING LICENSURE

Q: Please indicate your current nursing licensure.

	Non-claims	Claims	Average paid indemnity
Registered nurse	85.4%	86.5%	$35,702
Retired	6.5%	7.5%	$78,368
Licensed practical/vocational nurse	8.1%	6.0%	$68,125

Gender

The overall distribution of male and female respondents is roughly equal in both the non-claim and claim groups. This implies that the likelihood of a claim is roughly the same for male and female nurses, although women constitute a much larger proportion of the program. Males who experience a claim have a higher average paid indemnity than do their female counterparts.

2 GENDER

Q: What is your gender?

	Non-claims	Claims	Average paid indemnity
Female	93.9%	91.5%	$38,570
Male	6.1%	8.5%	$55,175

The likelihood of a claim is roughly the same for male and female nurses, although women constitute a much larger proportion of the program.

Pre-licensure nursing program

The data suggest that completing a pre-licensure nursing program through a traditional brick-and-mortar institution results in a lower average indemnity payment. Additionally, the data suggest that nurses completing pre-licensing hospital-based programs are more likely to experience a claim.

5 PRE-LICENSURE PROGRAMS

Q: Which best describes the type of pre-licensure nursing program you completed?

	Non-claims	Claims	Average paid indemnity
University/college - on-site program	42.4%	39.6%	$29,991
Community college	31.8%	35.1%	$35,446
Hospital-based program	17.9%	20.9%	$60,931
Accelerated degree program	6.9%	3.0%	$73,146
Online program	1.0%	1.4%	$8,035

Origin of education

Nurses trained outside the United States have a higher likelihood of experiencing a closed claim than do nurses trained in the United States. However, the average paid indemnity for this group is about one-half the indemnity of those trained domestically.

6 ORIGIN OF EDUCATION

Q: What is your origin of education?

	Non-claims	Claims	Average paid indemnity
Trained in the United States	95.3%	85.0%	$42,542
Trained outside of the United States	4.7%	15.0%	$21,188

Additional certifications

On average, an additional certification in a specialty increases the likelihood of a claim, as nurses with additional certifications and training tend to care for patients with a higher acuity level.

The percentages in this figure add up to more than 100 percent, as respondents may have more than one additional certification.

8 ADDITIONAL CERTIFICATIONS

Q: In what areas(s) have you achieved additional certification to practice as a nurse? (check all that apply)

	Non-claims	Claims	Average paid indemnity
Critical care	18.7%	24.1%	$30,524
Medical/surgical	12.9%	21.5%	$32,289
Gerontology	8.6%	17.7%	$42,368
Emergency department	8.9%	16.5%	$50,661
Home health/hospice	8.6%	11.4%	$53,533
Operating room	3.9%	10.1%	$80,812
Psychiatric/behavioral health	5.0%	10.1%	$39,579
Ambulatory care	2.5%	8.9%	$64,246
Infusion	4.3%	8.9%	$47,387
Obstetrics/perinatal	4.7%	7.6%	$141,661
Oncology/hematology	9.7%	7.6%	$60,813
Pediatrics	5.7%	6.3%	$54,432
Community/public health	9.0%	5.1%	$112,433
Aesthetics/cosmetics	2.1%	3.8%	$175,500
Education	8.6%	3.8%	$64,117
Occupational health	1.4%	3.8%	$68,772
Correctional health	1.1%	3.8%	$33,111
Clinics	1.8%	2.5%	$83,367
School nursing	8.6%	2.5%	$83,367
Surgical day care	1.4%	2.5%	$57,375
Adolescent care	0.8%	1.3%	$100,000
Family practice	1.1%	1.3%	$343
Neonatal	3.6%	1.3%	$4,166
Urology/renal	1.1%	0.0%	$0

Years in practice

Nurses who have been in practice for at least 16 years are more likely to have a claim than are less experienced nurses. However, the largest average indemnity payment ($70,171) was for nurses in practice for three to five years.

9 YEARS IN PRACTICE

Q: How many years have you been a licensed nurse?

	Non-claims	Claims	Average paid indemnity
Less than 1 year	7.8%	0.0%	$0
1 to 2 years	9.3%	0.0%	$0
3 to 5 years	13.4%	1.5%	$70,171
6 to 10 years	13.4%	6.0%	$22,394
11 to 15 years	6.7%	7.5%	$12,432
16 to 20 years	9.1%	13.5%	$57,860
21 years or more	40.3%	71.5%	$40,118

Nurses who have been in practice for at least **16 years** are more likely to have a claim than are less experienced nurses.

Topic 2: Current Practice Profile

Technology and rapid access to information

The majority of nurses reported having technology available in their place of employment that permits rapid access to clinical information. Those without rapid access to information have a higher average indemnity payment.

17 TECHNOLOGY AND RAPID ACCESS TO INFORMATION

Does this technology provide you rapid access to clinical information?

	Non-claims	Claims	Average paid indemnity
Yes	94.3%	92.0%	$35,403
No	5.7%	8.0%	$44,150

Technology and patient records access

The majority of respondents report having technology available permitting immediate access to patient records. Those who report not having such technology have a higher average indemnity payment, although claim frequency is similar for both groups.

18 TECHNOLOGY AND PATIENT RECORDS ACCESS

Q: Does your technology provide you immediate access to patient records for documentation?

	Non-claims	Claims	Average paid indemnity
Yes	87.3%	85.5%	$35,153
No	12.7%	14.5%	$43,266

Managing technology and time

While technology is intended to drive standardization and efficiency, 69.1 percent of those experiencing a claim noted it takes more time to manage the technology system.

19 MANAGING TECHNOLOGY AND TIME

Q: Does managing the technology require additional time on your end?

	Non-claims	Claims	Average paid indemnity
Yes	54.8%	69.1%	$37,955
No	45.2%	30.9%	$30,972

Technology and information verification

The majority of respondents reported that they are required to verify information in their practice technology. Nurses who are required to verify any information managed through the mentioned technology are less likely to experience a claim than are nurses who are not required to verify information. Average indemnity payments for both groups are fairly consistent.

20 TECHNOLOGY AND INFORMATION VERIFICATION

Q: Are you required to verify any information managed through the mentioned technology?

	Non-claims	Claims	Average paid indemnity
Yes	84.8%	73.6%	$37,332
No	15.2%	26.4%	$33,543

Usage of electronic patient notes

Respondents reporting that patient notes were unnoticed or underutilized have a higher likelihood of a claim than respondents who reported otherwise.

21 USAGE OF PATIENT NOTES

Q: Do electronic patient notes go unnoticed or underutilized?

	Non-claims	Claims	Average paid indemnity
Yes	36.2%	41.5%	$28,373
No	63.8%	58.5%	$29,918

Access to evidence-based data

Evidence-based practice is becoming the standard for patient care and most nurses are benefiting from its availability. Those who reported having access to evidence-based information have a lower average paid indemnity. Those who did not have access to evidence-based practice information have average indemnity payments 67 percent higher than those who did.

22 ACCESS TO EVIDENCE-BASED DATA

Q: Does your place of employment provide access to evidence-based data base/practice information?

	Non-claims	Claims	Average paid indemnity
Yes	71.7%	69.0%	$31,479
No	28.3%	31.0%	$52,505

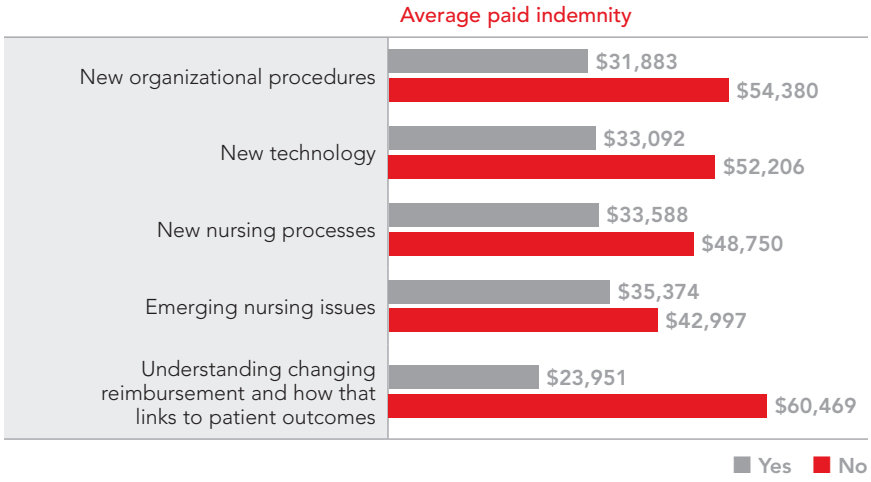
Staff development opportunities

Having regular staff development opportunities appears to have a positive effect on liability claims and payments.

23 STAFF DEVELOPMENT OPPORTUNITIES

Q: Does your place of employment provide regular staff development (1X per year) on:

	Non-claims		Claims	
	Yes	No	Yes	No
New organizational procedures	88.4%	11.6%	81.9%	18.1%
New technology	87.9%	12.1%	81.4%	18.6%
New nursing processes	81.9%	18.1%	75.9%	24.1%
Emerging nursing issues	67.4%	32.6%	72.2%	27.8%
Understanding changing reimbursement and how that links to patient outcomes	63.7%	36.3%	62.5%	37.5%



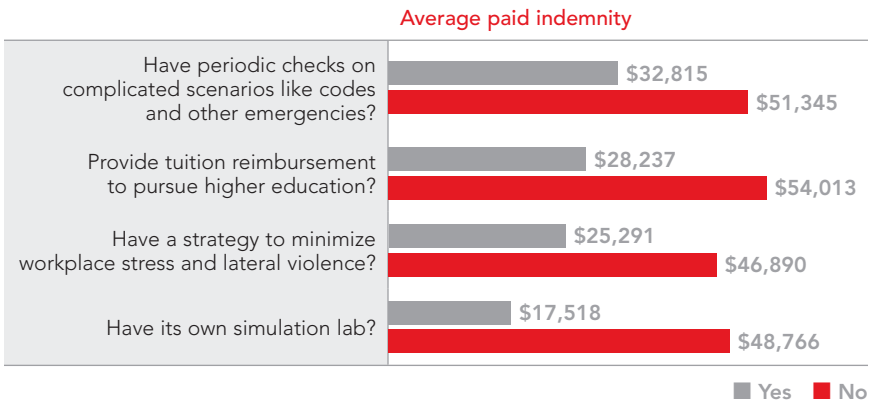
Employment practice periodic checks

Employers who have periodic checks and offer programs that support future educational opportunities, job satisfaction and proficiency seem to decrease the likelihood of a workplace incident. When these periodic checks and programs are in place, respondents experience lower average indemnity payments.

24 EMPLOYMENT PRACTICE PERIODIC CHECKS

Q: Does your place of employment …

	Non-claims		Claims	
	Yes	No	Yes	No
Have periodic checks on complicated scenarios like codes and other emergencies?	71.4%	28.6%	67.5%	32.5%
Provide tuition reimbursement to pursue higher education?	60.3%	39.7%	58.3%	41.7%
Have a strategy to minimize workplace stress and violence?	41.8%	58.2%	35.0%	65.0%
Have its own simulation lab?	24.2%	75.8%	28.7%	71.3%



Topic 3: About the Claim Submitted

Working situation at the time of the incident

Those working in a consistent location/unit are more likely to experience a claim. These nurses also have lower average indemnity payments.

27 WORKING SITUATION AT THE TIME OF THE INCIDENT

Claims Q: At the time of the incident, were you:
Non-claims Q: Which of the following best describes your current work assignment?

	Non-claims	Claims	Average paid indemnity
Working in your regularly assigned unit?	86.1%	81.0%	$34,599
Other	10.0%	11.2%	$56,642
Temporarily assigned/traveler?	1.8%	3.5%	$46,070
Temporarily assigned to another unit?	1.2%	2.6%	$76,774
Working in permanent pool?	0.9%	1.7%	$790

Employment status at the time of the incident

Full-time, self-employed or contracted nurses have higher average indemnity payments.

28 EMPLOYMENT STATUS AT THE TIME OF THE INCIDENT

Claims Q: At the time of the incident, what was your employment status?
Non-claims Q: What is your employment status?

	Non-claims	Claims	Average paid indemnity
Employed, full-time	58.4%	64.2%	$32,560
Employed, part-time	15.3%	15.5%	$21,710
Self-employed/contracted, full-time	3.5%	8.1%	$83,200
Working for a temp staffing service	2.0%	4.9%	$54,799
Other	10.1%	4.1%	$58,185
Self-employed/contracted, part-time	4.1%	3.2%	$72,968
Retired/permanently disabled	3.3%	—	$0
Student	3.3%	—	$0

Years in practice at the time of the incident

Nurses who have been in practice for 11 years or longer are most likely to experience a closed claim. As years of practice increase, so does the average indemnity payment.

29 YEARS IN PRACTICE AT THE TIME OF THE INCIDENT

Q: At the time of the incident, how many years have/had you practiced nursing?

	Claims	Average paid indemnity
Less than 1 year	1.7%	$3,921
1 to 2 years	0.8%	$343
3 to 5 years	6.6%	$12,220
6 to 10 years	11.6%	$21,050
11 to 15 years	11.6%	$48,627
16 to 20 years	21.5%	$21,592
21 years or more	46.3%	$53,752

Magnet™ designation at the time of the incident

A Magnet™ designation recognizes healthcare organizations for quality patient care, nursing excellence and innovations in professional nursing practice. The Magnet designation was developed by the American Nurses Credentialing Center (ANCC) to be a leading source of successful nursing practices and strategies. A majority of respondents reported they do not work in an institution that has a Magnet designation. While only a small percentage reported having Magnet™ designation, this group has a lower average indemnity payment compared with non-Magnet™ institutions.

32 MAGNET™ DESIGNATION AT THE TIME OF THE INCIDENT

Claims Q: At the time of the incident, was your hospital a Magnet™ Institution?
Non-claims Q: Is you hospital a Magnet™ Institution?

	Non-claims	Claims	Average paid indemnity
Yes	13.5%	9.0%	$7,361
No	44.8%	56.6%	$40,492
N/A	41.7%	34.4%	$44,120

Substance abuse procedure in place at the time of the incident

The majority of nurses report that their place of employment has a procedure in place for assessing substance abuse.

34 SUBSTANCE ABUSE PROCEDURE IN PLACE AT THE TIME OF THE INCIDENT

Claims Q: At the time of the incident, did your facility have a procedure in place for assessing substance abuse?
Non-claims Q: Does your facility have a procedure in place for assessing substance abuse?

	Non-claims	Claims	Average paid indemnity
Yes	71.3%	61.2%	$43,564
No	28.7%	38.8%	$34,473

Tenure in position at the time of the incident

At the time of the incident, 43.4 percent of nurses had been at their position for 11 years or more. Respondents with three to 15 years' tenure have the lowest average paid indemnity, while those nurses who have been at their position 16 or more years have the highest average paid indemnity.

35 TENURE IN POSITION AT THE TIME OF THE INCIDENT

Q: At the time of the incident, how many years had you worked in this particular position?

	Claims	Average paid indemnity
Less than 1 year	9.0%	$36,616
1 to 2 years	8.2%	$47,304
3 to 5 years	19.7%	$21,670
6 to 10 years	19.7%	$33,519
11 to 15 years	14.8%	$30,928
16 to 20 years	16.3%	$50,047
21 years or more	12.3%	$64,637

Topic 4: About the Facility Where the Incident Occurred

Technology in the workplace at the time of the incident

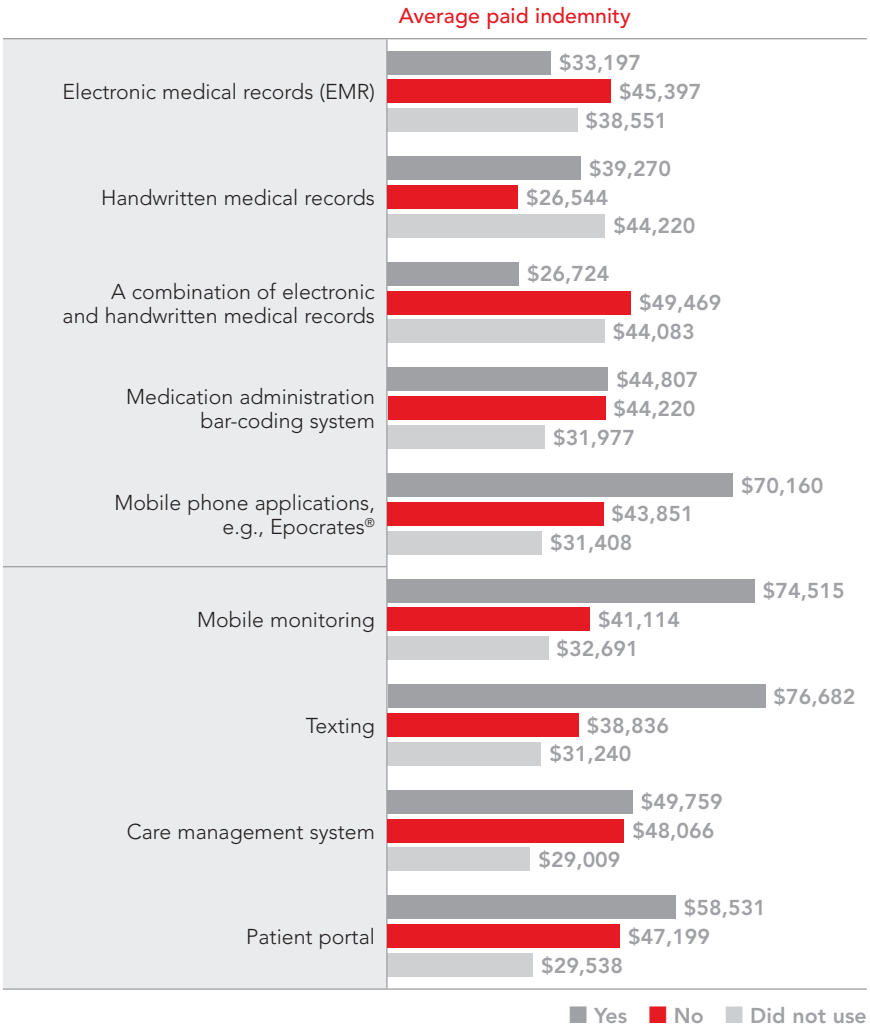
The benefits of technology in the workplace are apparent. Nurses who either did not have access to electronic technologies or who did not use the technologies they had access to were more likely to have a closed claim than nurses who used the technologies.

40 TECHNOLOGY IN THE WORKPLACE AT THE TIME OF THE INCIDENT

Claims Q: At the time of the incident, what types of technology did you use in your workplace? If you do not use it, please select "do not use."
Non-claims Q: What types of technology do you use in your workplace?

	Non-claims			Claims		
	Yes	No	Did not use	Yes	No	Did not use
Electronic medical records (EMR)	79.8%	1.0%	19.2%	35.0%	20.0%	45.0%
Handwritten medical records	81.3%	15.5%	3.2%	79.8%	10.9%	9.2%
A combination of electronic and handwritten medical records	36.5%	48.2%	15.3%	37.1%	28.5%	34.5%
Medication administration bar-coding system	52.6%	4.9%	42.5%	16.7%	33.3%	50.0%
Mobile phone applications, e.g., Epocrates®	42.9%	8.8%	48.3%	6.7%	35.0%	58.3%
Mobile monitoring	58.9%	2.6%	38.5%	5.9%	39.0%	55.1%
Texting	19.3%	7.2%	73.5%	7.6%	35.6%	56.8%
Care management system	31.0%	16.8%	52.2%	18.5%	28.6%	52.9%
Patient portal	39.6%	8.5%	51.9%	10.8%	30.0%	59.2%

40 TECHNOLOGY IN THE WORKPLACE... (CONTINUED)



How long were you using technology at the time of the incident?

Electronic technology seems to have a low adoption rate within nurse practices. Nurses who use the listed technology have been doing so for a year or less.

41 HOW LONG WERE YOU USING TECHNOLOGY AT THE TIME OF THE INCIDENT

Q: If you answered "Yes" to question 40, please check the answer that best describes the length of time using the technology mentioned in the previous question. At the time of the incident, how long were you using:

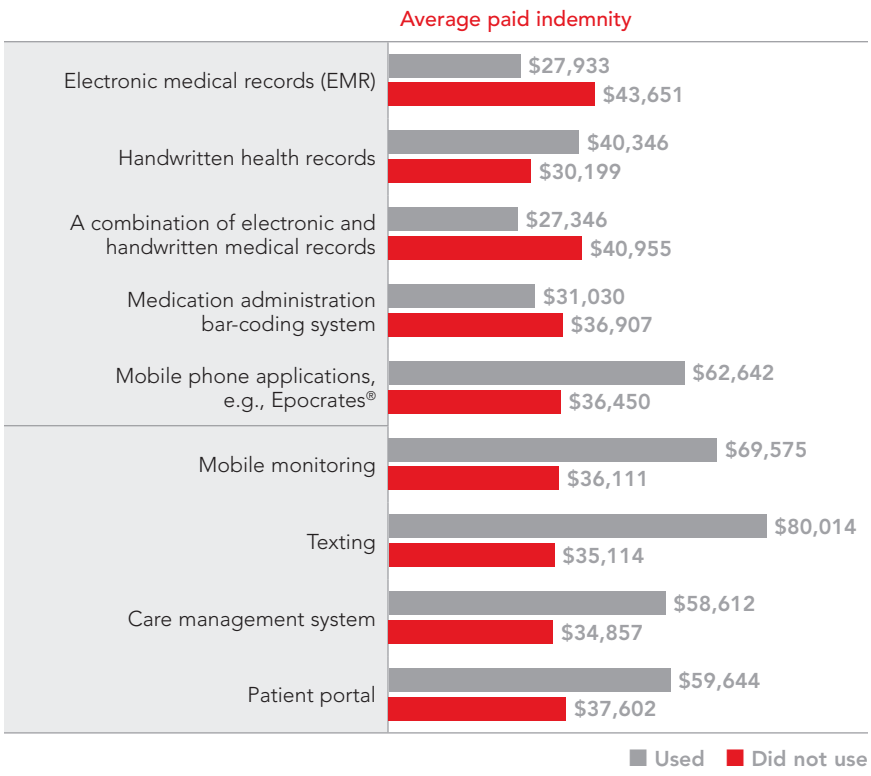
Non-claims

	0-3 months	3-6 months	6 months -1 year	Over 1 year	Do not know	Did not use
Electronic medical records (EMR)?	6.4%	8.3%	7.3%	22.9%	3.5%	51.6%
Handwritten health records?	4.3%	3.1%	4.2%	74.1%	2.5%	11.8%
A combination of electronic and handwritten medical records?	3.6%	6.2%	9.0%	28.9%	6.4%	45.9%
Medication administration bar-coding system?	0.7%	8.2%	4.1%	4.2%	5.3%	77.5%
Mobile phone applications, e.g., Epocrates®?	0.6%	0.5%	4.1%	5.6%	3.9%	85.3%
Mobile monitoring?	0.6%	1.3%	3.1%	17.5%	4.1%	73.4%
Texting?	1.4%	3.2%	6.3%	9.3%	10.5%	69.3%
Care management system?	1.6%	2.6%	5.1%	13.1%	8.3%	69.3%
Patient portal?	0.9%	4.5%	2.9%	8.2%	6.5%	77.0%

Claims

	0-3 months	3-6 months	6 months -1 year	Over 1 year	Do not know	Did not use
Electronic medical records (EMR)?	4.4%	1.8%	4.4%	23.0%	6.2%	60.2%
Handwritten health records?	2.6%	0.9%	3.5%	70.7%	5.2%	17.2%
A combination of electronic and handwritten medical records?	3.5%	0.0%	2.6%	30.7%	8.8%	54.4%
Medication administration bar-coding system?	0.9%	0.0%	0.9%	11.4%	6.1%	80.7%
Mobile phone applications, e.g., Epocrates®?	0.0%	0.9%	0.0%	7.0%	4.4%	87.8%
Mobile monitoring?	0.0%	0.0%	0.0%	7.0%	5.3%	87.7%
Texting?	0.0%	0.0%	1.8%	7.1%	3.5%	87.6%
Care management system?	0.9%	0.9%	0.9%	13.2%	9.7%	74.6%
Patient portal?	0.0%	0.0%	0.0%	11.5%	7.1%	81.4%

41 HOW LONG WERE YOU USING TECHNOLOGY... (CONTINUED)



The majority of nurses believe that streamlining their practice with technology enhances patient safety.

Perceived patient benefit of technology

A majority of nurses believe that streamlining their practice with technology enhances patient safety.

42 PERCEIVED PATIENT BENEFIT OF TECHNOLOGY

Claims Q: At the time of the incident, did you feel the technology used at your place of employment enhanced or jeopardized patient safety?
Non-claims Q: Do you feel the technology used at your place of employment enhances or jeopardizes patient safety?

	Non-claims	Claims	Average paid indemnity
Enhanced	83.4%	60.1%	$43,564
Jeopardized	16.6%	30.9%	$34,473

Rapid response team

Nurses not having a rapid response team were more likely to experience a claim.

44 RAPID RESPONSE TEAM

Claims Q: At the time of the incident, did you have/use a rapid response team?
Non-claims Q: Do you have a rapid response team?

	Non-claims	Claims	Average paid indemnity
No, my facility does not have an RRT	34.3%	51.4%	$48,374
Yes, my facility has an RRT, but I did not use it	23.3%	30.6%	$15,372
Yes, my facility has an RRT, and I used it	42.4%	18.0%	$45,731

Published 10/2015

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