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Nurse Practitioner 2012 Liability Update

A Three-part Approach

TWENTY YEARS OF PROVIDING PROFESSIONAL LIABILITY
COVERAGE FOR NURSE PRACTITIONERS

Part 1: Nurse Practitioner Professional Liability Exposures, CNA Five-year Closed Claims Analysis

(January 1, 2007–December 31, 2011)

Risk Control Recommendations

Risk Control Self-assessment Checklist for Nurse Practitioners

PART 1: INTRODUCTION

In 2012, CNA and our business partners at Nurses Service Organization (NSO) celebrate the 20-year anniversary of the nurse practitioner professional liability insurance program. We are proud to be one of the nation's largest professional liability insurance programs for nurse practitioners, with more than 27,000 policies in force. CNA/NSO nurse practitioners provide professional services in an increasingly broad array of specialties and locations, including physician office practices, hospitals, nurse practitioner offices, aging services/long term care facilities, patient homes, behavioral health facilities, prisons, clinics, community health facilities, schools, retail health settings, spas, aesthetic/cosmetic centers and other healthcare delivery settings.

PURPOSE

In collaboration with NSO, we at CNA are dedicated to educating nurse practitioners about risk. In support of that effort, we present this report, which examines CNA nurse practitioner claims that closed between January 1, 2007 and December 31, 2011, and identifies current liability patterns and trends. Using this report, nurse practitioners can better understand the risks and challenges they may encounter on a daily basis, evaluate their practices in relation to the claims and losses experienced by their peers, and modify their clinical practice to enhance patient safety while minimizing liability exposure.

This closed claims analysis contains several case studies, illustrating situations where nurse practitioners were alleged to have failed to comply with professional standards of care, resulting in patient injury and consequent claims of negligence. Additional risk control recommendations and a risk control self-assessment checklist are included at the end of Part 1. These tools can assist nurse practitioners in reviewing their custom and practice in relation to the risks identified in the report and determining whether their services and practices may leave them vulnerable to patient complaints and potential litigation.

EXECUTIVE SUMMARY

According to CNA data, the most frequent allegations made against nurse practitioners involved failure to diagnose and delay in making a correct diagnosis, failure to provide the proper treatment and care, and medication prescribing errors. This analysis focuses on identifying the illnesses and diagnoses most frequently associated with failure to diagnose claims, as well as some of the underlying causes of diagnostic failure or delay. In addition, specific allegations related to treatment and care and the prescribing of medications are discussed.

Specialty and Location

Our analysis reveals that nurse practitioners who experienced claims were more likely to work in the adult medical/primary care and family practice specialties. The healthcare delivery settings that experienced the greatest number of claims were physician office practices, community-based outpatient clinics and skilled nursing facilities.

Allegations

Claims against nurse practitioners typically involved diagnosis, treatment or prescription of medications, as described below:

- **Diagnosis-related allegations** were most likely to involve the failure to diagnose or delay in the diagnosis of infection/abscess/sepsis and cancer. The most frequent causes for a failure to diagnose or a delay in diagnosis were failure to order appropriate tests to establish diagnosis, failure to obtain consultations to establish diagnosis, and failure or delay in obtaining/addressing diagnostic test results. Claims involving failure to diagnose cancer more commonly involved lung cancer, while claims alleging delay in diagnosing cancer more frequently involved breast cancer.
- **Treatment-related allegations** commonly involved the failure to timely or properly establish and/or order appropriate treatment, improper technique or negligent performance of a treatment or test, improper or untimely management of an aging services resident, or improper or untimely management of a medical patient or medical complication.
- **Medication-prescribing allegations** often involved the failure to recognize a known contraindication and/or known adverse interaction among ordered medications, or improper prescribing/management of an anticoagulant.

Injuries

Unexpected death (i.e., death unrelated to the normal course of illness) was the most common patient injury associated with nurse practitioner negligence claims, followed by cerebral vascular accident/stroke, cancer that was either undiagnosed or delayed in diagnosis, and infection/abscess/sepsis. When death occurred, it was most likely to be the result of an infection/abscess/sepsis, followed by cancer, cardiopulmonary arrest, myocardial infarction, bleeding/hemorrhage or a medication prescribing error.

DATABASE AND METHODOLOGY

For this analysis, we reviewed and analyzed only those professional liability closed claims that met the following inclusion criteria:

- The claim involved a nurse practitioner or nurse practitioner student.
- Regardless of when the claim was first reported or initiated, it closed between January 1, 2007 and December 31, 2011.
- The claim resulted in an indemnity payment of $10,000 or greater.

These inclusion criteria were applied to 1,880 reported adverse incidents and claims that closed during the designated time period. The final database comprised 200 nurse practitioner closed claims, which were subsequently reviewed and analyzed.

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

SCOPE

The analysis focused upon the severity (as defined in the "Terms" section, below) of nurse practitioner closed claims that satisfied the inclusion criteria noted in the "Database and Methodology" section, above. Claim characteristics analyzed within the report include location of the event, nurse practitioner specialty, type of allegation, resulting injury and level of patient disability.

TERMS

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

- **Aging services** – Specialized facilities or organizations that provide care to a senior population. (Sometimes also referred to as long term care, aging services settings include, but are not limited to, nursing homes, skilled nursing facilities, assisted living centers and independent living facilities.)
- **Expense payment** – Monies paid in the investigation, management or defense of a claim, including but not limited to expert witness expenses, attorney fees, court costs and record duplication expenditures.
- **Incurred payment** – The total costs or financial obligations, including both indemnity and expenses, resulting from the resolution of a claim.
- **Indemnity payment** – Monies paid on behalf of an insured nurse practitioner in the settlement or judgment of a claim.
- **Location** – The healthcare setting where the nurse practitioner worked.
- **Practitioner** – A licensed independent healthcare provider such as a physician, nurse practitioner or advanced practice nurse.
- **Severity** – The average paid indemnity for nurse practitioner claims that closed with an indemnity payment of $10,000 or greater.

LIMITATIONS

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

- The database includes only closed claims made against nurse practitioners insured by CNA through the NSO program, and does not necessarily represent the complete spectrum of nurse practitioner activities and nurse practitioner closed claims.
- Noted indemnity payments are only those paid by CNA on behalf of its insured nurse practitioners through the NSO program and exclude additional amounts paid by employers, other insurers or other parties in the form of direct or insurance payments.
- The process of resolving a professional liability claim may take many years. Therefore, while some of the claims included in this report may have arisen from an event that occurred prior to 2007, all claims closed during the stated time period.

CLAIM MANAGEMENT

CNA is aggressive in its claim management. During the time frame of this analysis, of those nurse practitioner claims deemed suitable to proceed to trial, the vast majority had a favorable outcome for the nurse practitioner. (See page 35 for an example of a claim that was successfully defended on behalf of the nurse practitioner.)

Obstetrical and aging services claims were identified as two areas within the healthcare industry that require particular expertise and experience on the part of defense counsel. To provide insureds with that expertise, CNA Claim developed its National Birth Trauma and National Aging Services panel counsels. In addition to handling complex or difficult claims, these experienced attorneys also consult with and/or refer to nationally recognized experts for opinions regarding standard of care and causation, mitigation of damages claimed and optimal defense strategy.

Rapid investigation, including early assignment of counsel and experts, expedites resolution of nurse practitioner claims and contributes to improved legal outcomes and lower litigation expenses. Nurse practitioners can assist in this process by reporting adverse incidents and any indications or notices of litigation in a timely manner.

The 2012 analysis reveals a higher percentage of closed claims in the three highest severity groups (i.e., $500,000 to $1 million). Thus, the number of very severe claims has increased significantly since the 2009 analysis.

Analysis of Claims by Insurance Type

- A total of 95.5 percent of the closed claims involved nurse practitioners (and one student nurse practitioner) who maintained their own individual professional liability policy.
- Only 4.5 percent of the closed claims involved nurse practitioners who were covered through a CNA-insured healthcare business, such as a nurse practitioner office practice.
- The single closed claim attributed to a student nurse practitioner involved alleged failure to notify the physician that a pregnant patient was showing signs of premature labor and required hospitalization. The infant was born severely impaired.
- The average paid indemnity for closed claims with an indemnity payment of $10,000 or greater was $221,852. In the 2009 CNA/NSO nurse practitioner claims analysis, which included claims that occurred between 1998 and 2008, the average paid indemnity for closed claims with an indemnity payment of $10,000 or greater that closed during the study period was $186,282. Thus, the average paid indemnity has increased 19.0 percent in the interim.

1 **Closed Claims by Insurance Type for All Nurse Practitioners**

Insurance type	Percentage of closed claims	Total paid indemnity	Total paid expense	Average paid indemnity	Average paid expense	Average total incurred
Student nurse practitioner, individually insured	0.5%	$850,000	$158,080	$850,000	$158,080	$1,008,080
Nurse practitioner, individually insured	95.0%	$43,055,407	$12,222,170	$226,607	$64,327	$290,935
Nurse practitioner receiving coverage through a CNA-insured healthcare business	4.5%	$465,083	$378,188	$51,676	$42,021	$93,697
Overall	**100.0%**	**$44,370,490**	**$12,758,438**	**$221,852**	**$63,792**	**$285,645**

The average paid indemnity has increased 19.0 percent between the 2009 CNA/NSO nurse practitioner claims analysis and the current one, rising from $186,282 to $221,852.

Closed Claims with Expense Payment but No Indemnity Payment

This report focuses on the severity of closed claims with indemnity payments of $10,000 or greater. However, during the five-year period of this analysis, there were 649 nurse practitioner closed claims that had no indemnity payment but did experience paid expenses of one dollar or more. Expenses paid for this group totaled over $9.2 million.

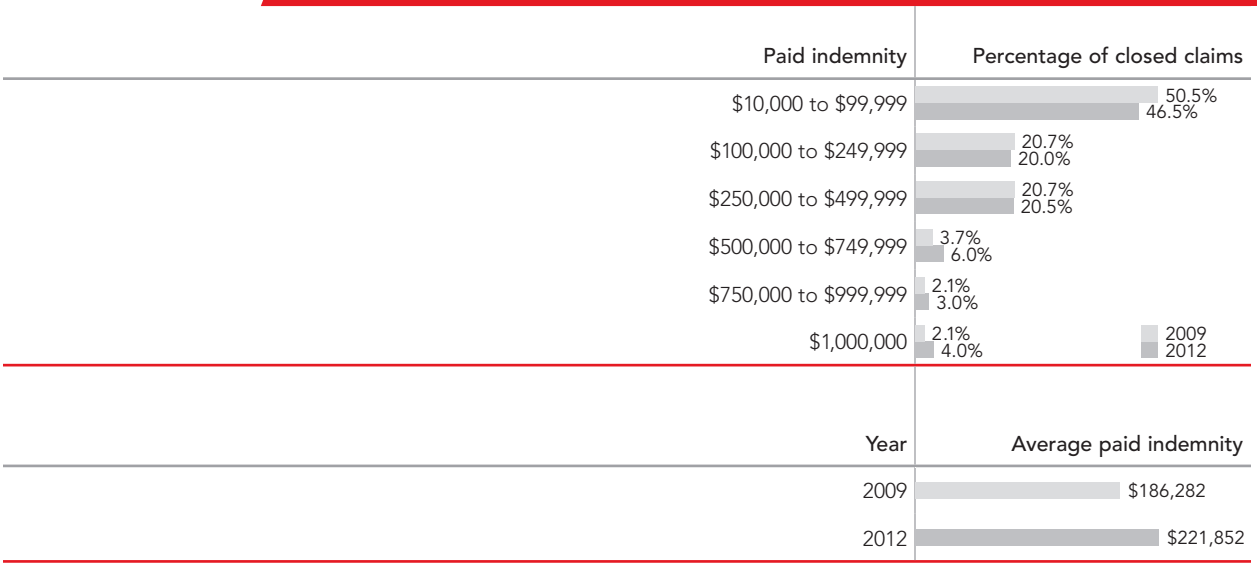
Closed claims in this category include those that were

- successfully defended on behalf of the nurse practitioner
- investigated and prepared for trial, but were settled by codefendants with no indemnity attribution to the nurse practitioner
- dismissed or abandoned by the plaintiff at some point in the investigative or discovery process
- terminated in favor of the nurse practitioner by the court prior to trial

Comparison of Nurse Practitioner Average Paid Indemnity, 2009 and 2012

Figure 2 reveals that for both the 2009 and 2012 claims analyses, the highest percentage of closed claims had a paid indemnity in the $10,000-$99,999 range. However, the 2012 analysis reflects a slightly lower percentage of claims in this category, which is the least severe. The two different analyses show similar percentages of closed claims in the $100,000-$249,999 and $250,000-$499,999 average paid indemnity categories.

Comparison of 2009 and 2012 Average Paid Indemnity Distribution for Nurse Practitioner Closed Claims **2**



Analysis of Severity by Nurse Practitioner Specialty

Four specialties accounted for 5.0 percent or more of the closed claims, as described below:

- **Together, adult medical/primary care and family practice accounted for 75.5 percent of all the closed claims in this analysis.** Both categories included allegations of failure to diagnose/delay in diagnosis, improper treatment and care, failure to refer patients to emergency care, and improper prescribing or management of medications.
- **Behavioral health accounted for 6.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $203,365. Of these closed claims, four involved patient suicide and two alleged improper prescribing of controlled drugs. Another claim involved a juvenile patient who murdered an infant soon after his last appointment with the nurse practitioner managing his psychoactive medication.
- **Women's health (gynecology) accounted for 5.0 percent of all the closed claims in the analysis,** with an average paid indemnity of $235,783. This specialty was affected by claims alleging failure to diagnose or delay in diagnosing cancer. A nurse practitioner specializing in this area also experienced a claim involving insertion of an intrauterine contraceptive device into a pregnant woman's uterus, resulting in the premature birth of a neurologically impaired infant.
- **Pediatrics, women's health (obstetrics) and emergency medicine accounted for 7.0 percent of all the closed claims in the analysis,** and had the highest average paid indemnity amounts, due, in part, to the following costly claims:
  - Pediatrics claims included death of an infant due to improperly prescribed medication and failure to manage a child's vomiting, leading to aspiration, anoxia and permanent brain damage.
  - Women's health (obstetrics) claims included the allegation that a nurse practitioner student had failed to notify the physician that a patient was prematurely dilated, resulting in a premature delivery and a neurologically impaired infant.
  - Emergency medicine was affected by several costly claims involving failure or delay in diagnosis, as well as improper care and treatment.

3 **Severity by Nurse Practitioner Specialty**
(Closed claims with indemnity payment of ≥ $10,000)

Nurse practitioner specialty	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Pediatrics	1.0%	$1,050,000	$525,000
Women's health (obstetrics)	2.5%	$2,185,000	$437,000
Emergency medicine	3.5%	$1,915,292	$273,613
Adult medical/primary care	52.0%	$26,349,319	$253,359
Women's health (gynecology)	5.0%	$2,357,833	$235,783
Occupational health	0.5%	$225,000	$225,000
Behavioral health	6.5%	$2,643,750	$203,365
Family practice	23.5%	$6,904,296	$146,900
Gerontology	1.0%	$272,500	$136,250
Aesthetics/cosmetics	4.5%	$467,500	$51,944
Overall	**100%**	**$44,370,490**	**$221,852**

Analysis of Severity by Location

While nurse practitioners work in many locations, four locations accounted for a significant percentage of all the closed claims in the analysis: physician office practices (36.5 percent), community-based outpatient clinics (18.5 percent), skilled nursing facilities (13.5 percent) and nurse practitioner private practices/offices (7.0 percent). Nurse practitioner claims arising from physician offices also represented an average paid indemnity higher than the overall average due to several high-indemnity claims. The claims alleged failure to refer the patient to an emergency department, failure to diagnose or delay in diagnosing the patient, failure to properly manage anticoagulant therapy, improper prescribing of medications and failure to provide indicated treatment.

Five locations accounted for a relatively low number of claims, but had an average paid indemnity greater than the overall average:

- **A pediatric intensive care unit was the site of a single claim,** where a nurse practitioner failed to manage and report a child's vomiting. The child aspirated emesis and suffered anoxia with permanent brain damage.
- **Patient's homes accounted for 1.0 percent of closed claims,** including one claim that involved failure to identify infection and sepsis, resulting in the patient's death. Another claim involved failure to diagnose an evolving myocardial infarction despite abnormal blood and EKG findings, also leading to the patient's death.
- **Freestanding emergency/urgent or convenient care centers accounted for 3.0 percent of all the closed claims in the analysis,** including one claim where the patient presented with hematuria, was not referred to a urologist and was later found to have bladder cancer. In addition, two claims involved the failure of the nurse practitioner to identify a pulmonary embolism and to refer the patient to emergency hospital care.
- **Inpatient hospital settings accounted for 1.5 percent of all the closed claims in the analysis.** This location was affected by claims where the nurse practitioner failed to
  - heed the transferring physician's note regarding the need to rule out viral encephalitis, and the patient suffered permanent brain damage
  - order an MRI following an abnormal chest X-ray, and the patient died of a ruptured dissecting aortic aneurysm
  - consider the emergency department's notations of chest pain and order a stress test, and the patient died from cardiopulmonary arrest
- **Hospital-based outpatient clinics accounted for 1.5 percent of all the closed claims in the analysis.** This location includes a claim where the nurse practitioner inserted an intrauterine contraceptive device into a woman who was 18 weeks pregnant. The mother delivered a premature infant at 22 weeks gestation, who suffers from severe developmental delays.

4 Severity by Location

(Closed claims with indemnity payment of ≥ $10,000)

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Pediatric intensive care unit	0.5%	$550,000	$550,000
Patient's home	1.0%	$1,082,720	$541,360
Emergency/urgent care walk-in care center, freestanding	3.0%	$2,677,500	$446,250
Hospital, inpatient medical service	1.5%	$1,100,000	$366,667
Hospital-based outpatient clinic	1.5%	$1,037,500	$345,833
Physician office practice	36.5%	$21,152,235	$289,757
School	0.5%	$250,000	$250,000
Hospital emergency department	3.5%	$1,715,292	$245,042
Community-based outpatient clinic	18.5%	$8,374,164	$226,329
Inpatient rehabilitation at hospital or long-term acute care hospital	0.5%	$225,000	$225,000
Aging services, rehabilitation/physical therapy	1.0%	$312,500	$156,250
Aging services, assisted living	2.0%	$562,000	$140,500
Aging services, skilled nursing	13.5%	$3,653,416	$135,312
Hospital, inpatient surgical service	1.0%	$168,750	$84,375
Dialysis, freestanding	0.5%	$75,000	$75,000
Spa, medispa	1.0%	$142,500	$71,250
Aging services, subacute care	2.0%	$270,163	$67,541
Behavioral health/psychiatric, outpatient	1.0%	$105,833	$52,917
Nurse practitioner private practice/office	7.0%	$640,500	$45,750
Prison health service, inpatient or outpatient	2.0%	$141,250	$35,313
Behavioral health/psychiatric, inpatient	2.0%	$134,167	$33,542
Overall	**100.0%**	**$44,370,490**	**$221,852**

Analysis of Severity by Allegation Category

The analysis of allegations begins with Figure 5, which examines the average and total paid indemnity for all major allegation categories.

Five allegation categories accounted for 96.0 percent of all the closed claims in the analysis:

- **Diagnosis-related closed claims accounted for 43.0 percent of all closed claims,** and had an average paid indemnity higher than the overall average paid indemnity of $221,852.
- **Treatment and care management closed claims accounted for 29.5 percent of all closed claims,** and had an average paid indemnity very similar to the overall average paid indemnity.
- **Medication (prescribing) closed claims accounted for 16.5 percent of all closed claims,** and had an average paid indemnity higher than the overall average paid indemnity.
- **Equipment-related closed claims accounted for 3.5 percent of all closed claims,** and had an average paid indemnity lower than the overall average paid indemnity,
- **Monitoring-related closed claims accounted for 1.5 percent of all closed claims,** and had the highest average paid indemnity at $321,667. This category includes a high-severity claim in which the nurse practitioner failed to monitor a patient's Gentamycin blood levels, resulting in the patient suffering permanent deafness and renal insufficiency.

Severity by Allegation Category 5
(Closed claims with indemnity payment of ≥ $10,000)

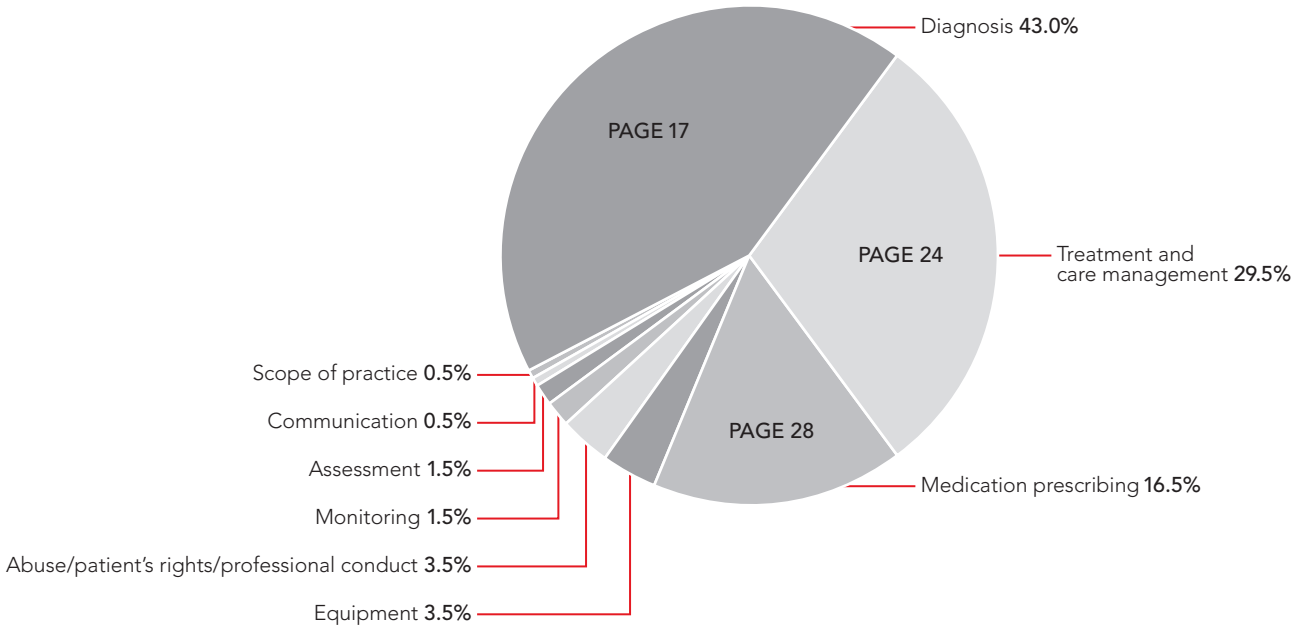
Allegations related to	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Monitoring	1.5%	$965,000	$321,667
Diagnosis	43.0%	$21,573,135	$250,850
Medication prescribing	16.5%	$7,660,197	$232,127
Treatment and care management	29.5%	$13,005,408	$220,431
Equipment	3.5%	$640,000	$91,429
Assessment	1.5%	$271,250	$90,417
Abuse/patient's rights/professional conduct	3.5%	$216,000	$30,857
Communication	0.5%	$27,500	$27,500
Scope of practice	0.5%	$12,000	$12,000
Overall	**100.0%**	**$44,370,490**	**$221,852**

Figure 5a provides a clearer visual representation of the allegation category findings in Figure 5.

In order to better understand the allegation categories with the largest percentages of closed claims, additional analysis was performed for claims involving diagnosis, treatment and care management, and medication prescribing, as follows:

5a Allegation Categories: Claim Distribution

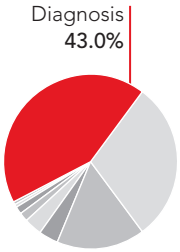
(Closed claims with indemnity payment of ≥ $10,000)



Additional Analysis: Diagnosis-related

Diagnosis-related closed claims are further divided into two sub-categories: failure to diagnose and delay in diagnosis. These two sub-categories are explored in more depth in Figures 6 through 6d.

Diagnosis-related closed claims were the most common category in the analysis, at 43.0 percent (i.e., 30.0 percent failure to diagnose plus 13.0 percent delay in establishing diagnosis). Both diagnosis-related allegation subcategories had a very similar average paid indemnity, which was higher than the overall average paid indemnity.



Severity of Allegation Subcategories Related to Diagnosis 6
(Closed claims with indemnity payment of ≥ $10,000)

Allegation sub-category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to diagnose	30.0%	$15,120,548	$252,009
Delay in establishing diagnosis	13.0%	$6,452,587	$248,176
Overall	**43.0%**	**$21,573,135**	**$250,850**

Diagnosis-related allegations accounted for 43.0 percent of all the nurse practitioner closed claims in the analysis, and had an average paid indemnity of $250,850.

Additional Analysis: Illnesses/Injuries Related to Failure to Diagnose

As noted in Figure 6, failure to diagnose allegations represented 30.0 percent of all the closed claims in the analysis. Figures 6a and 6b examine these allegations in more detail.

Two allegations – failure to diagnose infection/abscess/sepsis and failure to diagnose cancer and benign tumors – accounted for more than half of the failure to diagnose closed claims, as noted below:

- **Failure to diagnose infection/abscess/sepsis accounted for 10.0 percent of all the closed claims in the analysis,** and had an average paid indemnity of $208,917.
- **Failure to diagnose cancer and benign tumors accounted for 7.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $242,719. This group included multiple types of cancer, with one claim involving an aggressive benign brain tumor that resulted in the death of an infant.
- **Failure to diagnose Down's syndrome was limited to a single claim.** However, this claim had an indemnity payment of $975,000, the highest in the failure to diagnose category. The claim involved the nurse practitioner's failure to order prenatal testing as required by the facility's clinical protocols, resulting in a claim of wrongful life.
- **Failure to diagnose pulmonary embolism accounted for 1.0 percent of all the closed claims in the analysis,** but these claims had a high average paid indemnity of $925,000.
- **Failure to diagnose cerebral vascular accident/stroke accounted for 1.5 percent of all the closed claims in the analysis,** with a high average paid indemnity of $466,013.
- **Failure to diagnose laceration/tear/abrasion was limited to a single claim,** involving significant permanent disability to a child's hand, which resulted in an indemnity payment of $250,000.

6a **Severity of Failure to Diagnose Claims by Illness/Injury**
(Closed claims with indemnity payment of ≥ $10,000)

Diagnosis	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Down's syndrome	0.5%	$975,000	$975,000
Pulmonary embolism	1.0%	$1,850,000	$925,000
Cerebral vascular accident/stroke	1.5%	$1,398,040	$466,013
Laceration/tear/abrasion	0.5%	$250,000	$250,000
Cancer and benign tumors	7.5%	$3,640,792	$242,719
Infection/abscess/sepsis	10.0%	$4,178,333	$208,917
Cardiovascular injury other than myocardial infarction	2.5%	$1,025,000	$205,000
Subdural hematoma	1.5%	$550,000	$183,333
Fracture/dislocation	2.0%	$595,163	$148,791
Myocardial infarction	2.0%	$513,220	$128,305
Lupus	0.5%	$125,000	$125,000
Focal glomerulosclerosis	0.5%	$20,000	$20,000
Overall	**30.0%**	**$15,120,548**	**$252,009**

This figure demonstrates nine underlying causes for the failure to diagnose. In claims with more than one cause, the cause that most directly contributed to the failure to diagnose was selected for purposes of this report.

Four identified causes accounted for the majority of failure to diagnose closed claims:

- **Failure to order appropriate diagnostic tests accounted for 10.0 percent of all the closed claims in the analysis.** These claims resulted in an average paid indemnity of $181,698. One example is included in the case study on page 26, where the nurse practitioner failed to order an EKG and a cardiology consultation, or to refer the patient to an emergency department.
- **Failure to obtain consultations to establish the patient's diagnosis accounted for 9.0 percent of all the closed claims in the analysis,** with an average paid indemnity of $354,792. One example is included in the case study on page 20, where the nurse practitioner failed to obtain a dermatological or surgical consultation for a skin lesion and the patient was subsequently diagnosed with melanoma.
- **Failure or delay in obtaining/addressing diagnostic test results accounted for 3.5 percent of all the closed claims in the analysis,** reflecting an average paid indemnity of $178,543. There was no underlying pattern for these claims. However, two claims involved abnormal chest X-ray findings that were present in the patient's chart during the course of treatment, but were not observed by the nurse practitioner. Both of the patients were subsequently diagnosed with lung cancer.
- **Failure to obtain/refer the patient for immediate emergency treatment accounted for only 3.0 percent of all the closed claims in the analysis,** but represented the highest overall average paid indemnity of $465,833.

Interestingly, 1.0 percent of all the closed claims in the analysis involved the patient refusing or delaying the performance of indicated tests or treatments due to a lack of health insurance or funds to pay for care. Heretofore, the claims data did not include this specific reason for refusing or delaying diagnostic tests or treatments recommended by the nurse practitioner.

Severity of Failure to Diagnose Claims by Cause of Failure 6b
(Closed claims with indemnity payment of ≥ $10,000)

Cause of failure to diagnose	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to obtain/refer for immediate emergency treatment	3.0%	$2,795,000	$465,833
Failure to obtain consultations to establish diagnosis	9.0%	$6,386,250	$354,792
Failure to perform/document a timely or complete history and physical examination	1.5%	$580,540	$193,513
Failure to order appropriate tests to establish diagnosis	10.0%	$3,633,955	$181,698
Failure or delay in obtaining/addressing diagnostic test results	3.5%	$1,249,803	$178,543
Failure to timely order/obtain diagnostic test or consultation at patient's request due to lack of insurance coverage or funds	1.0%	$225,000	$112,500
Failure to assess the need for medical intervention	1.0%	$165,000	$82,500
Wrong/incorrect information provided or recorded	0.5%	$70,000	$70,000
Failure to notify patient/family/healthcare team of patient's condition	0.5%	$15,000	$15,000
Overall	30.0%	$15,120,548	$252,009

CASE STUDY: FAILURE TO DIAGNOSE MELANOMA

Undiagnosed cancer accounted for a significant number of failure to diagnose closed claims, as illustrated in this case study:

The patient was a 36-year-old woman who sought treatment with the dermatology group that employed the nurse practitioner. The patient had a mole-like lesion on her arm, which her gynecologist deemed "suspicious." The patient, whose father had died of melanoma, was concerned because the lesion was getting larger and darker. The gynecologist recommended that the patient have the lesion examined.

The nurse practitioner visually inspected the lesion and performed a cryosurgical removal. The patient returned one month later, because the lesion had returned and was growing. The nurse practitioner performed a second cryosurgical removal. Approximately seven months later, the patient saw a physician who performed a biopsy and subsequently diagnosed the patient as having malignant melanoma with brain metastases. The patient underwent craniotomy for removal of multiple large metastatic brain lesions and died five months after the surgery.

Investigation and review of the case by multiple experts identified the following departures from the standard of care by the nurse practitioner:

- *failure to perform and document a manual physical examination of the lesion at either treatment session*
- *failure to consider the patient's family history and stated history of the increasing size and darkness of the lesion*
- *failure to carry out an informed consent discussion with the patient*
- *failure to obtain a biopsy*
- *improperly performing a second cryosurgical procedure when the initial cryosurgery was unsuccessful*
- *failure to consult with the collaborating physician, a dermatologist or surgeon regarding the patient's lesion and plan of care*

During the investigation of the claim, several other contributing factors were identified – e.g., the nurse practitioner's brief tenure at the practice at the time of the initial patient encounter, and lack of prior experience in the treatment of skin diseases or skin cancer. No training or orientation was received, other than a limited opportunity to observe one of the practice's physicians while she was providing patient care. The nurse practitioner's collaborating physician, a codefendant in the case, never saw the patient. Moreover, the practice lacked clinical protocols or policies relating to treating skin lesions or obtaining informed consent prior to removal of a lesion. The nurse practitioner continued to provide diagnosis, treatment and care under these unacceptable conditions.

Although it was determined that the nurse practitioner's multiple departures from the standard of care and failure to diagnose the patient's cancer did not result in the patient's disease process, this rationale was not deemed likely to support a successful defense. The claim was settled on behalf of the nurse practitioner. The claim resulted in an indemnity payment approaching $500,000 and expense payments in excess of $200,000. (Note that these figures represent only the payments made on behalf of the nurse practitioner, as codefendant payment amounts are not available.)

Risk Control Recommendations

The following general strategies can help prevent errors and reduce exposure in any type of practice setting:

1. **Practice within one's clinical specialty and area of expertise.** If entering a new area of clinical practice, request and obtain appropriate training, orientation, and direct physician or expert collaboration/supervision/mentoring, as needed.
2. **Comply with state regulations regarding physician involvement,** including collaborative or supervisory agreements. Obtain additional physician specialist consultations, as needed.
3. **Request and review the facility's policies, procedures and clinical protocols,** and obtain clarification and assistance/training, as needed. This process is especially critical for new nurse practitioners or those working in a new clinical setting.
4. **Obtain, review and consider pertinent patient and family medical history,** and document all findings.
5. **Perform a patient clinical assessment and physical examination** to evaluate and address the specific clinical issues under consideration.
6. **Engage in an informed consent discussion with the patient or responsible party,** including, at a minimum, an explanation of the patient's condition, the risks and benefits of the proposed procedure, the risks and benefits of alternative procedures or treatments, the right to decline treatment and the risks of no treatment.
7. **Respond to patient questions or concerns** prior to obtaining a witnessed, signed consent for the procedure.
8. **Establish the patient's diagnosis** by obtaining and documenting the results of biopsies and other appropriate diagnostic tests, as well as by initiating consultations and referrals, as indicated.
9. **Notify the practice as well as the professional liability insurance carrier immediately following the unexpected death of a patient** or whenever one's actions may be under scrutiny.

Additional Analysis: Illnesses/Injuries Related to Delay in Diagnosis

As previously noted in Figure 6, the delay in diagnosis subcategory accounted for 13.0 percent of all the closed claims in the analysis. Figures 6c and 6d examine the delay in diagnosis sub-category allegations more closely:

In this subcategory, only two diagnoses accounted for 3 percent or more of all the closed claims in the analysis. They are the same two diagnoses that accounted for more than half of the failure to diagnose closed claims:

- **Delay in diagnosing cancer accounted for 5.5 percent of all the closed claims in the analysis,** with an average paid indemnity of $281,955.
- **Delay in diagnosing infection/abscess/sepsis accounted for 3.0 percent of all the closed claims in the analysis,** with an average paid indemnity of $159,848.

Delay in diagnosing cerebral vascular accident/stroke, aortic dissection and myocardial infarction each had an average paid indemnity higher than the overall average paid indemnity of $221,852, but these categories combined accounted for only 2.0 percent of all the closed claims in the analysis.

6c **Severity of Delay in Diagnosis Claims by Illness/Injury**
(Closed claims with indemnity payment of ≥ $10,000)

Diagnosis	Percent of closed claims	Total paid indemnity	Average paid indemnity
Cerebral vascular accident/stroke	1.0%	$1,325,000	$662,500
Aortic dissection	0.5%	$475,000	$475,000
Cancer	5.5%	$3,101,500	$281,955
Myocardial infarction	0.5%	$250,000	$250,000
Infection/abscess/sepsis	3.0%	$959,087	$159,848
Pregnancy	1.0%	$222,000	$111,000
Dislocation of the hip	0.5%	$55,000	$55,000
Pulmonary embolism	0.5%	$40,000	$40,000
Herniated disk	0.5%	$25,000	$25,000
Overall	**13.0%**	**$6,452,587**	**$248,176**

The delay in diagnosis causes were very similar to the failure to diagnose causes. Only two identified causes for delay in diagnosis involved 3.5 percent or more of all the closed claims in the analysis:

- **Failure to obtain consultation to establish diagnosis accounted for 4.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $436,649.
- **Failure to order appropriate diagnostic tests accounted for 3.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $174,393.

Severity of Delay in Diagnosis Claims by Cause of Delay 6d
(Closed claims with indemnity payment of ≥ $10,000)

Cause of delay in diagnosis	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to obtain consultation to establish diagnosis	4.5%	$3,929,837	$436,649
Failure to timely manage or report complication of pregnancy/labor to physician	0.5%	$200,000	$200,000
Failure to order appropriate diagnostic tests to establish diagnosis	3.5%	$1,220,750	$174,393
Failure or delay in obtaining/addressing diagnostic test results	2.0%	$652,000	$163,000
Failure to perform/document timely or complete history and physical examination	0.5%	$110,000	$110,000
Failure to obtain/refer for immediate emergency treatment	1.5%	$315,000	$105,000
Failure to consider/assess patient's expressed complaints or symptoms	0.5%	$25,000	$25,000
Overall	13.0%	$6,452,587	$248,176

Delay in diagnosing cancer accounted for 5.5 percent of all the closed claims in the analysis, with an average paid indemnity of $281,955.

Additional Analysis: Treatment and Care Management-related

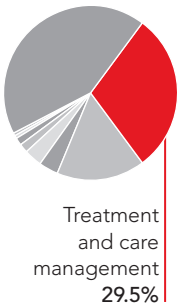
Four treatment and care management allegation categories accounted for 3.0 percent or more of all the closed claims in the analysis. Three additional treatment and care management allegations with the highest average paid indemnity were affected by a small number of costly claims:

- **Failure to timely or properly establish and/or order appropriate treatment accounted for 5.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $204,727. This category was affected by one claim alleging failure to establish and order appropriate treatment for a patient with cardiac symptoms, resulting in death, and another alleging failure to order emergency hospital care for a patient with atypical hypertension, resulting in stroke with permanent disability.
- **Improper technique or negligent performance of treatment or test accounted for 5.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $110,864. This category included
  - a claim of improper suturing of a hand wound, resulting in loss of function and disfigurement
  - a claim of improper irrigation and suture of a knee wound, resulting in necrotizing fasciitis, coma and brain damage
  - several instances of faulty intrauterine device insertions, resulting in uterine perforations
- **Improper or untimely management of aging services residents accounted for 4.0 percent of all the closed claims in the analysis,** and had an average paid indemnity of $85,250. This category included a claim where the resident suffered severe pressure ulcers after the nurse practitioner failed to ensure that ordered wound care was being properly implemented.
- **Improper or untimely management of a medical patient or medical complication accounted for 3.0 percent of all the closed claims in the analysis,** reflecting an average paid indemnity of $328,221. This category included one claim where the nurse practitioner examined a patient complaining of persistent cough, determined there was no airway problem, ordered cough medication and a pulmonary consultation for the following day, and sent the patient home. The patient died that night, but no autopsy was performed.
- **Failure to timely respond to a patient's concerns related to the treatment plan was limited to a single claim,** with the highest average paid indemnity ($550,000) in the category. In this case, the nurse practitioner failed to consider the patient's stated concerns that a prescribed drug resembled another drug to which the patient was highly allergic. The nurse practitioner ordered the drug despite the patient's concerns and the patient developed Stevens Johnson syndrome, with multiple permanent injuries and disability.
- **Improper or untimely management of obstetrical patient/complication accounted for 1.5 percent of all the closed claims in the analysis,** but generated a high average paid indemnity ($495,000), which was affected by
  - a nurse practitioner's failure to diagnose gestational diabetes and a large fetus, with the infant subsequently suffering Erb's palsy
  - a student nurse practitioner's failure to notify the physician of the patient's degree of premature dilation and the need to hospitalize the patient, resulting in fetal intrauterine hypoxia and severe infant neurological impairments
  - implantation of an IUD by a nurse practitioner into a patient who was 18 weeks pregnant, resulting in a premature delivery of a severely impaired infant
- **Failure to timely address/manage complication or a condition change in a surgical patient accounted for 1.5 percent of all the closed claims in the analysis,** with a high average paid indemnity of $435,417. This category was affected by one claim alleging failure to diagnose postoperative sepsis, which resulted in death. Another claim alleged failure to manage post-operative vomiting, resulting in aspiration and anoxic brain damage.

Severity of Allegations Related to Treatment and Care Management

(Closed claims with indemnity payment of ≥ $10,000)

7



Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to timely respond to patient's concerns related to the treatment plan	0.5%	$550,000	$550,000
Improper or untimely management of obstetrical patient/complication	1.5%	$1,485,000	$495,000
Failure to timely address or manage complication or change in surgical patient	1.5%	$1,306,250	$435,417
Failure to timely/properly address medical complication or change in condition	2.0%	$1,590,000	$397,500
Improper or untimely management of medical patient or medical complication	3.0%	$1,969,325	$328,221
Failure to timely or properly establish and/or order appropriate treatment	5.5%	$2,252,000	$204,727
Failure to timely address behavioral health condition/complication	2.0%	$730,833	$182,708
Failure to obtain/refer for immediate emergency treatment	2.5%	$902,500	$180,500
Improper or untimely treatment or management of pressure ulcer or other nonsurgical wound	1.0%	$268,000	$134,000
Improper technique or negligent performance of treatment or test	5.5%	$1,219,500	$110,864
Improper or untimely management of aging services resident	4.0%	$682,000	$85,250
Improper management of patient in need of physical restraints	0.5%	$50,000	$50,000
Overall	29.5%	$13,005,408	$220,431

Treatment and care management-related allegations accounted for 29.5 percent of all the nurse practitioner closed claims in the analysis, with an average paid indemnity of $220,431.

CASE STUDY: TREATMENT AND CARE MANAGEMENT-RELATED CLAIM

Death, the primary injury in 45.5 percent of all the closed claims in the analysis, sometimes occurred as a result of improper treatment and care management. The following case exemplifies such a situation:

The patient was a 55-year-old man who sought treatment at a walk-in clinic with the nurse practitioner, complaining of severe shortness of breath, fatigue and lower extremity swelling. The patient had a history of asthma, hypercholesterolemia, diabetes and hypertension. He was noncompliant with dietary guidelines and medication regimens, and both his blood pressure and blood sugar were significantly elevated.

The nurse practitioner reviewed the chest X-ray and diagnosed the patient as having acute congestive heart failure and unstable diabetes. She changed the patient's heart, hypertension and diabetes medications, added a diuretic and ordered baseline blood tests. After counseling the patient on the importance of following ordered treatment, she told him to return to the clinic in one week.

A week later, the patient returned, stating that while he felt somewhat better, he remained short of breath and had continued swelling in his legs. His chest X-ray showed some improvement, but his blood sugar and blood pressure stayed elevated. Laboratory tests had been ordered but not performed. During the second visit, the nurse practitioner failed to document that the previously ordered tests had not occurred, and she did not order new tests. She also did not collaborate or consult with a physician regarding any aspect of the patient's diagnosis, treatment or care.

Believing that she had corrected the patient's acute congestive heart failure, the nurse practitioner focused on his pulmonary and diabetic status during his second visit. Breathing tests revealed a moderate obstruction, which she diagnosed as asthma. The nurse practitioner discontinued the patient's diuretic because it was contraindicated in the presence of asthma, ordered asthma medication instead and discharged the patient. Two days after the patient's second visit, he collapsed at home. CPR, administration of epinephrine and intubation by 911 staff proved unsuccessful, and the patient was pronounced dead on arrival at the hospital. As EMS monitoring revealed ventricular arrhythmia, the cause of death was stated as ischemic heart disease. There was no autopsy.

The lawsuit alleged that the nurse practitioner failed to obtain an electrocardiogram, echocardiogram and cardiology consultation. In view of expert review of the chest X-ray and the documented presence of satisfactory oxygen saturation levels at the time of the patient's first visit, none of the experts fully supported the nurse practitioner's care or her diagnosis of acute congestive heart failure. An electrocardiogram, echocardiogram and cardiology consult were deemed warranted. Two experts also stated that the patient should have been sent directly to the emergency department for laboratory tests, cardiology consultation and angiography.

It was apparent that the nurse practitioner failed to adequately evaluate the cardiac and hypertension components of the patient's acute symptoms. She also failed to either refer him to an emergency department or timely perform appropriate diagnostic tests, including laboratory studies, electrocardiogram, echocardiogram and cardiology consultation. The decision was made to settle the claim. An indemnity payment in excess of $200,000 and expense payments of over $100,000 were made on behalf of the nurse practitioner.

Risk Control Recommendations

Providing care in a walk-in or other short-term acute care setting involves specific risks that can be mitigated by the following strategies:

1. **Understand and maintain the scope and standard of care that applies to the relevant setting,** including determining whether the patient's clinical symptoms can be appropriately and safely managed.
2. **Refer unstable and acutely ill patients to emergency services,** if the clinical and diagnostic services they require are not readily available in the current clinical setting.
3. **Discuss the patient's condition, medications and care needs with the collaborating or supervising physician,** per state scope of practice laws and regulations.
4. **Consult with a pharmacist (as needed) regarding multiple long-term medications prior to making significant changes,** if the patient will be monitored on an ongoing basis by a professional other than the nurse practitioner.
5. **Perform appropriate diagnostic tests to determine the cause or causes of a patient's multi-symptom presentation,** including blood tests, X-rays, electrocardiograms and consultations, as needed.
6. **Obtain, review and document the results of ordered diagnostic tests,** creating a baseline to manage follow-up.
7. **Refer the patient to his or her primary care practitioner for ongoing care and treatment** or, if the patient has no primary care practitioner, make a suitable referral.
8. **Document all patient-related discussions,** as well as consultations, clinical information and actions taken.

Additional Analysis: Medication Prescribing-related

Prescriptive authority in some form is a significant aspect of every nurse practitioner's scope of practice, as well as a significant source of risk. Allegations involving the prescribing of medications had a higher average paid indemnity than the overall average paid indemnity of $221,852. The following medication-related allegations were the most common:

- **Failure to recognize known contraindications/adverse reactions among ordered medications accounted for 4.5 percent of all the closed claims in the analysis,** with an average paid indemnity of $178,241. This result was affected by a claim alleging that the nurse practitioner had prescribed Bactrim with Coumadin, which is contraindicated, and also had failed to seek physician consultation when attempting to manage the patient's subsequent bleeding.
- **Improper prescribing/management of anticoagulants accounted for 3.0 percent of all the closed claims in the analysis,** and had an average paid indemnity of $250,625. The data were affected by one claim involving the failure to manage Coumadin, resulting in retroperitoneal bleeding with permanent parasthesia. Another claim alleged that the nurse practitioner had failed to monitor the patient's international normalized ratio (INR) and regulate Coumadin accordingly, resulting in a subdural hematoma.
- **Prescribing the wrong medication accounted for 2.5 percent of all the closed claims in the analysis,** and had the highest average paid indemnity in this category at $361,033. Such claims represent a breach in the standard of care and are difficult to defend successfully, as the following examples illustrate:
  - An order for the wrong medication at 10 times the normal dose of that medication was not noticed by the nurse practitioner or the dispensing pharmacist, resulting in a severe, prolonged skin reaction with associated deformity and disability.
  - An order for the wrong antibiotic resulted in exacerbation of infection and subsequent leg amputation.
  - An order for the wrong weight-loss medication resulted in a stroke and permanent seizure disorder.
- **Prescribing the wrong dose of the right medication accounted for 2.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $286,533. These data were affected by a costly claim in which a nurse practitioner prescribed a wrong dose of Lamictal, resulting in Stevens Johnson syndrome with permanent blindness in both eyes and subsequent surgical removal of one eye.
- **Improper prescribing/management of controlled drugs accounted for 2.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $224,640. This category was impacted by two claims alleging prescription of large amounts of controlled drugs. The first case resulted in patient addiction and revocation of the nurse practitioner's license, while the second led to a fatal motor vehicle accident involving an impaired driver.

Severity of Allegations Related to Medication Prescribing

(Closed claims with indemnity payment of ≥ $10,000)

8

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Prescribing error, wrong medication	2.5%	$1,805,164	$361,033
Prescribing error, wrong dose	2.5%	$1,432,667	$286,533
Improper prescribing/management of an anticoagulant	3.0%	$1,503,750	$250,625
Improper prescribing/management of controlled drugs	2.5%	$1,123,200	$224,640
Failure to recognize contraindication and/or known adverse interaction among ordered medications	4.5%	$1,604,166	$178,241
Prescribing action outside the scope of practice	0.5%	$150,000	$150,000
Failure to resolve medication question with pharmacist and/or practitioner prior to administration	0.5%	$31,250	$31,250
Prescribing error, wrong patient	0.5%	$10,000	$10,000
Overall	**16.5%**	**$7,660,197**	**$232,127**

Medication prescribing-related allegations accounted for 16.5 percent of all the nurse practitioner closed claims in the analysis, and had an average paid indemnity of $232,127.

Injuries

By knowing those injuries that most often lead to claims, as well as those with the greatest severity, nurse practitioners can better focus their risk control, patient safety and incident reporting efforts. Prompt reporting of injuries to the employer and insurance company expedites investigation and assignment of counsel, when appropriate, and facilitates the claims management process.

Death (excluding the single fetal death) accounted for 45.0 percent of all the closed claims in the analysis, constituting by far the largest category, and had an average paid indemnity of $226,073. In the 2009 CNA nurse practitioner claims analysis, death also accounted for the highest percentage of injuries, with 42.6 percent of closed claims and an average paid indemnity of $203,815. In the current study, the percentage of closed claims resulting in death rose 2.4 percent, and the average paid indemnity increased by 10.8 percent, or $22,258.

Nine types of injury accounted for 3.0 percent or more of all the closed claims in the analysis. Of those, four also reflected an average paid indemnity higher than the overall average paid indemnity for all deaths (excluding the single fetal death) of $226,073:

- **Cerebral vascular accident/stroke injuries accounted for 5.5 percent of all the closed claims in the analysis,** with an average paid indemnity of $436,413. This category included a claim where the patient had a stroke and died after the nurse practitioner failed to investigate the cause of the patient's hypertension.
- **Infection/abscess/sepsis accounted for 3.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $280,190.
- **Brain injury (non-birth-related) accounted for 3.0 percent of all the closed claims in the analysis** and had an average paid indemnity of $337,778. This category included one high-indemnity claim alleging failure to diagnose Guillain-Barre syndrome and permanent brain damage.
- **Neurological deficit injuries accounted for 3.0 percent of all the closed claims in the analysis,** representing an average paid indemnity of $245,333. This category was affected by one claim where the patient's transfer for treatment of a spinal cord abscess was delayed, resulting in permanent paralysis. The claim was resolved for $1 million.

Other significant injuries included the following:

- **Sexual assault by a nurse practitioner accounted for 3.0 percent of all the closed claims in the analysis,** reflecting one nurse practitioner's inappropriate conduct with multiple patients.
- **Eye injury or vision loss injuries accounted for 2.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $435,000. This category was affected by a claim involving eye injury and blindness, which resolved for $1 million.

Death-related claims are analyzed in more detail in Figure 10.

Severity by Injury

(Closed claims with indemnity payment of ≥ $10,000)

9

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Wrongful life	0.5%	$975,000	$975,000
Fetal/infant birth-related brain damage	1.0%	$1,475,000	$737,500
Cerebral vascular accident/stroke	5.5%	$4,800,540	$436,413
Eye injury/vision loss	2.5%	$2,175,000	$435,000
Brain injury (other than birth-related brain injury)	3.0%	$2,026,667	$337,778
Increase or exacerbation of illness	1.5%	$970,337	$323,446
Cardiac condition other than heart attack or myocardial infarction	0.5%	$300,000	$300,000
Infection/abscess/sepsis	3.5%	$1,961,333	$280,190
Addiction	1.0%	$540,000	$270,000
Ear injury/hearing loss	2.0%	$1,073,000	$268,250
Amputation	1.0%	$512,500	$256,250
Neurological deficit/damage	3.0%	$1,472,000	$245,333
Death (other than fetal death)	45.0%	$20,346,533	$226,073
Cancer	4.5%	$1,821,500	$202,389
Fetal death	0.5%	$200,000	$200,000
Fracture	2.0%	$660,000	$165,000
Pulmonary/respiratory failure	0.5%	$162,500	$162,500
Self-induced injury	0.5%	$150,000	$150,000
Emotional/psychological harm/distress	0.5%	$150,000	$150,000
Burn	3.0%	$892,500	$148,750
Bleeding/hemorrhage	1.0%	$283,750	$141,875
Loss of organ or organ function	3.0%	$652,000	$108,667
Glycemic event	1.0%	$125,164	$62,582
Paralysis	0.5%	$60,000	$60,000
Dislocation	0.5%	$55,000	$55,000
Embolism	0.5%	$50,000	$50,000
Scar(s)/scarring	1.5%	$95,000	$31,667
Retained foreign body	0.5%	$27,500	$27,500
Medication-related injury	1.5%	$82,500	$27,500
Allergic reaction/anaphylaxis	1.0%	$51,666	$25,833
Disfigurement	1.0%	$47,500	$23,750
Laceration/tear/abrasion	1.5%	$55,000	$18,333
Pressure ulcer	1.0%	$30,000	$15,000
Wound (other than vascular or pressure ulcer)	0.5%	$15,000	$15,000
Abuse/sexual assault by nurse practitioner	3.0%	$66,000	$11,000
Erb's palsy/brachial plexus palsy	0.5%	$10,000	$10,000
Overall	**100.0%**	**$44,370,490**	**$221,852**

Causes of Death

Six causes of death accounted for 3.0 percent or more of all the closed claims in the analysis. Three of these more frequent causes of death also resulted in an average paid indemnity higher than the overall average paid indemnity of $221,852: heart attack/myocardial infarction, bleeding/hemorrhage (mainly subdural hemorrhage) and cancer.

- **Death caused by pulmonary embolism accounted for 2.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $408,500.
- **A highly unusual homicide occurred.** The claim involved a minor patient, diagnosed with attention deficit hyperactivity disorder and post-traumatic stress disorder, who was being evaluated by a psychiatric nurse practitioner to manage his medication therapy. The nurse practitioner saw the patient on the day of the incident and believed that he was responding well to the medications she had prescribed. The patient later murdered an infant who was living in the patient's household. Allegations against the nurse practitioner included failure to properly manage the patient's medications and failure to involuntarily commit the patient to an inpatient behavioral health facility. The nurse practitioner was not directly involved in the homicide, and no criminal charges were instituted against her.
- **Infection/abscess/sepsis deaths accounted for 10.0 percent of all the closed claims in the analysis,** and had an average paid indemnity of $153,599.
- **Cardiopulmonary arrest deaths comprised 4.5 percent of all the closed claims in the analysis,** and had an average paid indemnity of $163,472.
- **Medication prescribing errors resulting in death accounted for 3.0 percent of all the closed claims in the analysis,** and had an average paid indemnity of $188,033.

Three causes of death accounted for 3.0 percent or more of all the closed claims in the analysis, while resulting in an average paid indemnity higher than the overall average paid indemnity of $221,852: heart attack/myocardial infarction, bleeding/hemorrhage (mainly subdural hemorrhage) and cancer.

Severity by Cause of Death (Excluding Fetal Death)

(Closed claims with indemnity payment of ≥ $10,000)

10

Selected cause of death	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Pulmonary embolism	2.5%	$2,042,500	$408,500
Homicide (murder of a third party, committed by a patient while under the care of the nurse practitioner)	0.5%	$400,000	$400,000
Heart attack/myocardial infarction	4.0%	$2,713,220	$339,153
Bleeding/hemorrhage	4.0%	$2,610,750	$326,344
Cancer	7.0%	$4,305,792	$307,557
Seizure	0.5%	$250,000	$250,000
Respiratory arrest	1.0%	$500,000	$250,000
Allergic reaction/anaphylaxis	0.5%	$225,000	$225,000
Medication-related	3.0%	$1,128,200	$188,033
Cardiopulmonary arrest	4.5%	$1,471,250	$163,472
Infection/abscess/sepsis	10.0%	$3,071,988	$153,599
Pneumonia/respiratory infection	2.5%	$720,000	$144,000
Meningitis	0.5%	$105,000	$105,000
Brain injury other than birth-related brain injury	0.5%	$105,000	$105,000
Cardiac condition (excluding heart attack or myocardial infarction)	1.0%	$200,000	$100,000
Suicide	2.0%	$350,833	$87,708
Congestive heart failure	0.5%	$75,000	$75,000
Dehydration/malnutrition	0.5%	$72,000	$72,000
Overall	**45.0%**	**$20,346,533**	**$226,073**

Disability Outcome

- **Death (including the single fetal death) accounted for 45.5 percent of all the closed claims in the analysis,** with an average paid indemnity slightly higher than the overall average paid indemnity of $221,852.
- **Permanent total disability accounted for 13.0 percent of all the closed claims in the analysis,** and had the highest average paid indemnity of any disability outcome, almost twice that of death. As permanently disabled individuals require significant medical and social support for the remainder of their lives, this result is expected.
- **Permanent partial disability accounted for 22.5 percent of all the closed claims in the analysis,** reflecting an average paid indemnity similar to the average paid indemnity for death-related closed claims.

11 **Severity by Disability Outcome (Including Fetal Death)**
(Closed claims with indemnity payment of ≥ $10,000)

Disability	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Permanent total disability	13.0%	$11,407,540	$438,752
Permanent partial disability	22.5%	$10,366,670	$230,370
Death (includes one fetal death)	45.5%	$20,546,533	$225,786
Temporary total disability	7.5%	$1,303,580	$86,905
Temporary partial disability	11.5%	$746,167	$32,442
Overall	**100.0%**	**$44,370,490**	**$221,852**

CASE STUDY: SUCCESSFUL DEFENSE OF A NURSE PRACTITIONER

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

The patient was a 72-year-old woman who had been receiving hospital care for acute back pain resulting from a fall. Her past history included chronic pain management and end-stage renal disease, for which she received hemodialysis. She was to be transferred to the codefendant aging services facility for rehabilitation and physical therapy prior to returning home. The nurse practitioner was on call at the time of the patient's transfer.

The aging services facility's admitting nurse contacted the nurse practitioner and read the hospital's transfer orders to her over the telephone. The nurse practitioner questioned the presence of two morphine orders for different dosages, with both dosages to be administered twice daily. She instructed the aging services facility's admitting nurse to confirm with the transferring hospital's pharmacist that this was the correct morphine dosage, and to admit the patient only after the pharmacist checked and approved the morphine orders. The nurse practitioner had no further communication with the aging services facility and no other involvement in the patient's care.

As the on-call provider, the nurse practitioner was not considered responsible for visiting this clinically stable resident upon her readmission to the aging services facility. The resident's primary care practitioner was deemed responsible for the resident's ongoing care within the time frames mandated by the aging services facility.

The aging services admitting nurse telephoned the hospital pharmacist as directed, and the transferring hospital's pharmacist approved both morphine orders, noting they were the same dosage that the resident had received in the hospital. Having clarified the morphine issue, the admitting nurse then admitted the patient as a resident of the aging services facility.

During the first evening and full day of her stay, the patient was alert and oriented, according to documentation. On the second day, she was discovered lifeless by nursing staff and could not be revived, despite immediate chest compressions and other resuscitation measures. The autopsy results listed the cause of death as morphine intoxication. Surprisingly, the patient also had an elevated blood alcohol level, equal to drinking three to four alcoholic beverages. Because the source of the alcohol could not be identified, the medical examiner was unable to rule out accident, suicide or homicide, and classified the manner of death as undetermined.

Defense experts found that the nurse practitioner's actions at the time of admission were within the standard of care. The experts stated that the patient's final morphine blood levels, even considering her renal disease, could not have resulted from the amount of morphine ordered, administered and recorded in the patient's health information record. The elevated morphine and alcohol levels led the medical examiner and subsequent experts to the opinion that the patient may have ingested morphine and alcohol received from an outside source. This question was never resolved.

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

After more than a week of trial testimony, but prior to receiving the verdict, the codefendants settled the case with no liability attributed to the nurse practitioner. No indemnity payment was made on behalf of the nurse practitioner as a result of this successful legal defense, although expenses were in excess of $225,000.

Risk Control Recommendations

Providing coverage or acting in an on-call role for another practitioner encompasses certain risks, as the nurse practitioner is often unfamiliar with the patient being treated. The following strategies can help minimize exposure in such situations:

1. **Obtain a thorough and accurate history** prior to providing patient treatment orders.
2. **Consult with the patient's primary care provider regarding patient care treatment orders,** if appropriate, and ensure that any concerns are resolved before accepting responsibility for the patient's care.
3. **If the patient is in need of immediate medical care, be prepared to take the following measures:**
   - Communicate urgent or critical patient care concerns to the primary practitioner in a timely manner.
   - Consult with the collaborating or supervising physician in accordance with state statutes and/or regulations.
   - Discuss medication concerns with the involved or consulting pharmacist.
4. **Examine the patient if clinically appropriate** and if there is any question about the patient's condition that may require direct examination, evaluation or intervention.
5. **Document all patient-related discussions, consultations, clinical information and actions taken,** including any treatment orders provided, and ensure that the documentation is provided to the primary practitioner in a timely manner.

RISK CONTROL RECOMMENDATIONS

The following risk control recommendations – in addition to the strategies included in the preceding section – can serve as a starting point for nurse practitioners seeking to assess and enhance their patient safety and risk control practices:

Scope of Practice

- **Annually review state nurse practice acts and other pertinent state and federal regulations defining the scope of practice for nurse practitioners,** and revise physician collaborative or supervisory agreements and other documents accordingly. Ensure that collaborative or supervisory agreements provide appropriate support for the scope of services being provided.
- **Seek alternative physician assistance or consultation if the collaborating/supervising or employing physician is not providing adequate nurse practitioner support.** Determine whether the collaborative/supervising/employment agreement requires revision or whether alternative agreements are required.

Professional Liability Coverage

- **Ensure that collaborating and supervising professionals, practice partners, and employing or contracting facilities maintain appropriate professional liability insurance limits,** as required by the practice setting, state law and/or regulations. In addition, if insurance is provided through the employer, review the policy and employment contract/agreement to determine if employment-based coverage is adequate, or whether it is advisable to obtain individual coverage. Finally, determine the steps needed to ensure continued coverage if employment status changes or the employer changes insurers.
- **Ensure that one's individual professional liability coverage limits are aligned with the other members of the practice,** in order to protect one's private assets.

Health Information Records

Properly maintain patient health information records, in accordance with the following guidelines:

- Ensure that patient health information records comply with established standards of documentation.
- Retain patient health information records in accordance with relevant state and federal law, and consult state-specific recommendations promulgated by nurse practitioner professional associations.
- Perform periodic audits of patient health information records to identify departures from documentation standards and determine opportunities for improvement.
- Sequester the patient health information record if there is an incident of concern. When copies of patient health information are released for legal reasons, the original record should be sequestered or maintained with limited access to avoid actual or alleged tampering or inappropriate late entries.
- Designate an individual within the practice to manage legal demands regarding records, such as a request for patient health information, a subpoena, or a summons and complaint.

Documentation

A complete health information record is the best legal defense. The following information and interactions should be carefully documented:

- discussions with the patient and/or responsible party regarding diagnostic test results (both normal and abnormal), as well as recommendations for continued treatment and patient response to results
- informed consent or informed refusal of recommended treatment, as well as preceding discussions
- clinical decision-making process and rationale for any deviation in practice from established clinical protocols, guidelines or standards
- patient telephone encounters, including after-hours calls, with the name of the person contacted, advice provided and actions taken included in the written summary
- dated and signed receipt of test results, procedures, referrals and consultations, including a description of subsequent actions taken
- referrals for consultation or testing and actions taken to facilitate the process and determine patient compliance
- reviews and revisions of patient problem and medication lists during every visit and with every change in diagnosis
- prescription refills authorized via telephone, including the name of the pharmacy and pharmacist, and read-back of the prescription
- missed appointments, including all efforts to follow up with the patient
- educational materials or references provided to the patient
- use of an interpreter and related contact information, recognizing that the use of family members, especially children, is discouraged
- counseling of noncompliant patients and/or responsible parties regarding the risks resulting from their failure to adhere to medication and treatment regimens

Additional documentation is required if it becomes necessary to terminate the practitioner-patient relationship. In such cases, a copy of the termination letter should be retained in the practice's files and the nurse practitioner should additionally document the following actions and responses:

- Inform the patient in writing that his or her persistent noncompliance with treatment has created an unacceptable level of risk, and that he or she will be terminated from the practice.
- Write down the patient's response to the termination decision.
- Suggest at least three other practitioners, and offer the patient assistance in transitioning to a new practitioner.
- Record the patient's acceptance or refusal of assistance.
- Instruct the patient on how to obtain or transfer health information records.
- Note whether the records were provided or forwarded, and if so, when and to whom.
- Send all written communications via certified, registered mail and maintain the mailing receipts with copies of all communications in the patient's health information record.

Diagnosis and Treatment

Diligently screen, test for, monitor and/or treat diseases known to have high morbidity and mortality, such as cancer, infection, heart disease, hypertension and diabetes. The following strategies can enhance quality of care and reduce risk:

- Utilize evidence-based clinical practice guidelines or protocols when establishing a diagnosis and providing treatment, and document the clinical justification for deviations from protocols.
- Refer unstable patients and patients with undiagnosed acute symptoms to emergency medical care.
- Obtain results from indicated diagnostic tests, procedures and consultations before documenting the diagnosis and implementing the treatment plan.
- Document the clinical decision-making process leading to the diagnosis and treatment plan.
- Perform indicated culture and sensitivity testing for suspected infection prior to initiating antibiotic therapy. When results are positive, prescribe the most appropriate antibiotics.
- Seek diagnostic procedure and test results proactively, and document all findings and subsequent treatment actions.
- Notify patients of abnormal findings in a timely manner and schedule follow-up appointments without delay.
- Consult with the collaborating or supervising physician at least as frequently as required and for all cases of difficult or delayed diagnosis.
- Request regular chart review and ongoing feedback regarding the appropriateness of treatment and care.
- If no collaborative or supervisory agreement is required, seek opportunities for peer review within the practice or organization to support continuing competence and enhance expertise.
- Seek timely specialist consultations and advice regarding patients with recurring complaints and/or signs and symptoms that do not respond to the prescribed treatment.
- Notify patients when indicated health screening activities are due and follow up if patients do not respond, documenting all communications.
- Record all patient noncompliance with ordered testing and treatment, as well as all counseling given and other efforts made to encourage compliance.
- If noncompliance is related to a lack of health insurance or financial resources, refer the patient to appropriate social agencies and/or free or low-cost clinics or related programs, and follow up to ensure compliance.
- Maintain appropriate infection control procedures during the diagnosis and treatment of patients, and educate patients and families regarding appropriate infection control measures.

Medication Management

Prescribe the right drug, for the right patient, in the right dose, by the right route, at the right times, for the right duration and for the right indications. The following strategies can help reduce the likelihood of drug-related error:

- Include the purpose of the medication on the prescription.
- Never abbreviate medication indications, name, dose, frequency or route.
- Limit telephone refills to one, and require an in-office evaluation before providing additional refills.
- Maintain awareness of and identify look-alike and sound-alike drugs used in the practice. Remove drugs with similar sounding names from the practice formulary, if possible, and if this is not possible, place highly visible warnings on storage spaces and drug packaging.
- Avoid storing similar-looking drugs near one another to prevent possible confusion.
- Maintain current drug reference materials and other hard-copy or electronic resources that provide information on medications, including potential interactions. Regardless of the medium selected – books, journals, electronic prescribing tools, online resources, or personal digital devices and applications – ensure that the most current version of the resource is used and that electronic updates are made automatically or regularly downloaded.
- If an electronic order entry system is in use, double-check the selected drug and dosage, as error is always just one click away.
- Never override a warning from a computerized drug management system without first ensuring that the order entered is entirely correct and free of potentially harmful interactions.
- Consult with physicians, pharmacists or evidence-based resources, as needed, in order to mitigate the risk of prescribing the wrong medication or dosage, clarify the risks of "off-label" use, and avoid drug interactions or contraindications.
- Order regular patient monitoring and blood tests, and proactively obtain results when prescribing and managing higher-risk drugs. These include anticoagulants and certain antibiotics, as well as psychoactive or known toxicity-prone medications.
- Closely monitor patient use of controlled drugs to avoid overdependence or potential addiction, and refer chronic pain patients to a pain management center or specialist.
- Discuss with patients whether they are taking their medications exactly as prescribed and in the full, recommended dosage.
- If patients are reducing their dosages for financial reasons, assist them in enrolling in reduced-cost or manufacturer drug-provision programs.
- Utilize drug samples with caution and document the lot and serial number of all samples provided to patients.
- Comply with established standards for educating and informing patients and families about prescriptions, including the brand and generic names of the drug, the purpose of the medication, realistic expectations regarding drug efficacy, potential side effects, and indications for contacting the nurse practitioner or seeking emergency assistance.
- Participate in ongoing education and instruction regarding new medications, focusing on clinical indications, potential patient risk and recommended dosages.

Communication

Develop, maintain and practice professional written and spoken communication skills, as suggested by the following strategies:

- Always consider what information to share, when to share it, how to share it (e.g., written versus spoken or in-person versus by telephone) and with whom it will be shared, in order to both communicate effectively and protect patient privacy.
- Ensure that spoken and written communications with collaborating/supervising physicians, consultants, other caregivers and patients are timely, accurate, and relevant to the diagnostic and treatment needs of the patient.
- Determine the patient's primary language and follow practice or organizational procedures regarding translation/interpreter services, in order to ensure that the patient understands his or her diagnosis, treatment, plan of care and compliance responsibilities. Document the translator's name and/or number in the patient's health information record.
- Utilize sound handoff communication methods when covering for another practitioner or transferring the patient's care to another practitioner for any period, as failure to adequately communicate during patient handoffs is a common contributing factor to delays or errors. At every handoff, relay information to the accepting practitioner about acute and/or chronic conditions, allergies, special needs, and pending results of tests or consultations.
- Be aware of the practice's error disclosure and apology policies and protocols, and be prepared to admit error when appropriate. Contact the employer's risk manager and/or legal counsel for assistance as needed.

Competencies

Maintain clinical competencies aligned with the relevant patient population and certified clinical specialty, taking into consideration the following professional responsibilities:

- Remember that nurse practitioners have a duty – and, in most states, a licensing renewal requirement – to proactively obtain and update the clinical and professional information, education and training needed to maintain and enhance their expertise.
- Remain current regarding clinical practice, medications, biologics and equipment utilized for the diagnosis and treatment of acute and chronic illnesses and conditions related to one's specialty.
- Obtain regular continuing education to retain and enhance clinical competencies. Contact the state nurses association, board of nursing, board of medicine or pharmacy, and nurse practitioner professional associations for information about reputable educational and training offerings.

RECOMMENDATIONS FOR COLLABORATING/SUPERVISING PHYSICIANS AND EMPLOYERS OF NURSE PRACTITIONERS

- Provide appropriate clinical support for nurse practitioners, in compliance with collaborative, supervisory or employment agreements.
- Confirm that everyone understands each party's role under the agreement, and communicate openly and swiftly about any question or concerns that may arise.
- Understand the current state scope of practice for nurse practitioners and support them in practicing within their scope of practice.
- Review all agreements at least annually and revise them as needed with the assistance of legal counsel, if appropriate.
- Implement standardized processes for credentialing nurse practitioners.
- Establish a process for regular review and delineation of clinical privileges.
- Ensure nurse practitioner competency through ongoing peer review and professional performance evaluation, focusing on the nurse practitioner's clinical performance, documentation practices, and overall assessment and management of patients.

CONCLUSION

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

RISK CONTROL SELF-ASSESSMENT CHECKLIST FOR NURSE PRACTITIONERS

This checklist is designed to help nurse practitioners evaluate risk exposures associated with their current practice. For additional nurse practitioner-oriented risk control tools and information, visit **www.cna.com** and **www.nso.com**.

Self-assessment topic	Yes	No	Actions needed to reduce risks
Clinical specialty			
I work in an area that is consistent with my licensure, specialty certification, training and experience.			
I know that my competencies – including experience, training, education and skills – are consistent with the needs of my patients.			
I understand the specific risks of caring for patients within my clinical specialty.			
I decline an assignment if my competencies are not consistent with patient needs.			
I ensure that my competencies and experience are appropriate before accepting an assignment to cover for another practitioner.			
I am provided with orientation, or request and obtain it, whenever I work in a new or different clinical setting.			
I obtain continuing education and training, as needed, to maintain my competencies in my clinical specialty.			
Scope of practice and scope of services			
I read my state nurse practice act at least once per year to ensure that I understand and am in compliance with the legal scope of practice in my state.			
I know and comply with the requirements of my state regarding physician collaborative or supervisory agreements, and I review and renew my agreements at least annually.			
I comply with the requirements of my state regarding other regulatory bodies, such as the board of medicine (if applicable).			
I collaborate with or obtain supervision from a physician as defined by my state laws and/or regulations and as required by the needs of my patients.			
I seek alternative physician consultation if I am not provided with appropriate support from my collaborating/supervising/employing physician(s), and modify my agreements accordingly.			
I decline to perform requested actions/services if they are outside of my legal scope of practice.			
Assessment			
I elicit the patient's concerns and reasons for the visit and address those concerns.			
I obtain and document a current list of the patient's prescribed and over-the-counter medications, including nutritional supplements and holistic/alternative remedies.			
I document any patient allergies and adverse reactions to medications.			
I gather, document and utilize an appropriate patient clinical history, as well as relevant social and family history.			
I ascertain the patient's level of compliance with currently ordered treatment and care instructions, medication regimens and lifestyle suggestions.			
I perform a physical examination to determine the patient's health status and evaluate the patient's current symptoms/complaints.			
I determine if the patient's current health status requires immediate medical treatment, and refer the patient to an emergency department if needed.			
I adhere to facility documentation requirements regarding assessment findings.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Diagnosis			
I utilize an objective, evidence-based approach, applying organization-approved clinical guidelines and standards of care to timely and accurately determine the patient's differential diagnosis.			
I consider the findings of the patient's assessment, history and physical examination, as well as the patient's expressed concerns, in establishing the diagnosis, and document my findings.			
I order and timely obtain results of appropriate diagnostic testing – including laboratory analysis, radiography, EKG, etc. – before determining the diagnosis, and document ordered tests and results.			
I consult with my collaborating/supervising physician, as required, to establish the diagnosis and treatment plan, and document all such encounters.			
I request, facilitate and obtain other appropriate consultations, as necessary, to achieve a timely and correct diagnosis.			
When establishing the diagnosis, I comply with the standard of care, as well as my facility's policies, procedures, and clinical and documentation protocols.			
If a patient is unstable, acutely ill and in need of immediate diagnostic testing and/or consultation, I refer him or her to hospital emergency care and facilitate this process, if necessary.			
If a diagnostic test or procedure involves risk, I conduct and document an informed consent discussion with the patient and obtain the patient's witnessed consent.			
I proactively gather, document and respond to the results of diagnostic tests/procedures and provide necessary orders.			
I obtain, document and respond to the results of diagnostic consultations with physicians and other healthcare providers.			
I establish the diagnosis, determine a treatment plan, document clinical decision-making, and order and implement the treatment and care plan.			
I discuss clinical findings, diagnostic test/procedure results, consultant findings, diagnosis, the proposed treatment plan and reasonable expectations for a desired outcome with patients, in order to ensure their understanding of their care or treatment responsibilities. I document this process, noting the patient's response.			
I counsel the patient regarding the risks of not complying with diagnostic testing, treatment and consultation recommendations, and document discussions. If recurrent noncompliance is potentially affecting the safety of the patient and regular counseling has been ineffective, I consider discharging the patient from the practice.			
If the patient is uninsured or unable to afford necessary diagnostic and consultative procedures, I refer him or her for financial assistance, payment counseling, and/or free or low-cost alternatives, and document these actions.			
If I work in a state with autonomous nurse practitioner authority, I regularly seek peer review to assess my diagnostic skills and expertise and to identify opportunities for improvement.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Treatment and care			
I educate the patient regarding the diagnosis, treatment plan, and need for compliance with treatment recommendations, medication regimens and screening procedures. I document the discussion.			
I prescribe clinically indicated treatment and care and provide appropriate health screening for the patient.			
I discuss the patient's treatment plan and ongoing response to treatment with my collaborating/supervising physician as required and appropriate, and document the interaction.			
I discuss with the patient and document any deviation from established protocols, guidelines or standards, and explain the clinical rationale for the alternative plan.			
I advise the patient to obtain emergency medical treatment in the event of unexpected adverse symptoms or effects of treatment, and document the discussion.			
I conduct and document an informed consent discussion with the patient prior to implementing any aspect of the treatment plan that involves potential risk, ask the patient to repeat the main points of the discussion, and obtain the patient's stated and written consent.			
I perform regular monitoring tests and consultation, as needed, to appropriately manage the patient's healthcare, and document all findings.			
I inform the patient of test and consultation results, both normal and abnormal, and document the discussion.			
I schedule follow-up visits to monitor the patient's response to treatment, and I adjust the patient's treatment plan as needed and appropriate.			
I remind patients of regular appointments and screening tests, and document these reminders.			
I contact patients after missed appointments for rescheduling, and document these contacts.			
I counsel patients regarding their treatment plan responsibilities and the need for compliance with ongoing testing, medication regimens and lifestyle choices that potentially affect outcomes, ensure their ability to repeat the information correctly, and document these interactions.			
I follow up to ensure that patients have obtained ordered tests and scheduled/completed referrals or consultations, facilitate the process, if necessary, and document these actions.			
I explain to patients that if they are noncompliant to the point of endangering themselves or creating a liability risk, I may be forced to withdraw my care. I document this communication and the patient's response.			
I terminate from treatment persistently noncompliant patients, assist them in transitioning to another healthcare provider, retain registered mail receipts, and document all patient support and other actions taken.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Medication prescribing			
I prescribe medications in compliance with the state nurse practice act, state prescriptive authority for nurse practitioners, my collaborative/supervisory agreement, and employer policies and protocols.			
I consult with my collaborating or supervising physician regarding medication orders.			
I provide the full name of the medication, as well as its proper dosage, frequency and route. I also include the purpose of the medication ordered to prevent prescribing and dispensing errors.			
I write legible, complete prescriptions, using no abbreviations.			
I ensure that the patient's health information record clearly reflects any drug allergies or adverse reactions.			
I check all computerized medication orders to protect against inadvertent entry errors.			
I address any computerized prescribing warning screens and never override warning screens without considering identified contraindications or interactions.			
I secure prescription pads to prevent theft or loss.			
I discuss any medication questions or concerns with a pharmacist, and document the interaction.			
I minimize use of look-alike and sound-alike medications, and always verify the correctness of orders for such medications.			
I use caution when prescribing anticoagulants, antibiotics, psychoactive medications and other known toxicity-prone drugs, order and follow up with all indicated monitoring tests, and document results.			
I monitor controlled drug usage by patients and refer chronic pain patients for pain management therapies.			
I confer with physicians, pharmacists and/or evidence-based resources, as needed, to identify and mitigate any additional risks related to off-label drug use, and document these actions.			
I talk to my patients about their medications, informing them of brand and generic names, dose or strength, route, frequency and times, realistic expectations of results, potential side effects, signs of adverse reaction and symptoms warranting immediate medical attention. I document these interactions and the patient's ability to correctly repeat the shared information.			
I educate my patients regarding their responsibilities for adhering to medication and treatment regimens, including beneficial dietary and lifestyle modifications, as well as the risks of noncompliance.			
I ensure that patients are taking the full, prescribed dosage. If financial issues interfere with compliance, I refer the patient to reduced-cost or manufacturer-provided drug assistance programs, and document these actions.			
I conduct and document an informed consent discussion prior to prescribing investigational or experimental medications or any medication with significant risks, and obtain the patient's consent prior to initiation of the medication or medication protocol.			
I assist patients in obtaining financial assistance for their medications, when appropriate.			
I counsel patients who do not comply with their medication regimen regarding the risks to them and to my practice, document these interactions, and appropriately terminate the patients from my practice, if necessary.			
I limit telephone refills to a maximum of one refill for routine medications, pending a return patient visit.			
I manage telephone refills of high-risk medications on a case-by-case basis and require that the patient schedule a timely appointment.			
I speak directly to pharmacists who call with questions regarding a prescription.			
I dispense drug samples with caution and record the lot and serial numbers of samples.			
I neither maintain nor provide samples of controlled drugs.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Competencies			
I attend continuing education and training programs in compliance with state licensing regulations and as needed, in order to ensure the safe and effective care and treatment of my patients.			
I remain current regarding clinical practice, medications, treatment and equipment utilized for the diagnosis and treatment of acute and chronic illnesses and conditions related to my clinical specialty.			
I consult regularly with my collaborating/supervising physician to ensure that my competencies are appropriate and sufficient.			
I engage in peer review and/or quality review in my organization/practice.			
I participate in quality improvement and patient safety committees or initiatives in my organization/practice/professional organization, in order to enhance my clinical competencies and patient safety awareness.			
I contact my board of nursing and/or board of medicine to identify learning opportunities in my region and state.			
I identify and pursue additional learning opportunities through my professional organizations.			
Patient care equipment and supplies			
I check that emergency and required patient care equipment is readily available and in proper working order.			
I activate and respond to any equipment alarms and never turn off alarms when equipment is in use.			
I examine all equipment before each use to ensure proper functioning.			
I report broken/malfunctioning equipment, remove it from use and obtain an appropriate replacement.			
I sequester any broken/malfunctioning equipment involved in a patient incident, in order to preserve it exactly as it was at the time of the event.			
I provide oral and written reports of broken/malfunctioning equipment to all appropriate parties.			
Professional conduct			
I speak to patients, families and staff in a respectful and professional manner.			
I monitor the patient care environment to ensure privacy and safety.			
I explain procedures and treatments to patients, including any touching that may occur during sessions, and I obtain their permission before proceeding.			
I respect the patient's rights throughout the episode of care.			
I maintain patient privacy and confidentiality.			
I avoid harsh physical touching or abrupt movement with patients at all times.			
I include a chaperone, when indicated, if intimate touching is required for the patient's treatment.			
I refrain from personal relationships outside of the care setting with patients and family members.			
I divulge protected information only with written authorization from the patient or a legal representative.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Other documentation practices			
I refrain from subjective comments, including statements about patients, colleagues and other members of the patient care team.			
I document contemporaneously and never make a late entry unless it is appropriately labeled and necessary for the safe continued care of the patient.			
I factually and thoroughly document any unusual occurrences that arise during the patient's treatment and care.			
I complete an incident report for unusual patient incidents and/or patient injuries, following practice protocols.			
I never remove any portion of the patient's health information record or alter a record in any way.			
I do not remove patient health records (paper or electronic) from the patient care location, and I do not make entries from home or other inappropriate locations.			
I allow no one else access to my laptop, electronic pad or personal digital assistant, never share my passwords or access codes, and maintain electronic equipment safely and securely.			
I immediately report lost or stolen paper health information records or electronic patient healthcare recording or storage devices.			
I contact the organization's risk manager or legal counsel for assistance prior to making an entry if I am in any way unsure about it.			

CLAIM TIPS

The following concepts and behaviors can help reduce nurse practitioner professional liability risks. Also included are steps to take if you believe that you may be involved in a legal matter related to your practice:

1. **Practice within the requirements of your state Nurse Practice Act,** in compliance with other professional boards, organizational policies and procedures, and within the standard of care.
2. **Document your patient care assessments, communications, clinical decision-making process, diagnosis, treatment plan and patient care actions** in an objective, timely, accurate, complete, appropriate and legible manner.
3. **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 into the record, properly label the addition as a late 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 collaborating/supervision physician, the organization's risk manager and/or legal counsel to determine appropriate action.
4. **Immediately contact your personal insurance carrier if you become aware of a filed or potential professional liability claim asserted against you,** receive a subpoena to testify in a deposition or trial, or have any reason to believe that there may be a potential threat to your license to practice nursing. Keep in mind that allegations involving failure to diagnose, delays in diagnosis, deaths and infection/abscess/sepsis are most likely to result in litigation.
5. **If you purchase your own professional liability insurance policy, report possible claims or related actions to your insurance carrier,** even if your employer advises you that he or she will provide you with an attorney and/or will cover you for a professional liability settlement or verdict amount.
6. **Refrain from discussing the matter with anyone** other than your defense attorney or the professionals managing your claim.
7. **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.
8. **Provide your insurance carrier with as much information as you can when reporting real or potential legal situations,** including contact information for the organization's risk manager and for the attorney assigned to the litigation by your employer.
9. **Never testify in a deposition without first consulting your insurance carrier** or, if you do not purchase your own professional liability insurance policy, without first consulting the organization's risk manager or legal counsel. In addition, do not testify in a deposition without having had specific deposition preparation by your attorney.
10. **Copy and retain any summons and complaint, subpoena or attorney letters for your records** and to share with your attorney and professional liability insurer.
11. **Maintain signed and dated copies of any employer contracts,** including past agreements.

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

(January 1, 2007–December 31, 2011)

PART 2: INTRODUCTION

An action taken against a nurse practitioner'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 provided by the nurse practitioner. Another difference is that amounts paid related to license protection claims represent the costs of providing legal representation to the nurse practitioner in defending such actions, rather than indemnity or settlement payments to a plaintiff.

DATABASE AND METHODOLOGY

There were 504 reported incidents or claims regarding license protection defense from 2007 through 2011 attributed to nurse practitioners who were insured through the CNA/NSO insurance program. The final data set included 133 license protection defense paid claims that

- closed between January 1, 2007 and December 31, 2011
- concerned a nurse practitioner
- resulted in a license protection defense expense payment

A board complaint can be filed against a nurse practitioner's license by a patient, patient's family member, colleague or employer. Understanding the most common allegations filed can assist nurse practitioners in identifying where they may be vulnerable.

Of the 504 total reported license protection defense incidents, 26.4 percent resulted in payment, with an average amount of $4,441. This average payment reflects the legal expenses and associated travel, food, lodging and wage loss reimbursable under the policy. The average payment amount may not be reflective of the total expense paid by the nurse practitioner for his or her license protection defense.

License Defense Claim Payment 1
(Closed 1-1-2007 – 12-31-2011)

	Percentage of total reported incidents	Total payment	Average payment
Paid claims	26.4%	$590,718	$4,441
Closed without payment	73.6%		
Total	100.0%		

LICENSE PROTECTION DEFENSE PAID CLAIMS

Paid claims for license protection defense involved medical and non-medical regulatory board complaints against nurse practitioners. There were 133 license protection defense paid claims, with a total payment of $590,718. There were 126 paid claims (94.7 percent) where the nurse practitioner was individually insured in the CNA/NSO program, and seven paid claims where the nurse practitioner group practice was insured in the program. The nurse practitioner group practice includes employees or independent contractors providing professional services on behalf of the nurse practitioner practice.

Nurse practitioners with a license protection defense paid claim most often worked in an office setting (69.2 percent), followed by hospitals (19.5 percent), aging services facilities (4.5 percent), home health services (4.5 percent) and schools (2.3 percent). The average indemnity for two practice settings – patient's home ($4,992) and office ($4,592) – was higher than the overall average indemnity ($4,441). Two paid claims occurred in the patient's home, involving allegations of inadequate patient care (in which an injury to the patient led to loss of vision in one eye) and drug diversion. Ensuring that practice protocols and procedures are established and documented in the patients' records is key to controlling risk.

2 **License Protection Defense Claim Payment**
(Closed 1-1-2007 – 12-31-2011)

Insured type	Percentage of paid claims	Total paid	Average payment
Individually insured	94.7%	$549,343	$4,360
Nurse practitioner group practice	5.3%	$41,375	$5,911
Overall	**100.0%**	**$590,718**	**$4,441**

3 **Severity by Practice Location**

Location	Percentage of paid claims	Total payment	Average payment
Patient's home	4.5%	$29,951	$4,992
Office	69.2%	$422,454	$4,592
Hospital	19.5%	$114,565	$4,406
School	2.3%	$8,887	$2,962
Aging services	4.5%	$14,861	$2,477
Total	**100.0%**	**$590,718**	**$4,441**

ANALYSIS OF ALLEGATIONS

The following section provides detail for primary allegation classes and highlighted statistics for the top three allegation classes: improper treatment and care, unprofessional conduct and medication errors.

The allegation classes with the highest percentage of license protection defense paid claims were improper treatment and care (25.6 percent), unprofessional conduct including drug diversion (23.3 percent), medication error (20.3 percent), patient abuse (9.0 percent) and beyond scope of practice (9.0 percent).

Primary Allegation Classes 4

Allegation class	Percentage of paid claims*	Total paid	Average payment
Failure to monitor	1.5%	$17,649	$8,825
Breach of confidentiality	2.3%	$20,961	$6,987
Unprofessional conduct	23.3%	$182,673	$5,893
Beyond scope of practice	9.0%	$59,538	$4,962
Improper treatment and care	25.6%	$150,114	$4,415
Medication error	20.3%	$97,745	$3,620
Abuse/patients rights	9.0%	$39,971	$3,331
Failure to diagnose	6.0%	$18,472	$2,309
Failure to assess	1.5%	$1,868	$934
Documentation error	1.5%	$1,727	$864
Overall	**100.0%**	**$590,718**	**$4,441**

*Total percentage is calculated within the allegation class.

Allegations related to improper treatment and care represented 25.6 percent of the total paid claims. The top three allegations within this category involved improper or untimely management of medical patient or medical complication (29.4 percent), failure to timely implement/order established treatment protocols (23.5 percent) and patient abandonment (14.7 percent).

- Allegations of improper or untimely management of medical patient or medical complication (29.4 percent) resulted from a number of alleged situations, including poorly explained test results, unclear treatment plan, treatment provided to a patient with a chemical dependency where the nurse practitioner was not appropriately trained, and failure to follow up on test results or the patient's medical condition. With an average payment of $5,014, this allegation exceeded the average paid expense for all claims of $4,441.
- Allegations of failure to timely implement/order established treatment protocols (23.5 percent) resulted from such issues as failing to create a treatment plan, failing to document reasons for medications, failing to see the patient directly and writing an order, and failing to follow up on test results. With an average payment of $4,886, this allegation exceeded the average paid expense for all claims of $4,441.
- The allegation of patient abandonment (14.7 percent) resulted from complaints alleging discontinued services without providing an alternative to the patient, releasing the patient from care before the patient should have been released and refusing to see a patient for follow-up on a medical complaint. With an average payment of $4,806, this allegation exceeded the average paid expense for all claims of $4,441.

5 Detailed View of Allegation Class – Improper Treatment and Care

(25.6 percent of Total License Protection Defense paid claims)

Allegation detail	Percentage of paid claims*	Total paid	Average payment
Failure to notify patient/family/healthcare team of patient's condition	8.8%	$22,021	$7,340
Improper or untimely management of medical patient or medical complication	29.4%	$50,141	$5,014
Failure to timely implement/order established treatment protocols	23.5%	$39,090	$4,886
Patient abandonment	14.7%	$24,028	$4,806
Failure to timely/properly address medical complication or change in condition	8.8%	$6,937	$2,312
Improper technique or negligent performance of treatment or test	5.9%	$3,852	$1,926
Failure to timely respond to patient's concerns related to the treatment plan	2.9%	$1,871	$1,871
Failure to contact patient's physician	2.9%	$1,674	$1,674
Failure to obtain/refer to immediate emergency treatment	2.9%	$500	$500
Total within allegation class	**100.0%**	**$150,114**	**$4,415**

*Total percentage is calculated within the allegation class.

The top three allegations within the unprofessional conduct allegation class are substance abuse (53.5 percent), patient abuse (27.9 percent) and failure to provide proper credentials (11.6 percent).

- Substance abuse was the most frequent allegation within the unprofessional conduct allegation class, with 53.5 percent of paid claims in this allegation class. Specific allegations against the nurse practitioner included diverting medication for self or others, overprescribing, neglecting to document proper disposal of narcotics, inaccurate medication counts not reported/detected, and apparent intoxication from alcohol or drugs while on duty. All resulted in an allegation of drug diversion or substance abuse. With an average payment of $6,550, this allegation exceeded the average paid expense for all claims of $4,441.
- Patient abuse (27.9 percent) was the second most frequent allegation in this class. Within this group, sexual abuse of the patient by the nurse practitioner was the leading allegation. Specific allegations of sexual abuse included an inappropriate relationship with a former patient and inappropriate touching. In another case, the nurse practitioner was alleged to have ignored signs of sexual abuse by a colleague.
- Allegations related to failure to provide proper credentials (11.6 percent) included the nurse practitioner's failure to complete continuing education requirements, failure to remove a physician from the list of supervising physicians and failure to provide required documentation to the board of nursing.
- One claim included an allegation of cruelty to animals, a criminal charge unrelated to patient care.

Detailed View of Allegation Class - Unprofessional Conduct 6
(23.3 percent of Total License Protection Defense paid claims)

Allegation detail	Percentage of paid claims*	Total paid	Average payment
Substance abuse	53.5%	$150,643	$6,550
Billing practices	4.7%	$11,790	$5,895
Criminal act	2.3%	$4,592	$4,592
Patient abuse	27.9%	$39,971	$3,331
Failure to provide proper credentials	11.6%	$15,648	$3,130
Total within allegation class	**100.0%**	**$222,644**	**$5,410**

*Total percentage is calculated within the allegation class.

- Allegations related to medication error complaints represented 20.3 percent of total paid claims. Prescribing the wrong medication (33.3 percent), failure to recognize a contraindication or adverse interaction (33.3 percent), and prescribing the wrong dose (11.1 percent) represented the majority of the allegations in this category.
- Overprescribing for pain, using discontinued medication, skin reaction to medication and mismanagement of controlled substances were also reasons for patient complaints.
- Paid claims in this allegation category averaged $3,620, below the overall paid claims average of $4,441.
- Injuries resulting from prescribing errors included hearing loss, lithium toxicity and loss of vision in one eye.

7 Detailed View of Allegation Class – Medication Error

(20.3 percent of Total License Protection Defense paid claims)

Allegation detail	Percentage of paid claims*	Total paid	Average payment
Improper management of medications	7.4%	$12,556	$6,278
Improper prescribing/management of controlled drugs	7.4%	$10,624	$5,312
Wrong dose	11.1%	$11,094	$3,698
Failure to recognize contraindication and/or known adverse interaction	33.3%	$29,824	$3,314
Wrong medication	33.3%	$28,358	$3,151
Prescribing practice not included in state scope of practice	7.4%	$5,289	$2,645
Total within allegation class	**100.0%**	**$97,745**	**$3,620**

*Total percentage is calculated within the allegation class.

Allegations related to medication error complaints represented 20.3 percent of total paid claims, with an average payment of $3,620.

LICENSING BOARD ACTIONS

Most board complaint outcomes for paid license protection defense claims favored the nurse practitioner, with 61.7 percent of the board's final decisions resulting in no action taken. Another 35.2 percent resulted in monitoring, education or caution from the board on nursing practice, among other outcomes. A small number of decisions resulted in the end of a nurse practitioner's career, including license surrender at 0.8 percent and revocation at 2.3 percent.

Explanation of terms:

- **Consent agreement** – A stipulation of a condition or conditions that must be met in order for the nurse to continue to practice.
- **Public censure** – A public written reprimand regarding a violation of the Nurse Practice Act, which does not impose any conditions on the nurse practitioner's professional license.
- **Letter of concern** – A communication from the Board of Nursing expressing concern that the nurse may have engaged in questionable conduct.

Analysis of Board of Nursing Outcomes for Paid Claims **8**

Outcome	Percentage of total paid claims
Closed - no action	61.7%
Fine or CE or both	6.0%
Administrative warning	2.3%
Revocation	2.3%
Surrender	0.8%
Suspension	6.0%
Probation	9.0%
Consent agreement	3.0%
Public censure	0.8%
Professional assistance program	1.5%
Letter of concern	3.8%
Reprimand	3.0%

RISK CONTROL RECOMMENDATIONS

By incorporating the following essential risk control recommendations into their practice, nurse practitioners can help protect patients as well as themselves against a board complaint:

- Maintain consistent documentation, follow established procedures, and deliver clear and timely communication to patients and their family.
- Recognize the stressors that may lead to substance abuse and allegations of unprofessional conduct, and be proactive in seeking support to manage the situations or circumstances that increase one's vulnerability.
- Make certain that the patient understands and is comfortable with the assessment process before it begins. When appropriate or when requested by the patient, include another staff member to observe the patient's examination/treatment.
- Document all discussions with the patient in the clinical record. By documenting both patient discussions and actions taken, nurse practitioners can protect themselves and the patient from a misunderstanding that could jeopardize their career.
- Submit updates for credential requests on time and respond by indicated deadlines to any board of nursing inquiry regarding an investigation or request for documentation.
- Maintain required educational requirements and up-to-date physician agreement documentation, as failure to do so can lead to disciplinary action.
- Maintain current drug reference materials and other resources that provide information on medications and potential interactions or side effects.
- Be certain that the patient understands the prescribed drug dosage and frequency. Encourage them to call with questions, and document the discussion and any instructions provided.
- Know what medications are outside of a nurse practitioner's prescribing scope of practice. When necessary, consult with another practitioner to mitigate the risk of prescribing the wrong medication or dosage, which could result in a board allegation.

Additional risk control recommendations can be found beginning on page 37 and elsewhere in Part 1 of this report.

Part 3: Highlights from Nurses Service Organization's 2012 Qualitative Nurse Practitioner Work Profile Survey

PART 3: INTRODUCTION

In 2012, CNA and NSO conducted three separate studies in order to analyze nurse practitioner closed professional liability claims (Part 1), review nurse practitioner license protection defense closed claims (Part 2), and survey nurse practitioner customers about a range of professional and risk issues (Part 3).

Part 3 differs significantly from the closed claims analyses in Parts 1 and 2, as it presents selected highlights from the Nurses Service Organization's 2012 Qualitative Nurse Practitioner Work Profile Survey. (The complete results of the survey may be accessed on the NSO Web site at **www.nso.com/NPClaimReport2012**.*) It reflects direct feedback from two subsets of our insured nurse practitioners – one group of nurse practitioners who had a claim filed against them, and a demographically similar group of insured nurse practitioners with no claims. Both groups of respondents electively opted to complete the 2012 NSO survey tool. In this survey, the term *respondent* refers to those NSO-insured nurse practitioners who voluntarily replied to the NSO survey.

This survey was performed at the request of those who sought to compile data from nurse practitioners about issues that are not addressed by the analysis of closed claims. It should be noted that the findings in Part 3 are derived only from those nurse practitioners who responded to the 2012 NSO nurse practitioner survey, and do not reflect all NSO-insured nurse practitioners or all nurse practitioners in general.

The survey approach enabled us to compare several variables that influence professional liability exposure, including

- the effect of level of education on average total payment
- the effect of required continuing education (CE) credits on average total payment
- the benefit of policies for disclosing errors
- the impact of aesthetics procedures now performed by nurse practitioners on average total paid amounts and risk

NSO engaged Wolters Kluwer Health, Lippincott Williams & Wilkins to survey nurse practitioners on these and associated issues. The survey participants included nurse practitioners who participated in the NSO insurance program between January 1, 2007 and December 31, 2011.

*Note that the numbering of the figures in Part 3 is not sequential because they have been excerpted from the full survey results posted on the NSO Web site in a somewhat different order.

SURVEY BACKGROUND AND METHODOLOGY

The purpose of this survey was to examine the relationship between professional liability exposure and a variety of demographic and workplace factors. To that end, the responding nurse practitioners were divided into two groups: those who had experienced a professional liability claim resulting in loss that had closed between 2007 and 2011, and those who had never experienced a claim.

The sample for the group who experienced claims consisted of 640 nurse practitioners who have submitted a professional liability claim within the past five years. This claim group sample consisted of two subgroups: 227 with an indemnity payment only made on their behalf and 413 with an expense-only payment (no indemnity payment). The non-claims sample was produced from a randomized sample of 4,000 current CNA/NSO customers, which approximately matched the geographic distribution of the claims group. The survey questions differed for each group. For the claims group, questions focused on conditions at the time of the incident. For the non-claims group, the same questions were asked, but in relation to current workplace conditions and other variables.

A hybrid methodology was used, consisting of a printed mail survey along with an e-mailed invitation to complete an online version of the survey. To ensure a nurse practitioner did not take the survey twice, each participant was sent the print version and, if an e-mail 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 ensure against duplicate respondents. To encourage study participation, respondents were eligible to receive a prize.

Survey Response Rates Summary

	Claims group			Non-claims
	Indemnity	Expense-only	Total	Total
Initial sample size	227	413	640	4,000
Undeliverable/opt out	12	15	27	86
Usable sample	215	398	613	3,914
Number of respondents	79	130	209	901
Response rate	**37%**	**33%**	**34%**	**23%**

Within the report, results are reported on overall responses for both the claims and non-claims segments. Results were combined for the expense-only claim group and indemnity claim group for the claims portion. The margin of error at the 95.0 percent confidence level for the claims portion of the study was ±4.7 percent, while the corresponding mark for the non-claims version was ±3.5 percent. In either case, 95.0 percent of the time we can be confident that percentages in the actual population would not vary by more than this in either direction.

Please note that the survey findings are based on self-reported information and thus may be skewed due to the respondents' personal perceptions and recollections of the requested information. This report provides selected findings from the total survey and the reader will notice that charts are not numbered consecutively. Please feel free to review the results of the entire survey and all the accompanying charts at **www.nso.com/NPClaimReport2012**.

The qualitative NSO survey results are not comparable to the quantitative CNA nurse practitioner closed claims data in Part 1 or the nurse practitioner license protection defense closed claims data in Part 2. Some figures and narrative findings in Part 3 include a reference to the average total paid amount of the respondents' closed claims. It is important to remember that *the average total paid amount reflects the combined average paid indemnity and expense-only payments. In this section this figure reflects only those payments made on behalf of NSO-insured nurse practitioners who had a closed claim and who responded to the survey.* Therefore, average total paid findings in Part 3 should not be compared with average paid indemnity findings in Part 1.

SUMMARY OF FINDINGS

- Most respondents who experienced claims had a master's degree in nursing. Average total paid amounts were directly correlated with level of education, with higher levels experiencing higher average total paid amounts.
- The number of claims increased with the respondents' experience. Nearly 73 percent of respondents who experienced claims had worked as a nurse practitioner for more than 11 years. Highest average total paid amounts were for those who had been in practice for six to 10 years. This correlates with the findings that the longer a nurse practitioner is in practice, the higher his or her risk of experiencing a claim.
- As the clinical hours and continuing education credits required in the respondents' nurse practitioner program increased, the average total paid amounts declined slightly.
- Most respondents (76.4 percent) indicated that they refuse to perform out-of-scope actions. Those who experienced claims related to practicing outside their scope of practice indicated that the biggest factor influencing their decision to practice beyond their scope was the finding that they were trained to do the procedure by their supervising physician.
- A majority of respondents, both those who experienced claims and those who did not, do not perform aesthetics procedures. Of the small percentage of respondents who do perform these procedures and experienced claims (6.9 percent), the average total paid amount on their behalf was $159,926.
- A majority of respondents who experienced claims indicated that supervision was available if needed. Respondents who indicated they were not supervised at all had the highest average total paid amount.
- A little more than one-third of respondents who experienced claims spent an average of 16 to 20 minutes in direct contact with their patients. With one exception, more time spent in direct contact with patients correlated with slightly decreased average total paid amounts.
- Nearly 77 percent of respondents who experienced claims indicated that their practice/facility *did not* have an error disclosure policy at the time of the incident. This group had the highest average total paid amount. Of the respondents who did not experience a claim, nearly 42 percent *did* have an error disclosure policy in place.
  - Of respondents who experienced claims and had an error disclosure policy in place, more than half did not utilize the policy.
  - A majority of respondents (82.1 percent) who did not experience a claim did utilize their error disclosure policy.
- Using electronic medical records was associated with the lowest average total paid amount.

Gender

No significant differences appeared from a gender perspective between those nurse practitioners with and without claims. A higher proportion of respondents were women, which reflects Institute of Medicine statistics (2010) that place the percentage of men in the nursing profession at 7 percent.

Gender 1
Q: What is your gender?

	Non-claims	Claims	Average total paid
Female	91.6%	89.9%	$89,994
Male	8.4%	10.1%	$70,224

Age

The majority of respondents who experienced claims tended to be more than 40 years old, with 48.3 percent between the ages of 51 and 60. The highest average total paid amount occurred in respondents between the ages of 46 and 50 ($111,835).

Age 2
Q: What is your age?

	Non-claims	Claims	Average total paid
30 years or younger	13.9%	0.0%	$0
31 to 35 years	12.2%	1.9%	$78,925
36 to 40 years	13.4%	7.7%	$102,417
41 to 45 years	12.3%	15.0%	$102,587
46 to 50 years	13.9%	16.9%	$111,835
51 to 60 years	27.6%	48.3%	$76,170
61 years or older	6.9%	10.1%	$73,825

Highest Level of Education

Most respondents (80.6 percent) who experienced claims had a master's degree in nursing, which is similar to the percentage of respondents without claims (79.0 percent of whom had a master's degree in nursing). This reflects findings of the American Academy of Nurse Practitioner's National Nurse Practitioner Database, which indicates that 90.0 percent of nurse practitioners have graduate degrees.

The highest average total paid amount occurred among those with a doctorate in nursing ($97,830), compared with the average payment among those with a master's degree in nursing ($90,708). Average total paid amounts were directly correlated with level of education, with higher levels experiencing higher average payments.

3 **Highest Level of Education**
Q: What is your highest level of education completed?

	Non-claims	Claims	Average total paid
Associate's degree	0.7%	1.5%	$27,287
Bachelor's degree in nursing	9.8%	5.8%	$71,173
Master's degree in nursing	79.0%	80.6%	$90,708
Master's degree, non-nursing	3.6%	1.9%	$81,447
Doctorate degree in nursing	5.6%	9.2%	$97,830
Doctorate degree, non-nursing	1.3%	1.0%	$1,950

Location

The average total paid amount was higher for respondents who experienced claims and worked in a rural area ($131,808). The overall distribution of practice location varied somewhat between the claims and non-claims groups.

4 **Location**
Q: Which of the following best describes the location of your practice?

	Non-claims	Claims	Average total paid
Rural	22.3%	22.4%	$131,808
Suburban	42.5%	51.2%	$79,170
Urban	35.2%	26.3%	$67,777

Employment Status

More than half of the respondents who experienced claims indicated they were employed full-time at the time of the incident. Those respondents who indicated they were the owner/partner of the practice (9.5 percent) had the highest average total paid amount of $141,721.

Employment Status 38
Q: At the time of the incident, what was your employment status?

	Non-claims	Claims	Average total paid
Employed full-time	64.5%	59.5%	$86,012
Independent contractor, self-insured	7.7%	18.4%	$76,580
Employed part-time	13.7%	12.6%	$103,071
Owner/partner	8.4%	9.5%	$141,721
Student	5.6%	0.0%	$0

Years in Practice

A majority of respondents who experienced claims had worked as a nurse practitioner for more than 11 years (72.5 percent). The highest average total paid amounts were on behalf of those who had been in practice for six to 10 years ($95,433). This correlates with findings that the longer a nurse practitioner is in practice, the higher his or her risk of experiencing a claim.

Years in Practice 5
Q: How many years have you been practicing as a nurse practitioner?

	Non-claims	Claims	Average total paid
Less than 2 years	32.8%	0.0%	$0
2 to 5 years	17.8%	4.4%	$55,771
6 to 10 years	17.1%	23.0%	$95,433
11 to 15 years	17.6%	42.6%	$90,434
More than 15 years	14.6%	29.9%	$82,996

Number of Annual Continuing Education (CE) Credits Required

A majority of respondents in both claims (49.0 percent) and non-claims (53.9 percent) groups indicated that their state licensing board required them to complete 30 to 60 hours of CE credits per year. Average total paid amounts decreased slightly as required hours increased. Average total paid amounts were lowest for those who indicated they were required to complete more than 60 hours of CE.

8 **Number of Annual CE Credits Required**
Q: According to your state licensing board, how many CE credits are you required to complete annually to retain your nurse practitioner licensure?

	Non-claims	Claims	Average total paid
None	9.2%	10.0%	$94,480
Less than 30	35.7%	39.0%	$90,838
30 to 60	53.9%	49.0%	$85,192
More than 60	1.2%	2.0%	$57,586

Average total paid amounts decreased slightly as required continuing education (CE) hours increased, and amounts were lowest for those who indicated they were required to complete more than 60 hours of CE.

Years in Practice Before Becoming a Certified Nurse Practitioner

More than one-third (34.1 percent) of respondents who experienced claims indicated that they practiced for more than 15 years as a registered nurse before becoming a certified nurse practitioner. This number is down compared with the 2009 NSO Nurse Practitioner Survey, which found that 41.0 percent of those experiencing claims worked for more than 15 years in practice before becoming a nurse practitioner. The percentage of those experiencing claims in the less than two years and two to five years categories were nearly identical to the 2009 Survey (4 percent and 18 percent, respectively).

Average total paid amounts were fairly consistent across all levels of experience, with a slightly higher average total paid amount for those who had worked less than two years in practice ($109,145). Respondents who experienced claims and worked 11 to 15 years had the lowest average total paid amounts ($79,321).

Years in Practice Before Becoming a Nurse Practitioner 9
Q: How many years did you practice as a registered nurse before becoming certified to practice as a nurse practitioner?

	Non-claims	Claims	Average total paid
Less than 2 years	9.3%	4.9%	$109,145
2 to 5 years	24.1%	18.4%	$88,428
6 to 10 years	25.3%	28.9%	$93,241
11 to 15 years	14.0%	13.6%	$79,321
More than 15 years	27.3%	34.1%	$85,932

Person Conducting Clinical Review

The majority of respondents who had experienced claims as well as those in the non-claims group indicated that their supervising or collaborating physician conducted their clinical review. Average total paid amounts were highest in this group at $105,540.

Respondents who experienced claims and who indicated a physician not associated with the practice conducted their clinical reviews had the lowest average total paid amounts ($41,117).

Person Conducting Clinical Review 11
Q: Who does your clinical peer review?

	Non-claims	Claims	Average total paid
Supervising or collaborating physician only	43.2%	50.4%	$105,540
Nurse practitioner peer review	16.4%	17.4%	$101,351
Other physician associated with practice	7.4%	8.7%	$60,765
Physician not associated with practice	5.3%	4.1%	$41,117
Does not apply	27.6%	16.4%	$54,041

Reaction to Being Asked for Out-of-scope Practice

More than half of respondents who experienced claims indicated that they refused to perform out-of-scope actions. None of the respondents who experienced claims indicated that they would practice out of scope.

17 **Reaction to Out-of-scope Practice**
Q: How do you generally respond to requests to practice outside of your scope?

	Non-claims	Claims	Average total paid
I refuse to perform out-of-scope actions	60.6%	76.4%	$57,043
Before responding, I confirm scope with my licensing board and document why I cannot comply	27.3%	11.8%	$25,740
Ask for additional training	8.1%	11.8%	$850
I will practice out of scope	4.0%	0.0%	$0

Performing Aesthetics Procedures

A majority of respondents, both those who experienced claims and those who did not, do not perform aesthetics procedures. Of the small percentage of respondents who do perform these procedures and experienced claims (6.9 percent), the average total paid amount on their behalf was $159,926.

22 **Performing Aesthetics Procedures**
Q: Do you perform any aesthetics procedures in your practice?
(e.g., Botox injections, microdermabrasion, laser hair removal, chemical peels, etc.)

	Non-claims	Claims	Average total paid
Yes	4.2%	6.9%	$159,926
No	95.8%	93.1%	$84,601

Aesthetics Procedures Performed

Only a small number of respondents who experienced claims (n=13) perform aesthetic procedures. Of the respondents who experienced claims, the majority injected Botox and derma fillers. Of the respondents who did not experience a claim, the majority also performed Botox injections and derma fillers, but were more likely to do chemical peels (40.6 percent for non-claims versus 15.4 percent for those experiencing claims).

Aesthetics Procedures Performed 26
Q: Which aesthetics procedures do you perform?

	Non-claims	Claims
Botox injections	68.8%	84.6%
Derma fillers	50.0%	53.8%
Laser skin resurfacing	12.5%	38.5%
Laser hair removal	28.1%	38.5%
IPL skin rejuvenation	18.8%	30.8%
Chemical peels	40.6%	15.4%
Microdermabrasion	18.8%	15.4%
Mesotherapy	6.3%	7.7%
Permanent cosmetics	3.1%	0.0%
Collagen injections	0.0%	0.0%
Tattooing	0.0%	0.0%
Silicone injections	0.0%	0.0%

Of the small percentage of respondents who do perform aesthetics procedures and experienced claims, the average total amount paid on their behalf was $159,926.

Practice Collaboration Status

At the time of the incident, 70.7 percent of respondents who experienced claims indicated they were working under a collaborative practice agreement. This group had the lowest average total paid amount at $84,552. Respondents experiencing claims who indicated they had no physician oversight or autonomous practice at the time of the incident had the highest average paid amount at $117,237.

32 **Practice Collaboration Status**
Q: At the time of the incident, I was practicing under the following capacity:

	Non-claims	Claims	Average total paid
No physician oversight or autonomous practice	12.2%	10.2%	$117,237
Direct physician supervision	19.2%	20.1%	$91,332
Collaborative practice agreements	68.6%	70.7%	$84,552

Onsite Presence of Supervising or Collaborating Physician

Half of the respondents who experienced claims indicated that a physician was onsite when the incident occurred. This group had a higher average total paid amount of $104,714, indicating that the presence of a supervising or collaborating physician had little impact on the extent of the liability.

33 **Was a Physician Onsite?**
Q: At the time of the incident, was your supervising or collaborating physician onsite?

	Non-claims	Claims	Average total paid
Yes	65.1%	50.3%	$104,714
No	34.9%	49.7%	$68,136

Level of Supervision/Collaboration

A majority of the respondents who experienced claims indicated that supervision was available if needed. Those respondents who indicated they were not supervised at all (3.0 percent) had the highest average total paid amount of $293,240.

Level of Supervision 34
Q: At the time of the incident, I was practicing under the following capacity:

	Non-claims	Claims	Average total paid
Not supervised at all	1.9%	3.0%	$293,240
Available if needed	78.1%	70.2%	$83,608
Partial supervision	14.1%	13.1%	$77,894
Direct supervision	5.9%	13.7%	$4,790

Frequency of Clinical Chart Reviews

Just about half of the respondents who experienced claims indicated that they received a monthly clinical chart review by their supervising or collaborating physician. Respondents who experienced claims and indicated that they "never" had such a review (6.9 percent) had the highest average total paid amount of $191,288.

Frequency of Clinical Chart Reviews 35
Q: At the time of the incident, how often did your supervising or collaborating physician do a clinical chart review?

	Non-claims	Claims	Average total paid
As needed	10.9%	6.9%	$86,747
Monthly	38.0%	49.4%	$80,151
Once a quarter	21.3%	13.8%	$28,176
Once every 6 months	6.4%	8.7%	$108,343
Once a year	7.5	8.7%	$152,698
Never	12.3%	6.9%	$191,288
Other	3.6%	5.6%	$18,426

Practice Setting Where Incident Occurred

Nearly half of the respondents who experienced claims (46 percent) indicated that they worked in a physician office or clinic practice when the incident occurred. This group had the third-highest average total paid amount of $124,938.

This finding reflects the results of a 2011 Advance Nurse Practitioner Salary Report, which indicated that nearly 40 percent of nurse practitioners work in a family practice office or clinic.

39 **Practice Setting**
Q: Which of the following best describe your practice setting where the incident occurred?

	Non-claims	Claims	Average total paid
Physician office/clinic practice	35.7%	46.0%	$124,938
Skilled nursing facility/LTC	5.0%	14.8%	$46,617
My own solo private practice	7.6%	10.0%	$83,538
Hospital inpatient	7.6%	8.4%	$67,563
Community or hospital-based clinic or ambulatory health facility	11.3%	5.3%	$112,339
Emergency services (hospital)	3.3%	3.2%	$25,899
Nurse practitioner group practice	2.9%	3.2%	$12,834
Urgent care/walk-in clinic (non-hospital-based)	3.1%	2.6%	$26,612
Prison/correctional health	0.7%	1.2%	$17,302
School/college clinic	3.1%	0.8%	$125,171
Primary care medical home (PCMH)	3.6%	0.8%	$56,944
Surgicenter (non-hospital-based)	0.0%	0.8%	$25,044
Residential care facility (not aging services-related)	0.3%	0.4%	$15,000
Behavioral health acute inpatient facility	0.9%	0.4%	$54,398
Patient's home	1.7%	0.4%	$400,000
Retail-based convenient care clinic	2.8%	0.0%	$0
Industrial/occupational health	3.1%	0.0%	$0
Surgicenter (hospital-based)	0.3%	0.0%	$0
Hospital ICU	3.9%	0.0%	$0
Hospice care	1.5%	0.0%	$0
Home health agency	0.4%	0.0%	$0
Public health department	1.2%	0.0%	$0

Prescribing Authority

At the time of the incident, 58.2 percent of respondents experiencing a claim had a Schedule II-V level of prescription authority.

These numbers are higher than the 2009 NSO Nurse Practitioner Survey, which indicated that 49 percent of respondents experiencing a claim had Schedule II-V prescribing authority. The number of respondents who experienced claims and had prescribing authority for non-scheduled prescription or legend drugs has dropped since the 2009 survey; in 2009, 32 percent had this level of prescribing authority, compared with 23.2 percent in 2012.

The number of respondents who experienced claims and had prescribing authority for non-scheduled prescription or legend drugs, such as antibiotics, saw the highest average total paid amount of $108,285.

Prescribing Authority 40

Q: At the time of the incident, what level of prescriptive authority did you have?

	Non-claims	Claims	Average total paid
Schedule II-V	59.8%	58.2%	$102,215
Schedule III-V	24.4%	19.0%	$70,265
Schedule V	10.3%	7.4%	$87,447
Non-scheduled Rx or legend drugs	26.6%	23.2%	$108,285
None of the above	10.9%	7.9%	$21,870

Average Patient Load

At the time of the incident, nearly 45 percent of respondents experiencing claims were caring for 15 to 24 patients (24.3 percent cared tor 15 to 19 patients and 20.6 percent cared for 20 to 24 patients). The highest average total paid amount occurred with respondents who cared for 20 to 24 patients ($155,611).

According to the AANP National Nurse Practitioner Database, 60.0 percent of nurse practitioners see three to four patients per hour (24 to 32 patients in an eight-hour shift), and 7 percent see over five patients per hour (over 40 patients per eight-hour shift).

41 **Average Patient Load**
Q: At the time of the incident, what was your average patient workload per 8-hour day?

	Non-claims	Claims	Average total paid
Less than 10	21.2%	9.6%	$84,419
10-14	27.9%	18.0%	$98,477
15-19	25.0%	24.3%	$61,303
20-24	14.2%	20.6%	$155,611
25-29	6.5%	15.3%	$58,870
30 or more	4.3%	9.0%	$97,369
Do not remember	0.9%	3.2%	$56,469

Average Time Spent with a Patient

A little more than one-third (36.9 percent) of respondents who experienced claims spent an average of 16 to 20 minutes in direct contact with their patients. The highest average total paid amount occurred with those respondents who spent 21-30 minutes with their patients. (Note: one large claim of $625,000 may have skewed the results for this group.)

With one exception, more time spent in direct contact with patients correlated with slightly decreased average total paid amounts.

42 **Average Time Spent with a Patient**
Q: At the time of the incident, what was the average amount of time you were able to spend in direct contact with your patients?

	Non-claims	Claims	Average total paid
10 minutes	4.5%	5.3%	$110,196
11-15 minutes	18.8%	21.4%	$85,597
16-20 minutes	30.9%	36.9%	$84,600
21-30 minutes	25.7%	18.2%	$120,953
30 minutes or more	20.1%	18.2%	$60,740

Error Disclosure Policy

A majority of respondents who experienced claims (76.9 percent) indicated that their practice/facility did not have an error disclosure policy at the time of the incident. This group had the highest average total paid amount of $101,650. Of the respondents who did not experience a claim, 41.1 percent did have an error disclosure policy in place.

Error Disclosure Policy 45
Q: At the time of the incident, did your practice/facility have a policy regarding disclosure of error?

	Non-claims	Claims	Average total paid
Yes	41.1%	23.1%	$50,855
No	58.9%	76.9%	$101,650

Utilizing Error Disclosure Policy

Of those respondents who experienced a claim and had an error disclosure policy in place, 56.2 percent did not utilize the policy. Those who did utilize the error disclosure policy had an average total paid amount of $79,195.

A majority of respondents (82.1 percent) who did not experience a claim did utilize their error disclosure policy.

Utilizing Error Disclosure Policy 46
Q: If "yes," did you utilize the policy in managing your incident?

	Non-claims	Claims	Average total paid
Yes	82.1%	43.8%	$79,195
No	17.9%	56.2%	$24,219

Medical Records Documentation

At the time of the incident, 72.9 percent of respondents experiencing claims used handwritten medical records, while only 14.1 percent of them used electronic medical records. Of those who experienced claims, those who used electronic medical records had the lowest average total paid amount of $83,576.

These findings are similar to the 2009 NSO Nurse Practitioner Survey, which also found that 72.0 percent of respondents who experienced claims used handwritten records. The number of respondents with claims using electronic medical records has almost doubled, from 8 percent in 2009 to 14.1 percent in 2012.

47 **Medical Records Documentation**
Q: At the time of the incident, did your facility utilize:

	Non-claims	Claims	Average total paid
Electronic medical records	47.4%	14.1%	$83,576
Handwritten medical records	19.9%	72.9%	$118,409
Combination of both	32.7%	13.0%	$99,010

FOR MORE INFORMATION

The entire NSO 2012 nurse practitioner survey may be viewed at **www.nso.com/NPClaimReport2012**. For additional information, please contact NSO at 1-800-247-1500.

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In addition to this publication, CNA has produced numerous studies and articles that provide useful risk control information on topics relevant to nurse practitioners. These publications are available by contacting CNA at 1-888-600-4776 or at **www.cna.com**. Nurses Service Organization (NSO) also maintains a variety of online materials for nurses, including nurse survey results, articles and useful clinical and risk control resources, as well as information relating to nurse practitioner professional liability insurance, at **www.nso.com**.

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