



NURSE PRACTITIONER CLAIMS STUDY

REGISTERED
NURSES: What
You Need to
Know to Work As
a Nurse
Practitioner

An Analysis of Claims with
Risk Management Recommendations

1994-2004

CNA

*As the clinical role of the nurse practitioner expands,
it is essential to incorporate effective risk management
strategies in order to minimize risk and liability.*



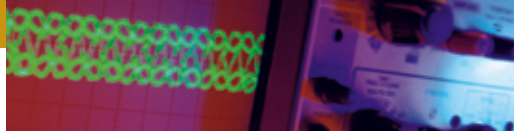


TABLE OF CONTENTS

INTRODUCTION	2
Today's nurse practitioner	2
The legal and regulatory environment	3
Understanding and using the data	4
FINANCIAL ANALYSIS OF NURSE PRACTITIONER CLAIMS	5
Ultimate frequency and severity of claims by year of loss	5
RISK ANALYSIS OF NURSE PRACTITIONER CLAIMS	6
Database and methodology	6
Claims by claim status	6
Claim severity by year	7
Severity by state	8
Frequency and severity by clinical specialty	9
Severity by location	11
Severity by injury	11
Severity by injury outcome	11
Frequency and severity by allegation category	12
Severity of allegations related to medication	12
Severity of allegations related to diagnosis	14
Severity of allegations related to treatment	15
RISK MANAGEMENT RECOMMENDATIONS	16
Scope of practice	16
Patient health information records	16
Documentation	17
Diagnosis	19
Cancer screening and diagnosis	20
Treatment	20
Medication	21
Informed consent for participation in human medical research	23
Equipment	23
CONCLUSION	24
EXPLANATION OF TERMS	25

INTRODUCTION

Nurse practitioners, like other healthcare providers, are vulnerable to professional liability claims. This liability creates clinical, legal, financial, and operational challenges for nurse practitioners, their employers, and physician collaborators or supervisors. As a major provider of liability insurance for nurse practitioners, CNA, along with the Nurses Service Organization, are dedicated to improving the risk awareness of nurse practitioners. Increased awareness is important if nurse practitioners are to focus on patient safety and improve their loss experience.

Reviewing where professional liability claims occur most frequently, understanding the nuances of the claims that are the most expensive, and analyzing associated allegations and injuries can help nurse practitioners focus risk management resources and efforts to reduce their risk. This study uses CNA-insured nurse practitioner claims data as a database to identify high risk areas for nurse practitioners. The review is limited to nurse practitioners and does not include registered nurses or other advance practice nurses such as certified registered nurse anesthetists or certified nurse midwives. In addition to the analysis of the claims data presented, the study provides risk management recommendations.

The study also provides an analysis of the overall litigation environment in which nurse practitioners work. Understanding the litigation environment is a key component in the risk management practices of nurse practitioners and all healthcare providers.

A description of the methodology of the claims selected for this study is included on page 6. An explanation of the terms used throughout the study is available on page 25.

Today's nurse practitioner

The increasing demand for qualified nurse practitioners, recognition of the importance of the nurse practitioner's clinical role, and improving third party reimbursement for nurse practitioner clinical services, have encouraged more nurses to become nurse practitioners. Estimates indicate that the number of nurse practitioners in the U.S. rose from 48,237 in 1992 to approximately 115,000 in the first quarter of 2004.

Having issued professional liability insurance to nurse practitioners since 1993, CNA has seen an increase in the number of nurse practitioners seeking professional liability coverage, from 718 policies in 1993 to 22,311 policies by the end of 2004.

Approximately one half of all nurse practitioners provide primary care in family or adult care specialties. The remaining nurse practitioners deliver healthcare services in other clinical specialties such as emergency medicine, psychiatry, gerontology, pediatrics, and women's health.

Nurse practitioners have become essential providers of primary care throughout the healthcare delivery system and fulfill a critical role on the healthcare team. In physician office, hospital, prison health, freestanding clinic, and emergency department settings, nurse practitioners ease escalating patient loads. They also fill service provider gaps created by federal work rules limiting the number of work hours for physicians in training. Increasing numbers of independent physicians and physician group practices are employing or contracting with nurse practitioners to manage and provide collaborative and/or independent primary care within their practices. This allows each healthcare practitioner to expand their practice as well as maximize his/her expertise in a team approach to the delivery of patient-centered healthcare services.

In some states, nurse practitioners are permitted by regulation to practice independently in both individual and group environments for the provision of primary care, often in areas where physician access is limited. In addition to diagnosing, treating, and managing illness and disease, nurse practitioners also provide health education, promote optimal health, work to prevent disease, and participate in clinical research.

As the clinical role of the nurse practitioner expands, it is essential to incorporate effective risk management strategies into standard clinical practice in order to minimize risk and liability. This study is designed to facilitate nurse practitioners' understanding of the risks of their practice and how to mitigate those risks.



The legal and regulatory environment

Regulatory bodies in every U.S. jurisdiction are authorized to regulate the practice of nursing. Under state nurse practice acts, the scope of practice of various advance practice nurses, certified registered nurse anesthetists, clinical nurse specialists, certified nurse midwives, and nurse practitioners is specifically defined. These state statutes also set forth the licensure requirements and grounds for disciplinary action imposed on nursing professionals. The majority of state nursing boards also exercise regulatory authority over nurse practitioners. In a limited number of jurisdictions, both the nursing board and the state medical board may share this role.

Scope of practice

The nurse practitioner's specified scope of practice is critical with respect to any theory of liability or potential allegations that may be asserted in malpractice litigation. It also forms the context within which a court will determine whether negligent conduct occurred and whether the nurse practitioner acted within the scope of practice. This framework enables a jury to decide whether the nurse practitioner adhered to, or breached, the standard of a reasonable and prudent nurse practitioner in the same or similar circumstance in a specific liability claim. The scope of practice for nurse practitioners typically encompasses educational background, clinical experience, and collaborative activities with other health-care professionals.

Prescribing authority

The vast majority of state nurse practice acts grant prescribing authority for prescription medications, including controlled substances, to nurse practitioners. Regulatory agencies are authorized to investigate complaints against nurse practitioners, including those involving prescriptions. Such complaints often arise in the context of prescribing controlled substances, as well as the adherence of nurse practitioners to policies and procedures pertaining to pain management.

Continuing education, including education related to prescribing drugs, remains a significant concern of regulatory agencies. The ability of nurse practitioners to sustain and enhance their prescribing knowledge, especially with respect to pain management, is critical in this high risk aspect of the nurse practitioner's scope of practice.

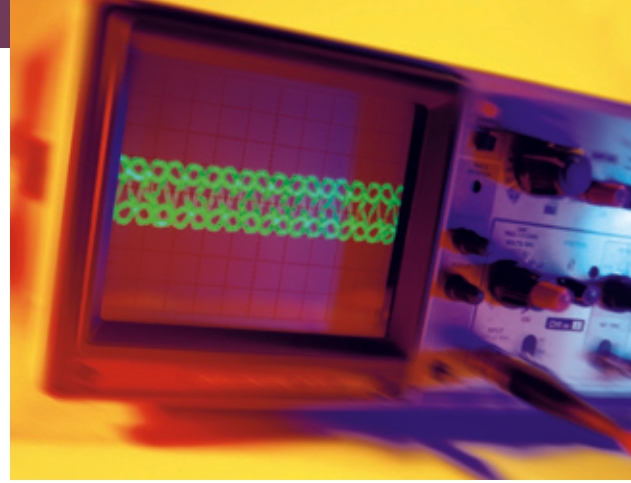
Diagnosis

Generally, the definition of "diagnosis" under state medical practice acts has been very broad. For the nursing profession, however, a nurse practitioner has been defined as one who "assesses the physical and psychosocial status of clients by means of interview, health history, physical examination, and diagnostic tests, ... interprets the data, develops and implements therapeutic plans, and follows through on the continuum of care of the client... [The NP] implements these plans through independent action, appropriate referrals, health counseling, and collaboration with other health-care providers."

American Nurses' Association, American Nurses' Association Congress For Nursing Practice, The Scope of Nursing Practice: Description of Practice, Nurse Practitioner, Clinician, Clinical Nurse Specialist (1976)



CNA is dedicated to improving the risk awareness of nurse practitioners, enabling them to focus on patient safety and improve their loss experience.



Collaboration protocols, practice, and liability

Nurse practitioners often work with other healthcare professionals in a collaborative setting. Laws governing the degree of formality of collaboration protocols vary by state. Some states, such as Alabama, have enacted specific collaboration requirements between physicians and nurse practitioners. Other states, such as Florida, require nurse practitioners to establish a formal protocol agreement with a supervising physician, wherein the responsibilities of each healthcare professional are expressly delineated. In addition, these agreements address the level of physician oversight.

In the most constructive settings, collaborative practice results in optimal patient care. However, collaborative practice also may create a lack of cooperation between physicians, nurse practitioners, healthcare entities, and pharmacies in the course of defending themselves against allegations of malpractice. Such deficiencies in collaboration raise complex issues should a professional liability claim arise. For example, the ability to release and review patient health information records on a timely basis may be jeopardized. In addition, evidence to corroborate claims regarding prescribing practice may be difficult to obtain.

The level of collaboration may affect whether theories of vicarious liability, agency, or corporate responsibility will be asserted to hold physicians, employers, or hospitals liable for the negligent acts of nurse practitioners. Similarly, if a nurse practitioner works as an independent contractor, the entity that contracts with a hospital or physician may be held legally responsible for negligent hiring or selection of the nurse practitioner.

Since the nurse practitioner has the ability to examine, diagnose, and establish treatment plans for patients, friction may develop among the various healthcare professionals. Should these professionals become co-defendants in professional liability litigation, an adversarial situation may result. In some jurisdictions, physicians may carry lower limits of professional liability coverage than a nurse practitioner. In such cases, the nurse practitioner may become the focus of the defendant's claim in order to attach additional liability insurance coverage.

Baker, Susan E. (1992). The nurse practitioner in malpractice actions: Standards of care and theory of liability. *Journal of Law-Medicine*. Summer.

Lazarus, Jean B and Downing, Belinda (Wendy). (2003). Monitoring and investigating certified nurse practitioners in pain management. *Journal of Law, Medicine and Ethics*. (Volume 31, p. 101)

Waldman, J.D., Mitchell. (2005). Physicians, surgeons, and other healers. *Florida Jurisprudence*. February. Section 169.

Understanding and using the data

This study reports and analyzes the data collected from the CNA database. The study reflects some inherent limitations as any conclusions drawn from the data are based on the following parameters:

- The database includes only CNA-insured nurse practitioners, which may not necessarily represent the entire spectrum of nurse practitioner activities.
- Many nurse practitioners are insured through their employers and do not obtain independent professional liability coverage from a third party insurer, making their claim data difficult to obtain.
- Noted indemnity and expense payments are only those paid by CNA on behalf of its insured nurse practitioners and do not represent amounts paid by other insurers, non-CNA defendants, or by the insureds or other third parties in the form of deductibles or self-insured retentions.
- CNA coverage is provided on an "occurrence" basis which means claims may occur, be reported, and be resolved over a period of years. Therefore, data directly correlating the number of insured nurse practitioners to the number of paid claims for any given policy or loss year is unavailable. However, the number of insured nurse practitioners and the overall frequency and severity of claims have both increased over the years included in the study.





FINANCIAL ANALYSIS OF NURSE PRACTITIONER CLAIMS

Ultimate frequency and severity of claims by year of loss

Statistically, the most revealing financial analysis of claims is determined through the application of specialized actuarial calculations called ultimate loss projections. Ultimate loss projections are based on historical patterns. Ultimate losses represent reported losses to date plus a provision for future loss development.

In order to establish the ultimate loss information for the CNA nurse practitioner claims database, the actuarial ultimate loss projection process was applied to a database of 841 claims brought against CNA-insured nurse practitioners. These events occurred between January 1, 1994 and December 31, 2004. Of those 841 claims, 288 are currently projected to ultimately result in an indemnity payment.

The ultimate paid indemnity column in Table 1 refers to the projected money that will be paid for the total number of claims projected to close with indemnity payments in a specific loss year. For purposes of this table, and for the overall nurse practitioner claims study, this column reflects the most predictive figures in projecting severity. The actuarial projection considers future development and optimally, the ultimate losses would not change. As no model can predict claim settlement amounts with precision, ultimate values may increase or decrease.

As reflected in Table 1, the ultimate paid indemnity generally increases each loss year after the 1995 loss year. The ultimate average indemnity, however, remains in the \$130,000 to \$170,000 range after 1995, with the exception of 1998 when it dropped to \$78,667.

Ultimate Frequency and Severity of Claims by Year of Loss

table 1	Loss year	Ultimate number of claims	Ultimate paid indemnity	Ultimate paid expense	Ultimate average indemnity	Ultimate average expense
	1994	3	\$893,500	\$111,327	\$306,878	\$18,469
	1995	5	\$759,000	\$278,763	\$151,800	\$22,950
	1996	14	\$2,231,698	\$774,081	\$159,407	\$29,169
	1997	15	\$2,510,240	\$1,076,045	\$167,349	\$32,403
	1998	24	\$1,888,017	\$1,463,338	\$78,667	\$23,150
	1999	32	\$5,446,380	\$2,001,664	\$170,199	\$26,109
	2000	35	\$4,671,783	\$2,673,635	\$133,480	\$23,701
	2001	50	\$6,950,000	\$4,469,786	\$139,000	\$26,572
	2002	53	\$8,000,000	\$4,783,108	\$150,943	\$23,191
	2003	57	\$8,310,406	\$4,360,322	\$145,797	\$18,363

Although data for losses occurring during calendar year 2004 were collected and used in the Risk Analysis section of this study, the 2004 claim data was excluded from the Financial Analysis because they were considered statistically immature for this specific projection.



RISK ANALYSIS OF NURSE PRACTITIONER CLAIMS

Database and methodology

A database of 841 open and closed claims brought against CNA-insured nurse practitioners (excludes other advance practice registered nurses) between January 1, 1994 and December 31, 2004 was compiled and used in the Financial Analysis section of this study. For the Risk Analysis section, additional inclusion criteria were applied to the original database, resulting in 318 claims being eliminated from the risk analysis section for one or more of the following reasons:

- Incidents only – an adverse event or injury occurred but did not result in a formal legal claim
- Deposition assistance was the only claim service provided to the nurse practitioner
- Legal assistance for protection of the nurse practitioner's license was the only claim service provided
- Nurse practitioner was ultimately dismissed from the legal action
- Drug class action suits not alleging nurse practitioner malpractice (Initial lawsuit naming nurse practitioner was moved into class action suit and no nurse practitioner negligence was alleged)
- No nurse practitioner liability coverage provided by CNA because the corporate entity elected to provide a joint defense among all named parties or because coverage was declined due to policy conditions

Analysis of claims by claim status

Claim status refers to whether the claim is open (pending or active) or closed (settlement, judgment/award, or dismissal). Of the 523 claims included at this point in the study, 342 were closed and 181 remain open. The status of claims becomes important when determining patterns and/or trends related to claim frequency and severity.

Each open claim is assigned an indemnity reserve amount. The reserve is based on the projected indemnity payment that claim experts estimate will be required to resolve the claim by either settlement or judgment. Reserves are adjusted up or down as the claim investigation and management process matures.

The 342 closed claims fall into one of three status types:

- closed without any payment (113)
- closed with expense payment only and no indemnity payment (122)
- closed with indemnity payment (107)

Table 2 reflects the number of open and closed claims of each status type, the amount of indemnity and/or expense that has been paid for each status type, and the amount of indemnity reserves for the open claims. A total of \$38,687,742 has been paid or reserved in the 523 open and closed claims analyzed in Table 2.

Significant expenses have been paid to date for the investigation and management of the 181 open claims. Indemnity monies may have also been paid, although the claims remain open. This may indicate one or more of the following:

- One or more open claims are pending imminent closure and partial indemnity payment(s) has been made
- The claims examiner has not yet completed the claim closure procedure although monies have been paid
- A component of the indemnity payment such as medical costs has been paid, but the claim has not been fully resolved



Claims by Claim Status

table

2

Claim status type	Reported claims	Paid indemnity	Paid expense	Case reserve	Total paid indemnity, expense, and reserves
Closed without payment	113	0	0	0	0
Closed with expense only	122	0	\$1,574,862	0	\$1,574,862
Closed with indemnity payment	107	\$16,453,890	\$4,027,982	0	\$20,481,872
Open	181	\$735,000	\$2,658,518	\$13,237,490	\$16,631,008
Total	523	\$17,188,890	\$8,261,362	\$13,237,490	\$38,687,742

Analysis of claim severity by year

CNA provides professional liability insurance to nurse practitioners on an occurrence coverage basis. Occurrence coverage protects the nurse practitioner against any claim that occurs during the year the policy is in effect, regardless of when the claim is reported. This means that claims are posted to the policy year in which they occur, rather than the year in which the claim is reported or resolved. Loss experience for occurrence policies continues to develop as claims are reported, investigated, and resolved over time. For purposes of this study, however, claim data is analyzed by the year the claim closed. This methodology permits the study to reflect the loss experience of a specific calendar year.

Table 3 displays the number of claims with indemnity payments that closed in each policy year, the paid indemnity, paid expense, average paid indemnity, and average paid expense in each year. With few exceptions, the average paid indemnity has steadily increased from year to year. Given the increase in the number of nurse practitioners insured by CNA each year and the increased liability they face, it is reasonable to expect the frequency and severity of claims to increase as well.

Claim Severity by Year the Claim was Closed

table

3

Close year	Closed claims	Paid indemnity	Expense paid	Average paid indemnity	Average paid expense
1997	1	\$76,000	\$3,800	\$76,000	\$3,800
1998	7	\$890,432	\$76,237	\$127,205	\$10,891
1999	6	\$1,602,216	\$151,785	\$267,036	\$25,298
2000	6	\$678,000	\$166,824	\$113,000	\$27,804
2001	15	\$1,787,194	\$623,764	\$119,146	\$41,584
2002	23	\$3,177,000	\$1,022,043	\$138,130	\$44,437
2003	21	\$2,762,804	\$646,536	\$131,562	\$30,787
2004	28	\$5,480,244	\$1,336,993	\$195,723	\$47,750
Total	107	\$16,453,890	\$4,027,982	\$153,775	\$37,645

Analysis of severity by state

At least one nurse practitioner claim was reported in each of 45 states. Of those, 29 states had at least one claim that closed with paid indemnity. The frequency pattern of nurse practitioner claims by state may reflect similar patterns of increasing malpractice claims as those of physicians and other healthcare practitioners, as well as the population of CNA-insured nurse practitioners included in the study.

Florida had the highest overall frequency of claims. California, New York, Massachusetts, Pennsylvania, Texas, Arizona, and Mississippi, each had 20 or more claims during the period included in the study. Table 4 highlights those states where at least one claim closed with an indemnity payment.

When considering nurse practitioner claim severity by state, it is important to note the total number of closed claims for that state. For example, Illinois had only one closed claim with indemnity payment that was resolved for \$1,000,000. While this is a significant claim, it is not predictive that a nurse practitioner claim in Illinois will have an indemnity payment of \$1,000,000. Since Florida had 34 closed claims, it is possible to state that an average nurse practitioner claim in Florida resulted in an indemnity payment of \$161,000.

As nurse practitioners continue to assume independent practice positions in states where the litigation climate is volatile, it is anticipated that their claim patterns may increasingly reflect a similar volatility. Some states with high claim frequency and severity are focusing on tort reform and other approaches to decrease the malpractice claims crises in their states.

Severity by State

table 4	Loss State	Total number of reported claims (open and closed)	Total number of closed claims with paid indemnity	Average paid indemnity
	IL	4	1	\$1,000,000
	NJ	12	1	\$500,000
	GA	10	2	\$433,083
	KY	7	1	\$378,000
	TX	25	9	\$318,139
	NH	6	2	\$242,500
	NM	12	4	\$214,125
	AR	3	1	\$182,500
	FL	87	34	\$160,726
	MO	7	3	\$158,917
	AZ	21	6	\$132,083
	WA	12	5	\$129,200
	MD	7	3	\$93,667
	NC	9	1	\$90,000
	OR	11	4	\$88,832
	MS	20	2	\$87,500
	KS	9	2	\$85,000
	CO	5	2	\$58,323
	NY	48	5	\$45,600
	OK	8	2	\$40,000
	PA	28	1	\$40,000
	CA	48	9	\$36,059
	UT	6	1	\$32,500
	AK	1	1	\$20,000
	OH	8	1	\$15,000
	MA	29	1	\$9,000
	IN	8	1	\$2,500
	DC	1	1	\$2,050
	MT	5	1	\$995





Analysis of frequency and severity by clinical specialty

As indicated in Table 5, nearly 75 percent of CNA claims involved nurse practitioners within the family practice and adult/geriatric specialties. This may reflect the fact that nurse practitioners tend to provide healthcare services more frequently in those primary care specialties. Table 6 displays that those two specialties also had similar average paid indemnities. On average, an adult specialty claim was resolved for \$134,945 and a family practice specialty claim was resolved for \$154,463.

Claims in the pediatric/neonatal specialty occurred far less often, but had the highest average paid indemnity of \$307,952. Child and infant injuries may carry higher severity due to the provision of complex medical and support services for prolonged periods. Claims for obstetrics/gynecology specialties, which are traditionally the most severe healthcare claims, did not reflect the highest severity for nurse practitioners. While nurse practitioners provide prenatal and post-partum care, they are typically not involved in the actual labor and delivery. The data pertaining to the obstetrics/gynecology specialty presented in this study supports this practice pattern.

The anesthetist and midwifery nurse advance practice specialties have not been included in this nurse practitioner study and may be interesting areas for future focus claim reviews.

Severity by Clinical Specialty* (Closed Claims with Indemnity Payment)

Clinical specialty	Number of closed claims	Percentage of closed claims	Average paid indemnity
Pediatric/neonatal	7	6.56%	\$307,952
Specialty not available	7	6.5%	\$213,776
Family practice	41	38.3%	\$154,463
Adult/geriatric	41	38.3%	\$134,945
Psychiatric	2	1.9%	\$103,750
Obstetrics/gynecology	9	8.5%	\$80,950

* Excludes the other nursing advance practice specialties of certified registered nurse anesthetist and certified nurse midwife.

Frequency by Clinical Specialty* (Open and Closed Claims)

Clinical specialty	Number of open and closed claims	Percentage of reported claims
Family practice	215	41.1%
Adult/geriatric	176	33.7%
Pediatric/neonatal	42	8.0%
Obstetrics/gynecology	39	7.5%
Specialty not available	28	5.3%
Psychiatric	20	3.8%
Student nurse practitioner	3	0.6%

* Excludes the other nursing advance practice specialties of certified registered nurse anesthetist and certified nurse midwife.

Severity by Location

table
7

Location	Number of closed claims	Percentage of closed claims	Average paid indemnity
Hospital – inpatient service	5	4.7%	\$531,333
Clinic – non-hospital based	17	15.9%	\$240,962
Physician office	48	44.9%	\$161,482
Prison health	1	0.9%	\$99,500
Patient’s home	3	2.8%	\$63,667
Emergency department	12	11.2%	\$62,178
Other	11	10.3%	\$56,914
Hospital – outpatient service	2	1.9%	\$52,073
Freestanding urgent care	2	1.9%	\$46,450
Other practitioner office	5	4.7%	\$17,500
Location not provided	1	0.9%	\$2,500

The greatest percentage of claims occurred in the physician office. While less frequent, the most expensive claims occurred in hospital inpatient settings.

Severity by Injury (The 12 Most Expensive Injuries*)

table
8

Injury	Number closed claims	Average paid indemnity
Paralysis	1	\$750,000
Back injury	1	\$600,000
Dislocation (joint)	1	\$400,000
Brain damage	6	\$377,736
Obstetrical/maternal death	1	\$300,000
Cancer	10	\$234,950
Cerebral vascular accident (stroke)	2	\$191,500
Neurological deficit/damage	3	\$190,833
Death	33	\$176,550
Loss of organ or organ function	9	\$160,833
Other	4	\$105,856
Eye injury/vision loss	2	\$105,000

* When a claim involved multiple alleged injuries, the primary or most serious injury was identified as the dominant injury. Closed claims with average paid indemnity of less than \$100,000 are not included in this table because it addresses only the 12 most expensive injuries.



Analysis of severity by location

Table 7 illustrates that the greatest percentage of claims, 44.9 percent, occurred in physician offices. The second most frequent location was clinics. These are locations within the industry where nurse practitioners typically provide the majority of their services. While less frequent, the most expensive claims occurred in hospital inpatient locations.

Analysis of severity by injury

As noted in Table 8, the three most expensive closed claims involved paralysis, back injury, and joint dislocation. These were interesting findings, but given the limited sample size and maturing database, they cannot be considered predictive of future severity of injuries. The most frequent injury was death, which occurred in 30.8 percent of these claims and resulted in an average paid indemnity of \$176,550.

Closed claims related to cancer appear with the second highest frequency in Table 8. Those claims resulted in an average paid indemnity of \$234,950. The cancer-related claims involve the failure to diagnose, misdiagnosis, mistreatment, or lack of treatment by the nurse practitioner. In these cases, plaintiffs allege that their condition worsened, or their prognosis and/or course of treatment were altered due to the nurse practitioner's actions or failure to act.

Analysis of severity by injury outcome

Table 9 indicates that claims with outcomes that reflected permanent total disability and permanent partial disability were the most severe. As such injuries are likely to incur ongoing costs to support the needs of disabled claimants, the severity cited correlates with the nature of the claim. Death claims, which were the second most frequent, also resulted in high severity.

**Severity of Injury Outcome
(Closed Claims with Indemnity Payment)**

table 9	Injury outcome	Number of closed claims	Percentage of closed claims	Average paid indemnity
	Permanent total disability	12	11.2%	\$269,721
	Permanent partial disability	38	35.5%	\$176,766
	Death	35	32.7%	\$175,747
	Temporary partial disability	15	14.0%	\$19,238
	Temporary total disability	5	4.7%	\$9,986
	No injury	2	1.9%	\$5,250

Analysis of frequency and severity by allegation category

As noted in Table 10, claims occurred most frequently in the three allegation categories of diagnosis, treatment, and medication. These top three categories accounted for 81.6 percent of the total claim allegations. The data indicates that 44.7 percent of the allegations were included in the diagnosis category. The prevalence of claims in this category reflects an environment in which nurse practitioners may be held responsible for the determination of patient diagnosis.

Of the 523 open and closed claims, 107 are closed with an indemnity payment and their average severity is reflected in Table 11. The potential severity for the remaining open claims will mature over time and ultimately affect severity.

While monitoring and patient assessment were the most expensive allegation categories, they represented relatively few closed claims. Closed claims related to medication and diagnosis were both frequent and severe. The treatment allegation category, though frequent, had relatively low severity.

Claims involving allegations of diagnosis, treatment, and medication accounted for 81.6 percent of the total claim allegations.

Analysis of severity of allegations related to medication

Of the 60 open and closed claims with allegations related to medication, 17 are closed and their average severity is reflected in Table 12. The potential severity for the remaining open claims will mature over time and ultimately affect severity.

Because most state laws grant some level of prescribing authority to nurse practitioners, the medication category accordingly reflected allegations related to the prescription as well as the administration of medications. The most expensive allegations, failure to properly discontinue medication and administering the wrong medication, involved two claims with indemnity payments of more than \$750,000 each. Five claims involved the prescription of incompatible/contraindicated medications and resulted in average indemnity payments of \$256,586.

Frequency by Allegation Category (Open and Closed Claims)

table 10	Allegation category	Number of reported claims (open and closed)	Percentage of reported claims (open and closed)
	Diagnosis	234	44.7%
	Treatment	133	25.4%
	Medication	60	11.5%
	Monitoring	20	3.8%
	Other	20	3.8%
	Patient's rights	20	3.8%
	Patient assessment	16	3.1%
	Practitioner conduct	8	1.5%
	Scope of practice	6	1.1%
	Equipment	4	0.8%
	Documentation only	2	0.4%





Severity by Allegation Category (Closed Claims with Indemnity Payment)

table 11		Allegation category	Number of open and closed claims	Number of closed claims	Percentage of closed claims	Average paid indemnity
		Monitoring	20	5	4.7%	\$325,200
		Patient assessment	16	3	2.8%	\$263,167
		Medication	60	17	15.9%	\$189,815
		Diagnosis	234	49	45.8%	\$187,810
		Treatment	133	26	24.3%	\$57,684
		Scope of practice	6	3	2.8%	\$31,667
		Patient's rights	20	3	2.8%	\$4,517
		Equipment	4	1	0.9%	\$499
		Practitioner conduct	8	0	0	0
		Documentation only	2	0	0	0
		Other	20	0	0	0
		Total	523	107		

Severity of Allegations Related to Medication (Closed Claims with Indemnity Payment)

table 12		Allegation category – medication	Number of open and closed claims	Number of closed claims	Percentage of closed claims	Average paid indemnity
		Prescription by NP - failure to properly discontinue medication	1	1	5.9%	\$775,000
		Administration by NP – wrong medication	4	1	5.9%	\$766,666
		Prescription by NP - incompatible/contraindicated	16	5	29.4%	\$256,586
		Administration by NP – wrong route	1	1	5.9%	\$150,000
		Administration by NP – missed dose	4	1	5.9%	\$112,500
		Administration by NP – wrong dose	3	2	11.8%	\$34,950
		Administration by NP – incompatible/contraindicated	3	1	5.9%	\$30,000
		Prescription by NP - wrong dose	7	1	5.9%	\$10,000
		Prescription by NP - wrong medication	15	4	23.5%	\$7,463
		Prescription by NP – wrong route	2	0	0%	0
		Prescription by NP – outside prescriptive authority	2	0	0%	0
		Administration by NP – wrong patient	1	0	0%	0
		Administration by NP – Failure to properly discontinue medication	1	0	0%	0
		Total	60	17		



Analysis of severity of allegations related to diagnosis

Of the 234 open and closed claims with allegations related to diagnosis, 49 are closed and their average severity is reflected in Table 13. The potential severity for the remaining open claims will mature over time and ultimately affect severity.

The most frequent and most expensive allegation related to diagnosis was failure to diagnose, accounting for 77.6 percent of these claims. This reflects responsibility imposed on the nurse practitioner for determining the correct diagnosis for patients in his or her care.

The most frequent and most expensive allegation was failure to diagnose, which reflects the nurse practitioner's expanded role in determining a patient's correct diagnosis.

Severity of Allegations Related to Diagnosis
(Closed Claims with Indemnity Payment)

Allegation category - diagnosis	Number of open and closed claims	Number of closed claims	Percentage of closed claims	Average paid indemnity
Failure to diagnose	183	38	77.6%	\$206,824
Delay in establishing diagnosis	41	9	18.4%	\$134,267
Failure to obtain tests	10	2	4.1%	\$67,500
Total	234	49		

table
13





Analysis of severity of allegations related to treatment

Of the 133 open and closed claims with allegations related to treatment, 26 are closed and their average severity is reflected in Table 14. The potential severity for the remaining open claims will mature over time and ultimately affect severity.

The most expensive allegation related to treatment was failure to treat symptoms in accordance with established standards. These claims indicated that nurse practitioners were expected to practice in accordance with established treatment standards and protocols.

Severity of Allegations Related to Treatment (Closed Claims with Indemnity Payment)

table 14	Allegation category – treatment	Number of open and closed claims	Number of closed claims	Percentage of closed claims	Average paid indemnity
	Failure to treat symptoms within established standards	15	3	11.5%	\$136,250
	Improper management of behavioral health patient	6	2	7.7%	\$96,250
	Failure to order/obtain consultation(s)	11	3	11.5%	\$93,048
	Failure to properly treat established diagnosis(es)	28	5	19.2%	\$51,000
	Delay in treatment/care	7	2	7.7%	\$36,825
	Improper technique	20	6	23.1%	\$35,791
	Improper management of medical patient	20	2	7.7%	\$20,000
	Failure to order/perform necessary treatment(s)	4	2	7.7%	\$17,500
	Improper management of surgical patient	6	1	3.8%	\$1,000
	Improper management obstetrical patient	7	0	0%	0
	Improper management of surgical complication	5	0	0%	0
	Abandonment of patient	1	0	0%	0
	Premature cessation of treatment	1	0	0%	0
	Failure to respond to patient's concerns	1	0	0%	0
	Improper treatment related to restraints	1	0	0%	0
	Total	133	26		

RISK MANAGEMENT RECOMMENDATIONS

Scope of practice

risk management recommendations

- Review, at least annually, and comply with the relevant state nurse practice act as it defines the scope of practice for nurse practitioners
- Review, at least annually, and comply with any additional state-specific regulatory authority requirements governing nurse practitioner scope of practice
- Maintain effective collaborative and/or physician supervision agreements that are, at a minimum, as specific and formalized as may be required under relevant state regulations
- Review, at least annually, and comply with established clinical protocols, guidelines, treatment standards, or critical pathways for practice setting and/or clinical specialty
- Ensure that collaborating and supervising professionals, nurse partners, and facilities employing or contracting with the nurse practitioner maintain appropriate professional liability insurance limits as may be required by practice setting or state law or regulations

Patient health information records

risk management recommendations

Record order and maintenance

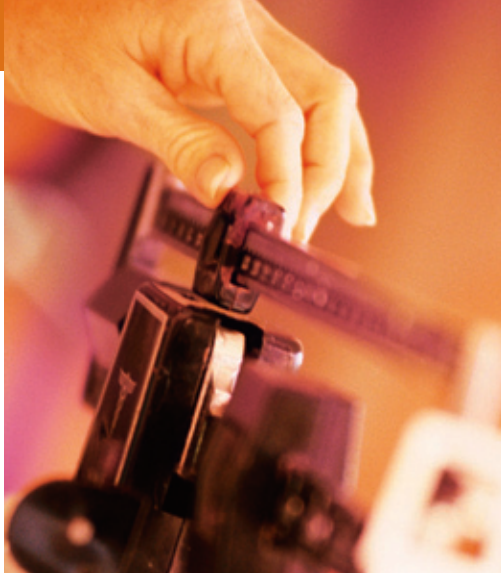
- Maintain patient health information records in a confidential manner
- Retain patient health information records as long as is reasonably possible, but at least in accordance with state and federal law related to health information record retention
- Use binders or closed-type patient health information records that protect against the loss of loose pages
- Develop and adhere to a standard format and order for every patient health information record
- Perform periodic audits of patient health information records to identify departures from appropriate practice and to identify opportunities for future improvement

Contents of patient health record

- Record the patient's name and record number on every page of the patient health information record
- Each patient's health information record should reflect a comprehensive picture of the patient, his/her entire course of diagnosis and treatment and, at a minimum, should include:
 - Demographic information
 - History and physical
 - Accurate, up-to-date problem list
 - Medication list updated at each patient visit
 - Allergies conspicuously noted (include medication, food, and environmental allergies)
 - Progress notes updated at each patient contact including telephone and face-to-face contacts
 - Laboratory and diagnostic test results
 - Referral and consultation requests and results

Using knowledge gained from the claims analysis portion of this study, these risk management recommendations are a useful resource for nurse practitioners.





Documentation-related risk management recommendations

Documentation – general principles

Maintaining a consistent, professional patient health information record is essential to providing quality patient care and establishing an effective defense should litigation arise.

- Make entries in ink and legible
- Sign, date, and time all entries
- Obtain required countersignatures
- Avoid subjective comments regarding the patient or other healthcare providers
- Document actions and patient discussions as soon as possible after the event
- Never leave blanks or unfilled data spaces
- Identify, date, and time contemporaneously late entries as such
- Prohibit late entries for any reason after a lawsuit has been initiated
- Contact the risk manager, insurance company, or legal counsel to obtain advice about proper drafting of a written addendum if there is a legitimate need to do so
- Never alter a record for any reason
- Use only approved abbreviations
- Use only approved methods for correction of documentation error(s) and never erase, obliterate, or use "white out" in any portion of the record for any reason

Release of patient health information

- Release medical and health information only with written permission of the patient/authorized agent or as medically necessary in a medical emergency for continuity of care purposes and in accordance with HIPAA and state legal requirements
- Obtain special additional written authorization required to release patient medical information related to treatment for HIV and AIDS, alcohol and substance abuse, and mental/behavioral illness
- Legal demands for patient health information such as subpoenas, summons and complaints, court orders, etc., should be handled by a single, designated, authorized individual
- Consider the demand for patient health information and review the record prior to releasing the health information
- Sequester or maintain patient health information that has been released for legal reasons with very limited access to avoid tampering or inappropriate late entries



Documentation – clinical

The following provide documentation guidelines for several clinical areas of the patient health information record:

- History and physical examination
 - Chief complaint
 - Review of symptom(s)
 - Allergies
 - Past medical history
 - Positive examination findings
 - Pertinent negative findings
 - Family history
 - Pain assessment
 - Use of alternative therapies or over the counter remedies
- Contemporaneous actions and patient diagnostic and treatment events
 - Summary of patient's current condition
 - Presenting problem(s)
 - Clinical findings and assessment
 - Treatment plan
 - Patient's response to treatment
- Content of discussion with patient regarding results, including normal and abnormal results and recommendations for continued treatment and the patient's response
- Informed consent or informed refusal of treatment discussion
 - Documentation that the patient has been provided with an explanation of the medical condition, illness, or diagnosis and the risks, benefits, and alternatives to the recommended treatment, medication, or procedure
 - Documentation that the patient has had the opportunity to ask questions, is able to repeat the reasons for the recommended treatment, and wishes to proceed
 - Copy of signed informed consent document
 - Documentation that the patient has been provided with the risks and alternatives of refusing the recommended treatment, has had the opportunity to ask questions, is able to repeat the reasons for the recommended treatment, and wishes to refuse
 - Copy of signed refusal of consent
 - Documented use of an interpreter, if needed, with the interpreter's contact information

- Medications administered including injections, samples, etc., along with discussion of potential benefits, side effects, and relevant instructions
- Appropriate tracking information for vaccines and medication samples should be logged and retained
- Patient telephone encounters, including after-hours, with summary of contact, advice provided, action(s) taken

Documentation – diagnostic tests, referrals, consultations

- Receipt of results and subsequent action involving test, procedure, referral, and consultation results, including signing or initialing the results prior to filing
- Referral for consultation or testing
 - Name of test, consultant, or referring practitioner
 - Patient's ability to understand and repeat the reasons for the referral, consultation, or testing
 - Instructions provided to patient

Documentation – medications and prescriptions

- Current medication list
- Prescription refills authorized via telephone and name of pharmacy and pharmacist

Documentation – patient tracking and education

- Missed appointments including documentation of all efforts to contact patient
- Patient education efforts
- Oral and written assessment of patient's ability to comprehend and repeat information provided
 - Copy of written material provided or specific reference to a standard item always used and maintained on file in the practice area
 - Patient-signed receipt for education materials
 - List of family members or authorized persons also receiving education related to patient's care and treatment
 - Documented use of interpreter, if needed, with the interpreter's contact information

Maintaining a complete and accurate medical record is essential in defending any potential allegations of malpractice.

Diagnosis-related risk management recommendations

Clinical decision-making process

- Document the suspected diagnosis(es) in the patient's health information record along with supportive analysis and the clinical decision-making process used
- Incorporate clinical practice guidelines or protocols related to establishing a diagnosis when applicable/available
- If deviating from guidelines and/or protocols, document the clinical justification for the change in plan

Diagnostic tests, referrals, consultations

- Obtain necessary diagnostic tests/procedures to confirm or eliminate diagnosis(es) and track and acknowledge results
- Obtain consultation(s) with clinical specialist(s) as needed to ensure all appropriate and reasonable diagnostic possibilities are considered and address recommendations in writing in the patient's health information record
- Refer patients for specialized diagnostic testing or procedures as appropriate
- Refer patients to clinical specialists for additional clinical diagnosis and track follow-up as needed

Patient communication

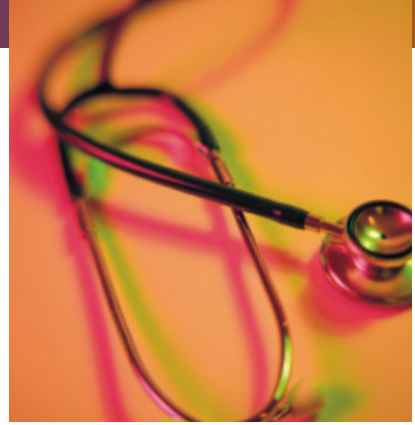
- Utilize proper therapeutic and listening skills to elicit the patient's information and obtain an interpreter, if needed
- Document the discussion of diagnostic results (normal and abnormal results) with the patient
- Explain the diagnosis and prognosis with the patient including a discussion of anticipated symptoms and effects of the diagnosis and allow the patient to ask questions as needed until understanding is achieved
- Document discussions related to diagnosis, anticipated symptoms, expected progression of symptoms, and prognosis

- While some diagnostic tests such as blood and urine testing carry little or no risk to the patient, other diagnostic tests and procedures may involve invasive or other higher risk activities. For those higher risk or invasive diagnostic tests and procedures that carry significant patient risk, the informed consent discussion process should be implemented. The informed consent process should:
 - Comply with any state-specific laws relative to informed consent
 - Ensure the patient is fully aware of the current clinical findings or symptoms that necessitate the proposed diagnostic test or procedure
 - Describe in detail the diagnostic test or procedure to the patient and explain why it is recommended
 - Discuss the risks, benefits, and alternatives to the proposed diagnostic test or procedure
 - Discuss the risks of not performing the indicated diagnostic test or procedure
 - Allow the patient to ask questions to achieve patient satisfaction and until the patient has the ability to repeat the information correctly to the nurse practitioner
 - Document the entire informed consent discussion and the patient's desire to accept or refuse the proposed diagnostic test or procedure
 - Obtain the patient's signature for informed consent or refusal of treatment as appropriate and retain in the patient's health information record

Continuum of care

- Document receipt of diagnostic test, consultation, and referral results (both normal and abnormal results) and indicate how those results are incorporated into the patient's plan of care
- Update the patient's problem list with every change in diagnosis(es)
- Document the results of diagnostic tests or procedures, and indicate the specific reasons or clinical rationale for continuation, modification, and/or termination of treatment(s)





Cancer screening and diagnosis risk management recommendations

In addition to general diagnosis risk management recommendations, there are specific recommendations related to cancer screening and diagnosis promulgated by the American Cancer Society. Patient care related to cancer screening and diagnosis should be diligently monitored and documented in the patient's health record as claims relative to cancer screening and cancer diagnosis are both frequent and carry severe economic impact.

Cancer check-up examination

- The cancer-related health examination should include reviewing and documenting the patient's family and personal medical history
- The discussions focusing on the patient's current medical and psychosocial status should include environmental risk factor questions related to cancers, and should be documented in the history and physical section of the patient health record
- In addition to routine examination, include and document examinations specific for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries

Age-related cancer screening

- Know the American Cancer Society's recommended routine cancer screening diagnostic testing regimens (www.cancer.org) and recommended ages for testing, for both average and high-risk patients
 - Clinical breast examination
 - Mammogram
 - Fecal occult blood test
 - Sigmoidoscopy, double contrast barium enema, colonoscopy
 - Cervical cancer and human papilloma virus testing
 - Digital rectal examination – prostate
 - Prostate-specific antigen test
 - Endometrial biopsy for high-risk patients
- Be familiar with any additional routine cancer screening testing regimens recommended by clinical specialty professional organizations
- Notify patients when screening testing is due, follow-up if patient does not respond, and document communications in the patient's health record
- Document result receipt, nurse practitioner review, and discussion of results (both normal and abnormal) with patient
- Document modifications to the patient's plan of care as a result of the clinical findings

Treatment-related risk management recommendations

For purposes of this section, treatment is expanded to include a specific treatment, procedure, or medication that is ordered or recommended for the patient's disease, condition, illness, or injury.

- Discuss the proposed treatment with the patient and if the proposed treatment involves potential risk to the patient, implement the informed consent process that includes:
 - Ensure the patient is fully aware of the current diagnosis(es) that supports the proposed treatment
 - Provide a detailed explanation of the proposed treatment to the patient
 - Discuss the risks, benefits, and alternatives to the proposed treatment
 - Discuss the risks of providing no treatment
 - Allow patients to ask questions to achieve patient satisfaction and ability to repeat the information correctly to the nurse practitioner
 - Document the entire informed consent discussion and the patient's desire to accept the proposed treatment
 - Obtain the patient's signature for informed consent and retain in the patient's health information record along with any drawings, pictures, or diagrams that were used to explain the contemplated treatment to the patient
- Document the objective clinical signs of the patient's response to treatment(s)
- Document the patient's subjective reports regarding the response to treatment(s)
- Document the specific reasons or clinical rationale for continuation, modification, and/or termination of treatment(s)
- Document the content of discussions related to the cost of treatment including costs related to medications and the use of generic or brand name medications



Medication-related risk management recommendations


Professional practice/scope of practice

- Know and comply with the state laws and regulations regarding prescribing of medications
- Know and comply with the state nurse practice act related to medication prescribing authority
- Limit access to prescription pads and notify local pharmacies and the drug enforcement agency if blank prescriptions are stolen
- Limit telephone refills to one prescription and require the patient to come in and be seen before providing additional telephone refills
- Avoid refilling narcotics and pain medication by telephone and outside of regular office hours
- Perform peer review of the prescribing practices of licensed independent practitioners and obtain additional education and expertise as needed
- Maintain drugs in a safe area with limited access and, if appropriate or required by law, under lock and key
- Store drugs at manufacturer's recommended temperature
- Store drugs in a separate location away from food or other materials or supplies
- Avoid storing similar looking drugs near one another
- Avoid keeping drugs with similar sounding names on the formulary, but if such similarities do occur, provide adequate additional warnings on packaging
- Regularly check drug expiration dates and properly discard/destroy expired drugs

Prescribing medications

- Know the appropriate indications, dosage range, route(s) of administration, contraindications, side effects, and warnings related to the drugs prescribed and/or administered
- Maintain readily available, current drug reference materials and refer to them whenever there are questions regarding a drug or when prescribing a drug that is not frequently prescribed
- Maintain access to resources that provide clinical information on drug interactions
- Consult with physicians and pharmacists when appropriate to confirm appropriate drug selection, prescription and ordering, and to check for potential drug interaction or contraindication with patient's existing drug therapy(ies)

Consult with physicians and pharmacists when appropriate to confirm appropriate drug selection, prescription and ordering, and potential drug interactions or contraindications



Understand and use all components of the informed consent process to ensure patients fully understand the risks, benefits, and alternatives of any proposed treatment.

Continuum of care

- Maintain accurate allergy information on patient medical records and query patients regarding any new or different allergies when prescribing any drug
- Provide a complete, legible, written order for every drug prescribed
- If a verbal or telephone order for a drug is given, ensure the verbal order was correctly taken by having it read back, and sign the order within 24 to 48 hours depending on state and/or facility regulations
- Document telephone requests for refills, and note the name and telephone number of the pharmacy, pharmacist name, drug, dose, and number of doses authorized, on the patient's health information record
- Document all medication samples provided to patients including the name and dose of the drug, the number of doses, expiration date, lot, and serial numbers
- Document the informed consent discussion with the patient when prescribing a drug and include at least the following:
 - Ensure the patient is fully aware of the current diagnosis(es) that support the proposed medication
 - Discuss the proposed medication with the patient and explain why it is recommended
 - Discuss the risks, benefits, and alternatives to the proposed medication
 - Provide off-label-use information, warnings, and additional risks involved when appropriate
 - Discuss the risks of not taking the medication
 - Allow the patient to ask questions to achieve patient satisfaction and ability to repeat the information correctly to the nurse practitioner
 - Document the entire informed consent discussion and the patient's desire to accept the proposed medication
 - Obtain the patient's signature for informed consent and retain in the patient's health information record
- Document all instructions and warnings related to patient regarding the unplanned discontinuation of medication or increasing or decreasing the dosage from that which is ordered
- Maintain a current drug list for each patient and query the patient at each visit regarding any changes that may have occurred
- Document any medication administered to a patient and include:
 - Drug name
 - Expiration date, vaccine lot, and serial number of vaccinations
 - Expiration date, lot, and serial number of samples
 - Dose
 - Route and site
 - Diluent or solution if appropriate
 - Infusion pump information if appropriate
 - Rate of administration
 - Time administered
 - Duration of administration if given over a period of time
 - Reaction if any
 - Vital signs if appropriate
 - Length of time patient observed and any signs of reaction or distress noted
 - Status of site of medication administration and patient's general condition when patient leaves location where medication is being administered

Informed consent for participation in human medical research

Informed consent is a process that involves a discussion between the practitioner and the patient wherein the risks, benefits, and alternatives of a proposed treatment, medication, or procedure are explained. The specific informed consent discussion elements are provided under the diagnosis, treatment, and medication risk recommendation portions of this study.

However, when medical research includes human research subjects, additional elements of informed consent are required as part of the study protocol and must be added to the informed consent discussion between the nurse practitioner and the patient. Each clinical research protocol includes an informed consent document that must be approved as part of that protocol. At a minimum, the consent must include all the potential risks, benefits, and alternatives to the treatment provided by the research protocol. In addition, the consent must clearly indicate:

- The purpose of the treatment and identify its experimental nature
- The expected duration of the course of treatment
- That the treatment may not be helpful or beneficial to the patient and may even be harmful
- Any adverse effects or side effects that may occur
- How to obtain emergency treatment in the event of adverse response to the treatment
- Who will be responsible for payment of emergency treatment required
- The patient's right to refuse to participate in the research protocol without jeopardizing any other aspect of care with the participating nurse practitioner or facility
- The patient's right to withdraw from the research protocol at any time without jeopardizing any other aspect of care with the participating nurse practitioner or facility

Equipment-related risk management recommendations

- Maintain all manuals and instructional materials provided with equipment at the time of purchase or lease
- Inspect all equipment for obvious defects
- Remove any damaged or broken equipment from use
- Obtain adequate training in the proper use of each piece of equipment
- Ensure that, at a minimum, equipment is monitored, maintained, and serviced in accordance with manufacturer recommendations
- Know and comply with the Food and Drug Administration reporting requirements for adverse events related to equipment under the Safe Medical Devices Act
- Maintain written documentation of equipment inspection, preventive maintenance, and repairs
- Maintain written documentation of nurse practitioner training and education related to the use of medical equipment
- Maintain written documentation of patient education related to the use of medical equipment



CONCLUSION

As illustrated in this study, the frequency and severity of liability claims brought against nurse practitioners are on the rise. In part, this is due to the increased number of nurse practitioners and the scope of their practice. Today's nurse practitioner plays a critical role in delivering healthcare in a wide range of clinical settings. With this increased role, there is an increase in potential risk.

Nurse practitioners provide a high level of clinical services, including the diagnosis and treatment of patients. These services carry inherent risks. CNA prepared this study to identify areas where nurse practitioners are most at risk for professional liability claims. Comparing and contrasting one's own practice with the findings in this study can assist nurse practitioners in understanding their own risks. Understanding those areas of practice with high frequency and severity of claims represents a critical step in preventing or minimizing patient injury and financial loss.

The risk management recommendations outlined in this study are provided as a resource for nurse practitioners. They have been developed by risk management professionals and focus on the areas where CNA-insured nurse practitioners have experienced professional liability claims. These recommendations will assist nurse practitioners as they develop their own risk management approaches to providing quality care to their patients in a safe environment.

Nurse practitioners will benefit from taking a proactive risk management approach in their clinical practice. These efforts must be coordinated with the overall risk management program in place in their practice setting, whether that is a hospital, physician office, or other setting. All healthcare presents risks. The best health care is provided in a setting that works to minimize those risks, delivers quality care, and ensures patient safety.

Nurse practitioners will benefit from taking a proactive risk management approach to their clinical practice. The best healthcare is provided in a setting that works to minimize risks, deliver quality care, and ensure patient safety.



EXPLANATION OF TERMS

For purposes of this study and report the following definitions are used:

ABUSE Physical, sexual, emotional, and/or verbal mistreatment of a patient

ALLEGATION A statement asserting that the nurse practitioner has done something wrong or illegal, but which has not yet been proven

BREACH OF CONFIDENTIALITY Failure to maintain patient information related to medical, personal, or financial information in a private manner in accordance with legal requirements

CLAIM Legal action/proceeding against a CNA-insured nurse practitioner alleging professional liability resulting in allegation(s) of patient harm or injury

CLOSED CLAIM A legal action/proceeding where financial compensation has been sought based on the legal liability of the health-care professional pursuant to error, omission, or negligence in the performance of professional services, and the matter has been resolved through a judgment, settlement, or verdict with or without payment of a damages award

DEATH Death that is unexpected, not expected as a result of the course of patient's disease/illness, death as a result of alleged negligence or malpractice. The facts and circumstances do not include death that occurred as a result of the natural course of the patient's disease or illness.

EXPENSE PAYMENT Monies paid in the investigation, management, or defense of a claim

FAILURE TO DIAGNOSE Failure of the nurse practitioner to properly diagnose the patient's illness(es) or condition(s)

FAILURE TO MONITOR Harm or injury to a patient when the nurse practitioner should have known about evolving or pre-existing patient condition(s) and failed to create an appropriate plan of care to adequately review and oversee the patient's medical condition/illness to prevent decline in patient's condition or patient injury

FAILURE TO TREAT Failure of the nurse practitioner to order or otherwise direct staff to provide appropriate medical care to the patient

FREQUENCY The number of open and closed claims with the specified attribute

IMPROPER MANAGEMENT Failure of the nurse practitioner to order or otherwise obtain appropriate care, diagnostic tests, consultation, referral, or medication for the patient's medical diagnosis(es) or symptom(s)

INDEMNITY PAYMENT Monies paid in the settlement or judgment of a claim

INJURY Harm or damage to the patient as a result of an accident, incident, or other adverse event

LACK OF INFORMED CONSENT Failure of the nurse practitioner to provide the patient/legal representative with a clear description of the diagnosis or condition, proposed treatment (includes treatment, diagnostic procedure, or medication), risks, benefits, and alternatives to the proposed treatment, reasonable expectations for the desired effect/result, and risks and benefits of failing to obtain treatment. Additionally, the discussion failed to include the opportunity for the patient/representative to ask questions to the level of his or her satisfaction.


MEDICATION EVENT Any nurse practitioner-related medication event including prescribing and administration issues

OPEN CLAIM A legal action/proceeding that has been asserted against a claimant and alleging damages for personal injuries claimed to have been caused by an error, omission, or negligence in the performance of professional services, where financial compensation has been sought, but which remains unresolved


SEVERITY The average paid indemnity for closed claims that involved indemnity payment(s) resulting from a settlement or jury verdict of a claim

VIOLATION OF PATIENT RIGHTS Purposeful or inadvertent infringement upon a patient's legal rights

This material has been developed from sources believed to be reliable. The CNA Insurance Companies make no representation as to the correctness of the information contained herein and accept no liability for any injury or damages that may arise, directly or indirectly, from its use. CNA is a registered service mark and trade name of CNA Financial Corporation. © CNA Financial Corporation, 2005. Printed 9/2005



CNA HealthPro
CNA Center-265
Chicago, IL 60685
1.888.600.4776
www.cna.com



Nurses Service Organization (NSO) is the nation's largest administrator of professional liability insurance coverage to individual nursing professionals. Nurses Service Organization is a registered trade name of Affinity Insurance Services, Inc., an affiliate of Aon Corporation. For more information about NSO, or to inquire about professional liability insurance for nursing professionals, visit NSO on line at www.nso.com or call 1-800-247-1500.