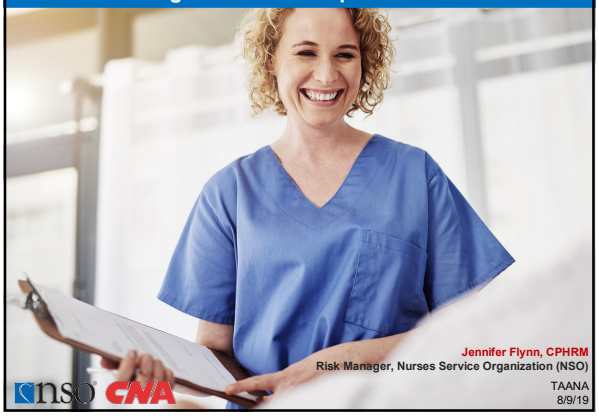
Reducing the Risk of Malpractice for the RN



Jennifer Flynn, CPHRM
Risk Manager, Nurses Service Organization (NSO)

TAANA
8/9/19

Today's Speaker

Jennifer Flynn, CPHRM
Risk Manager, Nurses Service Organization (NSO)

Disclosure Statement: **All faculty and planners in a position to control the content of this CE activity and their spouses/life partners (if any) have disclosed that they have no financial relationships with, or financial interests in, any commercial organizations pertaining to this educational activity with the extent of their participation in the activity.**

Presentation Objectives

- List the leading allegations made against nurses in malpractice lawsuits.
- List the leading allegations made against nurses in Board of Nursing complaints.
- Identify key risk management tools that nurses can incorporate into their practice.

Case Study

Nurse Claim Summary

- A 38 ½ weeks pregnant patient arrived at the emergency department (ED) at 8:29 p.m. with complaints of abdominal pain and decreased fetal movement.
- The mother described her symptoms as “continuous episodes of vomiting for the past three hours, left side abdominal pain, the pain is cramping that does not radiate, is aggravated by movement, and nothing seems to alleviate the symptoms”.
- She stated that she had some Chinese food earlier that afternoon and later she began having abdominal pain and vomiting.
- She presented to the ED because her mother (a registered nurse at the same hospital) instructed her to come to the ED because she would be seen faster.
- Initially, there was some confusion regarding if the patient should be sent directly to the Labor and Delivery (L&D) unit or evaluated first in the ED.

Nurse Claim Summary (Continued)

- The patient was seen in the ED by a nurse at 8:31p.m. She reported her pain as an 8 on a 10-point scale.
- The health information record states that the patient was first seen by an ED nurse practitioner (NP) at 8:33 p.m. and then by an ED physician at 8:37 p.m.
- The NP documented a complete physical examination. Her differential diagnosis was: “gastritis, cholecystitis, labor.”
- At 8:42 p.m., our insured L&D registered nurse came to the ED to monitor the mother and baby.
- The nurse applied a fetal heart monitor in the ED and noticed the fetal heart rate was in the 130’s with minimal variability, and no decelerations noted.
- The nurse started IV fluids and only infused 50 ml as she wanted to see if the fluids would improve the fetal heart rate.
- After 20 minutes of monitoring the patient, the nurse determined that the contractions and fetal heart rate were unlikely to be reversed by hydration.

Nurse Claim Summary (Continued)

- The patient was in the ED for less than 25 minutes when the decision was made to transfer and admit the patient to the L&D unit.
- The insured disconnected the fetal heart monitor and transported the patient to the L&D unit.
- When the nurse and patient arrived at L&D, the monitor was reattached.
- The nurse wrote documented that at 9:18 p.m. she had "Reviewed the fetal hear monitor strip and the patient was being examined by OB".
- At 9:20 pm the OB practitioner documented a progress note, "Patient is G1 @ 37+ weeks, presented to ED with nausea and vomiting, mild abdominal pain. Didn't feel well today. Decreased fetal movement, FHTs 130s NR, decreased LTV. Assessment/Plan: probable GI virus, hydrate with IV fluids – monitor FHTs".

Nurse Claim Summary (Continued)

- At 9:25 p.m. the insured documented that she turned the patient on her right side "due to minimal variability".
- At 9:30 p.m. an entry was made by a second L&D nurse, "The contractions are moderate. The FHR baseline was 125 and the variability was minimal with no accelerations or decelerations".
- At 9:55 p.m. the insured documented that "Contractions are mild to moderate and the FHR baseline are 120 with minimal variability and no accelerations or decelerations.
- At 10:16 p.m. the insured documented, "The FHR baseline is 115 with minimal variability and no accelerations. OB performed an ultrasound and a biophysical profile.

Nurse Claim Summary (Continued)

- At 10:35 p.m. the OB called for an operating room team in order to perform a C-section.
- The last note by the OB prior to the C-section stated:
  - "C-section was performed due to non-reassuring fetal testing. The patient had felt movement in the earlier that morning, but it had decreased throughout the day and the biophysical profile after IV hydration showed an AFI of 5, no movement, no breathing. Since patient is only 1 cm and remote from delivery she will proceed with C-section."
- The delivery was accomplished at 11:21 p.m. Apgar scores were 1 @ one minute, 4 @ five minutes and 6 @ ten minutes.
- The baby's global condition is that of hypoxic-ischemic encephalopathy, cerebral palsy with spastic quadriparesis, and profound brain damage.
- The child cannot sit up or crawl; and is totally dependent for all activities of daily living. The child is nonverbal, but by gestures and is able to respond to simple questions.

Nurse Claim Summary: Additional Information

- There were several defendants in the case. They included our insured nurse, a second L&D nurse (employed by the hospital), the OB practitioner and the hospital.
- The allegations against our nurse were:
  - Failure to immediately transfer plaintiff to L&D;
  - Failure to identify the risk of placental abruption in light of the history and presentation;
  - Failure to properly interpret non-reassuring fetal heart monitor tracings;
  - Failure to attach a scalp electrode when the toco was not picking up the fetal heart tones; and
  - Failure to advocate for a more timely C-section and implement the chain of command.

Was the Registered Nurse Negligent?

- Do you believe this registered nurse was negligent?
- Do you believe any other practitioners were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the registered nurse?
- If yes, how much?

Nurse Claim Scenario: Other Factors

- Other factors were considered:
  - Given the allegation that the insured RN failed to implement the chain of command, presenting an expert who was critical of the OB might serve to directly or indirectly support the claim that the RN should have recognized the MD was mishandling the delivery, and escalated.
  - The defense expert opined the strips in this case were non-reassuring despite hydration; thus, an emergent C-section was appropriate and should have been performed shortly after the patient arrived on the L&D floor.

How Much was Paid on Behalf of the Nurse?

- Total incurred: **$773,000**

Figures represent only the payments made on behalf of our registered nurse and do not include any payments that may have been made by the registered nurse's employer on her behalf or payments from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

Risk Control Recommendations

- ***Act as the patient's advocate*** in ensuring patient safety and the quality of care delivered.
- ***Know and comply*** with your facility's policies, procedures and protocols.
- ***Invoke the chain of command policy*** to ensure timely attention to the needs of every patient and persist to the point of satisfactory resolution.
- ***Proactively address communication issues between nursing and medical staffs,*** and identify instances of intimidation, bullying, retaliation or other deterrents.
- ***If the organization's current culture does not support the chain of command, explain the risks posed to patients***, staff, practitioners and the organization, and initiate discussions regarding the need for a shift in organizational culture.
- ***Contact the risk management department*** or legal department regarding patient or practice safety issues, if necessary.

NURSE
CLAIM METRICS

Reducing the Risk of Malpractice for the RN

Professional Liability Closed Claims for Nurses

	% DIST	Total	% INC
Open	7.2%	$43,025,697	27.8%
Closed w/ no payment	73.5%	$0	0.0%
Closed w/ Indemnity Paid ($1-$9,999)	3.4%	$2,411,136	1.6%
Closed w/ Indemnity Paid ($10,000-$1 million)	6.5%	$99,342,883	64.2%
Closed w/ Expense Only	9.4%	$10,069,493	6.5%
Total	**100.0%**	**$154,849,209**	**100.0%**

Data 2013 thru 2017 as of September 1, 2018

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Reducing the Risk of Malpractice for the RN

Closed Claims with Payment by Coverage Extension Type

	% DIST	Total	% INC
License Protection	91.1%	$5,828,678	94.8%
Deposition Assist	8.0%	$291,801	4.7%
Records Request	<0.1	$7,075	<0.01%
HIPAA	<0.1	$22,440	<0.01%
Personal Injury	<0.1	$1,052	<0.01%
Total	**100.0%**	**$6,151,046**	**100.0%**

Data 2013 thru 2017 as of September 1, 2018

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Reducing the Risk of Malpractice for the RN

Closed Claims by Nurse Specialty

Nursing specialty	% DIST	Total paid	Average total incurred
Adult medical/surgical	39.4%	$32,930,288	$169,744
Gerontology	16.1%	$11,792,245	$149,269
Home health/hospice	18.1%	$18,809,405	$211,342
Emergency/urgent care	6.5%	$7,241,049	$226,283
Obstetrics	8.1%	$19,265,480	$481,637
Critical care	3.5%	$3,736,357	$219,786
Correctional health	3.0%	$2,088,617	$139,241
Behavioral health	1.5%	$416,126	$59,447
Pediatric/adolescent	1.8%	$2,162,742	$240,305
Aesthetic/cosmetic	2.0%	$900,574	$90,057
Total	**100.0%**	**$99,342,883**	**$201,916**

Closed w/ Indemnity Paid ($10,000-$1 million); Data 2013 thru 2017 as of September 1, 2018

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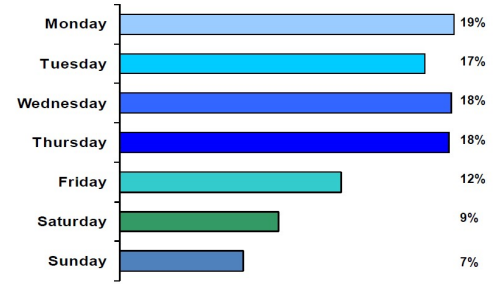
Closed Claims by Nurse Location

Location	% DIST	Total paid indemnity	% INC	Average total incurred
Patient's home	18.2%	$19,107,769	19.0%	$212,308
Hospital, inpatient mother and baby unit	5.9%	$14,968,043	15.0%	$516,139
Hospital, medical inpatient services	22.2%	$17,096,930	17.4%	$156,853
Hospital, emergency department	7.9%	$8,239,550	8.4%	$211,271
Aging services	16.1%	$11,792,254	11.8%	$149,269
Hospital, inpatient surgical services	5.3%	$5,397,849	5.4%	$207,610
Hospital, adult critical care	3.3%	$3,576,978	3.6%	$223,561
Practitioner office practice	5.5%	$4,271,662	4.2%	$156,210
Hospital, obstetrics	1.4%	$2,530,391	2.4%	$361,484
Hospital, operating room/suite	2.0%	$1,777,976	1.7%	$177,979
Correctional health, inpatient or outpatient	3.3%	$3,288,192	3.3%	$205,512
Clinic, hospital outpatient	3.7%	$3,375,144	3.4%	$210,947
Hospital, neonatal/pediatric critical care	0.6%	$293,890	0.4%	$97,963
School, (preschool through university)	1.4%	$1,785,755	1.7%	$255,108
Behavioral/psychiatric health	1.2%	$288,314	0.3%	$48,052
Ambulatory surgery	1.8%	$1,336,801	1.3%	$148,533
Hospital, nursery	0.2%	$215,395	0.2%	$215,395
Grand Total	**100.0%**	**$99,342,893**	**100%**	**$201,916**

Closed w/ Indemnity Paid ($10,000-$1 million); Data 2013 thru 2017 as of September 1, 2018

Reducing the Risk of Malpractice for the RN

Most Frequent Date of Loss



Data 2013 thru 2017 as of September 1, 2018

Reducing the Risk of Malpractice for the RN

Case Study

Nurse Claim Summary

- An 77 year-old male patient recently underwent a total left hip arthroplasty due to multiple years of arthritic pain.
- The patient's medial history included mild-moderate Alzheimer's disease, gait dysfunction (related to arthritic hip), and occasional incontinence (due to radical prostatectomy for prostate cancer, five years prior).
- After a successful total left hip arthroplasty, the patient remained in the hospital a few days due to an sudden increase in the severity of his Alzheimer.
- The family refused all referrals to a rehabilitation facility for post-surgical physical therapy and treatment to stabilize his Alzheimer.
- Instead, the patient's wife insisted that she could care for him at home with the help of their children and home health services.

Nurse Claim Summary

- On the day of discharge from the hospital, a home health nurse met the patient and family at their home for admission.
- The nurse noted that the patient was slightly confused, but was easily refocused.
- The nurse also noted that the patient was a large man (6' 5", 260 pounds) and currently chair-bound requiring a one-person assist to stand, but could ambulate using a walker.
- The admitting nurse noted the patient had a good support system which consisted of his wife and three daughters that lived locally and were able to assist with his care.
- The plan of care was for the patient to receive nine-weeks of:
  - physical therapy, three times-a-week,
  - wound care treatment to the left hip incision site, three to five times-a-week, and
  - personal care assistance, three to five times-a-week.

Nurse Claim Summary

- During the first week of home care, the patient made little progress in physical therapy.
- At beginning of week two, the wife complained to our insured nurse (defendant) that over the weekend the patient would not do anything on his own, refused all medications and at times became verbally aggressive. The wife explained that his behavior was polar opposite from his normal character.
- The wife stated that due to her size (5' 0", 120 pounds) it was difficult for her to get the patient to the bathroom, so she would leave his adult briefs on until her daughters arrived and able to help.
- After several attempts, the patient reluctantly allowed the nurse to change the dressing to his incision site. The incision site was slightly red, but did not appear infected.
- The nurse contacted the patient's primary practitioner about the patient's behavior and was given an order to increase his Aricept dosage, which the patient began that day.

Nurse Claim Summary

- Two days later, the nurse returned to the patient's home. The wife stated that the patient's aggressive attitude had improved, but he still refused to get out of his chair. The wife also informed the nurse that the patient had a bruise-like area on left inner buttocks.
- The nurse assessed the area and noted it as a Stage II pressure ulcer. She obtained an order for wet-to-dry dressings and trained the family on wound care and pressure ulcer prevention. She encouraged the family to purchase a 'donut pillow' for the patient.
- At the next nursing visit, the insured noted the pressure ulcer to be "Stage II 1x 0.5 open area on the left buttock, wound bed pink, no drainage, surrounding skin intact."
- She documented that the "family was taught how to do dressings, advised to do dressing changes 2x per day, educated on how to avoid pressure sores, and to keep pressure off area as much as possible".
- She further documented that "patient spends most of his day sitting, is fearful of walking, and is unsteady on his feet".

Nurse Claim Summary

- Over the next two weeks, the pressure ulcer continued to worsen, despite the nurse contacting the referring practitioner for additional wound care orders.
- Three weeks after the pressure ulcer was discovered, a second wound appeared on the patient's right buttocks.
- The insured nurse made numerous suggestions to her manager for the patient to be evaluated by a wound-care specialist, but her request were denied as the manager felt it was unnecessary.
- Over the next month, the patient's medical status and pressure ulcers continued to worsen.
- Several attempts were made to counsel the family about transferring the patient to a rehabilitation facility, but the family refused.
- Ultimately, the patient was diagnosed with sepsis and died due to irreversible disease.

Was the Registered Nurse Negligent?

- Do you believe this registered nurse was negligent?
- Do you believe any other practitioners were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the registered nurse?
- If yes, how much?

Risk Control Comments

- After the lawsuit was filed, the insured nurse retired from nursing. She had been a nurse for over 30-years.
- The home health agency's manager testified that she thought our insured was just being lazy and didn't want to take care of the patient's pressure ulcers.
- The referring practitioner testified that he was unaware of the severity of patient's pressure ulcers until the ulcers had progressed to a Stage III/IV.

Risk Control Comments

- Experts determined that our insured nurse breached the nursing standard of care in the following areas including:
  - Not staying current on appropriate pressure ulcer treatment.
  - Failure to monitor the patient care environment to ensure patient safety.
  - Failure to follow established institution's policies and procedures on the chain of command.
  - Failure to accurately document care, observations and conversations with practitioners, colleagues, patients, family and /or caregivers.
- Given the deviations from the standard of care and the negative testimony from other staff members regarding the defendant's care, the decision was made to settle the case on behalf of the defendant.

How Much was Paid on Behalf of the Nurse?

- Indemnity payment: Approximately **$175,000**
- Expense payment: Greater than **$45,000**

Figures represent only the payments made on behalf of our registered nurse and do not include any payments that may have been made by the registered nurse's employer on her behalf or payments from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

Risk Control Recommendations

- ***Know and comply with your state scope of practice, nurse practice act and facility policies, procedures and protocols.*** Know the organization's policies and procedures related to clinical practices and documentation.
- ***Maintain clinical competencies relevant to the patient population and healthcare specialty.*** Nurses are accountable for their professional actions to themselves, their healthcare consumers, their peers, and ultimately to society.
- ***Invoke the chain of command when necessary to focus attention on the patient's status.*** Nurses are the patient's advocate, ensuring that the patient receives appropriate care when needed.
- ***When faced with a patient situation that has legal implications, proceed in a manner that provides the best care for the patient.***
- ***Monitor and document the patient's symptoms, response to treatment and changes in condition*** in the patient care record.
- ***Timely report all significant findings to the patient's physician.***

Managing Noncompliant Patients

- Review the recommended care plan with patients, respond to any concerns, and confirm that they agree with the treatment strategy and understand their responsibilities.
- Convey clearly and simply the need to comply with the care plan, and document all compliance-related communications, including questions asked, explanations given, and assistance offered and/or rendered.
- If necessary, give patients a written description of the potentially harmful consequences of noncompliance. Request that they sign the document and offer them a copy, placing the original in the healthcare information record.
- Assess the risk involved in continuing to treat a chronically noncompliant patient. In some cases, it may be necessary to suspend or terminate the relationship.

Managing Noncompliant Patients – Refusal-to-Consent Form

- If a patient persistently fails to heed medical advice, having the patient complete a refusal-to-consent form can serve to formally confirm that the provider fully disclosed to the patient the risks of forgoing the proposed test, treatment, or procedure.
- By signing the form, patients acknowledge that they have discussed the proposed course of care with their practitioner and understand that failure to follow medical recommendations can have serious or even life-threatening consequences.
- The completed refusal-to-consent form should be placed in the healthcare information record.

Reducing the Risk of Malpractice for the RN

NURSE CLAIM METRICS

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Reducing the Risk of Malpractice for the RN

Closed Claims by Allegation

Allegations	% DIST	Total Incurred	% INC	Average incurred
Diagnosis	1.2%	$2,865,711	2.9%	$477,619
Treatment and care management	51.4%	$51,396,767	51.7%	$203,149
Medication	8.9%	$10,625,605	10.7%	$241,491
Monitoring	20.9%	$20,209,831	20.3%	$196,212
Assessment	4.0%	$3,410,618	3.4%	$170,531
Professional misconduct	4.7%	$3,856,206	3.9%	$167,661
Transfusion	0.8%	$458,172	0.5%	$114,543
Patient rights	6.5%	$5,101,449	5.1%	$159,420
Equipment	1.4%	$1,418,524	1.4%	$202,646
Grand Total	**100%**	**$99,342,883**	**100%**	**$201,916**

Closed w/ Indemnity Paid ($10,000-$1 million); Data 2013 thru 2017 as of September 1, 2018

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Reducing the Risk of Malpractice for the RN

Closed Claims by Resulting Injury

What are the highest average incurred injuries?

Injury	Distribution	Total Incurred	% Incurred	Average
Seizure	0.2%	$1,199,575	1.1%	$1,199,575
Brain injury, related to birth	3.7%	$13,010,852	13.0%	$722,825
Paralysis	1.2%	$2,658,916	2.7%	$443,153
Brain injury, excludes birth injury	2.8%	$5,523,443	5.5%	$394,532
Neurological deficit/damage	3.5%	$5,443,613	5.4%	$320,213

What is the most frequent injury resulting in a claim?

Injury	Distribution	Total Incurred	% Incurred	Average
Death	34.8%	$31,956,381	32.1%	$186,879
Fracture	9.8%	$5,914,949	5.5%	$123,249
Infection/sepsis	7.5%	$6,937,219	6.8%	$187,492
Pressure injury	6.7%	$2,836,187	2.7%	$85,945
Brain injury, related to birth	3.7%	$13,010,852	13.0%	$722,825

Closed w/ Indemnity Paid ($10,000-$1 million); Data 2013 thru 2017 as of September 1, 2018

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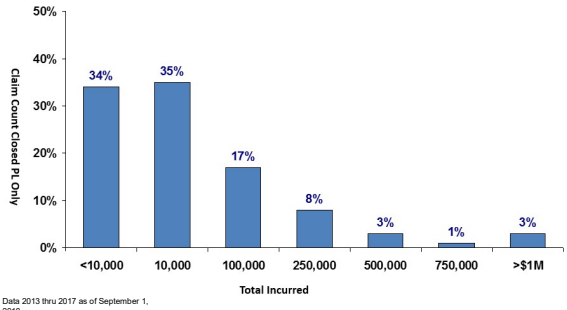
Reducing the Risk of Malpractice for the RN

Distribution by Total Incurred



Data 2013 thru 2017 as of September 1, 2018

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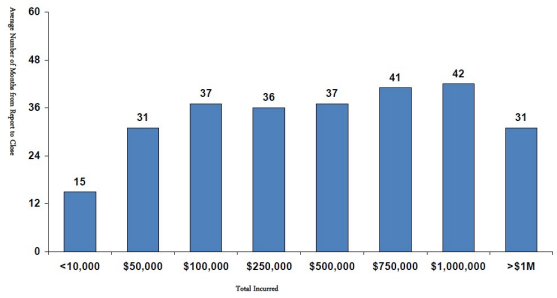
Reducing the Risk of Malpractice for the RN

Time to Closure



Data 2013 thru 2017 as of September 1, 2018

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Reducing the Risk of Malpractice for the RN

Case Study

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Nurse Claim Summary

- The insured was an independently contracted registered nurse who provided nursing consultation to a residential facility that cared for adults with mild to moderate mental health issues (not substance abuse).
- The resident was an adult foster care resident at the residential home and was his own guardian.
- His medical history included a traumatic brain injury, anxiety, schizoaffective disorder, and a history of substance abuse.
- The resident had a history of sleeping-in and isolating himself in his room.
- He received medications from the facility's staff twice per-day, in the morning and evening.
- He typically had to be awakened in the morning to receive his morning medications. After receiving his medications, he would usually fall back asleep.

Nurse Claim Summary (Continued)

- The resident's stay was typically uneventful except for a few times he would appeared lethargic and disoriented.
- Each time this happened he would state that his mother his mother provided him with a narcotic medication (Vicodin) for pain.
- On one occasion, the resident fell into a deep sleep and could not be awakened, though he was visibly and audibly breathing.
- Our insured was contacted via phone and told the facility staff to monitor him every 30 minutes and hold his medications until he woke up.
- When the resident awoke he broke into the office with the medication cabinet and accessed the locked medicine cabinet and allegedly ingested Tylenol PM. After this incident, he was taken to the hospital for evaluation.
- On a second occasion, the resident reportedly took 16 anti-nausea/motion sickness pills from his mother and ingested them over the course of an evening. He was again taken to the hospital for evaluation.

Nurse Claim Summary (Continued)

- Two weeks after the second incident, the resident spent the day with his mother. When he came back to the facility he was very excitable.
- The next morning (8:00 a.m.) the staff could not wake the resident for morning medications despite repeated attempts.
- The staff contacted our nurse at 9:30 a.m. and requested she to come to the facility and assess the patient.
- When she arrived she found the resident sleeping and breathing normally (10:30 a.m.).
- The insured tried to wake the patient, but he responded with a grunt and a dismissive shoulder shrug. The nurse interpreted this as a deliberate response from the resident.
- The nurse spoke with the facility's supervisor via phone and reported that the resident was being uncooperative.

Nurse Claim Summary (Continued)

- She instructed the staff to continue attempts to wake the resident and to call her when he awoke.
- The nurse left soon after giving those instructions and speaking to the supervisor.
- The first shift staff continued to check-in on resident every 30-minutes until 1:00 p.m.
- When the second shift arrived at 1:30 p.m., the technician who checked on the resident found that he was not breathing and called 911.
- Resuscitation efforts were unsuccessful and the patient was pronounced dead on-scene at approximately 2:30 p.m.
- The medical examiner attributed the resident's cause of death to mixed drug toxicity, including morphine, phenobarbital, and clonazepam.
- He was only prescribed clonazepam.

Was the Registered Nurse Negligent?

- Do you believe this registered nurse was negligent?
- Do you believe any other practitioners were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the registered nurse?
- If yes, how much?

Nurse Claim Summary: Additional Information

- The mother filed a lawsuit against the residential facility, the healthcare company that provided nurse staffing assistance, and our insured nurse.
- During discovery, the resident's mother testified she had morphine pills at home in an unsecured location, and that she noticed that a number of morphine pills were missing, but at no point was this information communicated to the facility or to our insured nurse.
- The mother claimed that our insured:
  - Failed to provide adequate care to the patient on the day of his death by not calling 911 when she could not wake him.
  - Failed to recommend that the resident have a urine drug test when he arrived back at the facility from his mother's home.
  - Failed to communicate the need for emergency treatment to the supervisor on the day of the patient's death.

Nurse Claim Summary: Additional Information

- Several defense experts were asked to review this claim and most were supportive of the nurse's actions.
- There was one concern that the nurse's role was one of consultation only and she may have crossed that by responding to requests to come and check on the patient.
- The experts found that the claims asserted against her were too far outside the scope of practice as she could not perform a drug screen on the patient without an order from a provider.
- Considering the positive expert opinions and because the insured was an independent contractor, who was not responsible for the treatment of residents, demands for a settlement were turned down.

How Much was Paid on Behalf of the Nurse?

- Indemnity payment: $0.00
- Expense payment: in excess of **$59,000**

Figures represent only the payments made on behalf of our registered nurse and do not include any payments that may have been made by the registered nurse's employer on her behalf or payments from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

Risk Control Recommendations

- ***Understand and comply with state regulations relevant to the consultant role*** within the particular healthcare delivery model.
- ***Ensure that the description of the position accurately reflects the scope of practice***, as well as the scope of services and specific job duties to be performed.
- ***Engage an attorney to review all contracts involving consulting services*** for a clinical facility prior to signing and executing such contracts.
- ***Read the employment contract carefully to determine the full extent of responsibility being assumed***, and request that legal counsel negotiate the removal of inappropriate, overly broad or undesirable descriptions of duties and responsibilities.
- ***Review facility policy and procedure manuals*** to determine if policies and procedures comply with required standards of care.

NURSE
CLAIM METRICS
License Defense

License Defense

An action taken against a nurse's license to practice differs from a professional liability claim in that it may extend ***beyond matters of professional negligence and involve allegations of a personal, nonclinical nature****, such as substance abuse. License protection claims represent only the cost of providing legal defense for the nurse, rather than indemnity or settlement payments to a plaintiff.*

License Defense by License Type

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

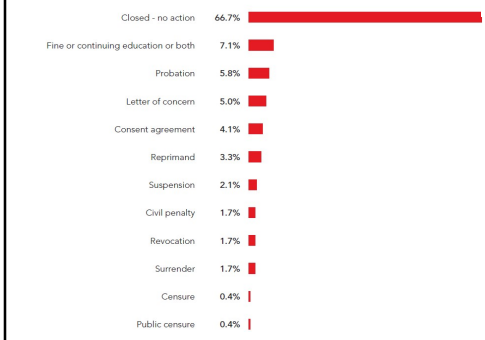
License Defense by Allegation

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

License Defense by Sub-Category: Professional Conduct

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

Frequency of Board Decisions



License Defense

License Defense Case Study

- This case involves a registered nurse working in an acute care facility. The nurse took the facility's narcotic keys out of a fellow nurse's bag, opened the narcotic drawer, and removed a bubble pack of oxycodone, placing it in her purse. The nurse then brought the bubble pack into the staff bathroom with the intent to take the oxycodone for her personal use.
- A coworker witnessed what happened and followed the nurse into the bathroom, confronting her about taking the oxycodone.
- The nurse was asked about the incident by her manager. While at first the nurse initially denied taking the oxycodone, she eventually admitted to her actions. She claimed that she did not ingest the three tablets as planned but flushed them down the toilet.
- The nurse resigned from her job in lieu of termination. Following her resignation from her job, she self-reported to the Board's nurse assistance program and was admitted. The State Board of Nursing initiated an investigation following her admission to the nurse assistance program.
- During her conference before the board, the nurse disclosed that she is a recovering alcoholic. The nurse had been sober for almost 20 years, but after the death of a family member she relapsed. The nurse reported that she was on bereavement leave from her job during her relapse and had been sober for nearly 9 months since returning to work following her leave. She said that she had never taken drugs from her employer before. She said that she could not handle the stress of her job that day and made a grave mistake in trying to cope by taking the oxycodone. The nurse admitted to taking the oxycodone tablets for her personal use, but denied ingesting them, stating that she was interrupted while in the bathroom and flushed the tablets.
- The nurse indicated that since this incident she had been active in maintaining her recovery by attending treatment and support groups since the incident with the oxycodone, and that she had been under the treatment of a psychiatrist who was managing her medication for mental health issues.
- The review panel determined that the public would best be protected by monitoring to ensure the nurse's continued sobriety and management of her health. The board imposed a civil penalty of $500 and placed limitations on the nurse's license for two years, including requiring that she be supervised by another registered nurse while she is working, and prohibiting her from administering, handling, or have any responsibility for controlled substances.

License Defense Case Study

- This case involves a nurse who worked in the Emergency Department at a regional medical center. The nurse manager for the ED received an anonymous email with posts from the nurse's Facebook page. At the top of the email, a comment was typed "thought you would find it interesting what one of your nurses is saying on Facebook." The manager was then able to go through the posts that this person sent and match the information in the posts to records from patients that were either assigned to the nurse or were patients in her unit while she was on duty. The manager was also able to determine that some of the posts were made while the nurse was on duty.
- The nurse was subsequently fired from her job and investigated by the State Board of Nursing. During the nurse's questioning by the Board, the nurse admitted that when she realized that there was an investigation related to her social media posts, she deleted the posts in question from her Facebook page. When questioned further about the nature of the social media posts, the nurse said that she assumed that there was a certain degree of anonymity about posting on social media, and that she realized in hind sight that was a foolish assumption.
- The Board ruled that the nurse failed to maintain minimum standards of nursing by breaching patient confidentiality and given a settlement order which required her to complete a Board-approved course on ethical/legal decision making and pay a $300 fine. The total costs associated with defending the nurse's license before the board exceeded $6,500 in this case.

License Defense Case Study

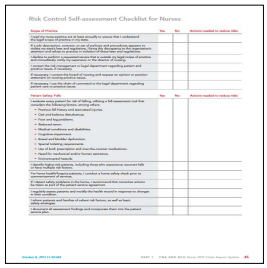
- On January 9th, the nurse was on shift as an ED nurse, when a patient presented with shoulder pain. The patient expressed concern for his privacy because he had an outstanding warrant for his arrest. The patient was assured by hospital staff that his privacy would be protected, and law enforcement would not be notified of his presence. However, the insured nurse violated the patient's privacy and sent a text message to her friend, a local police officer, advising him that the patient was in the ED and had a warrant out for his arrest. The officer responded to the ED and arrested the patient.
- On January 22nd, the Board received information alleging that the nurse violated a patient's right to privacy and opened an investigation into the matter.
- On March 1st, the nurse left a letter in her manager's mailbox stating she was resigning her position, effective immediately. That same day, the nurse hid raw chicken in the employee break room, inside zippered couch cushions, behind the staff refrigerator, and behind a filing cabinet. She also hid raw chicken inside chair cushions in the ED's bereavement room.
- The rotted, raw chicken caused the rooms to have a repulsive odor and created a potential biohazard to hospital staff and visitors, including a family that utilized the bereavement room during the time period the rotting chicken was in place. The raw chicken placed by the nurse ultimately caused over $11,000 in damages to hospital property. Three weeks later, the nurse was arrested for criminal mischief, a felony in her jurisdiction.
- During the Board's investigation into the incident with the patient and her conduct thereafter, the nurse failed to answer the Board's questions truthfully and completely. In light of the findings of the Board's investigation, and the nurse's behavior, the Board suspended the nurse's license for 180-days for violating the client's rights of privacy and confidentiality, inaccurate recordkeeping, failing to answer questions truthfully, and failing to conform to the essential standards of acceptable nursing practice. The total costs associated with defending the nurse's license before the board exceeded $9,000 in this case.

Reducing the Risk of Malpractice for the RN

Nurse Self-assessment Checklist

Nurse Self-assessment Checklist
and
Claim Tips

www.nso.com


Risk Control Self-assessment Checklist for Nurses

Reducing the Risk of Malpractice for the RN

Questions ?

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