CNA nso

Nurse Practitioner Professional Liability Exposure Claim Report: 5th Edition

Minimizing Risk, Achieving Excellence

Many of the top findings from this report are discussed in greater detail within subsequent topic-driven publications, entitled Nurse Practitioner Spotlights. The Nurse Practitioner Spotlights include resources such as case scenarios, risk control recommendations, and self-assessment checklists designed to help NPs evaluate risk exposures associated with current practice. See page 12 for additional information on Nurse Practitioner Spotlights.

Top Ten Key Findings of the Nurse Practitioner Professional Liability Exposure Claim Report

The **average total incurred of professional liability claims** in the 2022 dataset ($332,137) **increased more than 10.5 percent** compared to the 2017 dataset ($300,506). (See page 6.)

The **neonatal specialty** represents the **highest average total incurred** in the 2022 and 2017 datasets. (See page 7.)

Aging services claims increased from 17.2 percent of the total distribution in the 2017 dataset to **20.3 percent of the total distribution** in the 2022 dataset. (See page 11.)

The top three locations in which a nurse practitioner (NP) incurs claims remains the **physician office practice, aging services facility** and **nurse practitioner office practice**. (See page 11.)

In the 2022 dataset, **diagnosis-related claims** represent the **highest percentage of claims at 37.1 percent** and have an **average total incurred of $385,947** which is greater than the overall average total incurred of $332,137. (See page 14.)

Death and **cancer** are the two most common injuries, representing more than half of the claims. (See page 16.)

The **average total expense ($26,349)** of professional liability claims that closed without an indemnity payment in the 2022 dataset **increased 11.1 percent** since the 2017 dataset. (See page 20.)

The **average cost ($7,155)** of defending allegations in license protection matters involving a nurse practitioner in the 2022 claim report represents an **increase of 19.5 percent** compared to the 2017 claim report and **61.1 percent** compared to the 2012 claim report. (See page 23.)

Professional conduct, medication prescribing and **scope of practice** allegations reflect the highest distribution of license protection board matters. (See page 23.)

Approximately **43 percent** of license board matters led to some type of board action against a nurse practitioner's license. (See page 28.)

Part 1: Nurse Practitioner Professional Exposures and Data Analysis

Introduction

In collaboration with our business partners at Nurses Service Organization (NSO), CNA has been providing professional liability insurance to nurse practitioners (NPs) for 30 years and currently insures NPs across the country and in a variety of practice settings.

In 2005, our joint professional program published the first report reviewing the professional liability claims encountered by CNA/NSO on behalf of insured NPs.

CNA and NSO are proud to offer this fifth comprehensive analysis of professional liability risks encountered by NPs. Our goal is to help NPs enhance their practice and minimize professional liability exposure by identifying loss patterns and trends in the following categories:

- NP specialties
- Healthcare delivery locations
- Allegations made against NPs
- Patient injuries associated with claims
- NP owned practices
- Expenses associated with claims
- License protection matters

Database and Methodology

Unless otherwise noted, the dataset comprising Parts 1 and 2 of this report (referred to as the "2022 dataset") includes 232 CNA professional liability claims that:

- Involved an NP, NP owned practice or NP student;
- Closed between January 1, 2017 and December 31, 2021, regardless of when the claim was first reported or initiated; and
- Resulted in an indemnity payment of $10,000 or greater.

This report provides selected findings from the CNA/NSO 2012 and 2017 NP claim reports for purposes of comparison. As some elements of the inclusion criteria in this report may differ from that of the previous reports, we ask readers to exercise caution about comparing these findings with other reviews. Similarly, due to the uniqueness of individual claims, the average total incurred amounts referenced in this report are not necessarily indicative of the actual incurred amounts for any individual claim.

Although the 2022 dataset includes professional liability claims and license protection matters that closed in 2020 and 2021, it is important to note that, for the majority of these claims, *the events that gave rise to these incidents* occurred prior to the COVID-19 pandemic. Although the COVID-19 pandemic has presented the healthcare industry with new challenges and loss potential, the ultimate effect of this pandemic upon litigation, claim frequency and severity remains uncertain.

Terms

For purposes of this report only, please refer to the terms and explanations.

2012 dataset – A reference to the prior CNA study, entitled "Understanding Nurse Practitioner Liability, 2007-2011: A Three-part Approach."

2017 dataset – A reference to the prior CNA study, entitled "Nurse Practitioner Claim Report: 4th Edition, A Guide to Identifying and Addressing Professional Liability Exposures."

2022 dataset – A reference to the current CNA study, entitled "Nurse Practitioner Professional Liability Exposure Claim Report: 5th Edition, Minimizing Risk, Achieving Excellence."

Average total incurred – The costs or financial obligations including indemnity and expenses, resulting from the resolution of claims, divided by the total number of claims.

Expense payment – Monies paid in the investigation, management or defense of a claim, including but not limited to expert witness expenses, attorney fees, court costs and record duplication expenditures.

Total paid indemnity – Monies paid on behalf of an insured NP in the settlement or judgment of a claim.

Claims Analysis Overview

The general analysis includes 232 closed claims involving an NP, NP receiving coverage through a CNA-insured healthcare business or NP student that resulted in paid indemnity of ≥$10,000.

KEY FINDING

The **average total incurred of professional liability claims** in the 2022 dataset ($332,137) **increased more than 10.5 percent** compared to the 2017 dataset ($300,506).

- In the 2012 and 2017 datasets, the average total incurred was $285,645 and $300,506, respectively. This indicates increases of 5.2 percent between the 2012 and 2017 datasets.
- Claims involving NPs who were covered through a CNA-insured healthcare business, such as an NP office practice, had an average total incurred higher than claims involving insured NP students and those NPs who were individually insured. This result is expected, as NP practice coverage is the primary source of insurance coverage for multiple parties, including the corporation as well as its employees and independent contractors.

Claims involving NP students tend to be infrequent but still have an average total incurred of more than $200,000. NP student claims typically arise from situations involving inadequate supervision of the treatment of high acuity patients.

Examples include NP students who were not properly supervised while performing complex care, as observed in the following scenario:

An insured NP student inserted a central internal jugular line under the supervision of the critical care intensivist. The intensivist was in the room but not in immediate proximity to the insured NP student, as this was not the first central venous catheter line insertion for the student. While using an ultrasound guided Seldinger wire technique, the NP student inadvertently punctured the jugular vein. A post-procedure chest x-ray showed the incorrect line placement. The line placement necessitated the transfer of the patient to another facility for removal of the line by a vascular surgeon. Following transfer, the patient had a cerebrovascular accident during the removal of the line and suffered permanent brain injury. The claim was settled on behalf of the NP student with a total incurred in excess of $100,000.

How Courts Define Malpractice

Four elements must exist for an incident to be considered malpractice:

1	**Duty**	A nurse practitioner-patient relationship must exist.
2	**Breach**	Standard of care was not met.
3	**Cause**	Injury was caused by the nurse practitioner's error.
4	**Harm**	Injury resulted in damages.

1 Analysis of Closed Claims by Licensure and Insurance Type

Closed Claims with Paid Indemnity of ≥ $10,000

Licensure and insurance type	Total paid indemnity	Total paid expense	Average total incurred
Nurse Practitioner, individually insured	$58,165,658	$11,454,873	$329,955
Nurse practitioner receiving coverage through a CNA-insured healthcare business	$5,575,000	$857,313	$402,020
Student nurse practitioner, individually insured	$896,333	$106,633	$200,593
Overall average total incurred	$64,636,991	$12,418,818	$332,137

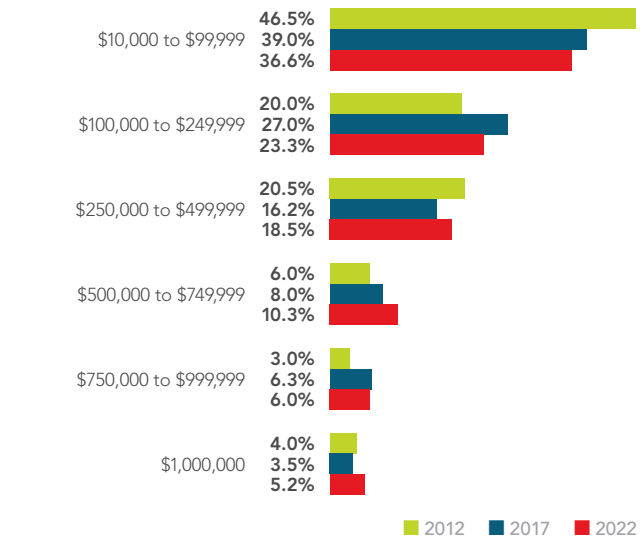
Distribution of Closed Claims

Figure 2 demonstrates that, although claims with indemnity payments between $10,000 and $99,999 comprise the largest indemnity range, there has been a continued shift towards larger claim settlements. For example, claims that resolved for greater than $500,000 represented 21.5 percent of all claims in the 2022 dataset, compared to 13 percent in the 2012 dataset.

This is demonstrated in **Figure 3**, which compares the average total incurred of professional liability claims in the 2012, 2017 and 2022 datasets.

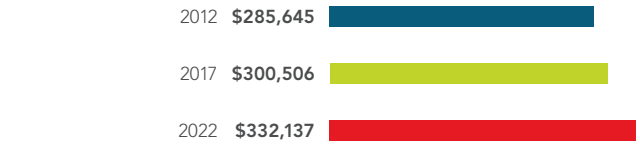
2 Comparison of 2012, 2017 and 2022 Closed Claim Count Distributions

Closed Claims with Paid Indemnity of ≥ $10,000



3 Comparison of 2012, 2017 and 2022 Claim Reports Average Total Incurred

Closed Claims with Paid Indemnity of ≥ $10,000



Analysis of Claim Outcomes

The following sections summarize the percentage of total claims and the average claim costs across various data points, including the NP's specialty, location of the incident, allegation and injury.

Analysis of Specialty

Figure 4 shows neonatal and pediatric specialties experienced the highest average total incurred.

KEY FINDING

The **neonatal specialty** represents the **highest average total incurred** in the 2022 and 2017 datasets.

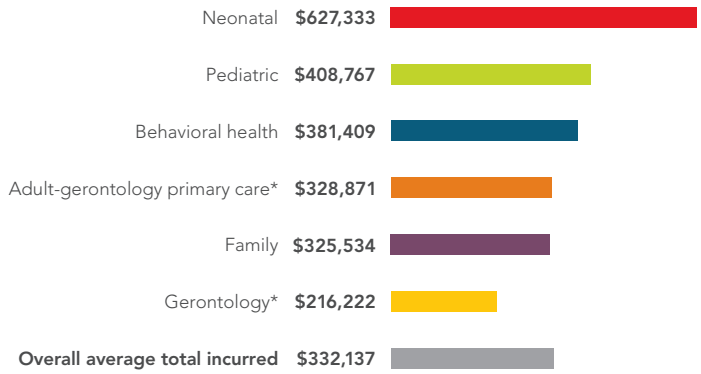
Many of the neonatal and pediatric claims have indemnity payments in the mid-to-high six-figure range. These payments were due primarily to the cost of lifelong, one-on-one nursing care required by the injured party. Examples of allegations against NPs that resulted in patients requiring lifelong, one-on-one nursing care include:

- Failure to recognize contraindication and/or known adverse interaction between/among ordered medications.
- Failure to diagnose pertussis.

4 Average Total Incurred of Closed Claims by Specialty

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those specialties with the highest average total incurred.



* **Adult-gerontology primary care** refers to an NP who provides healthcare management of acute and chronic health issues for adults across the lifespan, from adolescence to old age. **Gerontology** refers to an NP whose practice is limited to treatment of the patient population from adult to the elderly.

Examples of neonatal claims involving the cost of lifelong and one-on-one nursing care for the patient include the following:

- A Neonatal Nurse Practitioner (NNP) was providing care to an infant immediately following premature birth at 32 weeks. At the time of birth, the infant was in respiratory distress and needed resuscitation measures. The NNP successfully resuscitated the infant and contacted the perinatologist due to the infant's metabolic status. Twenty minutes after the birth, the perinatologist arrived to assume the care of the infant. The perinatologist and NNP were preparing the infant for transfer to a higher acuity facility while she continued to experience difficulty breathing, as well as severe hypotension and hypovolemia. In the rush to transfer the infant, the NNP failed to timely initiate normal saline boluses and inotropes to address her severe hypotension and hypovolemia, which led to brain injury. The parents alleged that this delay in treatment caused permanent neurological issues in the infant. The claim resolved with a total incurred of greater than $240,000.
- A Women's Health Nurse Practitioner (WHNP) provided prenatal care to a 35-37 week gestational age patient. Prior to 35 weeks, the patient had an uneventful pregnancy with normal weight gain, blood pressure readings and fetal growth. At 35 weeks, the WHNP documented a three pound weight gain from the previous week, blood pressure of 122/85 and a uterus measuring 35 cm. At 36 weeks, the WHNP documented another three pound weight gain, blood pressure of 129/89 and uterus measuring 36 cm. At the 37 week appointment, the patient's blood pressure was 132/92, with a fundal height of 35 cm and 1+ protein in her urine. The WHNP documented that there was positive fetal movement and fetal heart rate. At 38 weeks, the patient was seen by the co-defendant OB/GYN. The OB/GYN documented an additional three pound weight gain, a blood pressure of 130/93 and a fundal height of 36 cm. The OB/GYN ordered a contraction stress test (CST) and biophysical profile (BPP). The BPP was 0/10, leading to an emergent caesarean section being performed with delivery of a neurologically compromised infant. The WHNP was added as a co-defendant to the lawsuit following the OB/GYN's deposition which stated that the insured WHNP should have notified him of the patient's intrauterine growth restriction at her 37 week office visit. Despite supportive testimony on behalf of the WHNP, the claim was resolved with a total incurred of greater than $975,000.

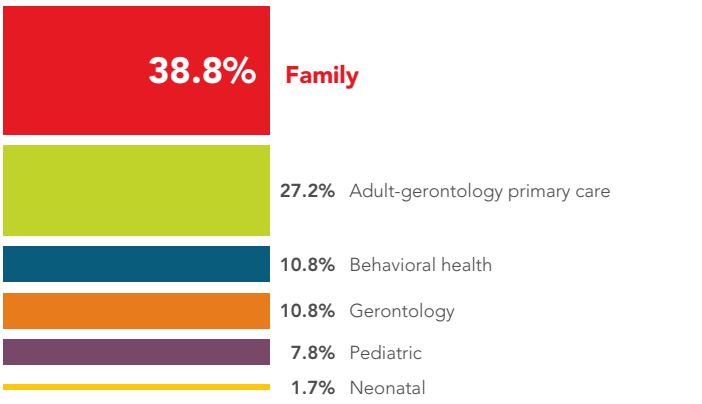
Figure 5 highlights the specialties with the highest percentage of claims from the 2012, 2017 and 2022 datasets. In the 2022 dataset, six specialties account for 97 percent of all claims.

- Family and adult-gerontology primary care constitute 66 percent of all claims. Most of these claims occurred in the office of an NP or physician, with many involving diagnosis and medication failures, as in the following cases:
  - A patient with chronic obstructive pulmonary disease and a history of being a two-pack-a-day cigarette smoker for more than 40 years presented with complaints of congestion and shortness of breath. The insured NP ordered a chest x-ray that, due to technical issues, was of poor quality, which limited the ability to determine the patient's diagnosis. Instead of repeating the x-ray or ordering a CT scan, the NP treated the patient for pneumonia. The patient was later diagnosed with stage three lung adenocarcinoma. The claim resolved with a total incurred of greater than $120,000.
  - A patient with a history of hypothyroidism presented to the insured NP. A complete medical history was not obtained, which would have revealed a history of heart disease and high blood pressure. The insured NP prescribed Nature-Throid® in an excessive dose, and the patient asserted that this excessive dose resulted in a myocardial infarction and cerebrovascular accident. The claim resolved with a total incurred of greater than $75,000.

5 Distribution of Top Closed Claims by Specialty

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those specialties with the highest distribution.



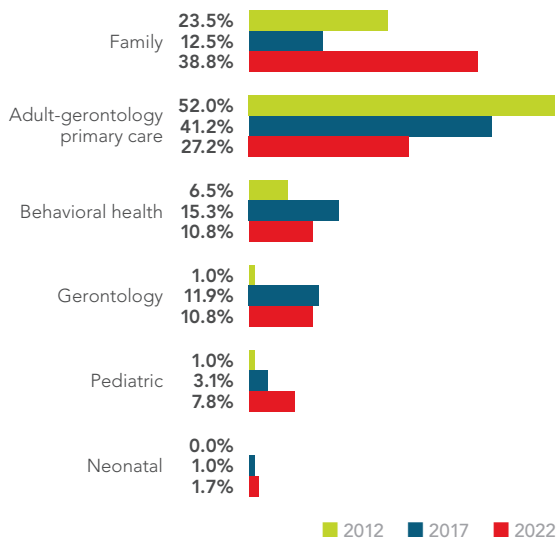
The majority of gerontology claims occurred in an aging services setting. The two allegations that occurred most often included improper or untimely management of a pressure injury and improper prescribing/management of anti-coagulants and controlled medications. Examples of claims included the following:

- Resident was admitted to an aging services facility with multiple co-morbidities as well as a Stage 1 sacral pressure injury. During the NP's ongoing care of the resident, she failed to document the existence of, or any treatment related to, the pressure injury. Over the next few weeks, the sacral pressure injury worsened and the resident's overall physical condition declined. The resident was eventually transferred to the hospital. The sacral pressure injury was assessed as a Stage 3. The resident died two days later. The plaintiff alleged that the failure to assess, treat and manage the pressure injury led to sepsis and death. The claim resolved on behalf of the insured NP with a total incurred of greater than $210,000.
- The insured NP failed to discontinue a resident's Lovenox® when her international normalized ratio (INR) became therapeutic on warfarin. The nursing staff continued to administer the Lovenox® to the resident for two additional weeks. The resident began to complain of abdominal pain that was attributed to fecal impaction. Over a six-day period, the NP ordered a saline laxative enema on two occasions. The day following the second enema, the resident became hypotensive, pale and unresponsive. She was transferred to the emergency department. The resident was diagnosed with acute coagulopathy and died due to complications of a retroperitoneal and pelvic hemorrhage. The claim resolved with a total incurred of greater than $425,000.

6 Comparison of 2012, 2017 and 2022 Closed Claim Count Distributions by Specialty

Closed claims with Paid Indemnity of ≥ $10,000

This figure highlights only those specialties with the highest distribution.



Behavioral health claims represented 10.8 percent of the 2022 dataset, which demonstrated a decrease of 4.5 percent compared to the 2017 dataset. Despite this decrease in distribution, behavioral health claims remain costly due to high-severity claims related to improper prescribing of medications and failure to address a mental health disorder in a timely manner, as in the following scenario:

- A patient with a long history of depression and anxiety was admitted to an inpatient behavioral health facility. One week after her admission, the patient demanded to be released. The insured NP performed an exit evaluation of the patient for more than 90 minutes, with the patient's husband included in the last 60 minutes of the interview. During the evaluation, the patient denied any suicidal thoughts or plans. Shortly after the evaluation, the husband asked to speak privately to the NP. He voiced concerns that his wife was making plans to harm herself upon returning home. Due to the husband's concerns, the NP asked the patient if she would agree to a "No Harm Contract." The patient agreed to sign the contract and scheduled an outpatient appointment for follow-up. Two days following discharge, and one day prior to the scheduled outpatient appointment, the patient died by suicide. The husband filed a lawsuit against the NP claiming that she failed to perform a proper evaluation on the patient's mental health status and failed to conduct a suicide risk assessment. He alleged that these oversights resulted in the lack of an adequate care plan, thus causing the patient's death. The claim resolved with a total incurred of greater than $120,000.

Figure 6 compares the specialties with the highest percentage of closed claims from the 2022 dataset to the 2017 and 2012 datasets. Family and adult-gerontology primary care have consistently represented the majority of claims across all three datasets.

Allegations that occurred most often in the **aging services** setting included **improper or untimely management** of a **pressure injury** and **improper prescribing/management** of **anticoagulants and controlled medications**.

Analysis of Location

The following analysis is based upon the location of the patient at the time that the incident occurred.

Figure 7 displays the average total incurred for locations with the highest average severity. Many of the NP office practice and community-based claims experienced indemnity payments in the mid-to-high six-figure range. These payments are due primarily to the cost of lifelong, one-on-one nursing care required by the injured party, as well as allegations of wrongful death. Examples of these allegations against NPs include:

- An insured NP working in a primary care, NP-owned office practice, treated a 41 year-old male patient over a two year period. He had a history of gastroesophageal reflux disease (GERD), chronic sinusitis and lower back pain, as well as a 25 plus year history of smoking a pack of cigarettes per day. The NP referred the patient to an ear, nose and throat (ENT) specialist for chronic sinusitis, but the patient did not keep the appointment due to a lapse in his medical insurance. The patient healthcare information record did not reflect any follow up on the missed ENT appointment or the risks associated with non-treatment of his GERD and chronic sinusitis. It wasn't until the patient experienced an unintentional weight loss of 20 pounds, as well as a change in his voice, swollen lymph nodes in his neck and difficulty swallowing, that he sought treatment with a different primary care provider. The new primary care provider (PCP) noted white patches on his tongue and a mass on the right side of his throat. The PCP immediately referred the patient to an ENT specialist who provided a diagnosis of metastatic throat carcinoma. The patient underwent several rounds of chemotherapy and radiation, and a surgical resection of his larynx, thyroid, vocal cords, lymph nodes and portions of his lower jaw. Due to the trauma of the radiation and surgery, the patient was unable to speak, had a permanent tracheostomy and received all his nutrition via gastrostomy tube. Allegations included that the NP failed to refer him to an ENT, despite his unintended weight loss, loss of voice and 25-year smoking history. The claim resolved with a total incurred of greater than $595,000.
- A patient with a long history of atherosclerosis sought treatment at a community-based outpatient clinic for new onset heartburn. The NP diagnosed the patient with gastroesophageal reflux disease and recommended an over-the-counter H2 blocker and prescribed a Proton Pump Inhibitor. The patient healthcare information record revealed that the insured NP failed to obtain the patient's complete medical and surgical history. The patient died a few weeks later. The autopsy listed the cause of death as a myocardial infarction due to severe atherosclerotic coronary artery disease. The family initiated a wrongful death claim and asserted that, if a complete medical and surgical history had been obtained, the NP would have discovered that the patient's symptoms were related to his atherosclerosis, rather than heartburn, and referred him to a higher level of care or ordered further testing. The claim resolved with a total incurred of greater than $425,000.

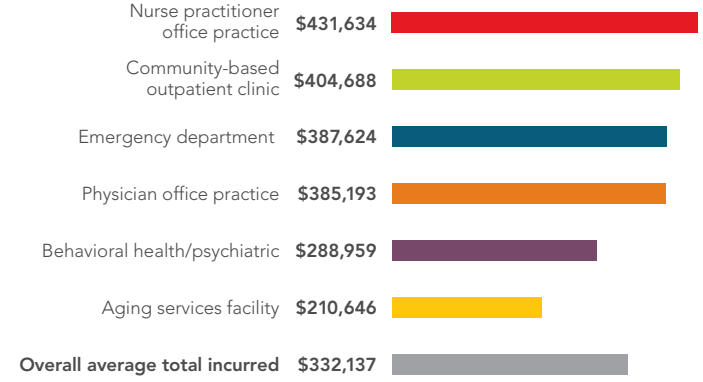
Figure 8 displays the top claim distributions by location in the 2022 dataset. The top three locations in which an NP incurs claims remains the physician office practice, aging services facility and NP office practice.

Several high indemnity claims occurred in the NP office practice setting. These claims resulted from alleged failure to diagnose or delay in diagnosing the patient, failure to properly manage anticoagulant therapy, failure to recognize contraindications and/or known adverse interactions between ordered medications, and failure to timely/properly address medical complications or changes in condition.

7 Average Total Incurred of Closed Claims by Location

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those locations with the highest average total incurred.



8 Distribution of Closed Claims by Location

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those locations with the highest distribution.

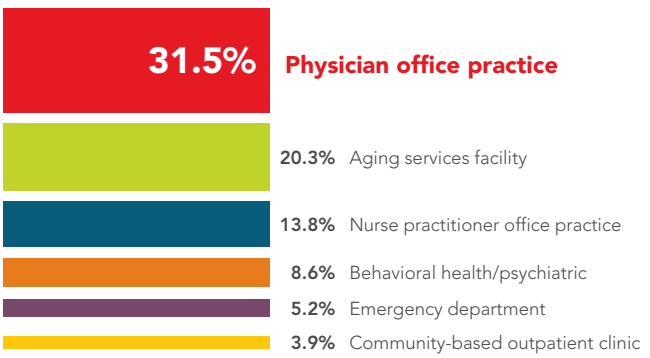


Figure 9 compares the 2022 dataset to the 2017 and 2012 datasets. This comparison delineates that physician office practice, aging services facility and NP office settings comprise 65.6 percent of the claims in the 2022 dataset. While the claim distribution for these three locations has fluctuated between the 2012 and 2017 datasets, they have remained the top three location settings for claims in the CNA/NSO NP claim reports.

KEY FINDING

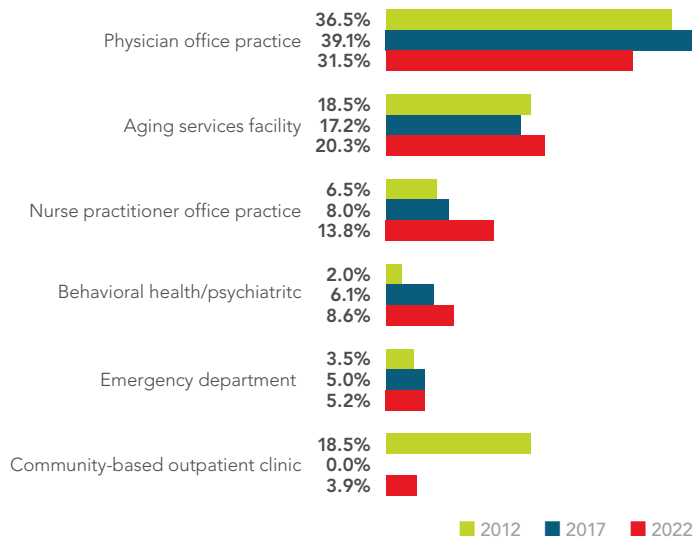
Aging services claims increased from 17.2 percent of the total distribution in the 2017 dataset to **20.3 percent of the total distribution** in the 2022 dataset.

The **increase in job opportunities**, expected **job growth** and the **addition of more** universities and colleges offering **psychiatric mental health NP degrees**, will likely continue to contribute to an **increase in claim distribution in behavioral/psychiatric health** locations.

9 Comparison of 2012, 2017 and 2022 Closed Claim Count Distributions by Location

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those locations with the highest distribution.



This increase in claims may be attributed to the overall increase of NPs in the workforce coupled with the increase of NPs working in underserved specialties, such as aging services facilities, as well as the steady decline of primary care physicians. In December 2019, the American Association of Nurse Practitioners (AANP) reported that an estimated 290,000 NPs were licensed to practice in the United States. In April 2022, the AANP reported that the number of NPs in the workforce had increased to 360,000.

Claims that occurred in behavioral/psychiatric health locations have increased in the 2022 dataset compared to the 2012 and 2017 datasets. There are a variety of causes for the increased distribution of behavioral health/psychiatric closed claims. According to a report published by the Health Resource and Services Administration, the demand for psychiatric NPs is anticipated to increase by 18 percent from 2016-2030. This increase in job opportunities, expected job growth and the addition of more universities and colleges offering psychiatric mental health NP degrees, will likely continue to contribute to an increase in distribution of behavioral health/psychiatric closed claims. The majority of the claims in this location involve improper prescribing of medications and failure to address a mental health disorder in a timely manner. An example includes the following:

- A psychiatric patient died by suicide via a medication overdose. The medications had been prescribed by the insured Psychiatric and Mental Health (PMH) NP. The PMH-NP failed to order the required drug screen, which would have revealed the patient's history of drug abuse prior to his death. The claim resolved on behalf of the insured PMH-NP with a total incurred of greater than $425,000.

KEY FINDING

The top three locations in which an NP incurs claims remains the **physician office practice, aging services facility** and **nurse practitioner office practice.**

Analysis of Allegation

Figure 10 depicts the average total incurred for the allegation categories with the highest severity. These claims include allegations of the NP's failure to perform a proper assessment. Assessment-related claims include failure to complete a patient assessment or perform/document a complete history and physical. Examples include the following:

- A resident with a left hemisphere cerebrovascular accident (CVA) was admitted to a skilled nursing facility. The NP failed to properly monitor the newly admitted resident's INR within the recommended range. The resident's INR level remained sub-optimal for several weeks without being corrected. The resident suffered a second CVA which resulted in his death. The claim resolved with a total incurred loss of greater than $100,000.
- A resident was admitted to a skilled nursing facility for rehabilitation following a laminectomy. On the third week of her admission, the staff found the resident on the floor. The resident reported that she had gone to the bathroom unassisted and fell while ambulating back to bed. The staff notified the insured NP of the resident's fall. Two days after her fall, the resident complained of hip pain, an inability to move her legs and hallucinations. Despite being notified of the resident's condition, the NP failed to conduct a complete physical and neurological examination. The resident began to exhibit neurological decline, which included her inability to hold herself up while in a seated position. The staff again notified the NP, but there was a further delay in transferring the resident to the hospital. The resident was ultimately diagnosed with a T10 spinal fracture and epidural hematoma resulting in paraplegia. The claim resolved with a total incurred of greater than $750,000.

Figure 11 Diagnosis, treatment and care management and medication prescribing allegations account for 90.1 percent of all the claims in the 2022 dataset.

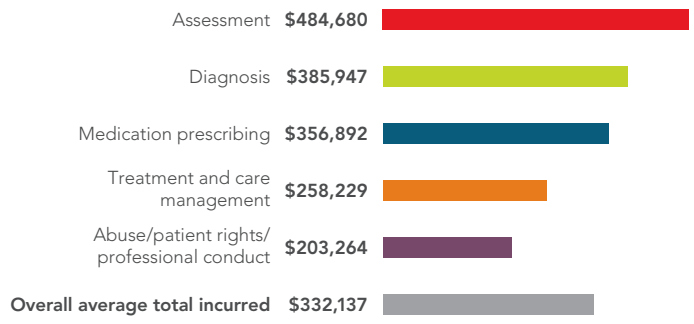
In the 2022 dataset, diagnosis-related claims represent the highest percentage of claims and have an average total incurred of $385,947. This amount is greater than the overall average total incurred of $332,137. Although diagnosis-related claims occurred in many locations, the most common settings where such claims arose were NP and physician offices. Claims associated with out-patient tests ordered in the office setting involve allegations of negligence in either diagnosis (e.g., failure to diagnose or delay in diagnosis) or treatment (e.g., failure to treat, delay in treatment or premature end of treatment). To minimize potential risk, increase patient satisfaction and improve quality in this critical area, practices should require a written policy that clarifies practitioner and staff responsibilities regarding clinical tests, including ordering tests, reviewing results and notifying patients of findings. Since diagnosis-related claims continue to be the most common of all allegations, a further analysis of diagnosis allegations can be found on page 13 and in the Nurse Practitioner Spotlight: Diagnosis.

The second most common allegation in the 2022 dataset relates to treatment and care management. Within treatment and care management allegations, an NP's failure to perform a technique properly (such as obtaining a punch biopsy or injecting a trigger point) and the improper/untimely treatment or management of a pressure injury or non-surgical wound resulted in the highest percentage of these claims.

10 Average Total Incurred of Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those allegations with the highest average total incurred.



11 Distribution of Top Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those allegations with the highest distribution.

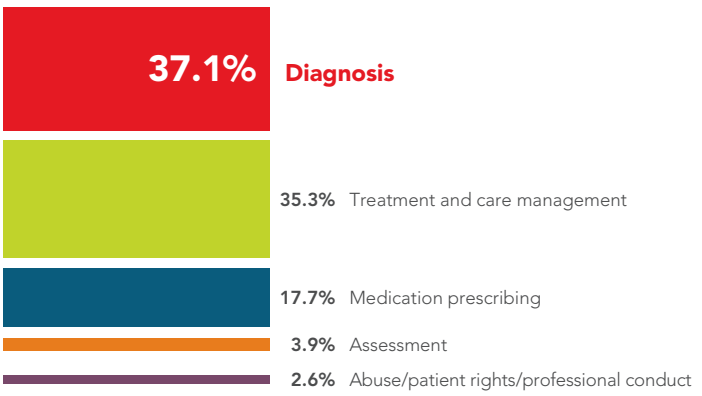


Figure 12 reveals that distribution of allegations in the 2012, 2017 and 2022 datasets have fluctuated.

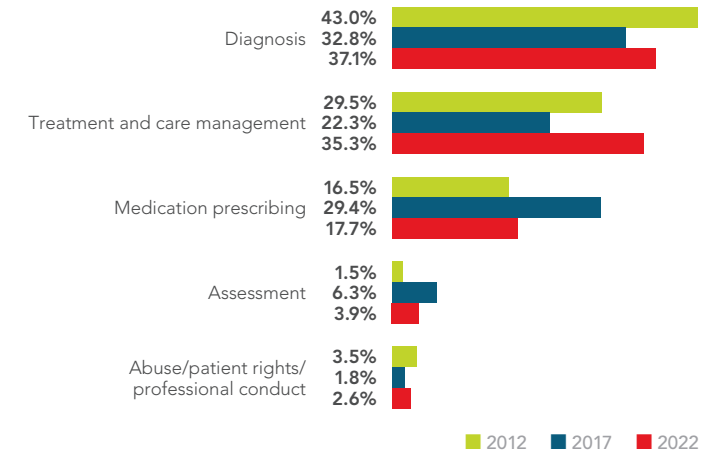
For example, the percentage of medication prescribing allegations increased significantly in the 2017 datasets when compared to 2012. However, in the 2022 dataset, the percentage of medication prescribing claims decreased. This decrease may be attributed, in part, to the opioid prescribing guidelines that were established by professional healthcare associations and state and federal regulatory agencies in response to the opioid epidemic in the mid 2010s, in addition to the changing nature of the opioid epidemic.

In the 2022 dataset, many of the medication prescribing claims were characterized as being difficult to defend. These claims involved failure to recognize known contraindications/adverse reactions among ordered medications, improper prescribing/management of anticoagulants and improper prescribing/management of controlled drugs. An example of a claim related to the improper prescribing/management of anticoagulants can be found on page 8.

12 Comparison of 2012, 2017 and 2022 Closed Claim Count Distributions by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those allegations with the highest distribution.



Nurse Practitioner Spotlights

For risk control strategies related to:

- Defending Your License
- Depositions
- Patient Adherence
- Telemedicine
- Diagnosis
- Documentation
- Prescribing

Visit nso.com/npclaimreport

Risk Management Recommendations for Everyday Practice

- ☐ **Practice within the requirements of your state nurse practice act, in compliance with organizational policies and procedures, and within the national standard of care.**
- ☐ **Maintain basic clinical and specialty competencies by proactively obtaining the professional information, education and training needed to remain current regarding nursing techniques, clinical practice, biologics and equipment.**
- ☐ **Document your patient care assessments, observations, communications and actions in an objective, timely, accurate, complete and appropriate manner.**
- ☐ **If necessary, utilize the chain of command or the risk management or legal department regarding patient care or practice issues.**
- ☐ **Maintain files that can be helpful with respect to your character, such as letters of recommendation, performance evaluations and continuing education certificates.**

Medication prescribing claims that were difficult to defend involved **failure to recognize known contraindications/adverse reactions** among ordered medications, **improper prescribing/management** of **anticoagulants** and improper prescribing/management of **controlled drugs**.

Analysis of Diagnosis-related Allegations

Diagnosis-related allegations have represented the most frequent allegation in the 2012, 2017 and 2022 datasets.

KEY FINDING

In the 2022 dataset, **diagnosis-related claims** represent the **highest percentage of claims at 37.1 percent** and have an **average total incurred of $385,947,** which is greater than the overall average total incurred of $332,137.

Failure to refer a patient (referral management) to a higher level of care or to a specialist had the highest severity, as noted in **Figure 13**. An example of this type of claim includes:

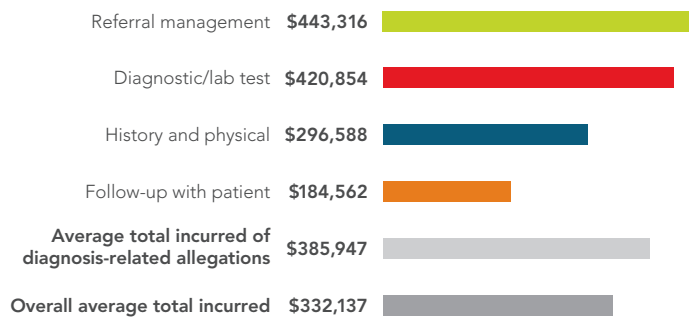
- A 51 year-old diabetic male patient presented to the NP's office practice following an emergency department (ED) visit due to a wound on his right foot that appeared to be infected. The NP photographed the wound, documented that it was 0.5 cm in diameter, and confirmed that the patient was still taking the antibiotics as prescribed to him by the ED provider. Although he was instructed to return in a week for a recheck, he presented two weeks later. The NP documented the wound as 2 cm in diameter with granulation tissue, purulent drainage and the forefoot was reddened, warm and swollen. The NP opined that he may need to perform a procedure to evacuate the infected area, but, for unknown reasons, the procedure was not performed. The patient was given a prescription for a different antibiotic, and his wound was cleaned and redressed. One week later, the patient returned, reporting that he was vomiting and feeling weak. His eyes were jaundiced and his right toe and right leg were more swollen than the prior week. The NP ordered Ceftriaxone 1 gram intramuscularly in the office and then every 24 hours for the next three days via home health. Also ordered were daily dressing changes to the affected foot, vital signs and bi-weekly (twice-a-week) blood work for the next two weeks. When home health arrived for the initial visit at the patient's home, he appeared diaphoretic, pale and his vital signs were indicative of sepsis (high fever, elevated heart and respiratory rate and low blood pressure). The patient was transferred to the ED and diagnosed with sepsis. He eventually underwent a below the knee amputation of his right leg. Defense experts were unable to defend the claim, as they indicated that the patient should have been sent to the ED during his last visit with the NP, or referred to an infectious specialist or wound care provider after his second visit. The NP testified that he had encouraged the patient to go to the ED for treatment at the second and third visit, but that the patient refused. There was no documentation in the patient's health-care information record to corroborate this testimony. The claim resolved with a total incurred of greater than $950,000.

Diagnosis-related allegations represented the **most frequent** allegation with **failure to refer a patient** to a higher level of care or to a specialist having the **highest severity**.

13 Severity of Diagnosis-related Allegations

Closed Claims with Paid Indemnity of ≥ $10,000

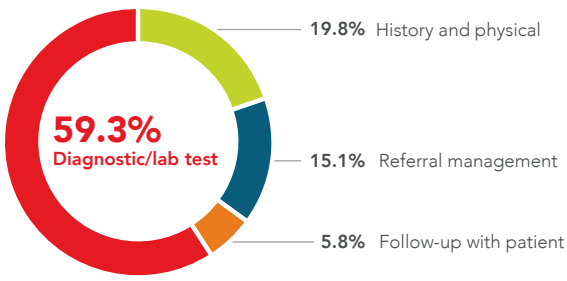
This figure highlights only those causes of death with the highest distribution.



14 Distribution of Diagnosis-related Allegations

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only diagnosis-related allegations.



Diagnosis-related allegations include the NP's failure to order appropriate diagnostic tests to establish a diagnosis, delay in establishing a diagnosis and the failure or delay in obtaining/addressing diagnostic test results. The failure to order appropriate or needed diagnostic/laboratory testing is the most frequent diagnosis-related allegation. An example of the NP's failure to order diagnostic/laboratory testing includes:

- A 48 year-old male, in otherwise good health, presented with complaints of a lack of energy and fatigue. The treating NP prescribed a regimen of testosterone injections. The patient had no history of prostate or colon cancer and no urinary symptoms. The office had a protocol requiring any male receiving testosterone to have a Prostate-Specific Antigen (PSA) test before beginning treatment and annually thereafter. The patient asserted that he had been on testosterone therapy for more than two years before the first PSA was ordered by the NP and that the resulting level was greater than 200. He was referred to a urologist for the high PSA and was given a Gleeson score of 10 (high-grade cancer). Further testing revealed that the patient had stage IV metastatic prostate cancer. The patient alleged that the NP prescribed a regimen of testosterone therapy without establishing a PSA baseline and if the initial PSA had been obtained, per protocol, his cancer would have been identified earlier and not allowed to metastasize over the next two years. The claim resolved with a total incurred amount equal to the policy limits.

Approaching the Diagnostic Process

To help improve the diagnostic process, consider potential unintended consequences of pursuing a specific diagnosis:

- ☐ **Are factors present that do not align with the diagnosis?**
- ☐ **Are there elements that cannot be explained?**
- ☐ **Are there symptoms that are inconsistent with the current diagnosis?**
- ☐ **Why are these symptoms not indicative of another diagnosis?**
- ☐ **Is there a life-threatening condition with similar symptoms that hasn't been considered?**
- ☐ **Is it possible that there are multiple issues ongoing?**

Figure 15 demonstrates the top injuries associated with diagnosis-related closed claims.

A delay in the diagnosis of cancer and infection comprised the highest percentage of closed claims in this sub-category. Of the diagnosis-related allegations in the 2022 dataset, the four most commonly missed cancers included breast cancer, colorectal cancer, female reproductive cancer and lung cancer. Failure to perform diagnostic/laboratory tests (screening tests), failure to obtain a complete patient and family history and thorough patient physical assessment, and failure to follow up with the patient on test results (such as an abnormal chest x-ray or PSA) were the most common causes of diagnosis-related allegations.

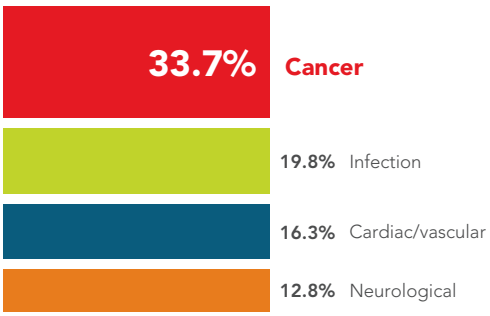
In many diagnosis-related closed claims, a lack of sound documentation supporting the decision-making process of the treating NP or other staff members under the supervision of the NP hindered the legal defense of the case. Examples of missing or incomplete documentation noted in the dataset include:

- Lack of a complete patient and family history.
- Incomplete physical assessment.
- Failure to list current medications and/or complaints.
- Failure to document patient noncompliance with appointments, ordered diagnostic tests and/or prescribed medications.
- Absence of notification of diagnostic test results and recommendations for further treatment or testing.

15 Distribution of Diagnosis-Related Injuries

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only diagnosis-related injuries.



Analysis of Injury

An awareness of those injuries that most often lead to claims, as well as those with the highest average total incurred, may allow NPs to better focus their risk control, patient safety and incident reporting efforts.

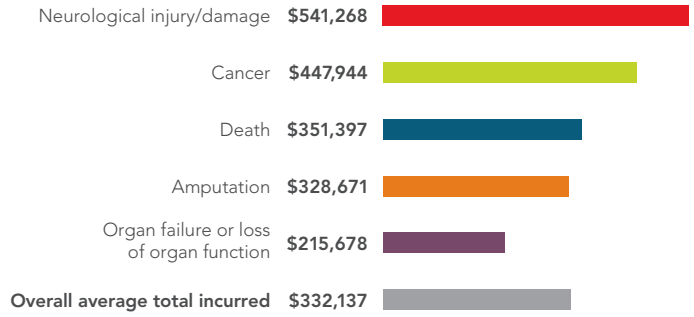
Figure 16 shows the average total incurred for injury types with the highest severity. Injuries with higher than average severities typically represent lifelong medical costs for patients who will require 24-hour medical care. Neurological deficit/damage and amputation injuries reflect a higher average total incurred than the overall average. While these injuries occur infrequently, the higher average total incurred is directly due to the permanence of the injury and lifelong medical costs for patients. An example of a claim requiring lifelong care includes the following:

- A 28-year-old male was referred to a neurological practice due to ongoing, debilitating headaches. The insured NP was an employee of the practice and provided treatment to the patient for approximately two years, with the patient experiencing only short periods of headache relief during that time. The NP failed to order any imaging studies or to refer the patient to the collaborating neurologist, despite the patient's many requests. After a new onset of neurological symptoms (dizziness, blurred vision, gait instability), the patient sought treatment from a different neurology practice. He was then diagnosed with an atypical meningioma, a slow-growing brain tumor. An attempt to perform an embolization of the tumor failed and the patient underwent resection of the meningioma with subsequent radiation therapy. The patient asserted that he suffered from numerous post-operative complications and ongoing neurological deficits. The claim resolved with a total incurred of greater than $475,000.

16 Average Total Incurred of Closed Claims by Injury

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those injuries with the highest severity.



In **Figure 17**, death accounts for 45.7 percent of all the claims in the 2022 dataset, constituting by far the highest percentage of claims, with an average total incurred of $351,397. Claims associated with death are discussed in greater detail beginning on page 16.

KEY FINDING

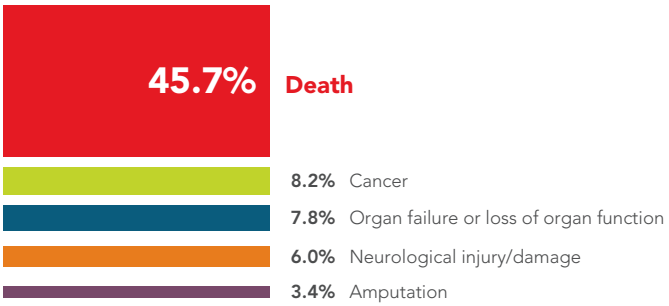
Death and **cancer** are the two most common injuries, representing more than half of the claims.

Figure 18 displays the distribution of claims by injury type in the 2012, 2017 and 2022 datasets. Injuries resulting in death have consistently remained the highest percentage of claims in all three datasets.

17 Distribution of Top Closed Claims by Injury

Closed Claims with Paid Indemnity of ≥ $10,000

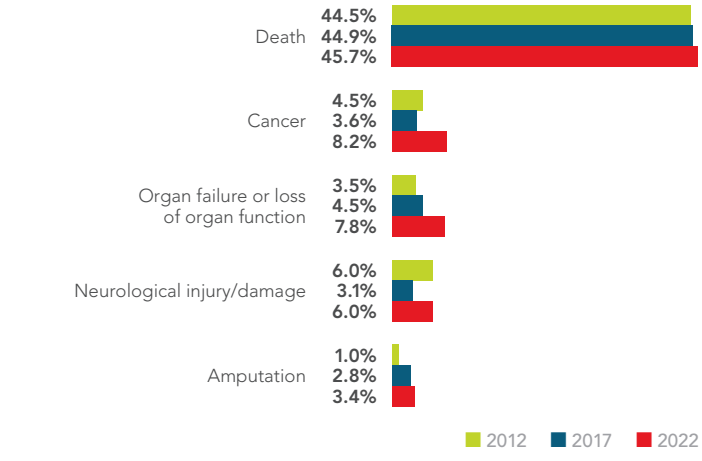
This figure highlights only those injuries with the highest distribution.



18 Comparison of 2012, 2017 and 2022 Closed Claim Distribution by Injury

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those injuries with the highest distribution.



Analysis of Fatal Injuries by Identified Cause of Death

As displayed in **Figure 19**, the underlying events leading to death with the highest average total incurred are suicide, cardiac/pulmonary arrest, cancer, cardiac condition and infection/abscess/sepsis.

Five causes of death (infection/abscess/sepsis, cardiac/pulmonary arrest, cancer, cardiac condition and suicide) account for 63.3 percent of death claims, as shown in **Figure 20**.

Death caused by infection/abscess/sepsis accounts for 18.9 percent of all fatal injuries, almost twice the 10 percent rate seen in the 2012 and 2017 datasets as shown in **Figure 20**. The majority of infection/abscess/sepsis deaths occurred in aging services facilities.

Suicide as a cause of death comprised 9.4 percent of all fatal injuries. As a cause of death, suicide has continued to increase when compared to the 2017 (7.0 percent) and 2012 (4.4 percent) datasets. Unlike the 2017 and 2012 datasets, the majority of the claims related to suicide as a cause of death in the 2022 dataset occurred in a behavioral health or addiction recovery facility. The Joint Commission, and others, offer resources and recommendations designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide.

Conversely, causes of death noted in the 2017 and 2012 datasets either did not occur or represented a smaller distribution of claims in the 2022 dataset – including pulmonary/respiratory infection, fetal death, overdose and glycemic events. The decrease in these causes of death are attributable to various reasons, which may include tighter opioid prescribing regulations and better availability of diagnostic testing.

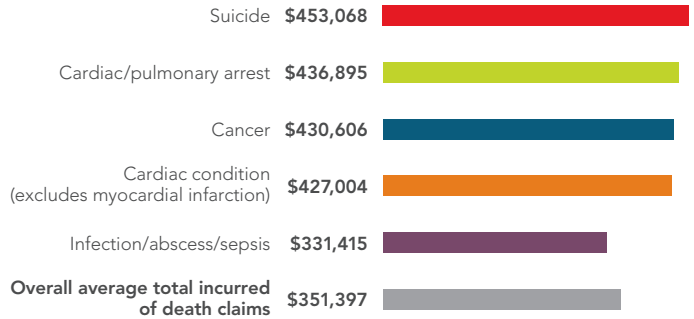
Cancer and cardiac conditions are tied for the third-highest distribution at 10.4 percent each. Claims often result from allegations that the NP failed to follow up with the patient after an abnormal diagnostic test. Allegations include that the patient's cancer may have been treatable at the time of the test, but it metastasized due to the delay in diagnosis, resulting in death, as in the following example:

- The patient was a 35-year-old female with a history of vague abdominal pains and bloody stools. She also reported a family history (her father and grandfather) of metastatic colon cancer requiring surgical resection, chemotherapy and radiation. The patient was seen by another provider in the office and had a fecal blood test, which came back positive. The test results were sent through the electronic healthcare information system to alert the provider's nurse to inform the patient of the test results. Due to a system error, this never occurred. Three months later, the insured came in for her chronic disease (hypothyroidism and gastroesophageal reflux disease) follow-up visit. The insured NP treated the patient but failed to review the patient's previous healthcare information records related to the fecal blood test results. Over the next nine months, the patient was seen by other providers in the practice who also failed to address the positive fecal blood test results. More than a year later, the patient scheduled an appointment with the insured NP due to ongoing abdominal pain. The NP referred the patient for a colonoscopy, where a large mass was discovered in the patient's transverse colon. The patient was diagnosed with Stage IVB colon cancer and referred to an oncologist for treatment. The cancer had metastasized to the liver and lungs. After several failed attempts to treat the cancer, the 37-year-old patient was placed on hospice care and later passed away. The claim resolved with a total incurred of greater than $1,000,000.

19 Average Total Incurred of Closed Claims by Cause of Death

Closed Claims with Paid Indemnity of ≥ $10,000

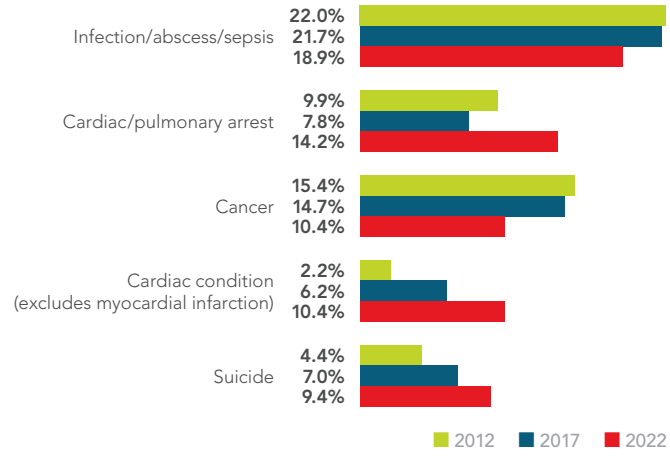
This figure highlights only those causes of death with the highest average total incurred.



20 Comparison of 2012, 2017 and 2022 Closed Claim Distribution by Causes Death

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those causes of death with the highest distribution.



Analysis of Claims by NP Owned Practice

NP practice owners must recognize that, as business owners, they assume the liability exposures of their practice, including those of their employees and independent contractors.

The distribution and severity of NP office practice setting claims have increased since the 2017 dataset. In the 2017 dataset, the NP office practice setting accounted for 8.0 percent of the claims, with an average total incurred of $335,767. In the 2022 dataset, the NP office practice setting increased both in distribution and in average total incurred. An example of this increase in liability is shown in **Figure 21**.

The increase in percentage and severity since the 2017 dataset may be attributed to evolving state licensure laws permitting NPs to practice more independently. Currently, half of the states and U.S. territories have adopted Full Practice Authority (FPA) licensure laws for NPs. With the changes to and updates of state licensure laws, CNA/NSO anticipates an increase in NP-owned practices.

However, NP practice owners should understand that, the increase in practice authority, as well as being the primary source of insurance coverage for multiple parties – including the corporation, employees and independent contractors – increases liability and potential cost exposures.

Figures 22 and 23 depict the claim distribution and average incurred loss for the top three allegations made against NP owned practices. Medication prescribing, diagnosis and treatment and care management allegations account for 93.8 percent of all claims in this analysis.

The **increase in practice authority**, the responsibility for the acts and omissions of employees and being the primary source of insurance coverage for multiple parties **increases the liability and potential cost exposures** for NP practice owners.

21 Comparison of 2017 and 2022 NP Owned Practice Closed Claim Distribution*

Closed Claims with Paid Indemnity of ≥ $10,000

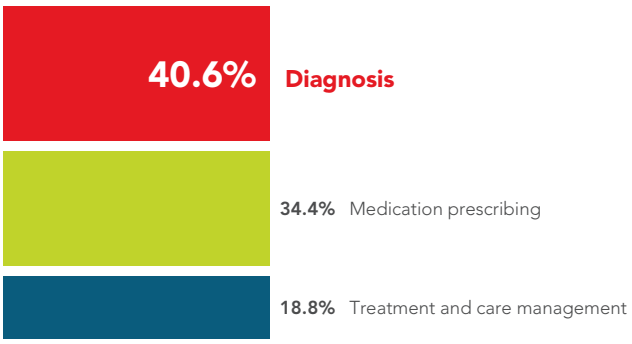
	2017	2022
Percentage of closed claims	8.0%	13.8%
Average total incurred	$335,767	$431,634

* 2017 dataset excludes recurring claims from select providers which may have skewed the underlying severity. These claims were not representative of future prescribing practice.

22 Distribution of NP Owned Practice Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

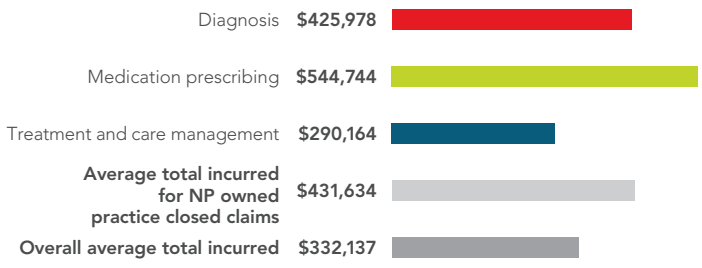
This figure highlights only those nurse practitioner owned practice claims by injuries with the highest distribution.



23 Average Total Incurred of NP Owned Practice Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those nurse practitioner owned practice claims by allegation with the highest average total incurred.



As in the overall 2022 dataset analysis, death as an injury in NP owned practices is the most common injury, representing 31.3 percent of claims, as shown in **Figure 24**. The average total incurred for death-related claims ($652,294) in the NP owned practice, as seen in **Figure 25**, is approximately twice that of death related claims in the overall 2022 dataset ($351,397).

NP practice owners and employers of NPs **should provide** the appropriate **clinical and business support** for all staff.

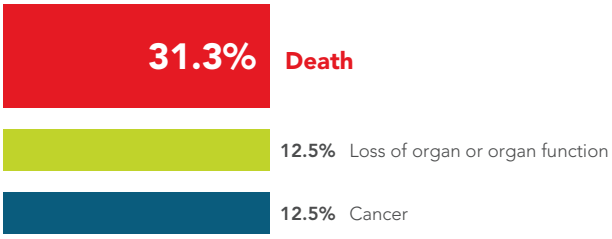
Key Risk Management Principles

- ☐ Appropriate Communication
- ☐ Thorough Documentation
- ☐ Effective Adverse Event Management
- ☐ Detailed Patient Assessment
- ☐ Well-documented Informed Consent
- ☐ Delineated Treatment and Referral Process

24 Distribution of NP Owned Practice Closed Claims by Injury

Closed Claims with Paid Indemnity of ≥ $10,000

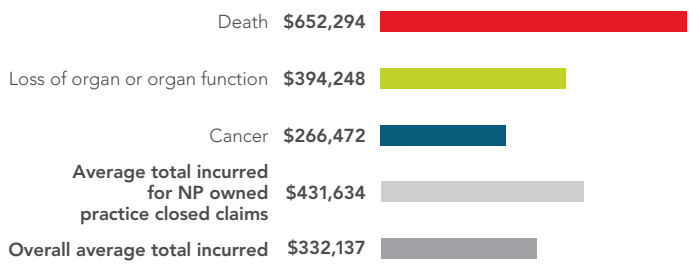
This figure highlights only those nurse practitioner owned practice claims by injuries with the highest average total incurred and distribution.



25 Average Total Incurred of NP Owned Practice Closed Claims by Injury

Closed Claims with Paid Indemnity of ≥ $10,000.

This figure highlights only those nurse practitioner owned practice claims by injuries with the highest average total incurred and distribution.



Spotlight: Vicarious Liability

The legal theory of vicarious liability holds employers responsible for the acts and omissions of their employees. As employers, NP business owners are vicariously liable for the conduct of employees who are acting within the scope of their employment. Consider the professional conduct of your employees as extensions of you and your business – and ensure that staff also view their actions in this manner.

Business Owner Responsibilities:

- Policies and Procedures
- Hiring and Credentialing
- Supervision
- Outlining Staff Duties and Responsibilities
- Staff Conduct
- Training

Recommendations for NP Practice Owners and Employers of NPs

NP practice owners and employers of NPs should provide the appropriate clinical and business support for all staff. Examples of such support may include, but not be limited to the following activities:

- Confirm that all staff understand their job descriptions and communicate openly and swiftly about any questions or concerns that may arise. Examples include the following:
  - A medical assistant having questions about his/her responsibility to measure and document vital signs in a patient's healthcare information record;
  - A medical assistant's understanding of the need to inform the NP immediately of any critical lab results that have been received by the practice.
- Understand the current scope of practice licensure laws for NPs in your state and support them in practicing within their scope of practice.
- Review all agreements (i.e., collaboration, supervisory or employment agreements) at least annually and revise them as needed with the assistance of legal counsel, as appropriate.
- Implement standardized processes for credentialing NPs.
- Establish a process for routine review and delineation of clinical privileges for all staff, including current certifications required as part of their job descriptions (e.g., CPR, ACLS, PALS, etc.).
- Ensure NP competency through ongoing peer review and professional performance evaluation, focusing on the NP's clinical performance, documentation practices, and overall assessment and management of patients.

Additional resources for NP practice owners and employers of NPs can be found at NSO.com and in The Joint Commission's Ongoing Professional Practice Evaluation requirements and Focused Professional Practice requirements even if the practice is not seeking accreditation by The Joint Commission.

Analysis of Expenses

Claim expenses may vary widely due to the unique circumstances of each matter. In **Figure 23**, expenses in the 2022 dataset are displayed and compared. The categories of expenses include:

- Expenses associated with a paid indemnity of greater than or equal to $10,000.
- Expenses associated with a paid indemnity of less than $10,000.
- Expenses associated with no indemnity payment.

Claims that resolve without an indemnity payment also may incur costs. For example, such a claim may be:

- Successfully defended on behalf of the NP, resulting in a favorable jury verdict.
- Withdrawn by the plaintiff during the investigation or discovery process.
- Dismissed by the court prior to trial in favor of the defendant NP.

Figure 26 compares the expense costs of claims with paid indemnity of ≥$10,000, claims with paid indemnity of <$10,000 and claims with expense only. Claims with a paid indemnity of ≥$10,000 have a higher average cost as compared to those claims with paid indemnity of <$10,000 and closed claims with expense only. The difference in defense expense costs correlate to the medical complexity of a claim and the costs associated with defending the claim. NP closed claims with an indemnity payment of ≥$10,000 typically require additional medical and financial experts to assist with the defense and the cost of a jury trial. The average number of years from loss to close are similar across the three categories.

KEY FINDING

The **average total expense ($26,349)** of professional liability claims that closed without an indemnity payment in the 2022 dataset **increased 11.1 percent** since the 2017 dataset.

26 Comparison of Expense Costs

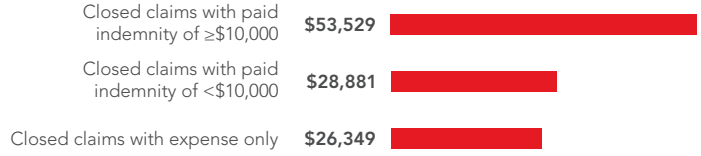


Figure 27 lists the average number of years from notice of the claim to closure for each expense category. While CNA/NSO promote efficient and focused defense of every claim, defending a claim can be costly and may continue for several years. Irrespective of their merit or final outcome, claims against an NP may pose significant emotional and professional impact on the individual NP. On average, claims that solely generate expense costs can take more than four years to close. An example of an expense only claim includes the following:

- A 46-year-old male with non-controlled diabetes had been receiving treatment from the insured NP for several months. The patient had shared that he was unable to adhere to treatment due to financial reasons. The patient presented with complaints of pain to the top and side of the left foot with unknown cause and was having a difficult time walking with any type of shoe. In addition to the foot pain, the patient had a broken toenail that he had cut back, which appeared to be infected. The NP documented: *"A small bruise was documented to the top of the foot. Toenail (big toe) is cut short, skin exposed, red and purplish in color at the lateral border. The left foot has mild swelling, but no deformity. Intact range of motion though movement is painful. Tenderness noted over the tarsal tunnel."* The NP's documented plan was to order lab work as well as an arterial Doppler color flow study of his left foot, but the patient refused due to the expense. The insured NP instructed the patient that, absent further testing, he should go to the ED as she thought he could have a blood clot. The patient reported that he would go to the ED if his condition worsened. He was prescribed an antibiotic and instructed to use NSAIDs for musculoskeletal pain. A wrap was applied to the ankle, and he was instructed to keep ice on his ankle for the swelling.

27 Comparison of the Average Number of Years from Notice to Closure

Three days later, the patient was evaluated in the ED with a complaint of increased pain to the left foot and thigh pain as well as a cold sensation in his foot. The provider documented a cold left foot without dorsalis pedis pulse. A CT angiogram revealed an occlusion of the anterior tibial artery, posterior tibial and peroneal arteries. The patient was admitted and ultimately underwent a below the knee amputation due to irreversible ischemia to the left lower extremity.

The patient filed a malpractice claim against the NP and other treating providers. The patient asserted that the NP failed to perform an adequate diabetic foot exam; failed to document the temperature of the left foot; negligently diagnosed him with cellulitis/abscess and negligently ordered compression and ice for a cold foot. Defense experts were supportive of the NP's care and believed that her documentation of the patient's care was thorough. The defense team believed that the case was defensible. The NP was ultimately dismissed from the case on summary judgment. The claim required seven years to resolve, and the expense costs to defend the insured NP exceeded $140,000.

Responding to Adverse Events

Adverse events should be reported to a clinical supervisor or risk manager per policy requirements, and an incident report should be completed promptly. Adverse events include incidents involving one or more of the following:

- ☐ **A patient is harmed or sustains an injury.**
- ☐ **Potential clinical significance.**
- ☐ **An outcome differs from anticipated results.**
- ☐ **An unexpected safety crisis.**

For more information on patient safety and responding to adverse events, we recommend consulting the following resources:

- NSO: Are You Completing Incident Reports Properly?
- The Joint Commission
- AHRQ: TeamSTEPPS® Trainings
- Institute for Safe Medication Practices (ISMP)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)

Part 2: Analysis of License Protection Matters with Defense Expense Payment

Introduction

State Board of Nursing (SBON) investigations are serious matters, requiring legal assistance as well as significant investment of time and effort by the NP until they are resolved. License protection matters in the CNA/NSO program involve reimbursement for the defense of the insured NP before a regulatory agency or SBON. License protection matters include reimbursement for the cost of legal representation to defend the NP during the investigation, whereas professional liability claims also may include an indemnity or settlement payment to a patient or family. Therefore, the average defense expense displayed within this section of the report is not necessarily indicative of the severity of the allegation that is the subject of the SBON investigation. In addition, a regulatory or licensing board action against an NP's license to practice differs from a professional liability claim in that it may or may not involve allegations related to patient care and treatment. For example, license protection matters may include instances where an NP allegedly engaged in unprofessional conduct, was charged with a crime, or failed to disclose certain information in a license renewal application. For more information about license protection and SBON matters, see the Nurse Practitioner Spotlight: Defending Your License.

Defense payments for license protection matters reflect **legal expenses** and associated travel, food, lodging, and **wage loss** costs **reimbursable under the policy**.

Database and Methodology

As noted in the introduction, three datasets are referenced in this report. The 2022 claim report dataset discussed in this section is comprised of license protection matters that closed between January 1, 2017 and December 31, 2021 and resulted in a defense expense/payment of at least $1.00. These criteria applied to the total number of reported NP license protection matters create a 2022 dataset consisting of 250 closed matters. Similar criteria produced a 2017 dataset comprised of 240 closed matters and a 2012 dataset of 133 closed matters.

License Protection vs. Professional Liability. What's the difference?

License Protection	Professional Liability
Inquiry by the State Board of Nursing, arising from a complaint.	**Civil lawsuit** arising from a patient's malpractice claim.
Allegation can be directly related to a nurse practitioner's clinical responsibilities and professional services, and/or they may be of a nonclinical nature (i.e., substance abuse, unprofessional conduct or billing fraud).	**Allegations are related to clinical practice** and professional responsibilities.
The State Board of Nursing is authorized to suspend or revoke a license. Its primary mission is to protect the public from unsafe practice of the professional.	**The civil justice system cannot suspend or revoke your license to practice.** Rather, professional liability lawsuits serve to fairly compensate patients who assert that they have suffered injury or damage as the result of professional negligence.

Data Analysis

As shown in **Figure 28**, the number of license protection matters with a payment of at least $1.00 per five-year claim report period has increased 88 percent since the 2012 claim report.

KEY FINDING

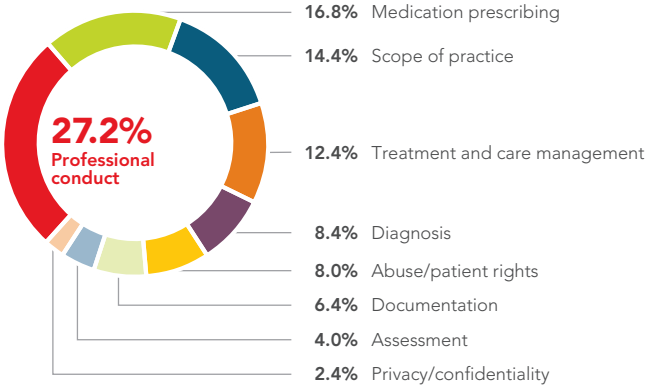
The **average cost ($7,155)** of defending allegations in license protection matters involving a nurse practitioner in the 2022 claim report represents an **increase of 19.5 percent** compared to the 2017 claim report and **61.1 percent** compared to the 2012 claim report.

Defense payments for license protection matters reflect legal expenses and associated travel, food, lodging and wage loss costs reimbursable under the policy. The reasons for the rising SBON defense payments include the escalating costs of defense counsel, inflation and the individual nature of each SBON disciplinary investigation, which may require years to resolve.

28 License Protection Data Comparison of 2012, 2017 and 2022 Claim Reports

	2012	2017	2022
License protection paid matters	133	240	250
Total paid	$590,718	$1,436,876	$1,788,804
Average payments	$4,441	$5,987	$7,155

29 License Defense Matters by Primary Allegation Class



Analysis of Matters by Allegation Class

This section of the report highlights the most common licensing board allegations against NPs. Although complaints against an NP's license to practice often involve multiple allegations, this analysis classified matters based upon the primary reason for the complaint.

Professional conduct complaints represent the highest distribution of all license protection closed matters in the 2022 dataset, at 27.2 percent.

KEY FINDING

Professional conduct, medication prescribing and **scope of practice** allegations reflect the highest distribution of license protection board matters.

As seen in **Figure 29**, professional conduct, medication prescribing and scope of practice complaints account for more than half of all license protection closed matters at 58.4 percent. Discussion of primary allegation categories does not appear in the same order as delineated in **Figure 29**; each of these top allegation categories will be discussed in greater depth in this section of the report.

Scope of practice represents 14.4 percent of all license protection matters and includes allegations of practicing outside the parameters of the state Nurse Practice Act and failure to maintain minimum standards of practice, as in the following examples:

- The NP was treating a patient who had a low blood platelet count. When the NP accidentally removed the patient's IV catheter, the patient began bleeding heavily. The NP asked a nursing assistant for help with the patient, asking the nursing assistant to wrap a towel around the patient's arm and apply pressure to the wound to stop the bleeding. The NP then left the room to attend to another patient. The nursing assistant stayed with the patient for approximately 15 minutes, then left the room, believing that the bleeding had stopped. The NP later returned to the room to find that the patient was bleeding heavily. The patient's vital signs showed that the patient was going into hypovolemic shock. After the patient was stabilized, the NP was sent home for the remainder of her shift. The hospital later reported the incident to the SBON. The SBON concluded that the NP violated established standards of practice when she

improperly delegated the task of stopping the patient's wound from bleeding to a nursing assistant and failed to maintain responsibility and accountability for this delegated task. The SBON further concluded that the NP's lack of assessment and evaluation of the patient's condition resulted in the patient going into hypovolemic shock. The SBON placed the NP's license on probation for one year. The total costs incurred to defend the NP in this case exceeded $4,000.

- The insured NP worked in a behavioral health counseling practice, under a collaborative agreement with the practice physician. The State Board of Medicine entered a final order against the NP's delegating physician which limited his license to practice for one year. During the term of limitation, the physician was prohibited from prescribing, dispensing or administering any Schedule II controlled substance. At a follow up conference, the Board of Medicine discovered that the physician was relying on the NP to prescribe medications to his patients during the term when his license was limited. The Board of Medicine reported to the SBON that during the one-year period, the NP issued nearly five hundred prescriptions for Schedule II controlled substances, including amphetamines and hydrocodone combination products. The SBON concluded that the NP's conduct constituted a breach of the state scope of practice guidelines for NPs, by exercising improperly delegated authority to prescribe Schedule II controlled substances. The SBON placed the NP on probation for two years, during which time she was banned from possessing, prescribing, dispensing or administering any Schedule II controlled substances. The total costs incurred to defend the NP in this case exceeded $4,800.

Nurse Practitioner Spotlights

For risk control strategies related to:

- Defending Your License
- Depositions
- Patient Adherence
- Telemedicine
- Diagnosis
- Documentation
- Prescribing

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Treatment and care management comprises 12.4 percent of all license protection closed matters and includes allegations of improper technique or negligent performance of treatment or test, premature cessation of treatment and failure to timely/properly address medical complication or change in condition. Evidence-based practice and clinical guidelines are designed to enhance patient outcomes by strengthening the clinical decision-making process. However, they should not be followed blindly or rigidly. NPs have a professional obligation to evaluate the patient's condition and be aware of the patient's response to treatment- or lack thereof. Further, if NPs make a treatment decision that deviates from established guidelines, their rationale must be documented and explained to the patient. This practice can help to reduce professional risk and strengthen the provider-patient relationship.

Diagnosis allegations constitute 8.4 percent of all license protection closed matters with payment. While diagnosis-related allegations reflect a greater proportion of NP professional liability claims, these matters also may result in SBON action, as in the following examples:

- A Family Nurse Practitioner (FNP), employed in an outpatient primary care clinic, saw a male patient in his mid 60s, regarding a mole on his upper back that the patient reported had been there for several years. At the time, the patient reportedly declined a referral to a dermatologist and a biopsy, but the FNP failed to document the declination in the patient's healthcare information record. The FNP also failed to adequately assess the mole and document the patient's family history of skin cancer, and the onset and growth rate of the mole. When the patient returned three months later, the FNP failed to appropriately assess the mole using the ABCDEs (asymmetry, borders, color, diameter, and evolving) and instead, removed the mole via cauterization. The patient was subsequently diagnosed with malignant melanoma. The patient filed a lawsuit against the FNP, and subsequent to the settlement of that case, the matter was reported to the SBON. The SBON issued a consent order against the FNP, ordering him to complete 26 hours of remedial education courses and requiring him to work with a SBON-approved monitor who is required to submit quarterly performance reports to the SBON regarding the FNP's capability to practice nursing for two years. The total costs incurred to defend the NP in this case exceeded $7,000.

- While working at an urgent care clinic, an NP saw a young pediatric male patient who had been evaluated at the clinic two days prior by another provider for a fever and rash. However, the NP failed to document a complete history and physical of the patient and failed to review the documentation from the patient's visit two days prior, which noted that the patient had sustained a tick bite. As a result, the NP failed to order any diagnostic laboratory testing and misdiagnosed the patient with hand, foot, and mouth disease. The patient's condition deteriorated over the next several days, eventually requiring hospitalization and treatment for seizure activity, cardiac dysfunction, and respiratory compromise, which required intubation. During the patient's hospitalization, he was diagnosed with Rocky Mountain spotted fever and treated with antibiotics. After the patient was discharged, the patient's parents filed a lawsuit against the NP. After the lawsuit was settled, the settlement payment was reported to the SBON. The SBON investigated the NP's conduct, and ultimately ordered the NP to complete 20 hours of continuing education courses and pay a $500 fine. The total costs incurred to defend the NP in the SBON matter exceeded $6,300.

For more information on diagnosis allegations, diagnostic errors and diagnostic improvement, see the Nurse Practitioner Spotlight: Diagnosis. For more information on enhancing the diagnostic processes, see the Pennsylvania Patient Safety Authority's resources on diagnostic improvement, the Agency for Healthcare Research and Quality's papers on diagnostic safety topics, and the National Academies of Sciences, Engineering, and Medicine 2015 report, *Improving diagnosis in health care*.

Abuse/patient rights allegations constitute 8.0 percent of all license protection closed matters with payment, which is comparable to findings from the 2017 and 2012 claim reports. The majority of matters in this category involved sexual and emotional abuse of a patient or former patient, as well as a few other violations of patients' rights, such as in the following example:

- The NP violated a patient's right to informed consent by signing the patient's name to a pre-surgical toxicology screening consent form, and failing to properly inform the patient regarding the proposed treatment. The SBON suspended the NP's license for one month, following which her license was placed on probation for two years, and she was ordered to pay a $1,000 fine. The total incurred to defend the NP in this case was nearly $9,000.

The Importance of Documentation

The healthcare information record is a legal document. A well documented record can:

1. **Provide an accurate reflection** of assessments, changes in clinical state, and care provided.
2. **Guard against miscommunication and misunderstanding** among the interdisciplinary patient care team.
3. **Demonstrate your competence as a provider** and help to bolster your credibility.
4. **May help guard** against a lengthy litigation process.

Nurse Practitioner Spotlight

- The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Helpline, also known as the Treatment Referral Routing Service, a source of support for substance abuse issues is available to provide free, confidential assistance at 1-800-662-HELP (4357).
- For resources related to substance use in nursing, you can also visit the NCSBN website.

Analysis of Allegation Class Sub-Categories

Figures 30 and 31 provide additional information regarding the two most frequent and severe allegation sub-categories. Note that percentages are calculated based upon the total matters with defense expense payments for NPs.

Allegations Related to Professional Conduct

Allegations related to the professional conduct of NPs comprise 27.2 percent of all license protection closed matters with payment in the 2022 dataset. Professional misconduct as defined by the state includes allegations such as unprofessional conduct with patients or coworkers, termination from employment due to unspecified performance issues and professional boundary issues with patients, as in the following example:

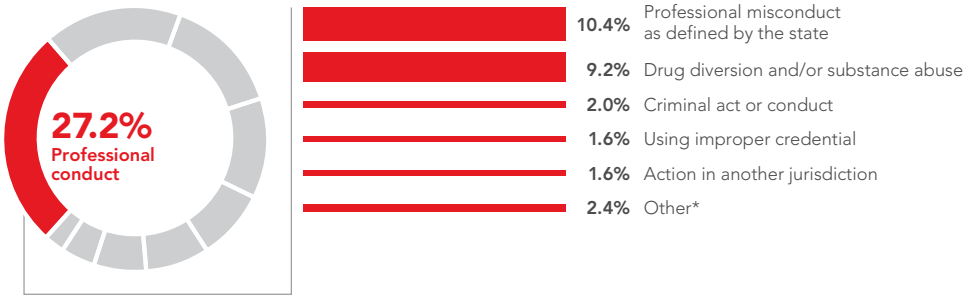
- A former patient posted a review for an addiction treatment center online. The review expressed his belief that he had been exploited by one of his providers while he was a patient. He noted that the experience was detrimental to his recovery, and he relapsed shortly after leaving the facility. A facility risk manager soon began investigating the relationship between the NP and the patient during his time at the facility. The risk manager discovered that the NP engaged in an unethical relationship with the patient, which began when the NP accepted the patient's friend request on a social media site and gave him her phone number. The NP and the patient frequently communicated via text messages and on social media, and soon began a personal/sexual relationship. In addition, it was discovered that the NP gave $2,000 to the patient to help him secure housing upon his discharge from the facility. The risk manager submitted a complaint regarding these allegations to the SBON, including supporting documentation. The SBON placed the NP on probation for three years and ordered her to pay a $10,000 fine. The total costs incurred to defend the NP in this matter exceeded $1,200.

NPs assume a position of trust and authority with their patients, frequently becoming familiar with the most intimate and sensitive aspects of their lives. These relationships may become personal and potentially lead to an erosion of boundaries, confusion of roles and/or incidents of abusive or exploitive behavior. Even if the patient attempts to initiate or consents to sexual/romantic interactions, or other extensions of the provider-patient relationship, NPs are responsible for maintaining professional boundaries as defined by ethical standards, state-specific nurse practice acts, state licensing/certification boards and applicable employer policies. NPs should be aware of warning signs and take steps to establish and maintain appropriate boundaries with all current and former patients. NPs also should adopt conservative privacy settings for their social media accounts and decline "friend" requests from current and former patients.

Similar to the 2017 dataset, allegations related to drug diversion and/or substance abuse remained one of the top allegations for NPs, representing 33.8 percent of professional conduct matters (**Figure 30**). Examples include diverting medications to oneself or others, and apparent intoxication from alcohol or drugs while on duty. Many NPs will confront the problem of substance abuse disorders firsthand during their career, either through their own experience or that of a colleague. NPs with unaddressed substance abuse issues can place both their patients and their livelihood at risk. Co-workers can play an important role in early detection of substance use disorders and drug diversion by being aware of common signs and symptoms. Healthcare providers are often reluctant to report a co-worker for a variety of valid reasons. Nonetheless, NPs should be aware that they may have legal and ethical responsibilities to identify and report suspected substance abuse through the appropriate chain of command. Some states as well as employers, have issued reporting requirements which can hold providers responsible for harm to patients for failure to alert when they become aware of a colleague with a suspected substance use disorder.

30 Allegations Related to Professional Conduct

* Other allegations in the professional conduct category, which account for <2% of all license protection matters in the 2022 dataset, include practicing without a license, inaccurate information provided on license renewal application, and inappropriate supervision.



Allegations Related to Medication Prescribing

Allegations related to medication prescribing make up 16.8 percent of all license protection closed matters with payment in the 2022 dataset. Medication prescribing will be discussed further in the Nurse Practitioner Spotlight: Prescribing.

With allegations related to medications (**Figure 31**), most are due to prescribing or administration errors, such as improper prescribing or management of medications (11.9 percent of medication allegations), failure to recognize a contraindication prior to prescribing a drug (14.3 percent of medication allegations) or prescribing the wrong dose or wrong medication (7.1 percent and 2.4 percent of medication allegations, respectively). Safety features inherent to computerized provider order entry systems, including clinical decision support tools, have generally led to a decrease in medication errors that occur during the process of prescribing medications. However, when medication errors occur, these errors typically involve workarounds and at-risk conduct where the NP failed to follow the proper procedures. Failure to adhere to medication safety procedures can make it more difficult to defend the NP's actions, as in the following example:

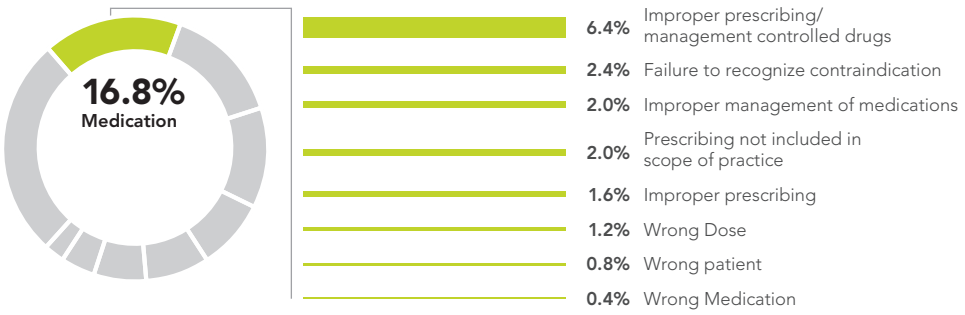
- An NP working in a skilled nursing facility was busy assisting another resident when she gave a verbal order for a medication to an LPN who was standing down a long hallway. The NP failed to verify the resident, or even the medication, the LPN was referencing. The NP told the LPN that if it was the resident's "routine medication", then the LPN could simply reorder and administer the medication. However, the LPN placed the order for the medication and administered it to the resident without verifying that the resident had been given that medication previously. The resident was then given 1000 mg divalproex sodium twice per day for one week. By the seventh day, the resident's spouse asked for the resident to be examined due to the resident's lethargy. The NP examined the resident but did not notice that the resident had been started on the incorrect medication, and that this could account for the lethargy. It was not until the next day, the eighth day, that another nursing staff member identified the error. The resident was then transferred to a local ED to be treated for divalproex sodium poisoning. The resident's family filed a complaint against the NP with the SBON. The SBON reprimanded the NP, and the total costs incurred to defend the NP in this matter exceeded $6,300.

More than one-third (38.1 percent) of medication prescribing allegations involved prescribing opioids and other controlled substances in a manner inconsistent with the applicable standard of care (**Figure 31**). All patients suffering pain should be given a thorough physical and have a history taken, including an assessment of psychosocial factors and family history. NPs should reevaluate the level of pain and the efficacy of the treatment plan at every visit. To minimize the risk of abuse, NPs must comply with state Prescription Drug Monitoring Program (PDMP) requirements, conduct an opioid risk assessment and depression scale test before prescribing opioids, and perform periodic screening thereafter. Some commonly used screening tools include:

- CDC Guidelines for Prescribing Opioids for Chronic Pain
- Diagnosis, Intractability, Risk, Efficacy (DIRE)
- Screener and Opioid Assessment for Patient in Pain (SOAPP®-R)

Remember that NPs, similar to all healthcare providers, have the right to determine whom they will treat. Yet, improperly discharging a patient in chronic pain also may lead to SBON complaints or legal action. NPs can help protect themselves against allegations of abandonment by rigorously documenting instances of patient non-adherence, communicating clearly and straightforwardly with patients, such as providing the patient and/or their caregiver with a written plan of care, and establishing and consistently implementing formal policies and procedures.

31 Allegations Related to Medication Prescribing



State Board of Nursing Actions

While the terminology used to describe the types of disciplinary actions SBONs impose may differ between states and jurisdictions, disciplinary action taken by a SBON can affect an NP's licensure status and ability to practice. SBON actions may include fines, public reprimands, continuing education (CE), monitoring, remediation, practice restrictions, or suspension, surrender, or revocation of the NP's license.

Figure 32 compares the distribution of SBON licensing actions between the 2012, 2017 and 2022 datasets. In the 2022 dataset, the largest percentage of license protection matters, 56.8 percent, were closed with no action taken by the SBON. The distribution of matters that have closed with no action taken by the SBON has decreased since the 2017 and 2012 claim reports. A SBON decision not to impose disciplinary action represents a successful defense of the insured NP.

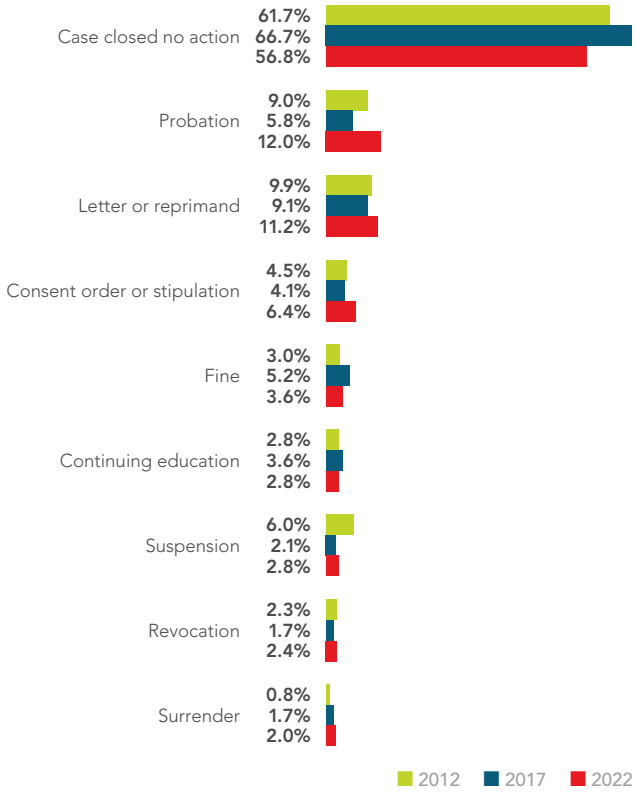
KEY FINDING

Approximately **43 percent** of license board matters lead to some type of board action against a nurse practitioner's license.

Other SBON decisions, such as surrender of license (2.0 percent), revocation (2.4 percent), and suspension (2.8 percent), are less common, but can effectively end the NP's career. The distribution of SBON matters that resulted in revocation and or surrender of license have remained relatively consistent since the 2017 and 2012 reports, while distribution of SBON matters that resulted in license suspension has decreased.

Even complaints resulting in less severe disciplinary decisions by the SBON, such as probation, consent agreements or stipulations, fines, mandated CE, or even letters or reprimands may result in significant emotional and professional impact on the NP. SBONs often maintain lists of disciplinary actions on state databases, newsletters, or websites as these matters are considered public information. SBONs also report disciplinary action to NURSYS® and the National Practitioner Data Bank (NPDB). The SBON also may report that disciplinary action to other agencies, regulatory authorities, or other SBONs, which may decide to initiate their own investigation and take disciplinary action against the NP.

32 Comparison of 2012, 2017 and 2022 Distribution of State Board of Nursing



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