The Nursing Risk Management Series

An Overview of Risk Management

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To obtain the print publication that this CE is based upon, see Take Control: A Guide to Risk Management which can be purchased online.

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Abstract and Objectives

Abstract

In 1998, the independent study text "Take Control: A Guide to Risk Management" was published and co-provided by Seabury & Smith (formerly Maginnis & Associates), the Chicago Insurance Company and the Illinois Nurses Association. It was distributed by the American Nurses Association's Constituent Member Associations. The objectives of this text were to: identify key issues of concern in risk management and describe strategies nurses can use to manage risk.

Seabury and Smith Corporation has now asked ANA to transform this text into "The Nursing Risk Management Series" of three different independent study modules (ISMs) for placement on ANA's Nursingworld.org Web Site. The information and knowledge gained should assist nurses in all clinical practice areas to take control and manage the risks within their individual workplace and nursing practice.

Each module contains the abstract, specific objectives, text, reference list through 1998, an updated reference list through June 2001, the nursing post test and its feedback section. The registrant who successfully completes each ISM will earn ANA's nursing continuing education contact hour certificate. These independent study modules are: I: "An Overview of Risk Management" (1.4 contact hours); II: "The Rewards and Risks of the functional Aspects of Nursing Education, Information systems and Management" (2.8 contact hours) and III. "Ethical Issues and Specific Risk Hazards Faced by Nurses in Their Practice." (1.4 contact hours).

Objectives:

1. Describe regulations governing nursing practice and the related risks.
2. Relate the nurse practice act to risk management.
3. Identify the steps in a lawsuit.

Yes, You Can Be Sued

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During the course of a work day, the nurse confronts hundreds of situations that give rise to potential lawsuits. For example, a just-mopped floor is an invitation for a patient fall; a hurried exchange between nurse and an assistant sets the stage for an error in treatment; and a mislabeled prescription is a medication error waiting to happen.

"Fortunately, only a small percentage of the mistakes made by nurses actually produce injury to patients. Of this small number of injured patients, an even smaller percentage go on to seek compensation for damages through legal action. Nevertheless, the numbers of lawsuits filed against nurses continue to increase" (Aiken & Catalano, 1994, p. 118). "In 1994, the current statistics on a national level taken from data reported in the National Practitioner Data Bank from 1990 to 1993 indicated that as of 1990, about five nurses in 10,000 are sued in a given year" (Kelly & Joel, 1995, p. 502). O'Sullivan (1996) reports an increase in suits brought against nurses working in critical care and obstetrics and against nurse practitioners.

Nursing, the Law, and Other Codes of Conduct

The legal status of nursing derives from the Nurse PracticeAct of each state. The Practice Act defines the practice of nursing and the standards to which nurses will be held accountable and along with accompanying administrative rules and regulations become principal sources of law that govern a nurse's practice. Other laws such as state healthcare facilities statutes and medical and pharmacy practice acts also influence the practice of nursing. These laws set a standard of care or duty to which the nurse is held accountable in practice. A violation of the standard of care or duty is generally thought of as negligence and can lead to malpractice.

Four conditions of negligence must be present for nurses to be adjudged guilty of malpractice. Aiken and Catalano (1994) report that the plaintiff (patient) must prove that:

- the nurse owes the patient a duty,
- the nurse has breached that duty or standard of care,
- harm or damage has resulted and can be linked to the duty owed, and
- the breached duty is the proximate cause of the harm or damage.

Members of a profession often establish standards of practice and codes of ethics which are authoritative statements by the profession on how care should be delivered and the kind of conduct or behavior the

professional practitioner should engage in. For example, the American Nurses Association has set forth a *Code for Nurses.* Hospitals adopt policies and accrediting agencies set standards all in the interest of guiding how care is provided. For example, the Joint Commission on Accreditation of Healthcare Organizations prescribes a set of guidelines that healthcare organizations must meet in order to be accredited. These professional pronouncements and policies can also be used in determining whether or not malpractice has occurred.

The Changing Nature of Liability

Changes of epic proportion in today's healthcare system invite further litigation in an already litigious society. The rapid expansion, of scientific knowledge and use of technology increases patient expectations for favorable outcomes as a result of treatment received. Shorter hospital stays mean discharging patients that are sicker and more likely to experience adverse events at home or in another care setting. In a recent instance, a nurse from a temporary staffing agency was sued for failing to protect a patient in a congregate living facility from a violent resident.

Increasing reliance on technology to capture and convey patient information and the use of assistive personnel to provide care enlarges the opportunity for errors to occur. New or different practice sites mean unfamiliar procedures or protocols and fresh occasions for error. Ethical dilemmas such as end of life decisions also provide a medium for a perceived breach of duty to arise. As well, society's standards have changed giving rise to changing norms in professional conduct. For example, sexual harassment laws govern how professionals interact, and fraud and abuse statutes control how payment systems are used. In one recent situation, a nursing school faculty member was sued by a student for alleged sexual harassment.

The profession of nursing has grown, changed, and acquired a new professional status as well. Nursing education has moved into institutions of higher learning; nurse practice acts have been amended to recognize a number of independent nursing practices, such as diagnoses; and many nurses are in solo practice. Nurses are no longer absolved of poor practice as a result of following doctor's orders. Thus, nurses are held to standards of care that are more rigorous than in days past and are held accountable for increasing professional judgment. According to Horsley (1986)...there's always a price to be paid for professional status. That price is expanded legal accountability."

Myers and Fergusson (1989) suggest that nurses with advanced knowledge of pharmacology, anatomy, and physiology are held to an even higher standard of care as their knowledge infers the ability to handle ever more complex and specialized practice. Kelly and Joel (1995) caution that nurses who assume they are at little risk because they don't work in a high pressure area like the emergency room make a mistake. In reviewing a number of cases Kelly and Joel (1995) found that, in the majority of instances where nurses were held liable, the mistakes were everyday situations where nurses did not use good nursing judgment or common sense.

Patient falls, burns, and medication errors have historically been among the most frequent contributors to nurses' malpractice. Today, nurses are also held accountable for failure to communicate, failure to diagnose a patient condition and take appropriate action, and for misapplication of therapies or misuse of devices. Lack of knowledge and poor judgment are also major causes of litigation.

Pepper (1995) reports a case study derived from actual occurrences demonstrating the consequences of lack of knowledge, poor judgment and inattention to orders. A staff nurse administered 40 meq of potassium chloride by injection to an elderly man. The order was for 40 mg of Lasix, IV push. The man expired and the family filed suit. The board of nursing investigated the nurse, nursing supervisors and vice president for nursing as this was the staff nurse's third medication error. The board of nursing put the staff nurse on probation for eight months. The employer terminated the staff nurse's employment on the advice of the hospital's risk manager.

Two recent cases demonstrate the nature of today's lawsuits against nurse practitioners. In the first instance, a nurse practitioner failed to diagnose a myocardial infarction even though the patient presented such classic signs and symptoms as chest and arm pain, obesity, and a family history of heart disease. In the second example, a nurse practitioner failed to diagnose and treat cervical cancer.

The Size of Awards

Some cases can be settled for as little as $ 1,000 and others are settled in the millions of dollars. Northrop (1989) examined ten nursing negligence cases published between March and August 1989 and found that three of the cases were decided for the plaintiff. In these three cases the jury verdicts were $2,089,886.92, $

20,000, and $2,300,000. Northrup (1989) reports that the cases resulting in these verdicts involved the following "poor" nursing practices:

- The first jury verdict revolved around trauma suffered by an infant that was mishandled by nursing staff.
- The second verdict resulted from an incorrect sponge count by circulating and scrub nurses which caused patient injury.
- The third verdict resulted from the failure of nurses to recognize a post-surgery emergency, failure to notify physicians in a timely manner, and an inadequate medical record.

Student Nurses

Student nurses can be held liable for their actions and can be sued. A student nurse is held to the same standard of care as a registered nurse when performing RN duties. If a student nurse cannot safely function in the performance of these duties while unsupervised, the student should not be carrying out the duties. Kelly and Joel (1995) report the case of a first year student who administered an intramuscular injection into a patient's sciatic nerve causing severe damage. The student was found to be negligent because she should have known the proper procedure and taken special precautions with the patient who was very thin. In another set of circumstances, the instructor might have been found liable on the basis of inadequate supervision had the instructor given the task to the student knowing the student was not capable or competent to perform the task.

Kelly and Joel (1995) report another student case involving student and teacher responsibility. In this case, Central Anesthesia Associates v. Worthy (1985), a senior student nurse anesthetist was accused of causing injury to a patient by improper administration of anesthesia. The student nurse anesthetist was under the supervision of a physician's assistant employed by the corporation that had the nurse anesthetist program. The court held the student liable and failing to meet the standard of a Certified Nurse Anesthetist. The anesthesiologist teachers were held liable for not delegating properly, and the PA was held liable for not supervising adequately.

Protection Against Suits

Nurses must continuously monitor their practice to manage away from risk. Keeping up to date on new technologies, treatment modalities, medications, and employer policies and procedures is a must. Current knowledge about professional standards, codes of conduct, and accreditation criteria are also important. Familiarity with the reasons nurses are sued is also relevant to managing risk.

A professional liability insurance policy is another risk management tool. Liability insurance protects against the financial consequences of suits. Insurance is basically a contract between an insured and an insurance company that upon the payment of a premium the company will provide the insured certain financial payments when the insured is accused of causing injury to another.

Often, nurses believe that an employer's liability insurance is all the coverage needed. O'Sullivan (1996) points out that some hospital policies have not kept up with the changing role of the nurse and that an employer's policy may not cover nurses off-duty or volunteering in a community role. O'Sullivan (1996) also advises that nurses can no longer assume the hospital will provide the best defense in lawsuits as a hospital attorney's primary concern will be the hospital; concern for the nurse will be secondary.

There are also a number of myths about liability insurance in the nursing profession. One myth is that a nurse runs a greater risk of being sued if the nurse has liability insurance. "In reality, lawyers normally do not know if the nurse named in lawsuits has extra insurance or not" (O'Sullivan, 1996). Another myth is that a nurse who purchases liability insurance is no longer covered by an employer's policy. It is illegal for an employer's policy to drop an employee because he/she has liability insurance.

Summary

Nurses, like people in almost every walk of life, can be sued. Nurses are held accountable for their practice by virtue of various laws and regulations. Standards of conduct set by professional organizations and employing agencies also dictate norms to which nurses can be held accountable. The changing healthcare environment and the evolution of the nursing profession also contribute to the changing nature of liability for today's nursing professional. An occasional review of claims brought against nurses can help the practitioner identify actions that might lead to malpractice and guide the nurse in managing risk in day to day practice. Liability insurance is

one of the best risk management tools for the registered nurse's risk management tool kit.

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Note: These references are not part of the independent study module, but are provided to you as suggestions for additional reading.

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Regulation of Nursing Practice

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Some individuals may espouse the point of view that no industry is more regulated than the healthcare industry. Statues and regulations give individuals a right to a cause of action or the government the right to demand that healthcare providers and hospitals carry out certain activities (Hudson, 1990). While laws provide the legislative and legal authority, regulations provide further detail for implementation of laws. Lack of knowledge in these areas can lead to violations of state government regulations that ultimately result in disciplinary measures, fines, or litigation.

In this article the author will discuss regulations governing the practice of nursing, assess potential risks in relation to specific practices, and offer strategies to manage these risk. While there are numerous regulations governing the healthcare delivery process, this article will be limited to nursing practice acts and authority of boards of nursing.

The word law is defined as the sum total of manmade rules and regulations by which society is governed in a formal and binding manner (Betts & Waddle, 1992). It encompasses the actions of the legislative branch in enacting statues, executive branch in administering statutes through rules, and the judicial branch in interpreting statutes and rules. There are three major sources that provide laws governing our society: statutory laws, common laws, and administrative laws. Statutory laws are those generated by state legislatures or Congress. Common laws evolve from judicial decisions. Administrative law is developed under the authority of regulatory agencies such as state boards of nursing.

In addition to knowing how law is established, it is also important to understand how laws are violated. Criminal law relates to a violation of the law. In criminal cases, an individual commits a crime and faces trial in the criminal court system. In contrast, civil law deals with disputes over legal rights and duties of individuals in relation to one another. In civil cases, compensation may be awarded to the injured party from the person who caused the harm (Harris, 1991). Finally, administrative law relates to a regulatory agency or board of nursing restricting one's ability to practice.

These laws are not mutually exclusive. Depending on the violation, a nurse may be tried in more than one system. For instance, misappropriating patient funds or controlled substances may lead to a criminal conviction. However, these activities are also violations of the nursing practice act, and as such, may result in disciplinary actions from the board of nursing. Therefore, in addition to receiving criminal punishment, the nurse may also have his/her license to practice revoked or suspended or the nurse may be placed on probation.

Nursing Practice Acts

The regulation of healthcare providers, professionals and institutions, is a state function. Each state licenses healthcare providers practicing within the state's geographic boundaries. The authority for this activity is provided by the United States Constitution which dictates that healthcare providers be regulated by the states as opposed to the federal government. Therefore, each state has established a regulatory agency, referred to as the board of nursing, to carry out these duties with respect to the nursing profession. Statutory authority is provided to the boards of nursing by state legislatures. These statutes are known as nursing practice acts.

The mission of these regulatory boards is to protect the health, safety, and welfare of the public. This is accomplished through the administration of responsibilities such as establishing criteria for practice, issuing licenses, regulating standards of conduct, investigating complaints against licensees, and promulgating rules that regulate nurses and nursing practice. Implicit in these major responsibilities for upholding public protection are (1) rule making authority, (2) quasi-judicial authority, and (3) administrative authority (Betts & Waddle, 1992).

Authority of Regulatory Boards

Rule Making Authority	Provides for setting standards, as well as for due process requirements.
Quasi-judicial Authority	Provides for enforcement of standards and outlines procedures for adjudication of contested matters.
Administrative Authority	Provides for elements needed to enforce standards such as agency budget, personnel, and office management.

Risk Management Laws

In recent years, there has been an increase in the establishment of risk management laws, more commonly known as "mandatory reporting laws." The intent of such laws is to provide a mandatory mechanism of reporting substandard nursing practice to the appropriate licensing agency. Mandatory reporting laws require that certain actions of licensed nurses, such as alcohol, drug, and patient abuse or neglect, be reported to the licensing board.

An important aspect of mandatory reporting laws is the definition of a *reportable incident.* For example, the Kansas law defines *reportable incident* as an act by a "healthcare provider which: 1) is or may be below the applicable **standard of care** and has a reasonable probability of causing injury to a patient; or 2) may be grounds for disciplinary action by the appropriate licensing agency" (Jaeger, 1993).

Minnesota regulations require, "any healthcare institution or organization located in this state shall report to the board any action taken by the institution or organization or any of its administrators or committees to revoke, suspend, limit, or condition a nurse's privilege to practice in the institution, or as part of the organization, any denial of privileges, any dismissal from employment, or any other disciplinary action" (Minnesota Board of Nursing, 1994, p. 16).

In order to minimize professional risk, it is important that nurses understand the concept of a prevailing standard of care. The nursing standard of care is what the reasonably prudent nurse, under similar circumstances, would have done. It is a peer standard of care that reflects not excellence but a minimum standard of "do no harm." The nursing standard of care is determined by statute such as nursing practice acts, professional organizations such as the American Nurses Association, and employing institutions through policies and procedures. Although many standards of care are well defined and long standing, new standards are regularly being formulated to address changes in the practice of nursing.

Unlicensed AssistivePersonnel

The American Nurses Association defines unlicensed assistive personnel as individuals who are trained to function in an assistive role to the licensed registered nurse in the provision of patient/client care activities as delegated by the nurse. The increasing use of assistive personnel in the healthcare delivery system poses several risks for nurses. Nurses should be aware of issues regarding scope of practice, delegation, and supervision of assistive personnel. While this discussion is limited to unlicensed assistive personnel, concepts

of delegation are also applicable to licensed practical nurses and certified nurse aides.

Generally, assistive personnel perform patient care/support tasks that are non-threatening and noninvasive. However, as the costs of healthcare services rise, facilities are attempting to contain costs. One popular means of decreasing expenditures is to reduce labor costs. Registered nurses comprise the largest portion of facility labor cost. In order to quickly reduce expenses, facilities are reorganizing their workforce and decreasing registered nurse staffing. A reduction in the number of registered nurses is accompanied by an increase in the use of unlicensed assistive personnel.

Unlicensed assistive personnel are minimally educated healthcare workers who receive on-the-job training. There are no state or federally-mandated education programs for these workers. Further, there are not standard methods for testing competency or for regulating these individuals. Data indicate that quality and safety of patient care decreases as the use of assistive personnel increases.

Unlike nurses, whose profession is regulated by state nursing practice acts, unlicensed personnel are legally allowed to perform only activities which fall outside of nursing activities as delineated in nurse practice acts (Kreplick, 1995). Nursing practice incorporates knowledge, judgment, and skill. Professional nursing skills include assessment, diagnosis, interventions, and evaluation. These are skills far beyond the scope of unlicensed assistive personnel. Risk for both hospitals and nurses increases when the lists of tasks performed by unlicensed assistive personnel involves judgment and skill as in sterile dressing changes and catheterization. If the unlicensed individual is providing nursing care and/or representing his/her care as nursing care without proper authority, regulatory interventions should be implemented to stop the unauthorized practice of nursing.

In addition to assistive personnel practicing nursing without a license, inappropriate delegation poses both professional and legal risk for nurses. The concept of delegation incorporates legal and managerial principles. Delegation is the transfer of authority by one person to another. Because delegation or the transfer of authority is never absolute, the one in authority may not delegate all their authority, responsibility, or accountability. The professional nurse is accountable legally, based upon licensure laws, to use the nursing process in making the decision to delegate in a manner that does not jeopardize patient safety.

In other words, when delegating, it is the registered nurse who uses professional judgment to determine the appropriate activities to delegate. Any nursing intervention that requires independent, specialized nursing knowledge, skills or judgment cannot be delegated (Kreplick, 1995). Since boards of nursing are charged with protecting the health, safety, and welfare of the public, disciplinary actions may be taken against the license of the registered nurse who fails to delegate or supervise unlicensed personnel as outlined in the statutes and regulations.

Thus, nurses must consider their professional responsibility and liability when overseeing the activities of unlicensed personnel. State nursing practice acts provide the legal definition circumscribing the scope of nursing practice. In the case of delegation, nurses risk action from the board of nursing in the following four instances: 1) delegation to an individual lacking sufficient education or experience to perform the nursing function; 2) delegation of tasks and responsibilities contrary to the state nurse practice acts; 3) delegation that poses substantial risk or harm to a patient; and 4) inadequate supervision of unlicensed personnel to whom nursing tasks have been delegated (Kreplick, 1995).

In addition to being professionally responsible for improper delegation and supervision of unlicensed personnel, nurses may also be held liable for any incorrect actions which may result. Professional nurses who negligently delegate or supervise unlicensed personnel may be subject to civil liability if a patient is injured, providing the patient can show the following: 1) the professional nurse had a duty; 2) he/she breached that duty by failing to act as a reasonably prudent nurse would have; 3) the professional nurse's conduct caused harm complained of, and 4) the nurse's conduct was the proximate cause of the harm (Kreplick, 1995).

Changes in the healthcare delivery model have implications throughout the system. The healthcare delivery system will continue to use unlicensed assistive personnel to augment staff mix. States continue to evaluate the effectiveness of statutes and regulations governing delegation and supervision. Therefore, it is important that nurses are knowledgeable of the state's rules and regulations pertaining to delegation and supervision. In addition, nurses must understand the components of the delegation process and successfully incorporate delegation into their practice.

Continued Competence

Changes in the organization, financing, and delivery of services are having a substantial effect on the practice of healthcare professionals and on systems that establish competence to practice. Public advocacy groups, employers, and state and federal regulatory agencies have made regulatory reform related to professional accountability a national priority. Managed-care organizations, employers, and the government - - concerned with their own accountability -- recognize that competence affects both cost and quality of care.

Regulatory agencies such as state boards of nursing have the authority to issue and deny licenses and to remove those individuals deemed unsafe to practice. The usual qualifications for licensure are educational preparation and passing a licensure examination. The public recognizes licensure as a sign that the individual is safe to practice -that is the individual is competent. Black's Law Dictionary defines competent as being "duly qualified; answering all requirements; having sufficient ability or authority; and possessing the requisite natural or legal requirements."

Today, regulatory boards and employers are faced with the dilemma of determining competency after initial licensure. However, maintaining competency to practice has traditionally been the professional responsibility of the nurse.

Determination of continuing competency for renewal of licenses became the focus in the 1960s. Peer review, self evaluation, and continuing education are mechanisms currently in use to determine continuing competency. Many states require continuing education for renewal of licenses for registered nurses. Although the goal of mandatory continuing education is to ensure competence, it has not been adopted as a viable regulatory mechanism. Costs associated with mandatory continuing education are substantial, and its effectiveness is difficult to document.

However, new healthcare delivery and data collection systems have made the margin for poor performance narrower than ever. The importance of performance measures in maintaining and improving quality is well understood by nurses and most healthcare organizations (Willoughby, Budreau, & Livingston, 1997). A critical component of providing quality nursing care is the competence of the nursing staff. There is movement toward data collection to clearly document quality outcomes. Competency monitors are intended to document and monitor the ability of staff to perform safely and effectively in a given setting.

For years, the health professions have resisted reassessment as a condition of relicensure or recertification and have defended a system that examines professionals only once in their lifetime. Yet as early as 1981, the National Organization for Competency Assurance stated:

> "Healthcare technology is advancing too fast for a certificate of competency earned at the beginning of one's career to constitute proof of competency many years later. Demonstrations of continuing competence are as reasonable and necessary as are required demonstrations of entry-level competence. However, the lack of any standardized procedure for assuring that licensees have kept abreast of technology or research developments and can still provide quality services to the public has led to demands for regulatory agencies to monitor the continued competence of healthcare providers" (Willoughby, Budreau & Livingston, 1997, p. 44).

The National Council of State Boards of Nursing defines the elements of competence as specific knowledge base, awareness of practice standards, psychornotor skills, decision-making skills, communication skills, experience and attitude. Tools that can be used to quantify performance and characterize skills include continuing education credits; written documentation, such as copies of quality assurance logs; observation; peer review; quality assurance findings; a lab practicum in which the employee perfonns tests for evaluation; and verbal or written tests. A criterion used to measure employee job performance usually falls into one or more of three skills categories: critical thinking, interpersonal relations, and technical skills (Willoughby, Budreau, & Livingston, 1997).

Boards of nursing are obligated to take appropriate disciplinary measures against a practitioner who fails to meet the standard of practice or who practices in an unsafe manner. Although policy and regulations in this area are in flux, it is the individual nurse's responsibility to maintain competency through self assessment and self limitation.

Impaired Healthcare Providers

In the healthcare setting, practicing while under the influence of drugs or alcohol is a violation of the nursing practice act and endangers both the patient and nurse. Further, drug use may give rise to litigation if an impaired healthcare provider injures a patient while providing care. Because tort liability can arise for an

employer out of injury to a patient resulting from an act of negligence by a drug impaired employee, the healthcare employer has a special interest in intervening quickly and efficiently when drug use or impairment is suspected on the job.

Thus, the importance of developing and implementing clear policies and procedures concerning drug use, diversion, and impairment in the workplace cannot be overemphasized. Some hospitals and employers take a punitive approach with impaired nurses. However, the punitive approach is now giving way to a rehabilitative approach. The American Nurses Association and many boards of nursing focus on rehabilitating nurses whose practice may have been impaired by psychological dysfunction or substance abuse so that they may return to work.

Nurses suspected of being impaired or diverting drugs should be reported to the board of nursing. Almost every state nursing practice act includes statutory or regulatory language related to this behavior. Generally, impairment while on duty, habitual addiction to drugs or alcohol which affects the nurse in his/her professional duties, and/or diversion of drugs from the facility can result in disciplinary action against the registered nurse. Disciplinary action may include placing a nurse on probation or revoking or suspending a license to practice. However, many states have incorporated assistance programs which sleek to rehabilitate the nurse and allow continued employment. In such instances the nurse may practice on a restricted license while the state agency closely monitors his or her performance.

After a recovering nurse's re-entry to work, monitoring for continued abstinence is essential for both the employer and the recovering nurse in order to protect the patient and to provide documentation that the nurse continues to be "clean and sober" (Brent, 1991). Generally, the boards of nursing will define who will be responsible for monitoring the nurse. Regular reports detailing urine screen results, notification of employment changes, support group meetings, and performance evaluations are reviewed by the agency.

Chemical dependence in the workplace must be met with a sound plan of action, by both regulatory agencies and employers, in order to protect patient safety and reduce liability.

Advanced Practice Registered Nurses

Almost 140,000 advanced practice nurses are creating a new role in the healthcare delivery system. The term advanced practice registered nurse (APRN) is an umbrella term given to registered nurses who have met advanced educational and clinical practice requirements. These nurses may also be identified as nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists (American Nurses Association, 1995). These expanded roles have led to new statutes and regulations regarding advanced practice nursing as well as increased legal exposure. Therefore, it is imperative that APRNs understand the legal responsibilities that exist within their scope of practice.

The first area of difficulty encountered by APRNs is one of standardization. Regulatory requirements for being recognized as an APRN vary from state to state. Some states require master's level preparation and specialty certification, while others do not. In addition, each state defines advanced level nurses differently. Some states may not recognize all four categories of APRNs. For example, the Michigan Nursing Practice Act certifies clinical nurse specialists as nurse practitioners while Nevada recognizes only nurse practitioners, nurse midwives, and nurse psychotherapists as APRNs. Finally, some states, such as Illinois, Minnesota, and Tennessee, do not have title protection for advanced practice nurses. For example, in Minnesota, authority for nurse practitioners to practice is covered under a broad nursing practice act. In contrast, Nebraska enacted a separate act for APRNs.

A second important area of clarification involves legal distinctions in the definition of nursing practice as opposed to medical practice. Practice laws carefully define the scope of advanced nursing practice. Two states (Alaska and New Mexico) and the District of Columbia allow APRNs to practice independent of physician supervision. Thirty-four states have enacted statutes that authorize the nurse practitioner to provide care without physician supervision when controlled substances are not being prescribed. The remaining states require advanced practitioners to enter into collaborative or supervisory relationships with physicians. While the APRN remains legally responsible for his/her own actions, he/she must understand the parameters of these agreements before entering into any relationship with another healthcare provider (Henry, 1996).

Further, the practice of APRNs is regulated differently from state to state. Those states that allow APRNs to practice independently regulate advanced practice solely under the board of nursing. States that require some type of physician supervision or collaboration may regulate advanced practice through a joint committee of the

boards of nursing and medicine. These boards promulgate rules to define the scope of practice for APRNs including prescriptive authority and dispensing of medications.

A third area of confusion for advanced practice nurses is reimbursement of services. Direct reimbursement for advanced practice nurses has been recognized under Medicaid and Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and the Federal Employee Health Benefits Program (FEHB). However, Medicaid is a joint state/federal program. This means that in order for **APRNs** to receive Medicaid reimbursement, specific state legislation must be enacted. The same holds true for third party reimbursement. Reimbursement language is generally not included in nursing practice acts but instead in insurance related vehicles. As a result, changes in state insurance laws have been enacted in many states to achieve direct payment for nursing services from private insurance companies. The most common mechanisms through which APRNs have acquired access to direct payment are mandated benefits laws and nondiscrimination provisions. Again, it is important to note that statutory recognition of APRNs is a necessary component for reimbursement.

Decreasing Risk

Risk assessment should constitute a nurse's best effort to predict the probability of harm in a given situation. Having predicted the level or risk, the nurse then should take action to minimize the risk. A number of steps can be taken to improve the risk management process in relation to the regulation of nursing practice.

Changes frequently occur to either the statutory or regulatory language that govern nursing practice. In the first four months of 1997, more than 200 pieces of legislation were introduced that affect nurses or nursing practice (National Conference of State Legislatures, 1997). It is important that nurses keep abreast of these changes. Professional nursing organizations such as the American Nurses Association and their 53 state constituents can assist nurses in the legislative and regulatory arena.

Further, the nurses should establish life-long learning skills. The practice of nursing is not a static but rather an active field. It is the professional responsibility of nurses to update their skills and maintain their competency. Both formal and informal educational programs and peer review programs are helpful in evaluating and assessing competency.

Summary

In conclusion, following and maintaining standards of care will reduce professional and personal liability. Each nurse must read and keep on hand a copy of the nursing practice act. Becoming familiar with the nursing practice act is the best means for nurses to decrease professional and legal risk. Further, nurses are urged to develop a relationship with their board of nursing. Attend board meetings and invite board of nursing members to participate in educational opportunities sponsored by professional organizations or employers.

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What To Do If You Are Sued

Linda J. Shinn, MBA, RN, CAE and Laura L. Curtin

Being sued for malpractice is one of the most traumatic experiences a nurse can have. Regardless of one's guilt or innocence, receiving notification of being sued and the events that follow are not only traumatic but time consuming and expensive.

"Civil suits are brought for many reasons. Some are brought to enjoin an activity or challenge a law, but most-like malpractice suits-seek money damages" (Cushing, 1985, p.655). Shea (1993) notes that the genesis of a suit is a patient, dissatisfied with care, who contacts an attorney for redress. "If the attorney determines that the four elements of a medical malpractice case are present- the duty to provide care, a breach of the duty, an injury, and proximate causation - the attorney will probably notify the defendant or defendants of the allegation and attempt to negotiate a settlement. If no settlement is reached, the attorney will prepare to file the lawsuit" (Shea, 1993, p. 85).

Aiken and Catalano (1994) note that damages suffered by a plaintiff can be "hard" and "soft" damages. Hard damages include medical expense, funeral bills, and lost wages. Soft damages are generally intangible and can include pain and suffering and loss of consortium.

The Process (Summons)

A lawsuit (suit) begins with the serving of a summons or copy of the suit upon the defendant (nurse). The suit will have been filed by the plaintiff (patient). After keeping a copy for his/her own records, a copy of the summons should be forwarded to whoever was the nurse's employer at the time the care was given to the patient and a copy should be forwarded to the nurse's professional liability insurance agent.

Upon receiving notification of the suit, the nurse defendant should take time to think about the incident and

write down all aspects of the incident that come to mind. The notes should include the "who, what, when, where, how, and why" of the circumstances. The patient's chart might be consulted. All dates, times, places, and people involved should be part of the nurse's anecdotal documentation.

The nurse should notify his/her professional liability agent or insurance carrier and document the conversation including the following: who was called, the date, time, and what was said and the next steps the nurse should take. The employer's risk manager should also be notified verbally and in writing. As this is a highly emotional time, documentation can assist in ensuring that all who might have a role in assisting the nurse through the process are notified. While the nurse will be tempted to talk about the suit with others, it is important not to discuss the case with anyone but the nurse's insurance agent and claim representative, attorney, and employer's risk manager. Under no circumstances should the nurse discuss the case with the plaintiff (patient), plaintiff's family, plaintiff's attorney, news media, or individuals who might be witnesses for the plaintiff.

Insurance Carrier

The insurance agent will forward a copy of the suit to the insurance carrier. The carrier will begin a file on the case by entering the facts into a computer data base. The insurance carrier will cross check to determine if other claims are pending for that patient. As multiple healthcare providers are involved with the care of a patient, the carrier may already have a file open for another professional that also has been sued by the same patient.

Next, the carrier assigns a claim representative to handle the case. The skills of the claim representative are matched with the facts of the case to ensure that the most qualified staff member handles the case. If there are several claims from the same patient, the carrier will check to see if there is any conflict in having the same claim representative handle the lawsuit for all the insured(s) (defendants). If there is any indication by an insured that another insured is liable, a different claim representative is assigned to protect each insured. If there is agreement among the insured and the carrier that no one is at fault, or the fault lies with a defendant not insured by the nurse's professional liability carrier, one claim representative will handle all of the claims against the insured(s).

The assigned claim representative will then contact the nurse. The contact occurs 24 to 48 hours after the carrier has been notified of the lawsuit. The claim representative will interview the nurse by telephone and get as much information as possible about the incident. The claim representative will explain what the insurance policy will cover. The claim representative will contact any other insurance carriers that might be providing, or should be providing, coverage for the nurse (e.g. employer).

Legal Counsel

Upon confirmation of insurance coverage, the claim representative will advise the nurse what law firm will be used to represent him/her. The attorney will have expertise in the field of medical malpractice defense. At any one time insurance companies are handling hundreds of law suits across the country and, as a result, have negotiated representation fees with one or two law firms in a geographic locale. Fee schedules assist the insurer to manage the costs of litigation which can be millions of dollars per month and, thus, impact the cost of the nurse's professional liability insurance.

Once legal counsel is assigned, the attorney will contact the nurse. Counsel will interview the nurse to become more familiar with the case. The nurse will want to become comfortable with the attorney too. The nurse might want to ask the following questions:

- What are your credentials?
- How many cases of this type have you handled?
- How many have you taken to trial?
- What outcomes have you achieved?

If the nurse is not satisfied with the attorney assigned to the case, the claim representative should be notified at once. The insurance carrier wants to provide excellent customer service and wants a qualified attorney to handle the nurse's case.

The claim representative should provide the nurse defendant with a written letter outlining how the claim will be handled. For example, the letter will identify the law firm that will defend the insured. If an investigator is used, the letter will identify the investigating firm. Any coverage issues related to the insurance policy will be described and how the issues have been resolved will be detailed.

During this time there will be an investigation of the facts underway by the plaintiff and defendant's counsel. This is called the discovery period. While the counsel representing the nurse will interact informally and regularly with the nurse, counsel for the plaintiff (patient) must use more formal means of obtaining information from the nurse. For example, the patient's attorney might submit a list of written questions to be answered by the nurse. The nurse should answer the questions only in consultation with his/her counsel. The nurse might have to give a deposition. This process is conducted in the presence of all attorneys and a court reporter is used to record the answers to all questions. All information gathered will be used to try to reach a settlement or to ready the case for trial.

Settlement

Each case should be evaluated by the insurance carrier on its merits. In examining the merits of the case, the carrier will make every effort to determine who is liable (i.e., who is at fault). The insurer will try to decide:

- What is the appropriate standard of care?
- What would a reasonable, prudent person have done under these circumstances?
- Was the appropriate standard of care applied?
- Was there a breach in the standard of care?

As others are often involved in the case, the carrier will try to identify the insured's fault in percentages. For example, the insured was 10-20% at fault. Next, the carrier will evaluate the dollar amount that the case is worth. This determination will be based on experience, advice of counsel, previous jury verdicts in similar cases, laws in the jurisdiction or location of the claim, **and the** socioeconomic group of the plaintiff. The carrier will consider the ability of culpable parties to pay the claim and examine the potential for an excess verdict against the nurse. Taken together, these factors result in a decision about paying a claim when the insurer thinks the insured has some fault.

Cases may also be settled even when the insured is not at fault. Again, the case is evaluated on its merits. Some cases may be settled based purely on economics, particularly in smaller value claims. Other cases might be settled because the insured would make a poor witness on his/her own behalf or because the medical record may not support the nurse's action (e.g., treatment given and not charted).

Cases may be settled to avoid the risk of a jury verdict. Jury verdicts are very difficult to predict and some awards might far exceed the value of the case.

Nurses naturally wonder how much say they have in whether or not a case is settled or taken to trial. Many insurance policies include language that requires the insured to consent to any settlement prior to the insurer entering into a settlement agreement. Some state statutes require the insurer to obtain the consent of the insured. There are other instances in which the insurer has the final say in a settlement decision. Nurses should always make their views about settlement known to their lawyer and claim representative.

Trial

When settlement negotiations are unsuccessful, the case will be scheduled for a trial. Shea (1993) notes that courts are so backlogged in many jurisdictions that it may take years for a court date to be set.

At a trial, the plaintiff presents evidence and witnesses in an effort to prove that the defendant is guilty of malpractice. Aiken and Catalano (1994) report that the next steps after selection of a jury is for each side to present opening statements to summarize the position of each party. As the plaintiff has the burden of proof, the plaintiff s case is presented first. "Evidence must be sufficient to meet the four elements of negligence in order to be successful: duty, breach of duty, causal connection, and damage" (Aiken and Catalano, 1994, p. 92).

The plaintiff will present evidence and witnesses related to standards of care, policies, procedures, and medical records. Witnesses are questioned by the plaintiff s attorney and cross examined by the defendant's counsel. Once the plaintiff concludes, the defendant has the opportunity to present evidence and witnesses to disprove the plaintiff s allegations. According to Aiken and Catalano (1994), after the defendant rests, the defense can move for a directed verdict against the plaintiff for not meeting the burden of proof or making a valid case. Should the court agree, the trial ends. If the court does not agree, the trial continues; the jurors hear any additional evidence and closing arguments; and the jury deliberates and renders a verdict. "If the trial is a judge trial, the judge renders a judgment immediately or takes the matter under advisement and renders a judgment after reviewing trial materials or trial briefs submitted by counsel" (Aiken & Catalano, 1994, p. 93).

The verdict may be appealed. Should the verdict be against the nurse, then the nurse, counsel and insurer will determine the next steps.

Testifying

During the course of a career, a nurse might be called upon to testify in a trial on his/her own behalf as a defendant or as an expert witness on behalf of a plaintiff or other defendant. Giving testimony can be a terrifying experience. However, in-depth preparation can help alleviate those fears. Do's and don'ts of testimony, adapted from Myers and Fergusson, (1989, pp. 45-46) are as follows:

The dos:

- Get a good night's sleep the night before the testimony.
- Dress appropriately. If you want to be recognized as a professional, look like one.
- Have a clear understanding of the facts of the case.
- Speak clearly, directly, and honestly with short, unemotional answers. Sarcasm and wisecracks should not be a part of the testimony.
- Think about what to say before saying it. Do not blurt out an answer. For example:

    1. If you are asked a question about a document, don't hesitate to ask to see the document before responding to the question.
    2. If you are asked a hypothetical question, note the differences from the actual case before responding to the question.
- Answer the question asked of you. Nurses, often use rephrasing techniques in practice to elicit information from patients. This technique should not be used when giving testimony. Keep in mind, the witness is to answer questions, not to ask them.
- Stay alert. If you are tired and need a short break, ask for one. This is an accepted practice for witnesses.

Do what your attorney advises. If you are concerned about a line of questioning, explain your concerns to your attorney during a break.

The don'ts:

- Don't guess. If you don't know the answer, say so. It is better to admit to a gap in knowledge than to give the wrong answer.
- Don't waste energy trying to anticipate what the plaintiff s attorney is leading up to. (If you are a witness for the plaintiff, the attorney should have briefed you fully prior to the testimony.)
- Don't apologize. If you don't remember what happened, say "I don't recall."
- Don't be caught off guard. Attorneys use different approaches. For example, an attorney might switch from a hostile manner to a soft spoken one or from a friendly attitude to an unfriendly one in an effort to manipulate the witness.
- Don't be defensive. Tell the truth in an open, straightforward way.
- Don't be evasive.
- Don't answer off-the-record questions.
- Don't take any documents to a deposition or other session that you were not asked by counsel to bring.
- Don't use medical jargon. Speak in laymen's terms. Don't try to convince the lawyers; try to convince the jury or judge.
- Don't volunteer new information.
- Stick to what has been agreed to with counsel.

The Results

As noted earlier, a judge or jury may render a verdict at the end of a trial if no settlement has been reached. A verdict might be no culpability for the nurse or the nurse might be found guilty of malpractice. In either instance, the cost of defense will have to be paid for. Nurses who carry liability insurance should look to their insurance carrier to cover the cost of their defense.

A monetary award might also be issued by the court. Awards can be for a small amount or a considerable sum. Again, the insured nurse will look to the insurance carrier for payment of a covered claim.

Reporting The National Practitioner Data Bank (Data Bank) was created by the U.S. Congress. The Data Bank collects licensure action, adverse clinical privilege actions and adverse professional society membership actions. Medical malpractice payers must submit reports to the Data Bank and the appropriate State licensing board within 30 days of making a payment. Hospitals and other healthcare groups such as professional associations must report to the Data Bank within 15 days of taking action against a practitioners. While a healthcare practitioner cannot change a report, the practitioner can add a statement to the report, e.g. to dispute the accuracy of the report.

While the Data Bank is prohibited from disclosing information on a specific practitioner to a medical malpractice insurer, defense attorney, or member of the general public, hospitals must query the Data Bank when a practitioner applies for privileges and every two years for practitioners on the medical staff or holding privileges. State licensing boards may query the Data Bank at any time on healthcare practitioners and healthcare professionals may self-query at any time.

Summary

Being sued for malpractice is a difficult and unnerving experience for nurses. Malpractice insurance, competent legal counsel, and knowledge of what to expect at each step along the way can assist the nurse in dealing with this very difficult situation.

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Attachment #1

Common Insurence and Legal Terms

ABANDONMENT: Leave or give up a duty owed to another.

ACCIDENT: Unforeseen and unintended event or occurrence.

ACCREDITATION: A credential given to an agency or institution upon meeting a certain set of standards.

ACTUARY: A person trained in the mathematics of insurance such as the calculation of premiums, reserves, life expectancy and other values.

ADMINISTRATIVE LAW: The law created by administrative agencies of government. For example, laws made by the state boards of nursing.

ADMINISTRATOR: Companies responsible for issuing insurance policies, billing and collecting premiums, providing customer service and marketing insurance programs. For example, Maginnis and Associates, a Division of Kirke-Van Orsdel, Inc. is an insurance administrator.

ADVANCED DIRECTIVES: Instructions and desires regarding health care treatment stated by a competent adult. These instructions can be issued through spoken word, power of attorney, living will, or trust agreement.

AFFIDAVIT: Voluntary oral or written statement of facts, which a person swears to be true before an official

authorized to administer an oath.

AGGREGATE: The greatest amount recoverable on account of a single loss or during a policy period, or on a single project.

ALLEGATION: An unproved charge or assertion.

APPEAL: An appeal to a higher authority, e.g. a superior court, to reverse or correct a judgment of a lower authority such as a court or administrative agency.

ARBITRATION: The settlement of disputed questions, whether of fact or law, by a neutral third party whose decision may be binding or non-binding.

ASSAULT: A threat to harm another person physically, or an unsuccessful attempt to do so. Differs from battery in that no physical contact is made.

BATTERY: An offensive, intentional, unconsented-to-touching of a person.

BODILY INJURY: Physical injury to a person.

BORROWED-SERVANT RULE: A generally accepted principle that the negligent behavior of an employee who is temporarily under the control of another, becomes the responsibility of the persona who was temporarily in control. For example, a physician in an operating room could be held accountable for the negligence of a circulating nurse, even though the nurse might be employed by the hospital.

CAPTAIN-OF-THE-SHIP DOCTRINE: A doctrine by which the person in charge, the one who makes the final decision, may be held responsible for the acts of those under his or her supervision.

CASE LAW: Decisions of the courts.

CERTIFICATION: A credential awarded by a professional society of a person, e.g. a registered nurse upon the meeting of certain requirements such as an examination and a specified number of years in practice.

CIVIL LAW: The part of the law which is concerned with the legal rights and duties of private persons.

CIVIL WRONG: Contrasts with a criminal wrong in that it includes those actions that inflict damage to another person or the other person's property without criminal intent. Such actions might include automobile accidents, one's dog biting a non-resident person, one's negligence causing harm or damage to another person.

CLAIMS-MADE POLICY: An insurance policy that covers an insured for claims made against the insured during the current policy period. "Tail" coverage may be purchased for protection after the original policy period has ended. (See also tail.)

COMMON LAW: Common law is based on generally accepted customs, practices, procedures, and usage of a people, and which usually is accepted by courts of law as being enforceable. Generally, such law is established by judges who refer to such principles as federal, state, and local legislative bodies. Occasionally, such law also is called ordinance law.

COMPENSATORY DAMAGES: Amounts of money awarded for proven loss.

COMPETENCY: Determination of the ability to give a level of care according to a predetermined set of standards or law.

COMPLAINT: A document that sets forth the act or reason for a lawsuit; identifies the plaintiff(s) and defendant(s) in the suit.

CONSENT: A voluntary act by which one person agrees to allow someone else to do something. For medical liability purposes, consents should be in writing with an explanation of the procedures to be performed.

CONTRACT: A legally enforceable agreement between two parties in which each agrees to do something.

CONTRIBUTORY NEGLIGENCE: The act or failure to act by a person that contributes to the injury of another. For example, if a hospitalized patient were to injure himself or herself because the attending nurse failed to

apply appropriate restraints, the nurse could be held accountable for having contributed to the injury.

CORPORATE NEGLIGENCE: The failure of a hospital or other health care facility, to fulfill its responsibilities to exercise safeguards that would protect against injuries to patients or staff.

CREDENTIALING: A form of recognition that a person or entity has met certain predetermined requirements. For example, a license is a credential awarded by a state licensing board. Certification is a credential awarded to an individual by a professional society. Accreditation is a credential awarded to an agency.

CRIMINAL LAW: That area of the law dealing with criminal statues.

DAMAGES: A sum of money awarded by a court for an injury caused by the act of another. Damages may be actual compensatory (equal to the amount of loss shown); exemplary or punitive (in excess of the actual loss, and assessed to punish the person for the malicious conduct which caused the injury), or nominal (less than actual loss, often a trivial amount because of the injury is slight or because the exact amount of injury has not been determined.)

DEFAMATION: Injury to a person's reputation caused by another person making willful and malicious statements about him to a third person. Such defamation can include libel (the written form), or slander (the oral form).

DEFENDANT: The person or entity being sued.

DEPOSITION: Pretrial statements of a witness under oath, taken in question-and-answer format as if it were in court.

DOCTRINE: A rule, regulation, belief, tenet, practice, or principle that may be ascribed to. It may be a concept derived from a law or the interpretation of a law.

DUE CARE: The legal duty one owes to another according to the circumstances.

ETHICS: Standards on conduct or moral views about what is right or wrong, good or bad.

EVIDENCE: Includes testimony of witnesses, introduction of records, documents, exhibits, objects or any other matter which may be offered in a court setting for the purpose of proving or disproving a given fact or contention.

EXCLUSION: Matters not covered by an insurance policy.

EXPERT WITNESS: A witness having special knowledge of the subject about which she or he is to testify. The witness helps judge or jury understand Codes of Conduct, Standards of Care and accepted professional practices.

EXPIRATION: The date upon which an insurance policy terminates unless continued or renewed by paying an additional premium.

FELONY: A crime more serious than a misdemeanor and for which punishment can range from imprisonment to death.

FRAUD: An intentional act or statement that deceptively causes another persona to give up property or some lawful right.

GOOD FAITH: Being faithful to one's duty or obligation. An honest and sincere intention to fulfill one's responsibility, contract, or agreement.

GOOD SAMARITAN LAW: A state law that provides civil immunity from negligence lawsuits for individuals who stop and render care in an emergency. This doctrine is not recognized in all states.

INFORMED CONSENT: A doctrine that states that before a patient is asked to consent to a risky or invasive diagnostic or treatment procedure, he or she is entitled to receive certain information: (a) a description of the procedure; (b) any alternatives to the procedure and related risks; (c) the risk of death or serious bodily disability from the procedure; (d) the probable results of the procedure, including any problems of recuperation and time of recuperation anticipated; and (e) anything else that generally is disclosed to patients asked to

consent to the procedure. It should be noted that the requirement is a disclosure one only, similar to a bank disclosure or a Miranda warning, and in therapeutic setting most courts do not require a showing that the patient actually understood the disclosures only that they were made at a time and in a manner in which that patient could have understood them, e.g. that patient was not under the influence of drugs and the disclosures were in lay terms.

INSURANCE COMPANY: A company which takes risks on behalf of the insured.

INSURANCE POLICY: A contract for transferring risk to an insurance company or similar entity which pools a large number of similar insured in order to reduce each one's overall risk. In return for a premium, the insurance company will pay for certain acts or injuries caused by the insured. Many policies also cover other expenses such as cost of defense.

INSURED: The person to whom an insurance policy is issued.

INTENT: Acting to achieve a specific outcome.

JUDGMENT: The decision of a court or the reason for such decisions.

LIABILITY: The obligation of one party to another. The finding is usually imposed by a court and generally results from a finding of negligence.

LICENSURE: Permission given by a state government to practice an activity such as nursing. The activity is regulated or controlled by a state agency such as a state board of nursing.

LIMITS OF COVERAGE: The maximum dollar value of claims that will be paid under an insurance policy. For professional liability, there is a maximum amount for each claims and an annual aggregate amount that will be paid from all claims under that policy in a given year. For example, a $1,000,000/$3,000,000 policy allows for coverage of 1 million dollars per incident and a maximum amount of 3 million dollars per year.

MALPRACTICE: Professional negligence. Liability arising from improper practice of a profession; usually imposed when one has not met the standards of care required in that profession, resulting in harm to another.

MEDIATION: The process of resolving differences between two or more parties through the use of a neutral third party. Recommendations of the mediator are usually advisory and not binding upon the parties.

MISREPRESENATTON: A misstatement. (If done with the intention to mislead, it may void a policy of insurance).

NAMED INSURED: The person named in the policy to receive coverage. The covered person is then known as the party of the "first part." The insurance company is the "second part." Liability claims against the insured and the insurer are made by "third" parties.

NATIONAL PRACTITIONER DATA BANK: A data bank created by the U.S. Congress for the collection of information on medical malpractice awards; adverse licensure actions; adverse clinical privilege actions and adverse professional society membership actions.

NEGLIGENCE: Failure to act as a reasonable, prudent person in the protection/care of another. Failure to meet the standard of care.

OCCURRENCE POLICY: An insurance policy that provides coverage for a claim that occurred during the policy period even if the claim is made after the policy period has ended.

PERJURY: Giving false testimony under oath.

PLAINTIFF: The person who brings a lawsuit against another who is called the defendant.

PLEADINGS: The technical means by which parties to a dispute frame the issue for the court. The plaintiff's complaint or declaration is followed by the defendant's answer; subsequent papers are filed as needed.

PREMIUM: The amount of money paid to the insurance company in exchange for the insurance protection provided.

PREMIUM PERIOD: The length of time covered by the premium, usually identical with the policy period.

PRESCRIPTIVE AUTHORITY: Permission to prescribe or dispense medication.

PROXIMATE CAUSE: The act or happening that is directly responsible for an injury. In criminal and tort law, one' liability with respect to a given injury generally is limited to results proximately caused by the conduct or omission.

PUNITIVE DAMAGES: An amount awarded to a plaintiff, over and above actual damages, to punish the negligent party.

RES IPSA LOQUITUR: "The thing speaks for itself." A situation or happening that is self-evident. The event may include occurrences that do not ordinarily happen without negligence; the occurrence must have been caused by an object or instrument in the exclusive control of the person who inflicted the injury, and the occurrence must not have been caused in any part by the victim. Generally, there is at least an element of negligence involved.

RESPONDEAT SUPERIOR: "Let the master answer." Legal doctrine that imposes liability upon the employer for the results of negligent acts of employees acting within the scope of their employment.

RISK: The chance of loss. The greater the range of possible outcomes, the greater the risk.

RISK MANAGEMENT: A managed program or effort directed at reducing risk, avoiding accidents, and making effective use of purchased insurance.

RISK RETENTION GROUP: Persons or organizations who combine to share a part of their risks. The group may purchase insurance as a group above the retained amounts.

RULES AND REGULATIONS: Statements or guidelines having the force of law that are issued by a state agency such as the board of nursing to interpret a statute such as the nurse practice act. Rules and regulations can also be issued by a hospital or other work setting to guide the work of employees.

SCOPE OF PRACTICE: A range of activities, actions or requirements set by law or recognized by a profession as the domain of practice.

SPECIAL DAMAGES: These damages must be pleaded and proved apart from the original suit. For example, as the result of an injury, the victim also suffers loss of income which he or she believes there is a reasonable right to receive. In a separate action, the victim may bring suit against the defendant in an effort to recover such loss of income. Special damages might also be referred to as consequential damages.

STANDARD OF CARE: The "norm" for practice. Standards derive from the federal and state law, professional associations and policies of employing agencies. Standards may also arise from usual and customary practice.

STATUTE: A law enacted by Congress or a state legislature.

STATUTE OF LIMITATIONS: A legal limit on time allowed for filing suit in civil matters. Usually measured from the time of the wrong or from the time when a reasonable person would have discovered the wrong.

SUBPOENA: A court order compelling a witness to appear and testify in a certain proceeding.

SUIT/LAWSUIT: As a rule, an action in a civil court. A civil action usually involves private parties seeking redress against each other. By contrast, a criminal proceeding involves the state or government taking action against a person or organization.

SUMMONS: A notice delivered by a sheriff or other authorized person informing a person that he or she is a defendant in a civil action and telling the person when and where to appear in court to present his/her side.

TAIL: An extension of a insurance policy period. (See also claims made policy).

TERM: The length of time covered by a policy or a premium.

TORT: A civil wrong, in contrast to a criminal act, involving injury or damage to another party (not involving a breach of contact), for which the victim can sue for redress. It may include negligence liability.

UNDERWRITER: Refers to (a) an insurance company which takes the risk, or (b) the individual company employee who makes the decision about whether to insure an applicant. Sometimes the term is used to refer to life insurance agents.

UNDERWRITING: The process used by an insurance company to determine whether an on what basis it will accept an application for insurance.

VERACITY: The truth. A principle that requires a healthcare provider to tell the truth and not mislead a court, insurer, patient or other.

WARRANT: Authorization for a person to be taken into custody or arrested.

WRONGFUL DEATH: A type of lawsuit brought on behalf of a deceased person's beneficiaries that alleges that death was attributable to the willful or negligent act of another.

Adapted with permission from Myers, K. & Fergusson, P. (1989). *Nurse At Risk.* Des Moines: Health-Pro and Kirke-Van Orsdel, Inc.

How to Read and Understand Your Professional Liability Insurance Policy

Professional Liability Declarations

This part of the insurance certificate shows the covered person and his/her address; the professional occupation for which the person is covered; and the period of time that the coverage is in place. It also shows the company's limits of liability for all coverages provided and lists endorsements to the insurance certificate which contain information required by the state in which you practice or which modify the coverage provided in some way.

Coverages

This section tells you what the company agrees to insure you for. The professional liability coverage agreement provides protection for professional liability claims which might be brought against you for bodily injury to a patient; damage to a patient's property, and personal injury to a patient such as invasion of privacy, libel, or slander. The company will pay amounts you as the insured are legally required to pay as damages for covered claims or suits resulting from injury that arises out of the profession named under the "Professional Occupation" cited in the policy's Declarations. There are limitations and exclusions which apply to this protection. You should read your insurance policy carefully to determine the extent of coverage provided to you and other protected persons.

Important Definitions

When reading a policy, you will note that the insurance company has bold-printed some of the words. This is because the insurance company believes that these words are important enough to warrant a definition. You must be sensitive to the fact that it is the insurance company's definition of a word that is important, not the meaning that you may attach to the word, as the company's definition will be the one used in a claim situation. Some of the terms in the policy are defined as follows:

- **Claims** means a demand which seeks damages. The demand is generally in the form of suit papers received from an attorney representing the person allegedly injured; or in other words you are named in a lawsuit. It does not mean that you are guilty of negligent act

- **Damages** means monetary compensation to others.

- **Defense costs** means all reasonable and necessary costs incurred in the investigation, defense and negotiation of any covered claim or suit. They include, but are not limited to, attorney feed, witness fees, expert fees, travel costs, medical examinations, police or investigative reports. The company will pay these costs in addition to the limits of liability. This means that the limits of the company's liability will not be reduced by the payment of these amounts and the limits of liability are therefore completely available to pay damages. With a Maginnis policy, the following benefits/costs will also be paid **in addition to the limits of liability:**

    - Loss of earnings reimbursement - pays up to $500 per day (maximum $7,500 per incident) for attendance at a trial, hearing, or arbitration proceeding for a covered claim.

    - Defense costs paid up to $2,500 per incident, $5,000 per policy period if you are required to appear before a state licensing board or a government regulatory body (not available in New York).

    - Up to a $1,000 for medical expenses related to bodily injury to you or damage to your personal property if you are assaulted on your work premises or on ways immediately adjoining the work premises, such as a parking lot.

    - First aid reimbursement up to $500 for medically related expenses for first aid rendered to others as a result of any bodily injury to another as covered by the policy. If someone is injured and you incur expenses in providing care, you will be reimbursed for up to $500 of those costs.

    - Up to $250 per incident if you unintentionally damage someone else's property during any non-business pursuit.

- **Incident** means injury or death that results from providing or failure to provide professional health care services in the capacity of the profession named in the certificate's Declarations. This includes your service on a formal review board or committee that is responsible for the professional qualifications or performance of others.

For example: *A nurse applies to the facility where you are employed and serving on the committee responsible for granting privileges. The committee refuses to grant approval and the nurse sues both you and the facility for damages. The company will pay defense costs and damages you are required to pay up to the limit of coverage that applies as long as your opinion was rendered in the capacity of your profession.*

- **Insured** means the policy holder.

- **Occurrence form coverage** means you are covered for lawsuits filed at anytime for an incident which occurred during your policy period, even if the lawsuit is filed years from now.

- **Suit** means a civil proceeding which seeks damages. It also means an arbitration proceeding.

Exclusion - What the Policy Won't Cover

Following is a list of pertinent exclusions; **it is not all of them.** A policy holder should read the insurance certificate carefully in order to determine what the coverage exclusions are.

- **Contract liability.** The company won't cover claims or suits that result from professional liability of others assumed under any contract or agreement. But this exclusion does not apply to liability which is entirely the result of professional healthcare services that you provided or should have provided. *This policy only covers you.*

- **Absence of licensure/certification.** The company will not cover any claims or suits unless you are properly licensed or certified by the state(s) in which you practice.

- **Professional occupation.** The company will not cover any claims or suits resulting from the practice of an occupation or profession unless it is the profession that appears on the Certificate's Declarations. This means that you should notify your insurance company if you change professions during the policy period so that the Company can endorse your insurance certificate to show the change.

- **Inappropriate behavior.** The company will not cover any claims or suits that result from your physical assault, abuse, molestation, habitual neglect, or sexual assault. In addition, any behavior which threatens, intends to lead or to culminate in any sexual act whether intentional, negligent, inadvertent or committed with belief that the other party is consenting is not covered. The company will provide you with a defense for such allegations unless a judgment, final adjudication, or admission of guilt establishes that the policy holder caused the injury. The insurance company will not, for any reason, pay damages.

American Nurses Association
Reference Publications 1999 - 2001

American Nurses Association (2001). *ANA workplace health and safety guide for nurses: OSHA and NIOSH resources.* Washington, D.C. ANA Publishing.

American Nurses Association (2001). *Code of ethics for nurses with interpretive statements.* Washington, D.C. ANA Publishing.

American Nurses Association (2001). *Developing telehealth protocols: a blueprint for success.* Washington, D.C. ANA Publishing.

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American Nurses Association (2000). *Nursing quality indicators beyond acute care: measurement instruments.* Washington, D.C. ANA Publishing.

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American Nurses Association (1998). *Statement on the scope and standards for the nurse who specializes in*

developmental disabilities and/or mental retardation. Washington, D.C. ANA Publishing.

American Nurses Association. *Nursing quality indicators set.* Washington, D.C. ANA Publishing.

State Nurses Associations and State Licensing Boards

State	Nurses Association	Licensing Board
Alabama	360 North Hull Street Montgomery, AL 36104-3658 334-262-8321	770 Washington Avenue RSA Plaza, Suite 250 Montgomery, AL 36130-3900 334-242-4060
Alaska	237 East Third Ave., #3 Anchorage, AK 99501-2523 907-274-0827	3601 C Street, Suite 722 Anchorage, AK 99503 907-269-8161
Arizona	1850 E. Southern Avenue Suite #1 Tempe, AZ 85282 480-831-0404	1651 E. Morten Avenue Suite 210 Phoenix, AZ 85020 602-331-8111
Arkansas	804 N. University Little Rock, AR 72205 501-664-5853	1123 S. University Suite 800 Little Rock, AR 72204-1619 501-686-2700
ANA/California	1121 L Street Suite 409 Sacramento, CA 95814 916-447-0225	400 R Street Suite 4030 Sacramento, CA 95814-6239 916-322-3350
Colorado	950 S. Cherry Suite 508 Denver, CO 80246 303-758-7483	1560 Broadway Suite 880 Denver, CO 80202 303-894-2430
Connecticut	377 Research Parkway Suite 2D Meriden, CT 06450 203-238-1207	410 Capitol Avenue MS# 13PHO P.O. Box 340308 Hartford, CT 06134-0328 860-509-7624
Delaware	2644 Capitol Trail Suite 330	861 Silver Lake Boulevard Cannon Building

	Newark, DE 19711 302-368-2333	Suite 203 Dover, DE 19904 302-739-4522
District of Columbia	5100 Wisconsin Ave., NW Suite 306 Washington, D.C.20016 202-244-2705	825 N. Capitol St N.E. 2nd Floor, Room 2224 Washington, D.C. 20002 202-442-4778
Federal	600 Maryland Ave., SW Suite 100 West Washington, D.C.20024-2571 202-651-7333	
Florida	P.O. Box 536985 Orlando, FL 32853-6985 407-896-3261	4080 Woodcock Drive Suite 202 Jacksonville, FL 32207 904-858-6940
Georgia	3032 Briarcliff Rd, NE Atlanta, GA 30329-2655 404-325-5536	237 Coliseum Drive Macon, GA 31217-3858 912-207-1300
Guam	P.O. Box CG Hagatna, GU 96932 671-477-6877	P.O. Box 2816 1304 E. Sunset Boulevard Barrgada, GU 96913 671-475-0251
Hawaii	677 Ala Moana Boulevard, Suite 301 Honolulu, HI 96813 808-531-1628	P.O. Box 3469 Honolulu, HI 96801 808-586-3000
Idaho	200 North 4th Street Suite 20 Boise, ID 83702-6001 208-345-0500	280 N. 8th Street Suite 210 P.O. Box 83720 Boise, ID 83720 208-334-3110
Illinois	105 W. Adams Street Suite 2101 Chicago, IL 60603 312-419-2900x231	100 W. Randolph Suite 9-300 Chicago, IL 60601 312-814-2715
Indiana	2915 N. High School Rd. Indianapolis, IN	402 W. Washington Street Room W041

	46224 317-299-4575	Indianapolis, IN 46204 317-232-2960
Iowa	1501 42nd Street Suite 471 Wes Des Moines, IA 50266 515-225-0495	400 S.W. 8th Street Suite B Des Moines, IA 50309-4685 515-281-3255
Kansas	1208 S.W. Tyler Topeka, KS 66612-1735 785-233-8638	900 S.W. Jackson Suite 551-S Topeka, KS 66612 785-296-4929
Kentucky	1400 S. First Street P.O. Box 2616 Louisville, KY 40201-2616 502-637-2546/2547	312 Whittington Parkway Suite 300 Louisville, KY 40222 502-329-7000
Louisiana	5700 Florida Boulevard Suite 720 Baton Rouge, LA 70806 800-457-6378	3421 N. Causeway Boulevard Suite 501 Metairie, LA 70003 504-838-5332
ANA-Maine	P.O. Box 254 Auburn, ME 04212-0254 207-667-0260	158 State House Station Augusta, ME 04333 207-287-1133
Maryland	849 International Dr Suite 255 Airport Square 21 Linthicum, MD 21090 410-859-3000	4140 Patterson Avenue Baltimore, MD 21215 410-585-1900
Massachusetts Assoc. of Registered Nurses	P.O. Box 70668 345 Greenwood Street Worcester, MA 01607	239 Causeway Street Boston, MA 02114 617-727-9961
Michigan	2310 Jolly Oak Road Okemos, MI 48864-4599 517-349-5640x14	611 W. Ottawa 4th Floor Lansing, MI 48933 517-373-9102

Minnesota	1625 Energy Park Drive St. Paul, MN 55108 651-646-4807	2829 University Avenue, SE Suite 500 Minneapolis, MN 55414 612-617-2270
Mississippi	31 Woodgreen Place Madison, MS 39110 601-898-0670	1935 Lakeland Drive Suite B Jackson, MS 39216-5014 601-987-4188
Missouri	1904 Bubba Lane P.O. Box 105228 Jefferson City, MO 65110-5228 1-888-662-MONA	3605 Missouri Boulevard P.O. Box 656 Jefferson City, MO 65102-0656 573-751-0681
Montana	104 Broadway Suite G-2 Helena, MT 59601 406-442-6710	301 South Park Helena, MT 59620-0513 406-444-2071
Nebraska	715 So. 14th Street Lincoln, NE 68508 402-475-3859	301 Centennial Mall South Lincoln, NE 68509 402-471-4376
Nevada	P.O. Box 530399 Henderson, NV 89053-0399 702-260-7886	1755 East Plumb Lane Suite 260 Reno, NV 89502 775-688-2628
New Hampshire	48 West Street Concord, NH 03301-3595 603-225-3783	P.O. Box 3898 78 Regional Drive Building B Concord, NH 03302 603-271-2323
New Jersey	1479 Pennington Rd. 08618-2661 609-883-5335x10	P.O. Box 45010 124 Halsey Street 6th Floor Newark, NJ 973-504-6586
New Mexico	P.O. Box 80300 Albuquerque, NM 87198	4206 Louisiana Boulevard NE, Suite A Albuquerque, NM

	505-268-7744	87109 505-841-8340
New York	11 Cornell Road Latham, NY 12110 518-782-9400x279	89 Washington Avenu 2nd Floor West Wing Albany, NY 12234 518-474-3817x120
North Carolina	103 Enterprise Street P.O. Box 12025 Raleigh, NC 27605 919-821-4250	3724 National Drive Suite 201 Raleigh, NC 27612 919-782-3211
North Dakota	549 Airport Road Bismarck, ND 58504-6107 701-223-1385	919 South 7th Street Suite 504 Bismark, ND 58504 701-328-9777
Ohio	4000 E. Main Street Columbus, OH 43213-2983 614-237-5414x1020	17 South High Street Suite 400 Columbus, OH 43215-3413 614-466-3947
Oklahoma	6414 No. Sante Fe Suite A Oklahoma City, OK 73116 405-840-3476	2915 N. Classen Boulevard Suite 524 Oklahoma City, OK 73106 405-962-1800
Oregon	9600 S.W. Oak Suite 550 Portland, OR 97223 503-293-0011	800 NE Oregon Street Box 25, Suite 465 Portland, OR 97232 503-731-4745
Pennsylvania	P.O. Box 68525 Harrisburg, PA 717-657-1222 17106-8525	124 Pine Street Harrisburg, PA 17104 717-783-7142
Rhode Island	550 S. Water Street Unit 540B Providence, RI 02903-4344 401-421-9703	105 Cannon Building Three Capitol Hill Providence, RI 02908 401-222-5700
South Carolina	1821 Gadsden Street	110 Centerview Drive

	Columbia, SC 29201 803-252-4781	Suite 202 Columbia, SC 29210 803-896-4550
South Dakota	818 E. 41st Street Sioux Falls, SD 57105 605-338-1401	4300 South Louise Ave. Suite C-1 Sioux Falls, SD 57106-3124 605-362-2760
Tennessee	545 Mainstream Dr. Suite 405 Nashville, TN 37228-1201 615-254-0350	426 Fifth Avenue North 1st Floor Cordell Hull Bldg. Nashville, TN 37247 615-532-5166
Texas	7600 Burnet Road Suite 440 Austin, TX 78757-1292 512-452-0645	333 Guadalupe Suite 3-460 Austin, TX 78701 512-305-7400
Utah	3761 S. 700 East Suite 201 Salt Lake City, UT 84106 801-293-8351	160 East 300 South 4th Floor Salt Lake City, UT 84111 801-530-6628
Vermont	100 Dorset Street Suite 13 South Burlington, VT 05403 802-651-8886	109 State Street Montpelier, VT 05609-1106 802-828-2396
Virgin Islands	P.O. Box 583 Christiansted, St. Croix U.S. Virgin Islands 00821-0583 809-773-1261	Veterans Drive Station St. Thomas, VI 00803 340-776-7397
Virginia	7113 Three Chopt Rd Suite 204 Richmond, VA 23226 804-282-1808/2373	6606 W. Broad Street 4th Floor Richmond, VA 23230 804-662-9909
Washington	575 Andover Park West, Suite 101	1300 Quince Street, SE Olympia, WA

	Seattle, WA 98188-3321 206-575-7979x3002	98504-7864 304-558-3572
West Virginia	300 Capitol Street Suite 1310 Charleston, WV 25301 304-342-1169	101 Dee Drive Charleston, WV 25311 304-558-3596
Wisconsin	6117 Monona Drive Madison, WI 53716 608-221-0383	1400 E. Washington Ave P.O. Box 8935 Madison, WI 53708 608-266-0145
Wyoming	1603 Capitol Avenue Room 305 Cheyenne, WY 82001 307-635-3955	2020 Carey Avenue Suite 110 Cheyenne, WY 82002 307-777-7601

Note: Individuals choosing to take all three parts of the Nursing Risk Management Series are eligible for a 10% risk managment credit on their liability insurance.

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