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FIVE TOP
LIABILITY RISKS

FOR REGISTERED NURSES

proliability

ABSTRACT

This white paper identifies key and emerging areas of risk for registered nurses and provides practical strategies for enhancing patient safety and reducing risks.

Submitted by

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PURPOSE

The purpose of this paper is to explore the ongoing risks in the health care community that present liability concerns for nurses. These risks transcend the many efforts nurses make every day to mitigate potential patient harm. For nurses, liability risks are present in every practice setting, from the largest health care organizations to independent sites of service to the smallest community agency
or school. It is incumbent upon risk professionals and nurses to understand these risks and redouble our efforts to reduce medical errors, improve the care and services we provide, and limit liability risks as we move toward the goal of zero harm.

BACKGROUND

In the United States and abroad, health care safety has been a research focus for a number of years and continues to present caregivers, practitioners, and the public with improvement opportunities. Despite the patient safety movement of the past two decades, the increased focus on error prevention, and the pursuit
of high reliability among practitioners, health care professionals continue to cause harm to people at rates far above the commonly held goal of zero harm.

In its 1999 landmark report, "To Err Is Human," the U.S. National Institutes of Health (NIH), Institute of Medicine (IOM) called for a national effort to make health care safer. The report stated that every year, medical errors caused between 44,000 and 98,000 deaths and over one million injuries in American hospitals. Despite this report's compelling call to action, errors run rampant in health care. Though risk reduction and patient safety efforts have been front and center in health care liability conversations since then, strategies to improve patient safety and reduce liability have had
mixed success. This leaves patients, caregivers, and providers at risk of liability.

Many health care situations that present risk and compromise patient safety have been brought to light in recent years through efforts to increase the consistency and efficacy of reporting errors and near misses. High-reliability principles are being applied in and driven by professional health care organizations, and regulatory
and accreditation bodies have installed expectations and rules that promote a culture of safety. Despite these efforts, nurses and other health care professionals continue to get caught in the crosshairs of situations that lead to patient harm. Johns Hopkins patient safety experts analyzed medical death rate data over an eight-year period and calculated that, in the United States, more than 250,000 deaths per year were caused by medical errors.

In 2016, the Johns Hopkins team published more data on medical errors, demonstrating that deaths due to medical error surpassed the U.S. Centers for Disease Control and Prevention's (CDC's)
then third leading cause of death—respiratory disease—which kills close to 150,000 people per year. Like Johns Hopkins, many other organizations and agencies have committed themselves to improving cultures of safety to reduce medical errors; negative patient outcomes; and ultimately, malpractice claims.

High-quality, safe, and effective health care has also become a concern on a global scale. The Organisation for Economic Co-operation and Development (OECD), a partnership of 36 countries spanning the globe, names health as one of its primary concerns. The OECD assists countries in many areas related to economics,

one of which is achieving high-performing health systems. Health system improvement is achieved by measuring key health outcomes as well as using health-related resources. The OECD also

analyzes policies meant to improve access, efficiency, and quality of health care.

The OECD adopted a framework for quality in health care that included the six aims described by the NIH IOM: care that is effective, safe, person centered, timely, equitable, and efficient. A recent report from the OECD found that the number of patients who experience harm in ambulatory settings is 20% in developed countries and 25% in developing countries—and up to 80% of harm in these settings is caused by preventable errors. The OECD also discusses some of the most common causes of health care–related harm, namely, medication errors, missed and delayed diagnoses, and faulty transitions. It believes that truly meaningful research- based information about patient harm in ambulatory settings is just beginning to emerge.

Of course, in outpatient settings, care is often noticeably different than it is within hospitals. The OECD cites several differences that drive errors related to outpatient care. First, in outpatient settings, more occurrences of care occur across greater amounts of time. Second, this care is often performed outside of the direct supervision of care providers. Third, many safety alerts that are commonplace in hospitals do not exist in outpatient settings. Fourth, ambulatory providers are challenged to find rare to occasional positive diagnostic findings that require immediate intervention, whereas in hospitals, this happens frequently. This OECD report was discussed in a recent posting by the Institute for Healthcare Improvement (IHI).

Many other organizations, such as the National Quality Forum, the Agency for Healthcare Research and Quality (AHRQ), and the IHI, have fostered risk-reduction initiatives. The Joint Commission (TJC) established National Patient Safety Goals in 2002 and has since revised and expanded these recommendations annually. Despite this significant commitment to improving health care in all settings,

significant liability risk remains among practitioners, and, at the end of the day, people are still getting hurt. All practitioners and clinicians need to appreciate which aspects of practice place them
at highest risk and take every opportunity to reduce risk in every patient- and client-related activity.

NURSE MALPRACTICE CLAIMS DATA AND FINDINGS

Claims data from individual and group insurers provide some insight into the risk experiences that nurses and other health care professionals face. But reported data are retrospective in nature, and the availability of these data is limited and often proprietary. In 2012, Reising listed six common categories of malpractice claims and six common failures that can lead to them. Most of these
failures are related to standards of care; equipment use; patient assessment and monitoring; communication; documentation; and acting in the best interest of a patient.

A 2012 report by Proliability indicated that five allegations are commonly involved in malpractice claims and that these were consistent with the first five of Reising's categories of malpractice claims.

A 2019 ECRI report, "Top 10 Patient Safety Concerns," identified new issues in patient safety across the health care continuum. ECRI Institute leaders state that diagnostic errors and managing test results are at the top of the list and have been for two consecutive years. The report reminds readers that technology solutions have limits. Additional technology and work processes are often needed to support accurate diagnoses and assure that appropriate and

timely follow-up on test results occurs in all settings within the health care system. The report also discusses infections, sepsis, and antimicrobial stewardship as current patient safety issues as well as the significant overuse of antibiotics in outpatient settings.

TOP LIABILITY RISKS FOR NURSES

Though the general areas of high risk for nurses have remained relatively constant, some specific risks have changed over the years because of changes in health care settings, systems, and practices.
Today's patients require complex care and management. New risks have emerged from changing work processes, expanded settings of care, equipment use, medication, and new technology and communication systems. Patients with increased age and medical complexity as well as diversity in language and cultural considerations add new dimensions to nursing care. New and refined diagnoses and the ever-increasing number of diagnostic treatment options present new challenges.

According to the program for the 2019 Annual National Meeting for Critical Care Nurses, several risk-related topics are at the forefront for attendees: integrating research and evidence-based practices into daily practice, delirium management, diagnostic reasoning, sepsis, and new point-of-care technologies, among others. These topics are consistent with current larger cultural discussions of patient safety, errors, harm, and nurse liability.

Given the historical liability risks noted above and the ever-changing health care environment, there are five general categories of risk for registered nurses, which will be explored in detail in
the following section: general risks to patient safety; medication-related risks; risks related to communication, collaboration, and care management; risks resulting from failure to assess, recognize change in condition, monitor, and/or treat; and documentation-related risks, including use of new technologies.

TOP FIVE LIABILITY RISKS FOR REGISTERED NURSES

1 GENERAL RISKS TO PATIENT SAFETY

Liability risk around general patient safety situations commonly refers to problems with mobility, assistive device usage, falls, cognitive impairment, the environment, and behavioral health needs. Often, more than one of these factors contribute to patient harm.

Mobility impairment. Mobility impairment places patients at risk, especially when strength and/or balance are affected by their diagnoses. This is common among the elderly population and when patients of any age have undergone procedures—particularly when sedation is used. Assistive devices are often helpful, but they can pose additional risks to patients if the device is not well fitted or
the patient has not been instructed on safe use. Patient education should be well documented, and written use and safety instructions should be provided to the patient in a timely fashion. A nurse or therapist should assess the home environment prior to the patient returning to their home. This assessment will serve to identify and mitigate potential dangers and risks to the patient when using an assistive device in their home.

Falls. Falls in health care settings continue to result in varying

practitioners should make every effort to prevent falls. A great deal of research has been done on falls and fall prevention. TJC, Veteran's Health Administration, and many other organizations have led efforts to implement evidence-based practices for fall prevention. Despite being informed, many nurses continue to be accountable for patients who fall in a variety of settings.

Hospitals report many falls, and a high percentage of falls that cause serious injury result in death. Analysis of falls that cause injury in TJC's sentinel event database reveals the most common contributing factors pertain to inadequate patient assessment, communication failures, lack of adherence to protocols and safety practices, inadequate staff orientation, a lack of supervision, staffing levels or skill mix, deficiencies in physical environments, and a lack of leadership.

A recent fall-prevention initiative included assessment, a person-specific plan for fall prevention, and consistent implementation of the plan by patients, families, and staff. It provided a toolkit developed by a collaborative in the Fall TIPS (Tailoring Interventions for Patient Safety) program. The ECRI Institute also reports a significant number of falls occurring in nonhospital settings, such as long-term care facilities.

The CDC web-based Injury Statistics Query and Reporting System identified over 28,000 unintentional fall-related deaths among people aged 65 and older in 2015, with estimated medical costs of approximately $754 million. Approximately $50 billion was spent on fatal and nonfatal falls in the same year.

Approximately 20% of falls in health care settings cause serious injuries, such as broken bones and head wounds. Fall rates among the elderly population continue to rise from year to year, though, across 34 states, the number of in-hospital falls with resulting hip fractures decreased by 73.9%. Fall-prevention efforts in hospitals are paying off

when prevention interventions are consistently applied. The health care environment should be free of clutter and slipping/tripping hazards. A fall can be the result of failure to provide continuous observation or use available technologies, such as audiovisual surveillance monitoring systems. These and other fall-prevention interventions, such as alarms for beds and chairs, should be employed at the discretion of a nurse, based on his or her evidence-based assessments of the patient. Should the nurse be involved in a liability case involving a fall, evidence-based interventions appropriate to the fall-risk assessment and status of the patient will serve as his or her best defense.

Cognitive impairment. Cognitive impairment poses general safety risks to patients, especially when they are unable to remember or follow instructions from health care staff. Cues in the environment can be helpful such as reminder text, signs or graphics, but cognitively impaired persons are often inconsistent in terms of noticing or acting on these cues. For example, impulsivity, which poses serious risks, is common among brain-injured individuals.

For cognitively impaired patients in particular, a change in environment can remove important safety cues that previously kept them safe. Even when diagnoses contribute to cognitive impairment, it is very common for safety procedures to get lost in the handoff to a new environment and an unfamiliar team. A patient's cognitive impairment might be totally unrelated to his
or her acute illness or new health issues, but, sometimes, care is targeted toward only the acute illness, rather than the whole picture of the patient including chronic health care needs, leaving interventions for safety lagging.

Staff in the emergency department (ED), the admitting unit of a hospital, or skilled nursing facility might not pick up on cognitive deficits at the time of patient arrival. It is not uncommon for falls to occur soon after such transitions when staff have not yet thoroughly assessed the patient or put into place fall-prevention practices. This
is especially common if family is not present.

Health care environment. In addition to falls, the health care environment itself poses risks and potential harm to patients. This area of liability for nurses is often infection related. Because basic hand hygiene and wound management is commonly questioned, it is imperative that nurses demonstrate hand hygiene in the presence of patients and families. Nurses need to teach the importance of hand hygiene to patients, families, and assistive personnel. Ensuring that appropriate infection prevention and isolation procedures
are followed is imperative too. Wound care should be carried out according to physician orders and organizational policies.

Consistent practice. Consistent application of evidence-based general safety practices poses another risk to nurses in the health care environment. One example is assuring that a procedural time-out is conducted before surgeries and other procedures. This
includes invasive bedside procedures and is often the accountability of the registered nurse. In collaboration with other health team members, including physicians, anesthesia staff, or other assistive personnel, it is incumbent upon the registered nurse to assure the

time-out is conducted with all staff actively engaged in this safety procedure. Failure to conduct the time-out and other pre-procedure safety practices as intended continues to lead teams of health care providers and caregivers into very high-risk situations; consider the implications of surgery being performed on the wrong person, the wrong side, or the wrong site.

This evidence-based general safety practice has been promulgated by TJC, the World Health Organization, the Association of periOperative Registered Nurses (AORN), the American
College of Surgeons, and other professional organizations in nursing, medicine, and health care improvement. One of the most current integrated evidence-based resource on what is now called "universal protocol" (preprocedure verification, surgical site marking, and time-out) is available from TJC at https://www.jointcommission.org/standards_information/up.aspx. The AORN Comprehensive Surgical Checklist is available at https://www.aorn.org/guidelines/clinical-resources/tool-kits/correct-site-surgery-tool-kit/aorn-comprehensive-surgical-checklist. Surgical fires. Surgical fires have been a concern of patient safety experts for a number of years, but their incidence has decreased
due to detailed safety practices. Persons practicing in the operating rooms are typically well trained about surgical fire prevention and management. However, the risk remains. The Institute for Safe Medication Practices (ISMP) warns about medications that might be contributing factors in surgical fires. Alcohol-based preps continue
to be used, and some of them might take up to a full hour to dry if hair becomes wet. The hair does not dry as quickly as the skin does and remains flammable. It is recommended that some prep measures not be used on the head and face. Petroleum-based ointments and benzoin also pose similar risks. Nurses and other staff in areas where electrocautery is used are at risk for liability when harm occurs due to a procedure-related fire.

Suicide risk and prevention. This has long been an area of liability for

According to a 2018 report by Owens and colleagues, over 42% of inpatient stays for physical health conditions in 2014 also involved
a co-occurring mental or substance abuse disorder. This percentage
increased from approximately 37% in a 2010 study. Suicide-risk screening and prevention is now a key focus in nearly all health care settings, including home care, in addition to the long-held priority given to this aspect of care in psychiatric care settings.

In 2018, the ECRI Institute published new recommendations to meet behavioral health needs for patients in acute care settings. The ECRI Institute reported that patient violence against others was identified in more than half of the over 2,000 event reports. Temporary or
minor harm was described in over 3% of the reports. Major or permanent harm was rare, and one patient died.

Staff members in hospital units need to understand the behavioral needs of patients and be prepared to identify needs and respond appropriately and immediately. The report offers tools to better prepare general inpatient care staff in the management of this common dimension of care.

2 MEDICATION-RELATED RISKS

For nurses, medication management remains a minefield of potential harm. Throughout the medication processes—

nurses and will continue to be given the occurrence of mental health and substance use and abuse disorders among the general population and among hospitalized patients. In 2014, the overall suicide rate reached its highest level in nearly 30 years. In 2018, TJC expanded its expectations
around suicide-risk screening and prevention in all settings.

from the prescriber ordering a medication
to the nurse delivering it to a patient—many
opportunities for error are present. Medication safety relies on many clinicians in many settings being 100% accurate in each step of the medication-management communication and work processes. Prescribers, licensed caregivers, pharmacists, technicians, vendors, assistive personnel, parents, patients, and others contribute to medication-management safety—or the lack thereof. Nurses, whether they deliver care in hospitals, long-term care settings, outpatient surgery and treatment areas, the home, schools, or
other venues, are responsible for proper medication administration. Ultimately, nurses are responsible for ensuring that processes are in place to assure medication safety. This responsibility includes educating others who act on behalf of nurses and patients, such as staff in schools, medication aides in group care settings, and/or lay personnel.

Key risk points related to medication management include the basic procedures for medication administration, elderly patients' use of technology, documentation, narcotic management, medication reconciliation, and assessment and monitoring.

The "Five Rights", a standard practice to promote medication safety, has been used by nurses for many decades. This includes validation of five details prior to medication administration: right patient, right medication, right dose, right time, and right route. Nurses need to be aware of all policies, procedures, and standards related to the medications and infusions they administer as well as their effects, interactions, and potential adverse outcomes.

Many ED visits and hospitalizations are caused by adverse drug events (ADEs). Ambulatory and hospital patients alike suffer from ADEs, and preventable harm from medication-related errors often occurs during transitions of care. In a 2018 report focused on patient safety issues in primary care settings, researchers found that over 10% of hospital admissions were related to an ADE.

A recent study analyzed 13 years of non-health-care facility medication errors that resulted in serious medical outcomes. An increasing rate of medication errors resulting in serious medical outcomes was found to be present.

Interruptions. Many medication errors caused by nurses are influenced by interruptions, such as conversation with other staff, patients, family members, physician unexpected phone calls and general noise. Nurses rely on various practices to reduce interruptions during medication administration, and awareness about this risk has broadened in recent years.

Technology. It is incumbent upon nurses in all settings to fully develop medication-related technologies to their highest level of functionality to achieve the greatest degree of patient safety. Alerts meant to provide safety information (e.g., redundancy of similar medications, doses outside of usual range, allergies, and drug interactions) must be taken into account by each person throughout the medication-management process for the full benefit of safety to be afforded to the patient and the nurse, who is most often the final barrier between error and harm.

Automation, including robots in pharmacies, automated dispensing units at sites of care, and barcode medication-administration systems, has provided additional safety measures. Improved technology; electronic health records (EHRs); and pharmacy systems that are integrated with infusion pumps, PCA infusion pumps, epidural infusion pumps, and other stand-alone implantable infusion devices have also reduced medication-related errors in recent years.

The application of infusion therapy standards to peripheral intravenous (IV) access was the topic of a 2019 article by Nickel. Nurses and others in many health care settings commonly perform this procedure as an IV insertion, which provides a vehicle for medication and fluid delivery. Studies show that this procedure has a reported failure rate of up to 50%, with common complications, such as infiltration and infection. Nickel suggests strict adherence to evidence-based standards of practice to guide infusion access and use, as well as monitoring therapy appropriately to identify complications early. Organizations, such as the Infusion Nurses Society (INS), provide standards, policies, and procedures for clinical practice related to infusions. The companion reference Infusion Therapy Standards of Practice, 5th edition (2016), provides a framework to guide clinical IV practice. Its 2016 "Policies and Procedures for Infusion Therapy" are derived from these standards and provide step-by-step guides to clinical IV practice. Additional references by ISMP, the U.S. Food and Drug Administration (FDA), the American Nurses Association (ANA), and others also support safe infusion practices.

Specific concerns related to medication safety and the needs of the aging population were addressed in a 2009 position statement by the ANA. The report suggests the need for medication reconciliation at the time of transitions, the involvement of family and caregivers in communication, appropriate monitoring related to medications, and additional research.

Many of the above-mentioned safe medication principles and practices have become the standard for nursing and other health professions for all age groups in recent years. The Centers for Medicare and Medicaid Services (CMS), TJC, and other regulatory and accreditation bodies have focused on medication safety for many years. In fact, in the past year, TJC renewed its focus on anticoagulants by incorporating new evidence into expanded expectations.

The IHI has promoted medication safety practices and continues to partner with industry leaders to look for new technologies, processes, and systems that support this end. Many resources are provided at http://www.ihi.org/sites/search/pages/results. aspx?k=fall+data#k=medication%20safety. In addition, the

ISMP has adopted medication safety as its sole mission. Like IHI and others, ISMP promulgates research and supportive tools and resources that promote safe medication practices. Nurses need to attend to the latest medication safety research and practices that are shared by these organizations.

Medication reconciliation. Medication reconciliation has been a common evidence-based practice since 2004 and was the beginning of the IHI's "5 Million Lives" campaign. Reviewing medications for discrepancies each time a patient transitions to a different site or level of care has proven to be beneficial in preventing medication errors. Before patient discharge from any facility or hospital, medications need to be reviewed and clear directions given for what medications are to be continued. Across the health care continuum, medications should be reviewed on intake and clarified at the end of the visit or episode, and staff should clearly note when there are changes in a medication list. A number of tools and references can be located at http://www.ihi. org/Topics/ADEsMedicationReconciliation/Pages/default.aspx.

A 2017 publication by the AHRQ discussed liability for medication discrepancies. Responses to focus group questions identified that determining liability for medication discrepancies is complex and requires an understanding of each patient's context and situation. Healthcare professional participants provided consistent opinions, namely, that, when harm occurs from a medication error due to discrepancies, there are likely several levels of accountability, including, in some cases, the patient. The AHRQ also offered strategies for preventing medication discrepancies and potential resultant harm, including better patient education and a phone call following discharge regarding medications to be taken at home. Both of these strategies can be accomplished by the nurse, potentially reducing litigation risk from medication discrepancies.

A 2016 study on outpatient ADEs evaluated ED visits in the United States. Four drug classes were found to be most commonly implicated: anticoagulants, antibiotics, diabetes agents, and opioid analgesics. These are the same four classes of medications found in a similar study 10 years before.

Documentation. Properly documenting medication-related care is a responsibility of the nurse and others to whom medication administration is delegated. This documentation needs to be timely and accurate, and patient records need to include education about medications. Specific additional details are required for narcotic management. For example, all narcotic waste must be observed and documented by a second nurse. Narcotic diversion is common in health care, and patients who do not receive needed pain medication can become a focus of litigation. These investigations can also lead to the identification of criminal acts such as stealing if it is determined that the patient paid for medication that has been diverted. The nurse who is implicated might face consequences from his or her employer and/or licensing board. This situation could also lead to a liability claim.

Assessment. Medication-related assessment, reassessment, and monitoring are also areas of potential litigation for the nurse. Reevaluation of patients after medication is given for intended effect is the responsibility of the nurse.

New medications. New formulations of medications continue to be approved by the FDA, and nurses need to keep abreast of these changes. One medication recently approved is a sublingual sufentanil named "Dsuvia." It has limited approval for use in severe acute pain management in hospitalized patients, EDs, and surgery centers. Nurses should note that, although this is a sublingual preparation, it is 1,000 times more potent than morphine.

Failure to identify medication-related issues and manage them is common in litigation involving nurses. Pain management, sedation management, and postsedation procedures should be followed,
and the nurse needs to use critical thinking skills as well as report unusual or unexpected situations to the nursing manager and/or
the appropriate physician promptly.

Revised protocols. Ongoing research testing current practices can lead to changes in protocols. One such recent trial published in 2018 tested commonly given antipsychotic agents for the treatment of delirium and found no significant improvement in outcomes in
a study of over 500 critically ill patients who became delirious. The duration of delirium was not significantly different between the treatment and placebo groups. This is an example of a high-risk patient situation and changing evidence about treatment. Nurses
are in a prime position to readily change protocols that guide practice in their work environments to improve patient safety and reduce potential exposure to unnecessary medications.

There are many general medication safety suggestions that further reduce risk to patients and nurses. For example, patient-controlled analgesia syringes need to be disconnected from the patient infusion tubing or a stopcock set in the closed position when the syringe is not in the pump. This prevents inadvertent push dosing to the patient when handling the syringe and transporting or moving the patient.

3   RISKS RELATED TO COMMUNICATION, COLLABORATION, AND CARE MANAGEMENT

Communication and collaboration among team members continues to be a point of liability risk for nurses. Nurse practice acts in many states specifically require proper coordination of care. Several recent studies outline the continuing challenge of communication among health care team members in a significant number of legal cases.

Leaders at the IHI called one study's findings that communication failures were found to be a factor 30% of malpractice cases "disappointing". They suggest that not enough progress has been made in nearly 20 years of the patient safety movement and related work toward improving communication.

Risk related to communication and collaboration is broad and variable. Access to and awareness of ancillary team member notes and input to the patient plan of care is commonly seen as a barrier
to communication and collaboration. Electronic health records and telehealth solutions have, in some cases, improved access, awareness, and the ability of the health team to be "on the same page." In other cases, when patients' EHRs are not fully integrated, they become a barrier to complete and timely communication of key pieces of information. When ED physicians and nurses cannot access records for a patient's recent clinic visit, they are met with a lack of information that prevents them from making informed diagnostic decisions for a patient in crisis. Telehealth solutions when coupled with clear, real-time communication, based on protocols that demand accountability of all parties, can support enhanced communication and timely care.

Transitions in care present a particular opportunity for communication to falter. Patient transfers and handoffs are frequently cited in malpractice cases as contributing factors to harm. A number of current studies are validating standardized methods for handoffs as a way to improve communication and reduce medical errors that lead to harm. AHRQ is advocating

primary care settings. This handoff model comprises a discussion between two clinical staff members regarding the clinical problem, status, and plan of care. These same conversations must occur with patients and families too so that all parties have a clear understanding of the visit. The AHRQ also emphasizes the value of "teach-back" to promote communication and health literacy.

In one study, a web-based handoff training program for health care professionals was found to be associated with medical-error reduction specifically related to end-of shift communication. Trossman, in a 2019 publication, recounted the work on patient handoffs over time. TJC's Patient Safety Goals first addressed handoffs in 2006. The ANA, Emergency Nurses Association, and other professional nursing organizations have also addressed this patient care risk at various times over the past decade. Trossman reported on one organization that implemented a standardized communication tool and face-to-face bedside report model for when an ED nurse hands off a patient to an inpatient unit. Families, if present, are asked whether any pertinent information was omitted that they would like to add. Both nurses and families are satisfied that this process reduces communication gaps, and adoption of over 90% has been achieved. A second case review shared the benefits of a standardized, community-wide communication tool for referral centers. Nurses were involved in leading and participating in improvement teams for both projects.

The Department of Defense (DoD) and the AHRQ developed Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS™). The goal is to integrate teamwork into health care practice and improve quality, safety, and efficiency. TeamSTEPPS is based on many years of research related to teamwork, team training, and culture change. TeamSTEPPS was publicly released in 2006 and is now used by teams in many health care settings to enhance patient safety and team effectiveness.

Standardized communication formats are easy to remember. Researchers have developed many frameworks for consistent communication leading to action. Kaiser-Permanente in Colorado developed SBAR (situation, background, assessment, and recommendation) for team communication about patient condition. I-PASS (illness severity, patient summary, action list, situation awareness and contingency planning, and synthesis by receiver) was originally designed to improve pediatric resident physician handoffs and is now being adapted and used in a variety of health care settings. Resources for the ambulatory setting to support transitions in care are also available, such as this one from the AHRQ: https://www.ahrq.gov/professionals/quality-patient-safety/hais/ tools/ambulatory-care/safetransitions.html. The goal of this toolkit is to prevent gaps in care and promote effective communication across a variety of ambulatory care providers and services.

Lack of timely communication and follow-up also commonly contribute to harm. Situations where decision makers are not readily available delay communication and follow-up. Triage nurses are at particular risk for contributing to delays in communication. When a provider is requested, and the nurse intercepts the communication, the nurse must weigh the risk of delay versus the risk of interrupting the provider. The same is true when layers of medical students and physicians in training are responding to a call from a nurse for assistance with an urgent or emergent patient situation. All members of the team must either have the authority to perform at a level that meets the patients' needs or have the duty to escalate the communication without delay to someone who can manage the situation. Staff nurses have the duty to be certain that the communication is being escalated in a timely manner. Otherwise, if delay is not in the best interest of the patient, they should call the attending physician directly.

Follow-up is also a must. Patient care orders, referrals, and other communications must be initiated in a timely fashion so that appropriate care is not delayed. Communication received on behalf of a patient, such as results of lab and diagnostic tests, must be communicated appropriately and in a timely manner. Delay in such communications continues to delay appropriate care to the patient and can result in harm.

In a study that examined escalation of care, mobile phones and direct conversation were identified as being more effective when escalating care than hospital pager systems were. As texting and other forms of communication gain popularity, details pertaining to communications should be documented in patient records. If there is a timely, secure method of communication within an EHR system, nurses must be certain that the time stamps are correct and that all communications are properly saved in the permanent record. If communications are not saved in the permanent record, nurses need to record them. A nurse or clinical informaticist should assist in validating them if needed.

Delegation-related risks are another factor in nurse liability. Nurses are required to supervise the nursing care that has been delegated to others on the health team, evaluate that care, and make adjustments to the plan of care as needed. If the nurse is unsure whether assistive personnel or other nurses are capable of performing the duties and tasks that have been delegated to them, the nurse must evaluate the training and experience of other staff members to protect patients from potential harm. The nurse might then need to make adjustments in delegated care, and, later, he or she might insist on additional training for his or her colleagues to prepare them for future safe and successful delegation. According
to state nurse practice acts, nurses have limits on delegation and need to know what these limitations are before delegating care to another person.

Care management and coordination is a function of the registered nurse. The ANA discusses the role of registered nurses in care coordination as a key standard for nurses. The ANA asserts that care coordination serves to create quality outcomes because health care resources are optimized. Nurses and other health care professionals can lead processes and models that promote successful team-
based care coordination. In today's health care continuum, interprofessional collaboration by collaborative teams is more common than ever. Whether the setting is critical, ambulatory, or hospice care, teams are achieving improved communication and outcomes for patients. For example, daily and/or periodic team meetings that include a patient's family are increasingly common. These team meetings serve to coordinate care and provide early- discharge planning.

4 RISKS RESULTING FROM FAILURE TO ASSESS, RECOGNIZE CHANGE IN CONDITION, MONITOR, AND/OR TREAT

Failure to assess patients with enough detail and as frequently as their condition warrants is common in nurse liability cases. Assessment is the first component of the nursing process, and the remainder of nursing care is based on accuracy in assessment. Typically, guidelines, procedures,
and provider orders give direction to nurses about assessment frequency and depth. However, it is the nurse's responsibility to assess patients as needed to prevent harm. Often, nurses perform assessments only as ordered and fail to critically think about the needed changes in assessment and monitoring. This

commonly occurs when a patient's condition changes, procedures are done, and medications are administered.

When assessment is performed infrequently or not performed in enough detail to detect changes and initiate early detection and prompt intervention, further condition decline and harm to the patient can ensue. Nurses' failure to immediately recognize and communicate changes in condition often contributes to nurse liability. In many cases, nurses can immediately mobilize providers, rapid response teams, and other resources to meet the needs of the patient. Any delay in determining the need for a change in the plan of care based on assessment can lead to nurses' being held liable for the resultant harm.

Even when nurses appropriately carry out assessment, their failure to implement provider orders and care in a timely fashion can lead to their liability. It is up to the nurse to be certain that timely referrals are made and orders for immediate intervention are carried out as soon as possible. An area of recent interest around timeliness of assessment and interventions is related to sepsis. Evidence-based protocols suggest that initial care of fluid resuscitation and antibiotics be carried out immediately. Failure to deliver these early and critical interventions can lead to further worsening of the condition and even death. Nurses need to understand when aggressive care protocols, such as the protocol for sepsis, need to be applied while, at the same time, supporting antimicrobial stewardship efforts. The ANA and other national nursing organizations support multiple areas of infection-related efforts.

Assessing and monitoring patients are key competencies of the professional nurse. Failure to rescue a patient when a change in condition is noted can be prevented by expert assessment, timely monitoring and prompt communication by the nurse. With ongoing evaluation of patients based on appreciation of the

entire clinical picture, nurses can position themselves to avoid potential litigation.

5 DOCUMENTATION-RELATED RISKS, INCLUDING USE OF NEW TECHNOLOGIES
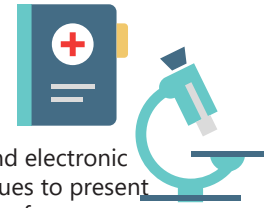
General documentation in traditional and electronic medical record (EMRs) and EHRs continues to present litigation risk for nurses. A 2014 analysis of one year of malpractice claims found that nearly 150 cases included EHRs as a causative factor. Lack of integration of records and workflow, routing issues with test results, and errors related to data entry were among the problems. Overall, approximately 20% of cases contained incorrect information in the EHR, which contributed to the claim. Some examples of incorrect information included incorrect labels on measurements, decimal point and conversion errors, and entries put into the wrong patient record. Nursing was frequently noted in these cases, and ambulatory care settings accounted for over half of the claims.

General documentation considerations are included in the following key questions. Do the documented data and information tell the story of what happened to the patient? Does the documentation show that the nurse applied critical thinking at the level another similar nurse in the same situation would? Does the documentation show that the nurse escalated concerns about the patient to the appropriate higher level in a timely fashion? Was documentation completed in near real time, or were entries made later? One published scenario summarizes the power of complete, timely, and accurate documentation in nurse liability to the point of lawsuit dismissal. The nurse's documentation demonstrated

that she performed proper escalation to her supervisor along with immediate, appropriate intervention, followed by accurate and thorough documentation. This documentation contributed to dismissal of the lawsuit.

STRATEGIES TO REDUCE RISK

Strategies that nurses can employ to protect themselves from a liability claim are consistent with many long-held basic best practices. Some of these strategies are addressed above, and additional confirmation is offered in other reports below.

In Reising's 2012 article, she suggested a number of actions a nurse can take to mitigate the risk of malpractice allegations. These
actions include following accepted standards and procedures and exhibiting excellence in all aspects of care, care management, planning, assessment, documentation, and communication. She reminds us that nurses have many responsibilities in patient care and excellence in all areas of nursing care leaves the nurse less likely to experience a malpractice claim.

In a 2012 report, Proliability suggests that nurses should know their limitations and practice within the scope of their licensing and training and be fully knowledgeable about equipment use and trouble-shooting and involve a supervisor if equipment is unfamiliar. They are responsible for accurate and complete documentation that reflects the nursing process; assessment and monitoring of patients at least as frequently as ordered by the physician or as required in organizational policies; reporting changes in assessment findings
to the physician; and documenting conversations related to patient care, especially at the time of discharge. The report also suggests
that fostering good relationships with patients and families and participating in ongoing education to stay current are helpful in reducing overall risk.

In 2016, a blog entry published by Minority Nurse discussed what nurses can do to help protect themselves against the risk of malpractice. Jelliffe suggested that there are seven things nurses should know to avoid professional or personal liability. These
items were based on clear interactions and communications with patients, keeping current on training and education, performing complete documentation, prompt referrals, consistently adhering to medication safety principles, asking for assistance or obtaining a referral as needed, and keeping patient care discussions off of social media.

In 2018, an employee survey to assess patient safety culture in nearly 2,500 medical offices was administered by the AHRQ. Over 50% of the more than 35,000 respondents were nurses and other clinical staff, excluding physicians. The survey results identified two areas of strength in patient safety culture. Over 80% of respondents valued teamwork and using reminders for tracking and follow-up. Both strategies are generally accepted to promote excellence in patient care and prevent malpractice claims.

A similar 2018 AHRQ survey was conducted in 630 hospitals and yielded 380,000 respondents (37% of respondents were nurses).
Of the 12 areas of patient safety culture this report analyzed, areas
of strength for most hospitals included teamwork within units, management support for patient safety, and mistakes leading to positive change. One area for opportunity was related to handoffs and transitions, with approximately 50% of respondents indicating that information was lost during transfers and shift changes. Continued learning and teamwork are consistent with

Nurses can also reduce risk of litigation through active participation in patient safety efforts, including fostering a safety culture in their practice environments. Nurses working in a direct care environment have the opportunity to observe many situations that might be potentially harmful and to proactively intervene.

SUMMARY

The health care environment and nursing practice have changed over the years: Controls have been added, and technologies have been introduced. However, risk to patients and nurses remains a consideration. Despite the best intentions of nurses and the health care community, evidence-based solutions and technologies, unforeseen events and unanticipated consequences of care causing harm occur and still present a barrier and have actually increased risk to patients. Five of the top nursing liability risk areas (general patient safety, medications, communication, assessment, and documentation), when managed well, prevent harm to patients and reduce nurse liability.

When a patient is harmed and more than one of these factors is present, liability risks for the accountable nurse can be multiplied. Whether led by a health care organization, professional organization, or the individual nurse, innovation and continuous improvement of patient care are essential. Nurses should practice in concert with state nurse practice acts and current evidence-based standards, policies, and procedures. They should also apply the risk-reduction strategies discussed here as well as others specific to their area of practice. Both of these areas of nurse practice will propel the nursing profession forward in reduction of professional risk and liability and move health care toward the quest for zero harm.

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