The National Practitioner Data Board (NPDB) classifies “professional nurses” into five licensure categories: non-specialized registered nurse, nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist. According to the NPDB Report (2012), between 1990 and 2011 all types of professional nurses had a total of 9,278 monetary malpractice payments, with an approximate mean of $282,297 per claim. Nurses must be concerned about malpractice litigation because each nurse is accountable for his or her own acts of negligence. To help decrease the risk of a malpractice claim, every nurse should know his or her nurse practice act, relevant laws and legal doctrines, agency policies and procedures, and applicable standards of care that impact daily clinical practice.

Despite continuous efforts to educate nurses on the law and their professional responsibilities through nursing programs and continuing education courses, the number of nurses named as defendants in malpractice actions continues to increase (Austin, 2009; CNA Health Pros and Nurse Service Organization (NSO), 2009; Croke, 2003; Croke, 2006; Dumrose, 2007; Guido, 2010; Miller, 2011; National Practitioner Data Bank Report (NPDB), 2012; Nolo, 2012a; Rasansky, 2012; Stein, 2000). Various reasons identified in the medical and nursing literature for this continuous trend have included shortage of qualified nurses, healthcare provider fatigue, improper supervision/delegation, miscommunication, early patient discharge, hospital downsizing, increased autonomy, advanced technology, inadequate training, high-level clients, short-staffing, failure to follow standard clinical nursing practice, and better-informed consumers (Austin, 2009; Croke, 2006; Guido, 2010; Nolo, 2012a; Stein, 2000). “Any errors in patient care often result in [a] patient’s death due to multiple complications and [may] lead a nurse into serious medical litigations under the medical malpractice law” (American Society of Registered Nurses, 2007, para 3). In 1999, the Institute of Medicine (IOM) reported that medical errors are responsible for between 44,000 and 98,000 patient deaths annually at an annual cost to the nation of approximately $37.6 billion and approximately $17 billion of the annual costs are associated with preventable errors (Graham, 2009). Nolo (2012a) cites the national average payout for medical (doctor) malpractice negligence is approximately $285,000.

Malpractice is the legal term for an act of negligence by any licensed professional (Stein, 2000). The Joint Commission (nd) defines negligence as a “failure to use such care as a reasonably prudent and careful person would under similar circumstances” and malpractice as “improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers, and public officers to denote negligent or unskilled performance of duties when professional skills are obligatory. Malpractice is a cause of action for which damages are allowed” (Croke, 2003, p.54-55).

For a nurse to become liable in a malpractice action, certain legal elements must be proven by the plaintiff before a successful case can be brought against the defendant nurse. Except as noted under the doctrine res ipsa loquitur, these liability elements include the following:

- Duty—nurse-patient relationship; employment relationship
- Breach of Duty—act of omission or commission in standard of care (SOC)
- Foreseeability—foresee a certain result based on actions or lack of actions at the time of occurrence
- Causation—breach in standard of care caused injury (cause-effect)
- Injury—physical, financial, emotional
- Damages—monetary awards

Each nurse is responsible for his or her own acts of negligence, but hospitals and doctors can also be held accountable. Under the doctrine of respondeat superior, the employer is responsible and accountable for an employee’s negligent acts. Because most nurses are employees of hospitals, hospitals are common defendants in nursing malpractice litigation (Nolo, 2012b). Common reasons for hospital liability for negligence of employees are:

- Negligent hiring or firing of employees
- Failure to ensure competency and continuing competency of employees
- Understaffing of healthcare providers
- Mislabeled medication

KEY WORDS
Malpractice, Claims, National Practitioner Data Bank (NPDB), Doctrine of Respondeat Superior
• Health Insurance Portability and Accountability Act violations
• Failure to provide a safe environment


Research has shown that hospitals with high nurse-patient ratios experience higher patient mortality rates, decreased quality patient care, increased complaints of nurse burnout, and job dissatisfaction (Aiken et al., 2002; Aiken et al., 2010; Stanton, 2004). Jenkins & Lemak (2009) reported “research on jury verdicts indicates that the median plaintiff award against hospitals and their employed health care providers is about $500,000”... and the average 250 bed hospital spends between $300,000 and $1 million dollars annually defending medical malpractice lawsuits, not including settlements and judgments (p. 52). Specialized nurses, known as legal nurse consultants (LNC), often work with attorneys on medical-legal related cases. The LNC helps the attorney “understand and analyze complex medical data” encountered in the client’s medical records. Duties of the LNC may include:

• Screening cases for merit
• Locating and interviewing witnesses and preparing witness reports for trial
• Formulating medical-legal theories
• Handling plaintiff’s medical records
• Analyzing and interpreting information for defense attorneys
• Serving as an expert witness (“What does a legal nurse consultant,” 2013,p.1)

Nurses must be concerned about malpractice litigation because each nurse is accountable for his or her own acts of negligence. To help decrease the risk of a malpractice claim, every nurse should know his or her nurse practice act, relevant laws and legal doctrines, agency policies and procedures, and applicable standards of care impacting daily clinical practice. The following website provides a state-by-state summary of medical malpractice laws.


CLAIMS and COSTS

Nurses and nursing students can be held liable for their actions or non-actions, and thus can be sued (Learning Express Editor, 2011). “Once money is exchanged through an out-of-court settlement or jury award, the nurse’s name is automatically reported to the state board of nurse examiners, to insurers, and to the federal government’s National Practitioner Data Bank” (NPDB) (Stein, 2000,p.1).

Types of Malpractice Claims Against Nurses

The most common malpractice claims against nurses identified in the medical and nursing literature between 2000 and 2012 include:

• Failure to get informed consent from the patient
• Failure to use a medical device properly
• Failure to follow the standard of care
• Failure to communicate
• Failure to assess and monitor
• Failure to act as a patient advocate
• Failure to update a physician on a patient’s condition
• Failure to document
• Failure to properly supervise a patient resulting in harm
• Negligent delegation and supervision
• Medication errors
• Working while impaired: controlled substances, alcohol or fatigue

The NPDB collects information on health care practitioners who, as a result of judgments in malpractice suits, have entered into settlements, had disciplinary action taken against them that resulted in their licenses being revoked or suspended, had their privileges to practice limited, or had to pay monetary awards (Croke, 2003; Croke, 2006).

According to the NPDB Report (2012) (Table 1) between 1990 and 2011 all types of professional nurses had a total of 9,278 monetary malpractice payments with an approximate mean of $282,297 per claim. The majority of payments made were less than or equal to $50,000, with the smallest number of payments made for amounts greater than $2,000,000. Similarly, as shown in Table 2, CNAHealth Pro and Nurse Service Organization (NSO) examined professional nurse liability payments made on behalf of CNA insured professional nurses. Table 2 reports professional nurse indemnity payments for closed claims for four separate CNAHealth Pro and NSO claims analysis periods. The highest and lowest amounts of closed claims awarded with an indemnity payment greater than $10,000 were made on behalf of registered nurses (RNs) and licensed vocational nurses (LVN/LPN), respectively. CNAHealth Pro and NSO (2011) reported RNs had an average paid indemnity of $168,438 while LVNs average paid indemnity was $83,213.

Nurse practitioner indemnity payments increased overtime from $16 million to more than $44 million. CNAHealth Pro and NSO reported that in 2009, the average paid indemnity for a nurse practitioner closed claim greater than $10,000 was $186,282, and increased to an average indemnity payment of $221,852 in 2012 – a 19% increase (CNAHealth Pro and NSO, 2012). As members of the profession of nursing seek greater autonomy in their clinical practice arenas, outcomes of increased responsibility, accountability, and potential liability arise (DiCicco-Bloom, 2009).

Table 3 shows the top three closed claim clinical practice areas reported by CNAHealth Pro and NSO Reports. The top two clinical practice areas for nurse practitioners’ liability have remained consistent through all CNAHealth Pro and NSO Reports – physicians offices and outpatient clinics. For RNs and LVNs the hospital environment has remained the highest area of liability. Painter, Dudjak, and Kidwell (2011) reported a literature review revealed that most
### Table 1: NPDB Nursing Malpractice Payment Range by Numbers of Professional Nurse Payments (1990-2011)

<table>
<thead>
<tr>
<th>Malpractice Payment Range</th>
<th>Number of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$50,000</td>
<td>3,185</td>
</tr>
<tr>
<td>$50,000-$99,999</td>
<td>1,368</td>
</tr>
<tr>
<td>$100,000-$249,999</td>
<td>2,019</td>
</tr>
<tr>
<td>$250,000-$499,999</td>
<td>1,239</td>
</tr>
<tr>
<td>$500,000-$999,999</td>
<td>838</td>
</tr>
<tr>
<td>$1,000,000-$1,999,999</td>
<td>434</td>
</tr>
<tr>
<td>&gt;=$2,000,000</td>
<td>195</td>
</tr>
<tr>
<td><strong>Total Number of Payments</strong></td>
<td><strong>9,278</strong></td>
</tr>
</tbody>
</table>

**Note. Adapted from:**

### Table 2: CNAHealth Pro and Nurse Service Organization (NSO) Closed Claims for Professional Nurse Liability

<table>
<thead>
<tr>
<th>Claim Study Years</th>
<th>Professional Licensure</th>
<th>Number of Closed Claims Examined With Paid Indemnity Greater than $10,000</th>
<th>Total Paid Indemnity Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994-2004</td>
<td>Nurse Practitioner</td>
<td>107</td>
<td>$16,453,890</td>
</tr>
<tr>
<td>1998-2008</td>
<td>Nurse Practitioner</td>
<td>96</td>
<td>$39,067,185</td>
</tr>
<tr>
<td>2006-2010</td>
<td>Registered Nurse Licensed Vocational Nurse</td>
<td>474</td>
<td>$79,839,387</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42</td>
<td>$3,494,965</td>
</tr>
<tr>
<td>2007-2011</td>
<td>Nurse Practitioner</td>
<td>200</td>
<td>$44,370,490</td>
</tr>
</tbody>
</table>

**Note. Adapted from:**
### Table 3: Top Three Closed Claim Clinical Practice Areas/Settings Reported by CNAHealth Pro and NSO Reports

<table>
<thead>
<tr>
<th>Year</th>
<th>Nurse Practitioner</th>
<th>Registered Nurse (RN)</th>
<th>Licensed Vocational Nurse (LVN)</th>
<th>Nurse Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994-2004</td>
<td>Physicians’ Office</td>
<td>Medical Care Office</td>
<td>Hospital PACU</td>
<td>Physicians’ Office</td>
</tr>
<tr>
<td></td>
<td>Nurse Practitioner</td>
<td>Clinic-Non-Hospital Based</td>
<td>OB Outpatient Services</td>
<td>Community-Based Outpatient Clinics</td>
</tr>
<tr>
<td>2006-2010</td>
<td>Registered Nurse (RN)</td>
<td>Hospital PACU</td>
<td>Hospital-Inpatient Surgical Service</td>
<td>Physicians’ Office</td>
</tr>
<tr>
<td></td>
<td>Nursing Home</td>
<td>Clinic-Hospital Outpatient</td>
<td>Patient’s Home</td>
<td>Community-Based Outpatient Clinics</td>
</tr>
<tr>
<td>2007-2011</td>
<td>Registered Nurse (RN)</td>
<td>Hospital-Inpatient Medical Service</td>
<td>Skilled Nursing Facilities</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Adapted from:

### Table 4: Top Three Closed Claim Clinical Specialties Reported by CNAHealth Pro and NSO Reports

<table>
<thead>
<tr>
<th>Year</th>
<th>Nurse Practitioner</th>
<th>Registered Nurse (RN)</th>
<th>Licensed Vocational Nurse (LVN)</th>
<th>Nurse Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994-2004</td>
<td>Family Practice*</td>
<td>Adult/Geriatric Neurology/</td>
<td>Hospital-Inpatient Surgical Service</td>
<td>Physicians’ Office</td>
</tr>
<tr>
<td></td>
<td>Adult/Geriatrics*</td>
<td>Family Medicine Obestrics</td>
<td>Home Health</td>
<td>Family Practice</td>
</tr>
<tr>
<td></td>
<td>Obstetrics/Gynecology</td>
<td>Pediatric/Neonatal Plastic/Reconstructive</td>
<td>Hospice</td>
<td>Behavioral Health</td>
</tr>
</tbody>
</table>

**Note.** Adapted from:
malpractice cases involving a nurse occurred in the acute care hospital and involved non-specialized RNs. Similarly, the Joint Commission (2012, Dec.31) reported the hospital environment has remained the top area for sentinel events from 2004-2012. The Joint Commission defines a sentinel event “as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient’s illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome” (Wikipedia, 2013, p.1).

Table 4 shows the top three closed claim clinical specialties reported by the CNAHealth Pro and NSO Reports. Family practice and adult/geriatrics have consistently remained the highest clinical practice specialties for liability claims for nurse practitioners. For RNs and LVNs, the only common clinical practice specialty involved the surgical environment.

Reducing Potential Liability
Malpractice litigation is both professionally and emotionally devastating to a nurse. “Each nurse can take steps to help reduce potential liability by using caution and common sense and by maintaining a heightened awareness of his or her legal responsibilities” (Croke, 2003, p.62). The following are ways nurses can help reduce potential liability:

- **Using nursing judgment on a case-by-case basis.** Utilizing each step of the nursing process and critical thinking may reduce the likelihood of “bad outcomes” that commonly lead to nursing malpractice (Giordano, 2003).
- **Maintain open, honest, respectful relationships and communication with patient’s family members, and physicians.** Poor communication may exist amongst nurse physician, nurse and other healthcare providers, and nurse-patient/family. Timely reporting changes in the patient condition to the physician is the most common communication basis for nursing malpractice (McCarthy, 2013).
- **Maintain competence in your specialty area of practice.** Each nurse needs to attend relevant continuing education programs, remain up to date on professional certification requirements and continue to expand professional knowledge, skills and experience (McCarthy, 2013).
- **Follow chain of command.** A nurse’s belief on a patient care issue may require action beyond a discussion of the nurse’s concerns with the physician. If the nurse’s concern is not resolved – the facility’s nursing hierarchy chain of command should be activated (Reising & Allen, 2007).
- **Obtain informed consent.** Obtaining a patient’s informed consent is needed to prevent charges of battery against a healthcare provider.
- **Practice within the bounds of professional licensure.** Each nurse must perform only the nursing skills allowed by the state nurse practice act, and state and federal laws (Croke, 2006; Guido, 2014; McCarthy, 2013; Reising, & Allen, 2007).
- **Know your strengths and weaknesses – each nurse must examine if he or she has the skill, knowledge, and experience to carry out the assignment.** If the nurse does not believe he or she has the competency – this lack of skill must be reported prior to accepting the assignment (Croke, 2003, Reising, & Allen, 2007).

Hospitals can reduce risk of malpractice claims by increasing RN staffing. Research has shown that limiting nurse workloads has a positive impact on quality and safety of patient care, fewer medical errors, increased nurse satisfaction and nurse retention, decreased adverse patient outcomes, and lowered patient mortality rates (Aiken et al., 2002; Aiken et al., 2010; Stanton, 2004). A facility’s communication policy that is known to both physicians and nursing staff can help reduce risk of liability.

Due to an ever-changing practice care environment, nurses are facing a plethora of ethical and legal dilemmas that increase their risk of becoming named in a malpractice litigation process. Nurses are being held accountable to the public for their professional judgment, actions, and outcomes. To help decrease liability, nurses must render safe and competent nursing care, recognize potential problems, identify potential risks in their practice care arena, and remain competent in technology and evidence-based practices (Guido, 2014).

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Nolo (2012b). If you are injured by a nurse’s negligence, you may have a claim for medical malpractice. Retrieved from: http://www.nolo.com/legal-encyclopedia/nursing-malpractice-300076.html

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