

Nursing

Claims Data Snapshot

2024



This publication contains an analysis of aggregated data from clinically coded cases opened between 2013-2022 in which Nursing is identified as the primary responsible service.

Keep in mind...

A clinically coded malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

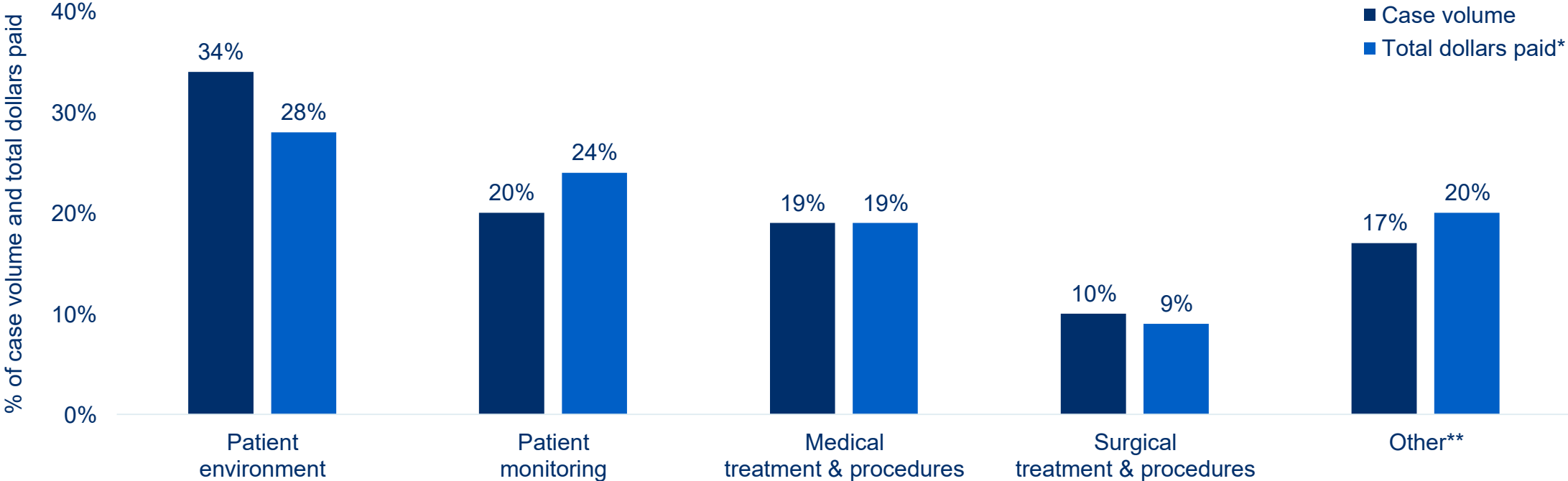
Key Points - Clinically Coded Data

INTRODUCTION | **KEY POINTS** | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | RISK MITIGATION

- **Patient environment allegations** account for one-third of Nursing case volume and one-quarter of total dollars paid*, and most often reflect patient falls. The most commonly noted contributing factors applied to the patient fall cases include inadequate monitoring/assessment of patients, failure to adhere to existing fall mitigation policies/procedures, and night/weekend/holiday shifts.
- **Patient monitoring and medical treatment allegations round out the top three allegations.** Patient injuries associated with these cases include pressure ulcers, arrest, IV infiltrations, burns, infections (including those progressing to sepsis)
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome**, and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities. Policy and procedure issues and communication deficiencies are the two most common key drivers of clinical Nursing case severity. An inadequate patient assessment process, insufficient documentation of findings (which enhances intra-team communication), and 'off-shift' hours should also be acknowledged as driving clinically severe outcomes.
- Note that this analysis focuses on cases arising in hospital and ambulatory care settings, and excludes senior care cases. [Click here to reference insights into the drivers of senior care cases.](#)

Major Allegations & Financial Severity

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report.

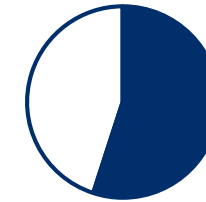


MedPro Group + MLMIC cases opened 2013-2022, Nursing as responsible service (N=2243; excludes senior care); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists – see page 14 for details

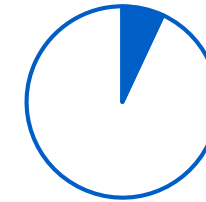
Clinical Severity* & Most Common Locations

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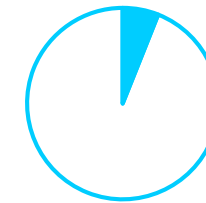
Clinical severity* categories	Sub-categories	% of case volume	Definitions
LOW	Emotional Injury Only	8%	Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay
	Temporary Insignificant Injury		Lacerations, contusions, minor scars, rash; no delay in recovery
MEDIUM	Temporary Minor Injury	43%	Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed
	Temporary Major Injury		Burns, drug side effect; recovery delayed
	Permanent Minor Injury		Loss of fingers or loss or damage to organs; includes non-disabling injuries
HIGH	Significant Permanent Injury	49%	Deafness, loss of limb, loss of eye or loss of one kidney or lung
	Major Permanent Injury		Paraplegia, blindness, loss of two limbs or brain damage
	Grave Injury		Quadriplegia, severe brain damage, life-long care or fatal prognosis
	Death		Death
		28%	% of cases resulting in patient death



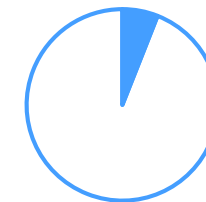
Patient room/ICU
55%



Inpatient surgery
7%



Ambulatory surgery
6%



Emergency
6%

MedPro Group + MLMIC cases opened 2013-2022, Nursing as responsible service (N=2243; excludes senior care);
*Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Contributing Factors

“Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation.”

Contributing Factors

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

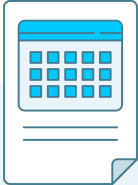
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



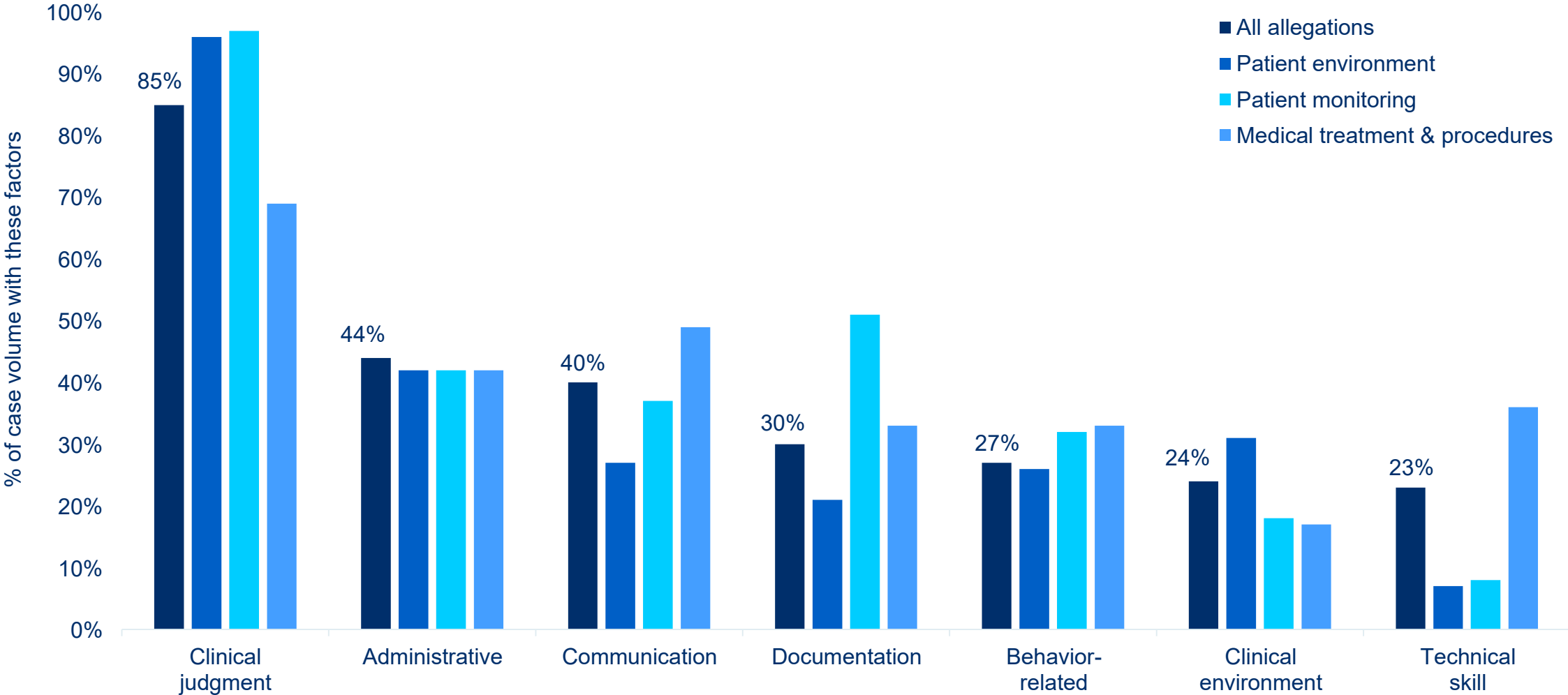
Technical skill

Contributing Factor Category Definitions

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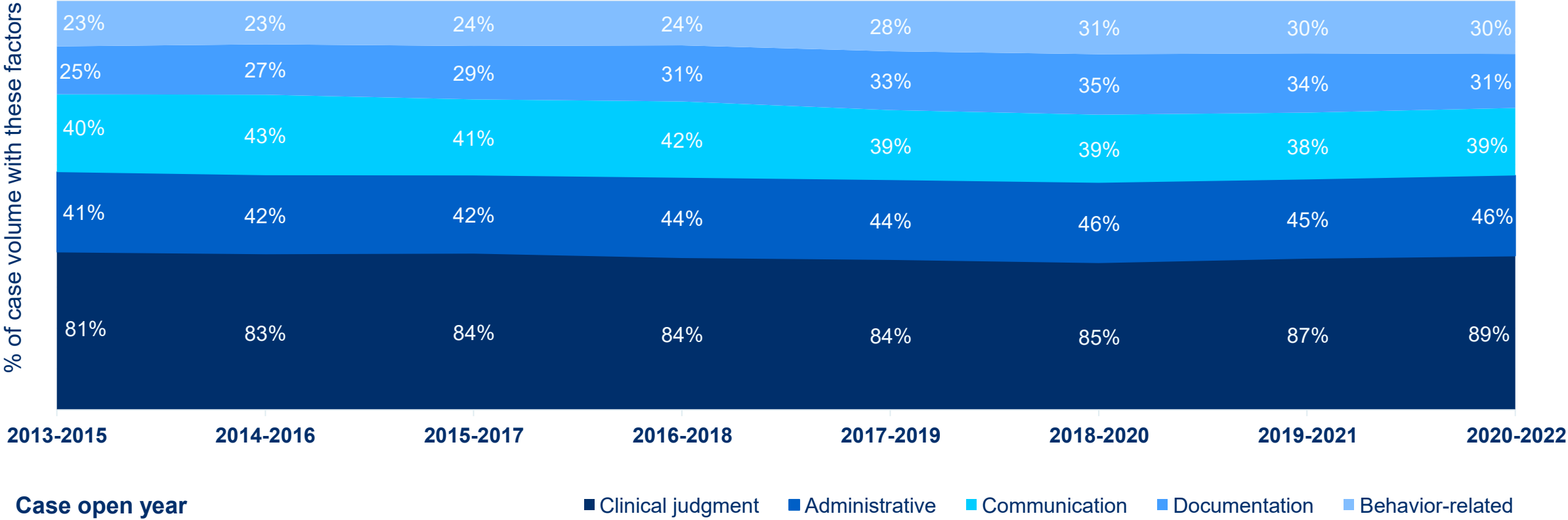
Administrative	Factors related to reporting of adverse events, adequacy of staffing, staff education/training, ethics, failure to follow and/or need for policy/protocols
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also, provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, diagnostic decision-making, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc.), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc.), and telehealth/tele-radiology
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2013-2022, Nursing as responsible service (N=2243; excludes senior care); More than one factor per case, therefore totals >100%

Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues.

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Focus on Most Common Drivers of Clinical Severity

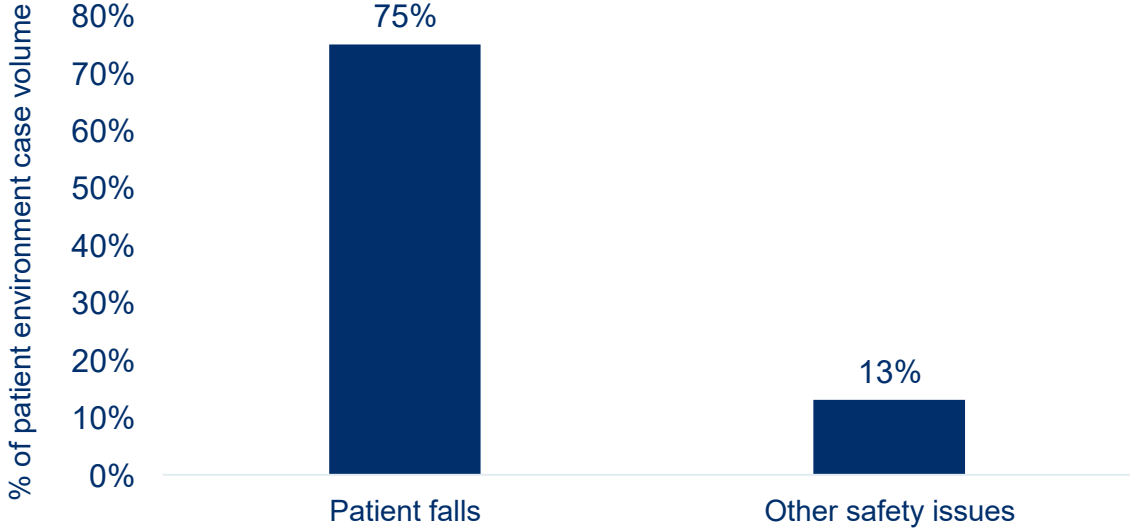
INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | RISK MITIGATION



Policy and procedure issues and communication deficiencies are the two most common key drivers of Nursing clinical case severity. An inadequate patient assessment process, insufficient documentation of findings (which enhances intra-team communication), and 'off-shift' hours should also be acknowledged as driving clinically severe outcomes. Of note, clinically severe cases are most costly to defend and any indemnity payments are, on average, more than twice as expensive than cases reflective of low and medium severity outcomes.

Focus on Patient Environment Allegations

Top allegation details



Examples of other safety issues:

Patient burns (surgical, chemical)

Choking/aspiration

Assaults on patients

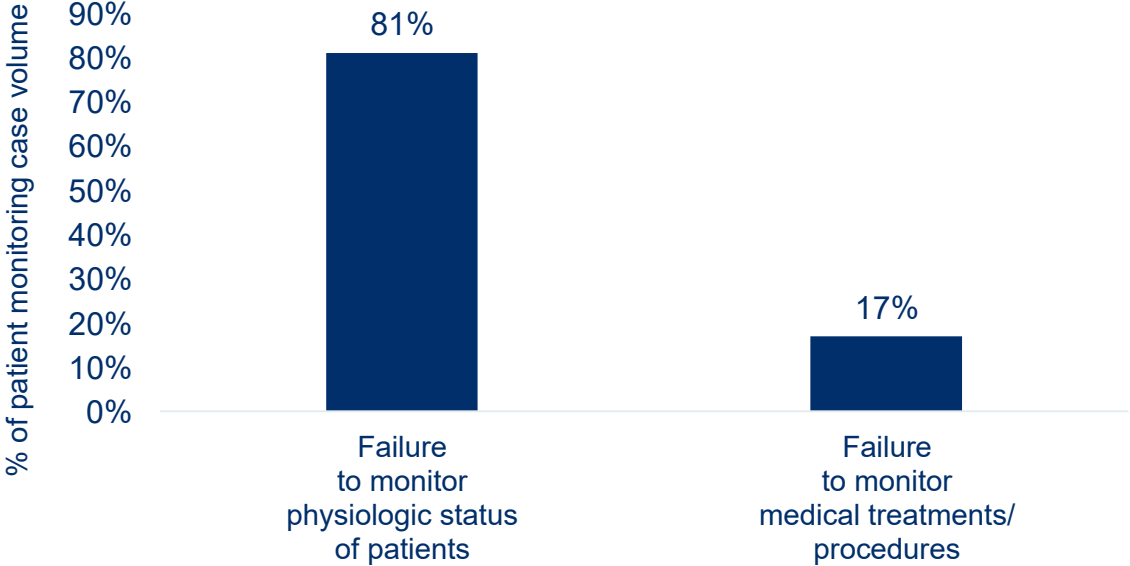
Patient suicides

The most commonly noted contributing factors applied to the patient fall cases include inadequate monitoring/assessment of patients, failure to adhere to existing fall mitigation policies/procedures, and nights/weekends/holidays.

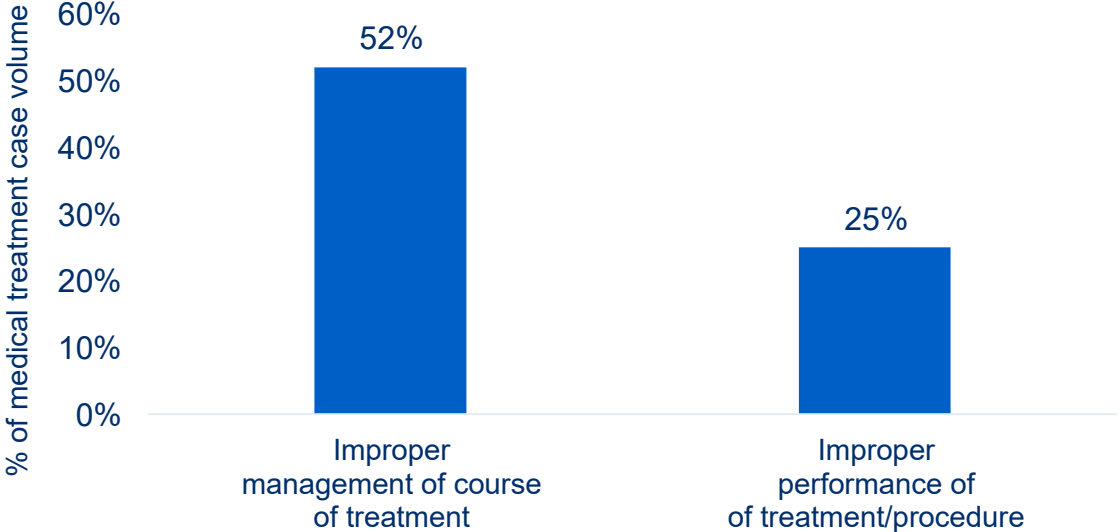
Focus on Patient Monitoring & Medical Treatment Allegations

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Top patient monitoring allegation details



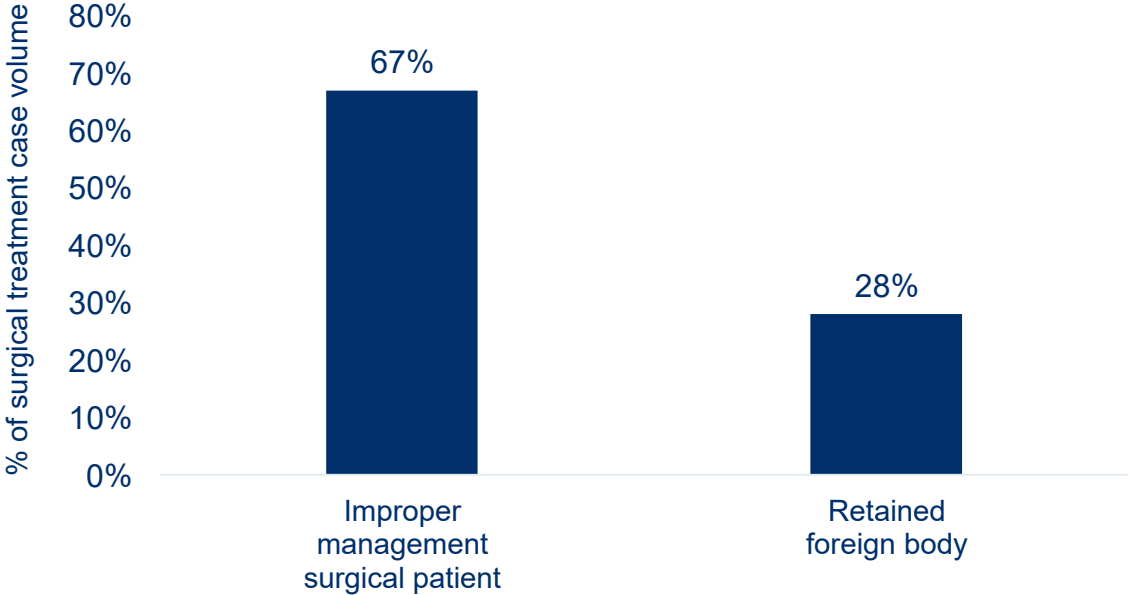
Top medical treatment allegations



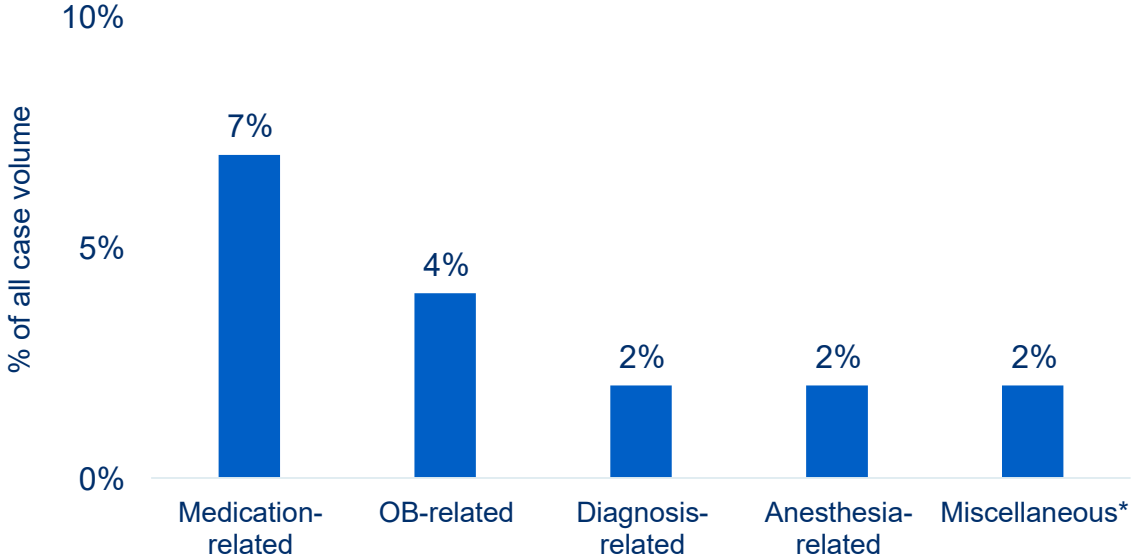
Most common injuries associated with these broad-scope allegation details:
Pressure ulcers, arrest, IV infiltrations, burns, infections (including those progressing to sepsis)

Focus on Surgical Treatment & Other Allegations

Top surgical allegation details



Other allegations (17% of Nursing case volume)



The most commonly noted contributing factors applied to the surgical cases include inadequate monitoring/assessment of patients, failure to adhere to existing policies/procedures, and suboptimal communication among the surgical and post-operative care teams .

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Risk Mitigation Strategies

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- **Conduct appropriate and thorough assessments of the patient.**
 - Understand patient complaints and concerns.
 - Be alert to evolving signs/symptoms/test results.
- **Communicate with each other.**
 - Focus on care coordination with other members of the care team, including next steps.
 - Give thorough and clear patient instructions.
- **Engage patients as active participants in their care.**
 - Consider the patient's health literacy and other comprehension barriers.
- **Document.**
 - Timely document thorough, objective information about the results of patient assessment.
 - Thorough, consistent documentation in the chart enhances communication between providers and provides a supportive framework for defense of any subsequent malpractice case.
- **Adhere to ambulatory and inpatient setting policies/procedures.**

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.



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