

● **A DOSE OF INSIGHT®**

A Nurse's Crucial Role in Patient Safety:

Through the Lens of Malpractice Claims



SEPTEMBER 2022

WHAT YOU'LL LEARN FROM THIS REPORT

- Specific types of nursing responsibilities that pose the greatest vulnerabilities—patient monitoring, fall prevention, medication administration and management, pressure-injury prevention, and patient-related communications—and how you can reduce risk in each situation.
- How communication, workplace culture, and chain-of-command issues factor into overall risk.
- The degree to which errors in nursing can result in serious patient harm as well as notable financial and emotional impact to providers.
- General principles for managing risk and improving safety for patients and the nurses who care for them.
- Data-driven insights into general principles for managing risk and improving safety.

This report is dedicated to nurses. Your devotion to your patients' safety, peace of mind, and optimal medical outcomes is an example to us all. We stand in your debt for all the ways in which the public health rests on your skills, talents, and innate compassion for the individuals in your care. Thank you for all you do to advance the health of your patients and communities.

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Introduction

The top areas of vulnerability for nursing are: patient monitoring, fall prevention, medication administration and management, pressure-injury prevention, and patient-related communications.

Nurses are the heart and soul of the healthcare industry—representing 56% of the total number of healthcare professionals in the United States,¹ they have been rated as the most trusted professionals in the world for 18 years running.²

For all the glowing accolades bestowed upon the profession of nursing, the harsh reality is that many nurses feel underappreciated and overwhelmed. In 2022, nursing is complicated by staffing shortages, demographic shifts, burnout and stress, disrupted education and training, bureaucratic and management challenges, tight budgets, and cultural shifts (including an increase in travel nurses and temporary assignments). While these issues were in play prior to 2020, they were exacerbated by the COVID-19 pandemic. As times and conditions continue to change, risks—for patients and for nurses—may be increasing.

This report provides insight into notable trends and root causes of malpractice claims involving nurses. We examined closed malpractice claims where nurses were directly involved in patient care and identified the top areas of vulnerability for nursing—patient monitoring, fall prevention, medication administration and management, pressure-injury prevention, and patient-related communications. The good news is that even in the wake of adverse patient outcomes, our data reveals that blaming nurses has not been the cultural default. In the claims data analyzed for this report, just 18% of medical malpractice claims involved nursing and only 2% of those involved the specific naming of a nurse as a defendant. These data—while relatively small—are not insignificant. The numbers and the stories reveal trends that warrant attention.

Coverys evaluated 4,634 events that closed between 2018 and 2021 and identified 850 specific events where nurses were directly involved in the care that resulted in the alleged medical error.* This report provides insight into notable trends and root causes of claims involving nurses, based on an analysis of those events.

*Unless otherwise indicated, statistics and other information in this publication were derived from this proprietary data. Data includes registered nurses (RN), licensed practical nurses (LPN), nursing assistants, and student nurses.

A Fresh Approach to Claims Data

At Coverys, we refer to claims data as “signal intelligence.” Our conclusions from analysis of the data are not absolute findings. Rather, they are hypotheses—signals from the past about where vulnerabilities existed and may still be at play.

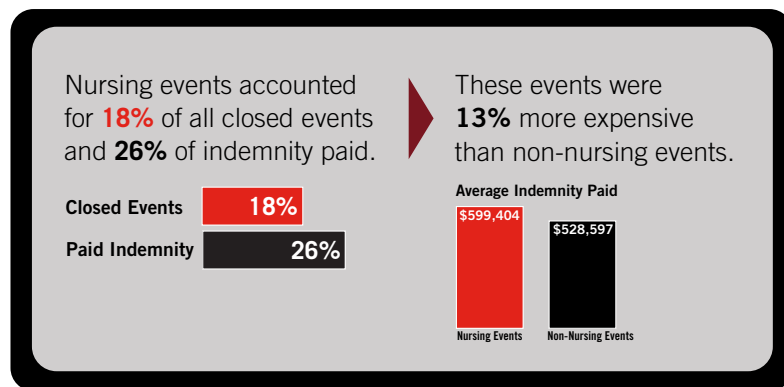
Typically, a fully investigated liability claim will include:

- Allegations.
- Patient health and demographic information.
- Injury severity.
- Physician specialty.
- Risk management issues.
- Location of the event (e.g., office/clinic, emergency department, hospital unit).
- Financial costs.
- Expert reviews and opinions.

Coverys uses this information to create evidence-based recommendations to help mitigate future risks in the delivery of care.

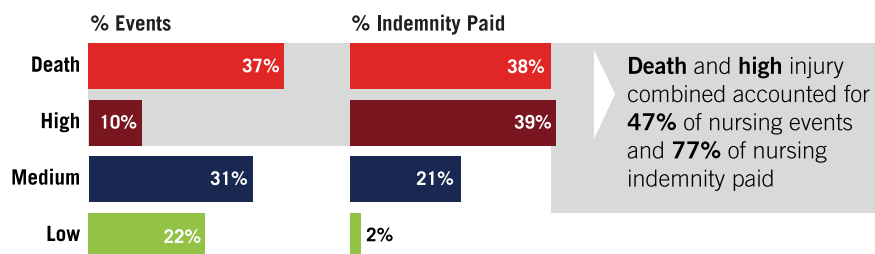
Adverse Nursing Events at a Glance

Frequency and Cost



N = 4,634 closed events 2018-2021.

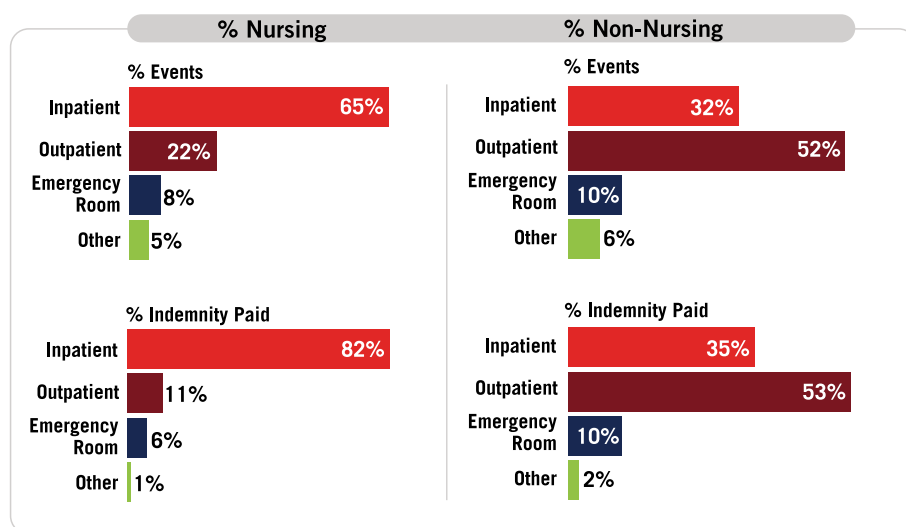
Injury Severity



N = 850 closed events 2018-2021, involving nursing.

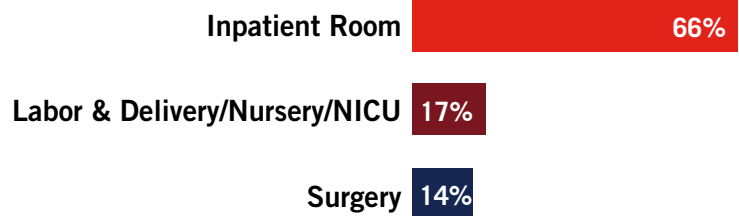
High injury severity is a category that includes major permanent injury (e.g., blindness in both eyes, paraplegia, bowel injury requiring permanent colostomy) and grave injury (e.g., cerebral palsy, vegetative state, or untreatable and widespread metastatic cancer).

Care Settings



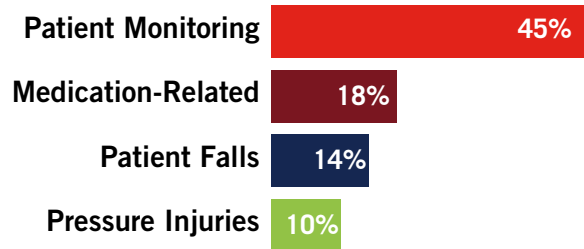
N = 4,634 closed events 2018-2021.

Top Inpatient Locations



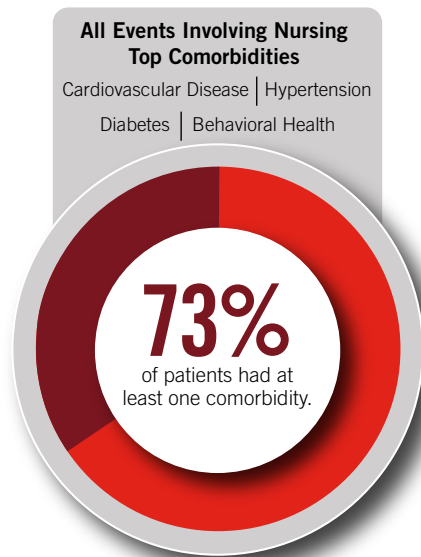
N = 552 closed events 2018-2021, involving nursing and occurred in an inpatient setting.

Top Themes



N = 850 closed events 2018-2021, involving nursing.

Top Comorbidities



N = 850 events closed 2018-2021, involving nursing.

Themes and Trends

Cultural barriers can make entire teams fear retribution or blame for questioning authority or reporting an error.

The Stories Behind the Numbers

Our data identified areas for potential improvement. Consider that:

- **Comprehensive information is critical to successful caregiving.** Poor outcomes are more likely in the absence of details about a patient's medical history, such as the presence of comorbidities, allergies, and other important factors. Nurses need to know: What is this patient's story? The story can be curated in many ways: by consulting the electronic health record and updating it along the way, by speaking directly to the patient and their other providers, by keenly observing a patient's behaviors and symptoms, and by asking critical questions.
- **Nursing vigilance can prevent adverse events.** Nursing requires multitasking, vigilance, and good workflows. When distractions or emergencies are combined with a heavy workload, it can be difficult to maintain a high level of vigilance.
- **Ongoing assessment and training are imperative.** Nursing events often involve an avoidable gap in knowledge, such as lack of proper training on how to assess skin integrity or administer uncommon medications. Adhering to best practices and providing training on important nursing skills inevitably creates safer environments. It's also imperative to regularly assess the skills of staff and travel nurses.
- **Nurse empowerment is key to patient safety.** Many nurses are not sufficiently encouraged to speak up when they have a concern. Cultural barriers can make entire teams fear retribution or blame for questioning authority or reporting an error. Institutions that empower their nurses and amplify their voices can significantly improve patient safety.
- **Teamwork is vital.** The decisions and behaviors of each team member impact the individual nurse's ability to succeed and the patient's ability to thrive. Our data highlights the importance of effective teamwork and team communication.

[View Video](#) - Key Findings and Trends

Patient Monitoring

Nurses are “the eyes and ears” of the clinical healthcare system, watching and listening for subtle details that indicate changes in a patient’s condition. This watchfulness is especially important during critical moments of “patient monitoring”—after surgery, after transfer to a new hospital unit, or when a patient has been admitted with a condition that requires ongoing observation. The majority of adverse events involving nursing—45%—were related to patient monitoring.

Further, the frequency of patient monitoring events involving nursing has been rising over the four years of closed claims examined in this report.

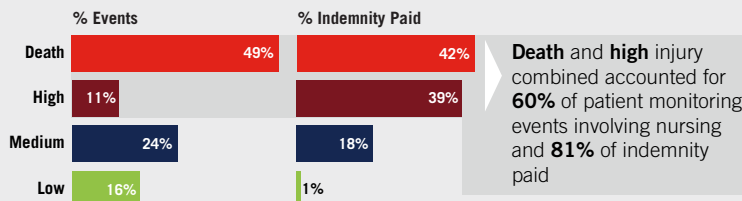
It is important to note that patient monitoring risk issues were also identified in all of the top areas of nursing vulnerability—fall prevention, medication, and pressure injury.



45% of events involved patient monitoring
→ **49%** of these resulted in death*

*Mostly attributable to pressure injuries, cardiac conditions and sepsis.
N = 850 closed events 2018-2021, involving nursing.

Injury Severity – Patient Monitoring

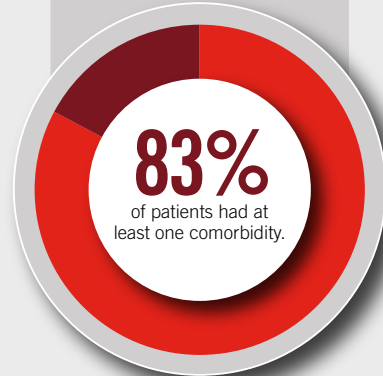


N = 382 closed events 2018-2021, involving nursing and patient monitoring.

High injury severity is a category that includes major permanent injury (e.g., blindness in both eyes, paraplegia, bowel injury requiring permanent colostomy) and grave injury (e.g., cerebral palsy, vegetative state, or untreatable and widespread metastatic cancer).

Patient Monitoring Top Comorbidities

Cardiovascular Disease | Hypertension
Diabetes | Dementia



N = 382 events closed 2018-2021, involving nursing and patient monitoring.



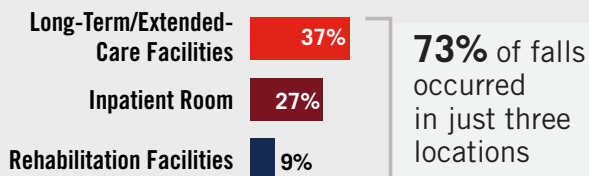
RISK MANAGEMENT RECOMMENDATIONS: Patient Monitoring

- **Create a monitoring algorithm.** Implement a scoring system or algorithm to help nurses evaluate signs of a worsening condition. Support nurses by creating clear policies regarding when providers must be notified of results.
- **Implement a chain-of-command policy.** Develop a reliable chain-of-command policy that provides specific steps for resolving conflict. Empower all staff to invoke the chain of command when they are concerned about a patient safety issue.
- **Develop clear guidance for monitoring.** Ensure that policies and procedures clearly describe requirements for monitoring, including method and frequency of monitoring and documentation requirements.

Patient Falls

Each year, approximately 700,000 to 1 million patients fall in hospitals.³ Nurse leaders have called patient falls “a nursing-sensitive outcome because their incidence has been linked to the quality of nursing care.”⁴ In fact, patient falls are one of the top causes of malpractice claims that implicate nursing; falls were responsible for 14% of nursing-related adverse events. Of most concern is the fact that 41% of patient falls resulted in death, typically attributable to fall-induced hemorrhages and fractures/dislocations.

Top Locations – Patient Falls



N = 121 closed events 2018-2021, involving nursing and a patient fall.

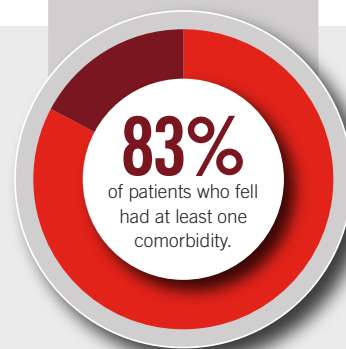


14% of events involved **falls**
 ↳ **41%** of these resulted in **death***

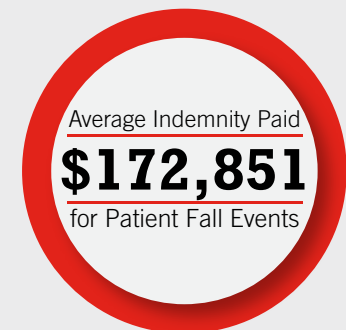
* Mostly attributable to fall-induced hemorrhages and fractures/dislocations.
 N = 850 closed events 2018-2021, involving nursing.

Patient Falls Top Comorbidities

Dementia | Cardiovascular Disease
Hypertension



N = 121 events closed 2018-2021, involving nursing and a patient fall.



N= 121 closed events 2018-2021, involving nursing and a patient fall.



CASE STUDY #1: Unattended Patient Suffers Fall

A 71-year-old male with fever and altered mental status was admitted to the hospital where he was diagnosed with heart failure and diverticulitis. He began experiencing intermittent episodes of delirium and was identified as a high fall risk through assessment with a structured tool. Fall precautions were in place, including signage, alarms, red slippers, and a plan for two-person assists on trips from bed or recliner to commode. His private patient room was directly across from the nurses' station.

A certified nursing assistant (CNA), acting alone, moved the patient onto the bedside commode. When the patient's nurse entered the room to administer medications, the CNA informed the nurse that she needed to leave to use the bathroom and asked the nurse to supervise the patient until she returned. Shortly after the CNA left, the nurse heard a bed alarm in an adjacent room. The nurse instructed the patient to stay seated and left to respond to the alarm. The patient subsequently attempted to get up by himself and fell backward, striking his head on the wall. The patient was transferred to another hospital with a C6 spinal fracture, where he underwent surgery. He died a month later due to respiratory failure related to his cervical-spine fracture.

At the time of the patient's fall, there were three patients who repeatedly set off fall alarms. Staff carried phones in their pockets to call for help if needed, but in this case, the nurse failed to do so. The unit was fully staffed at the time but still harried and operating in crisis mode.

[View Video - Key Takeaways from Case Study #1](#)



RISK MANAGEMENT RECOMMENDATIONS: Preventing Falls

- **Evaluate fall risk early and often.** Use a validated, standardized fall risk assessment tool to identify patients who are at high risk on admission to establish a baseline. Assess at regular intervals throughout the patient stay when medication or medical condition changes or during transitions in care. Remember that patients can fall anywhere and that doctors' offices and other medical facilities should be as proactively prevention-focused as hospitals.
- **Enlist champions.** A successful fall prevention program is an interdisciplinary team effort. Identify key individuals from each department/discipline to train staff and to champion efforts in the implementation and maintenance of the program. Patients and their families are valuable allies; educate them on fall prevention measures and enlist their help.
- **Mind the four P's.** Patient falls are often related to modifiable factors. Before you leave the patient room, make sure you have assessed for the following:
 - **Potty**—Does the patient need to use the bathroom?
 - **Position**—Is the patient uncomfortable?
 - **Pain**—Is the patient in pain?
 - **Placement**—Is everything the patient needs within reach?
- **Don't be overreliant on equipment.** Bedrails, restraints, and bed alarms are often used to prevent falls in patients who are frail, elderly, or confused. These devices can increase the risk of harm from a fall because patients can become caught, trapped, entangled, or strangled in these devices. Fall prevention equipment should not be used as a substitute for monitoring. Other options, such as sitters and video monitoring, should be evaluated carefully and in the context of the organization's staffing, budget, and patient population.
- **Communicate effectively.** Verbally communicate fall risk, medication updates, and changes in the patient's condition with the care team. This includes updates during care-planning sessions, during shift changes, when the patient is being transported, and upon transfer to other units/facilities. Document the date, time, information provided, and to whom it was given. Ensure that fall risk is noted conspicuously in the electronic health record (EHR) and in highly visible places for anyone who enters the room to see, such as above the bed, on the door, and on the patient's color-coded wrist band.

Medication

Medication errors are most likely to happen in inpatient settings.

More than 70% of Americans take at least one medication each day, which increases a patient's likelihood of suffering harm during the provision of care by clinical healthcare professionals.⁵ Risk management issues involving medication administration and management accounted for 18% of events involving nurses. The severity of these events is significant, with 39% of medication errors resulting in death.

Medication errors can happen in any healthcare setting, but they are most likely to happen in inpatient settings. Our data show that 19% of such events happen in a patient room, 13% in a long-term or extended-care setting, 11% in the emergency department, and 9% in a physician office.

Adverse events are more likely to occur when patients have serious comorbidities. Our data found cardiovascular disease, hypertension, chronic pulmonary disease, and diabetes are the most frequent comorbidities in events involving nurses. This is noteworthy because patients with these conditions are typically taking many medications (i.e., polypharmacy), which can exacerbate the vulnerability surrounding drug interactions and other prescribing complications.

Medication-Related Top Comorbidities

Cardiovascular Disease | Hypertension
Diabetes | Chronic Pulmonary Disease

75%
of patients had at least one comorbidity.

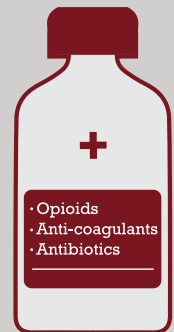
N = 181 events closed 2018-2021, involving nursing and a medication error.



18% of nursing events involved a medication error, namely administration and management
→ **39%** of these errors resulted in **death**

N = 850 closed events 2018-2021, involving nursing.

Most Common Medications



N = 181 events closed 2018-2021, involving nursing and a medication error. An event can include more than one medication.



CASE STUDY #2: Allergies, EHR Omissions, and Inadequate Discharge

A 66-year-old female with a history of chronic obstructive pulmonary disease (COPD) presented to the emergency department with complaints consistent with rib fractures and COPD exacerbation. Her Keflex (cephalexin) allergy was documented in the electronic health record (EHR) and alternative medications (IV SOLU-MEDROL and IV Rocephin) were administered during her hospital stay. Her condition improved, and she was discharged to home with a handwritten prescription for Keflex. The nurse failed to check the handwritten prescription against the patient's allergies in the EHR and gave the patient the handwritten prescription, which was against hospital policy.

At home, the patient collapsed shortly after taking her first dose, was resuscitated by emergency medical services (EMS), but remained unresponsive. EMS transported her to the hospital, where staff determined she had suffered an anoxic brain injury and would likely remain in a vegetative state. She died shortly after the prognosis was made. The medical examiner listed the probable cause of death as anoxic brain injury due to presumed anaphylaxis from cephalexin.

View Video - Key Takeaways from Case Study #2



CASE STUDY #3: Staffing Shortage and Deviation From Established Processes

A 54-year-old female patient presented to an outpatient clinic for dialysis treatment. The clinic had two sections (front and back), both of which were normally staffed with one RN and three patient-care technicians (PCT). A PCT called in sick, requiring a change in staff assignment. The patient's treatment was to be done in the back section under the care of a traveling nurse who had been with the clinic for two months and usually worked the front section.

The room was configured with patient/machine/patient/machine (Figure 1). One of the PCTs moved the patient's machine next to the neighboring machine, changing the configuration to patient/machine/machine/patient (Figure 2) with the two machines six inches apart. After getting all patients started on dialysis, both PCTs left the floor, leaving the traveling RN tending to 12 patients alone.

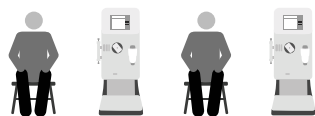


Figure 1

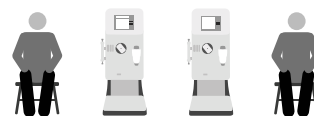


Figure 2

(Continued)

Medication

When fully staffed, a PCT is assigned to a pod of four patients and informs the RN when a pre or midway heparin bolus is due. Pod assignments were not created on this day, requiring the RN to monitor when the boluses were due. With this in mind, the traveling RN decided to walk down the row of patients so as not to miss anyone. As he was administering the heparin bolus, he realized he was injecting it into the wrong machine/patient. He immediately clamped off the line and asked the patient how she felt. She responded "OK." He then went to check the patient's orders and could not find an order for heparin. It was then that he saw that she had a heparin allergy.

The traveling RN, still alone on the floor, returned to the patient and found her unresponsive. He summoned help from an RN working in the front section of the clinic. 911 was called, and a call was placed to the patient's physician who ordered epinephrine and SOLU-MEDROL to be administered while waiting for EMS. CPR was started, but there was no epinephrine or SOLU-MEDROL in the crash cart. EMS arrived and gave a first dose of epinephrine 20 minutes after the code had started. One of the PCTs ran across the street to the hospital to retrieve SOLU-MEDROL, and it was given 30 minutes after the code was started.

It took 28 minutes for paramedics to arrive to transport the patient to the hospital across the street, where the patient later died.

View Video - Key Takeaways from Case Study #3

CRIMINALIZATION OF MEDICAL ERROR

In early 2022, a Tennessee jury found RaDonda Vaught, a former Vanderbilt University Medical Center nurse, guilty of criminally negligent homicide. The decision came after she gave a 74-year-old patient a fatal dose of the wrong medication in 2017. In the immediate wake of the verdict, the American Hospital Association (AHA) issued the following statement by Robyn Begley, DNP, RN, NEA-BC, FAAN, chief nursing officer of the AHA and CEO of the American Organization for Nursing Leadership: "The verdict in this tragic case will have a chilling effect on the culture of safety in healthcare. The Institute of Medicine's landmark report, *To Err Is Human*, concluded that we cannot punish our way to safer medical practices. We must instead encourage nurses and physicians to report errors so we can identify strategies to make sure they don't happen again. Criminal prosecutions for unintentional acts are the wrong approach."⁶



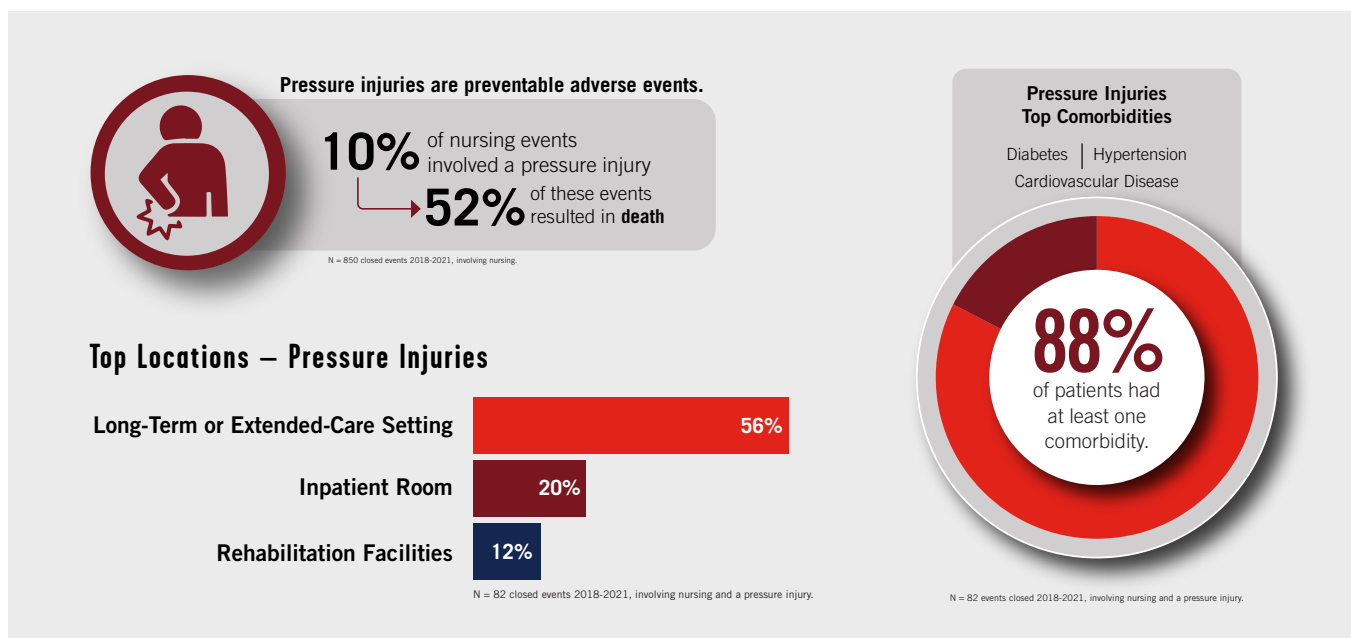
RISK MANAGEMENT RECOMMENDATIONS: Medication Administration and Reconciliation

- **Leverage and embrace technology.** Most EHR systems and electronic medical equipment have embedded safety features that can help prevent medication errors. Enlist the help of a multidisciplinary team to understand and optimize the use of these safety features such as reconfiguring medication dispensing cabinets to require input of at least the first five letters of a drug name and requiring generic medication names to be used when ordering medications. Educate staff on the importance of following the technologic safety features and the need to document the reason safety alerts are bypassed. Ensure that traveling nurses are oriented to the medication dispensing system and to the units on which they work.
- **Establish a “no interruption” zone.** Preparing and administering medications is a nursing activity that requires focus and concentration. Studies show that when interruptions are minimized during medication administration, errors are reduced significantly. When administering medications, nurses should be empowered to delay interruptions without fear of repercussion, and staff should understand why they may be asked to come back later.
- **Enhance the medication-reconciliation process.** The organizational medication safety plan should require a complete medication assessment/history to be documented upon admission and at all points of care transition. Ensure the medication history includes:
 - Current medications/dosages.
 - Route and time of last dose.
 - Over-the-counter medications, supplements, alternative medications, and cannabis products.
 - Illicit drug use.
 - Allergies and allergic response.
- **Educate patients, families, and caregivers.** Patients, families, and caregivers can serve as an extra set of “eyes and ears” when nurses are away from the bedside. Take the time to provide brief education on the medications the patient is taking, the dosage, desired effects, side effects, and adverse reactions. Instruct the patient, family, or caregiver to notify the nurse immediately if they notice any symptom that is consistent with a side effect or adverse reaction.
- **Report and monitor medication errors.** Provide education to all staff members on the importance of occurrence reporting to identify medication errors and near misses. Embrace and reflect patient safety culture principles and shared accountability to enhance reporting. Ensure that an appropriate nursing quality committee or patient safety/medication safety committee routinely evaluates, analyzes, and acts upon identified medication safety issues and efforts to bypass safety mechanisms.

Pressure Injuries

Our data show the frequency of events involving pressure injuries (PIs)—also known as pressure sores, decubitus ulcers, pressure ulcers, or hospital-acquired pressure injuries (HAPIs)—has increased. The issue of pressure injuries deserves significant attention for two reasons: 1) 52% of events involving nurses and a pressure injury resulted in death; and 2) Pressure injuries are preventable adverse events.

The Agency for Healthcare Research and Quality considers pressure injuries “never events,” yet 60,000 patients die every year from complications related to PIs.⁷ In our dataset, 10% of nursing events involved a pressure injury.



Top Risk Management Issues – Pressure Injuries

Situations that put a facility or a nurse at higher risk of having their patients suffer PIs include:

- Staffing challenges that make it difficult to find time to provide care to prevent PIs.
- Systems issues that make it difficult to maintain an adequate inventory of barrier creams, multilayer foam dressings, wound rulers, and cameras in areas of a facility where patients may be at risk.
- Inadequate training on PIs, particularly in common points of patient admission, like the emergency department, where PIs often initially develop in less than two hours of unrelieved pressure.⁸
- A high census of patients at high risk, such as patients with advanced age, immobility, or inability to voice their needs.



CASE STUDY #4: Failure to Communicate Relevant Findings

A 47-year-old male with paraplegia who was a long-term care facility resident was undergoing treatment of stage 4 pressure injuries, including one on his dorsal foot.

Six months after admission, the dorsal foot wound deteriorated with increased drainage and edema. Compression stockings and weekly dressing changes at the wound clinic were added to his treatment plan. There was no documentation of wound assessment during this time.

Two months later, the physician noted excessive foot edema and placed a non-adhering dressing and wrap above the ankle. A week later, the nurse reapplied the dressing very tightly after the patient insisted that was how the physician told him it needed to be done. His toes were blanching, but he refused to let the nurse rewrap it. The nurse did not inform the doctor of this interaction.

Three days later, the patient agreed to let the nurse unwrap his foot. The wound size was unchanged, but his toes were cool with blue/purple coloration. The physician was told that the wound size was the same; no other findings were reported. A recheck appointment was scheduled at the wound clinic for three days later.

The following day, the patient's wound was sloughing off skin and bleeding. Nursing recommended a transfer to the emergency department for evaluation. The patient refused, stating he wanted to keep his scheduled appointment at the wound clinic.

During his appointment at the wound clinic two days later, the wound had increased in size. The foot was more swollen, was cool to the touch, and had extensive necrotic tissue. The patient was diagnosed with gangrene and required transfer to an acute-care facility. IV antibiotics were started, and he underwent a radical debridement of the PI and amputation of the fifth digit of his foot. The patient suffered numerous complications, which ultimately resulted in a below-the-knee amputation.

[View Video - Key Takeaways from Case Study #4](#)



RISK MANAGEMENT RECOMMENDATIONS: Preventing Pressure Injuries

- **Evaluate early and often.** A head-to-toe skin assessment using a structured assessment tool should be done on admission and repeated at regular intervals throughout the patient stay. All areas of skin breakdown should be photographed and documented in the medical record. Patients and their families can be valuable assets in preventing pressure injuries—enlist them to be on the lookout for areas of skin breakdown.
- **Remember medical devices.** Many patients, especially those who are elderly or undergo surgery, require special equipment or a medical device—such as a bedside commode or oxygen nasal cannula—during their stay in the hospital. Prevention of PIs due to use of equipment or devices is often difficult because they may be used frequently or continuously, are often rigid, or may not fit well. Skin assessments should include evaluation of the skin that touches the equipment or device to identify early indicators of pressure.
- **Train *all* nursing staff.** Formal education that includes a competence-based curriculum for PI prevention and treatment should be provided for all nurses. Pressure injuries often begin during long stays in the ED or lengthy surgeries, so ED and surgical nurses should be provided with training as well. Ensure that all staff use a structured assessment tool and common language to describe pressure injuries.
- **Embed “triggers” in the reporting.** All staff members should understand the importance of occurrence reporting to identify pressure injuries and should embrace patient safety culture principles and just culture. Update the occurrence reporting system so that it triggers a “real-time” notification to the quality director and wound-care specialist for initiation of early intervention.

Communication and Culture

Communication/human factors played a role in each of the top risk areas (patient monitoring, patient falls, medication, and pressure injuries).

For all the ways in which nurses are the proverbial eyes and ears of healthcare, they are also the voices. Their vital communications—with patients, families, and the entire care team—often make them the most recognizable and influential voice during a patient’s episode of care.

Safe and effective care often comes down to complete, accurate, timely, targeted, and clear communication—sharing the right message or piece of information in the right way, at the right time, to the right person. Our data found communication/human factors played a role in each of the top risk areas (patient monitoring, patient falls, medication, and pressure injuries).

Most of these events involved one or more of the following risk issues:



Failure to function as a cohesive clinical team.



Communication: Physician to/from RN.



Presence of cultural/organizational vulnerabilities.



Failure to ensure a safe environment—adequate staffing and workplace design.



Distractions—lack of situational awareness.



RISK MANAGEMENT RECOMMENDATIONS: Communication and Culture

- **Analyze organizational culture.** Organizations with leaders that promote just culture and empower nurses to speak up about patient safety issues are less vulnerable to patient safety risks. Leadership should be dedicated to building and nurturing teams that exhibit trust, respect, and a commitment to patient safety. An error or a near miss should be viewed as an opportunity to identify a system issue rather than a chance to assign blame to an individual.
- **Strengthen communication and build teams.** Communication issues are often a factor in adverse events that lead to patient harm. Structured communication training and team building is essential to develop highly functioning work units. Provide communication training and team building opportunities to all members of the team, including medical staff and travelers, and reinforce it with periodic drills and simulations. Use plain language and “teach back” when communicating with patients and their families—especially when giving discharge instructions.
- **Monitor shortcuts and workarounds.** Systemic inefficiencies may lead nurses to create workarounds and shortcuts that can place patients at risk. When nurses feel rushed, they may overlook activities that require nursing skill and judgment such as administering medications, handoff communication, and monitoring patients. Evaluate whether the duties assigned to nurses require nursing judgment and skill and, if not, consider assigning those duties to others. Look for commonly used shortcuts and workarounds that may indicate system issues that require attention.
- **Combat burnout and stress.** Nursing teams that have no way to relieve stress or voice concerns may be at risk of burnout and job dissatisfaction. Evaluate the wellness of nursing staff through regular surveys and conversations and address sources of stress before they become causes for burnout, job dissatisfaction, or turnover.

Final Key Takeaways

Throughout this publication, we have provided data-driven recommendations for reducing risk and improving outcomes of patients cared for by nurses. **Following is a final list of recommendations that apply broadly to safety-minded nursing in U.S. healthcare.**



RISK MANAGEMENT RECOMMENDATIONS: Key Takeaways

- **Observation is essential.** Technology, no matter how innovative, cannot take the place of nursing observation and assessment. When the condition of a patient begins to deteriorate, time is of the essence. When nursing observations are noted and communicated promptly, the impact of those events may be lessened.
- **Communication is key.** Nurses who practice in teams that consistently use structured communication frameworks will reduce the frequency of miscommunication between nurses and other providers. Chain-of-command policies should be clear, effective, and reliable.
- **Teams should be cohesive.** In a healthcare environment in which physicians and nurses are rarely in the same room at the same time, building functional teams can be difficult. Team-based training should be an institutional priority, and leadership should be firm in their commitment to creating and nurturing cohesive teams. Engaged patients, families, and caregivers are also a great addition to the healthcare team!
- **Error reporting should be blameless.** Errors happen in the delivery of nursing care, but errors that are immediately reported and properly analyzed can serve as triggers for improved processes and policies and an overall reduction in patient safety risks. Mistakes can happen because of systemic issues, but the only way to reveal an organization's most acute deficiencies is by encouraging the reporting of errors and by creating an open-communication culture that is just and patient-focused.
- **Organizational culture is important.** Providing respect and continual care for nurses' workplace wellness is imperative to operating a team that delivers safe patient care. A strong focus on organizational culture—just culture, safety culture, blameless culture, continuous-improvement culture, wellness culture, open-communication culture—is a great place to start.

Conclusion

Making nursing safer requires acknowledging that vulnerabilities exist. Where there are vulnerabilities, there are opportunities for improvement.

Knowing that 18% of closed claims at Coverys involved nursing (and that those nursing events accounted for 26% of indemnity paid), it is important to acknowledge the steady—and sometimes worsening—risks at play. To prevent errors in nursing, we must understand what kind of errors happen, how frequently they occur, where they happen, and why they happen. Then, we must—as individuals, healthcare teams, organizations, and an entire culture—work to reduce the likelihood of these errors. The insights and risk management recommendations provided in this report are a good place to start.

[View Video](#) - Top Risk Issues and Final Recommendations

References and Citations

Unless otherwise noted, statistics and information in this publication were derived from an analysis of 850 specific events involving nurses in closed medical malpractice claims at Coverys across a four-year period (2018-2021).

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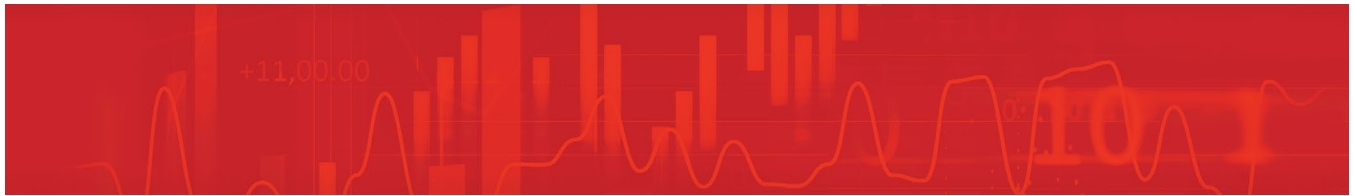
⁸Ibid.

For more information about the root causes of claims, access the Coverys Interactive Risk Analytics Dashboard at Dashboard.Coverys.com.

Case studies and other patient examples shared in this publication are derived from actual malpractice claims with identifying details removed or altered to protect the anonymity of patients, families, practitioners, and healthcare organizations.

The information in this report is intended to provide general guidelines for risk management. It is not intended as, nor should it be construed as, legal or medical advice.

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