RISK CONTROL SELF-ASSESSMENT CHECKLIST FOR NURSE PRACTITIONERS

This checklist is designed to help nurse practitioners evaluate risk exposures associated with their current practice. For additional nurse practitioner-oriented risk control tools and information, visit **www.cna.com** and **www.nso.com**.

Self-assessment topic	Yes	No	Actions needed to reduce risks
Clinical specialty			
I work in an area that is consistent with my licensure, specialty certification, training and experience.			
I know that my competencies – including experience, training, education and skills – are consistent with the needs of my patients.			
I understand the specific risks of caring for patients within my clinical specialty.			
I decline an assignment if my competencies are not consistent with patient needs.			
I ensure that my competencies and experience are appropriate before accepting an assignment to cover for another practitioner.			
I am provided with orientation, or request and obtain it, whenever I work in a new or different clinical setting.			
I obtain continuing education and training, as needed, to maintain my competencies in my clinical specialty.			
Scope of practice and scope of services			
I read my state nurse practice act at least once per year to ensure that I understand and am in compliance with the legal scope of practice in my state.			
I know and comply with the requirements of my state regarding physician collaborative or supervisory agreements, and I review and renew my agreements at least annually.			
I comply with the requirements of my state regarding other regulatory bodies, such as the board of medicine (if applicable).			
I collaborate with or obtain supervision from a physician as defined by my state laws and/or regulations and as required by the needs of my patients.			
I seek alternative physician consultation if I am not provided with appropriate support from my collaborating/supervising/employing physician(s), and modify my agreements accordingly.			
I decline to perform requested actions/services if they are outside of my legal scope of practice.			
Assessment			
I elicit the patient's concerns and reasons for the visit and address those concerns.			
I obtain and document a current list of the patient's prescribed and over-the-counter medications, including nutritional supplements and holistic/alternative remedies.			
I document any patient allergies and adverse reactions to medications.			
I gather, document and utilize an appropriate patient clinical history, as well as relevant social and family history.			
I ascertain the patient's level of compliance with currently ordered treatment and care instructions, medication regimens and lifestyle suggestions.			
I perform a physical examination to determine the patient's health status and evaluate the patient's current symptoms/complaints.			
I determine if the patient's current health status requires immediate medical treatment, and refer the patient to an emergency department if needed.			
I adhere to facility documentation requirements regarding assessment findings.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Diagnosis			
I utilize an objective, evidence-based approach, applying organization-approved clinical guidelines and standards of care to timely and accurately determine the patient's differential diagnosis.			
I consider the findings of the patient's assessment, history and physical examination, as well as the patient's expressed concerns, in establishing the diagnosis, and document my findings.			
I order and timely obtain results of appropriate diagnostic testing – including laboratory analysis, radiography, EKG, etc. – before determining the diagnosis, and document ordered tests and results.			
I consult with my collaborating/supervising physician, as required, to establish the diagnosis and treatment plan, and document all such encounters.			
I request, facilitate and obtain other appropriate consultations, as necessary, to achieve a timely and correct diagnosis.			
When establishing the diagnosis, I comply with the standard of care, as well as my facility's policies, procedures, and clinical and documentation protocols.			
If a patient is unstable, acutely ill and in need of immediate diagnostic testing and/or consultation, I refer him or her to hospital emergency care and facilitate this process, if necessary.			
If a diagnostic test or procedure involves risk, I conduct and document an informed consent discussion with the patient and obtain the patient's witnessed consent.			
I proactively gather, document and respond to the results of diagnostic tests/procedures and provide necessary orders.			
I obtain, document and respond to the results of diagnostic consultations with physicians and other healthcare providers.			
I establish the diagnosis, determine a treatment plan, document clinical decision-making, and order and implement the treatment and care plan.			
I discuss clinical findings, diagnostic test/procedure results, consultant findings, diagnosis, the proposed treatment plan and reasonable expectations for a desired outcome with patients, in order to ensure their understanding of their care or treatment responsibilities. I document this process, noting the patient's response.			
I counsel the patient regarding the risks of not complying with diagnostic testing, treatment and consultation recommendations, and document discussions. If recurrent noncompliance is potentially affecting the safety of the patient and regular counseling has been ineffective, I consider discharging the patient from the practice.			
If the patient is uninsured or unable to afford necessary diagnostic and consultative procedures, I refer him or her for financial assistance, payment counseling, and/or free or low-cost alternatives, and document these actions.			
If I work in a state with autonomous nurse practitioner authority, I regularly seek peer review to assess my diagnostic skills and expertise and to identify opportunities for improvement.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Treatment and care			
I educate the patient regarding the diagnosis, treatment plan, and need for compliance with treatment recommendations, medication regimens and screening procedures. I document the discussion.			
I prescribe clinically indicated treatment and care and provide appropriate health screening for the patient.			
I discuss the patient's treatment plan and ongoing response to treatment with my collaborating/supervising physician as required and appropriate, and document the interaction.			
I discuss with the patient and document any deviation from established protocols, guidelines or standards, and explain the clinical rationale for the alternative plan.			
I advise the patient to obtain emergency medical treatment in the event of unexpected adverse symptoms or effects of treatment, and document the discussion.			
I conduct and document an informed consent discussion with the patient prior to implementing any aspect of the treatment plan that involves potential risk, ask the patient to repeat the main points of the discussion, and obtain the patient's stated and written consent.			
I perform regular monitoring tests and consultation, as needed, to appropriately manage the patient's healthcare, and document all findings.			
I inform the patient of test and consultation results, both normal and abnormal, and document the discussion.			
I schedule follow-up visits to monitor the patient's response to treatment, and I adjust the patient's treatment plan as needed and appropriate.			
I remind patients of regular appointments and screening tests, and document these reminders.			
I contact patients after missed appointments for rescheduling, and document these contacts.			
I counsel patients regarding their treatment plan responsibilities and the need for compliance with ongoing testing, medication regimens and lifestyle choices that potentially affect outcomes, ensure their ability to repeat the information correctly, and document these interactions.			
I follow up to ensure that patients have obtained ordered tests and scheduled/completed referrals or consultations, facilitate the process, if necessary, and document these actions.			
I explain to patients that if they are noncompliant to the point of endangering themselves or creating a liability risk, I may be forced to withdraw my care. I document this communication and the patient's response.			
I terminate from treatment persistently noncompliant patients, assist them in transitioning to another healthcare provider, retain registered mail receipts, and document all patient support and other actions taken.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Medication prescribing			
I prescribe medications in compliance with the state nurse practice act, state prescriptive authority for nurse practitioners, my collaborative/supervisory agreement, and employer policies and protocols.			
I consult with my collaborating or supervising physician regarding medication orders.			
I provide the full name of the medication, as well as its proper dosage, frequency and route. I also include the purpose of the medication ordered to prevent prescribing and dispensing errors.			
I write legible, complete prescriptions, using no abbreviations.			
I ensure that the patient's health information record clearly reflects any drug allergies or adverse reactions.			
I check all computerized medication orders to protect against inadvertent entry errors.			
I address any computerized prescribing warning screens and never override warning screens without considering identified contraindications or interactions.			
I secure prescription pads to prevent theft or loss.			
I discuss any medication questions or concerns with a pharmacist, and document the interaction.			
I minimize use of look-alike and sound-alike medications, and always verify the correctness of orders for such medications.			
I use caution when prescribing anticoagulants, antibiotics, psychoactive medications and other known toxicity-prone drugs, order and follow up with all indicated monitoring tests, and document results.			
I monitor controlled drug usage by patients and refer chronic pain patients for pain management therapies.			
I confer with physicians, pharmacists and/or evidence-based resources, as needed, to identify and mitigate any additional risks related to off-label drug use, and document these actions.			
I talk to my patients about their medications, informing them of brand and generic names, dose or strength, route, frequency and times, realistic expectations of results, potential side effects, signs of adverse reaction and symptoms warranting immediate medical attention. I document these interactions and the patient's ability to correctly repeat the shared information.			
I educate my patients regarding their responsibilities for adhering to medication and treatment regimens, including beneficial dietary and lifestyle modifications, as well as the risks of noncompliance.			
I ensure that patients are taking the full, prescribed dosage. If financial issues interfere with compliance, I refer the patient to reduced-cost or manufacturer-provided drug assistance programs, and document these actions.			
I conduct and document an informed consent discussion prior to prescribing investigational or experimental medications or any medication with significant risks, and obtain the patient's consent prior to initiation of the medication or medication protocol.			
I assist patients in obtaining financial assistance for their medications, when appropriate.			
I counsel patients who do not comply with their medication regimen regarding the risks to them and to my practice, document these interactions, and appropriately terminate the patients from my practice, if necessary.			
I limit telephone refills to a maximum of one refill for routine medications, pending a return patient visit.			
I manage telephone refills of high-risk medications on a case-by-case basis and require that the patient schedule a timely appointment.			
I speak directly to pharmacists who call with questions regarding a prescription.			
I dispense drug samples with caution and record the lot and serial numbers of samples.			
I neither maintain nor provide samples of controlled drugs.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Competencies			
I attend continuing education and training programs in compliance with state licensing regulations and as needed, in order to ensure the safe and effective care and treatment of my patients.			
I remain current regarding clinical practice, medications, treatment and equipment utilized for the diagnosis and treatment of acute and chronic illnesses and conditions related to my clinical specialty.			
I consult regularly with my collaborating/supervising physician to ensure that my competencies are appropriate and sufficient.			
I engage in peer review and/or quality review in my organization/practice.			
I participate in quality improvement and patient safety committees or initiatives in my organization/practice/professional organization, in order to enhance my clinical competencies and patient safety awareness.			
I contact my board of nursing and/or board of medicine to identify learning opportunities in my region and state.			
I identify and pursue additional learning opportunities through my professional organizations.			
Patient care equipment and supplies			
I check that emergency and required patient care equipment is readily available and in proper working order.			
I activate and respond to any equipment alarms and never turn off alarms when equipment is in use.			
I examine all equipment before each use to ensure proper functioning.			
I report broken/malfunctioning equipment, remove it from use and obtain an appropriate replacement.			
I sequester any broken/malfunctioning equipment involved in a patient incident, in order to preserve it exactly as it was at the time of the event.			
I provide oral and written reports of broken/malfunctioning equipment to all appropriate parties.			
Professional conduct			
I speak to patients, families and staff in a respectful and professional manner.			
I monitor the patient care environment to ensure privacy and safety.			
I explain procedures and treatments to patients, including any touching that may occur during sessions, and I obtain their permission before proceeding.			
I respect the patient's rights throughout the episode of care.			
I maintain patient privacy and confidentiality.			
I avoid harsh physical touching or abrupt movement with patients at all times.			
I include a chaperone, when indicated, if intimate touching is required for the patient's treatment.			
I refrain from personal relationships outside of the care setting with patients and family members.			
I divulge protected information only with written authorization from the patient or a legal representative.			

Self-assessment topic	Yes	No	Actions needed to reduce risks
Other documentation practices			
I refrain from subjective comments, including statements about patients, colleagues and other members of the patient care team.			
I document contemporaneously and never make a late entry unless it is appropriately labeled and necessary for the safe continued care of the patient.			
I factually and thoroughly document any unusual occurrences that arise during the patient's treatment and care.			
I complete an incident report for unusual patient incidents and/or patient injuries, following practice protocols.			
I never remove any portion of the patient's health information record or alter a record in any way.			
I do not remove patient health records (paper or electronic) from the patient care location, and I do not make entries from home or other inappropriate locations.			
I allow no one else access to my laptop, electronic pad or personal digital assistant, never share my passwords or access codes, and maintain electronic equipment safely and securely.			
I immediately report lost or stolen paper health information records or electronic patient healthcare recording or storage devices.			
I contact the organization's risk manager or legal counsel for assistance prior to making an entry if I am in any way unsure about it.			

CLAIM TIPS

The following concepts and behaviors can help reduce nurse practitioner professional liability risks. Also included are steps to take if you believe that you may be involved in a legal matter related to your practice:

1. **Practice within the requirements of your state Nurse Practice Act,** in compliance with other professional boards, organizational policies and procedures, and within the standard of care.
2. **Document your patient care assessments, communications, clinical decision-making process, diagnosis, treatment plan and patient care actions** in an objective, timely, accurate, complete, appropriate and legible manner.
3. **Never alter a record for any reason or add anything to a record after the fact unless it is necessary for the patient's care.** If it is essential to add information into the record, properly label the addition as a late entry, but never add any documentation to a record for any reason after a claim has been made. If additional information related to the patient's care emerges after you become aware that legal action is pending, discuss the need for additional documentation with your collaborating/supervision physician, the organization's risk manager and/or legal counsel to determine appropriate action.
4. **Immediately contact your personal insurance carrier if you become aware of a filed or potential professional liability claim asserted against you,** receive a subpoena to testify in a deposition or trial, or have any reason to believe that there may be a potential threat to your license to practice nursing. Keep in mind that allegations involving failure to diagnose, delays in diagnosis, deaths and infection/abscess/sepsis are most likely to result in litigation.
5. **If you purchase your own professional liability insurance policy, report possible claims or related actions to your insurance carrier,** even if your employer advises you that he or she will provide you with an attorney and/or will cover you for a professional liability settlement or verdict amount.
6. **Refrain from discussing the matter with anyone** other than your defense attorney or the professionals managing your claim.
7. **Promptly return calls from your defense attorney and the claim professionals assigned by your insurance carrier.** Contact your attorney or claim professional before responding to calls, e-mail messages or requests for documents from any other party.
8. **Provide your insurance carrier with as much information as you can when reporting real or potential legal situations,** including contact information for the organization's risk manager and for the attorney assigned to the litigation by your employer.
9. **Never testify in a deposition without first consulting your insurance carrier** or, if you do not purchase your own professional liability insurance policy, without first consulting the organization's risk manager or legal counsel. In addition, do not testify in a deposition without having had specific deposition preparation by your attorney.
10. **Copy and retain any summons and complaint, subpoena or attorney letters for your records** and to share with your attorney and professional liability insurer.
11. **Maintain signed and dated copies of any employer contracts,** including past agreements.

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333 South Wabash Avenue
Chicago, Illinois 60604
1.888.600.4776 **www.cna.com**

159 East County Line Road
Hatboro, PA 19040
1.800.247.1500 **www.nso.com**

In addition to this publication, CNA has produced numerous studies and articles that provide useful risk control information on topics relevant to nurse practitioners. These publications are available by contacting CNA at 1-888-600-4776 or at **www.cna.com**. Nurses Service Organization (NSO) also maintains a variety of online materials for nurses, including nurse survey results, articles and useful clinical and risk control resources, as well as information relating to nurse practitioner professional liability insurance, at **www.nso.com**.

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