Using Malpractice Data to Identify Risks in School Nursing Practice

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Today's Speaker

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Disclosure Statement: All faculty and planners in a position to control the content of this session and their spouses/life partners (if any) have disclosed that they have no financial relationships with, or financial interests in, any commercial organizations pertaining to this educational activity with the extent of their participation in the activity.

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Objective

Analyze	Analyze the actions and issues that prompted allegations of negligence or unprofessionalism against nurses, as well as the areas of nursing practice named most frequently in complaints.
Define	Define the average incurred expenses for nurses involved in a malpractice lawsuit or licensing board investigation.
Identify	Identify processes that nurses can implement into their practice to reduce their potential liability.

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Who is NSO?

Provider of malpractice insurance to nurses and nurse practitioners for over **40 years**

Over **600,000+** nursing individual customers

Endorsed by **87** national, state and specialty nursing professional associations

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Defining Malpractice

Malpractice: is a type of negligence; it is often called "professional negligence". It occurs when a licensed professional (like an NP) fails to provide services as per the standards set by the governing body ("standard of care"), subsequently causing harm to the plaintiff.

To be successful, the patient (plaintiff) must establish:

Duty	Breach	Cause	Harm
The provider owed a duty to the patient;	The provider breached his or her duty;	The breach was the direct and proximate cause of injury;	The injury resulted in damages/harm.

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How Does a Patient Define Malpractice?

Perception of wrongdoing.

If a patient perceives he or she has been injured as a result of the care you provided, or failed to provide, that patient could sue.

Will an attorney accept the case?

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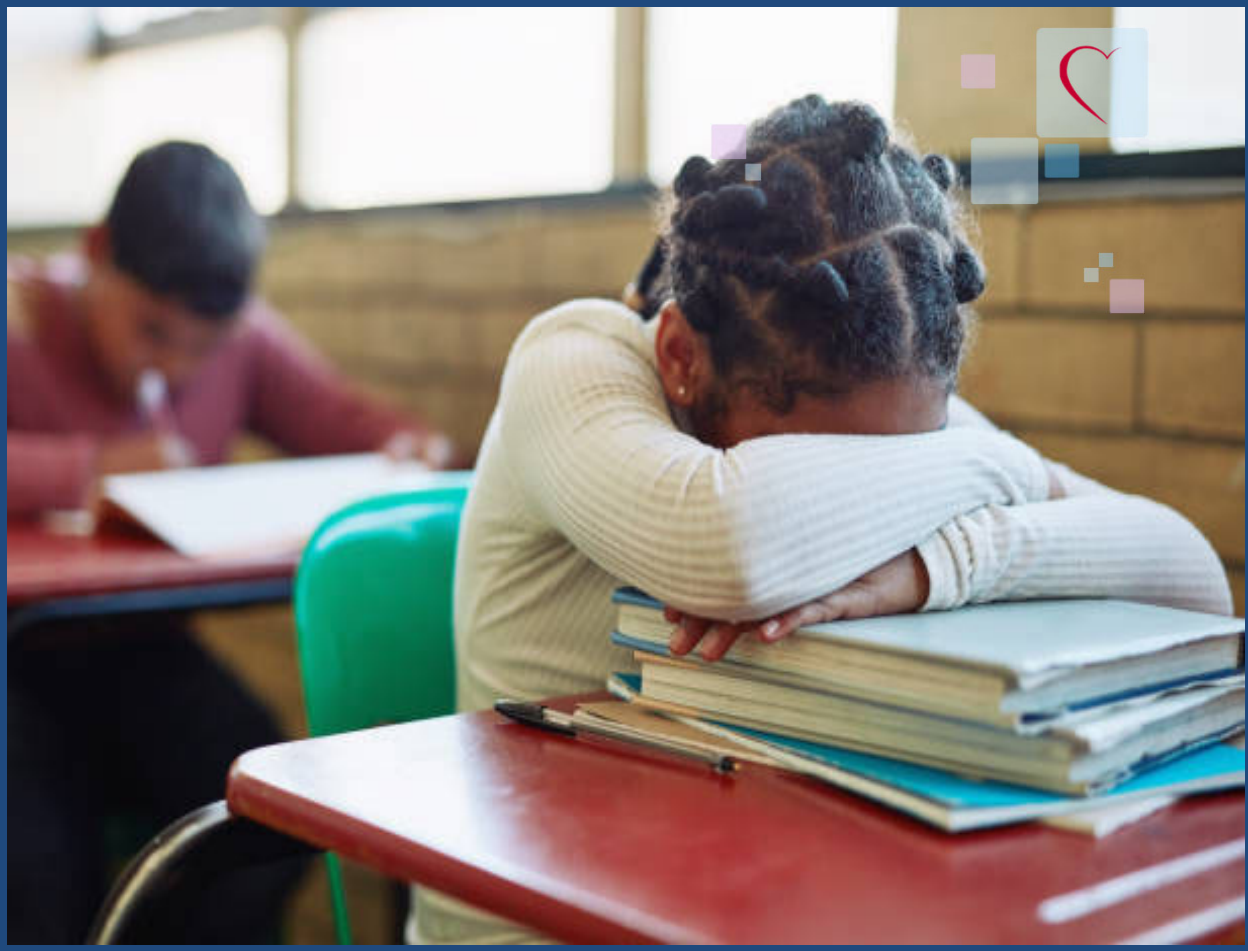
Case Study

Professional Liability



Case Study

- This case involves a registered nurse (RN) working as a school nurse in an elementary school. The patient was a seven-year-old first grade student.
- On the day of the incident, the student entered the classroom at 9 a.m. and asked the teacher for permission to go to the restroom. The student was given permission and proceeded to the restroom where he discovered a janitor in the process of cleaning the floor. He noticed that the janitor was spraying a liquid substance on the floor and mopping the area covered by the spray. He waited for the janitor to finish and then approached the nearest urinal to void.
- While he was washing his hands and preparing to return to the classroom, the student noticed that his undergarments were wet. He attempted to dry them with a paper towel and then returned to the classroom.
- Shortly after the student returned to the classroom, the teacher noticed that he had his head down on his desk and appeared lethargic. After observing him for a few minutes, she asked the student if he wanted to go to the nurse. The student complained of hip pain and agreed to see the nurse. At 9:30 a.m., the teacher accompanied the student to the nurse.

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Case Study

- The nurse greeted the student and asked him what was wrong. He told the nurse that he had left hip pain which started shortly after he used the restroom. The student denied having a fall or any other traumatic event. The nurse did not conduct much of an assessment, nor did she physically examine or palpate the affected area.
- The school policy required the presence of two adults whenever a student needed to disrobe for a nursing assessment. The student's teacher was unavailable to assist as there was no teacher aide available to monitor her classroom at that time. While the nurse knew of the policy, she did not reach out to any other staff to satisfy this requirement.
- In her deposition, the nurse testified that, based upon her observations that the student's gait was within normal limits, she did not regard the student's complaint as serious. Therefore, she did not pursue obtaining a staff member to witness an examination that would require disrobing. An ice pack was provided, and the student returned to the classroom. The visit with the school nurse lasted approximately fifteen minutes.

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Case Study

- At approximately 11 a.m., the teacher noticed that the student was becoming increasingly lethargic and continuing to complain of hip pain. She examined the student's left hip by slightly pulling down his sweatpants and identified a wound that was actively draining fluid. The teacher immediately recognized this as a serious medical situation and carried the student directly to the health room at about 11:15 AM.
- The nurse observed a 3 cm by 3 cm wound on the student's left hip, posterior to the iliac crest, which was surrounded by a reddish-yellow skin discoloration. She immediately contacted the student's mother to request that she pick up the student and obtain a medical evaluation.
- At 11:45 a.m., upon arrival to the school the student's mother observed the wound with the nurse. The nurse advised the mother to take the student immediately to the nearest emergency department, and the mother agreed.
- This discussion was not documented in the school health record. The only documentation by the nurse was that the student was sent to the nurse for hip discomfort and was given an ice pack. In addition, the student's underwear was wet but was not removed by the nurse or the student's mother.

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Case Study

- At approximately 12:21 p.m., the student arrived at the hospital emergency department (ED) and was seen by a triage nurse who placed the student in a “non-urgent" queue. Based upon the initial triage classification and the fact that the ED was extremely busy that day, the triage nurse did not examine the student’s hip.
- At 2:15 p.m., the student was evaluated by the ED physician who immediately transferred him to the hospital burn unit for treatment of a full-thickness chemical burn.
- During the hospital admission, the student underwent five procedures, including two wound bed preparations and three grafting procedures, one of which failed due to infection.
- Following discharge from the hospital, there was a protracted period of home care, which included intensive wound management and physical therapy.

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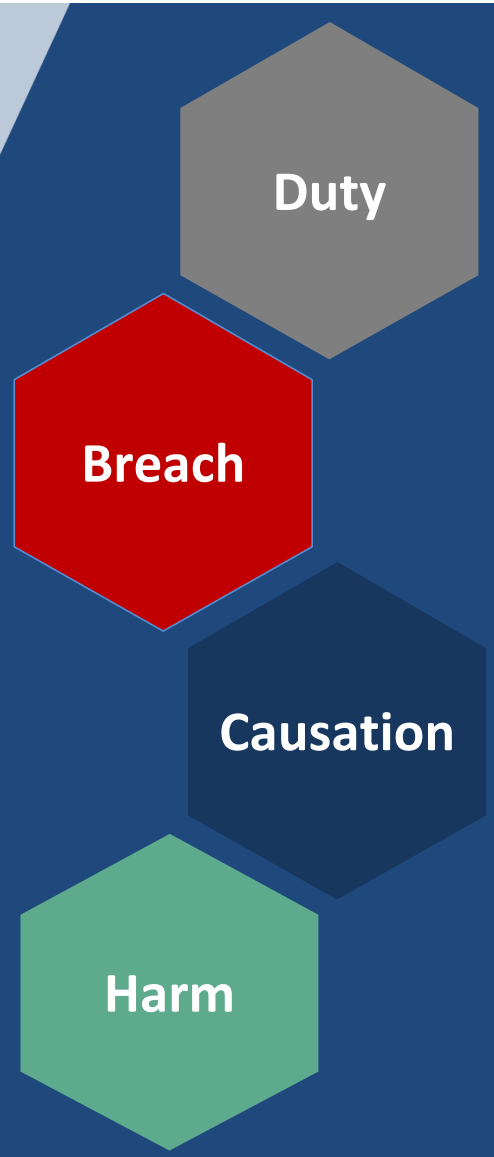
Do you think the nurse was negligent?

Do you believe that the nurse was negligent? Were any other parties negligent?

Do you believe that an indemnity payment was made on behalf of the nurse?

If yes, how much?



Risk Management Comments

- Six months after the student's skin graft surgeries, a lawsuit was filed by the student's parents (plaintiffs) against the school district asserting that the school was negligent in failing to conduct safety training for custodial staff regarding the use of caustic cleaning agents.
- The plaintiffs also named the school nurse individually, asserting that she was negligent in **failing to perform a complete assessment and physical examination when the student first presented, resulting in a delay in treatment and an exacerbation of the burn injury.** The hospital also was named in the lawsuit relating to the delays in assessment and diagnosis in the ED.
- Notably, shortly after the student was diagnosed with a chemical burn, an investigation was conducted to determine the cause of the burn. A chemical engineer was hired by the student's parents to evaluate the clothing that the student wore on the date of the incident. The investigation revealed that the wetness noted by the student on his clothing in the restroom was residual liquid from the caustic cleaning agent left on the floor by the janitor.
- Plaintiff's experts in school nursing opined that the nurse failed to conduct an appropriate nursing assessment when the student initially presented at 9:30 a.m. **This omission represented a departure from the standard of care. The nurse expert also raised concerns regarding the lack of documentation.**

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Risk Management Comments

- Plaintiff's experts in engineering and environmental management testified that the school district, through its employees, negligently applied an undiluted caustic substance to the bathroom floor which was absorbed into the patient's clothing causing the resulting chemical burn.
- **Burn care experts testified that if the patient had been properly assessed by the school nurse, the student would have received expeditious treatment which would have limited the extent of the burn.**
- All of the experts, including the defense experts, agreed that, at both the school and the hospital, the severity of the burn was exacerbated by the cumulative delays in assessing the skin.

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Risk Management Comments

- In a deposition, the burn specialist who treated the patient testified that the patient suffered a full-thickness chemical burn caused by an alkaline cleaning agent. The treating ED physician testified that he had never seen a chemical burn of this severity in his 10 years of practice.
- In her deposition, the school nurse initially testified that she did not believe that the student's presentation required a complete assessment and physical examination as he appeared to be ambulating without difficulty. However, in cross-examination, she later testified that her concern in **being unable to find a staff member to witness an assessment was the primary reason she had opted not to perform an assessment.**
- Although the student fully recovered from the surgeries, he suffered permanent disabilities including scarring, the inability to be in the sun without protective clothing and a lifelong restriction from engaging in contact sports. In his deposition, he testified that he always wore clothing that would conceal the scarring from the skin grafts.

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Resolution

Based upon the defense challenges and diminished potential for a successful defense verdict, as well as the sympathy factor associated with the painful burn injury, multiple surgical procedures and permanent scars, a settlement was negotiated on behalf of the insured nurse during mediation.

Total Incurred: More than $135,000

Figures represent only the payments made on behalf of our registered nurse and do not include any payments that may have been made by the registered nurse's employer on her behalf or payments from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

More About the Resolution

- Based upon the decedent's age and the sympathy factor potentially influencing a jury's decision, this case had the potential for a high jury verdict.
- The parents' testimonies also were compelling and sympathetic.
- The defense opined that the jury probably would believe that the nurse failed to adhere to the standard of care.
- Jurors' opinions regarding whether the standard of care was met is based upon many factors, including the credibility of the witnesses and the experts' deposition testimonies as well as the documentation.
- In this case, there was no nursing documentation to support the nurse's testimony that she advised the parents to seek immediate medical attention. The nurse's testimony stating that she did not complete an assessment due to short-staffing further complicated the defense.

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The National Association of School Nurse's (NASN) Framework for 21st Century School Nursing Practice™

Care Coordination

- Provide direct care for emergent, episodic, and chronic mental and physical health needs.
- Connect student and family to available resources.
- Collaborate with families, school community, mental health team (including school counselors, social workers, and psychologists), and medical home.
- Develop and implement plans of care.
- Foster developmentally appropriate independence and self-advocacy.
- Provide evidence-based health counseling.
- Facilitate continuity of care with family during transitions.

Leadership

- Direct health services in school, district, or state.
- Interpret school health information and educate students, families, school staff, and policymakers.
- Advocate for district or state policies, procedures, programs, and services that promote health, reduce risk, improve equitable access, and support culturally appropriate care.
- Engage in and influence decision-making within education and health systems.
- Participate in development and coordinate implementation of school emergency or disaster plans.
- Champion health and academic equity.
- Share expertise through mentorship/ preceptorship.
- Practice and model self-care.

Quality Improvement

- Participate in data collection for local, state, and national standardized data sets and initiatives.
- Transform practice and make decisions using data, technology, and standardized documentation.
- Use data to identify individual and population level student needs, monitor student health and academic outcomes, and communicate outcomes.
- Engage in ongoing evaluation, performance appraisal, goal setting, and learning to professionalize practice.
- Identify questions in practice that may be resolved through research and evidence-based practice processes.

Community/Public Health

- Provide culturally sensitive, inclusive, holistic care.
- Conduct health screenings, surveillance, outreach, and immunization compliance activities.
- Collaborate with community partners to develop and implement plans that address the needs of school communities and diverse student populations.
- Teach health promotion, health literacy, and disease prevention.
- Provide health expertise in key roles in school, work, and community committees/ councils/coalitions.
- Assess school and community for social and environmental determinants of health.

Standards of Practice

- Ensure practice consistent with the scope and standards of school nursing practice, health and education laws (consider the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, Nurse Practice Act, state laws regarding school nursing practice and delegation), federal/state/local policies and regulations, and NASN position statements and code of ethics.
- Employ clinical judgment and critical thinking outlined in nursing process and prioritization.
- Integrate evidence and best/promising practices (consider multi-tiered systems of support, clinical practice guidelines).
- Safeguard privacy of students and data (consider Health Insurance Portability & Accountability Act, Family Educational Rights and Privacy Act).

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Source: National Association of School Nurses. (2024). A contemporary Framework update for today's school nursing landscape: Introducing the School Nursing Practice FrameworkTM. NASN School Nurse, 0(0). doi:10.1177/1942602X241241092

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Risk Control Recommendations

- ***Know and comply with your state nursing practice act***, the National Association of School Nurses (NASN) position statements and school district policies and procedures.
- ***Conduct comprehensive, accurate and timely assessments and physical examinations*** of students prior to making conclusions about the etiology of pain and re-assess and monitor students who are awaiting parent pick-up and further clinical evaluation.
- ***Follow documentation standards established by professional nursing organizations such as the NASN and document all discussions with students/parents, and actions taken, including any treatment recommendations provided.*** Objective and concise documentation is essential for both continuity of care, as well as for the defense of a potential malpractice claim.
- ***Maintain competencies*** consistent with the needs of students and comply with evidence-based clinical practice guidelines, such as those promulgated by the NASN.

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Nurse Liability & Claim Metrics

Professional Liability Data as a Risk Management Resource

Analyzing incidents that led to adverse outcomes is the foundation for identifying vulnerabilities in our healthcare systems and reducing risk.

Understanding the underlying human and systemic factors that can lead to patient harm helps nurses prevent errors through education, training, and practice improvement approaches.

Professional liability data:

- Provides insight into the underlying causes in cases: what failed and why?
- Can reveal specific missteps, clinical errors, patterns of communication, and judgment failures that contribute to adverse events.
- Helps nurses learn from peers' experiences and proactively identify areas for improvement.

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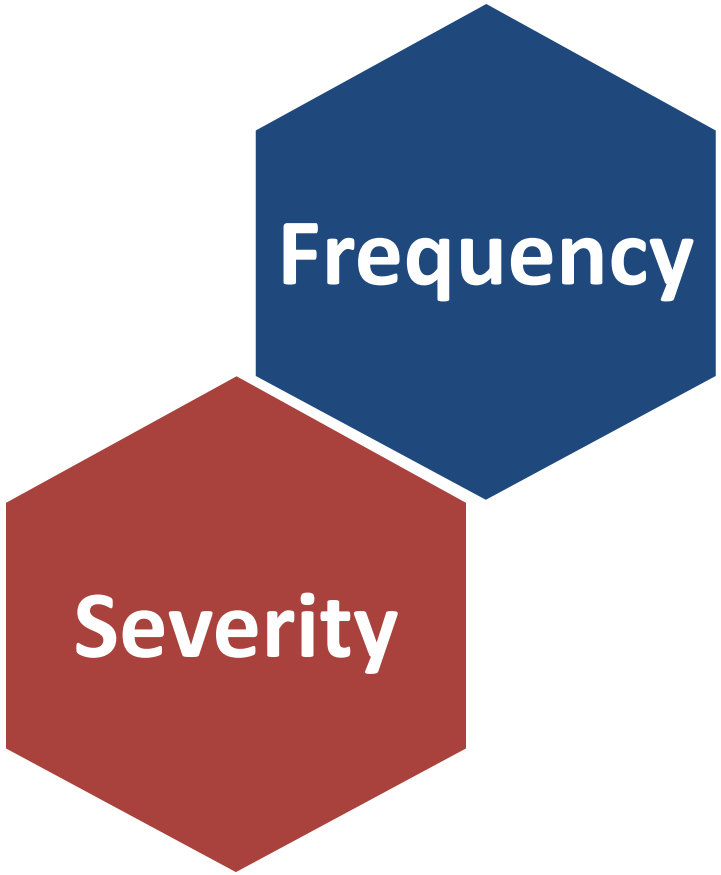
Losses are Measured by…



Frequency/Distribution: The percentage of closed claims with a common attribute, such as a specific allegation of injury.

Severity: The average paid indemnity to the injured third party for those claims which closed during the analyzed timeframe.

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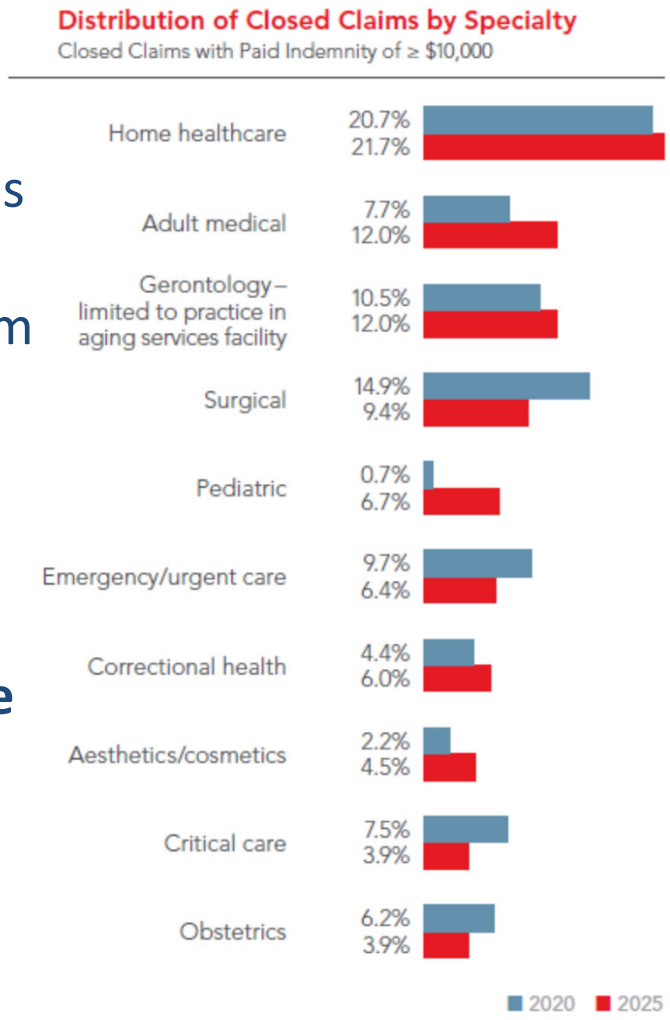
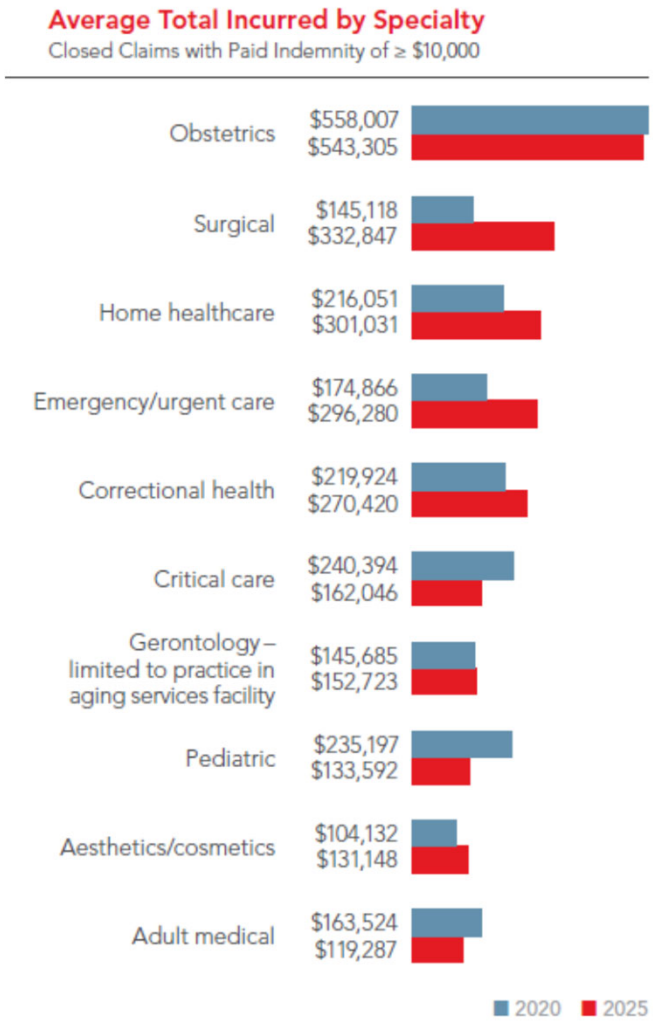
Nurse Specialty

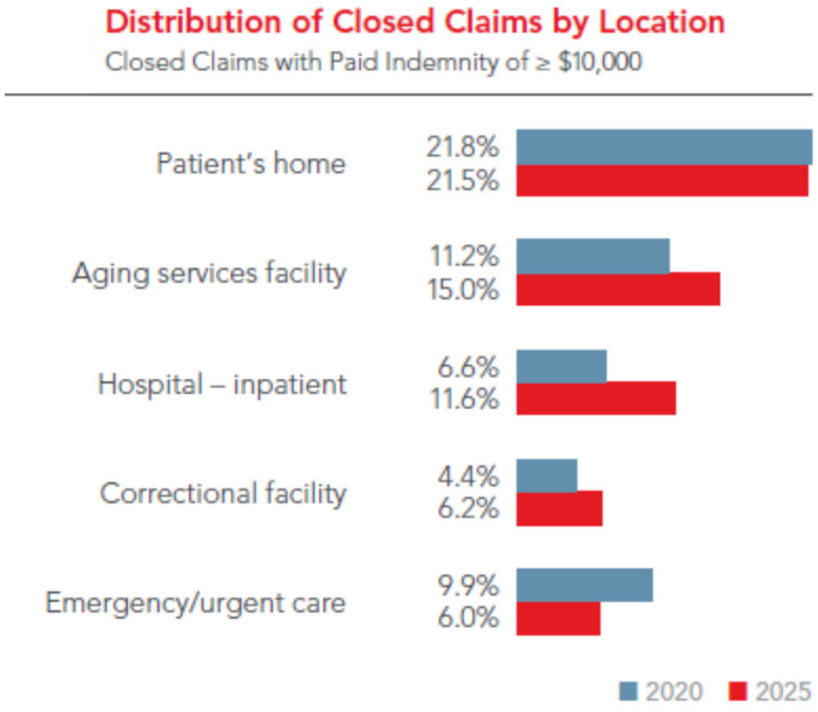
- The claims involving **home healthcare** remained as the largest proportion of claims, increasing slightly from **20.7%** to **21.7%** of the total distribution.
- Closed claims in **aesthetics** has **doubled** as compared to the 2020 dataset and **average total incurred** has also **increased** by **25.9%** from $104,132 to $131,148.

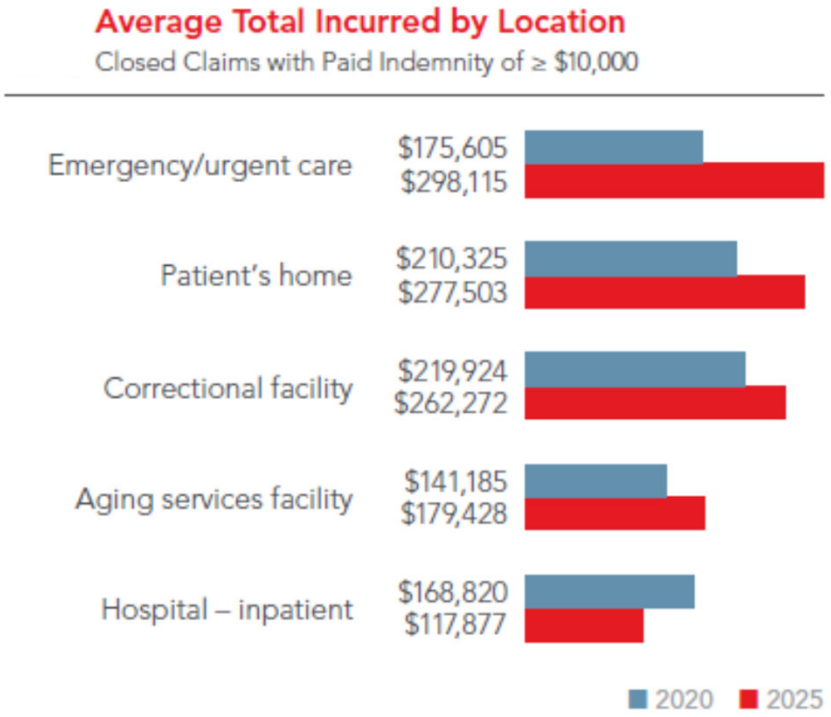




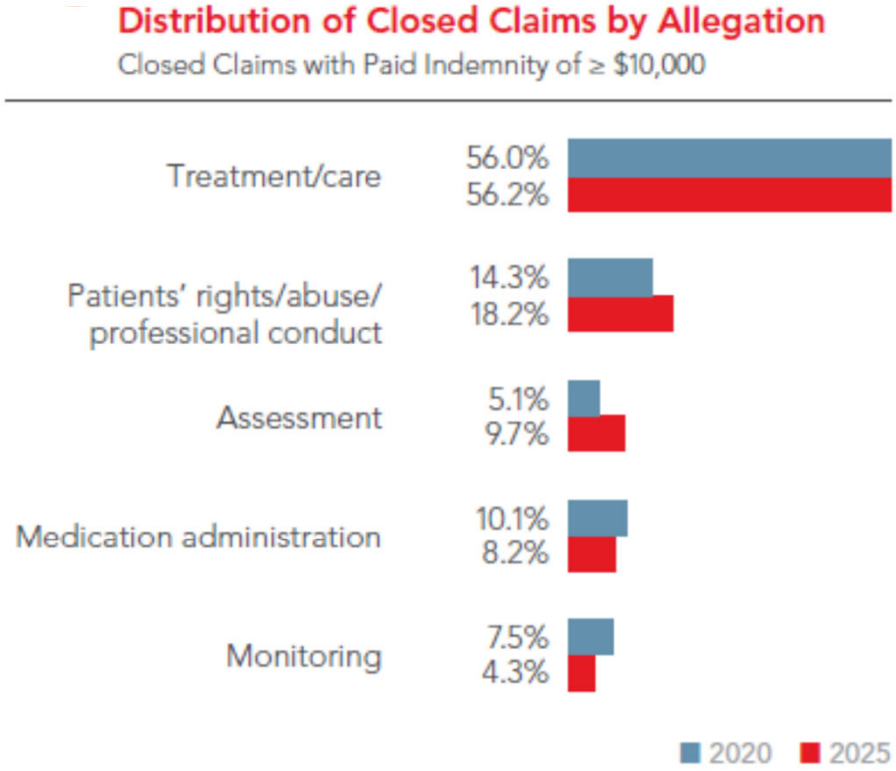
Nurse Location

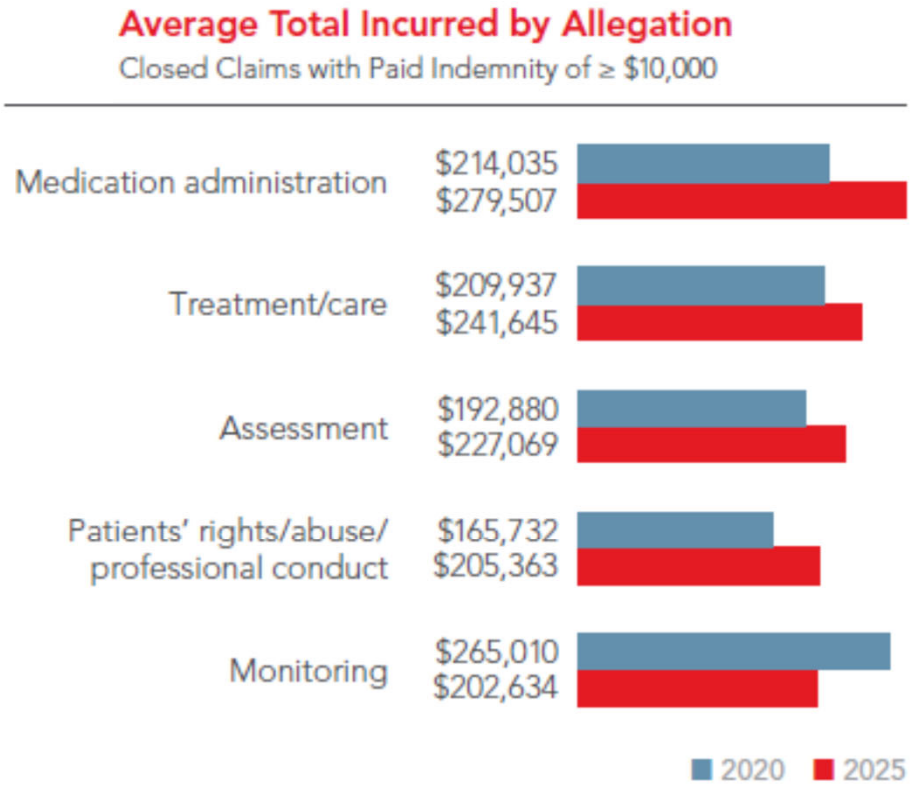
- **Patient's home** persist as the leading category.
- **Aging services** represented the second most frequent location.
- **Correctional facilities**, increased in distribution from 4.4% to 6.2 % and the average total incurred increased by 19.3%.





Top Malpractice Allegation Categories





Claims Criteria – School Nurses

- Professional Liability claims with at least $1 in paid indemnity
- Closed between 2014 and 2024
- Average Total Incurred: **$281,614**
- Average Time to Close: **2.6 years**

School Nurses – Top Allegations & Injuries

Common Allegations

- Treatment & Care: Improper Emergency Treatment
- Failure to Follow School Policy & Procedure
- Failure to Monitor
- Patient's Rights: Physical & Sexual Abuse

Common Injuries

- Death
- Emotional Injury
- Abuse
- Burn

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License Protection

What's the Difference?

- State Board of Nursing Mission
  - ➢To protect the ***Public***
- Powers and Duties
  - ➢Interpret and enforce nurse practice act
  - ➢Accredit and approve programs
  - ➢Develop nursing practice standards
  - ➢Develop policies, administrative rules and regulations
  - ➢Administer nurse licensure and discipline
- Anyone can file a complaint
  - ➢Employer, Co-worker, Patient, Parent, Friend, etc.

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SBON: The Disciplinary Process

- Investigation
  - ➢Report made against a license
  - ➢Investigator reviews case
- Gathers evidence
  - ➢Conducts interviews
  - ➢May not a medical professional at this stage
  - ➢Investigator provides report to prosecuting attorney
- Prosecution
  - ➢Informal conference
  - ➢Formal Hearing
- Outcome
  - ➢No Discipline…>>>>> Discipline

License Protection Matters: At a Glance

- The average payment per license defense matter has continued to increase.
- The rise of SBON defense payments can be attributed to the escalating costs of defense counsel, inflation, and the individual nature of each SBON disciplinary investigation, which can take years to resolve.
- Over the course of the three reports, the percentage of license protection matters with defense payments reflects the proportion of RNs and LPNs/LVNs within the overall CNA/NSO-insured nurse population.

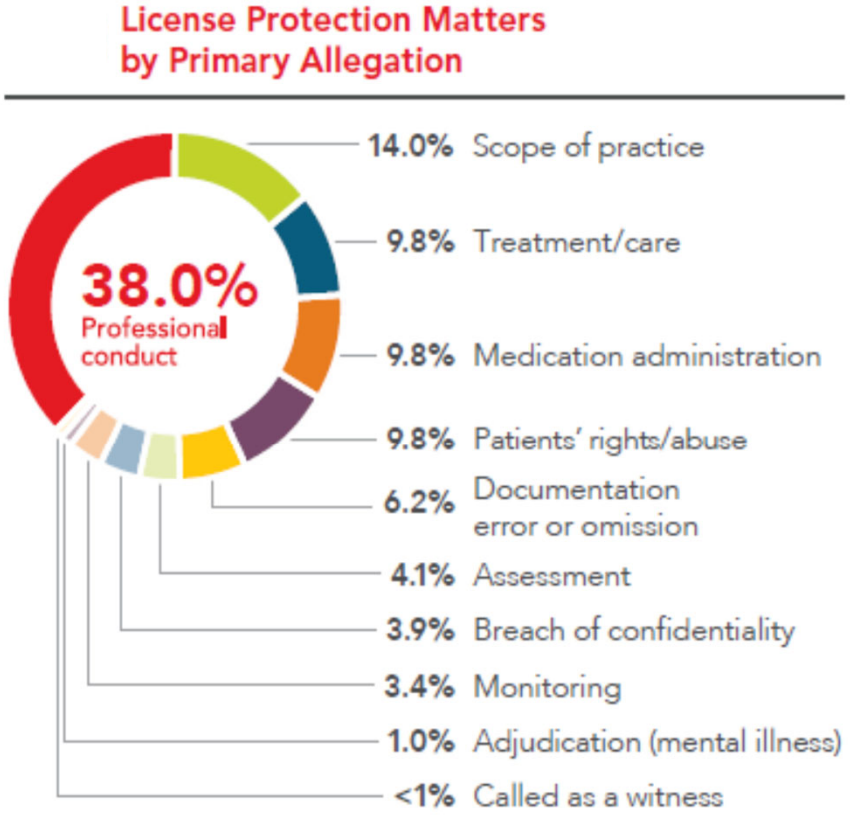
License Protection Matters
Data Comparison of 2015, 2020, and 2025 Reports

	2015	2020	2025
License protection paid matters	1301	1377	1125
Total paid	$5,188,984	$7,339,111	$7,091,612
Average payment	$3,988	$5,330	$6,304

License Protection Matters by Licensure Type
Data Comparison of 2015, 2020, and 2025 Reports

	RN			LPN/LVN		
	2015	2020	2025	2015	2020	2025
License protection paid matters	1127	1220	963	174	157	162
Percentage of license protection paid matters	86.6%	88.6%	85.6%	13.4%	11.4%	14.4%
Average payment	$4,041	$5,348	$6,309	$3,646	$5,186	$6,271

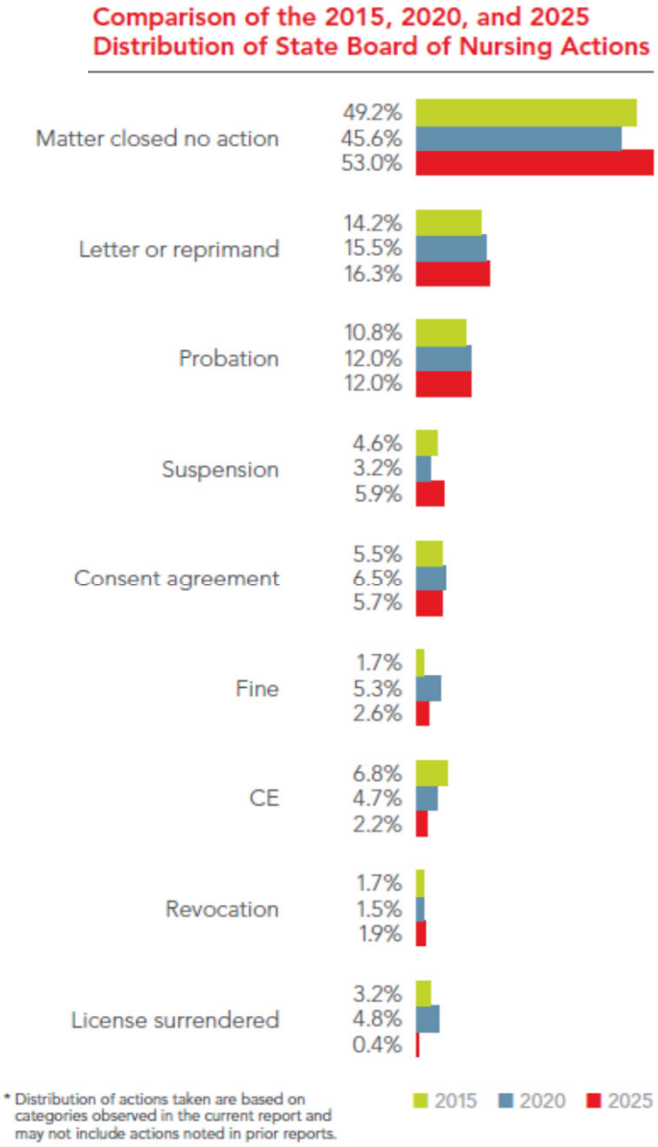
License Protection Matters: Allegations



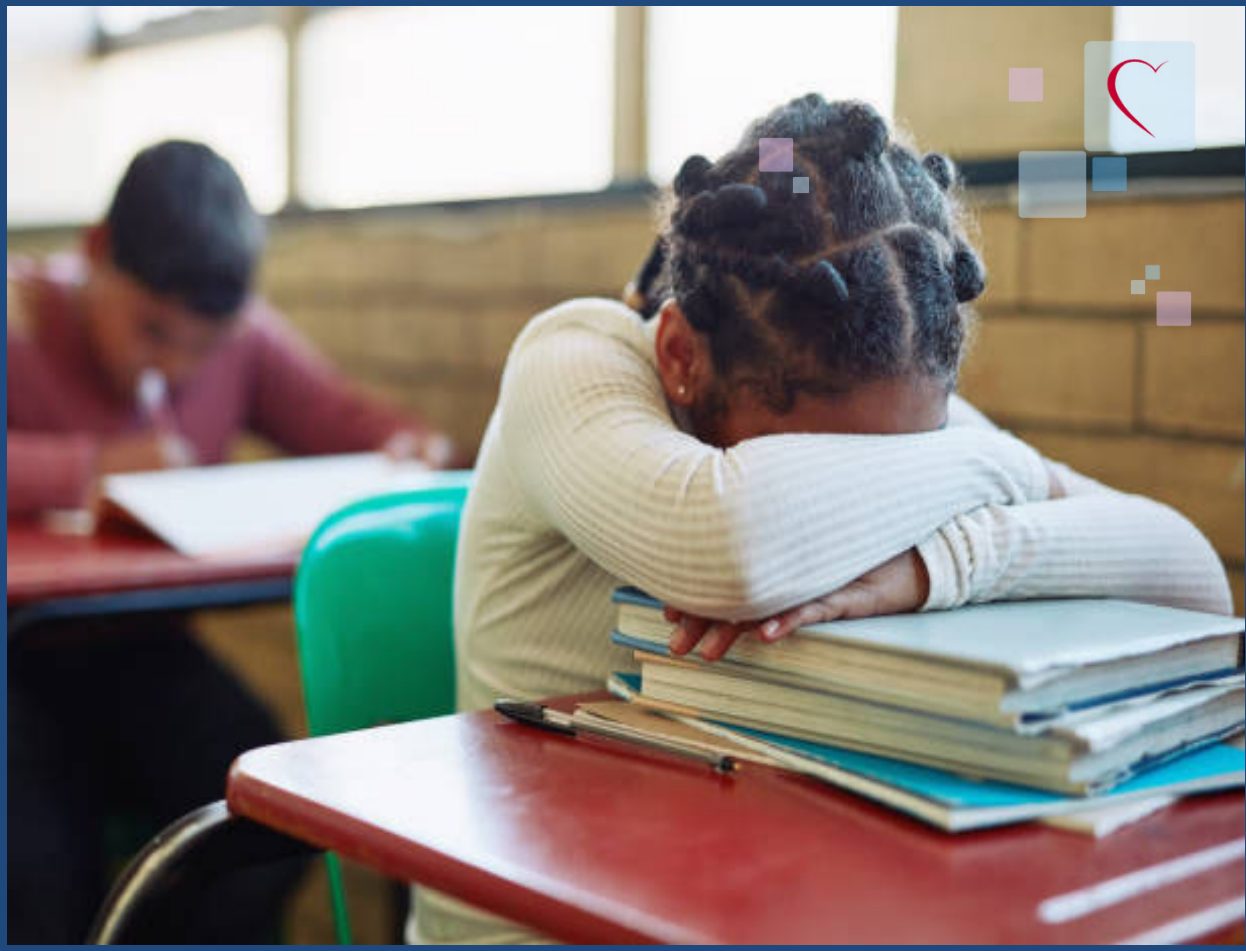
- **Professional conduct** complaints had the highest distribution of all license protection closed matters in the 2025 dataset, at **38.0%.**
- **Professional conduct** and **Scope of practice** allegations account for over half (**52%**) of all license protection.
- **The top three allegations within the Professional conduct** matters include:
  - **Drug diversion and/or Substance use**
  - **Professional misconduct as defined by the state**
  - **Criminal act or conduct**
- **Professional misconduct as defined by the state account** is a broad allegation category and includes **unprofessional behavior towards coworkers and/or patients**, as well as allegations of **posting on a social media site during work hours and in patient care area.**

Outcomes

- **53.0 %** of **Matters closed with no action** taken by the SBON.
- Distribution of SBON matters that resulted in mandated Continuing education (CE), Fines, Consent agreements, and License surrendered decreased in the 2025 dataset from the prior claim reports.
- Less serious outcome, such as Letters or reprimands, increased in 2025 (16.3%) as compared to the 2015 (14.2 %) and 2020 (15.5%) datasets.
- The overall distribution of outcomes involving Probation have remained relatively consistent with previous claim reports.



Case Study



Case Study

- This case involves a 14-year-old male student with a history of autism, obesity and developmental delays. The insured RN had been employed by the school for ten years and was familiar with the student.
- On the date of the incident, the morning bus driver noted that the student was limping as he boarded the bus. At 8:30 a. m., the student arrived at school and complained of severe lower right leg pain. A teaching assistant immediately escorted the student to the nurse's office.
- The RN conducted a physical exam which revealed a 4 cm X 4 cm reddened area on the student's right medial calf and a purple discoloration on the 4th toe of the right foot. The student was afebrile with normal pedal pulses. No swelling was observed at that time. These assessment findings were documented by the RN in the electronic health record.
- At 8:40 a.m., the RN attempted to reach the student's parents, as well as others on the emergency contact list, but was unable to reach anyone. Messages were left for all parties to call the school immediately.

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Case Study

- The RN believed that the student was stable and could return to the classroom while waiting to be picked up by a parent. At 9:40 a.m., the RN went to the classroom to check on the student but did not physically reexamine his leg. The student continued to complain of moderate to severe pain, for which Ibuprofen was administered.
- One hour later, at 10:40 a. m, the RN checked on the student, noting that he had received only minimal relief from the pain medication. At this time, the RN did not conduct a visual examination of the leg and did not instruct the student to self-monitor the leg and to notify the teacher if the condition worsened.
- Although the student communicated to his classmates sitting nearby that he was in severe pain and was reportedly tearful at times, he did not express any complaints to teachers or other staff members.
- At 11:00 a.m., the RN was called to cover a nearby school in the district for the lunch hour. Before leaving, he apprised the school's principal and the student's homeroom teacher that he needed to leave for an hour and asked them to monitor the student until he returned. Due to an emergency at the other school, the RN was delayed and did not return until 1:00 p.m.

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Case Study

- Upon his return, he noted that the student's parents were waiting in the nurse's office. The RN brought the student into the office and re-examined the leg in the presence of the parents. He noted a significant change in condition -- 3+ pitting edema and multiple areas of purple discoloration on the right foot and leg. The student remained afebrile and had positive pulses in the affected extremity.
- The RN advised the parents that the student required immediate medical attention and instructed them to take the student to the nearby emergency department or urgent care center. The parents stated that they would take the student to the pediatrician's office.
- The RN advised them again that it would be best to go to the emergency department, but that if they chose to go to the pediatrician, they must go there directly so that the student would be evaluated urgently. The RN did not document this discussion.

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Case Study

- At approximately 1:30 p.m., after leaving the school, the parents decided to stop for lunch on the way to the pediatrician's office.
- At 2:15pm, as they were getting back into the car in the restaurant parking lot, the student collapsed and became unresponsive.
- Resuscitation efforts were instituted immediately by the student's father and the student was transported to the hospital via ambulance, where he expired at 6:10 p.m.
- Based upon physical examination and laboratory studies performed at the hospital, the cause of death was determined to be sepsis due to necrotizing fasciitis - - although an autopsy was not performed.

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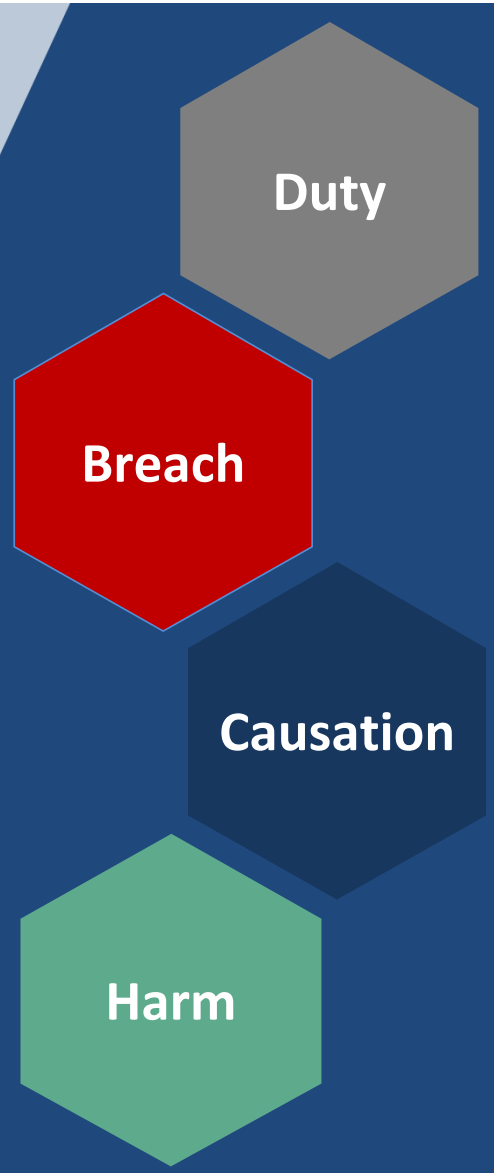
Do you think the nurse was negligent?

Do you believe that the nurse was negligent? Were any other parties negligent?

Do you believe that an indemnity payment was made on behalf of the nurse?

If yes, how much?



Risk Management Comments

- Approximately six months later, a lawsuit was filed by the parents (plaintiffs) asserting that the RN failed to recognize an emergent medical condition and that an immediate transfer to the hospital would have prevented the student's death.
- In their depositions, the plaintiffs testified that they were not advised of the symptoms of necrotizing fasciitis requiring urgent care and were not advised that immediate medical attention should be sought.
- Plaintiffs' experts in infectious disease opined that the RN should have arranged for an immediate transfer to the hospital, preferably when he realized that the parents were unavailable. At the very latest, transfer should have been arranged at 1:00 p.m. when he noted that the student's condition significantly deteriorated.
- Plaintiffs' experts further asserted that the RN should have monitored the student's condition more closely between 8:30 a.m. and 1:00 p.m., including visual assessments of the leg.
- They also contended that he should not have left campus to cover another school, as there was no qualified medical provider in the building to monitor the student. Although the plaintiffs' experts admitted that diagnosing medical conditions is not within the scope of practice of a registered nurse, they testified that the RN's failure to appreciate the potential risks related to the student's symptoms represented a departure from the standard of care.

Risk Management Comments

- Defense experts argued that between 8:30 a.m. and 1:00 p.m., the student's symptoms did not constitute a medical emergency.
- Moreover, when his condition changed, the RN adamantly advised the parents to seek emergent care.
- The plaintiffs' attorney countered that the parents did not have an understanding of the potential clinical risks due to limited health literacy and that they were not informed of the risks associated with the student's symptoms.
- The lack of nursing documentation regarding the instructions given to the parents created a significant challenge to the defense of this case. In retrospect, the RN admitted that it would have been a better course of action to call 911 when the student's condition deteriorated and to document an informed refusal if the parents then insisted on going to the pediatrician's office.

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Resolution

Based upon the defense challenges and diminished potential for a successful defense verdict, coupled with the sympathy factor associated with the death of a young patient, a settlement was negotiated in mediation on behalf of the insured RN.

Total Incurred: More than $450,000

Figures represent only the payments made on behalf of our registered nurse and do not include any payments that may have been made by the registered nurse's employer on her behalf or payments from any co-defendants.
Amounts paid on behalf of the multiple co-defendants named in the case are not available.

More About the Resolution

- This case had the potential for a high jury verdict, due to the decedent's age and the sympathy factor potentially influencing a jury's decision. Integral to the resolution plan of the defense team was the evaluation of the witnesses' credibility and the likelihood that the jury would believe the plaintiffs' testimony.
- The parents' deposition testimony was compelling and sympathetic, and the defense opined that a jury may believe that the parents were not properly informed of the need for emergent medical care.
- Jurors' opinions regarding whether the standard of care was fulfilled is based upon many factors, including the credibility of the witnesses and the experts' deposition testimony, as well as the documentation in the electronic health record.
- In this case, the nurse's documentation omitted details to support his testimony that he advised the parents of the risks of failing to seek immediate medical attention.

Risk Control Recommendations

- ***Document*** ***all discussions with students/parents, and actions taken, including any treatment recommendations that were provided.*** Objective and concise documentation is essential for both continuity of care, as well as for the defense of a potential malpractice claim. A comprehensive electronic health record is critical to any legal defense.
- ***Conduct comprehensive examinations and re-assessments*** of students who are awaiting parent pick-up and further clinical evaluation.
- ***Educate the patient, parent and/or responsible party about the need for compliance with treatment recommendations***, medication regimens and screening procedures.

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Risk Control Recommendations

- ***Assess the student's/family's health literacy level to ensure an adequate understanding of their role in the treatment plan.*** Consider using the "teach-back" method for communicating instructions about the treatment plan, using open-ended questions to prompt the student/parent to repeat critical information in their own words, thereby verifying their understanding.
- ***Engage in continuing education to maintain nursing assessment skills*** and up-to-date knowledge about potential clinical emergencies affecting the student population that is being served.
- ***Be prepared for student emergencies and align nursing practice with the NASN Emergency Preparedness Position Statement***, "To optimize student health, NASN advocates for a school nurse to be present in school all day, every day, and this presence is especially beneficial in planning for and responding to emergency situations."
- ***Ensure proper access to school nursing care*** in alignment with the **National Association of School Nurses (NASN) Professional Practice Documents.**
- ***Develop and implement policies and procedures to ensure student safety*** and provide for appropriate nursing coverage in the event that staffing limitations arise.

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Key Take Aways

Risk Management Recommendations for Everyday Practice: Representation

- Don’t wait, contact your insurer immediately if your policy provides coverage.
- Seek legal representation: your nursing license may be at stake.
- A claim professional and/or attorney will assist in complying with the board’s request(s).
- Never submit to a board investigator interview before meeting with your attorney and have your attorney present for the interview.
- Except for patient records, never submit anything to the licensing board, or to a board investigator or other investigative body without attorney consultation.

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Nurse Professional Liability Exposure Claim Report: 5th Edition

Visit nso.com/NurseClaimReport to download your free copy of the report and additional risk control resources.

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Questions?

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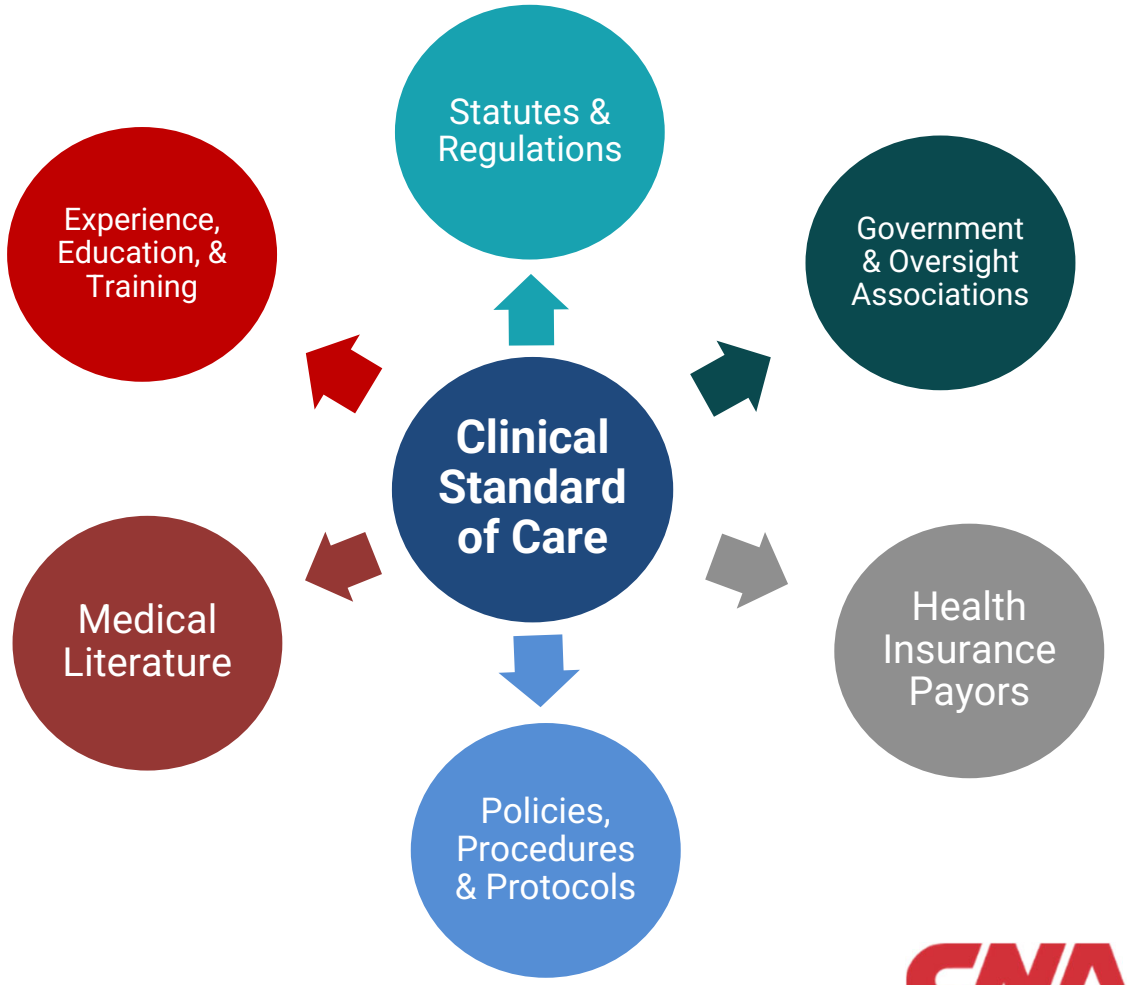
Defining Clinical Standard of Care

- The standard of care is a legal term, not a medical term. Basically, it refers to the degree of care a prudent and reasonable person would exercise under the circumstances.
- State legislatures, administrative agencies, and courts define the legal degree of care required, so the exact legal standard varies by state.



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