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Occupational Therapy
Claim Report

A Guide to Identifying and Addressing Professional Liability Exposures

INTRODUCTION . . . 4
Purpose . . . 4
Dataset and Methodology . . . 4
Definitions . . . 5

DATA ANALYSIS AND INCIDENT SCENARIOS . . . 6
Overview of Closed Claims . . . 6
Analysis of Closed Claims by Type of Insured and Coverage . . . 7
Analysis of Severity by Location . . . 8
Analysis of Severity by Patient Age . . . 9
Case Scenario: Improper Performance Using a Biophysical Agent . . . 9
Analysis of Severity by Allegation . . . 10
Allegations by Category . . . 10
Case Scenario: Improper Performance Using Therapeutic Exercise and Improper Behavior by a Practitioner . . . 13
Analysis of Severity by Injury . . . 14
Analysis of Occupational Therapy Practice Closed Claims . . . 15
Case Scenario: Successful Defense of an Occupational Therapist . . . 16

LOOKING FORWARD . . . 17
Information Technology (IT) . . . 17
Social Media and Internet Usage . . . 17
Fee-for-service Payment Regulations . . . 18
Student Oversight . . . 18
Independent Contractor Status . . . 19
New Technology . . . 19

RISK CONTROL RECOMMENDATIONS . . . 20

RISK CONTROL SELF-ASSESSMENT CHECKLIST . . . 25

PRACTICE AND CLAIM RESPONSE TIPS . . . 30

Introduction

CNA and Healthcare Providers Service Organization (HPSO) are among the nation's leading providers of professional liability insurance for occupational therapy practitioners, with more than 22,000 policies in force. Our insureds deliver services in an increasingly broad array of settings, including hospitals, clinics, outpatient and ambulatory centers, aging services and rehabilitation facilities, patients' homes, practitioner offices, schools, workplaces, spas and fitness centers. We are committed to helping these professionals protect themselves against loss not only by offering specialized insurance coverage, but also by enhancing their risk awareness.

As part of our ongoing educational effort, we are pleased to present this examination and discussion of current and emerging liability exposures confronting occupational therapy providers. This 10-year report, the first of its kind issued by CNA, focuses on CNA occupational therapy professional liability claims that closed between January 1, 2006 and December 31, 2015.

Purpose

This resource features analysis of closed malpractice claim data, incident scenarios and risk control recommendations addressing major areas of vulnerability for occupational therapy professionals. Our goal is to provide useful information and practical suggestions that, if integrated into daily practice, can help prevent incidents, increase patient satisfaction, and reduce exposure to complaints, lawsuits and licensure/certification actions. A self-assessment checklist is included to aid occupational therapists in reviewing their patient safety and risk control protocols.

Dataset and Methodology

Between 2006 and 2015, there were 289 professional liability closed claims and incidents attributed to CNA-insured occupational therapy professionals in the HPSO program. Professional liability claims were included in the final dataset only if they…

- Involved individually insured licensed occupational therapists (OTs), occupational therapy assistants (OTAs), certified occupational therapy assistants (COTAs), or occupational therapy aides or students, whether self-employed or employed by a CNA-insured occupational therapy practice.
- Closed between January 1, 2006 and December 31, 2015.
- Resulted in an expense and/or indemnity payment equal to or greater than one dollar.

These criteria generated a dataset of 72 closed claims.

This report examines the severity of occupational therapy closed claims, focusing on such claim characteristics as incident location, patient age, allegation and injury. It also categorizes claims by practitioner and coverage type (i.e., individually insured versus practice policy).

The listed indemnity payments or expenses were paid by CNA on behalf of an insured and do not include any additional payments by employers, other insurance companies or other parties. This analysis reflects CNA data only and is not necessarily representative of all closed claims for OTs and/or occupational therapy practices.

It may take several years to resolve a professional liability claim. Therefore, claims included in this report may have resulted from events that occurred prior to 2006, although in every case the claim closed between January 1, 2006 and December 31, 2015.

Please note that the methodology used in this report differs from claim reports issued by other organizations. For this reason, its findings should not be compared with other studies.

Definitions

For purposes of this publication, please refer to the definitions below:

- **Aging services** – Specialized facilities or organizations that provide healthcare primarily to a senior population, including nursing homes, assisted living centers and independent living facilities. (Also known as *long term care*.)
- **Allegation** – An assertion, not yet proven, that the professional or organization has done something wrong or illegal.
- **Expense payment** – Monies paid in the investigation, management and/or defense of a claim.
- **Indemnity payment** – Monies paid by CNA to a plaintiff on behalf of an insured in the settlement, arbitration or judgment of a claim.
- **Patient** – Any person receiving treatment or professional services from an insured occupational therapy professional and/or occupational therapy practice.
- **Vicarious liability** – A legal principle that assigns responsibility not solely to the individual whose negligent act or omission caused an injury (such as an occupational therapist or occupational therapy assistant, student or aide), but also to that person's employer or supervisor if the act or omission occurred during the course and scope employment or supervision.

The report's dataset consists of **72** closed claims.

Data Analysis and Incident Scenarios

Overview of Closed Claims

Figure 1 reflects the total costs (i.e., indemnity and/or expense, as noted in the column headings) for professional liability claims with indemnity payment, professional liability claims with expense only, deposition and record requests, and license protection claims. These closed claims are categorized by the type of responsive coverage.

As illustrated in Figure 1, the most severe (i.e., most costly) actions are professional liability claims with indemnity payments, incurring $2.44 million in total cost. As previously noted, professional liability claims typically resolve over a period of several years. For the purposes of this report, all indemnity and expense amounts are attributed to the year the claim closed.

Seventeen percent of the closed professional liability claims included in the dataset incurred expenses (including attorney, investigation and expert witness fees, plus related administrative costs), but closed without indemnity payment. These expense-only claims total $212,885. There are many reasons why a claim may incur expenses without an indemnity payment, including the following scenarios:

- The claim was successfully defended on behalf of the insured.
- The claim was abandoned by the complainant and/or the statute of limitations period passed without legal activity.
- The court determined that the insured should be removed or dismissed from the lawsuit.
- The adverse event was investigated and a claim file opened, but the insured was not named in the lawsuit and the claim was closed.
- A third party, such as an employer or employer's insurance carrier, made an indemnity payment on behalf of the insured.

1 Closed Claims by Type of Legal Action

Coverage category	Percentage of closed claims	Total paid indemnity	Total paid expense	Total incurred
Professional liability with indemnity payment	44%	$1,988,439	$451,808	$2,440,247
Professional liability expense only	17%	-	$212,885	$212,885
Deposition and record request	14%	-	$12,562	$12,562
License protection	25%	-	$51,935	$51,935
Overall	100%	$1,988,439	$729,190	$2,717,629

Analysis of Closed Claims by Type of Insured and Coverage

- Figure 2 provides an overview of claim results by type of insured and policy – i.e., individually insured versus practice-insured OTs, OTAs, COTAs and other related healthcare providers.
- Individually insured OTs have the highest average paid indemnity, due to several claims that closed with an indemnity payment of $150,000 or more. High-severity allegations asserted against individually insured OTs include failure to provide a safe environment and improper performance using a physical agent, as in the following example:
  - An OT used a hot pack on a patient. The hot pack caused a burn, which in turn led to an infection and the amputation of the tip of the small finger. This closed claim is discussed in detail on page 9.
- Individually insured OTAs have the highest average paid expense. Allegations against individually insured OTAs include failure to follow organizational polices and inappropriate behavior, as described below:
  - An OTA's former employer filed a claim alleging that she had made fraudulent statements regarding treatment and billing of patients, and had given patients improper medical advice. While the OTA's legal defense was ultimately successful, the case lasted more than five years and produced legal expenses exceeding $120,000.

2 Claims by Practitioner and Insurance Type

Chart reflects closed claims with paid expense and/or indemnity ≥ one dollar.

Insurance type	Percentage of closed claims	Total paid indemnity	Average paid indemnity	Average paid expense
Individually insured occupational therapist (OT)	61%	$1,386,897	$49,532	$9,770
Occupational therapy practice (encompassing OTs, occupational therapy assistants [OTAs], certified occupational therapy assistants [COTAs] and other professional designations)	29%	$395,292	$35,936	$9,511
Individually insured OTA or COTA	10%	$206,250	$41,250	$57,302
Overall	100%	$1,988,439	$45,192	$15,107

61% of the claims involve individually insured OTs.

Analysis of Severity by Location

- While occupational therapy professionals work in many locations, four settings account for most of the closed claims in the analysis: physical therapy office/clinic (27 percent), occupational therapy office/clinic (25 percent), patient home (18 percent) and aging services facility (14 percent).
- The costliest claim involves a graduate student intern observing pediatric occupational therapy patients in a hospital outpatient facility. The intern decided to observe a children's karate class being conducted by an insured OT, who was acting as an independent contractor for the children's hospital. During the class, a hospital volunteer picked up a balance beam that the OT had been using and placed it vertically against a wall. Shortly thereafter, it fell and struck the intern in the head. The intern suffered a concussion and closed head injury, causing long-term neurological deficits. The intern sued the OT for failure to provide a safe environment. The claim was settled in the six-figure range.
- Other aging services-related closed claims include allegations of OTs failing to follow organizational policies and functioning outside the acceptable scope of practice.
- The two claims that occurred in an acute medical/surgical inpatient hospital setting closed with no indemnity payment.

3 Analysis of Severity by Location

Chart reflects closed claims with paid expense and/or indemnity ≥ one dollar.

Location	Percentage of closed claims	Total paid indemnity	Average paid indemnity	Average paid expense
Acute medical/surgical hospital inpatient	5%	$0	$0	$6,580
Aging services facility	14%	$413,750	$68,985	$31,557
Physical therapy office/clinic (non-hospital)	27%	$114,669	$9,556	$18,631
Hospital outpatient	2%	$325,000	$325,000	$44,449
Occupational therapy office/clinic (non-hospital)	25%	$597,653	$54,332	$9,880
Patient home	18%	$299,417	$37,427	$6,874
School	9%	$237,950	$59,488	$7,627
Overall	100%	$1,988,439	$45,192	$15,107

Analysis of Severity by Patient Age

- The vast majority (75 percent) of patients asserting claims against insured occupational therapy professionals are adults.
- The average paid indemnity for adult claims is slightly higher than the overall average. This difference is due to the fact that many of the adult injuries required continued medical treatment, while the children's injuries tended to heal without residual effects.

4 Analysis of Severity by Patient Age

Chart reflects closed claims with paid expense and/or indemnity ≥ one dollar.

Severity of closed claims by patient age	Percentage of closed claims	Total paid indemnity	Average paid indemnity	Average paid expense
Child (0-17)	25%	$339,494	$30,863	$8,812
Adult (18 or older)	75%	$1,648,945	$49,368	$17,205
Overall	100%	$1,988,439	$45,192	$15,107

CASE SCENARIO: Improper Performance Using a Biophysical Agent

In a workplace accident, a 40-year-old welder sustained both arterial and tendon damage to his dominant hand and arm, requiring extensive surgical repairs. Three weeks after surgery, the patient appeared to be healing, but voiced concern that he had minimal feeling in the fourth and fifth fingers of his affected hand. The hand surgeon believed the loss of feeling was mostly due to the surgery and original injury, rather than arterial insufficiency, and informed the patient that it could take up to a year to fully recover feeling in his hand. He prescribed occupational therapy to treat ulnar nerve injury and increase mobility and strength in the affected hand.

The CNA-insured OT who provided treatment also owned the therapy facility. During the first therapy session, the insured used a hot pack on the patient's hand, leaving it on for approximately five minutes. Due to lack of sensation, the patient could not feel the hot pack burning his hand and fingers. When the OT inspected the patient's hand following treatment, she noticed a blister on the tip of his fifth finger. She immediately called the physician and scheduled an appointment for later that day.

The patient had suffered a third-degree burn to his fifth finger, which was further complicated by infections. Numerous medical interventions were attempted, but first the tip and ultimately the entire fifth finger had to be amputated. As a result of the burn and the amputation of the fifth finger, therapy could not continue on the fourth finger, which became permanently bent at a nearly 90-degree angle. Despite numerous surgeries, the patient did not regain full function in the fourth finger and could not return to his job.

The patient's employer argued that the permanent damage was not due to the original injury, and that the patient could have returned to work if he had not been burned during the OT treatment. The employer's decision not to pay for medical treatment to the fourth finger was supported by the state workers' compensation board, leaving the OT fully responsible for the patient's loss of employment, as well as related medical care. The claim was settled in the low six-figure range.

Analysis of Severity by Allegation

5 Severity of Allegations by Category

Chart reflects closed claims with paid expense and/or indemnity ≥ one dollar.

Allegation	Percentage of closed claims	Total paid indemnity	Average paid indemnity	Average paid expense
Equipment-related	9%	$110,153	$27,538	$5,121
Improper performance of manual therapy	5%	$35,450	$17,725	$2,316
Failure to supervise or monitor	16%	$130,400	$18,629	$3,205
Improper management over the course of treatment	16%	$440,000	$62,857	$16,706
Improper performance using therapeutic exercise	7%	$225,292	$75,087	$12,159
Environment of care	10%	$430,894	$86,179	$1,231
Improper behavior by practitioner	16%	$282,500	$40,357	$47,480
Improper performance using a biophysical agent	21%	$333,750	$37,083	$8,577
Overall	100%	$1,988,439	$45,192	$15,107

Allegations by Category

- **Environment of care closed claims** include equipment not mounted properly on the wall and cluttered treatment areas, resulting in patient falls. These closed claims have an average paid indemnity significantly higher than the dataset as a whole. Closed claims in this category occurred in occupational or physical therapy offices/clinics, hospital outpatient departments, schools and patients' homes. The following scenario exemplifies this type of claim:
  - *Failure to maintain a safe, uncluttered environment.* An OT was working with a pediatric patient who, when retrieving a toy from the treatment room, tripped over therapy equipment left on the floor and suffered a lateral malleolus fracture. The claim settled in the low four-figure range.
- **Improper behavior by a practitioner** comprises 16 percent of all closed claims. Closed claims in this allegation category include the following:
  - *Functioning outside the accepted scope of practice.* As part of her rehabilitation efforts, a patient was prescribed physical and occupational therapy. The patient requested that the OT assist her physical therapy exercises by having her stand at the sink. As the OT stood by her left side, the patient attempted to demonstrate her ability to reach into a kitchen cupboard. As she stretched, her knees buckled, causing her to fall straight down. The patient sustained an acute impacted displaced fracture of the proximal left tibial shaft and an acute fracture of the subcapital region of the proximal right fibula. The claim settled for greater than $145,000.

- *Failure to follow organizational policy.* An elderly patient who had recently undergone an above-the-knee amputation was recovering in a rehabilitation facility. The patient, who was documented in the care plan as requiring a two-person assist, asked the insured OTA take her to the restroom after therapy. While in the bathroom, the patient started to fall. The OTA attempted to catch her and lower her slowly to the floor. Immediately afterward, the patient appeared to be fine, but later complained that she may have twisted her ankle. The OTA helped the patient back into her wheelchair and called for her nurse, who assessed the patient and noticed swelling in her ankle area. An X-ray revealed that the patient had suffered a tibial and fibula fracture requiring surgery. The claim was settled for in the mid five-figure range.

- **Improper performance using therapeutic exercise** has an average paid indemnity nearly $27,000 greater than the overall average. This higher severity is driven by one claim, discussed in detail on page 13, involving an OT's failure to follow the referring practitioner's orders.
- **Improper management over the course of treatment** has an average paid indemnity nearly $20,000 greater than the overall average. This higher average paid indemnity is driven by two closed claims where the OT improperly managed a patient's course of treatment, resulting in the patient suffering a reinjury that necessitated surgical repair:
  - *Failure to report patient's condition to referring practitioner.* The patient presented to occupational therapy after undergoing extensor indicus proprius (EIP) to extensor pollicus longus (EPL) transfer surgery due to an extensive fracture of his dominant hand. The referring hand surgeon prescribed a "thumb spica splint with an extension," but did not specify static or dynamic spica splint. The OT made a dynamic spica, which she believed was appropriate for the tendon transfer surgery. The patient immediately went to see the referring hand surgeon, who approved the splint. The patient returned two days later, claiming the splint was not comfortable. Although she lacked a new order from the surgeon, the OT made him a new "courtesy" static spica splint, which was somewhat shorter so that the patient could semi-flex the distal interphalangeal joint. The OT did not write a chart note for the "courtesy" splint and did not bill for her services. A few days later, the patient followed up with the hand surgeon. The surgeon called the OT afterward and informed her that the second splint was too short, and the patient had re-ruptured the tendon. The patient was forced to undergo a second surgery to repair the tendon. The claim settled in the low six-figure range.
  - *Failure to follow practitioner orders.* A patient who had undergone an arthroscopic subacromial decompression with arthroscopic repair of her right rotator cuff was prescribed four weeks of therapy. One week into therapy, the OT had the patient perform straight-arm pull-down exercises using five-pound weights, even though the referring practitioner had ordered that no weights be used until the third week. On the second repetition, the patient heard a loud pop, followed by intense pain. The patient was sent directly to her referring practitioner, who noted that she had retorn her rotator cuff. The patient underwent two additional shoulder surgeries and was unable to return to full duty at work.

- **Improper performance using a biophysical agent** is the most frequent allegation, accounting for 21 percent of the OT closed claims. Following is an example of this type of allegation:
  - *Injury during electrotherapy.* A 35-year-old diabetic patient was prescribed infrared light therapy for diabetic neuropathy ankle and foot pain. On three occasions, the patient received infrared light therapy, but for the fourth treatment the OT utilized interferential current (IFC) therapy. The first treatment of IFC went well. After the second treatment, however, the patient suffered burns and tissue damage to the inside of both ankles. Due to her comorbidities, the patient had a complicated healing process and required multiple rounds of antibiotics and surgical debridement. There was no evidence that the OT had notified the referring practitioner of the change in therapy.
- **Equipment-related** closed claims typically reflect failure to properly test or use equipment, resulting in malfunction and patient injury. An example of such a claim is an exercise band breaking during therapy due to overuse and age, and striking the patient in the face.
- **Failure to supervise or monitor** refers to failure to oversee other care providers during patient care or to observe the patient during treatment. The majority of these closed claims involve failure to properly attend to patients using exercise equipment, resulting in a fracture or traumatic injury, as described in the following claim:
  - A pediatric patient with attention deficit hyperactivity disorder was prescribed occupational therapy to address sensory difficulties and learn coping techniques for use in school, home and other settings. The child attended a regular public kindergarten class and was allowed to play on a special swing, which had a calming effect on him. The therapist walked away for a moment, during which time the patient fell from the swing and fractured his arm in three places, requiring surgical repair. The claim was settled in the high five-figure range.
- **Improper performance of manual therapy** usually involves utilization of an improper technique during passive range of motion exercises. Such claims may be difficult to defend if the manual therapy technique is used incorrectly or overly aggressively, causing immediate patient injury, as in the following example:
  - *Injury during passive range of motion.* The OT, an independent contractor working within the public school system, was treating a pediatric patient with severe cerebral palsy who was recovering from a recent femur fracture. The OT was instructed by the referring orthopedic surgeon to perform passive range of motion exercises to gently increase the range of motion of the affected leg while decreasing pain, swelling and stiffness. Throughout the session, the patient cried constantly and seemed comfortable only when sitting in her wheelchair. Although the patient's position in the wheelchair was somewhat awkward, the OT decided to continue the therapy. As the session neared its end, the OT attempted to rotate the patient's leg when a loud pop was heard. The patient began to cry, and the OT noted an abnormality to the right thigh. The claim was settled in the low five-figure range.

CASE SCENARIO: Improper Performance Using Therapeutic Exercise and Improper Behavior by a Practitioner

A 9-year-old child born with cerebral palsy suffered from multiple orthopedic anomalies and a very serious scoliosis condition in his back. Eight months following right hip replacement surgery, the patient's pediatric orthopedic surgeon felt the patient was ready for physical therapy, to include practice standing in his mobile stander and general slow stretching of the hips, knees and ankles.

The insured OT was employed by an outpatient rehabilitation facility specializing in pediatric patients with motor skills disabilities. The OT was very familiar with the patient and his physical challenges, having treated him for the past five years. Due to the OT's good relationship with the patient, the family felt he should continue as the treating therapist, even though the referring practitioner's orders specified physical rather than occupational therapy.

The patient was scheduled for therapy three times a week for 12 weeks, with each session lasting approximately two hours. On the day of the incident, the child's grandmother left the child at the facility and went shopping, instructing the OT to call her when the session was over. During the therapy, the OT had the patient begin in a straight-leg sitting position and move to a crisscross sitting position. However, the child's right leg was not in position, and when the insured straightened it, a pop was heard. The child immediately began to cry inconsolably. The OT attempted to call the grandmother several times without success. He then called the mother, but she could not pick up the child because the grandmother had the child's special car seat. When the grandmother finally arrived at the facility, they decided that the child needed to be evaluated by a physician.

The child was taken by ambulance to the emergency department, where he was found to have a right spiral femur fracture. The fracture required surgical repair with hardware that will need to be removed as the child grows.

Several OT experts were asked to review the claim. Despite agreeing that placing the patient in a crisscross position was not contrary to the surgeon's orders, most felt that the insured may have been too forceful with the right leg. The experts were critical of the insured serving as the treating therapist, as the orders were written for physical and not occupational therapy. Therefore, in treating the child, the OT was providing legally unauthorized care.

The treating surgeon testified that the child's femur fracture would fully heal and that the child should suffer no long-term effects from the fracture. The claim was settled in the low six-figure range.

Analysis of Severity by Injury

- Traumatic brain injury has the highest average paid indemnity. However, this figure reflects exactly one claim, which is discussed on page 8.
- Fractures are the most common injury.
  - Many fractures are due to occupational therapy professionals acting outside their scope of practice or failing to follow organizational policies.
- Burns, which are the second most common injury, are primarily associated with allegations of improper performance using a biophysical agent.
  - Many burns involve patients who were left unattended or who had neurological deficits that prevented them from feeling pain or discomfort. Such a scenario is detailed on page 9.
- Claims in which an occupational therapy professional bypasses organizational policies or exceeds authorized scope of practice are difficult to defend, especially when the patient's injury is due directly to the provider's inappropriate actions.

6 Severity by Injury

Chart reflects closed claims with paid expense and/or indemnity ≥ one dollar.

Injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity	Average paid expense
Death	7%	$131,250	$43,750	$6,517
Traumatic brain injury	2%	$325,000	$325,000	$44,449
Amputation	2%	$250,000	$250,000	$0
Fractures	46%	$930,160	$46,508	$13,802
Emotion/psychological harm	7%	$0	$0	$51,294
Burns	18%	$83,750	$10,469	$9,649
Muscle/ligament damage	7%	$263,125	$87,708	$29,491
Peripheral vascular ulcer/wound	2%	$0	$0	$4,476
Bruise/contusion	9%	$5,154	$1,288	$156
Overall	100%	$1,988,439	$45,192	$15,107

Analysis of Occupational Therapy Practice Closed Claims

Occupational therapy practices have many of the same exposures as individually insured OTs and OTAs, except that claims may involve vicarious liability for injuries caused by the practice's employees or contractors. Analysis of occupational therapy practice claims reveals the following patterns:

- As noted in Figure 2, 25 percent of the claims in the dataset involve an occupational therapy practice. Of these practice claims, 73 percent occurred in a physical therapy office/clinic.
- Closed claims in locations other than an occupational and/or physical therapy office/clinic generally involve occupational therapy professionals working as contract employees. One example of such a claim involves an OT contracted to provide services at a long-term rehabilitation facility, assisting with wound debridement and exercise modalities. Another involves an OT contracted to work at a school for children with intellectual and developmental disabilities, helping them build muscle control.
- While occupational therapy practices have a different pattern of claims than do individually insured occupational therapy professionals, both groups are vulnerable to allegations of improper performance using a biophysical agent and failure to supervise or monitor.

73% of the occupational therapy practice **claims occurred** in a **physical therapy office/clinic.**

CASE SCENARIO: Successful Defense of an Occupational Therapist

A 35-year-old patient was injured in an on-the-job accident when an object struck his left (non-dominant) hand. The force of the blow severed his flexor tendon and median nerve, requiring surgical reattachment. Following surgery, the patient began occupational therapy with a CNA-insured OT. During the evaluation, the patient complained of minimal feeling in his hand, perhaps due to the injury and surgery. A treatment plan was established, which included heat therapy, massage, a splint for the affected hand and three-day-a-week therapy for six months.

During the third week of therapy, the OT placed a hot pack on the patient's affected hand and left the room. After 10 minutes, the insured returned to the treatment room and removed the hot pack. Noticing that the tip of the patient's left third finger was red, she placed a cold compress on the finger. According to the insured, the patient did not complain of pain at the time and refused any additional treatment. During the therapy session, the OT witnessed the patient picking at the burn with a paper clip, which he continued to do despite her pleas for him to leave the burn alone. At the end of the session, the OT told the patient how to take care of the burn and directed him to seek medical treatment if it showed any signs of infection. These instructions, as well as the incident itself and her related observations, were documented in the patient's healthcare record.

After the patient's therapy appointment, the OT contacted the referring surgeon to notify him of the burn. The surgeon stated that he was satisfied with the burn care instructions provided to the patient and that he wished to assess the burn himself. He also requested that the patient temporarily stop therapy until he could be evaluated. The OT conveyed this information to the patient and reiterated the need to keep the area covered, clean and dry.

Over the next two weeks, the surgeon's office made several attempts to contact the patient. The patient finally made an appointment and was seen by the surgeon, who noted that his third finger was swollen, warm to the touch and streaked with red. The surgeon's nurse cleaned the burned area and bandaged the finger. The patient was given a prescription for an oral antibiotic and instructed to keep the dressings on the finger for the next 24 hours. The surgeon instructed the patient to continue with occupational therapy and to keep the finger clean and dry.

The patient returned to therapy the following day. When the OT removed the bandages per the surgeon's order, she documented that the finger was red and swollen. Over the next few days, she noted that while the finger had appeared to heal, necrotic skin had developed at the site of the original burn. She then asked the surgeon to reexamine the finger.

The surgeon agreed that necrotic skin was present at the site of the burn but noted that the patient would suffer only when the dead skin sloughed off. The necrotic skin fell off eight weeks later, as documented by both the OT and surgeon. The patient never complained of pain at the burned area but did state that his entire hand felt numb after the injury and surgery.

The patient underwent a subsequent surgery on his left hand, but it was not related to the burn and the burn did not appear to interfere with the procedure. The patient's occupational therapy continued after the second surgery without complications. The patient was always complimentary of the OT and never mentioned the burn, so when she received a letter from the patient's attorney stating his intention to file a lawsuit, it came as a surprise.

The insured's documentation was very thorough and supported her deposition testimony. The surgeon praised the OT's treatment of the burn and related documentation. He testified that the patient did suffer a mild burn, but that in his opinion the patient contributed to the infection and necrosis by picking at the burn and delaying any medical treatment for two weeks.

Several OT experts reviewed the claim and found that the OT had properly documented her treatment of the patient. They also observed that the burn did not appear to cause any pain to the patient as it occurred in an area with little or no sensation, due to the preexisting injury. Finally, they noted that the patient did not follow the advice of the insured and did not seek any additional medical treatment for two weeks after the burn.

The insured OT and treating surgeon acknowledged that the patient's burn occurred while he was being treated with hot packs, resulting in some scarring and decrease of mass at the fingertip. Defense counsel believed the claim should be resolved for less than $10,000, but the patient refused any amount less than $200,000.

Since the patient and his attorney were unwilling to negotiate a settlement, the claim went to a jury trial. The trial lasted seven days and ended with a verdict of no liability on the part of the occupational therapist. The OT's careful documentation assisted in the successful defense of the claim, which lasted over three years and cost more than $35,000.

Looking Forward

"There is nothing permanent except change." – Heraclitus

The case histories included herein offer a snapshot of some of the common hazards confronting occupational therapy professionals today. However, as healthcare delivery models, laws and technology evolve, so do professional liability exposures. For this reason, OTs should consider the potential impact of the following emerging risks, among others:

Information Technology (IT)

IT refers not only to electronic health records, which must interface with other systems, but also to applications such as telemedicine, email, Skype™ and social networking. It is a basic component of strategic planning and should be addressed in capital budgets.

As technology develops and applications increase, OTs should consider the following hazards:

- *Inadequate backup practices and techniques*, leading to data loss or corruption.
- *Hacking of electronic records,* resulting in compromised patient confidentiality and the possibility of identity theft.
- *Inappropriate disclosure of patient information* contained in emails or text messages.
- *Lost or stolen portable equipment*, such as laptops and handheld devices that contain confidential information.

Social Media and Internet Usage

Utilization of social media sites presents a range of benefits and risks to OT professionals. On the one hand, networking platforms can enhance patient compliance, reinforce marketing efforts and strengthen patient-provider bonds. On the other hand, social media utilization may also lead to widespread circulation of negative consumer reviews, as well as exposure to the following liability risks, among others:

- *Inappropriate online behavior* and breaches of proper professional etiquette.
- *Unauthorized disclosure of protected health information* and/or the provider's or practice's proprietary information.
- *Potential legal consequences of marketing materials containing implied guarantees or warranties*, which are posted on the practice website or distributed through social media.
- *Claims of libel or slander* following injudicious postings.

Unconsidered use of social media also may result in boundary issues. Occupational therapy professionals must establish rules in regard to accepting "friending" requests from patients and family members and must avoid commenting on work-related matters on social media sites.

Fee-for-service Payment Regulations

Healthcare reimbursement is a complex system with strict and sometimes hard-to-navigate regulations. Every provider must stay current regarding payer requirements and expectations. Falsifying billing records, overcharging or even undercharging can place a healthcare business owner or the billing practitioner at risk of federal and state sanctions.

Depending upon their scope of practice, occupational therapists may be in a position to bill directly for patient services. If so, they must implement an effective compliance program and obtain training in interpreting and following federal laws designed to combat fraud, waste and abuse. The following resources may be of assistance:

- Information on creating a compliance program is available from the Centers for Medicare & Medicaid Services (CMS).
- Additional CMS publications, educational tools and podcasts are available from the Medicare Learning Network®.
- Contact the American Occupational Therapy Association, Inc. (AOTA) for revenue- and reimbursement-related educational resources.

Student Oversight

Supervising students in occupational therapy educational programs can be an excellent means of educating future OTs and recruiting qualified employees upon their graduation and licensure. When assuming the role of a preceptor for occupational therapy students or occupational therapy student aides, establish a clinical agreement with the student and/or school that delineates the following:

- *Roles and responsibilities* of the preceptor and student.
- *Professional liability insurance requirements* and proof of coverage for the school and/or student.
- *School expectations* (e.g., a weekly report from the OT on the student's progress).
- *Reasonable limitations* regarding patient interactions and interventions.
- *Criminal background checks* on students.
- *Student's commitment to comply with state and federal regulations*, including patient privacy requirements.

In addition, always meet with students prior to any patient contact, in order to review policies and procedures, establish clear expectations and define boundaries regarding patient care.

Independent Contractor Status

Occupational therapy professionals work in a wide range of practice settings, often as independent contractors. This form of employment poses certain unique risks, which can be mitigated by the following strategies:

- *Review and comply with state regulations* relevant to independent contractors within the particular healthcare delivery model.
- *Ensure that the job description is aligned with the legal scope of practice* and delineates the full range of job duties and patient services to be delivered.
- *Read the employment contract carefully* to understand the full extent of responsibilities being assumed and determine whether they comply with required standards of care.
- *Before signing the contract, engage an attorney to review contract provisions* and negotiate the removal of inappropriate, overly broad or undesirable descriptions of job duties and expectations.

New Technology

The healthcare industry is always developing new ways to improve patient outcomes, and occupational therapy training is at the forefront of these advances. In order to remain current, occupational therapy professionals may need to become familiar with devices that not long ago seemed more like science fiction than fact, such as the following examples of emerging technology:

- *Adhesive technology patches* that can monitor a patient's vital signs, detect pain and stress levels, and provide personalized feedback on sources of tension and effective relaxation techniques.
- *Use of additive manufacturing – commonly known as 3D printing* – to produce futuristic medical models and devices. In fact, scientists and engineers have begun developing a "four-dimensional printer" to manufacture healthcare products that adapt automatically to changes in the environment.
- *Stretchable electronic sensors*, worn on the fingertips, with therapeutic uses ranging from ultrasound imaging to burning away problem tissue and creating sutures.
- *Hands-free, wearable technology*, such as Google Glass™, which offers healthcare providers immediate access to critical information, checklists and prompts. For example, an OT could use voice command to instantly access a checklist of vital questions to ask when conducting a patient assessment.

All new technology introduces new risks, which must be understood by professionals and mitigated via sound policies and procedures. Practices should implement a formal acquisition process to weigh the benefits, costs and risks of new technology, as well as to assess specific products and vendors.

Risk Control Recommendations

Some of the occupational therapy closed claims in the dataset involve rare and unpredictable circumstances. Many of the incidents, however, are due to preventable lapses in patient care and documentation. The strategies described below can help OTs avoid these relatively common errors, thus significantly enhancing patient safety and reducing risk.

Know and comply with your state scope of practice and/or professional practice act, as well as facility policies, procedures and protocols.

Healthcare employers are required to create position descriptions and policies that comply with state regulations. If regulatory requirements and organizational scope of practice policies differ, follow the most stringent of the applicable regulations or protocols. If in doubt, contact your state professional licensing board or relevant national, state or professional association, such as the American Occupational Therapy Association, Inc. (AOTA) for clarification. The following additional strategies can help reduce the likelihood of scope-of-practice allegations:

- *Regularly review the legal scope of practice in the state*, and if a job description, contract, or set of policies and procedures appears to be in violation, bring this discrepancy to the organization's attention.
- *State clearly that you are unwilling to risk revocation of your license and possible legal action* by failing to comply with the state scope of practice/OT practice act.
- *Know the organization's policies and procedures* related to clinical practices, documentation and steps to take if given an assignment beyond your scope of practice or experience.

Maintain clinical competencies relevant to the specific patient population.

If the facility, practice, school or organization does not offer continuing education opportunities, contact the appropriate regulatory agency or professional association to obtain information about classes, seminars and resources necessary to maintain clinical competencies.

Ensure that clinical documentation practices comply with the standards promulgated by occupational therapy professional associations, state practice acts and facility protocols.

The importance of complete, appropriate, timely, legible and accurate documentation cannot be overstated, whether records are in electronic or handwritten form. At a minimum, records should include the following:

- *The date and time of each entry,* along with a signature.
- *Patient complaints, statements and ongoing concerns* related to the treatment plan, such as progress and pain levels.
- *Initial and ongoing assessment findings*, as well as patient responses to treatment.
- *Discussions regarding diagnosis, treatment options, and expected and possible outcomes* with the patient, family and healthcare team members.
- *Patient education efforts*, including self-care demonstrations and repeat-back of instructions.
- *Objective facts about adverse events*, including patient accidents, injuries or unexpected outcomes.

Avoid documentation errors that may weaken legal defense efforts in the event of litigation.
As documentation missteps can seriously compromise defensibility, occupational therapy professionals must be mindful of the following caveats:

- *Refrain from including subjective opinions or conclusions*, as well as making any derogatory statements about patients or other providers in the record.
- *Never remove any page or section from a healthcare information record* or alter a written or electronic medical record.
- *Try to avoid changing entries in the healthcare information record.* If it is necessary to correct documentation errors or make a late entry, ensure that alterations are signed and dated, and that they conform to organizational policies and procedures.
- *Contact your manager, risk manager or legal counsel for assistance with documentation concerns or questions* related to regulatory compliance or potential liability.

Take special care when treating minors.
Most healthcare professionals know the legal, ethical and regulatory requirements for treating adult patients. However, many find themselves uncertain when it comes to caring for minors, who may present more complex questions of autonomy, custody and consent. To reduce potential liability, familiarize yourself with the relevant legal and regulatory requirements. As state laws differ, contact your state licensing board and/or your organization's risk management department with any questions in regard to treating minors and obtaining consent.

Communicate effectively with patients and colleagues.
The following measures can help minimize misunderstandings and strengthen rapport with patients and their families:

- *Consider what type of communication is most appropriate for different situations*, e.g., written versus spoken, words versus pictures, in person versus by telephone, and one-on-one discussion versus having a translator and/or advocate present.
- *Recognize patients' nonverbal cues*, such as grimacing or flinching, as well as physical distress signs, such as pallor or diaphoresis.
- *Involve the patient in setting treatment goals and creating a care plan.* Have the patient sign a form acknowledging that he/she agrees with the goals and plans, and understands the risks and limits of treatment.
- *Actively solicit feedback from the patient*, and document the patient's and family's questions and statements in the healthcare information record.
- *Request that patients repeat back key information* to confirm their comprehension.
- *Obtain the patient's permission before sharing information* with family members or significant others, and remember to never disclose patient information on social media.
- *Notify all appropriate individuals of the patient's clinical responses to treatment*, and swiftly convey any signs or symptoms of physiological or psychological changes that could indicate a new pathological condition or a change in an existing condition.
- *Communicate clearly, concisely and methodically in urgent or emergent situations*, when time is of the essence and misunderstandings may have serious consequences.
- *Employ effective handoff communication techniques* whenever care of the patient is transferred to another occupational therapy professional or healthcare provider.
- *Utilize qualified and approved translator/interpreter services when necessary*, in accordance with organizational guidelines.

Delegate with care.
Delegate only those services that can be legally and safely provided by another level of staff, such as a student or volunteer. When delegating to students or volunteers, always provide appropriate supervision. The following additional guidelines can enhance patient safety in this situation:

- *Delegate only when the patient is stable* and his/her ability to tolerate the service is known.
- *Never leave the treatment area when the patient is receiving services* from another level of staff.
- *Periodically assess the staff member's technique and the patient's response* throughout the session, and document supervisory findings.
- *Promptly evaluate patients who complain of unanticipated pain, fatigue, or other signs and symptoms* that demand the supervising OT's direct attention.

Be vigilant about protecting patients from the most common types of injuries.
Our examination of closed claims indicates that *burns* and *fractures* should be a serious concern for all occupational therapy professionals. The following guidelines can help minimize liability and increase defensibility in the event of an adverse occurrence:

Burns:

- *Be aware of the high risk of burns from certain commonly used treatments, biophysical agents and interventions*, such as whirlpool therapy, hot packs, paraffin and cold/ice packs. Ensure that each of these treatments is clinically appropriate and that there are no clinical contraindications for their use.
- *Evaluate and document each patient's skin integrity, neurological status, and ability to perceive pain or discomfort*, conveying any problems to staff. Assessments should be conducted prior to the course of treatment and periodically thereafter.
- *Closely supervise and/or monitor patients during treatment*, checking skin condition frequently.
- *Note any perceived alterations in skin integrity* and mention them promptly to the referring practitioner and/or healthcare team.
- *Routinely test, monitor and log temperatures of whirlpool water, hot pack warmers, paraffin tanks and other equipment* in accordance with organizational policies.

Burns and fractures should be a serious concern for all occupational therapy professionals.

Fractures:

- *Maintain a safe, obstacle-free environment of care* with dry, level and unobstructed walkways and treatment spaces.
- *Check equipment before each use*, and perform and document scheduled maintenance according to manufacturer recommendations.
- *Immediately remove and sequester any equipment that has malfunctioned* or that does not meet safety standards.
- *Assess patients initially and periodically thereafter for fall and fracture risk* in light of underlying medical conditions.
- *Train staff and patients in the proper use of equipment* and require a demonstration of competency prior to initial use.
- *On an ongoing basis, evaluate patients' ability to use equipment in a safe manner* and to participate in rehabilitative therapy.
- *Utilize appropriate safety devices*, such as gait belts, floor and treatment table pads, and equipment alarms.
- *Always ensure that patients are correctly and securely positioned* on treatment tables and equipment.
- *Explain to patients what type of clothing and footwear should be worn during treatment/intervention*, and do not permit use of equipment without proper apparel.
- *Observe patients closely during sessions* to prevent falls and/or fractures, and never leave them unattended.
- *If there are signs or symptoms of a possible fracture, immediately determine the need for medical evaluation* and emergency medical services.

Be aware of patients' medical conditions, comorbidities and other risk factors that may affect treatment and rehabilitation.

Examples of preexisting conditions include the following:

- Deconditioning following extended hospitalization or recent surgery.
- Osteopenia and osteoporosis.
- Cardiac problems.
- Blood disorders requiring anticoagulant therapy.
- Diabetes.
- Pulmonary disease.
- Neurological impairments, dementia and behavioral health issues.
- Sensory loss involving heat/cold sensitivity, hearing, vision, speech or proprioception.
- Vestibular/balance disorders.
- Side effects of medications.

Treat patients with respect and compassion over the course of treatment.

The following measures can help reduce conflict and maintain appropriate boundaries:

- *Warn patients of potential treatment-related discomfort.* Assist the patient in recognizing the difference between discomfort and pain, and explain why it is necessary to communicate clearly about pain levels.
- *Have a second staff member present during treatments or procedures involving therapeutic touching* when the patient seems uneasy or requests additional staff presence.
- *Cease the treatment/procedure immediately if the patient expresses discomfort* or states that the touching seems excessive, painful, abusive or inappropriate in any way.
- *Arrange for someone to stay with the patient if it is necessary to walk away temporarily* for any reason.
- *Do not discourage patients from asking questions*, expressing their concerns, speaking with a supervisor or requesting another therapist.
- *Report any patient allegations about questionable activity immediately to a manager* and the referring practitioner.
- *Discourage inappropriate or questionable behavior*, and refrain from developing relationships with patients or family members that may result in a conflict of interest.

If questions arise regarding professional ethics or behavior, consult the American Occupational Therapy Association, Inc. (AOTA) for guidance.

Monitor the environment of care.

The following measures can help prevent accidents involving patients, staff and visitors:

- *Monitor entrances and exits*, and restrict access to private and non-care areas.
- *Maintain unobstructed hallways and treatment areas*, removing any clutter that may cause accidents.
- *Ensure that all staff are thoroughly trained in equipment use* and proper maintenance.
- *Regularly replace exercise bands* and other equipment known to wear out quickly.
- *Perform and document preventive maintenance for all equipment*, per manufacturer guidelines.
- *Inspect and/or test equipment prior to patient use*, removing any equipment that appears to be broken, unreliable or unsafe.
- *Ensure that equipment needed for each patient is readily available* and checked before each use.
- *Train patients in how to use equipment appropriately*, and explain the risks of improper operation.
- *Sequester any equipment involved in a patient injury*, as it may serve as evidence.
- *Provide a well-marked viewing/waiting space* that is clearly separated from the treatment or gym area.
- *Post conspicuous warning signs* stating that visitors who enter treatment or gym areas do so at their own risk.

Risk Control Self-assessment Checklist

The following checklist is designed to serve as a starting point for occupational therapists seeking to assess and enhance their patient safety and risk management practices. For additional risk control tools and information, visit www.cna.com and www.hpso.com.

Scope of practice	Yes	No	Actions needed to reduce risks
I read my practice act at least annually to ensure that I understand the legal scope of practice in my state.			
I regularly attend continuing education courses and know the annual requirements needed to maintain my certification/licensure.			
If a job description, contract, or set of policies and procedures appears to violate my state's laws and regulations, I bring this discrepancy to the organization's attention and refuse to practice in breach of laws and/or regulations.			
I decline to perform any requested service that is outside my legal, professional and personal scope of practice, and immediately notify my supervisor of the situation.			
I contact the supervisor, risk management and/or legal department regarding more complex patient and practice issues, and if that fails, I contact the state or national professional organization and request an interpretation, opinion or position statement on practice issues.			
If necessary, I make use of the chain of command to resolve patient care or safety issues.			
If I work in more than one state, I familiarize myself with and follow applicable practice rules and regulations in every relevant jurisdiction.			

Clinical specialty and competencies	Yes	No	Actions needed to reduce risks
I practice or work in an area that is consistent with my education and experience, and my competencies are aligned with the needs of my patients.			
If my competencies are not suited to a patient's needs, I refer the patient to another healthcare provider.			
When asked to provide coverage for different patient populations, I determine whether I possess the proper competencies and decline the assignment if I do not.			
I receive an orientation or skills check-off whenever I am covering a different patient care area or specialty.			
I obtain continuing education and training to maintain and further my competence and professional development.			

Documentation	Yes	No	Actions needed to reduce risks
I document every encounter with a patient, whether in person, by telephone, online or via any other communication tool.			
I document no-shows and appointment cancellations.			
I correct any charting errors in compliance with my organization's policy.			
I document concurrently and make a late entry only if it is necessary for the safe continued care of the patient, ensuring that the addition is appropriately dated and labeled as a late entry.			
I refrain from including in the record any inappropriate subjective opinions, conclusions or derogatory statements about patients, colleagues or other members of the patient care team.			
I follow sound documentation practices and check that my notes …			
▪ Are consistent with the treatment plan.			
▪ Justify the services billed.			
▪ Reflect billing codes and support coding procedures.			
▪ Meet state and local law.			
▪ Comply with organizational, professional and ethical guidelines.			
I contact my manager, risk manager or legal department/counsel for assistance with documentation concerns or questions related to potential liability or regulatory matters.			

Communication	Yes	No	Actions needed to reduce risks
I consider the best means of communication when interacting with practitioners, patients and family members – e.g., written versus spoken, words versus pictures or models, in person versus by telephone.			
I monitor nonverbal cues from patients, such as grimacing, flinching, pallor or diaphoresis.			
I request that patients repeat back or paraphrase important information and demonstrate specific home treatment techniques to ensure comprehension.			
I practice active listening skills and teach-back techniques to ensure that patients understand my instructions.			
I avoid the use of complex medical terminology when speaking with patients.			
Following a patient injury, I inform the referring physician and/or parent or legal guardian and note whether the patient appears to need further clinical treatment.			
I actively solicit feedback from patients and document significant comments and queries in the patient healthcare information record.			
I follow organizational protocols and HIPAA regulations/requirements when communicating with patients and/or transmitting any protected health information via email or social media.			
I obtain the patient's written permission before sharing any protected health information with family members or significant others.			
I am sensitive to language barriers and use an interpreter when necessary, in accordance with organizational protocols.			

Professional conduct	Yes	No	Actions needed to reduce risks
I speak to patients, families and staff in a courteous and professional manner, honoring their dignity and feelings.			
I respect patients' rights throughout the episode of care and am attentive to their wishes and preferences.			
I use a gentle touch and language when working with patients.			
I desist from using inappropriate or potentially insulting humor, sarcasm or idiomatic expressions (e.g., "No pain, no gain") that may impede communication and lead to reckless behavior.			
I am respectful of others' beliefs and values and am aware of my own cultural assumptions and the possibility of bias.			
I fully explain procedures and treatments to patients; describe any touching or discomfort they can anticipate during the assessment, monitoring and treatment process; and obtain their permission before proceeding.			
I treat the patient as a partner when developing a plan of care and throughout the course of treatment.			
I avoid inappropriate interactions and/or personal relationships with patients and family members.			
I offer patients the option of having a chaperone during treatment and utilize one if the patient requires treatment in sensitive areas, has expressed embarrassment or fear, or has displayed unusual behaviors.			
I do not hold sidebar conversations with other staff members when I am with a patient.			
I do not make or respond to personal telephone calls or text messages when I am with a patient.			
I refrain from discussing patient matters in public areas, such as hallways or elevators, as well as on social media sites.			

Patient Safety: Falls	Yes	No	Actions needed to reduce risks
I evaluate every patient for risk of falling, utilizing a fall-assessment tool that considers the following factors, among others:			
- Previous fall history and associated injuries.			
- Gait and balance disturbances.			
- Foot and leg problems.			
- Reduced vision.			
- Medical conditions and disabilities.			
- Cognitive impairment.			
- Bowel and bladder dysfunction.			
- Special toileting requirements.			
- Use of both prescription and over-the-counter medications.			
- Need for mechanical and/or human assistance.			
- Environmental hazards.			
I identify higher-risk patients, including those who have experienced recurrent falls or have multiple risk factors.			
I conduct a home safety check prior to commencement of services for home health/hospice patients.			
If I detect safety problems in the home, I recommend corrective actions and include these safety measures in the patient service agreement.			
I regularly assess patients and modify the healthcare record in response to changes in their condition.			
I inform patients and families of salient risk factors and basic safety strategies.			
I document all assessment findings and incorporate them into the patient service plan.			
I document the patient's condition at each visit, and I also …			
- Review previous fall history and associated injuries.			
- Check for gait and balance disturbances.			
- Report any changes to the physician and family in a clear and timely manner.			
- Perform frequent home safety checks, if applicable.			
- Reinforce fall-reduction tactics with patients and family.			
- Encourage patients to ask for assistance with risky tasks.			
- Keep accurate, detailed records of patient encounters.			
After a fall, I offer emotional support to the patient and caregiver.			
I perform post-fall analysis, describing the circumstances of the fall and also …			
- Identifying major causal factors, both personal and environmental.			
- Indicating the patient's functional status before and after the fall.			
- Noting medical comorbidities.			
- Listing witnesses to the fall.			
- Intervening to prevent or mitigate future falls.			
I conduct a thorough post-fall analysis and incorporate findings into quality assurance and/or incident reporting programs.			

Environment of care	Yes	No	Actions needed to reduce risks
I monitor the environment of care to prevent accidents, being careful to …			
- Secure entrances and exits.			
- Maintain unobstructed hallways and treatment areas.			
- Restrict access to hazardous substances and areas not used for patient care.			
- Conduct preventive maintenance and periodic safety checks on all equipment, per manufacturer guidelines and organizational policy.			
- Ensure that equipment needed for each patient is readily available and checked before each use, and to remove any equipment that appears to be broken, unreliable or unsafe.			
- Train patients in how to use equipment appropriately, and inform them of the risks of improper operation.			
- Sequester any equipment that is involved in a patient injury.			

I monitor the environment of care to prevent accidents.

Practice and Claim Response Tips

Of the recommendations that follow, the first set is designed to help occupational therapists minimize risk in their everyday practice, while the second set consists of steps to take in the event of an actual or potential claim situation.

Everyday practice:

- *Practice within the requirements of your state practice act*, in compliance with organizational policies and procedures, and within the standard of care. If regulatory requirements and organizational scope of practice differ, comply with the most stringent of the applicable regulations or policies. If in doubt, contact your state board or specialty professional association for clarification.
- *Document your patient care assessments, observations, communications and actions in an objective, timely, accurate, complete, appropriate and legible manner*. 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 information must be added to the record, properly label and date the late entry.
- *Never add anything 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 of pending legal action, discuss the need for additional documentation with your manager, the organization's risk manager and/or legal counsel.

Responding to a filed or potential claim:

- *Immediately contact your professional liability 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.
- *If you purchase your own professional liability insurance, report claims or potential claims to your insurance carrier*, even if your employer advises you that the organization will provide you with an attorney and/or that the employer's insurance policy will cover you for a professional liability settlement or verdict amount.
- *Refrain from discussing the matter with anyone other than your defense attorney* or the claim professionals managing the case.
- *Promptly return calls from your defense attorney and the claim professionals assigned by your insurance carrier*. Contact your attorney and/or claim professional before responding to calls, email messages or requests for documents from any other party.
- *Provide your insurance carrier with as much information as you can when reporting possible claims*, including contact information for your organization's risk manager and the attorney assigned to the litigation by your employer, if applicable.
- *Never testify in a deposition without first consulting your professional liability insurance carrier* or, if you do not have individual professional liability insurance, the organization's risk manager and/or legal counsel.
- *Copy and retain all legal documents for your records*, including the summons and complaint, subpoenas and attorney letters pertaining to the claim.

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