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Risk Management Strategies for Athletic Trainers



Understanding
and Addressing
Professional
Liability Exposures

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Introduction

CNA and Healthcare Providers Service Organization (HPSO) are among the nation's leading providers of professional liability insurance for the healthcare industry. Together, we insure over 5,000 athletic trainers, who deliver services in an increasingly broad array of settings, such as schools and colleges, hospitals, clinics, practitioner offices, performing arts companies, spas and fitness centers. We are committed to helping athletic trainers protect themselves against loss not only by offering specialized insurance coverage, but also by enhancing their risk awareness.

In collaboration with HPSO, we at CNA are pleased to present this examination and discussion of current and emerging liability exposures confronting athletic training professionals. Our goal is to help athletic trainers understand their major areas of vulnerability and take appropriate action to protect their patients from harm and themselves and their employers from potential litigation.

This resource features claim scenarios and high-level risk control recommendations which, if implemented appropriately, can help prevent incidents and increase patient satisfaction while minimizing exposure to lawsuits and licensure/certification actions. In addition, a self-assessment checklist is included to further aid athletic trainers in identifying risks and improving both patient safety and legal defensibility.

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

- **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.
- **Medical negligence** – Failure to exercise the degree of care that a reasonably prudent, similarly qualified practitioner in the community would have exercised under the same or similar circumstances (i.e., failure to meet the standard of care).
- **Patient** – Any person receiving treatment or professional services from a CNA/HPSO-insured athletic trainer.

Our **goal** is to help athletic trainers **understand** their major **areas of vulnerability**.

Claim Scenarios

Among their other areas of expertise, athletic trainers (ATs) are trained to quickly assess the physical condition of sports participants and determine whether they are fit to return to their sporting activities or must withdraw and seek medical care. In most cases, these assessments are correct and the athlete or patient (or occasionally visitor) resumes the activity without negative repercussions. On rare occasions, however, a decision or action by an AT leads to injury and allegations of negligence.

Examination of closed claims involving CNA/HPSO-insured ATs reveals that most claims include one or more of the following allegations:

- Failure to complete a proper assessment.
- Failure to provide a safe environment.
- Improper use of a physical agent.

The most common claim-related injuries suffered by patients and athletes include fractures, burns and traumatic brain injuries, such as concussion and subarachnoid hemorrhage.

The failure to utilize critical thinking skills when assessing or treating patients is a common theme within the professional liability claims, as seen in the following examples:

- **An AT applied a transcutaneous electrical nerve stimulation (TENS) unit to the left lower extremity of a patient with diabetic neuropathy.** The patient was left unmonitored for 25 minutes and suffered third-degree burns, which required several surgical debridements complicated by infection.
- **A young athlete was exercising under the direction of an AT when he complained of being too tired to continue the workout.** Nevertheless, the AT instructed the athlete to hold the push-up position for two minutes. After one minute, the athlete's hands slipped out from under him, causing him to fall on his face. The fall resulted in two broken teeth, requiring surgery.
- **A patient was receiving physical therapy after undergoing three right ankle surgeries, including ankle reconstruction and removal of hardware, in less than 18 months.** Following his third surgery, the patient was prescribed physical therapy, in order to strengthen his atrophied right ankle and increase his mobility. On the third visit, a CNA-insured AT, who was working under the guidance of a physical therapist, instructed the patient to perform right foot hop exercises, although the plan of care restricted such exercises. On the third hop, the patient felt immediate pain in his foot and ankle. The patient was later evaluated by his referring orthopedic surgeon, who determined that a fourth surgery would be needed. At trial, the AT testified that she had not read the plan of care before working with the patient and knew little about the patient's injury and prior surgical history.

These three brief scenarios, and the longer case histories that follow, demonstrate the potentially serious injuries and resulting large-scale losses that may occur when ATs fail to practice in a safe, conscientious and fully professional manner. The second half of this resource lists practical and effective risk control measures designed to help ATs enhance patient safety and reduce the likelihood of errors and adverse events.

CLAIM SCENARIO: Failure to Complete a Proper Assessment

In the process of making a tackle, a high school football player felt his entire body tingle. Upon reaching the sidelines, he told the insured AT what had occurred and also reported that his neck was beginning to hurt. However, before the AT could assess the player, the team coach purportedly told the athlete that he did not need medical attention and, according to the insured, instructed the youth to “stop being a baby and go back in and play.” The student ran back onto the field for a few more plays. The AT watched the player for a few minutes and determined that he seemed to be fine.

When the player returned to the sidelines, he complained to the coach that his neck pain had worsened. The coach instructed him to rest for a few plays and, if he did not feel any better, to let the AT know about his pain. The AT was busy with another athlete when he noticed the player sitting on the bench in obvious pain and directed him to the trainer’s table for assessment. The team physician then examined the player and diagnosed a brachial plexus stretch or compression from a hit to the shoulder. He told the player to sit out the remainder of the game.

At halftime, the AT advised the head coach that the football player could not return to the game. As a precaution, the insured gave the athlete’s coach and mother written information about the care and symptoms of a muscle strain and concussion. He advised both the coach and mother that if the player complained of a headache or exhibited any other signs of concussion, he should be taken to an emergency department.

Later in the game, the player was sitting on the sidelines and told the AT that his neck pain was getting worse, his extremities felt “tingly” and he felt nauseated. The AT again spoke to the mother and this time suggested that she have an ambulance take her son to the emergency department. She refused, explaining that she did not have any health insurance and would drive her son to the emergency department that evening. Instead, she took him home.

The following morning, the football player awoke with numbness in his arms and legs, at which point his mother took him to the emergency department. An MRI revealed C4 and C5 cervical fractures, a retrolisthesis of C3 on C4 and C4 on C5, a hematoma from C2 to C5, and tears of the inter and supraspinatus ligaments from C2 through C5 with a normal spinal cord. He required fitting with a halo ring for cervical spine immobilization, which involved surgery.

Throughout his recovery, the athlete developed recurrent infections at the insertion site of the halo pins and was diagnosed with depression, anxiety and generalized pain disorder. He continued to suffer from pain due to trigger points, spasms, restricted range of motion and general muscle weakness. Due to his generalized pain disorder, he became addicted to prescription drugs and underwent treatment at a drug rehabilitation facility.

The football player filed a lawsuit against the insured AT, the team physician, the school system and the high school coaching staff. The claim against the insured AT alleged that, although the player ran back into the game without any opportunity for the insured to examine him, he should have immediately instructed the coach to pull the player from the game for proper examination.

A defense expert who reviewed the claim believed that the player should assume a portion of the liability because he ran back into the game for several more plays even after informing the AT of his neck pain. The expert gave our insured an overall favorable review, but was concerned about the fact that the insured provided the mother and athlete with information on concussion and muscle strain instead of neck injury. The expert opined that the insured should have been more proactive when the athlete complained of his worsening neck pain with tingling in his extremities. His impression was that the insured should have made the mother and athlete aware of a potential cervical neck fracture and explained the potential risks of delaying emergent treatment.

The defense attorney believed the global settlement range for all defense parties involved would be in the mid-six-figure range, with the insured AT responsible for 25 to 30 percent of the total. Several attempts were made to resolve the case, but it remained unsettled for four years due to the unrealistic demands of the athlete and his mother. Two weeks prior to trial, the athlete agreed to a settlement offer on behalf of the insured AT. The overall cost of defending and resolving the claim against the AT was in the low six-figure range.

CLAIM SCENARIO: Failure to Provide Safe Environment of Care

A man came to watch his granddaughter, a high school cross-country runner, train at a large sports center owned by the insured AT. As the area designated for spectators or visitors was limited, the grandfather found himself strolling through the crowded center. While walking to a place where he could better watch his granddaughter, the grandfather collided with an athlete running on the track.

The grandfather immediately complained of pain in his left side and agreed to be taken to the emergency department for evaluation. He was diagnosed with six left rib fractures, a ruptured spleen, and an abdominal and pelvic hemorrhage. He underwent an emergent splenectomy and, due to his complicated health history, spent 14 days in the hospital, including seven days in an intensive care unit. While recuperating post-operatively at home, he suffered a deep vein thrombosis that required a second hospital admission and further delayed his recovery.

The grandfather seemed to have made a good recovery since his second hospital admission. However, at his deposition, he complained of continuing pain in the left side of his chest, as well as anxiety due to the incident.

The grandfather pursued a claim against the property owner, the sports center, and several ATs and personal trainers present in the gymnasium at the time of the incident. He alleged that the defendants had failed to adequately warn spectators/visitors of the risks associated with leaving the designated viewing area. The claim asserted pain and suffering, lost income and compensation for medical bills related to the injury.

An expert witness was critical of the facility's layout, noting that the running track was not sufficiently demarcated and obstructed egress from the building. The insured AT testified that he had designed the center based on his experience working in similar facilities, that there were warnings in place and that the turf training area was clearly marked. He was asked to produce photos of the warnings in place at the time of the incident, but was unable to comply with the request, as the facility had recently undergone extensive renovations. During the deposition proceedings, many of the ATs and personal trainers testified that while signs were present at the entrance prohibiting spectators from the track, visitors were, in fact, permitted to roam around the gym during training classes.

The defense expert was asked to review the policies and procedures of the sport center, and discovered that staff were instructed to restrict spectators from entering the gymnasium. He also found a statement signed by all employees upon their orientation confirming that they understood and would abide by all of the sports center's policies and procedures.

As employees had acknowledged their awareness of policies and procedures and knew that permitting spectators in the gymnasium was unsafe, the defense attorney believed it would be difficult to mount a successful defense in this case. A settlement agreement was reached, with the indemnity payment and associated expenses totaling in the low six figures.

Risk Control Recommendations

Providing a safe environment for employees, patients/clients and visitors can be a challenge, especially in high-traffic areas. The following strategies can help minimize exposure.

Assess the environment for hazards, including:

- Loose rugs and floor mats.
- Stray furniture and equipment.
- Cluttered hallways and stairways.
- Slippery floor surfaces.
- Poor lighting.
- **Empower employees** to recognize and address situations where visitor safety may be compromised.
- **Create a top-down culture of safety** that is active, visible and non-punitive.

CLAIM SCENARIO: Improper Use of a Physical Agent/Failure to Monitor (A Success Story)

A high school freshman and junior varsity lacrosse player came to the athletic training room at school during practice to get some ice immediately following a hit to her left leg by another player's helmet. The insured AT gave the athlete a bag of ice for her knee and, in accordance with his customary practice, told her to apply the ice for 15 to 20 minutes. The athlete left the training room and had no further contact with the AT that day.

The athlete returned to the training room the following day and again requested that ice be applied to her left leg. The AT applied an ice bag directly on the skin of her left leg, using plastic cling wrap to hold the bag in place. According to the AT, he again told her to keep the ice in place for 15 to 20 minutes – a contention disputed by the athlete, who stated that the trainer never instructed her to take the ice bag off after a set amount of time had elapsed. The athlete then left the training room and went out to the practice field.

After providing the ice bag, the AT saw 14 athletes in the training office over approximately the next hour. He then visited various volleyball, cheerleading, soccer, football and field hockey practices to check in with coaches and players. After assisting a few other athletes, he proceeded to the junior varsity lacrosse field. It was at this point that he saw the athlete with the bag of now-melted ice, which was still attached to her left leg. When asked why she had not removed the ice after 15 to 20 minutes, she told him that her leg “didn’t hurt anymore and it felt better.” The AT told her that she should have removed the ice bag, as applying ice beyond the recommended 15 to 20 minutes potentially could cause neuropathy and/or lead to a cryotherapy injury similar to frostbite.

The next day, the AT again saw the young athlete, who informed him that while her left knee had improved somewhat, her left foot was dropping as she walked. The AT conducted and documented an assessment. Per policy, he also prepared an injury screening report noting that after icing the left knee the prior day, the athlete felt some numbness and tingling in her left leg. According to the report, there was no bruising, but there was mild swelling, foot drop gait and positive knee valgus with mild pain, which had improved since the date of injury. The athlete scored a two out of five for strength in the eversion dorsiflexion and toe extension. She also had tingling and numbness in the anterior and lateral aspects of her left leg and foot. On the injury screening report, the AT noted his impression: left peroneal neuropathy resulting from a lateral collateral ligament sprain and possible ice application. The

AT documented the following instructions given to the athlete: “Rest, elevate and no ice. Consultation with the team orthopedic surgeon the following day.”

The following day, the orthopedic surgeon saw the athlete, who informed him of problems with her left knee, lower leg, ankle and foot, including sprain/strain, numbness and tingling. After examining the athlete, the surgeon's impression was that she had suffered an injury to the peroneal nerve. His differential diagnosis included “knee contusion and extended use of ice.” During his testimony, he explained that a differential diagnosis is a list of possibilities to consider in forming an opinion and that, while extended use of ice was part of his differential diagnosis, he did not believe that the nerve damage was caused by ice.

Two years following the injury, the athlete filed a claim against the AT, the AT's employer and the team's orthopedic surgeon. Allegations against the AT included:

- **Negligently rendering medical care and treatment** by failing to properly and adequately diagnose and treat the young athlete.
- **Failing to properly and adequately restrict application of the ice pack/wrap to the athlete's knee** and applying the ice pack/wrap too tightly.
- **Failing to properly and adequately monitor and timely remove the ice pack**, which caused injury when it remained too long on the athlete's knee.
- **Failing to inform or instruct the athlete of the dangers and risks involved in the application of the ice pack/wrap** and the need to remove it and/or have it removed within a proper length of time following application.
- **Negligently failing to obtain consent to treat** from the athlete and documenting this consent.

Several defense experts were retained to review the allegations and claims against the AT. All of the defense experts had a positive opinion of the care given and found no deviations in his treatment of the athlete. CNA's AT expert stated that it is standard practice to advise patients that ice should be applied for no longer than 20 minutes. Moreover, ATs are generally not expected to communicate the risk of not removing the ice pack/wrap.

A CNA-engaged orthopedic surgeon expert stated that the athlete's injuries were caused by the direct blow to her lateral knee by a helmet, rather than the application of ice. The expert witness stated that these types of injuries are common in contact sports, and that the location of the injury suggested that the injury was trauma-induced. In his expert opinion, the care provided by the insured AT was appropriate, it was unlikely that the AT had failed to tell the athlete to remove the ice and, in any event, the injury was not due to the application of ice.

During the athlete's testimony, she admitted to engaging in physical activity without restriction, including "four-wheeling," snow and water skiing, running, exercising, lifting weights, snowmobiling and bicycling. Soon after the athlete's testimony, a motion for final summary judgment was filed with the court. Pending the court's hearing of the motion, the claimant's attorney requested a settlement offer. The AT and his attorney declined to offer a settlement, deciding instead to await the results of the motion. The athlete's attorney subsequently filed a motion to dismiss the claim against the AT, his employer and the team's orthopedic surgeon. While the claim defense lasted six years and legal expenses were in the mid-five figures, no indemnity was paid.

The successful outcome was due to the fact that the AT had practiced within the standard of care, as demonstrated by his own documentation. The CNA defense experts effectively refuted the opinions offered by the athlete's experts, and the AT's attorneys aggressively defended the insured AT by filing appropriate court motions and declining the claimant's settlement offer.

Risk Control Recommendations

Careful assessment, supervision and documentation are key to patient safety and effective risk management. The following strategies can help protect patients and minimize liability exposure:

- **Evaluate each patient's skin integrity, neurological status, and ability to perceive pain or discomfort** prior to the course of treatment and periodically thereafter.
- **Closely supervise and/or monitor patients undergoing care.** Instruct patients to remain in the treatment area while care is being administered.
- **Document all patient-related discussions and actions taken.** Ensure that this documentation is provided to the treating provider(s) or other appropriate individuals in a timely manner.

Looking Forward

"There is nothing permanent except change." – Heraclitus

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

Information Technology (IT)

IT refers to electronic health records, which must interface with other providers' systems, as well as applications such as telemedicine, wireless online accessibility, 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, ATs should consider the following areas of risk:

- **Inadequate backup practices and techniques**, leading to data loss or corruption.
- **Intentional or unintentional breaches in security**, resulting in compromised patient confidentiality and the possibility of identity theft.
- **Inappropriate information** contained in emails or text messages.
- **Lost or stolen portable equipment**, such as laptops and hand-held devices.

Social Media and Internet Usage

Utilization of social media platforms and social networking has exponentially increased consumer access to information, including feedback posted by athletes, patients, their families, significant others and employees. This increase in access and networking has led to emerging exposures, including boundary issues, negative consumer reviews and inappropriate disclosures of protected health information. To minimize these risks, athletic trainers must establish rules regarding the sending or accepting of "friend requests" with respect to patients and family members, avoid commentary on work-related matters while on social media and implement policies addressing the following additional social media hazards:

- **Inappropriate online behavior** and violations of proper professional boundaries and etiquette.
- **Breach of confidentiality of protected health information** and/or proprietary information of the healthcare provider or practice.
- **Legal actions arising as a result of marketing materials that include guarantees or warranties**, which are posted on the organization's website or distributed through social media.
- **Claims of libel or slander** following injudicious postings.

Closely supervise and/or
monitor patients undergoing care.

Fee-for-service Payment Regulations

Healthcare reimbursement is a complex system with strict regulations that can be difficult to navigate. Every provider must remain current regarding payer requirements and expectations. Falsifying billing records, overcharging and 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, ATs may be able to bill patients directly for services rendered. 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 provide assistance in this area:

- 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 at the [Medicare Learning Network](#)[®].
- Revenue- and reimbursement-related educational resources are offered by the [National Athletic Trainers' Association \(NATA\)](#).

If an employer or third party is responsible for billing patient services, the AT should abide by all laws and regulations concerning billing practices. Patient documentation should support the care provided, but if there appears to be a billing discrepancy, contact a supervisor, risk manager, legal counsel and/or corporate compliance officer.

Blood Flow Restricted (BFR) Training

BFR training is the process of exercising an extremity that is wrapped tightly enough to produce a brief and intermittent vascular occlusion. The training utilizes a special surgical tourniquet that creates an ischemic/hypoxic environment designed to lessen post-injury atrophy and promote muscle hypertrophy, strength and endurance. Due to the nature of BFR training, athletic trainers wishing to utilize it as a therapeutic modality must be cognizant of the therapy's risks, benefits and contraindications, as well as state scope of practice limitations.

To reduce risk, ATs should receive industry-recognized training and certification prior to initiating BFR training. In addition, they should document all patient-related discussions, clinical information (including where the cuff or tourniquet was placed), and the patient's condition pre- and post-treatment. Finally, if a patient undergoing BFR training requires immediate medical care, ATs should implement proper emergency response and transfer measures, and also communicate urgent or critical patient care concerns to the referring practitioner in a timely manner.

Student Oversight

Supervising students in athletic training educational programs can be an excellent means of supporting future ATs and recruiting qualified employees upon their graduation and licensure. When assuming the role of a preceptor for athletic training students or athletic training 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 insurance liability requirements** and proof of coverage of the school and/or student.
- **School expectations** (e.g., a weekly report from the supervising AT on the student's progress).
- **Reasonable limitations** regarding patient interactions and interventions.
- **Criminal background checks** on all students.
- **Education about 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

In their role of keeping active individuals healthy and functioning at full capacity, athletic trainers work in a wide range of practice settings, often as independent contractors. This form of employment poses certain risks, which can be mitigated by the following strategies:

- **Review and comply with state regulations** that apply to independent contractors within the designated healthcare delivery model.
- **Ensure that the job description accurately reflects the scope of practice**, as well as the range of services delivered and specific job duties performed.
- **Read the employment contract carefully** to ascertain the full extent of responsibilities being assumed.
- **Engage an attorney to review contract provisions**, determine whether they comply with applicable standards of care, and negotiate the alteration or deletion of inappropriate, overly broad or undesirable contract terms.

Always **meet with students**
prior to any patient contact to review
policies and procedures.

New Technology

The healthcare industry is always developing innovative methods to improve patient outcomes, and athletic training is at the forefront of these new technologies. Examples of emerging AT-related technology include:

- **Wearable 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 multidimensional models of trouble spots inside and outside a patient's body.** In fact, scientists and engineers have begun developing a “four-dimensional printer” to manufacture healthcare devices and other 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™, that offers healthcare providers immediate access to critical information, checklists and prompts. For example, if an athlete sustains a back injury, the athletic trainer could use voice command to access a checklist of vital questions to ask while performing a physical assessment.

All new technology introduces new risks, which must be understood by professionals and mitigated via sound policies and procedures. In addition, practices should develop and implement a formal technology acquisition process addressing the following risk management issues:

- **Weighing the benefits, costs and risks** of new technology.
- **Assessing specific products** and vendors.
- **Verifying that the selected product has been approved by the FDA** for the intended clinical use.
- **Educating staff about proper use and maintenance of new equipment** prior to utilization.

Practices should **develop**
and implement **a formal**
technology acquisition process.

Risk Control Recommendations

Some of the AT closed claims involve rare and unpredictable circumstances. Most of the incidents, however, reflect preventable lapses in patient care and documentation. The following strategies can help ATs avoid these relatively common errors, thus significantly enhancing safety and reducing risk.

Know and comply with national, state and local laws regarding scope of practice.

ATs are responsible for reviewing and understanding the regulations in each state where they practice, as well as the policies and protocols of their employers and the organizations where they provide services. If regulatory requirements and scope of practice limitations differ from organizational policies or expectations, always comply with the most stringent of the applicable regulations or policies, in order to avoid potential regulatory actions. Also, if a job description, contract, or organizational policy or procedure appears to violate state regulations, bring this discrepancy to the attention of a supervisor. If the matter is not satisfactorily resolved, contact a [NATA](#) district and/or state association for clarification and guidance.

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 relevant competencies.

Exercise care when treating minors.

Most healthcare professionals understand the legal, ethical and regulatory requirements involved in treating adult patients. However, they may be less certain about managing therapeutic relationships with younger patients.

ATs should exercise due diligence when treating a minor who presents concerns in regard to legal guardianship. For example, if the child's parents are separated or divorced, a copy of the divorce decree or custody agreement should be readily available because both parents may share legal custody and can make treatment decisions, although only one parent has residential custody of the child. A copy of the court order also should be obtained in cases of a legal guardian or guardian *ad litem* (i.e., an adult appointed to act on behalf of a minor in a lawsuit).

The basic principles of obtaining consent for treatment should be followed, i.e., a verbal discussion followed by written documentation. Information should be in the patient's preferred language and at the appropriate literacy level. The consent process should be documented in the patient's health-care information record. (For additional information on consent to treat, see [page 25](#).)

In an emergency, a minor can be treated without consent. However, the burden of proof that treatment was needed falls on the provider, making thorough documentation especially important in such cases.

Minors tend to present more risk of litigation because their care may involve complex issues of custody and consent to treatment. To reduce potential liability, athletic trainers must be aware of relevant legal and regulatory requirements. As states differ, contact the state licensing board and/or an organizational risk manager or legal counsel for answers to questions about treating minors.

Develop a physical assessment process suited to the healthcare setting and patient population, and implement it consistently.

Because ATs work in a wide array of environments, it is essential to develop a systematic physical assessment process appropriate for each patient type/population. Since many settings demand a quick determination of a patient's condition, it may be necessary for an AT to receive additional professional education and training designed to strengthen physical assessment knowledge and skills.

Detailed assessment tools for head injuries and other specific situations can be very useful. Regardless of the complaint, however, all physical assessments should include a head-to-toe evaluation, in order to avoid overlooking a potentially serious secondary injury.

Ensure that clinical documentation practices comply with the standards promulgated by athletic trainer professional associations.

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:

- Date, time and signature for each entry.
- Patient complaints, statements and ongoing concerns related to the treatment plan, such as progress and pain levels.
- Findings of initial and ongoing patient assessments.
- Results of diagnostic procedures.
- Patient's consent to treatment and responses to therapy.
- Discussions regarding assessment findings, treatment options and expected outcomes with the patient, family and other healthcare team members.
- Patient education and discharge instructions, including assessment of the patient's ability to demonstrate self-care and follow instructions.
- Objective facts related to any patient accident, injury or adverse outcome.

The **importance of** complete, appropriate, timely, legible and **accurate documentation** cannot be overstated.

Avoid documentation errors that may weaken legal defense efforts in the event of litigation.

The measures below address potential documentation missteps that can seriously compromise legal defensibility:

- Refrain from documenting 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.
- If it is necessary to correct documentation errors or make a late entry, ensure that alterations conform to organizational policies and procedures, and always sign and date the corrected entry.
- Contact the manager, risk manager or legal counsel for assistance with documentation concerns or questions related to regulatory compliance or potential liability.

Communicate effectively.

The following measures can help minimize misunderstandings and strengthen rapport with patients:

- Consider the type of communication most appropriate for each situation, e.g., written versus spoken, words versus pictures, in person versus by telephone.
- Encourage patients to speak frankly and to ask questions.
- Involve the patient in establishing treatment goals and creating a care plan.
- Actively solicit feedback from the patient, and document the patient's statements in the healthcare information record.
- Request that patients repeat back key information to confirm their comprehension.
- Recognize patients' nonverbal cues, such as grimacing or flinching, as well as physical distress signs, such as pallor or diaphoresis.
- Obtain adult patients' permission before sharing information with family members or significant others. Never disclose patient information on social media.
- Notify providers and other 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, as time is of the essence and misunderstandings or delay may have serious consequences.
- Employ effective handoff communication techniques whenever the care of the patient is transferred to another AT or healthcare provider.
- Utilize qualified and approved translation/interpreter services when necessary, in accordance with organizational guidelines and legal requirements.
- Maintain a copy of all written materials provided to patients and document references to standard educational tools.
- Obtain signed receipts for any educational materials given to patients, and retain receipts in the healthcare information record.
- Document discussions with the patient about any medical issues that require additional explanation by a physician, licensed independent practitioner or other healthcare provider, and follow up with the patient to see if their questions have been answered.

Delegate with care.

Delegate only those services that can be legally and safely provided by another level of staff. When delegating to a student or volunteer for the first time, always provide appropriate supervision, verify that the student or volunteer has the competency to perform the designated tasks, and document observations about the student's or volunteer's ability in the appropriate educational file. The following additional guidelines can serve to enhance patient safety when care is delegated:

- **Delegate only when the patient is stable** and his/her ability to tolerate the service is known to the healthcare provider.
- **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 AT's direct attention.

Be vigilant about protecting patients from the most common types of injuries.

Our examination of closed claims indicates that the possibility of *head injuries* (e.g., concussion, skull fractures, hemorrhage), *burns* and *fractures* should be a critical concern for all athletic training professionals. The following guidelines can help mitigate harm to patients, minimize liability and increase defensibility if such an injury occurs.

Head injuries:

- **Adhere to the strictest applicable protocols.** National, state, local and organizational guidelines may differ in regard to head injury assessments, diagnosis and treatment. In such a case, comply with the most stringent of the relevant regulations or protocols.
- **Be aware of gender differences in concussion symptoms.** Many studies suggest that female athletes appear to sustain concussions and other sports injuries at a higher rate than their male counterparts.*
- **Review evidence-based best practices**, including the following:
 - [10 for 10 Presentation by the NATA College/University Athletic Trainers' Committee: Concussions in Intercollegiate Athletics.](#)
 - [CDC Injury Center: HEADS UP to Brain Injury Awareness.](#)
 - [A Comprehensive Approach to the Clinical Care of Athletes Following Concussion, 2014.](#)
 - [Concussion Infographic Handout](#) (pdf), page 201.
 - [The Epidemiology of Sport-Related Concussion.](#)
 - [Korey Stringer Institute: Concussion Policies.](#)
 - [NCAA Sport Science Institute™: Concussion Guidelines.](#)
 - [Test-Retest Reliability of Computerized Concussion Assessment Programs.](#)

* See Covassin, T., Moran, R. and Elbin, R.J. "[Sex Differences in Reported Concussion Injury Rates and Time Loss from Participation: An Update of the National Collegiate Athletic Association Injury Surveillance Program from 2004-2005 Through 2008-2009.](#)" *Journal of Athletic Training*, March 2016, volume 51:3, pages 189-194. See also Wick, J. "[Sports Injuries: Are Women More at Risk?](#)" *Pharmacy Times*, June 16, 2014.

- **Arrange emergency transportation to the nearest emergency room if an athlete exhibits any of the following symptoms:**
 - Glasgow Coma Scale <13.
 - One pupil larger than the other.
 - Prolonged loss of consciousness.
 - Focal neurological deficit that may suggest intracranial trauma.
 - Repetitive or uncontrolled emesis.
 - Persistently diminished/worsening mental status or other neurological signs/symptoms.
 - Significant spine-related trauma/injury.
- **Notify the employer, school officials and/or team physician/practitioner if an athlete, coach or parent/guardian disregards any recommended treatment or safety regimen, and document both the notification and the responses.**

Burns:

- **Be aware of the high risk of burns from certain commonly used treatments 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.**
- **Assess and document the patient's skin integrity, neurological status, and ability to perceive pain or discomfort, conveying any noted problems to staff. Assessments should be conducted prior to the course of treatment and periodically thereafter.**
- **Closely supervise and/or monitor patients during treatment and document this supervision.**
- **Discuss any perceived alterations in skin integrity with 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.**

Fractures:

- **Assess patients for fall and fracture risk in view of underlying medical conditions, both upon the initial visit and periodically thereafter.**
- **Train staff and patients in the proper use of equipment and require an initial demonstration of competency.**
- **Evaluate and document patients' ability to use equipment in a safe manner and participate in rehabilitation treatments.**
- **Utilize appropriate safety devices, such as gait belts, equipment alarms, and floor and treatment table pads.**
- **Ensure that patients are correctly and securely positioned on treatment tables or equipment.**
- **Educate patients regarding the appropriate clothing and footwear that 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 consequent fractures or other injuries, and never leave patients unattended.**
- **If there are signs or symptoms of a possible fracture, immediately determine the need for additional medical evaluation and obtain emergency medical services if necessary.**

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

Examples of preexisting conditions include:

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

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

The following measures can help avert 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 remain 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 AT.
- **Immediately report any patient allegations about questionable activity** to a manager and the referring physician/practitioner.
- **Discourage inappropriate or questionable behavior on the part of patients**, and refrain from developing relationships with patients or family members that may result in a conflict of interest.

If questions arise relating to professional behavior or ethics, refer to [NATA resources](#).

Monitor the environment of care.

The following measures can help maximize patient safety:

- **Secure entrances and exits**, and restrict access to private and non-care areas.
- **Prevent slips and falls** by ensuring that walkways and floors are dry, level and unobstructed.
- **Regularly replace therabands** and other equipment known to wear out quickly.
- **Perform and document preventive maintenance** for all equipment, per manufacturer guidelines.
- **Ensure that equipment needed for each patient is readily available and checked before each use**, removing any equipment that appears to be broken, unreliable or unsafe.
- **Train patients in how to use equipment appropriately** and explain the risks of improper operation.
- **Immediately remove and sequester any equipment that has malfunctioned** or that does not meet safety standards.
- **Sequester any equipment that is involved in patient injury**, as it may serve as evidence in a liability claim.
- **Provide a visitor viewing/waiting space** that is 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.

**Train patients in how to use
equipment appropriately** and explain
the risks of improper operation.

Risk Control Self-assessment Checklist

The following checklist is designed to serve as a starting point for athletic trainers 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 AT 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 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.			
If necessary, I contact the supervisor, risk manager and/or legal department regarding 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 utilize the chain of command to resolve patient care or safety issues.			
If I work in more than one state, I familiarize myself with applicable practice rules and regulations in every relevant jurisdiction and practice within those state requirements.			

Clinical Specialty and Competencies	Yes	No	Actions needed to reduce risks:
I practice or work in an area that reflects my education and experience, and my competencies (including experience, training, education and skills) are consistent 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 check whether I possess the proper competencies and decline the assignment if I do not.			
I receive an orientation and/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.			

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Consent to Treatment/Refusal of Treatment	Yes	No	Actions needed to reduce risks:
I know my state's informed consent regulations and consistently comply with them.			
I explain the reasoning behind proposed diagnostic tests or treatments and present relevant clinical findings prior to initiating therapy.			
I discuss the benefits and risks of the proposed diagnostic test or procedure, present alternatives and explain the risks of not performing the procedure.			
I permit the patient to ask questions about the proposed course of treatment, allotting enough time for multiple queries and full answers.			
I document the consent discussion, noting whether the patient accepts or refuses the proposed test or treatment.			
I obtain the patient's signature consenting to or refusing recommended treatment and retain the signed form in the patient's healthcare information record.			

Assessment	Yes	No	Actions needed to reduce risks:
I assess and document the following information during the initial assessment, upon a change in treatment, and after any change in a patient's condition or response to treatment:			
<ul style="list-style-type: none"> - Presenting problem(s). 			
<ul style="list-style-type: none"> - Vital signs. 			
<ul style="list-style-type: none"> - Comorbidities affecting the patient's status. 			
<ul style="list-style-type: none"> - Patient's understanding of his/her condition and plan of treatment/care. 			
<ul style="list-style-type: none"> - Mobility status, including use of mobility aids. 			
<ul style="list-style-type: none"> - Medications, including prescription drugs, over-the-counter products, biological therapies and nutraceuticals. 			
<ul style="list-style-type: none"> - Skin/wound status, including any wounds or lesions. 			
<ul style="list-style-type: none"> - Pain level and management. 			
<ul style="list-style-type: none"> - Cognition. 			
<ul style="list-style-type: none"> - Nutrition/hydration. 			

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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 follow sound documentation practices and check that my notes:			
<ul style="list-style-type: none"> - Are consistent with the treatment plan. 			
<ul style="list-style-type: none"> - Justify the services billed. 			
<ul style="list-style-type: none"> - Support coding procedures and billing codes. 			
<ul style="list-style-type: none"> - Comply with state and local laws and regulations. 			
<ul style="list-style-type: none"> - Comply with organizational, professional and ethical guidelines. 			
I document patient no-shows and appointment cancellations.			
I refrain from including in my documentation any inappropriate subjective opinions, conclusions or derogatory statements about patients, colleagues or other members of the patient care team.			
I document concurrently and make a late entry only if it is necessary for the safe continued care of the patient, ensuring that it is appropriately labeled as a late entry.			
I correct my charting errors in accordance with my organization's policies and procedures.			
I contact my supervisor, risk manager or legal counsel for assistance with documentation concerns or questions related to potential liability or regulatory matters.			

Environment of Care	Yes	No	Actions needed to reduce risks:
I monitor the environment of care to maximize patient safety, being careful to:			
<ul style="list-style-type: none"> - Secure entrances and exits. 			
<ul style="list-style-type: none"> - Maintain unobstructed hallways and treatment areas. 			
<ul style="list-style-type: none"> - Restrict access to hazardous substances and areas not used for patient care. 			
<ul style="list-style-type: none"> - Conduct preventive maintenance and periodic safety checks on all equipment, per manufacturer guidelines and organizational policy. 			
<ul style="list-style-type: none"> - Ensure that the equipment needed for each patient is readily available and in good condition. 			
<ul style="list-style-type: none"> - Test equipment prior to patient use, removing any equipment that appears to be broken, unreliable or unsafe. 			
<ul style="list-style-type: none"> - Train patients in how to use equipment appropriately, and inform them of the risks of improper operation. 			
<ul style="list-style-type: none"> - Sequester any equipment that is involved in a patient injury. 			

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Professional Conduct	Yes	No	Actions needed to reduce risks:
I speak to patients, families practitioners and others 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 refrain from harsh touching, movement and language with patients at all times.			
I refrain from using potentially insulting or inappropriate humor, sarcasm or idiomatic expressions (e.g., "No pain, no gain") that may impede communication and heighten the potential for injury.			
I am respectful of others' values and beliefs and am aware of my own personal and 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; obtain their permission before proceeding; and document my discussions with patients.			
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 behaved in an unusual manner.			
I do not hold sidebar conversations with other providers or staff members when I am with a patient, or respond to personal telephone calls or text messages.			
I refrain from discussing patient matters outside the clinical area, such as on elevators, in hallways or other public areas, and on social media sites.			

Treating Minors	Yes	No	Actions needed to reduce risks:
I am aware of the legal and ethical issues associated with treating minors, especially in the areas of custody and consent.			
When I have questions about treating a minor, I contact the supervisor, risk manager and/or legal department, and if answers are not satisfactory, I contact the state or national professional organization and request an interpretation, opinion or position statement on the issue.			
I obtain continuing education and training on treating minors and stay current with changing statutes and regulations.			

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Communication	Yes	No	Actions needed to reduce risks:
I determine the best means of communicating before interacting with practitioners, patients and family members – e.g., written versus spoken, words versus pictures, in person versus by telephone.			
I recognize nonverbal cues from patients, such as grimacing, flinching, pallor or diaphoresis (excessive sweating), and I cease treatment if necessary.			
I request that patients repeat back or paraphrase important information and demonstrate home-treatment techniques to ensure comprehension.			
I practice active listening skills and utilize teach-back techniques to ensure that patients understand my instructions.			
I avoid the use of complex medical terminology when speaking with patients and/or family members.			
I obtain the patient's written permission before sharing any protected health information with coaching staff, family members or significant others.			
Following injury to a patient, I notify the appropriate individual(s) – such as the coaching staff, team physician, and/or parent or legal guardian – and explain the need for further clinical treatment.			
I actively solicit ongoing feedback from the patient and document relevant patient statements in the healthcare information record.			
I am sensitive to language barriers and use an interpreter when necessary, in accordance with organizational protocols.			
I follow organizational protocols and HIPAA privacy requirements when communicating with patients and others, and I am especially careful when transmitting any protected health information via email.			

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**I practice active listening skills
and utilize teach-back techniques
to ensure that patients
understand my instructions.**

Practice and Claim Tips

Two sets of recommendations follow. The first is designed to help ATs minimize risk in their everyday practice, while the second 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 national 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 safe patient care. If information must be added to the record, properly label and date the late entry.

Responding to a filed or potential claim:

- **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.
- **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 threat to your license to practice.
- **Refrain from discussing the matter with anyone other than your defense attorney and the claim professional managing your case.**
- **Promptly return calls from your defense attorney and the claim professional assigned by your insurance carrier.** Contact your attorney 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.
- **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 legal counsel.



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