Presented by NSO and CNA

Nurse Practitioners Medical Malpractice

Case Study with Risk Management Strategies

Medical malpractice claims can be asserted against any healthcare provider, including nurse practitioners. In fact, over $44 million was paid for malpractice claims and expenses involving nurse practitioners, according to the most recent CNA HealthPro 5-year study*.

This case study involves a nurse practitioner as an owner and treating practitioner in a family medical office setting.

Case Study: Failure to advise patient of an urgent medical condition, Failure to keep an adequate medical record, Failure to timely address an emergent condition/ complication

Indemnity Reserve: Less than $150,000
Legal Expenses Incurred: More than $30,000

Summary

(Monetary amounts represent only the payments made on behalf of the treating nurse practitioner.)

Our insured family nurse practitioner (defendant) was the primary provider of a 67 year-old male patient (plaintiff) for various medical conditions including diabetes, Crohn's disease and hypertension. He had a 50 year history of one to two packs-a-day cigarette smoking habit and for the past 40 years he admitted to being a "heavy beer drinker." Our insured NP was his primary treating provider for five years after he was discharged from his previous primary medical provider due to non-compliance with his chronic illnesses and abusive statements to the former provider's office staff. The patient claimed that he had issues affording medications and this is the reason for his non-compliance, but offered no explanation for his abusive behavior.

During the first three years of treating with our insured NP, the patient had health insurance and this allowed him to afford his medications and be consistent with his medical treatments. At one point he had a pulmonary embolism diagnosed and was placed on blood thinners. The insured NP monitored his monthly international normalized ratio (INR) for a few months until the patient stopped coming into the office despite the insured NP's phone calls to advise the patient that monthly INRs were necessary to monitor blood thinner dosage. The last two years, he missed most of his scheduled appointments and when his medications required provider approval, he would call the practitioner and demand refills from the staff without an appointment. He was argumentative and even threatened to bring lawsuit against the staff if they failed to refill his medication or tried to contact him about missed appointments.

One evening the patient was seen in an emergency department (ED) complaining of tingling in his left arm and weakness in his left leg. The patient's initial tests, including the laboratory, electrocardiogram, chest x-ray and computerized tomography (CT) of the brain were essentially normal. The ED provider discharged the patient home and instructed to him to take a baby aspirin a day, follow up with his primary care provider, return to the ED with any concerns and scheduled an outpatient magnetic resonance imaging (MRI) of the brain.

The patient called our insured NP the next morning to advise them of his prior ED visit and that he had an MRI of the brain scheduled for the following day. He made an appointment with the nurse practitioner for after the MRI to review the findings. As soon as the MRI was completed, the radiologist called our insured NP to report his findings. The radiologist testified that the he conveyed the MRI findings with a sense of urgency and faxed the results soon after his phone call. He communicated that critical medical treatment was needed, such as starting the patient on a blood thinner and having a magnetic resonance angiogram (MRA) of the carotids. His medical opinion was that the patient was suffering from small strokes and that he possibly had a blood clot in the right carotid artery. (Our insured NP disputed the radiologist's testimony of how the test results were reported to her and stated that she was only told to schedule an MRA and start the patient on a blood thinner.)

Upon speaking with the radiologist regarding the results, our insured NP instructed her staff to call the patient to determine which pharmacy he wanted his blood thinner prescription sent and schedule a MRA (stat). Three hours later the patient was on his way home from picking up his prescription when he suffered a massive ischemic stroke and was involved in a motor vehicle collision (MVC).

The patient was admitted to the hospital for stroke care, but later transported to a trauma center where a CT scan of the brain noted

continued...

CNA nso

his stroke was progressing. His internal carotid artery was 80 percent occluded causing him to need a right hemicraniectomy. Four weeks after suffering from the massive stroke, the patient was discharged to a skilled nursing facility to work on regaining function (speech, mobility, use of extremities, motor function/skills, etc.). The patient remains in a skilled nursing facility unable to ambulate or care for himself, but is able to communicate and is somewhat able to participate in his care.

Several healthcare providers, including our insured NP and the ED practitioner were sued initially one year after the patient's massive stroke.

Resolution

The defense medical experts that reviewed the claim stated that little could have been done to have prevented the patient's stroke since it was less than four hours between the times our insured NP learned of the MRI results and when the patient's stroke occurred. Even if the insured NP would have instructed the patient to go to the ED, nothing would have prevented the stroke, he would have just had it in the hospital and his deficits would not be any less.

When the patient's health records were reviewed by our defense nurse practitioner expert witness, she was critical of the overall documentation. She noted omitted medical entries from the patient's past office visits and no references to the patient's missed appointments or follow-up phone calls for missed appointments. Missing documentation included education and counseling regarding the patient's noncompliance with his healthcare recommendations and regarding the rants he would use toward the office staff when he needed medication refills. The defense experts' opinion of the overall patient's care and the insured NP's actions on the day of his massive stroke was defensible. However, with the poor quality of medical documentation and nonexistent follow up on behalf of the office staff, the nurse practitioner expert stated that the health record gave the impression that the practitioner and her office appear incompetent.

Risk Management Comments

The lawsuit lasted more than six years due to the family firing their first attorney and hiring a second attorney. The medical cost the patient suffered was severe and the patient's attorney claimed damages of:

- Medical expenses related to stroke: $1,070,138
- Future economic damages: $2,913,376

The insured NP nurse practitioner was in poor health and wished to settle the claim even though the defense attorney claimed the likelihood for a defense verdict at 60 percent. Mediation was attempted several times, but three weeks prior to trial a settlement was reached on behalf of our insured NP.

Risk Management Recommendations

- ***Document all patient-related discussions, consultations, missed appointments, clinical information and actions taken,*** including any treatment orders provided, and ensure that the documentation factual and refraining from subjective statements.
- ***Counsel and document counseling of noncompliant patients and/or responsible parties*** regarding the risks resulting from their failure to adhere to medication and treatment regimens.
- ***Perform periodic audits of patient health records to identity departures from documentation standards*** and determine opportunities for improvement.
- ***Educate each patient regarding the steps involved in the treatment process,*** as well as the patient's responsibility to notify the practitioner of any condition, unusual occurrences or feelings of distress during the treatment.
- ***Refer unstable and acutely ill patients to the nearest emergency services.*** If a patient is in the office and needs emergent or urgent care, call 911 and allow the patient to be transported by ambulance instead of in a private vehicle. If a patient refuses to allow ambulance transport to the hospital, obtain an "Against Medical Advice" (AMA) form with the patient's signature acknowledging their acceptance of the risks associated with driving while needing emergent or urgent care.

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional's standard business practice. Risk Management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks – a good Risk Management Plan will help you perform these steps quickly and easily!

Visit **www.nso.com/riskplan** to access the Risk Management Plan created by NSO and CNA. We encourage you to use this as a guide to develop your own Risk Management Plan to meet the specific needs of your healthcare practice.

CNA nso®

*CNA HealthPro Nurse Practitioner 2012 Liability Update: A Three-part Approach, CNA Insurance Company, October 2012. To read the complete study, visit www.nso.com/npclaimreport2012.