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 working as a forensic nurse in an emergency department.

Case Study: Failure to consider/assess patient's expressed complaints/symptoms, failure to treat a sexual assault victim for HIV, failure to prescribe appropriate medication

Indemnity Incurred: Greater than $300,000
Legal Expenses Incurred: More than $300,000

Summary

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

A 40 year old female (patient/plaintiff) presented to the emergency department after being sexually and physically assaulted. According to the healthcare record, the patient was working alone at a wireless telecommunication store when a male came in the door with a knife in his hand. He physically and sexually assaulted the patient for over an hour before leaving. Shortly after the assault, the male was arrested a few blocks away from the store.

The patient presented to the emergency department four hours after the attack accompanied by her husband (co-plaintiff) and a police detective. On arrival to the emergency department the patient appeared to be medically stable, but was noted to be very upset, anxious and crying. She was taken to an exam room and shortly thereafter, the on-call, sexual assault nurse examiner (SANE-A®) was requested by the police detective. Approximately one hour later, our insured nurse practitioner (an independent contractor) arrived at the hospital and began the medical-legal examination. The insured NP noted the patient was alert to person, place and time, tearful, but easily composed. She documented that there were signs of physical trauma to the patient's face, neck, abdomen, extremities and back. The patient informed her that oral, vaginal and anal penetration had occurred during the assault. The pelvic exam showed no evidence of tears, swelling or bruises to her external genital organs. There was presence of stool and secretions at the vaginal orifice, but again, no redness, swelling, or tears were present. Rectal examination demonstrated multiple external hemorrhoids, without evidence of tears or swelling. The insured noted trace amounts of bright red blood with digital rectal exam and stool testing was positive for blood. The patient was uncertain if the assailant was wearing a condom; however, both vaginal and rectal examinations were negative for sperm.

After the exam, the patient joined her husband as the nurse practitioner reviewed the results of the laboratory tests that had been performed. The insured NP noted that the patient had a weakly positive HCG (pregnancy test) and that the patient was a 40 year old woman who had a prior hysterectomy due to a uterine tumor. The nurse practitioner's main focus switched from the rape exam to the concern of a possible ovarian tumor due to the positive HCG. She expressed her concerns to the patient and her husband about the positive HCG test results and likelihood of a ovarian tumor. She emphatically stressed the importance of immediate follow up; despite that the discharge documentation was written for follow up within two to three weeks. During the conversation, the patient's husband appeared unconcerned about the HCG test results and questioned the insured NP about prescribing antiretroviral medications to which the insured NP replied that this was unnecessary. She informed them that the police would have notified her if the rapist was HIV positive (as they had him in custody) and the community is considered to be a low risk for HIV transmission; thus further reducing the need for the antiretroviral drugs. The nurse practitioner gave the patient three prescriptions for prophylactic antibiotics and wrote for the patient to be discharged home.

The patient and her husband were given verbal and written follow up instructions by the hospital's emergency department nurse, which included the recommendation to see her primary care physician within the next two weeks (contradicting the verbal instructions by the nurse practitioner) and a referral to the local rape crisis center for psychiatric counseling.

Despite being verbally instructed by our insured NP to see her primary medical practitioner the next day, the patient did not follow up with any healthcare provider for approximately six weeks after her assault. At that time, she saw her primary family practitioner and made him aware of the assault. She continued to be emotional over the event and informed him that she had been "worked up" after the incident in the emergency department. The practitioner did not order any further laboratory tests or request the emergency department health record. He did a physical assessment and noted that all her physical traumas had healed. Her only complaints to him was that she was terrified to be alone and had trouble sleeping at night. He diagnosed her with anxiety and insomnia and gave her a prescription for an anti-anxiety medication and confirmed that she was being treated by a counselor.

Approximately two months after the assault, the patient was seen by her gynecologist. It was at this time that she was tested for HIV and seven days later the test was reported as positive. The patient immediately began taking antiretroviral medications; however the HIV diagnosis furthered her anxiety and put her in a deep depression.

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Risk Management Comments

The patient and her counselor testified having to "badger" the police until they eventually had the assailant tested for HIV. The counselor states that she may have made as many as ten calls to the police department and was told that assailant would not submit to a voluntary test because he was "afraid of needles." The assailant was finally tested and was positive for HIV. When the prison's medical providers questioned him about his knowledge of being HIV positive, he replied that he knew he was and had been positive for a few years.

Since the rape, the patient is unable to leave her home, because it is the only place she feels safe. She is afraid of men and suffers from depression and agoraphobia. She has been diagnosed with post-traumatic stress disorder (PTSD) and continues with counseling.

The patient and her husband filed a lawsuit against our insured NP and several other parties. The parties included the hospital where the patient was initially treated after the assault, the police department and the patient's primary medical practitioner.

During the nurse practitioner's interview with her attorney, she indicated that she felt that the patient's exam revealed only minimal signs of trauma. She also stated that the blood noted on patient's rectal exam was fresh from the exam and likely due to multiple hemorrhoids, not the rape. She stressed the fact that there was no evidence of rectal mucosal tearing noted during the exam, therefore placing the patient at a lower risk for penile-anal or penile-vaginal transfer of infection. She was deeply saddened over the patient's diagnosis of HIV and agreed that she should have followed up with the police department about the HIV status of the assailant. She affirmed that the information she provided to the husband regarding the community's low risk for HIV transmission was information she had learned many years prior and that she had not perused any new clinical information on HIV transmission in the last five years.

The police officer responsible for processing the assailant into jail admitted during his deposition that he did not ask if the assailant would consent to HIV testing because of "privacy laws." He admitted that he should have known of the existence of the state's statute of testing an assailant involved in a sex crime for HIV and that it was his responsibility to ensure that assailant was tested. He also admitted that assailant should have been tested immediately and that victim (patient) should have been notified of his HIV status promptly. He conceded that the police were negligent and that there is no excuse for the police department's failure to enforce the HIV testing state statute.

The plaintiff's experts claimed our insured:

- Failed to treat the patient appropriately
- Failed to consult or follow up with the police department on the status of the assailant's HIV status
- Failed to educate the patient and her husband appropriately about antiretrovirals
- Failed to consult with the supervising emergency department physician regarding the appropriateness of treatment and care
- Failed to maintain and stay updated in her field with regards to prescribing prophylactic antiretroviral medications to sexually assaulted patients where the HIV status is unknown
- Relied on erroneous statistics for the community's low HIV infection rate to base treatment

Resolution

We had a very strong panel of experts who supported the care and treatment our insured provided to the patient. The only concern was that the circumstances were so tragic and egregious we believed a jury could look past our viable defenses and award damages.

The defense attorney recommend settlement if a reasonable figure could be agreed upon especially since the police department, hospital and the patient's primary practitioner settled shortly after the lawsuit was filed.

Defense attorney estimated damage awards to be in the $2.5 million to $5 million dollar range for the patient and from $500,000 to $1 million dollar range for her husband.

Risk Management Recommendations

- ***Maintain clinical competencies aligned with the relevant patient population and certified clinical specialty,*** taking into consideration the following professional responsibilities:
  - Remember that nurse practitioners have a duty – and, in most states, a licensing renewal requirement – to proactively obtain and update the clinical and professional information, education and training needed to maintain and enhance their expertise.
  - Remain current regarding clinical practice, medications and biologics utilized for the diagnosis and treatment of acute and chronic illnesses and conditions related to one's specialty.
  - Obtain regular continuing education to retain and enhance clinical competencies. Contact the state nurse association, board of nursing, board of medicine or pharmacy, and nurse practitioner professional associations for information about reputable educational and training offerings.
- ***Educate the patient and/or responsible party*** regarding the diagnosis, treatment plan, and the need for compliance with treatment recommendations, medication regimens and screening procedures.
- ***Ascertain the patient's level of compliance*** with currently ordered treatment and care instructions, medication regimens and lifestyle suggestions.
- ***Document in the health record contemporaneously, factually and thoroughly.*** A complete health record is the best legal defense. Discussions with the patient and/or responsible party regarding diagnostic test results (both normal and abnormal), as well as recommendations for continued treatment and patient response to results.

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 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.

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