Nurse Practitioner Spotlight: Medication Management and Prescribing

Nurses Service Organization in collaboration with CNA has published the 4th Edition of our *Nurse Practitioner Claim Report*. It includes statistical data and legal case studies taken from CNA's claim files, along with risk management recommendations designed to help nurse practitioners reduce their malpractice exposures and improve patient safety.

You can find the full Report at: www.nso.com/npclaimreport

This **Nurse Practitioner Spotlight** focuses on our analysis and risk recommendations regarding one of the most significant topics from the report: allegations related to medication management and prescribing.

- The average paid indemnity for **medication** closed claims is close to the overall average paid indemnity ($240,471). However, the overall frequency of medication allegations in the current report (29.4 percent) has increased significantly since the 2012 report (16.5 percent).
- **Failure to properly instruct patient regarding medication** has the highest severity among the medication-related allegations, as resultant injuries include death, brain damage and seizures. An example follows:
  - An infant diagnosed with panhypopituitarism was taking Cortef®. The insured NP failed to advise and instruct the mother about the risk of hypoglycemia associated with the medication and the need to monitor her baby's blood glucose level. The infant suffered seizures due to hypoglycemia, leading to delays in motor and social skills, as well as speech. The claim settled in the mid-six-figure range.
- The increased frequency of medication-related allegations is due in part to the allegation of **improper prescribing/managing of controlled drugs,** including schedule II and schedule III opioids such as methadone, oxycodone, fentanyl and hydrocodone. Many times the patient had a history of drug/alcohol abuse and was currently using or abusing schedule IV controlled substances. The injuries associated with this category include addiction and fatal overdose.

11 FREQUENCY AND SEVERITY OF ALLEGATIONS RELATED TO MEDICATION PRESCRIBING

Allegation sub-category	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Failure to properly instruct patient regarding medication	1.0%	$2,385,000	$795,000
Failure to recognize contraindication and/or known adverse interaction between ordered medications	4.3%	$5,533,750	$461,146
Improper management of medications	3.9%	$4,212,000	$382,909
Improper prescribing/management of anticoagulant	3.2%	$2,085,024	$231,669
Prescribing error, wrong dose	2.4%	$1,169,000	$167,000
Prescribing/administering error, intravenous fluids and/or medication	0.7%	$310,000	$155,000
Prescribing error, wrong route	0.3%	$100,000	$100,000
Improper prescribing/managing of controlled drugs	12.9%	$3,687,500	$99,662
Prescribing error, wrong medication	0.7%	$120,000	$60,000
Overall	29.4%	$19,602,274	$233,360

Analysis of Allegation: Medication Claims by Illness/Injury

- **Ear injury/hearing loss** is the costliest medication-related injury.
- **Death** and **addiction** are the most common medication-related injuries, together accounting for 19.6 percent of all the claims in this subset. As noted in Figure 11, **improper prescribing/managing of controlled drugs** is by far the most frequent medication-related allegation.
- **Addiction** claims grew almost tenfold between 2012 and 2017, from 1.0 percent to 9.5 percent of all the closed claims in the dataset. Average paid indemnity of addiction claims is relatively low at $64,815. All of these claims occurred in a physician office practice or clinic and involved allegations that the nurse practitioner prescribed excessive amounts of medications, including opioids, antianxiety drugs and/or muscle relaxants. While this injury directly relates to the overprescribing of highly addictive medications, it does not include all injuries associated with prescribing of schedule II and III drugs.

12 FREQUENCY AND SEVERITY OF MEDICATION CLAIMS BY ILLNESS/INJURY

Illness/injury	Percentage of closed claims	Total paid indemnity	Average paid indemnity
Ear injury/hearing loss	0.3%	$925,000	$925,000
Brain injury (other than birth-related brain injury)	0.7%	$1,141,250	$570,625
Emotional /psychological harm/distress	0.7%	$997,000	$498,500
Allergic reaction/anaphylaxis	1.0%	$1,394,000	$464,667
Eye injury/vision loss	0.7%	$925,000	$462,500
Steroid-induced psychosis	0.7%	$900,000	$450,000
Cardiac condition (excludes myocardial infarction)	0.7%	$650,000	$325,000
Paralysis	0.3%	$312,500	$312,500
Cerebrovascular accident	1.0%	$875,000	$291,667
Death	9.9%	$7,990,024	$285,358
Loss of organ or organ function	1.0%	$765,000	$255,000
Neurological deficit/damage	1.4%	$742,500	$185,625
Infection/abscess/sepsis	1.0%	$205,000	$68,333
Addiction	9.7%	$1,750,000	$64,815
Pulmonary/respiratory failure	0.3%	$30,000	$30,000
Overall	29.4%	$19,602,274	$233,360

CASE SCENARIO: Improper Management of Medication

A nurse practitioner employed by a rural family practice began treating the 78-year-old mother of a co-worker. The patient presented at the first office visit with a six-month history of difficulty swallowing due to throat swelling and soreness, as well as a persistent cough. She also complained of a pimple-like sore in her right nostril. The patient's prior medical history was positive for coronary artery disease, atrial fibrillation, chronic obstructive pulmonary disease, hyperlipidemia and arthritis.

The insured nurse practitioner prescribed a broad-spectrum antibiotic and a prednisone dose pack, while scheduling the patient for a barium swallow and bloodwork. She also ordered a culture of the patient's throat and the pimple in her nasal passage. Several laboratory values were abnormal, including a decreased white blood cell count, low red blood cell count, low hematocrit, low lymphocytes, low sodium, low chloride, high glucose, high SGOT, low total protein and low albumen. The cultures indicated a positive result for Staphylococcus aureus and Pseudomonas aeruginosa.

The NP prescribed 350mg Gentamicin every day for 10 days to be administered intravenously, advising the patient to have the antibiotic administered at the hospital. The patient refused to receive treatment at the hospital, requesting that the drug be administered at home. The insured verbally informed the patient and her daughter of the medication's potential side effects – such as progressive kidney failure, blurred vision, permanent hearing loss and nerve damage – but did not document the conversation.

The following day the patient started a 10-day regimen of the antibiotic. On the second day of treatment, she fell due to weakness and was taken to the emergency department, where she was diagnosed with a right hip contusion and dehydration. She received intravenous hydration before being discharged home.

The next day the patient came to see the insured. She stated that the antibiotic was making her feel "very woozy" and causing her to fall. Her daughter, angry with the home health nurses, fired the agency and pressured the insured to allow the patient to receive the antibiotic in the office. The insured reluctantly agreed to the request, as she would be in the office the next several days and could oversee the infusions. The insured documented, "Reviewed sputum culture again with patient and daughter, reviewed susceptibility of meds, encouraged hospitalization, patient refuses, already fired home health, patient will come to office, order antibiotic Gentamicin." After administering the fourth dose of antibiotic on a Friday afternoon, the insured gave a verbal order to a medical assistant to obtain a serum gentamicin level from the patient and to perform several other laboratory tests. The assistant obtained the requested laboratory specimens but not the gentamicin level. The office was closed on weekends, so a medical assistant administered the antibiotic both days at the patient's home, with no NP or physician present.

On Monday morning, the nurse practitioner received a telephone call from the patient's daughter, who was concerned about her mother's condition and asked the NP to see the patient at her home. When she arrived, the patient complained of dizziness and was unable to get out of bed without assistance. Once the insured NP saw how weak the patient was, she called the office to ascertain the gentamicin level. Learning that no sample had been obtained, she drew one herself and discussed the patient with her collaborating physician. The physician advised starting the patient on intravenous fluids, but did not recommend hospitalization.

Later that day, the gentamicin level results were called in to the office. They were critically high. The insured instructed the patient's daughter to take her to the emergency department for treatment of gentamicin toxicity.

The patient suffered complete loss of hearing in both ears and acute renal failure, which has since resolved. She has been in and out of a nursing home for therapy. Her daughter has had to quit work to take care of her mother.

The claim settled in the high six-figure range, with expense costs of slightly less than $50,000.

Risk control recommendations:

- **Discuss the patient's condition, medications and care needs with the collaborating or supervising physician as needed,** and document these discussions.
- **Use caution when prescribing anticoagulants, antibiotics and psychoactive medications,** as well as other known toxicity-prone drugs.
- **Order and follow up with all indicated monitoring tests,** documenting results in the patient healthcare information record.
- **Avoid verbal orders** except in emergency situations.
- **Consult with a pharmacist as needed,** documenting all communications.
- **Remain current regarding clinical practice, medications, biologics and equipment** related to the diagnosis and treatment of illnesses and conditions encountered in one's specialty.
- **Prior to delegating patient care services,** ensure that the assigned services are within the scope of practice or work of the individual.
- **Be cautious about treating or providing care to family, friends or co-workers.** While it is not always easy to say no to requests from relatives and friends, the situation may cloud professional judgment and lead to ethical lapses.
- **Politely decline any suggestions or recommendations from patients that could jeopardize their safety** or lead to later questions about one's clinical expertise and/or judgment.
- **Refrain from initiating personal relationships outside of the care setting** with patients and their family members.

Risk Control Recommendations: **Medication Prescribing**

All Sound medication prescribing involves more than selecting the right dose of the right drug for the right person by the right route at the right times. It also means staying current with literature; guarding against patient allergies, side effects and adverse interactions; and educating patients about drug regimens and related risks. The following risk control recommendations, selected from CNA Nurse Practitioner Claim Report: 4th Edition, can serve as a starting point for nurse practitioners seeking to assess and enhance their patient safety and risk management practices.

Prescribing Recommendations

Prescribing is not a responsibility to be taken lightly. By prescribing a drug to any person – even as a "one-time favor" for a co-worker, relative, friend or neighbor – the practitioner has established a patient-practitioner relationship. The following strategies can help NPs avoid errors and minimize risk exposure:

- **Review current allergy information,** including descriptions of reactions, when ordering medications. In addition, ensure that such information is available to all prescribers in the practice. (See the Pennsylvania Patient Safety Advisory's "Medication Errors Associated with Documented Allergies.")
- **Learn about medication allergies, side effects and interactions,** including how to screen patients for potential allergic or other adverse reactions, recognize an allergic response and treat serious reactions. (See the above-listed resource for more information.)
- **Review previous medication orders alongside new orders and care plans,** and resolve any discrepancies each time a patient moves from one care setting to another. (See *ISMP Medication Safety Alert!®*, "Building a Case for Medication Reconciliation.")
- **Use developed standard order sets to minimize incorrect or incomplete prescribing,** standardize patient care and clarify medication orders. (See *ISMP Medication Safety Alert!®*, "ISMP Develops Guidelines for Standard Order Sets.")
- **When prescribing opioid drugs, use an appropriate opioid dose** based on patient age and opioid tolerance. (See *ISMP Medication Safety Alert!®*, "Beware of Basal Opioid Infusions with PCA Therapy.")
- **When reconciling medications, talk to patients and other practitioners** who may know more than what is written in the record. (See "The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles." Chicago: American Medical Association, 2007)
- **Emphasize the importance of keeping follow-up appointments,** especially when the patient is discharged on warfarin or direct oral anticoagulation therapy and there is a transition of care process. When necessary, verify that the patient has a confirmed, scheduled appointment with the laboratory, practitioner or anticoagulant clinic. (See the "2017 ISMP Medication Safety Self Assessment® for Antithrombotic Therapy.")
- **Consider integrating medical office electronic health record systems with inpatient systems,** thus permitting prescribers to view a more complete patient profile. It also facilitates medication reconciliation by comparing what the patient is taking at the time of the office visit with what was prescribed upon discharge. (See the Institute of Medicine [now the National Academy of Medicine] publication, *Preventing Medication Errors: Quality Chasm Series*, 2007.)
- **Develop a comprehensive medication patient education program** that includes both general written materials and specific spoken advice, and which is presented at an appropriate level for each patient. Copies of medication-related materials provided to patients should be retained in the healthcare information record. (See Shrank, W. and Avorn, J. "Educating Patients About Their Medications: The Potential And Limitations Of Written Drug Information." *Health Affairs*, May 2007, volume 26:3, pages 731-740.)

Opioid Risk Evaluation

All patients suffering pain should be given a thorough physical and have a history taken, including an assessment of psychosocial factors and family history. Reevaluate the level of pain and the efficacy of the treatment plan at every visit.

To minimize the risk of abuse, conduct an opioid risk assessment and depression scale test before prescribing opioids and perform periodic screening thereafter. Major risk factors of opioid abuse include, but are not limited to, family history of alcohol or drug use, history of physical or sexual abuse, and certain psychiatric conditions.

Many nurse practitioners perform random urine drug screens and regular pill counts on patients at risk of opioid overuse or abuse. Some other commonly used screening tools include …

- Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain.
- Diagnosis, Intractability, Risk, Efficacy (DIRE) tool.
- DIRE Score for Appropriate Opioid Use.
- Screening Instrument for Substance Abuse Potential (SISAP) Assessment Instrument, which evaluates the potential for misuse at every visit.

Remember that nurse practitioners, like all healthcare providers, have the right to determine whom they will treat, but discharging a patient in chronic pain may lead to complaints or legal action. Providers can help protect themselves against allegations of abandonment by rigorously documenting instances of noncompliance, communicating clearly and straightforwardly with patients, and establishing and consistently implementing formal policies and procedures.

Pain Treatment Agreements

A pain treatment agreement is a means of contractually defining the responsibilities of patient and provider, thus potentially reducing conflict and liability, while enhancing patient understanding and continuity of care. Such an agreement should address both prescription refill parameters (e.g., one provider, one pharmacy, refills only as scheduled, no early refills) and the repercussions of non-compliance, which may include discharging patients who repeatedly violate practice policies and procedures. Once the agreement is in place, it must be strictly enforced. Violations should be clearly communicated to the patient and documented in the patient healthcare information record.

Always seek legal counsel when drafting and revising pain agreements, and remember to update them regularly so that they reflect changes in level of pain, health status and medication dosages.

Prescription Drug Monitoring Programs

A prescription drug monitoring program (PDMP) is an electronic database that collects selected information on substances dispensed in the state. According to the Drug Enforcement Administration (DEA), the database serves a r ange of purposes, including the following:

- Supporting access to legitimate medical use of controlled substances.
- Deterring drug abuse, addiction and diversion.
- Identifying individuals addicted to prescription drugs and facilitating interventions.
- Strengthening public health initiatives by documenting drug use and abuse trends.
- Educating the public about the use, abuse and diversion of prescription drugs.

For additional information on state PDMPs, visit the U.S. Department of Justice's and DEA's Diversion Control Division's State Prescription Drug Monitoring Programs website.

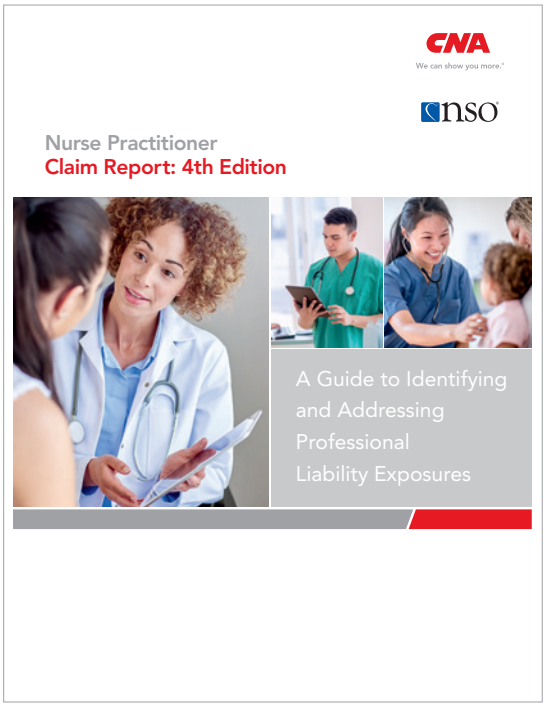
Risk Control Self-assessment Checklist for Nurse Practitioners: **Medication Safety**

The following abbreviated checklist, selected to focus on medication safety, is designed to help nurse practitioners evaluate risk exposures associated with their current practice.

Medication Safety*	Yes	No	Comments/Action Plan
Are all patient/caregiver concerns and questions about a prescribed medication addressed by the NP, including the drug's appearance, as well as the patient's ability to afford and swallow it and follow drug administration directions?			
Is all necessary patient identification information entered into the system before any medications are prescribed, including …			
- Full name (including preferred prefix)?			
- Gender?			
- Date of birth?			
- Weight?			
- Allergies?			
- Physical address?			
- All telephone numbers (e.g., home, cell, business)?			
- Alternate means of contact (e.g., email address, emergency contact person)?			
Is the current medications list reviewed, entered into the computer system and updated at each encounter, and does it include …			
- Prescriptions, including dose, frequency and route?			
- Over-the-counter products?			
- Immunizations, including vaccination dates?			
- Vitamins and other dietary supplements?			
- Homeopathic remedies, herbal products and other alternative medicines?			
Are telephone orders read back to the nurse practitioner by the pharmacist to confirm their accuracy?			
Is opioid prescribing strictly supervised, in compliance with the state's prescription drug monitoring program?			
Are allergies documented, including a description of past reactions?			
Are NPs and others in the practice trained to prevent medical errors by applying continuous quality improvement techniques?			
Are NPs and others in the practice trained to report adverse drug reactions to the U.S. Food and Drug Administration, as well as to follow internal reporting protocols?			

* Additional medication safety-related risk control self-assessment questions can be found in the **"2017 ISMP Medication Safety Self Assessment for Community/Ambulatory Pharmacy."**

This tool provides a reference for nurse practitioners seeking to evaluate basic risk exposures. The content is not intended to be a complete listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient/client needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. The statements expressed do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation encompassing a review of relevant laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.



This information was excerpted from NSO and CNA's full report, Nurse Practitioner Claim Report: 4th Edition. www.nso.com/npclaimreport

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X-12977-1217-A