Don't Become a Case Study!
NP Malpractice Data, Claim Scenarios, and Recommendations

CNA

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Objectives

List

List the leading allegations made against NPs in malpractice lawsuits.

Define

Define the average incurred expense for NPs in a malpractice lawsuit.

Identify

Identify key risk management tools NPs can incorporate into their practice.

Key Terms

- **Indemnity** - monies paid on behalf on an NSO/CNA insured nurse practitioner (NP) or NP healthcare practice in the settlement or judgment of a claim.
- **Total incurred -** monies paid, including indemnity and expenses, on behalf on an NSO/CNA insured NP or NP healthcare practice in the management and resolution of a claim.
- **Average total incurred -** the costs or financial obligations, including indemnity and expenses, resulting from the resolution of claims, divided by the total number of closed claims.
- **Defendant -** the party against whom a claim or charge is brought in court.
- **Plaintiff -** the party who brings suit in court.
- **State Board of Nursing (SBON)** – a jurisdictional, government-established board charged with regulating and overseeing nursing practice in their state or territory. They are responsible for enforcing nursing laws and for promoting safe and competent care.

Defining Malpractice

Malpractice: is a type of negligence; it is often called "professional negligence". It occurs when a licensed professional (like an NP) fails to provide services as per the standards set by the governing body ("standard of care"), subsequently causing harm to the plaintiff.

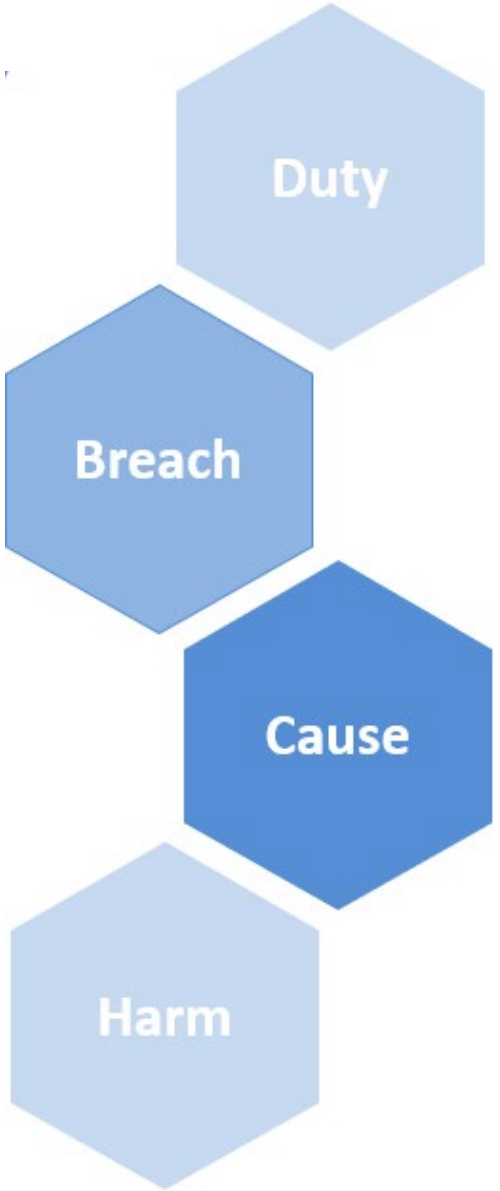
To be successful, the patient (plaintiff) must establish:

(1) the provider owed a duty to the patient;

(2) the provider breached his or her duty;

(3) the breach was the direct and proximate cause of injury;

(4) the injury resulted in damages/harm.



Professional Liability Data as a Risk Management Resource

- Analyzing incidents that led to adverse outcomes is the foundation for identifying vulnerabilities in our healthcare systems and reducing risk.
- Understanding the underlying human and systemic factors that can lead to patient harm helps nurse practitioners prevent errors through education, training, and practice improvement approaches.
- Professional liability data:
  - Provides insight into the underlying causes in cases: what failed and why?
  - Can reveal specific missteps, clinical errors, patterns of communication, and judgment failures that contribute to adverse events.
  - Helps NPs learn from peers' experiences and proactively identify areas for improvement.

Case Study

Case Study

- This case involves a family practice clinic, co-owned by a NP and a physician. The NP who treated the patient was covered as an employee of the practice and held a Doctor of Nursing Practice degree (DNP).
- The patient was a 22-year-old female who presented to the clinic, accompanied by her mother, with a complaint of left calf pain (5/10 pain level) over the past several days.
- The patient weighed over 400 pounds with a body mass index (BMI) of 54.74. The patient reported that she had been sedentary and not engaging in her normal physical activities for four to six weeks due to episodes of depression.
- Physical examination revealed non-pitting edema of the left calf, peripheral pulses 2+ throughout and a negative Homan's sign.
- The neurologic exam was documented as non-focal with normal motor strength in the upper and lower extremities.
- There was no documentation about the skin color or temperature of the affected limb.

Case Study

- Laboratory studies included a complete blood count with differential, lipid panel and complete metabolic panel, and were all within normal limits, with the exception of elevated cholesterol, triglyceride and glucose levels.
- The patient's vital signs were documented as follows:
  - Temperature-98.5
  - Heart rate-93
  - Respirations-20
  - Oxygen saturation-100 percent
  - Blood pressure-150/108.

Case Study

- The DNP prescribed an oral antihypertensive medication as well as Naproxen 500 mg every 12 hours for the calf swelling and instructed the patient to return in one week for a blood pressure recheck.
- A counseling appointment was scheduled to address the complaint of depression.
- Based upon the patient's chief complaint, the DNP ordered a Doppler ultrasound of the left lower extremity to rule out a DVT.
- The DNP intended for the ultrasound to be performed the same day and assumed that the office staff would arrange for it to be done expeditiously, as this was the normal office protocol.

Case Study

- However, the electronic medical record (EMR) order was entered as a “routine order” as opposed to a “same-day order” and the newly hired medical assistant interpreted it as “non-urgent”.
- There was no communication between the DNP and the medical assistant regarding the order and as a result, the ultrasound was scheduled for the following week, on the same day as the scheduled blood pressure recheck visit.
- A few hours after the patient left the clinic, the DNP realized that she had not received the patient’s ultrasound results from the diagnostic imaging center. However, it was an extremely busy day in the clinic, which led to distraction and ultimately, a failure to follow up on the results.

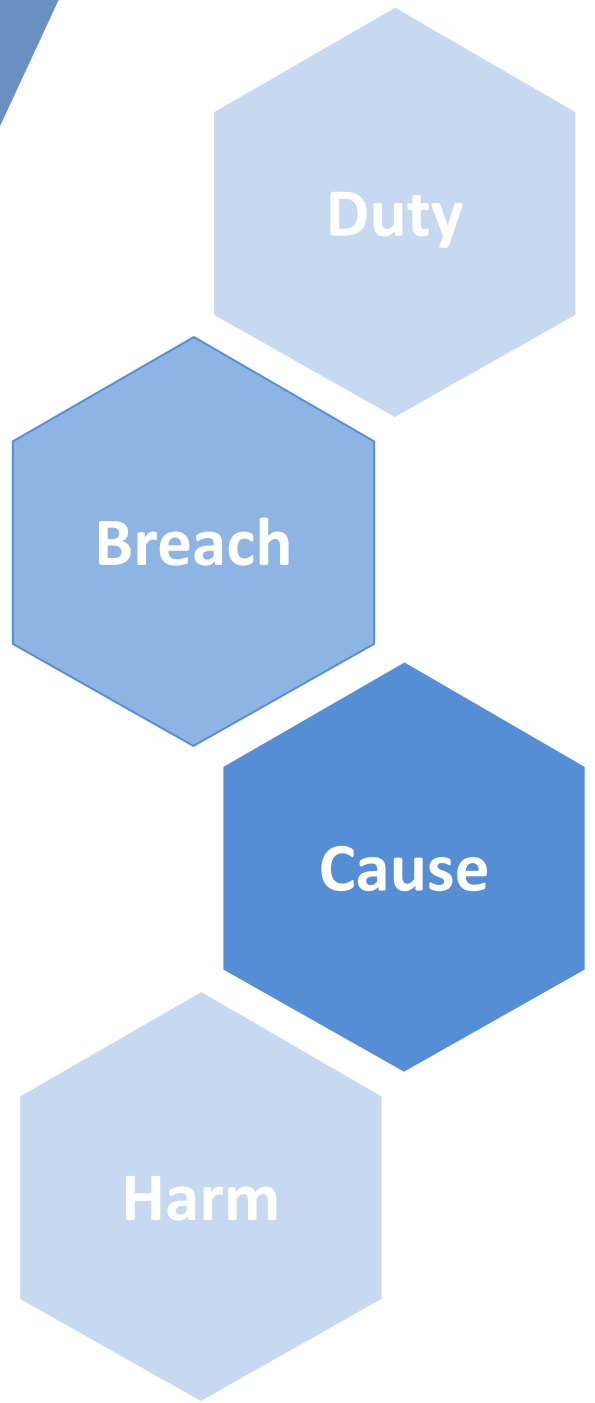
Case Study

- One week later, the patient returned to the clinic at 9 a.m., again accompanied by her mother. The patient stated that her pain had decreased to a 3/10 level but that she continued to have left calf swelling. Vital signs were stable with a normalized blood pressure. The patient denied chest pain, shortness of breath or dizziness.
- The DNP advised the patient to keep the ultrasound appointment which was scheduled for later that day and did not convey a sense of urgency or suggest an earlier appointment.

Case Study

- The ultrasound was performed at 2:11 p.m. and at 3:35 p.m., the DNP received a verbal report from the radiologist that the ultrasound revealed a DVT at the left popliteal and femoral veins.
- The DNP advised the patient to go to the hospital emergency department for treatment.
- The patient presented to the hospital approximately two hours later and while awaiting further testing and bed placement, coded and expired.
- The autopsy listed the cause of death as bilateral pulmonary emboli secondary to DVT of the left lower extremity.

Do You Believe the NP was Negligent?



Risk Management Comments

- Six months after the patient's death, the patient's mother (plaintiff) filed a lawsuit against the family practice firm and individually, against the treating DNP, alleging that a delay in the diagnosis of a DVT resulted in the patient's death, and that an earlier diagnosis would have prevented the fatal pulmonary embolism.
- The defense of this case was complicated by the conflicting testimonies of the DNP and the plaintiff regarding the discussions that took place during the office visits.
  - Specifically, the plaintiff denied that a "same-day" ultrasound was ordered during the initial visit.
  - With regard to the second visit, the plaintiff admitted that the DNP advised the patient to go to the hospital for treatment of the DVT. However, she did not convey a sense of urgency or inform them of the risks.
- The plaintiff testified that had she known about the risks she would have taken her daughter to the nearest hospital immediately.

Risk Management Comments

- Additional testimony regarding the DNP's credentials further complicated this case. The plaintiff testified in her deposition that she believed the DNP was a physician because she introduced herself as "doctor."
- The plaintiff was not familiar with the DNP designation, and testified that she would have requested a second opinion with a physician had the DNP informed the plaintiff about her qualifications.

What the Experts said…

- The defense experts opined that although the patient did not have all of the classic signs of a DVT (i.e. negative Homan's sign and not in a high-risk age group) she was in a higher risk category due to obesity, hypertension and a reported sedentary activity level.
- The experts collectively agreed that the DNP should have proactively followed up with the radiologist when she did not receive the ultrasound results as expected during the first visit.

What the Experts said…

- Jurors' opinions as to whether or not the provider met the standard of care are based upon many factors, including the credibility of the witnesses and expert testimonies as well as the provider's documentation in the healthcare information record.
- In this case, the DNP's documentation lacked details to support her testimony that she ordered a same-day ultrasound and that she informed the patient about the risks associated with a DVT.
- Defense experts were critical of the fact that the DNP-owner of the practice added a "late entry" referencing the order for a "same day" ultrasound test. This note was not dated and would appear to be self-serving to a jury.
- This case had the potential for a high jury award, given the decedent's age and the sympathy factor influencing a jury decision.

Resolution

Based on the low likelihood of a defense verdict, a settlement was negotiated on behalf of the insured DNP and the firm.

The claim resolved with a total incurred of greater than $950,000.

Figures represent only the payments made on behalf of our nurse practitioner and do not include any payments that may have been made by any co-defendants. Amounts paid on behalf of any co-defendants named in the case are not available.

Risk Control Recommendations

- ***Proactively follow up on diagnostic test results***, prioritizing those which have a propensity for identifying conditions requiring emergent care.
- ***Compile a comprehensive patient clinical history and consider risk factors which may influence the differential diagnosis.*** The diagnostic process is complex, involving clinical reasoning, coordinating test results, physical exams and past medical history. Diagnostic errors are rarely the result of one factor and frequently involve a combination of system issues, communication failures and clinical judgement errors.
- ***Document all patient-related discussions, and actions taken***, including any treatment recommendations provided.
- ***Discuss clinical findings, diagnostic test results, diagnosis, the proposed treatment plan and reasonable expectations for outcomes with patients/families***, in order to ensure their understanding of their care and their responsibilities. Document this process, noting the patient's responses.

Risk Control Recommendations

- ***Refrain from documenting subjective notes and avoid self-serving late entries***, especially after an adverse outcome has occurred.
- ***Document contemporaneously, factually and thoroughly and include the clinical decision-making process and rationale for the diagnosis.*** Objective and concise documentation is integral for both continuity of patient care, as well as for the defense of a potential malpractice claim. A complete healthcare information record is the best legal defense.
- ***Educate the patient and/or responsible party about the need for compliance*** with treatment recommendations, medication regimens and screening procedures.
- ***Assess the patient's health literacy level to ensure that they have an adequate understanding about their role in the treatment plan.*** Consider using the "teach-back" method for communicating patient instructions about required tests or other elements of the treatment plan.

Risk Control Recommendations

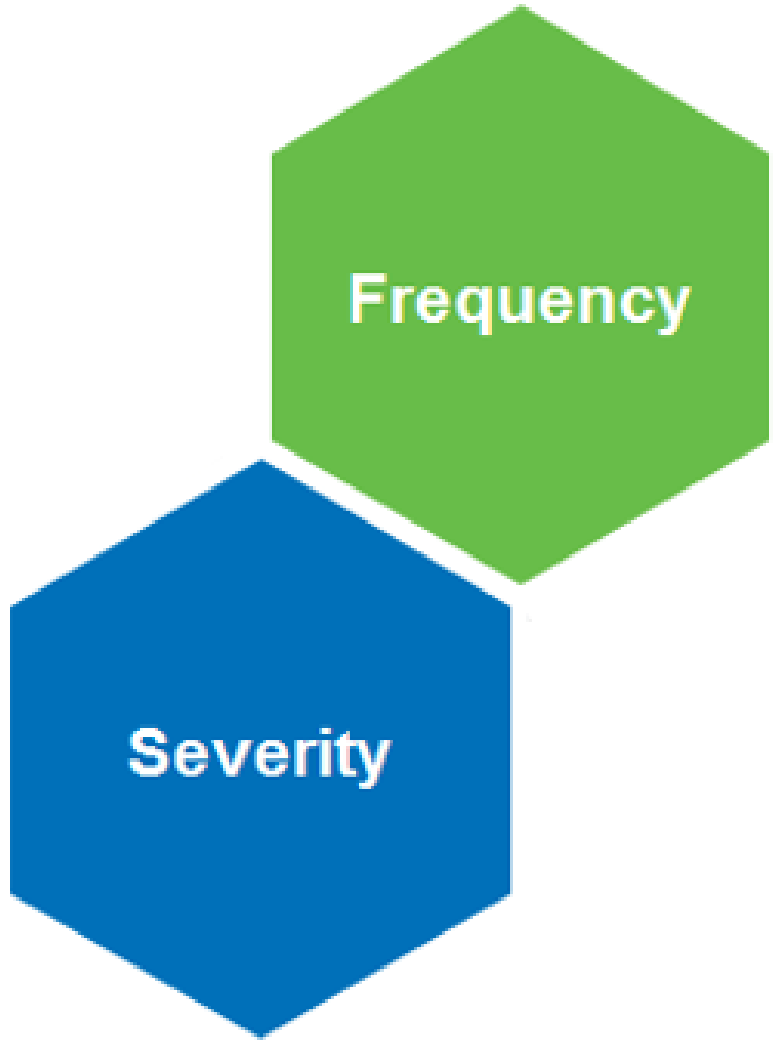
- ***Develop a standardized process for communicating with staff members***, especially when there are new team members who may be unfamiliar with office procedures. Communication and teamwork are critical elements of patient safety.
- ***Utilize evidence-based clinical practice guidelines or protocols when establishing a diagnosis*** and providing treatment and document the clinical justification for any deviation from protocols.

Risk Control Recommendations – Business Owners

- ***Develop and operationalize office practice protocols for ordering and following up on diagnostic tests***, and include all staff members in the policy development process and associated training. The system should be structured to ensure that the test was completed, the results were acknowledged and the patient was informed.
- ***Create protocols for providers to delegate diagnostic test follow-up to non-clinical members of the healthcare team***, when appropriate, in order to enhance workflow efficiency and reduce the potential for missed abnormal results during periods of high patient volume.
- ***Provide staff members with ongoing training*** in documentation strategies and conduct routine EMR audits to ensure compliance.

NP Claim Metrics

Losses are Measured by…



Frequency/distribution -
The percentage of closed claims with a common attribute, such as a specific allegation or injury.

Severity –
The average paid indemnity to the injured third party for those nursing claims which closed during the analyzed timeframe.

Claims at a Glance

- The average total incurred of professional liability claims in the 2022 dataset ($332,137) increased 10.5% compared to the 2017 dataset ($300,506).
- NPs should be aware of a greater risk of claims settling for higher amounts relative to historic averages. The range of adverse claim outcomes can vary significantly.

Analysis of Closed Claims by Licensure and Insurance Type

Closed Claims with Paid Indemnity of ≥ $10,000

Licensure and insurance type	Total paid indemnity	Total paid expense	Average total incurred
Nurse Practitioner, individually insured	$58,165,658	$11,454,873	$329,955
Nurse practitioner receiving coverage through a CNA-insured healthcare business	$5,575,000	$857,313	$402,020
Student nurse practitioner, individually insured	$896,333	$106,633	$200,593
Overall average total incurred	$64,636,991	$12,418,818	$332,137

NP Specialty

5 Distribution of Top Closed Claims by Specialty

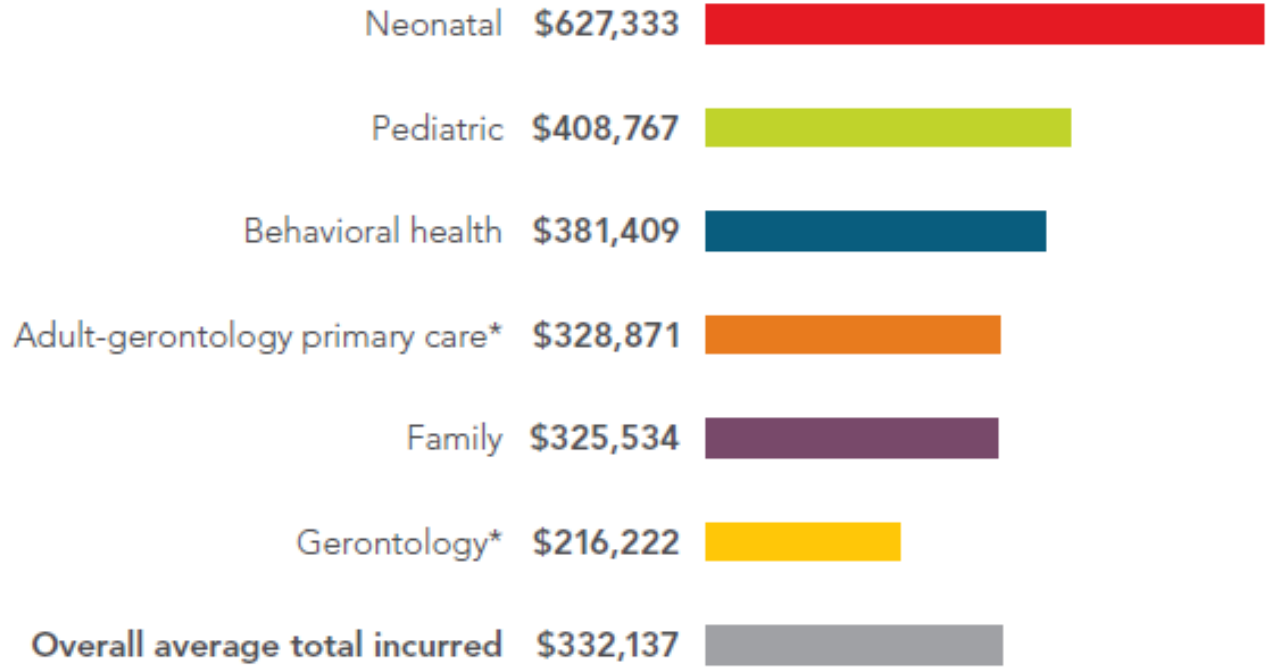
Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those specialties with the highest distribution.

4 Average Total Incurred of Closed Claims by Specialty

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those specialties with the highest average total incurred.



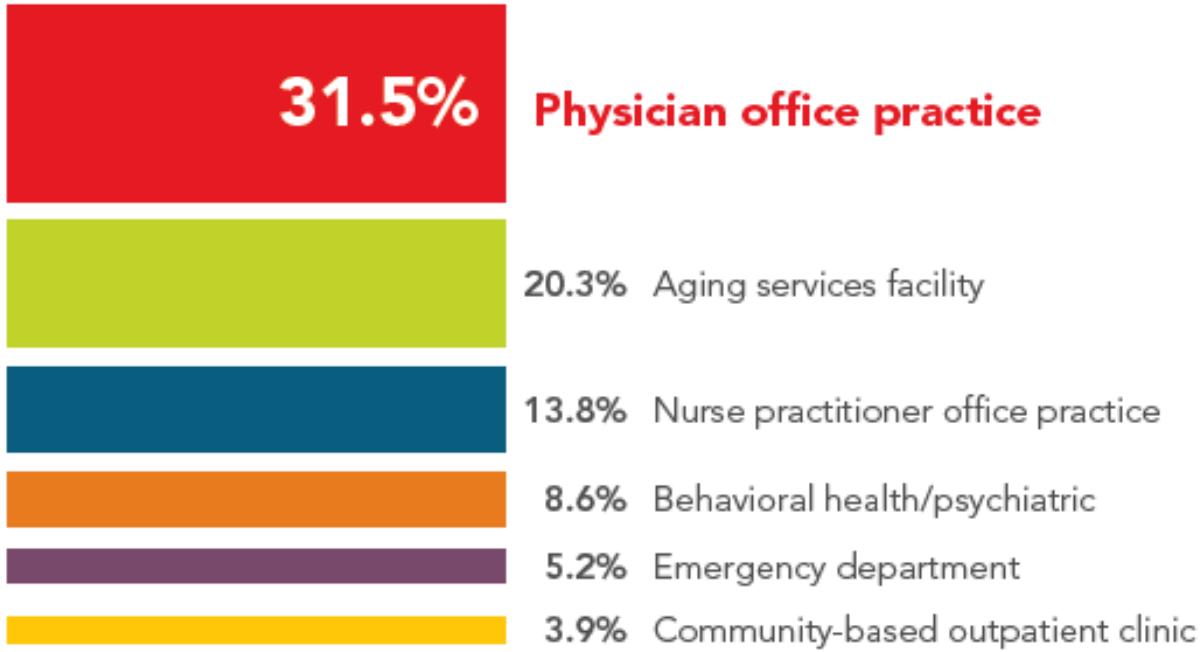
* **Adult-gerontology primary care** refers to an NP who provides healthcare management of acute and chronic health issues for adults across the lifespan, from adolescence to old age. **Gerontology** refers to an NP whose practice is limited to treatment of the patient population from adult to the elderly.

Location

8 Distribution of Closed Claims by Location

Closed Claims with Paid Indemnity of ≥ $10,000

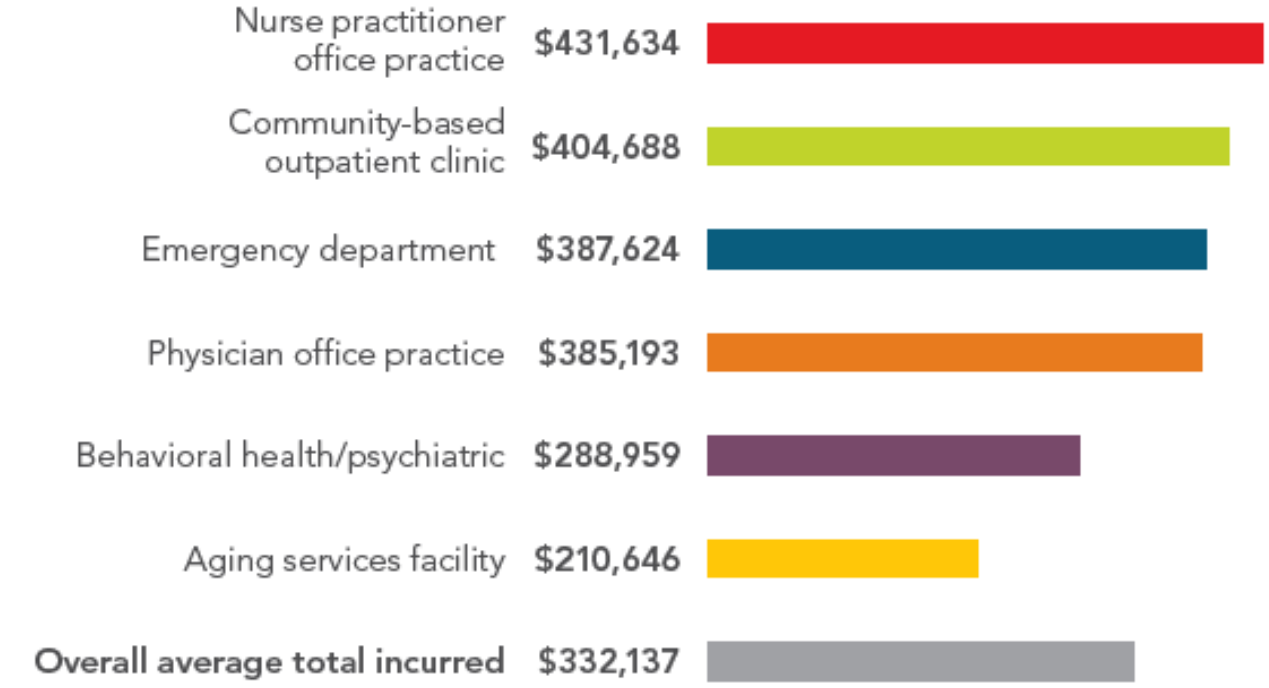
This figure highlights only those locations with the highest distribution.



7 Average Total Incurred of Closed Claims by Location

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those locations with the highest average total incurred.

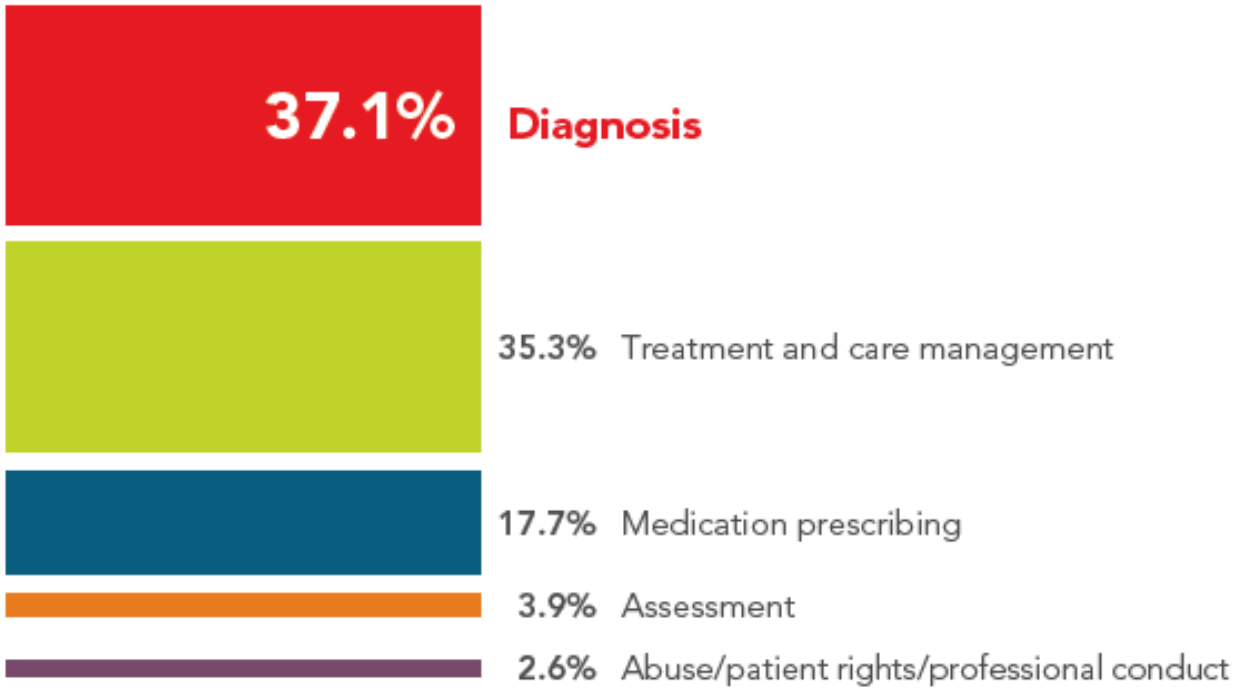


Top Malpractice Allegation Categories

11 Distribution of Top Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those allegations with the highest distribution.



10 Average Total Incurred of Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

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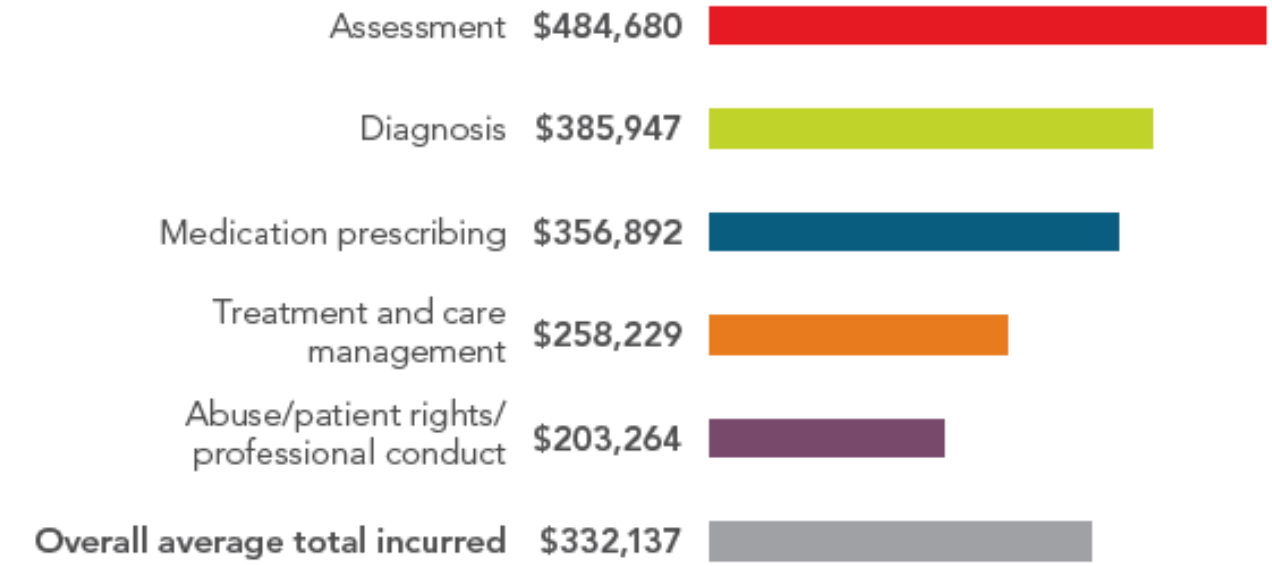
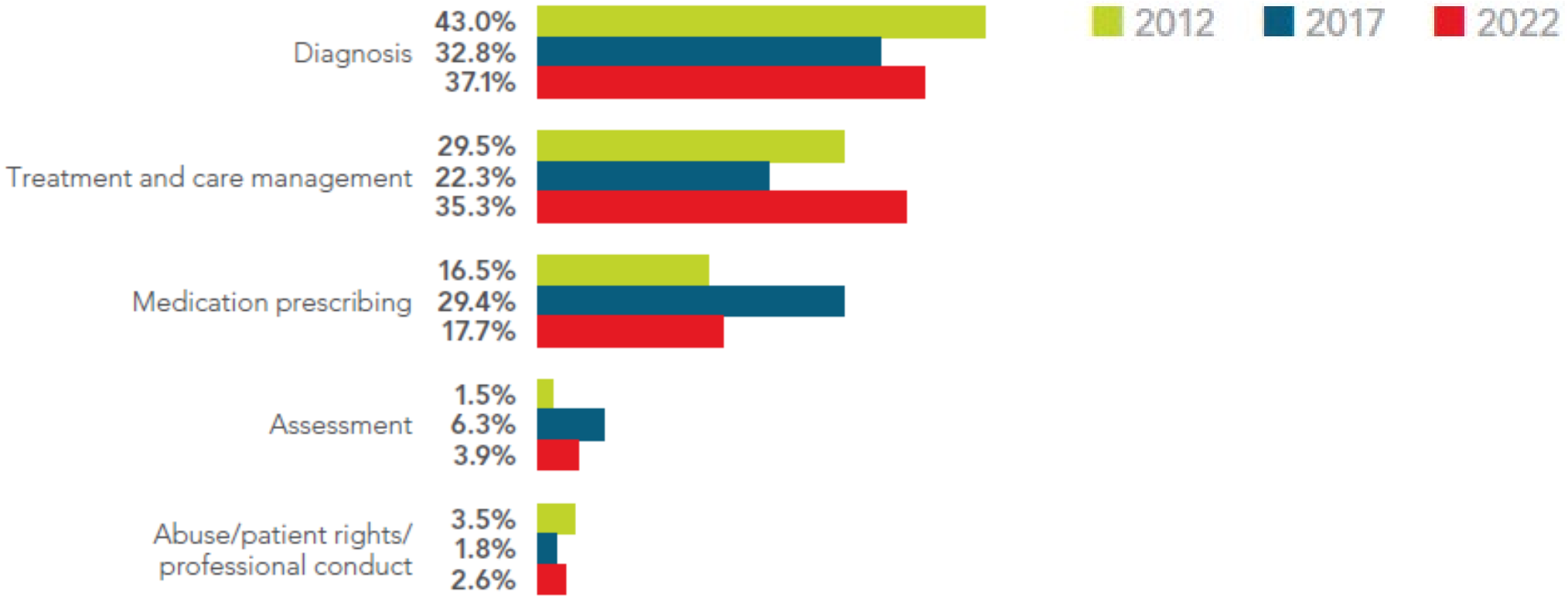


Comparison of Allegation Categories

12 Comparison of 2012, 2017 and 2022 Closed Claim Count Distributions by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those allegations with the highest distribution.



Diagnosis-Related Claims

Distribution and Severity of Diagnosis-Related Claims by Step of the Diagnostic Process

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those diagnosis-related causes of failures.

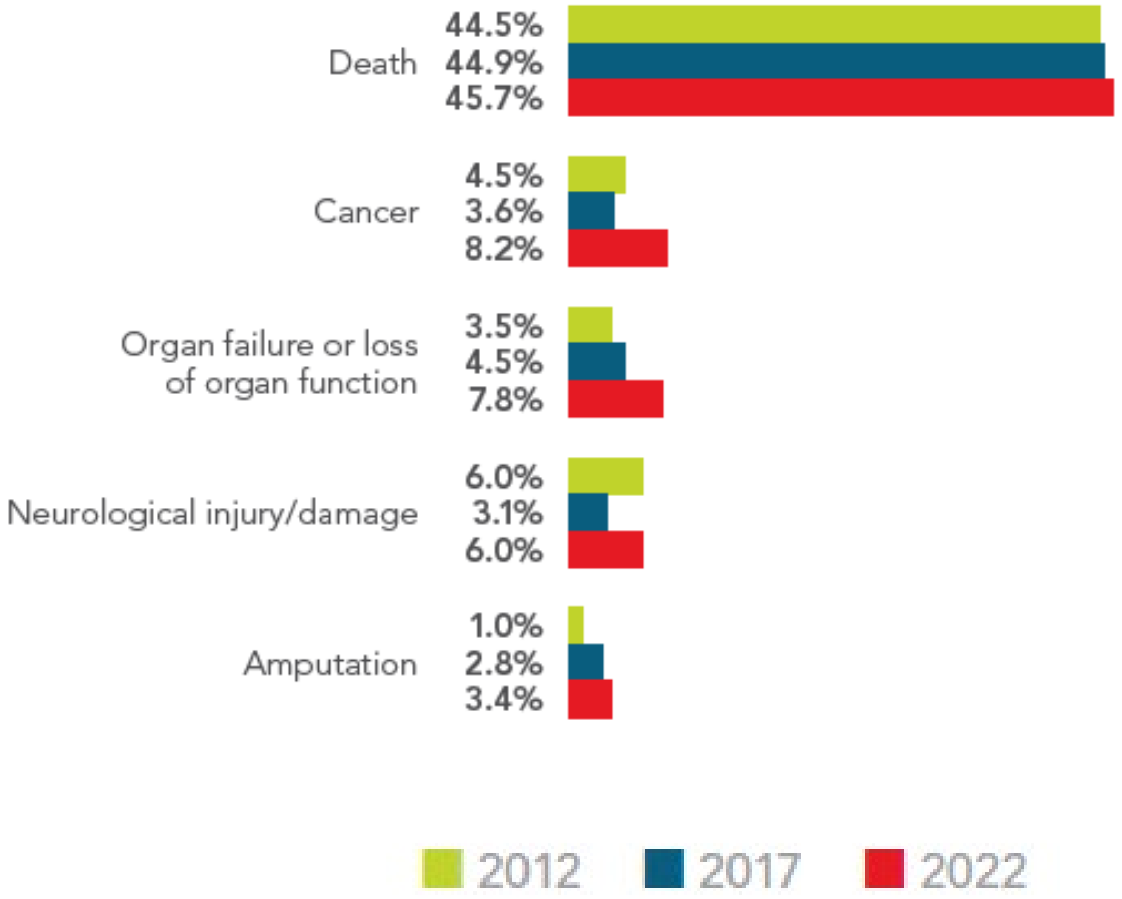
Average total incurred	Claim distribution	Diagnostic process step	Examples of potential failure points at each step
$443,316	15.1%	Referral management	• Failure to obtain consultations to establish a diagnosis • Failure to timely/properly establish and/or order appropriate treatment
$420,854	59.3%	Diagnostic/ lab testing	• Failure to order appropriate tests to establish a diagnosis • Failure or delay in obtaining/addressing diagnostic test results
$296,588	19.8%	History and physical	• Failure to consider/assess patient's expressed complaints/symptoms • Failure to perform and/or document a timely and complete history and physical examination • Failure to properly or fully complete patient assessment
$184,562	5.8%	Patient follow-up	• Failure to identify and report observations, findings, or change in condition • Failure to obtain/refer for immediate emergency treatment
$385,947	100.0%		

Injuries

18 Comparison of 2012, 2017 and 2022 Closed Claim Distribution by Injury

Closed Claims with Paid Indemnity of ≥ $10,000

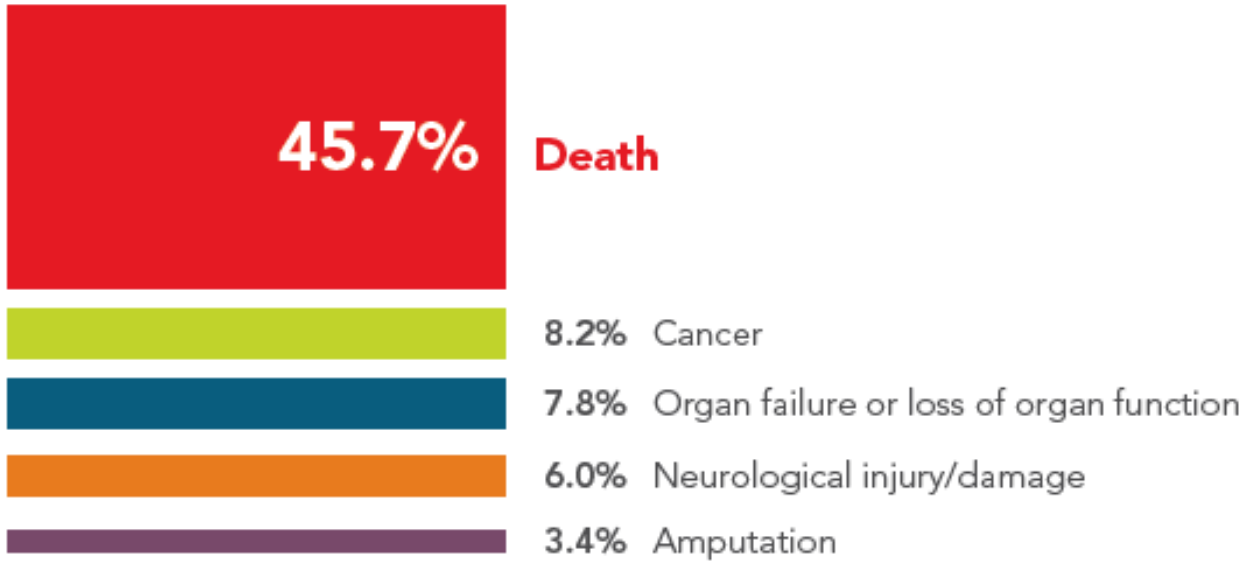
This figure highlights only those injuries with the highest distribution.



17 Distribution of Top Closed Claims by Injury

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those injuries with the highest distribution.



Case Study

Case Study

- The insured in this case was a psychiatric nurse practitioner who held a Doctor of Nursing Practice (DNP) degree and who owned the behavioral health clinic where they practiced. The DNP had an individual policy, and the practice had separate insurance coverage.
- The patient was a 29-year-old female patient who had a history of bipolar II disorder, ADHD and a generalized anxiety disorder for which she was taking:
  - Trazodone (antidepressant and sedative),
  - Lexapro (antidepressant, anti-anxiety) and
  - Trileptal (off-label mood stabilizer).
- The patient presented to the DNP for ongoing psychiatric care and reported that she had stopped taking all of her medications, which resulted in the development of suicidal ideation.
- The DNP reviewed the patient's psychiatric records and identified an ongoing pattern of non-adherence to the prescribed medication regime.

Case Study

- The DNP counseled the patient about the importance of complying with the prescribed medication plan, but did not document this discussion.
- Although the patient signed a consent form which listed the potential side effects of antipsychotropics, including the risk of tardive dyskinesia (TD), there was not any discussion specific to this risk, nor did the patient ask any questions about the side effects.

Case Study

- The patient treated with the DNP for approximately one year, vacillating between multiple medication changes and self-directed discontinuance of medications, with minimal improvement in symptoms.
- Over the course of the year, Lamotrigine, Latuda, Zypreza, Invega and Risperdal were prescribed and subsequently adjusted or discontinued.
- The patient’s non-adherence persisted, including one occasion when she stopped taking all medications without consulting with the DNP.

Case Study

- After approximately eleven months of treatment, the DNP notified the patient that he would be terminating the patient-provider relationship due to the ongoing non-adherence.
- The DNP followed the appropriate termination of care protocols, including providing the patient with proper notification, access to her healthcare information records and a referral for continuing care.

Case Study

- During the last month of treatment, the DNP prescribed Abilify for mood stabilization and Buspar for anxiety.
- Two weeks after prescribing these medications, the patient presented to the office complaining of neck stiffness. Based upon the patient's complaints, the DNP substituted Rexulti in place of Abilify.
- Two weeks later, the patient was seen by the DNP for ongoing complaints of neck stiffness as well as other extrapyramidal symptoms, such as muscle spasms, akathisia and jerky movements.
- Rexulti was discontinued and Benztropine was prescribed to treat the extrapyramidal symptoms.

Case Study

- Over the next few weeks, the patient communicated with the DNP via the patient portal, reporting that she was unable to tolerate the Benztropine and that she had stopped taking it.
- The DNP evaluated the patient in an office visit the following day and diagnosed the patient with drug-induced tardive dyskinesia (TD).
- TD, a known side effect associated with dopamine-blocking antipsychotic medications, is defined as “involuntary choreoathetoid movements usually associated with lower facial and distal extremity musculature”.
- The DNP gave the patient samples of Ingrezza for treatment of TD and referred the patient to a neurologist specializing in movement disorders.
- This was the last time the DNP met with the patient.

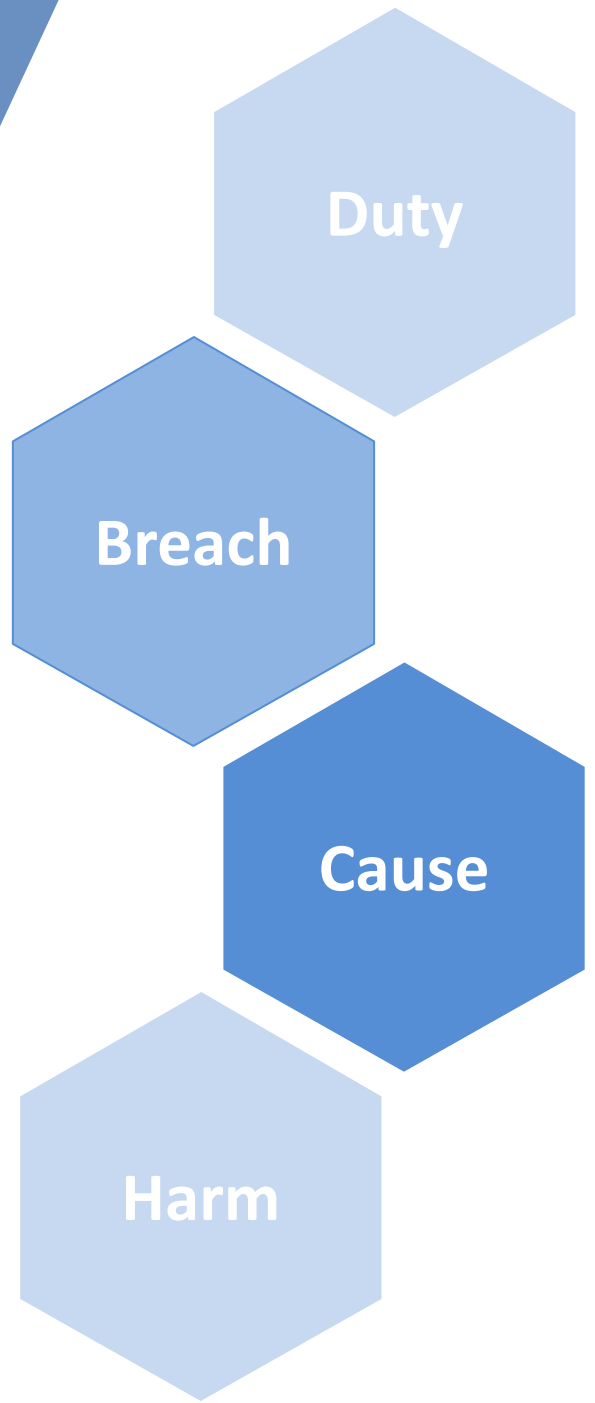
Case Study

- Approximately three weeks later, the patient presented to the neurologist and reported that she had been having extrapyramidal symptoms for four months.
- There was no documentation in the DNP's healthcare information record to reflect a four-month history of symptoms, rather the DNP documented a four-week history.
- During the medication reconciliation process, the neurologist identified that the patient had been taking an incorrect dosage of Ingrezza while using the sample medications.
- Since the medication was not dispensed by a pharmacy, the patient had not received written instructions about the dosage.

Case Study

- The neurologist provided the patient with a prescription of Ingrezza to be dispensed by a pharmacy along with detailed instructions for taking the medication.
- Over the course of the following year, the patient continued treating with the neurologist with a moderate improvement in symptoms.
- However, the neurologist determined that the symptoms associated with the diagnosis of TD would be permanent.
- One year after the patient's final visit with the DNP, a lawsuit was filed against the DNP, the behavioral health clinic and the DNP's supervising physician.

Do You Believe the NP was Negligent?



Risk Management Comments

- The plaintiff (patient) asserted that she developed permanent TD as a result of improper prescribing of mood stabilizing medications.
- The plaintiff further asserted that she was not informed of the risk of developing TD and had she known, she would have sought alternative treatments.
- The plaintiff admitted during her deposition that she signed a consent form stating that antipsychotic medications have the known side effect of TD, but testified that she did not understand the medical terminology in the consent form.
- In addition, there was an assertion that a delay in diagnosing and treating the TD caused this condition to be permanent.

What the Experts Determined…

- The plaintiff's psychiatry expert opined that the DNP failed to monitor the patient for early signs of TD, and neglected to utilize the Abnormal Involuntary Movement Scale (AIMS), promulgated by the American Psychiatric Association, when the patient first reported symptoms.
- The plaintiff's psychopharmacology expert testified that the DNP's prescribed course of treatment was "chaotic" with multiple medication changes and without documentation supporting the rationale for each of the changes.

What the Experts Determined…

- Experts for the defense included a psychiatrist, a psychiatric nurse practitioner and a psychopharmacologist.
- Although they acknowledged that the plaintiff's non-adherence to the treatment plan was likely a contributing factor to the development of TD, they were unable to support the DNP's care due to several factors:
  - There was a lack of documentation about the rationale for medication changes.
  - All of the DNP's psychiatric assessments appeared to have been generated using the electronic medical record "copy and paste" function.
  - The supervising physician was an orthopedic surgeon with no experience in psychiatry, who seemingly just "signed off" on the DNP's documentation.
  - There was a lack of appreciation of the severity of the risk related to the patient's non-adherence/self-imposed "drug holidays".

The DNP's Testimony

- The DNP contended that the multiple medication changes were necessary due to the patient's intolerance of the medications' side effects. The patient's history of suicide attempts was also of concern to him, and in his opinion, limited alternative treatment options.
- The DNP testified that he advised the patient to avoid abrupt discontinuation of the medications in order to limit the potential for untoward side effects. However, the patient did not comply and would frequently stop taking the medication abruptly.
- Communication with the patient about the medications and warnings would often take place via the patient portal. The conversations in the portal were not accessible during litigation.
- In retrospect, the DNP admitted that he should have documented all communications with the patient as well as the rationale for medication changes.

Resolution

Defense attorneys concluded that there was a low likelihood for a successful defense of the DNP.

Therefore, a settlement was negotiated.

The claim resolved with a total incurred of greater than $500,000.

Figures represent only the payments made on behalf of our nurse practitioner and do not include any payments that may have been made by any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.

Risk Control Recommendations

- ***Remain current in knowledge of new and specialty medications***, including but not limited to their pharmacology, side effects and drug-drug interactions. Consult with a pharmacist, as needed.
- ***Proactively monitor and assess patients on antipsychotic medications*** according to evidence-based industry standards, such as the American Psychiatric Association (APA) Guidelines, as early detection may increase the likelihood that complications will be transient and reversible.
- ***Utilize evidence-based clinical practice guidelines*** for treating TD and other side effects associated with antipsychotic medication use.
- ***Discuss the diagnosis, proposed treatment plan and reasonable expectations for outcomes with patients/families***, in order to ensure their understanding of the plan of care and their responsibilities. Document this process, noting the patient's responses.

Risk Control Recommendations

- ***Conduct detailed informed consent discussions*** to ensure that patients understand the risks and benefits of the prescribed therapy.
- ***Assess the patient's health literacy level to ensure an adequate understanding of the information provided*** during the informed consent process and the patient's role in the treatment plan. Consider using the "teach-back" method for communicating patient instructions about medications or other elements of the treatment plan.
- ***Educate the patient about the importance of adhering to treatment recommendations***, medication regimens and screening procedures, and document these discussions.

Risk Control Recommendations

- ***Ensure that supervisory relationships, when required, align with the specialty of the nurse practitioner and comply with state requirements.*** Execute contractual agreements outlining supervisory expectations through consultation with legal counsel.
- ***Document contemporaneously, factually and comprehensively, and include the clinical decision-making process and rationale for the diagnosis and treatment plan.*** Limit the use of the "copy and paste" function when documenting in the electronic healthcare information record. Objective and concise documentation is integral both continuity of patient care, as well as for the defense of a potential malpractice claim.

Risk Control Recommendations

- ***Discuss the following as part of the informed consent process when prescribing "off-label" medications*** and document the discussion with the patient:
  - Details regarding the proposed off-label use and the use for which the medication received FDA approval.
  - Known risks, complications, side effects and the potential for unknown risks related to the off-label use of the medication.
- ***Manage sample medication dispensing, storage, access, tracking and documentation*** in conformity with state/federal pharmaceutical regulations.
- ***Consider the following guidelines among others***:
  - Maintain medication logs documenting lot numbers, patient name, dose, frequency and amount dispensed.
  - Track drug recalls, maintain proper drug storage and monitor expiration dates.
  - Provide patients with written instructions about the prescription using clear language, while avoiding medical terminology.
  - Maintain proper security of medication storage area to avoid misuse.
  - Ensure that all dispensed samples are accompanied by a prescription and detailed dosing instructions.

Questions?

Thank you!

Nurse Practitioner Professional Liability Exposure Claim Report: 5th Edition: *Minimizing Risk, Achieving Excellence*

Visit nso.com/NPClaimReport to download your free copy of the report and additional risk control resources.

Nurse Practitioner Professional Liability Exposure Claim Report: 5th Edition

Minimizing Risk, Achieving Excellence

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