CASE STUDY WITH RISK MANAGEMENT STRATEGIES

Presented by NSO and CNA

Medical malpractice extends to every healthcare profession including nurse practitioners. As nurse practitioners assume an expanded role in the healthcare industry, related legal issues increase. As a result, nurse practitioners are more frequently being named in medical malpractice litigation. According to CNA HealthPro's and NSO's 2009 nurse practitioner claims study encompassing ten years of nurse practitioner claim data, over $64.8 million was paid for medical malpractice claims on behalf of nurse practitioners.*

Case Study: Failure to Assess Resident and Failure to Inform the Physician of Resident's Unstable Condition

Mediated Settlement Payment: $450,000 **Legal Expenses:** $181,225

Note: There were multiple co-defendants in this claim who are not discussed in this scenario. While there may have been errors/negligent acts on the part of other defendants, the case, comments, and recommendations are limited to the actions of the defendant; the nurse practitioner.

This case involves the treatment and subsequent death of a 78-year-old female resident of a nursing home. She had a number of medical conditions including hypertension, chronic anemia, chronic renal failure, congestive heart failure and morbid obesity. She was prescribed the anti-coagulant drug Coumadin because of atrial fibrillation and the related risk of blood clot formation.

The nursing home physician (who was also the president and medical director of the nursing home) contracted with a physician-owned healthcare staffing agency where the physician owner was also the agency's medical director. The nurse practitioner defendant was employed by the physician-owned healthcare staffing agency and was assigned to the nursing home to provide telephonic on-call resident care services, emergency telephone resident services and on-site resident care services as needed.

All three practitioners were involved in the case involving the decedent plaintiff. For purposes of this discussion, the nursing home physician/president/medical director will be referred to as the nursing home physician. The contracted staffing agency physician-owner and medical director will be referred to and the agency physician and the nurse practitioner defendant will be referred to as the nurse practitioner. The complex arrangement for the provision of resident services at the nursing home is a significant contributing factor in the events leading to the resident's death.

As noted above, the nurse practitioner was employed by the contracted staffing agency to provide on-call services to the nursing home and its residents. The nursing home physician delegated the responsibility to respond to all patient care calls from the nursing home staff on week day evenings from 5:00 p.m. to 10:00 p.m., on weekends from 8:00 a.m. to 10:00 p.m. and for emergent pager calls during the week from 10:00 p.m. to 8:00 a.m. to the nurse practitioner. The nurse practitioner was also expected to make resident visits as needed to assess patient status and well being.

On day one of the case, the nursing home physician ordered that the resident be started on Bactrim for a bladder infection. The nursing home staff correctly questioned the order, since Bactrim has the potential to adversely react with the blood thinner Coumadin but the nursing home physician continued the order. The resident also took daily doses of ibuprofen for pain which may further increase the risk of bleeding. On day two, the resident's laboratory test results showed no bladder infection, however, the Bactrim was not discontinued.

On day six, the resident's laboratory tests showed that her bleeding time had increased and that she was at risk of bleeding from the Coumadin. Documentation is unclear whether any of the three practitioners were notified of the resident's increased bleeding time. On day eight, the resident began bleeding from her gastrointestinal tract. The nurse practitioner was notified and provided orders to stop the Coumadin for two days and to recheck the resident's blood tests on day eleven. It was alleged on day 10 that the nurse practitioner was notified by the nursing home staff that the resident had blood clots in her stools, but the nurse practitioner has no recollection of being told this and maintained no documentation regarding the alleged notification.

The nurse practitioner stated that it was her custom and practice after each call from the nursing home, to fax her on-call report for the nursing home physician to the nursing home fax number. Since the nurse practitioner responded to resident calls outside of normal business hours, it is reasonable to assume that the nursing home physician would not receive the fax until the next time he was physically present in the nursing home. The nurse practitioner stated that she did not keep copies of the reports or her notes made during calls from the nursing home. The nursing home physician denied receiving the defendant's faxed on-call reports.

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The resident continued to bleed through days nine, 10 and 11. The nurse practitioner and the nursing home physician were notified of the continued bleeding but neither modified the resident's care plan. The nursing staff notes reflect that the resident was dizzy and nauseated but there is no evidence that the chain of command was utilized to involve nursing leadership in obtaining treatment for the resident. The morning of day 11, the resident was found to have expired in her bed. Subsequently, an autopsy was performed by the state's Medical Investigator's Office with the determination that the resident bled to death from a gastrointestinal hemorrhage.

The daughter of the deceased sought damages and sued the nursing home, the nursing home physician, the contracted staffing agency, the agency physician and the nurse practitioner. The allegations against the nurse practitioner included:

- failure to evaluate, monitor and treat the resident's severe anemia and bleeding
- failure to timely contact the nursing home physician about the resident's bleeding
- exceeding her scope of practice by making medical decisions about the resident's bleeding

According to the defense team's claim consultants, the nurse practitioner made a very credible witness. The defense team engaged numerous experts to defend her including a forensic pathologist, gastroenterologist, toxicologist, hepatologist, physician and two nurse practitioners. The defense argued that the nurse practitioner was within the standard of care when responding to a telephone triage call by ordering that the Coumadin be discontinued for two days and ordering a follow-up laboratory test of the resident's bleeding time.

The plaintiff experts argued that the nurse practitioner should have obtained vital signs, medications, current problem list, past medical history and laboratory studies. She should further have stopped the resident's Bactrim and ibuprofen, identified her anemia and ordered 'STAT' laboratory tests. If the nurse practitioner felt she did not have a clear understanding of the resident's condition, she should have ordered that the resident be transferred to the hospital or she should have gone to the facility to personally examine her. Plaintiff's experts indicated that it was the nurse practitioner's responsibility to order and obtain the information she needed to make an appropriate assessment of the resident's condition rather than to wait for information to be provided to her.

Resolution

After two and one-half years, the claim against the nurse practitioner settled at mediation for $450,000, and an additional $181,225 in legal expenses were paid. The physicians, nursing home and the staffing agency also settled the actions against them at mediation. The amount of the additional settlements is not available.

Risk Management Comments

- The daily responsibility for the clinical care of this resident was fragmented among multiple practitioners. Accountability and communication channels were unclear. It appears that the nursing home physician, agency physician and the nurse practitioner all contributed directly or indirectly to the resident's care at some point with no one professional acting as the primary care provider with responsibility for the oversight of the resident's unstable and rapidly failing condition.
- The nursing staff identified the potential for adverse interaction of the resident's medications but their concerns were not heeded. There is no evidence that the nursing staff persisted through the nursing chain of command regarding their concerns and the resident continued to receive the Bactrim and ibuprofen even after the Coumadin was discontinued.
- The role of the dispensing pharmacist in this resident's medication regime is unclear as the combination of medications had obvious contraindications and should have been reported to the nursing home physician (ordering physician) and clarified before being supplied to the nursing home by the pharmacist.
- The nurse practitioner never actually visited the resident during the period in question. She indicated that she had faxed information regarding clinical symptoms reported by nursing staff and laboratory findings for this resident to the nursing home physician. However, the nurse practitioner retained no copies of the faxed documents and made no entries into the resident's health record. The nurse practitioner performed no follow-up actions to determine if the nursing home physician timely received the faxed information in order to adjust the resident's care accordingly. The nurse practitioner maintained no notes related to her conversations with nursing home staff nor did she document her clinical decision-making process in any format.
- The nurse practitioner failed to physically assess the resident, failed to actively seek out the results of laboratory tests and when provided with clinical evidence of abnormal bleeding times and visible gastrointestinal bleeding, failed to order the resident's immediate transfer to the hospital.
- Without knowing the results of the claim against the additional defendants in this case, it would appear that many disciplines failed to communicate effectively and that oversight for this resident's care was not properly maintained by any individual practitioner.

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Risk Management Recommendations

- The role and scope of clinical practice of a nurse practitioner in any clinical setting (whether employed or contracted) must be clearly defined and understood among all involved parties including:
  - resident/patient/family
  - nurse practitioner
  - direct resident/patient care nursing staff
  - nursing leadership
  - attending, consulting and contracted physicians
  - facility medical director
  - dispensing pharmacist and consulting pharmacist
  - administrative leadership
- The contract defining the responsibilities of nurse practitioners providing on-call coverage for resident/patient care should specify under what conditions the nurse practitioner is allowed/required to visit the resident/patient rather than stating visits are "as needed".
- Communication between the nurse practitioner and any other party regarding the resident's/patient's care is to be documented in a pre-defined, consistent, confidential manner and retained where it is readily available to the members of the resident/patient care team.
- Verbal and telephone communication must be timely documented in the resident/patient health record.
- Each resident/patient must have an identified attending physician who is ultimately responsible for the overall clinical decision-making in determining the resident's/patient's care and treatment.
- On-call practitioners of all types should be required to physically assess a resident/patient in need if the attending physician is not available and the resident's/patient's condition is unstable or deteriorating.
- Practitioners of all types should be prohibited from faxing information without providing original documentation in the resident's/patient's health record within 24 hours.
- Practitioners of all types should refrain from providing orders and advice regarding complex or unstable residents/patients without obtaining full information regarding the resident's diagnoses, medications, response to treatment and on-going clinical monitoring results. If such information is not readily available, the unstable resident/patient should be transported to a hospital for acute and immediate 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.

*Understanding Nurse Practitioner Liability: CNA HealthPro Nurse Practitioner Claims Analysis 1998-2008, Risk Management Strategies and Highlights of the 2009 NSO Survey, CNA Insurance Company, December 2009. To read the complete study visit www.nso.com/NPclaimstudy2009

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