Medication Management for Nurse Practitioners: Protecting Yourself from Liability

Today’s Speaker

Michael Loughran, BA
President
Nurses Service Organization (NSO)

Disclosure Statement: All faculty and planners in a position to control the content of this CE activity and their spouses/life partners (if any) have disclosed that they have no financial relationships with, or financial interests in, any commercial organizations pertaining to this educational activity with the extent of their participation in the activity.


Objectives

1. List the leading allegations related to medication prescribing made against nurse practitioners in malpractice lawsuits.
2. Define the average cost to defend and the indemnity for nurse practitioners in medication-related malpractice lawsuits.
3. Identify key risk reduction strategies that nurse practitioners can incorporate into their practice to reduce the chance of a medication-related events.
Within the NSO and CNA 4th edition claims analysis for nurse practitioners, medication-related claims represented 29.4% of closed claims.

The overall frequency of medication-related allegations in the current report (29.4 percent) has nearly doubled since the 2012 report (16.5 percent).

By highlighting closed nurse practitioner medicated-related events that resulted in financial loss or expenses, we highlight the types of situations most likely to have serious adverse outcomes for patients and create liability exposures for nurse practitioners.

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Case Study

An insured nurse practitioner, working at a college infirmary, was asked by a maintenance employee at the clinic for a terbinafine prescription for fungal toe infection.

The nurse practitioner advised him to see his primary care provider for the prescription, but the employee explained that his primary care provider would not see him because of money owed.

The nurse practitioner reluctantly agreed to a one-time prescription, but informed the employee that he would need to arrange with his regular practitioner for any further treatment.
Later that day, the pharmacy contacted the nurse practitioner about changing the prescription from terbinafine ($400) to ketoconazole ($40).

The nurse practitioner agreed to the medication change, but told the pharmacist that the employee would need bloodwork prior to beginning the prescription.

The following day the nurse practitioner ordered baseline serum liver enzymes, which were normal.

She then verbally instructed the employee to avoid alcohol and contact his primary care provider for monitoring and follow-up.

A month later, the nurse practitioner left her employment at the college and had no further contact with the employee, who never followed up with his primary provider.

As a result, he suffered liver failure and needed an organ transplant due to acute hepatotoxicity.

When the lawsuit was filed against the nurse practitioner, she stated she never thought of the employee as a patient and had only prescribed him the medication as a favor.

Our insured testified that she approved the one-time refill of the prescription, which the employee filled.

No liver functions were performed before or after the refill and the only time he sought medical attention was when he was in liver failure.

The employee was never able to work after his liver transplant and had three minor children living at home.
Do You Think The NP Was Negligent?

- Do you believe that the nurse practitioner was negligent?
- Do you believe that any other practitioners or parties were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the nurse practitioner?
- If yes, how much?

Allegations

- Failure to secure an adequate history
- Failure to secure a thorough examination on a patient
- Failure to warn and advise a patient of risk involved in the use of medications
- Failure to properly monitor a patient on a medication that can cause organ failure

The Resolution

- After six years of defending the claim, the claim settled with indemnity and legal fees totaling more than $850,000.

*Figures represent only the payments made on behalf of our nurse practitioner and do not include any payments that may have been made by the NP’s employer or payments from any co-defendants. Amounts paid on behalf of the multiple co-defendants named in the case are not available.*
Risk Control Recommendations

- Discuss with the patient the need to be compliant of medical treatment and appropriate follow-up. Use language (spoken, written) the patient can understand.
- Use caution when prescribing medications with known toxicity side effects, if a patient has difficulty being medically adherent.
- Order and follow up with all indicated monitoring tests and document results in the patient healthcare information record.
- Consult with a pharmacist as needed, documenting all communication.
- Remain current regarding clinical practice, medications, biologics and equipment related to the diagnosis and treatment of illnesses and conditions encountered in one’s specialty.

Risk Control Recommendations

- 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 a patient that could jeopardize their safety or lead to later questions about one’s clinical expertise and/or judgment.
- Refrain from personal relationship outside of the care setting with patients and their family members.
### Claims by Licensor and Insurance Type

<table>
<thead>
<tr>
<th>Licensor and Insurance Type</th>
<th>Percentage of claims of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
<th>Average total indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-practitioner, individually issued</td>
<td>91.4%</td>
<td>$46,305,206</td>
<td>$149,132,182</td>
<td>$427,716</td>
</tr>
<tr>
<td>Student nurse practitioners, individually issued</td>
<td>1.0%</td>
<td>$380,000</td>
<td>$65,712</td>
<td>$136,665</td>
</tr>
<tr>
<td>Non-practitioner, employers coverage (CNA licensed healthcare business)</td>
<td>1.4%</td>
<td>$325,000</td>
<td>$96,669</td>
<td>$247,750</td>
</tr>
<tr>
<td>Overall</td>
<td>100%</td>
<td>$69,015,206</td>
<td>$172,235,073</td>
<td>$243,471</td>
</tr>
</tbody>
</table>

### Comparison of Average Paid Indemnity: 2009, 2012 and 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2012</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower than $25,000</td>
<td>2.1%</td>
<td>4.4%</td>
<td>3.5%</td>
</tr>
<tr>
<td>$25,000 to $99,999</td>
<td>2.1%</td>
<td>3.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>$100,000 to $199,999</td>
<td>3.7%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>$200,000 to $499,999</td>
<td>20.7%</td>
<td>14.3%</td>
<td>13.4%</td>
</tr>
<tr>
<td>$500,000 to $999,999</td>
<td>20.7%</td>
<td>14.3%</td>
<td>13.4%</td>
</tr>
<tr>
<td>$1,000,000 to $1,999,999</td>
<td>20.0%</td>
<td>27.0%</td>
<td>29.0%</td>
</tr>
<tr>
<td>$2,000,000 to $4,999,999</td>
<td>6.5%</td>
<td>46.3%</td>
<td>29.0%</td>
</tr>
<tr>
<td>$5,000,000 and over</td>
<td>45.5%</td>
<td>26.3%</td>
<td>29.0%</td>
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</tbody>
</table>

### Severity of Allegations

<table>
<thead>
<tr>
<th>Allegation category</th>
<th>Percentage of claims of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>1.7%</td>
<td>$2,347,500</td>
<td>$469,500</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>32.8%</td>
<td>$96,266,755</td>
<td>$295,263</td>
</tr>
<tr>
<td>Assessment</td>
<td>6.3%</td>
<td>$4,856,275</td>
<td>$247,571</td>
</tr>
<tr>
<td>Medication</td>
<td>29.4%</td>
<td>$79,402,274</td>
<td>$273,360</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>22.3%</td>
<td>$13,361,457</td>
<td>$299,335</td>
</tr>
<tr>
<td>Communication</td>
<td>0.3%</td>
<td>$200,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>Scope of practice</td>
<td>4.2%</td>
<td>$1,765,000</td>
<td>$146,250</td>
</tr>
<tr>
<td>Abuse/patient rights/professional conduct</td>
<td>1.8%</td>
<td>$600,000</td>
<td>$112,000</td>
</tr>
<tr>
<td>Equipment</td>
<td>0.3%</td>
<td>$70,000</td>
<td>$70,000</td>
</tr>
<tr>
<td>Documentation</td>
<td>0.3%</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>0.3%</td>
<td>$40,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>0.3%</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Overall</td>
<td>100%</td>
<td>$69,015,206</td>
<td>$240,471</td>
</tr>
</tbody>
</table>
Comparison of 2012 and 2017 Claim Distribution by Allegation Category

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>1.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>43.0%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Assessment</td>
<td>1.5%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Medication</td>
<td>14.5%</td>
<td>29.4%</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>29.5%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Scope of practice</td>
<td>5.5%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Equipment</td>
<td>3.5%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Frequency and Severity of Allegations Related to Medication Prescribing

<table>
<thead>
<tr>
<th>Allegation sub-category</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to properly instruct patient regarding medication</td>
<td>2.4%</td>
<td>$2,350,000</td>
<td>$975,000</td>
</tr>
<tr>
<td>Failure to recognize contraindication and/or known adverse interaction between ordered medications</td>
<td>4.3%</td>
<td>$5,350,000</td>
<td>$657,456</td>
</tr>
<tr>
<td>Improper management of medication</td>
<td>3.9%</td>
<td>$2,172,000</td>
<td>$382,000</td>
</tr>
<tr>
<td>Improper prescribing/management of anticoagulant</td>
<td>3.2%</td>
<td>$2,085,000</td>
<td>$221,666</td>
</tr>
<tr>
<td>Prescribing error, wrong dose</td>
<td>1.2%</td>
<td>$1,169,000</td>
<td>$147,000</td>
</tr>
<tr>
<td>Prescribing/administering error, intravenous fluids and/or medication</td>
<td>0.7%</td>
<td>$270,000</td>
<td>$155,000</td>
</tr>
<tr>
<td>Prescribing error, wrong route</td>
<td>0.3%</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Improper prescribing/managing of controlled drugs</td>
<td>12.9%</td>
<td>$3,167,000</td>
<td>$99,662</td>
</tr>
<tr>
<td>Prescribing error, wrong medication</td>
<td>0.7%</td>
<td>$120,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>Overall</td>
<td>24.4%</td>
<td>$19,602,274</td>
<td>$233,360</td>
</tr>
</tbody>
</table>

Frequency and Severity of Medication Claims by Remedy

<table>
<thead>
<tr>
<th>Remedy</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear injury/hearing loss</td>
<td>0.6%</td>
<td>$9,000,000</td>
<td>$15,000,000</td>
</tr>
<tr>
<td>Brain injury other than birth related injury</td>
<td>0.7%</td>
<td>$1,112,000</td>
<td>$150,300</td>
</tr>
<tr>
<td>Emotional (psychological) harm/damage</td>
<td>0.7%</td>
<td>$977,000</td>
<td>$99,662</td>
</tr>
<tr>
<td>Allergic reaction/anaphylaxis</td>
<td>1.0%</td>
<td>$1,394,000</td>
<td>$942,667</td>
</tr>
<tr>
<td>False negative diagnosis</td>
<td>0.7%</td>
<td>$100,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>David-related psychiatric</td>
<td>0.7%</td>
<td>$500,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Cardiac condition (acutus myocardial infarction)</td>
<td>0.7%</td>
<td>$650,000</td>
<td>$92,857</td>
</tr>
<tr>
<td>Fryalyn</td>
<td>0.3%</td>
<td>$32,500</td>
<td>$108,333</td>
</tr>
<tr>
<td>Cardiac arrest/ventilation</td>
<td>1.0%</td>
<td>$785,000</td>
<td>$785,000</td>
</tr>
<tr>
<td>Death</td>
<td>1.9%</td>
<td>$1,199,000</td>
<td>$385,300</td>
</tr>
<tr>
<td>Loss of forage or organ function</td>
<td>1.0%</td>
<td>$714,000</td>
<td>$260,000</td>
</tr>
<tr>
<td>Neurologic deficit/convulsion</td>
<td>1.8%</td>
<td>$714,000</td>
<td>$165,000</td>
</tr>
<tr>
<td>Infections/malnourishment</td>
<td>1.0%</td>
<td>$250,000</td>
<td>$225,000</td>
</tr>
<tr>
<td>Addiction</td>
<td>0.7%</td>
<td>$7,150,000</td>
<td>$70,000</td>
</tr>
<tr>
<td>Pulmonary/respiratory failure</td>
<td>0.3%</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Overall</td>
<td>20.4%</td>
<td>$19,602,274</td>
<td>$233,360</td>
</tr>
</tbody>
</table>
A 55-year-old female presented to an urgent care facility for treatment of a sinus infection and upper respiratory problem that had been ongoing for over two weeks.

The patient was treated by a nurse practitioner, who diagnosed bronchitis and ordered ceftriaxone and steroid intramuscular (IM) injection.

The patient's health information record noted an allergy to cephalosporin. The insured NP recalled questioning the allergy during the assessment and the patient replied that she suffered a rash several years ago, but the last two times she had taken a cephalosporin antibiotic she did not have any problems.

Unfortunately, the insured NP failed to document this discussion with the patient. The patient received the two IM injections and without being monitored for any length of time left the facility.
Case Study

- The patient then walked to a restaurant across the street and, while ordering her meal, went into respiratory distress.
- The restaurant called 911, summoning an emergency management team, which gave the patient 0.5 mg of epinephrine IM.
- Upon arrival at the hospital the patient was intubated, became unresponsive and died soon after. The cause of death was ruled as anaphylaxis.
- Once the insured NP learned of the patient’s response to the medication, she went back into the electronic healthcare record and documented that the nurse failed to monitor the patient per facility protocol.

Do You Think The NP Was Negligent?

- Do you believe that the nurse practitioner was negligent?
- Do you believe that any other practitioners or parties were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the nurse practitioner?
- If yes, how much?

Allegations

- Failure to secure an adequate history
- Failure to perform a thorough examination on a patient
- Failure to warn and advise a patient of risk involved in the use of medications
- Failure to properly monitor a patient on a medication that can cause organ failure
The Resolution

- Mediation was completed and a settlement included indemnity and legal fees totaling $1,018,148.

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

Risk Management Comments

- The claim was difficult to defend for many different reasons:
  - Defense counsel had problems finding an expert that would defend the antibiotic ordered by the NP. One expert felt that he could defend the insured NP’s decision of prescribing that particular antibiotic in an emergency situation where the patient would be monitored. However, in an outpatient (non-urgent) setting, there are many other antibiotics that would have been sufficient to treat bronchitis.
  - The expert was also concerned that the insured NP’s self-serving documentation was unnecessary and gave the appearance of being defensive.
  - During deposition, a nurse employed by the urgent care center blamed the NP for the incident and mentioned several other medication-related near-misses.
  - The NP blamed the nurse that administered the injection for not having the patient wait in the office 20 minutes per the urgent care’s policy requirements.

Risk Control Recommendations

- The Institute for Safe Medication Practices (ISMP) lists the following risk strategies regarding “Allergy Never Events” for business owners and prescribing practitioners. Additional information on ‘Allergy Never Events’ can be found at https://www.ismp-canada.org/download/safetyBulletins/2016/ISMPCSB2016-10-AllergyNeverEvents.pdf
- Confirm and update each patient’s medication allergy record whenever a medical history is obtained and at each transition in care. Because allergies can develop at any time and patient recall may be unreliable, confirm medication allergies and reactions using a standardized process. This helps to ensure that each patient’s record is current and complete.
Risk Control Recommendations

- Modify medication allergy information only after direct reconciliation and confirmation involving the healthcare provider and the patient and/or a family member. If the allergy status is modified, ensure that the history of previous allergy investigation and documentation is available to all practitioners.
- Distinguish between medication allergies and sensitivities, and document them separately, if possible. This distinction can be critical when other healthcare providers are considering treatment options.
- When documenting allergies, avoid the use of abbreviations for drug names (e.g., “PCN” for penicillin).

Risk Control Recommendations

- Consult a pharmacist, as needed, with questions regarding medication allergy concerns. Document the discussion in the patient healthcare record.
- Refrain from making or documenting subjective comments, including statements about patients, colleagues and other members of the patient care team.
- Factually and thoroughly document any unusual occurrences that arise during the patient’s treatment and care.

NP LICENSE PROTECTION
CLAIM METRICS
### 2012 and 2013 License Defense Claim Data Comparison

<table>
<thead>
<tr>
<th></th>
<th>2012 report</th>
<th>2013 report</th>
<th>Variance (nominal)</th>
<th>Variance (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident(s)</td>
<td>404</td>
<td>154</td>
<td>-250 (-62.14%)</td>
<td>-79.03%</td>
</tr>
<tr>
<td>Average number of incidents per year</td>
<td>87.6</td>
<td>100.8</td>
<td>13.2 (+15.06%)</td>
<td>15.06%</td>
</tr>
<tr>
<td>Paid claims</td>
<td>240</td>
<td>193</td>
<td>-47 (-19.58%)</td>
<td>-20.58%</td>
</tr>
<tr>
<td>Average number of paid claims per year</td>
<td>48.0</td>
<td>26.6</td>
<td>21.4 (+52.08%)</td>
<td>52.08%</td>
</tr>
<tr>
<td>Paid claims as percentage of total incidents</td>
<td>59.4%</td>
<td>26.4%</td>
<td>-33.0%</td>
<td>53.07%</td>
</tr>
<tr>
<td>Average payment</td>
<td>$5,087</td>
<td>$8,149</td>
<td>3,062 (+60%)</td>
<td>+60%</td>
</tr>
</tbody>
</table>

### Severity by Allegation Category

<table>
<thead>
<tr>
<th>Allegation category</th>
<th>Percentage of closed claims*</th>
<th>Total paid</th>
<th>Percentage of total paid</th>
<th>Average payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malpractice</td>
<td>6.3%</td>
<td>$1,160,14</td>
<td>6.4%</td>
<td>$3,428</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>3.9%</td>
<td>$66,636</td>
<td>4.7%</td>
<td>$7,605</td>
</tr>
<tr>
<td>Documentation</td>
<td>6.2%</td>
<td>$147,925</td>
<td>7.1%</td>
<td>$19,622</td>
</tr>
<tr>
<td>Scope of practice</td>
<td>22.1%</td>
<td>$354,417</td>
<td>24.7%</td>
<td>$6,607</td>
</tr>
<tr>
<td>Malpractice</td>
<td>27.7%</td>
<td>$1,233,250</td>
<td>35.0%</td>
<td>$6,607</td>
</tr>
<tr>
<td>Professional conduct</td>
<td>8.6%</td>
<td>$222,488</td>
<td>8.4%</td>
<td>$17,108</td>
</tr>
<tr>
<td>Malpractice</td>
<td>0.9%</td>
<td>$9,497</td>
<td>0.7%</td>
<td>$1,624</td>
</tr>
<tr>
<td>Malpractice</td>
<td>5.2%</td>
<td>$37,988</td>
<td>5.6%</td>
<td>$6,850</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>12.2%</td>
<td>$128,119</td>
<td>8.9%</td>
<td>$4,357</td>
</tr>
<tr>
<td>Assessment</td>
<td>3.3%</td>
<td>$27,953</td>
<td>1.9%</td>
<td>$2,449</td>
</tr>
<tr>
<td>Details of allegation unavailable**</td>
<td>3.2%</td>
<td>$23,619</td>
<td>1.7%</td>
<td>$3,322</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>$4,058,078</td>
<td>100%</td>
<td>$5,767</td>
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</table>

### Detailed View of Mediation-related Allegations

<table>
<thead>
<tr>
<th>Allegation detail</th>
<th>Percentage of total alleged</th>
<th>Total paid</th>
<th>Average payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper prescribing/management of medications</td>
<td>1.1%</td>
<td>$71,154</td>
<td>$71,154</td>
</tr>
<tr>
<td>Prescribing practice not included within clinical guidelines</td>
<td>10.8%</td>
<td>$58,920</td>
<td>$8,636</td>
</tr>
<tr>
<td>Improper management of medications</td>
<td>34.7%</td>
<td>$1,353,956</td>
<td>$38,318</td>
</tr>
<tr>
<td>Failure to recognize contraindication and/or known adverse interaction</td>
<td>7.7%</td>
<td>$35,960</td>
<td>$7,100</td>
</tr>
<tr>
<td>Wrongful diagnosis</td>
<td>15.4%</td>
<td>$65,800</td>
<td>$6,080</td>
</tr>
<tr>
<td>Impaired prescribing/management of consultations</td>
<td>27.7%</td>
<td>$166,604</td>
<td>$5,920</td>
</tr>
<tr>
<td>Wrongful administration</td>
<td>4.6%</td>
<td>$6,141</td>
<td>$630</td>
</tr>
<tr>
<td>Failure to properly identify patient re: medication</td>
<td>3.1%</td>
<td>$4,114</td>
<td>$1,333</td>
</tr>
<tr>
<td>Failing to notify patient’s healthcare team re: prescribing/intervention error</td>
<td>1.5%</td>
<td>$1,780</td>
<td>$1,780</td>
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<tr>
<td>Wrongful diagnosis</td>
<td>1.7%</td>
<td>$1,740</td>
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<tr>
<td>Details of allegation unavailable**</td>
<td>1.3%</td>
<td>$1,600</td>
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<td>Total</td>
<td>100%</td>
<td>$450,731</td>
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Case Study

A 15-year-old male patient came into an after-hours pediatric clinic with reports of an itchy rash on his abdomen, legs and feet.

The patient was evaluated by a primary care certified nurse practitioner (insured).

The nurse practitioner diagnosed the patient with allergic contact dermatitis from poison oak and prescribed Triamcinolone acetonide 0.1 percent cream to affected area twice a day and Benadryl 25 mg by mouth, twice-a-day. The cream prescription was sent electronically to a local pharmacy.

According to the patient’s mother, as she and the patient were leaving the clinic she remembered that Benadryl made the patient’s heart race.

She asked the front desk clerk if the nurse practitioner could prescribe something different for the patient.

The nurse practitioner was in a room with another patient when the clerk asked about changing the prescription.
Case Study

- When the clerk returned, she informed the mother that the nurse practitioner agreed to change the prescription and that the new medication would be sent to the pharmacy.
- The mother asked the clerk what medication the nurse practitioner prescribed. She stated that she didn’t remember, but it started with an “H”.

Case Study

- The clinic used scribes to document examinations, treatments, and prescriptions.
- The healthcare record reflected a scribe changed the Benadryl 25 mg medication order mistakenly to Hydralazine 25 mg (an antihypertensive) twice-daily for two-weeks (30 tablets), instead of Hydroxyzine 25 mg as the nurse practitioner requested.
- The medication error went undetected until the mother called the clinic a few months later.
- The patient’s mother advised the clinic’s office manager that the patient had suffered from severe episodes of hypotension, vertigo, and light-headedness that required hospitalization.
- A few months later, the patient filed a lawsuit against the nurse practitioner, the clinic, and the pharmacy that filled the medication.

Do You Think The NP Was Negligent?

- Do you believe that the nurse practitioner was negligent?
- Do you believe that any other practitioners or parties were negligent?
- Do you believe that an indemnity and/or expense payment was made on behalf of the nurse practitioner?
- If yes, how much?
Risk Management Comments

- At the time the lawsuit was filed, the nurse practitioner no longer worked for the clinic. He did not feel that the clinic would represent his best interest as his professional relationship with the office manager was contentious.
- The nurse practitioner did not remember the patient. However, his name appeared on the patient’s healthcare record for the date of the incident.
- The scribe’s name was not identified on the healthcare record and the clinic did not require that the scribes sign the healthcare record. Because of this, it was unclear which scribe mistakenly entered the wrong medication as there were several working at the clinic at the time of the incident.

Risk Management Comments

- A defense expert asked to review the claim agreed with the care provided by the NP. However, the expert could not fully defend the NP’s practice of not reviewing and verifying the scribe’s entries.
- The expert felt that if the NP had reviewed the information the scribed entered, he would have learned of the prescribing error and notified the pharmacy and/or warned the patient not to take the medication.
- The expert testified that both the pharmacy and the clinic shared responsibility for the incident. He stated that the pharmacy should have confirmed the medication order with the NP prior to filling, as Hydralazine is not a medication typically used in pediatric patients. He confirmed that the use of medical scribes is acceptable, but the clinic hired scribes with no experience and the training they received once hired did not prepare them for the clinic’s pediatric patient population.

Allegations

- Failure to properly evaluate the patient
- Failure to properly treat the patient
- Failure to properly prescribe medication to the patient
- Failure to convey appropriate information to patient
- Failure to have proper procedures in place to avoid mistakes and/or improper prescribing practices
- Failure to contact the patient in a reasonable time to advise of the improper prescription
The Resolution

- After a year of defending the claim, there was a joint settlement between the nurse practitioner, the clinic, and the pharmacy. While the pharmacy’s and clinic’s settlement amounts are not known, indemnity and legal fees for the NP totaled more than $35,000.

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

Risk Control Recommendations

- Prescribe the right drug, for the right patient, in the right dosage, the right route, at the right times, for the right duration and for the right indication. The following strategies can help reduce the likelihood of drug-related error:
  - Include the purpose of the medication on the prescription.
  - If an electronic order entry system is in use, double-check the selected drug and dosage, as error is always one click away.
  - Comply with established standard for educating and informing patients and families about prescriptions, including the brand names and generic names, the purpose of the medication, realistic expectations regarding drug efficacy, potential side effects, and indications for contacting the prescriber or seeking emergency assistance.

Risk Control Recommendations

- Follow documentation standards established by professional organizations.
- Document all patient-related discussions, consultations, clinical information and actions taken including any treatment orders provided.
- Authenticate any documentation written by ‘scribes’.
- Monitor the patient care environment to ensure privacy and safety. If there are safety concerns, act as the patient’s advocate in ensuring patient safety and the quality of care received.
Prescribing Recommendations

- Learn about possible medication reactions, side effects, and interactions, including how to screen patients for potential allergic or other adverse reactions, recognize an allergic response, and treat serious reactions.
- Collect/review current allergy information, including descriptions of reactions, when ordering medications. In addition, ensure that such information is available to all practitioners involved in the patient’s care.
- Review previous medication orders alongside new orders and care plans, and resolve any duplications or discrepancies each time a patient moves from one care setting to another.
- When reconciling medications, talk to patients and other practitioners who may know more than what is written in the record.
- Use developed standard order sets to minimize incorrect or incomplete prescribing, standardize patient care and clarify medication orders.

Monitoring/Education Recommendations

- Emphasize the importance of keeping follow-up appointments. When necessary, verify that the patient has a confirmed, scheduled appointment with the laboratory, practitioner or appropriate clinic.
- Obtain and follow up on results of diagnostic studies that monitor the safety of medication use.
- Consider integrating medical office electronic health record systems with inpatient systems, thus permitting prescribers to view a more complete patient profile.
- Develop a comprehensive patient education program for medications prescribed that includes both written materials and spoken advice, and which is presented at an appropriate level for each patient. Medication-related materials provided to patients should be recorded in the healthcare record.
Opioid Risk Evaluation

- Pain management should always include a thorough history and physical, including an assessment of social and psychosocial factors as well as family history.
- Reevaluate the level of pain and the efficacy of the pain treatment plan at every visit.
- Conduct an opioid risk assessment before prescribing opioids.
- When prescribing opioid drugs, use an appropriate opioid dose based on patient age and opioid tolerance.
  - Opioid naive
  - Opioid tolerant

Definition of Opioid Tolerance

- Patients receiving, for 1 week or longer, at least:
  - 60 mg oral morphine/day;
  - 25 mcg transdermal fentanyl/hour;
  - 30 mg oral oxycodone/day;
  - 8 mg oral hydrocodone/day;
  - 25 mg oral oxymorphone/day;
  - 60 mg oral hydrocodone/day;
  - or an equianalgesic dose of another opioid, including heroin and/or non-prescribed opioids.

Patients at High-risk for Opioid-induced Respiratory Depression

One or more of the following risk factors:

- Age greater than 55 years
- Obesity (e.g., body mass index [BMI] greater than 30 kg/m²)
- Hepatic or renal impairment (e.g., creatinine clearance [Ccr] less than 40 mL/minute)
- Known or suspected sleep-disorder breathing (e.g., snoring, upper airway resistance syndrome, obstructive sleep apnea-hypopnea syndrome)
- Large neck circumference (greater than 17.5 inches)
- Anatomical maxilla or mandible abnormalities
- Prolonged surgery (greater than 2 hours)
- Thoracic or upper abdominal surgical incisions that may impair adequate ventilation
- Pulmonary or cardiac disease or dysfunction (e.g., chronic obstructive pulmonary disease, congestive heart failure) or major organ failure
- Tobacco use (greater than 20 pack-years)
- Concomitant use of sedating agents (e.g., benzodiazepines, central nervous system (CNS) depressants, antihistamines, alcohol)
- High opioid dose requirements
Opioid Risk Evaluation

- Evaluate for major risk factors of opioid abuse, which include, but are not limited to:
  - Family history of alcohol or drug use
  - History of physical or sexual abuse
  - Certain psychiatric conditions

- Commonly used screening tools for patients at risk of opioid overdose or abuse include:
  - Random urine drug screens
  - Regular pill counts
  - Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain.
  - Diagnosis, Intractability, Risk, Efficacy (DIRE) tool: http://www.emergingsolutionsinpain.com/content/tools/esp_9_instruments/pdf/DIRE_Score.pdf
  - DIRE Score for Appropriate Opioid Use.
  - Screening Instrument for Substance Abuse Potential (SISAP) Assessment Instrument

- Remember that NPs, 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
  - Establishing and consistently implementing formal policies and procedures

Prescription Drug Monitoring Programs (PDMP)

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 range of purposes, including the following:

- Supporting access to legitimate medical use of controlled substances.
- Detering 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.

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 prescription refill parameters
  - Outline the repercussions of noncompliance, 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.
Additional Recommendations

- When appropriate, use multi-modal therapies for pain management; consider as necessary non-opioid medications.
- Have available an equi-analgesic chart for different opioid products.
- Establish standard protocols for pain management depending on the severity of pain.
- Incorporate prompts in electronic prescribing systems to verify past opioid use. (Drug Monitoring Program)
- Provide direct counsel, including written instruction and information of associated risk, to all patients receiving opioid products and/or their caregivers.
- Advise caregivers about the need to monitor patients who are taking opioids. Include information about contacting the prescriber regarding uncontrolled pain prior to taking more of the same or different pain-relieving medications, including over-the-counter products.

Additional Resources

- ISMP's Consumer Medication Website [http://www.consumermedsafety.org/]
- The ISMP's High-Alert Medication Learning Guides, designed to promote discussion and counseling about higher-risk pharmaceuticals. [http://www.consumermedsafety.org/tools-and-resources/medication-safety-high-alert-medications]
- The Pennsylvania Patient Safety Authority tools: [http://patientsafety.pa.gov/Pages/Opioids/hm.aspx]
  - “Opioid Knowledge Assessment”
  - “Organization Assessment of Safe Opioid Practice”
- “The CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016” [https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6532a1.htm]

NP Self-assessment Checklist and Claim Tips

[www.nso.com]
Thank you!

www.nso.com/NPclaimreport

References


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