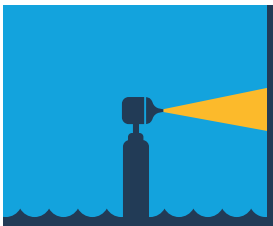
NURSE PRACTITIONER CLOSED CLAIMS STUDY

An expert analysis of medical malpractice allegations



We shine a light on risks and trends others cannot see

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INTRODUCTION

We shine a light on risks and trends that others cannot see by constantly looking ahead and providing innovative tools to identify potential sources of patient injury and enhance safety.

We rigorously analyze the claims experience of our 80,000 members and translate the findings into patient safety initiatives that protect our members and their patients. Analyzing the collective experience of nurse practitioners and physicians provides broader, more reliable information. It also expands knowledge beyond the experiences of any single person—even if that knowledge is gained over a lifetime of practice. We hope that the information presented here will prompt nurse practitioners and physicians to collaborate with colleagues and hospital leaders to identify system weaknesses, thereby reducing the risk of harm to patients.

STUDY DESIGN

We analyzed 67 claims* against nurse practitioners (NPs) that closed over a six-year period from January 2011 through December 2016. These claims arose in family medicine (FM) and internal medicine (IM) practices. To provide context, we compared the NP claims with 1,358 FM and IM claims that closed during the same time period. If a claim was against both the FM or IM physician and the NP, we eliminated it from this study to avoid counting the same claim twice.

We included cases that closed within the study's time frame regardless of how the claim or suit was resolved. This approach helped us to better understand what motivates patients to pursue claims and to gain a broader overview of the system failures and processes that resulted in patient harm.

Our approach to studying these malpractice claims began by reviewing plaintiffs'/patients' allegations, giving us insights into the perspectives and motivations for filing claims and lawsuits. We then looked at patients' injuries to understand the full scope of harm. Physician and nurse practitioner experts for both the plaintiffs/patients and the defendants/nurse practitioners/physicians reviewed claims and conducted medical record reviews. Our clinical analysts drew from these sources to gain an accurate and unbiased understanding of the events that lead to actual patient injuries.

Nurse practitioner or physician reviewers evaluated each claim to determine whether the standard of care was met. The factors that contributed to claims included clinical judgment, patient factors, communication, clinical systems, clinical environments, and documentation.

Our team studied all aspects of the claims and, using benchmarked data, identified risk mitigation strategies that nurse practitioners and their physician partners can use to decrease the risks of injury, thereby improving the quality of care.

Limitations: We did not take the following state differences in NP scope of practice (SOP) into consideration because the number of claims in each category would likely lack statistical significance:

- In 23 states and Washington, DC, NPs have full authority to practice independently. They can evaluate, diagnose, and manage treatment—including ordering and managing medications.
- In 15 states, NPs have reduced practice authority that requires a regulated collaboration agreement with a physician.
- In 12 states, NPs have restricted practice authority that necessitates supervision, delegation, or team management by a physician.

In this study, NP cases included both NPs named individually and those with physician codefendants. Of note: In 12 claims (18 percent), NPs were the only defendants. In 55 claims (82 percent), physicians were codefendants. These cases were eliminated from the FM and IM physician list.

*A written demand for payment

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MOST COMMON PATIENT ALLEGATIONS

When NPs worked in FM and IM practices, the three most common claim allegations against NPs accounted for 88 percent of their total claim allegations. The top three allegations in claims filed against FMs and IMs accounted for 89 percent of their total claim allegations.

The diagnosis- and medication-related allegation percentages were similar for both NPs and primary care physicians while medical treatment–related allegations were more common for primary care physicians (see **FIGURE 1**). The small number of NP claims may lack statistical significance.

FIGURE 1

Top three NP claims by claim allegation category

	NP Claims	FM and IM Claims
Diagnosis-Related (failure, delay, wrong)	48% (32 claims)	41% (556 claims)
Medication-Related	24% (16 claims)	19% (259 claims)
Medical Treatment–Related	16% (11 claims)	29% (391 claims)
Total Claims	67	1,358

Mean and median indemnity payments were lower for NP medication-related and medical treatment–related allegations. For diagnosis-related allegations, the mean indemnity paid was essentially the same for NP and physician claims, and the median indemnity payments were similar.

The indemnity payments for each of these three allegations are listed in **FIGURE 2**.

FIGURE 2

Indemnity paid: top three claim allegations

	Mean		Median	
	NP	FM and IM	NP	FM and IM
Diagnosis-Related (failure, delay, wrong)	$370,400	$369,500	$196,300	$200,000
Medication-Related	$141,600	$294,200	$92,500	$167,500
Medical Treatment–Related	$101,700	$211,400	$50,000	$162,250

Note: Includes paid claims only.

Diagnosis-Related Allegations

Diagnosis-related allegations accounted for 48 percent of claims against NPs. Of these claims, 42 percent involved the diagnosis of malignancy (most frequently breast, colon, lung, ovary, and skin). Other common diagnoses associated with this allegation included acute myocardial infarction (MI), pulmonary and arterial embolism, and venous thrombosis.

Diagnosis-related allegations accounted for 41 percent of claims against FM and IM physicians and commonly involved the diagnosis of malignancy (32 percent). The claims most frequently involved cancers of the lung, prostate, breast, and colon. Other frequent diagnosis-related allegations against primary care physicians included pulmonary embolism/infarction, acute cerebral vascular accident (CVA), acute MI, spinal epidural abscess, and pneumonia.

As illustrated in **FIGURES 3** and **4**, the final diagnoses in claims with a diagnosis-related allegation were similar for NPs and primary care physicians. The top six diagnoses are the same for both, with the exception of colon cancer (NPs) and prostate cancer (physicians). This conclusion is not surprising considering that nurse practitioners and primary care physicians work in comparable settings and see the same types of patients.

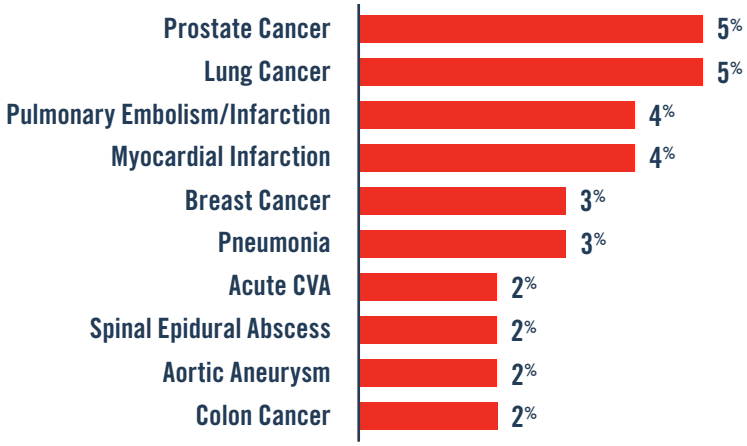
FIGURE 3

Top NP diagnosis-related claims

Note: Percentage of total NP diagnosis-related claims. Includes NP diagnoses with two or more claims.

FIGURE 4

Top FM and IM diagnosis-related claims



Note: Percentage of total FM and IM diagnosis-related claims. Includes FM and IM diagnoses with 10 or more claims.

CASE 1: A 40-year-old male presented to an NP complaining of a flare-up of his previously diagnosed gout. The NP prescribed prednisone and gave him a steroid injection in his left leg.

Three weeks later, he returned, complaining of swelling of his left calf with pain behind the knee and medial thigh. The NP measured the left calf as 42 cm. The right calf was 40.5 cm. The NP documented that he doubted this was a deep venous thrombosis (DVT) and attributed the pain to gout, Baker's cyst, or radiculopathy. The NP recommended another prednisone injection be placed in the ankle and documented that if the calf continued to swell, he would order an ultrasound to rule out DVT.

Later that day, the patient called the office complaining of increased swelling and pain. The NP ordered an ultrasound that was performed the following day. It revealed a DVT. The result was called to the NP's office, and the patient was instructed to come to the office for an evaluation. The calf was larger than the day before, so he was sent to the emergency department (ED). Shortly after arrival, the patient arrested. Resuscitation efforts were unsuccessful, and an autopsy revealed a pulmonary embolism (PE).

Experts stated that the NP should have ruled out a potential DVT by ordering the ultrasound when the patient first complained of swelling in his calf. They opined that an earlier diagnosis would likely have resulted in a different outcome. Experts were also critical of the supervising physician for failing to provide adequate oversight of the NP's work.

CASE 2: A 61-year-old obese male received care from his NP and, occasionally, from the supervising FM physician. He presented to the NP, complaining of chest pain and pain radiating down both arms with heavy lifting. His vital signs were within normal limits. The NP diagnosed costochondritis and muscle spasms. She gave a Toradol injection and prescribed Medrol and Celebrex. She recommended warm packs at the site of muscle pain and told the patient to schedule an appointment with a cardiologist if his symptoms did not improve or go to the ED if the pain worsened.

Four days later, the patient went to the ED with worsening symptoms. An EKG showed a massive MI. He was taken to the cardiac catheterization lab, where he went into ventricular fibrillation. A code was called, and the patient was intubated and placed on a ventilator prior to performing an angiogram, which showed complete blockage of the left anterior descending artery. The patient arrested, and resuscitation efforts were unsuccessful.

Experts criticized the NP for failing to recognize risk factors for coronary artery disease and the signs and symptoms of coronary ischemia. The NP's assessment was not adequate based on the patient's symptoms upon presentation. Coronary artery disease should have been part of the differential diagnosis, and the NP should have sent the patient directly to the ED. Experts opined that the patient's death could have been avoided if the NP had taken those steps when the patient was initially examined.

CASE 3: A 45-year-old male presented to a dermatology practice and asked the NP to evaluate a skin lesion on his back. The lesion was raised, pigmented, and scabby. The patient said it bled on occasion. The NP did a shave biopsy and curetted the area. She counseled the patient to return for a follow-up appointment in three months. The dermatologist interpreted the shave biopsy as basosquamous carcinoma but did not send it to a pathologist. During the second visit, the NP reexcised the area to obtain clear margins.

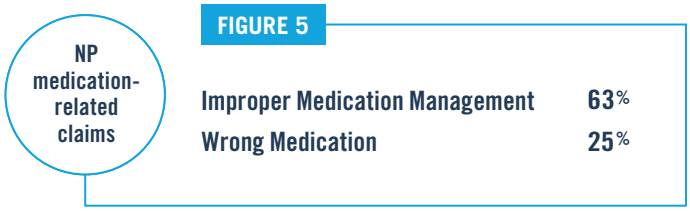
Three months later, the patient presented to the ED complaining of numbness in his lower extremities. CT scans showed metastatic lesions in the brain and lungs. A biopsy confirmed a stage IV melanoma. The hospital pathologist reviewed the slides from the initial biopsy, which showed melanoma, not basosquamous carcinoma. The patient died a few months later.

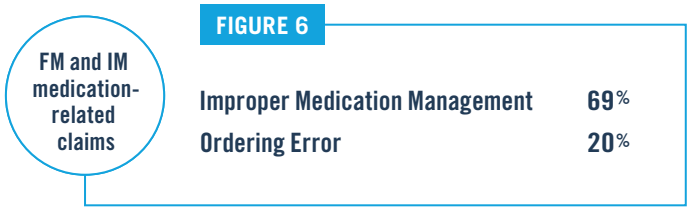
Experts criticized the failure to diagnose melanoma, thereby delaying treatment. They said the NP should have asked the dermatologist to see the pigmented lesion during the first visit and to assess the adequacy of the biopsy. The opportunity to see the lesion may have prompted the dermatologist to send the biopsy to a pathologist. During the second visit, the dermatologist should have checked to see if the NP's reexcision obtained clear margins. This case highlights the importance of collaboration between NPs and supervising physicians. They need to agree on conditions that, when identified by an NP, would warrant an assessment by the supervising physician.

> "This case highlights the importance of collaboration between NPs and supervising physicians."

Medication-Related Allegations

Of the NP medication-related claims, 63 percent involved improper medication management, and 25 percent involved ordering the wrong medication (see **FIGURE 5**). Of the FM and IM medication-related claims, 69 percent involved improper medication management, and 20 percent involved an ordering error (including 9 percent ordering the wrong medication and 6 percent ordering the wrong dose) (see **FIGURE 6**). In some cases, orders to continue anticoagulants were not written, chemotherapy orders were incorrectly written, patients suffered side effects from prescribed drugs, or patients failed to take medications as directed. Other examples included ordering incorrect dosages, ordering medications that were inappropriate for the patient's condition, and prescribing medications that were contraindicated because of another medication the patient was taking.





As shown in **FIGURE 7**, the seven most common types of patient injuries in NP claims with alleged improper medication management included adverse reactions to medications (80 percent), patient death (20 percent), need for surgery (20 percent), cardiac or respiratory arrest (10 percent), embolism or thrombosis (10 percent), limb mobility dysfunction (10 percent), and hospitalization (10 percent). In some of these cases, patients suffered more than one injury, such as an adverse reaction and respiratory arrest.

FIGURE 7

Top NP medication-management injuries

Adverse Reactions to Medications	80%
Death	20%
Need for Surgery	20%
Cardiac/Respiratory Arrest	10%
Embolism/Thrombosis	10%
Limb Mobility Dysfunction	10%
Hospitalization	10%

Note: Patients may suffer more than one injury.

Factors contributing to patient injuries in NP cases of improper medication management included selection of medications, insufficient documentation, inadequate communication among providers regarding a patient's condition, and inadequate communication with patients regarding medication risks. Other factors included failure or delay in obtaining a consult or referral and inadequate patient assessments. In cases of inadequate patient assessments, clinicians were faulted for failing to order appropriate diagnostic tests (such as gentamicin blood levels) or failing to reconcile relevant signs and symptoms (such as hearing loss) with test results. Patient behaviors also contributed to injury; e.g., they did not follow instructions for prescribed medications or did not adhere to treatment plans or instructions for follow-up appointments.

Factors contributing to patient injuries in FM and IM physician cases of improper medication management included incorrect selection of medications, inadequate monitoring of medications, and inadequate patient education regarding risks of medications. Other factors were failure or delay in ordering diagnostic tests, failure to reconcile relevant signs and symptoms with test results, failure or delay in obtaining a consult or referral, and inadequate communication among providers regarding the patient's condition.

Medical Treatment–Related Allegations

Sixteen percent of NP claims and 29 percent of FM and IM claims had allegations related to medical treatment. Allegations arose from cases in which patient care fell below accepted standards. In some cases, test results, findings, or orders were overlooked, and patients did not receive needed treatments or appropriate management of their conditions.

CASE 4: A 58-year-old female presented to a family practice complaining of chest pain. She explained that she had heard a rib crack. The NP evaluated the patient and ordered a chest x-ray, which revealed a 1.5 cm mass in the right middle lobe. The radiologist recommended a CT scan.

The NP never received the radiology report, and the office did not have a process in place to alert them when expected reports were not received. Sixteen months later, the patient returned complaining of cough and chest pain lasting several weeks. The NP ordered a chest x-ray and received the report showing a 4 cm mass in the right middle lobe. A CT scan revealed enlarged mediastinal lymph nodes.

A biopsy showed invasive adenocarcinoma, and a PET scan confirmed stage IV disease. She developed brain metastases and expired. It was determined that the delay in diagnosis compromised her chance of survival, and the delay resulted from the NP's failure to follow up on the report of the initial chest film that she ordered. Experts were also critical of the office practice's failure to have a procedure in place to verify that reports were received and reviewed by the NP.

PATIENT INJURIES

The top six patient injuries were the same for NPs (**FIGURE 8**) and primary care physicians (**FIGURE 9**), with two exceptions: hospitalization (NPs) and emotional trauma (physicians).

FIGURE 8

NP claims by patient injury

	Percent of Claims
Death (22 claims)	33%
Adverse Medication Reaction (15 claims)	22%
Malignancy (15 claims)	22%
Need for Surgery (10 claims)	15%
Hospitalization (8 claims)	12%
Infection (8 claims)	12%
Cardiac or Pulmonary Arrest (6 claims)	9%
Emotional Trauma (6 claims)	9%
Embolism/Thrombosis (5 claims)	7%
Infarction (heart, brain) (4 claims)	6%
Reduced Life Expectancy (4 claims)	6%
Metastasis (4 claims)	6%
Need for Ambulatory Care (4 claims)	6%
Sensory Impairment (4 claims)	6%

Note: Includes injuries with 6 percent or more of claims. Some percentages have been rounded. Patients may suffer from more than one injury.

FIGURE 9

FM and IM claims by patient injury

	Percent of Claims
Death (539 claims)	40%
Adverse Medication Reaction (205 claims)	15%
Malignancy (202 claims)	15%
Infection (189 claims)	14%
Emotional Trauma (117 claims)	9%
Need for Surgery (113 claims)	8%
Organ Damage (brain, heart, kidney, liver) (95 claims)	7%
Hospitalization (92 claims)	7%
Metastasis (86 claims)	6%
Cardiac or Pulmonary Arrest (82 claims)	6%
Infarction (heart, brain, lung) (82 claims)	6%
Embolism/Thrombosis (lung, brain, leg) (72 claims)	5%
Hemorrhage (70 claims)	5%
Mobility Dysfunction (69 claims)	5%
Pain (67 claims)	5%

Note: Includes injuries with 5 percent or more of claims. Some percentages have been rounded. Patients may suffer from more than one injury.

Death was the most common result of patient injury for both NPs (33 percent of all claims) and FM and IM physicians (40 percent of all claims). Adverse reaction to medications was the second most common NP patient injury (22 percent of all NP claims). The top five medication classes involved were anticoagulants, antibiotics, synthetic hormones, narcotics, and antidepressants. Adverse reaction to medications was the second most common patient injury in claims against FM and

IM physicians (15 percent of all claims). The top five medication classes involved narcotics, antibiotics, anticoagulants, steroids, and cardiovascular drugs (antihypertensives, antilipemics, Zocor, etc.).

Malignancy was the third most common patient injury for NPs, with 93 percent of the injuries related to diagnosis. Another allegation related to malignancy claims was improper management of treatment. Malignancy was the third most common patient injury for FM and IM physicians, and three of the cancers involved (breast, lung, colon) were the same as those in NP claims. The fourth most common injury for FM and IM was infection. The injury described as "need for surgery" refers to failure to diagnose punctures, lacerations, or other complications that occurred during surgical or invasive procedures and required surgical repair; it was the fourth most common patient injury for NPs.

INJURY SEVERITY

Patient injury severity was identified using the National Association of Insurance Commissioners (NAIC) Injury Severity Scale. The scale was rolled into low, medium, and high categories (**FIGURE 10**).

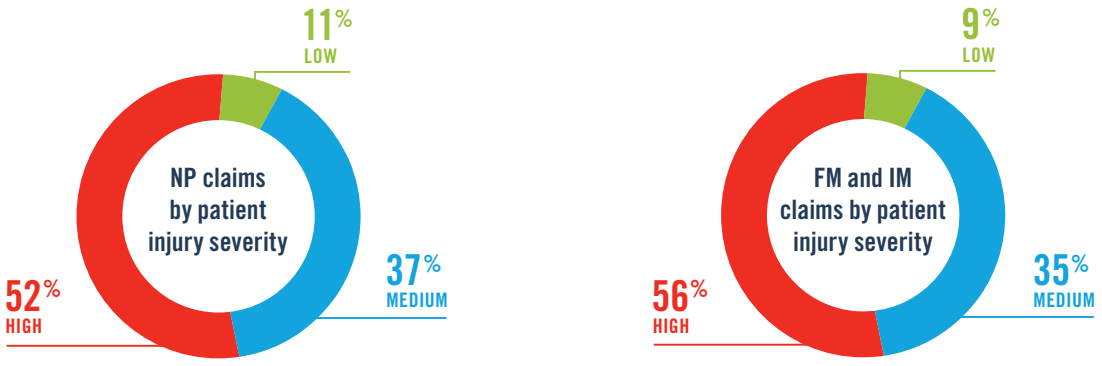
FIGURE 10

NAIC injury severity scale

LOW SEVERITY		
1.	Emotional only	
2.	Temporary insignificant	Lacerations, contusions, minor scars, rash, no delay in recovery
MEDIUM SEVERITY		
3.	Temporary minor	Infections, fractures, missed fractures, recovery delayed
4.	Temporary major	Burns, surgical material left in patient, drug side effect, recovery delayed
5.	Permanent minor	Loss of fingers, loss or damage to organs, nondisabling injuries
HIGH SEVERITY		
6.	Permanent significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung
7.	Permanent major	Paraplegia, blindness, loss of two limbs, brain damage
8.	Permanent grave	Quadriplegia, severe brain damage, lifelong care or fatal prognosis
9.	Death	

Patient injury severity was almost the same for NPs and FM and IM physicians (**FIGURE 11**).

FIGURE 11



FACTORS CONTRIBUTING TO PATIENT INJURY

FIGURE 12 illustrates the top contributing factors identified by our NP and physician reviewers. These factors are remarkably similar for both NPs and FM and IM physicians. There are two exceptions: patient assessment issues and the selection and management of therapy.

FIGURE 12

Top factors contributing to patient injury

	NP Claims	FM and IM Claims
Patient Assessment	45%	38%
Patient Factors	30%	29%
Selection and Management of Therapy	27%	15%
Communication Between Patient or Family and Provider	19%	20%
Insufficient or Lack of Documentation	19%	17%
Failure or Delay in Obtaining Consult or Referral	18%	15%
Communication Among Providers	10%	12%

Note: More than one factor may contribute to patient injury so the percentages total more than 100 percent.

CASE 5: A 63-year-old male presented to the ED complaining of shortness of breath and chest pain for two days. He had a history of hypertension. His BP was 140/90, heart rate 137, WBC was mildly elevated, and an EKG showed ST-T wave changes. He was admitted with a differential diagnosis of MI and pneumonia.

A hospitalist's evaluation of the lungs revealed rhonchi; a chest x-ray was unremarkable. A V/Q (ventilation/perfusion) scan was negative for pulmonary emboli. His impression was mild respiratory distress, possible bronchitis, and rule out MI. The patient's neck was supple; there was no mention of neck swelling. The hospitalist ordered antibiotics and a pulmonology consult. Several hours after admission, the patient's respiratory distress increased, and he was transferred to the ICU.

Less than an hour later, the pulmonologist was notified that the patient was in the ICU experiencing respiratory distress. The ICU transfer surprised him, because the consult was not stat. The pulmonologist was not in the hospital, so the NP was asked to evaluate the patient. The NP found that the patient was agitated, pacing his room, and complaining that his neck was swelling. The NP documented the swollen neck, respiratory distress, decreased upper airway breath sounds, and inability to swallow. The NP's impression was upper airway compromise. The NP called the pulmonologist, who questioned if the patient was experiencing an allergic reaction to ACE inhibitors with angioedema. The NP reported that the V/Q scan, chest x-ray, and arterial blood gases were normal. The pulmonologist said he would evaluate the patient and gave orders to the NP for steroids and an ENT consult (not stat). The NP entered the orders and left the unit.

Fifteen minutes later, the patient suffered respiratory arrest. The ED physician responded to the code, but 15 minutes elapsed before he was able to intubate the patient and place him on a ventilator. A CT scan of the patient's neck revealed no discernible airway. The patient expired, and an autopsy revealed a mediastinal abscess with extension of infection to the soft tissues of the pharynx that obstructed his upper airway.

Regardless of whether the patient's death could have been avoided, it is clear that inadequate communication among providers resulted in their delayed response and contributed to the patient's death. The patient's deteriorating condition should have prompted earlier intervention. The NP, who was in the best position to evaluate the patient's respiratory distress, should have recognized that the patient's condition was getting worse and alerted other providers that a crisis was imminent.

Patient Assessment Issues

Patient assessment is a key component in clinical judgment. As illustrated in this study, the frequency of patient assessment issues was similar to that of diagnosis-related allegations for both NPs (48 percent of claims) and FM and IM physicians (41 percent of claims), suggesting that patient assessment issues are a major contributor to diagnosis-related injury.

"Patient assessment is a key component in clinical judgment."

Patient assessment issues were similar for NPs and primary care physicians. Examples include failure or delay in ordering diagnostic tests (24 percent for NP claims versus 17 percent for physician claims), failure to appreciate and reconcile relevant signs and symptoms with test results (13 percent for NP claims versus 11 percent for physicians), failure to establish a differential diagnosis (15 percent for NP claims versus 13 percent for physicians), and inadequate history and physical (including allergies) (4 percent for NP claims versus 9 percent for physicians). Other patient assessment issues included narrow diagnostic focus for patients with atypical presentations, reliance on a previous diagnosis, and over reliance on negative findings in patients with continuing symptoms.

Selection and Management of Therapy

Twenty-seven percent of NP claims and 15 percent of FM and IM claims had allegations related to selection and management of therapy. This contributing factor was chosen by expert reviewers when prescribed medications caused an adverse reaction (GI ulceration, hemorrhage, kidney failure, etc.) and when assessments were inadequate or treatments were ineffective.

Patient Factors

Patient factors affected the outcome of care, highlighting the important role that patients play in their own care and treatment. This category includes injury claims made by patients who did not adhere to treatment plans, follow-up appointments, and medication plans.

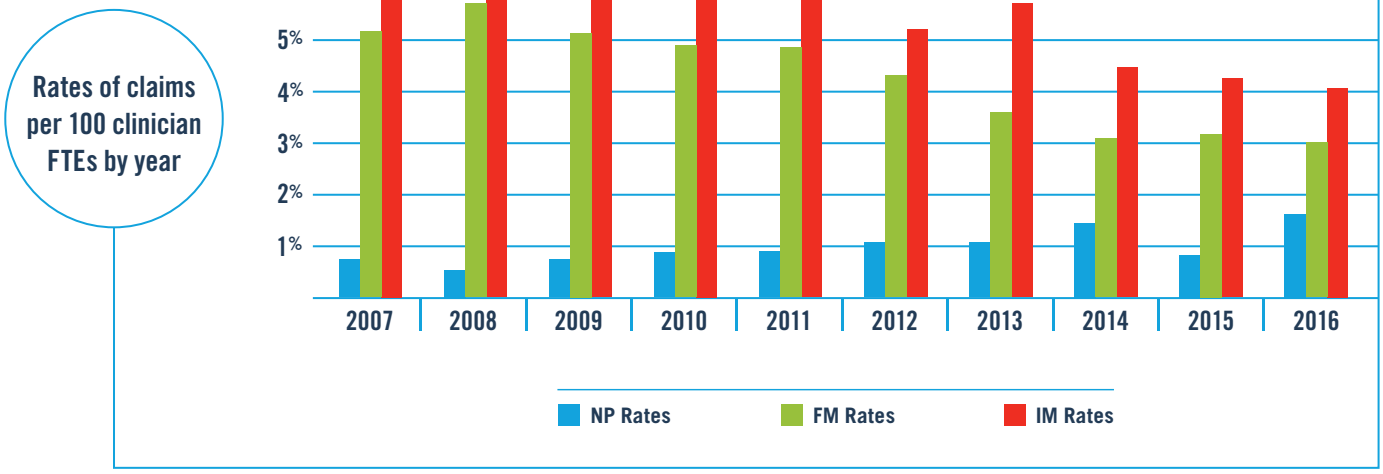
Examples of cases in which patients did not adhere to medical advice included delays in going to the ED that resulted in ruptured appendices, strokes, and MIs. Patients failed to schedule ordered diagnostic tests or radiographic studies, resulting in delayed diagnosis of malignancy. There were cases in which patients failed to complete medical treatments and to follow up with physicians after test results were received. Patient factors, such as nonadherence to treatment plans and follow-up appointments, occurred in approximately the same frequency for both NPs and FM and IM physicians.

FREQUENCY OF NURSE PRACTITIONER CLAIMS COMPARED WITH PHYSICIAN CLAIMS

As illustrated in **FIGURE 13**, the frequency of claims filed against physicians decreased over nine years (2008 through 2016), leveling off somewhat over the last three years of the study.

In contrast, the claims frequency for NPs is very low, but it has gradually increased over the same period. This rise in claims may be due to increased utilization of NPs in primary care practices or an increase in NP risk.

FIGURE 13



Note: Claims frequency is defined as the number of claims per 100 clinician full-time equivalents (FTEs) per year.

DISCUSSION

The adoption of the electronic health record (EHR) has negatively affected physician satisfaction and practice workflow. As a consequence, physicians are increasingly using medical scribes to untether themselves from their EHRs, enhance efficiency, and reduce burnout. Patient satisfaction also increases with the use of scribes due to improved physician-patient interactions during office visits. A growing body of evidence indicates that NPs provide similar benefits; i.e., they provide high-quality patient care, with patient satisfaction scores similar to those of physicians—which allows physicians to see more patients and focus on those with complex management or diagnostic problems.

Increasingly, the growing need for primary care services will be filled by NPs, not primary care physicians. Subject to individual state regulatory guidelines, NPs may take patient histories; conduct physical examinations; order, supervise, perform, and interpret diagnostic and laboratory testing; prescribe pharmacological agents; and render treatment. In 2017, there were approximately 234,000 licensed NPs in the United States, with 86.6 percent certified in primary care and 95.8 percent prescribing medications.[1]

Approximately 8,000 new primary care physicians enter practice each year. By 2020, it is estimated that about 8,500 will retire annually. As the number of primary care physicians declines, their services will increasingly be provided by NPs.[2] An estimated 23,000 new NPs completed their academic programs in 2015–2016.[1] It is projected that by 2025, physicians will represent 60 percent of the family practice workforce, and NPs will represent 29 percent (almost one-third).[2]

For these reasons, it is appropriate to review NP medical malpractice claims and compare them with those of primary care physicians to see if any unique NP risk management issues need to be analyzed. Although this NP claims analysis is statistically limited by the relatively small number of NP claims, it shows that diagnosis-related and medication-related allegations are similar for NPs and primary care physicians—as are the final diagnoses in claims with diagnosis-related allegations.

Medical treatment–related allegations are more frequent for FM and IM, while patient assessment issues, patient injury contributing factors, patient injury–related diagnoses, and injury severity are similar. The key differences are that NPs have lower claims frequency, and their medication-related and medical treatment–related claims have lower indemnity payments. The indemnity payments for diagnosis-related claims are similar for NPs and physicians.

> "Many NP malpractice claims can be traced to clinical and administrative factors."

An allegation of failure or delay in obtaining a specialty consultation or referral often occurred when an NP managed a complication that was beyond his or her expertise or SOP.

The alleged failure to perform an adequate patient assessment often occurred when an NP relied on the medical history or diagnosis in a previous medical record rather than performing a new, comprehensive exam.

Many NP malpractice claims can be traced to clinical and administrative factors:

- Failure to adhere to SOP.
- Inadequate physician supervision.
- Absence of written protocols.
- Deviation from written protocols.
- Failure or delay in seeking physician collaboration or referral.

Many of these factors can be remedied if physicians are clear about the nurse practice laws and regulations within their state and they support the NP in providing care within the SOP. The quality program within the practice should monitor the practice of the NP to ensure compliance with the laws and regulations of that particular state.

OBSERVATIONS FROM AN EARLIER STUDY

In an earlier study, The Doctors Company reviewed NP claims that closed between 2011 and 2015. Thirty-seven percent of claims involved diagnosis-related allegations. These allegations were often associated with lack of physician supervision, failure to consult with the physician when needed, and misinterpretation of information provided by the patient. Incorrect diagnoses often resulted from failure to establish a differential diagnosis or failure or delay in ordering diagnostic tests.

Communication problems were identified in 25 percent of claims and involved failure to communicate the patient's condition to other providers and failure to review the medical record. Physician reviewers identified insufficient or lack of medical record documentation in 21 percent of the claims. The claims often involved clinical findings and documentation of physician participation in patient care.

RISK MITIGATION STRATEGIES

The following strategies can assist NPs and physicians in preventing some of the injuries identified in this study:

- Collaboration agreements, if applicable, should outline circumstances that require the NP to refer patients to the physician or seek a second opinion. Agreements should include a description of the level of supervision that will be exercised by the physician, including the number and frequency of chart reviews and cosignatures.

  NPs and their physician partners must agree on the NP SOP based on the laws and regulations specific to that state.

- The most common patient allegation in claims filed against NPs and physicians in FM and IM was failure or delay in diagnosis. In this study, the most common factor contributing to patient injury was inadequate patient assessment.

  Complete a thorough clinical history and physical examination for each patient.

- The ability to engage patients and obtain accurate histories is essential when developing a differential diagnosis.

  Physicians, NPs, and office staff should take the time to explore patient complaints, especially when similar complaints are made on return visits.

- Some diagnostic errors occurred when patients presented multiple times with the same or worsening symptoms.

  If there is uncertainty about a diagnosis or about the appropriate testing to establish a diagnosis, the NP should ask the supervising physician to evaluate the patient.

- Some diagnoses were overlooked when patients with chronic illness presented for treatment on multiple occasions.

  Clinicians should consider new and unrelated illnesses when patients with chronic illnesses present multiple times for treatment.

- A significant number of patients with coronary ischemia present with atypical symptoms or are younger than expected.

  Thoroughly evaluate all age groups of patients presenting with chest pain.

- On occasion, NPs and their physician partners failed to identify complications from surgery in post-op patients. Although uncommon, DVT, PE, compartment syndrome, peritonitis, and wound infections are outcomes that represent serious threats to patients' well-being that may be difficult to diagnose.

  Train office staff to recognize complaints from patients or families that warrant immediate follow-up. Allocate office time to seeing patients with fever, bleeding, shortness of breath, and pain who may be experiencing complications of surgery or other invasive procedures. Direct patients with potentially serious conditions to an ED for immediate care.

- Documenting telephone conversations not only serves to provide information for other clinicians, but it can also be used to demonstrate that appropriate steps were taken when establishing a differential diagnosis.

  Document the details of telephone calls, including any recommended follow-up.

- Patients do not always follow physician or NP instructions for getting laboratory tests, imaging studies, or referral consultations. A tracking system will alert staff, NPs, and physicians when test results have not been received.

  Have a clear policy and procedure in place for tracking diagnostic test results and referrals and verifying that reports are received and reviewed.

- Patient compliance is a major problem, especially when patients don't understand discharge instructions or fail to receive adequate instructions.

  Use read-back or repeat-back techniques to confirm that patients understand discharge instructions, follow-up care, and medication plans. This form of interaction enables NPs and physicians to identify failures in communication between the patient and provider.

- Patient behaviors were a factor in the outcome of care in 30 percent of NP claims and 29 percent of physician claims.

  Document patient nonadherence to treatment plans, medication plans, and follow-up appointments.

- Responses to a question about a patient's intentions to follow instructions or purchase medications may provide clinicians with an opportunity to evaluate the patient's level of understanding and to learn about affordability concerns.

Provide a list of community resources that can help the patient receive needed treatment and services if he or she has a limited ability to pay for medications, diagnostic tests, or follow-up appointments.

- Informed consent is the responsibility of the clinician performing the procedure.

A physician cannot delegate responsibility for obtaining informed consent to an NP if the procedure will be performed by the physician. The NP (and RNs) can, however, assist with answering questions and ensuring the informed consent form is signed.

References

1. NP Fact Sheet. American Association of Nurse Practitioners Website. www.aanp.org/all-about-nps/np-fact-sheet. Accessed November 30, 2017.
2. Bodenheimer T, Bauer L. Rethinking the primary care workforce—an expanded role for nurses. *N Engl J Med*. 2016;375(11):1015-1017.

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