COOPERATIVE OF AMERICAN PHYSICIANS

Risk Management & Patient Safety
Focused Review

LEVERAGING DATA:

A Focused Review of Advanced Practice Professionals

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Failure to Diagnose and Treat Fulminant Bacterial Infection: Patient Disfigured and Disabled

A 57-year-old diabetic male laborer (DM) presented to a busy general practice office complaining of throbbing right foot pain, 8 on a scale of 1-10, with tenderness to touch, swelling, and an inability to bear weight. While at work the previous day, DM slipped from a squatting/kneeling position and caused the tip of his steel-toed work boot to hyper-flex and dig into the top of his right foot.

Office protocol required a physician to see DM at his initial visit. However, the physician was busy and DM was seen by the physician assistant (PA). PA's exam revealed moderate swelling and erythema, slight ecchymosis on the right dorsum mid-foot extending distally to all toes. The dorsalis pedal pulse was palpable. His nail beds had good capillary refill. X-rays of the foot and ankle were normal.

DM was prescribed Toradol 60mg IM, Ibuprofen, and Vicodin for pain. He was given a cold pack, crutches, and an open-toed shoe. Instructions included elevating his right leg and returning to the clinic in 2 days.

DM returned to the clinic two days later, as instructed, and was seen by the physician (MD). DM's pain is constant and now a 10. BP = 140/70. Pulse = 80. MD's exam revealed ecchymosis, severe swelling, and erythema of the right foot with proximal streaking upward to the knee. A diminished pedal pulse, hypoesthesia, and superficial de-vascularization of the skin were noted. MD diagnosed severe cellulitis with lymphangitis of the right foot and instructed DM to go to the ER STAT.

At the emergency room, DM tells the ER physician (ER) that he had a cut on his foot and developed a fever of 102 the prior day. WBC is 20,000. ER discovered a small laceration on DM's right foot, most likely occurring at the time of the injury. DM was diagnosed with a wound infection. Infectious Disease and Podiatry was consulted.

DM was admitted to the hospital that same day and scheduled for a surgical debridement. The surgeon found a sinus tract extending from the dorsum of DM's right foot progressing upward towards his ankle with liquefactive necrosis of the extensor digitorum muscle and purulent drainage – Necrotizing Fasciitis.

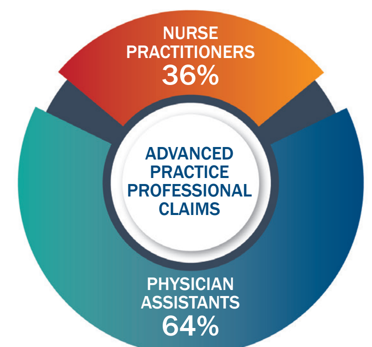
DM experienced an extended hospital stay. He received IV antibiotics, underwent two more debridement surgeries, and needed a skin grafting. DM now wears a foot brace, orthotic shoes, and walks with a cane leaving him unable to work.

Settled for $450,000!

In This Data Study...

Employment trends indicate an increasing number of Advanced Practice Professionals (APPs), specifically Nurse Practitioners and Physician Assistants, in healthcare settings. Correspondingly, CAP physicians will be more vulnerable to lawsuits due to the sheer number of these mid-level providers that they supervise. Therefore, CAP risk management staff evaluated forty-two (n=42) closed claims from 1/1/11 through 12/31/16 involving APPs. The sole purpose was to identify trends and to develop strategies for our members and their APPs that will improve patient care and reduce medical liability. This is what we found...

TOTAL CLAIMS REVIEWED	42
TOTAL INDEMNITY	$11,896,829
TOTAL EXPENSES	$2,311,847
TOTAL INCURRED	$14,208,676



Of the 42 CAP claims reviewed, Physician Assistants were sued nearly double the frequency as Nurse Practitioners. Our findings mirror an extensive study done by the Federation of State Medical Boards (FSMB).

AVERAGE INDEMNITY $223,149
*PIAA (2006) Average Indemnity $228,547

AVERAGE EXPENSES $55,044

Data results continue on pages 2-3.

The Rest of the Story…

Decisions made during the patient's initial visit resulted in some missed opportunities. DM had disclosed his diabetes on the H&P, yet the PA's exam was limited to the work-related injury. The PA did not inquire about diabetic complications. No test for peripheral neuropathy was conducted. A blood glucose test was not performed. And, the PA did not consult or refer with the supervising physician. At trial, experts testified that the PA should have appreciated DM's increased risk for cellulitis and vasculopathy. It was their opinion that even in the absence of a laceration, it was necessary to prescribe prophylactic antibiotics to this patient. They believed that the PA did not recognize the presence of an infection or he/she would have treated it.

Further complicating defense was deficient documentation in the medical record. There was no mention of diabetes in visit progress notes. No temperature was recorded. The PA did not address the appearance and integrity of the patient's skin – an important aspect of assessing a diabetic patient. And, there was no proof that the patient received any follow-up instructions to return to clinic before the return appointment, if symptoms worsened. Additionally, there was a glitch in the EHR system. The diagnosis of cellulitis with lymphangitis made by the MD at DM's second office visit had auto-filled in to the PA's office visit note. This created a challenge to the integrity of medical record.

DM may have had a better outcome had the PA conducted a more thorough H&P and physical examination, ordered prophylactic antibiotics, and informed the patient to return sooner than his appointment date for specific worsening symptoms. In addition, the following strategies may have prevented the patient's injury and improved defense:

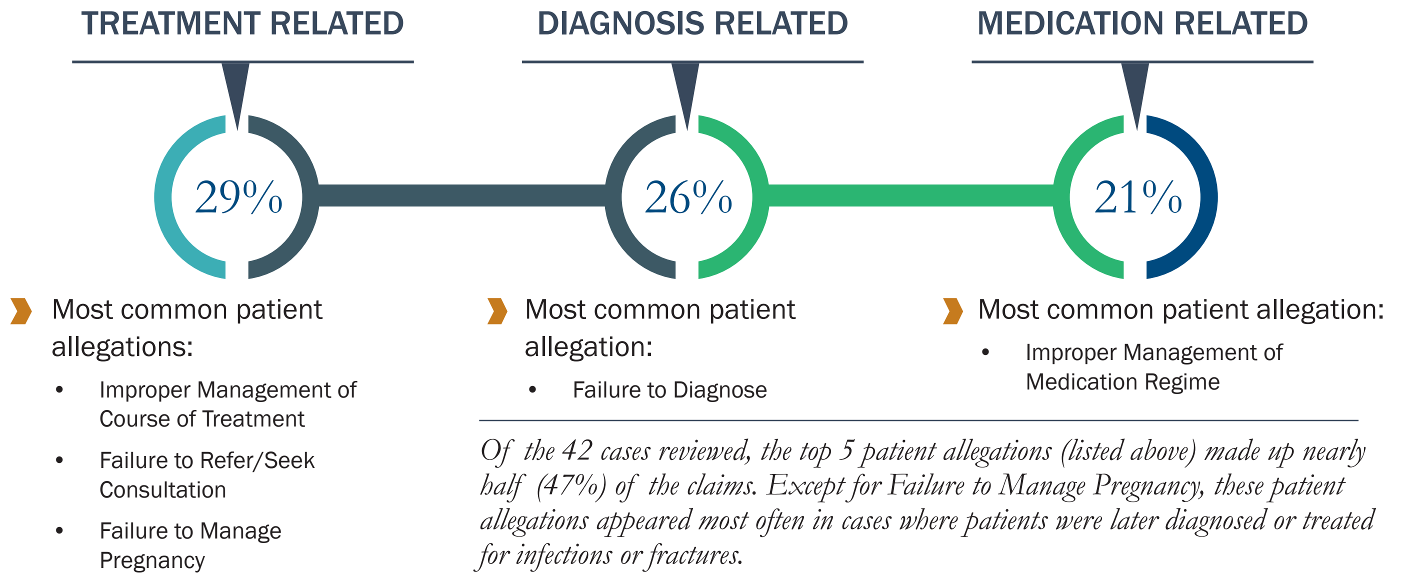
- Review the patient-completed H&P and address deviations from normal.
- Order necessary diagnostic tests to confirm or eliminate diagnoses.
- Contemporaneously document clinical findings, provider actions, and patient discussions/ responses to care.
- Never leave blanks or unfilled data spaces in the EHR/medical record.
- Provide patient with written educational materials and follow-up instructions.
- Adhere to protocols and collaborate with supervising physician.

Please see Risk Management Best Practices on page 4 for more risk reduction strategies.

Generally, nurse practitioners and physician assistants are a lower malpractice risk than physicians.

Their employment improves patient access to care and allows physicians to spend more time treating complex, high-risk patients. However, they are not a replacement for physicians- they are an agent of the physician. Physicians are responsible for the delegation of medical services to APPs, but they don't always understand their role in supervising their nurse practitioner or physician assistant.

Top 3 Allegation Categories



TREATMENT RELATED — 29%

Most common patient allegations:

- Improper Management of Course of Treatment
- Failure to Refer/Seek Consultation
- Failure to Manage Pregnancy

DIAGNOSIS RELATED — 26%

Most common patient allegation:

- Failure to Diagnose

MEDICATION RELATED — 21%

Most common patient allegation:

- Improper Management of Medication Regime

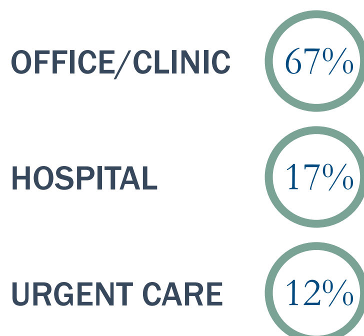
Of the 42 cases reviewed, the top 5 patient allegations (listed above) made up nearly half (47%) of the claims. Except for Failure to Manage Pregnancy, these patient allegations appeared most often in cases where patients were later diagnosed or treated for infections or fractures.

Warning: A Trend Emerges…

After reviewing the 42 cases, it became apparent that an adult patient with co-morbidities, such as diabetes mellitus, heart disease, and obesity and who presents to a medical office/clinic complaining of symptoms associated with an infection or fracture, is at greater risk for a poor outcome. The risk increases when the patient is non-compliant or non-adherent to their recommended medical regimen and have language barriers. Furthermore, these complex patients are usually treated for the same/similar issues over numerous visits by multiple healthcare providers, both advanced practice professionals and physicians, potentiating a problem with provider communication and follow-up. No one really knows the patient's full story or who's doing what, especially if there is poor documentation in the medical record.

In 59% of the cases, errors occurred during patient examination, the management of medication, and with follow-up. Frequently, the APP did not conduct a thorough enough physical exam or obtain important vital signs. They often relied on the patient's subjective complaints or were dependent on the previous provider's notes for diagnosis and treatment. Necessary diagnostic tests, such as an AFP or x-rays, were not ordered and acted upon. Medications were prescribed or changed without first consulting with the supervising physician. And, many patients fell through the proverbial cracks by not receiving adequate verbal or written information about referrals to specialists or when to return to the clinic.

Claims Based on Location



Claims Based on Specialty

Risk Management Best Practices

Building a strong foundation in excellent care and patient safety begins with ensuring that the APP is qualified, competent, and knowledgeable of his or her role. CAP recommends the following risk management strategies to reduce medical liability:

Employment – *Take your time when hiring a Nurse Practitioner (NP) or Physician Assistant (PA).*

- Evaluate credentials: verify graduation from an accredited program and active licensure. NPs are licensed by the CA Board of Registered Nursing. PAs are licensed by the Physician Assistant Board, a division of the Medical Board of CA.
- Perform background checks, including criminal and professional board actions.
- Verify professional liability coverage and obtain a copy of current policy. Investigate malpractice claims history with the National Practitioner's Data Bank (NPDB).
- Contact all references, including past supervising physicians and coworkers; even those not listed on resume.

Education and Training – *Play an essential role in mentoring and foster their educational development. Recognize that no two APPs are created equal--each professional has a unique skills set and level of experience.*

- Utilize skill checklists to determine areas of competency and deficiencies.
- Provide ongoing on-the-job training, especially for those new to practice. Longer training time may be needed if the APP is working in a group setting with multiple physicians. Experienced APPs will benefit from an orientation where performance expectations and practice standards are clarified.
- Support professional growth and need for continuing education. Consider topics relevant to clinical practice--communication, empathy, managing patient expectations, and improving patient satisfaction.

Comprehensive Written Protocols – *Liability can be mitigated by tighter adherence to clinic guidelines.*

- Understand state laws and regulations that define the APPs scope of practice.
- Clearly define their role in a written job description within the Standardized Procedures and Protocols (SPP) for the NP or the Delegation of Services Agreement (DSA) for the PA.
- Define their scope of practice. Protocols should outline the types of patients the APP can manage independently, the treatments they can provide, the type of drugs they can prescribe, and the types of procedures they can perform.
- Exemplify the types of problems, conditions, and clinical complaints that require real-time consultation with a physician and referral to a specialist.

These two categories of interventions can directly improve patient outcomes and prevent problems associated with ineffective communication and the lack of supervision further reducing medical liability.

Collaborative Relationship – *Patients' lives depend on effective communication and teamwork.*

- Create a "culture of safety:" encourage open communication and value good internal relationships; invite consultation; be available and approachable—your APP will feel more comfortable asking important clinical questions and seeking your guidance and involvement in patient care.
- Prioritize provider well-being and participation in quality improvement and workplace changes. Research solidly correlates a clinician's job satisfaction with favorable patient outcomes and improved patient satisfaction.

Supervision – *Don't be left out of the loop! Understand your role as supervisor.*

- Understand state laws and regulations; recognize that legal regulations are the minimal requirement.
- Conduct frequent meetings to discuss patient care, review charts, resolve conflicts, and reinforce policies and procedures.
- Maintain records of periodic performance evaluations and chart reviews in personnel files.
- Document all consultations with the APP--a simple note in the chart is sufficient.

The information in this publication should not be considered legal or medical advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.

Tools and Resources:

Cooperative of American Physicians
www.capphysicians.com

The Medical Board of California
www.mbc.ca.gov

California Board of Registered Nursing
www.rn.ca.gov

Department of Consumer Affairs' Physician Assistant Board
www.pac.ca.gov

The National Practitioners Data Bank
www.npdb.hrsa.gov

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