Mitigating Malpractice Risk in the Emergency Department: Strategies for Nurse Practitioners

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Objectives

1. Understand Legal Standards of Care and the anatomy of a malpractice claim: Explain the legal standards of care applicable to Nurse Practitioners in the Emergency Department and how adherence to these standards can prevent malpractice claims.
2. Identify common malpractice risks: Recognize and understand the common sources of malpractice claims in the ED.
3. Implement risk management strategies: Apply effective risk management techniques, including thorough documentation and clear communication, to minimize liability in emergency care.
4. Develop effective communication skills: Strengthen communication skills with patients, families, and interdisciplinary teams to improve patient outcomes and reduce misunderstandings that can result in legal action.
5. Implement Proactive Patient Education: Design and implement patient education strategies that inform patients about their care plans, potential risks, and follow-up instructions, thereby reducing the risk of dissatisfaction and potential malpractice claims.

Introduction

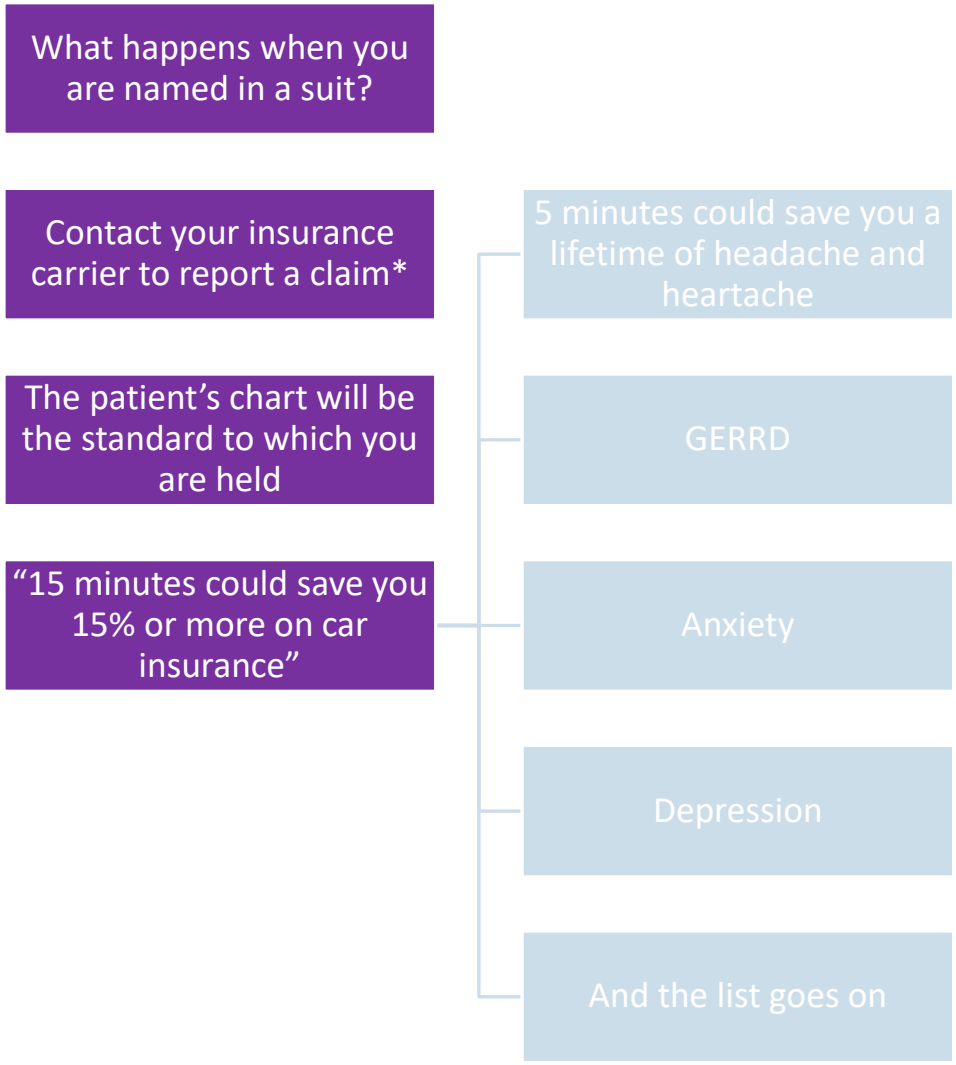
Criminal law vs Civil law and Tort law

What is medical malpractice?

Components of a malpractice claim

- Duty
- Breach in the standard of care*
- Harm
- Causative relationship between breach + harm*

What is the standard of care and how is it determined in a court of law?



What happens next?

The data

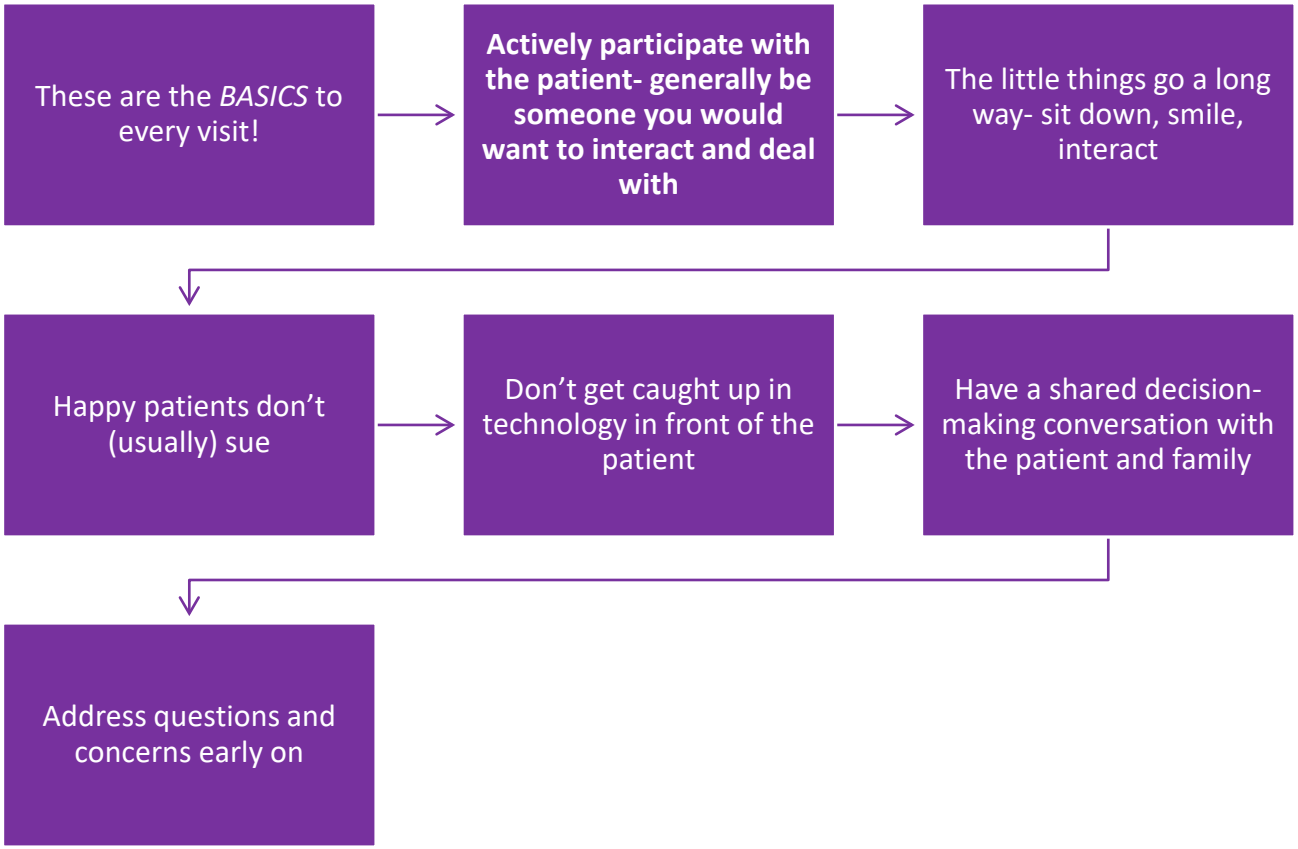
According to the NPDB, there were 14,480 medical malpractice payments made by insurers during the 2024 calendar year – inclusive of physicians and APRNs

- 809 payments from APRNs
- 13,671 payments from MD/DOs

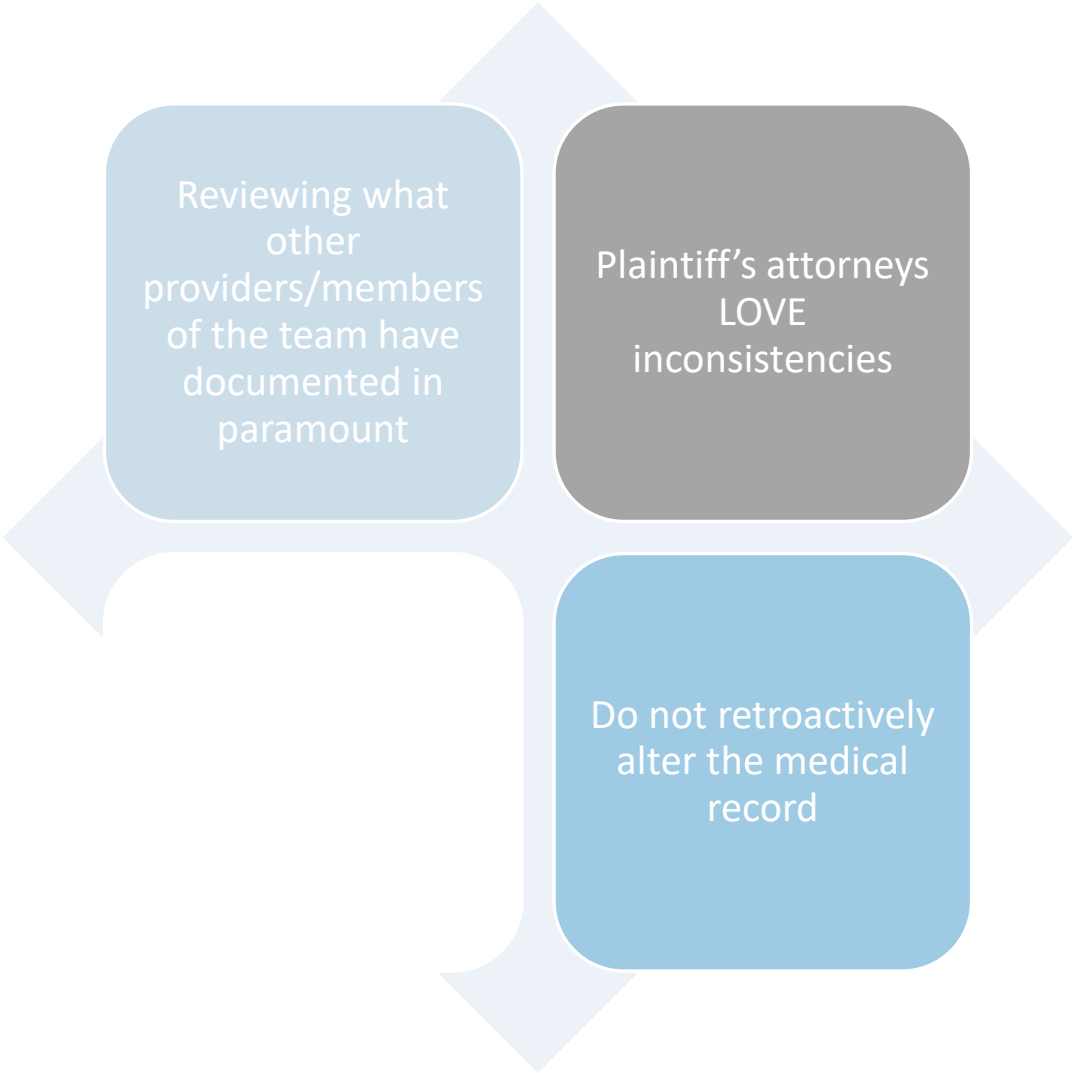
There is a downward trend year over year for the last 5 years

What can you do?

Actively participate



Review what others have documented



Examples of inconsistency

Triage note: 21-year-old female here today for chest pain and shortness of breath

- Provider note: 21-year-old female with no PMHx here today for refill of birth control pills
- Of note, the patient told the triage nurse that she had chest pain and dyspnea, however, on my history/exam, she denies this, and states she wanted to “get seen sooner”.

Triage note: 45-year-old female here today with abdominal pain and nausea/vomiting, reports some bloody emesis

- Provider note: 45-year-old female with no PMHx here today for abdominal pain and vomiting.
- Of note, the patient reported a few episodes of hematemesis to the triage nurse, however, denies these complaints to me.

How do you handle these inconsistencies?

Address the abnormal

Plaintiff attorneys LOVE when you don't address the abnormal

- This paints a picture of carelessness, even when it sometimes doesn't matter

It is very normal for the patient to have abnormal findings

Does every abnormal finding need to be addressed?

How many times have you discharged someone from the ED with an abnormal finding?

Examples of addressing the abnormal

Have you ever discharged a patient from the ED in 10/10 pain?

Have you ever discharged a patient from the ED with abnormal vital signs? (think tachycardia)

Have you ever discharged a patient from the ED with fever? (think pediatric patients)

Have you ever discharged a patient from the ED with an incidental finding on imaging or lab result?

Overall:

- Have an explanation for the finding and why the patient is stable for discharge
- Have an appropriate plan for follow up
- Have it in writing!

Explain your thinking

What is the single most important section of the chart?

The MDM section is a window into the brain of the practitioner treating the patient

This section should paint a picture of the ED visit

This section includes the differential diagnoses

- You MUST think through and document a differential diagnosis list

This section is where you rationalize your choice to discharge or admit the patient

This section of the chart will most likely be heavily scrutinized by the plaintiff attorney

Medical decision making (MDM)

Templates vs free text

- ALWAYS make this patient specific

Template for a rock-solid MDM

- Provide a brief history
- Highlight pertinent physical exam findings
- Provide rationale for differentials
- Highlight pertinent lab/imaging results
- Explain your thinking regarding discharge or admission

MDM example

This patient is a 47 y/o F who presented to the ED with abdominal pain. No past medical history. On reexam, the patient is resting comfortably and feels better, is alert and in no distress. The repeat abdominal examination is unremarkable and benign; in particular, there is no discomfort at McBurney's point, no peritoneal signs. The history, exam, diagnostic testing, and current condition do not suggest acute appendicitis, bowel obstruction, acute cholecystitis, bowel perforation, major gastrointestinal bleeding, severe diverticulitis, abdominal aortic aneurysm, mesenteric ischemia, volvulus, sepsis, or other significant pathology to warrant further testing, continued ED treatment, admission, or surgical evaluation at this point. The vital signs have been stable. The patient does not have uncontrollable pain, intractable vomiting, or other significant symptoms. The patient's condition is stable and appropriate for discharge from the emergency department. The patient will pursue further outpatient evaluation with the primary care physician in 48 hours as indicated in the discharge instructions. All questions answered.

Discuss discharge or admission

All patients should received discharge instructions and follow up

- Diagnosis specific
- Time specific
- Appropriate

This DOES NOT mean sending the patient home with “canned” discharge instructions

This DOES mean

- Sitting down with the patient
- Taking time to explain
- Providing timed specific follow up*

Document all the above

What about the “grey” discharge?

Examples of shared decision making conversations

This patient is a 6 y/o F who presented to the ED with generalized abdominal pain that migrates to RLQ. No PMHx. Labs unremarkable. Ultrasound did not visualize appendix. Had a **shared decision making conversation** with the mother about obtaining a CT scan to rule out acute intra abdominal pathology, specifically appendicitis. We discussed the risks and benefits; risks including exposure to radiation. After a careful conversation, mom elected to forego a CT scan. As such, the patient will return here in 12 hours or follow up with PCP in 12-24 hours for a repeat abdominal exam. Discussed specific warnings regarding abdominal pain- worsening pain, vomiting, fever. Mom is in agreement with the plan. On repeat exam at discharge, the child is happy, smiling, abdominal is non tender, tolerating PO liquids without vomiting.

Conclusion and questions

Recap

- Actively participate
- Review what others have documented
- Address the abnormal
- Explain your thinking
- Discuss discharge or admission

What questions do you have about this presentation?

References

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