

Cases Involving Nurse Practitioners and Physician Assistants

Data Insight

2023



This publication contains an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which a nurse practitioner (NP) or a physician assistant (PA) is identified as the primary responsible service “role.”

Keep in mind...

A clinically coded malpractice case identifies the “primary responsible service” as the specialty that is deemed to be most responsible for the resulting patient outcome. **The “roles” associated with that service reflect the specific position within the service team that was involved at the time of the event. There may be multiple roles within the same service team** (i.e., a PA and an attending/consult – both practicing medicine under the emergency medicine responsible service).

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

Introductory Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

SETTLED

\$4.3M

RESPONSIBLE
SERVICE

Internal medicine
(supervising
specialty)

PRIMARY ROLE

Nurse practitioner

FAILURE TO DIAGNOSE STROKE

Patient's **anticoagulation regimen** was being regularly monitored every six months by his internal medicine physician; INR levels remained stable and in the therapeutic range.

On a **Sunday, the patient presented to an urgent care clinic for a headache and neck pain** (8/10 reported pain level). The **physician assistant (PA) prescribed Vicodin** and discharged the patient to home.

Two days later, the patient returned to the same clinic with increased head and neck pain (now 10/10). The **nurse practitioner (NP) examined him, and prescribed a muscle relaxant**. The NP's chart documentation was very poorly written; it contained no detail regarding whether a neurological exam was completed, only that the patient had "no focal deficits." No head CT was ordered, despite readily available chart reference to the patient's chronic anticoagulant use, and repeat visits for head and neck pain.

The next day, the patient was taken to the Emergency Department with a vertebral dissection and hemorrhagic stroke.

Introductory Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

SETTLED

\$600K

RESPONSIBLE
SERVICE

General surgery
(supervising
specialty)

PRIMARY ROLE

Physician
assistant

IMPROPER PERFORMANCE OF SURGERY AND IMPROPER MANAGEMENT OF A SURGICAL PATIENT

A general surgeon performed a laparoscopic reduction and repair of a complex para-esophageal hiatal hernia. On post-operative day one, the patient complained of left shoulder pain. Some lab results were concerning, but **no new differential diagnoses were considered.**

Discharge was planned, but the **patient stated he didn't feel ready; he told the surgical physician assistant (PA) that he was unable to eat or drink** (even clear liquids didn't go down smoothly).

Despite a low grade fever, belching, nausea, and newly elevated blood pressures, the patient was discharged to home three days post-operatively on pureed diet. **He died one day later.**

Autopsy revealed gastric necrosis and perforation. **Experts were critical, opining there was a deviation by both the general surgeon and the surgical PA** in prematurely discharging this patient; both failed to order imaging studies and timely intervene with placement of a nasogastric tube for decompression or surgery that **would have avoided his death.**

Key Points - Clinically Coded Data

INTRODUCTION | **KEY POINTS** | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

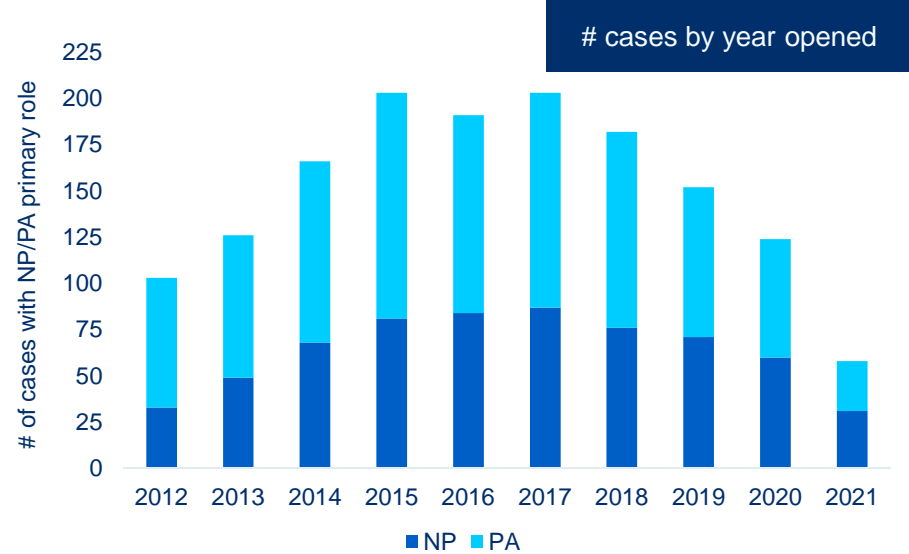
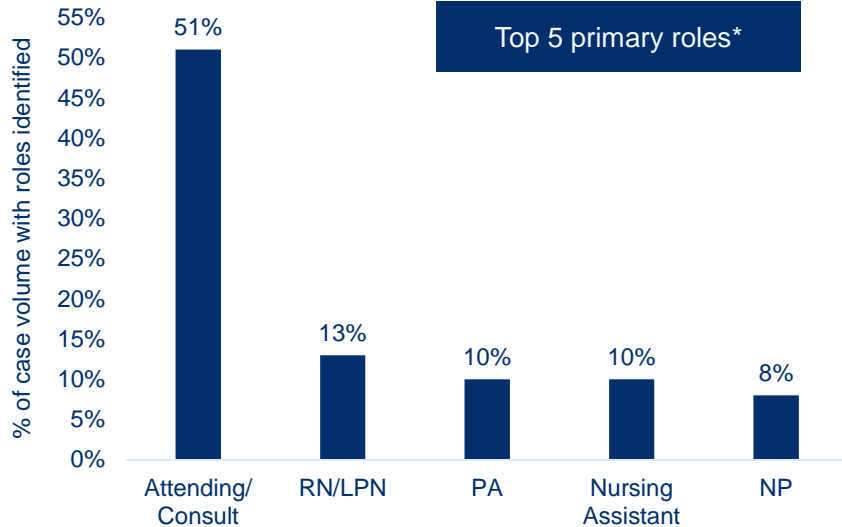
- **Nurse practitioners (NPs) and physician assistants (PAs) are noted in 18% of clinically coded cases opened between 2012-2021.** An increasing number of cases involving NPs and/or PAs are noted, and **most significantly, clinical and financial severity trends are climbing.**
- **Ambulatory settings** account for almost **two-thirds of the case volume.**
- **Diagnostic, medical, surgical and medication-related allegations** account for the majority of case volume. With the exception of surgical allegations, the distribution of allegations is similar among NPs and PAs.
 - Diagnostic allegations primarily reflect cancers, cardiac conditions and treatment of injuries (fractures, wounds). These cases commonly reflect breaks in the diagnostic process of care, most often including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, delays or failures in ordering diagnostic testing, and failures during the patient follow-up process.
- **Medical treatment allegations** reflect a higher volume of **medical management cases** as opposed to procedural issues. Procedural performance cases, which most commonly involve skin lesion excisions, can be impacted by delayed recognition of complications, while **management cases most often reflect issues with selection of the most appropriate procedure for the patient, and appreciating and reconciling symptoms and test results.**
- **Problems with selection of the most appropriate medication regimen**, monitoring/assessing the patient while on that regimen, insufficient education of patients/families about the risks of medications, and sub-optimal communication among providers about medication regimens and evolving signs/symptoms are the **most common contributing factors in medication cases.** Failure to identify which provider is coordinating care is noted as a specific risk issue in anticoagulant cases.

Key Points - Clinically Coded Data

INTRODUCTION | **KEY POINTS** | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

- **Cases involving the management of surgical patients**, including pre-, intra-, and post-operatively, are often related to NP or PA response to developing complications. While complications of procedures may have been the result of procedural error, the **failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome**.
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome**, and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities.
 - The three most common contributing factors linked directly to an NP or a PA are clinical judgment, communication and supervision. However, **administrative, documentation, clinical environment and clinical systems factors emerge as the evident drivers of closed case financial severity**.

Overall Case Volume



While the attending/consult physician role is most prevalent, **NPs and PAs combined are noted in 18% of all cases***. As the involvement of NPs and PAs in healthcare has continued to climb, **it is not surprising to see cases noting NPs and PAs in the primary role steadily increasing over many of the past 10 years**. The unexpected more recent decline in this data set is likely related to the fact that not all cases opened in 2020 and 2021 have yet matured for coding.

Clinical Severity*

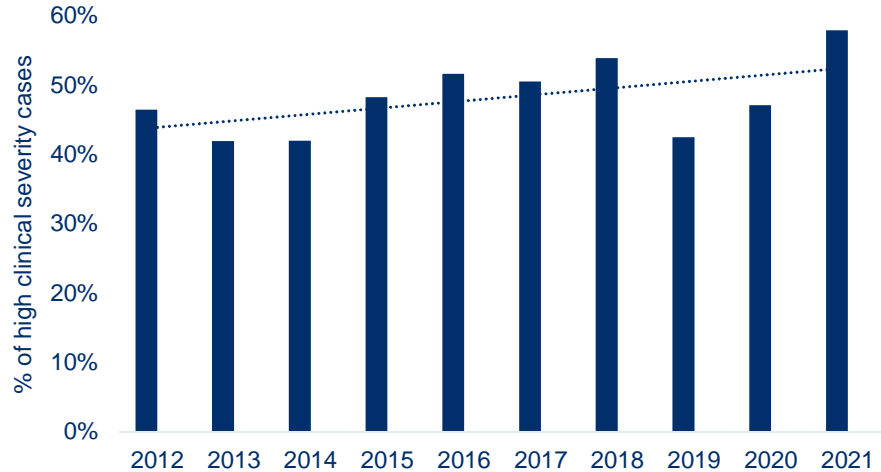
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Clinical Severity Categories	Sub-categories	% of all case volume	NP	PA
LOW	Emotional Injury Only	8%	8%	7%
	Temporary Insignificant Injury			
MEDIUM	Temporary Minor Injury	44%	37%	50%
	Temporary Major Injury			
	Permanent Minor Injury			
HIGH	Significant Permanent Injury	48%	55%	43%
	Major Permanent Injury			
	Grave Injury			
	Death			

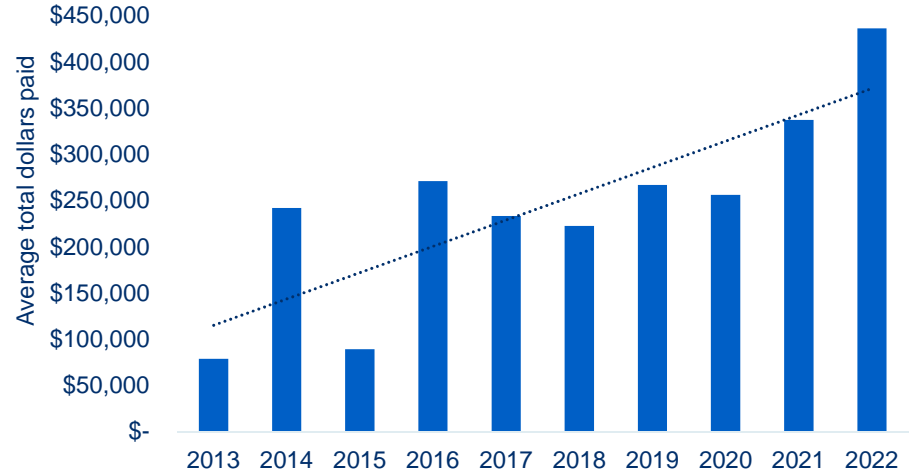
**Typically,
the higher the clinical
severity, the higher the
indemnity payments are,
and the more frequently
payment occurs.**

Clinical* & Financial Severity

High clinical* severity cases by open year



High clinical severity closed cases - financial** severity by closed year

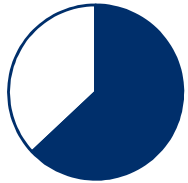


Across the years, the **percentage of cases opened each year noting a high clinical severity outcome is steadily rising**. Likewise, the **average cost to resolve high clinical severity cases is rapidly increasing**.

Claimant Type

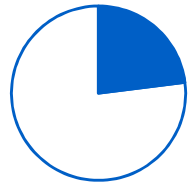
INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

Claimant type by % of overall case volume



Ambulatory
63%

43% high clinical severity*



Inpatient
23%

60% high clinical severity*



Emergency
14%

52% high clinical severity*

Claimant type by % of each role's case volume

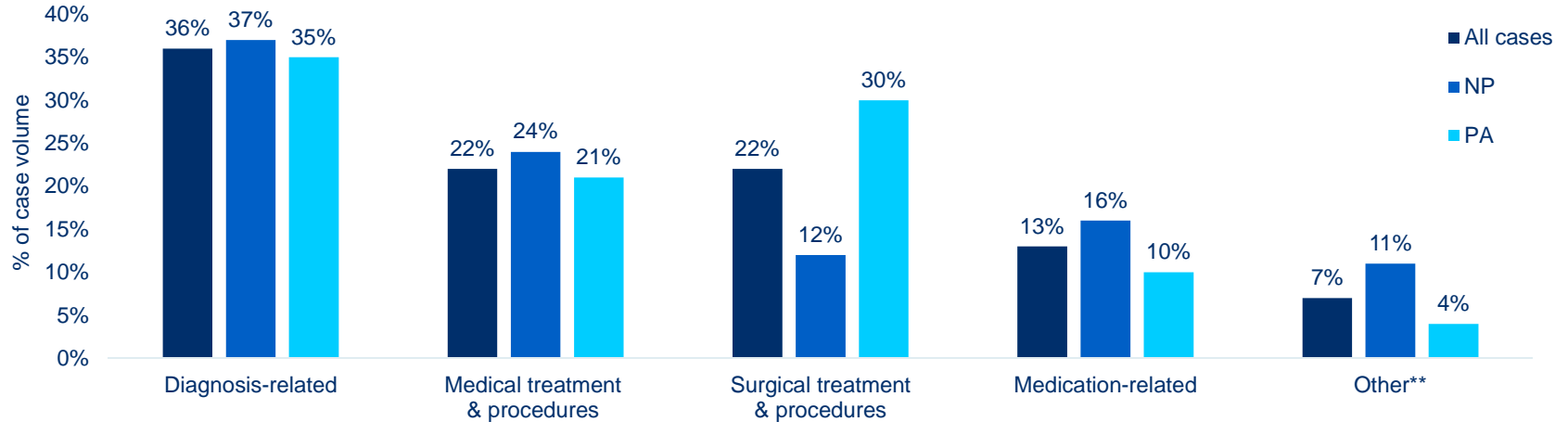
	Ambulatory	Inpatient	Emergency
NP	65%	25%	10%
PA	62%	21%	17%

Location

Most common locations	% of all case volume	NP	PA
Office/clinic	47%	51%	45%
Emergency department/urgent care	20%	15%	23%
Patient room/ICU	11%	14%	9%
Inpatient surgery	9%	4%	12%
Ambulatory surgery	5%	4%	5%

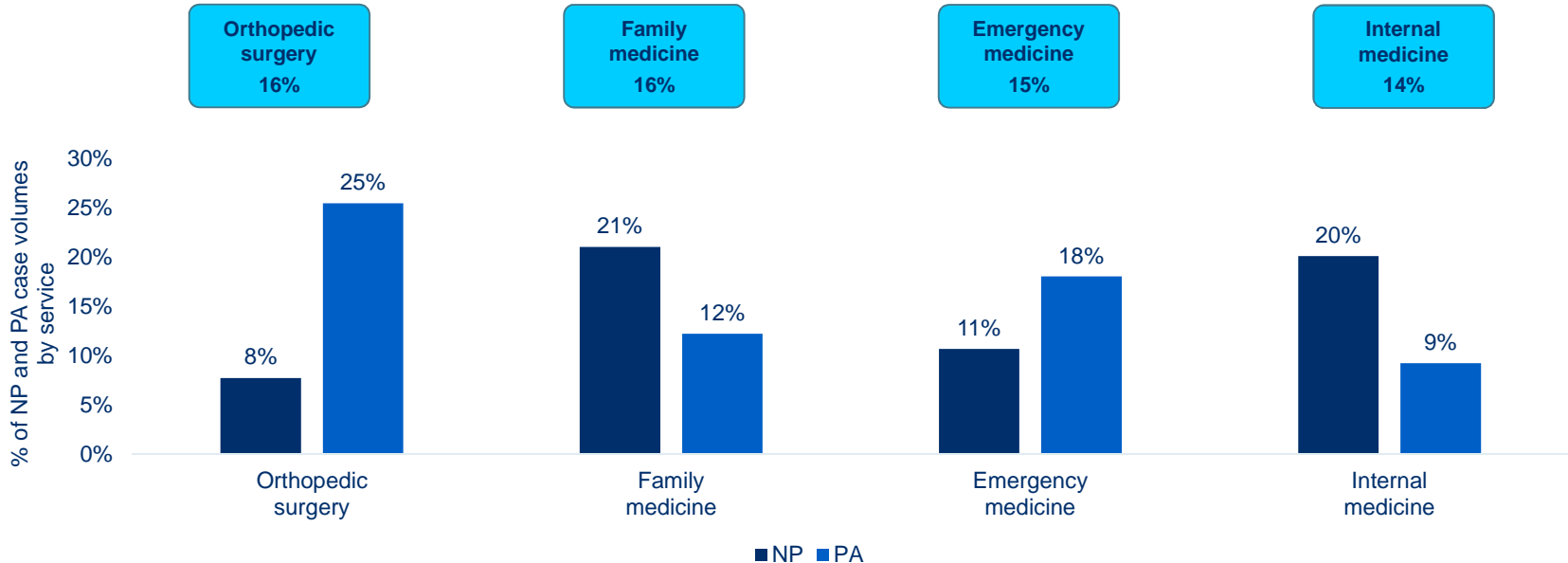
Major Allegations

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes **detailed allegation sub-categories; insight into these is noted later in this report.**



Primary Responsible Services

The **primary responsible service** in each case is the **specialty that is deemed to be most responsible** for the resulting patient outcome. The **four most common responsible services in cases with a NP or PA also involved are noted first**, by percentage of case volume. Then, the **distribution of NP and PA roles by their associated services** is displayed below.



Contributing Factors

“Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation.”

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



Technical skill

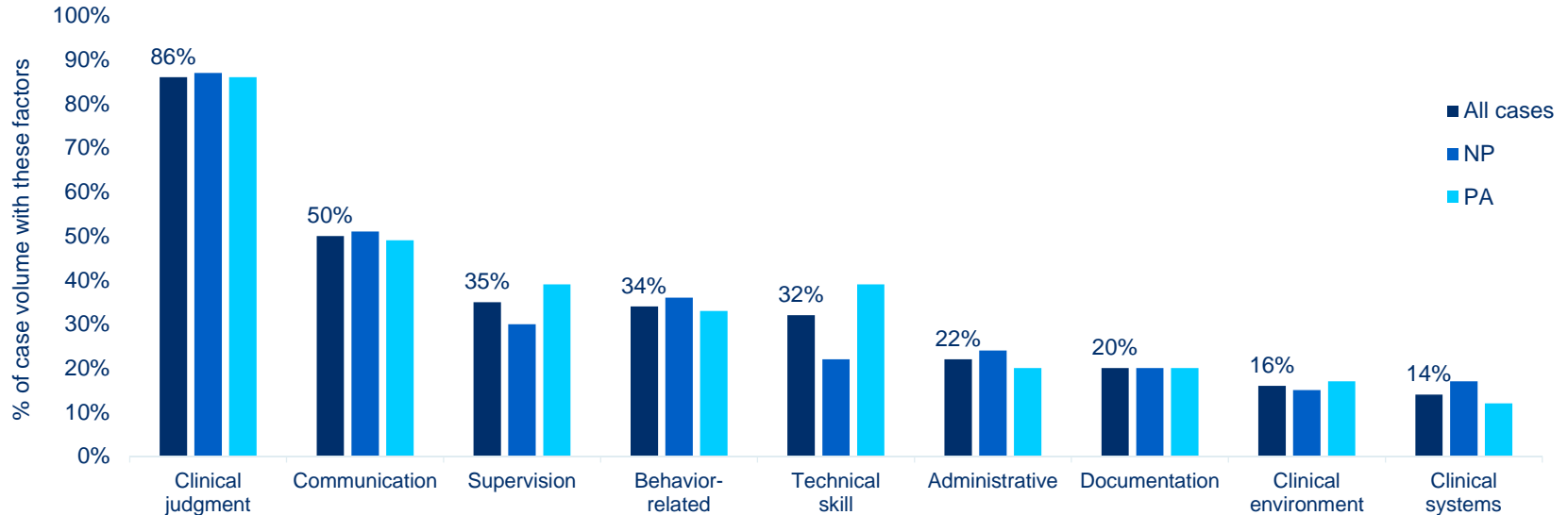
Contributing Factor Category Definitions

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Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc), and telehealth/tele-radiology
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

Most Common Contributing Factor Categories by Role

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With the exception of supervision and technical skill, **overall there are relatively few differences between NP and PA case volume distribution of contributing factors.** The comparative prevalence of PA-involved cases with technical skill and supervision issues noted is reflective of the high percentage of PA-involved orthopedic surgery cases.

Contributing Factor Focus by Claimant Type: Clinical Judgment

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The same contributing factors can be seen across settings (claimant types), although there are some visible differences. All factors are also linked to roles within the case*. This visual reflects those cases in which a **CLINICAL JUDGMENT** factor is specifically linked to either an **NP** or **PA**.

Most common clinical judgment details	All claimant types	Ambulatory	Inpatient	Emergency
Failure to appreciate/reconcile relevant sign/symptom/test result	47%	48%	52%	34%
Failure/delay in ordering diagnostic test	28%	32%	20%	32%
Failure to establish differential diagnosis	20%	21%	15%	23%
Failure/delay in obtaining consult/referral	20%	27%	12%	11%
Lack of/inadequate history/physical	18%	17%	16%	23%

The prevalence of diagnosis-related allegations in this data set (36% of all cases) increases the volume of clinical judgment factors.

One additional factor stands out. **Inadequate assessment resulting in premature discharge from care is present in 32% of the Emergency claimant type cases.**

Contributing Factor Focus by Claimant Type: Communication

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | **CONTRIBUTING FACTORS** | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

The same contributing factors can be seen across settings (claimant types), although there are some visible differences. All factors are also linked to roles within the case*. This visual reflects those cases in which a **COMMUNICATION** factor is specifically linked to either an **NP** or **PA**.

Most common communication details	All claimant types	Ambulatory	Inpatient	Emergency
Suboptimal communication among providers	57%	49%	75%	57%
Suboptimal communication between providers and patients/families	48%	58%	25%	43%

Communication failures with other providers, including nursing staff and supervising physicians, regarding relevant facts about the patient's care is a **concern noted across all locations**, especially in the inpatient setting. Of note, a **failure to escalate concerns is specifically noted in the inpatient cases**.

Inadequate patient education about medication risks and the management of patient expectations are the most often noted provider to patient communication concerns.

Contributing Factor Focus by Claimant Type: Supervision

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | **CONTRIBUTING FACTORS** | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

The same contributing factors can be seen across settings (claimant types), although there are some visible differences. All factors are also linked to roles within the case*. This visual reflects those cases in which a SUPERVISION factor is specifically linked to either an NP or PA.

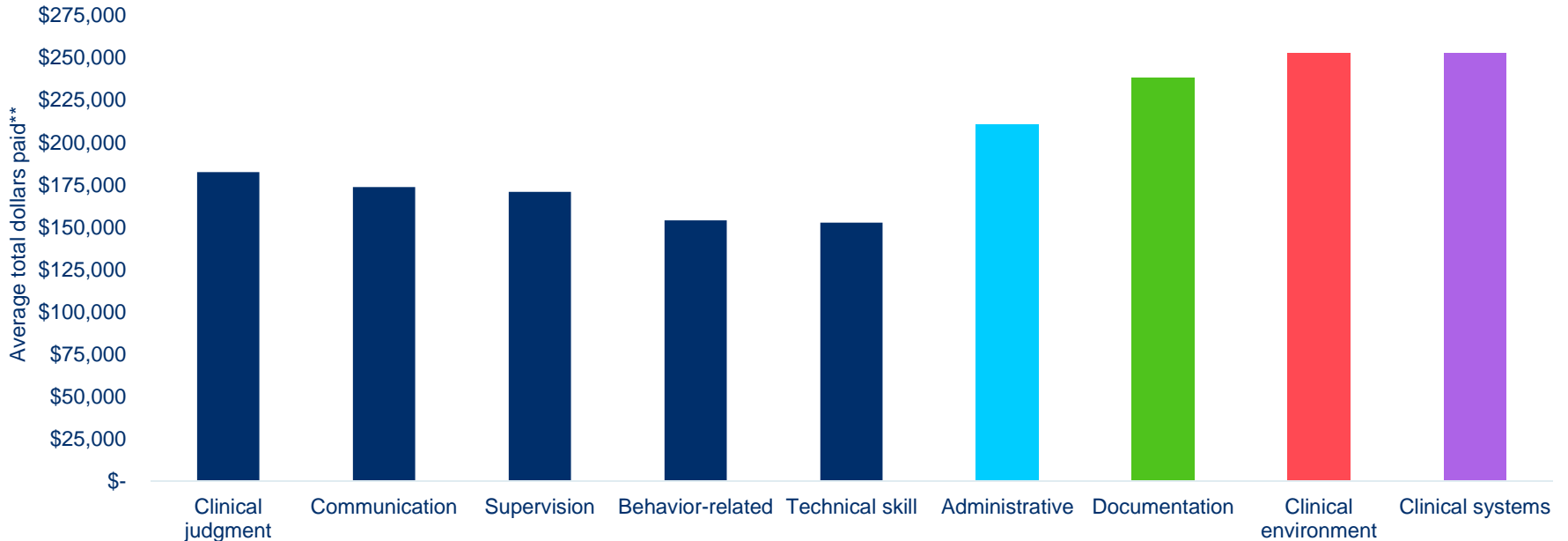
Most common supervision details	All claimant types	Ambulatory	Inpatient	Emergency
Supervision of PAs	63%	64%	56%	82%
Supervision of NPs	34%	33%	44%	9%

Insufficient supervision and oversight is present in 35% of all NP/PA case volume. As might be expected given the increasing autonomy of NPs, **more of the supervision issues are attributed to PAs. Physician sign-off on charts without review of/participation in care is a specifically noted concern** in cases arising in the emergency department.

Contributing Factor Focus by Financial Severity

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | **CONTRIBUTING FACTORS** | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

The focus has been on the three most common contributing factors linked directly to an NP or a PA – clinical judgment, communication and supervision. When refocusing on ALL factors noted in NP and PA cases, **administrative, documentation, clinical environment and clinical systems factors emerge as the evident drivers of closed case financial severity.**



Contributing Factor Focus by Financial Severity: Details

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | **CONTRIBUTING FACTORS** | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

Administrative, documentation, clinical environment and clinical systems factors are drivers of closed case financial severity. The most commonly noted details are listed below.

Factor (in order of increasing financial severity)	Most common details
Administrative	Policy/protocol not followed, and/or lack of policy/protocol
	Insufficient staff training
	Credentialing issues
Documentation	Insufficient/lack of documentation of clinical findings
	Insufficient/lack of documentation related to physician review of/participation in care
Clinical environment	Events occurring during night/weekend/holiday shifts
Clinical systems	Failure/delay in performing recommended diagnostic test
	Patient did not receive test results; lack of provider follow-up with patients after test results received

Focus on Diagnosis-Related Allegations

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | **FOCUSED DATA ANALYSIS** | CASE EXAMPLES | RISK MITIGATION

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. See below for the top diagnoses* noted in these cases.

Cancers (21%)

Primarily skin cancers,
followed by testicular, breast,
colorectal, lung and urinary
tract

Circulatory system diseases (19%)

Primarily cardiac disease
(myocardial infarction,
pulmonary embolus),
aneurysms and strokes

Injuries (18%)

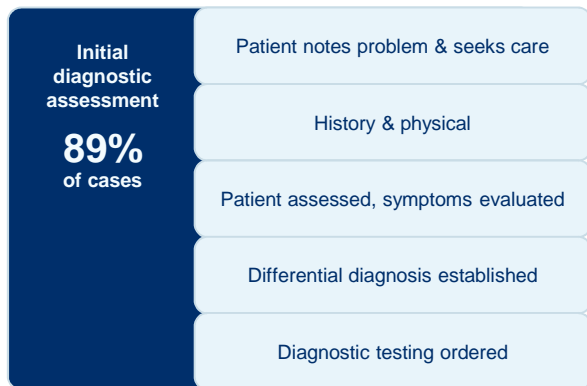
Primarily fractures,
complications of procedures,
open wounds

Focus on Diagnosis-Related Allegations

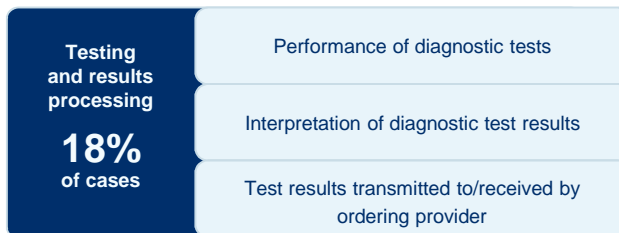
INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | **FOCUSED DATA ANALYSIS** | CASE EXAMPLES | RISK MITIGATION

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.

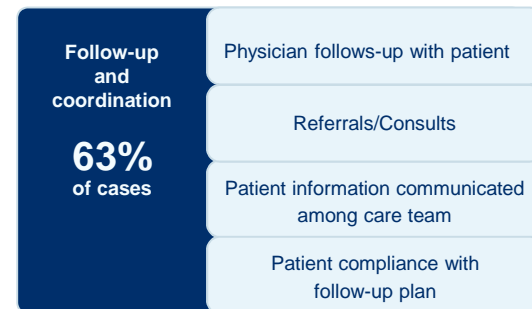
Phase 1



Phase 2

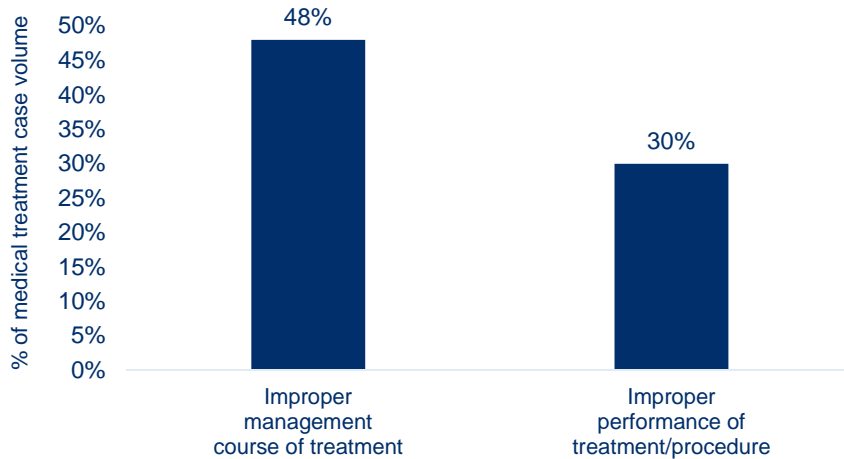


Phase 3

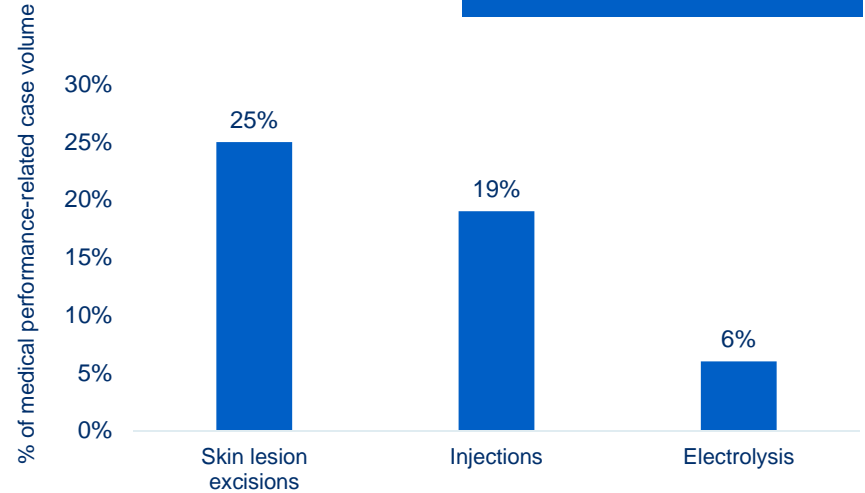


Focus on Medical Treatment Allegations

Top allegation details



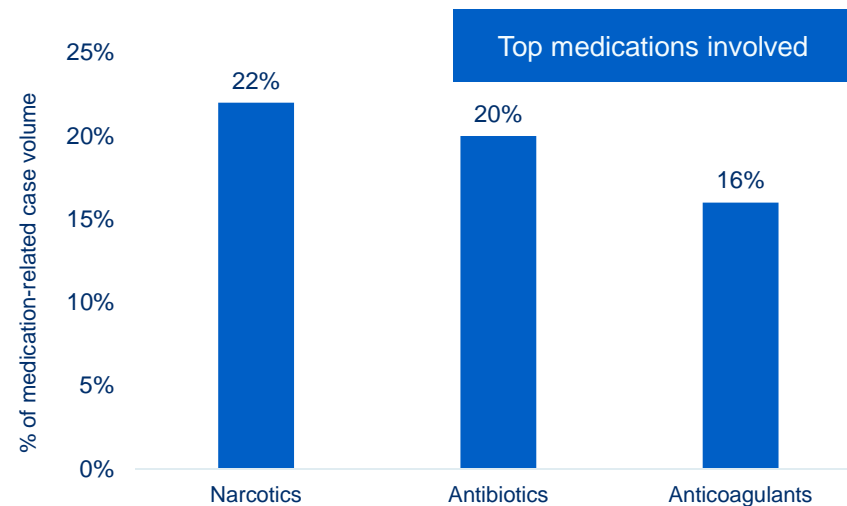
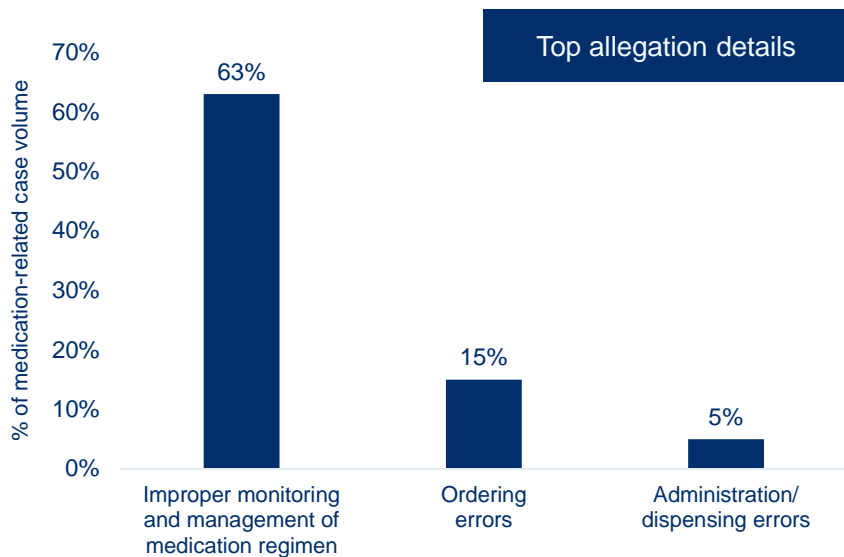
Top procedures involved



Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

Focus on Medication-Related Allegations

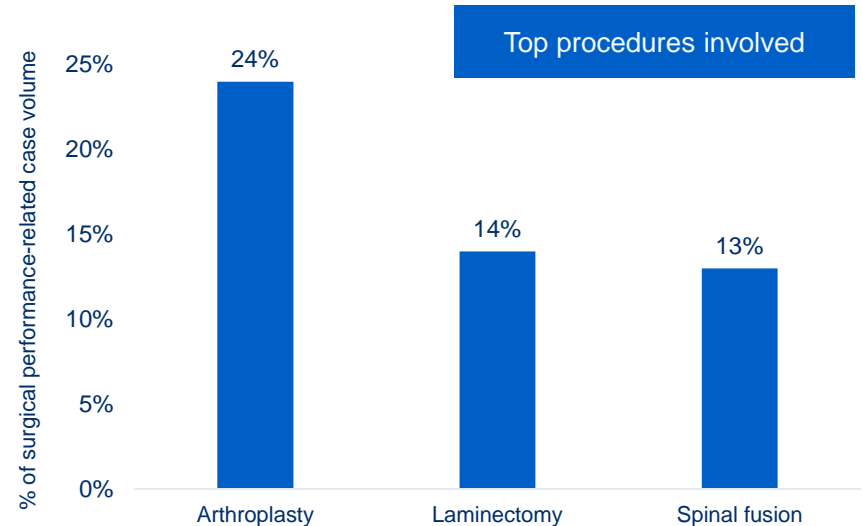
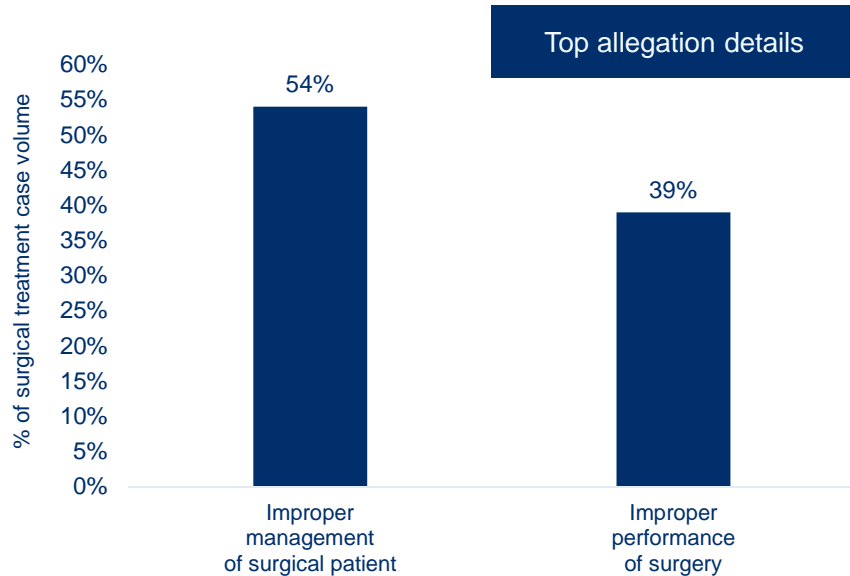
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Problems with selection of the most appropriate medication regimen, monitoring/assessing the patient while on that regimen, insufficient education of patients/families about the risks of medications, and sub-optimal communication among providers about medication regimens and evolving signs/symptoms are the most common contributing factors. Failure to identify which provider is coordinating care is noted as a specific risk issue in anticoagulant cases.

Focus on Surgical Treatment Allegations

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | **FOCUSED DATA ANALYSIS** | CASE EXAMPLES | RISK MITIGATION



Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the NP or PA response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.



The following stories are reflective of the allegations and contributing risk factors which drive cases involving nurse practitioners and physician assistants.

We're relaying these true stories as lessons to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | **CASE EXAMPLES** | RISK MITIGATION

SETTLED

\$900,000

CONTRIBUTING FACTORS

Administrative

Failure to follow policy/protocol

Clinical judgment

Patient assessment – narrow diagnostic focus

Failure to appreciate and reconcile relevant sign/symptom/test result

Failure/delay in ordering diagnostic test and consult/referral

Documentation

Inaccurate documentation in factual information

FAILURE TO DIAGNOSE MENINGIOMA WITH SPINAL CORD COMPRESSION RESULTING IN SPASTIC PARAPLEGIA

A 65-year-old male with a history of prostate cancer and diabetes presented to a neurologist (Neuro) with complaints of numbness and tingling in hands and feet and a left “floppy” foot. After an EMG (electromyography), he was diagnosed with moderately severe peripheral polyneuropathy. An MRI of the spine and lab results were essentially within normal limits.

Four months later, the patient presented to the Neuro office’s nurse practitioner (NP) with complaints of upper extremity tremors, worse with eating or writing. NP diagnosed essential tremor documented a plan “to monitor.” Three months later, the patient returned to the NP with **complaints of worsening tremors; however, the NP documented that the tremors were stable.**

Two years later, the patient saw the NP again and had significantly deteriorated; he was using a motorized wheelchair, had bladder and bowel issues, spasticity in the lower extremities, increased neuropathies, numbness/tingling to level of the chest. Patient mentioned he had been recently hospitalized for treatment of a diabetic ulcer; **his providers were concerned he had ALS (amyotrophic lateral sclerosis, a progressive neurodegenerative disease).** The NP ordered another EMG which showed that the patient’s strength in his lower extremities was 0/5 with significant spasticity.

At the next office visit three months later, his symptoms were still present with no improvement. An MRI of the spine was ordered by the NP; it revealed a **meningioma at T-1 and T-2.** The patient was referred to a neurosurgeon, and **ultimately underwent T-1 and T-2 laminectomies for removal of an intradural meningioma and decompression of the spinal cord.**

Neuro stated that at the time this patient was being cared for, he did not ever review the NP’s notes, nor did he ever sign them. However, the practice’s policy and procedure stated that all NP notes were to be randomly reviewed every four to six months.

Neuro stated that he believed the meningioma was blocked by the patient’s peripheral neuropathy, and in retrospect an MRI T-spine should have been ordered at the first office visit. The NP stated that she never conferred with Neuro, as peripheral neuropathy was confirmed by EMG. It is unclear why the patient didn’t return for two years, and why no MRI was done while he was hospitalized (when his providers considered ALS as a differential diagnosis).

SETTLED

\$750,000

CONTRIBUTING FACTORS

Clinical environment

Nights/weekends

Clinical judgment

Patient assessment – narrow diagnostic focus

Failure to appreciate and reconcile relevant sign/symptom/test result

Misinterpretation of diagnostic studies

Choice of practice setting (failure to refer to the ED)

Documentation

Lack of documentation – review of participation in care

FAILURE TO DIAGNOSIS ISCHEMIC HEART DISEASE RESULTING IN PERMANENT HEART DAMAGE

A female in her early 70's with history significant for coronary artery disease, hypertension, diverticulosis, and smoking, presented to an urgent care facility on a weekend with complaints of mild (1/10) chest pain, pressure, and a burning sensation in the right anterior chest and upper back **for the past 24 hours**. She was seen by a physician's assistant (PA). The patient stated she typically consumed "a lot of tomato juice" and that eating exacerbated her pain. She stated that antacids helped to alleviate her symptoms..

The PA's physical examination of the patient noted that she was in no acute distress, with stable vital signs. **A 12-lead echocardiogram (ECG) was interpreted as sinus rhythm with a left bundle branch h block**. The patient reported her last cardiology visit was over a year ago and her last stress test was over five years ago. She was advised to schedule a follow up with her cardiologist and to return to the urgent care facility the next day for a follow-up on the abnormal ECG. (Of note, the **facility's supervising family medicine physician did not see the patient nor sign-off on the PA's treatment until three days later.**)

That same evening, the patient's pain returned. She called 911 and then collapsed at home. When EMS arrived, they did CPR, revived the patient, and took her to the Emergency Department (ED). It was determined that she had **suffered an ST-elevation myocardial infarction (STEMI)**. The patient underwent surgery, and had two stents and a defibrillator device placed, but suffered permanent, significant heart damage.

The patient claimed the permanent damage to the heart was from failing to properly read the ECG and diagnose ischemic heart disease. Experts who reviewed the ECG noted that the **PA failed to recognize concerning ST elevations on the ECG which were concerning for myocardial ischemia**. Experts also opined the **PA failed to refer the patient to the ED immediately for further cardiac evaluation.**

- **Insufficient communication with other providers, nurses and supervising physicians regarding relevant facts about the patient's care is a concern.**
 - Ensure that NPs/PAs are comfortable communicating their concerns without fear of appearing non-confident.
 - Ensure that NPs/PAs understand that they are an essential part of a care team and that they must share pertinent patient information, which, when combined with other provider observations, could indicate a much more severe issue.
 - Ensure hand-off communication is effective and unrushed.
 - Authorize and invoke the “stop the line” concept by anyone who identifies a risk to a patient.
 - Encourage escalation of concerns up the chain of command.
 - Make sure that in all locations, nursing understands the role of the NP/PA to ensure appropriate care coordination.
- **Documentation styles can be widely varied when multiple providers are involved in a single patient's care.**
 - Inconsistent documentation of patient symptoms and a provider's clinical rationale for treatment can result in patient care errors and create malpractice case defensibility issues.
 - Ensure consistent documentation among providers, with explanations where there is any inconsistency.
 - Do not sign off on charted information without thoroughly reading it.

- **Insufficient supervision/oversight/training is a frequently noted risk issue in NP/PA cases.**
 - Supervision involves more than just signing charts.
 - Ensure that required supervision is a regular, on-going activity.
 - Establish that all staff who will be working on your behalf fully understand the norms/policies/procedures of each facility or office location.
 - Be able to effectively communicate how you are able to determine and/or assess the competency of NPs/PAs to perform their assigned tasks.
 - Use supervisory time to ensure that the NP/PA is comfortable relating doubts or questions.
- **Scope of practice is something that should be defined for each NP/PA and can be enhanced and/or expanded upon demonstration of requisite skills and knowledge.**
 - Not all NPs/PAs are the same; different experiences should result in more or less supervision.
 - NPs/PAs are not typically assigned a specialty designation. Therefore their interchangeability into other “specialty” jobs (say, surgery to primary care) should be treated with caution. Regardless of length of experience as a NP or PA, they may need to be viewed as a novice in a new setting.

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.



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