Nurse Practitioner License Protection Case Study: Negligent Treatment and Care of an Infant, Resulting in Death

Presented by NSO and CNA

A REGULATORY BOARD complaint may be filed against a nurse practitioner (NP) by a patient, colleague, employer, and/or a regulatory agency, such as the State Department of Health. Complaints are subsequently investigated by the State Board of Nursing (SBON) in order to ensure that licensed NPs are practicing safely, professionally, and ethically. SBON investigations may lead to outcomes ranging from no action against the NP to revocation of the NP's license to practice.

SUMMARY

This case involves a nurse practitioner (NP) employed by a pediatric office practice who had been working as a registered nurse (RN) for seven years before becoming an NP. She had been working as an NP for 14 years at the time of the incident.

The patient was a 10-month-old female who had been seen at the pediatric practice by our insured NP on at least once occasion before this office visit. On the day of the incident, the patient was brought in by her mother to be seen for what she described as a ,"bad cough." The mother explained that the patient had been experiencing fever, wheezing, and coughing with congestion and phlegm in her chest and nose for the past few days. The mother said that, in the past day, these symptoms had gotten worse.

The NP assessed the baby and diagnosed the patient with bronchitis. The NP ordered a breathing treatment with a nebulizer. The NP did not chart that the infant was wheezing, however, and later said that she would only have ordered a breathing treatment for the patient because the infant was wheezing. The NP also prescribed an albuterol inhaler, and amoxicillin and advised the mother to continue giving acetaminophen and ibuprofen until the infant's fever breaks. While the NP believed the infant to be suffering from bronchitis, she prescribed an antibiotic to prevent a possible bacterial infection. A medical assistant gave the infant the breathing treatment in the office and showed the mother how to use the nebulizer machine. The mother said the NP briefly came into the room after the breathing treatment and seemed satisfied with the results but did not provide any additional information or instructions to the mother. The NP admitted that the practice was busy that day and she did not chart the results of this post-treatment assessment of the infant after she received her breathing treatment in the office.

Ater the appointment, the infant and her mother returned home. There were multiple calls made by the mother to the NP and office staff after the office visit that day. The mother was repeatedly told by the office staff to "wait for the meds to take effect." She was not advised to seek care at the emergency department if symptoms continued or worsened. Later that night, while the infant was sleeping, she began choking, and her lips turned

blue. Her mother called 911, and CPR was started on the infant. The infant was transported to the hospital by ambulance in full cardiac arrest. The infant remained in the hospital for two days. Sadly, the infant was declared brain dead. The death certificate stated the cause of death was respiratory syncytial virus (RSV) and anoxic brain injury. The State Board of Nursing was informed of this case as a result of a malpractice lawsuit in which the NP settled the case with the family for an undisclosed amount.

RISK MANAGEMENT COMMENTS

The State Board of Nursing (SBON) investigated this case based on the allegations against the NP of unprofessional conduct and gross negligence in the treatment and care provided to the infant. The SBON found that while the healthcare information record indicated the chief complaint as fever and wheezing, the NP noted all categories as ,"within normal limits" under the exam portion of the chart. Further, there were no abnormal respiratory exam findings noted; the NP did not document the infant's heartrate, her respiratory rate or her oxygen saturation level in the chart.

The SBON's investigation focused on "gross negligence" because of the extreme departure from the standard of care. In light of these allegations, the SBON reviewed the NP's actions against what actions would have ordinarily been taken by a competent NP under similar circumstances. The SBON opined that there was a repeated failure to exercise ordinary care and take standard precautions which the NP knew, or should have known, could have jeopardized the patient's health or life. Specifically, the SBON noted the NP did not meet treatment and care standards by:

- Failing to perform a complete respiratory assessment
- Failing to document a complete respiratory assessment
- Failing to chart the patient's heartrate in the healthcare information record
- Failing to chart the patient's respiratory rate in the healthcare information record
- Failing to chart the patient's oxygen saturation level in the healthcare information record
- Failing to chart that the patient was wheezing in the healthcare information record
- Failing to chart the results of a post-treatment assessment of the patient after she received her breathing treatment in the office

RESOLUTION

After reviewing the evidence, including the NP's testimony, the SBON recommended disciplinary action against the NP. The SBON determined that, while this was an isolated incident in the NP's career, the NP's conduct was egregious as RSV is a common, and very contagious, virus that infects the respiratory tract of most children before their second birthday. It can be more serious in young infants, even life threatening. The SBON revoked the NP's license. However, the revocation was stayed, and the NP was placed on probation for three years during which time the following conditions had to be met:

- Pay a $10,000 civil penalty
- Refrain from taking a position with direct patient care for six months
- Submit performance evaluations
- Be supervised during employment
- Complete approved continuing education courses
- Participate in ongoing counseling, and
- Submit written reports verifying compliance with the Board,Äôs actions.

The disciplinary action was reported to the National Practitioner Data Bank.

This Board matter took five years to resolve, and the total incurred expenses to defend the NP in this investigation totaled just over $19,000. (Note: Monetary amounts represent the legal expenses paid solely on behalf of the insured nurse practitioner.)

RISK CONTROL RECOMMENDATIONS

- **Perform a patient clinical assessment and physical examination to evaluate and address the specific clinical issues under consideration**.
- **Utilize available clinical practice guidelines or protocols when establishing a diagnosis and providing treatment, documenting the justification for deviations from guidelines or protocols.**
- **Consider potential unintended consequences of pursuing a specific diagnosis,** including:
  - Are factors present that do not align with the diagnosis?
  - Are there symptoms that are inconsistent with the current diagnosis?
  - Why are these symptoms not indicative of another diagnosis?
  - Is there a life-threatening condition with similar symptoms that hasn,Äôt been considered?
- **Complete regular training and continuing education to serve pediatric patients, particularly nurse practitioners who work in settings that serve pediatric patients** and maintain awareness of and access to organizational/facility pediatric protocols and guidance.
- **Refer to RSV resources such as those on the National Association of Pediatric Nurse Practitioners (NAPNAP) website including NAPNAP's position statement on the RSV crisis.** NAPNAP has created a series of micro-learning videos, each just five minutes, to break down a specific clinical aspect of RSV.
- **Refer to CDC resources for healthcare providers on RSV Immunizations. CDC resources also includes information for RSV Prevention, FAQs, and an**

Immunization Information Statement.

- **Diligently screen for, monitor and/or treat diseases known to have high morbidity and mortality**, such as RSV, for infants and children under 5 years of age.
- **Document the decision-making process that led to the diagnosis and treatment plan.**
- **Document all patient-related discussions, consultations, clinical information and actions taken, including any treatment orders that are provided.**
- **Discuss clinical findings, diagnostic test/procedure results, consultant findings, diagnosis, the proposed treatment plan and reasonable expectations for the desired outcome with patients, parents and/or guardians, in order to ensure their understanding of their care or treatment responsibilities.** Document this process, noting the patient's response.
- **Never testify in a deposition without first consulting your insurer or legal counsel.** Contact your attorney or designated professional before responding to calls, emails, or requests for documents from any other party.

References online:
myamericannurse.com/?p=419698