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Nurse Practitioner License Protection Case Study: Failure to Document Medication Management in Accordance with the Standard of Care

A State Board of Nursing (SBON) complaint may be filed against a nurse practitioner (NP) by a patient, a patient's family member, colleague, employer, and/or other regulatory agency, such as the Department of Health. Complaints are subsequently investigated by the SBON to ensure that licensed nursing professionals 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. Therefore, when a complaint is asserted against an NP to the SBON, NPs must be equipped with the resources to adequately defend themselves. Being unprepared may represent the difference between an NP retaining or losing one's license. This case study involves a psychiatric mental health nurse practitioner (PMH-NP) who was working in an outpatient psychiatry practice.

SUMMARY

In this matter, the patient was a male in his early 20s with a history of attention deficit hyperactivity disorder (ADHD), general anxiety disorder, and major depressive disorder. The patient had also previously abused street drugs, including cocaine and opioids, but he had been sober for several years. The patient had previously been treated by another medical office when he transferred to an outpatient psychiatry practice closer to his

college, where he was treated by the insured PMH-NP.

The PMH-NP's documentation of his initial assessment of the patient in the electronic health record (EHR) contained minimal narrative and consisted primarily of checked boxes regarding medical issues. When the patient first arrived at the PMH-NP's practice, he was prescribed 60 mg of Adderall three times per day, 2 mg of Xanax three times per day, and Valium, 10 mg at bedtime. The PMH-NP reduced the patient's Adderall to 40 mg three times per day, and discontinued the prescription for Valium. The PMH-NP maintained the patient's prescription for 2 mg of Xanax three times per day. However, there was no documentation to indicate the PMH-NP's rationale for the medication reduction.

The PMH-NP saw the patient monthly over the course of the next year and a half for medication management, with each appointment lasting approximately 20 minutes. During the time that the PMH-NP treated the patient, his prescriptions remained the same. Each of the PMH-NP's progress notes were all almost identical, relying on EHR forms, with minimal narrative regarding the details of each visit.

More than a year into treating the patient, the patient's father wrote two letters to the PMH-NP, each dated one month apart, expressing concerns regarding his son's treatment. In the letters, the patient's father stated that he was worried about the dosages of Adderall and Xanax that the patient was prescribed, the impact of long-term use of these medications, and the possibility that the patient could be sharing his medications with his friends. The patient's father requested a review of the patient's records to assess the side effects and need for ongoing medication. However, there was no documentation in the EHR that the PMH-NP ever addressed any of these concerns with the patient or the patient's father.

RISK MANAGEMENT COMMENTS

The patient's father filed a complaint against the PMH-NP with the State Board of Nursing (SBON) asserting that the PMH-NP was negligent and unprofessional in his treatment of his son and management of his medications. Expert witnesses reviewed the EHR entries pertaining to the PMH-NP's treatment of the patient and provided their opinion to the SBON. The expert witnesses were critical of the PMH-NP's documentation. The PMH-NP's documentation of his initial assessment of the patient did not include a clear medical history establishing the basis for the patient's ADHD diagnosis, nor details of the patient's history of substance use, anxiety, depression, or suicidal ideation. The expert witnesses also opined that the PMH-NP failed to document his rationale for the amount and duration of the doses of Adderall and Xanax that he prescribed the patient, including an apparent failure to consider safer alternatives.

The expert witnesses were also critical of the PMH-NP's failure to document a plan to taper the patient off of the Adderall and Xanax. The experts noted that long term use of Xanax is not recommended due to its high potential for physical and psychological dependence. Additionally, the expert witnesses were concerned that some of the PMH-NP's entries failed to document the patient's vital signs, especially since the patient was prescribed Adderall, a stimulant, at twice the recommended dose. The experts emphasized the importance of monitoring the continued justification for the amount and duration of the patient's prescriptions, particularly in light of the patient's history of substance use.

The PMH-NP explained to the SBON that he had a plan to taper the patient off of Adderall and Xanax after the patient graduated from college in six months, and that the PMH-NP worked with a collaborating physician regarding the plan. However, the PMH-NP failed to document this plan in the EHR, or any of these discussions regarding the plan with the patient or the physician. The PMH-NP maintained that his treatment of the patient was appropriate because the patient was doing well and managing his anxiety and ADHD. Based on his interactions with the patient, the PMH-NP did not have concerns that he was diverting the medications. Additionally, the PMH-NP presented testimonial letters from several colleagues to the SBON that attested to the PMH-NP's stellar reputation, competence, and care for his patients. Nevertheless, the lack of documentation supporting the PMH-NP's decision-making process hindered the PMH-NP's legal defense.

RESOLUTION

The SBON concluded that the PMH-NP's lack of documentation constituted incompetence, gross negligence, and unprofessional conduct. According to state regulatory guidelines, the maximum disciplinary penalty that the SBON could impose for unprofessional conduct was license revocation, while the minimum recommended discipline for unprofessional

conduct was three years of probation. Considering the evidence that the PMH-NP presented that spoke to his long and upstanding career, the SBON determined that the minimum recommended discipline would be sufficient to carry out the SBON's duty to protect the public in this matter. Therefore, the SBON placed the PMH-NP on probation for three years. The matter took more than a year to resolve, and the total incurred to defend the PMH-NP in this matter was more than $10,500.

(*Note: Figures represent only the defense expense payments made on behalf of the insured nurse practitioner.*)

RISK CONTROL RECOMMENDATIONS

NPs may utilize the following risk control recommendations to evaluate their current practices regarding documentation and prescribing:

- Follow basic documentation principles, adhering to relevant policies, procedures, regulations, and guidelines. Whether documenting on paper or in an electronic health record (EHR), the same basic principles apply. Document promptly, accurately, and without bias. Remember that the EHR provides a date and time for each entry, providing a clear documentation trail.
- Copy and paste cautiously. Review and update information found elsewhere in the EHR before pasting it into current entries, especially problem lists, diagnoses, allergies, current medications, and patient history. The copy and paste feature in EHRs can be a time saver, but errors, including errors of omission, can easily occur and may adversely affect the record's reliability and usefulness.
- Beware of autofill and templates. Similar to copy and paste, the autofill feature can save time by avoiding repetitive entries, but verify that the information automatically populated is correct. Similarly, templates for regularly occurring events, such as new patient assessments, can help save time and ensure needed information is collected. However, awareness of individual patient needs and assessment findings is imperative.
- Perform a physical examination to determine the patient's health status, and evaluate the patient's current symptoms/complaints.
- Compile, document and utilize an appropriate comprehensive patient clinical history, as well as relevant social and family history.
- Review and document the patient's medication history as an essential component of the medical history for all patient encounters. Review the current medication list with the patient, including prescribed and over-the-counter medications, supplements, and holistic/alternative remedies. Document the patient's reported adherence.
- Prescribe medications in compliance with the state Nurse Practice Act, state prescriptive authority, authority for nurse practitioners and employer policies.
- Clearly document patient responses to medications, both expected and unexpected, as well as adverse drug reactions.
- Document all patient-related discussions, consultations, clinical information, and actions taken, including any treatment orders or patient education. Summarize all communications with other practitioners, including those via telephone, email, text message, and patient portal communication, and note any subsequent orders and interventions.
- Educate patients regarding their responsibilities for adhering to medication regimens, as well as the risks of nonadherence, and assess the patient's ability to comprehend the instructions using a "teach-back" approach. Document all patient education in the healthcare information record.