Legal Case Study

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In the case study the defendants are Lucia and her guardian. As the provider, I would want to know what documentation is available for the PMHNP to review from Lucia’s emergency room visit including any related testing and labs, medications and diagnoses given. Before seeing the patient it should have been established as to whether the patient and her guardian needed interpretation assistance if English was not their primary language. The PMHNP in this case should have completed an in-depth screening and safety risk of the patient to determine if she had suicidal or homicidal ideations. If the PMHNP determination of the visit was leading to a diagnosis of depression, why didn’t she complete a depression related screening questionnaire, such as the PHQ9? Without proper documentation there isn’t enough supporting evidence to back the PMHNP diagnosis of depression. The PMHNP should also have completed patient education on the medications she prescribed for Lucia. This education should have explicitly identified the FDA black box warning of suicide risk when prescribed Prozac. The patient also should have been given a follow up appointment within two weeks of her initial appointment and starting the Prozac to determine the efficacy, side effects, and possible changes in mood and emotional state.

Appropriate screening measures and safety risk assessment procedures should be utilized in adolescents with depression. In this case the PMHNP stated that the suicide resulted due to environmental stressors, but how do we know that is what happened and that the medication did not play a role on the suicide. In a case like this I would have requested and reviewed the previous medical records and hospital visit testing outcome, results, and pertinent records. I also would have completed a thorough patient and family medical and psychiatric history, as well as obtained a history of the presenting illness and recent medication history. If lab work and a pregnancy test was not completed at her most recent emergency room visit, this should have been completed at her visit with the PMHNP to rule out possible medical conditions that could be causing her presenting symptoms. According to adolescent screening and diagnosis guidelines for adolescents, the PHQ-9 and PHQ-9A with additional screening questions is the recommended screening tool to assess for depression and depending on the severity rating, the provider should consider a crisis response plan, follow up appointment, medication changes, referral to behavioral health services, Baker Act, or outside therapy treatment options, as well as bright light therapy is also a recommended non-pharmacological depression treatment option (Kaiser Permanente, 2018). It is also important to educate your patient and the patient’s family of signs and symptoms to monitor for that need to be reported to a provider, as well as medication education of signs and symptoms and black box warnings of medications that the patient is taking and conduct a suicide risk assessment.

Malpractice is defined as the failure of professional skill resulting in injury, loss or damage that requires existence of a client-provider relationship with the duty of care; behavior below the standard of care; a causal link between the practitioner’s failure to conform to treatment standards and harm to the patient; and actual injury to the patient (Joel, 2018, Chapter 29). This differs from negligence which is identified as failure to follow up, refer, disclose essential information or give necessary care and results in a form of harm to the patient (Joel, 2018, Chapter 29). When a case is presented to a jury they must follow the criteria necessitated to determine if malpractice or negligence exists. Verdicts can go either way, and this case presentation has only given a small amount of information to try to predict what the outcome is. Based on the information provided, I would say that the verdict was issued for the defendant, finding the PMHNP provider neglect. Given the lack of documentation to substantiate the PMHNP diagnosis of depression and lack of education and timely follow up, the PMHNP did not provide the standard of care that should have been given to the patient in the case.

One case that recently was presented in court where allegations of breach of duty after the patient committed suicide because the provider failed to recognize that the patient’s change in symptoms related to her depression and failed to evaluate her antidepressant appropriately. The findings of the Granicz resulted with the following: The Supreme Court ruled that the First District court in its decision and the petitioners "the original brief showed that the decedent's suicide was not foreseeable. However, Granicz 1) pointed out that Dr. Chirillo knew that patients who stopped taking Effexor abruptly had an increased risk for suicide, and 2) ultimately opined that stopping Effexor was "a contributing factor" in the decedent's suicide that led to evidentiary finding that there is a genuine issue of material fact remaining as to proximate cause" (Frellick, 2016). Looking at this outcome of this case, I would think that the PMHNP caring for Lucia may not have an established defense that will dispute her claim and that the outcome would side with the defendant’s family due to the lack of evidence supporting that the PMHNP failed to recognize and evaluate the patient appropriately and that the use of the antidepressant was a contributing factor in the patient’s suicide, resulting in a breach of duty on the PMHNP’s part.

According to Buppert, risk reduction measures should be implemented in practice to reduce errors that cause safety risks to patients, including electronic order policies, clinician orders when away from the electronic medical record (EMR) or when the EMR is down, auditing patient charts periodically on paper, as a provider review charts to be audited or submitted for litigation, highlight important aspects to template information, be cautious with generic templates, and do not utilize prepopulated template recording keeping systems (2018). Risk-reduction measures could have been implemented to assist in avoiding safety errors in Lucia’s case. It appears that there wasn’t a policy or a policy protocol that was followed by the PMHNP regarding electronic order entry for the Lucia’s visit and her prescription, especially since it is illegal for a provider to presign prescriptions. There was no indication that the PMHNP was utilizing an electronic system that down and that was the reason there was not an electronic record entry utilized for Lucia’s visit. While printing our progress notes from time to time and evaluating them from an auditor’s perspective was not mentioned and may not have helped specifically in Lucia’s case, it could have assisted with routine policy and procedures and implementing changes that could have provided safety precautions and practices that may have resulted with a different care process for Lucia. When Lucia’s case reaches litigation, I would hope there would be a records review and all relevant data would be included and reviewed by an expert and with the PMHNP. I work as a sexual assault nurse examiner and because there is high probability of all of our cases going to trial, we conduct a supervisor review of every chart within 48 hours of exam completion and have an examiner chart review, per our policy and this has resulted in improvement in charting, patient care and case outcomes in favor for the victim. It would also have been beneficial to utilize an electronic record system that highlights important aspects to template information, as well as refraining from using generic and repopulated templates. These are all risk reduction strategies to consider and implement before there is a safety error or threat to a patient’s safety. It is important that providers document all care thoroughly and practice above the basic standard of care, providing patients with quality care for their illnesses and disorders.

References

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