COPIC
Better Medicine • Better Lives

COPIC Tip

MAKING URGENT CARE SAFER FOR PATIENTS

Failure to Diagnose Remains a Major Risk in These Settings

CASE STUDY:

A 52-year-old female checked into an urgent care facility and said the reason for her visit was a severe cough. The receptionist checked the patient in and placed the "cough/URI/bronchitis" template in her chart. When the patient is called to the exam room, her husband needed to assist her. The medical assistant sees the patient and noted "cough for 10 days, worse at night. Feels sweaty." The only vital signs recorded are blood pressure of 96/46 and temperature of 98 degrees.

She is seen next by a physician assistant (PA) who is staffing the urgent care facility along with a family medicine physician who is the PA's primary physician supervisor. Pertinent parts of the PA's chart indicate: "HEENT: WNL; CV: RRR lungs: scattered rhonchi and rales." The patient is diagnosed with bronchitis and prescribed an antibiotic (Z-Pack) and a cough suppressant. The patient needed assistance by her husband to leave the facility. Twelve hours later, the patient became severely dyspneic and too weak to move. An ambulance is called and she presented to the emergency department in extremis. The exam revealed florid pulmonary edema due to congestive heart failure. After two hours, she suffers respiratory insufficiency and is intubated. Shortly after, an arrhythmia occurs and the patient is unable to be resuscitated.

Upon investigation and expert review, it's clear that the severity of the patient's illness was significantly underappreciated. In addition, the following items should be noted:

1 Insufficient examination of patient history.

The cough was associated with exertional dyspnea. The "worsening at night" likely indicated paroxysmal nocturnal dyspnea due to congestive heart failure. The report of "feels sweaty" was not thoroughly evaluated and could have differentiated fever from diaphoresis.

2 Insufficient and underappreciated vital signs.

If more vitals had been taken in the urgent care facility, they would have likely been considered abnormal given that the emergency department noted a weight gain of 16 pounds in the prior 10 days, respiration rate of 28, pulse of 124, and pulse oximetry reading of 84 percent (room air). The patient was also hypotensive. Even without the benefit of having access to her prior medical record, she did indicate that she was on antihypertensive medication, suggesting this was not her baseline.

3 Insufficient differential diagnosis.

Did the cough/URI/bronchitis form that the nonclinical receptionist put in the chart cause a bias that led to the PA only considering these diagnoses?

4 Concerns regarding supervision and training.

The PA's experience was primarily in an ambulatory setting. He did not have significant experience seeing severely ill patients. Protocols for training and consulting with supervising physicians could have been improved.

5 No appreciation of the importance of the "road test."

The patient had moderately strenuous occupation and was working the past month, yet she was unable to walk without assistance.

CONTINUED ON PAGE 2

Copyright 2019 by COPIC Insurance Company. All rights reserved. No part of this publication can be produced or transmitted in any form or by any means without written permission from the publisher.

MAKING URGENT CARE SAFER FOR PATIENTS

MAKING URGENT CARE SAFER FOR PATIENTS (FROM PAGE 1)

The only defense could have been a "causation" defense—arguing that they couldn't prove that the outcome would have been different had the patient been diagnosed with congestive heart failure in urgent care. Would diagnosing congestive heart failure in urgent care have allowed earlier intervention and optimized treatment of the process? In this case, experts concluded that the 12-hour delay was significant and could have changed the outcome with aggressive treatment.

Urgent care facilities include "after-hours" clinics, walk-in clinics, "fast tracks," free-standing minor medical clinics, and urgent care centers. Incidents and claims continue to arise from care provided in urgent care facilities. We first examined this trend in 2004, and believe it is influenced by both an increased relative rate of incidents and claims, and an increased volume of patients who visit urgent care facilities. It's important for physicians, PAs, advanced practice nurses (APNs), and nursing staff to be aware of the risks unique to urgent care facilities and to examine how the diversity of resources, disparity in patient expectations, and the differences in provider training can affect their facilities.

DIVERSITY OF RESOURCES

Because there is no single definition, licensure, or accreditation required to operate an "urgent care" facility, they possess a diversity of resources. These facilities can vary from a hospital-based facility with resources similar to an emergency department to a freestanding clinic in a strip mall that employs a non-clinical receptionist and a provider with a limited scope of what services they can offer patients.

Variables include:

- The experience, training, and turnover rate of the support staff.
- The availability of consultants and laboratory diagnostic services.
- The availability of diagnostic imaging services and access to radiologist consultation.
- Access to and working relationships with existing emergency departments—including any communication problems that exist between the parties.

PROVIDER TRAINING, EXPERTISE, RESOURCES, AND DRILLS

Just as we have described disparities in the resources available, equally important is the disparity of provider training and expertise. Remember, procedural complications typically do not cause claims in urgent care; claims are caused by a failure or delay in diagnosis.

We hope that those staffing urgent care facilities recognize these risks and assign qualified, experienced, and "diagnostically-inclined" physicians to this area. Providers must be well-versed in the potential adverse diagnosis that might be lurking behind a seemingly minor complaint. They must be able to take steps via diagnostic work up, consultation, or close clinical follow up, document the course, and pick up those significant diagnoses. When PAs and APNs provide care, be sure that protocols are in place to recognize potential diagnostic areas which may require closer physician supervision or consultation.

From a risk perspective, acute and unscheduled ill patients represent a significantly higher risk than regularly scheduled patients. Yet, physicians often have a full schedule, meaning acute and ill patients are seen by the PAs and APNs. This can be especially risky when there is a general attitude that physicians should not be interrupted to consult on acute cases.

Furthermore, cost pressures and insurance issues may cause difficulties. For example, a patient might be worried about a significant medical condition that could represent a medical emergency if not recognized promptly, but chooses to go to an urgent care facility due to perceptions of lower out-of-pocket costs, greater convenience, or a subconscious denial that the problem could be something serious. This latter mindset can be difficult to overcome when the providers in the urgent care setting appropriately diagnose the condition, but find it hard to get the patient to seek subsequent admission, consultation or emergency department referral. Asking these patients to sign "against medical advice" (AMA) forms can assist in the defense of claims when serious adverse outcomes or deaths occur following refusal to complete the work up or be admitted.

The relative low frequency of emergencies in some settings can represent a challenge when inevitably a patient does present with an emergency. Specific advice to deal with such inevitabilities include drills and training. Providers in urgent care centers should strongly consider maintaining certification in ACLS, ATLS, PALS, and maintain proficiency in EKG reading. Drills and practice protocols that clearly define the roles and responsibilities of each care team member in an emergency can assist in preparing for the inevitable.