

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.

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TOP PATIENT SAFETY CONCERNS FOR 2018



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WHAT’S WRONG WITH THIS PICTURE?

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.



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.

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TOP PATIENT SAFETY CONCERNS FOR 2018

The ECRI Institute, a nonprofit and patient safety organization (PSO), issued its Top 10 Patient Safety Concerns for 2018. This list identifies key areas to “support health care organizations in their efforts to proactively identify and respond to threats to patient safety.” ECRI selected the items on the list using data from reported events—they receive over 2 million event reports from their partnerships with PSOs. They also reviewed concerns, health care safety literature, and sought insight from a panel of experts. The outlined concerns are authentic: they are causing harm—often serious harm—to real people.

Below is the top 10 list. We highlight five items that are new to the annual list and have relevance for COPIC insureds. In addition, we draw upon our experience, and provide commentary and some practical suggestions to address these concerns.

- 1 Diagnostic errors
- 2 Opioid safety across the continuum of care
- 3 Internal care coordination
- 4 **Workarounds**
- 5 **Incorporating health IT into patient safety programs**
- 6 Management of behavioral health needs in acute care settings
- 7 **All-hazards emergency preparedness**
- 8 Device cleaning/disinfection/sterilization
- 9 **Patient engagement and health literacy**
- 10 **Leadership engagement in patient safety**

4 Workarounds

A workaround occurs when rules are bent to circumvent or temporarily fix a real or perceived barrier or system flaw. They are difficult to detect as they often become entrenched in work processes. And the dangers of workarounds are usually not detected until someone is harmed.

- Organizations should foster an open, nonpunitive environment where staff can discuss workarounds.
- A gap analysis of processes susceptible to workarounds can help identify mismatches between the scripted and actual processes.
- Staff input is vital to assessing the feasibility of policies and procedures.
- Workarounds often occur with technology. An ongoing maintenance plan ensuring the technology works reliably is of utmost importance.

EHRs are prime examples of systems that invite workarounds as they may be seen as inhibitors that disrupt clinical patterns. Common errors include misuse of copy/paste functions and design barriers to obtaining the most relevant clinical information swiftly. Alert fatigue and multiple, non-standard, and/or non-interoperable EHRs within and among institutions also contribute to the use of workarounds.

5 Incorporating Health IT and Patient Safety Programs

A health information technology (IT) safety program plays an important role in improving the safety and quality of health care. Its success, however, depends on the ability of users to recognize, react to, and report health IT-related events for analysis and action.

- Poorly designed or poorly embraced health IT systems can cause patient harm.
- Health IT is an important part in the daily workflow, and is also an effective tool to optimize benefits and reduce risks associated with modern health care.

COPIC continues to see claims around lack of communication of vital clinical results. All IT systems should ensure that patient information that may require an action is communicated to the right individuals at the right time to allow for interpretation, critical review, reconciliation, initiation of action, acknowledgment, and appropriate documentation.

7 All-Hazards Emergency Preparedness

2017 saw major hurricanes, wildfires, mass shootings, and ransomware attacks. Each situation brought a

host of challenges, including power outages, computer shutdowns and staff shortages. Preparation for these disasters is essential so that staff understand how to respond and manage these situations effectively.

9 Patient Engagement and Health Literacy

While patients certainly have responsibilities in managing their health, “we don’t do a great job of engaging patients and making sure they understand their health and health care.”

- Health care organizations should involve patients and families in identifying, planning, and testing health literacy and patient engagement initiatives.
- Experts recommend “universal precautions” for health literacy by making all materials and discussions easy to understand.
- Patient engagement techniques include bedside rounds, daily goal sheets, and patient coaching.
- Eliciting patient goals and connecting them with recommended actions is a key step.

Use teach-back methods to assure patient/family comprehension. When family members understand treatment plans, they may catch potential medical errors. Patients with high health literacy will be able to communicate with their providers about their health care concerns as well as potential treatment plans.

10 Leadership Engagement in Patient Safety

Visible engagement of hospital leadership in patient safety is essential. “It all starts with emotional and intellectual engagement.” Without leadership investment, options for patient safety initiatives are limited. Suggestions for achieving engagement include:

- The patient safety, risk, or quality manager should recruit patient safety champions throughout the organization and achieve buy-in.
- The issues and concerns should be presented to the “C-suite” and board of trustees.
- Data supporting the need should be crisp and on-target.

COPIC has been promoting a “culture of safety” for decades. The term refers to a values-supportive system of shared accountability: organizations are accountable for the systems they have designed and for responding to the behaviors of their employees in a fair and just manner, while employees are accountable for the quality of their choices and for reporting both their errors and systems vulnerabilities. Hospital leadership should also attend safety initiatives.

WHAT'S WRONG WITH THIS PICTURE?

Look closely at this ER patient board and identify the concerning issue

Emergency Department = 36				Rapid Care = 4			Waiting Room *				
Time	UnATT	PT	Gender	Complaint	C	Age	BP	Temp	Pulse	O2Sat	Resp
13:43 01/28	51		Male	Inj, Shoul	2	56 Years	157/100	97.9	99		14
13:59 01/28	84		Male	CP	2	51 Years	153/90	98.4	108	98	14
14:22 01/28	10		Female	HTN	2	77 Years	197/89	98.4	87		14
14:28 01/28	33		Female	Abcess	2	77 Years	128/49	98.1	81		14
15:27 01/28	17		Female	Complaint	2	20 Years	128/77	98.8	72	99	14
15:34 01/28	11		Female	Sr Thrt	2	21 Years	117/81	98.5	86		14
12:56 01/28	169		Female	HyperG	3	57 Years	172/89	99.1	94		14
13:02 01/28	73		Female	N/V	3	18 Years	113/68	98.7	70		14
13:05 01/28	73		Male	HTN	3	45 Years	151/83	97.8	64		14
15:20 01/28	23		Male	HA	3	39 Years	139/93	97.7	80		14
15:41 01/28	5		Female	GYN	3	28 Years	117/81	101.6	105		14
15:44 01/28	1		Female	Dizzy	3	29 Years	135/99	98.8	82		14
14:52 01/28	54		Male	Pain, Back	4	58 Years	147/97	97.9	85		14

Answer:

Yes, everyone on the ED board has the same respiratory rate, a phenomenon that could light heartedly be called Pansynopnea.

Unfortunately, failure to measure and record an accurate respiratory rate is a serious underlying factor in many potentially preventable errors and adverse outcomes. Some examples include:

1. The post-procedure sedated patient who is now trending to hypoventilation prior to respiratory arrest. The pulse oximetry spiraling downward is a late finding, and when it does, there were probably many minutes prior to that event in which a decreasing respiratory rate would have been a warning sign. Failure to recognize is as important as failure to rescue, as a cause of preventable medical errors.
2. The septic patient whose respiratory rate is increased due

3. The value of the respiratory rate is made evident by the qSOFA score, a bedside prompt that may identify patients with suspected infection who are at greater risk for a poor outcome outside the ICU. It uses three criteria, assigning one point for low blood pressure (SBP \leq 100 mmHg), high respiratory rate (\geq 22 breaths per min), or altered mentation (Glasgow coma scale $<$ 15). More information is available at www.qsofa.org
4. The dehydrated patient who is really in DKA, the uremic patient, the toxic patient and all those with underlying metabolic acidosis might be diagnosed more readily by the compensatory respiratory

alkalosis in face of metabolic acidosis.

5. The ambulatory patient with "bronchitis" who really has something more, and is about to face a crisis of air exchange.
6. The pediatric patient, who despite a higher than normal baseline respiratory rate, is now trending much higher and one should be considering critical diagnoses earlier.

It has been said that you can't find a fever if you don't have a thermometer. Not accurately measuring respiratory rates should sound the same.

Please share this story with your office staff, your hospital staff, the emergency department staff, and all those who are tempted to either not record a respiratory rate, or fall into the evident epidemic of Pansynopnea.



*Image repurposed from Department of Emergency Medicine, University of Pennsylvania, Philadelphia, PA. Ann Emerg Med. 2005;46:469.



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.





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