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COPIC Tip

HOW PROVIDERS CAN MAKE URGENT CARE SAFER FOR PATIENTS

Part 1: Failure to diagnose remains a major risk in urgent care settings

CASE STUDY

A 46-year-old male checks into an urgent care facility for a persistent cough. When the patient is called to the exam room, his family member needs to assist him. The patient first sees the medical assistant who notes "cough for 10 days, worse at night. Feels sweaty." The only vital signs recorded are blood pressure of 96/46 and temperature of 98.0 degrees.

He is seen next by a physician assistant (PA) who is independently staffing the urgent care facility. The PA's primary physician supervisor is seeing regularly scheduled patients at his primary practice location. The pertinent parts of the PA's chart indicate: "HEENT: WNL; CV: RRR lungs: scattered rhonchi and rales." The patient is diagnosed with bronchitis and is prescribed an antibiotic (Z-Pack) and a cough suppressant. The patient has to be assisted by his family member to leave the facility.

Twelve hours after the visit, the patient becomes severely dyspneic and too weak to move. He presents to the emergency department in extremis; the exam reveals florid pulmonary edema due to congestive heart failure. After two hours, he 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 patient's illness was significantly underappreciated. In addition, the following items can be noted:

1. **Insufficient examination of history.** The cough was exertional dyspnea. The "worsening at night" likely indicated paroxysmal nocturnal dyspnea due to congestive heart failure. The report of "feels sweaty" was not thoroughly examined and could have differentiated fever from diaphoresis.
2. **Insufficient and underappreciated vital signs.** Had more vitals 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 his prior medical record, he did indicate that he was on antihypertensive medication, suggesting this was not his baseline.
3. **Insufficient differential diagnosis.** Was there a bias towards diagnosing the most common condition, or the diagnosis that applied to the previous patients that day?
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 a moderately strenuous occupation and was working the past month, yet he was unable to walk without assistance.
6. **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.

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PROVIDER TRAINING, EXPERTISE, RESOURCES, AND DRILLS

Provider training and expertise can be a disparity in urgent care settings. 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 an "informed refusal" form (a sample template is available at **www.callcopic.com/resource-center/guidelines-tools/consent-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 centers 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.