10 REASONS YOUR URGENT CARE MAY NOT BE AS SAFE AS YOU THINK IT IS

Based on our experience, research, and an analysis of thousands of malpractice cases in acute care, including emergency departments and urgent care centers, we have uncovered several critical risk and safety issues of which you may not be aware.

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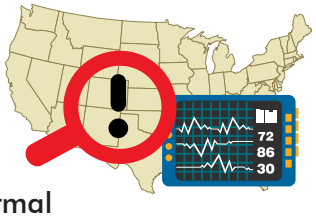
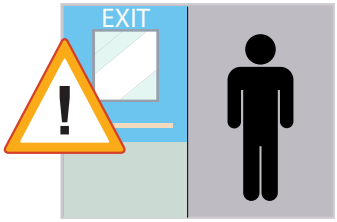
1 Sending Patients Home with Very Abnormal Vital Signs

TSG conducted a study on vital sign re-evaluation that demonstrates a significant problem across the nation. The bottom line is that if you do not have a system solution for re-evaluation of abnormal vital signs, your patients are at risk.



In our study of high-risk patients, over **16%** of patients with at least one very abnormal vital sign were discharged without a single re-evaluation of that abnormal vital sign.

Retrospective case analysis clearly indicates the association between patients discharged with abnormal vital signs and morbidity or mortality.



HOW IS YOUR CENTER DOING?

YOU NEED TO KNOW

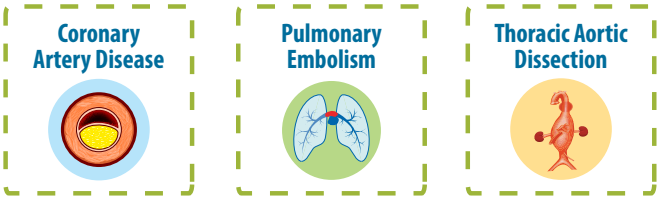
This is a high-risk area that must be addressed to reduce medical errors and keep your patients safe.

2 Risk Factor Analysis – Poor Compliance, Missed Opportunities

The TV star John Ritter presented to an ED with chest pain. The practitioners considered the possibility of coronary artery disease. They did not ask about nor did they consider the fact that there might have been a family history of thoracic aortic dissection. In fact, Mr. Ritter's father died of a dissection, as did Mr. Ritter; the first-degree relative risk factor was key in this case. If the practitioner had asked the question, he would have considered the possibility of thoracic aortic dissection and he would have discovered that Mr. Ritter's father died of the disease. It is likely that the physician would have ordered a CT scan and discovered the dissection.

A TSG study demonstrates poor compliance with risk factor analysis across several high-risk clinical entities. Practitioners often provide inadequate care regarding risk factor analysis.

When dealing with an adult chest pain patient, among other things, the practitioner may consider:

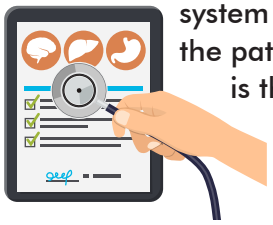


THERE ARE OVER 20 INDIVIDUAL RISK FACTORS THAT SHOULD BE CONSIDERED

IT IS SIMPLY NOT POSSIBLE TO KEEP THEM ALL FRONT OF MIND

Thus, practitioners consistently fall short in this important part of the medical history.

3 Charts are Missing a Complete Examination of the Relevant Organ System



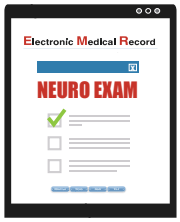
The practitioner must examine the organ system that is the subject of the patient's complaint. This is the standard of care. Careful documentation of the exam is evidence of a quality evaluation. This documentation is missing in a surprisingly large number of medical records.

This examination typically involves the abdomen and the neurologic systems. There are significant issues with careful and complete documentation of the abdominal exam in patients presenting with abdominal pain; the same is true of the neurologic system in patients with:

- Headache
- Head injury
- Possible cervical spine injury

THE ISSUE OF MISSING EXAMS IN CHARTS IS SIGNIFICANT IN MANY URGENT CARE CENTERS

IN SOME CASES, THE EXAM OF THE NEUROLOGIC SYSTEM IS MISSING IN UP TO **10%** OF MEDICAL RECORDS

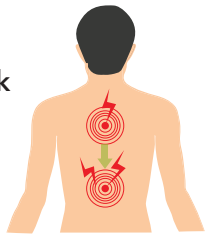


This is unacceptable, and represents either an inadequate patient evaluation or indefensible documentation.

Our RSQ® Education library, Point-of-Care Clinical Decision and Documentation Support, and the ongoing RSQ® Assessment tool ensure that practitioners are 100% compliant with documentation of the relevant organ system. Thus, the chart reflects a high-quality examination and adverse outcomes are more defensible.

4 Radiation of Pain – Key History is Missing from Many Examinations

Pain radiation is an essential component of the patient history in certain presentations, including chest pain, abdominal pain and back pain. The failure to evaluate whether a patient with pain in these areas is experiencing radiation of the pain is a medical error, represents inadequate care, and may result in patient injury.



Evaluation of pain radiation may help distinguish between coronary artery disease and thoracic aortic dissection in a chest pain patient. Radiation of pain to the back or flank in patients presenting with abdominal discomfort may be the key clue to the presence of an abdominal aortic aneurysm.

OBTAINING THE RADIATION HISTORY PROVIDES A CRITICAL OPPORTUNITY TO CONSIDER OR MAKE A DIAGNOSIS

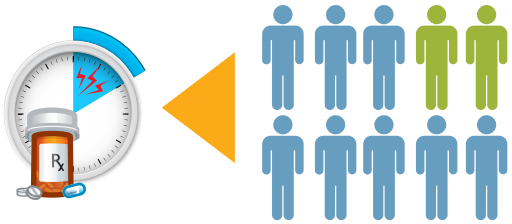
A TSG study of medical record documentation of these high-risk complaints in patients **over the age of 50** concluded:

Abdominal Pain	Chest Pain
30% OF MEDICAL RECORDS 	**10%** OF MEDICAL RECORDS 
are missing key historical documentation	are missing documentation of the presence or absence of pain radiation

This represents either inadequate care or inadequate documentation; both are critically important issues.

5 Severe Pain Not Addressed in a Timely Fashion

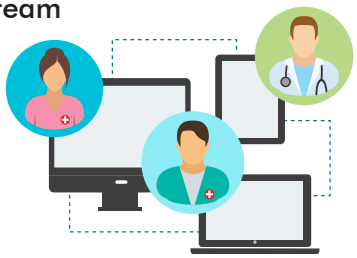
TSG performance evaluations show that a significant percentage of patients do not get their severe pain addressed in a timely fashion. This does not mean that every patient should receive a narcotic or even a medication for their pain, especially since there are non-opioid alternatives that are proven to be even more effective. However, patients deserve to have their pain addressed promptly, especially if it is severe.



KNOWLEDGE IS POWER

DETERMINING WHETHER YOUR CENTER IS EXPEDITING PAIN MANAGEMENT IS THE FIRST STEP

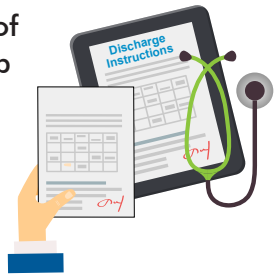
This leads to an action plan and a system solution. The physician and nurse team want to do a great job, but without knowledge and direction, they don't know what is broken. A delay in addressing a patient's pain needs is a problem, and we can help provide the knowledge and solution to fix the problem.



THE RESULT WILL BE A SATISFIED, LESS LITIGIOUS PATIENT

6 Not Taking Full Advantage of the Power of Discharge Instructions

Great discharge instructions represent high-quality care and are a powerful risk management tool. The patient's discharge is not the end of the visit; it is simply a step on the road toward a return to good health.



Here is a great example from an actual case.

> *A patient presented with an eye injury after something got into his eye while riding his motorcycle. The physician diagnosed an abrasion and ordered an eye patch.*
>
> *After discharge, the patient got back on his motorcycle to drive home. Because of his impaired vision, he hit a car, killing a mother and three children.*

A discharge instruction warning about driving with impaired vision could have protected the patient and the driving public. There are many other examples and opportunities.

WELL WRITTEN DISCHARGE INSTRUCTIONS ARE CRITICAL

THEY PROVIDE THE PATIENT WITH THE INFORMATION NECESSARY TO ACHIEVE WELLNESS

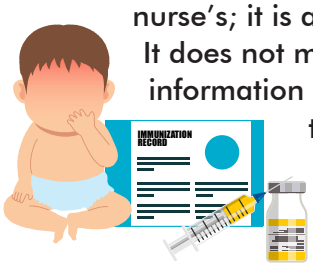
Great discharge instructions place some of the responsibility for "return to health" where it belongs – with the patient.

The fact is that many discharge instructions do not accomplish these goals.

Our RSQ® Education library teaches appropriate discharge, integrates those instructions into the medical record, and measures the administration of appropriate discharge instructions.

7 Inadequate Analysis of Immunization Status of Febrile Children

TSG performance evaluations show that a practitioner evaluation of a child's immunization status is a critical part of the patient history. This is not the physician's obligation, nor is it the nurse's; it is a team obligation. It does not matter where the information comes from; immunization information must be elicited and documented on the medical record.



TSG research on febrile children **under age 6** indicates that immunization information is missing in over **10%** of cases. Although most children are properly immunized, some parents are opting out of standard childhood immunizations. Also, immunization status in children from other countries is an issue.

IMMUNIZATION INFORMATION IS KEY

IN THE PROPERLY IMMUNIZED CHILD, THERE IS LESS CONCERN ABOUT SEVERAL HIGHLY VIRULENT ORGANISMS

Without knowing the child's immunization status, it would be easy to fail to recognize the risk of a life-threatening infection.

TSG RSQ® Education educates physicians and nurses about this critical issue, creates a reminder to ask and document inside the medical record, and measures appropriate clinical behavior. Our system solution creates certainty around obtaining immunization information in febrile children.

8 The Patient Re-Evaluation – A Missed Opportunity

Patient re-evaluation is key to high-quality care and avoiding delayed or missed diagnoses. This is particularly important in the high-risk presentation. Practitioners and nurses are not taking advantage of this opportunity or are failing to document critical information.

The medical record should make it simple and straightforward to enter a re-evaluation.

PRACTITIONERS AND NURSES ARE MISSING THIS RE-EVALUATION OPPORTUNITY OR ARE FAILING TO DOCUMENT CRITICAL INFORMATION

PARTICULARLY FOLLOWING THE ADMINISTRATION OF MEDICATIONS TO THE PATIENT

TSG courses stress the importance of the re-evaluation and power of documentation. Our performance assessments demonstrate the need for improved compliance with patient re-evaluations.

9 The Unequivocal, Unassailable Medical Conclusion – The Power of the Pertinent Negative

Certain elements of documentation are so powerful that they can stop litigation before it gets started. The fact is that practitioners don't usually miss the diagnosis of meningitis; patients typically develop the problem after discharge. Other conditions are often sub-clinical on initial presentation; the practitioner never had a chance to make the diagnosis during the visit. But something goes wrong after the visit, and the search for someone to blame begins.

With this understanding in mind, certain elements of documentation can make it very clear that the care provided was high quality and that there was no failure to diagnose. However, all too often practitioners do not take advantage of this powerful tool.

For example, most children who present with fever have a viral syndrome and are otherwise well. In every case, the physician should document that the child did not have a stiff neck or meningeal signs.

The statement "normal neck exam" leaves the door open to a challenge such as, "Well doctor, did the child have any meningeal signs?" The correct approach is to state the medical conclusion that there are "no meningeal signs." This position is unequivocal and unassailable.

Coupled with the documentation that the child appears well, happy and playful, it is clear to all that this child did not have a serious problem during the visit.

CERTAIN DOCUMENTATION ELEMENTS CAN MAKE IT VERY CLEAR THAT HIGH-QUALITY CARE WAS PROVIDED AND THERE WAS NO FAILURE TO DIAGNOSE

HOWEVER, ALL TOO OFTEN PRACTITIONERS DO NOT TAKE ADVANTAGE OF THIS POWERFUL TOOL

This type of documentation is so important. It is repeatedly highlighted throughout our RSQ® Education courses, EMR Tools and RSQ® Assessment. Our goal is to hard-wire this type of documentation into the urgent care practice environment.

10 Not Looking to the Future of Patient Safety and Risk Reduction

This document has addressed several of today's patient safety and risk management issues.

What about tomorrow?

What is on the horizon?

What issues will hit the risk and safety radar screen in the future?

TSG has its finger on the pulse of evolving patient safety and risk issues. We have evaluated many claims for several of our larger clients. When we spot a trend occurring, we integrate these new issues into our RSQ® Education, EMR tools and RSQ® Assessments. For example, there is an increased incidence of spinal epidural abscess. MRSA is largely responsible for this uptick.

OUR GOAL IS TO PROMOTE PATIENT SAFETY, REDUCE MEDICAL ERRORS, AND IMPROVE THE DIAGNOSTIC PROCESS

We are also seeing patients present with severe back pain and no mechanism of injury. Practitioners are not thinking about spontaneous spinal epidural abscess, so the patient is discharged with the diagnosis of musculoskeletal low back pain; not all back pain is a strain.

Our RSQ® Education incorporates key risk factors and red flags for serious causes of back pain into our course content.

Now that you understand these commonly overlooked risk and patient safety issues, you can identify which are present within your organization. If you're interested in a systematic approach to improving the safety of your urgent care practice, you may:

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