COOPERATIVE OF AMERICAN PHYSICIANS

Risk Management & Patient Safety
Focused Review

# A Look into Urgent Care

Cynthia Mayhan, RN, BSN, PHN
Senior Risk Manager and Patient Safety Specialist

Urgent Care Centers fill a much-needed gap in an overwhelmed healthcare system. According to the Urgent Care Association (UCA) there has been steady growth in the number of UCCs operating in the United States over the last ten years. In 2013 there were a total of 6,100 nationwide. That number is now approaching 10,000[1]. The physicians practicing in these centers, like emergency medicine and family medicine practitioners, need a broad knowledge base and skill set that enables them to quickly assess and identify acute problems as well as unknown chronic conditions that may present as a benign common symptom.

Because of the wide range of clinical issues UCCs encounter on a regular basis, seemingly routine care processes have the potential to pose serious risks to patients, leaving physicians vulnerable to medical professional liability.

## In this Focused Review . . .

The risk management and patient safety experts with the Cooperative of American Physicians, Inc. (CAP) identify five common areas of liability risk associated with claims against Urgent Care (UC) physicians. Cognitive bias, supervision of Advanced Practice Professionals (APP), documentation, repeat visits with the same complaint, and patient referrals and transfers to higher levels of care are among the issues reviewed, along with supporting case studies. Effective and actionable risk reduction strategies are also provided for each area.

As Urgent Care Centers (UCC) continue to expand their presence in the healthcare market and evolve their services, a greater awareness and understanding of the risks associated with the practice of UC medicine by physicians of all specialties and backgrounds will play a crucial role in ensuring the implementation of essential patient safety measures in urgent care center settings, and across the continuum of care.

## Risk Issue: **Cognitive Bias**

UC specialists are trained to recognize, interpret and balance a multitude of data when treating patients. The hope is that their training will help them avoid scenarios that lead to misdiagnoses, patient harm, and potential claims.

Cognitive bias is manifested in many ways and can lead to devastating missed or delayed diagnoses. Bias occurs when practitioners tend to interpret the information gained during a consultation to fit their preconceived diagnosis, rather than the converse. For example, suspecting the patient has an infection and the raised white cells proves this, rather than asking, "I wonder why the white cells are raised, what other findings are there?" Cognitive bias can result in a diagnostic error, which is an issue seen in CAP's UCC claims.

**Case Study** A 60-year-old man, Mr. J, presented to a UCC in the middle of cold and flu season. He complained of a cough and increasing fatigue for a week. The physical exam revealed both rales and rhonchi over the right lung, along with crackles over the left. Mr. J was awake and alert, and his vital signs were 119/59, pulse 102, respiratory rate 18, and temperature of 98.3. His 02 saturation was 96% on room air. He had a history of Insulin-Dependent Diabetes Mellitus (IDDM). Mr. J was diagnosed with acute bronchitis and was prescribed an antibiotic and cough medicine.

A few hours after he returned home, Mr. J was found unresponsive by his wife; paramedics were called and upon arrival they found Mr. J in asystole. CPR was begun and Mr. J was transported to a hospital where his blood sugar was over 1200 mg/dl. Unfortunately, Mr. J arrested several times over the next two days resulting in an anoxic brain injury. He died two days following the UCC visit. The cause of death was determined to be diabetic ketoacidosis and severe hyperkalemia.

In this example, the treating physician's bias failed to consider any other differential diagnosis. Since it was the cold and flu season, bronchitis was assumed to be the diagnosis.

## Strategies to Consider

1. Always consider alternative diagnoses, especially when you have decided or arrived at a diagnosis quickly.
2. Consult with a colleague. They may see or consider something that you missed or misinterpreted.
3. Create a list of differential diagnoses and as test results return, eliminate those that are ruled out. Show your thought process to demonstrate that the standard of care was met.
4. Actively try to invalidate your belief by looking for evidence that opposes it.
5. While factors like fatigue, frequent interruptions, and feeling rushed are sometimes unavoidable in a busy setting, knowing that they play a role in cognitive bias can help you recognize when they are affecting your decision making.

## Risk Issue: **Lack of Supervision and Communication**

With the collaborative approach of team-based healthcare combined with the increased utilization of Advanced Practice Professionals, such as Nurse Practitioners (NPs) and Physician Assistants (PAs), physician leadership is crucial.

The role of the physician as a supervisor is a common liability issue across multiple specialties, but in the case of the UCC when expanded staff and resources are critical to a fast-paced practice operation requiring immediate results, the stakes can be even higher for a malpractice claim and patient safety.

When an APP is involved in or responsible for an adverse outcome, this situation can not only result in a claim against the involved provider, but can also result in a claim against the supervising physician through vicarious liability. In 2013 the Joint Commission found that of the 901 reported sentinel events from the previous year, 59% were related to breakdowns in communiction.[3]

This significant finding gives more credence to the need for a well-defined policy for overseeing supervised staff. A physician's focus on successful team communication is more important than ever, and appropriate supervision is essential to prevent patient injury or harm.

**Case Study** Mr. C, a 58-year-old man presented to a UCC following a work-related injury to his left leg. On his initial visit, Mr. C was seen by a a Physician's Assistant (PA), Mr. M. The exam revealed that the leg was pale, cold to touch and numb. Mr. C was unable to ambulate, had difficulty standing, and was diagnosed with muscle strain. He was discharged home with instructions to keep the leg elevated and to alternate a cold/hot pack.

The following day, Mr. C returned to the same UCC with complaints of increased pain and numbness. He was seen by PA, Mr. N, who noted moderate swelling and again found the leg to be pale and cold. Mr. N prescribed hydrocodone, diagnosed muscle strain, and advised Mr. C to return for follow up in two days.

At the next visit Mr. C was seen by a third PA, Ms. C, who found the affected leg to be tender and swollen. X-rays showed soft tissue swelling over the lateral malleolus but no evidence of recent bone or joint pathology. Physical therapy (PT) was ordered and Mr. C was told he that could return to work on modified duty.

Two days later, Mr. C presented to PT where the therapist found the limb to be pulseless. The patient was transferred to an an emergency department (ED) where compartment syndrome was diagnosed. A fasciotomy was performed the same day. Despite surgical intervention, Mr. C did not improve, and experienced multiple complications including a stroke, cardiac arrest, and multi-organ failure.

During the subsequent investigation, the supervising physician acknowledged that if he had been aware of the patient's initial presentation, he would have referred him to an ED immediately. Although the supervising physician was not involved in the care of Mr. C, he was held responsible due to his role as supervisor.

### Strategies to Consider

1. Understand the supervision requirements for your APPs and have the appropriate collaborative agreements in place.
2. Have a process in place to perform an annual review of the professional license status for all employed providers, to ensure no action has taken place that would require you to monitor or supervise.
3. Be immediately available, by phone or other means of communication, should your APPs need assistance.
4. Designate a substitute supervising physician that can cover for you when you are not available.
5. Plan regular huddles, daily or weekly, with those you supervise to discuss challenges, expectations, and cases.

## Risk Issue: **Documentation Concerns**

Common documentation errors in the age of the Electronic Health Record (EHR) that result in patient harm and impact a claim include: failure to document patient noncompliance, failure to document patient education, data entry errors, and failure to follow up on abnormal findings.

For UC physicians, as for all physicians, accurate and timely documentation of patient symptoms, interactions, and exam findings is essential. Accurate documentation can be a key factor in preventing patient injury and can also assist in defending the care in question should a claim get filed. To the contrary, absent or manipulated entries are almost always detrimental for both physician and patient.

**Case Study** Mr. A, a 49-year-old man, presented to a UCC with complaints of fever, cough, congestion and muscle aches for three days. His vital signs were: 110/70, pulse 76, temperature 97.5, and respirations 16. Mr. A was initially seen by an NP, Ms. K, who diagnosed him with viral syndrome. He was then discharged home with acetaminophen and instructions to return if his symptoms worsened.

The following day, Mr. A returned with worsening symptoms and was seen by both the NP and the supervising physician, Dr. C. The NP triage note indicated Mr. A was hypotensive and tachycardic at 97/40, 118. Unfortunately, Dr. C's note for the same visit stated "no tachy" and "RRR" (regular rate & rhythm). The physical exam revealed swollen lymph nodes. A subsequent rapid strep test was positive. Dr. C diagnosed an upper respiratory infection, and pharyngitis. Mr. A was given antibiotics and discharged home with instructions to increase fluids and rest.

The next day, Mr. A took his first dose of antibiotics. After a short nap, he woke up nauseous and vomited before going back to sleep. Later he was found unresponsive by his wife, Mr. A was transported to the ED where he was pronounced dead upon arrival.

An autopsy found that the patient had cardiomegaly with fibrosis and epiglottitis with edema, and the cause of death was acute myocarditis with an unknown cause.

Mr. A's family alleged that Dr. C's care fell below the standard by failing to recognize a potential emergent condition based on the significant change in vital signs between the two visits. During the investigation period, Dr. C shared that he/she felt that the change was due to dehydration. Experts opined if that was the case, Dr. C should have documented clinical findings to substantiate that conclusion and either attempted to treat or refer to an ED. Unfortunately, it was later revealed by the NP that Dr. C altered the record by adding "no tachy" and "RRR" two months after the patient's death. While experts opined that the cause of death was a probable cardiac event that the treating physician would not have been able to anticipate, Dr. C's failure to address the suspected dehydration, along with the allegation of altered records, made this an indefensible case.

### Strategies to Consider

1. Document all vital signs including weight. For any abnormal vital signs or findings, be sure to document what action was taken. If no action is taken, be sure to document your reason why. Document a re-check prior to patient discharge.
2. Document that you reviewed the patient's medical history. Quote the patient when applicable.
3. Document careful review of the system or organ which concerns the patient's complaint. Include pertinent negative findings. (For example, instead of documenting that an abdominal assessment is WNL, it is a better practice to document the negative findings, i.e., no tenderness, no masses noted, negative Murphy's sign, etc.)
4. Ensure that your EHR's default template does not not incorporate anything that contradicts your documented findings.
5. Document every test you order or recommend. If a patient declines a recommendation, document it and obtain the patient's signature on a refusal form.
6. Never alter your documentation. If you find that you need to later add to your documentation, be sure to clearly indicate that an additional or late entry has been made.
7. Establish a process that ensures all significant calls from patients are noted in the medical record.

## Risk Issue: **Repeat Visits with Same Complaint**

Patients will often utilize UCCs as their primary healthcare source, even if follow up elsewhere has been previously recommended. While more visits can help the UCC's bottom line, it is not in the best interest of the UC physician to continue to see the same patient multiple times for the same condition. This practice can give providers (and patients) the false sense that the UC physicians are able to treat an ongoing problem, when they should refer the patient to a specialist.

**Case Study** Mr. R, a 44-year-old male, presented to a UCC with burns to his right upper arm, axilla, and upper back from a failed attempt to light a BBQ grill. His left hand was also burned. Mr. R was seen by a PA, Ms. D, who found a full thickness burn at the right axilla that extended to the right scapula and upper humerus area, and noted blanching of the skin and decreased sensation with bullae present. Mr. R was diagnosed with second-degree burns in multiple areas. Ms. D cleaned and dressed the wounds with silver sulfadiazine and a non-adherent dressing, then provided pain medication. Prior to discharge, she spoke with a nurse in a burn center at a local medical facility who advised that Mr. R should report to the burn center immediately for further evaluation. This direction was relayed to Mr. R. He did not follow the recommendation.

The following day, Mr. R returned and was seen by a different provider, Dr. A, who advised that he could manage treatment of the wounds at the UCC, even though he spoke with the patient regarding the recommendation to follow up at a burn center. Dr. A did not document this conversation. The wounds were re-dressed, and Mr. R was advised to return in five days.

Mr. R returned to the UCC for an additional seven visits, and each time the wounds were cleaned and dressed by Dr. A who noted both bruising and erythema each time. At the ninth and final UCC visit, Mr. R was seen by the PA, Ms. D, who noted that the burns on the right axilla were contracting and there was a minimally sensate layer of granulation tissue on the volar side of the right forearm with some proximally pink tissue that was not yet granulating. Additionally, Mr. R had significant pain with flexion and abduction of the right forearm, and was only able to flex to 80 degrees with assistance. Ms. D again assessed the wounds as second-degree burns and again recommended that he follow up at the burn center to prevent further contractures. Again, Mr. R did not follow the recommendation.

Five days later, Mr. R noted an odor coming from the burn sites and finally reported to the burn center. He was found to have second-degree and third-degree burns to the posterior and anterior trunk, respectively. Mr. R was admitted for pain and infection control, IV antibiotics, and ultimately underwent surgical debridement, excision, and then allograft to the excised areas. Following discharge 18 days later, he required outpatient treatment for several months.

Mr. R alleged that the error in diagnosis caused delay of appropriate treatment, causing his wounds to become infected and require hospitalization. Experts agreed that the severity of the burns were not appropriately diagnosed and treated at the UCC.

### Strategies to Consider

1. If you are seeing a patient for the first time on a return visit, review the chart before you examine the patient. Do more than a cursory review, as you may catch something that your colleague or APP missed.
2. If a provider in your practice sees a patient on consecutive visits for the same complaint, have a policy in place to require the provider to review the case with you, while the patient is still in the UCC.
3. If a patient returns to your UCC despite being referred to a specialist, discuss this with the patient to determine why and reiterate the need. Document the conversation, especially if the patient refuses.
4. When you deem a referral is necessary, provide patients with written instructions and materials, and consider assigning a staff member to call patients the day after discharge to remind them to make their follow-up appointments.

## Risk Issue: **Patient Referrals and Transfers to Higher Level of Care**

UCCs provide patients with easy access to care when treatment is needed for non-life-threatening conditions. However, just because a patient arrives with a non-emergent need, does not mean the UCC is the appropriate place to provide ongoing care. Chronic conditions that require continuing care are better suited for the primary physician's office. For the UC physician, the challenge is making a timely referral to a specialist or transfer to a higher level care.

**Case Study** Mr. B, a 64-year-old male with a history of diabetes, presented to a UCC with complaints of a sore area on his upper back for one week. Upon examination, Dr. M found a 12 cm abscess at his left mid-back. An incision and drainage (I&D) were performed, and a drain was placed. Mr. B was diagnosed with cellulitis and instructed to return in two days for a wound check.

Mr. B returned to the UCC for six more visits. Dr. M continued to express increasing amounts of drainage and after each visit, and instructed Mr. B to return to the UCC for wound follow up.

On the seventh and final visit, Mr. B was seen by Dr. N who noted that the affected area was 26 cm (10 inches) with moderate duration and yellow purulent drainage. Dr. N immediately referred the patient to the ED for surgical consultation, IV antibiotics, and deep tissue I&D. At the ED, the abscess measured 26 cm and Mr. B's white count was 37,800/mL. Mr. B was admitted and underwent I&D and debridement. His post-operative diagnosis was soft tissue staphylococcus aureus infection of the left back, status I&D of necrotic 26 cm x 16 cm left back wound. After discharge, 12 days later, Mr. B required home healthcare for wound checks, followed by irrigation and debridement.

Mr. B alleged the delay in appropriate care and referral caused worsening of the abscess, resulting in infection necessitating hospitalization for I&D and debridement. Experts opined that the standard of care was not met and agreed that due to the patient's underlying diagnosis of diabetes, antibiotics should have been prescribed and the patient should have been referred to the ED as early as the second visit when increased drainage was noted.

### Strategies to Consider

1. If a patient visits the UCC multiple times for the same complaint, it may indicate that a referral to a specialist or to an ED is warranted. Consult with a trusted colleague or specialist to assist you in making that determination.
2. When transfer to the ED is needed, determine the proper mode of transfer. For any unstable condition or one that you suspect may deteriorate quickly, opt for transport via emergency medical services (EMS).
3. Make the appropriate decision on destination. For example, if you have a patient with a suspected ST-elevation myocardial infarction (STEMI), it would not be in the patient's best interest to send him or her to a facility that doesn't have a cardiac cath lab.
4. When transferring a patient to the ED, contact the covering ED physician so that you can communicate the whole patient picture, inclusive of the acuity and your specific concerns.

# Conclusion

UC physicians face complex challenges unique to their specialty. As growth in this field of medicine continues and as more patients rely on UCCs for their healthcare, existing and new risk issues are sure to be ever present in the urgent care setting. CAP's team of risk managers and patient safety specialists make it a priority to share the real experiences and stories of fellow CAP UC physicians, so that all physicians, regardless of specialty or setting, can learn valuable lessons and implement effective risk-mitigating strategies that support better patient outcomes and reduce risk.

CAP's priority is to support its members with specialty-specific education around risk and patient safety issues that can impact your career, with the goal of reducing your liability, protecting your patients, and helping you succeed in practice.

While the risks emphasized in this focused review are not inclusive of all the potential areas of liability that a UC physician may face, it does bring to light the common allegations and contributing factors that are seen most often in claims.

CAP members may seek assistance if a situation arises that calls for guidance on how best to handle an adverse event or outcome, reduce exposure, or manage the risks involved via the Risk Management Hotline at 800-252-0555. Experienced risk managers are available to members 24/7 to provide guidance and answer questions.

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Cooperative of American Physicians
**www.CAPphysicians.com**


**Cooperative of American Physicians, Inc.**

333 South Hope Street, 8th Floor
Los Angeles, California 90071

*General:* 800-252-7706
*Hotline:* 800-252-0555
*Email:* riskmanagement@CAPphysicians.com


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