



Training Our Teams to Meet the Needs of Our Patients

Countless times over the last year I have heard variations on a “we can’t” theme. It’s a specific and focused “we can’t” related to the services we are *not* able to provide to our urgent care patients. “We can’t do that test.” “We can’t use that medication in clinic.” “We can’t have our medical assistants do that.” Sadly, it is purely a reflection of education and training. However, as opposed to responding with increased training and educational support for our team members, we are restricting services and lowering the level of our patient care. We can and should do better for our patients.

If our medical assistants don’t know how to take a respiratory rate, the response might be that our clinic leadership considers eliminating that vital sign. I have to admit I was shocked when I heard about this very situation. Respiratory rate is a critical vital sign. There have been many instances when I have seen a patient who looked otherwise quite well, except for an elevated respiratory rate. And that elevated respiratory rate was the key urgent care finding, which led to an ultimate diagnosis of severe respiratory infection, metabolic acidosis, or pulmonary embolism.



“If a clinician orders a test, they need to be able to interpret the test.”

The confusion stems from the math required to calculate the respiratory rate: count respirations for 15 seconds and multiply by 4; or count respirations for 20 seconds and multiply by 3; or count respirations for 30 seconds and multiply by 2; or count respirations for 60 seconds and don’t multiply. I get it. On a busy 12-hour shift, sometimes we can’t slow down to think it through, or maybe our medical assistants weren’t trained well enough. Regardless, taking 5 minutes during a staff meeting to train the medical assistants on one approach would minimize confusion. Reminder posters could also be placed in exam rooms. This seems like a way to ensure that our patients get quality care in urgent care—as opposed to eliminating a vital measurement.

Experienced clinicians are also not immune to these

types of statements. “Our clinicians don’t know how to read a pediatric electrocardiogram, so I’m not sure we should expect them to perform that study.” I absolutely agree with the underlying sentiment in this statement. If a clinician orders a test, they need to be able to interpret the test. Incorrectly interpreting a test will put patients at risk and ultimately cause harm. However, the response should not be to stop doing the test. Doesn’t a 17-year-old obese male patient who presents to urgent care with chest pain need an electrocardiogram to evaluate for early acute coronary syndrome or pericarditis? Seems that missing a diagnosis like this by not performing an indicated test ultimately causes harm to the patient too.

I acknowledge that clinician education, training, and years of experience are variable and that there are most likely gaps for each clinician practicing urgent care medicine.¹ Regardless, leadership teams should encourage clinicians to gain the education and training necessary to fill those gaps. Clinicians should also feel a responsibility to provide the best possible care to our patients, which means becoming proficient in all aspects of care related to our clinical setting—the urgent care center. After all, each of us took an oath to “do no harm.” Not doing tests because we don’t know how or doing tests we don’t know how to interpret potentially creates harm. Continuing medical education is easily available in many formats to help close these gaps.

So today I encourage each and every one of us to redirect our attention to raise the bar as opposed to lowering the level of patient care. If you are a clinical leader, offer trainings to your clinicians and support staff during team meetings. If you are a clinician, take initiative and seek out continuing medical education opportunities to fill gaps in your medical knowledge, clinical reasoning, and procedural skills. Together we can raise the bar in urgent care patient care. ■

Reference

1. O’Malley P, Botchway A, Stoimenoff, L, Fish LE. Urgent Care Clinician Procedural Benchmarking Survey Results. *J Urgent Care Med.* 2025; 20(1):4-6

Lindsey E. Fish, MD, FCUCM

Editor-in-Chief, *The Journal of Urgent Care Medicine*

Email: editor@jucm.com