Potential Pitfalls While Finding the Needle in the Haystack

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It's nearly midnight on Saturday and I am between patients in an ED on an unseasonably cold November evening in Phoenix, Arizona. Among the head bleeds, overdoses, MI's, and strokes, I have had these chief complaints thrown at me:

- "Smoke inhalation after blowing out a candle"
- "I can't stop playing with my number one."
- "I'm here for my 40-year-old physical." (The patient was 43.)
- "I fell asleep at a party and woke with a sore throat. I think I have an STD in my throat."

I have often mentioned that I think urgent care medicine is much more challenging then emergency medicine inasmuch as in the ED, I have at my fingertips essentially any diagnostic test I can dream up and all the help I need.

In an urgent care center, relying on your gut and great diagnostic skills is a necessity. Although it is true that most patients who present to an urgent care are generally healthy and have non-life-threatening complaints, the challenge is sifting through the hundreds of "well" to identify the one "sick."

The High-Risk Patient: Diagnostic Considerations

The following are some tips from the literature and from my experience to help mitigate your risks, identify the sick, and improve patient safety in the urgent care setting:

- When a patient presents with a chief complaint of headache, considering the possibility of a subarachnoid bleed is essential. CT scanning of the brain has a false negative rate of 3%-5% for warning (sentinel) bleeds. If you are ordering an outpatient CT for a headache, you may want to consider sending the patient to an ED, since, if the CT is negative, the patient should have a lumbar puncture. Advise the patient of the "game plan" prior to sending him to the hospital and document the conversation.
- Remember to palpate over the temporal artery for those patients with visual changes and headache. Rapid administration of IV steroids for temporal arteritis is the standard of care.
- Be wary of mild head trauma in patients who are on warfarin (Coumadin), aspirin, or clopidogrel (Plavix). Have a low threshold for CT scanning in these patients and ensure close follow-up. Delayed bleeding in an anticoagulated patient is not uncommon.
- LS spine films are of little value without a history of significant trauma to the back. A patient presenting with any red flags (eg, IV drug abuser, saddle anesthesia, myelopathic findings, incontinence, etc.) should receive an MRI (with gadolinium if epidural abscess is suspected). Avoid getting caught in the "narcotic seeker" mode and perform a thorough exam documenting strength, reflexes, and sensation. "WNL" is not sufficient.
- Most cervical injuries can be cleared clinically; in those that can't, the literature is clear that CT is superior to the three-view C-spine series. However, it delivers a significant dose of radiation to the neck and thyroid gland.
- In patients with hand/wrist injuries, the rate of occult scaphoid fractures is believed to be as high as 20%. MRI is the diagnostic test of choice. However, the common approach, which is also the standard of care, is documentation of snuff box tenderness, thumb spica splinting, and re-imaging in a week to 10 days.
- Regarding the use of midlevel providers, the rate of claims based upon "failure to supervise" are increasing. Check your state's statutes regarding what is required to supervise a midlevel provider and make sure you are in compliance.
- If a patient complains of an eye injury, ask about activities such hammering, grinding, chiseling, etc. These activities have an increased risk of intraocular foreign bodies. CT scanning is the modality of choice to diagnose intraocular for-

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eign bodies. Always check visual acuity no matter what the eye complaint and inquire about tetanus status.
- Patching an eye for corneal abrasions is not the standard of care. Think of pseudomonas infections in patients with conjunctivitis who are also contact wearers. In these patients, patching is definitely contraindicated.
- In patients with nasal trauma, look for and document the presence or absence of a septal hematoma. If present, it must be drained. Also, evaluate for CSF rhinorrhea and consult neurosurgery if present.
- Button battery ingestion in children is an emergency. These must be removed to prevent tissue necrosis.
- For patients presenting with vertigo, the goal of the evaluation is to differentiate peripheral versus central etiology. Peripheral etiology is typically acute onset and positional. In addition, the patient often complains of ringing in the ear and nausea and has nystagmus. Twenty-five percent of patients over age 60 will have a central cause of their vertigo such as a cerebellar stroke or vertebral artery dissection.

The High-Risk Patient: Additional Considerations

- Don't waive copays for patients or staff, especially for government-insured patients. Waiving copays is considered an inducement by the Centers for Medicare & Medicaid Services and is generally prohibited in all payor contracts.
- Follow up on all abnormal lab and x-ray results and don't fall into the trap of ordering tests unnecessary to help solve the issue at hand.
- Be careful on your discharge instructions to give patients an avenue for follow-up. Don't document, "See your provider in one week or as necessary." If a patient cannot get in to see her PCP, offer her a return appointment to your center for reevaluation. In fact, make a return appointment for the patient at discharge.
- For "complaint management," remember the pneumonic LAST: **L**isten; **A**pologize without implying or admitting error (eg, "I'm sorry that our care fell below your expectations"); **S**olve; and **T**hank you. Check to see if your state has an "I'm Sorry" law—and read it—before apologizing. Physician apology laws differ from state to state. Most I'm Sorry legislation limits evidentiary protections.
- Be careful of postings on social media sites. Never post a picture of a patient or a patient's body part on a social media site. I know of multiple providers whose "innocent rants" have come back to haunt them.
- If a chart is billed under your name, you bear responsibility for the outcome of the patient.
- The use of checklists reduces the potential for error and improves patient safety.
- Metadata records keystrokes in an EHR. A knowledgeable plaintiff's attorney will always subpoena that EHR metafile to review what was documented and when the keystrokes occurred.
- Don't ever throw colleagues under the bus in the chart. This behavior is unprofessional and unnecessary and may come back to bite you if litigation ensues. Plaintiff attorneys love nothing more than finger-pointing.
- Always generate a medical record on a patient (even if the patient is your friend or relative). No chart can equal no medical malpractice coverage.
- At the end of the day (and it literally is the end of my day), much of the risk in urgent care medicine can be mitigated by compassionate patient care, great documentation, and excellent customer service and service recovery.

In case you are still wondering about my patient who couldn't stop playing with his "number one," well, let's just say that he is now resting comfortably and continues to hold himself in high regard. ■