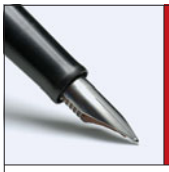
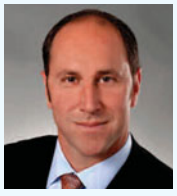


LETTER FROM THE EDITOR-IN-CHIEF

Risk Mitigation in Urgent Care: Part 3



In my previous column, I discussed three core areas where risk and potential liability exposure lurk and ways to mitigate that risk. This month, the last in the three-part series, I will focus on specific clinical policies and procedures that can effectively reduce liability risk and enhance patient safety, quality and patient satisfaction...the holy grail of high-performing practices.

Eliminating 'Pre-triage'

The term "pre-triage" is used to describe the all-too-common practice of determining the appropriate level of care for a patient prior to any physician evaluation. Examples include: 1.) "Pre-triaging" head trauma to the ED because it "might" need a head CT; 2.) "Pre-triaging" chest pain to the ED; 3.) "Pre-triaging" young infants with fever because the provider won't see babies; 4.) "Pre-triaging" abdominal pain because it "might" need a CT. Well, the fact is that most of these presentations, if given a fair and thorough clinical evaluation, DO NOT require evaluation in the ED and DO NOT need CTs. And even if they do, how can we determine the proper method of transfer WITHOUT a clinical evaluation? What if the abdominal pain is a ruptured AAA? What if the baby is grunting and cyanotic? What if the chest pain patient dies in his car? While the answers to each of these questions is obvious, it is common practice for the staff at urgent care centers to base their transfer decisions on a "quick eyeball" test. Worse yet, documentation of the decision-making is almost never done and vital signs are rarely taken. Eliminating "pre-triage" is a must for all urgent care practices and should be applied systematically and without exception to be effective.

Triage for high-risk complaints and high-risk clinical signs

Creating a policy and procedure for triage of high-risk complaints and clinical signs is an easy and extremely effective way to ensure that delays in evaluation do not occur for patients known to carry a higher risk. High-risk complaints include things like chest pain, shortness of breath or fainting spell. These complaints, and others like them, should be triaged by the clinical staff immediately. The triage may reveal that the risk is low or the story is less concerning. These patients can return to the waiting room. High-risk clinical signs include pallor, sweating, and confusion. When such clinical signs are present, a patient should be assessed immediately by the clinical staff. A full list of high-risk complaints and clinical signs can be found on the *JUCM* home page (*www.jucm.com*).

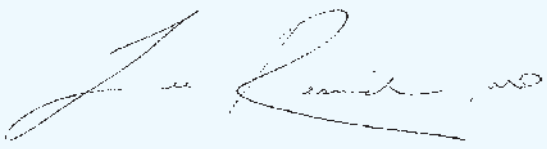
Abnormal vital signs

Abnormal vitals should ALWAYS be explained and evaluated. Elevated heart rate is an independent sign of cardiovascular compromise and frequently indicates a potentially unstable condition. Frequently encountered clinical entities that can present with tachycardia alone without hypoxia include PE and pneumonia. Don't miss these. Also, ensure that all clinical support staff are trained on AND their proficiency tested for proper procedure in taking vital signs and ranges in BOTH adults and children.

Follow-up for high-risk conditions

Consider a policy around follow-up for any high-risk complaint or diagnosis. Simply referring patients with these conditions to primary care for follow-up is not good enough. If you made the diagnosis, you are responsible for the outcome. Things like pneumonia, cellulitis, asthma, non-cardiac chest pain, and pyelonephritis require follow-up to ensure that interventions are working, vital signs are normalizing, and worrisome signs or symptoms are absent. For a full list of recommendations, go to *www.jucm.com*.

I hope you found this series informative, relevant, and actionable for your practice. Attention to some very basic principles, along with implementation of policy and procedure, can help protect you, your practice, and your patients from unnecessary risk and harm. ■



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