It's About Time: Repeat Vitals and Long Waits

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It was with great interest that I read Dr. Joshua Russell's opinions on the value of repeating vital signs in the urgent care setting in the November 2022 issue of *JUCM*.[1] Having stated that this does not seem to be common practice amongst his peers, he went on to highlight a couple of very reasonable scenarios in which he recommended repeating vital recordings.

Importantly, he alluded to the often-underappreciated phenomenon of regression to the mean as justification for this practice.

I agree with Dr. Russell in his assertion that repeating vitals is critical for identifying unstable patients and is, therefore, an essential skill for ensuring patient safety.[1] In fact, it is my belief that one of the core attributes that distinguishes urgent care as a unique specialty is our ability to identify the patient who needs further care, before it becomes obvious.

As we look to sieve through the slightly unwell or injured members of the population to find these patients, we are forced to do so without access to a complete laboratory or advanced imaging which one might find in an emergency department.

Moreover, we approach patient evaluation and workup always with consideration of the costs of the unnecessary referral. These errors in judgment cost not only the patient, but the clinic and health system at-large as well.

We must balance this with the anxieties that naturally arise when considering the prospect of missing important diagnoses and any subsequent negative outcomes which may ensue—both for the patient and for us as we face the possibility of an investigation of our practice.

There is an art and skill to being able to utilize good history-taking, sound clinical examination, and clinical

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reasoning while simultaneously remaining aware of the ever-growing queue in the waiting room. Vital signs are quick, cheap, and powerful tools available to us all, and we should not be overlooking them in identifying the deteriorating patient.

Quinten, et al demonstrated the association between vital signs and clinical outcomes among ED patients. Building on this, Candel, et al showed that this predictive power of abnormal vitals for impending poor outcomes increases with increasing patient age.[2,3] So, we'd all be wise to perform more vital sign checks in urgent care to increase the sensitivity of our sieve for catching a catastrophe on the horizon.

In addition to the scenarios Dr. Russell identified as opportunities to improve clinical assessment through vital rechecks, my mind also moved to another. Allow me to elaborate.

The recent winter here in Aotearoa, New Zealand has been a tough one for UC clinicians. In addition to the increased volumes expected with the large numbers of unwell people, COVID has also impacted the healthcare workforce through both clinician illness and that of their families. With similar experiences in general practice and EDs, wait times have skyrocketed throughout our centers. While historically, some patients may have waited up to 90 minutes, at peak winter this wait ballooned to over 4 hours in some places during the most recent surge (an unprecedented experience in New Zealand).

These situations are an understandable consequence of UC centers' role in providing open-access care for the

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entire community they serve. However, such wait times clearly are not ideal.

Given the reality of the world in which we currently find ourselves, we must not forget that like the stock market, vitals can and will fluctuate continuously. Consider this common scenario: A patient had their vitals recorded at triage and the clinician sees them a while later—perhaps even after a few hours. This is where we must consider repeating those vitals. To say that person is afebrile, or normotensive based on old data, risks missing a deteriorating picture. We want to assess the current version of the patient sitting in front of us and not the historic version of themselves who checked in several hours earlier.

In addition to the scenarios outlined in Dr. Russell's editorial, I would propose that we should all be repeating vitals on patients whose last (or only) set of vitals was performed a while ago. How long? Well, this will depend on the presenting complaint, how the patient appears when you're evaluating them, and on what your gut is telling you.

To be more specific, a reasonable rule of thumb might be for any patient who has waited longer than an hour, particularly if they have had some therapy administered after triage, to have their vitals retaken by the clinician during their physical exam. Cheap, quick, and easy—there's no real excuse not to recheck vitals, especially after there's been a long delay since triage. This is, after all, the critical moment of urgent care: when we decide if this is the patient who might very well have a disastrous, but preventable, outcome looming.

References

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