White Paper: Managing Risk in Your Emergency Department

For Hospital Groups, ASCs, and Specialty Medical Facilities

Executive Summary
Emergency physicians face the unique challenges of treating patients whom they may never see again and diagnosing and treating urgent and emergent conditions that require immediate care. These challenges occur under circumstances that can range from unpredictable and uncomfortable to life-threatening. The lack of an ongoing relationship with the patient increases the risk of legal actions when things go awry. Identifying high-risk presentations to the emergency department (ED) can help to improve early treatment and optimize prioritization in the ED, where timeliness is of the essence.

Risk management and quality improvement functions, such as peer review, are rallying behind patient safety and finding ways to collaborate more effectively and efficiently in order to ensure the delivery of safe, high-quality patient care. A proactive approach to peer review facilitates the identification and resolution of potential problems at their onset, thereby increasing patient safety and the quality of patient care. A commitment to continuous improvement, accountability, and transparency promotes a culture that is open and honest about deficiencies. Focusing on the educational aspects of peer review may reduce the perception that it is a punitive process.

Introduction
Emergency Departments operate 24 hours a day, 7 days a week and provide unrestricted access to patients with all types of injuries and illnesses of different degrees of severity. Patient attendance fluctuates and can be unpredictable as well as overwhelming. Patient conditions are usually acute and unexpected, and patients and the individuals accompanying them are often anxious and impatient. Critical decisions must be made within the short patient stay in the department, which can be taxing for inexperienced staff. In some EDs, the rapid turnover of junior staff and inadequate senior supervision may further aggravate this already risky situation.

High-Risk Complaints & Conditions in the Emergency Department
Chest pain is one of the most frequently seen chief complaints in patients who present to EDs and is considered a high-risk chief complaint. The differential diagnosis for chest pain is broad, and the potential causes range from benign conditions to those that are immediately life-threatening. Although many ED patients with chest pain do not have an immediately life-threatening condition, correct diagnoses can be difficult to make, incorrect diagnoses may lead to potentially harmful therapies, and the failure to make a timely diagnosis may contribute to significant morbidity and mortality.

Other high-risk complaints and conditions that commonly occur in EDs include:

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<tr>
<th>Acute coronary syndrome</th>
<th>Pulmonary embolism</th>
<th>Thoracic aorta dissection</th>
</tr>
</thead>
<tbody>
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<td>Abdominal pain</td>
<td>Abdominal aortic aneurysm</td>
<td>Appendicitis</td>
</tr>
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<td>Headache</td>
<td>Subarachnoid hemorrhage</td>
<td>Stroke</td>
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<td>Pediatric fever</td>
<td>Meningitis</td>
<td>Airway</td>
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<td>Trauma</td>
<td>Head injury</td>
<td>Spinal injury</td>
</tr>
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<td>Wounds</td>
<td>Fractures</td>
<td>Testicular torsion</td>
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<td>Ectopic pregnancy</td>
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Identifying, assessing, controlling, minimizing, and preventing risk are especially important in the practice of Emergency Medicine, which is particularly vulnerable to potential errors and dissatisfaction.
Operational Risks in the Emergency Department

A hospital’s operational risks stem from the people, systems, and processes through which it operates. They can also include other classes of risk, such as fraud, legal risks, or physical or environmental risks. Operational risks for the ED can arise from issues with:

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<th>Facility</th>
<th>Privacy</th>
<th>Equipment</th>
</tr>
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<tbody>
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<td>Security</td>
<td>Safety</td>
<td>Credentialing</td>
</tr>
<tr>
<td>Orientation</td>
<td>ED staff</td>
<td>Patient satisfaction</td>
</tr>
<tr>
<td>Consent</td>
<td>Telephone</td>
<td>Special patients</td>
</tr>
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<td>Discharge instructions</td>
<td>Specific problems</td>
<td>Test follow-up</td>
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Factors That Contribute to Increased Risk in the Emergency Department

As with any specialty, the practice of Emergency Medicine has its own unique processes that are followed during the course of patient care. Each of these processes can be thwarted by barriers that increase risk and threaten patient safety. The 10 most common vulnerabilities found in claims of medical negligence involving the ED are described below.

- **Knowledge deficit:** Despite extensive education, training, and experience, the emergency physician will not have seen every variation of every condition that presents to the ED. It is important for emergency physicians to focus on learning as much as possible about high-risk ED presentations.

- **Failure to take adequate history:** This typically involves the absence of documentation of one or more key elements of the history of present illness, risk factors, past medical history, family history, and personal/social history. One of the main areas of deficiency seen in suits is the lack of documentation of risk factors for serious conditions such as acute coronary syndrome, pulmonary embolism, aortic dissection, abdominal aortic aneurysm, and subarachnoid hemorrhage.

- **Failure to perform adequate exam:** Every patient expects that an adequate physical examination will be performed and documented. If important elements of the physical exam are not documented, it will be assumed that the physician was sloppy and simply did not perform the exam. Examples of alleged negligence include the failure to perform a neurological exam in a headache patient and the failure to examine the mental status, neck, and skin in a febrile infant.

- **Failure to consider differential diagnoses:** Chart documentation should reflect the physician’s medical reasoning. The documentation of principal differential diagnoses is critical for high-risk complaints, along with a brief discussion of why those diagnoses were considered, dismissed, or ruled out. Patients may resort to lawsuits if they experience a bad outcome and the chart documentation lacks a discussion of medical reasoning.

- **Failure to order/interpret diagnostic studies:** Certain diagnostic studies may be expected based on the patient’s presenting symptoms and signs. Patients who experience adverse outcomes often allege that additional testing was necessary. Examples include the failure to perform an electrocardiogram to evaluate chest pain, the failure to perform a lumbar puncture for a patient with sudden severe headache and a negative CT scan, and the failure to perform a pregnancy test for women of childbearing age with pelvic pain.

- **Failure to diagnose:** It is not always possible to definitively diagnose conditions in the ED. Every effort must be made to use the available resources to arrive at and record a reasonable provisional diagnosis before the patient’s disposition.

- **Failure to treat:** The failure to diagnose leads to the concomitant failure to treat the missed diagnosis. Examples of delays in time-sensitive treatment include the failure to use heparin, aspirin, and beta blockers for acute coronary syndrome; the failure to treat a stroke with thrombolytics; and the failure to administer antibiotics for pneumonia, meningitis, or sepsis in a timely manner.
Managing Risk in Your Emergency Department

- **Failure to consult:** When a physician would be reasonably expected to consult a specialist and does not and there is a bad patient outcome, the outcome can be used as proof of the need for consultation. Examples include early consultations for trauma patients, and consultations with Cardiology for an acute myocardial infarction, Orthopedics for an open fracture, and Vascular Surgery for an ischemic limb.

- **Failure to admit:** The majority of malpractice claims in Emergency Medicine involve a patient who was discharged home from the ED and ended up suffering a complication. This failure is usually coupled with the allegation of failure to diagnose.

- **Failure to communicate:** Although this specific failure is rarely mentioned in lawsuits, it serves as the foundation upon which almost all negligence claims and other allegations are built. Physicians must explain the “who, what, when, where, and why” of the workup to the patient.

### Issues Related to Timeliness of Care in the Emergency Department

The lack of timeliness can result in emotional distress, physical harm, and higher treatment costs for patients. Patient flow management, adequate staffing levels, and cost reductions are issues with which EDs regularly deal.

Three main factors that affect timeliness of care in the ED include:

- **Patient triage:** Mandatory triage may delay critical care for high-acuity patients;
- **Hospital capabilities** The patient’s needs and injuries may exceed the hospital’s capabilities; and
- **Physician quality:** The hospital may have ED staffing issues, and physicians may lack experience with the wide variety of complaints and conditions that present to the ED.

### Importance of Documentation

Amidst the apparent chaos of the ED, documentation often suffers. The ED chart serves as the sole means for the emergency provider to note the details of the care provided to the patient during a visit. Thorough physician documentation is the only lasting record of the ED visit, and it can inform primary or future healthcare providers about the ED evaluation and treatment, as well as protect the ED physician in the event of bad outcomes and litigation.

Documentation of the initial condition of the patient, timely and thorough examinations and evaluations, prompt resuscitation, and the timing of specialty consults can be of special importance in cases of major trauma, stroke, myocardial infarction, and other emergent conditions. Excellent documentation may protect a physician from liability during a malpractice suit, whereas poor documentation, although not necessarily tied to worse outcomes, often leads to the assertion that care was not provided if it was not documented.

High-risk diagnoses in particular require careful documentation because of the potential for litigation resulting from missed diagnoses or bad outcomes. Proper documentation of a careful history, a physical examination, and the physician’s thought process regarding worst-case scenario diagnoses may help protect the provider to some degree.

### The Role of Risk Managers in Evaluating & Monitoring Physician Performance

Hospitals and physicians have become more aware of the risks and potential problems associated with providing healthcare services as lawsuits have increased significantly in recent years. Peer review focuses on improving physician performance and the quality of patient care, thereby reducing hospital risk through performance and quality improvement and the identification of underperformance. The goals of both risk management and peer review include:

- Minimizing harm to patients;
- Minimizing liability exposure of practitioners; and
- Minimizing hospital financial losses.
Managing Risk in Your Emergency Department

As risk managers aim to minimize professional liability losses for the hospital, they must be able to recognize events that are likely to result in costly litigation, whether an error is involved or not. Malpractice risk can be difficult to target, since the majority of patients who suffer an injury due to medical negligence do not file a malpractice claim. However, in order to improve quality of care, the underlying causes of an actual or potential medical error must be identified and eliminated. As a risk management tool, peer review:

- Detects and resolves physician performance issues that can lead to loss;
- Prevents medical errors through increased transparency and accountability;
- Reduces negative consequences and costs for both the physician and the hospital; and
- Reduces risk of litigation between facility and physicians, when managed properly.

If not managed properly, peer review can actually increase a hospital’s risk. Hospitals have been found liable to patients when peer review did not effectively prevent harm, and physicians subjected to corrective action resulting from peer review have successfully argued that the peer review was tainted by bias or incompetence. Despite the significant litigation risk associated with peer review, many states have statutes that impose an obligation on healthcare providers to monitor the quality of services through a mechanism such as peer review. Similarly, hospital accreditation bodies impose a requirement that hospitals engage in regular quality review. Peer review has long been around, but many facilities face ongoing challenges to make the peer review process effective.

Peer Review Challenges That Increase Risks

In order to effectively address clinical deficiencies and behavior problems through internal peer review, there must be:

- A pool of competent, actual peers with the same specialty credentials;
- Unquestioned integrity and judgement that are free from conflict of interest (COI);
- Willfull devotion of considerable time and effort to reviewing, analyzing, and evaluating a colleague’s work and demeanor;
- Willingness to conduct peer review without additional compensation; and
- Maintenance of one’s own active clinical practice while keeping up-to-date on the latest developments in one’s specialty.

Unfortunately, these assumptions are often unrealistic. Physicians sometimes misuse the peer review process for their own political or economic agenda; sham peer review of this nature has resulted in litigation and large awards in some cases. Even when peer review is undertaken for the legitimate purpose of improving the quality of health care, hospitals rarely have access to an adequate pool of physicians who are willing to engage in peer review, and the physicians who are willing may not have the training or experience to serve as peers in a given case.

Hospitals face many obstacles to effective peer review, including:

- Conflicts of interest (COI), which lead to reduced visibility on underperforming physicians;
- Bylaws, policies, and procedures regarding peer review can be unclear or not followed;
- Peer review committee (PRC) is made up of volunteers; infrequent meetings lead to slow follow-up and turnover, which leads to inconsistency in handling sensitive matters;
- PRC lacks same-specialist expertise necessary to evaluate performance;
- Cases with negative outcomes get slowed down or suppressed to avoid conflicts;
- Medical executive committee (MEC) fails to take consistent action on identified performance deficiencies; and
- External peer review is not used consistently to mitigate above issues, because of the costs involved or MEC’s aversion to bringing in outside parties.
Effective Peer Review

Effective, proactive, educational peer review uses best practices in risk management to minimize negative events and costs by identifying and dealing with potential exposures early on. Risk management best practices related to peer review include:

- Risk avoidance through prevention;
- Proactive/systematic peer review to measure and monitor performance and identify risk areas;
- The regular assessment of high-risk specialties; and
- The establishment of an external peer review (EPR) program to complement and strengthen internal peer review.

Role of External Peer Review in Ensuring Quality of Patient Care & Safety

Ongoing evaluation of hospital practitioners ensures excellence in physician performance and the highest standard of care for patients. External peer review allows hospitals to perform not only in-depth evaluation of sentinel events but also (re)credentialing, (re)privileging, proctoring, and ongoing measurement and monitoring of physician performance.

Peer review committees that are composed primarily of in-house personnel often lack the resources to help the hospital achieve their performance improvement goals, and social and professional relationships can lead to conflicts of interest. External peer review avoids conflicts of interest that can arise from economic, professional, or social ties among physicians within a single institution. It may also be an effective solution for hospitals that lack adequate physician resources to conduct timely performance analyses.

When properly executed, external peer review can reduce medical errors through objective evaluations performed in a non-punitive, educational context that supports a healthy culture of continuous improvement. This results from physicians knowing that their work will be objectively evaluated at regular intervals by board-certified specialists with the same credentials and from similar practice settings, thereby leading to improved quality of care and patient safety. Ongoing evaluation of physicians can also uncover problematic practice patterns, as well as physician- and hospital-level issues that need to be addressed.

External peer review can also play a key role in reducing or eliminating the risks associated with increased malpractice claims. Unlike internal peer review, which only looks at sentinel events, external peer review can help hospitals to quickly and efficiently discover, highlight, and deal with physician performance issues before they turn into claims.

Conclusions

The working environment of the ED is a unique, complex, and dynamic environment. This is reflected in the varying, often overwhelming volume of patients seen in busy EDs, as well as in the range of acuity of clinical encounters. With decisions being made under time constraints, often with incomplete information, emergency physicians are highly vulnerable to error and claims of malpractice. Thorough physician documentation is critical not only for protecting emergency physicians but also for ensuring the continuity and quality of care for patients.

Hospitals should realistically assess the efficacy and quality of their internal peer review procedures, keeping in mind the significant litigation risk associated with peer review activities. To mitigate these risks, facilities should incorporate external peer review as an integral part of their overall risk management strategies.
Bibliography


About AllMed Healthcare Management

AllMed provides external peer review solutions to leading hospital groups and ASCs, nationwide. AllMed offers MedEval® and MedScore®, which help facilities improve physician performance through both periodic and ongoing case reviews at the individual or departmental levels. Services are deployed through PeerPoint®, AllMed’s state-of-the-art medical review portal. For more information on how AllMed can help your organization improve the quality and integrity of healthcare, contact us today at info@allmedmd.com.

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