THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

We're back! You may have noticed we took a newsletter hiatus for the last year. The reason? We've been busy. In the last year, we have expanded The Sullivan Group staff by over 200%, established a client support division, and established several key strategic relationships with electronic medical record providers, discharge instruction vendors, insurance companies and one of the largest insurance brokers in the world. In addition, the number of TSG client hospitals has almost doubled over the last year, and we have now provided computer-based risk and safety courses to over 25,000 medical practitioners.

One year later, and our mission is unchanged. We must follow the lead of other error-prone industries in reducing errors and improving patient safety. We have now proven that implementing the cycle of risk and patient safety: standardized web-based education, intelligent medical record tools, and routine performance evaluation, improves patient safety and reduces risk, the "failure to diagnose," and the incidence of malpractice litigation. Our larger clients now recognize their total benefit of risk reductions in the tens of millions of dollars ■

In This Issue...

A Life Saved

TSG recently received an email "thanks" for our online courses. The physician wrote:

"Aside from earning CME and discounts on malpractice insurance, I learned a great deal from the courses. The two about pulmonary embolism were extremely

valuable. In fact, it was your course that helped me diagnose a PE in a young patient s/p shoulder surgery.

I was recently consulted on a patient in his 40s who underwent shoulder surgery and was complaining of SOB. His sats on room air were in the high 90s. But, I remembered your course telling me that I should not ignore otherwise unexplained abnormal vital signs: he was tachycardic despite looking very comfortable.
I checked for PE (afraid of telling the referring physician because I didn't want him to think I was crazy) and I found it on CT chest! It was your course that helped me think of PE. The referring MD was shocked.

Thanks again" ■

Our case reviews consistently demonstrate that unexplained pulse elevations, although often overlooked, suggest serious pathology. Typically the cases involved the failure to diagnose pulmonary embolism or sepsis.

Combine 1) computer-based courses on point; 2) an intelligent medical record that provides a warning or an alert when there is a temperature/pulse disparity; and 3) analysis with regular feedback of vital sign evaluation to reduce the medical errors related to vital signs in your department or hospital ■

TSG Now Supports Primary Stroke Center Certification

Stroke has become a high-risk clinical entity, and the number of lawsuits related to stroke has begun to increase dramatically. Ironically, it seems that half of the cases allege the failure to administer a thrombolytic agent; the other half allege inappropriate administration of a thrombolytic agent. You're damned if you do, damned if you don't.

The key in stroke is to be proactive, to take a position on the administration of lytic agents, and then to stick to your protocols. The pendulum is clearly swinging toward the administration of lytic agents in appropriate cases as the JCAHO, the American Stroke Association, the American Heart Association, the Brain Attack Coalition, and others line up in support of administration. On the other hand, the emergency medical associations do not recognize administration of lytic agents in stroke as a standard of care but support its use in appropriate cases. If you have a stroke program, it is

critical that you carefully follow established protocol. If you don't believe that lytic administration is appropriate, be certain that your hospital and medical staff stand with you. Don't go it alone. Public awareness is high, and plaintiff's attorneys received their education in lytics from failure-to-treat myocardial infarction cases and are circling the waters waiting for stroke cases. These are high-dollar cases. You don't want that risk or several years of aggravation in your career.

Primary stroke centers need a source of regular education to maintain certification. This subject area is right 'on mission' for TSG. Therefore we have created a stroke library to support hospitals that want, need, or require education for physicians and nurses involved in the management of stroke. JCAHO requires 16 hours of stroke-related education in order to recertify every two years. You can find that education in the TSG stroke library at www.thesullivangroup.com ■

Case Review: The Failure To Diagnose Sepsis

A 58-year-old male recently presented to a rural emergency department with three days of right flank pain. His initial blood pressure was 90/64, pulse 90, respiratory rate 16, and temperature 99.0 F. He had a history of hypertension and one episode of kidney stones 10 years prior to his visit. He had no history of fever, or other associated symptoms. No prior surgical history, no relevant family history.

On physical exam he had right flank tenderness. HEENT, lungs, heart, abdomen, extremities, and neurologic exams were normal.

The physician ordered an ECG, electrolytes, CBC, and a urinalysis. The ECG was completely normal. Electrolytes were all within normal limits. The CBC revealed a white blood cell count of 16,000 with 20% bands. The urinalysis showed a large number of white blood cells and a few red blood cells, and nitrite was positive.

The physician's initial impression was a recurrent renal stone with associated infection. There was no imaging service available at this rural facility. The physician treated the patient with two grams of IV Rocephin and a fluid bolus of one liter of normal saline. Repeat vital signs following treatment: blood pressure 118/72; pulse 90; respiratory rate 16; temperature 99 F.

The patient was discharged with suspected renal stone and a UTI. The patient deteriorated through the night and the family called EMS the next morning. On presentation the patient was in septic shock and needed high-dose vasopressor therapy. The patient died within 48 hours. The family has filed suit for a failure to diagnose sepsis and wrongful death ■

Case Discussion

The failure to diagnose sepsis is one of the highest risk areas in all of medicine, particularly geriatric and emergency medicine. There is now literature that has established evidence-based management of sepsis. The new guidelines result in a significant reduction in sepsis-related morbidity and mortality. This should be a key area of focus for physicians managing the elderly as well as all emergency practitioners. The evidence-based guidelines provide practitioners with tools for case management. They also provide a standard against which practice will be measured.

The key issue in this case is the presence of a urinary tract infection and the presenting blood pressure of 90/64 in a patient with a history of hypertension. This should have caused the emergency physician to seriously consider sepsis. The white blood cell count and left shift leave little doubt that the patient required aggressive management for sepsis. This will be a major obstacle in the defense of this case. The experts will line up to testify against this emergency physician on this issue.

In addition, ureterolithiasis with associated infection is an indication for admission. This patient should have been admitted for parenteral therapy irrespective of the failure to diagnose sepsis.

Failure to diagnose sepsis is a common allegation against emergency practitioners. The fact pattern in this case is common. An initial abnormal blood pressure responds to therapy and sepsis no longer remains in the differential diagnosis. If a patient presents with infection and low blood pressure, don't use a response to fluid therapy as a criteria for discharge ■

The EMRI (Emergency Medicine Risk Initiative) Audit Update

TSG created the first EMRI audit in 2001. Since then, our client physician groups and hospitals have provided us with tremendous feedback and constructive criticism. As of fall 2006,

we have gone live with our updated audit which is far more robust than our first effort. New features include:

- An executive summary.
- A complete ED nursing report.
- Benchmarking: multiple ED measures are compared to
  1) historical performance;
  2) a designated comparison group; and
  3) a national benchmark comprised of the entire TSG database.
- A vital sign table delineating the failure to evaluate abnormal and 'very abnormal' vital signs with a drill-down for each vital sign.
- Appropriate administration of pain medication.
- Compliance with time to administration of pain medication in 60 minutes.
- Compliance with ECG at 10 and 20 minutes from arrival.
- Shift comparisons.
- The ability to download reports in a presentation-quality format (PDF).

Case review over the last two years indicates that malpractice cases have started to move from the ED into the waiting room. With increased ED volumes and ED holds becoming a national problem, the waiting room is a disaster waiting to happen. Patient injury in the waiting room has made major headlines and has increased exposure to liability for hospitals and physician groups. Throughput is key.

Therefore, we have created a freestanding throughput evaluation tool. The tool analyzes every time frame from arrival to discharge and in each part of the ED including the main room, fast track, and pediatrics.

For more information call 630-268-1188 ■

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