



SAVING LIVES - REDUCING RISK

## From The Editor

Welcome to the Winter TSG Newsletter. I think you will enjoy this issue describing the 'top ten' areas of vulnerability in emergency practice and how to avoid them. We often present cases with an accompanying analysis or 'cognitive autopsy.' However, sometimes it is useful to take a look at a large number of cases from 20,000 feet and identify the common elements.



We present those common elements in this newsletter.

In 2005 TSG published a study of documentation and clinical practice patterns

based on an analysis of 170,000 high-risk medical records<sup>1</sup>. We used that and other information to

prepare this newsletter, and plan on presenting the results of that study in

subsequent newsletters. The study demonstrates a fascinating national profile of clinical practice and documentation issues in emergency medicine.

## Welcome New Hires

Please join me in welcoming two recent arrivals at TSG. Debbie McRoberts is a seasoned emergency nurse with operational, management, and educational experience. Debbie will serve as Audit Executive, responsible for the EMRI audit process for all clients, including ongoing education and support. Chris Ferron is a veteran physician assistant with extensive experience in ED practice and information systems. Chris will serve as a Clinical Risk Executive with specific responsibilities in client support. Both Chris and Debbie share our mission and core values and will be invaluable assets to the TSG team. Welcome Debbie and Chris ■

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## New TSG Courses

TSG strives to provide you with the most pertinent course topics related to your practice. New additions to the TSG Library accredited for both CME and CE are:

- 1) **Community-Acquired Methicillin-Resistant Staph Infections (CA-MRSA): Medical Error and Risk Reduction.** CA-MRSA is an emerging phenomenon in the medical-legal risk area. Emergency physicians and primary care practitioners are seeing a huge increase in the numbers of CA-MRSA. This course presents recent literature updates on CA-MRSA, and shares a discussion with an infectious disease specialist on the topic.
- 2) **Neonatal Emergencies: Medical Error and Risk Reduction.** The neonate often presents a significant diagnostic challenge. TSG believes that this patient group deserves special attention in the risk and safety curriculum. There is probably no medical condition more frightening to a physician than a neonate in distress or exhibiting an acute problem.
- 3) **Pediatric Abdominal Emergencies: Medical Error and Risk Reduction.** The pediatric emergency patient is a high-risk patient group and often presents a significant diagnostic challenge, particularly those children who are too young to communicate. The author, a pediatric emergency specialist, will share insights in assessment, diagnostics, and treatment of this challenging age group ■

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## Top Ten Areas Of Vulnerability In Emergency Medicine Practice

As with any specialty, the practice of emergency medicine has its own unique processes which are followed during the course of patient care. Each of these processes can be thwarted by



barriers that increase risk and threaten patient safety. From the physi-

cian standpoint, these barriers are known as "vulnerabilities" – potential medical-legal land mines which may be encountered in the practice of emergency medicine. Below is a list of the ten most common vulnerabilities found in claims of medical negligence involving the ED. Every emergency practitioner should be familiar with the items in this list. The importance of documentation can be summed up in this one quote: "Use the history, risk factors, exam, test results and ED





course to shape your differential diagnosis and medical reasoning into a compelling story so logical that any reasonable physician and every juror can only come to one conclusion – yours.”

## Knowledge Deficit

Consider two types of knowledge deficit.

**Type 1:** You never learned about it in the first place. It’s not in data storage.

**If you aren’t aware of it, you won’t diagnose it!**

Despite extensive education, training, and experience, the emergency practitioner will

## TSG And EPOWERdoc Announce The Development Of

## TSG PowerDoc™, an ED Risk And Documentation System

EPOWERdoc, the innovation leader in template development for ED documentation, has teamed up with TSG to create a documentation tool that is the cornerstone of a complete Risk, Safety and Quality program – the **TSG PowerDoc**.

If your electronic medical record has not yet materialized, consider this alternative, which will give you so much more than just documentation. The **TSG PowerDoc** program includes:

- Access to the TSG web based training modules
- An intelligent medical record template system, designed to interact and guide the prac-

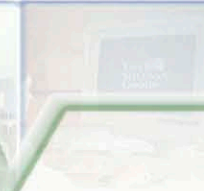
itioner through the clinical encounter, reduce medical errors, and meet quality initiatives

- Chart addendums and searchable RSQ Database to provide real time risk management and clinical decision support at the bedside
- A web based performance evaluation measuring compliance with critical risk, safety, and quality data elements, and highlighting specific areas for improvement

This hybrid between an electronic medical record and the traditional paper template provides several critical benefits including:

- A systems approach to patient safety and risk reduction
- Real time clinical decision support
- Prompted risk, safety, and quality data elements
- Optimized documentation for coding and billing
- Medical error reduction
- Improved patient safety
- Improved compliance with core measures
- Actionable performance feedback to the clinician, department, hospital, and system

We believe that there is a strong need for this sort of easily accessible Risk Management system in many EDs, especially those that need the simplicity and low cost of a paper system, but want to advance toward an electronic solution. If you have any interest in the **TSG PowerDoc** system, please contact us at [info@thesullivangroup.com](mailto:info@thesullivangroup.com).



not have seen every variation of every condition. For example, a practitioner may simply not be aware that the initial presentation of thoracic aortic dissection (TAD) may be a visual deficit or other stroke symptom or even hematuria. Practitioners may not be aware that pregnancy and Turner's Syndrome are risk factors for TAD.

While it is not possible to conquer the entire body of available medical knowledge, from a standpoint of risk and patient safety, it is important for emergency practitioners to focus on learning as much as possible about the high-risk ED presentations. TSG believes in a career-long commitment to this focused learning process.

**Type 2:** You learned it. It's in hard storage somewhere, but there is no front-of-mind awareness.

This is a completely different cognitive issue. With Type 1, the information never hit your 'hard drive' (so to speak). With Type 2,

however, consider the thousands of things that you actually know (kind of) but don't have immediate cognitive access to, particularly in the middle of a busy shift with several ambulances bearing down on the ED. This is the concept of "front-of-mind awareness." The data is there, but is it available for immediate use during the clinical encounter? See if the following are front-of-mind for you:

- Name all the risk factors for pulmonary embolism.
- Which cranial nerve causes lateral deviation of the eye? How exactly do you test the 5<sup>th</sup> cranial nerve?
- Name all the critical neonatal infectious exposures.
- How do you verify adequate function of the extensor carpi radialis tendon?
- What is the significance of a Jone's fracture?
- What are the NEXUS criteria utilized in con-

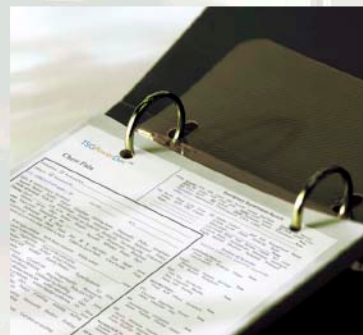
sideration of a neck radiograph?

You know these things (kind of); you are aware of the issues, but they are often not front-of-mind. You need the information right now and it's not there. Working without access to this critical information leads to key omissions and medical errors.

This is the human condition. This specialty and several others require immediate or urgent

access to a repository of information that is well beyond the human intellect (*you may be the exception!*).

So what? **That's what resource books are for!** Check your library. Your resource books are prehistoric or they may be current editions but 'out on permanent loan.' Or that one page you need has been ripped out. **Arrgghhhh!** Not to worry. Pull out the pocket computer. Push the on button. Forgot to charge it. **Arrgghhhh!**







TSG believes that the risk, safety, and quality information that practitioners require for timely 'at the bedside' decision making should be available within the four walls of the medical record. Whether you are working on paper template systems or electronic medical records, emergency medical practitioners should be working with intelligent medical records that support the human condition and augment front-of-mind awareness and real-time clinical decision support.

We face a historic moment. As we move toward the electronic health record, there is an opportunity to demand systems that augment the human intellect and assist in this front-of-mind awareness that is essential to

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## TSG Unveils New, Easy-Navigation Website

The Sullivan Group is excited to announce the release of our **newly updated and expanded website**. Thanks to the suggestions and feedback from our clients, we have implemented dynamic enhancements, including an easy-to-use graphic interface, intuitive navigation and clear, concise instructions on how to take advantage of TSG's many interactive risk resource utilities. Take a look through our free Risk Resources; you may be surprised at what you find.

We hope you enjoy the new site, and we welcome your feedback at [comments@www.thesullivangroup.com](mailto:comments@www.thesullivangroup.com)

high-quality, risk-managed medical care.

When should we apply the principles of risk management and patient safety? At the bedside in real time, not retrospectively in peer review or in the courtroom.

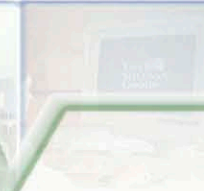
### Failure To Take An Adequate History

The allegation of this "failure" is frequently found in medical negligence suits and typically involves the

absence of one or more key elements of the history of present illness, risk factors, past medical history, family history, or personal/social history. The basic skill of history taking learned in medical school requires ongoing diligence and refinement in order to establish high-quality clinical practice and to produce chart documentation which reflects the outstanding care that you deliver.

These 'historical omissions' may represent a practice failure or simply a failure to document. This is a critical distinction. On the one hand, the practitioner never asked the question (practice failure). On the other, the practitioner asked the question, but did not document the response (documentation failure). Far and away, the practice failure is the more significant issue. However, in either case, the practitioner is at risk. Common areas of deficiency seen in malpractice lawsuits include:

- Failure to evaluate the timing of onset of symptoms



- Failure to evaluate the patient for radiation of pain
- Failure to determine whether the patient has risk factors for one of several high-risk conditions (e.g., subarachnoid hemorrhage, abdominal aortic aneurysm)
- Failure to adequately ascertain the condition of the patient at home prior to arrival
- Failure to utilize the history obtained by the nurse or EMTs

Any veteran practitioner will tell you that the key to success is good history taking. A good listener with outstanding history-taking technique is likely to avoid adverse outcomes and litigation.



Think back to the discussion regarding knowledge deficit. Consider that you may be presented with a multitude of clinical entities during a

single shift. In order to practice the highest quality care, the practitioner must recall **all** of the critical risk, safety, and quality historical factors for every clinical entity. One miss may result in a failure to diagnose and patient injury.

Is that level of recall possible? Clearly it is not. TSG data from medical records of over 170,000 high-risk patient presentations unequivocally demonstrates multiple deficiencies in eliciting critical historical information across a number of clinical entities. Medical records should be built with this history taking support system in mind.

### Failure To Perform An Adequate Physical Exam

This “failure” may not be one of the most common allegations in malpractice suits, but when the allegation is made and is true, the results can be disastrous. Once again, this “failure” may represent a failure to perform the exam or the failure to write it down.

The standard is to evaluate the relevant organ system(s). Writing it down is an important afterthought. If you diagnose appendicitis and send a patient to the OR, you met the standard of care regardless of what is documented in the record. But if you discharge the abdominal pain patient and that patient returns with a ruptured appendix, what you failed to document during that initial exam may turn into an ‘omission’ allegation against you. You may have performed an appropriate exam, but the failure to document the exam may force you to prove that you actually did it. You don’t want that burden whether in peer review, a state disciplinary proceeding, or a malpractice action.

Common physical examination-related allegations include:







- Failure to perform an adequate neurologic exam in a headache patient that develops a subarachnoid hemorrhage
- Failure to adequately examine the febrile child who ultimately develops meningitis or a serious bacterial infection
- Failure to repeat abnormal vital signs
- Failure to perform a testicular examination in young males with lower abdominal pain in failure to diagnose torsion cases
- Failure to evaluate the peripheral circulation in older patients with abdominal pain in failure to diagnose abdominal aortic aneurysm cases

### Failure To Consider Differential Diagnoses

This is so important in the medical cognitive process and it is an important area of EM vulnerability. All too often a practitioner becomes

anchored on one possible clinical entity and does not appropriately respond to additional data that suggests an alternate diagnosis. For example, in a recent case, a 42-year-old man came in with chest pain that radiated to his left arm with associated shortness of breath. The physician became anchored on the impression of coronary artery disease. The nurse elicited a history that this pain had moved from the chest down into the lower back. She communicated this information to the physician as she suspected a dissection of the aorta. The physician remained anchored on coronary artery disease and did not appropriately expand his differential diagnosis, to the patient's detriment. This differential diagnosis concept is absolutely a key element of high-quality medical care.



The key here is **not** making circles around 20 different

clinical entities on a differential diagnosis list. This may be counterproductive and potentially damaging. The key is making certain the documentation reflects

a consideration of a differential diagnosis. For example, in an older abdominal pain patient, you considered an abdominal aortic aneurysm (AAA)

in your differential. You determined that the patient did not have one. Six months later, the patient dies from a ruptured AAA.

Your chart reflects your consideration of AAA because it was in your differential. The medical record includes a negative risk history for AAA, no sudden onset of pain, no pulsatile abdominal mass, and normal femoral pulses and peripheral circulation. Upon questioning in any forum, the fact that you considered AAA in your differential is unassailable.



## Failure To Order / Interpret Diagnostic Studies

For the lay public and medical profession alike, there are expectations that certain diagnostic studies are required based on the presenting signs and symptoms. This “failure” is a common allegation when a patient experiences an adverse outcome and feels that blood work, x-rays, ECG, or other tests should have been done but were not, or that lab or test data was misinterpreted.

Examples include:

- Failure to perform an ECG to evaluate chest pain
- Failure to properly interpret an ECG (very common allegation)
- Failure to properly interpret the significance of a Troponin level elevated in the intermediate zone
- Failure to perform an LP for the patient with sudden severe headache and negative head CT
- Failure to perform a pregnancy test for women of child-bearing age with pelvic pain



## Failure To Diagnose

All national organizations monitoring malpractice in emergency medicine list “failure to diagnose” as the most common allegation of “failure” in this specialty. It is the final common pathway leading to claims of negligence in the emergency department and is usually accompanied by at least one of the other “failure” allegations. The emergency physician is expected to combine his knowledge with the patient’s history,

exam, and diagnostic testing to arrive at the correct diagnosis.

If you drill down into the “failure to diagnose” allegation, this failure is always the result of one of the prior ‘failures.’ For example:

- The failure to recognize that a chest pain patient had rotator cuff surgery two weeks prior (history taking failure) resulted in the failure to diagnose pulmonary embolism.
- The failure to recognize that a neonate had been exposed to herpes in the maternal birth canal (history taking failure) led to the failure to diagnose herpetic encephalitis.
- The failure to recognize a child’s skin rash (physical exam failure) led to a failure to diagnose meningococcal septicemia.
- The failure to recognize the significance of an intermediate Troponin result (failure to interpret lab) led to a failure to diagnose myocardial infarction.





## Failure To Treat

This “failure” is also reported as one of the most common failures in emergency medicine. This vulnerability goes hand in hand with failure to diagnose. It follows logically that if there was a failure to diagnose, there will also be a failure to treat the “missed diagnosis.”

However, there are cases in which the practitioner makes the correct diagnosis but fails to adequately manage or treat the patient’s condition. Examples include:

- Delay in management of coronary artery syndrome
- Failure to use heparin, aspirin, and beta blockers for acute coronary syndrome
- Failure to treat stroke with thrombolytics



- Failure to administer antibiotics for pneumonia, meningitis, or sepsis in a timely fashion

## Failure To Consult

This allegation is self-explanatory. This allegation is made when a physician would be reasonably expected to consult a specialist (e.g., early consultation for trauma patients, cardiology for acute myocardial infarction, orthopedics for open fractures, vascular surgery for an ischemic limb) and does not, and there is a bad patient outcome.

## Failure To Admit

A large number of malpractice claims in emergency medicine involve patients who were discharged home from the ED and ended up suffering a complication or worsening of their condition. This “failure” is usually coupled with the allegation of failure to diagnose. Every emergency practitio-

ner is thoroughly familiar with the critical disposition thought process. The emergency practitioner, often working without complete information, having no prior contact with the patient, feeling that the disposition is made based on a ‘sixth sense’ as opposed to black and white clinical information, carries the huge responsibility to make the **right** disposition. Admit or discharge?

Clearly this is a major vulnerability in emergency practice. However, much can be done to decrease the risk to the patient and the practitioner. This includes: rapid timed follow up; clear, well-written, instructions to return or call for a change in condition; a signed agreement between the practitioner and the patient that the instructions are understood and that compliance is critical for the patient’s return to good health; a telephone call-back system for high-risk patients; and an ED hotline for patients who need additional information.



## Failure To Communicate

Although this specific “failure” is rarely mentioned in a lawsuit, this vulnerability serves as the foundation or cause upon which other allegations are built. A drill-down on large numbers of EM malpractice cases clearly indicates that more careful communications can create opportunities to avoid failure to diagnose, medical errors, and patient injury.



<sup>i</sup> Hafner JW, Parrish SE, Hubler JR, Sullivan DJ/University of Illinois College of Medicine at Peoria, Peoria, IL; The Sullivan Group; Cook County Hospital/ Rush Medical College. *Quality in Emergency Department Care: Results of the Sullivan Group's Emergency Medicine Risk Initiative National Audit.*, Abstract # 211 in *Annals of Emergency Medicine*, Vol. 36 Issue 3; September 2005.

It should be a part of every practitioner’s routine to explain the “who, what, when, where, and why” of the patient workup. Strategies include listening to patients and their families, soliciting and listening to ED staff input, and delivering service to achieve best patient and family satisfaction. Striving to achieve optimal patient satisfaction by treating patients as if they were your own relatives and communicating clearly and often serves to increase patient safety and reduce risk.

## Summary

Emergency medicine is a high-risk specialty. Patient safety and medical error and risk reduction must be part of ongoing EM education and a catalyst for creation of tools that support the clinical experience, real time. Insurance companies look at risk management as a way to reduce costs **after** the incident has already occurred. Emergency practitioners should look at risk management as a way to avoid the event altogether. We must bring focus on the patient encounter, recognize the strengths and weaknesses of the human condition, and make a career-long commitment to patient safety and risk and medical error reduction ■



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## **Clinical Risk Executive (CRE) Position Available**

TSG is currently recruiting for a Nurse Practitioner and a Physician Assistant to fill new positions at the Oakbrook Terrace, IL office as Clinical Risk Executives. This is a great opportunity for experienced allied health practitioners (8 plus years) to bring risk management, patient safety, and quality improvement programs to hospitals all over the United States. There are no weekend shifts, nights, or holidays! TSG has grown rapidly over the last 18 months and there is a strong need for this critical role to support our client base. The CREs will be working directly with emergency medicine practices, insurers, and hospitals to implement the TSG cycle of risk and safety. There are many opportunities for growth and development in this organization. The CREs will need strong communication skills, be comfortable with live and web-based presentations, and have a better than average familiarity with the Microsoft Office suite of products. Knowledge of informatics would be particularly welcome as we develop cutting edge solutions in risk and safety in the electronic medical record marketplace.

