Healthcare
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Urgent Care: Five Essential Strategies to Minimize Common Risks

Located between primary care and emergency medicine on the healthcare spectrum, urgent care has become both a popular and profitable venture. A combination of walk-in appointments, extended hours, easily accessible locations and lower costs has enabled urgent care centers to outpace traditional emergency departments (EDs) in terms of growth and utilization. (See "Urgent Care: By the Numbers" on page 4.)

However, the nature and limitations of urgent care present certain liability exposures, which must be understood and addressed by leadership. This issue of *inBrief*® reviews the customary scope of urgent care services and offers risk management strategies designed to prevent or mitigate clinical lapses that may result in patient injury and consequent litigation.

Urgent Care Classifications

The National Urgent Care Center Accreditation program classifies urgent care centers into four distinct levels, ranging from what are essentially freestanding EDs staffed by board certified physicians (Level I), to clinics that offer a more limited range of services and are staffed by non-physician providers under remote supervision by a licensed MD (Level IV). While capabilities vary, most centers provide basic imaging services, such as X-rays and ultrasound, and many offer routine blood work, as well as drug screens and urinalysis; strep throat and STD cultures; and TB, flu and COVID testing. Other common services include employment physicals and workplace wellness education.

Treatable and Non-treatable Conditions

Urgent care is designed to meet the needs of adults and children who, while not experiencing a clinical emergency, cannot wait days or weeks for an appointment with a primary care provider. Urgent care clinics typically treat the following urgent-acute or sub-acute conditions, among others:

- **Minor illnesses,** e.g., coughs, influenza, seasonal allergies, dehydration.
- **Skin irritations,** e.g., insect bites, rashes, abrasions.
- **Superficial wounds and lacerations,** e.g., first-degree burns and minor cuts and injuries.
- **Non-life-threatening bacterial and viral infections,** e.g., bronchitis, strep throat, otitis media, urinary tract infections and sexually transmitted diseases.
- **Sudden exacerbation of chronic diseases,** e.g., asthma, COPD, diabetes.
- **Bone fractures** and muscle sprains and strains.
- **Workplace illnesses** and minor injuries.

Urgent care settings are *not* designed for long-term treatment of chronic illness(es), nor should they serve as the first encounter for life- or limb-threatening conditions, including the following:

- **Weakness in the extremities,** slurred speech and other stroke-like symptoms.
- **Chest pain** or other signs of a possible heart attack.
- **Sharp abdominal pain** or other signs of possible organ blockage, infection or rupture.

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Common Urgent Care Allegations

Failure to Diagnose

Failure to identify cancers, cardiovascular events, infections and other serious medical conditions may result in adverse patient outcomes, as well as more intense and costly treatment.

Key mitigating measures:

- **Complete a comprehensive history and physical,** focusing on family history.
- **Ask open-ended questions** and be attentive to the patient's subjective responses.
- **Document pertinent negatives** to rule out diagnostic possibilities, such as the absence of pain, fever or shortness of breath.

Delayed Diagnosis

Failure to recognize stroke, sepsis, pneumonia and other ailments in a timely manner may lead to worsening of symptoms, initiation of therapy when the condition is less treatable and, in some cases, death.

Key mitigating measures:

- **Conduct a wider range of tests** for patients with atypical symptoms.
- **Consult with specialists, when indicated,** to enhance the diagnostic process.
- **Promptly transfer patients to an emergency care setting** if their condition requires emergent care.

Misdiagnosis

Limitations in observation time and diagnostic tools may lead to misdiagnosis of symptoms, e.g., interpreting shortness of breath as a sign of pneumonia rather than pulmonary embolism (PE).

Key mitigating measures:

- **Document applicable screening scores**, such as a PERC or Wells score for a PE or deep vein thrombosis, to help rule out high-risk conditions.
- **Revisit vital signs** and document actions taken to address any abnormalities.
- **Reevaluate patients if symptoms do not abate quickly,** and transfer or refer them elsewhere if resources are limited.

Failure to Properly Treat

Neglecting to follow up swiftly and effectively after confirming a diagnosis may eventuate in a failure-to-treat claim.

Key mitigating measures:

- **Document referral to a specialist for new-onset or uncontrolled chronic conditions,** such as diabetes, asthma and COPD.
- **Provide written after-care instructions,** including a directive to return if symptoms worsen.
- **Be prepared to transfer patients** who require a higher level of care.

Scope of Practice Liability

New and expanded roles for nurse practitioners (NPs) and physician assistants (PAs) can lead to "practice creep" and claims of negligence for practicing beyond one's competency or designated statutory or regulatory limits.

Key mitigating measures:

- **Refrain from assigning patients to non-physicians** if they require intensive assessment, intervention and/or observation.
- **Maintain up-to-date credentialing files** of staff at every level.
- **Draft and adhere to detailed practice agreements for NPs and PAs,** outlining clinical functions and supervisory or collaborative arrangements with physicians.

Miscommunication

Communication lapses between providers, or between providers and their patients, may result in medication errors, clinical oversights, delays in care and other adverse outcomes.

Key mitigating measures:

- **Eliminate verbal orders** and verify that all medications and dosages are accurate before administering them.
- **Communicate with patients** regarding diagnosis, treatment, referrals, and the risks of noncompliance.
- **Implement an urgent communication protocol** among providers for atypical or worsening symptoms.
- **Delineate roles and responsibilities** when transitioning care to other providers/facilities.

Failure to Interpret Tests

Failure to review duly ordered diagnostic or laboratory tests is a common contributing allegation.

Key mitigating measures:

- **Establish protocols for relaying test results to ordering providers,** including time frames and documentation requirements.
- **Promptly report abnormal results** to the ordering provider.
- **Report test results to the patient,** documenting the time and method of reporting.
- **Implement a quality improvement program** to enhance laboratory processes and minimize reporting errors.

Failure to Follow Up

Failure to follow up with patients post-discharge represents a missed opportunity to confirm the accuracy of a diagnosis, mitigate possible complications and improve patient outcomes.

Key mitigating measures:

- **Develop a callback protocol whereby most patients are contacted one to two days post-visit,** and patients at greater risk of complications are contacted sooner.
- **Assign callback duties to a medical professional** who is fully conversant with potential complications and has been trained to identify patients in need of further assessment/treatment.
- **Document provider follow-up** in the patient healthcare information record.

Diagnostic Equipment Failure

Equipment malfunctions in urgent care clinics may result in misdiagnosis, as well as delayed diagnosis or treatment.

Key mitigating measures:

- **Document preventive maintenance, inspections and repairs** of all diagnostic equipment, retaining service reports.
- **Place stickers on equipment indicating when they have passed inspection** and testing, as well as the date of the next scheduled inspection.
- **Sequester equipment according to protocol** following a malfunction.
- **Ensure that equipment repairs are performed by a qualified professional** or third-party vendor pursuant to a written contract.

- **Gunshots** or knife wounds.
- **Pregnancy-related medical problems,** such as severe edema, elevated blood pressure or decreased fetal movement.
- **High fever** in an infant.
- **Back, neck and head injuries** with loss of consciousness.
- **Shortness of breath** or severe allergic reactions.

These scope of care limitations should be clearly communicated to current and prospective patients. Marketing campaigns and websites should not overstate service capabilities, e.g., "guaranteed better healthcare" or "as good as ED care." To prevent potential lawsuits, legal counsel should review all language.

Five Essential Strategies

1. Delineate Advanced Practice Provider (APP) Roles and Responsibilities Through Practice Agreements

More than half of all urgent care centers employ some combination of physician assistants (PAs) and nurse practitioners (NPs), with the percentage of PAs working in urgent care nearly doubling in the last 10 years, according to the *Journal of the American Academy of PAs*. In addition, given that some urgent care settings provide remote supervision only, APPs are less likely to have their patients seen by a physician over the course of a visit, as compared to their peers in EDs and office practice settings.

In view of these risk factors, APP roles, expectations and delegated authorities should be clearly delineated in formal practice agreements. When crafting such agreements, be aware that state regulations have been trending toward a more collaborative rather then supervisory relationship between APPs and MDs, especially with respect to the expanding role of PAs. Notwithstanding the trend, an urgent care center's agreement for services provided by NPs and PAs should never extend to services prohibited by applicable state laws and regulations. For a review of services typically included within collaborative practice agreements, see CNA *Vantage Point*® "Nonphysician Providers: A Guide to Safer Delegation," republished in 2019, and also the NCSL Scope of Practice Policy, posted on the website of the National Conference of State Legislatures.

Quick Links

- CNA *inBrief*® 2019-Issue 1, "Stopping the Line: Training Staff to 'Speak Up' for Safety."
- CNA *inBrief*® 2022-Issue 2, "Diagnostic Errors: Common Causes, Effective Countermeasures."
- CNA *Vantage Point*® 2022-Issue 1, "Scope of Practice Changes: Ten Keys to Safer Delegation."

2. Identify "At-risk" Encounters

Unexpected and adverse clinical events in urgent care settings are always a possibility. To minimize potential harm, providers should be alert for the following "at-risk" clinical encounters, which often require a higher level of triage and physician evaluation or consultation:

- Rare disorders or conditions of first presentation to the provider.
- Abnormal vital signs.
- Altered level of consciousness and/or slurred speech.
- Chest pain and shortness of breath.
- Extreme agitation.
- Uncontrolled bleeding.
- Weakness in the extremities or facial muscles.

Acute conditions require scrupulous documentation in the patient healthcare information record of the presenting complaint and symptoms, as well as supporting clinical data. In such cases, providers should avoid taking documentation shortcuts, such as relying upon auto-populated histories and physicals in the electronic healthcare record. In the event of litigation, the time spent documenting background history and the nuances of the clinical presentation can significantly strengthen legal defensibility.

In addition, the patient healthcare information record should clearly convey the provider's decision-making criteria, reflecting reasonable clinical judgment relative to the applicable standard of care. All consultations with supervising physicians and specialists should be comprehensively documented therein. Abiding by these caveats help to minimize liability exposures, especially regarding newer therapies and service offerings, including cosmetic/aesthetic procedures, disease management, remote consultations, and orthopedic-related steroid injections and regenerative treatments using platelet-rich plasma infusions.

3. Triage High-risk Complaints

High-risk patient encounters require immediate triage, guided by a written protocol, in order to ensure that patients who may require emergency care are swiftly assessed by licensed clinical staff. For high-volume centers, a rapid response team – including, at a minimum, a physician, nurse, and respiratory technician or therapist – may be deployed to assess patients at risk for respiratory failure, cardiac arrest or other life-threatening outcomes, thereby potentially precluding malpractice claims asserting failure to recognize, rescue and treat.

Patients who meet any of the following clinical criteria, among others, should be swiftly transferred to a local emergency department, in accordance with written protocols:

- Hemorrhage, seizure or chest pain.
- Systolic blood pressure <80 mm Hg.
- Heart rate of <40 or >140 beats per minute.
- Respiratory rate of <8 or >30 breaths per minute.
- Oxygen saturation of <88% for more than five minutes.

4. Heed Abnormal Vital Signs

Vital signs outside the normal range should be evaluated and explained in the patient healthcare information record. Repeat checks of abnormal signs are necessary in order to confirm that anomalous readings are outliers, rather than a sign of underlying disease.

Achieving consistently accurate, precise measurement of vital signs requires ongoing staff training and competency testing. Training sessions should emphasize the importance of documenting serial vital signs following any kind of abnormality, in order to rule in or out serious medical conditions.

5. Reexamine Certain Patients

By reexamining patients with more serious complaints, urgent care providers can evaluate their response to medications, IV infusions and other interventions, thus helping to determine whether they need additional treatment or referral. In the event of a subsequent lawsuit asserting failure to treat a worsening condition, clear documentation of reevaluation can help to enhance legal defensibility.

Urgent care is a fast growing area of healthcare, providing quick, lower cost treatment to tens of millions of consumers. However, the flexibility, efficiency and pace of urgent care – its major competitive advantages – also pose certain risks to both providers and facilities. By maintaining appropriate limits with respect to available services and scope of practice, triaging higher-risk patients, and implementing sound assessment and documentation protocols, organizational leadership can protect patients while minimizing liability exposure.

Urgent Care: By the Numbers

- The urgent care industry produces about $48 billion in annual revenue and experts expect nearly an 11 percent annual growth rate between 2023 and 2030.
- More than 11,000 urgent care centers are operating in the U.S., greater than twice the number of emergency departments.
- Approximately 89 million patient visits occur annually, accounting for more than 29 percent of all primary care visits and nearly 15 percent of all outpatient physician encounters.
- 70 percent of patients are seen within 20 minutes at urgent care centers, and 94 percent within 30 minutes.
- On average, urgent care services cost a fraction of hospital care, with centers charging $168 for the typical visit, versus $2,250 at hospital-based EDs.

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