



INSIDE

Geriatric patients present unique legal risks 68

Why healthcare leaders need to make equity a priority. 69

Which pediatric patients are at risk for severe COVID-19 disease? . . 71

Surge in cannabis-related visits is opportunity for prevention 72

Communication major factor in ED malpractice claims 73

A lack of proper handoff documentation hinders claim defense 74

Staffing with travel nurses can be risky. 76

Patients who present with syncope. 77

EPs named in aortic pathology suits. 78

Long waits for inpatient beds linked to higher risk of death 79



From Relias

ED Leaders Take Multiple Paths to Improve Geriatric Emergency Care

By Dorothy Brooks

It has been several years since the Geriatric Emergency Department (GED) Guidelines were published and then endorsed by the American College of Emergency Physicians (ACEP), the Emergency Nurses Association (ENA), and other groups.¹ But although it is well understood the U.S. population is rapidly aging, experts agree only a few EDs provide the kind of care the GED Guidelines recommend. Where’s the disconnect?

“Some of the things EDs need [to align with GED Guidelines] are help from a pharmacist, expanded physical therapy coverage and, most important, a social worker or some person who can help arrange extra care for some of these patients,” says **Richard Shih**, MD, professor of emergency medicine at Florida Atlantic University and a medical toxicologist. “These are great things to strive for, but there is no specific funding for them, and they require time, resources, and personnel.”

In his communications with geriatricians, Shih has observed many of these specialists incorrectly assume the kind of care described in the GED Guidelines is delivered in the ED because guidelines

generally drive what practices are appropriate and accepted.

To clear up this misconception, and to hopefully help EDs consider how to best move toward providing better care to older adults, Shih participated in a panel discussion at the American Academy of Emergency Medicine’s (AAEM) Scientific Assembly held last year. The panel, which included both emergency physicians and geriatricians, focused on how to best balance the aspirations of the GED Guidelines with what the panel members viewed as realistic expectations of what many EDs can reasonably hope to achieve.

More recently, in a summation of the discussion, Shih and colleagues highlighted three significant medical issues that frequently arise in the care of older adults: delirium, falls, and polypharmacy.² “If you don’t have the ability to meet the GED Guidelines, [consider] what ways you can practically address these three areas,” Shih says.

Regarding delirium, Shih and colleagues noted 10% of older adults who present to the ED experience this condition, but it is only recognized about one-third of the time. “It is hard to tell



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sometimes if [a patient has] dementia ... or delirium," Shih observes. "Delirium implies there is an acute medical process that is causing a patient's presentation, but many patients have background dementia that has been there or is gradually getting worse over a period."

The distinction is important because while dementia is not reversible, the acute medical process that may be causing delirium is important to identify and address. Further, if clinicians miss delirium, studies show patients experience worse outcomes over time, according to Shih. "What we are recommending is No. 1, pay attention to this issue," he explains. "No. 2, you can do a brief delirium screen, and if the patient is at high risk for having delirium as opposed to dementia, then start really assessing for that ... through blood testing."

Shih acknowledges delirium is a more complex diagnosis to pin down than a heart attack or stroke, particularly during a pandemic when access to knowledgeable family members or caretakers is limited. "This is difficult, and [delirium] does get missed sometimes," Shih says. "When it gets missed, the patients don't do as well."

Falls are a big problem for older adults. Data show that close to one-third of adults older than age 65 years who live in the community experience a fall each year. Further, older adults who present to the ED following a fall are at serious risk of experiencing functional decline and depression in the next six months.^{3,4}

While the GED Guidelines advocate for a comprehensive approach to evaluating and managing patients who have fallen, Shih notes many EDs lack the resources to comply with such recommendations. "For a busy ED that is taking care of

multiple patients, it is hard to do a full fall assessment and make a plan for the patient in the ED unless you have a dedicated person to do it," he says. In the absence of such resources, Shih and colleagues recommend emergency clinicians focus on educating patients and caregivers about the significance of the fall. For instance, patients who have fallen are at extremely high risk of experiencing another fall leading to a subsequent injury. Shih advises clinicians to urge patients who have experienced a fall to follow up with their primary care physician (PCP) to learn what steps they can take to reduce their risk of subsequent falls.

Emergency clinicians with more time or resources at their disposal also may be interested in taking advantage of Stopping Elderly Accidents, Deaths, and Injuries (STEADI), an initiative of the CDC that gives healthcare providers resources pertaining to screening, assessment, and interventions related to fall risk in older patients. At the very least, this program offers educational materials that can be passed on to patients and/or their caregivers.⁵

Regarding polypharmacy, older adults often take multiple medications, and this can lead to adverse events, but what can EDs reasonably do to address the problem? Shih says the American Geriatrics Society's Beers Criteria lists dozens of medications that can lead to adverse events in older adults, but it is difficult for emergency providers to stay on top of so many drugs.⁶ Consequently, Shih and colleagues suggested highlighting a much smaller list of medications that are particularly problematic. "Find five to 10 groups of medications that are especially high risk," he advises. For instance, the most common drug classes that

cause adverse effects in older patients who present to the ED include hematologic agents, hypoglycemics, cardiovascular medications, psychoactive medications, and antibiotics. However, Shih acknowledges it is unclear how to manage a patient who is on a potentially problematic drug or drug combination. “I believe that [issues related to polypharmacy are] best dealt with by the primary care physician, someone who is looking at everything,” Shih offers.

Nonetheless, that does not mean the ED physician cannot begin a dialogue about the issue with the patient. For example, in the case of a patient who is on two sedation medications, Shih will tell the patient he is worried he or she could become too sedated, leading to a potential fall. But Shih also will advise the patient to discuss the issue with his or her PCP. “You have to be very tactful and respectful to the PCPs and all the other physicians involved,” he explains. “If a physician makes a change without [the PCP’s] knowledge and without making sure they are both on the same page, people get frustrated.”

Shih notes there might be good reasons why a patient needs to be on a medication that is on the potentially problematic list. “The PCP probably knows the patient better than we do ... and a lot of patients have very complex medical problems,” he says.

Still, drug-related adverse events occur most commonly in older adults. Shih says the ED encounter is an opportunity to identify any medication concerns and to discuss these concerns with the patient.

To align their care of older adults with at least some of parts of the GED Guidelines, a growing number of departments are following ACEP’s Geriatric Emergency Department Accreditation (GEDA) program. Begun a little more than three years ago, the

program offers three different tiers of accreditation to suit the capabilities and resources of different EDs.⁷

The GEDA requirements closely align with the GED Guidelines, although EDs have options in determining which best practices they intend to implement. “You can start by taking the interventions that are attainable to you with your resources and your patients, beginning with level three, which is the lowest level. Then, work your way up to level two or level one,” explains **Kevin Biese, MD, FACEP**, chair of ACEP’s GEDA accreditation team. “Start with what you can do and build on that record of success.”

Even with the COVID-19 pandemic straining resources, the GEDA program has continued to grow. Currently, Biese notes there are 300 EDs that have achieved some level of GEDA accreditation, with 100 more in the process. “That’s 6% or 7% of [all U.S.] EDs. It’s not enough, but we are making progress,” Biese says.

Biese concurs the GED Guidelines are aspirational at this point, but he likens the move toward improvements in geriatric care in the ED to the push that took place some years ago to improve pediatric emergency care. In an earlier era, many hospitals balked at the idea they were supposed to handle many extra tasks for kids. “But some hospitals really rose to that challenge and made themselves full-fledged pediatric EDs and centers of excellence in that area,” Biese observes. “All hospitals and all EDs over time incorporated some of those best practices and made care better for all of those patients.”

Biese agrees falls, delirium, and polypharmacy are important areas of focus for EDs that want to improve their care of older adults. He views the AAEM panel’s recommendations

as practical and applicable. Other areas EDs commonly choose to focus on within the GEDA accreditation process include the identification of elder mistreatment and the appropriate use of urinary catheters.

Although lack of funding is cited as one reason why the GED Guidelines are difficult to meet, Biese notes there is funding available to EDs that choose to make improved geriatric care a priority. “Align with your [accountable care organization], Medicare Advantage, or risk-based contracting. [Recognize] that you can improve quality and decrease costs,” he says. “That can help with the resources to make [improved geriatric care] a reality.”

Biese also points to a program underway at Dartmouth-Hitchcock Medical Center in Lebanon, NH, where staff are using telemedicine to connect some of its in-house geriatric expertise with critical access hospitals in surrounding rural areas. The goal is for EDs to improve the emergency care they are providing to older adults while also meeting the requirements for GEDA accreditation.

The push to improve the emergency care of older adults is gaining momentum. “Everyone knows it is the right thing to do,” Biese says. “The challenge is just how do we work together to get it done.” ■

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The Unique Legal Risks of Treating Geriatric Patients

By Stacey Kusterbeck

If the end of an ED patient's life is in view, some EPs might see it as futile to expend a lot of time and energy to prolong that life, according to **John C. West, JD, MHA, DFASHRM, CPHRM.**

"There can be an inherent bias against older adults. ED physicians may 'write them off' and not take them seriously because they are old," says West, principal at West Consulting Services, a Signal Mountain, TN-based risk management and patient safety consulting firm.

Geriatric patients are subject to "vulnerable adult" laws that vary by state. "ED physicians absolutely have an obligation to report elder abuse if they become aware of it," West says. "There is little downside risk to reporting abuse. The reporter gets qualified immunity if the report is made in good faith."

Older adults undergo more diagnostic tests, stay longer in the ED, and are more likely to be admitted to the hospital vs. younger patients, says **Marie Boltz, PhD, GNP-BC, FGSA, FAAN,** professor at the Penn State Ross and Carol Nese College of Nursing.

"ED providers are challenged to do a comprehensive evaluation to detect critical health issues hidden

within a complex clinical and social presentation," Boltz says.

Older adults may present to the ED with vague complaints that in fact indicate serious disease. One 88-year-old woman reported mild lower abdominal pain that she described as "not too bad." The patient's daughter was worried because the pain had persisted for three days. The patient's vital signs were normal, with slight hypothermia and no leukocytosis.

Upon exam, there was mild tenderness in the right lower quadrant, no rebound tenderness, and no guarding. The eventual diagnosis was appendicitis with an atypical presentation. "Younger patients typically have fever, leukocytosis, nausea, vomiting, pain localized to the right lower quadrant, with guarding and rebound tenderness," Boltz notes.

When compared to younger persons, older adults are more likely to experience missed or incorrect diagnoses and inadequate pain management.^{1,2} "Older adults who are discharged from the ED are more likely to be readmitted. They also risk functional loss and higher rates of mortality," Boltz says.

Whenever possible, and with the permission of the older adult, the ED nurse should include the patient's

significant other, family, or support person in the assessment process. That person might convey something that changes the diagnostic picture (e.g., the patient fell recently, or the patient recently exhibited an abrupt change in mental status). "Risk assessment is necessary to prevent avoidable functional decline, falls, medication errors, and delirium," Boltz says.

In Boltz's experience, two tools are particularly helpful: The Identification of Seniors at Risk instrument and the Triage Risk Screening Tool. These evaluate the presence or absence of risk factors for adverse outcomes.

"These tools are useful in guiding a plan to prevent avoidable complications during the ED stay, if admitted during hospitalization, and after an ED visit when discharged," Boltz says.

For ED nurses, Boltz says the main challenge is to identify high-risk patients more likely to benefit from a comprehensive geriatric evaluation and follow-up, a longer observation time (or access to observation units), and appropriate referrals (primary physician, geriatric evaluation and management unit, and/or social service).

Prevent delirium by controlling noise and avoiding bright lights.

“Cohort older adults, when possible, after triage, in a space away from trauma or high-traffic areas,” Boltz says.

To assess for fall risk, nurses can use a tool such as the Timed Up and Go test. “Pay attention to toileting,” Boltz says. “For the person who is at risk for injury caused by cognitive impairment, weakness, and low

mobility, provide low beds with bedside mats.” Finally, nurses should conduct a thorough medication reconciliation to look for polypharmacy and inappropriate medications. For instance, commonly used over-the-counter medications contain diphenhydramine. “In older adults, it often causes confusion, dizziness, falls, and urinary retention,” Boltz cautions. ■

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As Call to Address Disparities Grows Louder, Prescriptions for Improvement Emerge

By Dorothy Brooks

Frontline providers are well aware disparities exist. Many are confronted with the consequences daily, as patients from disadvantaged communities present with problems that might have been prevented with earlier or better-quality care. However, recently suggested because of the hectic pace of busy EDs, emergency providers may be susceptible to letting bias seep into their decision-making. Thus, researchers contended it is important for emergency clinicians to be aware of potential biases and how they contribute to inequities.¹

Confronting racism and bias is difficult, but prescriptions for improvement are beginning to emerge. For example, the American Medical Association (AMA) unveiled a toolkit designed to help organizations start toward meaningful improvements. It is an outline of actions investigators with experience in this area deem critical to embedding racial and health equity into an organization’s DNA.² However, **Denard Cummings**, MPA, one of the authors and the AMA’s director of Equitable Health System Integration, says this pathway is only appropriate for organizations that are motivated to advance racial equity. “It

is not for those who aren’t sure,” he says. “It is for the early adopters who are ready to take steps and just don’t know where to start.”

The first step, “Commit as a Health System to Do the Work,” requires organizations to figure out where they stand with respect to racial justice and equity. That means asking many questions, both formally and informally. Be forewarned that discussing issues around racism, justice, and health equity likely will make some people uncomfortable.

From there, identify champions to lead the improvement effort. “By creating an infrastructure and allocating financial resources to this type of an initiative, the organization is far better positioned to create long-term and radical change,” Cummings says. “Advancing racial justice and health equity requires leadership. It also requires the courage to approach this work with genuine respect to facilitate and create safe spaces for difficult conversations ... and to commit to meaningful action.”

In the second step, “Start Shifting Organizational Norms and Practices by Learning About What You Don’t Know,” the authors instruct organizations to develop a shared

understanding of racism in medicine. For instance, the toolkit authors highlighted four types of racism that occur in this arena: structural, institutional, interpersonal, and internalized. This step can be carried out through both individual and group learning.

“Organizations can learn from the experiences of others by talking with other leaders and colleagues about the benefits and challenges of beginning this work, and by reading about the experiences of other health systems in advancing health equity and racial justice,” Cummings says.

Eventually, it is important to pursue opportunities to engage with and support patients, community members, and local leaders, especially those from historically marginalized communities. The toolkit includes questions clinicians might ask patients in the exam room (e.g., whether a patient has lost trust in the health system).

Step three, “Get a Handle on Your Data,” concerns the importance of routinely capturing patient and department-level demographic data, such as race, ethnicity, and primary language. The toolkit authors suggest organizations may want to leverage

other data, such as sexual orientation and gender identity, to learn about other negative patterns. Organizations also could learn about food insecurity and housing instability, two issues that often fuel health disparities.

Originally developed at Brigham and Women's Hospital in Boston, the AMA toolkit includes four data categories organizations can use to assess equity and prioritize action: access, transitions, quality of care, and socioeconomic/environmental impact.³ "You focus on these four points that are already being evaluated by a health system, and you begin to embed equities into those areas," Cummings says.

After collecting data, organizations move to step four, "Develop a Shared, Clear, Compelling Vision and Goals for the Entire System." Here, organizations should develop a project charter, a document that spells out specific, measurable goals.

"It [identifies] the population that you want to serve, the tools you are going to use, [and] it establishes the way the different players within the project will agree to interact within the scope of the project," Cummings says.

With a detailed charter in place, the toolkit directs organizations to move to step five, "Launch Targeted Improvement Efforts Across the System." One example is the Accountability for Cancer Care through Undoing Racism and Equity (ACCURE) trial.⁴

In that project, researchers sought to eliminate disparities in care between Black and white patients with early-stage breast and lung cancers by addressing barriers that prevented some from completing radiation treatment. To do this, they deployed four interventions: an automatic alert in the electronic medical record to flag any missed appointments or

anticipated milestones that were not reached, a nurse navigator who was trained in race-related barriers to help patients surmount barriers flagged by the automatic alerts, a physician champion charged with providing clinicians with equity-related feedback on treatment completion, and regular equity-related training for all staff.

Before these interventions, the five-year survival rate for Black patients with early-stage breast cancer (89%) lagged behind that of white cancer patients (91%). The gap was similar with surviving lung cancer. After intervention implementation, the survival rate for both groups with early-stage breast and lung cancers improved.

ED leaders might use different metrics in their equity work. For example, if racial disparities are observed in the leave-without-being-seen rate or stroke care, EDs can develop interventions to address those gaps. However, Cummings emphasizes the goal of the AMA toolkit is to help organizations ensure their overall patient populations experience the best outcomes.

"The [ACCURE] trial demonstrates that health equity interventions do not only impact the patients from marginalized populations," Cummings stresses.

The AMA toolkit is just one of several resources health systems can leverage. For example, in May 2021, the AMA unveiled its overall strategic plan for embedding racial justice and enhancing health equity.⁵ Later this year, the AMA plans to roll out national health equity grand rounds, a lecture series that will feature thought leaders in the equity arena. Cummings notes this series will be followed by workshops designed to help leaders learn how to operationalize equity into their organizations.

In November 2021, The Joint Commission (TJC) issued a *Sentinel*

Event Alert, calling for accredited healthcare organizations to address disparities, indicating such action is "a moral and ethical duty."⁶

The alert noted the COVID-19 pandemic has exacerbated disparity gaps, citing data showing Black and Hispanic patients with the virus have experienced nearly three times the hospitalization rate as white patients.⁷ When combined, these two minority groups experienced more than half the deaths from COVID-19, even though they make up only one-third of the U.S. population.⁸ The alert also cited multiple other stark disparities in care related to gender, culture, religion, and disabilities.

Considering many of these disparities have been recognized for years, why are healthcare organizations only now making a big push to address equity? "There has previously been no accountability by healthcare leaders to address equity and inclusion. Leadership [teams] have not viewed equity and inclusion as a quality [or] patient safety concern," observes **Ana Pujols McKee**, MD, executive vice president; chief medical officer; and chief diversity, equity, and inclusion officer at TJC. "Healthcare leaders have been allowed to not address how racism and bias negatively impact under-represented groups."

TJC's alert made several suggestions about how organizations should address equity, many of which echo the steps contained in the AMA's toolkit. McKee says TJC intends to put more teeth behind equity improvements soon.

"The Joint Commission's teams are currently working to have requirements reviewed by the field, which is part of our current process, in anticipation that these requirements will be ready for release to our accredited healthcare organizations in 2023," she explains.

One tip for administrators is to address diversity opportunities within the leadership ranks. “When those who make decisions understand the needs of under-represented groups served in the community, it is more likely that attention to these concerns will occur,” McKee says. “Each organization must determine its best approach to improve diversity. This opportunity also applies to the governing body.”

Although discussions about racism and diversity may make some uncomfortable, it is important leaders ensure workers and patients fully understand what promoting equity really means.

“Some people wrongfully believe that promoting equity will result in them receiving less access to healthcare,” McKee says. “Rather, equity is inclusive, which means

all people will receive appropriate healthcare at the right time and not at the expense of any other group. Equity is inclusive, not exclusive; it is not just for under-represented people but for all people.” ■

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Why Some Children Develop Severe COVID-19 Disease

By Dorothy Brooks

Researchers have identified risk factors associated with more severe outcomes in children with COVID-19. To cull this information, researchers followed more than 10,300 children who presented to 41 EDs in 10 countries. Among the more than 3,222 children who tested positive for COVID-19, 107 developed severe outcomes within two weeks of their ED visit. A total of 735 patients were hospitalized.

Severe outcomes included cardiovascular complications (e.g., myocarditis), neurologic complications, respiratory problems, and infectious-related issues. Four patients died.

Most COVID-positive children who were discharged from the ED

were low risk for developing severe disease. However, those with pre-existing chronic disease, older age, and longer symptom duration put them at serious risk for severe outcomes. Reassuringly, most children who were considered healthy at their ED visit rarely declined significantly following this encounter.

Further, while asthma has been discussed as a potential risk factor for severe disease in COVID-19 patients, these researchers did not find such an association. Similarly, the authors reported young infants were not found to be at higher risk for severe outcomes. (*Editor's Note: For more data and information about methodology, please visit this link online: <https://bit.ly/3wAWCm6>*)

Clinicians should consider the fact these data were collected and analyzed before the omicron variant swept the United States, according to co-author **Stephen Freedman**, MDCM, MSc, a professor of pediatrics and emergency medicine in at Alberta Children's Hospital Research Institute in Canada.

“When faced with a child who might have one of the higher-risk features, if they are deemed well enough to be discharged, close follow-up is likely all that is required. We found that such children have a very low likelihood of deterioration and severe outcomes,” Freedman says. “On the other hand, if a child with a high-risk feature for a severe outcome requires hospitalization,

then consideration should be given to ensuring that the admitting facility has the resources and skill set necessary to provide care to a child with COVID-19 who develops severe disease.”

Freedman adds that as therapeutic options become available for children

older than age 12 years, frontline providers should consider treating such children if they meet eligibility criteria.

More broadly, Freedman advises clinicians to integrate these new findings into their overall assessments of children who present with

COVID-19, and to stay attuned to the evolving evidence base. “We plan to explore whether similar risk factors occur in children infected by the omicron variant, and to look more specifically at the risks associated with individual underlying medical conditions,” he says. ■

Cannabis-Related Visits Surge, Especially Among Children and Older Adults

By Stacey Kusterbeck

Cannabis-associated ED visits increased significantly, and specific subgroups of patients are at higher risk.¹ “We saw a gap in the literature on how often Americans were reporting to EDs for cannabis-associated reasons using recent data. With the constantly evolving cannabis landscape, such information is critical from a public health perspective,” says **Doug Roehler**, PhD, MPH, an epidemiologist at the CDC’s National Center for Injury Prevention and Control.

Roehler and colleagues studied trends in cannabis-associated visits from 2006-2018, using data from the Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project’s Nationwide Emergency Department Sample. From 2006 to 2014, cannabis-associated ED visits increased, on average, by 12.1% annually. The rate increased 17.3% from 2016 to 2017, and increased 11.1% from 2017 to 2018. Notably, patients age 0-14 years recorded some of the largest increases in cannabis-associated visits from 2017 to 2018.

In another study, researchers found a higher number of cannabis-involved ED visits for children age 0-11 years during 2020 and 2021.² “We suspect that the youth cases may be due to

increases in unintentional ingestions of edibles that were not safely stored,” Roehler offers.

Older adults (age 65 years and older) also stood out. For this group, researchers suspect lack of education in how to safely consume cannabis is the cause of the surge in ED visits. “Legally available product can have extremely high THC concentrations, and older Americans are increasingly turning to cannabis to treat ailments,” Roehler explains.

When a patient presents to the ED with a cannabis-associated visit, especially if the patient is a child, it is a “golden opportunity,” Roehler says. Providers can discuss safe storage practices with the parent or guardian, including where they can purchase lock boxes.

If an older patient presents with a cannabis-associated complaint, clinicians could offer referrals to trained providers to prevent future visits. “Most physicians have not received training on safe cannabis use while in medical school, given how new this policy shift is,” Roehler notes. “In states where nonmedical adult use of cannabis is legal, it is important for clinicians to be trained in cannabis safety practices and treatment.”

Legalization of cannabis has led to more ED visits for cannabis ingestions

in adults and children, reports **Jason Chu**, MD, an associate professor of emergency medicine at Columbia University Medical Center. Chu has seen some patients who were unfamiliar with the delay of symptom onset with oral cannabis products, consumed too much, and presented to the ED with severe symptoms.

In Chu’s experience, when adults and adolescents come to the ED, they usually present with severe symptoms of anxiety, panic, paranoia, hallucinations, confusion, or sedation. Young children often present with nonspecific symptoms, including drowsiness, ataxia, lethargy, or stupor.³

In those cases, EPs often are unaware of the cannabis ingestion. Encephalopathy, sepsis, meningitis, and seizures are all part of the differential diagnoses. “Without a history of ingestion, children with CNS depression from cannabis product ingestion can be difficult to diagnose,” Chu says.

In addition to asthma exacerbation and pneumothorax, patients who use cannabis vape products can experience an acute respiratory failure syndrome known as EVALI (e-cigarette or vaping product use-associated lung injury). Patients report flu-like symptoms of fatigue, fevers, cough, shortness of breath, chest pain, nausea, vomiting, and

abdominal cramps.⁴ “They will often be tachypneic, tachycardic, and hypoxic,” Chu notes. ■

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Many ED Malpractice Claims Are Rooted in Poor Communication

By Stacey Kusterbeck

Most ED patients are, at some point, handed off to other providers — admitting physicians, the ICU team, on-call consultants, or primary care physicians. Good communication is crucial in the ED, “more so than in most settings,” according to **Chris Landrigan**, MD, MPH, chief of general pediatrics at Boston Children’s Hospital. “The ED doctor takes an initial sense of what’s going on and, in every case, has to convey that to someone else. It’s just so core to what they do that thinking about miscommunication for ED docs is particularly important.”

Landrigan and colleagues set out to learn the proportion of malpractice claims that involved a communication failure and the nature of those claims.¹ “We wanted to better understand how frequently, and in what way, communication impacts medical malpractice,” says **Kate E. Humphrey**, MD, MPH, CPPS, a pediatric hospitalist at Boston Children’s Hospital and associate medical director of patient safety and quality.

Researchers analyzed 498 malpractice claims that were filed from 2001-2011 in the CRICO Strategies Comparative Benchmarking System. They searched for claims

that involved a communication failure and failure type. About 10% of the claims involved the ED. “We knew that in studies looking at adverse events in hospitals in general, miscommunications are responsible for something like 50% to 80% of the most serious medical errors that happen in hospitals,” Landrigan says. “Typically, cases are multifactorial. But communication is this thing that kind of goes awry in almost all serious cases reported.”

However, in the malpractice literature, it was unclear what role communication was playing because claims usually are analyzed based on setting and clinical subtype of errors, rather than root causes. “We wanted to see if in the malpractice world, the same things held true that we were seeing in the patient safety world generally,” Landrigan explains.

Miscommunication was responsible for 49% of malpractice cases. “This is largely in line with the broader literature in patient safety, but it hadn’t emerged from the malpractice literature. It was great to harmonize that, and to harmonize ways of looking at malpractice,” Landrigan says.

Contingency plans, diagnosis, and illness severity were the information

types miscommunicated most often. If there was a communication error, researchers examined who it involved. In ED claims, “a lot of times, the communication error was between the providers and the families, as opposed to the medical team itself,” says **Melissa Sundberg**, MD, MPH, another study author and a pediatric emergency physician (EP) at Boston Children’s Hospital.

Of claims with communication failures, failed handoffs were involved 40% of the time. For ED claims with handoff errors, the problem was providers did not know the next step if the patient’s condition declined. “Contingency plans are not always communicated well,” Sundberg notes.

As a hospitalist, Landrigan has observed poor communication when ED patients are handed off. In some cases, the EP obtained a neurology consult for a patient with a ventricular peritoneal shunt. The neurologist indicated it probably was OK for the patient to go to general service because the problem did not seem like a shunt failure. Those cases did not always go as expected. “If things start to deteriorate, you need to get neurosurgery involved very quickly,” Landrigan says.

It is critical the team on the floor is attuned to the EP's thought process on what to do if things do not go as planned. "In digging through the claims on the types of communication failures that contributed to malpractice claims most often, it was exactly that type of thing," Landrigan observes.

In some cases, providers were quite worried about a patient, but that did not come across to whoever treated the patient next. "In those cases, there may be a delay in escalating care or taking action because the team up on the floor or ICU is not adequately keyed up on just how sick this patient is and what our worries are," Landrigan says.

Securing buy-in from hospital administrators to make investments to improve patient safety, including handoff communication in the ED, can be challenging. Compelling anecdotes about cases when things went terribly wrong can grab leaders' attention. "But you also need hard data to make a financial business case," Humphrey argues. "Having numbers behind us to show the financial burden of medical malpractice can help us speak to different leaders in the organization to further that work."

Malpractice claims that included communication failures were less likely to be dropped, denied, or

dismissed than claims that did not involve communication failures (54% vs. 67%) and were more expensive to defend. Mean total costs for cases involving communication failures were higher (\$237,000 vs. \$154,000).

Investigators studied how many malpractice claims could have been mitigated with a properly used handoff tool. "We found that a structured handoff tool can be very helpful to make sure the appropriate information is transferred," Humphrey reports.

In looking at the subgroup of handoff-related claims, researchers found 77% of those cases could have been averted if clinicians had used a handoff tool. "We found there is a lot of potential there," Landrigan says.

As co-founder of the I-PASS Patient Safety Institute, Landrigan's work has focused on how to hand off in an evidence-based way. One problem is handoffs have been handled inconsistently and haphazardly in EDs. "It was really idiosyncratic and based on individual physicians. A lot of times, handoffs weren't happening at all," Landrigan says.

During his own training, Landrigan often heard providers making comments such as, "You don't have to tell me anything. If something goes wrong, I'll figure it out."

"There is a growing recognition of the notion of the importance of making people attuned to the things you're worried about," Landrigan notes.

Although small communication problems arise all the time with ED handoffs, major adverse outcomes that result in litigation rarely happen. Thus, individual EPs do not take it as seriously as they should. "We need to shift that thinking," Landrigan asserts.

Many EPs view handoffs as a task they have to handle without the appropriate sense of urgency. "There's a failure to recognize that doing a handoff in those few minutes at the end of a shift is probably the most dangerous thing you're going to do all day," Landrigan says. "Getting it right is really critically important."

For EDs, the implementation of handoff tools can lower the likelihood of errors. "It's not a huge leap to say that if you are decreasing injurious errors, you are probably avoiding malpractice claims," Landrigan says. "Connecting the dots is not terribly difficult." ■

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Detailed Charting on Handoffs Stops Legal Finger-Pointing

By Stacey Kusterbeck

Handoffs are one of the "most dangerous procedures in emergency medicine because a majority of errors and sentinel events in patients in the ED are related to gaps in communication," according

to **Chadd K. Kraus, DO, DrPH, MPH, CPE, FACEP**, system director of emergency medicine research at Danville, PA-based Geisinger.

During ED handoffs, omissions of an abnormal vital sign or test result

can be dangerous. "These omissions could lead to diagnostic errors or delays in treatment of time-sensitive conditions," Kraus warns.

In Kraus' view, a standardized approach to handoffs is the best way

to minimize risk of patient harm. “Equally important is documenting the process in a clear way in the medical record,” Kraus adds.

The ED chart should include a concise summary of the clinical information that was conveyed (e.g., “Patient re-examined; labs, imaging, and vital signs reviewed.”). Include a plan for disposition and next steps in care (e.g., “Plan for evaluation by surgical team pending results of CT scan.”). Finally, the chart should include a clear transition of care (e.g., “Patient care transitioned from Dr. Smith to Dr. Lee for additional management.”). “This can help to minimize communication gaps and improve patient safety,” Kraus offers.

EPs make decisions based on limited information and under time pressure to diagnose a condition. “Malpractice claims in this arena boil down to communication, whether between ED providers or between ED providers and other specialists,” according to **Edna McLain**, JD, a partner at Chicago-based SmithAmundsen.

If a decision is made to admit, the ED provider may not have all the test results or even a definitive diagnosis. “Malpractice claims occur when the communication between providers is not clear as to what diagnoses have been ruled out and what diagnoses are still under consideration; what test results are pending and may still be needed; and when it is not clear which provider is responsible for the patient’s care, since the responsibility may be shared for a time,” McLain says.

As with any medical negligence case, documentation in the ED chart about handoffs is crucial. “In situations involving communication between providers, it behooves all providers to chart thoroughly as to when communication occurred, who was involved in the communication, what

was discussed, and, if possible, which provider is responsible for the patient’s care,” McLain says.

Michael M. Wilson, MD, JD, would like ED providers to bear in mind that every time a patient is handed off, there is a possibility of error leading to serious injury and a lawsuit. “The key to protecting yourself is to carefully document,” says Wilson, a Washington, DC-based healthcare attorney.

These high-risk handoff scenarios can trigger malpractice claims:

- **Oncoming EPs do not always receive critical information from outgoing providers.** In one malpractice case, an ED patient reported symptoms of syphilis. The patient stated he had recently donated blood, and was told he had tested positive for syphilis. After the first EP went off shift, the oncoming provider tested the patient for every STD except syphilis.

The patient was told the STD tests were negative, without anyone specifying syphilis was not part of the testing battery. “After several months without treatment, the syphilis advanced and caused severe neurological injury,” Wilson reports.

In this case, the deposition testimony from the two EPs could be in conflict. Presumably, the first EP would testify that he told the second EP about the previously positive serology test for syphilis. The second EP might counterargue that he was never informed about the positive serology test. This would make the case difficult to defend.

Clear documentation by the EPs would help the defense. Ideally, the first treating EP would have documented that the patient came in with a chief complaint of a positive serology test for syphilis from blood donation. Here, the chart should indicate follow-up care for suspected syphilis treatment is necessary. Then, if the second

EP failed to order appropriate follow-up syphilis testing, the fault would have been with the second EP.

- **EPs do not always communicate clearly with consultants.** In another malpractice case, a patient came to an ED with new onset of priapism, for which there is a time-sensitive treatment window to prevent permanent erectile dysfunction. There was not a urologist on staff; instead, the facility contacted an outside urologist. That urologist promised to come to the ED and provide treatment within the treatment window. “For whatever reason, the urologist failed to come and provide treatment. When later contacted, [the urologist] cited schedule conflicts and refused to come in,” Wilson explains.

At deposition, the EP testified the urologist had agreed to come to the hospital and render timely treatment. The urologist testified he never agreed to come and provide treatment; rather, the urologist argued he had stated he would try to reschedule patients and come if possible. “That kind of conflicting testimony may render the case indefensible at trial,” Wilson says.

Ideally, the EP would have sent a confirmatory email, fax, or text confirming the urologist promised to come and provide treatment for priapism within the window for effective treatment. “That could establish that the urologist, and not the ED physician, was at fault if the urologist fails to come and provide treatment within the time window,” Wilson offers.

- **Once ED providers hand off a behavioral health patient who is involuntarily admitted for psychiatric care, ED providers may believe they are no longer responsible for that patient.** “There is a significant risk that staff will be under the impression that by triggering the agency system to come to the hospital to evaluate the patient, the ED is done with the

case. That is absolutely not true,” says **Nathan A. Kottkamp**, JD, a partner at Richmond, VA-based Williams Mullen.

In Virginia, to involuntarily admit a patient, the hospital must activate a Community Services Board (CSB) system. The patient must remain in the ED while the CSB worker visits for an evaluation. “I’ve seen cases where the ED staff feel like their duties are done once they call the CSB,” Kottkamp reports. “The CSB is an adjunct to hospital care, but not a substitute for it.”

Under EMTALA, the hospital is obligated to medically screen the patient to determine if an emergency condition exists. If one is found to exist, the hospital must stabilize, admit, or arrange an appropriate transfer to a facility that can stabilize. Therefore, if the relevant agency has determined involuntary admission is appropriate, but finding an accepting facility takes hours, the documentation should reflect the fact hospital staff/the EP continued to monitor the patient’s condition during that period. The medical record should show ED staff

periodically checked on the patient and confirmed there were no significant changes to the patient’s condition. “ED staff should never simply defer to the agency to monitor the patient while an available bed is being located,” Kottkamp says.

In all handoff cases, Kottkamp says ED providers must be mindful of the distinction between “handing off” patients and “passing off” patients. “Shift change, for example, should inherently involve a discussion of current patients to prevent things falling through the cracks,” Kottkamp says. ■

Consider Risk Implications if Department Is Staffed with Travel Nurses

By Stacey Kusterbeck

Working dangerously short-staffed, many ED leaders are turning to travel nurses to solve the problem. “While it varies greatly across systems and geographies, we hear reports that fully half of the nurse staff are travel nurses in some EDs. We also hear that up to half of the open nursing positions are unfilled. I don’t think anybody has got a finger on just how acute the situation is,” observes **Alan Lembitz**, MD, chief medical officer at COPIC, a Denver-based medical professional liability insurance provider.

So far, there is no comparable shortage of EPs. “Physicians are paid more, are under contracts that are difficult to move from, and tend not to travel. But if that same thing that starts to happen where we start to have serious physician shortages in EDs, that would create additional challenges. I haven’t seen that,” Lembitz reports.

However, nursing shortages are acute, fueled in part by surging wages for travel ED nurses. “We are seeing

people who are happy in their roles in a certain system. But if they can travel a short distance and get paid twice as much, that can be a strong incentive,” Lembitz says.

Unfortunately, travel nurses will not know the nuances of the EDs in which they are working. This hinders teamwork and communication. “It is an enormous aspect, in terms of burnout and in terms of quality of care,” Lembitz says. “Working with people you know who can anticipate what you want is a big deal for reducing your stress level.”

Thus, staffing EDs with travel nurses carries some potential risk management implications. It might take travel nurses more time to access resources, manage medications, and set up procedures. “We don’t know how these issues will play out in subsequent liability claims, but reduced communication, teamwork, and the appearance of not knowing where things are can make fertile ground for plaintiff attorneys to assert claims of substandard care,” Lembitz says.

It is not negligent for hospitals to staff EDs with whatever resources are available. “But failure to do so, and reaching critically low staffing ratios, generates long wait times and reduced patient experiences,” Lembitz warns.

When EPs and ED nurses work together regularly, there is a lot of unspoken communication. “Working with travel ED nurses reinforces the need for closed-loop communication,” Lembitz says. “EPs can prevent communication mishaps by routinely and politely asking ED nurses to repeat orders, directions, and patient care instructions back.”

A related concern is providers will vent frustration in the chart. “Those finger-pointing, opinion-based notes do not improve the defensibility of the physicians, the ED, or the hospital,” Lembitz says.

It can take years for EPs to know and trust their nursing partners. “A consistency in nurse staffing ensures open communication and confidence in nursing staff. Traveling nurses can cause a higher stress level for ED

physicians,” says **Susan Martin**, Esq., executive vice president of litigation management and loss control in the Plano, TX, office of AMS Management Group, a medical professional liability insurer.

On the positive side, traveling nurses usually have experience, and can keep the hospital in compliance with nurse staffing ratios. However, in terms of liability, says Martin, “it can be a more risky decision. Traveling nurses, by definition, are temporary and more of a revolving door.”

If deposition testimony reveals the traveling nurse was a novice, was unaware of procedures, or could not respond promptly to a patient’s critical needs, “the hospital will bear this responsibility,” Martin warns.

In a fast-track setting, directing travel nurses to evaluate patients may not be as critical. “But with acutely ill patients, it is paramount to know that the ED nursing staff will quickly intervene, will get your attention if you are in another room, and will triage patients accordingly,” Martin says.

During a code, the traveling nurse might not know the location of the crash cart, equipment, or supplies. This could cause a delay in response

for a critical patient. “ED nursing staff are also pulled in different directions in orienting the traveling nurses and getting them up to speed with policies, procedures, and standing protocols,” Martin says.

Martin suggests it may be more appropriate to use travel nurses on a nonacute side of the ED (e.g., a fast track) and to direct existing nurses to manage patients with more urgent needs. As a former ED nurse, Martin recalls starting in a new ED environment is highly stressful. ED nurses must know where medications and equipment are stored, but there also are some intangible factors. It is vital to gain the confidence of other providers. “That’s not something that develops on the first day. It may take many months to know the physician staff and other nursing staff. Travel nurses come and go, without that long-term benefit,” Martin says.

There is “tremendous concern” about the effect that a high proportion of travel nurses could have on patient outcomes, including in the ED, says **Patricia Pittman**, PhD, FAAN, professor of health workforce equity at George Washington University.

The authors of two U.K. studies learned higher levels of temporary nurses raised mortality rates and left care undone.^{1,2} There are few data on risks of travel nurses in the United States.

“We are currently conducting a study on this topic,” Pittman reports. “We will be assessing the effects of travel nurses on patient outcomes in different hospital units.”

Pittman says that to mitigate risks, administrators could require travel nurses to have at least one or two years experience in an ED. “Hospitals can also create their own internal supplemental nurses agency that they train and orient in ways that help ensure quality,” Pittman suggests. ■

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Does Chart State Why Syncope Patient Was Deemed Low Risk?

By Stacey Kusterbeck

An otherwise healthy patient suddenly falls unconscious. This dramatic presentation can cloud the fact patients who present to EDs with syncope generally are low risk.

“Physicians sometimes just don’t trust their judgment, especially in high-risk medical-legal climates,” observes **James Quinn**, MD, a professor of emergency medicine at Stanford.

Quinn and colleagues assessed the rate of adverse events in ED patients with syncope at 24 hours (5.1%), 72 hours (7%), seven to 10 days (8.4%), one month (10.3%), and one year (21.3%) after the evaluation.¹ “Most cases of syncope are benign but can be associated with arrhythmia and death. Fortunately, as these studies show, most of these patients can be predicted,” Quinn says.

Quinn and colleagues analyzed nine studies that included 12,269 syncope patients presenting to EDs. They found risk of death or life-threatening adverse events are rare. Brady and supraventricular arrhythmias were the most common adverse events, which occurred during the first three days after the ED visits.

Prolonged ECG monitoring in the ED, in an observation unit

followed by ambulatory monitoring, can mitigate risks for intermediate- and higher-risk patients. “Many low-risk patients are still admitted at significant cost,” Quinn notes. “Over time, the number has declined with clinical decision support.”

If the EP is discharging a patient with syncope, Quinn says documenting reasons why he or she believes the

patient is low risk is important. These include the absence of cardiovascular risks (especially congestive heart failure), the absence of pulmonary embolism risk factors, the absence of family risk of sudden death, and a normal ECG.

“Most physicians have good judgment,” Quinn offers. “When they augment it with clinical decision

guidelines, they can minimize any liability and medical/legal risk.” ■

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ED Providers Are Frequent Defendants in Aortic Pathology Malpractice Claims

By Stacey Kusterbeck

When a group of vascular surgeons analyzed malpractice claims involving aortic pathology, they found emergency medicine was the most commonly named specialty. Researchers identified 196 cases involving aortic aneurysms and 150 cases involving aortic dissections in the Westlaw database from 1987-2019.¹

“We were looking at the cases from a surgical perspective. We were focused on postoperative complications,” says **Krystina Choinski**, MD, the study’s lead author and a resident in the division of vascular surgery at the Icahn School of Medicine at Mount Sinai in New York.

In fact, postoperative complications were involved in just 10% of the malpractice claims. “The big claim that stood out was failure to diagnose and treat,” Choinski observes.

That allegation was included in 61% of claims. Delayed diagnosis and treatment also was a frequent allegation (21% of claims). Both allegations directly involve the ED. “The ED is the front line, the people who are talking to these patients and getting the diagnosis. The really big thing, since there is such high morbidity and mortality, is getting the right

diagnosis in the first place,” Choinski explains.

EPs were defendants in 29% of claims. Other specialties were named less frequently (20% for cardiology, 14% for internal medicine, 11% for radiology, 10% for cardiothoracic, and 10% for vascular surgery).

Most (63%) patients with aneurysms presented with abdominal pain, and 37% presented with back pain. Most (78%) patients with dissections presented with chest pain. Patients were misdiagnosed with gastrointestinal conditions in 12% of cases, with cardiovascular conditions in 9% of cases, and shortness of breath in 14% of cases.

Many (83%) cases were wrongful death lawsuits. In 53% of cases, juries ruled in favor of the defendant. Juries ruled in favor of the plaintiff in 25% of cases. The rest resulted in a settlement. Notably, EPs were more likely to be named in malpractice cases than the surgical intervention team. “That shows that the initial task of getting the diagnosis is everything — to avoid patient injury and, ultimately, to avoid litigation,” Choinski says.

This finding spotlights the importance of improving diagnostic accuracy in the ED.

“We see litigation as a way of representing patient complications and injuries, because complications and injuries result in patients bringing cases to court,” Choinski explains. “We wanted to try to use that information to see how medical practice could be improved to hopefully prevent these injuries.”

Many ED patients complain of nonspecific abdominal pain. “But in the right patient population, for patients where there are red flags, the threshold for getting imaging and for calling vascular should be lower,” Choinski advises.

Even in lower-risk patients, “it can never hurt to think about it, and add it on to the differential,” Choinski offers. “When in doubt, get the scan. It requires IV contrast, but we really think it’s worth it in terms of having an accurate diagnosis and, if necessary, prompt treatment.”

In missed aortic dissection malpractice cases, some patients had been worked up in the ED for chest pain but in fact had an aortic dissection. For other younger patients, there was a history of substance abuse but no other risk factors. “With aortic dissection, there’s an immediate need for blood

pressure control to prevent the dissection from extending further,” Choinski notes.

The vascular team will determine if the patient needs to go to the OR right away or if the patient can be monitored in the ICU.

“An additional team the ED can contact, in addition to the vascular team, is the ICU, because these patients are going to need to be put on drips for blood pressure,”

Choinski says. Recently, an ED patient with abdominal pain reported a previous abdominal aortic aneurysm (AAA). “The ED did an excellent job of calling us immediately, before the imaging even came up,” Choinski reports.

Fortunately, staff were watching the patient closely and noticed right away the patient had become clammy and pale, and was hypotensive. The AAA had ruptured. That patient was

taken immediately to the OR, and survived. “In that case, every moment mattered. Everything worked,” Choinski says. ■

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Long Waits Raise Risk of Death for Admitted Patients

By Stacey Kusterbeck

Boarding of admitted patients in EDs for longer than five hours is linked to a higher risk of death in the following 30 days, a group of researchers found.¹

Investigators analyzed ED visits in England that occurred from 2016 to 2018. There was one extra death for every 82 patients who waited between six and eight hours for an inpatient bed. This figure rose to one in 72 with delays between eight and 12 hours.

“Very long delays for patients awaiting admission to a hospital bed are now ubiquitous,” reports **Chris Moulton**, MBChB, DRCOG, DFSRH, MRCP, FRCA, FCEM, a consultant in emergency medicine at the Royal Bolton Hospital in England and head of the National Health Service (NHS) Integrated Urgent and Emergency Care program.

Previous smaller studies conducted in Canada and Australia showed these delays may be associated with harm to patients.^{2,3} “But a larger study was required both to confirm and to quantify that association,” Moulton says.

Moulton and colleagues did not show a causal relationship between

long ED stays and patient mortality. “To prove cause and effect is very difficult when so many other factors, both known and unknown, are involved,” Moulton says. “Nevertheless, there does seem to be good reasons for limiting a patient’s time in the ED to less than five to six hours.”

Long waits are inevitably responsible for unrecognized additional patient morbidity, and certainly contribute to poor patient experiences. “We must, therefore, strive to minimize those delays and to ensure that patients who do have to wait do so in the very best circumstances that we can provide,” Moulton says. ■

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Identify and explain the legal and regulatory issues related to the delivery of emergency services;
3. Implement effective operational procedures and risk management into daily practice.



ED MANAGEMENT

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CME/CE OBJECTIVES

- Data show close to what percentage of adults older than age 65 years who live in the community experience a fall each year?**
 - 10%
 - 23%
 - 33%
 - 50%
- The most important thing leaders can do to address disparities is to ensure:**
 - under-represented minority groups have power.
 - surveillance is conducted to identify disparities.
 - resources are allocated to address equity.
 - equity is highlighted and prioritized.
- What did researchers find to be associated with more severe outcomes in children who present to the ED with COVID-19?**
 - Younger age
 - Asthma
 - Longer symptom duration
 - Preterm birth history
- Which did researchers find regarding ED malpractice claims?**
 - Communication errors in the ED happened between the medical team, but not between the provider and families.
 - Contingency plans, diagnosis, and illness severity were the information types miscommunicated most often.
 - Providers consistently overstated the patient's illness severity at handoffs over fears of litigation.
 - Malpractice claims that included communication failures were more likely to be dismissed than claims that did not involve communication problems.
- What did researchers find regarding boarding of admitted patients in EDs?**
 - Boarded patients were less likely to leave without being seen.
 - Boarding of admitted patients in EDs for longer than five hours is linked to a higher risk of death in the following 30 days.
 - Mortality rates were the same regardless of the amount of time patients waited for an inpatient bed.
 - Boarding affected mortality rates only if patients waited longer than 12 hours.
- Which is true regarding ED patients with syncope?**
 - About half of syncope cases involve life-threatening adverse events.
 - Brady and supraventricular arrhythmias were the most common adverse events.
 - Prolonged ECG monitoring in the ED in an observation unit (followed by ambulatory monitoring) is unsafe for intermediate-risk patients.
 - ED providers discharge too many patients deemed low risk who need admission.
- Which is true regarding allegations in aortic pathology claims?**
 - Most claims involve postoperative complications.
 - Few claims allege failure to diagnose.
 - Most patients with aneurysms present with abdominal pain.
 - The surgical intervention team is the group of clinicians at highest risk for being named in lawsuits.