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'Scheduling' an Appointment in the ED: Is it Allowable Under EMTALA?

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Waiting time has always been the number one complaint against hospital emergency departments (EDs). In an attempt to address the waiting issue, hospitals recently began allowing patients with nonemergency conditions to "schedule" their ED visits through the Internet and then wait at home until their "projected treatment time" in the ED.[1-2]

Through cloud-based Internet software vendors or phone-in applications, hospitals choose which days and times to make available for patients to sign-up for, or "check-in" for, in advance of coming to the ED. Typically, hospitals provide slots during their off-peak hours, such as early morning or late at night, but the systems are customizable and changeable so that hospitals can add, subtract, modify the available slots, or even turn off the system via the web at any time based on patient flow.

Patients choose an available time at a participating hospital and complete an online registration form, which includes the patient's chief complaint and other relevant medical data. The system is ***only*** for patients with a nonemergent condition. The registration form is then transmitted to the hospital ED and serves as the placecard to hold the patient's place in line to be seen in the ED.

In actuality, patients are just checking into the ED in advance of coming to the ED; the system is really ***an advance ED registration process; it is NOT a scheduling, appointment, or reservation service.*** It is better seen as a mechanism to "hold a place in line" and receive a "projected treatment time" when visiting a specific ED.

Upon arrival at the hospital, the patients who have registered in advance are triaged in the usual manner, and if their condition is deemed to be an acute emergency, they are taken care of in exactly the same manner as any other patient with the same acuity would be managed. If they are determined to be nonacute, they are placed in the queue to be seen in the order in which they "arrived" at the ED, but their online registration time is deemed to be the time they "arrived" at the ED.

Vendors and hospitals assert that the patients who register in advance "are not skipping the line in front of everyone else. They're simply waiting somewhere other than the waiting room."[3] However, it is true that some patients who come to the ED before the person who registered online physically arrives at the hospital, will get seen *after* that person who registered online.

In other words, patients at these participating hospitals can now sign into the ED by registering online or by showing up at the ED and registering in person. It's analogous to "call-ahead seating" at your favorite restaurant. If the eatery allows you to call to reserve your place in line, you may get seated before those who actually arrived at the restaurant before you did.

A typical hospital advertisement for the service is: *"[General Hospital] is pleased to offer our patients the convenience of online registration and emergency room appointments so that you can hold your place in line and wait for your pre-scheduled ER appointment in the comfort of your home — or anywhere else you choose."*

Charges for the service. Hospitals pay the vendor a contractual amount each month to provide the technology. Hospitals, in turn, charge the patient from $9.99 to $24.99 for the privilege of holding their place in line at the ED. The fee is in addition to any of the other usual costs for the ED visit. Hospitals typically refund the fee paid if the patient has to wait more than 15 minutes past their projected treatment time to be seen by the emergency physician.

Not all hospitals charge the patients a fee to use the system, and some hospitals which originally charged a fee to patients have since stopped charging for the service.

The advantages to the patients from the ED advance check-in system are that:

- They don't have to wait in a crowded hospital ED where they may not feel comfortable.
- They spend less time in the ED waiting room, reducing the risk of spreading or contracting infections.
- The ED is often the only source of care available to some persons, particularly during off hours and on weekends/holidays. Additionally, many patients don't have primary care providers, and even if they do, the providers are frequently too busy or it's too difficult to get timely appointments.
- The ED is a "one stop does all" proposition. Other facilities and physician offices often don't have the resources or the knowledge base to handle urgent medical or traumatic conditions.
- They have greater satisfaction with their care and the hospital ED experience

Advantages to the providers from the ED advance check-in system include:

- Improved operational efficiency because entry of patients into the system is smoothed out and volume is better managed by shifting some patients out of the busy times to the non-busy times.
- Decreased length of stay of the ED patients and decreased "left before examination" (LBE) rates — both of which increase hospital/emergency physician group revenue, enhance patient satisfaction, and decrease litigation risk.
- Revenue added to less busy times, which helps cover fixed costs of the hospitals and physician groups; patients who use the service are typically more sophisticated and technically savvy, and more likely to be insured/have financial resources to pay

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• Greater patient and family satisfaction with the ED experience

Are hospitals that use pre-registration systems violating EMTALA, the federal law that prohibits discriminatory treatment in the emergency department?[4-5]

Whether the "scheduling" ED visits system complies with the Emergency Medical Treatment and Labor Act (EMTALA) is best examined from two perspectives: first, if the hospital charges the patient a fee to use the service, and, second, if the hospital does not charge the patient to use the service.

1. The hospital charges the patient a fee to "hold their place" in line before they arrive.

EMTALA requires the hospital to provide an "appropriate" medical screening exam to any individual who "comes to the ED" and requests examination or treatment of a medical condition.[4,6]

When individuals pre-register with the ED online, they have not yet legally "come to the ED," as that term is defined by the Centers for Medicare and Medicaid Services (CMS) in the EMTALA regulations and accepted by the federal courts.[6-7] Therefore, the pre-registration process is not governed by EMTALA.

However, EMTALA is triggered once the individual physically "comes to the ED" and requests examination or treatment. At that point in time, the hospital has a legal obligation under the law to provide an "appropriate" medical screening exam (MSE).[4,6] The purpose of the "appropriate" MSE is to determine whether the patient has an emergency medical condition (EMC), as that term is defined by the law.

Triage by an ED nurse (including review of the patient's complaint and medical information submitted with the pre-registration form) does not constitute an MSE. Triage determines the acuity of the patient's condition and the order in which the individual will be medically screened by the emergency physicians (which includes mid-level providers under the supervision of the emergency physicians.) Triage does not count as an MSE no matter how trivial or "non-emergent" the patient's condition appears to be at the time of triage (or via the online registration).

All persons presenting to the ED with *any* medical complaint, not just urgent or emergent complaints, must be medically screened by the emergency physicians.[4.6.8]

For the MSE to comply with EMTALA, it must be an "appropriate" MSE, which is a legal term of art defined by CMS and the federal courts to be an exam "reasonably calculated" to determine if an EMC exists, ***and*** one that is provided uniformly in a non-disparate and non-discriminatory manner to all.[4,6-8]

Let's assume hospitals provide an exam reasonably calculated to exclude the presence of an EMC, irrespective of whether the patient pre-registered or registered upon arrival to the ED.

The issue then becomes whether the hospital's process for screening the pre-registered patient is uniform, non-disparate, and non-discriminatory compared to the hospital's process for screening patients who register upon arrival to the ED.

It is the *process* the hospital uses to screen patients that the CMS and the federal courts will examine to determine if the MSE was "appropriate" and compliant with EMTALA.

Furthermore, EMTALA at its core is a non-discrimination statute; CMS and the courts hold that any disparate treatment of a patient in an ED for non–medically indicated reasons is generally considered against the law. As stated by the 10th Circuit Court of Appeals, the disparate treatment standard imposes an obligation on the hospital to assure that they "treat every patient perceived to have the same medical condition in the same manner."[7,9]

Since the MSE requirement is triggered upon the patient's presentation to the ED, from that point forward, the hospital's screening *process* must be the same for everyone. In the case of a patient who paid a fee to be pre-registered, that patient is seen faster upon arrival than a patient who did not pay the fee prior to arrival; ***therefore, in my opinion, the hospital's use of the pre-registration system and charging a fee is clearly illegal under EMTALA.***

Giving preference to one patient for monetary reasons necessarily means delaying the MSE for other patients who don't pay the fee. There is no question that once EMTALA is triggered upon arrival to the ED, that the process of medically screening the two groups of patients is different, and it's especially different because one group is paying for the privilege of a premium service.

In the federal 6th Circuit Court of Appeals, which governs the states of Michigan, Ohio, Kentucky, and Tennessee, a plaintiff must prove not only that the hospital failed to follow its standard screening procedures (i.e., it provided "disparate screening"), but also that the hospital had an illicit motive for failing to follow its standard procedures.[7,10]

The 6th Circuit defines improper motives to include financial reasons, as expected by the legislative history of EMTALA, which would, in my view, include the payment of the pre-registration/"hold place in line" fee. The 6th Circuit also adds to the definition nonmedical prejudicial reasons such as race, sex, politics, occupation, education, personal

prejudice, drunkenness, HIV status, and spite.[7,10]

Only the 6th Circuit holds that the term "appropriate" refers also to the motives with which the hospital acts. Every other circuit, as well as CMS, holds hospitals liable for disparate screening regardless of the hospital's motivation because the plain language of the law does not include motive as a necessary element for EMTALA liability.[11]

To my knowledge, as of yet, no court has ruled on the legality of the pre-registration/fee charge "scheduling" process utilized by hospitals, as described. Furthermore, there has been virtually nothing published in the medical or legal literature on the issue. One health care attorney opined in an article published in *ED Legal Letter* that the practice "is a pretty clear EMTALA violation" … and that the practice will "undoubtedly bring scrutiny from regulators and legislators."[12]

In summary, in my opinion, the described hospital practice of screening patients who pre-registered and paid a required fee differently than those who didn't is a violation of EMTALA. In my opinion, both CMS and the federal courts would also view it as a violation of the law.

2. The hospital does not charge the patient a fee to utilize the "hold their place" service.

Even if hospitals don't charge a fee, but pay a licensing fee to a vendor in order to provide the pre-registration service to the hospital's patients, *it is my opinion that the practice still violates EMTALA*. However, this is not as clear-cut.

Hospitals could argue that their "standard medical screening process" includes the option to register online as well as to register in person at the ED. The hospitals could further argue that every patient has the same opportunity and choice of registering online instead of in person. (The counter argument is that only those patients with access to the technology [Internet/smart phones with mobile apps] can use the online system, which is ultimately to the detriment of those less well off who may not have the means to afford or procure access to the technology. For example, according to a recent Pew report, 20% of adults in the United States do not use the Internet at all, and cost of access is one of the reasons.[14]

Ultimately, though, I believe that CMS and the courts would focus on the fact that after patients arrive at the ED and EMTALA is triggered, the process the hospital utilizes to provide the MSE is not the same for everyone; some individuals receive preference over other individuals who present with the same or similar complaints. It is this *disparate process* that would lead the government entities to determine that the practice violated both the spirit of EMTALA and the letter of the law.

I don't believe this process would be considered a violation by the 6th Circuit, however, as there would be no illicit motive for the disparate treatment. In fact, the hospital's motives would be deemed a good faith attempt to improve the overall service to its community and enhance patient satisfaction. However, this salutary motive would be irrelevant to CMS and to all the other circuits in deciding whether the practice violated EMTALA.

Additional EMTALA or Liability Issues to Consider

There is an *exception to EMTALA's medical screening exam requirement* that applies to registered outpatients brought to the ED. Individuals who have begun to receive scheduled outpatient services as part of an encounter (as defined by CMS), other than an encounter that the hospital is obligated to provide by EMTALA, are not considered to have "come to the emergency department" for purposes of triggering EMTALA.[14] This exception was designed to avoid the application of EMTALA to outpatient encounters that experience complications that necessitate bringing the patient to the ED for emergency intervention. For example, if a patient suffered complications during an outpatient endoscopy procedure at the hospital and needed to be moved to the ED for emergency care, EMTALA would not apply to that patient's visit to the ED.

A hospital's ED pre-registration process would not meet the CMS definition of an outpatient encounter that would obviate the application of EMTALA. First, the clinical encounter would not have begun by the time of the patient's arrival to the ED, and, second, the individual's arrival at the ED requesting examination or treatment for a medical condition would clearly trigger the application of an encounter (the MSE) that the hospital was obligated to provide by EMTALA.

EMTALA also has a "no delay on account of insurance" requirement.[4,6] This means the hospital can't delay an individual's access to the MSE on account of their insurance status, to obtain any financial information, or because of any economic reason. The ED pre-registration forms often include a request for insurance information.

Since this registration process occurs before EMTALA is triggered, the process itself does not violate the law. However, if the hospital used the information on the registration form to either speed the MSE for those insured or to delay the MSE for

those uninsured once they arrived at the ED, then it would be a violation of the law.

It is always better that the triage staff and the physicians providing the MSE be blinded to the patient's insurance status until the time of disposition. That way, CMS or a litigious patient cannot reasonably claim that the hospital delayed access to the MSE or treated the patient any differently due to their uninsured status. It also minimizes the avenues of attack by plaintiff attorneys.

The pre-registration process may also expose the hospital to *state malpractice liability risk*.

The websites have plenty of disclaimers that the system is "*not for use with life-threatening, urgent or emergent medical conditions.*" However, as a "safeguard," when the hospital receives the pre-registration form, one of its triage nurses reviews the chief complaint and medical information provided to determine if it is reasonable for the patient to wait until his or her projected treatment time or whether the nurse should call and instruct the patient to come to the ED immediately. Thus, the triage nurse is making a decision that either it is not necessary to call the patient to come to the ED right away, or it is necessary to call the patient and recommend that he or she come to the ED immediately. Legally, this may be construed under state law to be "assuming a duty" and establishing a hospital-patient relationship. Once the duty is assumed, it must be carried out reasonably in accordance with the standard of care.

Failure to call the patient to come to the ED immediately when a reasonably prudent nurse would do so may then be actionable negligence on behalf of the hospital should a patient who waited until his or her "projected treatment time" suffer an adverse outcome.

As noted earlier, because the interaction occurs before the patient "comes to the ED" under CMS's regulations, there can be no EMTALA civil liability related to this aspect of the pre-registration process.

Ironically, hospitals would most likely be better off from a liability perspective if they didn't ask for the patient's chief complaint or transmit medical data to the ED in advance to have the triage nurse review to determine if the patient should come to the ED immediately. Thus, the decision of whether and when to come to the ED would remain solely with the patient. This would be exactly as if the patient called the ED for advice and the ED said, "Sorry, we don't give advice over the phone but we are here 24/7 to evaluate your condition if you believe it is warranted." The reason hospital EDs stopped giving phone advice years ago was to leave the decision-making responsibility of whether or when to come to the ED for medical evaluation to the patient, so as to specifically avoid liability related to providing advice to persons who had not yet been examined.

Should we be encouraging patients with urgent, but not emergent, medical conditions to utilize a hospital emergency department for their care?

No, we shouldn't. In the short term, the practice may help the hospital's bottom line and improve patient satisfaction, but in the long term, it would be better to drive patients to more appropriate and less expensive settings that better serve the interests of the patients, the providers, the payers, and the community/nation as a whole — and that don't violate federal anti-discrimination laws such as EMTALA.

One way to enhance patient satisfaction related to ED waiting times and to smooth out the volume of both emergent and less urgent patients presenting to the ED without violating EMTALA is to better publicize, in real time, the average wait times of area hospitals.

For example, Wake Med Health & Hospitals runs six EDs in the Raleigh-Durham area of North Carolina. The system posts online the average wait times of each of its facilities so that anyone can check the wait times of the hospitals in their area and "self select" one based on wait times, location, etc. (Available at http://www.wakemed.org/landing.cfm?id=1615.) It also has a mobile app for smart phones, which provides the same data on a real-time basis. (Available at http://www.wakemed.org/landing.cfm?id=1606.)

Communities as a whole, rather than individual health care systems, could collate the average wait times of hospitals in their community and make the information publically available via web and mobile platforms, particularly smart phone apps. Patients can then use the average wait times in their decision-making process of which hospital ED to utilize.

However, the long-term goal should be to set up systems that allow patients to use technology to get to the right health care service at the right time at the best price.

Patients with non-emergent but urgent medical conditions will continue to use the ED until health care providers figure out a way to provide the same services available at the ED in a manner that is acceptable to the patients. Patients long ago figured out the extensive advantages of ED services, even if they usually had to wait longer than they would like, including:

- immediate access to care;
- care at a location nearby;

• care at a location that has the necessary resources to evaluate and manage the condition, including imaging studies such as CT, ultrasound, X-rays, and laboratory studies; and

• immediate access to physician specialists, if indicated.

The ED is the ideal "one-stop shop," and everything that needs to be done gets done in a single visit — no traipsing around town over days (or weeks) from primary care provider to X-ray and/or lab centers and then to specialists and/or hospitals. If you show up at an ED and need a surgeon, one is provided for you. If your bone is broken, it is fixed. If you need a diagnostic CT scan, it is done, with the results known in a matter of hours before you leave the ED.

The objective should be to establish locations that can achieve the same advantages as the ED, but without the EMTALA restrictions and without the high charges.

That location is an **urgent care center**, particularly one attached/integrated with a primary care system that can amalgamate the patient into a medical home type of arrangement for future care.

There are ways to legally structure urgent care centers such that they do not come under the umbrage of EMTALA. In that case, payments for preferred appointments or advance pre-registration systems, such as the practice described above, are perfectly legal as well as desirable for the patients and providers. They are also highly favored by the insurance companies or state Medicaid offices, which pay the bills.

Additionally, providing the services outside the control of EMTALA allows providers, insurers, managed care organizations, and even state Medicaid agencies to establish such programs for select patient populations, such as only their patients, only insured patients, or only Medicaid patients.

Witness the currently ongoing firestorm created by the Washington state Medicaid agency when it tried to curtail "inappropriate" ED visits by not paying the providers for medically screening those patients, even though the providers were required to do so by federal law (EMTALA). The same issue is burning in every state, although to a lesser extent than in Washington. For example, the South Carolina Medicaid agency recently explored whether it was possible to circumvent EMTALA for Medicaid patients presenting to EDs with non-urgent medical conditions. The Medicaid agencies could instead use real-time scheduling technology to redirect patients and, thus, reduce unnecessary emergency room visits by securing immediate appointments for their Medicaid patients with community health centers or contracted providers. CMS may even provide funding for such programs.

Hospitals and EDs themselves would benefit from systems incorporating urgent care centers/primary care systems through the ability to schedule urgent or timely follow-up appointments at those locations upon discharge from the inpatient setting or the ED (the urgent care centers, particularly when staffed with emergency physicians, can often handle more conditions/follow-up issues than primary care providers).

Using technology to make the follow-up appointment before the patient leaves the ED leads to more patients actually keeping their recommended follow-up appointments. For example, a study recently published in the *Annals of Emergency Medicine* demonstrated that the use of an Internet-based scheduling program linking a safety-net ED with local community clinics significantly improved the frequency of follow-up for patients without primary care relationships.[14]

This is the expectation of the future, particularly as the health reform act is implemented and accountable care organizations take center stage. Governments will demand that "inappropriate visits" to the ED be reduced, and that providers and insurers act in concert to provide the right level of care at the right locations. Rather than encouraging non-emergent patients to visit EDs, we should be thinking longer-term and implement methods to drive those patients to non-ED locations that are properly staffed and equipped to meet their needs on a timely basis. Real-time, cloud-based or mobile appointment scheduling systems fit very nicely into that future.

Summary

In my opinion, hospitals preferentially screening patients who pre-registered with the ED via an online service is prohibited by EMTALA, regardless of whether the patient pays a fee for the premium service. Additionally, I believe the practice, as it is currently implemented, does create some malpractice litigation risk for the hospital, although it is likely minimal.

Moreover, there are better methods to accomplish the same goals as the pre-registration program that do not violate EMTALA, do not increase a hospital's malpractice risk, and, in the long-term, will better serve the patients, the community, the payers, and the country as a whole as we struggle to provide timely access to quality emergent and urgent medical care in a cost-effective manner. ■

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Suits for Missed Sepsis in EDs Are on the Rise

Lawyers looking for treatment delays

If an emergency department (ED) patient with impending sepsis is discharged, returns hours later in septic shock, and dies or develops organ failure, "you're likely to get sued," warns **Bruce Wapen**, MD, an emergency physician with Mills-Peninsula Emergency Medical Associates in Burlingame, CA.

Wapen says he is seeing an increasing number of lawsuits involving sepsis cases missed in EDs. Just as EDs are now held to a different standard of care for myocardial infarction, acute coronary syndrome, and stroke due to new treatment options, the same is now true of sepsis cases, he explains.

"This goes back to about 2003, when it became apparent we weren't doing a good job of identifying sepsis in the ED, let alone treating it," he says. "Patients are at risk for a very rapid demise if they aren't treated aggressively."

EDs began implementing new interventions to identify existing or pending sepsis at that point in time, says Wapen. "EDs had this pretty well worked out as of around 2008. By now, it should be implemented everywhere," he says. "Lawyers are looking at charts of people who died of sepsis to see if it was identified early on and treated in an aggressive manner."

Plaintiff attorneys can effectively argue that the emergency physician (EP) "knew or should have known" that in order to diagnosis sepsis, a serum lactate is ordered, and if it's elevated, that is an indication of sepsis, he says.

EDs will also be held to the standard of care for treatment once sepsis is identified, adds Wapen, including the early administration of fluids and antibiotics.

Cases May Be Insidious

Sepsis can present in an obvious manner, with systemic inflammatory response syndrome and end organ dysfunction, "or, all too often, insidiously," says **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS in Chardon, OH.

The patient may or may not have a fever in the ED, says Garlisi, and the elderly or immunocom-

promised patient may not have leukocytosis. By the time sepsis is obvious, the patient has spiraled downward, he adds.

If the allegation in a medical malpractice suit is that an EP missed the signs and symptoms of sepsis, it would be framed as a misdiagnosis allegation, along with claims of breach of the standard of care, according to **Linda M. Stimmel**, JD, an attorney at Wilson Elser Moskowitz Edelman & Dicker in Dallas, TX.

"I have defended missed sepsis cases. Inevitably, there is a breakdown in communication — either between healthcare providers or with the patient regarding how important it is to return to the ED if symptoms persist or change," she says.

A plaintiff could allege that the EP failed to order the proper labs or diagnostic tests, or that the EP misinterpreted the results of the tests, she says.

If sepsis is suspected, ED physicians should document these items, advises Stimmel:

- the differential diagnosis, which would include sepsis;
- the labs or diagnostic tests that are ordered to determine if sepsis is present;
- the results and subsequent interpretation of the results;
- the treatment communicated to the patient, including charting that the patient understood what he or she was supposed to do, any referrals that were made, and clearly stating whether follow-up was required.

"If those elements occurred and were correctly documented, the case would be very defensible," says Stimmel.

If a plaintiff alleged that the wrong tests were ordered, Stimmel says this could be proven by expert testimony that shows most EPs would have ordered different diagnostic tests or performed different interventions when sepsis is suspected.

"I would recommend regular communication among the ED physicians in the hospital that discusses what each physician is doing when sepsis is suspected," she says. This can prevent a plaintiff using other EPs' actions to prove the standard of care was breached in a case of missed sepsis, she adds.

If the patient is admitted, the ED chart should indicate that a report was given on the potential sepsis diagnosis, says Stimmel. "Chart that the nurse who orients the patient to the floor has acknowledged the ED information," she adds. ■

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Missed Sepsis: ED Nurses Are "First Line of Defense"

Nurses share in culpability

The ED nurse is the "first line of defense" against a malpractice lawsuit alleging missed or delayed diagnosis of sepsis, according to **Paula Mayer**, RN, LNC, a partner at Mayer Legal Nurse Consulting in Saskatchewan, Canada.

"It is widely recognized that sepsis is a leading cause of preventable death in patients," she warns. Mayer says the ED nurse is most likely to be sued for breach of fiduciary duty in a failure to recognize, assess, monitor, communicate, advocate, and/or document adequately.

"The ED nurse must recognize that infections can place patients at risk of sepsis, and fully assess and monitor their status," she says. "They must have clear and ongoing communication with the physician regarding their assessment findings, changes in status, and deteriorating condition."

ED nurses must advocate for their patient to receive treatment prior to the patient entering a shock state, which can develop very quickly, she adds.

"The physician may be sued for a failure to recognize and a failure to treat sepsis," says Mayer. "But all the information necessary to recognize this condition can come from a full nursing assess-

ment. Nurses share in the culpability when this diagnosis is missed."

In the ED, nurses should expect the patient will be started on intravenous (IV) crystalloid fluids, oxygen, and be started on their first dose of IV antibiotics, says Mayer.

"If the patient is entering a shock state, the fluid challenges will become more aggressive, the oxygen administration at higher flow rates," she says. "If the blood pressure drops, they may be started on vasopressors or be considering colloid preparations."

Sepsis diagnosed and treated within the first six hours drastically improves outcomes, underscores Mayer.

"Failure to recognize and adequately intervene in a case of sepsis in the ED can mean a septic patient can be discharged home to further decompensate," she says. "By the time they return to the ED for treatment, if they do, their status can be critical, and even lead to death."

Document This

Mayer recommends that ED nurses document all of the information below in the patient record if sepsis is suspected. "If it is not documented, it is not done if the case goes to court," she says.

- Document frequent checks of the patient's vital signs including temperature, respiratory rate, pulse, blood pressure and oxygen saturation, and level of consciousness.
- Document frequent assessments of the patient's status.

It is important to put a patient suspected of sepsis on a cardiac monitor and an oxygen saturation monitor, says Mayer. "As they decompensate, the shock state will cause an increase in heart rate," she explains. "This increases myocardial oxygen demand and consumption and necessitates the use of oxygen to maintain adequate oxygen saturation levels."

- Note monitoring of level of consciousness at regular intervals, as disorientation, confusion, agitation, and dizziness are all signs the patient may be deteriorating into septic shock.
- Document a full physical assessment to determine skin color and temperature, lung sounds, assess for diaphoresis, rash or purpura, any wounds (including size, type, appearance and drainage), and any other evidence of infection.
- Note the patient's intake and output.
- If the patient is admitted, ED nursing reports to the floor nurses must include all assessment findings, relevant test results, treatments and interventions, responses to treatment, and what the patient is being admitted for.

"If all that is included in the report, the floor nurses should know what to watch for," says Mayer.

To reduce risks, Mayer says that EDs can implement "team huddles" to ensure adequate communication among team members to better recognize sepsis.

"One group of hospitals is introducing 'time-outs' during the discharge phase of treatment," she reports. "This allows the team to catch anything that may have been overlooked, such as sepsis." ■

Source

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Ensure Patients Are Placed Back on Monitor

Lawyers will be looking for this

Even if continuous cardiac monitoring is ordered, ED patients may be taken off the monitor for transport or to go to the restroom — and kept off the monitor due to oversight, warns **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS in Chardon, OH.

Blood pressure may be normal initially but then slip downward unnoticed while the patient is in the radiology department undergoing a CT scan. "The patient may then be returned to the ED and not placed back on the cardiac and blood pressure monitor," says Garlisi. "As the patient slips deeper into the downward spiral of severe sepsis, he or she enters the point of no return and dies."

He gives the example of a diabetic patient with generalized weakness and acute abdominal pain, examined by an EP who suspects sepsis from an

intra-abdominal source and orders an intravenous fluid bolus and various ancillary studies, including abdominal CT.

In this case, says Garlisi, the EP assumes the nurse will repeat the vital signs in a timely manner, but is unaware of the nursing policy for repeat vital signs on noncritical patients.

"The EP assumes that the vital signs are rechecked prior to transfer to the CT department, but they are not," he says. The nurse asks the physician if the patient can go to CT off the monitor, the EP enters the order, and a technician brings the patient back to the ED.

"One hour later, the physician returns to the patient's room to discuss the CT results — intra-abdominal abscess — but the patient is semi-responsive," says Garlisi. "He has weak pulses, and the physician is shocked to discover that the patient is not on the cardiac monitor."

The physician calls for the nurse, who places the patient back on the monitor. The patient's heart rate is 134, and the blood pressure has plummeted to 62/38. Despite resuscitation efforts, the patient dies of septic shock.

"This scenario is a relatively common occurrence in our nation's emergency departments," says Garlisi.

Don't Assume

Electronic orders may give the EP the option to allow patients to be taken off the monitor for transport to CT, he notes. However, since the EP cannot assume that the patient will be placed back on the monitor when he or she returns, Garlisi suggests making this additional entry: "Place the patient back on the cardiac monitor when he/she returns from the radiology department."

If the ED's policy states that patients should be placed back on the monitor after returning from studies performed outside the ED, and they are not, and a downward drift of the blood pressure is missed, Garlisi says this is "a clear violation of their own policies, creating an indefensible position in court."

On the other hand, if the ED had no clearly stated policies regarding patients being placed back on the cardiac monitor after returning from the radiology department, this would also make a malpractice case difficult to defend, says Garlisi.

"The plaintiff attorney could convincingly describe the lack of such policy as an irresponsible, careless, and neglectful act, compromising the safety of the patient," he says. ■

Delayed Transfer for MI? ED's Legal Risks Are Many

Emergency medical services (EMS) crews are all on assignments, it's rush hour, the cardiologist hasn't called back, or the transfer center is waiting for approval before assigning a bed. These are all valid reasons for delays in transfer of a patient with an ST-elevation myocardial infarction (STEMI), says **Kevin Brown**, MD, MPH, FACEP, FAAEM, principal with Brown Consulting Services in Armonk, NY, and former director of the department of emergency medicine at Greenwich (CT) Hospital, but if any of these delays occur, times should be documented by the emergency physician (EP).

"Should questions later develop, you will be grateful you did, especially if it backs up your timeline," he says.

If a STEMI patient presents to an ED that lacks a cardiac catheterization laboratory (cath lab) and the decision is made to transfer the patient to obtain treatment with percutaneous coronary intervention (PCI), any delays in getting the patient there can result in significant legal risks for the transferring ED, says **Kurt Dischner**, MD, FACEP, director of critical care for the ED at Mercy Medical Center in Rockville Centre, NY.

"Delays in treatment may be due to the patient not being transferred out quickly enough," he says, adding that this may result from failure to immediately identify the patient's MI due to a nondiagnostic EKG.

"The initial EKG may be nondiagnostic for an MI. In approximately 45% of patients having an acute MI, the initial EKG is normal or nonspecific," says Dischner. Dischner advises doing repeat EKGs if acute coronary syndrome is suspected, even if the first EKG is normal or nonspecific.

If the EKG shows an MI, but there is a miscommunication and the EKG is never handed to the EP to review, this could result in a delay. Dischner recommends having an ED policy in which all EKGs performed in the ED must be handed to an ED attending to be reviewed.

"This prevents the situation where an EKG showing evidence of an acute MI is placed in a chart without anyone ever reviewing it," he says.

Dischner also advises adhering to strict clinical guidelines once a STEMI is identified. "At that point, you are on the clock. If your treatment is thrombolytics, you need to be pushing them within 30 minutes," he says. "If you are treating with a car-

diac cath, then door-to-balloon time is 90 minutes."

There are potential legal risks if the patient being transferred decompensates or develops an arrhythmia and goes into cardiac arrest, Dischner adds, because the transferring physician is still responsible until the patient arrives at the next institution.

Aside from an extraordinary mass casualty situation, documenting that the ED was crowded with other patients doesn't afford much protection for the EP, according to Dischner. "Juries will be less sympathetic if there was a breakdown in the system or evidence of carelessness, such as if the EKG was done and just left somewhere," he adds.

However, if a delay occurs with a STEMI patient because the EP was involved in another critical care case and was unable to leave the bedside, Dischner advises documenting this.

"It's kind of hard to fault the doctor if he can't leave the bedside of another critical care patient who is severely unstable or about to code," he says. Documentation of the reason for the delay may offer some protection for the EP, adds Dischner, by showing the jury that the delay was not due to incompetence or carelessness but to another critical patient receiving care at the same time.

"Still, when a jury looks at a case, they imagine the patient as the only one in the ED," he says. "They will want to know, 'Why wasn't this done right away?'"

Examine Each Step

The steps involved in detecting a STEMI patient and transferring him or her to another hospital with a cath lab are more complex than most EPs realize, according to Brown.

"Each step needs to be examined to see if it 'adds value,' and if not, whether it can be eliminated," he says. He gives these examples:

- Does the EMS agency that does interhospital transfers have enough resources — or might the ambulance that will be used to do the transfer be responding to a 911 call and, therefore, unavailable for an hour?
- Does an EMS system have a backup plan to get assistance, such as utilizing on-call emergency medical technicians or employing a mutual aid agreement?
- What delays might occur in contacting the accepting cardiologist?

"I have been involved in some cases where there are delays getting through to the telephone center, as they didn't have a dedicated phone line or the cardiologist took 20 minutes to return my call," says Brown. "It was very frustrating."

The best approach for EDs, says Brown, is to adopt a transfer-friendly "call and ship" approach, with the referring facility making a single call to a dedicated phone line with the accepting cath lab facility, with brief information given, followed by the name of the accepting cardiologist.

"An immediate call can then be made to EMS, which shortens the process," he says. ■

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

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4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

1. If a patient presented with fever or hypothermia, low blood pressure, rapid pulse, and rapid respiratory rate, failure to do which of these interventions would make the case difficult to defend, according to **Bruce Wapen**, MD?
   A. failing to order a lactate to confirm the diagnosis of sepsis
   B. failing to order other diagnostic tests to identify the source of sepsis
   C. failing to aggressively treat the sepsis with fluids and antibiotics
   D. any of the above

2. Which is true regarding a plaintiff's allegations of missed or delayed diagnosis of sepsis in the ED, according to **Linda M. Stimmel**, JD?
   A. A plaintiff could allege that the proper labs or diagnostic tests were not ordered, or that the results of the tests were misinterpreted by the EP.
   B. It is not advisable to document in ED charts that the floor nurse has acknowledged receiving information on the patient's potential sepsis diagnosis.
   C. If the plaintiff alleges that the wrong tests were ordered, this cannot be proven by expert testimony that shows most EPs would have ordered different diagnostic tests when sepsis is suspected.
   D. Legal risks are increased if EPs regularly discuss with one another what they are doing when sepsis is suspected.

3. Which is recommended to reduce risks of delays in transfer of ST-elevation myocardial infarction (STEMI) patients, according to **Kevin Brown**, MD, MPH, FACEP, FAAEM?
   A. EPs should always document the fact that the ED was experiencing crowding at the time, as this will provide significant legal protection for the EP in the event a lawsuit is filed.
   B. EPs should avoid documenting the fact that they were involved in another critical care case and unable to leave the patient's bedside, if this contributed to a delay in transfer.
   C. Each of the steps involved in detecting a STEMI patient and transferring him or her to another hospital with a cath lab should be examined as to whether it can be eliminated.
   D. EDs should not utilize a "call and ship" approach, with the referring facility making a single call to a dedicated phone line with the accepting cath lab facility, as this has been shown to increase legal risks.

ED Legal Letter

Reader Survey 2012

In an effort to ensure *ED Legal Letter* is addressing the issues most important to you, we ask that you take a few minutes to complete and return this survey. The results will be used to ensure you are getting the information most important to you.

Instructions: Mark your answers by filling in the appropriate bubbles. Please write in your answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope. The deadline is **July 1, 2012**.

Questions 1-12 ask about coverage of various topics in *ED Legal Letter*. Please mark your answers in the following manner:

	A. very useful	B. fairly useful	C. not very useful	D. not at all useful
1. The critically ill patient in the ED (June 2011)	O A	O B	O C	O D
2. Jury awards $200,000 in EMTALA case (July 2011)	O A	O B	O C	O D
3. Legal risks of HIV testing in the ED (Aug. 2011)	O A	O B	O C	O D
4. Review of close clinical encounters (Sept. 2011)	O A	O B	O C	O D
5. Noneconomic damage caps at issue in FL (Oct. 2011)	O A	O B	O C	O D
6. Current liability perspectives by emergency medicine leaders (Nov. 2011)	O A	O B	O C	O D
7. Medical malpractice and EMTALA (Dec. 2011)	O A	O B	O C	O D
8. Legal risks of charting methods (Jan. 2012)	O A	O B	O C	O D
9. EMTALA whistleblower lawsuit (Feb. 2012)	O A	O B	O C	O D
10. Legal cases involving drug dispensing (March 2012)	O A	O B	O C	O D
11. The legal risk of delayed treatment (April 2012)	O A	O B	O C	O D
12. Setting appointments for ED visits (May 2012)	O A	O B	O C	O D

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O A. very satisfied O B. somewhat satisfied O C. somewhat dissatisfied O D. very dissatisfied

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O A. always O B. most of the time O C. some of the time O D. rarely O E. never

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33. What specific topics would you like to see addressed in *ED Legal Letter*? _____

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