

# Are we prepared to triage this patient call?

**RISK: PATIENT IS IN NEED OF MORE IMMEDIATE CARE THAN IS CONVEYED OVER THE PHONE**

What seemed like the flu was much more serious



## Closed Malpractice Case

On a Saturday (8:00 p.m.), a father called his son’s pediatrician’s office and told the nurse practitioner (NP) that his 9-year-old had not felt well for three days: nausea, vomiting, decreased oral intake, weakness, and lethargy (sleeping 24 hours straight).

Suspecting the flu, the NP asked if the boy was alert (yes), had passed any urine (yes), or had a fever or rash (no). When the NP asked if he felt if his son would be “okay” that night or should be seen right away, the father replied, that he didn’t think his son needed to be seen right away, but was concerned that he hadn’t eaten. The NP advised pushing ginger ale and making sure he was urinating.

When checked on at 4:00 a.m., the boy was sleeping and his breathing was more rapid. At 8:30 a.m., however, the father found his son was not breathing, called 911, and started CPR... but the boy could not be revived. Autopsy revealed diabetic ketoacidosis (the child had undiagnosed diabetes mellitus). His blood sugar was 1,165 (nl 50–80) and his HgA1c was 15.3% (nl 4–5.9%).

Diagnostic Process of Care in Ambulatory Diagnosis Cases\*  
 Inadequate patient assessment is a contributing factor in 35% of CRICO (31% of CBS) ambulatory cases alleging a missed or delayed diagnosis.

STEP	PERCENT OF CASES**	
	CRICO (N=175)	CBS† (N=2,919)
1. Patient notes problem and seeks care	1%	1%
2. History and physical	10%	8%
3. Patient assessment/evaluation of symptoms	35%	31%
4. Diagnostic processing	43%	35%
5. Order of diagnostic/lab test	40%	31%
6. Performance of tests	5%	3%
7. Interpretation of tests	37%	23%
8. Receipt/transmittal of test results to provider	4%	5%
9. Physician follow up with patient	21%	18%
10. Referral management	13%	21%
11. Provider-to-provider communication	12%	12%
12. Patient compliance with follow-up plan	14%	17%

\* Cases with claim made date 1/1/11–8/31/16

\*\* A case will often have multiple factors identified

† CBS is CRICO's Comparative Benchmarking System

## Patient Safety Vulnerabilities

- Once the child’s symptoms were ascribed to the flu, the history-taking was cut short and the NP jumped to a conclusion (i.e., fixation error) and prematurely moved on to the plan.

**SAFER CARE:** An evaluation of symptoms over the telephone requires the same focused and relevant history-taking as in an office visit. Asking more open-ended questions may improve the quality of the information collected, resulting in a more reliable diagnosis.

- The NP relied on the patient’s father to decide whether the problem was emergent enough to require immediate attention.

**SAFER CARE:** Patients (or parents) should not be doing their own triage. Calling a patient/family back after a few hours to check on progress of a symptom can be reassuring as a way to check the initial triage decision and an opportunity if necessary to revise the plan.

## Are we prepared to triage this patient call? (continued)

- The NP did not ask any questions to hone in on the seriousness of the situation.

**SAFER CARE:** Effective use of telephone triage protocols may lead to a more disciplined approach and improved safety. Always err on the side of caution. Instructions that the patient be evaluated right away must be clear, repeated twice, and documented.

### Quick Assessment

- Has this type of event happened at our practice?
- What is our practice/policy for telephone triage for patients calling-in after hour?
- Have we implemented best practices for telephone triage? Can we leverage decision-support tools?
- Can we integrate triage call notes into the EHR?
- How do we close the loop with the primary care physician related to the after-hours care?

### Improvement Opportunities

RECOMMENDED PRACTICE	CURRENT STATE	HOW TO IMPROVE (IF NECESSARY)
1. Make an extra effort to talk directly with the patient when possible.		
2. Avoid premature closure in your decision-making.		
3. Adopt telephone triage protocols, especially for ruling out serious problems.		
4. All after-hours calls must be documented in the medical record.		
5. Close the loop with the primary care provider.		

CRICO *Are You Safe?* materials are designed to help all members of a multidisciplinary team reduce the risk of patient harm in the course of diagnosis and treatment. Office-based events that trigger malpractice cases present valuable opportunities to identify vulnerabilities in communication, clinical judgment, and patient care systems. Successful practices shared by local and national peers inform the *Are You Safe?* recommendations. CRICO works closely with your organization's Patient Safety and Risk Management staff to build expert resources for individual and team-based education and training.

Email comments, resources, or questions to [areyousafe@rmf.harvard.edu](mailto:areyousafe@rmf.harvard.edu).

### Additional Resources

[www.rm.harvard.edu/safecare](http://www.rm.harvard.edu/safecare)

Please visit the CRICO website for related:

- CME Bundles
- Podcasts
- Clinical Decision Support
- PowerPoint presentations to share with your team
- Patient Safety Alerts
- Additional topics in the *Are You Safe?* series



### How to Earn Category 2 Risk Management Credits

This *Are You Safe?* case study is suitable for 0.25 Category 2 risk management credit for Massachusetts physicians. Risk Management Study is self-claimed; complete, date, and retain this page for your record keeping.

### About CRICO

CRICO's mission is to provide a superior medical malpractice insurance program to our members, and to assist them in delivering the safest health care in the world. CRICO, a recognized leader in evidence-based risk management, is a group of companies owned by and serving the Harvard medical community.