Risk management opportunities for ED discharge process

1. Discharge instructions and education

Educate patients on their diagnosis, prognosis, treatment plan, and expected course of illness. This includes informing patients of the details of their visit (treatments, tests, procedures). Before patients are discharged from the ED, emergency health providers should effectively communicate crucial information, verify comprehension, and tailor teaching to areas of confusion or misunderstanding to ensure patient safety in the home environment. Note any language barrier and use of translators.

2. Post discharge test results

Identify who should receive the test or who is responsible for addressing them. Consider that the ordering provider may not be on shift when the results are finalized. Effective communication between providers is key to ensuring appropriate follow-up care.

3. Telephone follow-up

Nurses typically perform telephone follow-up calls. Primary goal is to clarify discharge instruction, answer questions and reinforce compliance with discharge instructions.

4. Emergency department-made appointments

Case management and patient navigators focus on high-risk patients accessing PCP follow-up. The AHRQ found that appointments made for cardiac stress testing increased the likelihood of follow-up (72.5% vs. 56.1%).

5. Prescription assistance (access to needed prescriptions)

A common barrier correlated with discharge plan adherence is accessing needed prescriptions. Providing prescription assistance to low-income and uninsured patients increases medication adherence, prevent progression of disease, and decreases the rate of ED revisits.

6. Transportation assistance

Transportation is considered a social determinate of health, non-medical factors that influence health outcomes. While hard to measure on its own for efficacy, offering transportation assistance through vouchers, public transit passes, etc. can reduce barriers to follow-up care and increase discharge plan adherence.

ED Case Study

A 24-year-old, non-smoking male presented to the Emergency Department complaining of chest and rib pain after playing recreational softball two days earlier, with mild shortness of breath and coughing. His body mass index (BMI) of 42.6 indicated obesity. The ED physician considered intercostal strain and rib fracture; he ordered a chest x-ray. The study was negative for rib fracture, however, the radiologist identified a round infiltrate in the superior lobe of the right lung and his differential diagnosis included round pneumonia, inflammatory etiology, and neoplasm. The radiologist recommended follow-up but did not flag the actionable incidental finding contained in his report, and he did not contact the ED physician about the finding. The ED physician's diagnosis was musculoskeletal chest wall pain, and he ordered an injection of Toradol. The ED physician discharged the patient before reviewing the chest x-ray report in detail. The discharge summary incorrectly indicated a negative chest x-ray. There was no further contact with the patient. He died a week and a half later. An autopsy revealed bilateral empyema and pulmonary abscesses. Plaintiffs claimed poor reporting and communication within the ED discharge process resulting in death of patient. **Case settled for policy limits of $1M**

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