

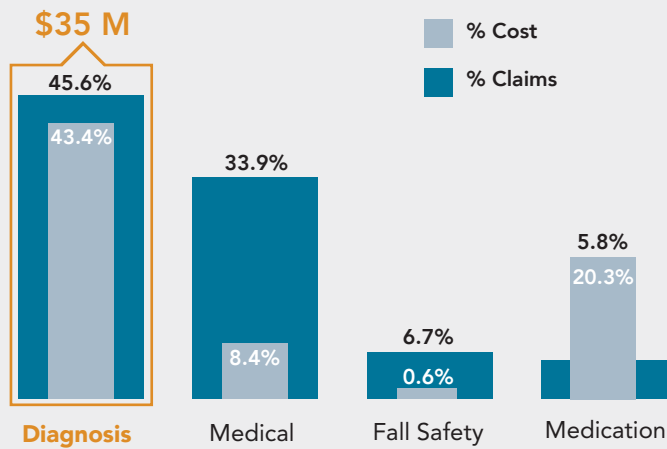
Risk Report



Reducing Patient Harm in the Emergency Department

In our analysis of Constellation medical professional liability claims*, **diagnostic error** is the **#1 most frequent allegation and #1 most costly** in Emergency Department (ED) claims.

Allegations Triggering ED Claims

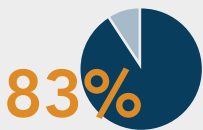


ED Process of Care

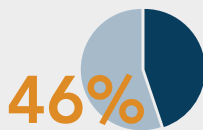
We leveraged CRICO Strategy's Emergency Department Process of Care:

1. Initial diagnostic assessment
2. Tests and results processing
3. Follow-up and coordination

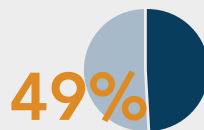
Snapshot of Claims % Claims



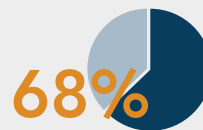
involved issues with the initial diagnostic assessment



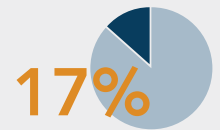
involved follow-up system failures



involved high severity injuries including death



involved Emergency Medicine as the primary responsible service



involved Radiology as the primary responsible service

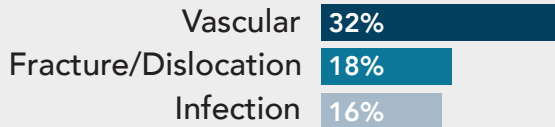
Stage 1: Initial Diagnostic Assessment



A 70-year-old presented to the ED with generalized abdominal pain and nausea. After a narrow diagnostic focus, he was discharged with a diagnosis of GERD. There was a failure to appreciate his symptoms, which were not monitored, and no testing done to rule out a potential serious diagnosis. A day later he returned with complaints of RUQ pain and decreased bowel sounds. The CT read by the radiologist revealed appendicitis with probable perforation and peritonitis. The man's post-op recovery was prolonged and complicated by respiratory failure, intubation, sepsis and renal failure.

What diagnoses do we miss in the ED?

% Claims



When a diagnosis is missed...

% Claims

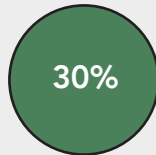
65%

involve a delay/failure to order a diagnostic test

44%

involve failure to assess or evaluate symptoms

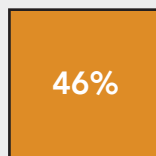
Stage 2: Tests and Results Processing



CTs and X-rays were the most commonly misinterpreted tests. Radiology was the clinical service identified as most responsible for misinterpretations.

A 51-year-old man presented to the ED with complaints of a severe headache, visual loss and a fall at work. The ED physician ordered a CT with contrast and the on-call radiologist reported it as normal. The ED physician discharged the man with a diagnosis of migraine headache. The next day the man was found unresponsive by his wife and he was transported to the ED where he was diagnosed with a middle cerebral artery occlusion. Surgery to reopen the artery was unsuccessful. The initial CT was overread by another radiologist during the second visit to the ED and he identified the occlusion. The man suffered permanent neurologic deficits and was moved into a skilled nursing facility.

Stage 3: Follow-up and Coordination



A man presented to the ED with complaints of right ankle pain after sustaining a twisting injury at work. The ED physician read the ankle X-ray as negative for fracture. However, the radiology over-read identified an avulsion fracture. Due to a failure in the ED's test result reporting system, the ED physician and the patient were never notified of the X-ray overread discrepancy. The patient's fracture was diagnosed one year later and he underwent ORIF to repair the unhealed fracture. He was unable to return to work due to disability caused by the delay in diagnosis.

Did you know?

With almost half of the claims involving follow-up system failures, analysis reveals that **accurate and timely diagnosis depends nearly as much on the health care team and systems as it does on the diagnosticians themselves.**

Investing time and resources to enhance communication between clinicians and patients, re-engineer diagnostic test management workflows, and implement reliable HIT systems creates stronger care teams, engages patients as part of the diagnostic team and enhances the diagnostic process.

What You Can Do to Reduce Harm in the ED

Learn about the causes and contributing factors to harm in the ED.

Use symptom-based checklists and clinical decision support tools to rule out potential serious diagnoses.

Implement reliable follow-up systems to manage referrals/consults and patient notification of pending/final test results.

Enhance communication to ensure patients understand discharge instructions and the need for follow-up care.

Good for care teams. Good for business.

