Australasian College
for Emergency Medicine

Patient Safety Workshop

Did I miss anything?

7 March 2019

Welcome and introduction to patient safety

Dr Carmel Crock

Director, Emergency Department

Royal Victorian Eye and Ear Hospital, Victoria

Dr Stephen Priestley

Patient Safety Lead/iEMER, Emergency Senior Consultant

Sunshine Coast University Hospital, Queensland

IHI/ACEM
Accelerated
Patient Safety Course

Dr Stephen Priestley FACEM
Chair ACEM Patient Safety Working group

15 March 2016

Institute for Healthcare Improvement

Australasian College for Emergency Medicine

Program hosted by:

Accelerated Patient Safety Course

WHAT IS THE ACCELERATED PATIENT SAFETY COURSE?

The Accelerated Patient Safety Course is conducted by the world renowned Institute of Healthcare Improvement and hosted by ACEM. The IHI is a leader in health and health care improvement across the world. For more than 25 years they have collaborated with a variety of organisations and introduced creative ways to improve the health of individuals and populations.

You will learn about:

- The skills, theory and practical means necessary for developing a patient safety program in your emergency department;
- How to diagnose and measure the safety of your emergency department;
- Developing and applying this new knowledge to improve patient safety in your emergency department.

WHAT TOPICS DOES THE COURSE COVER?

The Accelerated Patient Safety Course includes:

- A framework for conceptualising patient safety;
- Diagnostics for patient safety;
- Strategies for building support for patient safety;
- Assessing the human factor in patient safety breaches;
- Understanding the key components of a well-designed patient safety model;
- The essential elements of teamwork and how workplace culture influences patient safety;
- The role of middle-managers and engaging them in patient safety improvements.

FACULTY FOR THE COURSE

Patient Safety experts from the Institute for Healthcare Improvement aided by local FACEMs who completed the IHI Patient Safety Course in Boston in 2014.

WHAT IS THE COST OF THE COURSE?

Australian FACEMs—registration fee $2,420 AUD (incl GST)

WHEN AND WHERE IS THE COURSE?

Date: Tuesday 15 March, 2016 to Friday 18 March, 2016

Venue: InterContinental Hotel, 495 Collins Street, Melbourne, Victoria

Accelerated Patient Safety Course
15-18 March 2016 · Australasian College for Emergency Medicine

DAY 1: System of Improvement

DAY 2: Reliability

DAY 3: Safety and Flow

DAY 4: Culture

IHI Faculty

Carol Haraden

Joseph T. Crane

Carol Peden,

Accelerated PS Course Evaluation

96 participants from Australia and NZ

-69 FACEMs

-26 Senior Emergency nurses

-1 Critical Care paramedic

Accelerated PS Course Evaluation

96 participants from Australia and NZ
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-1 Critical Care paramedic

Q Would it be Valuable for ACEM to Invest in Future Patient Safety Courses?

YES - 98.7% of respondents (78 of 79)

Australasian College
for Emergency Medicine

What goes wrong?

What goes wrong in emergency departments?
A medicolegal perspective

Ms Maria Mota

Head of Insight, VMIA, Risk Management and Insurance

Emergency claims trends, themes and action

Maria Mota
Head of Insights

7 March 2019

Agenda

Agenda

- Emergency claims trends overtime
- Emergency claims critical causes and contributing factors
- VMIA’s role in supporting the sector prevent harm

Quick facts

4,600

clients across the State

$201 billion

insured State assets

84%

client satisfaction score

Medical Indemnity exposure context

67%

costs per year

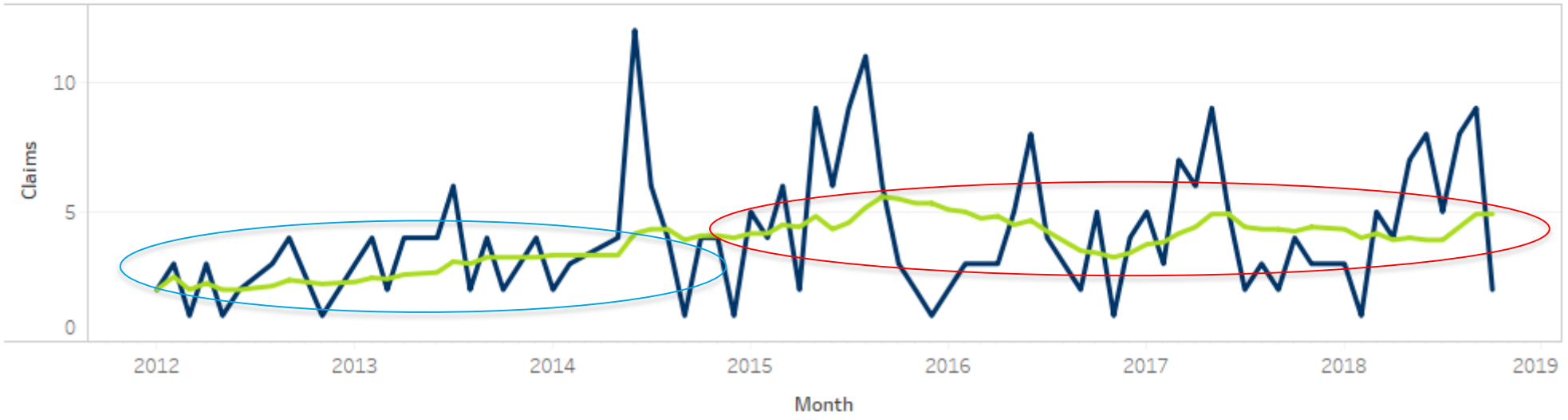
Emergency Claims trends

Emergency claims trends – Public Hospitals Victoria

Overall Claims Trends

Date Range	Date Type	Claim Type (group)	Specialty (group)	Client Category	Parent Organisation	Organisation
From 1/01/2012	Report Date	Medical Indemnity	Emergency	Multiple values	All	All

Number of Claims by Report Date

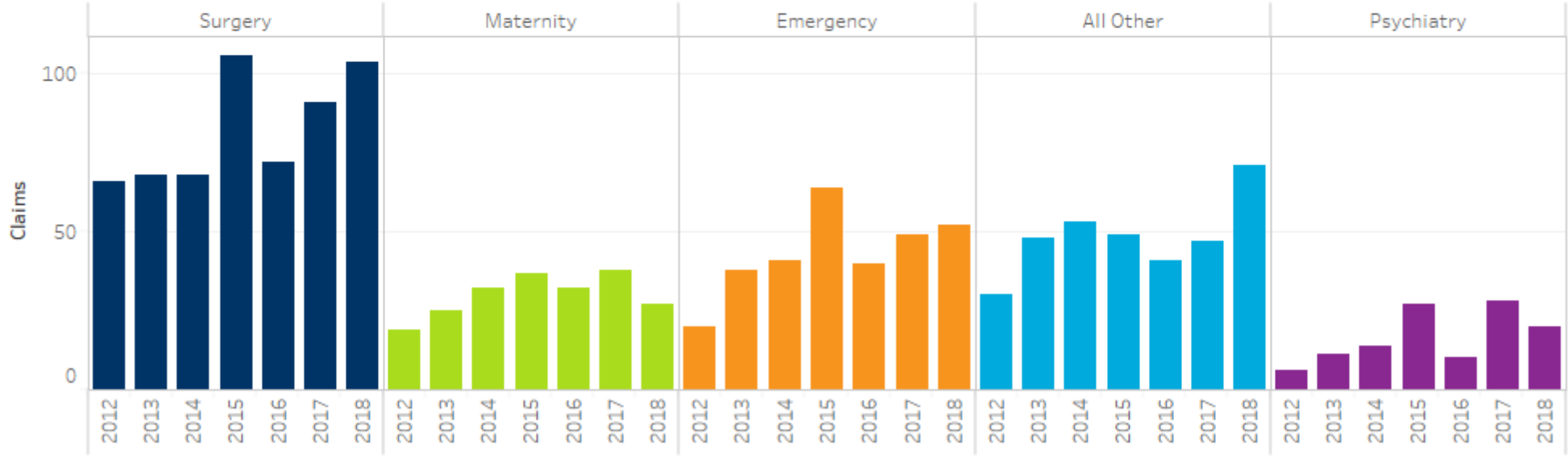


Emergency vs other clinical areas

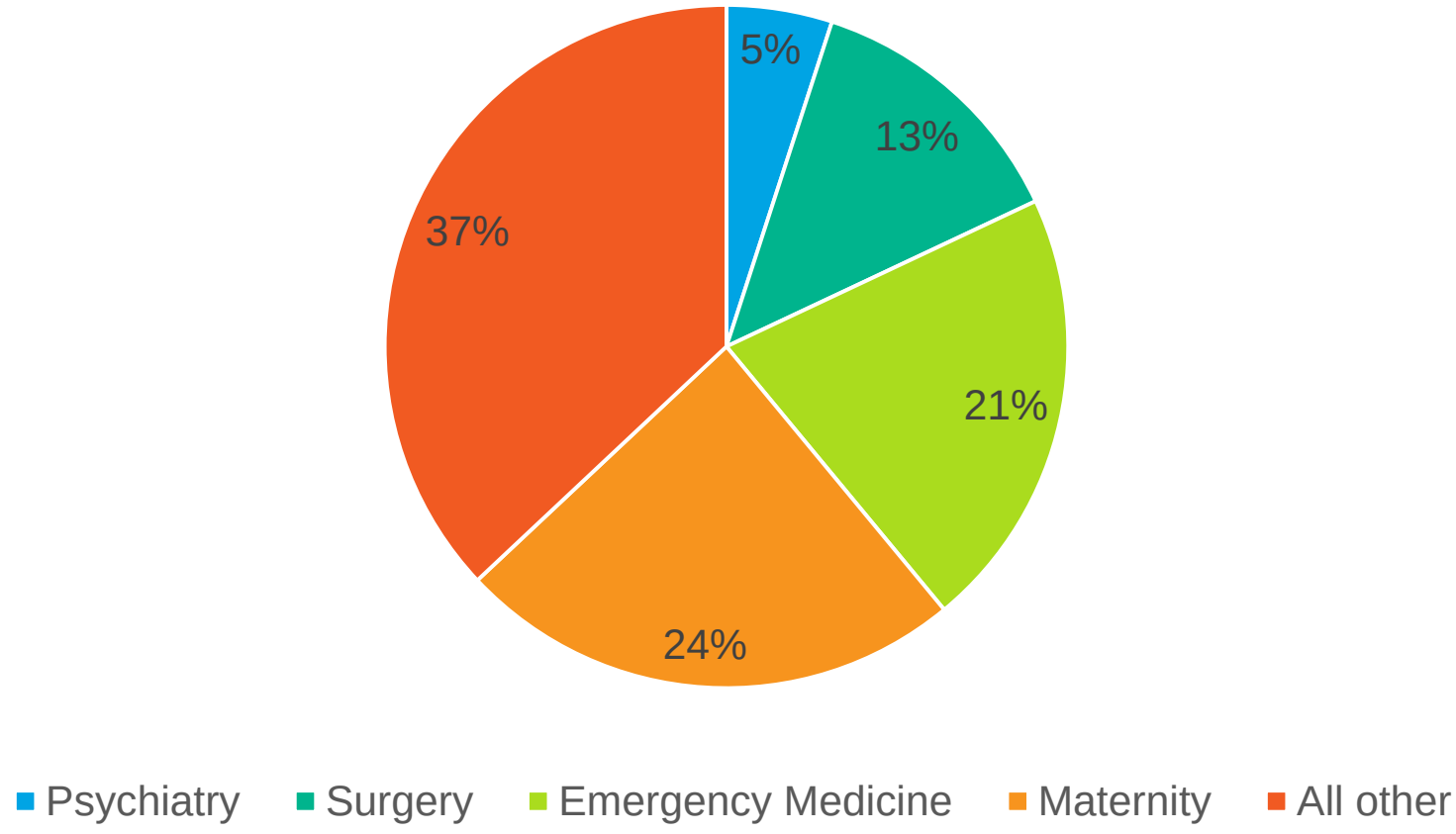
MI Specialty Dashboard

DatetoUse	Date Type	Client Category	Parent Organisation	Organisation
From 1/01/2012	Report Date	Multiple values	All	All

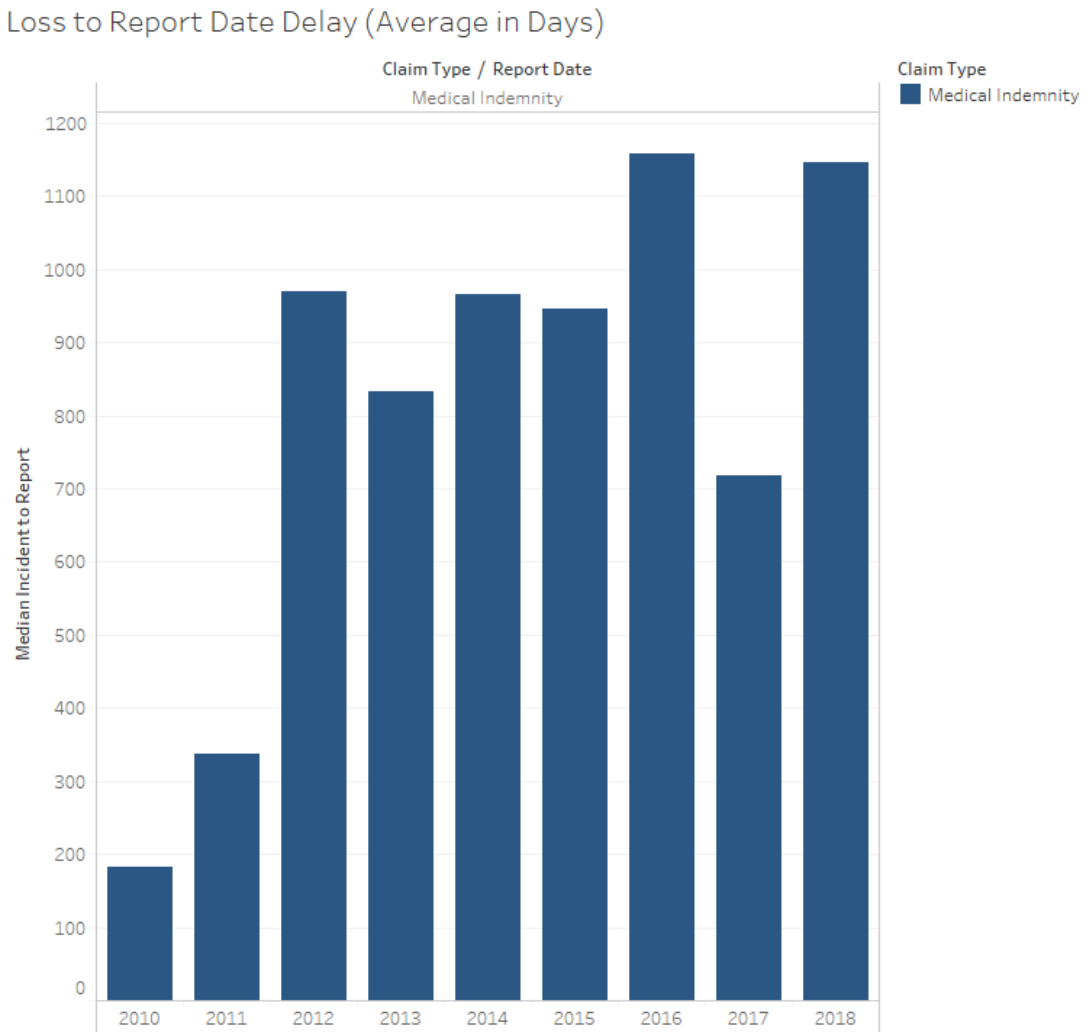
Number of Claims by Report Date



Total Claims Costs 1 July 2013 – 30 June 2018

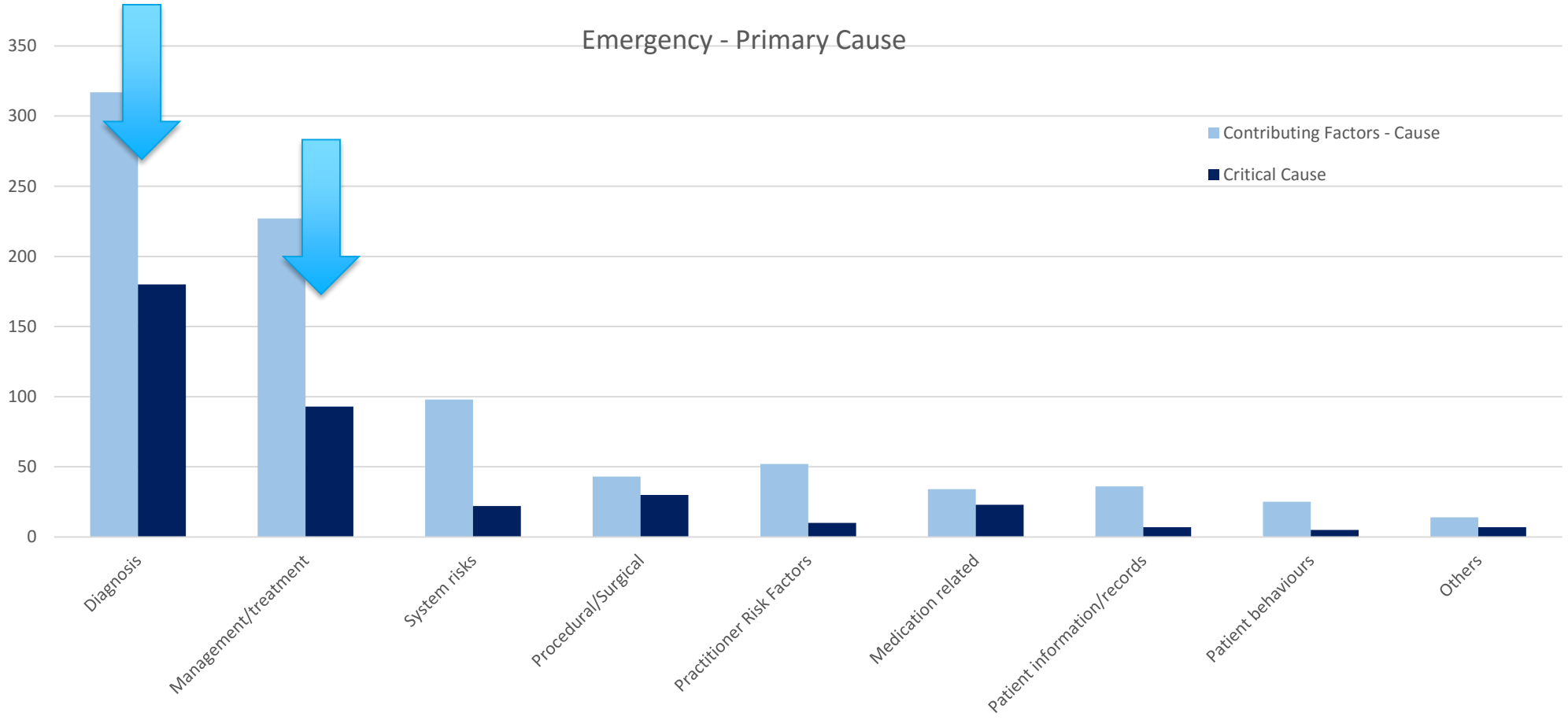


Emergency Reporting Delay
Public Hospitals - Victoria

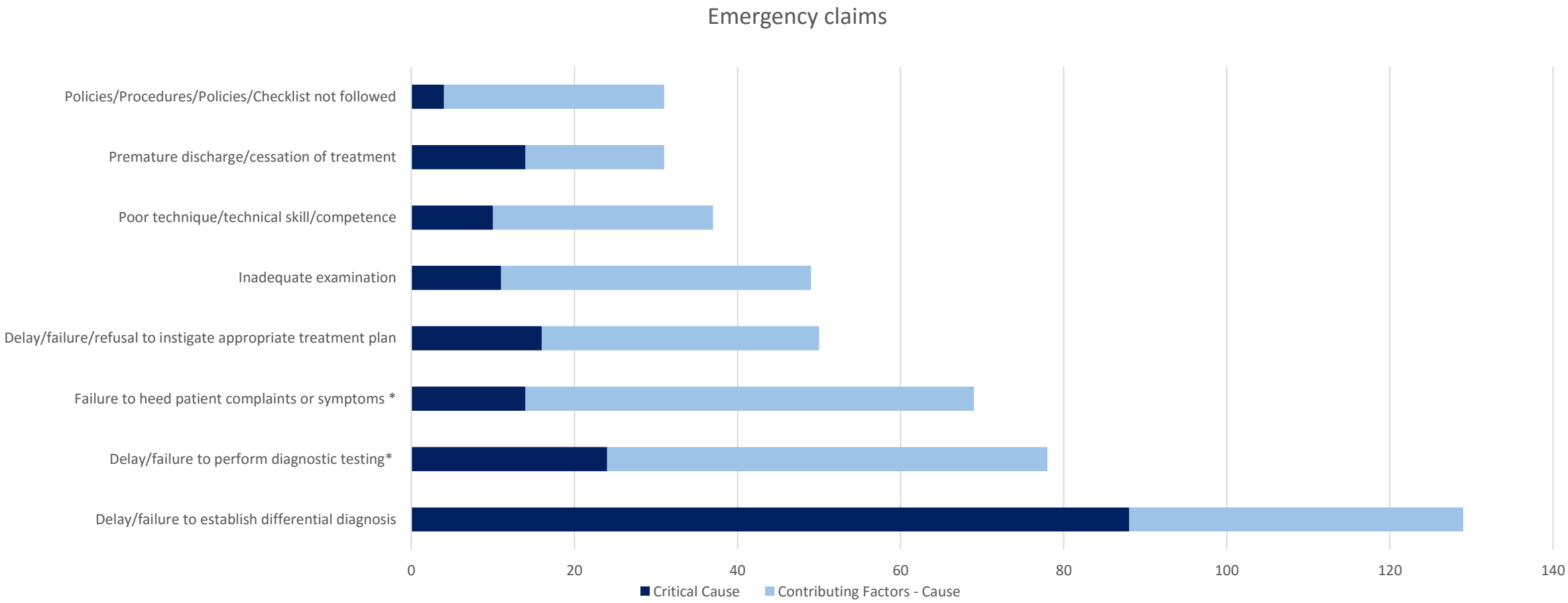


Emergency themes – causes and contributing factors

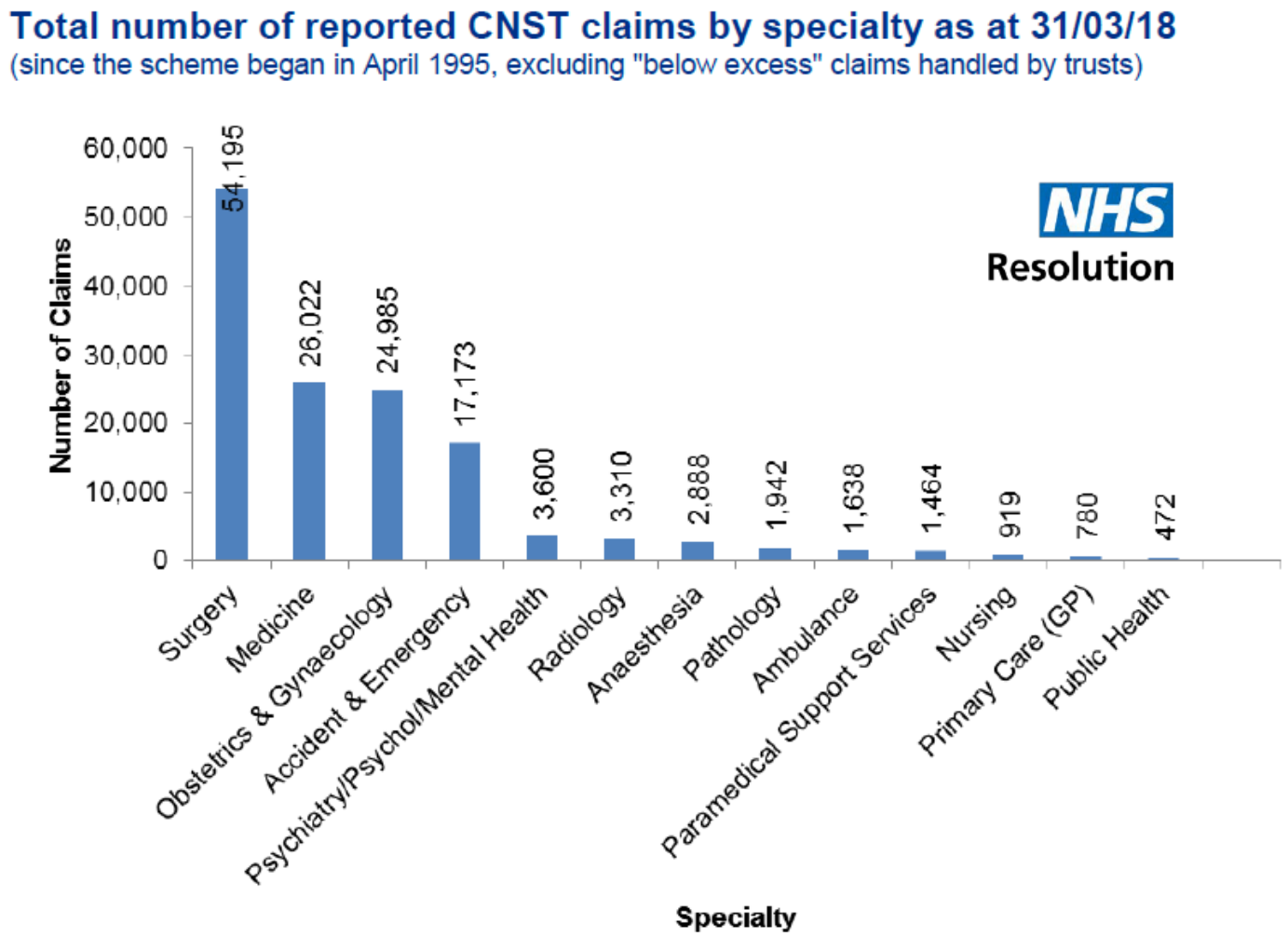
Emergency claims – critical causes and contributing factors



Emergency claims – critical causes and contributing factors



International Comparisons - UK



International Comparison - US

Diagnostic errors are the most common—and costly—allegation in ED cases.

TOP ALLEGATIONS	CASES FILED	INDEMNITY INCURRED
	PERCENT OF CATEGORY	
MISSED OR DELAYED DIAGNOSIS	47%	62%
MANAGEMENT OF MEDICAL TREATMENT	28%	24%
MEDICATION-RELATED	7%	4%
SAFETY OR SECURITY	6%	2%
SURGICAL TREATMENT	3%	3%

International Comparison - US

At a Glance...

About four of every 100,000 ED visits result in an allegation of malpractice.

47% of ED cases allege a failure to diagnose.

39% of ED cases alleging a missed diagnosis cite a judgment error related to ordering a test or image.

41% of diagnosis-related ED cases involve inadequate assessment leading to premature discharge.

Community hospital-based nurses are named twice as frequently in ED malpractice cases as are nurses in academic medical centers.

Medical malpractice indemnity costs approximately $8 per ED visit.

Four Areas of potentially emerging Risk

Already exist but **may increase**

Driven by **new legislation**

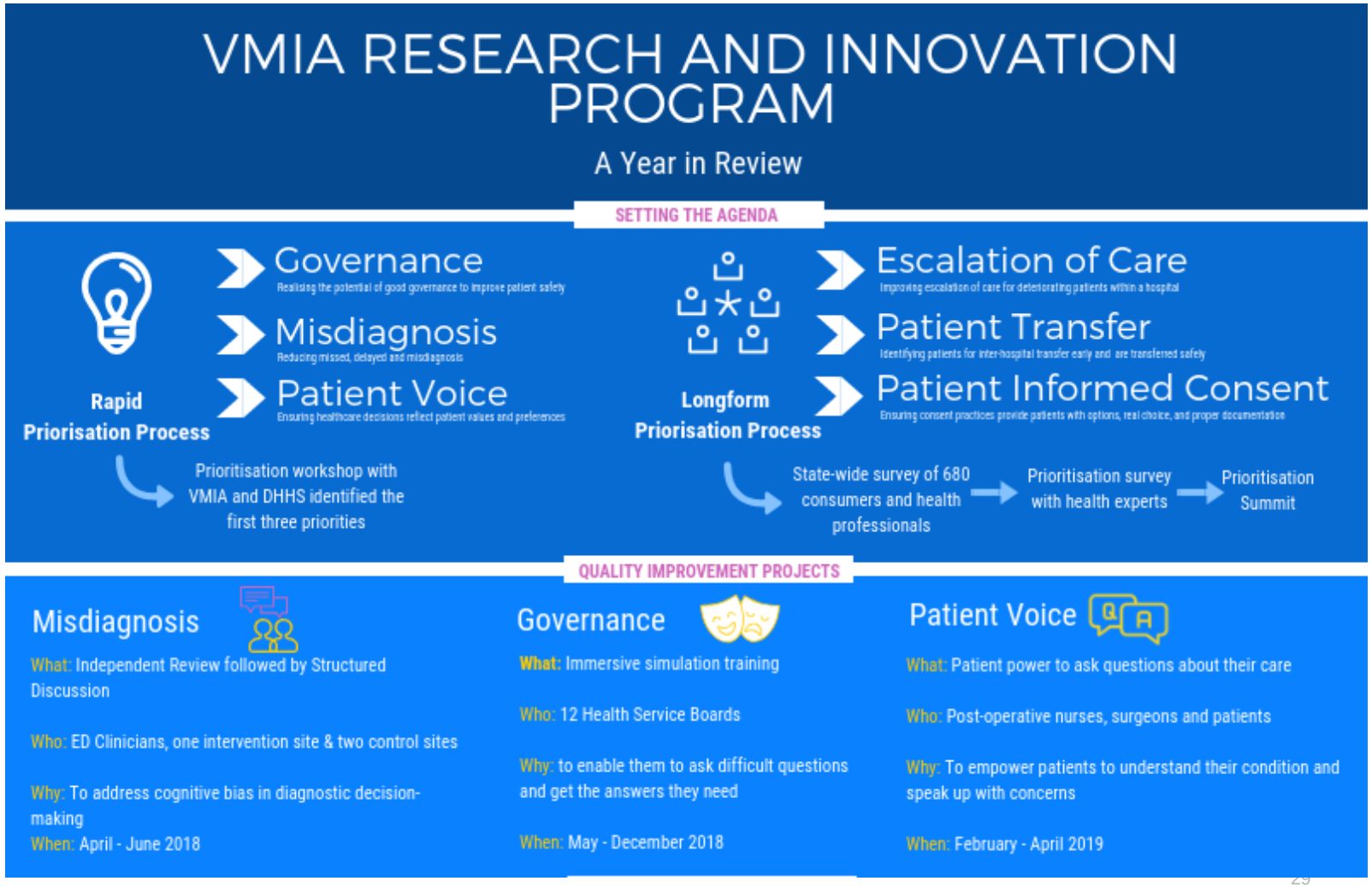
Driven by increase in **public awareness**

Relatively new

VMIA’s role in preventing harm

Research and Innovation Program

BehaviourWorks AUSTRALIA



Two heads are better than one

RaDD (Rapid Diagnosis Discussion) trial results show significant improvements in diagnostic decision-making. Find out how below.

WHAT WE DID

How can we minimise diagnostic error in Victorian emergency departments?

How can our intervention be simple and sustainable?

A good trial begins with a good set of questions

1 A second opinion by a clinician with fresh eyes

2 A scripted talk between clinicians designed to challenge cognitive bias

We trialled a 2-part intervention to find some answers

158 CASES went through the RaDD trial

3 hospitals participated – 1 intervention and 2 control sites

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What goes wrong?

Learning from coroners' cases

Dr Nicola Cunningham

Emergency Physician, St Vincent's Hospital Melbourne

Senior Forensic Physician, Forensic Services, Victorian Institute of Forensic Medicine

Adjunct Senior Lecturer, Department of Forensic Medicine, Monash University

Academy Member, Incident Response Team, Safer Care Victoria

Learning From Coroners' Cases

ACEM Patient Safety Workshop 07.03.2019

Dr Nicola Cunningham
Emergency Physician, St Vincent's Hospital Melbourne
Senior Forensic Physician, Victorian Institute of Forensic Medicine
Academy Member, Incident Response Team, Safer Care Victoria

RETURNS OF CORONERS' INQUESTS, 1852—*continued.*

Date.	Place.	Before whom.	Name.	Verdict of Jury, or Result of Inquiry before Magistrate.	Remarks.
1852. June 3	Melbourne ...	W. B. Wilmot, Cor....	Charles Toogood ...	Death from effects of a gun-shot wound, by some person or persons unknown	The wound, according to the account given, was inflicted three months previous to the death of deceased; at first trifling—it occasioned death by repeated hæmorrhages. No mention was made by the deceased of the man who had shot him, and since his death the guilty person has not been discovered.
,, 4	,, ...	,, ,, ...	James Feecy	Manslaughter against some person unknown	Deceased had been playing at cards with some person whose name is unknown; they quarrelled; deceased striking the other first. Deceased was struck by the other, and fell heavily. Death was attributed, by the medical man who made a *post mortem* examination of the body, to the rupture of a blood vessel, caused by falling or being thrown down heavily. Deceased was at the time intoxicated. Save bruises, there were no marks of violence. The man who struck the blow has not been discovered. From the depositions, it seems more than questionable whether a case of manslaughter could be sustained
,, ,,	,, ...	,, ,, ...	William Brudenell ...	Died by the visitation of God	
,, 7	,, ...	,, ,, ...	John Simmonds... ...	Death from natural causes	
,, ,,	Summertown ...	W. H. Campbell, ,, ...	Charles Andrews ...	Accidental death, by drowning	
,, ,,	Forest Creek ...	W. McCrea, ,, ...	Christopher Kelly ...	Justifiable homicide	Shot—having burglariously entered a store at the gold fields
,, 10	Williamstown ...	W. H. Campbell, ,, ...	John August Ohlsson ...	Accidental death, by drowning	
,, ,,	Geelong	Foster Shaw, ,, ...	Thomas Cochrane ...	Death from intemperance	
,, 11	,, ...	,, ,, ...	Man unknown	Accidental death, by drowning	
,, ,,	Melbourne ...	W. B. Wilmot, ,, ...	Matthew Crighton ...	Accidental death, by drowning	
,, 12	Fryer's Creek ...	W. McCrea, ,, ...	Walter Boyle, a boy ...	Accidental death, by drowning	
,, 15	Melbourne ...	W. B. Wilmot, ,, ...	William Norton ...	Death from natural causes	
,, 16	,, ...	,, ,, ...	John Atkinson	Death from shock produced by inhalation of chloroform.—Deceased at the time suffering from disease of the heart	Medical men fully exonerated by a special finding of the jury
,, ,,	Geelong	Foster Shaw, ,, ...	John Hayes	Found dead, from natural causes	Deceased was found dead in his bed; no marks of violence; had been in a weak state for some time previously
,, ,,	Bendigo	J. McCrea, ,, ...	William Bishop... ...	Accidental death.—Suffocation from fumes of charcoal	
,, 17	Melbourne ...	W. B. Wilmot, ,, ...	— Perry, a female infant	Accidental death	
,, 21	Ballaarat... ...	R. Cockburn, J.P. ...	Thomas Jones	Accidental death	
,, 23	Fryer's Creek ...	W. McCrea, Cor....	Michael Law	Found dead in a water hole.—Cause of death unknown	
,, 24	Melbourne ...	W. B. Wilmot, ,, ...	Samuel Clark	Death from natural causes	
,, ,,	,, ...	,, ,, ...	James Williams... ...	Accidental death	
,, ,,	,, ...	,, ,, ...	Man unknown	Found drowned.—Means unknown	
,, 25	Fryer's Creek ...	W. McCrea, ,, ...	Joseph Bennett, a child ..	Accidental death	
,, ,,	Melbourne ...	W. B. Wilmot, ,, ...	Man unknown	Death from natural causes	
,, 26	Bendigo	J. McCrea, ,, ...	Emily Morgan	Self-destruction	Deceased took a large dose of laudanum whilst laboring under temporary insanity


ALERT

The Five Stages of Medical Treatment-Related Death Prevention

Stage I	**Preparedness**. The context in which a medical treatment–related death is investigated.
Stage II	**Recognition and reporting**. How relevant cases are identified and the mechanisms for notifying the designated person(s) of the need to investigate a death.
Stage III	**Investigation and analysis**. Of the nature, depth, methods, materials and persons involved in achieving an understanding of the cause/contributing factors to the death.
Stage IV	**Findings and recommendations**. The outcome of the investigation including any suggestion to improve care or prevent future harm.
Stage V	**Response**. The actions taken to implement the recommendations or suggestions to prevent a recurrence, this also includes an evaluation post-implementation of the recommendations.

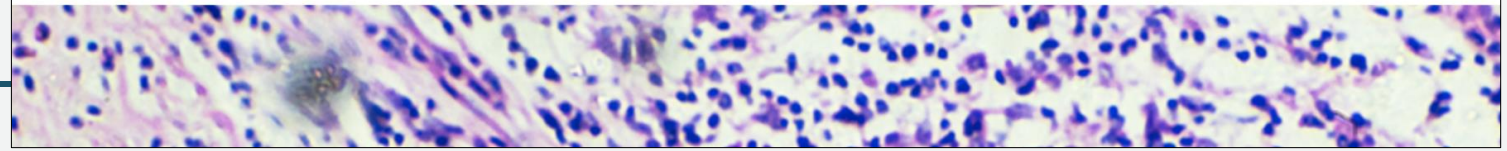
Clinical failures, delays contributed to woman's death after pain ordeal, Tasmanian coroner finds

By Tamara Glumac • 1 Jun 2018, 2:46pm

Updated

Victorian man dies alone after test results faxed to wrong number – coroner slams use of “antiquated” tech

Lynne Minion | 11 May 2018



Inquest into junior doctor death told of long hospital hours

Mother says daughter who took her own life worked 95 hours a week

Mon, Nov 18, 2013, 18:31 | Updated: Mon, Nov

Doctor's overdose death prompts warning over misuse of anaesthetics

NSW coroner finds Dr Beata Vandeville self-administered a cocktail of drugs including the powerful drug propofol

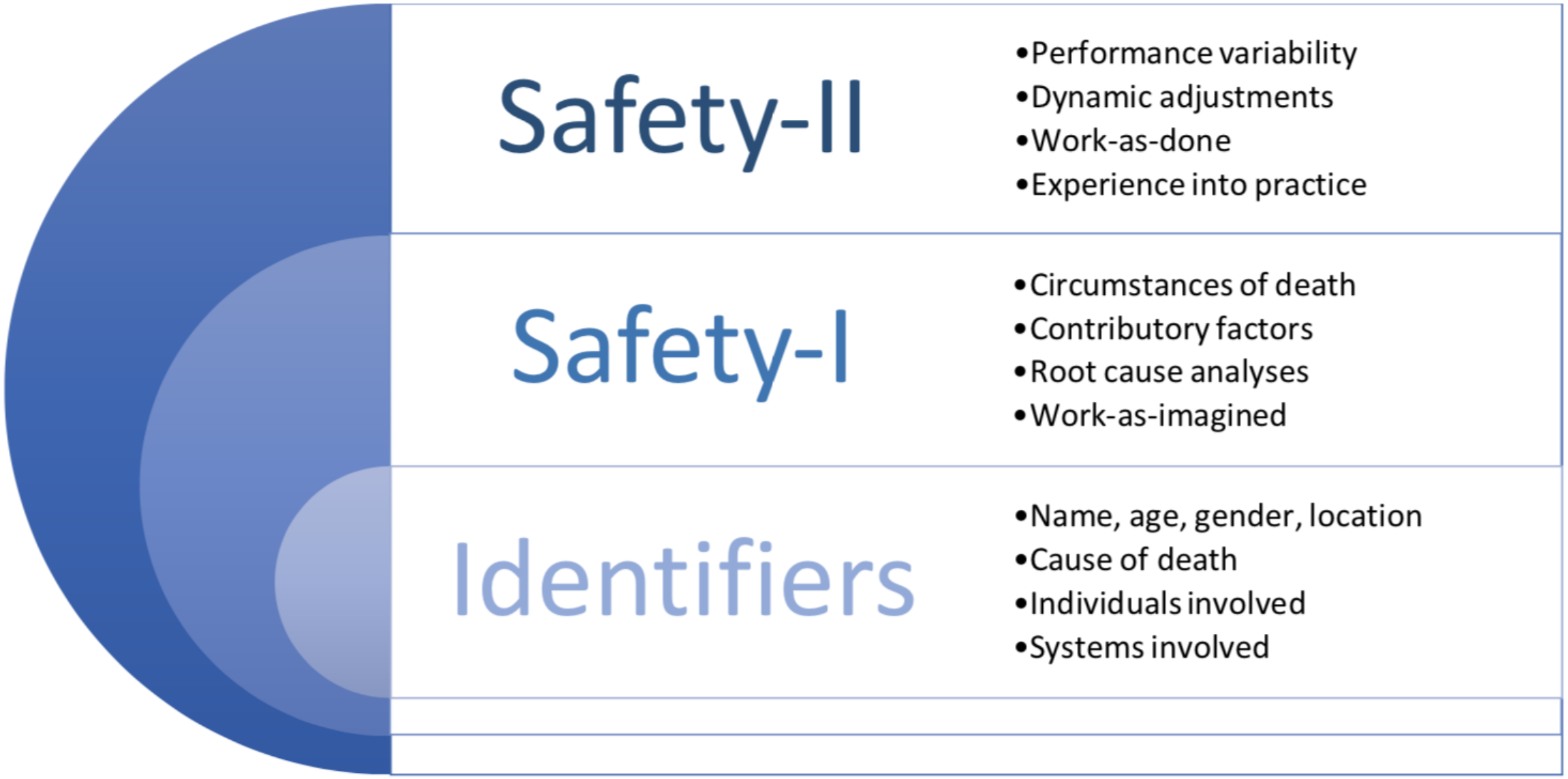
The challenges in learning from coroners' findings

- Timing, framing and linkage of coronial data
- Enforcing and implementing recommendations
- Informing practice change at the coalface


No thanks!
We are too busy

The future of learning from coroners' findings

- A combined Safety-I/Safety-II approach
- Improve the linkage between jurisdictional cases and recommendations
- Strengthen the delivery of safety messages from coronial inquests to clinicians


Safety-II
•Performance variability
•Dynamic adjustments
•Work-as-done
•Experience into practice
Safety-I
•Circumstances of death
•Contributory factors
•Root cause analyses
•Work-as-imagined
Identifiers
•Name, age, gender, location
•Cause of death
•Individuals involved
•Systems involved

- **Identifiers**

TO was a 4-year-old boy who died of severe rhabdomyolysis (muscle breakdown) that he suffered as a result of a rare genetic abnormality that was undiagnosed at the time of his death. In the months leading up to his death, he had been seen by a number of general practitioners (GPs), paediatricians and emergency doctors for an array of symptoms including sleepiness, dark urine and joint pains, but was sent home each time.

Safety-I Framework

The coroner explored whether there were earlier clinical signs which should have alerted medical staff to undertake further reviews and investigations. The coroner felt there were missed opportunities to make the diagnosis of rhabdomyolysis but was not critical of the doctors involved in TO's care for being unaware of the genetic abnormality. Expert opinions were obtained during the inquest from an emergency physician, a paediatrician, and a GP. All the experts reflected that they had never seen a child present with spontaneous rhabdomyolysis. It was felt that the actions of the GPs, and the care provided at hospital was appropriate and conducted according to relevant professional standards. The coroner acknowledged that the hospital had made changes to its procedures regarding discharge letters and the review of pathology results. He stated, "whilst policies are all very well, such matters should in reality be matters of sensible and good clinical practice." The coroner did not make any formal recommendations.

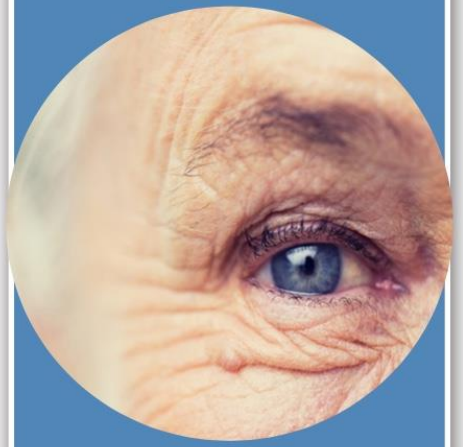
Safety-II Framework

In this case where there were missed opportunities to recognise TO was unwell, and no recommendations given, a Safety-II approach has the potential to draw material benefits for clinicians from the tragic event. Focussing on one of his emergency department visits as an area to map: What is the staffing on a typical day and how many paediatric patients are seen? How are the patients with undifferentiated illnesses investigated? How are they managed when a diagnosis has not been made? What was different this time? Why was he sent home when another child with a fever might not be? Did the doctor do the same thing he/she always does? Has it worked before? What factors would need to be different next time to change the decision? And are there applicable examples of best practice? (e.g. automation of triggers on blood tests, mandating that patients do not go home until all tests are back, requirement for all representing patients to be seen by a senior clinician).

CLINICAL COMMUNIQUÉ

Hospital-based case studies

The Clinical Communiqué is an electronic publication containing narrative case reports about clinical lessons learned from patient deaths that have been investigated by the Coroners' Court.



RESIDENTAL AGED CARE COMMUNIQUÉ

Residential aged care-based case studies

The Residential Aged Care Communiqué is an electronic publication containing narrative case reports about lessons learned from Coroners' investigations into preventable deaths in Residential Aged Care settings.

FUTURE LEADERS COMMUNIQUÉ

Junior practitioner inspired content

The Future Leaders Communiqué is an electronic publication containing narrative case reports about lessons learned from Coroners' investigations into preventable deaths. These articles are written by healthcare graduates with a fresh take on current matters.

The Polygon of Patient Safety

THANK YOU

Email:

NICOLA.CUNNINGHAM@VIFM.ORG

Resources:

- http://vifmcommuniques.org
- How do coroners' findings in Australian jurisdictions apply to healthcare practitioners within Safety-I and Safety-II paradigms? *Journal of Law and Medicine* 2018; 25: 1079-1099.
- Safe working hours for doctors – Whose duty of care? *J Health, Saf Environ* 2018; 34(2): 105-127.

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The big misses – why do they still happen?

ACEM Patient Safety Workshop 2019

A/Prof Sally McCarthy FACEM MBA FIFEM

Senior Emergency Physician Prince of Wales Hospital Sydney

Director Emergency South East Regional Hospital Bega

Chair, National Program ACEM

President-Elect IFEM


Main Entry
Emergency

A case

Triage assessment

70 year old male

Vomiting since last pm. Has continued to vomit approx 6 x times today.
Denies diarrhoea. Has opened bowels today x 2 - looser than normal.
Nil other illness within the family.
Decreased oral intake today.

PHx: AVR, warfarin, gout, high chol

Triaged to waiting room TC 4

Triage

Respiratory Rate : 18 brpm

Oxygen Saturation : 99 %

Systolic Blood Pressure : 146 mmHg

Diastolic Blood Pressure : 55 mmHg

Peripheral Pulse Rate : 76 bpm

Peripheral Pulse Rate Regularity : Regular

Temperature, Oral : 37.1 Deg C

MO assessment

Summary of Care
PH- AVR metallic on warfarin
HTN
T2DM on oral hypoglycaemics

travelling from major city with family- staying in (nearby small town)
vomiting small amts, up to 10 vomits since last night
vague abdo discomfort
opened bowels x 2 today- soft ,semisolid stools
unable to tolerate food
tolerating small sips of water and his usual meds
nil fevers/GI bleed/sick contacts/overseas travel

MO assessment

o/e- afebrile

mild dehydration

vitals stable

Abdo - soft, nontender, bs+,

Thoughts….

Are we concerned?

Older patient with multiple co-morbidities

Non-specific presentation (vomiting, no diarrhoea)

What else do we need to know?

Medications (and impact on electrolytes, renal function, ?INR)

Urine output (dehydration, renal function)

Simple bedside investigations ECG, BSL, UA, VBG

Thoughts…

Poor oral intake

BSL?

What medication is he on?

Renal function?

Discharged

Diagnosis of gastroenteritis

Brought back to ED via ambulance minutes later

? syncopal episodes

pt put on monitor had ventricular standstill for approx 10 seconds > self resolved into AF rhythm
coffee ground vomits x 2
GCS 15

Respiratory Rate : 29 brpm

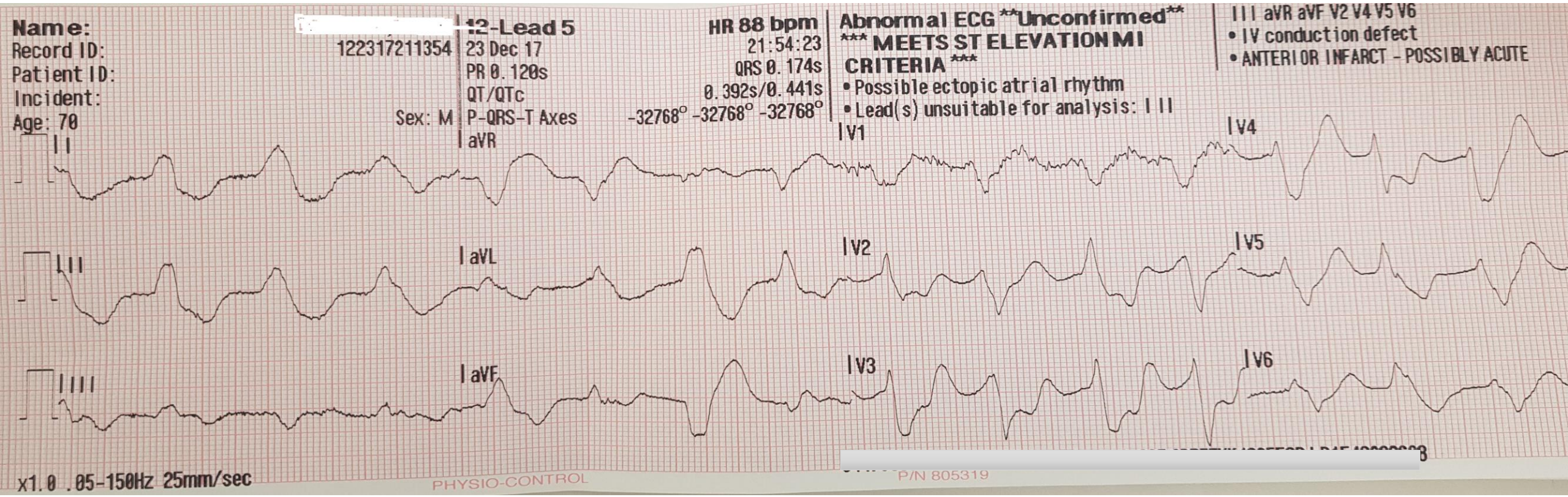
Oxygen Saturation : 99 %

Systolic Blood Pressure : 142 mmHg

Diastolic Blood Pressure : 58 mmHg

Peripheral Pulse Rate : 78 bpm

Peripheral Pulse Rate Regularity : Irregular


Name:
Record ID: 122317211354
Patient ID:
Incident:
Age: 70
Sex: M
12-Lead 5
23 Dec 17
PR 0.120s
QT/QTc
P-QRS-T Axes
-32768° -32768° -32768°
HR 88 bpm
21:54:23
QRS 0.174s
0.392s/0.441s
Abnormal ECG **Unconfirmed**
*** MEETS ST ELEVATION MI CRITERIA ***
• Possible ectopic atrial rhythm
• Lead(s) unsuitable for analysis: I II
I II aVR aVF V2 V4 V5 V6
• IV conduction defect
• ANTERIOR INFARCT - POSSIBLY ACUTE
II
III
I
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
x1.0 .05-150Hz 25mm/sec
PHYSIO-CONTROL
P/N 805319

Another case

42yo male referred by GP with generalised abdominal pain, 3-day history of fever, nausea and diarrhoea.

At triage, observations:

- *HR 125/min*
- *T37C*
- *BP 142/88mmHg*

Another case

Patient reviewed by registrar, with physical examination findings of mild tenderness to right iliac fossa on deep palpation.

Impression: acute gastroenteritis with differential diagnosis of appendicitis.

Patient given IV fluids and analgesia.

Another case

Repeat observations:

- *HR 112/min*
- *BP 121/87mmHg*
- *T38C*
- *RR 16/min*

Another case

Two hours later, blood results revealed elevated WCC (10.9), lactate (2.6).

Observations at this time:

- *HR 91/min*
- *BP 130/90mmHg*
- *T36.7C*

Another case

Patient was now pain-free. Decision made to discharge the patient home, with specific instructions given to return to ED if not improving.

Another case

The next day, the patient re-presented to ED complaining of ongoing diarrhoea but no abdominal pain.

A second registrar assessed the patient and found no abdominal pain and active bowel sounds. WCC had normalised. Abnormal LFTs were noted.

Another case

Given diagnosis of viral hepatitis.

Following discussion with Gastroenterology Registrar, a plan was made to discharge the patient home and outpatient abdominal ultrasound and follow-up arranged.

Another case

The next day, the patient re-presented again with ongoing complaints of diarrhoea.

Observations:

- *HR 110/min*
- *BP 140/100mmHg*
- *T36.6C*

Another case

Reviewed by a third registrar, who found no significant physical examination findings. Patient was admitted to the Emergency Medical Unit (EMU) for overnight observation.

Received IV saline and metoclopramide for nausea. Stool sample sent.

Another case

Patient afebrile and haemodynamically stable overnight .

Reviewed the next morning by an ED consultant, who discharged the patient home.

Another case

The next morning, the patient re-presented after being referred by GP for further investigation of ongoing diarrhoea and vomiting.

Observations at triage:

- *HR 120/min*
- *T37.1C*

Another case

Reviewed by JMO, who found abdominal distention, nil tenderness and high-pitched bowel sounds.

AXR ordered, which showed: dilated loops of bowel consistent with bowel obstruction, no free air below diaphragm.

Another case

Patient was reviewed by a surgical registrar, and had a CT performed, showing perforated acute appendicitis with an associated periappendiceal abscess and a secondary small bowel ileus.

Another case

Twenty-five days after initial presentation to ED, patient was discharged home following admission involving a right hemicolectomy with formation of ileostomy due to faecal peritonitis, prolonged administration of IV antibiotics, and commencement on total parenteral nutrition.

What's the problem?

Emergency Medicine is an inherently challenging area of clinical practice.

Over time, guidelines, policies and pathways have been developed and re-developed to assist emergency clinicians in the management of the entire spectrum of disease and conditions.

Yet we continue to see a significant number of adverse events in our departments, with *some being repeated over and over* again.

Day to day examples

Lack of knowledge eg voltaren v ketolorac

Lack of knowledge, and experience gradients eg reg not believing vital signs can be normal despite significant intra-abdominal blood loss, refusing to receive advice from outside specialty

Lack of knowledge eg accepting physician delay in pursuing imaging for suspected aortic dissection, neurological emergencies in young woman

Geographical bias eg referring clinician from small or rural hospitals assumed to be less competent

And, conversely, clinicians from tertiary hospitals not questioned even when wrong assessment/ advice given to rural site eg cardiology registrar not recognising VT on ECG trace

Doctors under pressure to fully assess patients in ED ambulance bay, corridor or other compromised site due to overcrowded ED and need to meet time targets

Excessive and unnecessary test ordering used as substitute for decision making or asking for advice

Day to day examples

Inadequate use of simple analgesic regimens and overuse of oxycodone

Failure to investigate recurrent presentations of atypical abdominal pain in high risk patients

Failure to take full history including patient's usual pattern of activity

We have ruled out ACS but then what?

The EP relied on the intern's assessment and did not personally review the patient

The RCA review team noted "it was an unusually busy evening"

Steps to avoid error

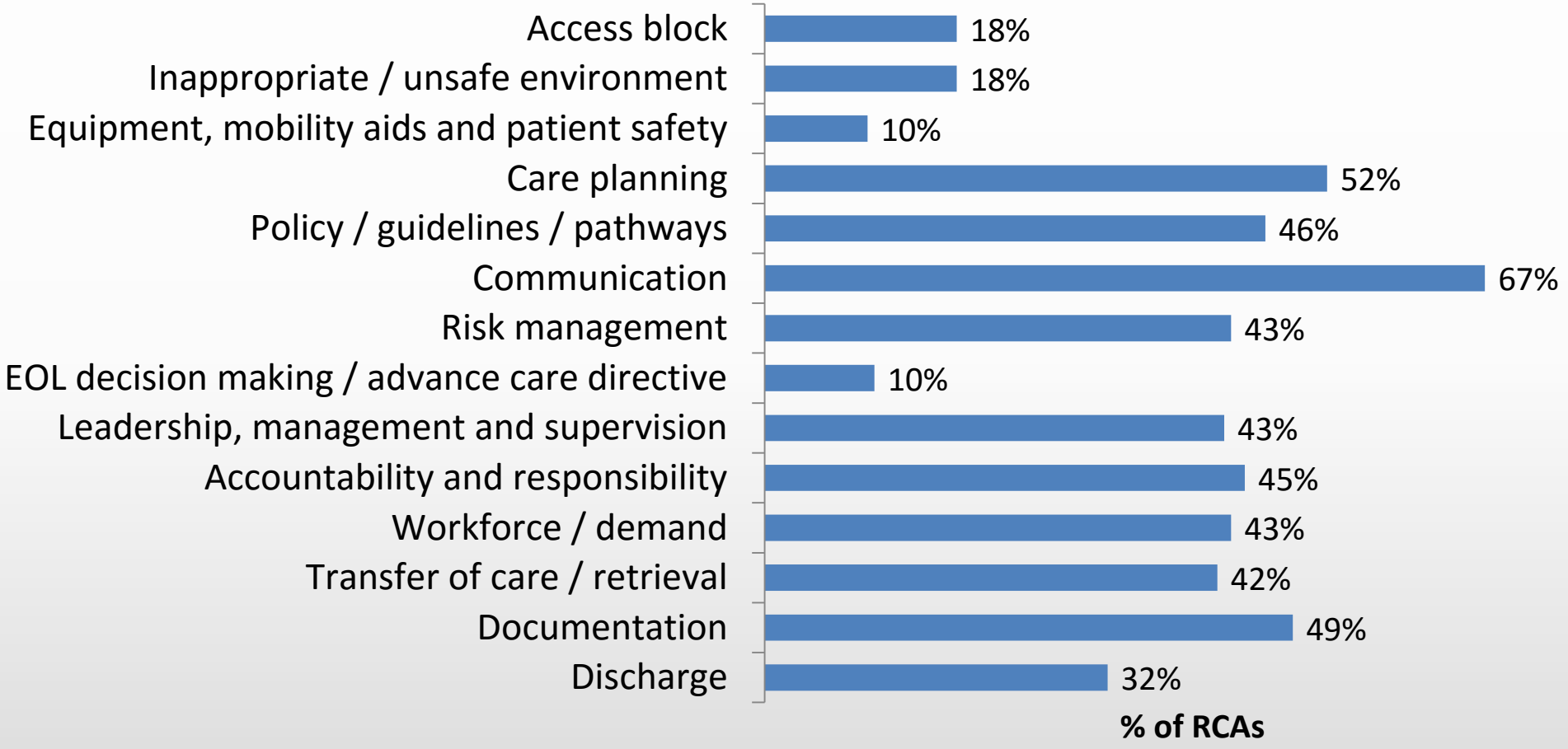
Self

The team

A collective mind

The work environment

Underlying system/contributory factors identified



ACI NSW Agency for Clinical Innovation

Emergency Care Institute NEW SOUTH WALES

Headline contributory factor *(% of 138 RCAs reviewed)*	**Supporting/underling main factor(s)** *(% of 138 RCAs reviewed)*
Access block (16%)	• Access block: To service bed delayed not available (10%)
Inappropriate/ unsafe environment (17%)	• Overcrowding / No bed available in ED (11%)
Care planning (54%)	• High risk presentation not considered (43%) • Inadequate care plan documented in the patient records (18%) • Lack of consensus by clinicians regarding appropriate patient care (12%)
Policy / guidelines / pathways (52%)	• Inadequate, not clear (37%) • Policy not known (26%)
Communications (69%)	• Communication within ED team (39%) • With or by GP Specialist/VMO (21%) • Inadequate handover in ED (19%) • Between ED and ward (15%) • With or by ED consultant ED physician (13%) • With patient or carer (12%)
Risk management (45%)	• Review monitoring systems inadequate (25%) • Discharge decision wrong (13%)
Leadership, management and supervision (43%)	• Inadequate clinical leadership / teamwork (31%) • Supervision / staff-support inadequate (22%) • No identified lead clinician (12%)
Accountability and responsibility (46%)	• No consultant or issues in regards a request for or need for a consultation (29%) (e.g. delayed consultation) • Weak or no escalation plan (28%) • Failure to understand clinical responsibility or level of skill required (13%)
Workforce / demand (46%)	• Training / skills / education inadequate (39%) • Senior staff unavailable (13%) • Skill mix inappropriate (10%)
Transfer of care / retrieval (43%)	• Handover inadequate (24%) • Inadequate initiation of patient transfer retrieval (13%) • Delay in speciality accepting patient (10%)
Documentation (51%)	• Inadequate documentation in patient records (38%)

The reality

Few patients present in a manner that can be managed according to a well-prescribed pathway.

Many patients with potentially life-threatening conditions will present in an unusual or atypical manner and/or fail to respond to initial management for a condition as expected.

It is these presentations in high-risk or complex patients that constitute a significant proportion of ED-related incidents and adverse events.

Distilled wisdom

Often, patients do not fit the classic mould

While guidelines provide a uniform approach to management of patients who present in a typical manner for immediately or imminently life-threatening conditions, many patients with potentially life-threatening conditions will present in an atypical manner, and/or fail to respond to the initial management as expected. Atypical presentations pose an increased risk of an adverse outcome or event.

Atypical presentations

Atypical presentations or patients whose progress or response to treatment is not as expected, should trigger clinicians to consider early reassessment, investigation and consultation. This may not only manifest as deterioration, but also where there is no change in condition.

Distilled wisdom

Start Over

Re-assessment means starting from scratch, and approaching the patient with no preconceptions. Clinicians must ignore a “diagnosis” that has been previously given. For example, labelling abdominal pain in an elderly person as constipation before serious surgical diagnoses have been ruled out, and simultaneously, clinicians should consider all information available from other sources.

Representing patients pose a higher risk

Any recent presentation to an ED or any other medical provider for the same complaint should flag this patient as high risk.

Distilled wisdom

Use “red flags”

“Red flags” are indicators in the patient history or examination that alert us to potential serious diagnoses that may be mimicked by more common and less sinister conditions. Excluding potential serious diagnoses must be a conscious and active process once red flags are identified, even if the patient looks well.

Keep an open mind

It is acceptable to not know the diagnosis as clinical signs will evolve. Deliberately keeping an open mind, thinking broadly and seeking advice while addressing early stabilisation and therapy, will generally avoid the wrong clinical path.

Initially “undifferentiated” patients constitute a high risk group and lack of a clear diagnosis may prevent assignment of the patient to a familiar care pathway. In this situation, re-assessment and early consultation is essential and keeping an open mind will reduce the risk of initiating inappropriate treatment.

Other ways of thinking about risk in ED

Risk management in a dynamic society (e.g. the boundaries of risk in an organisation, and how such boundaries are formed, defined, perceived and tested).

Organisational resilience, and the failure of organisational resilience and adaptability.

Supervision and perspectives on what it means to be ‘in control’ in networks.

Team dynamics and theories..

Economics, resource use, and quality control (managing the quality of products and tolerances).

Australasian College
for Emergency Medicine

What goes wrong?

Panel and discussion – What goes wrong?

Facilitator: Dr Stephen Priestley

Panellists:

Ms Maria Mota

Ms Ursula Harrisson

Dr Nicola Cunningham

A/Prof Sally McCarthy

Australasian College
for Emergency Medicine