EMER

Emergency Medicine Events Register

Consumer Reporting of Diagnostic Errors in Emergency Medicine

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EMER Clinicians

*2012 Specialty-specific, **online anonymous** incident reporting for **clinicians***

- What happens in EDs?
- Why?
- What can we do to prevent these incidents?

*Different perspective **equally** valuable information*

EMER Consumer

*2016 Specialty-specific, **online anonymous** incident reporting for **consumers***

- What happens in EDs?
- Why?
- What can we do to prevent these incidents?

Consumer Perspective

Described as the missing piece of the puzzle that is safe healthcare.

Can be used to identify

- Diagnostic errors
- Contributing factors
- Preventive strategies

What value do consumers add to patient safety?

- Are errors, contributing factors and preventive strategies able to be identified by consumers?
- Are consumers seeing things we don't see??

Why do things go wrong in EDs?

- Is it our environment?
- Is it our training?
- Is it about how we communicate?

"Most people will experience at least one diagnostic error in their lives, sometimes with devastating consequences." [1]

"Patients have a key role to play in helping to reach an accurate diagnosis, in deciding about appropriate treatment, in choosing an experienced and safe provider, in ensuring that treatment is appropriately administered, monitored and adhered to, and in identifying adverse events and taking appropriate action." [2]

Background

The Emergency Medicine Events Register (EMER) is an adverse event and near-miss reporting system that is peer-led, online, anonymous and confidential.

A one year pilot study was initiated in 2012, followed by implementation of EMER across Australia and New Zealand in 2014. Initially, only open to clinicians, it was expanded in 2016 to enable consumer reporting. EMER is the first emergency medicine specific incident reporting system in Australia.

Statement of the problem

Since the inception of modern patient safety movements in the late 1990s, little attention has been given to the knowledge and experience of consumers on patient safety, and the role they could play in making healthcare safer.

For clinicians to calibrate their diagnostic reasoning, feedback on their diagnosis is crucial. Encouraging consumers to report back when their diagnosis evolves or is incorrect, is essential for clinicians to improve their diagnosis.

Aim

The patient perspective could be described as a missing link in the puzzle that is safe healthcare. Consumer reporting can be used to help identify diagnostic errors in medicine, as well as contributing factors and preventive strategies. On the EMER website a consumer reporting portal was added to gather incidents across all hospitals from the consumer perspective.

Methods

Consumer recruitment is performed through EMER site champions, consumer group advocates, EMER website (www.emer.org.au), social media and "word of mouth". Consumers navigate through a set of questions specifically designed to elicit relevant information in a succinct manner to enable maximum information extraction (Box 1).

Submitted incidents are categorised using similar codes to clinician categories to enable comparisons on what goes wrong in our EDs, and further analysed by expert data analysts (see Results 1 & 2) and reviewed by those involved in emergency medicine and consumer advocates. Learnings are disseminated through publications, conference presentations and workshops

Conclusions

Diagnostic errors are amongst the most frequently reported incidents by consumers. Consumer reports demonstrate cognitive biases in clinician thinking, including premature closure, triage cueing and fundamental attribution bias. Consumers identify poor coordination of care and problems with communication (clinical handover, disrespectful communication, and " not listening"). Several reports describe clinicians disregarding parent and family concerns regarding their relative's diagnosis.

The patient is an essential part of the diagnostic team and is often overlooked. This ground-breaking project endeavours to incorporate the patient experience, helping to improve diagnostic accuracy.

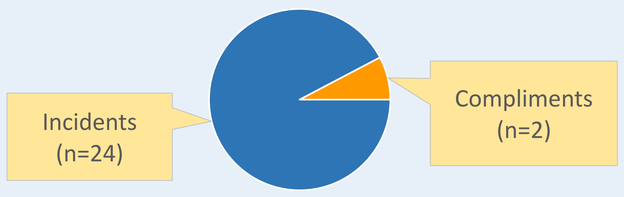
Consumer Report Form (Box 1)

10 questions (4 mandatory*)

- Who did the experience happen to?*
- Tell us what happened*
- What was the result of your experience?*
- How could your experience have been prevented?
- What could the emergency department have done better?
- Age
- Gender
- Country*
- How recently did your experience occur?
- Time of day

Incidents vs Compliment

(n=26)



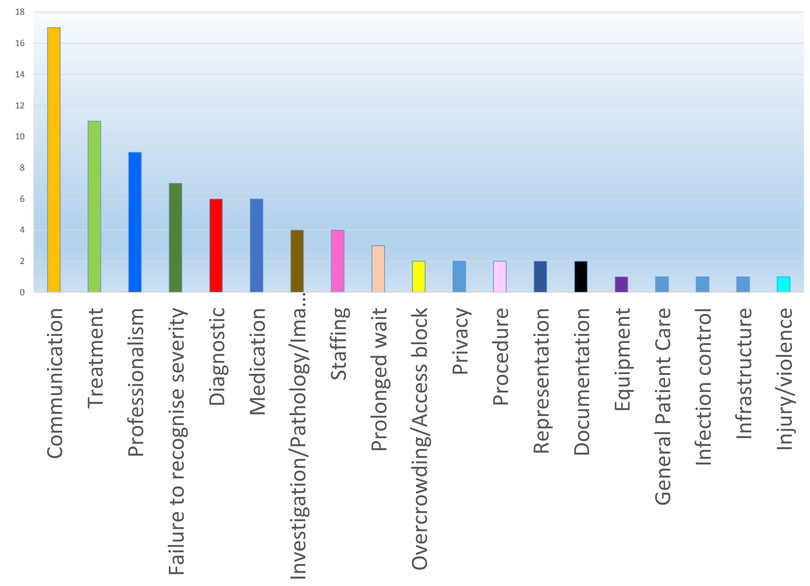
Consumer perspectives on incident prevention

(Thematic analysis)

- Monitoring of vital signs
- Recognising severity
- Improved communication
- Improved assessment and/or examination
- Show compassion
- Improved clinical decision making
- Verify & validate
- Better history taking

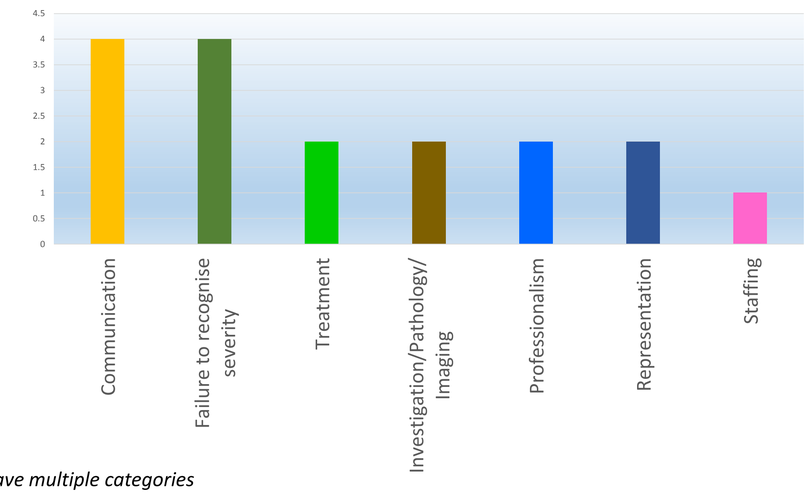
Results 1

Consumer Incident by Category* *(n=77)*



Diagnostic Error and Associated Category*

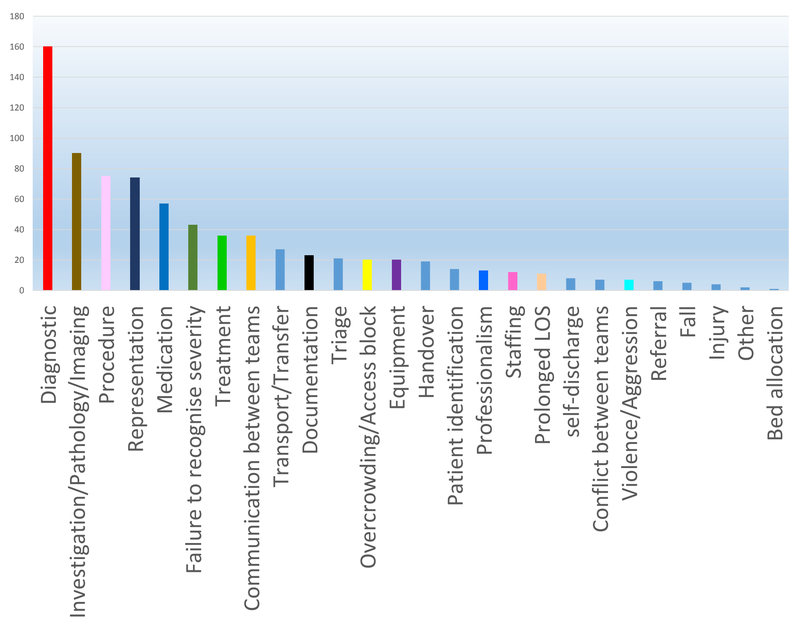
(6 incidents, 17 categories)



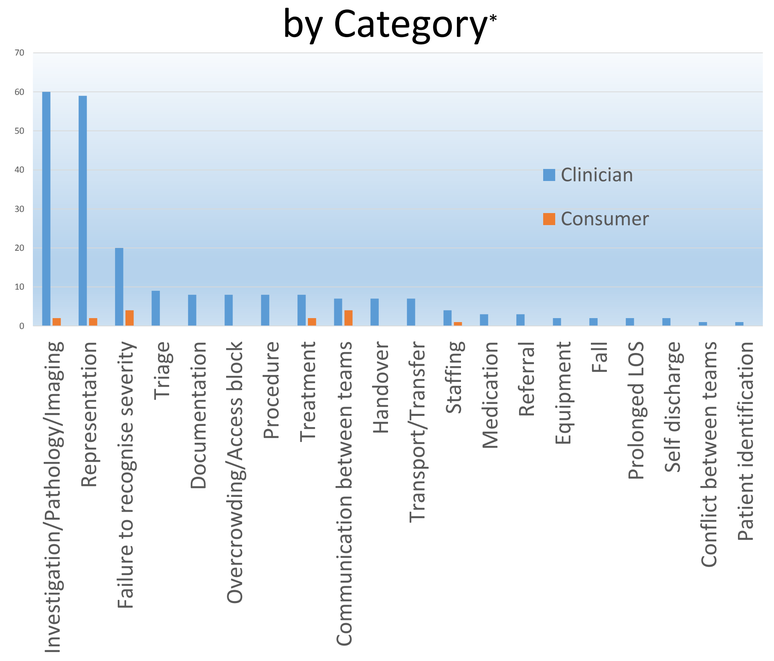
**An incident may have multiple categories*

Results 2

Clinician Incident by Category* *(n=791)*



Clinician vs Consumer Diagnostic Error by Category*



[1] National Academies of Sciences, Engineering, and Medicine. (2015). Improving diagnosis in health care. Washington, DC: The National Academies Press.
[2] Vincent, CA., and Coulter, A. (2002) Patient safety: what about the patient?. Qual Saf Health Care. 11:76-80