“Voices from the grave”
Deaths in the Emergency Medicine Events Registrar
emer.org.au

Dr Kim Hansen  MBBS(HonsI) FACEM
Senior Emergency Consultant
The Prince Charles Hospital, Brisbane
Brisbane Northside Emergency
ACEM Quality Management Committee, Vice-Chair
ACEM CAPP member
EMER Steering Committee
IFEM Quality and Safety Special Interest Group Chair
• Dr Carmel Crock, Royal Victorian Eye and Ear Hospital
• Dr Tim Schultz, Australian Patient Safety Foundation
• Prof William Runciman, Australian Patient Safety Foundation
• Ms Anita Deakin, Australian Patient Safety Foundation
• Dr Andrew Gosbell, ACEM

With thanks to the EMER Steering Group and Site Champions

Follow us on @EmergMedER
Forum on Investing in Young Children Globally (iYCG)
clinical human factors group
working with clinical professionals and managers to make healthcare safer
Welcome to the Emergency Medicine Events Register (EMER)

EMER is an adverse event and near-miss reporting system that is peer-led, online, anonymous and confidential. It is a means of supporting improvement in safety and quality in emergency medicine by understanding of contributing factors and how the risk of harm to patients can be minimised or prevented.

For more information please click here to watch the EMER video “Learning from our errors - Emergency Medicine Events Register”.

The EMER is supported by ACEM and managed by the Australian Patient Safety Foundation (APSF). The College encourages members to enter incidents to the database. CPO points can be claimed for reports submitted.

EMER will guide you to:

Identify  Report  Inform

Learn more about EMER
Incident Report

Page 1 of 4

Please enter incident details below - mandatory fields are marked with an asterisk (*).

Country *
Australia

How is the organisation funded? *

On what date did the incident occur? (Please use date picker on right hand side) *

Date is
Exact date

Timeband
00:00 to 00:59

Methods
Incident Report

What was the patient's triage score on presentation?*

Which medical specialty(ies) was involved in the incident?
- Ambulance Service
- Anaesthetics
- Burns
- Cardiology
- Cardiothoracic Surgery
- Colorectal
- Dermatology
- Drug & Alcohol
- Emergency Medicine
- ENT
- Endocrinology
- Faco-Maxillary Surgery
- Gastroenterology
- General Medicine
- General Surgery
- Geriatrics
- Haematology
- Immunology
- Infectious Diseases
- Intensive Care
- Neurology
- Neurosurgery
- Obstetrics & Gynaecology
- Oncology
- Ophthalmology
- Orthopaedics
- Other
- Paediatric Medicine
- Paediatric Surgery
- Palliative Care
- Plastic Surgery
- Psychiatry
- Radiology/Imaging
- Rehabilitation Medicine
- Renal Medicine
- Respiratory
- Rheumatology
- Urology
- Vascular Surgery

What was the patient's age at the time of the incident?

Gender

Clinical presentation
Incident Report

Page 3 of 4

What happened?*

What were the contributing factors?

What were the factors that reduced the impact of the incident?

What were the consequences or outcomes of the incident?

How could the incident have been prevented?
Incident Report

What was the immediate action(s) taken to manage the incident?

What is your designation? *

At what stage of the patient’s journey was the incident first initiated? *

At what stage of the patient’s journey was the incident detected? *

Did this incident or near miss involve a failure associated with application of the correct patient, correct site or correct procedure policy?

Did the incident involve a problem with handover?

Is this incident a 'burst report' on either of the following incident types?

Enter the correct numbers into the box below:

37,95
Deaths in Emergency Medicine Events Register
## Device

<table>
<thead>
<tr>
<th>Device Category</th>
<th>Acquisition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sessions</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
</tr>
<tr>
<td>desktop</td>
<td>6,079</td>
</tr>
<tr>
<td>mobile</td>
<td>975</td>
</tr>
<tr>
<td>tablet</td>
<td>370</td>
</tr>
<tr>
<td></td>
<td>7,424</td>
</tr>
</tbody>
</table>
Deaths in EMER

December 2012 – November 2016

Database search of 324 cases for death, died, CPR, mortality, coroner

56 found

42 deaths analysed

14 excluded as patient survived
Deaths in EMER

• 42 of 324 incidents entered (12.3%)
• 38 were at an Australian Public Hospitals
• 19 were Triage Category 1 or 2 (45.2%)
• 15 patients were female (36%), 27 were male (64%)
Triage Category

Triage Score (All vs deaths)

- Category 1: Immediately life-threatening
- Category 2: Imminently life-threatening
- Category 3: Potentially life-threatening
- Category 4: Potentially life-serious
- Category 5: Less urgent
- Unknown
- (Blank)

Number of Incidents

Triage Score

Legend:
- Blue: All Incidents
- Orange: Deaths Only
Age

Age Band (All vs Deaths)

Number of Incidents

0 to 28 days
29 days to 11 months
12 to 23 months
2 to 4 years
5 to 9 years
10 to 14 years
15 to 19 years
20 to 24 years
25 to 29 years
30 to 34 years
35 to 39 years
40 to 44 years
45 to 49 years
50 to 54 years
55 to 59 years
60 to 64 years
65 to 69 years
70 to 74 years
75 to 79 years
80 to 84 years
85 to 89 years
90 to 94 years
Unknown Age

All Incidents
Deaths Only

Age Band

emer.org.au
“At what stage of the patient’s journey was the event detected?”
Diagnosis

- Sepsis
- Trauma
- Cardiac arrest NOS
- MI
- Meningitis
- Bowel ischaemia / Rupture
- ICH / SDH
- Tension PTX
- Other

emer.org.au
Diagnostic Error

- Chest pain – 5
  - ACS
  - Aortic dissection
  - PE

- Sepsis - 3

- Meningitis - 3
Investigations

• Delay to investigations eg CT

• Delay to reporting

• Follow-up of test results (after patient has left ED)
  o 2 x results indicating possibility of malignancy
Airway Management

- Oesophageal intubations x 2
- Failure to recognise complications
  - Tension pneumothorax
  - Misplaced NGT
There are lessons to be learnt from medical errors and patient deaths.

- **EMER** provides the opportunity to collect incidents, which, after analysis and reporting, can be used to improve patient safety in your ED.
Recommendations

1. Learn from EMER (other’s mistakes)

2. Safe guard high risk areas
   1. Diagnosis of chest pain, sepsis, meningitis
   2. Follow-up of tests results
   3. Time to imaging and time to report
   4. Airway management

3. Contribute to EMER’s database to ensure future learning for all
Case Study

Chest pain diagnosis case study

Details available at

All coroner’s reports referred to ACEM are entered into EMER
ED Details

- 55 year old male
- Triage cat 3
- Arrival 19.00
Clinical Presentation

• Sudden onset chest pain (rated 8/10), dizziness, “numb from waist down” while at gym

• Ambulance called - ECG and bilateral BPs done

• On arrival to ED: Ongoing buttock pain and leg weakness. No further chest pain.
What happened?

- Patient in distress with pain
- IV analgesia given
- Minimal history taken
- Limb examination only
- CT lumbar spine ordered
- Ambulance notes lost...

emer.org.au
What happened?

• Dr reviewed patient (approx. 2 hours after arrival) and attempted to get history of chest pain, patient was “quite dismissive”

• CT lumbar completed and was normal

• Able to convince patient to have blood tests, and to see GP next day for results. ECG done.
What happened?

- Ongoing back pain but able to mobilise
- Patient left ED
- Friend offered to take to another nearby ED but patient declined.
What happened?

• Patient found deceased the next day

• D-dimer positive

• Autopsy showed aortic dissection
  o Aortic root to left common iliac artery
  o Inflammation at initial tear indicates time between aortic tear and death
  o Haemopericardium caused death
Contributing factors

• No ambulance notes / handover available
• Patient placed in fast track bay
• Full history and examination not done
• Early closure to “back pain” diagnosis
• Patient left prior to pathology results available
How could the incident have been prevented?

- Ambulance notes and handover available to ED doctor and nurse
- Full assessment by ED doctor
- Avoid early closure to benign diagnosis
- Patient presenting to another ED as suggested by friend
- Recall after d-dimer result positive
Coroner’s report

• Comments from patient while in ED
  Patient called friend and family member and was not happy with ED treatment, and arranged to be picked up

  • “doctor only saw me for 10 seconds”
  • “not happy with the service”
  • “massive pain”
  • “someone please help me”
    (when in a corridor in severe pain)
EM is risky business...
FAQ

Emergency Medicine Events Register
How to we share EMER’s information?

- ACEM Bulletin
- EMA, BMJ
- Conferences – ASM, ICEM, SMACC, IFSQH etc
- Site champions network, EMER newsletters
- Twitter - Follow us @EmergMedER
- Hospital education sessions
- Patient Safety Alerts

emer.org.au
Patient Safety Alert

Subject: Testicular Torsion

Testicular torsion in young males is over-represented in the EMER database. Currently, 3% of incidents (7/235) involved a probable testicular torsion. All incidents in the EMER database are coded into categories by an expert panel. The most common incident categories in reports involving torsion is delay to treatment, conflict between teams and diagnostic error.

The management of testicular torsion is rapid surgical exploration to maximise the chance of a positive outcome. The patient should be given analgesia and kept fasted. Ultrasound scanning should not delay surgical exploration.

Referral and treatment pathways should be established by the ED Leadership team in advance.

Report ED incidents to
EMER.org.au

Improving patient safety

---

We need YOU!
• Visit us at emer.org.au
• Follow us @EmergMedER
• Email us emer@acem.org.au

@doctor__dora
kim.hansen@health.qld.gov.au