Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Claims relating to Emergency Departments

Claims Review Report

The State Claims Agency completed a five-year review of claims related to the care of patients in emergency departments (EDs) nationally. The aim of this report is to present the key findings of that review and provide advice for healthcare staff to help mitigate the risk of similar claims occurring.

This review included claims taken by patients, or their family members, related to the clinical care of those patients, and claims taken by patients related to non-clinical issues (e.g., slips trips and falls due to state of premises). Claims concluded and finalised, and where damages had been paid, from 2018–2022, inclusive, were included. Claims where the incident resulting in the claim occurred before 2017 were excluded.

Claim files related to the care of 61 patients were reviewed; in 55 cases, the claims were related to the direct provision of clinical care, and, in 6 cases, they were not related to the provision of care.

Review of Claims – A Snapshot

The paid damages for all **67* claims** amounted to **€11,242,277**: almost half (**45%**) of the claims resulted in paid damages of less than **€50,000**; in **93%** of claims, the paid damages were less than **€500,000**.

Diagnostic error featured as both the most common NIMS 'sub-hazard', and the most common cause of claims on qualitative analysis.

After 'Other', which is typically selected if there is more than one injury, the most common NIMS 'Type of Injury' was 'Fracture' (n=13).

The service of Emergency Medicine accounted for most claims; claims also occurred under the services of Medicine, Surgery, Mental Health, Radiology, and Maternity (non-obstetric).

In **48%** (n=29) of cases, the patient re-presented to an ED at least once with the same issue.

31% (n=19) of cases involved delays seeing a doctor post-triage. Of these, seven breached Manchester triage category 2 and twelve breached Manchester triage category 3 (Table 1).

In **21%** (n=13) of cases, the patient deteriorated while waiting to see a clinician.

*n=67, which includes claims taken by patients and claims taken by family members (dependents) in relation to the death of a patient

Table 1. Time taken to see a doctor where a delay happened (n=19)

Manchester Triage Category 2 (within 10 mins)		**Manchester Triage Category 3** (within 60 mins)	
Wait time	**Number of claims**	**Wait time**	**Number of claims**
>10 mins – 1hr	3	**1–2 hrs**	4
1–2 hrs	2	**2–3 hrs**	3
>2hrs	2	**3–4 hrs**	2
		>4 hrs	3

The primary cause of each claim (what happened) and issues contributing to each claim (why it happened) are outlined in Tables 2 and 3.

A clinical case study is presented on page 3 and advice for all healthcare staff working within the ED is set out on page 4.

Learning from Claims

Table 2. What happened – primary causes of the incidents resulting in claims (n=61)

Injury, as a consequence of:	**Number**
Diagnostic error	**25**
▪ Missed diagnosis	13
▪ Misdiagnosis	8
▪ Delayed diagnosis	4
Treatment and procedures	**18**
▪ Inadequate treatment	14
▪ Collapse (preventable)	4
- Fainting	2
- Cardiac arrest	1
- Medication	1
Slip, Trip, Fall	**6**
Patient environment	**6**
▪ Fall	5
▪ Patient to patient VHA (violence, harassment, aggression)	1
Assessment	**3**
▪ Inadequate assessment	2
▪ Incorrect assessment	1
Medication error	**3**

Table 3. Why it happened – issues that contributed to the occurrence of the claims

	Issues identified	Examples
1	Inadequate clinical decision making (e.g. failure to carry out tests/investigations, failure to refer, failure to escalate, inadequate assessment)	Testicular torsion not considered in the differential diagnosis; subarachnoid haemorrhage not considered in the differential diagnosis; failure to recognise neurological deterioration
2	Inadequate technical skill (e.g. inadequate treatment, incorrect interpretation of diagnostic tests)	Missed fracture; inadequate wound assessment
3	Lack of/inadequate supervision (risk of falls)	Patient left unattended in non-clinical area
4	Failure to consider patient/family concerns	Regarding deterioration; regarding self-harm
5	Inadequate documentation (e.g. decision making, assessment/tests, treatment, history, discharge)	Inadequate documentation of x-ray interpretation, wound exploration, previous surgery, medical history, patient's condition
6	State of premises/equipment	Environmental hazard in bathroom resulting in a fall
7	Failure to follow policy, procedure, protocol or guideline (PPPGs)	Sepsis guidelines; local policy on headache assessment
8	Lack of/inadequate assessment (risk of falls)	Fall post-injection
9	Behaviour	"Rude" junior doctor; "dismissive" nurse
10	Inadequate monitoring	Vital signs not taken when required
11	Medication error	Penicillin prescribed when known penicillin allergy
12	Failure to ensure patient safety	Patient to patient aggression

Table 4. Clinical case study

Misdiagnosis of testicular torsion

Case presentation:

A teenage male attended ED with lower abdominal pain and pain in his right testicle. A diagnosis of epididymo-orchitis was made but the patient was discharged home without medication and advised to return if the pain became worse or did not improve. "No sign of torsion" was reported in the medical notes.

The patient was again referred to the ED by his GP a couple of weeks later and referred to general surgery. An ultrasound was performed, and he was diagnosed with testicular torsion.

He was admitted and an orchidectomy performed.

Learning:

- On first presentation, investigations were not performed to exclude or confirm testicular torsion.
- The pain score, which the plaintiff stated was 10/10, was not recorded in the notes.
- Despite suspecting an infection on first appearance, the doctor did not prescribe antibiotics.
- No process was apparent to allow discussion of the patient with a senior colleague. Had this happened, it is likely there would have been concerns resulting in patient recall.
- Appropriate care was provided on the second presentation.

Advice for all Healthcare Staff working within the Emergency Department

Based on our analysis of the claims in this review, we have prepared the following advice for all healthcare staff working within EDs:

Assessment, observation and patient flow

- The Emergency Medicine Early Warning System (EMEWS) should be implemented in all emergency departments and used from triage to discharge to support the recognition of, and response to, deteriorating patients. Its use should be audited regularly.
- The care of service users, identified as being "high risk" at triage, should be prioritised and escalated where appropriate.
- A falls risk assessment should be undertaken as part of the nursing assessment to identify service users who are at increased risk of falls and to guide implemention of preventative measures where necessary. Consideration should be given to the use of available ED-specific fall risk assessment tools.
- Risk assessments of overcrowding and patient flow should be undertaken and, where possible, mitigating actions implemented to reduce the risk of patient safety incidents.
- The location of vulnerable patients should be known and increased supervision should be considered and documented.

Preventing diagnostic errors

- Emergency departments should implement multidisciplinary training programmes with a focus on reducing diagnostic error and, in particular, the diagnostic assessment of those presenting with acute headache and testicular torsion.
- Processes should be put in place to identify patients who present to ED on more than one occasion with the same clinical problem and ensure that a senior decision-maker is involved in their assessment and care plan.
- ED staff should pay attention to concerns raised by patients or their family members, particularly in relation to deterioration. They should be documented and incorporated into the assessment of the patient.
- A full differential diagnosis should be considered and advice sought from senior decision-makers where necessary. Referral documentation (GP letter/referral letter etc), triage notes and radiology reports should be considered when arriving at a diagnosis.
- Necessary tests and investigations should be completed and their results followed up on by the doctor who ordered them. Specialty referrals should be considered.
- A working diagnosis should be arrived at before discharge, where possible. Consideration should be given to huddles involving senior decision-maker before discharging patients without a working diagnosis, or who have presented more than once to ED with the same complaint.

Education and training

- Clinical staff should have the competence to carry out diagnostic assessments and therapeutic interventions and should be supervised where necessary.
- National and local PPPGs should be implemented and clinical staff should be aware of them and trained in their use, e.g., relevant national guidelines for sepsis management.
- All healthcare professionals should know when, how and to whom to escalate uncertainties or concerns about a patient.
- Training in de-escalation techniques for incidents related to violence and aggression should be considered for at-risk personnel.

Providing a safe environment

- Policies on when, where and how cot sides are to be used, in line with patients' will and preference for alternative arrangements, should be developed and implemented.
- Deliveries of goods should be unpacked in a designated area and then safely transported, avoiding equipment that may obstruct walkways.
- Equipment and personal belongings should be stored away from pedestrian walkways to help mitigate slip, trip and fall hazards in the workplace.

Communication

- Effective communication is required between healthcare staff, particularly in relation to clinical information and handover of care.
- Symptoms, vital signs, findings on physical examination, course of care, discharge advice and consent should be fully and adequately documented. Good documentation enables effective communication and enhances the chances of successfully defending a claim.

Learning from adverse events

- Incidents should be reported in a timely manner in accordance with the statutory requirement to report incidents to the SCA, and in line with the HSE's Incident Management Framework. Analysis of incidents should be undertaken on a regular basis so that learning and ongoing service improvements can occur.

If you require further information, please get in touch with us via stateclaims@ntma.ie

Scan the QR Code to learn more about our Clinical Risk Unit.