EMERGENCY MEDICINE

PATIENT SAFETY & RISK SOLUTIONS
INTRODUCTION

This publication contains an analysis of the aggregated data from MedPro Group’s emergency medicine claims opened between 2005 and 2014. All claims included in this analysis identify an emergency medicine physician as the primary responsible service. Claims in which another specialty is identified as the primary responsible service are not included, unless otherwise noted.

This analysis is designed to provide MedPro Group insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed claims data to assist them in purposefully focusing their risk management and patient safety efforts.

Data are based on claim counts, not on dollars paid (unless otherwise noted). The type of claims and the details associated with them should not be interpreted as an actuarial study or financial statement of dollars paid; however, the information may be referenced for issues of relativity.

Please Note: This report is divided into two sections — an executive summary and a more detailed analysis of allegations and risk factors. The executive summary begins on page 3, and the detailed analysis begins on page 7.
Medication-related allegations currently represent a relatively small segment of emergency medicine claims. However, trends show these claims increasing, in part due to adverse events related to prescription narcotics.
Myocardial infarctions (MIs), which fall into the “cardiac (noninfective)” category, are the single most frequent diagnosis noted in emergency medicine diagnosis-related claims; however, infections as a broad grouping represent the largest volume of diagnosis-related claims (specific infections noted in these claims include pneumonia, sepsis, endocarditis, and, most recently, spinal abscesses).
KEY RISK FACTORS

Poor patient assessment, including inadequate history taking, test/consult ordering, and reevaluation of patients prior to discharge

Failure to follow policies and procedures, particularly those related to triage, medication monitoring, and reevaluation of patients admitted but not transferred from the ED

Inadequate communication among providers (particularly related to shift changes and other handoffs) and poor collaboration between physicians and nurses

Patient noncompliance due to poor discharge instructions or lack of follow-up

Inconsistent and incomplete documentation that does not support the final diagnosis or include adequate details about the differential diagnosis

Inadequate supervision of advanced practice providers

Poor tracking systems that prevent postdischarge test results from reaching patients or their physicians

EHR systems that prevent providers from accessing all relevant findings, changes, and prior records
**Claim Volume by Allegation Category**

*Diagnosis-related* allegations involve failure to diagnose or delay in diagnosis. These allegations account for 82% of total defense and indemnity dollars paid.

*Treatment-related* allegations are related to improper management of treatment and improper performance of treatment/procedures. Related outcomes include infections and scarring after suturing, constriction injuries following application of splints, injuries related to intubation technique, and improper management of behavioral health issues, cardiac arrest, and CVAs.

*Medication-related* allegations include improper ordering of medications, insufficient monitoring/documentation of at-risk patients’ responses to narcotics (e.g., patients who have sensitivity issues or a history of obstructive sleep apnea), improper administration/management of anticoagulant regimens (resulting in overdose), and delayed administration of tissue plasminogen activator (tPA).

*Other* allegations include those for which no significant claim volume exists. Examples include discrimination and breach of confidentiality issues.
Diagnosis-related allegations remained the top allegation category over the 10 years analyzed and are trending higher as a percent of total cases.
High-severity claims most often are associated with:

- MIs
- PEs
- CVAs
- Aortic aneurysms

Medium- and low-severity cases have outcomes such as:

- Manageable infections
- Need for additional surgical procedures
- Prolonged hospital stays
- Unanticipated scarring
**DIAGNOSIS-RELATED ALLEGATIONS BY DIAGNOSIS TYPE**

**Significant Risk Factors in Diagnosis-Related Claims**
- Failure to access patients’ prior medical records
- Patient flow issues related to wait times for consults and tests, which result in failure to order as indicated
- Inadequate patient assessment, which results in narrow diagnostic focus. Potential causes of this risk factor include cognitive biases, inadequate medical and family history taking, and inadequate sharing of information among providers
- Inadequate patient reassessment, which results in premature discharge
- Failure to communicate test results received postdischarge to the patient or the patient’s physician

**Note:** MIs — which fall into the cardiac (noninfective) category — are the largest individual diagnosis (8% of all diagnosis-related allegations).
TREATMENT-RELATED ALLEGATIONS

Treatment-related allegations, although not the largest allegation category, can be significant in terms of poor patient outcomes. These allegations typically are related to faulty triage, including:

- Problems associated with assessment and observation in the waiting room
- Failures in reassessment and monitoring of patients admitted but not transferred from the emergency department (ED)
- Failure to treat conditions such as CVAs in a timely manner
TOP RISK FACTORS IN ALL CLAIMS

Risk factors are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims. Because the decision-making process in a fast-paced ED setting is complex, the factors are varied.

- **Clinical Judgment**: 89%
- **Communication**: 40%
- **Documentation**: 24%
- **Administrative**: 21%
- **Clinical Systems**: 19%

Inadequate patient history and assessment
- Failure to order consults or tests
- Maintaining a narrow diagnostic focus

Insufficient charting of clinical findings and treatment rationale
- Failure to document differential diagnosis and evidence to support final diagnosis

Poor communication among providers
- Inadequate communication with patients, particularly in medication-related claims

Failure to follow established protocols, specifically triage (level assigned and waiting room monitoring), medication protocols, critical test result notifications, boarded patient reassessments, and advanced practice provider consultations

Encompasses breakdowns throughout the patient care continuum; particularly, issues with reporting results (including incidental findings) to patients or their physicians

Increasingly noted over the past few years
FOCUS ON CLINICAL JUDGMENT

Various factors can contribute to clinical judgment issues, particularly in diagnosis-related claims. The primary issue is inadequate patient assessment, which includes:

- Lack of access to patients’ prior medical records, including family history
- Failure among providers to share subtle patient changes
- Inadequate patient reevaluation processes, particularly in relation to abnormal vital signs.
- Inadequate EHR system functionality/integration, which prevents effective compilation of patient information

Learn More: A study by The Sullivan Group of 90,000 high-risk ED patients showed that 10% had at least one very abnormal vital sign. Of these patients, 16% were discharged without a reevaluation.

Source: Ten reasons your emergency department may not be as safe as you think it is. The Sullivan Group. (2006).
Focus on Communication

Claims involving communication issues with patients have several recurring themes, including incomplete discharge instructions, poor patient comprehension of instructions, and provider failure to adequately document both issues. Also, patient noncompliance is an increasingly noted issue that is greatly influenced by the above factors.

Communication issues in an emergency setting are primarily related to provider-to-provider interactions and information sharing. Factors that can negatively affect communication among providers include:

- EHR systems that limit interactions among providers and don’t allow easy viewing of other providers’ notes
- Breakdowns in transitions of care (handoff) procedures during shift changes

Consider the patient with resolving chest pain who is being discharged with an appointment to see a cardiologist in 2 days. Emphasize to the patient the importance of keeping that appointment, and ask the patient to state his or her intent to see the cardiologist as scheduled.
OTHER TOP RISK FACTORS

DOCUMENTATION
- Insufficient documentation within patient records
- Lack of consistent documentation among providers
- Inappropriate documentation that is not pertinent to the patient’s care
- Failure to follow protocols for addendums, corrections, and alterations to records
- Key concerns: Documenting clinician’s rationale for inclusion/exclusion of differential diagnoses and treatment decisions

ADMINISTRATIVE
- Lack of, or failure to adhere to, policies and procedures
- Physician coverage and staffing issues
- Unavailability of equipment
- Lack of staff training and education
- Key concerns: Triage, medication protocols, radiology over-read timing, staff supervision, reassessment of patients who have been admitted but not transferred from the ED

CLINICAL SYSTEMS
- Issues with care coordination during the emergency visit, including (a) lack of interaction between systems for tracking test results, and (b) an inadequate process for obtaining consults
- Key concerns: Tests results received postdischarge, incomplete discharge instructions, primary care providers unaware of patient visits, and reassessment of patients who have been admitted but not transferred from the ED

To better illustrate the impact of failures in the diagnostic test reporting process, consider lung cancer diagnoses. Two-thirds of claims associated with these diagnoses involved a critical test result that was identified but not reported to the patient. One-fourth of these claims involved suspected disease incidental findings not reported to the patient. The remaining 8% of these claims involved misread tests, even when the suspicion for the diagnosis existed.
CLINICAL JUDGMENT AND COMMUNICATION RISK STRATEGIES

CLINICAL JUDGMENT

• Implement comprehensive test tracking and referral tracking procedures that include protocols for complete review of imaging studies, patient follow-up, and documentation.

• Thoroughly screen patients for risk factors, atypical presentations, and associated symptoms to avoid a narrow diagnostic focus.

• Utilize evidence-based guidelines for MIs, CVAs, intracranial bleeds, etc. Consider the use of clinical decision support aids and group decision-making to support clinical reasoning.

• Ensure timely ordering of tests and consultations to prevent problems associated with ruling out or documenting abnormal findings.

COMMUNICATION

• Define and implement a detailed process for patient handoffs, including expectations for verbal and written communication. Audit for compliance with the policy.

• Ensure prompt communication and documentation of relevant findings from consultations and referrals.

• Thoroughly review the medical record at each patient encounter to stay informed of the most recent clinical information.

• Provide patients/caregivers with written and verbal instructions related to their treatment plans and follow-up care. Make sure written instructions are at an appropriate reading level.

• Utilize comprehension techniques, such as “teach-back” to ensure patients fully understand instructions.

• Consider implementing follow-up calls with patients/caregivers to reinforce compliance with treatment plans.
Review patient records to ensure that information is complete, concise, accurate, and consistent.

Verify that documentation supports clinical rationale, diagnosis, and treatment decisions.

Provide thorough and timely documentation of each patient’s condition at discharge.

Adhere to processes for following up on radiology discrepancies and communicating test results received after discharge.

Be aware of and adhere to supervisory requirements for medical residents, advanced practice providers, and scribes.

Use team drills and situational simulations to improve teamwork between all providers in the ED.
A patient presented to an ED complaining of acute onset of back, abdominal, and lower chest pain, as well as difficulty walking. A toxicology screen was positive for illicit drug use. A teleradiologist determined that a preliminary chest CT scan of the patient was normal. As a result, the emergency physician concluded that the patient’s symptoms were related to drug withdrawal and discharged the patient. An on-staff radiologist provided an over-read of the CT scan postdischarge and identified increased density at T8–T9, attributed to degenerative disc disease. However, the patient was not notified to seek an additional consultation.

Three days later, the patient presented again to the same ED with cough, chill, body aches, and a fever. Lab work revealed an elevated white blood cell count and sedimentation rate and positive toxicology; a chest X-ray revealed pulmonary infiltrates. An abdominal CT scan, which was read by another teleradiologist, showed degenerative spine changes.

The emergency physician diagnosed the patient with pneumonia and drug withdrawal, and the patient was discharged with an antibiotic prescription. The over-read of the abdominal CT scan by a second on-staff radiologist noted pulmonary infiltrates, but made no mention of spinal changes.

One day later, the patient developed numbness in his lower extremities and presented to a different ED, where MRI revealed an epidural abscess at T7–T10. The patient developed permanent lower extremity paralysis despite treatment.

The teleradiologists involved in the patient’s first two visits were not aware of the patient’s complaints of back pain and difficulty walking; they indicated that lack of information influenced their conclusions after reading the films. They relied on the facility’s radiologist and emergency physician to render a final diagnosis.

The on-staff radiologist at the second ED visit was not aware of the patient’s previous admission to the ED with a history of back pain; he noted that an MRI would have been warranted at that point.

**Risk management issues for this claim:**

Failure to establish a differential diagnosis when all clinical information was available

Ineffective communication among the teleradiology team, radiologists, and the emergency physicians

Misinterpretation of diagnostic studies
CLAIMS IN THE EMERGENCY DEPARTMENT: OTHER RESPONSIBLE SERVICES

Claims associated with the ED setting identify an emergency medicine physician as the primary responsible service about 75% of the time. However, as seen below, nursing and radiology providers also are noted as the primary responsible service in 7% and 4% of claims, respectively. The “other” category includes other consulting physicians, such as surgeons and medicine specialists (e.g., neurologists and cardiologists).

Patient falls resulting in fractures, triage-related issues (including incorrect triage level designation and waiting room monitoring), and problematic IV-related procedures were the allegations most commonly attributed to nursing staff. Failure to diagnose fractures was the most common allegation against radiologists.

Risk Strategies

- Enhance systems and processes that support open lines of communication and more opportunities for physicians, nurses and consulting physicians to interact.
- Develop documentation standards to reduce inconsistencies between nurse and physician notes, and requirements for complete documentation of critical information.
- Implement a well-designed process to streamline communication of critical results to patients, including results received postdischarge.

Coordination of care among all providers in the ED is critical; it provides a safety net for the patients. Any failures in the system of care can result in allegations of malpractice against the emergency medicine physician, even if he or she is not named as the primary responsible service.
IMPORTANT RISK MITIGATION STRATEGIES

TRIAGE

• Ensure rapid evaluation, reevaluation, and use of symptom-based protocols.

PATIENT SATISFACTION

• Communicate with patients, including about wait times, and apologize for delays.
• Develop a procedure for managing and responding to patient complaints.
• Gauge patient satisfaction through the use of surveys.

CLINICAL JUDGMENT

• Reconsider differential diagnoses of returning patients, patients who have no signs of improvement, and patients who are intoxicated or seeking drugs.
• Prior to discharge, reevaluate patients who have abnormal vital signs/labs.

DOCUMENTATION

• Describe rationale for inclusion/exclusion of differential diagnoses.
• Ensure consistency in the notes of physician and other providers.
• Make a thorough notation of each patient’s condition at discharge.
**IMPORTANT RISK MITIGATION STRATEGIES (CONTINUED)**

**PATIENT EDUCATION**
- Consider patients’ health literacy skills, and provide information in layman’s terms.
- Use comprehension techniques, such as the “teach-back” method.

**TEST TRACKING AND FOLLOW-UP**
- Focus on radiology discrepancies, test results received after discharge, and the patient callback process.

**CROSS-TEAM TRAINING**
- Ensure training includes nurses, advanced practice providers (such as nurse practitioners and physician assistants), hospitalists, radiologists, etc.
- Include cross-team training as part of quality improvement programs.
In all major allegation categories, emergency medicine is among the specialties that have the highest percentage of claims involving high clinical severity outcomes. High-severity outcomes include death or permanent injury — and, as one would expect, these claims have large payments.

Claims involving spinal abscesses, pneumonia, sepsis, spinal fractures, CVAs, aortic aneurysms, PEs, traumatic intracranial bleeds, appendicitis, and cancer — along with MIs — account for nearly 70% of the dollars paid on diagnosis-related claims.

Diagnosis-related allegations account for the majority of emergency medicine claim volume (64%) and claim-related payments (82%).

Medication-related allegations represent a relatively small volume of emergency medicine claims; however, claims related to narcotic overdose appear to be on the rise.

MIs are the most frequent individual diagnosis cited in the emergency medicine diagnosis-related allegations. However, infections as a broad class represent the largest subcategory of diagnosis types in these allegations.

In some circumstances, nurses, radiologists, or other types of providers are identified as the primary responsible service in emergency medicine claims, but most claims in the ED setting name emergency physicians as the primary responsible service.
A NOTE ABOUT MEDPRO GROUP DATA

MedPro Group has entered into a partnership with CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions. Using CRICO’s sophisticated coding taxonomy to code claims data, MedPro Group is better able to identify clinical areas of risk vulnerability. All data in this report represent a snapshot of MedPro Group’s experience with emergency medicine claims, including an analysis of risk factors that drive these claims.

DISCLAIMER

This document should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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