Welcome to learning forum on Learning from Emergency Department (ED) Claims

We have looked at 220 claims, with damages paid, in Emergency Departments in England between 2014 and 2018.

While the numbers are small in relation to the number of patient episodes in EDs we have found commonality of breaches in duty (care) in a number of areas. The three reports cover the following:

- **High value and fatalities;**
- **Missed fractures; and**
- **Hospital Acquired Pressure Ulcers and falls.**

Email: nhsr.safety@nhs.net
Twitter: @NHSresolution

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Meet the team behind the scenes

NHS Resolution

Dr Denise Chaffer
Director of Safety & Learning|

Tim Shurlock
Safety & Learning |DDaT

Justine Sharpe
Safety & Learning Lead|
London

Dr Alex Crowe
Deputy Director for Incentive Schemes and Academic Partnerships|

Beverley Hunt
Safety & Learning Lead|
Mediation

Nana Owusu-Afriyie
Admin Support Officer|

Housekeeping rules for today's session

- Please have your microphones on mute
- Please turn your camera off unless you are speaking
- Please feel free to put comments and questions in the chat box
- Please ask lots of questions and feedback any improvements that could spread the learning
- We are recording the first part of the forum (speaker presentations). To encourage participation and interaction in the panel discussion, we will stop the presentation.
- Chatham House Rule …

Welcome to today's learning from ED claims programme:

Safety and Learning Emergency Department Virtual Forum
Date: Monday 30 May 2022
Time: 12.30-13:40
Eventbrite link to register:
https://www.eventbrite.co.uk/e/nhs-resolution-safety-and-learning-emergency-department-ed-virtual-forum-tickets-334649093447

Please note registration is restricted to NHS staff only

NHS Resolution's Safety and Learning team are hosting a virtual forum to share the key themes from our latest reports which led to claims in the Emergency Department in England between 2014 and 2018. Recognising the unique challenges and diversity of clinical presentations seen in Emergency Departments, our forum focuses on: high value and fatalities; missed fractures; falls and pressure ulcers.

Clinical themes extracted from our claims data can provide a unique insight to enhance safety, patient experience and strengthen evidence to improve and redesign practices. Claim numbers for emergency medicine have risen in recent years and we have identified areas to improve service. The purpose of the forum is to share insight and promote spread of experiential learning in collaboration with the Royal Colleges of Emergency Medicine and Nursing to inform best service and practice pathways.

We acknowledge our reports have been published during unprecedented times for the NHS and staff working in EDs. While ED claim numbers are higher than most other specialties, it is useful to know they are low in comparison to patient activity/ acuity.

Programme chair: Justine Sharpe, **Safety and Learning Lead (London)**

Speakers:

Summary of clinical findings and recommendations of NHS Resolution Emergency Medicine claims:

- High value and fatality claims - Dr Denise Chaffer, **Director of Safety and Learning**
- Missed fracture claims - Tim Shurlock, **Safety and Learning Lead (South)**
- Hospital acquired pressure ulcers and falls claims. Bev Hunt, **Safety and Learning Lead (Mediation)**

Panel discussion:

How have the findings of the reports fed into national health strategy and improvement work?

Are there examples of local improved urgent care pathways?

Chair: Dr Alex Crowe, **Deputy Director for Incentive Schemes and Academic Partnerships**

- Dr Denise Chaffer, **Director of Safety and Learning**
- Bev Hunt, **Safety and Learning Lead (Mediation)**
- Katherine Henderson, **President of Royal College of Emergency Medicine**
- **** , Royal College of Nursing**

How to access the forum

Registration is via Eventbrite portal, please use the above link and follow the instructions.
This virtual forum will be hosted on Microsoft Teams and the link will be emailed before the event.
Please report any difficulties experienced to **nhsr.safety@nhs.net** before the event.

Please avoid:

Please do not record the forum. This is in line with GDPR guidance and to encourage open discussion.

Future forum dates and topics will be released shortly

Format: interactive
Duration: 70 minutes
Chair: Justine Sharpe

Guest speakers:

Katherine Henderson, President of Royal College of Medicine and EM Consultant at St Thomas' Hospital
https://twitter.com/rcempresident

Sarah Cato, Chair Emergency Care, Royal College of Nursing

Safety and Learning team speakers:

Dr Denise Chaffer
Tim Shurlock
Bev Hunt
Alex Crowe

Email: nhsr.safety@nhs.net
Twitter: @NHSresolution

Learning from Emergency Department (ED) Claims

NHS Resolution

Dr Alex Crowe

Deputy Director of incentive schemes

And academic partnerships

NHS Resolution

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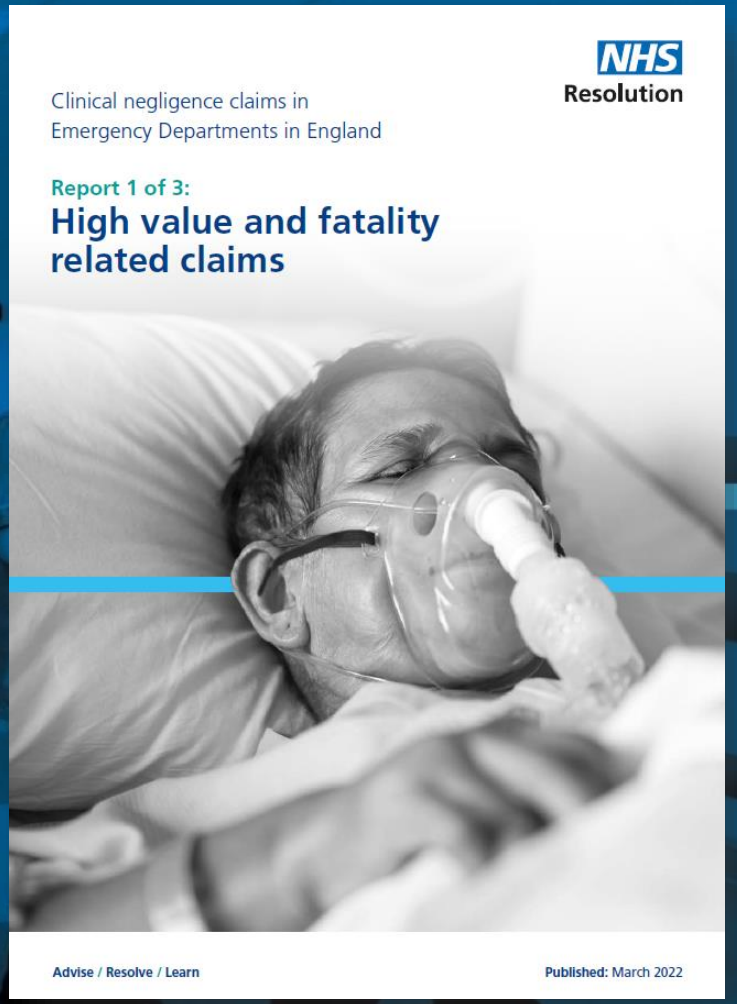


Background: Emergency Department claims

- ↑ High volume: 11% of all claims by volume[a]
- ↑ High value: 5% of estimated total value of all claims[a]
- ↓ Low volume: relative to activity levels (1 claim per 17,000 episodes of care)
- Wide range of clinical presentations in ED[b] result in diverse group of claims. Review of claims split into three reports

a) Claims notified to NHS Resolution 2020/21
b) Emergency Department

High value and fatality related claims

16 High Value[a] claims

86 fatality related claims

Common Themes:

1. Diagnostic error including missing signs of deterioration.
2. Failure to investigate and/or diagnose, and missed, wrong and delayed diagnoses.
3. Failure to recognise the significance of repeat attendance and/or patient not re-attending when advised to.
4. Delays in care, including specialty reviews and missed therapeutic options.
5. Problems with communication, escalation and cross specialty team working.

a) In excess of £1 million

High value and fatality related claims

High Value claims	Fatality related claims
Average damages awarded £2,069,029.	Average damages awarded £45,284.
Missed Diagnosis was the most common theme	
Evidence of local incident reporting in half of the claims, but only two formal serious incident investigations	Causes of death: • Infection/Sepsis • Pulmonary embolus • Falls • Suicide • Coronary related • Iatrogenic harm

High value claims

- Spinal Conditions
  - Re-attendance without senior review
  - Gaps in clinical history and examination
  - MRI delay, lack of urgency, lack of 24/7 access
  - Cross specialty communication
- Cerebral Conditions
  - Rare conditions and atypical presentations
  - Handover from GP/Ambulance not available/considered
  - Delays in imaging and senior review
- Lower Limb Conditions
  - Knee examination not extended to hip, hip injuries missed

Fatality claims

- Pulmonary Embolus
  - Iatrogenic Harm, Missed Diagnosis
  - Lack of risk assessment
- Sepsis
  - Presence of co-morbidities
  - Delayed assessment
  - No action in response to abnormal neutrophil count, CRP, pyrexia and other symptoms
  - Incorrect interpretation of x-ray
  - Incomplete assessment
  - Lack of escalation
  - Delay in administering antibiotics

Fatality claims

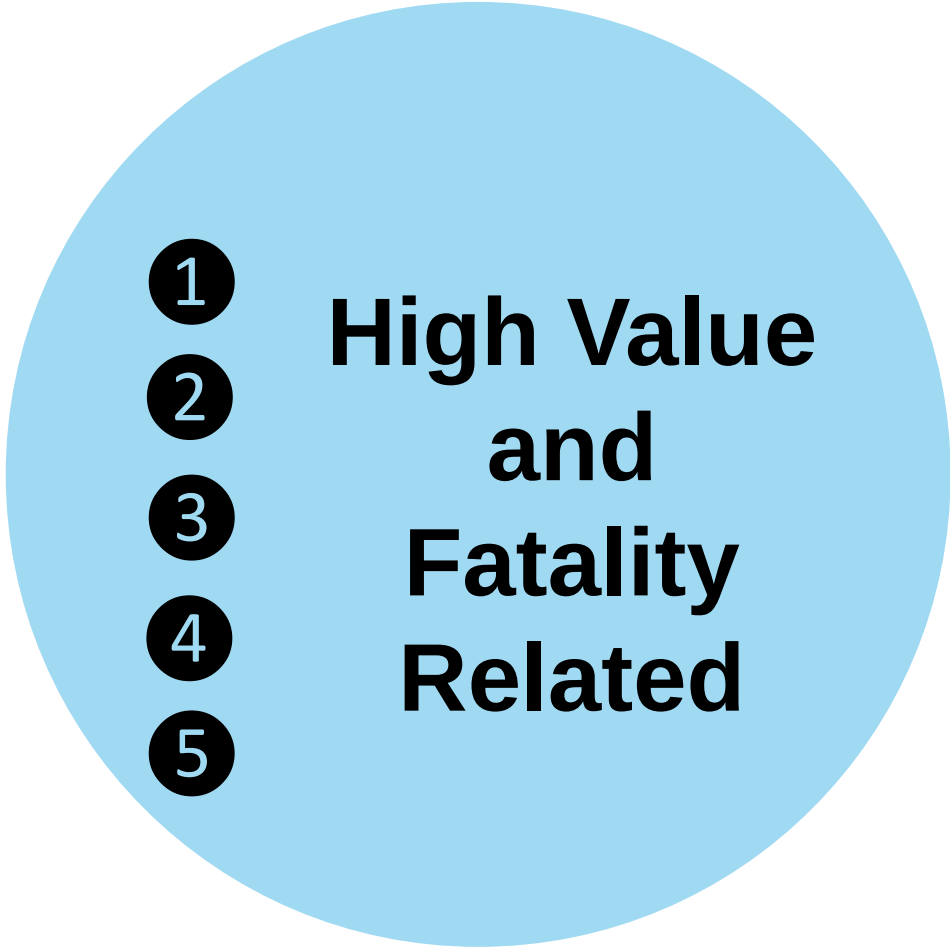
- Aortic Disease
  - ruptured AAA
  - Aortic dissection
  - Missed significance of presenting symptoms
  - Ambulance/triage notes not utilised
  - Poor communication and escalation
- Cardiac Conditions
  - Abnormal ECGs or biochemical investigations, not recognised or acted on
  - Busy units/patients treated outside of recommended environment causing delays in care
- Suicide
  - Overcrowded units preventing provision of correct care in correct environment
  - Communication within ED and between ambulance and ED staff

Fatality claims

- Bowel conditions
  - Failure to act on severe pain, high NEWS
  - Missed diagnostic tests/ interpretation of abnormalities
  - Delay in speciality review
  - Poor communication and discharge planning with patient
- Medication error
  - Dosage, allergy and wrong patient errors
  - Failure to provide regular prescription

Key conclusions

No.	Conclusion
1	Diagnostic errors including missing signs of deterioration, particularly for spinal and cerebral injury.
2	Failures in the investigation process leading to missed or delayed diagnosis.
3	Failure to recognise the significance of re-attendance to ED.
4	Delay in accessing senior and specialty reviews, leading to missed therapeutic options.
5	Communication issues impacting the escalation and handover of care and cross specialty team working.



**HAPU: Hospital-Acquired Pressure Ulcers*

Learning from Emergency Department (ED) Claims

NHS Resolution

Tim Shurlock

Safety and Learning Lead

NHS Resolution

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Missed fracture claims

78 missed fracture claims

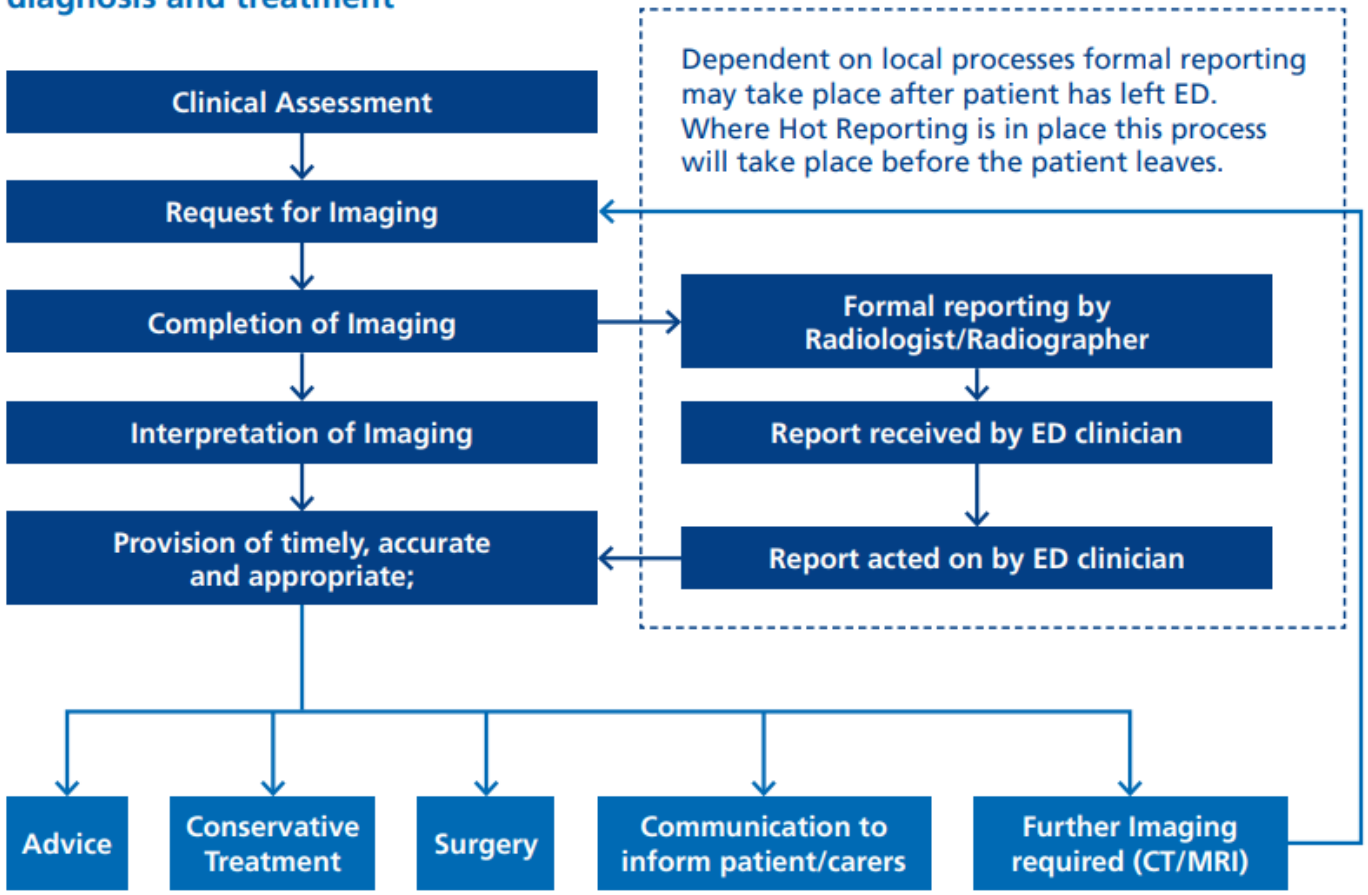
Common Themes

1. Diagnostic error, particularly early incorrect diagnosis of soft tissue injury
2. Requests for imaging, reporting, interpretation and follow up.
3. Communication, team working and escalation.
4. Delays in care, including specialty reviews and missed therapeutic options.

a) In excess of £1 million

Care pathway: fracture diagnosis/ treatment

Figure 4: Care pathway for fracture diagnosis and treatment



Existing guidelines for fracture diagnosis and management

Cost of claims

- Total cost £1.1 million
  - £469K total damages
  - £649K total legal costs (NHS and claimant)

	Average total cost per claim	Average NHS costs per claim	Average damages per claim	Average claimant costs per claim
Missed fracture claims	£14,346	£1,535	£6,021	£6,790

Missed fracture claims: harm

	Pain/ suffering	Loss of function	Additional procedures	Cosmetic deformity	Fatality	Nerve damage	Prolonged recovery
Number of claims	61	5	5	3	2	1	1

Decision to request imaging

- Key stage in pathway- can cause a ‘break in the chain’ for diagnostic pathway
- 36% cases no x-ray, almost all due to early diagnosis of a soft tissue injury (thus incorrectly excluding the possibility of a fracture).
- Where correct x-ray was completed the main point of error was ED clinician's interpretation of imaging.
- In 50% where a correct x-ray was completed there were issues the formal reporting process
- 13 cases where cross sectional imaging was indicated but not completed

Missed fracture claims: lower limb

- Hip fracture
  - Distinct group, major injury, older patients with risk factors
  - Failure to interpret fracture on hip x-ray
  - Delay in radiology/orthopaedic opinion
  - No x-ray (in older patients who had fallen)
- Foot/Ankle and Knee
  - No x-ray (when indicated by Ottawa ankle/knee rule)
  - Insufficient views requested

Missed fracture claims: upper limb

- Wrist and Hand
  - Scaphoid fractures- no cross sectional imaging
  - Interpretation errors
  - Orthopaedics delay
  - Lacerations treated and fracture overlooked
  - Failure in safety net/follow up
- Shoulder and elbow
  - Delay in formal reporting or communication

Missed fracture claims: spine, facial and ribs

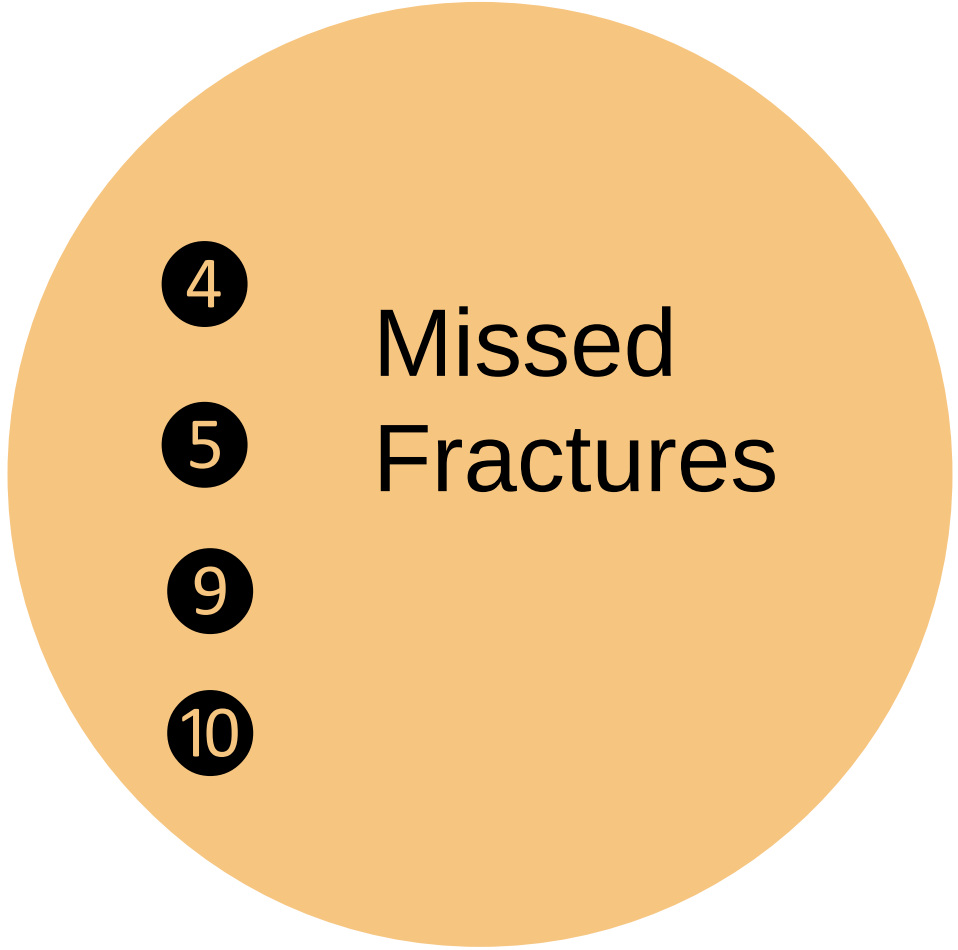
- Spine
  - Insufficient examination- no imaging
  - Failure of safety net/follow up
- Facial
  - Insufficient views for imaging
  - Incorrect interpretation
  - Delay in follow up
- Ribs
  - One case- rib fractures were identified but under appreciation of the severity of the injury.

Recommendations

- **Workforce-** models that optimise the use of ED and imaging workforce to deliver timely and accurate diagnosis
- **Models of Care-** Care models that provide accurate and timely diagnostic pathways and address the high demand in ED.
- **MDT meetings-** Consistent framework for EM/Radiology MDTs
- **Training and competence-** standard qualification for interpretation of emergency imaging
- **Hip Fracture-** Prioritise accurate diagnosis including sufficient access to cross sectional imaging

Key conclusions

No.	Conclusion
4	Delay in accessing senior and specialty reviews, leading to missed therapeutic options.
5	Communication issues impacting the escalation and handover of care and cross specialty team working.
9	Diagnostic error, specifically where early incorrect diagnosis prevented further investigation.
10	Obtaining images to support diagnosis, including requesting, reporting, interpretation and follow up of images.



**HAPU: Hospital-Acquired Pressure Ulcers*

Learning from Emergency Department (ED) Claims

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Beverley Hunt

Safety and Learning Lead (Mediation)

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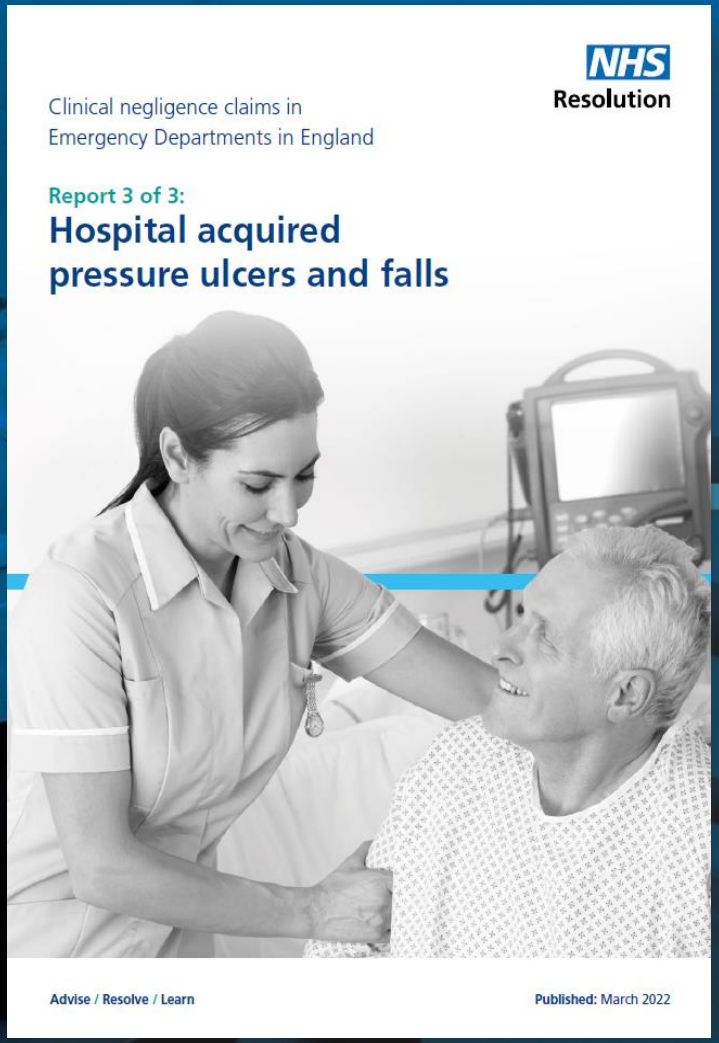

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HAPU and fall claims

15 HAPU claims

25 Fall claims

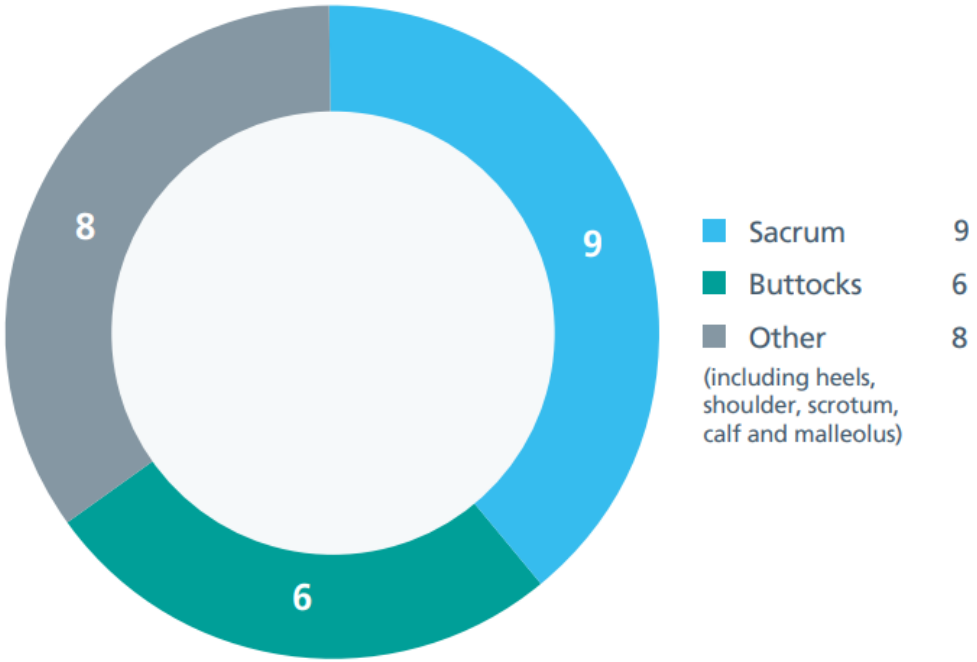
Common Themes:

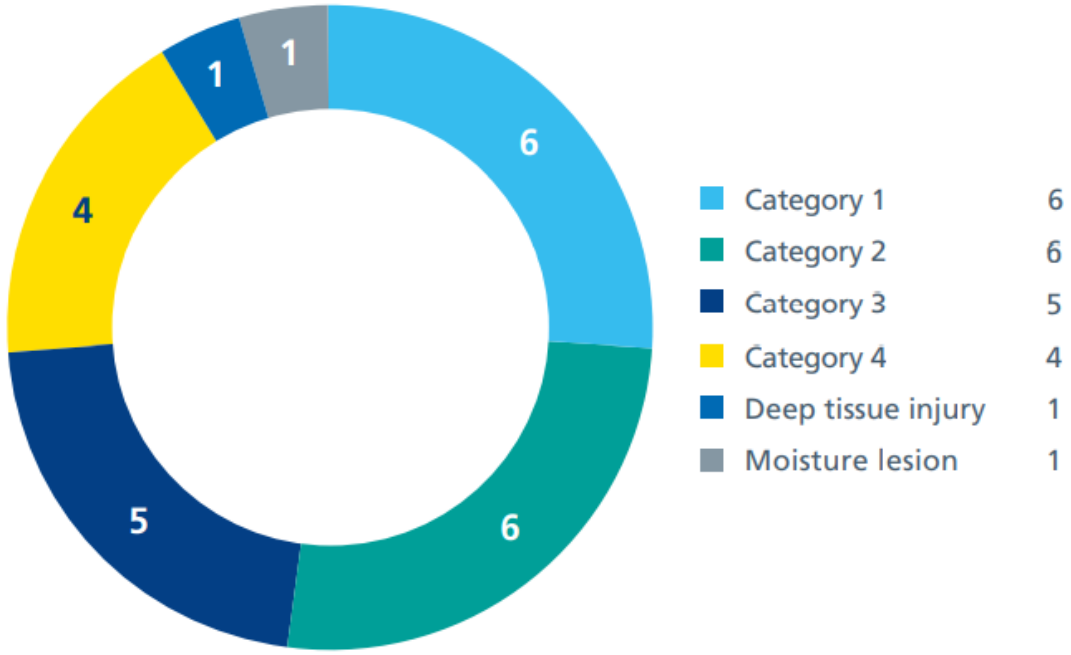
1. Risk assessments: not completed and/ or not accurate
2. Proactive care: fundamental interventions not provided, inadequate level of observation
3. Communication: ineffective handover to nursing colleagues
4. Reporting & investigating incidents: not all serious harm incidents reported or appropriately investigated

HAPU and falls claims:

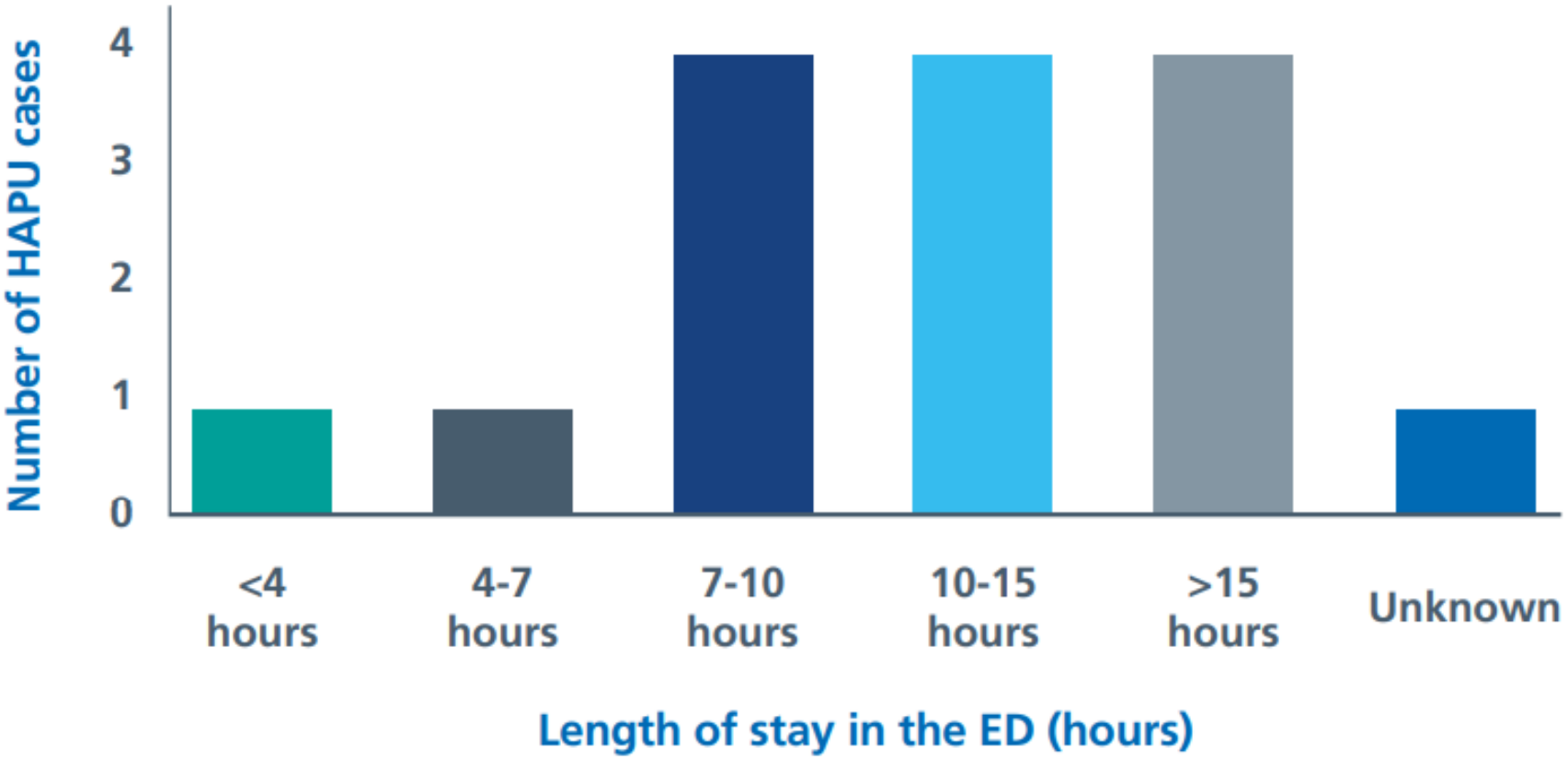
	HAPU (15 claims)	Falls (25 claims)
Average damages paid	£12,200	£19,430
Age >65 years	13	15
Gender	11: female 4: male	15: female 10: male
Patients with medical comorbidities	100%	84%
Complaint preceding the claim	3	9
Incident reporting	8	23

HAPU claims: anatomical site & category

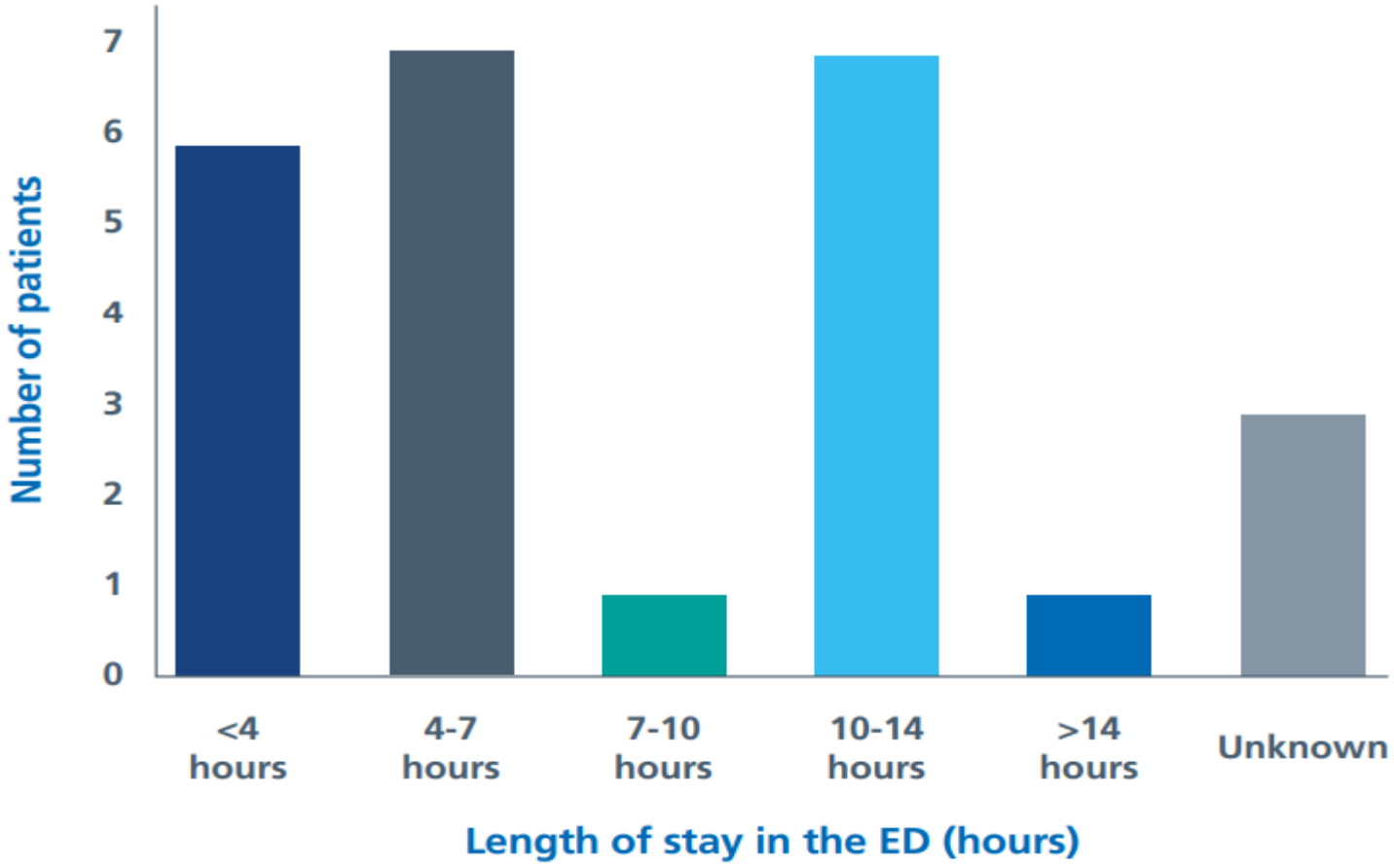




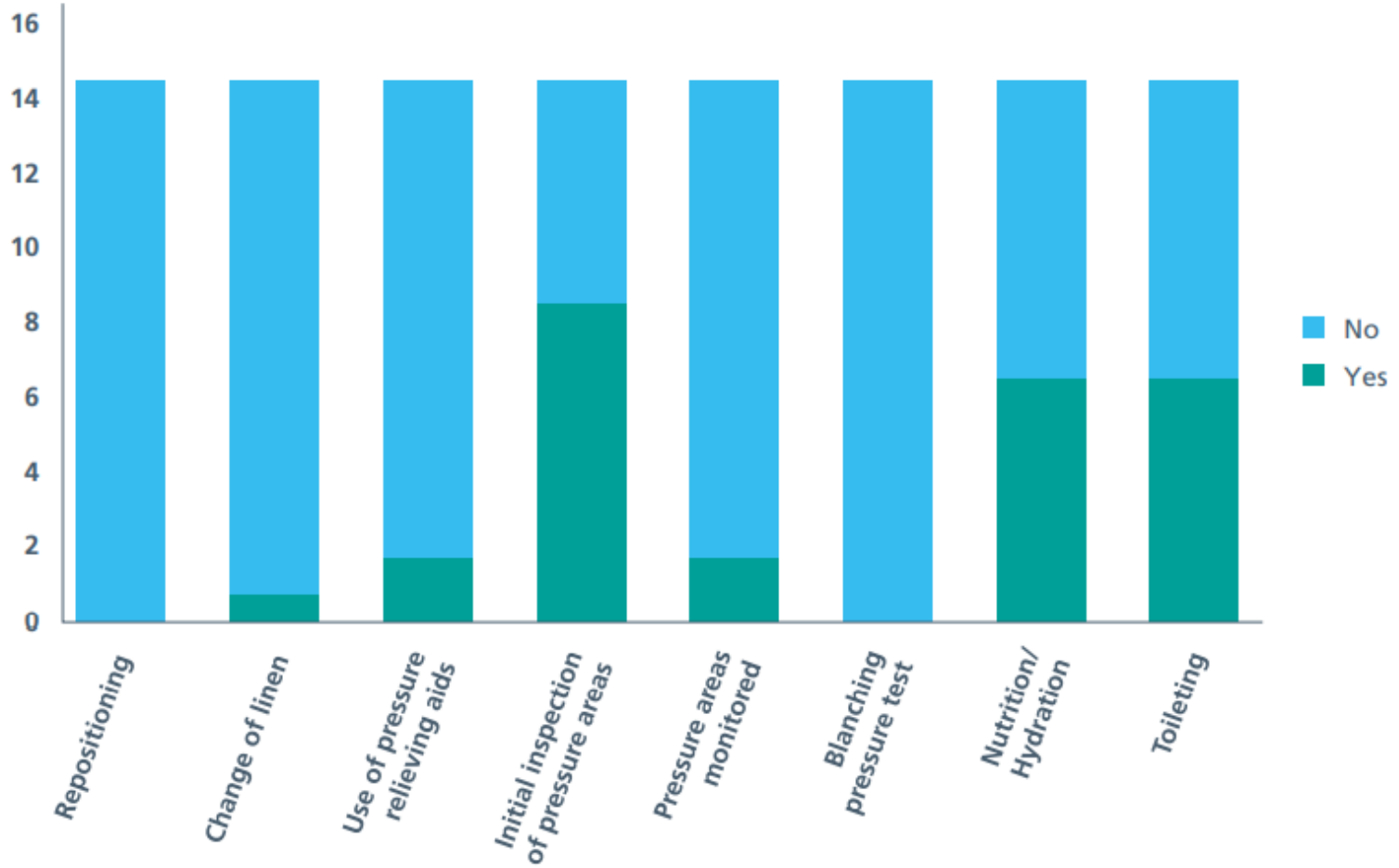
HAPU claims: length of stay in ED



Fall claims: length of time in ED

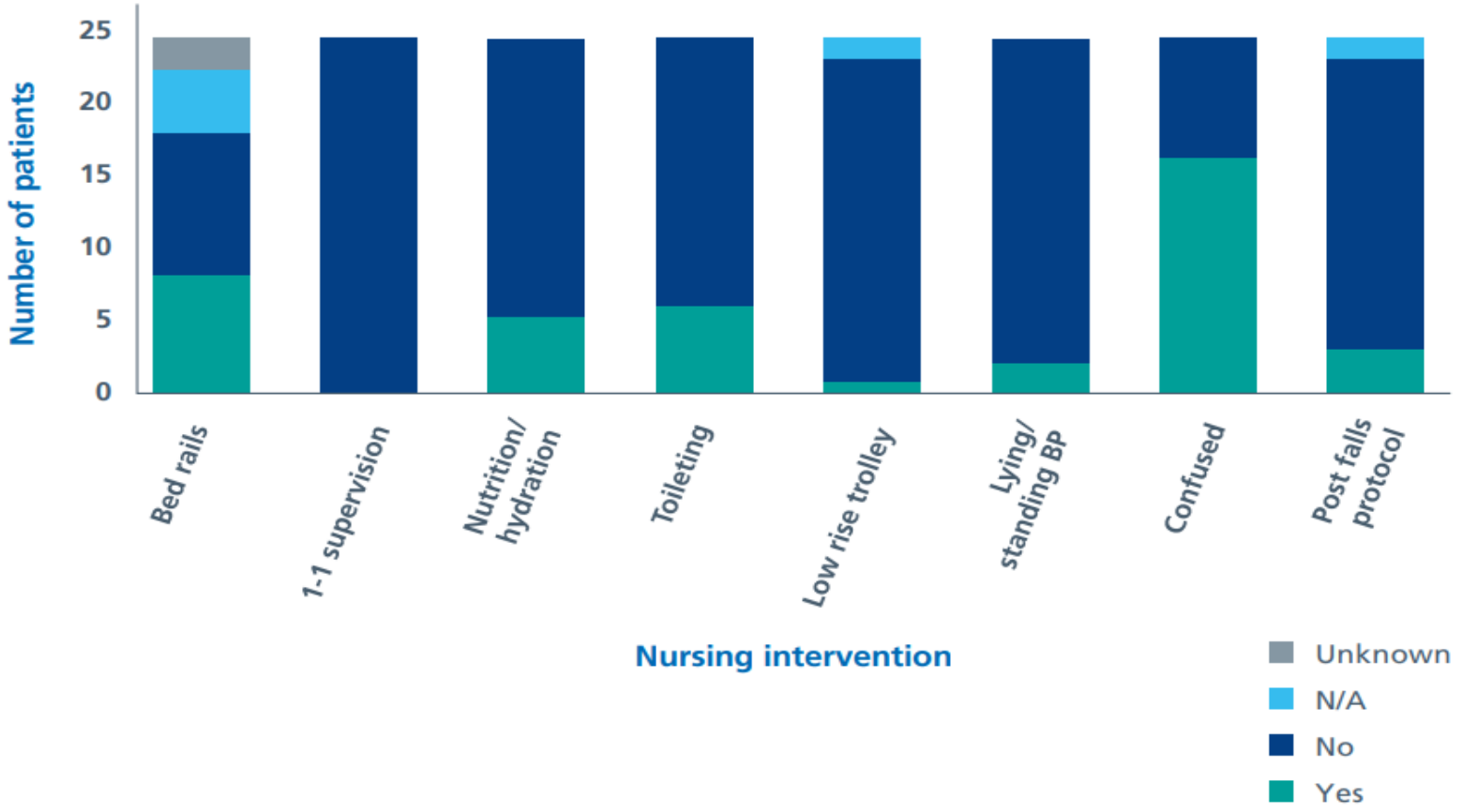


HAPU claims: nursing interventions



Fall claims: nursing intervention

Figure 18: Nursing interventions provided/not provided in ED



Common themes

- **Risk assessments:** not completed/ not accurate
- **Proactive nursing care/ close observation:** not consistent or not undertaken
- **Communication:** handover over care not effectively given between shifts or clinical areas
- **Incident reporting:** HAPUs not reported, key information missing
- **Incident investigation:** not appropriate to level of harm

Summary of recommendations

Risk assessments

- Introduction of standardised digital risk assessment tools, to overcome human error and missing information

Nursing care:

- Introduce ‘Nursing Guardians’ to safeguard the provision of fundamental nursing interventions
- Ensure vulnerable patients are in easily observable areas of ED

Communication:

- National targeted campaign to improve record keeping (NMC)
- Local audits of documentation, including risk assessments and handover

Incident reporting and investigation:

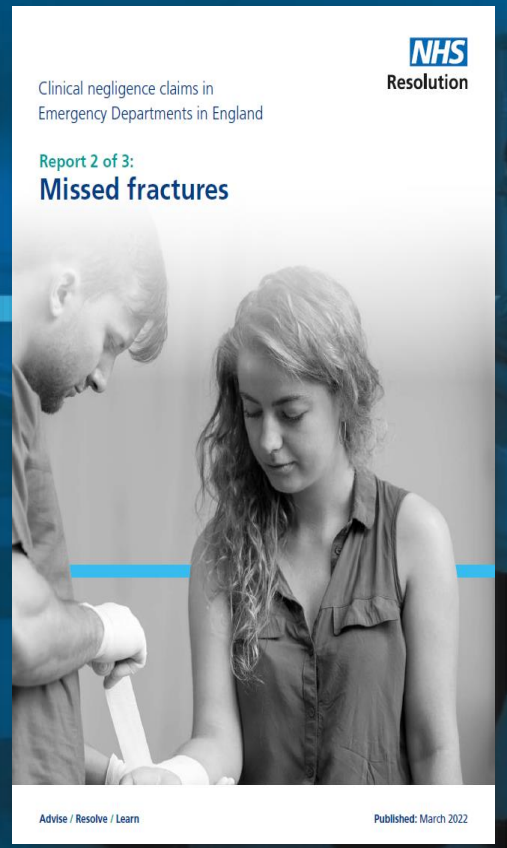
- Providers must promote reporting of incidents
- Provider and commissioner standards of incident investigation must align to national guidance
- Providers should promote trust-wide learning, demonstrating transparency and commitment to improving safety

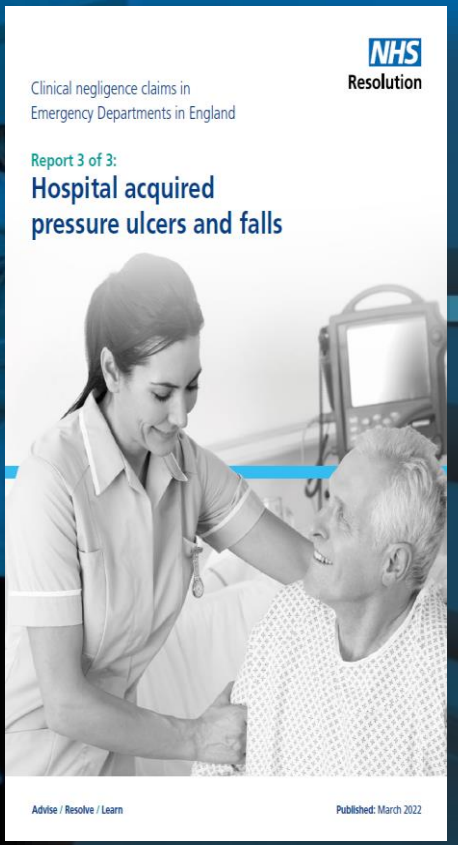
Learning from Emergency Department (ED) Claims – Key conclusions of reports

NHS Resolution

Katherine Henderson

President, Royal College of Emergency Medicine and ED Consultant St Thomas' Hospital NHS Foundation Trust





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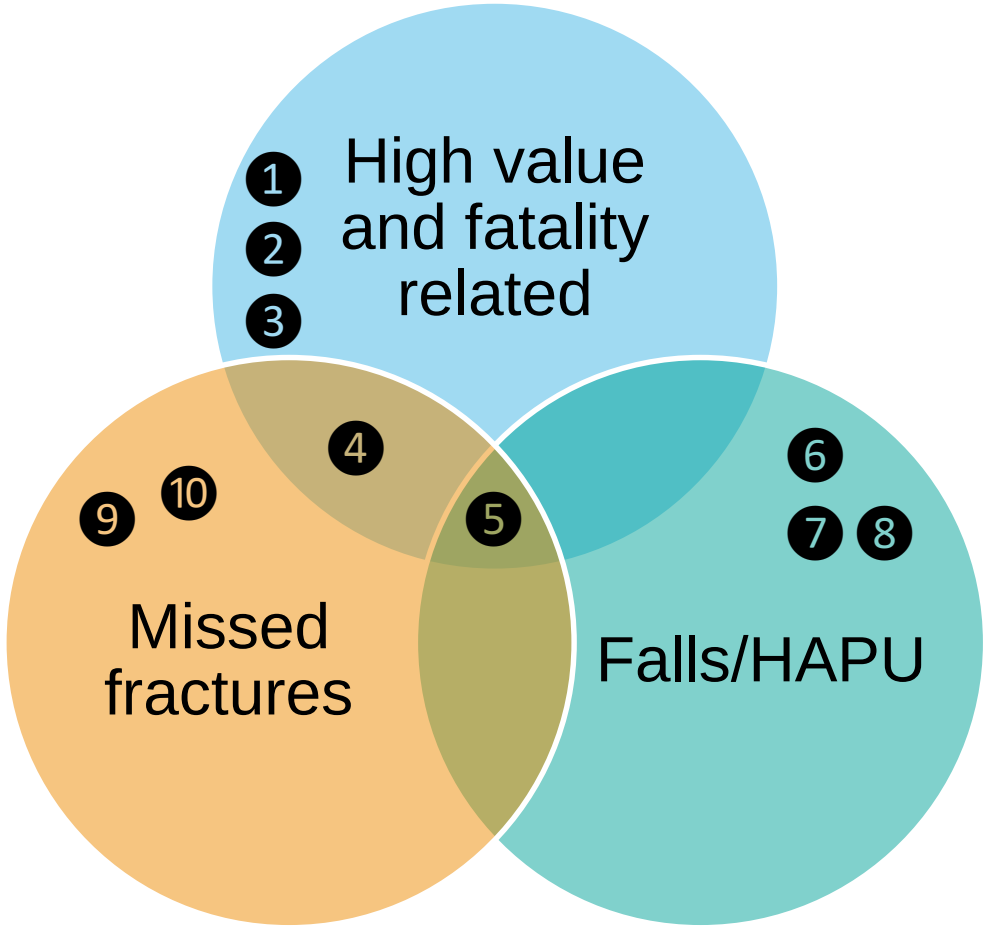
Key conclusions

No.	Conclusion
1	Diagnostic errors including missing signs of deterioration, particularly for spinal and cerebral injury.
2	Failures in the investigation process leading to missed or delayed diagnosis.
3	Failure to recognise the significance of re-attendance to ED.
4	Delay in accessing senior and specialty reviews, leading to missed therapeutic options.
5	Communication issues impacting the escalation and handover of care and cross specialty team working.
6	Absence of standardised risk assessments.
7	Failure to deliver proactive nursing interventions in ED, leading to harm.
8	Inconsistent use of incident reporting and investigations as tools for learning from harm to make care safer.
9	Diagnostic error, specifically where early incorrect diagnosis prevented further investigation.
10	Obtaining images to support diagnosis, including requesting, reporting, interpretation and follow up of images.



**HAPU: Hospital-Acquired Pressure Ulcers*

Learning from Emergency Department (ED) Claims

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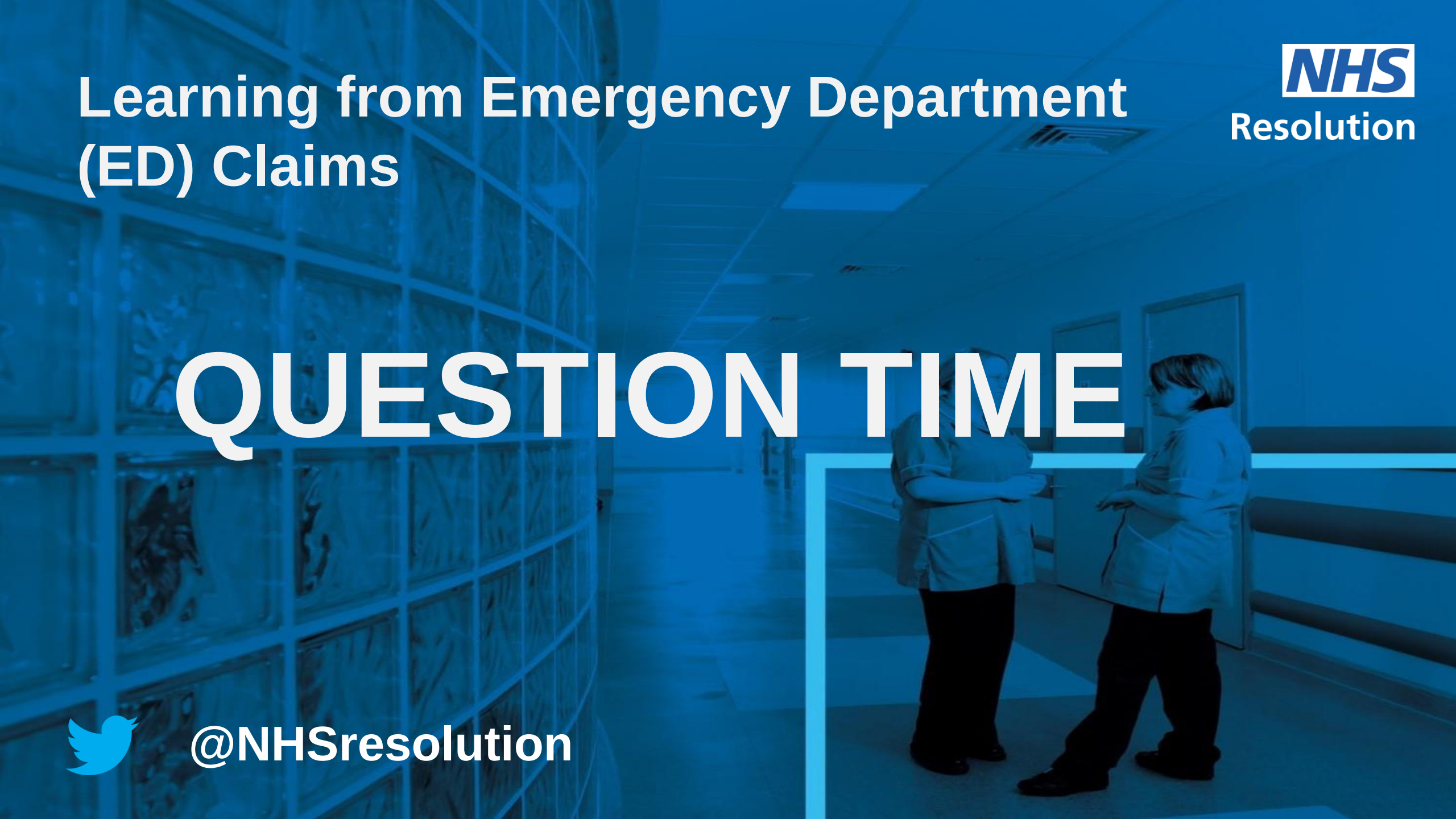
QUESTION TIME



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Panel discussion:

Led by: Alex Crowe

Katherine Henderson
Sarah Cato
Denise Chaffer (d.chaffer@nhs.net)
Tim Shurlock (t.shurlock@nhs.net)
Bev Hunt (beverley.hunt10@nhs.net)

Thank you for joining

Further queries or information please contact our team:

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https://resolution.nhs.uk/resources/