

Emergency Department Risks: Through the Lens of Liability Claims

AUTHORS:

Tara Gibson, CPCU, RPLU, AR
Vice President, Risk Management

Ann Burke, RN, CPHRM, CPPS
Director, Risk Management

Solveig Dittmann, RN, BA, BSN, CPHRM
Senior Risk Specialist

Maryann Small, MBA
Director, Data Governance & Business Analytics

JUNE 2019



- Specific areas of greatest vulnerability during the emergency department episode of care — when and where risk is the highest, why, and for whom.
- What can be done to reduce risk during emergency department (ED) visits — including new processes, practices, attitudes, training, and improved communications.
- How common societal trends impact ED trends.
- Which case scenarios, conditions, and patient populations dominate the claims data.
- The complex nature of emergency medicine claims and issues unique to ED risk.

“Patients have spoken with their feet, seeking [emergency department care] in unprecedented numbers. We are the ones you come to when you’re really sick, possibly sick, or kind of sick and in need of rapid evaluation, diagnosis, and treatment. We are the place you come to when you cannot or will not wait for others to find a place in their schedules for you, and the site of medical refuge when you don’t know where else to turn. Despite limited resources, unrealistic expectations, and impossible demand, emergency medicine delivers on our promise to provide the best possible care to every patient regardless of their ability to pay or what time of day they choose to seek care.”

– Brian Keaton, MD, Past President, American College of Emergency Physicians

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EDs are the fourth most common healthcare delivery location to trigger a malpractice claim.

The hospital emergency department (ED) is at the forefront of healthcare delivery. Each year in the United States, there are more than 138 million visits to EDs.¹ Coverys data shows that EDs are the fourth most common healthcare delivery location to trigger a malpractice claim. It is also where:

- Acutely ill and distraught patients gain initial access to the healthcare system.
- Resources may be stretched thin during periods of high occupancy or acuity.
- The vast majority of patients present with predictable complaints (like abdominal pain, chest pain, fever, cough, headache, back symptoms, or shortness of breath),² yet the causes can be anything but predictable.
- Healthcare providers are under pressure to quickly prioritize, diagnose, and treat patients with whom they typically have no prior relationships to guide their assessments and actions.

This report provides insight into the root causes of claims occurring in the ED based on an analysis of 1,362 ED-related closed medical professional liability claims at Coverys across a five-year period (2014-2018).^{*} Our goal is to provide emergency medicine providers and healthcare leaders with fresh perspectives, data-driven insights, and more effective strategies to meet the needs of patients seeking emergency services.

^{}Unless otherwise indicated, statistics and other information in this publication were derived from this proprietary data.*

This report is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice.

At Coverys, we refer to claims data as “signal intelligence.” Our conclusions from analysis of the data are not absolute findings. Rather, they are hypotheses — signals from the past about where vulnerabilities existed and may still be at play.

Typically, a fully investigated liability claim will include:

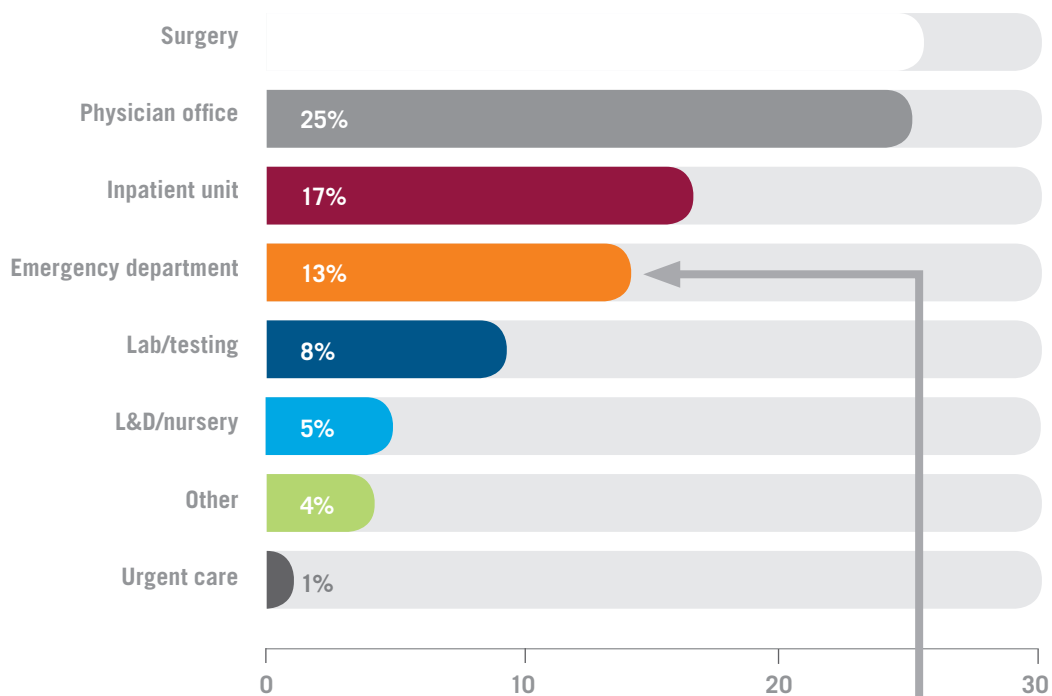
- Allegations.
- Patient health and demographic information.
- Injury severity.
- Physician specialty.
- Risk management issues.
- Location of the alleged error (e.g., emergency room, radiology/lab, hospital bed).
- Financial costs.
- Expert reviews and opinions.

Coverys uses this information to create evidence-based recommendations to help mitigate future risks in the delivery of care.



TOP CLAIMS LOCATIONS

The ED is the fourth highest location to trigger claims. 13% of all medical professional liability (MPL) claims involve care that occurred in the ED.

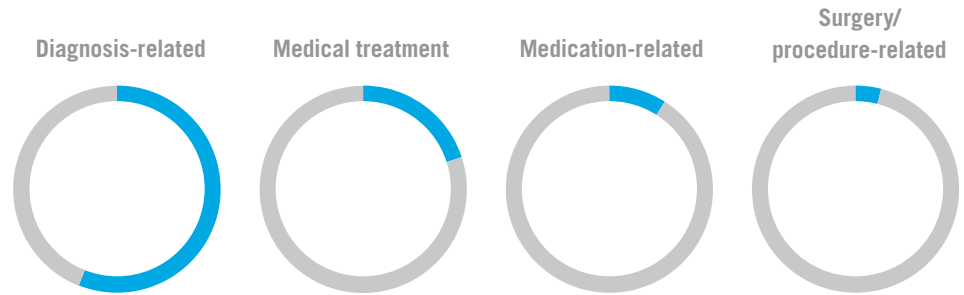


N = 10,263 traditional MPL closed claims between 2014 and 2018.

ED is the fourth highest location to trigger claims.

TOP ALLEGATIONS

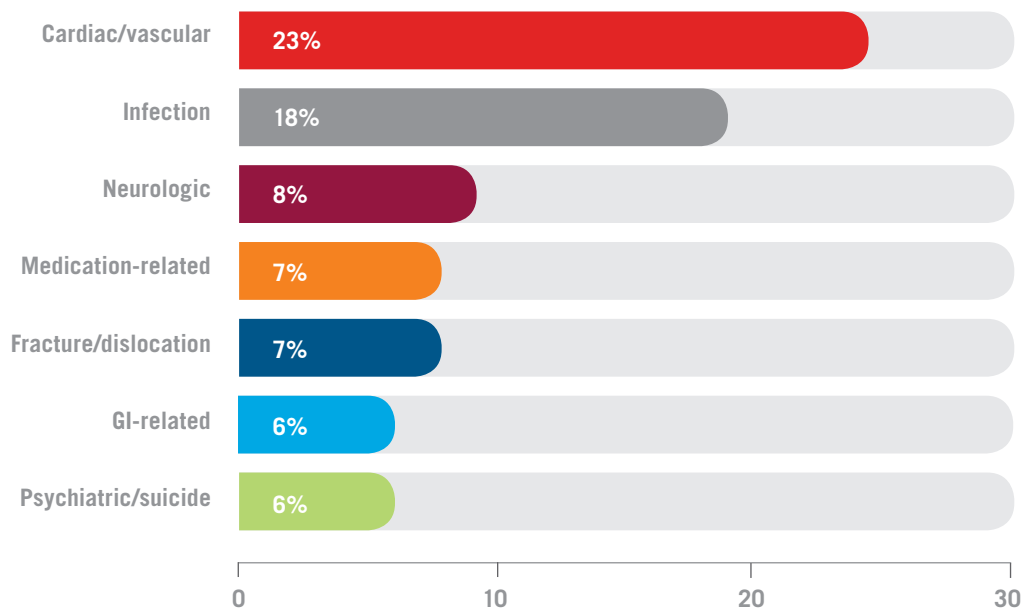
The majority of allegations for ED claims involved a failure or delay in making a diagnosis including the lack of an appropriate patient/family history and physical as well as inappropriate ordering of diagnostic tests.



N = 1,362 closed claims between 2014 and 2018 with an ED location.

TOP CONDITIONS THAT TRIGGER CLAIMS

The most common conditions identified on ED claims involve cardiac or vascular illnesses (23%), followed by infections (18%).

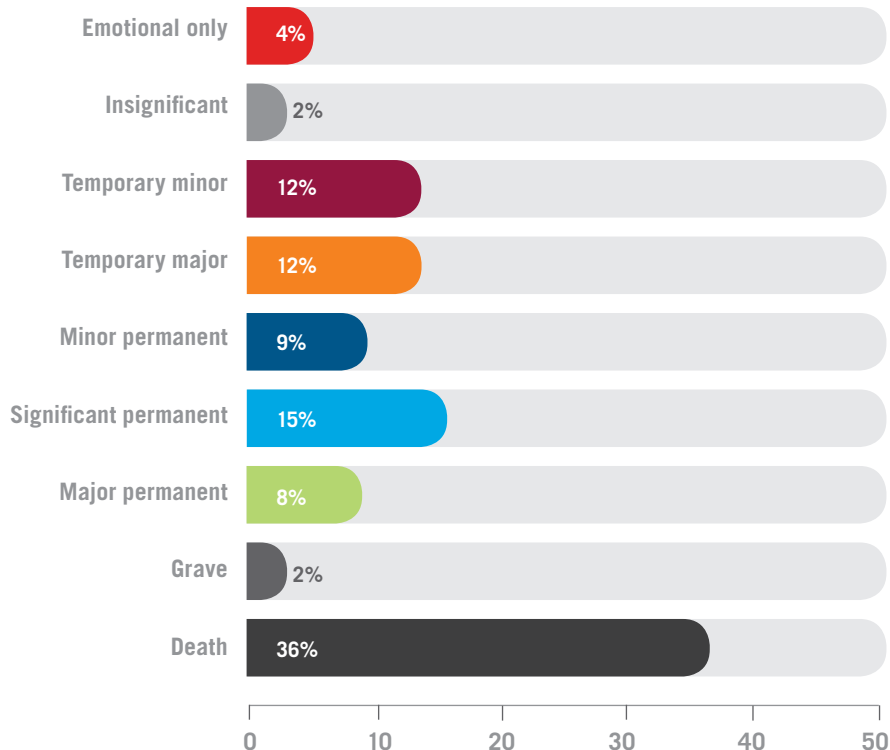


N = 1,362 closed claims between 2014 and 2018 with an ED location.



INJURY SEVERITY

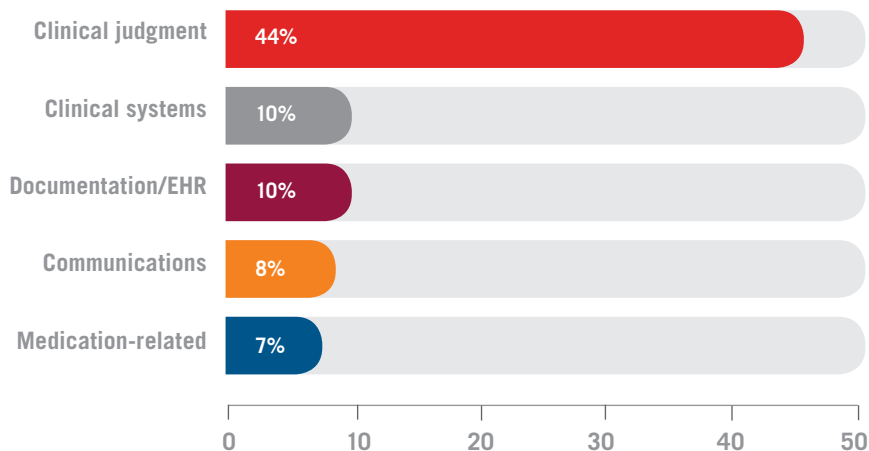
Injuries resulting from alleged malpractice in the ED span a spectrum of severity, with more than a third of injuries resulting in death.



N = 1,362 closed claims between 2014 and 2018 with an ED location.

TOP RISK MANAGEMENT ISSUES

Clinical judgment was cited as a factor in 44% of ED-related claims. These claims involve issues in assessing the patient, inappropriate selection of therapy, and a failure or delay in obtaining a consult.



N = 1,432 closed claims between 2014 and 2018 with an ED location and a risk management issue identified.



More than 50% of inpatient hospital admissions begin in the emergency department.³ Coverys data shows that EDs are the fourth most common healthcare delivery location to trigger a malpractice claim (after surgical units, physician offices, and inpatient units).

Care and treatment in the ED have the potential to impact a patient's entire medical journey. The ED experience is analogous to the first domino in a chain of falling dominos. The decisions and actions of healthcare providers and other staff impact whether a patient seeks specialty care or follows up with a primary care provider. Likewise, these decisions and actions influence how the patient thinks of his/her health and prognosis for the future, as well as the steps that will be taken by the patient and those entrusted with his or her care long after the patient is transitioned to another department in the hospital, transferred to another facility, or discharged from the ED.

Paying close attention to specific risks in the ED can and will enhance patient care and safety overall.

ED staff often don't have a full understanding of patients' medical histories or other background information to guide their plan of care.

The ED is a unique and complex ecosystem. Ask anyone who has worked in an ED, and they'll tell you it is like no other point of care, due to:

- **Pace and pressure** — The pace of activity in the ED can quickly vacillate from slow to fast and a myriad of different scenarios from minute to minute. This can challenge the staff's diagnostic, organizational, and communication skills.
- **Stress** — ED staff don't know what's going to come through the door and must be able to transition from a relatively calm environment one moment to a sheer adrenaline-pumping pace the next. They may also experience emotional fatigue due to their responsibility to care for the acutely ill, as well as physical fatigue from working long hours, late nights, and weekends.
- **Acuity** — In the face of traumatic situations — like heart attacks, seizures, and serious injuries — staying alert and focused is critical.
- **Lack of information** — ED staff often don't have a full understanding of patients' medical histories or other background information to guide their plan of care. For example, when a patient arrives unconscious and unaccompanied by anyone who knows him.



The ED, for better or for worse, is a reflection of the top health concerns and vulnerabilities in the U.S. Our review of claims across specialties and different types of care delivery locations has uncovered the following key themes:

- Clinical judgment can be impaired for a variety of reasons, not the least of which is that the diagnostic journey can be a solitary, rushed, and high-pressure affair.
- A narrow diagnostic focus can contribute to misdiagnosis.
- There are effective tools to assist with diagnostics and communication. Using these tools can be effective, but training and practice are critical.
- Communication breakdowns among providers at all levels, including front desk staff, can be minimized if you treat communication and collaboration as a combination of art and science.
- Practitioners and staff in radiology and other diagnostic departments (such as laboratory) too often function in silos, opting for electronic notes when a timely phone call or hallway conversation could significantly improve patient outcomes.
- Epidemics of drug abuse, heart disease, diabetes, obesity, and chronic pain have left EDs vulnerable to risks related to medications like antibiotics, opioids, and anticoagulants, the top three types of medications involved in malpractice claims.



While every scenario in the ED is unique, there is predictability in the steps taken from patient arrival to ultimate discharge to home, admission to floor, or transfer to another facility. This section provides insight into the process vulnerabilities we have identified at each step.

STEP 1: ARRIVAL/TRANSPORT

For ED patients who arrive by ambulance or private transport, their care starts before they arrive at the hospital. The decision by emergency medical services (EMS) or others to call ahead to inquire whether the ED staff is ready for a critical patient is a crucial one.

Risk Management Recommendations: Ensuring Optimal Patient Transports

- Develop strong relationships with local EMS providers and define communication expectations.
- Work with EMS providers to ensure they use screening tools during transport, such as the IV tPA Screening Checklist for stroke symptoms.
- Develop a protocol to determine when the ED must go on “divert” status (meaning no patients are to be brought to the ED) due to various factors including patient census or staffing issues, and how to communicate this to the local EMS community.

STEP 2: TRIAGE

Before the patient is seen by an emergency medicine physician, he or she is assessed by a staff member responsible for triage, and important decisions about their care are made. Triage assessment must be available 24 hours a day and performed by a professional staff person (e.g., RN, NP, or PA).

Documentation is key when it comes to triage in the ED. Triage documentation should reflect the use of a system to classify patients into categories based on priority. The Emergency Severity Index (ESI) is the most widely used triage classification system in the U.S.⁴ The ESI triage algorithm yields rapid and clinically



relevant stratification of patients into five groups, from level 1 (most urgent) to level 5 (least urgent). The triage process should also include documented patient reassessments to confirm condition status or elevate the patient's priority as clinically indicated by the patient's medical condition and the facility's triage classification system.⁵

Patients who call the ED asking for medical advice should be told that they should either call their primary care provider or come to the ED for evaluation. Emergency departments should have a telephone triage policy that prohibits providing medical advice by telephone. The only exception to this rule is the patient who calls to clarify discharge instructions after ED discharge.

CASE STUDY



A man in his late 50s arrived at the ED via EMS, complaining of shortness of breath and reporting that his primary care provider had diagnosed him with pneumonia earlier that day. The patient had poorly controlled diabetes, and an EKG performed during transport indicated a right bundle branch block and sinus tachycardia. The nurse who performed the patient's triage when he arrived deemed him "non-urgent." Nearly an hour and a half later, the patient had not been evaluated by a physician, and his condition was deteriorating. An emergency physician just coming on duty was asked to evaluate the patient, and a code was called. After intubation, the patient went into cardiac arrest, resuscitation efforts were unsuccessful, and the patient was pronounced dead. Cause of death was recorded as cardiac arrest and sepsis, and the resulting claim alleged negligent ED triage of the patient.

Risk Management Recommendations: Engineering Safe and Reliable Triage

- Have one or more RNs designated as triage nurses. This is a professional responsibility and must not be delegated to anyone who has not completed the required training and competency evaluation from nursing leadership to function in this role.
- Use an evidence-based triage classification tool. Ensure all triage nurses receive annual triage education in assessment and the use of the tool.
- Reassess patients who are waiting and do so at intervals appropriate for their symptoms or conditions.



STEP 3: WAITING ROOM

After initial triage, some patients will spend a period of time in the ED waiting room or other area before treatment begins. Monitoring the status of patients while they wait can be a challenge.

Risk Management Recommendations: Keeping Patients Safe in the Waiting Room

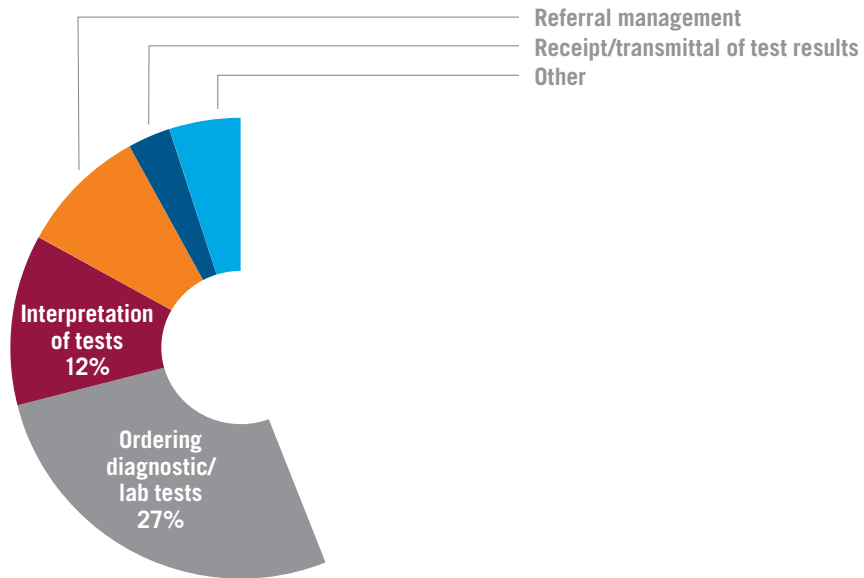
- Keep patients informed about wait times and when they can expect to be seen.
- Place patients who are at risk of falls in an area where they can be monitored and use direct observation or camera surveillance if there is someone who can constantly watch the camera monitor.
- Consider moving disruptive patients to another area of the ED as these behaviors may disturb and agitate other patients.
- Develop and practice scripts that staff can use to communicate with patients who become angry while waiting and are at risk of leaving without being seen by a provider.
- Consider adding a special room or area in the ED for patients with psychiatric issues. This area should be designed to be free of objects that patients could use to harm themselves or others.
- Provide masks and hand sanitizers. Use signage to direct patients with potentially communicable illnesses to use these items.

STEP 4: TREATMENT ROOM

Most ED patients spend the majority of their time in a treatment room. What happens there — from the communication and decision-making authority among providers, to the development of a treatment plan — sets in motion a treatment journey that can unfold quickly. Based on insights from claims data, we've identified two primary areas of focus for practitioners seeking to reduce risk in the ED: 1) the history and physical examination; and 2) the diagnostic decision-making process.



DX-RELATED ALLEGATIONS: PHASE OF CARE



N = 756 closed claims between 2014 and 2018 with an ED location and a diagnosis-related allegation.

HISTORY & PHYSICAL RISKS

A staggering 44% of the Coverys cases that were classified as diagnosis-related identified the initial history and physical (H&P) and evaluation of the patient as the stage at which the diagnostic process broke down. Patient acuity and the fast-paced environment of an ED can impact the provider's ability to obtain and perform a comprehensive H&P. Therefore, the H&P in the emergency department must be focused and complaint-driven. Unlike a general H&P in the primary care setting, the primary goal of the ED history and physical is to diagnose or exclude any potentially life- or limb-threatening condition. The secondary goal is to rule out any causes of serious morbidity and come to an accurate diagnosis for the patient's complaint.

of diagnosis-related ED claims allege failure at the history and physical (H&P) evaluation stage.



What can organizations do to assist providers in conducting an effective complaint-driven H&P? Many EDs have implemented H&P templates to guide providers in evaluating specific complaints and clinical presentations. Emergency medicine residencies train physicians and advanced practice providers in the best methods for extracting crucial information when speaking to and examining emergency department patients. It's important to provide ongoing training and refreshing of skills through in-person and online courses.



CASE STUDY



A woman in her mid-20s sought treatment from a chiropractor for a severe headache. She developed slurred speech and weakness of her limbs and neck immediately after spinal manipulation. Brought to the ED by ambulance, the patient was regaining normal function by the time her evaluation was performed by the physician. Despite a neck magnetic resonance angiogram (MRA) with “sub optimally visualized right vertebral artery” and the history of immediate neurologic symptoms after spinal manipulation, the patient was discharged with a diagnosis of migraine.

The patient returned to the ED the following day, and again two days later, with worsening symptoms — difficulty speaking and swallowing, and excessive sleepiness. Due to a lack of neurology coverage in the ED, the patient was transferred to a tertiary care facility where an MRA of the brain showed a pontine stroke, and digital subtraction angiography (DSA) demonstrated a basilar artery occlusion, right vertebral artery occlusion, and left vertebral artery dissection. She deteriorated neurologically over the next 24 hours with the development of dense quadriparesis and locked-in syndrome resulting in permanent disability.

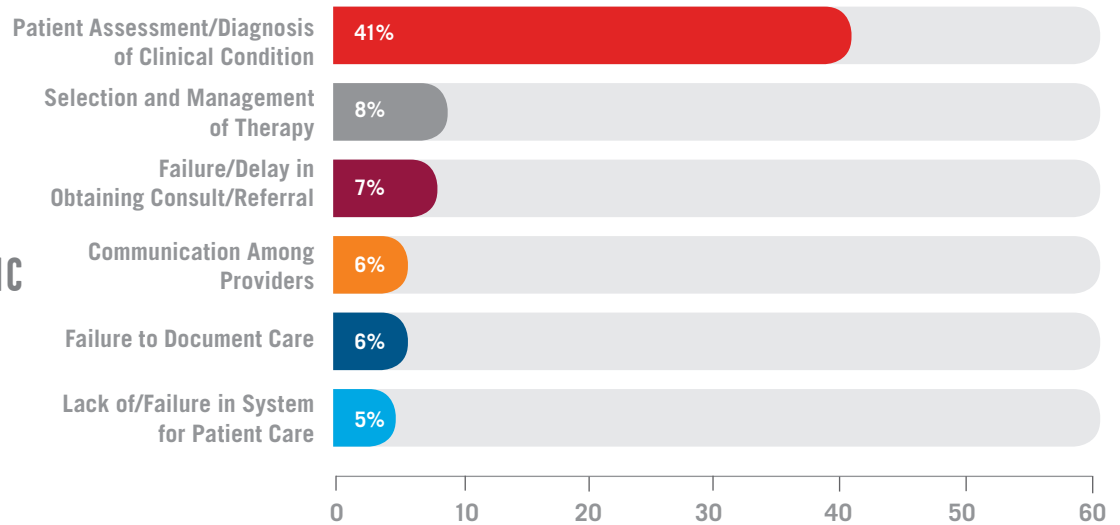
Overreliance on what was considered a negative MRA and under-reliance on the patient’s medical history led multiple physicians to undertreat the patient. This is a case where paying more attention to the patient’s description of symptoms and not relying as heavily on the imaging could have made all the difference.

DIAGNOSTIC RISKS

EDs present unique issues for the providers who work there, not the least of which is that treating patients in the ED is an exercise in providing care to a stranger. Emergency medicine providers do not have an ongoing relationship with most of the patients they see. More challenging yet are patients who arrive unable to speak for themselves and with no reliable historian accompanying them. These issues are compounded by the fact that emergency medicine providers are working in an environment in which they may have to make immediate and often lifesaving decisions with little or no information and where patient handoffs may require a rapid transition of care.



KEY RISK MANAGEMENT ISSUES ASSOCIATED WITH DIAGNOSTIC ERROR CLAIMS IN THE ED



N=770 risk management issues on closed claims between 2014 and 2018 with an ED location and a diagnosis-related allegation.

Risk Management Recommendations: Improving Diagnostic Accuracy

- Ensure that patient evaluation occurs on an ongoing basis in the ED episode of care by requiring documentation of patient status at certain prescribed intervals.
- Implement clinical decision support tools to assist providers in the diagnostic process, such as practice guidelines for high-risk presentations, clinical decision applications, and provide access to a dedicated radiologist and pharmacist to assist with diagnosis and treatment.
- Always use two patient identifiers (such as name and date of birth) when performing diagnostic testing.
- Label specimens at the bedside at the time they are obtained.
- Develop a protocol to manage communication of outstanding test results to the patient, primary care provider, and consultants, and hardwire those practices into everyday routines. Implement or customize a strong electronic system that supports the protocol and its objectives.
- Implement a chain-of-command policy to escalate situations in which there is a difference of opinion on patient treatment, and embed that policy into the workflow.
- Commit to enhancing communication handoffs at all transitions of care (e.g., shift to shift, ED to inpatient unit, ED to another facility, ED to home at discharge) based on a policy and structure for communication of patient information.



DIAGNOSTIC TOOLS

Some experts might argue that there's no time in the fast-paced environment of an ED to consult a diagnostic decision tool when making a diagnosis. Others might argue that the nature of emergency medicine is precisely what makes it necessary to rely on additional resources that can help practitioners arrive at an accurate and timely diagnosis.

OTHER RISKS IN THE TREATMENT ROOM

Medical Management

It is notable that while the vast majority of claims related to treatment room decisions are considered diagnostic in nature, 20% of ED claims allege an issue with the medical treatment itself. These allegations include a failure or delay in providing care. The largest portion of these allegations (53%) relate to the overall management of the treatment provided, while failure or delay in providing treatment account for 41% of these allegations.

Medication

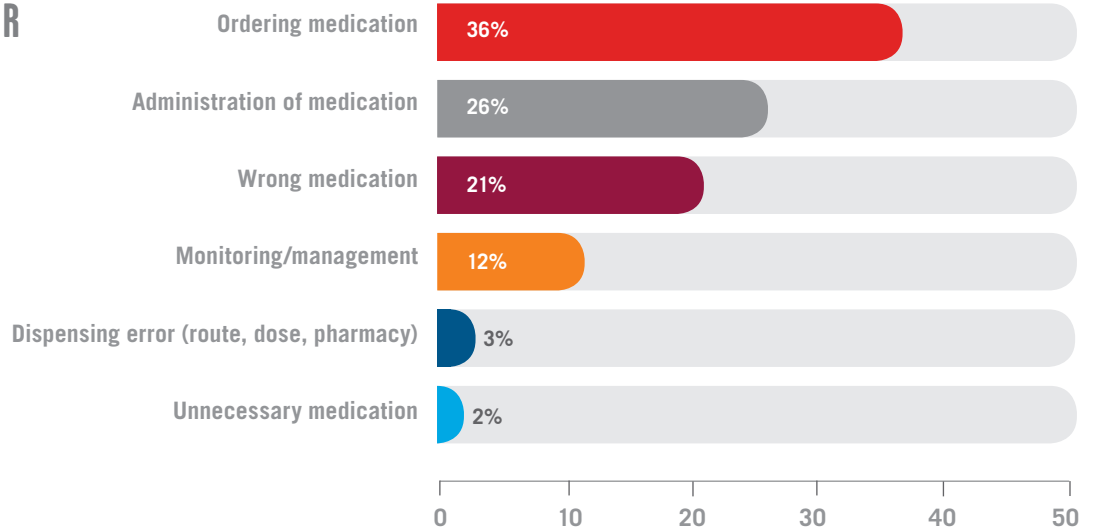
Allegations of issues related to medication management are also of note in ED claims, accounting for 9% of claims. Risks occur at every step of the medication ordering and administration process, as outlined in the chart on the following page. The most common medications involved in an ED allegation are antibiotics, opioids, and anticoagulants; 49% of all medication-related allegations in the ED involve these three types of drugs.

of medication-related allegations in the ED involve three types of drugs: antibiotics, opioids, and anticoagulants.





MEDICATION ERROR IN THE ED: TOP VULNERABILITIES



N = 121 closed claims between 2014 and 2018 with an ED location and a medication-related allegation.

STEP 5: DIAGNOSTIC TESTS (RADIOLOGY AND LABS)

The second most common group of allegations in diagnostic-related ED claims are those involving issues related to ordering diagnostic/lab tests. The entire testing continuum, which also includes performance of tests, receipt/transmittal of test results, and interpretation of tests, combine to trigger 44% of all diagnostic-related ED claims.

of
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EDs present a paradox when it comes to diagnostic testing. Practitioners may neglect to order crucial tests for symptoms or may order costly tests that may not be initially necessary. Diagnostic/lab testing steps are often integral to arriving at a timely and accurate diagnosis, but the testing continuum involves many risks including failure to:

- Choose and order the appropriate diagnostic/lab tests.
- Properly perform tests (including obtaining, handling, and labeling of specimens).
- Accurately interpret test results.
- Receive or transmit test results.
- Communicate clearly and efficiently between lab and radiology professionals, the ordering physician, and other relevant providers.



DIAGNOSTIC TESTS (RADIOLOGY AND LABS) (continued)

- Clearly communicate results to the patient.
- Repeat tests or order additional diagnostics, if needed.
- Provide annual education and validate the competency of nurses and technicians in use of other point-of-care diagnostic testing equipment (e.g., glucometers, ECG machines).

CASE STUDY



A male patient in his 30s arrived at the ED complaining of abdominal pain. An abdomino-pelvic CT scan showed appendicitis and a 1.5-cm lesion on the left kidney. The radiologist recommended an ultrasound and documented that his findings were immediately telephoned to the patient's attending nurse in the ED. No mention of the kidney lesion appeared in the patient's records.

The patient was taken for an appendectomy and was discharged without being informed about the kidney lesion. About a year and a half later, the patient was seen in the same ED for sudden onset of sharp pain in his left flank area. A kidney stone was suspected, and the patient was sent home when pain resolved with medication. Another year and a half later, the patient was seen in a different ED with complaints of severe left flank pain. An ultrasound revealed, and CT confirmed, a 7.1-cm mass on the left kidney. Further testing revealed renal cell cancer. The patient underwent radical left nephrectomy and recovered without complication. The very first radiology report, three years prior to the cancer diagnosis, revealed the kidney lesion, and neither the ED physician, attending surgeon, nor surgical resident acknowledged or took action on this.



Risk Management Recommendations: Improving Diagnostic/Lab Testing

- Ensure that initial radiology interpretations by the ED provider are validated by radiologist interpretation.
- Develop a defined process for documenting the communication of incidental findings in diagnostic radiology results to patients and primary care providers.
- Confirm verbal communications regarding diagnostic results by writing them down and reading them back to the communicator.
- Clearly define roles and responsibilities for communication of diagnostic results to the patient and the primary care provider.
- Ensure that if ED nurses collect laboratory specimens, they receive training from laboratory department phlebotomists and that their competency is regularly validated.

STEP 6: SPECIALTY CONSULTS

Failure or delay in obtaining a specialty consult accounted for 11% of clinical judgment-related ED claims.

The effective practice of emergency medicine requires that ED physicians identify patients in need of specialty consults and coordinate with staff to help ensure the specialty ED consult occurs. In large medical centers, specialty consultation is likely to be readily available. In smaller, especially rural facilities, a patient may need to leave the community to obtain a specialty evaluation. If the need for consultation is urgent, but not available in the community, the patient may need to be transported for care at another hospital. In hospitals of all sizes, communication of specialty consults is often a major issue; specialty consults may be consistently and appropriately completed, but not documented in the right place (or at all).

Failure or delay in obtaining a specialty consult accounted for 11% of clinical judgment-related ED claims.



Risk Management Recommendations: Developing a Better Approach to Specialty Consults

- Hospitals that have available physician specialists should designate a call schedule for ED consultation and post this schedule in the ED desk areas.
- Issues with obtaining consultation from individual on-call providers should be brought to the medical executive committee for review and action.
- If the patient can be stabilized without immediate consultation, consideration should be given to making appointments for patients who need specialty consultation to increase compliance with follow-up.
- Medical record documentation by the consulting physician should include the reason for consultation, pertinent findings, test results, and recommendations for treatment. Whenever possible, there should be a verbal exchange of information between all involved providers.

When a patient needs to be transferred to a tertiary care facility for consultation, the transferring facility must clearly document that the transfer is necessary in order to obtain emergency consultation with a specialist not available at the transferring facility.

STEP 7: DISCHARGE, ADMISSION, OR TRANSFER

A patient's ED experience generally ends in one of three ways: discharge to home; admission to a hospital floor; or transfer to another care facility. In each instance, timing and attention to detail are key.

ED staff must take care to ensure patients are not discharged prematurely and that communication handoffs are conducted to ensure complete information follows the patient.



ED staff must take care to ensure patients are not discharged prematurely and that communication handoffs are conducted.

Risk Management Recommendations: Admission or Transfer Process

DISCHARGE TO HOME

- Provide patients with written discharge instructions in layman's terms that include the diagnosis, treatment provided, symptoms that require action and which actions to take, referral information for more definitive testing, medications (and their expected response), and other pertinent information, such as what actions to take if symptoms persist or worsen. Instructions should be time-specific and should always suggest timely follow-up with the patient's primary care doctor.
- Review the written discharge instructions and validate the patient's understanding using techniques such as teach-back or repeat-back.
- Provide discharge instructions in the patient's primary language whenever possible. If written instructions are not available in that language, use an interpreter or a phone interpreter service to ensure instructions are understood.
- Arrange to have any new prescriptions filled at a pharmacy that is convenient for the patient.
- Consider making follow-up appointments for patients to increase compliance.
- Develop a list of the clinical diagnoses and conditions for which a follow-up call to the patient should be made within 24 to 48 hours. Develop an outline or script for the call that includes identification of symptoms that should be reassessed in the ED.
- Consider employing a social worker to assist in the discharge process for patients with socioeconomic challenges and/or the need for temporary or permanent placement in a care facility.

ADMISSION TO THE HOSPITAL UNIT

- Ensure that an ED provider performs a verbal handoff to communicate all pertinent clinical information to the hospitalist or inpatient physician.
- Establish clarity in the timing of transferring responsibility for inpatient orders to the inpatient provider once the decision is made to admit the patient, even if the patient must remain for a time in an ED treatment area or hallway before transfer.
- Ensure that an RN accompanies all patients transferred to critical care units and that a verbal nursing handoff occurs between the transferring nurse and receiving nurse, preferably at the bedside.
- Use nonprofessional patient transporters or volunteers for noncritical patients and ensure that a structured, verbal nursing handoff occurs prior to or at the time of transfer.



TRANSFER TO ANOTHER FACILITY

- Provide annual education to ED staff members on Emergency Medical Treatment and Labor Act (EMTALA) regulations.
- Make every effort to stabilize the patient prior to transfer. This includes pregnant patients in active labor.
- If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.
- In hospitals without OB services, ensure that ED providers and staff members are prepared to deliver pregnant patients by conducting periodic education and drills.
- Ensure that the transferring ED provider has communicated with the receiving provider and has gained acceptance of the transfer. Document the name of the accepting provider and the time of acceptance on an EMTALA transfer form.
- Transport all unstable or critically ill patients via EMS. Determine if the patient's condition warrants sending additional professional personnel with EMS providers for the transport.
- Send copies of all pertinent documentation to the receiving facility electronically and/or on paper with the EMS personnel.



The ED is arguably one of the most high-risk areas of medicine when it comes to keeping staff sharp and up-to-date on current standards of care. Of the ED claims that alleged a communications failure, the majority involved communication among providers (MD to/from MD, MD to/from RN, and MD to/from advanced practice provider), followed by communication between patient/family and providers. When it comes to communicating effectively in the ED, initial education is, of course, crucial, but ongoing training is what ultimately keeps patients safest. It's about sustaining a culture of high reliability — an environment in which it is agreed that every voice will be heard and where standard protocols are adhered to, pathways are followed, and risk factors are consistently identified and acted upon. Proactive organizations have hard-wired refresher training into their daily operations. During down time, they are conducting simulation activities, such as active shooter, local disaster, and infectious disease outbreak drills.

Effective communication in the ED involves, to a large degree, the meticulous and timely use of documentation.

It's important to note that effective communication in the ED involves, to a large degree, the meticulous and timely use of documentation, often involving electronic health records (EHR). Issues pertaining to documentation and EHR issues account for 10% of all ED claims. The majority of these allegations come down to human error related to missing or inadequate recording of crucial information in the medical record.

In general, EDs are environments with inherent stress and variability — a stark reality that sometimes makes it difficult to deliver care with excellence and accuracy and to always communicate clearly and fully. But difficult as it may be, there is cause for optimism. ED teams that are vigilant about embracing strong cultures, ongoing training, and best practices can improve outcomes. Many ED providers and staff find that consistent use of electronic communication boards supports instant access to crucial information about patients currently under their care. The Agency for Healthcare Research and Quality (AHRQ) provides a comprehensive team-training program called TeamSTEPPS®, which includes communication mnemonics, video vignettes, and practice to enhance communication in challenging healthcare situations. More information can be found at: <https://www.ahrq.gov/teamstepps/index.htm>.⁷



Odds are that if you see a societal trend at large, that trend will eventually warrant thoughtful attention from those who work in U.S. emergency departments. Top issues in the ED include violence, behavioral health challenges, boarding, opioids, diversity, geriatric care, and patients who frequently visit the ED. Below, we address these trends one by one.

Violence: EDs are high-risk environments and can also be environments exposed to violence. Staff members should be trained to de-escalate behavior, offer patients choices, and include them in decision-making whenever possible. It's recommended that hospital EDs pursue de-escalation and aggressive behavior management education through programs such as those offered by the Crisis Prevention Institute.⁸ Anyone working with patients in a hospital setting should be required to complete this education. Hospitals should conduct active shooter drills or, at the very least, tabletop drills. When possible, work in collaboration with local law enforcement when planning and conducting these drills.

Behavioral Health Challenges: EDs are becoming increasingly proactive in managing patients with mental illnesses. Some have designated special care areas with soothing light, colors, and music; no furniture that can be picked up and thrown; and no other objects that could be used for harm to self or others. Because behavioral health issues can be significant in the ED, hospitals should consider hiring someone with experience in a behavioral health setting and who has effective skills when it comes to interacting with behavioral health patients. This is particularly important because sensitive communication can help to prevent deterioration of psychiatric symptoms if the patient must wait for placement.

Opioids: It's estimated that there are 1,000 opioid-related visits to U.S. emergency departments every day.⁹ Opioid addiction is a national emergency. According to the CDC, among the more than 72,000 estimated drug overdose deaths in 2017, the sharpest increase occurred among deaths related to fentanyl and fentanyl analogs (synthetic opioids) with nearly 30,000 overdose deaths.¹⁰ Persons with addiction problems frequently present to the ED with complaints of chronic or acute pain in order to meet their dependency needs. However, the ED is not the appropriate setting to manage chronic pain or addiction.



Risk Management Recommendations for Opioid Prescribing

- Develop clear protocols for opioid prescribing in the ED. Include those presentations where opioids may be prescribed (e.g., acute abdominal pain, bone fractures) and limit the prescription to the days from discharge to the next follow-up appointment.
- Provide clear directives for clinical presentations for which opioids are not indicated (e.g., migraine headache, chronic pain not related to a terminal illness).
- Consult state prescription monitoring databases whenever prescribing narcotics.
- Develop a list of pain management practitioners in the area and refer patients who present with uncontrolled chronic pain.

Diversity: It's difficult enough to diagnose and treat a patient in the ED if it's a slow day and you share the same spoken language, customs, and values. But in the ED, awareness of the unique aspects of diversity is essential in order to provide respectful and appropriate care. Transgender patients, in particular, can find themselves in suboptimal situations in EDs where providers haven't had enough training to adequately address patient concerns. For example, when a transgender woman presents with blood in her urine, a prostate exam may be warranted and payment for this test may be denied by the insurance company. And when ED staff use the wrong gender pronoun for a patient (he, she), respect and trust are eroded. Obese patients may encounter bias in the ED from staff members who consider obesity to be a sign of emotional weakness. Language and communication barriers can add to the complexity of obtaining a history, prescribing treatment, and communicating discharge recommendations.

Risk Management Recommendations for Diversity

- Encourage ED providers and staff members to obtain education on the care of transgender patients.
- Provide sensitivity training for the care of obese patients. Ensure that the facility is equipped with bariatric-sized furniture, wheel chairs, and medical equipment, such as blood pressure cuffs and airway equipment. Ensure that exam tables and X-ray tables have appropriate weight limits to accommodate obese patients.
- Contract with interpretive services to provide in-person or electronic language assistance. Develop printed discharge materials in the most commonly used languages in the community.



Repeat ED patients: Just because a patient is known to the ED because of frequent visits for the same complaints, doesn't mean that today's visit will be the same. Today could be the day that your known patient presents with a serious health issue, where preconceived notions that narrow a clinician's diagnostic focus can be dangerous or even deadly.

Risk Management Recommendations for Repeat Patients

- Ensure that repeat patients receive a complete medical screening appropriate for their symptoms each time they present for treatment.
- Refer cases in which less-than-adequate medical screening resulted in a misdiagnosis or missed diagnosis to the organization's peer review committee for evaluation.

Geriatric care: Forty-six million people in the U.S. are age 65 or older and can present care challenges.¹¹ Because this patient population is at increased risk of falling, EDs must provide fall risk assessments and plan care accordingly by the use of bed egress alarms and/or constant observation for those at risk. What may appear to be a behavioral or cognitive issue (e.g., disorientation, confusion, or agitation), may be a delirium from a medical issue (e.g., diabetes, urinary tract infection, thyroid dysfunction, pneumonia). ED providers also need to be cognizant about adjusting medication doses for the elderly population, as what is considered a normal adult dose of some medications can be harmful or even lethal in this population. It's also important for EDs to have an effective social services staff, aware of and with established connections to community services for geriatric patients.



Across the nation, boarding in the ED is on the rise. Boarding is a patient flow phenomenon in which patients remain in the ED after they have orders to be admitted for inpatient hospitalization. Many boarded patients are psychiatric patients waiting for acute psychiatric bed placement. It has been estimated that 50 acute psychiatric beds are needed for every 100,000 people in any given community. Currently, however, only 11.7 beds are available per 100,000 people.¹² Most other boarded patients are typically those that have been stabilized but are waiting to transfer to an inpatient bed in the facility.

ISSUES RELATED TO BOARDING

- Patients waiting for transfer or admission and occupying an ED bed may result in a backup of patients waiting for emergency evaluation.
- Placing patients who have been discharged from the ED but are waiting for admission or transfer in areas other than treatment rooms may compromise their privacy and dignity.
- Boarding patients in a busy ED results in longer wait times for new patients that can lead to patients leaving without being seen or leaving against medical advice.
- Once a patient is admitted but remains in the ED, there is sometimes confusion about which physician (inpatient or ED) is providing directives and ongoing orders.
- ED nurses who are busy with acutely ill ED patients do not have time to provide care that the patient would receive as an inpatient (e.g., ambulation, skin care, elimination needs, routine medications, pain assessment, and reevaluation).
- Situations have occurred where boarding patients' conditions deteriorate, and nurses are too busy with ED patients to notice in time to intervene.
- Psychiatric patients who are boarding may not be supervised closely enough to keep them safe, especially if they demonstrate suicidal ideation or aggressive behavior.



CAUSES OF ED BOARDING

- Hospital census at capacity, such as during flu season.
- Inpatient staffing shortages may make transfer to an inpatient bed impossible.
- Inpatients who are ready for discharge are waiting for a discharge order from the inpatient physician (e.g., a surgeon who is in surgery all day or a primary care doctor who is in clinic all day).
- Discharge delays may occur due to lack of available transportation, transitional care, or other support services.
- Psychiatric patients may be waiting for an inpatient bed in another facility that provides acute psychiatric services.

Risk Management Strategies to Reduce or Prevent Boarding

- Employ hospitalist physicians who are on inpatient units 24/7 to expedite discharge orders when inpatients are ready to go.
- Set clear policies that once a patient is admitted, ongoing orders and therapies for inpatients boarding in the ED should be provided by the inpatient physician/hospitalist. ED nursing staff must continue to provide care until an inpatient nurse assumes responsibility for the care at transfer.
- Consider having inpatient nurses provide care in the ED for boarding patients until they can be moved to the floor. Consider employing nursing assistants in the ED to provide routine nursing care (e.g., feeding, skin care, ambulation, hygiene) for patients who are boarding.
- Employ inpatient case managers who proactively work to help discharge patients as soon as they are ready.
- Use a bed control manager or team to keep abreast of all admissions and discharges and make bed assignments efficiently.
- Ensure that boarding patients are monitored as frequently as their condition warrants (i.e., as frequently as they would be on the inpatient unit).
- Ensure that medication reconciliation is completed, so patients will not miss any of their routinely prescribed medication while boarding.
- Ensure psychiatric patients are not only screened for suicidal ideation upon admission to the ED, but are reevaluated at intervals while boarding. Results of the suicide risk screening should drive the patient monitoring and observation plan.
- Some states have enacted laws to address boarding and overcrowding in emergency departments. It's important that ED staff are familiar with and in compliance with state-specific laws and regulations.



**30% of ED claims
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Throughout this publication, we have provided data-driven recommendations for reducing risk and improving outcomes related to the emergency department episode of care. Following is a general list of principles that apply broadly to emergency department risk in U.S. healthcare. As you and your colleagues approach each new day with an eye toward improving patient care and reducing risk, we strongly encourage you to consider these general principles.

- **Education/Training:** Ensure ED staff complete competency-based orientation and ongoing education, including with respect to high-risk clinical presentations. Document education and training in their employee files.
- **Credentialing:** Implement policies and procedures to ensure a thorough, objective, evidence-based credentialing process and documentation for recently appointed and reappointed physicians, advanced practice providers, and locum tenens providers (as applicable). The process should include consideration of peer review, quality, and outcomes data.
- **Collaborative Agreements:** Ensure that clear supervisory and/or collaborative practice protocols are in place for ED advanced practice providers that specify situations when consultation with or evaluation by the ED physician must occur.
- **Compliance:** EDs should review their practices as they relate to the Emergency Medical Treatment and Labor Act (EMTALA) to ensure that all patients, regardless of their ability to pay, receive a medical screening and appropriate stabilization prior to transfer or discharge.
- **Documentation of High-Risk Presentations:** It's imperative that medical record documentation of high-risk presentations is clinically pertinent and includes a triage assessment, a pertinent medical history, a history and physical, the medical care provided, and a disposition appropriate for the patient's condition. High-risk presentations include: chest pain/MI, headache/stroke, abdominal/pelvic pain, infection/sepsis, pregnancy/labor, and psychiatric emergencies. These common complaints warrant close attention as 30% of ED claims involved cases that were cardiac-related or GI-related, two of the most common complaint types nationally.¹³



- **Medication Management:** Put into place and/or review the existing formal medication management plan which includes involvement of a pharmacist and goals specific to the ED population. It should include strategies to promote medication safety and take advantage of technology that enhances quality improvement with regard to all aspects of medication administration and management.
- **Security Plan:** Develop a comprehensive security plan for your facility which is based upon a recent analysis of security/safety risks in the ED and within the facility overall. Include ongoing staff training and drills in the plan and schedule periodic assessments to ensure the plan is up to date and effective.



Improving patient safety in EDs will require scrutiny of every step in the patient's ED journey.

In the coming year, hospital emergency departments in the U.S. will receive more than 138 million patient visits.¹⁴ This high volume of patients comes with distinct risks. Coverys claims data shows that EDs are the fourth most common healthcare delivery location to trigger medical professional liability claims. On a national scale, 52% of emergency medicine physicians will be sued, 26% of them more than once.¹⁵ And the burden of that risk rests not just with emergency medicine physicians, but with all who practice in the ED. Of the healthcare providers implicated in ED malpractice claims, 33% are not emergency medicine physicians, but rather general medicine physicians, radiologists, surgeons, other specialists, and advanced practice providers. In the ED, we succeed and we fail as teams — teams whose members must, in working together, provide expertise and care that eclipses the impact that one provider alone could deliver.

Emergency medicine physicians, advanced practice providers, consulting specialists, and other healthcare professionals provide outstanding care to most patients who pass through their EDs. But the claims data — which reveal that 32% of malpractice claims in the ED involve permanent injuries and 38% involve grave injury or death — must serve as signals for greater vigilance for all who contribute to the complex patient care ecosystem in the ED.

As we have explored in this data-inspired report, there is much that can be done to improve patient outcomes when the healthcare journey begins in the ED. From mastering complaint-driven H&Ps, to implementing timely and appropriate specialty consults, to building new cultures characterized by clear and detailed communication, there are opportunities to deliver better care. EDs can be more thoughtful in medication prescribing, dosing, and management; more scrupulous in their activities along the diagnostic/lab testing continuum; and more strategic in the hiring and training of the men and women who provide care to patients.

Improving patient safety in EDs will require scrutiny of every step in the patient's ED journey — from transport/arrival, then to triage and waiting room, on to treatment room, diagnostic tests, specialty consults, and ultimately to discharge, hospital admission, or transfer. It will also require fresh perspectives on how decisions made in the ED impact the entire continuum of care for every patient who passes through its doors. We believe the data holds keys to improved patient safety. As such, we urge you to heed the signals, understand the trends, and rise to the challenge of implementing new practices, new processes, and new mindsets.



Unless otherwise noted, statistics and information in this publication were derived from an analysis of 1,362 emergency department-related closed medical professional liability claims at Coverys across a five-year period (2014-2018).

1. Brian J. Moore, PhD, et al, "Trends in Emergency Department Visits, 2006-2014," Statistical Brief #227, Healthcare Cost and Utilization Project (H-CUP). Agency for Healthcare Research and Quality (AHRQ), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf>.
2. The Centers for Disease Control and Prevention, "National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables," Table 10, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf.
3. Brian J. Moore, PhD, et al, "Trends in Emergency Department Visits, 2006-2014," Statistical Brief #227, Healthcare Cost and Utilization Project (H-CUP). Agency for Healthcare Research and Quality (AHRQ), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf>.
4. Nicki Gilboy, Paula Tanabe, Debbie Travers, and Alexander M. Rosenau, "Emergency Severity Index (ESI): A Triage Tool for Emergency Departments," Emergency Severity Index Implementation Handbook, 2012 edition. Agency for Healthcare Research and Quality (AHRQ), <https://www.ahrq.gov/professionals/systems/hospital/esi/esi1.html>.
5. Nicki Gilboy, et al, "Emergency Severity Index (ESI)" A Triage Tool for Emergency Department Care," Implementation Handbook, 2012 edition. Agency for Healthcare Research and Quality (AHRQ), <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf>.
6. VisualDx website homepage. <https://www.visualdx.com/>
7. TeamSTEPPS Curriculum, Training, and App. Agency for Healthcare Research and Quality (AHRQ). <https://www.ahrq.gov/teamsteps/index.html>.
8. Training and Events. Crisis Prevention Institute. <https://www.crisisprevention.com/Training-and-Events>.
9. Substance Abuse and Mental Health Administration. Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. The DAWN Report. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2013. <http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.html>.



10. Overdose Death Rates. National Institute on Drug Abuse. National Institutes of Health (NIH). Revised August 2018. <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.
11. Population Reference Bureau (PRB), Population Bulletin: Aging in the United States, Vol. 70, No. 2, December 2015, <https://www.prb.org/wp-content/uploads/2016/01/aging-us-population-bulletin-1.pdf>.
12. Treatment Advocacy Center, “Psychiatric Bed Supply Need Per Capita,” September 2016, <https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3696>.
13. Brian J. Moore, PhD, et al, “Trends in Emergency Department Visits, 2006-2014,” Statistical Brief #227, Healthcare Cost and Utilization Project (H-CUP). Agency for Healthcare Research and Quality (AHRQ), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf>.
14. Ibid.
15. American Medical Association, “AMA 2016 Benchmark Survey,” Table 2, <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-medical-liability-claim-frequency.pdf>.

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Case studies and other patient examples shared in this publication are derived from actual liability claims with identifying details removed or altered to protect the anonymity of patients, families, practitioners, and healthcare organizations.

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