

# National clinical incidents and claims in Emergency Medicine, 2010- 2014

Authors; Fiona Culkin, Deirdre Walsh, Dr. Dubhfeasa Slattery.  
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## Aim

To review and analyse clinical incidents which occurred and claims created pertaining to emergency medicine (EM) nationally from 2010-2014 and to identify opportunities for learning.

## Method

A report was run using the National Incident Management System (NIMS) under the specialty of *emergency medicine*.

## Results Incidents

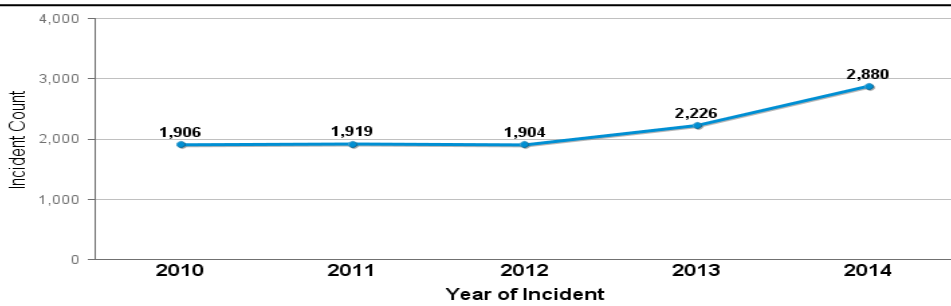


Figure 1 Total clinical incidents which occurred, 2010-2014

A total of 2,880 clinical incidents occurred in EM in 2014. This represents an increase of 974 incidents since 2010 (n=1,906), which equates to a 51.1% increase over that time period.

Analyses of the 2014 data revealed severity rating of;

- Extreme 43 (1.5%)
- Major 10 (0.4%)
- Moderate 944 (32.8%)
- Minor & Negligible 584 (20.3%)
- Legacy data 1,299 (45.1%)

Analysis of the sub-hazard category revealed that *clinical procedures* account for 2,181(75.7%) of incidents, *medication fluid and medical gases* 137 (4.8%), *blood and blood products* 23 (0.8%) and *birth specific* 3 (0.1%). Sub-hazard was unknown for 536 (18.6%).

Four main identified processes accounted for 1,783 (61.9%) incidents: *procedures, treatment or intervention; diagnosis and assessment; document and records; and equipment* (figure 2).

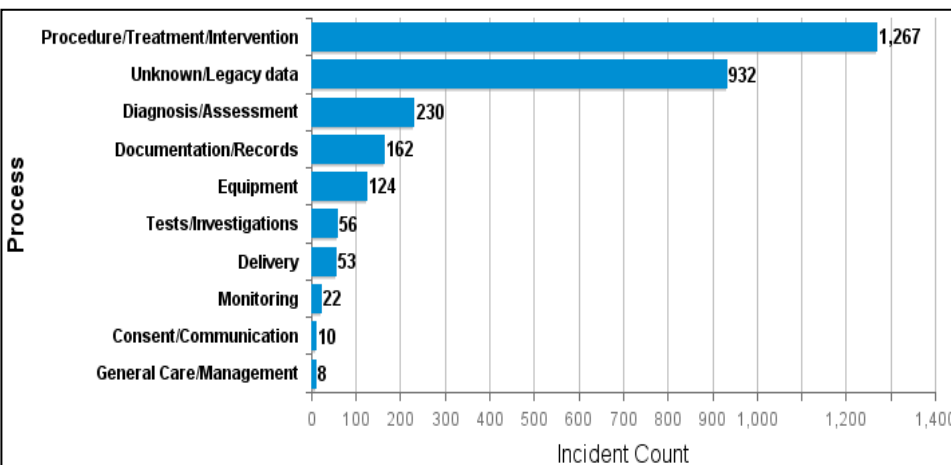


Figure 2 Clinical care incidents by process in 2014

## References

- The National Emergency Medicine Programme. A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland, Health Service Executive 2012
- Medical Protection Society (2013) *Medical Records in Ireland*. Medical Protection Society.

## Results Claims

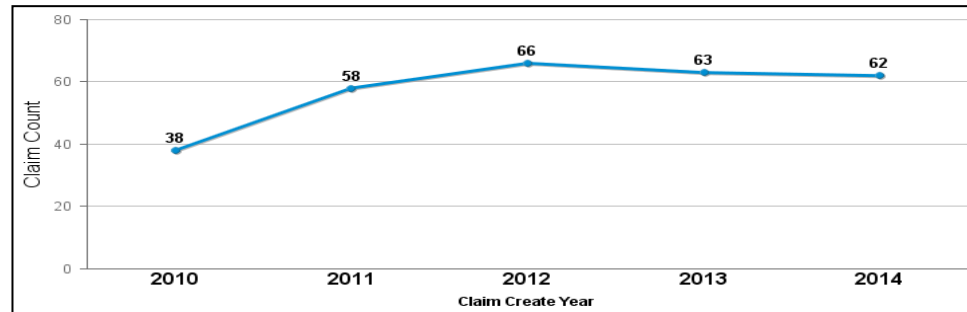


Figure 3 Total clinical claims 2010-2014

In 2014, 62 clinical claims pertaining to EM were created. This represents an increase of 24 (63.1%) from claims created in 2010 (figure 3).

Analyses of the 2014 data revealed severity rating of;

- Extreme 9 (14.5%)
- Moderate 20 (32.3%)
- Minor & Negligible 1 (1.6%)
- Legacy data 32 (51.6%)

Analysis of the process categories identified that 37 (59.7%) were associated with *diagnosis and assessment* followed by *procedure treatment and intervention* (n=17,27.4%).

Regarding the problem cause (figure 4), the most prevalent was *not performed when indicated* (n=22, 35.5%) while the remaining, where identified, related to *inadequate or insufficient records* (n=13, 20.1%), *adverse effect* (n=5,8.1%), *wrong process/procedure or treatment* (n=4,6.5%) and *incomplete or inadequate* (n=4, 6.5%; to include management of a fracture (n=2), treatment of palpitations (n=1), and a medication error (n=1)).

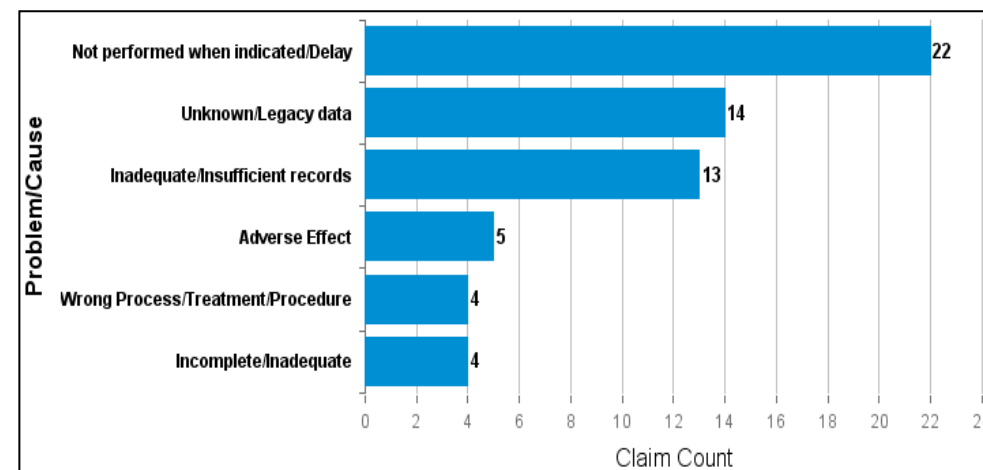


Figure 4 Clinical claims created in 2014 by problem/cause

## Conclusion

Analyses of incidents which occurred and claims created over a five year period identified a significant increase in both. Opportunities for learning;

- Timely **assessment** and appropriate **clinical escalation** is important.
- Clear and accurate **documentation** is required.
- **Delays** in treatment, should be minimised where possible.