

Lay Summary:

An examination of past patient safety reports to look at previous errors made in diagnosing patients attending Emergency Departments

Mistakes in diagnosis occur more frequently in the Emergency Department (ED) than in regular in-patient hospital care. The types of mistakes made in hospital EDs from 2013 to 2015 were studied to look for patterns and ways the errors could be reduced.

Information on errors in diagnosis in EDs were taken from a national database of safety incidents. This was then analysed to identify what had happened, what factors might have caused the error and what harm had been caused to the patient.

The results showed that in 86% of cases the diagnosis had been delayed and in 14% the diagnosis was wrong, with one in seven cases resulting in severe harm or death. Most errors were made in diagnosing fractures. Mistakes were also made in cases of heart attacks and bleeding in the brain.

Possible causes of delayed and wrong diagnoses were mostly human mistakes including inadequate skills or knowledge of staff and not following recognised procedures. These led to poor assessment, failure to order the right tests and interpreting the results of tests incorrectly.

Better support for a doctor in assessing a patient's condition is needed in order to reduce errors in the future. Possible improvements could be developed such as standardised checklists, structured reporting and improvements in equipment used in investigations. These would need to be tried out and evaluated in the ED setting.