

**A Patient died after being discharged
from a Hospital’s Emergency Department (ER)**

***Case:***

A 50-year-old male suffering from vertigo, speech disturbance, high blood pressure and off-balance was admitted to the ER for medical assessment and diagnostic clarification. A medical assessment and lab tests have been performed during transportation in the ambulance. The patient was not hospitalized since this was not an emergency case; however he was scheduled for hospitalization at later stage and currently referred back to his GP. 20 minutes after leaving the ER, on his way home the man died in the public transport.

***EAMA’s Involvement:***

A letter received from the prosecutor’s office to investigate the case.

***EAMA’s Actions:***

As a supervisory body, the EAMA’s investigators examined the case. They studied the patient’s track record from the time he was transported to his discharge from the ER. The following information was collected and analyzed:

1. Patient’s file
2. Written standpoints by the physicians who provided medical consultations at the ER

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| ***N*** | ***Available Data*** |
| 1. | Date and time of registration at the ER |
| 2. | Patient’s ID  |
| 3. | Sex |
| 4. | Address |
| 5. | Marital status |
| 6. | Social status |
| 7. | Health insurance status |
| 8. | Name and phone of contacting person |
| 9. | Type of medical consultations provided to the patient |
| 10. | Date and time of medical consultations |
| 11. | Place where the consultation were given |
| 12. | Name and specialty of the physicians who provided consultations |
| 13. | Names of other members of the medical team (if any) |
| 14. | Duration of the consultation |
| 15. | Description of the consultation |
| 16. | Case history |
| 17. | Physical status assessment |
| 18. | Diagnosis |
| 19. | ***Results from the lab tests performed during transportation\**** |
| 20. | ***Work-schedule at the ER\****  |
| 21. | Conclusions and follow-up treatment |
|  | ***Missing data*** |
| 1. | Comorbidities |
| 2. | Case history from the second physician |
| 3. | Assessment from the second physician |
| 4. | Prescription of additional lab tests and/or X-Ray |

*N.B.: \*Data indicating a risk situation*

The data were available from the hospital information system and on paper.

The information was used to analyze and find out the root cause of the patient’s death. The investigators came up with conclusions the patient had lacked **timely and adequate health care** due to the following reasons:

1. The physician did not take into account the abnormally high results of the glucose and didn’t prescribe additional lab tests or X-Ray. In addition, the treating physician did not perform some of the activities according to the requirements of the medical standard of emergency care.
2. At the same time the physician was providing care to this patient, 3 more emergency patients were being discussed.
3. The **root cause** for the adverse event was the work-load at the ER: there is only **one** physician on duty for 12 hours without regulated rest. The physician on duty provided medical care to 30-40 patients.

***EAMA’s Recommendations and Actions:***

1. Although the hospital meets the requirements of medical standard in terms of minimum number of the staff at the ER, it does not meet the requirement regarding the work-load and patient flow: according to the standard, there should be minimum **one physician to provide medical care of approximately 83.33 patients per month.** Thus, the management of the hospital should seriously consider this very requirement and take steps for attracting and hiring physicians at the ER.
2. Together with the scientific society, to prepare control checklists of activities mandatory to be performed according to the requirements of the medical standard of emergency care.