FP07 PREVENTABILITY AND ERRORS IN TRAUMA DEATHS PRESENTING TO AN EMERGENCY DEPARTMENT IN A UNIVERSITY HOSPITAL

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INTRODUCTION

Trauma-related deaths remain a leading cause of mortality in Malaysia. Being able to determine the preventability of trauma deaths and establishing the pattern of errors may improve quality of care.

METHODS

A three-phase study was conducted in a university hospital in Malaysia. The retrospective study analysed the total number of trauma deaths from January to December 2017 initially and followed by qualitative in-depth individual and group interviews. An expert panel then determined the preventability of these trauma deaths and the classification of errors pertaining to preventable trauma deaths.

RESULTS

This study identified a total of 22 trauma deaths with 3 cases that were deemed preventable and 2 potentially preventable deaths revealing a 13.6% Preventable Death Rate (PDR). Errors were categorised as error domain where 80% found during initial intervention, 60% during initial assessment and resuscitation; Error type where 100% of cases had errors in treatment; 60% in diagnosis and communication and Error category where 60% of cases were knowledge-based, human resource and equipment errors.

DISCUSSION

Frontline assistance in Emergency Departments is often carried out by junior staff and may have inadequate management knowledge in areas of initial intervention, assessment, resuscitation and correlating with knowledge-based errors. Having a senior Emergency Physician on the floor have reduced this impact to a large extent, however the efficacy of can be difficult to evaluate in real-world practice. In a university hospital, a diverse background of trainees from different hospital settings within Malaysia and other countries lead to the increased risk for errors to occur, as evident with errors in communication. This is not limited only within the Emergency Department but also intra-departmental. Errors can be mitigated via a comprehensive risk-reduction strategy such as SOPs, checklists and continuous training. Identifying errors pertaining to trauma deaths is important for quality improvement and patient care.