Clinical Indemnity Scheme
Newsletter

CIS Newsletter, January 2012

2011 - Reflections on the Year

As we approach the end of another busy year at the State Claims Agency (SCA), we would like to take this opportunity to wish all our readers a very happy Christmas and good wishes for the New Year.

The past year has been a turbulent and difficult one for the State. The state of the public finances has dictated necessary cutbacks across our public services, to include the provision of health services by the HSE.

As the financial cutbacks bite, there is a greater than ever responsibility on the part of the HSE in relation to the proper allocation of financial resources to clinical risk management. Apart altogether from the obvious patient safety issues at stake, if clinical risk management resources are cut, there are also the associated claims and litigation costs. Less management of clinical risk necessarily entails more injured patients and greater claims/ litigation payouts.

During 2011, the SCA has piloted two *"open disclosure"* projects at the Mater Misericordiae University Hospital, Dublin, and Cork University Hospital. Both projects continue into 2012 when they will be formally reviewed by the SCA and the two hospitals.

Throughout the year, the SCA's clinical risk management unit hosted Systems Analysis training for hospital consultants, NCHDs, nursing and healthcare staff. Approximately 400 personnel have received such training during 2011.

During 2011, the SCA has settled a number of cerebral palsy cases on the basis of lump sum interim payments and a *"suspended Periodic Payment Order (PPO)"* - the PPO to come into play once the relevant PPO legislation is in place, hopefully during 2012. There is little doubt that a PPO basis of settlement, in catastrophic medical negligence injury cases, has compelling moral features underpinning the introduction of such an approach to the compensation of these cases. The fact is that no parents should have the worry, into the future, of how their brain damaged infant will be cared for. A PPO ensures that this is the case and the transition from traditional lump sum payments, in these kinds of cases, to PPOs represents a significant move forward in the area of personal injury compensation.

However, notwithstanding the bona fides of such an approach by the State, problems have begun to emerge such that unnecessary disputes are taking place, in the context of the interim lump sum payment, concerning issues such as accommodation, assistive technology, aids and appliances and the introduction of new heads of special damages. In fact, if these issues are not amenable to being resolved with plaintiffs' lawyers without the need for ongoing mini-trials concerning these issues, with all of the attendant legal costs, a radical re-think of PPOs may have to be considered. This would be unfortunate given the endorsement of PPOs by the Medical Negligence Working Group, established by Mr Justice Kearns, President of the High Court, under the chairmanship of Mr Justice Quirke.

2011 also saw the introduction of the Legal Services Regulation Bill which was explored, in terms of its contents, in the last editorial. The firm hope is that the new Bill, when it is enacted, will bring much greater certainty and transparency to the assessment of legal costs. Legal costs, in relation to clinical negligence cases, are far too high and require to be re-calibrated downwards. Hopefully, the necessary changes to the taxation of legal costs system will occur during 2012, following the enactment of the Bill.

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The Continuous Quality Improvement of the Ambulance Service Pre-Shift Check List System

An Ambulance Service is a demand led system, where the call volumes fluctuate minute by minute. There are over 600 items of equipment on a modern front line emergency ambulance. When a crew takes possession of an ambulance, they have to ensure that all of this equipment is in date, of the correct sizes (Neonatal to Adult) and in the correct quantities. Simultaneously, they must be ready to respond within 90 seconds to an emergency call.

The main items that need to be checked are Communications, ie phones and radio, the Ambulance itself for fuel, oil and water, as well as all lights etc. Other essential items are battery power for defibrillators, glucometers, IO devices and thermometers. One also has to check that an adequate supply of medical gases are on board, such as oxygen and entonox, both fixed and portable cylinders. One then has to ensure that all of the resuscitation and splinting equipment is also present and correct, which is approximately 600 items, requiring 3 checks each, which is 1200 checks.

Flabouris et al, studied incidents during pre-hospital retrieval and found that equipment was implicated in 38% of adverse events, with equipment failure resulting in 40% of these incidents and missing equipment accounting for 15% of these incidents. We need to ensure that ambulances are continuously ready at all times to respond to an emergency.

We have adopted the following, as a guiding principle:

In every system we develop, we need to:

1. Design the system to prevent failures.
2. Design the system to make failures 'visible', if they do occur.
3. Design procedures to mitigate the harm caused, if failures are not detected and corrected.

Aims:

The aim of this project was to determine if a sealed kit, check list system would:

- Reduce the time taken to check equipment.
- If a visual seal system (white tamper proof tag) would identify missing equipment faster.
- That we would have a record that shows the status of our equipment.
- That we would make minimal system changes, which could extract maximum improvement.

Our guiding belief was that:

"Good system design makes it hard for staff to get it wrong".

Results:

Example of our tamper proof seals, with National Ambulance Service logo and Unique Identifier in Ireland. Incorporated into design is a manual tear line, which allows the seal to be opened without a scissors.

The current system was studied first and was shown to take approximately 37 minutes to complete. 23 staff member completed an anonymous online survey, where 97% of staff stated they had responded to a call before their shift start. 100% of respondents stated that they had responded to an emergency before having fully checked their vehicle. 94% of staff had discovered stock out of date and 83% had discovered missing stock.

They compared this system to our drug bag system and found that 11% had found drugs out of date, and 5% had found missing drugs. The obvious conclusion for the author was to incorporate the sealed drug bag system into the check list project.

We developed 30 kit bags, that were age appropriate, and specified the contents with a check list. On the outside of the kit was written the first expiry date or the first inspection date, where no expiry date existed. We then sealed these kits with a white tamper proof seal.

This reduced the checking time to 15 minutes, a saving of 22 minutes. One staff member also indicated that the visual tag missing identified that an item of equipment had been removed at a Road Traffic Collision by another Health Care Professional, whilst he was attending to a patient. He commented that it allows for a rapid visual inspection of stock, with rapid identification of potential problems.

Staff Feedback:

Staff feedback was that this was a faster and better system. They also said that it reduced the repetition of checking and focussed the checking on the high risk equipment, which was easily remembered by the mnemonic 'CABG' Communications, Ambulance vehicle, Batteries and Gas. Equipment such as splints, where the seal was intact and the inspection date in the future, no longer

Presentation of the State Claims Agency Bursary for Best Personal Project - Graduate Diploma in Health Care (Risk Management and Quality), UCD, 2010-2011

Pictured left to right are: Asim Sheikh, Barrister-at-law, UCD, Kevin Flannery, Quality, Safety & Risk Manager-National Ambulance Service West , and Dr. Ailis Quinlan, Head of Clinical Indemnity Scheme (CIS), State Claims Agency

needed to be checked on a daily basis. Staff also said that this system was more likely to detect missing equipment. Staff also suggested a schematic diagram for each vehicle type, outlining which cupboard the kit is stored in, to reduce source time in an emergency.

Action Plan:

We presented our findings to the National Ambulance Service Leadership Team and the National Director gave permission to role out the project to a wider geographic area.

The Pilot project is ongoing, but so far the results are good, and we would hope to implement this system across a wider area.

Challenges:

The challenge we are facing is identifying how much equipment is enough, ie to manage a single patient to a large scale road traffic collision. The equipment list and number of check lists are continuously being revised and reduced.

The main challenge is to make the system easy to use, but that it still maintains its integrity.

References available on request.

Kevin Flannery, QSRM, National Ambulance Service West. Email: Kevin.flannery@hse.ie

Introduction of Complementary Therapy into an Acute Paediatric setting

The introduction of Complementary Therapy into the Acute setting of the Paediatric Haematology/Oncology Unit in OLCHC.

The inspired vision of a mother and her daughter who attended the Haematology/Oncology unit in Our Lady's Hospital for Sick Children, Crumlin has led funding for a Complementary Therapy service for the Malignant Haematology Oncology Patients and their families. **She believed that parents, their carers and indeed the patients themselves, needed more psychological support to cope with their diagnosis and the treatment. Hence the Julie Wrenn Complementary Therapy Unit was established in January 2011.**

Complementary Therapy (CT) refers to a diverse group of health related therapies and disciplines which are not part of mainstream medical care, playing an important role in relieving symptoms and in turn improving quality of life, (House of Lords 2000). It is described in much of the literature as a treatment that satisfies a demand not met by orthodox medicine. Furthermore, it diversifies the conceptual framework of conventional medicine. The ever increasing popularity of therapies coupled with patients' demand has inevitably led to integration of CT's into main stream health care. For parents of children with cancer, CT enables them to alleviate some of their child's discomfort during a time when they often express feelings of helplessness.

Multi disciplinary collaboration and communication are essential if Complementary Therapy (CT) is to play a significant role in providing holistic care to the patient and their families attending the Haematology/Oncology Unit. It is very important to create an environment that fosters a culture of respect, trust and awareness and where dialogue and feedback are welcome. (The Prince of Wales Foundation for Integrated Health) 2002. It is vital for the success of the CT unit that there is a supporting infrastructure within the Haematology/Oncology Unit. Moreover it is imperative that all staff members have an awareness of their own attitude to CT, have the knowledge of what Complementary Therapies are been provided and an informed understanding of what is involved in these therapies. It is hoped that having Clinical Governance and the ability to demonstrate safety in the deliverance of high quality therapies, that integration into the Haematology/Oncology Unit along side conventional medicine will not alone be achieved, but proved to be an effective aid to conventional medicine.

The therapies that are currently being provided in the unit are: Hand and Foot Reflexology, Indian Head Massage, Aromatherapy and Full Body Aromatherapy Massage and Visual and Breathing relaxation techniques. Referral for this service is from the Multi-Disciplinary team. The treatment that they receive is based on a clinical assessment and then tailored specifically to their needs. Anecdotal evidence from the first six months of offering this service suggests that Reflexology helps chemotherapy induced nausea. **One 14 year old boy described it as the only thing that helped his nausea while on chemotherapy. It has helped in the relief of peripheral neuropathy, constipation, headaches and insomnia.**

However, the most positive impact the service has to date is in relieving some of the enormous stress and anxiety levels amongst both the patients and their parents. **To sum it all up, one 16 year old girl said that having Reflexology was the "best part of being in hospital" when the therapist came to work her "magic hands."**

It is anticipated that an evidence based paper will in 5 years showcase the use of Complementary Therapy in both the acute cancer care and in the palliative care settings.

Olive O'Neill, Complementary Therapy Clinical Nurse Specialist

References

Helen & Douglas House, Children's Hospice, Oxford, Oxfordshire, England

Children's Services, Nottingham University Hospital, Nottingham, London

"Complimentary therapies in palliative care of children with cancer: a literature review"

"National Guidelines for the Use of Complementary Therapies in Supportive and Palliative Care.

Armishaw J, Grant C (1999) Use of complementary treatment by those hospitalised with acute illness. Archives of Disease in Childhood. 81, 133-137.

Chadwick D (1999) What are the reasons for nurses using complementary therapy in practice? Complimentary Therapies in Nursing and Midwifery. 144-148.

Dimond B (1997) Questions and answers on the legal aspects of complementary therapies. Complementary Therapies in Nursing and Midwifery. 6, 156-159.

Downer S et al (1994) Pursuit and practice of complimentary therapies by cancer patients receiving conventional treatment. British Medical Journal. 309, 86-89.

Fitch M et al (1999) Nurses' perspectives on unconventional therapies. Cancer Nursing. 22, 3, 238-245.

Grootenhuis M et al (1998) Use of alternative treatment in pediatric oncology. Cancer Nursing. 21, 4, 282-288.

House of Lords (2000) Science and Technology – sixth report. Available from: www.parliament.co.uk

Kemper K (2001) Complementary and alternative medicine for children: does it work? Western Journal of Medicine. 174, 272-276.

Rankin-Box D (1997) Therapies in practice: a survey assessing nurses' use of complimentary therpies. Complimentary Therapies in Nursing and Midwifery. 3, 92-99.

Settled cases that were resolved in 2010, reviewed by SCA's Clinical Risk Team

Settled cases that were resolved in 2010 reviewed by the clinical risk team of the State Claims Agency

There were 166 settled cases closed in 2010. The top specialties of the settled cases relate to Surgery, Emergency Medicine, Obstetrics, Medicine and Gynaecology, this is consistent with the trend in 2009. Over 50% of these cases were within the specialty of Surgery and Emergency Medicine as presented in *Figure 1*. The Clinical Risk Team reviewed 64% of these cases. Diagnosis, peri natal, peri operative/peri procedure, treatment and medication related events accounts for over 87% of the cases reviewed.

Diagnosis related events accounted for over a quarter of the settled cases resolved in 2010, 51% of these were reviewed by the clinical risk advisors. The following examples of these relate to diagnosis events such as:

- Failure to recognise and act upon the deterioration of a patient that resulted in delayed surgical intervention resulting in catastrophic consequences.
- Inadequate review of results, resulting in non treatment of a patient, resulting in catastrophic consequences.
- Incorrect diagnosis applied as a result of mix up of samples, resulting in unnecessary major surgery.
- Incorrect diagnosis, by two different health care facilities, in relation to a patient who subsequently developed peritonitis and a significantly extended length of stay in hospital.

In recent times there has been an increasing awareness of requirements to more readily identify deterioration in a patient and ensure that this is communicated effectively to the relevant healthcare practitioner. A large body of evidence continues to demonstrate that patients who become acutely unwell on general wards may receive suboptimal care, and furthermore, that action taken during these early stages can prevent deterioration that may often progress to cardiac arrest and death. Indeed, such issues are discernible in claims managed by the SCA. A national governance group, which includes representation from HSE and CIS, has agreed a National Modified Early Warning Score (MEWS) system **(http://www.hse.ie/eng/about/Who/ONMSD/practicedevelopment/Mews/).**

This initiatve is a component of the acute medicine programme designed to improve outcomes for such patients.

Effective communication and team work among healthcare professionals is an essential component, in appropriate recognition of, and response to, clinical deterioration. A number of structured communication protocols exist that can be used for handover and as part of ongoing patient management, a prime example of this is a tool known as ISBAR (Identify oneself, Situation, Background, Assessment, and Response). Practical training workshops to support roll out of this tool are being delivered in hospitals by members of the CIS Risk team.

Peri natal events accounted for 12% of the settled cases resolved in 2010. All of these cases were reviewed by the CRA with responsibility for Obstetrics. The following represents the type of issues identified by the clinical risk advisor in relation to some of the cases reviewed:

- Standard of documentation specifically in relation to recording of clinical assessment
- Inadequate assessment
- Failure to identify and act upon abnormal CTG resulting in delayed clinical intervention
- Care management issues.

A number of initiatives such as the obstetrics forum, presentations at both undergraduate and post graduate level, continue to be available to maternity services in order to raise awareness of the types of issues identified in claims reviews. Specialist systems analysis training continues to be provided to obstetric staff with the aim of encouraging the review of and learning from adverse events.

The specialty associated with over a quarter of the settled cases resolved in 2010 is surgery. It is therefore unsurprising that peri operative events accounted for 25.9% of these. Examples of the issues identified were inter alia delayed diagnosis, resulting in development of peritonitis, leading to post operative complications and an extensive length of stay, (including periods spent in intensive care), and puncture of organs during surgery identified in the post operative period and therefore requiring a return to surgery and extended length of stay in intensive care units. Therefore, in addition to the harm to the patient, there is also potentially significant financial cost to the health services as a result of potentially preventable injury.

In 40% of the cases reviewed, STARS was the notification method utilised by the enterprise reporting the event. However of note, in 10.7% of the cases the incident occurred prior to the commencement of the Clinical Indemnity Scheme, and also one must take into consideration the incremental rollout of the STARS reporting system since November 2003.

There were 36 different contributory factor types influencing clinical practice identified in the cases that were analysed.

The top factors identified are presented in *Figure 2*. These results are consistent with the results of the analysis of the cases settled in 2009, with practitioner error, delay/failure to treat and delays/failure in recognising complications accounting for 40% of the contributory factors identified.

As practitioner error is cited as a contributory factor in the cases reviewed, it is unsurprising that staff knowledge/skills/competency is identified as a factor when looking at the root cause of the event.

Overall, the findings in the closed claims analysis reviews are consistent with previous years. The main themes evident as factors contributing to the occurrence of adverse events consistently relate to leadership, knowledge, communication and documentation, (including availability of protocols). The Clinical Risk Advisors continue to incorporate the findings from analysis of these cases into governance and education training programmes in order to extend the learning.

Debbie Dunne, Clinical Risk Advisor

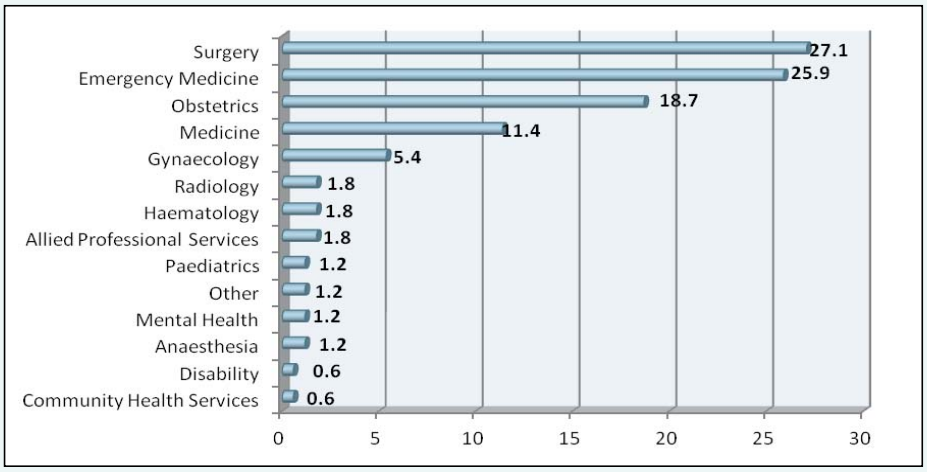

Figure 1: Settled cases closed in 2010 by specialty

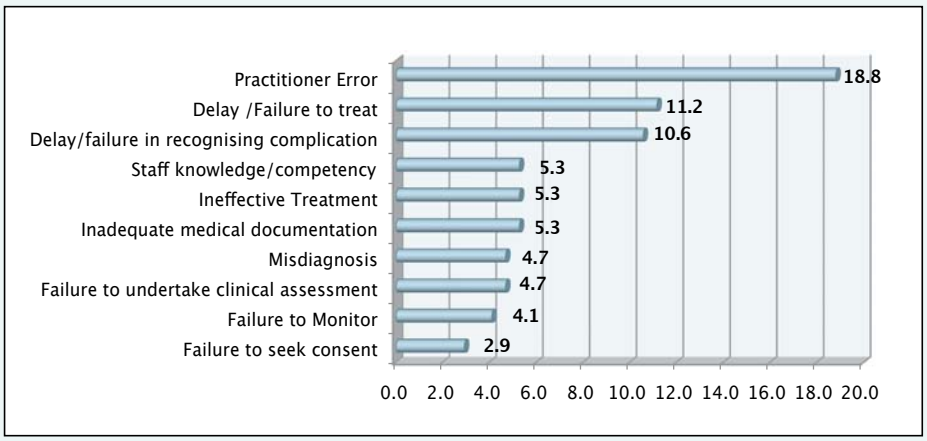

Figure 2: Top contributory factors identified

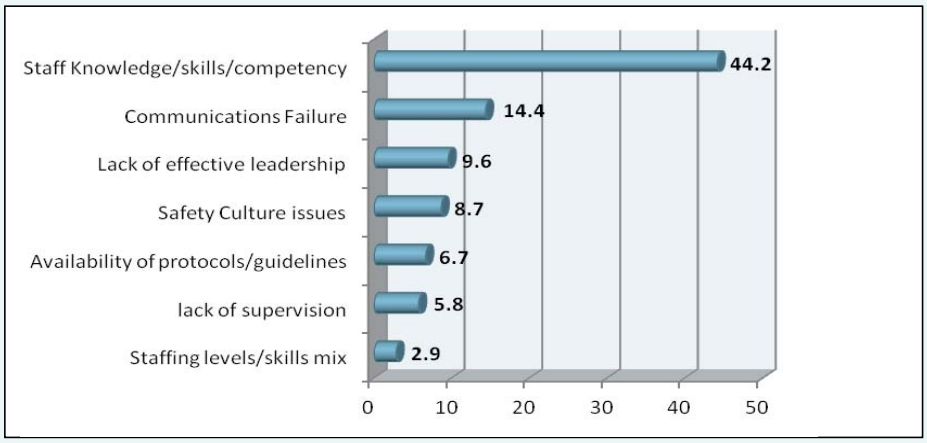

Figure 3: Top Root causes identified

Case Report - Medication Case Report

Please note the following case report is based on a real case that some of the facts have been changed in order to maintain confidentiality.

The patient in this instance was admitted to hospital following complaints of epigastric pain and nausea. A required gastroscopy and colonoscopy was to be performed in a routine fashion. The operating surgeons made the decision that a laparotomy was required due to the presence of extensive adhesions. The plaintiff made a reasonable postoperative recovery and was discharged. Two months later, the patient was readmitted to hospital with further complications including partial bowel obstruction. Further surgical intervention was performed which confirmed a large inflammatory mass with associated dense fibrosing adhesions. A small part of the small bowel was in turn resected.

The patient's condition deteriorated, complicated by paralytic ileus. She was placed in ICU on a regime of total parenteral nutrition. The patient became withdrawn and developed an acute mentally confused state. On examination, this perceived confused state was considered to be due to an unknown organic cause. A number of further clinical investigations were performed. An eventual diagnosis concluded that the total parenteral nutrition regime did not contain the required vitamin components including thiamine. As a result of this finding, the treating clinicians were in a position to confirm the patient was suffering from Wernicke-Korsakoff Syndrome. Due to this condition, the patient suffered neurological damage including partial seizures with associated cognitive complications and further physical injuries specifically to the bowel and abdominal areas.

The State Claims Agency commissioned a number of specialist experts to comment on this complex case. Essentially the experts were critical that the regime of total parenteral nutrition was commenced at too late a stage and also the lack of Vitamin B1 and Thiamine led to the adverse outcome. For these reasons the State Claims Agency sought to settle this claim at the earliest opportunity. Before any negotiations could take place, detailed investigations were undertaken in order to correctly quantify the potential of this very serious claim.

Considering the nature of the injuries, intensive rehabilitation was required including physiotherapy, occupational care and cognitive therapy. A decision was taken that the patient would be required to be supervised at all times as her injuries would mean diminished capabilities, including communication skills. Thankfully, the patient made some functional improvements which meant she could carry out some daily activities independently but a return to employment was unlikely. This assessment was based on the conclusion of an altered intellect in the category of "borderline learning disability" meaning the memory system was also significantly affected.

Due to these ongoing complications recommendations were made for supervision with motivation and organisation for weekly contact through a community rehabilitation assistant. Another aspect of the claim was the consideration given to the extent of nursing care assistance required on a permanent basis into the future. Always, when investigating the extent of nursing care assistance life expectancy must be evaluated. In this instance, although the serious complex nature of the injuries sustained, life expectancy was not affected.

Once all of the above investigations into this complex claim was concluded successful settlement negotiations took place on a "without prejudice basis".

Karl Redmond,
Clinical Claims Manager

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HSE Healthcare Records Management Programme

Information regarding this programme can be accessed at:

http://www.hse.ie/eng/about/Who/Quality_and_Clinical_Care/Quality_and_Patient_Safety_Documents/hcrecs.html

Who can I contact to find out more about this programme?

Programme Lead: Gay Murphy
c/o Room 151, Dr. Steeven's Hospital, Dublin 8.
Tel: 053 9153199
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Human Factors Study Day

November 24th, 2011

All presentations and other interesting information, including LinkedIn discussion fora is now available on http://www.stateclaims.ie/ClinicalIndemnityScheme/HEHN.html
Key contact Irene at iobyrnemaguire@ntma.ie or 01 6640984

Best Wishes for Happy and Peaceful New Year

Governance Day

held in Farmleigh on October 27th. 2011

All presentations now available at http://www.stateclaims.ie/ClinicalIndemnityScheme/presentations.html

The CIS newsletter is also available on our website @ www.stateclaims.ie under CIS Publications section

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