Clinical Indemnity Scheme
Newsletter

CIS Newsletter, July 2012

A New Dawn: The State Claims Agency Newsletter

This is the last edition of the CIS Newsletter in its present format. Since the publication of the first edition in November 2006, the Newsletter has concerned itself, exclusively, with clinical negligence and clinical risk management related issues and topics.

In December 2009, the Government delegated to the State Claims Agency (SCA) the management of the HSE's employer's, public and property damage liabilities and associated risk exposures - National Treasury Management Agency (Delegation of Functions) Order, 2009.

The next edition of the Newsletter, thus, will be renamed - State Claims Agency Newsletter - and will be expanded to include topics and issues reflecting the SCA's wider remit, as outlined above. It is our hope and wish that the newly expanded Newsletter, next edition, will provide our readership with significant updates, to include statistical analysis, on claims and risk management topics and issues of interest. The SCA newsletter will now be published on a bi-annual basis, in December and June.

Clinical Claims Trend

For the first time since the inception of the Clinical Indemnity Scheme, the SCA has observed an upwards trend in the number of clinical claims received in the first six months of 2012, when compared with previous years. It is difficult to discern exactly why clinical claims numbers are increasing. However, we understand that a similar upwards trend has been observed by medical defence organisations offering indemnity to Irish doctors and dentists.

Anecdotally, there appears to be a link between the prevailing difficult economic and fiscal circumstances and the higher rate of claims. It appears that people, injured as a result of a medical negligence event, are more likely to sue doctors, dentists and hospitals in these more difficult economic times. All the more reason, therefore, that, despite the funding pressures on our hospitals, the resourcing of clinical risk management should remain a top priority.

Clinical Incident Analysis

The SCA has carried out an in-depth analysis of adverse clinical incidents reported during the 2010 year. The report will be published shortly on the SCA's website. It is intended that a similar analysis will be carried out each year from now on. There is much to be learnt from this analysis in terms of the quality and frequency of reporting of adverse clinical events and how this can be improved.

Contents in this issue

Leadership and Accountability for Quality and Safety

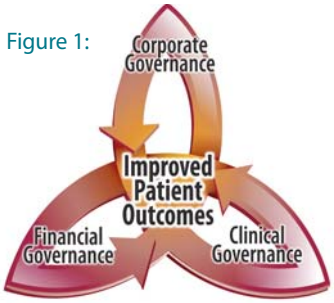
Introduction

Safety and high quality care requires vigilance and cooperation of the whole healthcare workforce. Improving quality and protecting patients from harm is our responsibility - clinical governance delivers the leadership and accountability systems to achieve this.

Clinical governance is described as *a system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered.* For health care staff this means: *specifying the clinical standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do.*

Effective governance recognises the inter-dependencies between corporate, financial and clinical governance across the service and integrates them to deliver high quality, safe and reliable healthcare (see Figure 1).

Figure 1:



HSE approach to governance

The Celtic design is used to demonstrate the continuous ongoing interweave between corporate, financial and clinical governance, all working together to achieve improved patient outcomes. Clinical governance means corporate responsibility for clinical performance built on the model of the CEO/GM or equivalent working in partnership with the clinical director, director of nursing/midwifery and the service/professional leads. This is based on the single point of accountability principle i.e. whoever is in charge of a health service, hospital or community, is responsible for the quality of care patients receive and the patients health outcome.

In summer 2011, the Health Service Executive (HSE) established a renewed focus on clinical governance development. A national lead was appointed and a steering group supported by an international reference panel and multidisciplinary working group was established. The aim of the initiative is *creating a culture where quality and safety is everybody's primary goal. The objective is that all clinical and social care is aligned within a clinical governance framework.* The three priorities in achieving this are:

- building clinical **leadership** capacity;
- developing **cultures** supportive of clinical governance; and
- focusing on **systems** and methodologies for clinical governance.

As part of the communications strategy the need for succinct information on clinical governance was identified. This article provides an overview of the material prepared for this purpose. The purpose is to inform the wider health community of the vision, guiding principles, and matrix for clinical governance along with gaining momentum and support for implementation of the processes.

Vision

It is anticipated that the further development, implementation and ongoing commitment to quality and safety, will create an environment where each individual as part of a team:

- knows the purpose and function of leadership and accountability for good clinical care;
- knows their responsibility, who they are accountable to and their level of authority;
- understands how the principles of clinical governance can be applied in their diverse practice; and
- consistently demonstrates a commitment to the principles of clinical governance in decision making.

Resulting in:

- a culture of trust, openness, respect and caring which is evident among managers, clinicians staff and patients; and
- clinical governance being embedded within the overall corporate governance arrangement for the statutory and voluntary health and personal social services in realising improved outcome for patients.

Guiding Principles

Ten principles for good clinical governance were developed to assist healthcare providers (see Table 1). The principles developed by a multi-disciplinary working group were reviewed for comprehensives usefulness and clarity by all stakeholders. It is proposed that the principles inform each action and provide the guide for managers and clinicians in choosing between options.

Figure 2: *Guiding principles*

It is recommended that each decision (at every level) in relation to clinical governance development be tested against the principles set out in Figure 2 and described in Table 1.

Table 1: *Guiding principles descriptor*

PRINCIPLE	DESCRIPTOR
Patient First	Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.
Safety	Identification and control of risks to achieve effective efficient and positive outcomes for patients and staff.
Personal Responsibility	Where individuals as members of healthcare teams, patients and members of the population take personal responsibility for their own and others health needs. Where each employee has a current job-description setting out the purpose, responsibilities, accountabilities and standards required in their role.
Defined Authority	The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manger.
Clear Accountability	A system whereby individuals, functions or committees agree accountability to a single individual.
Leadership	Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.
Multidisciplinary Working	Work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care. Multidisciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.
Supporting Performance	Managing performance in a supportive way, in a continuous process, taking account of clinical professionalism and autonomy in the organisational setting. Supporting a director/manager in managing the service and employees thereby contributing to the capability and the capacity of the individual and organisation. Measurement of the patients experience being central in performance measurement (as set out in the National Charter, 2010).
Open Culture	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research and improvement, and appropriate action taken where there have been failings in the delivery of care.
Continuous Quality Improvement	A learning environment and system that seeks to improve the provision of services with an emphasis on maintaining quality in the future not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results so that the improvement is ongoing.

Governance, leadership and accountability

Each healthcare provider has a responsibility to articulate the governance and accountability arrangements for quality and safety including the establishment of a quality and safety (clinical governance) committee with responsibility for overseeing clinical governance arrangements and reporting to the Board/CEO/Executive Management Team. However committees cannot make clinical governance happen in practice without the proactive involvement of teams in the ward/department and in the community. While leadership, direction and support can come from management, it is clinical leadership and individual teams that deliver best care for patients and the public.

A *clinical leader* is a competent professional involved in providing direct and indirect clinical care who enables oneself and influences others to improve care. *Clinical leadership* is about driving service improvement and the effective management of teams to provide excellence in patient care.

The approach to clinical governance involves each individual working within their ward/department/team having:

- Clear lines of responsibility authority and open accountability.
- A commitment to implementing and maintaining standards.
- A programme of improvement in systems and processes.
- Objective, focused clinical audit.
- Feedback from patients, staff and members of the public.
- Data and evidence to drive change.
- Participation in ongoing education and training.
- Risk management and assurance processes.
- Clarity on how they report into the quality and safety (clinical governance) committee.

The multidisciplinary team's role in quality and safety

The focus is on creating the atmosphere and culture where excellence can flourish with strong multidisciplinary team collaboration.

Multidisciplinary teams consist *of representatives from different disciplines and professional backgrounds who each have complementary experience, qualifications, skills and expertise. Members of the team provide different services for patients in a coordinated and collaborative way. Membership of the team may vary and will depend on the patient's needs and the condition or disease being treated.*

A culture and commitment to agreed service level and the quality of care to be provided are characteristic of clinical governance. If clinical governance is to be effective, it must start with the patient and build through the organisation. Clinical governance is a truly multidisciplinary activity.

Conclusion

With the emphasis on cost containment in healthcare and the necessity to be assured that the services provided are safe and of a high quality, there is a risk that the drive to cut health costs becomes the dominant logic and may compromise good clinical governance.

A bottom up and top down approach is being used to further leadership and accountability for quality and safety by supporting:

- the national clinical programmes: with a clinical governance checklist for use across the 35 programmes. The success of each clinical programme is dependent on incorporating sound clinical governance arrangements in the model of care/pathways.
- healthcare providers: in clinical governance development which is being organised and delivered through the development of a clinical governance toolkit for healthcare providers. This incorporates an assurance check for quality and safety structure and processes and a methodology for patient safety culture survey among staff.
- leadership development: by strengthening the clinical director role, the establishment of directorates, the provision of targeted education on leadership and quality in healthcare and methodologies for safety leadership walk rounds.
- multidisciplinary teams: through the provision of prompts to assist, stimulate, or provoke discussion on quality and safety at local team meetings.

The mantra for clinical governance development is ***we are all responsible and together we are creating a safer healthcare system***.

Acknowledgement

With thanks to the members of the steering group, international reference panel and working group for clinical governance development who are central in advising on the initiative, the preparation of the materials and piloting their use in practice.

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For further information see
http://www.hse.ie/go/clinicalgovernance

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High Court awards €450,000 to Plaintiff after 41 years...

Background

The recent judgment handed down by Mr. Justice Sean Ryan in the case of *Kearney-v-McQuillan & the North Eastern Health Board* will have significant implications for both Plaintiffs and Defendant hospitals and clinicians, in cases which would previously have been considered to be statute barred due to the length of time passed since the alleged negligence occurred.

This case involved a woman who underwent a symphysiotomy procedure in Our Lady of Lourdes Hospital in Drogheda in 1969, following the delivery of her first child by Caesarean section. Symphysiotomy involves the surgical enlargement of the pelvis by sawing the fibro-cartilaginous joint between the pubic bones during childbirth. The aim is to widen the pelvis in order to accommodate a baby's head and aid delivery, where there is disproportion and the baby's head will not fit through the woman's pelvis. In this case however, the baby had already been delivered when the symphysiotomy was carried out. Proceedings were issued on behalf of Mrs. Kearney in 2004, by which time the Anaesthetist, Radiologist and the Consultant Obstetrician involved in her care were deceased. It was Ms. Kearney's evidence that she only realised in 2002 that a symphysiotomy had been carried out, having been prompted to request her medical records from the hospital on hearing a radio discussion about symphysiotomy. It was alleged that this discovery triggered an acute stress disorder.

In light of the length of time passed and the potential prejudice to the defence of the case, solicitors for the first named Defendant, the nominee of the Medical Missionaries of Mercy who ran the hospital, brought a preliminary Motion seeking to have the case dismissed on the basis there had been inordinate and inexcusable delay on the part of the Plaintiff in bringing the case, resulting in severe prejudice to the Defendants in mounting a defence to the claim. The High Court ruled that the delay had been inordinate and inexcusable and the hospital had been *"severely prejudiced"* and struck out Mrs. Kearney's claim.

On appeal, the Supreme Court overturned this decision. They did this on the basis that the Plaintiff limit her claim to the plea that there was no justification under any circumstances prevailing in 1969 for the performance of a symphysiotomy, in a situation where the baby had already been delivered successfully by Caesarean section. The Court held that if the claim was limited to this re-formulation, the fact that all the records were not available or that the clinicians involved were not available to give evidence would be rendered immaterial and no prejudice would be caused to the Defendant. The Court would simply have to decide on the balance of evidence whether there was a realistic reason for carrying out a symphysiotomy in the prevailing climate of the time.

Judgment

The case was returned to the High Court. Mr. Justice Ryan heard expert evidence from both sides. Arguments were limited to the claim as re-formulated. The Defendant's argument was that there was a significant body of opinion amongst senior Obstetricians in Ireland in 1969, based on a Catholic ethos, which advocated symphysiotomy if it negated the necessity for a woman to have a Caesarean section every time she became pregnant. The thinking at the time was that a woman would have a lot of babies and requirement for a major operation like Caesarean section may encourage them to use artificial methods of contraception. However, even the potential prejudice to the Defendants evidence, was that disproportion would have to be present to justify symphysiotomy. In this particular case the baby's head never got to the pelvis because the cervix had not dilated sufficiently. The Obstetrician in question did not have information on which to diagnose disproportion and so in carrying out a symphysiotomy he was not following a general and approved practice. Mr. Justice Ryan commented that even if this had been such a practice, it was one which had obvious inherent defects, being wholly unnecessary and having significant morbidity.

Judgment was handed down on 23rd March 2012, in which Mr. Justice Ryan found for the Plaintiff and awarded the sum of €300,000 for past general damages and €150,000 for damages into the future. In giving judgment, he concluded that this unnecessary operation had altered the course of the Plaintiff's life and said it was *"disturbing to consider how close this victim of grave medical malpractice came to being sacrificed on the altar of fair procedures".*

Analysis

The Supreme Court heard an appeal of the decision, and the level of damages awarded, on 23 May 2012. Judgment has been reserved. The result of the appeal is eagerly awaited, given that there are other women who had symphysiotomies carried out around the same time period. If the appeal is unsuccessful, it may lead to a situation where Plaintiffs in this position are re-formulating the way their claim has been pleaded, moving away from the plea of a lack of informed consent and instead focusing on the plea that there was no justification for the performance of a symphysiotomy in the climate of the time.

Zoe Richardson, Clinical Claims Manager/Solicitor

Case Report - Retained Obstetric Swab

Please note the following case reports are based on real cases and some of the facts have therefore been changed in order to maintain confidentiality.

The Plaintiff in this instance was admitted to hospital for the delivery of her baby at term plus ten days having experienced mild abdominal cramps at home. On admission her fundus was equal to her dates and the CTG was reassuring. Following an artificial rupture of membranes and induction of labour the Plaintiff went on to deliver a healthy baby girl. An episiotomy had been performed and the operation note pertaining to same indicated that a swab count at the time of surgery had been correct.

Following delivery the Plaintiff and her baby returned to the post natal ward. Lochia was described as minimal. The Plaintiff remained apyrexial and the episiotomy wound was described as healing. She required regular analgesia. Her post natal checks were all within normal limits and she was discharged on the fourth post natal day.

Following discharge the Plaintiff complained of abdominal pain, offensive vaginal discharge and pyrexia. Some five days later she attended her General Practitioner who performed a vaginal examination and removed a retained swab. She was commenced on antibiotic therapy due to the presence of infection.

The Plaintiff subsequently issued proceedings against the hospital alleging failure to count adequately or at all the number of swabs that were used prior to, in the course of and/subsequent to the surgery (i.e. the episiotomy). Allegations were also made in respect of the hospital's failure to document how and when the swab counts were made and failure to document how many times the swab count had been carried out.

Expert opinion stated that retained swabs are unacceptable and that contemporaneous swab counts should be performed before and after surgery and each count accurately documented. Expert opinion also stated that the actual process by which swabs are checked and confirmed as correct is vital.

In such circumstances the claim concluded following successful negotiations which took place on a without prejudice basis.

In another similar case the Plaintiff's baby was delivered by way of ventous and forceps. Post natal checks were within normal limits and the Plaintiff was discharged on the 5th post natal day. However, following discharge she presented to her GP with signs of infection at the episiotomy site and was commenced on antibiotic therapy for same. Some six weeks later the Plaintiff's GP identified a retained swab at the episiotomy site and removed same. The Plaintiff subsequently issued proceedings alleging negligence in respect of the manner in which the procedure - i.e. suturing of the tear - was carried out. The Plaintiff also alleged that she suffered psychologically and that her enjoyment of her new born baby was affected by the said sequence of events. This case also settled on a without prejudice basis subsequent to successful negotiations.

Cases such as these which relate to retained swabs in obstetrics and in particular in the context of episiotomies raise issues in respect of the manner in which swab counts are performed and documented before, during and after this procedure. There is generally no legal defence to a retained swab which can often lead to adverse physical and psychological sequelae for the patient concerned. In light of this perhaps, review of the policies, guidelines and procedures in place governing the procedure of swab counts in the context of episiotomies is warranted. This would help heighten the awareness of such incidences occurring and ultimately contribute to the prevention of same.

Rebecca Conlon,
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Taoiseach's Public Service Excellence Awards 2012

The National Early Warning Score Governance group are delighted to announce that the National Early Warning Score and associated Education Programme have won a Taoiseach's Public Service Excellence Award for 2012.

The National Early Warning Score initiative, and associated education programme, is a work stream of the Acute Medicine Programme, in association with the Critical Care, Emergency Medicine, and Elective Surgery programmes, Quality and Patient Safety, Office of the Nursing and Midwifery Services Director, Clinical Indemnity Scheme, the Assistant National Director, Acute Hospital Services - Integrated Services Directorate, Irish Association of Directors of Nursing and Midwifery (IADNAM) and Therapy Professionals.

Great credit is due to all for the support given, especially to those champions who are rolling the project out at local level. The Showcase Conference and Awards Presentation Ceremony for the Taoiseach's Public Service Excellence Awards 2012 took place in June, 2012 at Dublin Castle.

More information on this project can be found at http://www.hse.ie/go/nationalearlywarningscore/

Comments and Submissions

can be forwarded to

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

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