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State Claims Agency

Clinical Risk Unit & Snapshot Insights

Dr Cathal O'Keeffe, Deputy Director -
Head of Clinical Risk

Agenda

- State Claims Agency risk mandate and claims profile
- Clinical Risk Unit updates
- Snapshots and insights from claims and incident analysis

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About Clinical Risk Unit & updates

Our services

We provide a number of **specialist services** to State Authorities, in line with our mandate.

Claims Resolution

Risk Management

Legal Costs Management

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SCA's statutory risk management mandate

NTMA (Amendment) Act, 2000, Section 8(4)

The Act sets out that the SCA shall advise and assist a State Authority whenever it considers it appropriate to do so for the purpose of reducing risks that may occasion claims. Such advice may include:

- the **provision of information, instruction and training** for the purposes of identifying and taking appropriate measure to counter such risks
- the **assessment of any such risk**, including the determination of whether it could give rise to a serious hazard
- the **evaluation of the adequacy of the measures adopted by such an authority** to counter any such risk
- the provision to such an authority of **safety audits, inspections and reviews**

Clinical Indemnity Scheme

Covered

- Professional medical services provided in public hospitals, clinics and healthcare facilities
- Clinical care during transfer of patients
- Representation at Coroners' Inquests
- Good Samaritan acts within Island of Ireland

Did you know?
Principle of "enterprise liability" applies – the health and social care service assumes vicarious liability for the acts and omissions of its employees providing professional medical services.

Not Covered

- Private hospitals
- Private practice in private settings
- Disciplinary hearings
- Criminal cases
- GPs

NB: Supplementary insurance required

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Statutory requirement

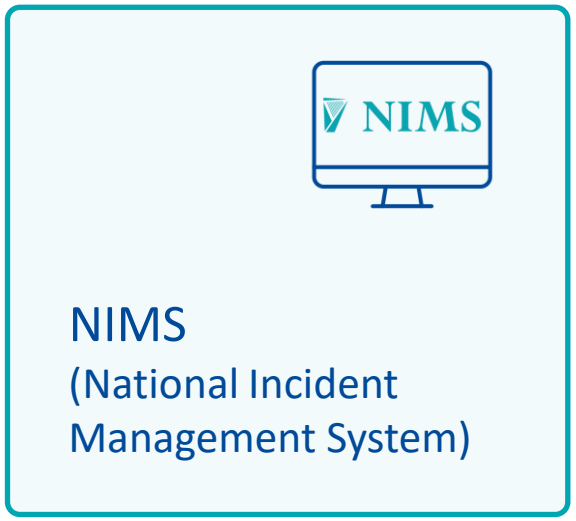
Under Section 11 NTMA (Amendment) Act 2000, State Authorities must:

Report adverse incidents/claims to the State Claims Agency

Furnish all necessary and requested information and documentation to the State Claims Agency

Permit and assist the State Claims Agency to investigate adverse incidents/claims

NIMS – the National Incident Management System



- A confidential national end-to-end incident, risk and claims management platform
- System used by State Authorities to fulfil the statutory requirement to report incidents to the State Claims Agency and for their own incident and risk management purposes

Safety and insights. Powered by data.

Incident reporting

	Incidents Recorded
2019	213,269
2020	211,251
2021	207,785
2022	246,129
2023	238,658

More than

2.77m

incidents reported by end 2023
since the inception of NIMS

Refers to incidents reported by State Authorities via NIMS

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SCA claims activity (to end-2023)

Active Claims		Outstanding Liability
11,137 Number of Active Claims	=	**€5.18bn** Total Estimated Outstanding Liability in 2023
36% Relate to Clinical Claims	=	**80%** Total Estimated Outstanding Liability Relate to Clinical Claims

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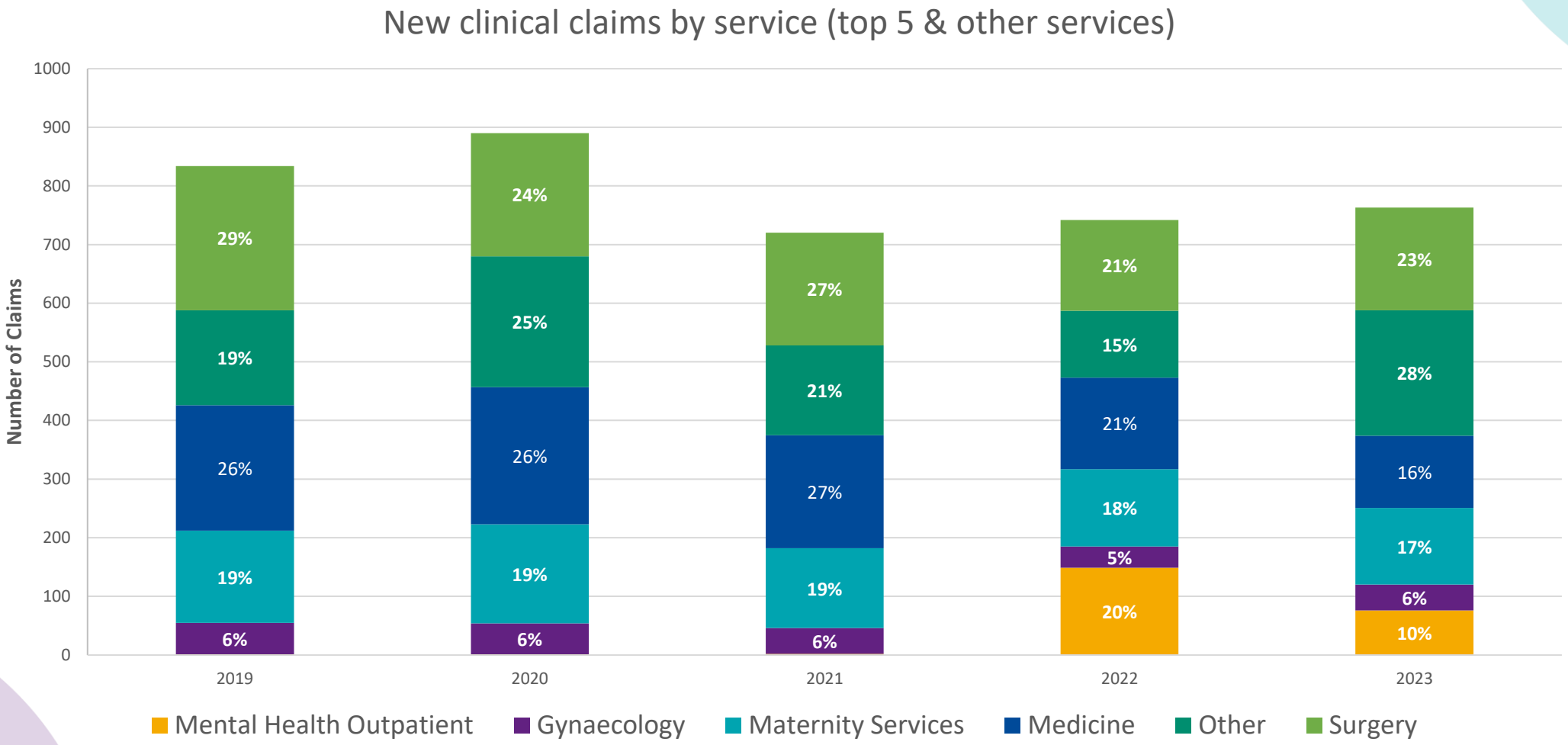
New clinical claims by service



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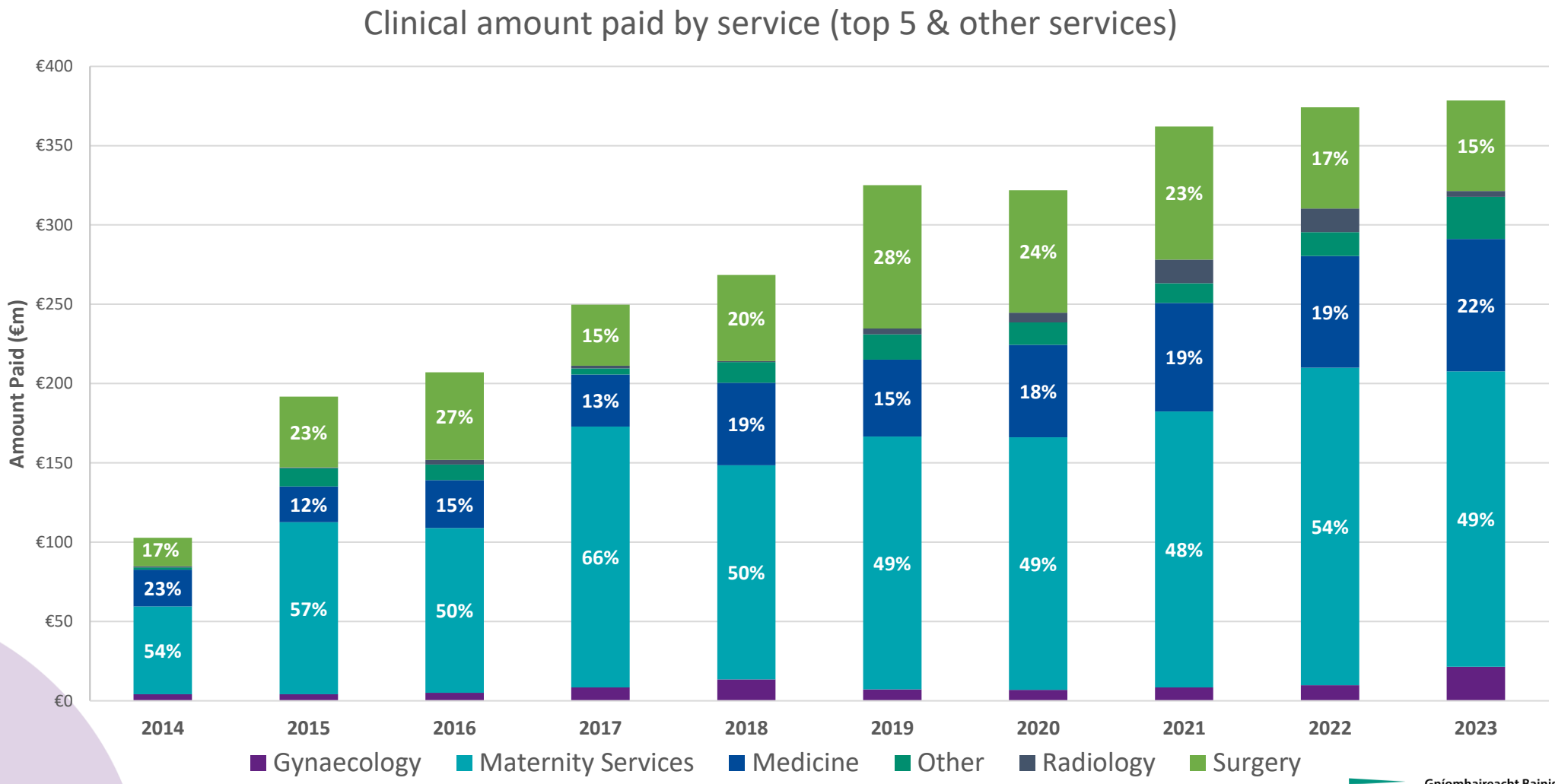
Clinical amount paid by service (top 5 & other services)



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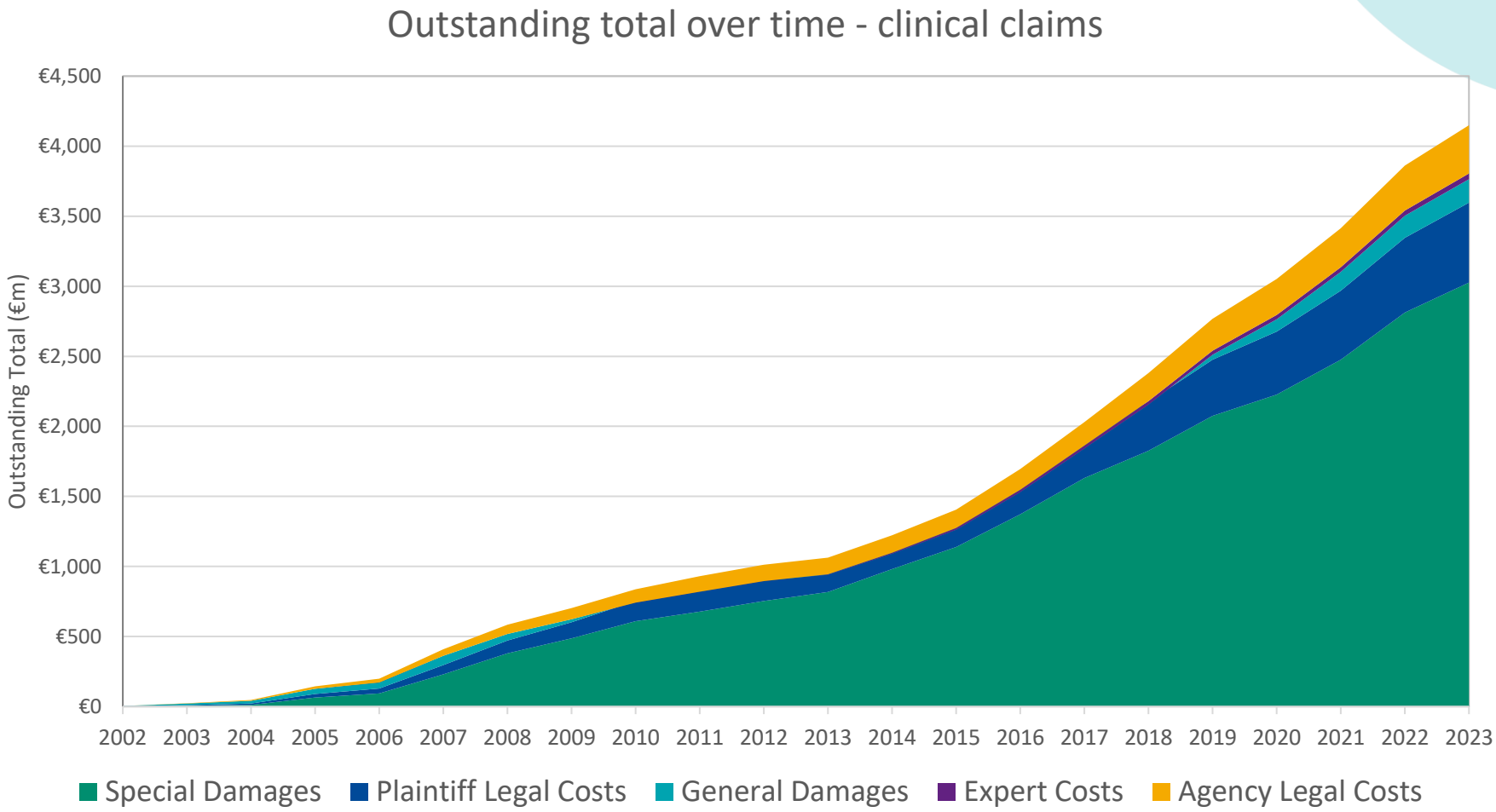
Outstanding total over time – clinical claims

Sum of reserves' amounts less paid amounts, over time.

Growing prominence of special damages in the overall outstanding position.



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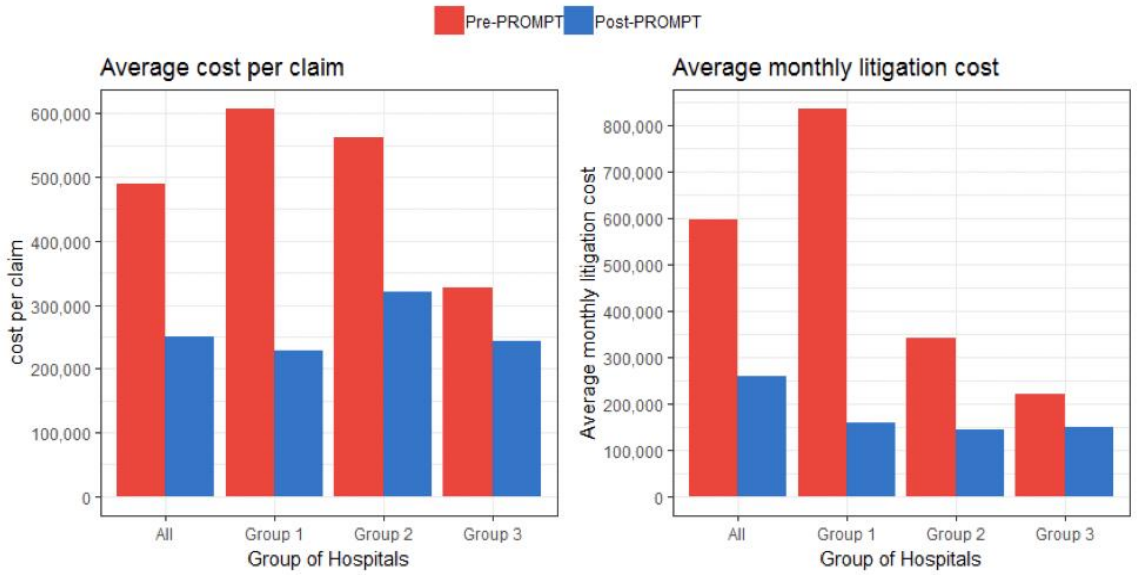
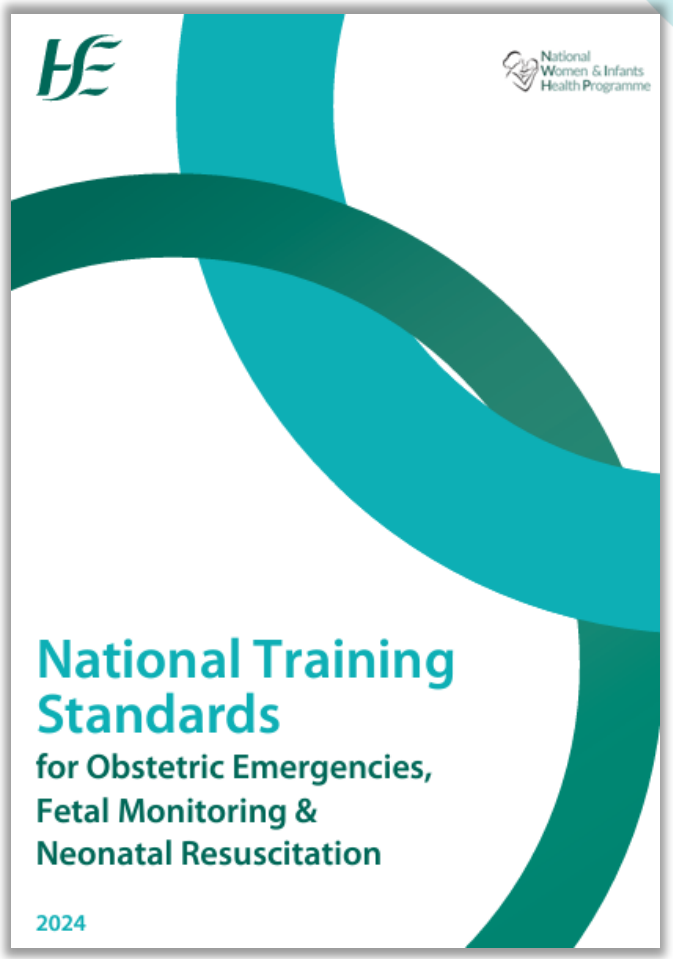
National influence – Interdepartmental Working Group report

- Group established by the Minister for Health to examine the rising cost of health-related claims
- Found that rising claims costs are mainly driven by rising costs of individual claims rather than rising numbers of claims
- Recommendations included:
  - capturing and learning from adverse events
  - specific recommendations for maternity services
  - recommendations in relation to introduction of the pre-action protocol, re-introduction of periodic payment orders and review of the real rate of return

National influence - NNEAG WS4: Mandatory Training



Reduction in litigation costs (Aus$) associated with introduction of PROMPT training into maternity units in Victoria, Australia. Barnett et al., (unpublished).



C.L.A.I.M Project: Claims, Learning, Actions, Implementation, & Monitoring

- **Analysing individual claims shortly after settlement** in order to extract **as early as possible learning** that can be shared with the service involved
- Engaging with organisations to share learning in order to **reduce the risk of recurrence**
- **Seeking assurance** on the implementation of recommendations and preventative actions

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C.L.A.I.M Project: Claims, Learning, Actions, Implementation, & Monitoring

Our Aim

Continuous engagement with hospitals in relation to high value claims and claims where an outcome was extreme to share learning and seek assurance

What do you need to do?

- Liaise with State Claims Agency Clinical Risk Advisor/Manager
- Consider/analyse any learning from the claim internally
- Provide assurance to State Claims Agency about measures taken to prevent reoccurrence

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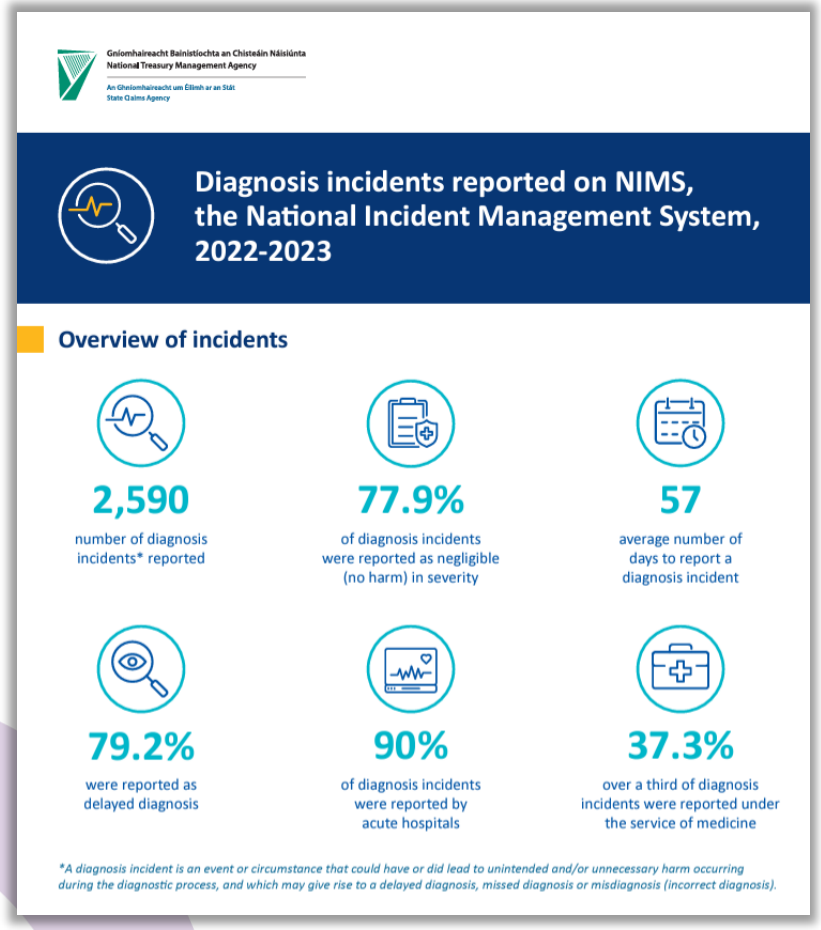
Snapshot insights from incidents and claims

New resources available

Diagnosis Infographic



- In line with our statutory risk management mandate in support of World Patient Safety Day 2024 'Improving diagnosis for patient safety - Get it right, make it safe!' the Clinical Risk Unit completed an analysis of **diagnosis incidents reported on NIMS** between 2012 – 2023
- This infographic shares **national data on reported diagnosis incidents** and provides **learning opportunities** for health and social care services

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Diagnosis Infographic

Key findings

- **79% of diagnosis incidents** were reported as **delayed diagnosis**, frequently related to delayed access to diagnostic services or delays in receiving diagnostic results
- **41.5% of diagnosis incidents** were reported by nursing and midwifery staff, 32.0% by allied health professionals, and 15.6% by medical staff
- Over half of the incidents were reported by stage of process as ‘test/investigations’. **Sampling issues** accounted for some of these incidents
- The majority of diagnosis incidents were reported with **a negligible (no harm) severity rating**

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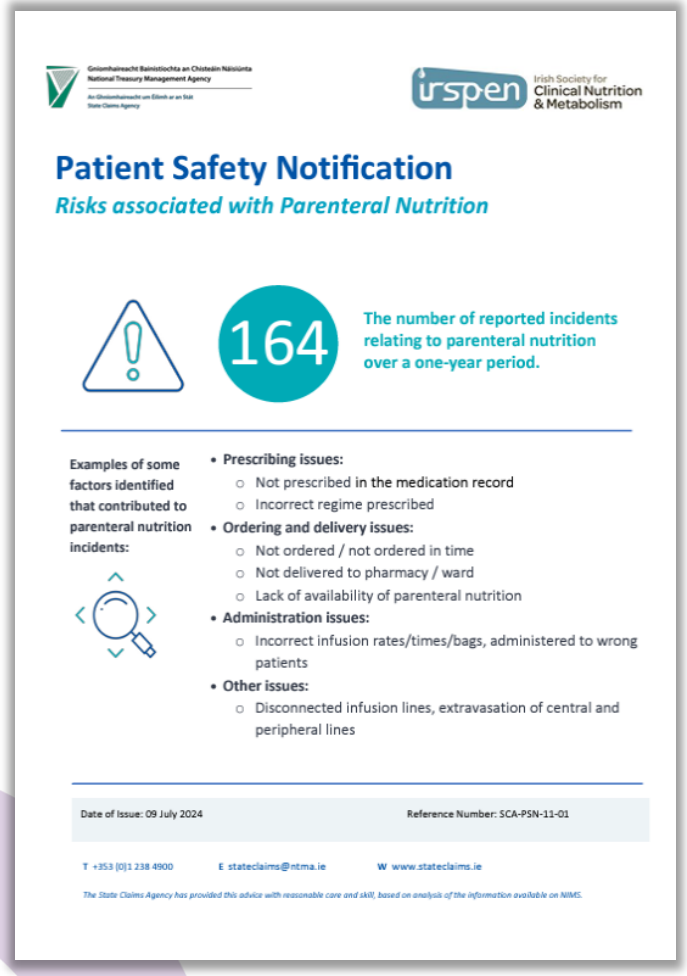
Patient Safety Notification – Reducing the risk of patient safety incidents associated with the use of parenteral nutrition



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irspen Irish Society for Clinical Nutrition & Metabolism

Patient Safety Notification

Risks associated with Parenteral Nutrition

164

The number of reported incidents relating to parenteral nutrition over a one-year period.

Examples of some factors identified that contributed to parenteral nutrition incidents:

- **Prescribing issues:**
  - Not prescribed in the medication record
  - Incorrect regime prescribed
- **Ordering and delivery issues:**
  - Not ordered / not ordered in time
  - Not delivered to pharmacy / ward
  - Lack of availability of parenteral nutrition
- **Administration issues:**
  - Incorrect infusion rates/times/bags, administered to wrong patients
- **Other issues:**
  - Disconnected infusion lines, extravasation of central and peripheral lines

Date of Issue: 09 July 2024 Reference Number: SCA-PSN-11-01

T +353 (0)1 238 4900 E stateclaims@ntma.ie W www.stateclaims.ie

The State Claims Agency has provided this advice with reasonable care and skill, based on analysis of the information available on NIMS.

- Parenteral nutrition (PN) is the intravenous administration of nutrition, bypassing the gastrointestinal (GI) tract
- PN is associated with **several avoidable risks**, which include **infectious complications**, **catheter insertion complications and metabolic complications** (e.g., related to glycaemic control, lipid clearance and biochemical imbalances)

The Clinical Risk Unit has prepared this patient safety notification, in conjunction with the Irish Society for Clinical Nutrition and Metabolism (IrSPEN)

Reducing the risk of patient safety incidents associated with the use of parenteral nutrition

Key take home messages

- Adhere strictly to **infection prevention and control measures**, which should include care bundles for venous catheters and monitoring for suspected catheter related infections
- Ensure all **health and social care professionals have the correct level of education** and training on the use and administration of PN
- **Educate patients / service users** and their carers on the **risks associated with infusion lines**, to include the risk of dislodging and disconnecting lines, such as when mobilising and dressing
- **Monitor biochemistry** and adjust PN accordingly to optimize treatment and prevent electrolyte imbalances

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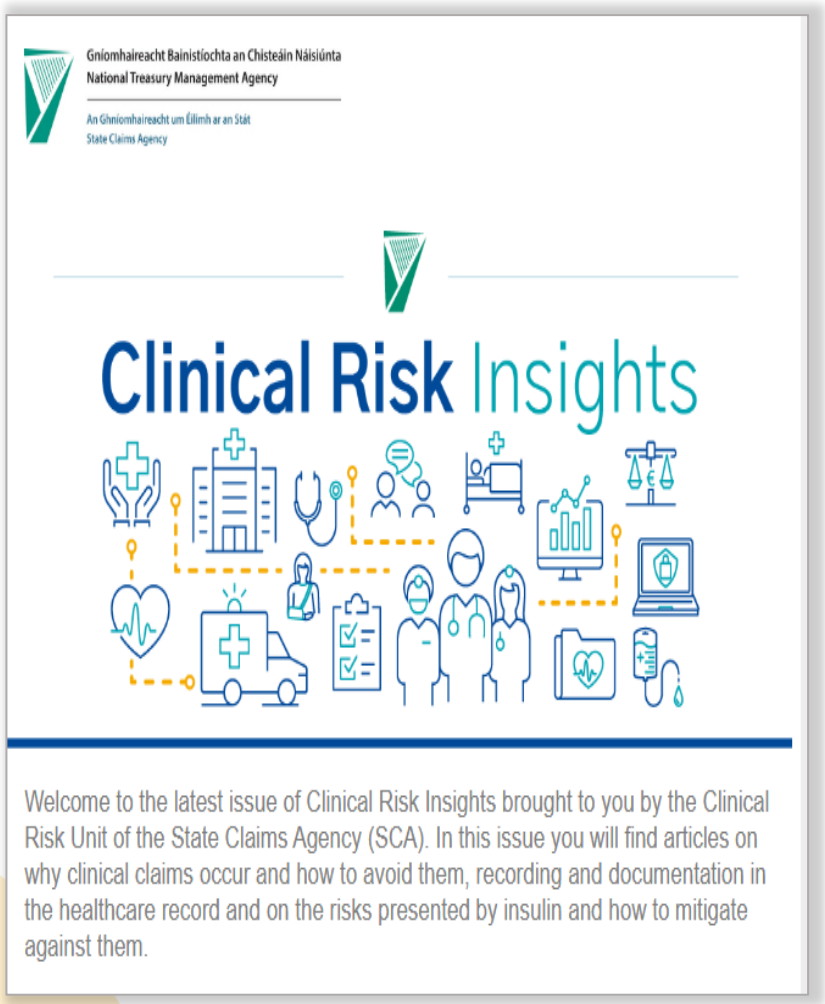
Clinical Risk Insights newsletter



- Clinical Risk Insights is the regular newsletter issued by the Clinical Risk Unit
- Each edition includes articles on managing clinical risk, information on upcoming webinars and events, and notifications of any updates to NIMS

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Transfer of care: Focus on handover

- Transfer of care ensures the **coordination and continuity of healthcare as patients** transfer between different locations or different levels of care within the same location
- It is recognised as **a high-risk situation** for patient safety, and **healthcare professionals have a responsibility** to ensure correct and accurate transfer of clinical information
- Poor handover during transfer of care can result in **suboptimal treatment**, failure to identify or manage a **deteriorating patient**, **medication error**, and **poor service user experience**
- Challenges with handover arise when demands are high, there are **capacity issues**, **time pressures**, **shift changes**, and continuous interruptions

Transfer of care: Focus on handover

Key take home messages

- At handover, **communicate**, at a minimum, **patient identification**, **clinical history**, **treatment/interventions** undertaken or planned, **medication** prescribed and administered and **any special requirements**
- **Standardise the handover process** using handover tools or checklists such as ISBAR
- Where possible, consider having **uninterrupted**, **protected handovers** to aid clear communication and delivery of information
- Where possible, **handover face-to-face rather than by phone** to promote positive relationship
- Consider using educational interventions to improve handover – roleplay and **simulation of handovers** can improve professional relationships, staff confidence, and reduce error

Errors with the specimen and sample collection process

- Specimen and sample collection is a routine and **essential part of medical care,** allowing for laboratory analysis **to inform diagnosis, treatment, and monitoring of medical conditions**
- Errors during specimen and sample collection, including labelling, occur; if not recognised, they can lead to the **issue of incorrect results**, **diagnostic error**, **delayed or incorrect treatment or transfusion of incompatible blood**
- These errors have the potential to place service users at the **risk of significant delays**, errors and harm in their care and treatment

Errors with the specimen and sample collection process

Key take home messages

- Ensure **uninterrupted collection and labelling of specimens/samples as one continuum** at the service user's bedside or place of collection
- Ensure **positive patient identification** by confirming identification on service user's wristband and asking service user to confirm their details
- Attention should be paid to **effective communication** between health and social care personnel, particularly in relation to clinical information and handover of care
- **Optimise availability of appropriate equipment** used in sample labelling (label printers, computer terminals) including implement **point-of-care-testing barcoding systems** where available

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Preparing for an Inquest

Marie Hutton, Solicitor/Clinical Risk Legal Advisor

Preparing for an inquest - objectives

- What is an inquest
- Preparing a statement
- What happens on the day of the inquest
- Types of verdicts

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What is an inquest?

An inquest is an inquiry into the circumstances surrounding a sudden, unexplained, or violent death heard in public by a coroner, sitting with or without a jury.

The purpose of the inquest is to:

- establish the facts surrounding the death
- place those facts on the public record
- make findings concerning the identification of the deceased, the date and place of death and the cause of death

At the completion of an inquest, a verdict will be returned in relation to how the death occurred.

Questions of civil or criminal liability cannot be considered or investigated at an inquest

Assisting the Family and the Coroner

- If you are involved in the care of a patient whose death is the subject of an inquest, engage in the process as soon as possible because this will assist the family of the deceased
- A death cert cannot be issued until an inquest is concluded
- The family of the deceased person cannot administer an estate without a death cert
- Assist the Coroner at your earliest opportunity

Deaths in hospital

Death on arrival to hospital

Death within 24 hours of admission

Death due to surgical procedure or anaesthesia or, as a result of complication of surgery/anaesthesia

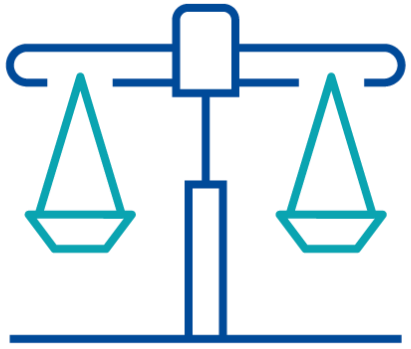
Death as a result of an allergic or toxic reaction to a drug

Maternal deaths

Certain healthcare acquired infections

Where there is any doubt as to the cause of death

Who represents you?



- The State Claims Agency (SCA) manages the Clinical Indemnity Scheme (CIS). The CIS provides legal representation at Coroner's inquests.

- The legal representation is offered to all clinical personnel who have provided professional medical services to the deceased person

Who can ask for a statement

You may be asked to prepare and provide a statement. The request may come from:

- the Coroner (who will usually communicate with the relevant person in the hospital)
- An Garda Síochána
- a solicitor acting for and on behalf of the State Claims Agency (SCA) or
- the person who manages legal matters on behalf of the health and social care service involved

Preparing a statement

1
Obtain a copy of the medical records from the hospital / organisation involved

2
State your name, address, qualifications, experience, and your employment status at the time you were involved in the care of the patient

3
Carefully read the records and set out, in chronological order, your involvement in the patient's care and treatment, referring to your entries in the records where relevant

4
Should you identify any inaccuracies or inconsistencies in the medical records, explain them in your statement - never alter the records

5
Refer to any guidelines or protocols you relied on to treat the patient and explain any deviations from these

6
Sign and date your statement, send it to the relevant person in your organisation, and keep a copy for yourself

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Who receives your statement

- Your statement will be forwarded to the assigned Clinical Claims Manager within the SCA, who will review and forward it to the legal firm representing you/your hospital at the inquest
- Frequently, the Clinical Claims Manager and nominated solicitor will arrange to meet you in advance of the inquest to go through your statement and answer any questions you may have
- The Coroner reviews all statements and invites those the Coroner thinks will help him or her to determine the circumstances and cause of death
- Frequently, the Coroner will advise that your statement is sufficient, on its own, and your attendance at the inquest may not be necessary

On the day of the inquest

It is usual to meet the hospital's legal team on the day of the inquest

Should you be asked to give evidence you will be asked to take an oath or state an affirmation

It is usual for you to be asked to read your own statement/or you may elect for the Registrar to read it

You may be asked questions by the Coroner, or the legal team representing the patient's family or members of the hospital's legal team

Address the Coroner and answer the questions within your own expertise and knowledge

If you don't understand the question or know the answer, say so

Stick to the facts and don't offer opinions

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Potential verdicts

- Natural causes
- Narrative verdict
- Accident
- Misadventure/ medical misadventure
- Suicide
- Stillbirth
- Open verdict

Narrative verdict

Frequently the Coroner will give a narrative verdict where the Coroner will **summarise their findings and make recommendations** to the hospital.

This is different to the finding of medical misadventure.

Final words of advice

- Remember you are assisting the Coroner and the family
- Have copy of your statement and be familiar with it
- Address the Coroner as “Coroner”
- When answering questions, be professional and concise
- You can refer to the medical records anytime
- If you don’t understand the questions, say so
- If you don’t know the answer, say you don’t know

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Spotlight on the Emergency Department (ED)

Wayne Meehan, Clinical Risk Advisor

Dr Karen Power, Clinical Risk Researcher

Agenda

Incidence Surveillance – a ‘lens’ on Emergency Medicine

Clinical Claims Review – 5-years of claims related to Emergency Departments (EDs)

- Analysis of NIMS data (quantitative data)
- Analysis of claims files (qualitative data)
- Key take home messages

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Incidence Surveillance – a 'lens' on Emergency Medicine

Incident analysis – methodology

10,592

Total number of service user incidents reviewed in incident surveillance in Q2 2022

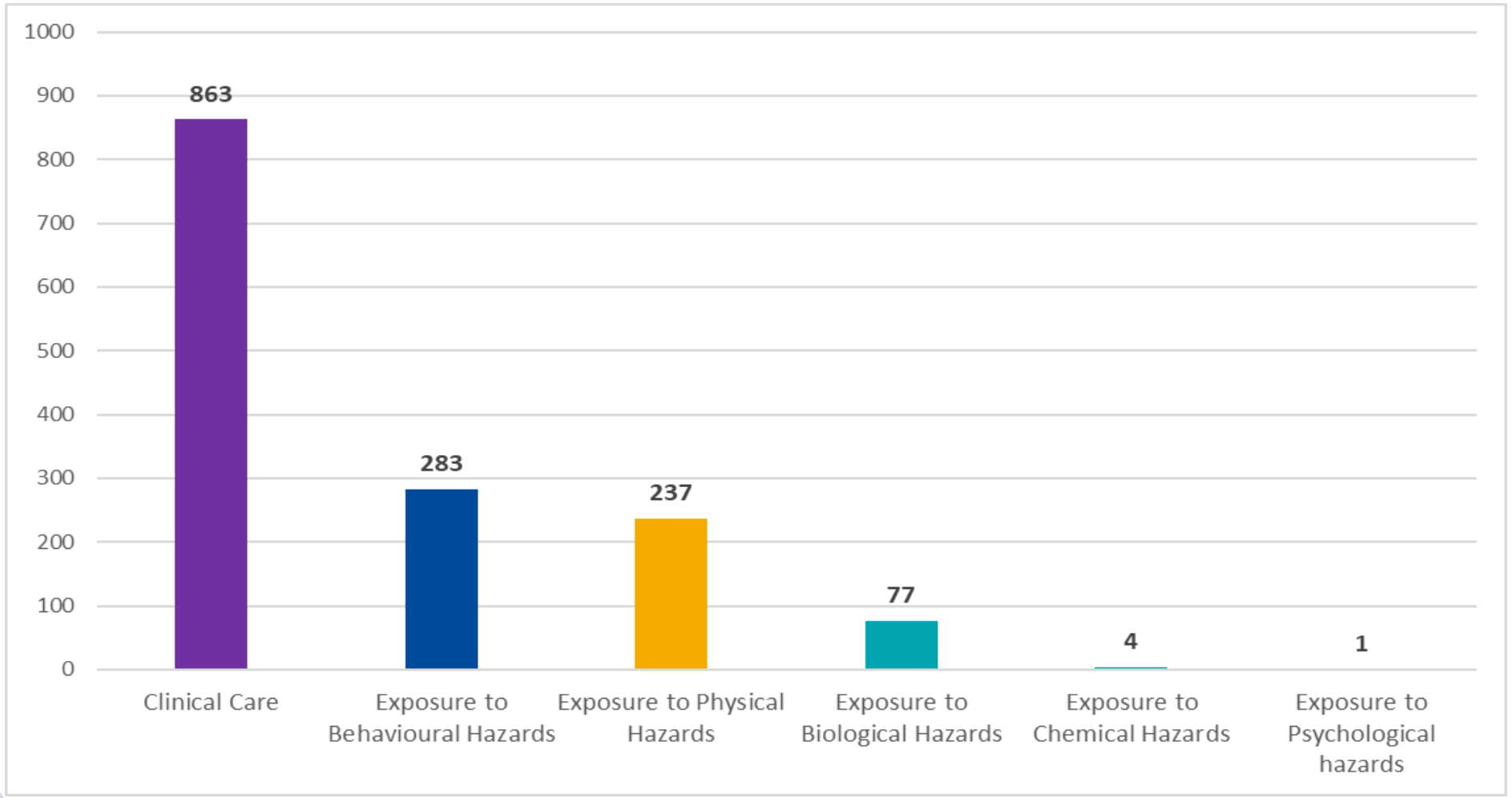
14%

Emergency medicine service user incidents as a % of Q2 2022 incident surveillance

1,465

Emergency medicine service user incidents reviewed in Q2 2022

Incident hazard category



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Clinical care themes – ED capacity (n=83)

Overcrowding

- Lack of availability of beds/trolleys
- SU accommodated and managed in corridors
- Procedures carried out in inappropriate areas of the ED

Prolonged wait times

- Delayed ambulance offloading
- Delayed access to triage, medical assessment, diagnostics and treatments
- Delayed transfer from ED to wards due to lack of inpatient beds

Inadequate monitoring and observation

- SU deterioration whilst awaiting assessment/in the waiting room
- Lack of emergency call bells, oxygen or suction equipment
- SU requiring cardiac monitoring/telemetry in ED

Clinical care themes

Inadequate referral processes and lack of agreement between teams on referral and clinical pathways

Delay or inability to contact on-call staff

Team factors (n=83)

Inadequate or no communication within ED teams or between ED teams and other hospital services

Ineffective communication or handover of care

Other incident/hazard categories

Exposure to behavioural hazards	Self-injurious behaviour (SIB) 205 incidents Violence, harassment and aggression (VHA) 78 incidents
Exposure to physical hazards	Slips, trips and falls (STF) 212 incidents

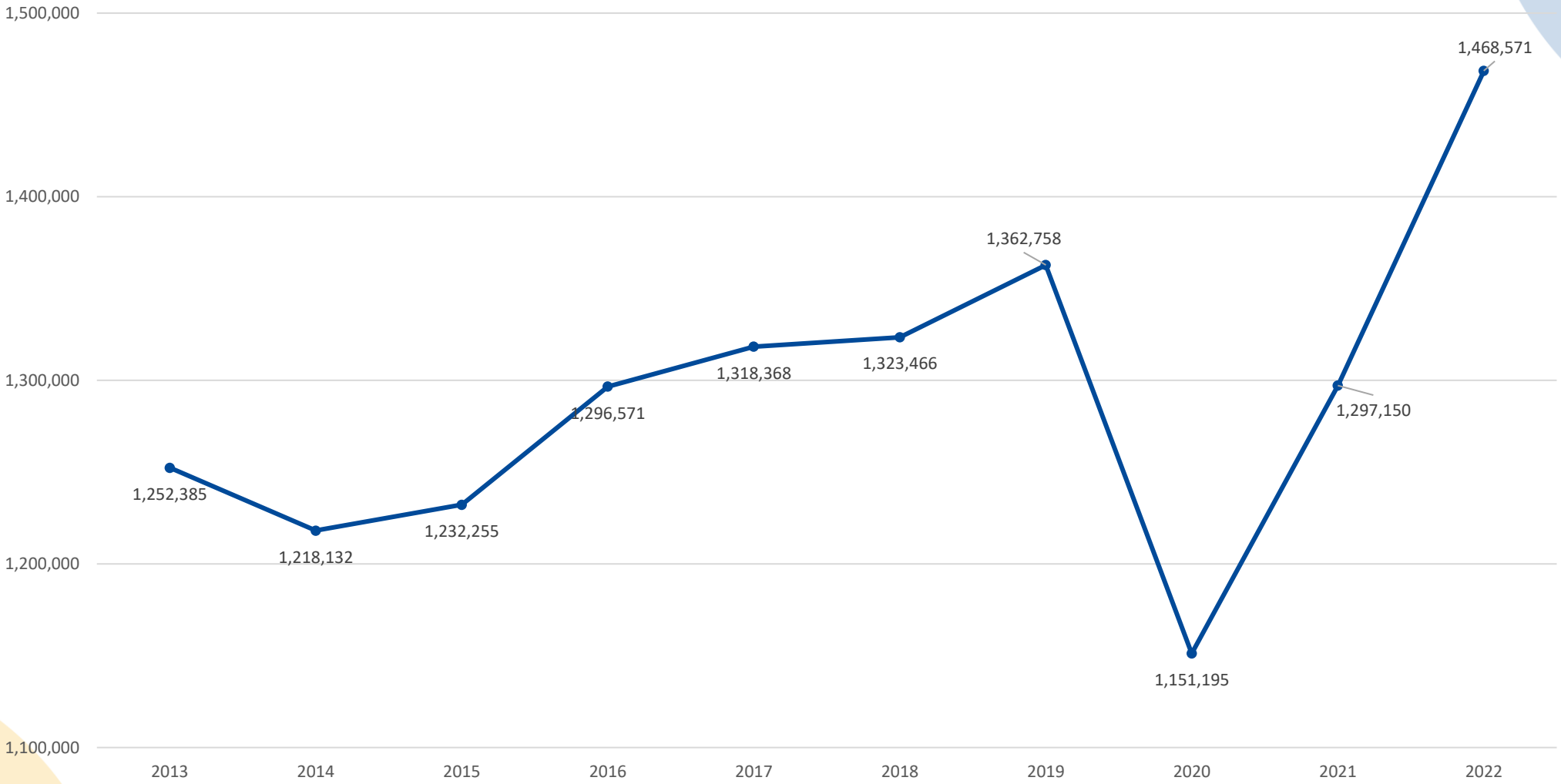
Review of 2017 claims

Table 1 Top 10 services and subservices by number of claims and associated paid total

Number of claims	Service	Subservice	Paid total
50	Medicine	Emergency medicine	€9,393,710
47	Maternity	Delivery	€46,602,161
42	Medicine	General medicine	€11,614,223
35	Surgery	Orthopaedic surgery	€9,782,771
33	Surgery	General surgery	€7,074,171
22	Gynaecology	General	€5,047,011
14	Maternity	Antenatal	€3,005,343
12	Maternity	Postnatal	€2,790,836
10	Surgery	Gastrointestinal	€1,403,998
10	Surgery	Neurosurgery	€14,967,298

Reference: Power, K.A. *et al.* (2024) 'Lessons learnt from a 2017 Irish national clinical claims review: a retrospective observational study', *BMJ Open Quality* 13(3):e002688. doi:10.1136/ bmjoq-2023-002688

Emergency Department Attendances



Department of Health (2024) *Health in Ireland Key Trends 2023*.

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Clinical Claims Review – Claims related to EDs 2018-2022

Methods

- Service-user related claim
- Member of the public claims under “Exposure to psychological hazards” (usually family members)
- Claims concluded between 2018-2022 with paid damages
- Incidents occurring since 1st January 2017

Exclusions:

- Incidents that occurred outside of the emergency department or after the patient was admitted to a ward
- Emergencies related to pregnancy

Results

67 claims relating to **61** patients

53
Servicer users

14
Family members

53
Servicer users
=
47
Clinical

6
General

8
Deaths
=
8
Clinical

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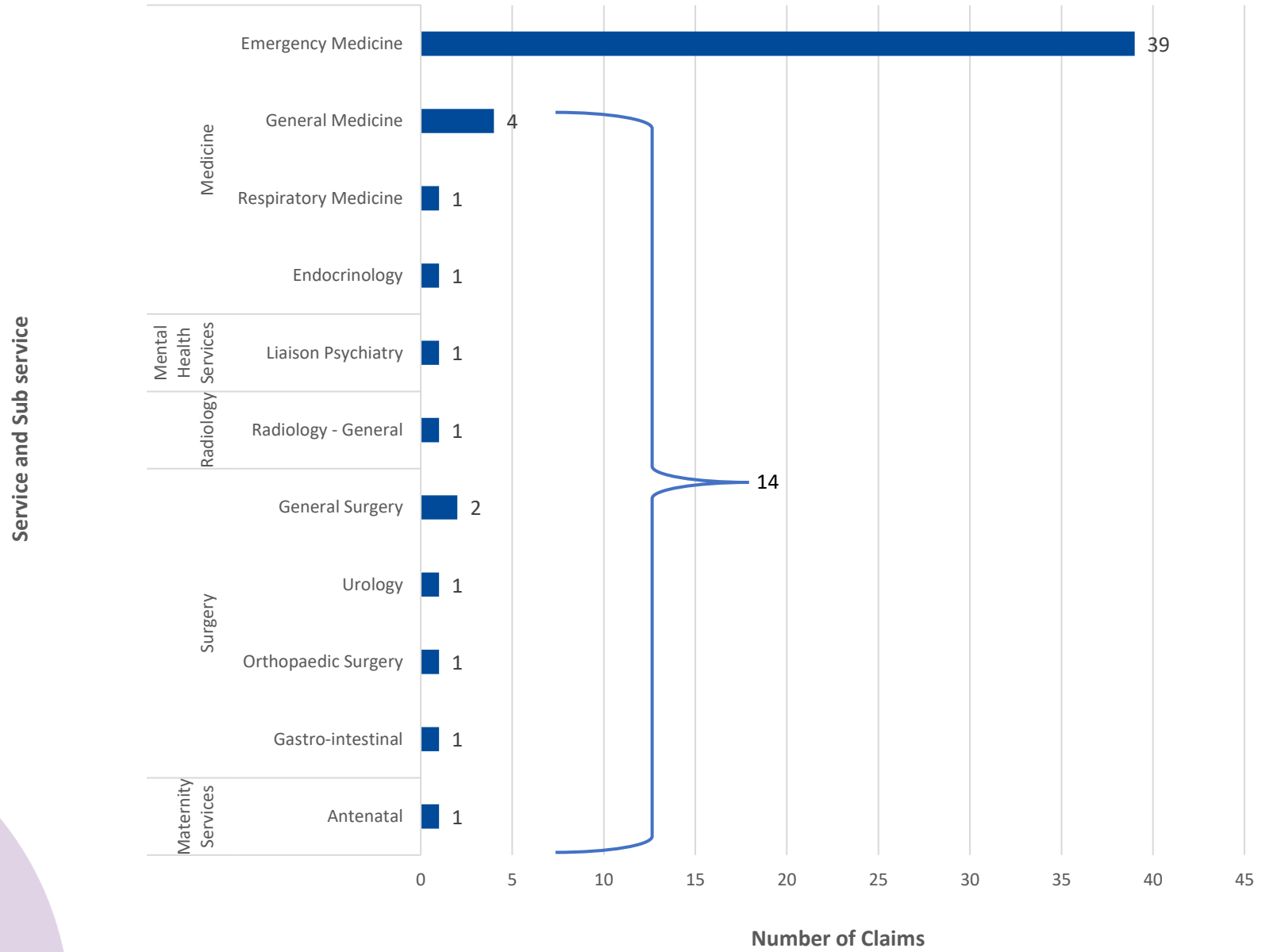
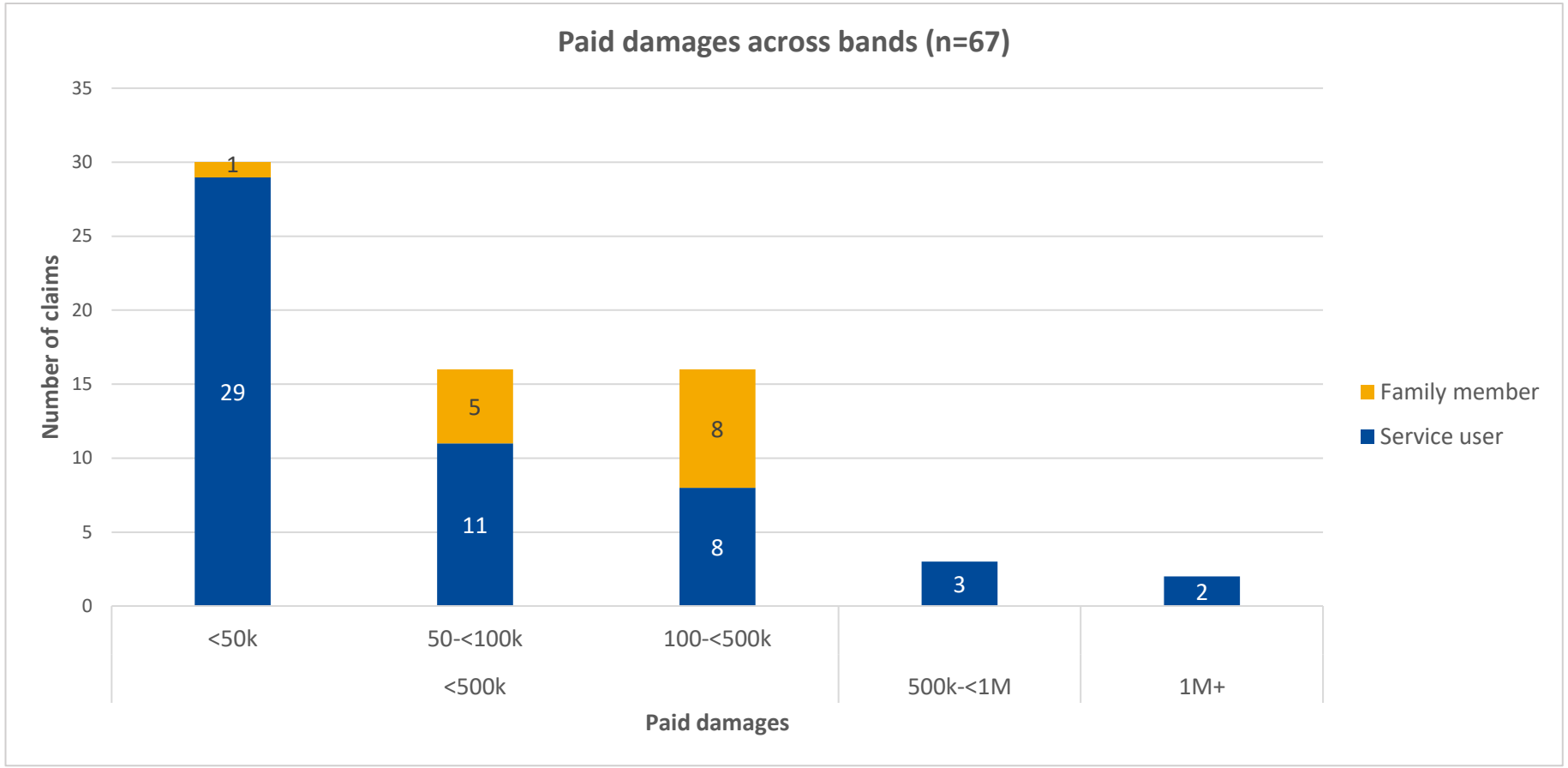
Claims by Service and Sub service (NIMS-available only for service user claims) (n=53)

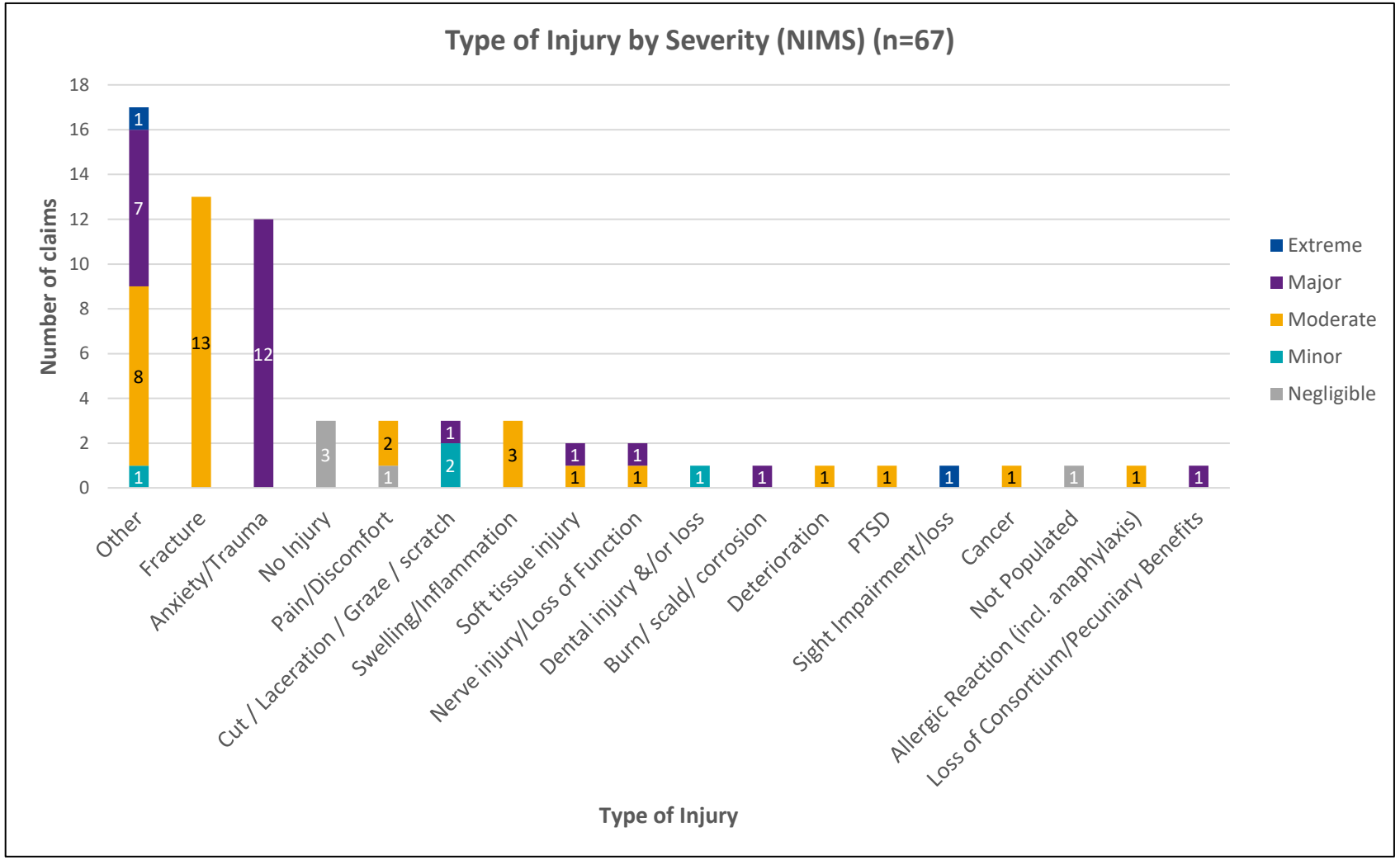


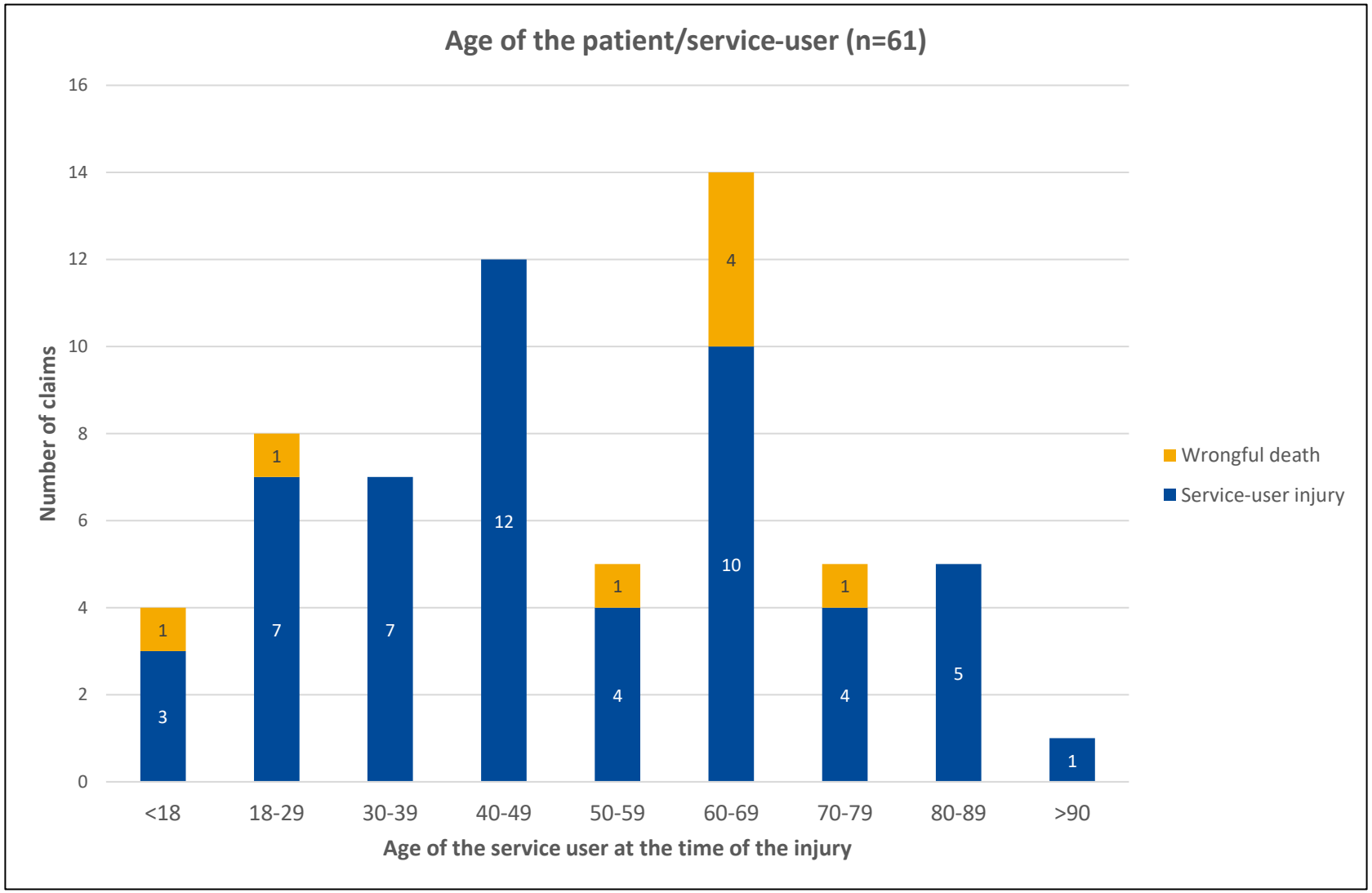


Case outcome	Number (n=67)
Settled	64
Court award	1
Injuries resolution board (PIAB)	1
Lodgement/tender accepted	1

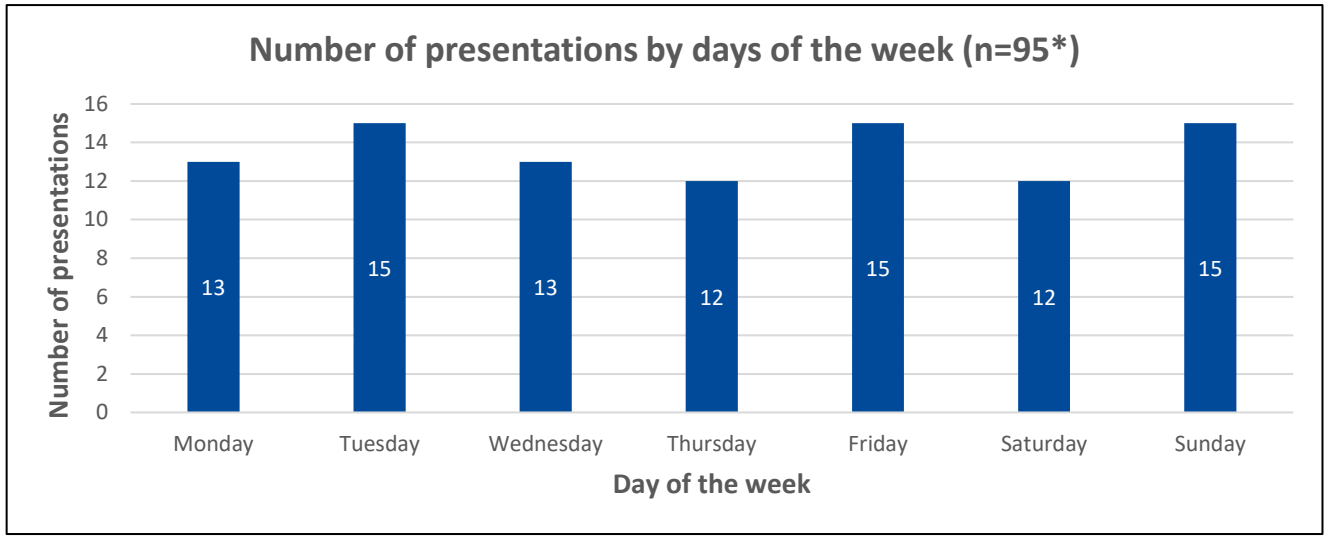
Sub Hazard Type (Top 5)	Number of claims	Paid damages (Total)	Paid damages (AVG. per claim)
Diagnosis	19	€ 2,206,422.48	€116,127.50
Slips, trips, falls	13	€ 497,879.00	€38,298.38
Wrongful death	13	€ 1,645,800.00	€126,600.00
Care management	11	€ 5,797,818.90	€527,074.45
Surgical/medical procedures	4	€ 880,000.00	€220,000.00
Other*	7	€ 214,357.00	€30,622.00

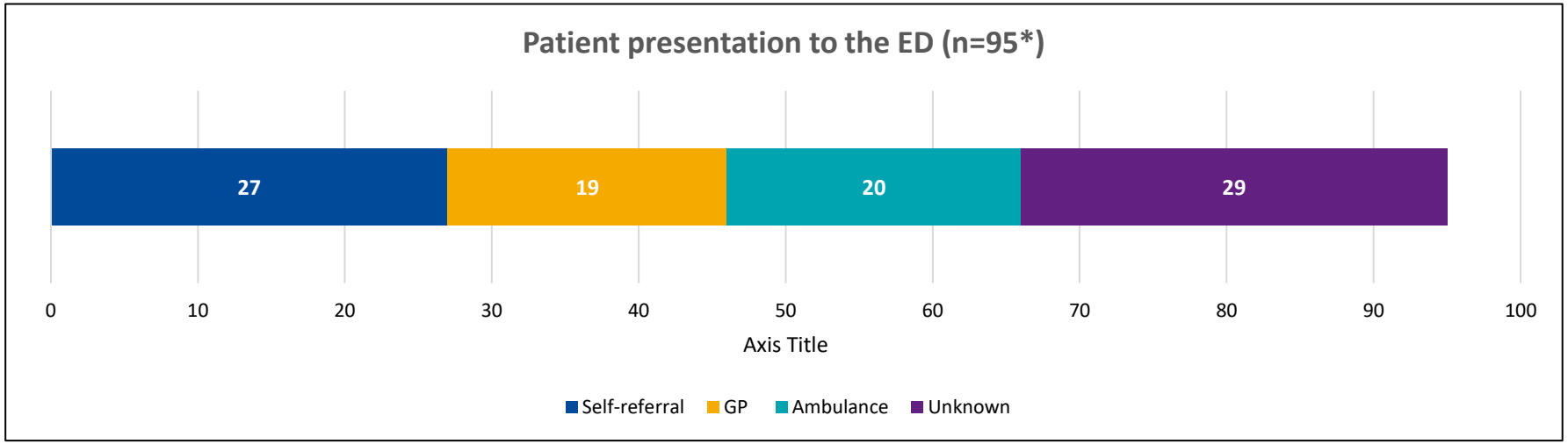
**Other includes the Sub Hazard categories not included in the top 5.*


Type of Injury by Severity (NIMS) (n=67)
Number of claims
18
16
14
12
10
8
6
4
2
0
Other
Fracture
Anxiety/Trauma
No Injury
Pain/Discomfort
Cut / Laceration / Graze / scratch
Swelling/Inflammation
Soft tissue injury
Nerve injury/Loss of Function
Dental injury &/or loss
Burn/ scald/ corrosion
Deterioration
PTSD
Sight Impairment/loss
Cancer
Not Populated
Allergic Reaction (incl. anaphylaxis)
Loss of Consortium/Pecuniary Benefits
Type of Injury
Extreme
Major
Moderate
Minor
Negligible



Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency
An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency





**48% (n=29) patients/service-users presented on >1 occasion to the ED*

Delay in clinician assessment	Number of claims (n=61)
Not enough information available	36
Yes	17
No	5
Yes, and the triage category was not urgent enough	2
No, but the triage category should have been more urgent	1

13 patients deteriorated while waiting to see a clinician

Manchester Triage Category for those where there was a known delay (n=19)

Category 2 (within 10 mins)		Category 3 (within 60 mins)	
Wait time	**Number of claims**	**Wait time**	**Number of claims**
> 10 mins – 1 hr	3	**1 – 2 hrs**	4
1 – 2 hrs	2	**2 – 3 hrs**	3
> 2 hrs	2	**3 – 4 hrs**	2
		> 4 hrs	3

What happened?

Injury as a consequence of:	Number (n=61)
Diagnostic error	
• Missed diagnosis	14
• Misdiagnosis	6
• Delayed diagnosis	5
Inadequate treatment	14
Fall	
• Falls risk	6
• Environmental	5
Collapse (preventable)	
• Fainting	2
• Medication	1
• Cardiac arrest	1
Medication error	3
Inadequate assessment	2
VHA patient to patient	1
Incorrect assessment	1

Common issues identified	Examples
Inadequate assessment	E.g., of soft tissue injury; of nerve function; of tendon function; of falls risk
Inadequate clinical decision making	E.g., failure to consider diagnosis of testicular torsion; of intracranial haemorrhage
Inadequate monitoring	E.g., failure to supervise patients at risk of falls; failure to monitor patients in non-clinical areas
Inadequate documentation	E.g., of clinical assessments or therapeutic interventions
Failure to refer appropriately	E.g., to specialist services such as plastic surgery for hand injuries; to orthopaedics for complex fractures
Failure to carry out tests/investigations	E.g., to investigate unexplained elevated CRP, to refer for indicated radiological investigations
Incorrect interpretation of diagnostic tests	E.g., missed fractures on x-ray
Failure to escalate	E.g., failure to refer patients with complex presentations to senior decision makers
Failure to acknowledge patient/family concerns	E.g., patients' symptoms, deteriorating patient
Failure to follow PPPGs/best practice	E.g., sepsis guidelines; inappropriate mobilisation of patients

Vignette

Case presentation

- Teenage male attended ED with lower abdominal pain and pain in right testicle
- A diagnosis of epididymo-orchitis was made but the patient was discharged home without medication and advised to return if the pain became worse or did not improve
- “No sign of torsion” was report in the medical notes
- Referred by GP a couple of weeks later and referred to general surgeon
- Ultrasound performed. Diagnosed with testicular torsion
- Admitted and orchidectomy performed

Vignette (cont.)

Learning

- On first presentation, doctor had no cause to write "no sign of torsion" as no investigations were carried out to support this
- Pain score, which the plaintiff stated was 10/10, was not recorded in the notes
- Despite suspecting an infection on first appearance the doctor did not prescribe antibiotics
- No process to allow discussion of the patient with a senior colleague was apparent. Had this happened it is likely there would have been concerns and patient recall.
- Appropriate care was provided on the second presentation

Key take home messages

- Prioritise the care of service users identified as being high risk at triage and escalate where appropriate
- Use the Emergency Medicine Early Warning System (EMEWS) from triage to discharge, to support the recognition of, and response to, deteriorating patients
- Effective communication is required between health and social care personnel, particularly in relation to clinical information and handover of care
- Undertake falls risk assessments as part of the nursing assessment, to identify service users who are at increased risk of falls and to implement preventative measures. Consideration should be given to the use of available emergency department-specific fall risk assessment tools.
- Risk assessments of overcrowding and patient flow should be undertaken and, where possible, mitigating actions implemented to reduce the risk of patient safety incidents

Key take home messages (cont.)

- A full differential diagnosis should be considered and advice sought from senior colleagues where necessary
- Clinical staff should have the competence to carry out diagnostic assessments and therapeutic interventions and should be supervised where necessary
- Necessary tests/investigations should be completed and their results followed up on by the doctor who ordered them
- Symptoms, vital signs, findings on physical examination, course of care, discharge advice and consent should be fully and adequately documented. Good documentation enables effective communication and enhances the chances of successfully defending a claim.
- National and local PPPGs should be implemented, and clinical staff should be aware of them and trained in their use