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State Claims Agency

Clinical Risk Unit & Snapshot Insights

Presenter:

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

12 March 2025

Clinical Risk Unit & Snapshot Insights – Agenda

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

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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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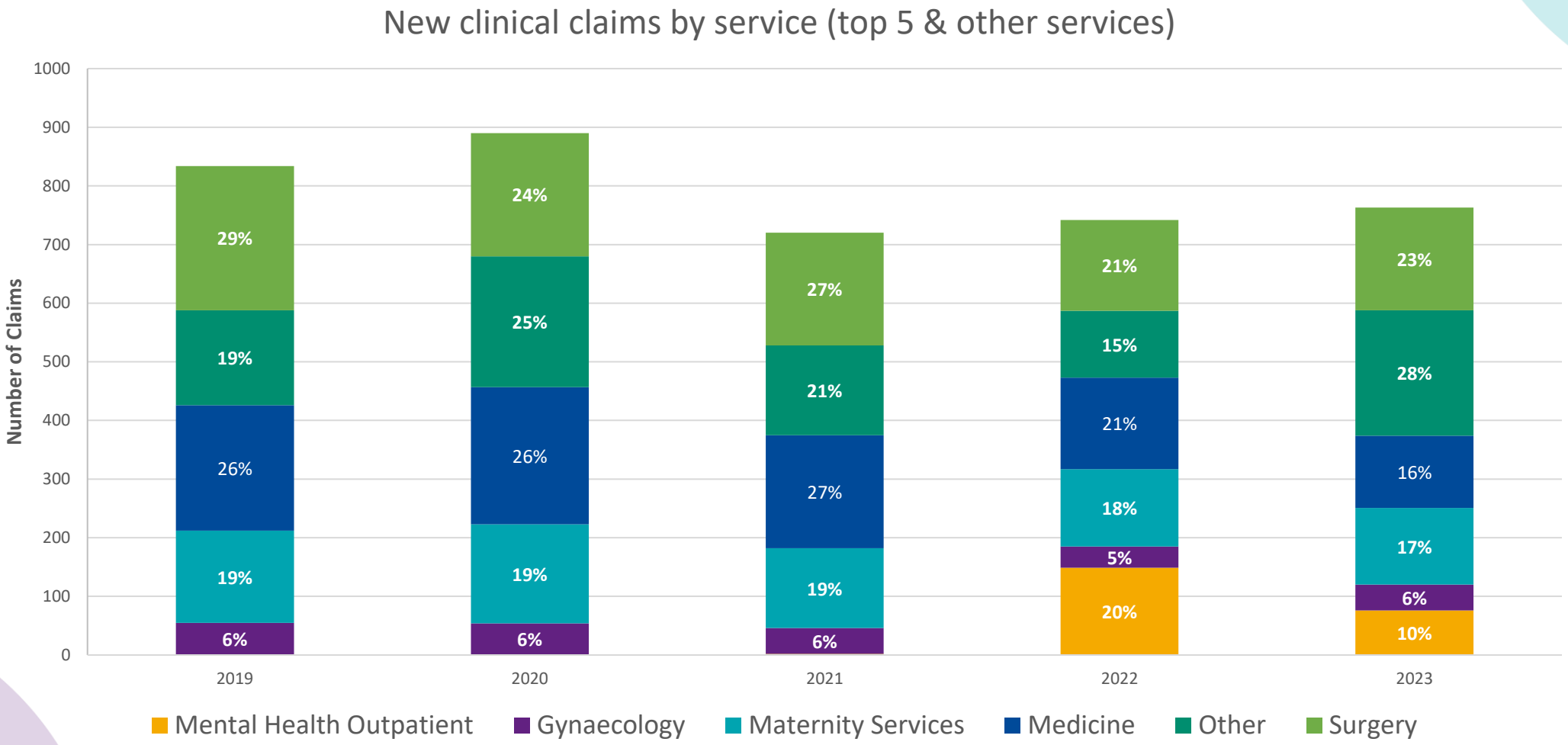
The SCA's Statutory Risk Management Mandate

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**

New clinical claims by service



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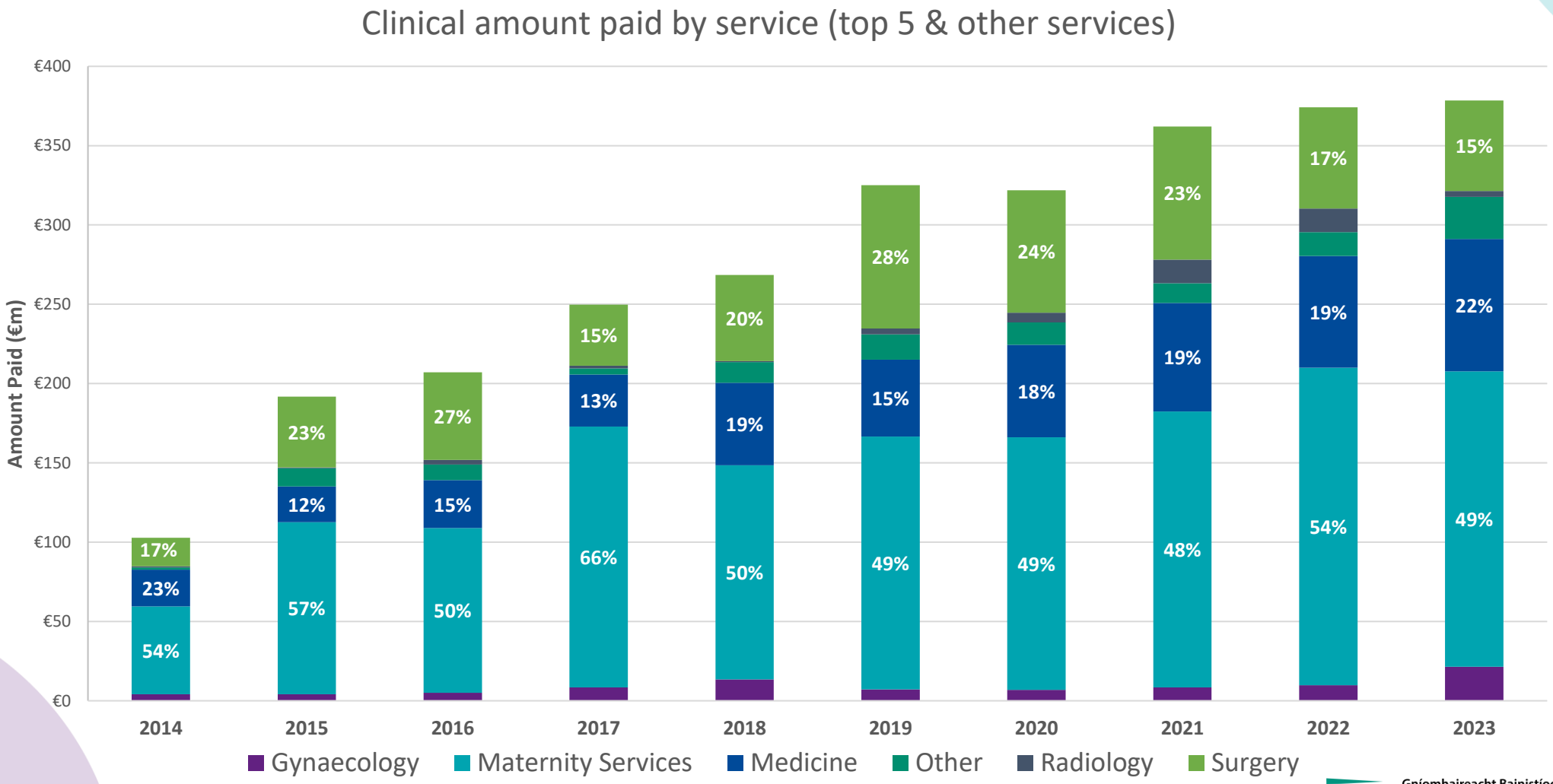
Clinical amount paid by service (top 5 & other services)



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National influence – Interdepartmental Working Group (IDWG) report on rising cost of claims

- 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
- The Report identifies six strategic priorities, which aim to reduce the requirement for litigation in healthcare and to improve the litigation process for those taking this path.

https://www.gov.ie/en/publication/9bcc5-interdepartmental-working-group-on-the-rising-cost-of-health-related-claims-report/

National influence – Interdepartmental Working Group (IDWG) report on rising cost of claims

Six strategic objectives:

1. Learning from adverse events, capturing data, and promoting key research
2. Preventing adverse events: strategy, people and resources
3. Enhanced response when harm occurs
4. Care for babies born with neonatal encephalopathy and other maternity initiatives
5. Faster and more efficient resolution of claims
6. Standardised approach to mass claims

Each strategic priority has a corresponding set or recommendations, and in total there are 30 recommendations made.

Strategic Objective 1: Capturing data, learning from adverse events and promoting key research recommendations research

All publicly-funded healthcare report incidents on NIMS.

Disseminate learnings to all relevant staff

Provide reassurance to the SCA when requested

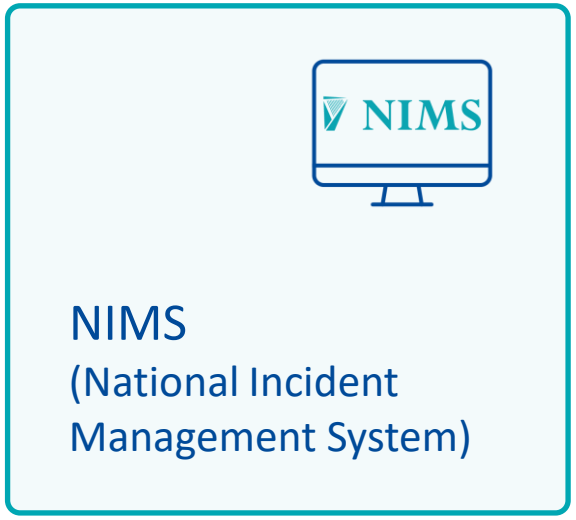
Enhance feedback to frontline clinical staff

Capability to undertake swift and comprehensive analysis of and response to serious adverse events

Endeavour to capture positive outcomes and promote a balanced culture of learning.

Audit primary clinical outcomes annually and publish their results in an annual clinical report.

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.

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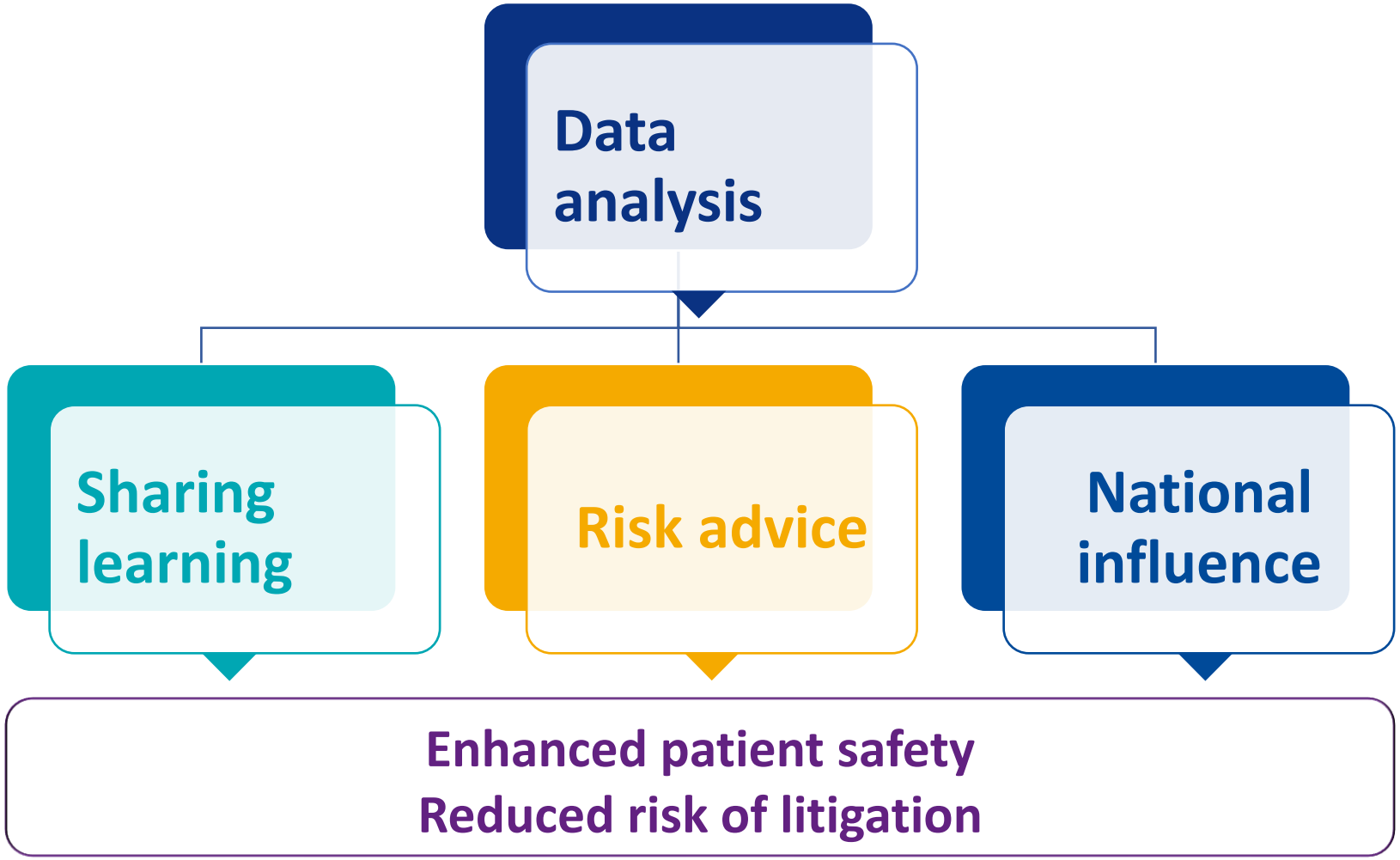
Clinical Risk Unit – How we use the data



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

Patient Safety Notification: Bed rails/cot sides - falls prevention and safety practices

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Patient Safety Notification

Bed rails/cot sides – falls prevention and safety practices

52

The number of incidents relating to bed rails/cot sides reported on NIMS in a three-month period

Unwitnessed fall in bathroom…found sitting in the middle of the room on the floor. Bed rails in situ but service user climbed out and mobilised without suitable footwear or mobility aid

Example of an incident from NIMS

Incorrect or inappropriate use of bed rails/cot sides can result in:

- **Harmful falls from beds/trolleys**
- **Entrapment involving the head and limbs**
- **Allegations of inappropriate restraint**

Issue Date: 14 January 2025 **Reference Number: SCA-PSN-12-01**

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 and best practice guidelines and research.

- Bed rails are used widely in health and social care settings. Their use may be considered as **part of the service user's care plan** to reduce their risk of **accidentally slipping, sliding or rolling from the bed**.
- Bed rails are associated with **several avoidable risks**, which include **harmful falls** from beds/trolleys, **entrapment** involving the head and limbs, and allegations of **inappropriate restraint**.
- Bed rails **must not be used as a restraint** to prevent the person from leaving the bed and to do so can cause harm. Prior to initiating their use, best practice requires relevant policies, procedures, protocols and guidelines (PPPGs), a **documented risk assessment and full consent**.

Patient Safety Notification – Bed rails/cot sides - falls prevention and safety practices

Key take home messages

- **Undertake multifactorial risk assessment and implement interventions** to address modifiable risk factors for falls if using bed rails/cot-sides in a service user's care plan.
- Make sure bed rails/cot sides are **fit for purpose** and are assembled according to **manufacturer's guidelines** and recommendations.
- **Ensure inflatable or padded bed sides** are compatible with the bed and mattress. Assess bed rails and mattress to ensure there are **no risks of entrapment**.
- Explore options to minimise the use of bed rails including: **mobility and social aids** are in easy reach, obtain **special nursing care supports** where appropriate, place **fall mats** to reduce the severity of impact, use **pressure sensitive alarms.**

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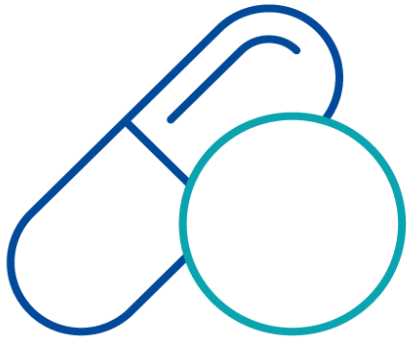
Clinical Risk Snapshots: Focus on medication - Vancomycin



- Vancomycin is an antibiotic which is active against methicillin resistant Staphylococcus aureus (MRSA). It has been designated as a **high-risk (high-alert) medication** by the World Health Organization (WHO).
- Due to its narrow therapeutic index and toxicity profile (nephrotoxicity and ototoxicity, vancomycin **requires therapeutic drug monitoring.**
- **Incident on NIMS include:**
  - **Prescribing incidents**: incorrect dose, prescribed in mg/Kg rather than the actual dose required, inappropriate target range.
  - **Administration incidents**: incorrect frequency, incorrect route, rapid infusion leading to 'Red Man Syndrome'.
  - **Monitoring incidents**: failure to check levels before administration, failure to take levels at the correct time or at all.

Clinical Risk Snapshots: Focus on medication - Vancomycin

Key take home messages

- The intravenous dose should be **calculated in mg/Kg**. The initial dose should be based on total body weight. **Subsequent doses** should be based **on serum concentrations**. **Renal function** must be considered when calculating subsequent doses.
- In patients with normal renal function, **serum concentration should be measured** on the **second day** of treatment immediately before the next dose.
- Prescribers should provide the **actual dose required** rather than stating the dose in mg/Kg.
- Vancomycin should be administered as a **slow intravenous infusion** of at least one hour or at a maximum rate of 10mg/min
- Vancomycin **should not** be administered by the intravenous route **for Clostridium difficile-associated diarrhoea or enterocolitis**; similarly, vancomycin should not be administered orally for systemic infections due to poor absorption from the gastrointestinal tract.

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Clinical Risk Snapshots: Spotlight on errors when interpreting laboratory test results

- Laboratory tests **are crucial in the provision of results** that are used for diagnosis, prognosis, monitoring a condition and/or treatment decisions.
- However, laboratory tests **have potential limitations that** can **impact on patient care and treatment**.
- Incidents on NIMS related to laboratory testing fell into five themes:
  - **issue of incorrect result**
  - **false negative** results
  - **transcriptional errors** in reports
  - **test sensitivity and specificity**
  - **misinterpretation** of test results

Clinical Risk Snapshots: Spotlight on errors when interpreting laboratory test results

Key take home messages

- Be alert to **inconsistent or conflicting** laboratory results, **seeking clarification** and confirmation of the results where necessary
- Ensure where a **confirmatory or supplementary result is required** that these results are received and reviewed; until then preliminary results should be **considered presumptive**
- Ensure test results are **consistent with the clinical picture** and test request as well as the results of any additional tests performed (past and present)
- Understand the sensitivity and specificity of frontline testing and **request superior testing when indicated**
- **Seek advice** in interpreting **complex** test results

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Learning from claims case study

Learning from claims case study: Poor documentation in the clinical note

Vignette

A 45-yo patient presented to ED after GP referral with sudden onset of occipital headache and an episode of vomiting; the GP letter reported no neck stiffness/photophobia.

Vital signs at triage were normal but pain score and the episode of vomiting was **missing from the nursing and medical notes;** triaged as **Manchester category 2.**

There was a significant delay before the patient was reviewed. Bloods were taken and returned as normal. The Registrar **discharged** the patient without a working diagnosis and the patient was reassured.

The following morning, the patient collapsed and was brought to ED by ambulance. An urgent CT scan was ordered and revealed an extensive **subarachnoid haemorrhage**.

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Learning from claims case study: Poor documentation in the clinical note

Learning

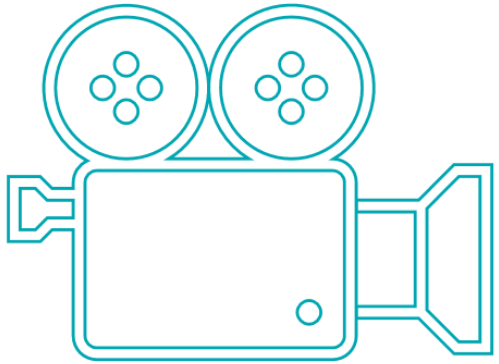
- While noting the high level of activity and acuity in the ED that day, there was a **failure to review the patient in a timely manner**.

- The presenting symptoms indicated a possible subarachnoid haemorrhage. **Red flag symptoms** should have been noted, and as such, a CT ordered.

- Experts were critical of lack of **documentation** of pain score, vital sign recordings on discharge and of a working diagnosis on discharge.

All medical practitioners have a professional responsibility to **keep accurate and up-to-date** medical records either on paper or in electronic form. (IMC 2024)

New Educational Video – Coming Soon



Documentation in the Clinical Record

stateclaims.ie/learning-events

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Clinical Indemnity and Frequently Asked Questions

Presenter:

Cliodhna Grady, Senior Clinical Risk Manager

12 March 2025

Clinical Indemnity and FAQs - Agenda

- How Clinical Indemnity works
- Who and what is covered by the Clinical Indemnity Scheme
- Clinical Indemnity FAQs

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Clinical Indemnity Scheme

Delivering our mandate through State Indemnity Schemes

Two State Indemnity Schemes operated by the State Claims Agency:

General Indemnity Scheme

- State indemnity is provided to State Authorities for injuries to people, such as **staff members, members of the public,** or service users which was the result of **negligence on the part of the State Authority,** its servants and/or agents.
- Also provides indemnity to third-parties for **damage to their property,** where a State Authority has been negligent

Clinical Indemnity Scheme

- State indemnity is provided to State Authorities in respect of the provision of **professional medical services**

How does clinical indemnity work?

Enterprise liability operates on the basis that the State authority assumes liability for the acts and omissions of its employees providing **professional medical services.**

When a claim is made against a State authority, the State authority remains the legal defendant.

The SCA manages and resolves the claim on the State authority's behalf, in line with its statutory mandate.

What does professional medical services mean?

Professional medical services means —

a. services provided by registered medical practitioners or registered dentists of a diagnostic or palliative nature, or consisting of the provision of treatment, or the conduct of research in respect of any illness, disease, injury or other medical condition (as amended by S.I. No. 628 of 2007),

b. services provided by health professionals including but not limited to nurses, midwives, pharmacists, paramedics, ambulance personnel, laboratory technicians in the performance of their duties, or

c. services connected with the provision of health or medical care provided by persons acting under the direction of a person to whom paragraph *(a)* or *(b)* applies.

Relevant legislation is S.I. No. 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 Section 2.

Clinical Indemnity Scheme – what is covered?

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 the island of Ireland

Not Covered

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

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.

NB: Supplementary professional/indemnity insurance required

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Obligations of State indemnity

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

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Clinical Indemnity FAQs

Clinical indemnity query:

A service user who is a resident in a Section 39 organisation in Co. Louth, with which the HSE have a Service Level Agreement, would like to travel for short trips to Northern Ireland. If the service user becomes ill and has to attend a hospital in Northern Ireland, would their care be covered by the Clinical Indemnity Scheme?

The Clinical Indemnity Scheme would not cover the provision of medical services by hospitals in Northern Ireland. Further to the provisions of Statutory Instrument (S.I.) 63 of 2003 – National Treasury Management Agency (Delegation of Functions) Order, 2003, the State offers indemnity in respect of the provision of professional medical services within the Republic of Ireland.

The Clinical Indemnity Scheme applies to Good Samaritan Acts within the island of Ireland (to include Northern Ireland) and the transfer of patients to hospitals in other jurisdictions.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

Clinical indemnity query:

I have been asked to accompany a patient who is being transferred to a hospital in the United Kingdom for ongoing treatment. Am I covered to do this?

In this instance, the benefit of the Clinical Indemnity Scheme would extend beyond the jurisdiction of Ireland, in circumstances where a medical team is accompanying a patient for handover to a hospital outside the jurisdiction of Ireland.

The 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.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

Clinical indemnity query:

Several 4th year GP Scheme trainees will be assisting at a rheumatology injection clinic at an acute hospital for a number of sessions. This arrangement has been agreed by the Department of Rheumatology and Hospital Management. Will the 4th year GP trainees be covered by the HSE indemnity, or should they be providing their own separate indemnity?

The Clinical Indemnity Scheme (CIS) will provide cover for the provision of professional medical services by the trainees once they are acting with the authority and consent of the hospital, and once the hospital is covered by the CIS. The CIS operates on an Enterprise Liability basis where indemnity is provided for the acts or omissions of the enterprise/hospital/clinic/clinical practitioners, provided the practitioner is acting with the authority and consent of the Enterprise/hospital/clinic.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

Clinical indemnity query:

Are Clinical Directors covered by Clinical Indemnity Scheme for any decisions or advice they may provide during the course of their duties ?

The Clinical Indemnity Scheme (CIS) provides cover for claims arising from allegations of medical negligence only in relation to the provision of professional medical services. The CIS would apply to Clinical Directors if any decisions taken by them or guidance issued by them could be considered to have resulted in a personal injury to a patient.

The CIS would not otherwise apply to clinical directors' management, governance or administrative functions. Allegations such as defamation, bullying, harassment, etc, would not be covered by the CIS.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

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Spotlight on transfer of care

Presenters:

Dr Natasha Coen, Senior Clinical Risk Manager

Wayne Meehan, Clinical Risk Advisor

12 March 2025

Agenda

Learning from claims case study

Incidence surveillance – overview of a 'lens' on transfer of care

Qualitative findings

- Analysis Findings
- Focus: Handover
- Focus: Provision of Care
- Focus: Admission & Discharge
- Learning from claims case study

Advice to reduce transfer of care incidents

Transfer of Care: Definition

"a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location"

(WHO 2016)

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Learning from claims case studies: Transfer of care

Learning from claims case study: Delayed transfer to specialist unit

Vignette

A 55-year-old woman attended emergency department (ED) with a history of abdominal pain and vomiting. Following medical review, the patient was referred to the surgical team and was admitted from ED to ward with a diagnosis of acute pancreatitis.

A few days later a repeat CT of the patient's abdomen and pelvis revealed acute necrotising pancreatitis. Over the following days the patient's condition deteriorated with increased respiratory rate, reduced oxygen saturations, tachycardia and a low-grade temperature.

A further CT showed worsening features of necrotising pancreatitis. Given the worsening condition, arrangements were made for transfer to a specialist unit in another hospital. However, while waiting for transfer the patient continued to deteriorate and died following a cardiac arrest.

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Learning from claims case study: delayed transfer to specialist unit

Learnings

- Poor documentation in the clinical record, including that interventions were not adequately recorded and there was no medical note made in ED prior to transfer to ward
- In view of the patient's deterioration and rising early warning score, transfer to a high dependency unit or intensive care should have been secured
- There was a delay in the decision to transfer the patient to a specialist unit in another hospital, which was warranted given the patient's condition and deterioration
- On the day of transfer to the specialist unit, there was delayed recognition of deterioration, as the primary team, in expectation of transfer, had not reviewed the patient.

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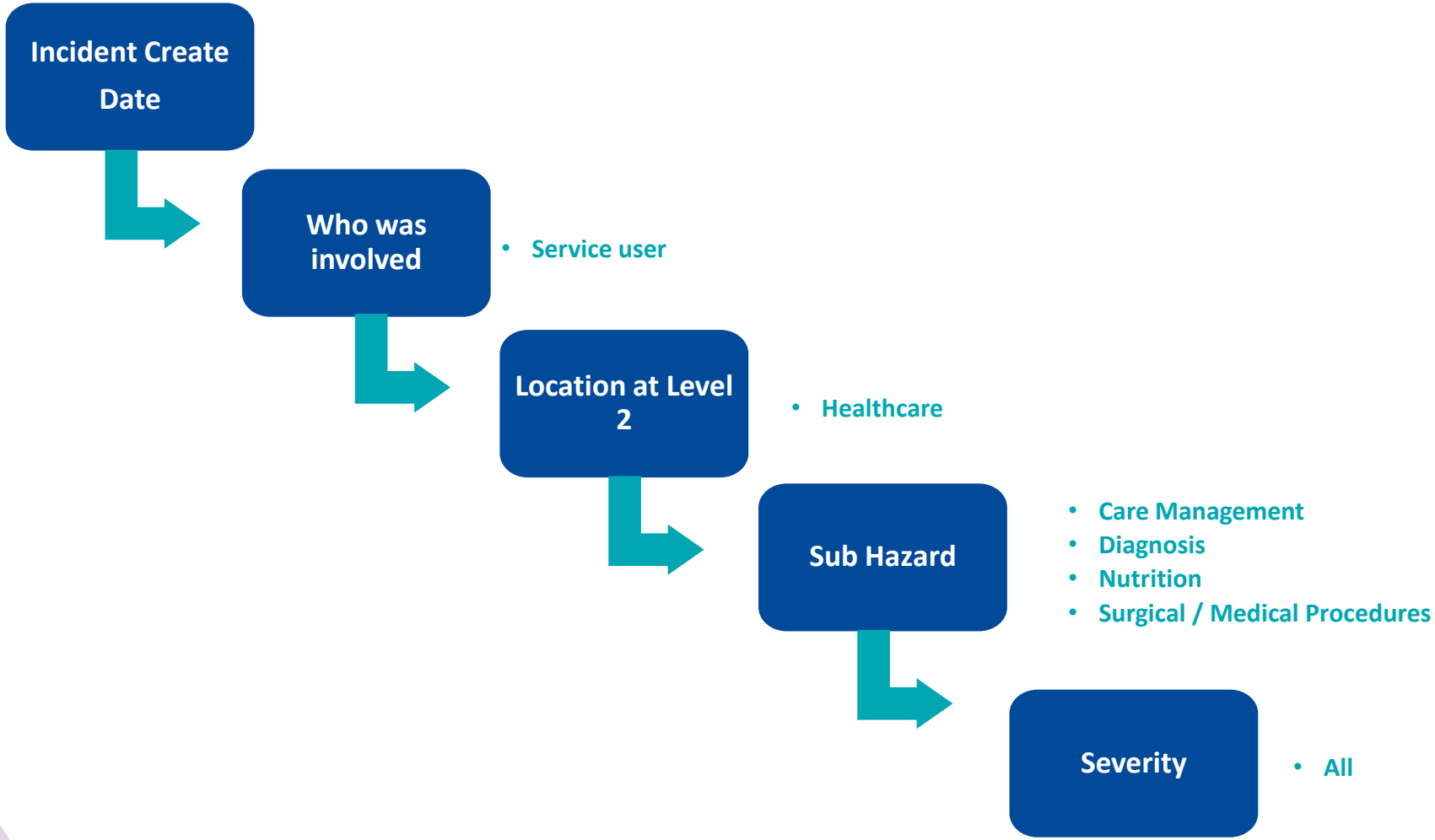
Incidence surveillance: A ‘lens’ on transfer of care

Incident surveillance: National Incident Management System (NIMS) search criteria for transfer of care lens



Transfer of care lens results*

350

Potential transfer of care service user incidents identified over a quarter in 2023

246

Actual transfer of care service user incidents identified that underwent further analysis

6

Number of themes identified based on the NIMS free text field for the description of the incident

Exclusions: Incidents not directly related to transfer of care

*Incident data extracted from NIMS - date range Q1 2023

Overview of results

246
Transfer of care incidents

92%
Care management
(sub-hazard)

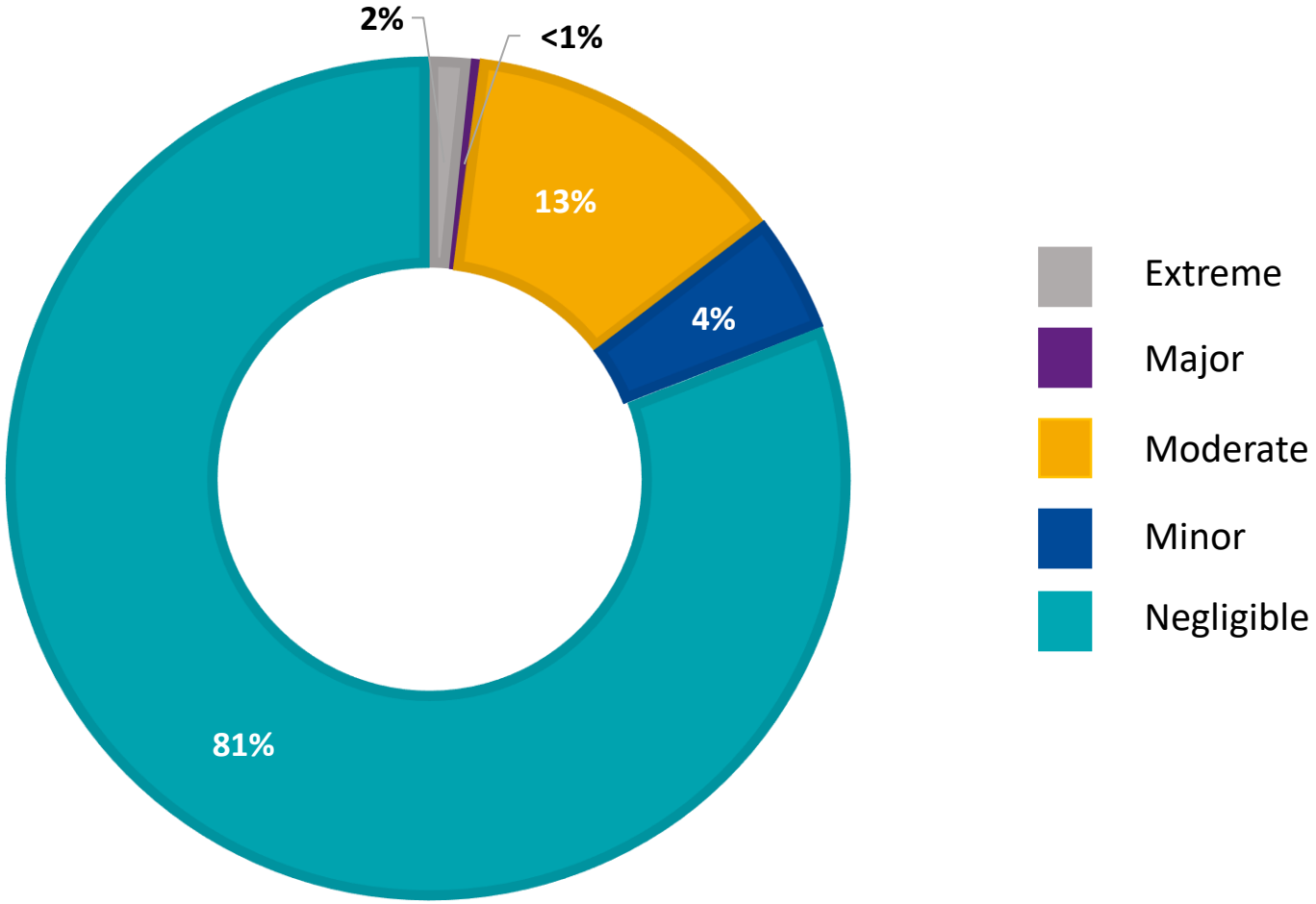
62% Medicine
17% Surgery

94%
Reported by acute services

72%
Communication, provision of care & documentation

81%
Incidents reported as negligible (no harm)

NIMS severity rating for transfer of care incidents



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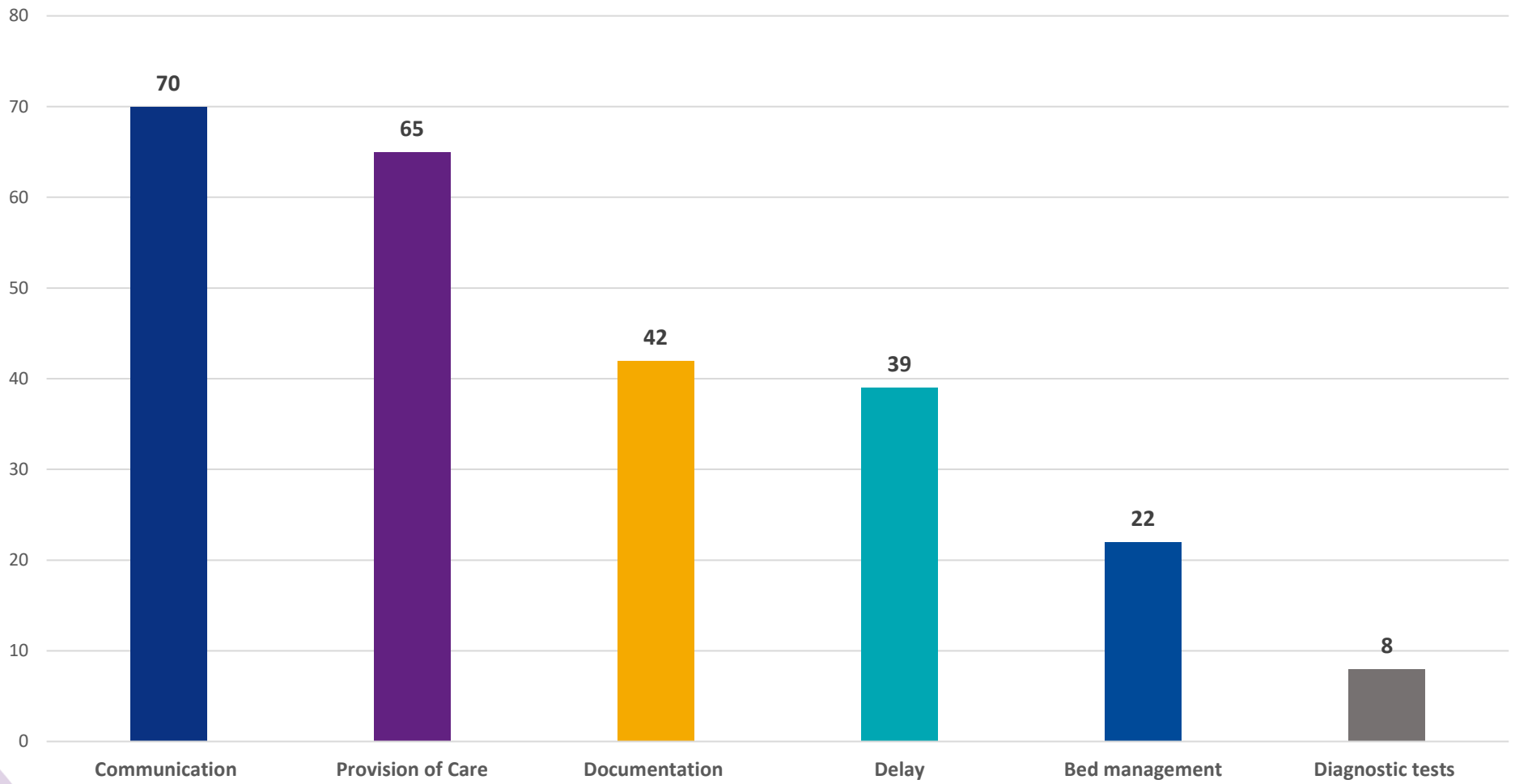
Qualitative analysis results for transfer of care

Qualitative analysis results (n=246)



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Examples of issues for each of the themes

Communication (n=70)

- Incorrect or inadequate handover given
- No handover given
- Patient arrived on ward, staff unaware of transfer

Provision of Care (n=65)

- Inappropriate transfer of patient
- Delayed transfer leading to deterioration
- PIVC management

Documentation (n=42)

- Inadequate documentation of care
- Incomplete discharge forms
- Missing documentation from notes

Examples of issues for each of the themes

Delay (n=39)

- Delayed ambulance arrival for hospital-to-hospital transfer
- Inadequate resources leading to delay in handover, triage and referrals

Bed Management (n=22)

- Bed unavailable on ward
- Isolation bed unavailable

Diagnostic Tests (n=8)

- Lost/missing sample
- Delayed reporting of results

Transfer of care: Focus on handover

Key issues identified

- **Suboptimal treatment:** e.g., where incomplete or inadequate handover was provided, e.g., failure to communicate clinical details or specific care requirements, treatment provided prior to or during transfer or infection control status
- **Failure to identify or manage a deteriorating patient:** e.g., where missed episodes of care (e.g. recording of observations, treatment, or interventions) were not communicated or documented
- **Medication error:** e.g., where medication was omitted, or an extra dose administered because medication administration was not clarified and/or documented at handover
- **Incorrect patient identification:** e.g., where patient details were incomplete or incorrect, addressographs and ID bands had incorrect identifiers, or another patient's details were found in notes
- **Poor patient experience:** e.g., when patients were transferred to a ward not ready to receive them or transferred to incorrect locations

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Transfer of care: Focus on provision of care

Key issues identified

- **Management of the deteriorating patient:** e.g., patient complex medical needs/pre-existing condition, undetermined clinical pathways for specialist care, inadequate management of care
- **Inappropriate transfer management:** e.g., transfer without escort, transfer to incorrect location, care management not appropriate during transfer, conflicting team goals, patient refusal to transfer, failed discharge
- **Lack of coordination and preparedness:** e.g., inadequate treatment for condition prior to transfer, not meeting patient care requirements on arrival, patient history unknown/not communicated, non-adherence to policies and procedures
- **PIVC management:** e.g., infiltrations, extravasations, cannula left in situ on discharge
- **Unavailable resources:** e.g., lack of available services, isolation rooms or equipment

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Transfer of care: Focus on admission and discharge

Key issues identified

- **Lack of admission coordination:** e.g., patients arriving without confirmation of acceptance or bed availability in the receiving facility, lack of clarity about care pathways resulting in inappropriate transfers, unclear criteria resulting in admissions declined/not accepted on arrival
- **Poor discharge planning:** e.g., discharge before being medically fit and/or without appropriate care plan, diagnostic tests not reviewed prior to discharge, bed unavailability due to inefficient allocation and communication, discharged without appropriate referrals
- **Documentation issues:** e.g., lack of comprehensive admission notes, no accompanying medical charts, unclear discharge care and treatment plan, no discharge notifications to onward referral services, and no / incomplete discharge letters
- **Lack of resources:** e.g., no / low bed availability, in particular ICU beds, insufficient personnel and specialists to meet demand and lack of appropriate infection protection control environments.

Learning from claims case study: Delayed treatment following transfer of care

Vignette

67-year-old man visited a consultant ophthalmologist regarding issues with their vision. The patient was diagnosed with age-related macular degeneration in one eye requiring urgent treatment. A referral was made to a specialist ophthalmology clinic.

On numerous occasions, the patient contacted the specialist clinic advising of the urgency of their problem and seeking an appointment date.

Following significant delays in scheduling an appointment and worsening sight, the patient decided to have the treatment done privately.

The patient suffered permanent visual impairment.

Learning from claims case study: Delayed treatment following transfer of care

Learnings

- The urgency of the referral was not recognised by the receiving clinic nor were there any guidelines for the timeframe within which urgent referrals were to be made.
- Once care was accepted by the specialist clinic, the patient was not provided with an appointment and had to follow up on their referral to seek an appointment date.

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Advice to reduce transfer of care incidents

Key advice to reduce transfer of care incidents

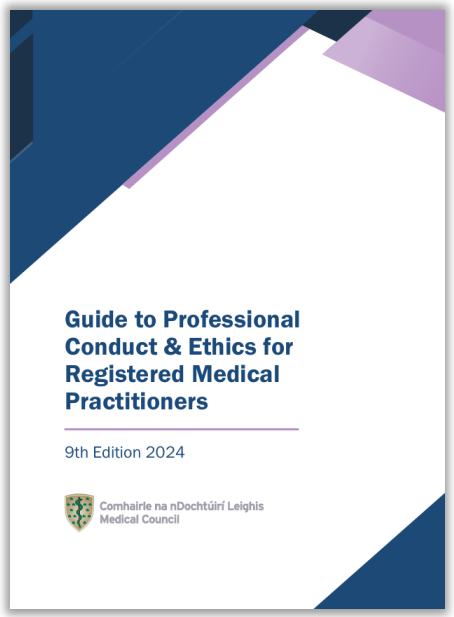
- **Streamline administrative** processes through use of **standardised admission notes**, consider implementation of integrated electronic health record and ensure clear communication pathways for pre-transfer acceptance
- Ensure **early discharge planning** to identify issues that would impact a patient's discharge or transfer so that action may be taken early to address them. Use **checklists and standardised criteria** to arrange medications, discharge letters and continuity of care with other healthcare professionals
- Recognise **deviations from normal clinical signs** and ensure appropriate and timely **interventions/decision-making/escalation** when **clinical concerns** are present
- Anticipate **the need for multidisciplinary assistance** (e.g., anaesthetics, radiology, microbiology) and communicate this as soon as possible to the relevant team members

Key advice to reduce transfer of care incidents (cont.)

- At handover, **communicate**, at a minimum, **patient identification**, **clinical history**, **treatment/interventions** undertaken or planned, **medications** prescribed and administered and **any special requirements**
- **Standardise the handover process** using handover tools or checklists such as ISBAR[3]
- **Prior to transfer,** ensure requirements for **PIVC management** and adherence to care bundles are handed over including **detailed records** of PIVC insertion, maintenance, and any complications
- **Relevant documentation** should always accompany the patient on transfer to ensure that all **required information is** available at the **point of clinical decision making**
- **Engage patients and their families** in the decision-making process. Ensure they understand the **reasons for the transfer and what to expect**. This can help reduce anxiety and improve cooperation

Key advice to reduce transfer of care incidents (cont.)

Professional Responsibility for Medical Practitioners



- The doctor who orders **diagnostic tests or investigations must follow** up to ensure these investigations have taken place, results are followed up and appropriate action taken, including communication to the GP or community services

- Discharge of a patient from care must be accompanied by a timely and prompt **discharge summary** which includes at least the minimum basic information:
  - A summary of relevant medical and treatment history
  - Medication and medication changes
  - Any planned follow-up by the discharging service
  - Action required by primary care/community services (if involved)
  - Action required by the receiving GP clearly documented

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Thank you