



Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta  
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát  
State Claims Agency

# Clinical Risk Unit & Snapshot Insights

Presenter:

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

Clinical Risk Matters Series 2: Clinical Risk  
Updates and Spotlight on Diagnostic Errors

12 March 2024



# Clinical Risk Unit & Snapshot Insights – Agenda

State Claims Agency Risk Mandate & Claims Profile

Clinical Indemnity and Incident Reporting Obligations

Clinical Risk Unit Updates

Snapshots and Insights from claims and incident analysis



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# About Clinical Risk Unit



# Our Services

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



Claims  
Resolution



Risk  
Management



Legal Costs  
Management

# 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**

# Claims Position (to end-2022)

## Active Claims



=

## Outstanding Liability



# Clinical Claims Activity (to end-2022)

## Active Claims

**3,875**

Clinical Active Claims

=

## Outstanding Liability

**€3.86bn**

Total Estimated  
Outstanding Liability  
relating to clinical  
claims in 2022

## Top 5 service user claims received in 2023 by sub-hazard type

Claims occurring in hospital locations and National Ambulance Service (NAS), including claims occurring in private hospitals covered under Safety Net during the COVID-19 pandemic

Sub hazard type	No. of claims received	Estimated Liability (€M)
Surgical/Medical Procedures	174	74.54
Diagnosis	151	108.46
Care Management	100	106.08
Labour/Delivery	90	243.05
Slips, Trips, Falls	35	4.25
Other Categories*	121	49.98

All community and voluntary community locations (i.e. delegated Section 38s, Section 39s, National Social Care) are included.

Sub hazard type	No. of claims received	Estimated Liability (€M)
Medication	42	8.96
Care Management	33	6.39
Slips, Trips, Falls	8	0.99
Diagnosis	5	1.45
Wrongful Release	4	0.05
Other Categories*	30	5.26

\*Other Categories includes the remaining Sub Hazard types which are not included in the top 5 by claim count. This data is correct as of 29/02/2024.

# 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**

# Obligations of State Indemnity

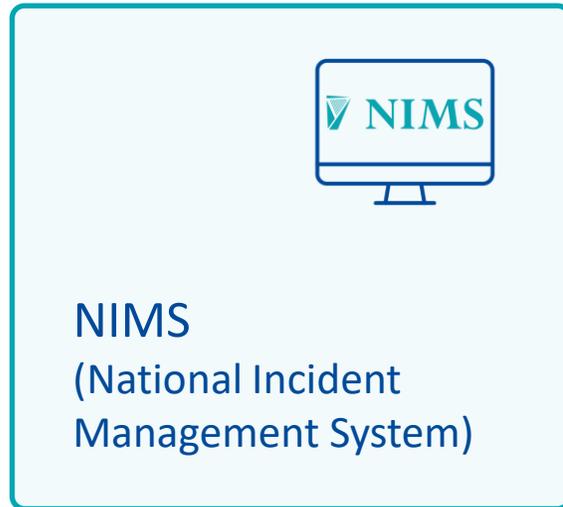
## Under Section 11 NTMA (Amendment) Act 2000, State Authorities must:

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

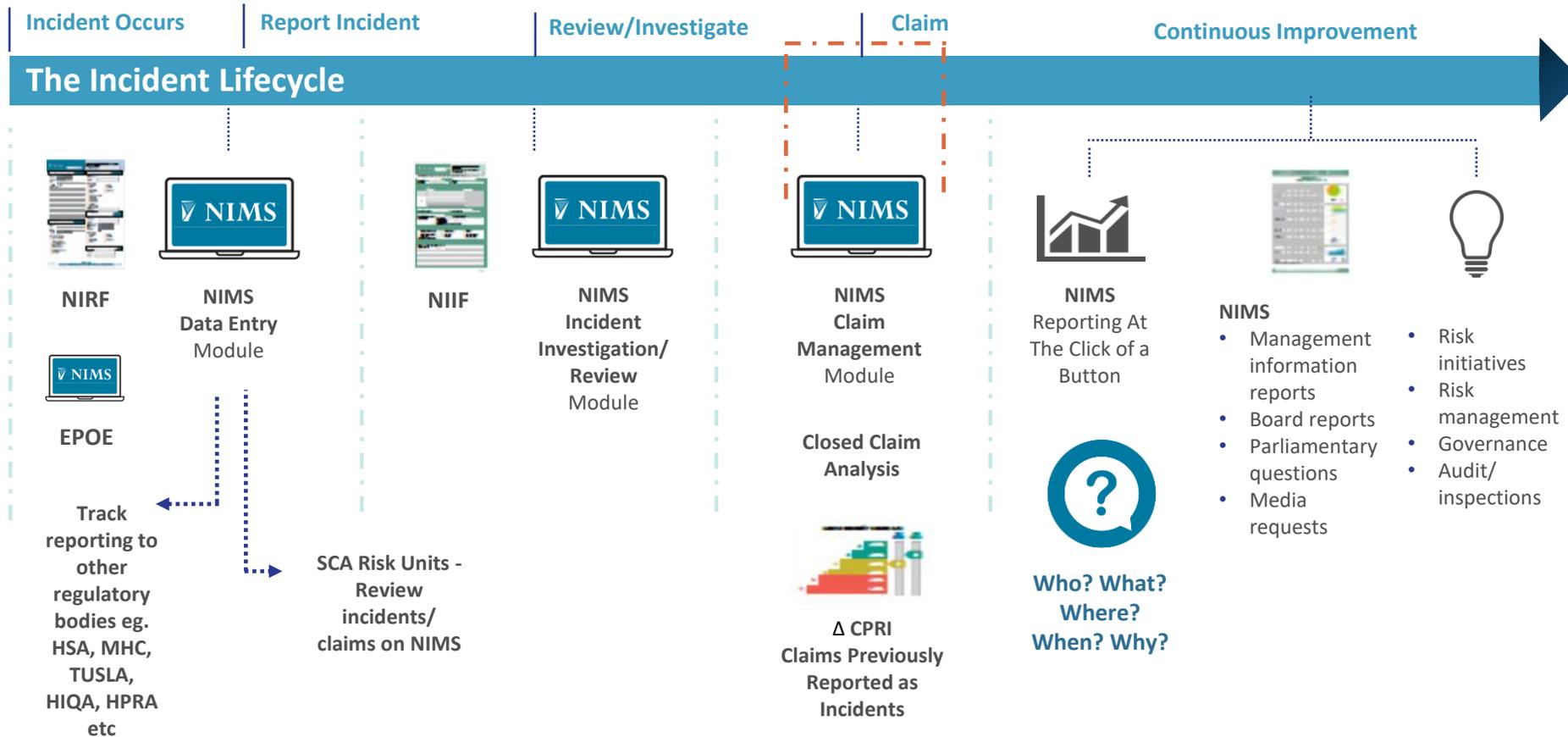
# NIMS – the National Incident Management System



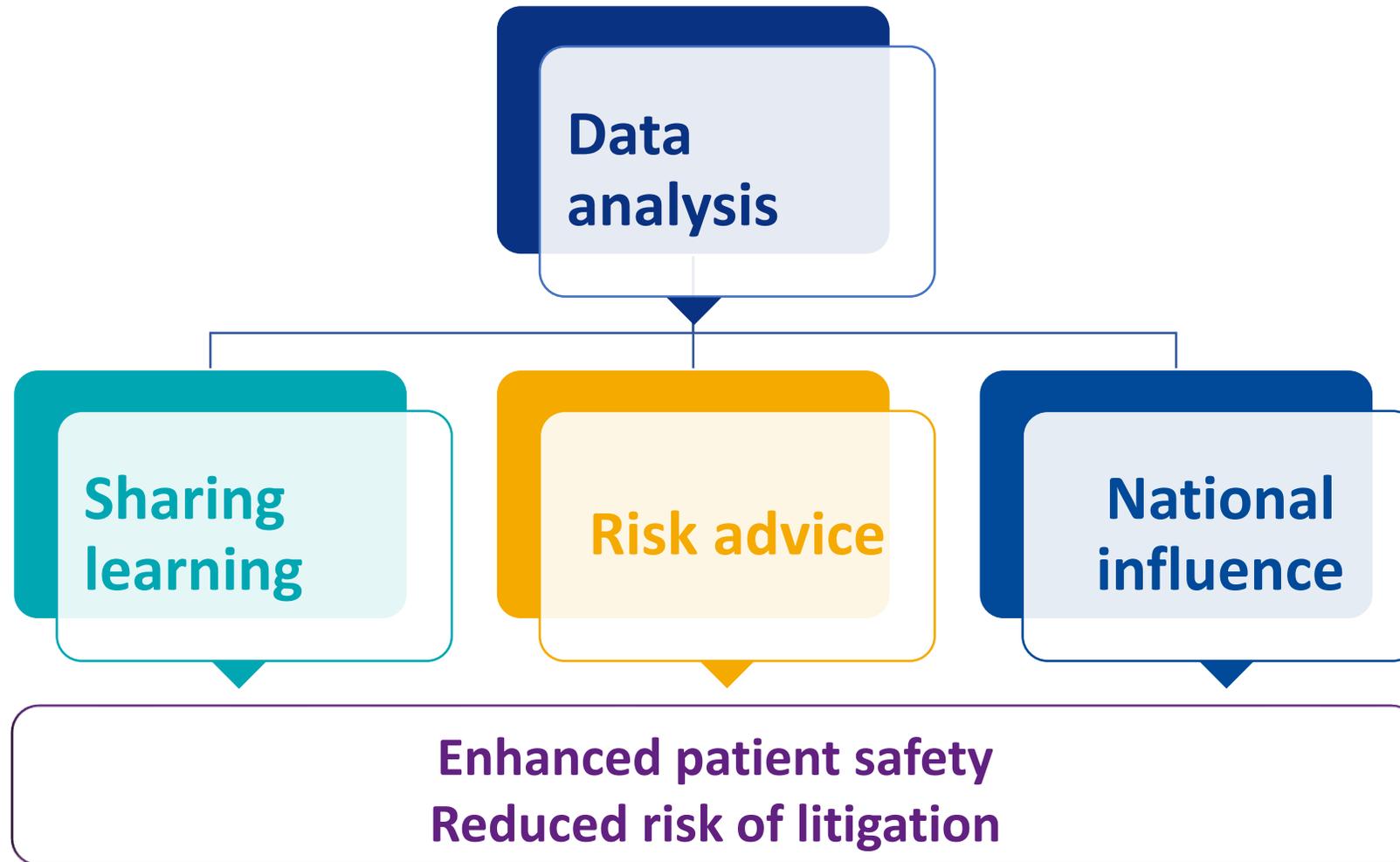
- A confidential national end-to-end incident, risk and claims management platform
- System used by State Authorities to fulfil the statutory requirement to report incidents to the State Claims Agency and for their own incident and risk management purposes

**Safety and insights. Powered by data.**

# NIMS and the Incident Lifecycle



# Clinical Risk Unit – How we use the data

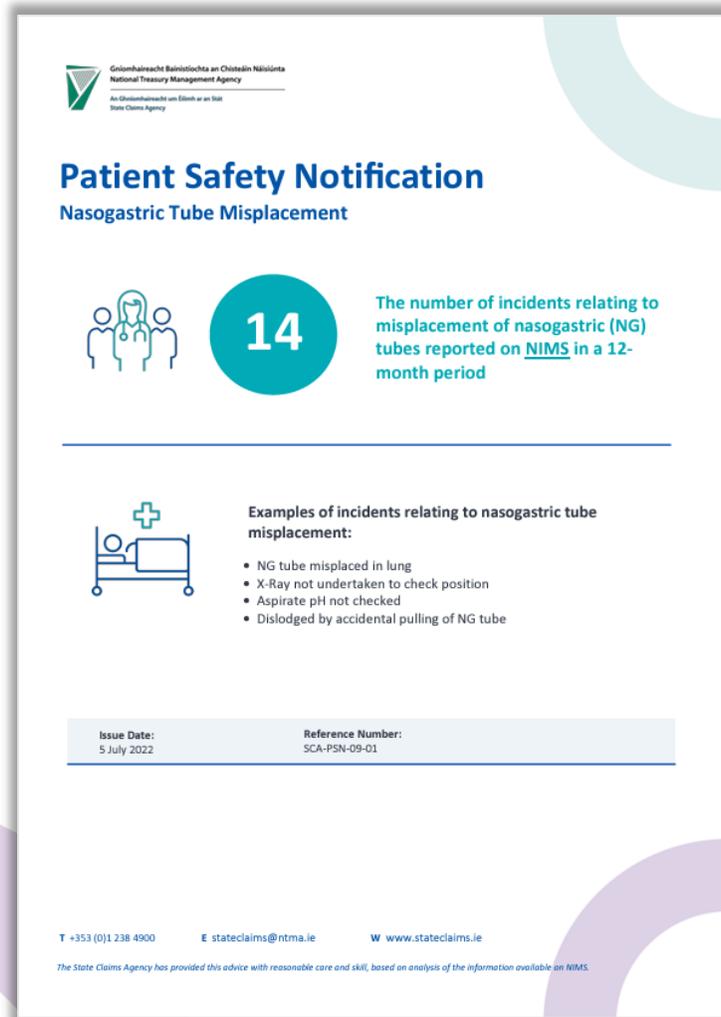


# Launching the C.L.A.I.M Project

- **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



# New Resources Available - Patient Safety Notifications



**Galíomhaiscáil Baineálachta an Chláirín Náisiúnta**  
**National Treasury Management Agency**  
An Ghníomhaireacht um Éilimh ar an Stát  
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## Patient Safety Notification

### Nasogastric Tube Misplacement

 **14** The number of incidents relating to misplacement of nasogastric (NG) tubes reported on NIMS in a 12-month period

 **Examples of incidents relating to nasogastric tube misplacement:**

- NG tube misplaced in lung
- X-Ray not undertaken to check position
- Aspirate pH not checked
- Dislodged by accidental pulling of NG tube

Issue Date: 5 July 2022      Reference Number: SCA-PSN-09-01

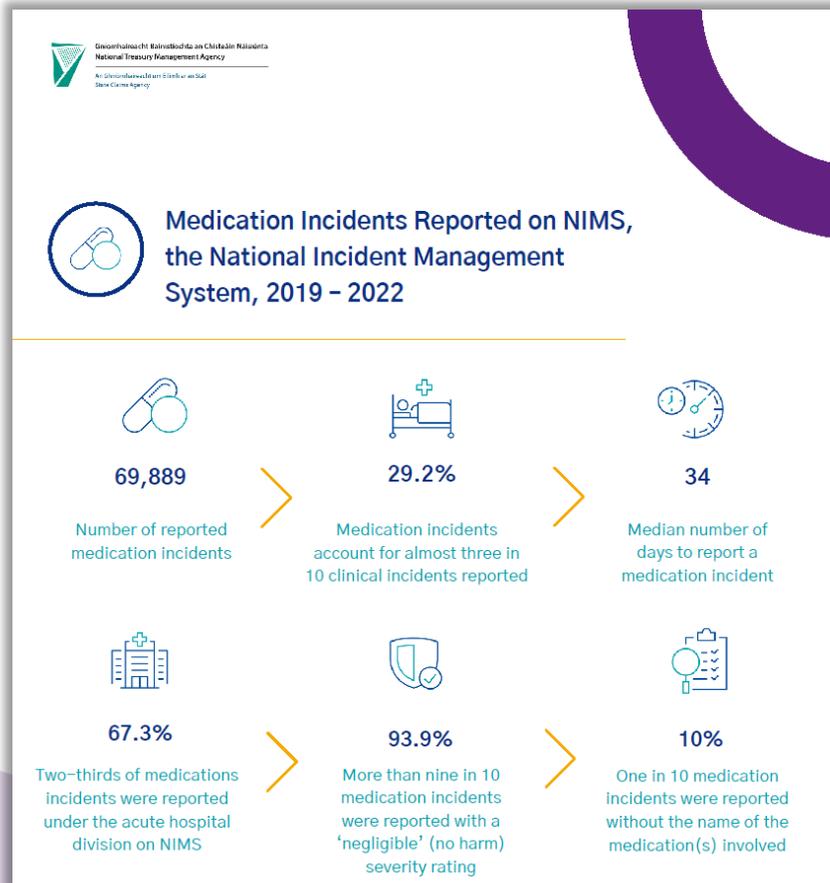
T +353 (0)1 238 4900    E [stateclaims@ntma.ie](mailto:stateclaims@ntma.ie)    W [www.stateclaims.ie](http://www.stateclaims.ie)

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

- In line with our statutory risk management mandate, the SCA **reviews and analyses incidents reported on NIMS**, the National Incident Management System.
- Based on this analysis the Clinical Risk Unit may prepare **Patient Safety Notifications** containing advice to enhance patient safety.



# New Resources Available - Medication Infographic



- In line with our statutory risk management mandate the Clinical Risk Unit has completed an analysis of medication incidents reported on NIMS by **hospitals and Community Healthcare Organisations** between 2019 – 2022.
- This infographic shares **national data on reported medication incidents** and provides **learning opportunities** for health and social care services.

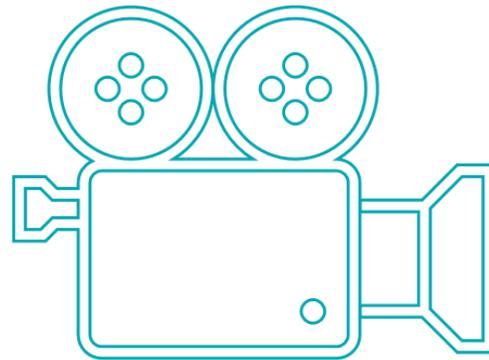


# Medication Infographic Highlights

## Key findings

- ✓ Administration incidents and prescribing incidents accounted for the majority of medication incidents by stage of process.
- ✓ 45.2% of medication incidents were reported by nursing and midwifery staff and a further 41.6% by Allied Health Professionals, which includes pharmacists, indicating the valuable role these staff groups play in identifying and reporting medication incidents.
- ✓ Only 3.9% of medication incidents were reported by medical staff, i.e., doctors, indicating that this is an area for improvement.
- ✓ The medication subgroups most frequently featured in medication incidents were, in descending order, antithrombotics, antiepileptics, opioids, antipsychotics and viral vaccines.

# New Educational Videos – Coming Soon



Let's Talk About Consent Preview

[stateclaims.ie/learning-events](https://stateclaims.ie/learning-events)



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# Snapshot Insights from Incidents and Claims



# Snapshot Insights: 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.



# Clinical Risk Snapshots - Addison's Disease in Children: Keep it in Mind



- Addison's disease is a **rare disorder** of the adrenal gland that results in **deficiencies of the hormones cortisol and aldosterone**.
- Cortisol deficiency results in the non-specific symptoms of **weakness, fatigue, anorexia, weight loss, vomiting and abdominal pain**. Aldosterone deficiency causes hyponatraemia, salt craving, and postural hypotension.
- **Addison's disease in children is easily 'missed'** because of its non-specific symptoms, its rarity (1:10,000), and because doctors have a **low index of suspicion** for the diagnosis.

## Authors

Dr JF Murphy, Clinical Lead Programme in Paediatrics and Neonatology,  
Dr N McGrath, Consultant Paediatric Endocrinologist, University Hospital Galway and  
Dr A Nicholson, Professor of Paediatrics, RCSI Medical University of Bahrain.

# Clinical Risk Snapshots - Addison's Disease in Children: Keep it in Mind

## Key take home messages

- ✓ The diagnosis should be considered in those presenting with characteristic symptoms.
- ✓ In such cases it is important to look for **postural hypotension** and **pigmentation** in areas not exposed to the sun – knuckles, elbows, knees, scars, oral mucosa.
- ✓ Physicians are often **falsely reassured by the normal potassium** concentration.
- ✓ Diagnostic tests reveal low cortisol levels and very high levels of the hormone ACTH.
- ✓ It is the responsibility of the doctor ordering the test to check the result and ensure appropriate follow-up.

# Clinical Risk Snapshots – Emergency Medicine Lens



- Recent review of incidents on NIMS, the National Incident Management System, relating to the service of **emergency medicine** (Q2 2022).
- Most incidents (88%) were reported as **negligible or minor in severity**
- The majority of incidents related to clinical care, including those related to emergency department capacity, **such as overcrowding, prolonged waiting times and inadequate staffing levels.**
- Clinical care incidents also arose where there was a **lack of clear referral pathways**, processes or communication between teams/services.
- A significant number of **slips, trips and falls incidents** were reported.

# Clinical Risk Snapshots – Emergency Medicine Lens

## Key take home messages

- ✓ The care of service users with complex profiles and/or identified as being high risk at triage should be prioritised and escalated where appropriate.
- ✓ The **Emergency Medicine Early Warning Score (EM EWS)** should be used from triage to discharge, to support the recognition of, and response to, deteriorating patients.
- ✓ Attention should be paid to effective communication between health and social care personnel, particularly in relation to clinical information and handover of care.
- ✓ **Falls risk assessments** should be undertaken as part of the nursing assessment, to identify service users who are at increased risk of falls and to implement preventative measures.

# Save the Date – Learning Event



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## State Claims Agency Learning Event: Training for Competence in Healthcare'

Dublin Castle | 29th May 2024

### Speakers

- **Professor Dara Byrne**, Health Service Executive National Clinical Lead for the National Simulation Office (NSO)
- **Professor Anthony G Gallagher**, Director of Research & Skill development, ORSI Academy, Melle, Belgium
- **Professor Oscar Traynor**, Professor of Postgrad Surgical Training & Surgical Affairs, RCSI
- **Lisa Fallon**, high-performance Strategy Specialist and UEFA Pro License Manager/Coach



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# Lifecycle of A Clinical Claim: Legal and clinical aspects of hospital care

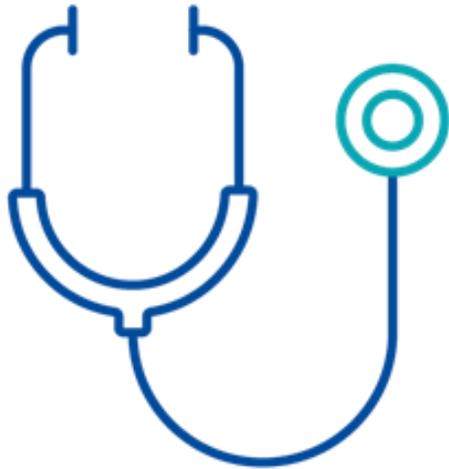
Presenter:

Marie Hutton, Solicitor/Clinical Risk Legal  
Advisor

Clinical Risk Matters Series: Clinical Risk  
Updates and Spotlight on Diagnostic Errors

12 March 2024

# What is a Clinical Claim?



- A civil action against a hospital and/or clinical person
- Usually taken by the patient but can also be by family members or relatives
- Taken because alleged personal injury incurred during course of care and treatment

# The Lifecycle of a Claim



# How will you know if there is a claim?



Do not be  
alarmed



Notified by  
hospital claims  
coordinator or  
clinical risk  
manager

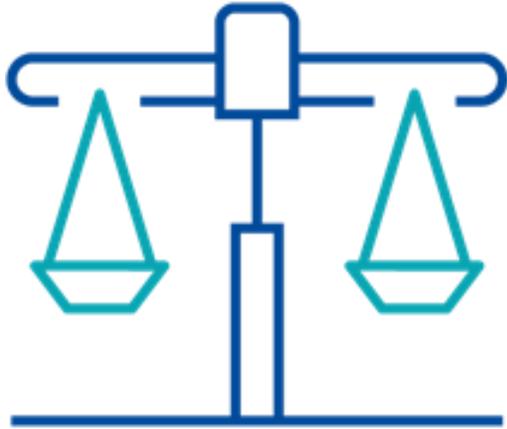


Notified by the  
State Claims  
Agency Clinical  
Claims Unit



Personally  
served with  
solicitor's  
letter of  
claim (rare)

# Institution of Proceedings



- Statute of Limitations
- Section 8 Letter of Claim based on critical expert evidence
- Personal Injuries Summons
- Proceedings served within 12 months of date of issue

# Claim Notifications Procedure



Forward the notification to us via [stateclaims@ntma.ie](mailto:stateclaims@ntma.ie):

Quote the NIMS reference number, if applicable



We will respond to the notification:

Hospital may acknowledge the notification indicating that the claim is being managed by the State Claims Agency and that all further correspondence should be forwarded to us



Claims Managers have remits/relationship with hospital risk manager/legal co-ordinator who will link with the Hospital/ State Authority to investigate the claim to assess liability



All information relating to the claim should be sent to SCA as soon as it is available e.g. Incident report forms, witness statements

# The Lifecycle of a Claim



# Importance of Statements



- Provide firsthand information of the incident
- Clarify your involvement in the case
- Assist in interpreting the clinical records
- Used to brief relevant clinical expert(s)
- Shared with defence legal team
- Assist in assessing liability
- Based on factual information of the statements / expert evidence, the hospital swears a Verifying Affidavit (validate the facts) in respect of the Defence

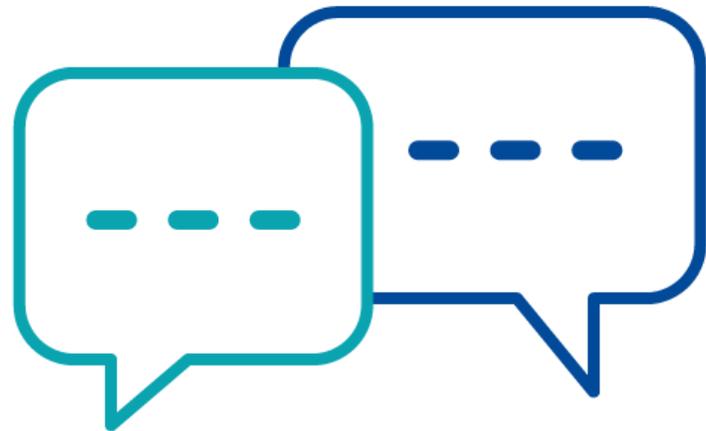
# Statement Format

- ✓ Privileged
- ✓ Name / Address
- ✓ Qualifications and when obtained
- ✓ Employment status at the time
- ✓ Previous relevant experience
- ✓ Chronological account of involvement in the patient's treatment
- ✓ Any other comments
- ✓ Signature and date

# Discovery

- Case progressing - we seek Discovery
- Both sides obliged to disclose all relevant records –including up to date records
- Furnished to experts for a fully informed report
- Useful litigation tool
- Everything must be discovered! Records, notes, diagrams, incident report forms, notes from case meetings etc.





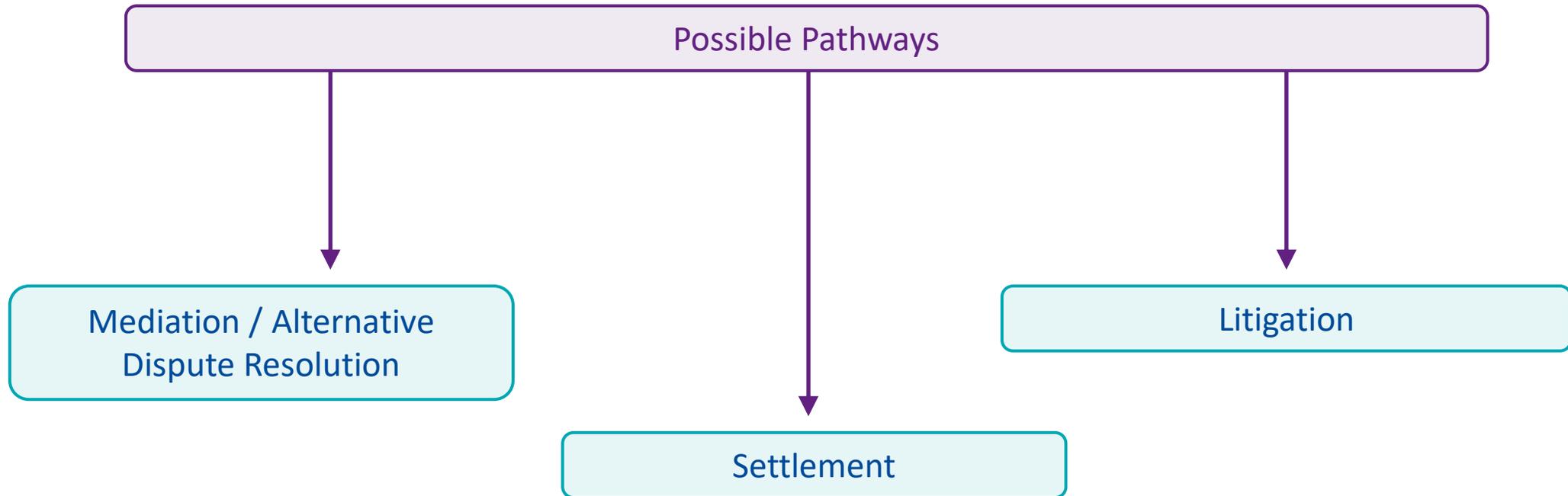
## What happens next?

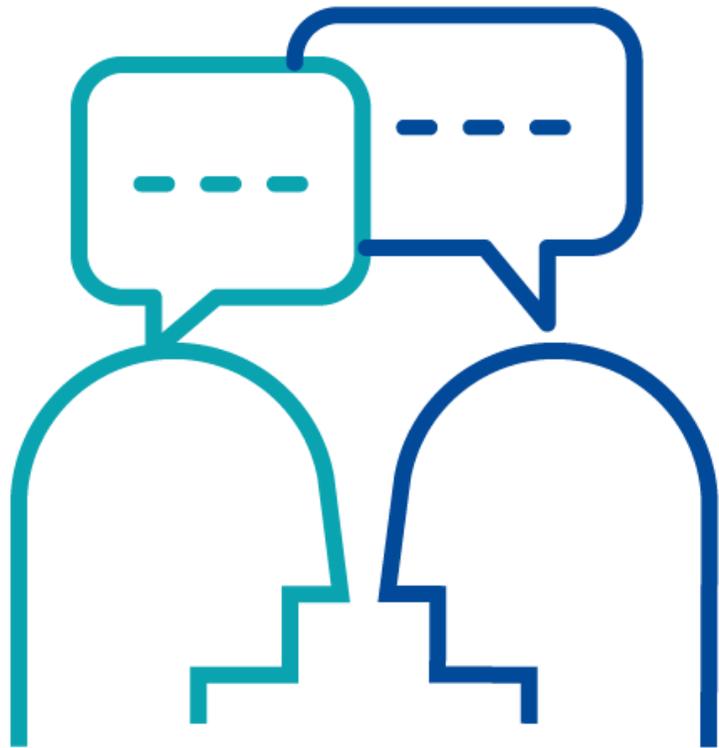
- Additional reports
- Consultation with legal team
- Pre-trial consultation with full defence team – if case is proceeding to hearing
- Opportunity to give your views, voice your concerns and have your questions answered
- Counsel will play “devil’s advocate” – can you withstand a robust cross-examination
- You can change your mind

# The Lifecycle of a Claim



# Claims Resolution Approach





## Our Claims Resolution Objective

While **acting fairly and ethically in dealing with people** who have suffered injuries and/or damage, and their families, manage claims taken against the State so that the liability of the State is contained at the lowest achievable level.

# The Lifecycle of a Claim



**1**

**Claim  
Notification**



**2**

**Claim  
Investigation**



**3**

**Claim Liability  
Determination**



**4**

**Claim  
Resolution  
Approach**



**5**

**Claim  
Outcome**



**6**

**Claim  
Learning**

# Claim Outcome

Case Discontinued

Tender

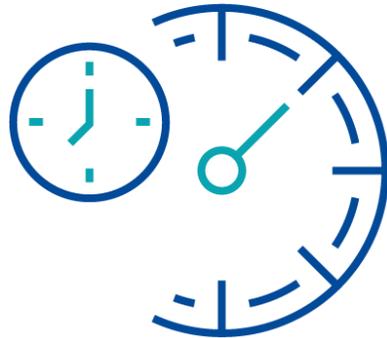
Settlement/Mediation

Trial – Judge Decides

# Resolving Cases

(A) Full and final settlement on a lump sum basis

(B) Interim Agreement settlements / Periodic Payment Orders



# The Lifecycle of a Claim



# Why can it be difficult to defend a claim ?

- ✔ Negligence
- ✔ Inability to gather evidence to successfully defend the claim
- ✔ Unable to locate witnesses to fact, i.e., doctors, nurses/midwives
- ✔ Insufficient/missing records (in part or full)
- ✔ Poor or absent records / Illegible handwriting or abbreviations

# Clinical Claims Unit

- Conducting thorough/timely investigations of claims to determine liability
- Apply a reserve to the claim
- Commissioning medical/other expert reports
- Utilise our claims resolution approach/make decisions relating to early claims resolution
- Appoint in-house solicitors/panel firm solicitors
- Continuously reviewing claims/monitoring contingent liabilities
- Offer/engage in alternative dispute resolution methods (Mediation)/settlement negotiations
- Prepare for Trial where relevant
- Liaise with DSA during the claim resolution process
- Notify DSA when claim resolved
- Collaborating with SCA clinical risk advisers to develop learning from closed claims
- Provide legal representation at inquests





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# Spotlight on Diagnostic Error

Presenters:

Dr Natasha Coen, Senior Clinical Risk Manager

Irene O'Byrne Maguire, Clinical Risk Adviser

Clinical Risk Matters Series 2: Clinical Risk Updates  
and Spotlight on Diagnostic Errors

12 March 2024



# Agenda

Overview of service user incidents reported under 'diagnosis' on NIMS (2022-2023)

Review of claims relating to diagnostic errors in Radiology Services (2016 – 2020)

- Analysis of claims (qualitative findings)

Review of claims relating to diagnostic errors in Dermatology Services (2012 – 2021)

- Analysis of claims (qualitative findings)

Advice to frontline staff for reducing diagnostic errors



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# 1. Overview of service user incidents reported under 'diagnosis' on NIMS (2022-2023)

# Definitions

‘An **error** can be defined as an act of omission or commission in planning or execution that contributes or could contribute to an unintended result.’

Grober ED, Bohnen JM (2005). Defining medical error. Can J Surg. 48(1):39-44

‘A **diagnostic error** can be defined as an error that emerges when a diagnosis is missed, inappropriately delayed, or is wrong (incorrect).’

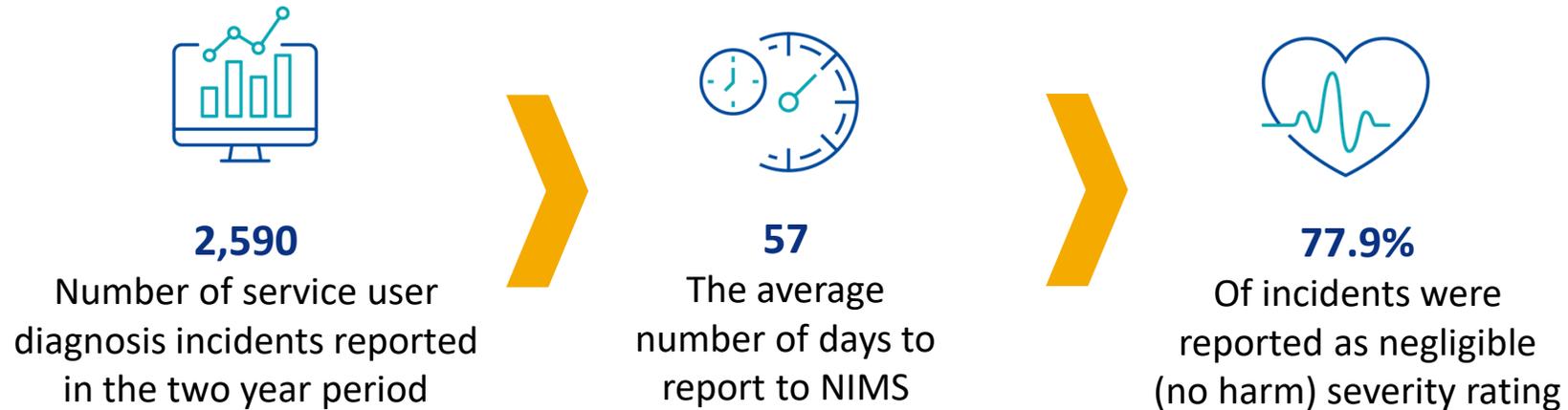
WHO, (2016). ‘Diagnostic error’. World Health Organisation.

# Reporting of 'Diagnosis' incidents on NIMS



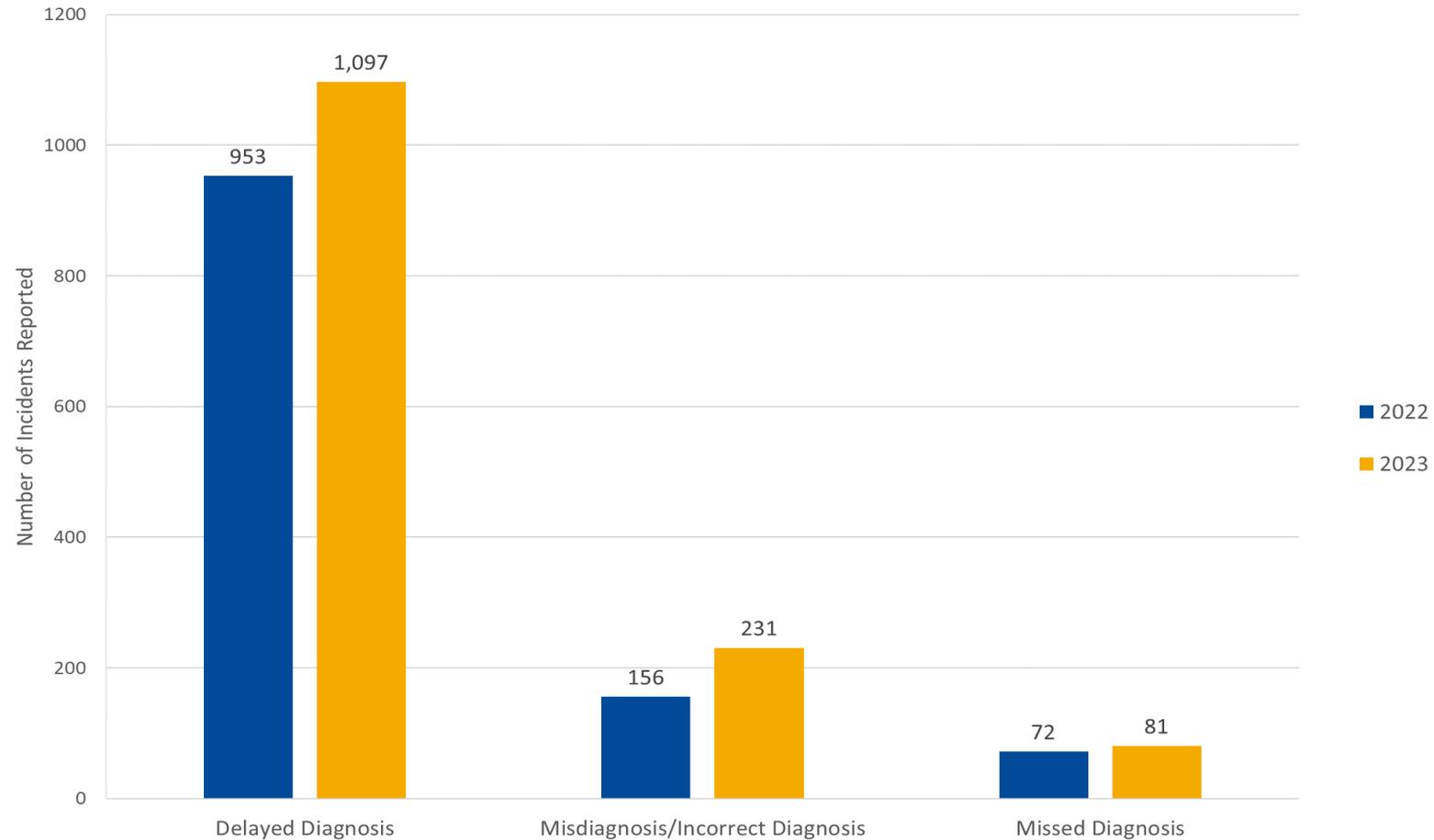
- Enhancements implemented on NIMS in December 2021 aimed to **improve data quality** and enhance standardisation of reporting
- Part of the enhancement included enabling improved capturing of '**diagnosis**' incidents
- Captures stage in diagnosis process and diagnosis type of incident
- The SCA review incident and claims data to **foster, promote and disseminate learning**, in line with our statutory risk management mandate.

# Overview of service user incidents reported on NIMS for sub-hazard category 'Diagnosis' by 'incident created date' for 2022 and 2023

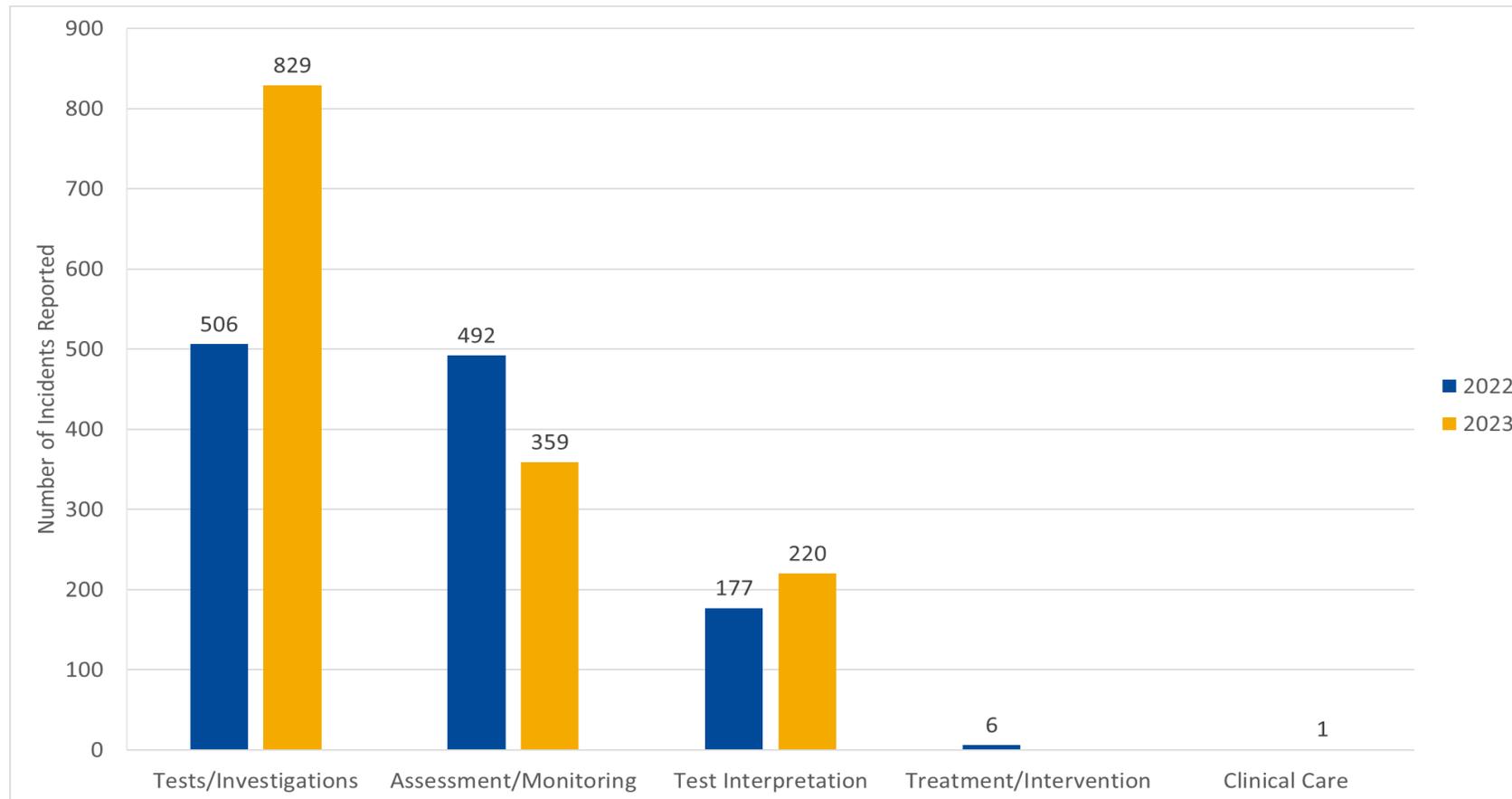


\*A small number of additional incidents may fall outside of the search criteria i.e., null values  
The year in which the incident was created (reported) on NIMS. This may not be the same as the year in which the incident occurred (happened).

# Service user 'diagnosis' incidents reported on NIMS by 'sub-hazard, please specify' category for 2022 and 2023



# Service user 'diagnosis' incidents reported on NIMS by stage in the process the incident occurred for 2022 and 2023



## Top 5 service user claims received in 2023 by sub-hazard type

Claims occurring in hospital locations and National Ambulance Service (NAS), including claims occurring in private hospitals covered under Safety Net during the COVID-19 pandemic

Sub hazard type	No. of claims received	Estimated Liability (€M)
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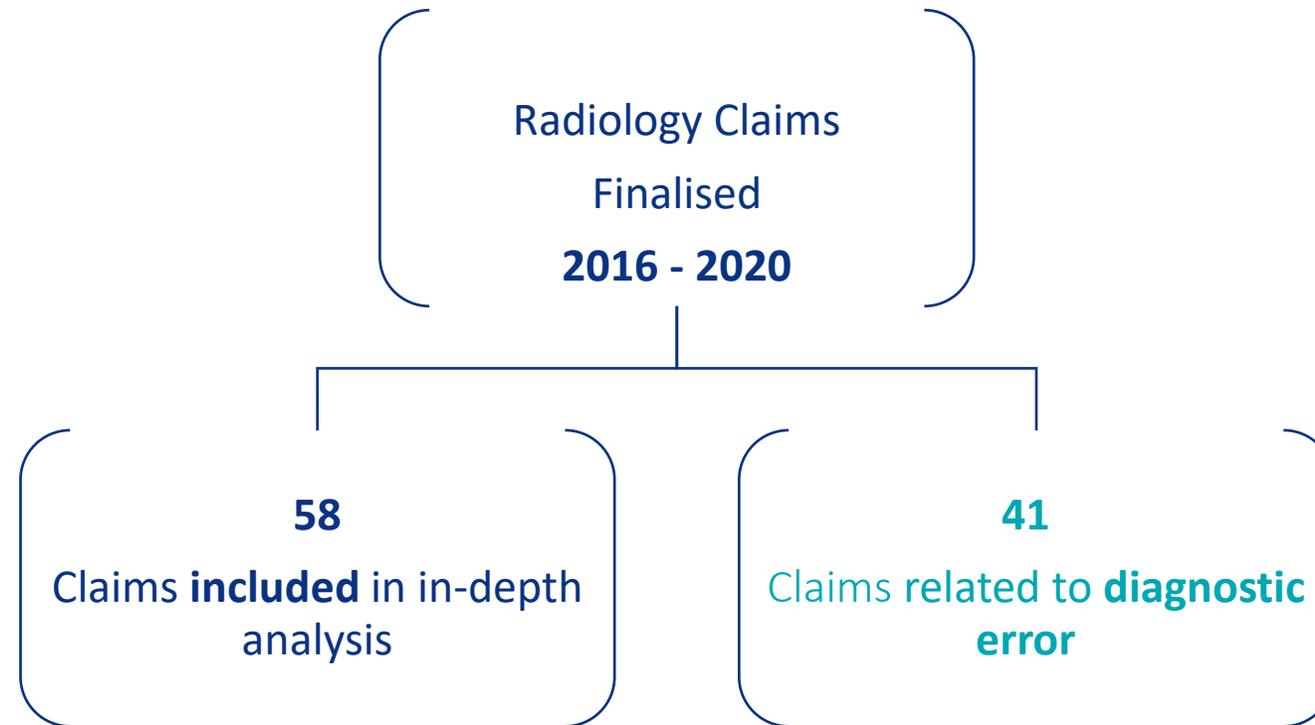


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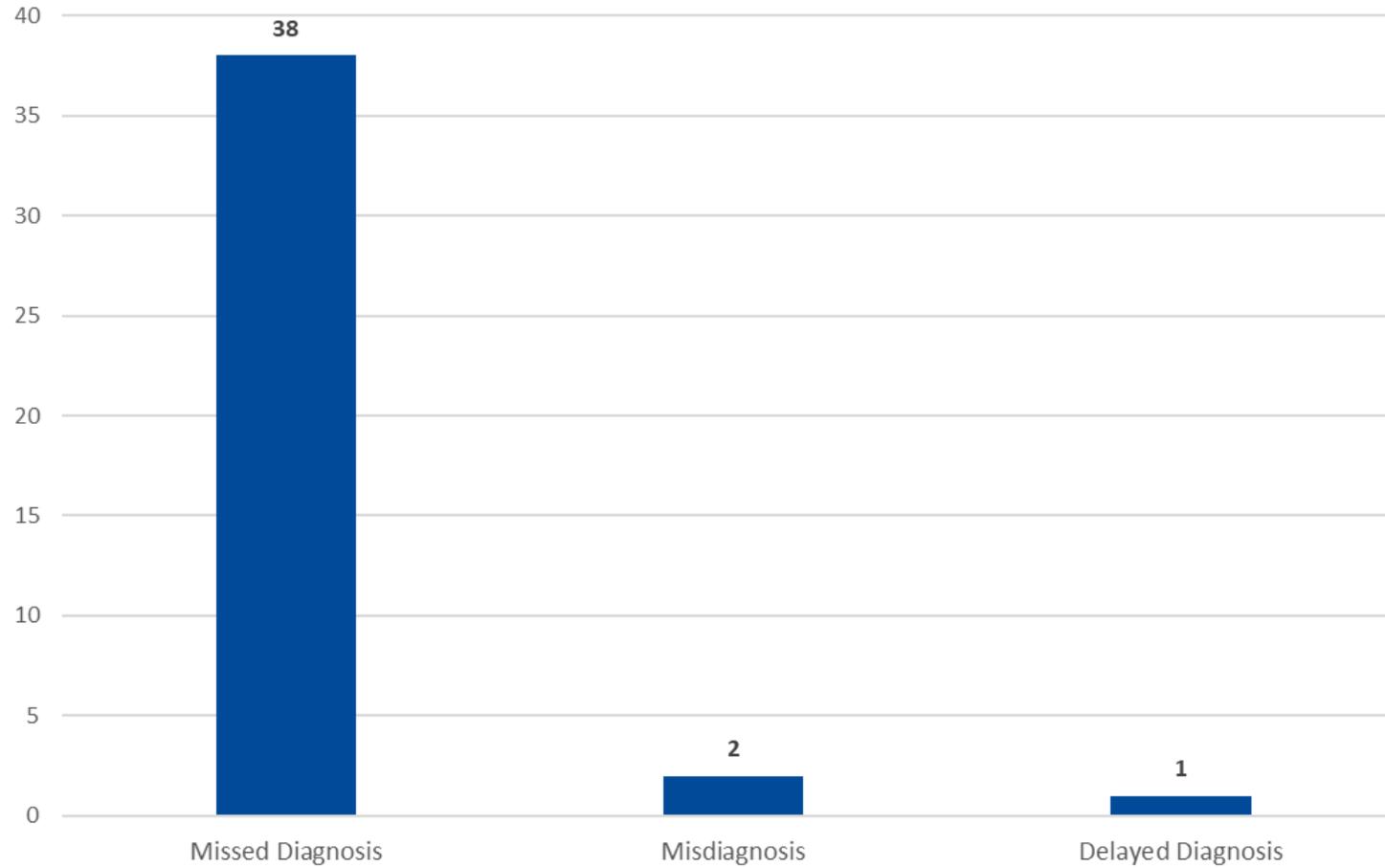
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## 2. Review of claims relating to diagnostic errors in Radiology Services (2016 – 2020)

# Claims Analysis - Methodology



# Qualitative analysis findings for type of diagnostic error (n=41)



# Findings of Radiology claims analysis (n=41)

**93%**  
related to missed  
diagnosis



**55%**  
missed diagnosis claims  
related to missed fractures



**24%**  
missed fractures related  
to scaphoid fractures



**21%**  
of missed diagnosis claims  
related to missed cancers



**50%**  
missed cancers related  
to lung cancer

The remaining diagnostic errors related to delayed diagnosis (5%) and misdiagnosis (2%)

# Factors identified resulting in diagnostic error

Abnormalities not recognised on imaging (most commonly fractures or cancers)

Misinterpretation or incorrect reporting of radiology imaging findings

Failure to recognise all fractures where multiple fractures were present

Failure to perform the requested radiological exam

Failure to consider a differential diagnosis

## Case Study – Missed diagnosis

A 55-year-old person with a history of persistent cough was referred to hospital by his GP for a chest X-ray (CXR). The CXR was reported to the GP as normal. Because the service user had persistent symptoms, the GP arranged for a second CXR six months later, which identified an abnormality in the right upper lobe. A CT thorax was arranged, which identified a right upper lobe mass. A subsequent biopsy confirmed the diagnosis of lung cancer. At that stage, a review confirmed that the lesion had been visible on the initial CXR.

*\*The details of this case are drawn from a number of different claims*

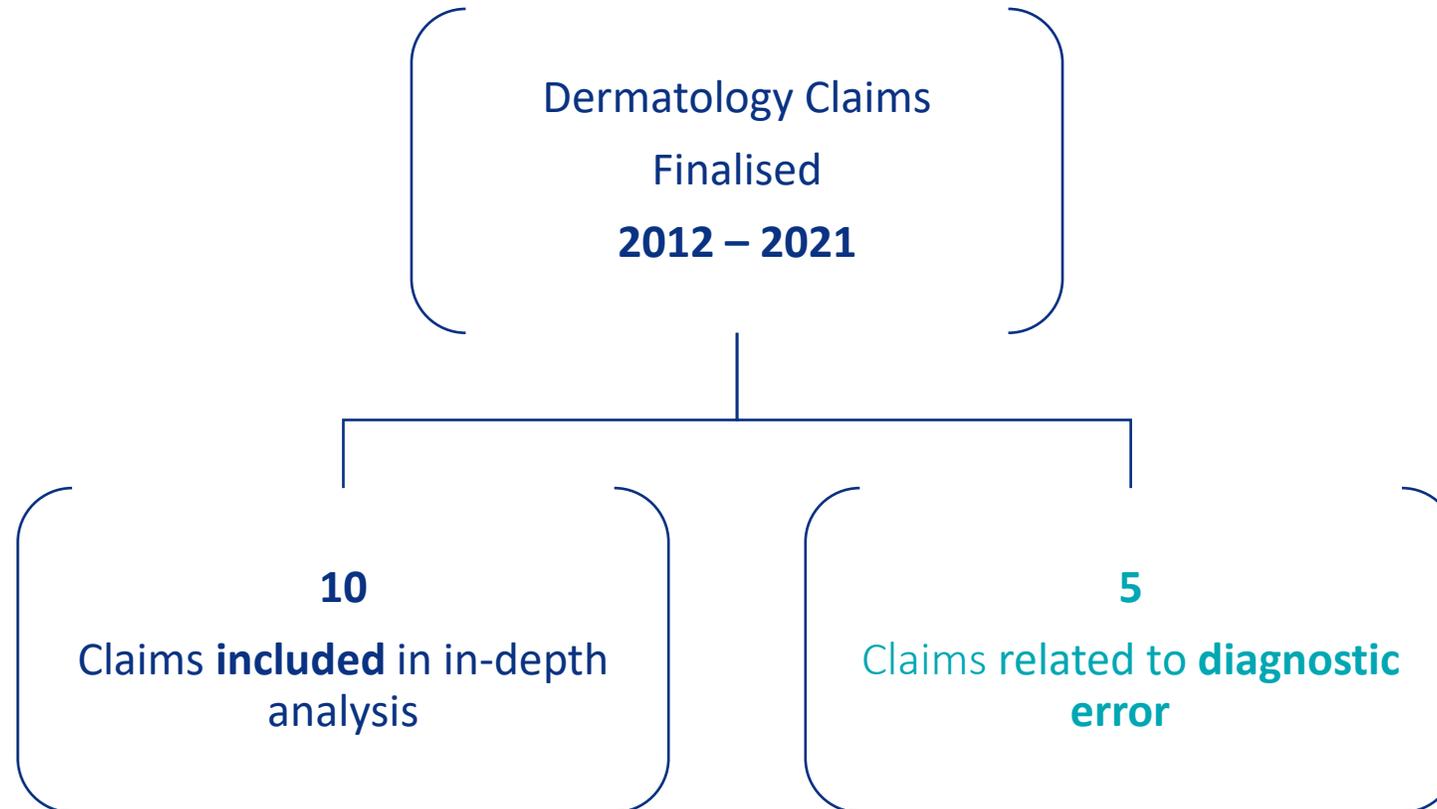


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# 3. Review of claims relating to diagnostic errors in Dermatology Services (2012 – 2021)

# Claims Analysis - Methodology



# Findings of Dermatology claims analysis – diagnostic error

**50%**  
Claims related to  
diagnostic error



**80%**  
Claims related to  
delayed diagnosis



**60%**  
related to delayed diagnosis  
of squamous cell carcinoma

The remaining diagnostic error relates to a misdiagnosis of cancer (20%)



# Factors identified resulting in diagnostic error

Deficits in the triage of service users considered high risk

Failure to recognise and respond to deteriorating patient

Failure to take account of family history of cancer, and to provide follow up care

Inadequate implementation of an integrated care pathway to include communications

Delayed referral for specialist diagnosis and treatment

## Case Study – Delayed diagnosis

A 59-year-old person with a family history of skin cancer was referred to a dermatologist by their GP for review of a rough nodule on the skin. Despite family history the service user's referral was triaged as routine. When the service user was seen seven months later the nodule had deepened and a subsequent biopsy confirmed a diagnosis of squamous cell carcinoma. The service user was referred for surgical intervention and required extensive surgical treatment.

*\*Details are based on an aggregate of a number of claims*



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## 4. Advice to frontline staff to reduce diagnostic errors

# Key advice to reduce diagnostic errors



Enhance and develop **care processes** that minimise the risk of delayed diagnosis, missed diagnosis and misdiagnosis including timely assessment, diagnostic testing and follow up of results .



Consider implementing mechanisms when **interpreting and reporting on tests** to reduce the occurrence of events that may give rise to diagnostic errors, for example mechanisms such as peer review/checks for accuracy.



Enable **continuity of service user care** by ensuring the implementation of timely risk assessment and management practices such as triage to prioritise 'at risk' service users.



**Audit of quality assurance procedures** to ensure alignment with service user goals and organisational objectives, as well as regulatory requirements.



Continue to **report clinical incidents** in a timely manner in accordance with your statutory requirement to report incidents to NIMS, and in line with the HSE's Incident Management Framework, so that learning, and ongoing service improvements can occur.