The State Claims Agency
# Newsletter
Gníomhaireacht Éileamh an Stáit

State Claims Agency Newsletter, May 2014

## Clinical Negligence Litigation: complex cases and simple principles

The State Claims Agency's (SCA) approach to managing complex clinical negligence claims is guided by a simple principle - where it is just and proper, people who have suffered a personal injury as a result of clinical negligence event must be compensated appropriately and as quickly as the circumstances of their cases allow.

Clinical negligence litigation is complex. The State Claims Agency deals with plaintiffs and their families who, in many cases, have suffered enormous trauma and pain and it is conscious that it has a duty to act fairly, ethically and with compassion in all its dealings.

The Agency must ensure that no one is under-compensated but, in accordance with its statutory role, it must also ensure that no one is over-compensated.

Many people express concern that, in some cases, parents of children who have been catastrophically injured as a result of clinical negligence have had to undergo the additional trauma of giving evidence in court and being cross-examined on their evidence. So why does it happen?

Sometimes it happens because the case is so complex that liability or causation have been difficult to determine or are in dispute. But it mostly happens in cases where the settlement demands made by plaintiffs' lawyers are significantly overstated.

The Agency has direct experience of cases where solicitors acting on behalf of plaintiffs have originally demanded a multiple of 2 or even 3 times the figure that they were eventually prepared to settle for.

One striking example is a case where a plaintiff's lawyers initially sought €13 million in compensation. They refused to settle for a lesser figure before the case went to court but then settled the case for €5 million, following a number of days of court hearing. Had the Agency settled at the figure originally proposed, it simply would not have been doing its job on behalf of the taxpayer.

Some media have recently reported criticism of the SCA's management of clinical negligence cases and, in particular, cases involving brain damage to infants, occurring at or around the time of their birth. This criticism referenced comments made by a High Court Judge to the effect that unreasonable delays in admitting liability had occurred in a small number of infant brain-injury cases handled by the SCA on behalf of the HSE.

Reports of the judge's comments failed to mention that, in one case, the judge, having subsequently heard a full account of the SCA's conduct of the case, withdrew the criticism. In a second case, the same judge accepted that there was no deliberate policy by the SCA to withhold admissions of liability.

Coverage of this nature can wrongly create an impression that the SCA, in its management of clinical negligence claims, operates a "defend and deny" strategy at all costs, effectively forcing families of brain-damaged children into court to prove their cases. Nothing could be further from the truth.

It is a simple truth that the SCA does not employ a "defend and deny" strategy. However, it is a fact that the SCA, as part of its remit, has certain obligations that it must fulfil.

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Among these is an obligation to doctors, nurses, midwives and other allied healthcare practitioners in public hospitals to defend their professional reputations and vindicate the exercise of those practitioners' duty of care to patients.

Given that many clinical negligence cases involve multi-million euro settlements, the SCA also has an obligation to the taxpayer to verify the scientific and expert medical evidence put forward by the plaintiff in proof of his/her case. An additional obligation is to verify the actuarial and other figures constituting the measurement of special damages in any individual case. Catastrophic injury cases arising in a clinical setting invariably involve complex issues of liability and causation. Multiple independent experts are engaged by both sides to explore the issues of liability, causation, condition and prognosis and the calculation of special damages. This inevitably takes time and is understandably frustrating for plaintiffs and their families.

The Agency is acutely conscious of the ordeal that individuals and their families have suffered and it takes every step it can to ensure that litigation is handled sensitively and that, wherever possible, such litigation does not add to the considerable distress already suffered by the affected individuals and their families.

But the SCA cannot ignore the fact that it has a statutory mandate that it must carry out. If it does not investigate claims and manage litigation conscientiously and professionally, that would constitute a failure on its part to do what it has been tasked to do by the Oireachtas.

There are occasions where, faced with a plaintiff's lawyer presenting a case with settlement demands that are excessively high, the only way the SCA can discharge its duty to the taxpayer is to reluctantly proceed with allowing the case to go to a formal court hearing. This can result in the SCA facing criticism for the way it manages these cases but it is criticism that the Agency believes is unwarranted.

However, the Agency recognises that the current system requires reform and that is why it has taken a number of important steps, in an effort to shorten the time required to settle cases and make the process easier for the families involved.

The SCA absolutely recognises the need to mitigate the more adversarial aspects of the Tort system as it applies to clinical negligence cases. These cases, by their very nature, frequently involve considerable trauma to the injured party and his/her family, trauma which is worsened by the uncomfortable journey afforded by the Tort system before he/she receives compensation. Mediation affords the parties in clinical negligence cases a calmer, less adversarial environment within which to resolve such cases.

Despite this, the number of mediations in clinical negligence cases remains stubbornly low. The SCA settled 19 cases by way of mediation in 2013 and offered mediation in many other cases. But some plaintiffs' lawyers - and, it must be stressed, a minority of them - remain implacably opposed to mediation in these cases and have been vocal in denouncing it. It is difficult to understand why. The Agency genuinely feels that mediation would be in the best interests of their clients, yet these lawyers disagree.

In addition, the SCA has been to the forefront of attempted reforms in clinical negligence litigation. It was represented on the Medical Negligence Working Group which recommended the introduction of Pre-Action Protocols. There is little doubt that if the Protocols were introduced, they would lead to much needed improvement and reform of clinical negligence litigation by reducing the current unacceptable delays.

The SCA, on its own initiative, has also pioneered the introduction of Periodic Payment Orders to compensate catastrophically-injured victims in order to alleviate their families' worries relating to the guaranteed payment of their future care and other requirements throughout their lifetime.

The SCA, in conjunction with the HSE, piloted a significant Open Disclosure Project which has been rolled out to approximately 46 hospitals, at various levels of engagement, countrywide. This is a significant patient-focussed project which seeks to establish an open and consistent approach to communications when things go wrong in healthcare. It includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.

The SCA welcomes scrutiny of the way it conducts clinical negligence litigation. Such scrutiny is an essential aspect of reassuring both taxpayers and people who make clinical negligence claims that the SCA does its job properly, ethically and fairly. But it is important that this scrutiny is informed by facts. Criticising the SCA for properly carrying out its statutory mandate to manage clinical negligence cases and defend the reputations of hospitals and their practitioners does not represent a fully balanced view. The truth of what is occurring in clinical negligence litigation is much more complex than the distilled version put forward by some commentators. Despite the complexity involved and the limitations of the Tort system, the Agency does all in its power to keep things less adversarial and as simple as possible for the families involved. It considers that it has a duty to do so.

*Ciarán Breen - Director of the State Claims Agency (SCA)*

# Upgrade to National Adverse Event Management System progress update

## RE-CAP

The State Claims Agency (SCA), in conjunction with the Department of Health, HSE, voluntary health enterprises and other key stakeholders, is upgrading the National Adverse Events Management System (NAEMS, previously known as STARS-Web). In the previous issue of the newsletter, the background and project deliverables for the upgrade to the NAEMS were fully discussed. For the full article see the September 2013 edition of the SCA newsletter (http://stateclaims.ie/2013/09/state-claims-agency-newsletter/).

## CURRENT STATUS

The system has completed user assessment testing (UAT) and approximately 100 people have viewed and tested the system. The feedback was extremely positive and it was universally acknowledged that in respect of speed, ease of data entry, risk management functionality and data analytics tools significant improvements had been made to the system.

From the UAT we are confident that as an end to end adverse event risk management system NAEMS shall deliver a solution that surpasses anything else available in the country.

The project is on target to go live for 61 state bodies in June of this year. This is in respect of reporting adverse events on the system, allowing for report generation and the addition of risk management functionality.

## ROLL OUT TO WEB BASED USERS

The roll out to those in healthcare and the Prison Service, who use the web based system, will commence from June. The first Early Adopters will be the Mater Misericordiae University Hospital Ltd, the Rotunda Hospital and Mountjoy Prison. This phase will also include HSE locations which will be selected by the HSE. The aim is to include acute and community sectors. The training plan and supporting documentation required for the roll out phase is currently being developed by the SCA and key stakeholders.


## NATIONAL REPORT FORM

As part of this project the SCA recognises there may be a need to also update current event report forms in use across the enterprises who will be reporting on NAEMS. As part of the project, a national form for both personal injury, motor and property damage events will be developed and rolled out with the implementation of the system.

## NAEMS GOVERNANCE GROUP

Following various discussions between stakeholders, it was agreed to establish an overall body called the NAEMS Governance Group when the upgrade is launched. The purpose of this Group is:

- To develop a framework to support implementation, maintenance, upgrade, use and review of the NAEMS
- To oversee governance of data on the system to include data protection, freedom of information, ownership of and access to data
- To oversee the development of Key Performance Indicators for the management of adverse events and to support effective risk management
- To oversee development and roll-out of training to support effective risk management
- To develop a communication strategy to ensure stakeholder understanding and engagement.

The Group will be chaired by Dr. Tony Holohan, Chief Medical Officer, Department of Health (DoH) and membership of this Group will include:

- Mary Jackson, Principal Officer, Workforce Planning, Agency Governance and Clinical Indemnity Unit, DoH
- John Kenny, Programme Manager, Quality and Patient Safety Division, HSE
- Jennifer Martin, Consultant in Public Health Medicine, HSE
- Gordon Dunne, Chief Executive Officer, Cappagh National Orthopaedic Hospital
- Lorcan Birthistle, CEO, Our Lady's Children's Hospital
- Pat Kirwan, Deputy Director, Head of Risk and Operations and Ailis Quinlan, Head of Clinical Risk, SCA.

The SCA looks forward to rolling out the upgrade in the future. The Agency would like to acknowledge the hard work and support of various stakeholders involved in the process both within the SCA and outside.

*Pat Kirwan, Deputy Director, Head of Risk and Operations, SCA*

# A Clinical Audit on Improving Patient Safety in Catheter Care

The objective of the dissertation was to illustrate how a change to practice reduced the catheter infection rate in an Orthopaedic Hospital through the implementation of new intermittent catheters in place of the existing indwelling catheters.

A clinical audit was conducted on the use of indwelling catheters in patients after Orthopaedic surgery. More than 80% of hospital Catheter Associated Infections are associated with an indwelling catheter.

The audit was the joint effort of both nursing staff and the Laboratory. It was observed by the Laboratory Staff that there was an increasing trend of positive catheter culture. Not all healthcare associated infections (HCAI) are avoidable. However, a significant proportion can be prevented.

The dissertation discusses the previous practice which was examined through clinical audit which identified the insertion of an indwelling urinary catheter which remained in situ until the morning of day 2 post surgery.

- No documentation was available in the nursing chart as to: the date and time catheter was inserted; who inserted the catheter, and when review of the catheter should take place.
- No information pamphlet was available to educate patients on the catheterisation procedure and why it was considered necessary for medical treatment.

### *Audit 1*

The dissertation outlines the results of the first audit focused on 40 patients who had been catheterised (48 hours) and who were examined over a 2 month period which found that 65% developed a Urinary Tract Infection (UTI) and of these 52.5% required antibiotics.

After these findings, it was initially decided to reduce the in situ time on the basis that the removal of the catheter could be performed in tandem with the removal of drains/IV lines, usually 24 hours post operation.

The nursing staff re-audited over a 2 month period another 38 patients and liaised with the laboratory to identify whether there was a reduction in the number of positive Catheter Specimen Urine (CSU) being reported.

### *Audit 2*

The dissertation outlines the results of the second audit which looked at the number of positive CSU reports where recorded which found that 52% of these patients had developed a UTI with 45% of this number requiring a post operative antibiotic. The above audited patients had the indwelling catheter in situ for 24 hours. Thus reducing the time of the indwelling catheter made no real impact and did not prove to be advantageous.

The nursing change to practice was based on the above audit. However, further research suggested intermittent catheterisation; this was therefore researched, reviewed and pursued to place into practice.

### CHANGE TO PRACTICE:

The dissertation discusses the objectives of the change of practice which were to illustrate that the use of intermittent catheters would reduce:

a) UTI
b) Antibiotic Use
c) Risk of Antibiotic Resistance
d) Morbidity
e) Hospital Stay
f) Cost
g) Workload

### NEED FOR A CHANGE?

The dissertation discusses the findings of audits 1 and 2 which indicated that there was an increased risk of HCAI when an indwelling catheter was used.

The dissertation outlines the advantages of the intermittent catheter:

a) Which is lubricated with glycerine (antiseptic) - can act as an extra infection barrier for pathogens
b) Reduces patient morbidity as HCAIs are associated with urinary catheterisation
c) Increases post operative mobility - potentially contributing to earlier discharge
d) Decreases antibiotic use - and via association decreases antibiotic resistant organisms
e) Increases cost effectiveness
f) Reduces cost of care - when a patient develops an infection and the inherent cost implications.

### MAKING THE CHANGE

The dissertation outlines the changes that were made to the previous practice, including updating the urinary catheterisation procedure and the re-writing of the Standard Operating Procedure to include the use of the intermittent catheter, recommending nurses with expertise in urinary catheterisation must share their knowledge and that existing

*A Clinical Audit on Improving Patient Safety in Catheter Care* ***cont.***

senior staff members should have their skills assessed on a regular basis.

### INITIAL AUDIT OF CHANGE TO PRACTICE

The dissertation looks at the audit results following the change of practice which found that out of 30 patients, 90% were successful and did not develop further retention, 6.66% required a second catheterisation and the staff were unable to catheterise 1 patient (3.33%) with an intermittent catheter due to altered anatomy.

None of the 27 patients developed a UTI thus reducing the risk of HCAI's.

Each patient is given an information pamphlet in relation to the procedure, a review sticker is also put in the nursing notes for review every 24/48 hours.

Each month Maintenance Care Bundle for Urinary Catheters and a urinary catheter care compliance graph is compiled and distributed to each ward. The results demonstrate that the implementation of this new procedure has had a very positive effect on infection and prevention control in the hospital.

### CONCLUSION

The dissertation concludes that the changes to practice have been advantageous to both patients and staff. It notes that improvements in the quality system in the hospital are a fundamental goal of the HSE. The dissertation notes that change of practice discussed is an example of a change of an existing practice which has resulted in an enhancement to patient safety and care which should be the health sectors continued goal.

*Ruth O'Donoghue, Biomedical Scientist*

**Presentation of the State Claims Agency Bursary for Best Professional Project - Graduate Diploma in HealthCare (Risk Management and Quality), UCD 2012-2013**

*Pictured are: Ruth O'Donoghue, Biomedical scientist and Dr. Ailis Quinlan, Head of Clinical Indemnity Scheme (CIS) State Claims Agency*

## Open Disclosure: Bridging the gap between policy and implementation

### BACKGROUND

On 12th November 2013, Dr James Reilly, Minister for Health, launched the national policy and guidelines on Open Disclosure. These documents were developed by the HSE and State Claims Agency following a two year pilot programme at two large acute hospitals, the Mater Misericordiae University Hospital, Dublin and Cork University Hospital. They also incorporate international learning and best practice guidelines. Open disclosure is a requirement of the national standards for safer better healthcare 2012 and is also a provision of the National Healthcare Charter 2012. The Open Disclosure policy and guidelines are currently being implemented on a phased basis across all health and social care services in the Republic of Ireland.

### CULTURE

The learning from the pilot programme demonstrated that health care professionals are positive about open disclosure. However, in reality open disclosure does not always happen. Evidence, globally, has demonstrated that staff experience difficulties with open disclosure because of (i) a fear of litigation, (ii) fear of reputational damage and impact on professional advancement (iii) lack of training and guidance in relation to managing the open disclosure process and (iv) the influence of the culture in the organisation. Approaches to open disclosure can vary from organisation to organisation. It is important that health and social care services foster a positive, supportive work environment where good communication, support and mutual respect is the norm. A just culture supports a disclosure culture. Where a true just culture

*Open Disclosure: Bridging the gap between policy and implementation* ***cont.***

exists no one is ever hesitant to speak up on behalf of a patient and everyone has a high degree of confidence that their concerns will be heard respectfully and acted upon.

Health and social care services have a responsibility to ensure that there are effective systems, processes and resources in place to identify, manage and reduce risks to members of the public and staff. This requires a culture that encourages the notification of adverse events when they occur and which also promotes open, honest and timely communication between staff and patients following an adverse event.

## THE PATIENTS PERSPECTIVE

Patients have specific information needs when they have been involved in an adverse event. They expect

(i) an acknowledgement that an adverse event has occurred

(ii) an explanation as to why it happened

(iii) an apology

(iv) reassurance regarding their ongoing care

(v) involvement in their ongoing care plan

(vi) information and reassurance in relation to the steps being taken or planned by the healthcare provider to try to prevent a recurrence of the event

(vi) to be involved in and kept informed in relation to any reviews being undertaken by the healthcare provider and to be provided with a copy of the review report.

Patients prefer this communication via open dialogue.

> ***"Financial compensation was never on our agenda. Money would never have compensated us for losing our wonderful and precious son. Instead we simply wanted answers, information, explanations, solid reassurances that what went wrong would never happen again. We wanted a proper and meaningful apology".*** (Mrs Loretta Evans speaking at a patient safety conference in 2011)

## IMPLEMENTING A POLICY ON OPEN DISCLOSURE

Having an Open Disclosure policy in place may not ensure that open disclosure always happens. Implementing this policy requires a cultural shift and a change management approach with the need for health and social care services to develop an organisational structure with the capabilities to support and manage this process and to identify and address any factors which may impede implementation. The successful implementation of the principles of open disclosure will depend on the following factors:

- Leadership and visibility of the senior management team in the organisation including senior managers at hospital group/PCCC/division level
- Training programmes to support and facilitate organisational and individual learning
- The alignment of internal open disclosure policies with the national policy
- Embedding an open disclosure policy organisation wide
- Having adequate support systems in place for staff and patients/families affected by adverse events
- Approaching open disclosure as an ethical practice that prioritises organisational and individual learning from adverse events and not as an organisational risk management strategy solely
- Recognition that the principal drivers for open disclosure are the needs, expectations and rights of patients
- Having good systems of clinical governance in place.

## CONCLUSION

Bridging the gap between the development of an Open Disclosure policy and it's successful implementation is dependant on a supported and resourced implementation programme. We are currently delivering an implementation programme to 45 acute hospitals and 5 PCCC areas. For further information on this programme and the resources available please contact *angela.tysall@hse.ie* and/or *aduffy@ntma.ie*.

*Angela Tysall (RGN, RM) HSE National Advocacy Unit and National Lead for Open Disclosure*

*Ann Duffy (MSc, Clinical Risk Adviser) CIS/SCA and National Lead for Open Disclosure*

***From left to right:*** *Mr Greg Price, Director of HSE National Advocacy Unit; Ms Angela Tysall, HSE National Advocacy Unit and National Lead for Open Disclosure; Dr James Reilly TD, Minister for Health; Ms Ann Duffy, Clinical Risk Adviser, State Claims Agency & National Lead for Open Disclosure; Dr Ailis Quinlan, Head of Clinical Indemnity Scheme (CIS), State Claims Agency; Mr Ciarán Breen, Director of State Claims Agency.*

# Case Report - Eye Surgery Complications

The State Claims Agency recently defended a case concerning an elderly Plaintiff who underwent surgery at a Dublin hospital to correct a cataract affecting her left eye which had deprived her of almost all functional vision. Unfortunately, the Plaintiff's surgery was not a success. An uncontrolled pseudomonas infection developed which necessitated the surgical evisceration of her left eye approximately one week after the operation. The Plaintiff contended that she was not warned of the risks of surgery and, in particular, was not advised that a general anaesthetic would be used. She alleged that she would never have gone ahead with the procedure had informed consent been obtained from her.

When the case came on for trial, the Court found that the Plaintiff was confused and no weight could be attached to her evidence. Her adult son, who was also her carer, had attended the hospital appointments with his mother and gave evidence that no risks at all were explained to his mother at the pre-operative appointments or on the day of the surgery itself. He claimed that he and his mother were given to understand that the procedure would be performed under local anaesthetic and that there was no discussion of the possibility of general anaesthetic. He maintained that had there been such a discussion that he would have strongly advised his mother against the surgery and that she would not have elected to proceed as a result.

The Plaintiff's son's evidence was in contrast to that of the doctors who saw the Plaintiff prior to, and on the day of, her surgery. The doctor who saw the Plaintiff approximately two months prior to her surgery had made a note referring to the risks of surgery and the need for general anaesthetic. The doctor who was tasked with obtaining the Plaintiff's consent on the day of the surgery gave evidence that she had initially incorrectly written "LA" (local anaesthetic) in her notes but she had corrected this error in the presence of the Plaintiff and her son. She gave evidence that she made the Plaintiff aware that her surgery would be general anaesthetic before the Plaintiff signed the consent form. She also gave evidence that she warned the Plaintiff of all relevant risks and complications, including possible loss of the eyeball.

The Court therefore had to decide which version of events was correct, the version offered by the Plaintiff's son or the account given by the doctors involved.

In relation to the pre-operative appointment, the Court examined the doctor's note and was satisfied that the Plaintiff was warned of the various risks involved. The Court noted

that while there was no direct allegation that the note had been falsified or altered in any way, the doctor in question had left the country prior to the Plaintiff's procedure, which made it likely that the note was genuinely contemporaneous.

In relation to the taking of consent on the day of the surgery, the Court noted that the doctor in question had given evidence that the reason she had incorrectly written "LA" in the notes was because most of her patients underwent procedures by local anaesthetic and it was her practice to complete part of her notes in advance. This approach was deemed less than satisfactory by the Court but the Court was satisfied that the doctor took appropriate steps to amend the error and made the Plaintiff aware that her surgery would be under general anaesthetic before she signed the consent form.

The Court found that the appropriate disclosure of information had been made to the Plaintiff in this case. For the sake of completeness, the Court found that even if the Plaintiff had not been warned of the risks inherent to the procedure she would have gone ahead with the surgery in any event. Accordingly, the Plaintiff's case was dismissed.

The judgment in this case is consistent with the case law on the issue of consent. The case illustrates, once again, the importance of good contemporaneous notes. The best way a clinician can protect himself/herself against an incorrect allegation of failure to obtain consent is by taking accurate, detailed notes during the consent process. The judgement also serves as a reminder that the consent process is not limited to the consent form signed on the day of surgery but includes all pre-operative advice given to a patient, which can include advice given some months previously. This case is under appeal.

*Eamonn Carroll, Solicitor/Clinical Claims Manager, CIS/SCA*

# AFFINITY National Falls Prevention and Bone Health Implementation Project

Falls are the dominant cause of injuries among older persons, accounting for approximately one-third of fatal injuries in persons aged 60 and over. Falls can often lead to long-term physical disability (e.g. loss of mobility), severe dependency and reduction in quality of life. The causes of falls in older persons are multi-factorial, many of which are modifiable and preventable. Slips/trips/falls contributes annually to over one third of National Adverse Event Management System (formerly STARSWeb) reported incidents from the publicly-funded health and social care system which could have or did lead to unintended and unnecessary harm. In addition, and given our ageing demographics, some €520 million is the estimated annual spend in dealing directly with the sequelae of falls and fractures in the absence of implementation of the 'National Strategy for the Prevention of Falls and Fractures in Ireland's Ageing Population (2008)', hereafter known as the National Strategy.

The National Strategy was prioritised for implementation by the HSE and the State Claims Agency in 2013. Noel Mulvihill, HSE Assistant National Director for Older Persons at that time stated: *Falls in older persons is a serious public health issue and a needless cause of ill-health and death. It makes sense to try and implement the National Strategy now given that the burden of falls and related injuries could double in the next 20 years as Ireland's population ages.* The vision of the National Strategy is a "life free from falls and fractures in our ageing population" (Figure 1).

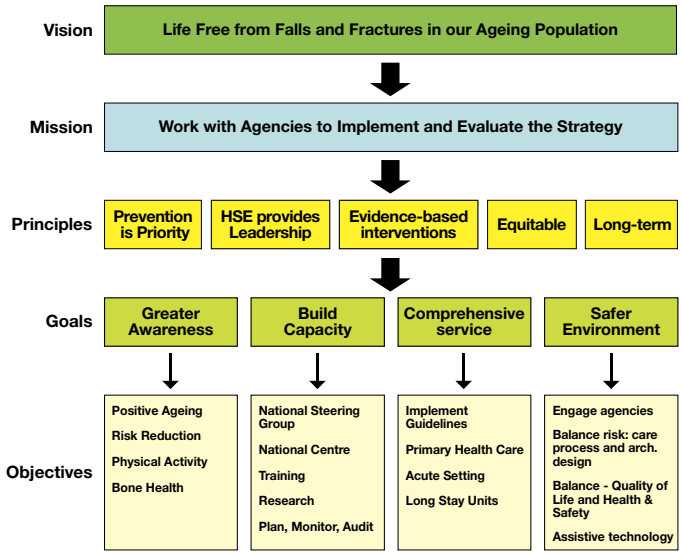



**Figure 1** *The Vision, Mission, High Level Principles, Goals and Objectives of the National Strategy for the Prevention of Falls and Fractures in Ireland's Ageing Population (p.102)*

AFFINITY (Activating Falls and Fracture Prevention in Ireland Together), the national strategy implementation project, aims to prevent harmful falls amongst persons aged 65 years and older, enhance the management of falls and improve health and wellbeing through a focus on bone health. Its core principles are: ***Integration, Implementation and Innovation*** and its core values are: **Mutual respect, Inclusion, Caring and Sharing**. The primary implementation pillars of AFFINITY include robust governance, an integrated service delivery model operating to a population health improvement approach and change management supports.

The governance framework (Figure 2) includes a National Sponsorship Team (NST), a National Implementation Team (NIT) and four (4) Regional Implementation Teams (RIT) aligned to the four HSE Administrative Areas.

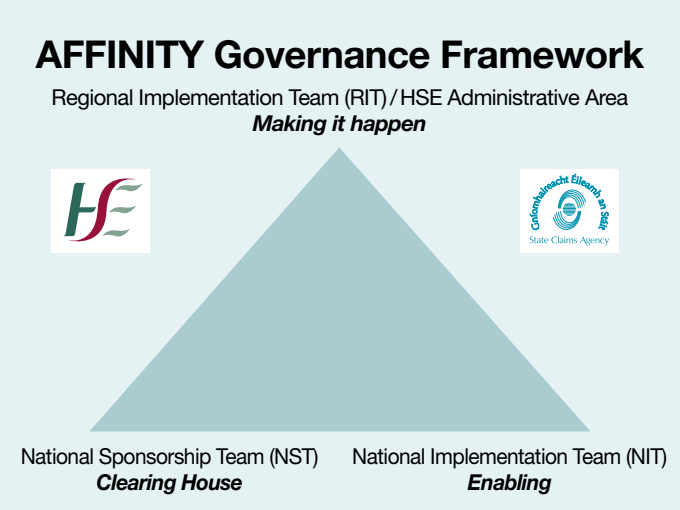



**Figure 2** *AFFINITY National Falls and Bone Health Project Governance Framework*

The National Sponsorship Team (NST) comprises key leads from the HSE, State Claims Agency, Department of Health, Special Delivery Unit and the National Clinical Programme Older Persons. Its remit is to act as a support structure to enable the AFFINITY to meet its goals. It works under the auspices of Mr Pat Healy, National Director, HSE Social Care Division.

The National Implementation Team (NIT) comprises members from various disciplines and roles within/across multiple settings to ensure adequate representation of a "whole system" integrated approach. This approach requires timely and targeted prevention, screening, assessment, intervention and monitoring of older persons from multi-disciplinary, multi-agency and multi-level perspectives. Its remit is to work with the National Joint Co-ordinators to meet the project aims.

Regional Implementation Teams (RIT) for the four HSE Administrative Areas, are forming. These teams will enable the

*AFFINITY National Falls Prevention and Bone Health Implementation Project* ***cont.***

development of pilot sites/early adopters to implement an integrated care pathway (ICP) for falls prevention and bone health in line with the Specialist Geriatric Services Model and best available evidence. The ICP should be able to respond to the needs of an older person with one or more co-morbidities, living in their own home with/without a home care package or in a residential/hospital care setting. These clients may have a fear of falling and/or have fallen in the last 12 months from which the fall may have resulted in a fracture.

To become an AFFINITY pilot/early adopter, multidisciplinary team (MDT) members working in the following settings: primary care, community care, hospital/groupings and/or residential care need to commit to working together for a designated population within an existing Integrated Service Area (ISA). The MDT teams are empowered to do so by their respective organisational/unit/service managers.

There are many examples of evidence informed services happening nationally, however sometimes these services are fragmented or may be missing key MDT personnel or may be under resourced to deliver a falls prevention and bone health initiative. Dr Ailis Quinlan, Head of Clinical Indemnity Scheme within the State Claims Agency and co-sponsor with the HSE of AFFINITY states: *AFFINITY aims to support the development/enhancement of more integrated MDT falls prevention, management and bone health services, so that all older persons will have access to quality, person-centred care in a timely manner, according to their needs and preferences.*

Change management supports for AFFINITY include such elements as a web based repository or project communication's hub being developed, education and learning resources and interventions being progressed, e-learning packages being sourced, coaching resources being made available and "best of breed" resources being identified and shared, such as **www.bonehealth.co**

This is a significant safety and quality improvement project that will need the combined and generous efforts of everyone to make changes leading to safer better outcomes for older persons.

*Rachel Fitzgerald, HSE and Irene O'Byrne-Maguire, CIS/SCA*

To learn more or get involved please contact **National Joint Co-ordinators:** Rachel Fitzgerald *rachel.fitzgerald1@hse.ie Tel:* ***01 890 8748*** or Irene O'Byrne-Maguire *iobyrnemaguire@ntma.ie Tel:* ***01 238 4184***

*AFFINITY Web Repository* ***www.fallsbonehealth.ie*** *is under construction. See State Claims latest news* ***http://stateclaims.ie/news/*** *to alert you when live.*

## AFFINITY PEER LEARNING

The next Peer Learning session will be on **Thursday 12th June,** from **11.30-12.30pm**, by Louise Brent, of Waterford Regional Hospital and Lead Nurse NCP Orthopaedics and Trauma, delivered to your workplace using telco and remote session technology (PDF presentation emailed in advance as backup).

Louise has completed the IHI Falls Collaborative Quality Improvement programme, is a key player in the ongoing development of the Irish Hip Fracture Database (IHFD) and of the National Hip Fracture Care Pathway.

Learning outcomes are:

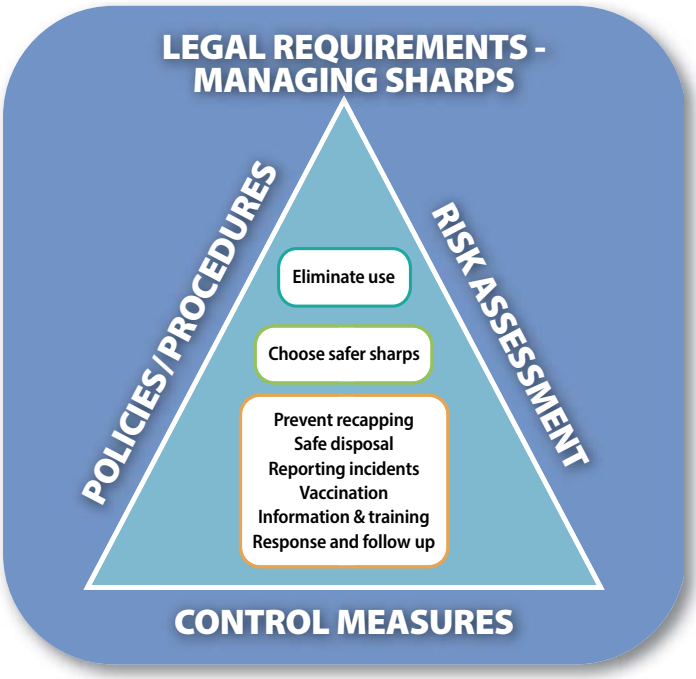
- to understand how to get falls prevention and bone health programme started in a hospital setting
- to understand how the IHI Falls Collaborative helped maintain momentum and overcome challenges
- to get an overview of the work happening nationally re IHFD and hip fracture care pathway development
- to understand the need to build partnerships with primary care and community services within existing ISAs, as being progressed in HSE Waterford/Wexford to work towards a seamless pathway of care for service users.

***For details on how to book, see Noticeboard (page 16).***

# FOCUS ON SHARPS: Sharps Injuries in Healthcare

## SCA INTRODUCTION

Now is an opportune time to highlight the area of management of sharps in healthcare settings due to the recent legislative changes under the EU directive on sharps. These Regulations build on existing health and safety and biological agents' legislation but also place a particular emphasis on sharps in healthcare settings.




In particular, under the Regulations, employers must endeavour to eliminate the unnecessary use of sharps, for example, eliminating unnecessary injections or needle-free systems.

The Regulations also re-enforce the need for specific risk assessment of sharps in individual settings and introduce specific control measures. They serve as a clear benchmark of what those in healthcare settings must do to minimise risk. Now more than ever, there is an onus on those in healthcare to tackle this issue.

## INTRODUCTION

Sharps injuries in the healthcare setting may result in the transmission of blood borne viruses such as hepatitis B, hepatitis C, or Human Immune Deficiency Virus. Healthcare workers may acquire a blood borne virus if exposed to infected blood or body fluids. This could be via the mucous membranes (eyes, mouth and nose), through broken skin or through an inoculation injury where the skin is punctured or scratched by a needle or sharp device that has been used in a medical procedure, this final route is known as a needle stick or sharps injury.

**Factors increasing the risk of transmission of blood borne viruses:**

- Deep percutaneous injuries
- Visible blood on injuring device
- Hollow needle from source patient artery or vein
- Large bore needle
- Personal protective equipment e.g. gloves not being worn.

The risk of infection following a percutaneous injury, especially a deep penetrating injury involving a hollow bore needle or a device visibly contaminated with infected blood, has been estimated at 1 in 3 for hepatitis B virus, 1 in 30 for hepatitis C virus and 1 in 300 for HIV.

## LEGISLATION

Up until March 2014, the main legislation covering the risk of exposure to injury and infection from sharps at work is the Safety, Health and Work Act 2005 and the Safety, Health and Welfare at Work (Biological Agents) Regulations, 2013 S.I No 572 of 2013. Recently, these have been supplemented by The European Union (Prevention of Sharps Injuries in the Healthcare Sector) Regulations 2014 (S.I. No. 135 of 2014) which transpose into Irish Law Council Directive 2010/32/EU.

The Regulations relate to the use of sharps in healthcare and provides a legal framework for the agreement on the prevention of sharps injuries in hospitals and the healthcare sector.

In the Regulations, sharps are defined as:

> **"...objects or instruments necessary for the exercise of specific healthcare activities, which are able to cut, prick, and cause injury and/or infection".**

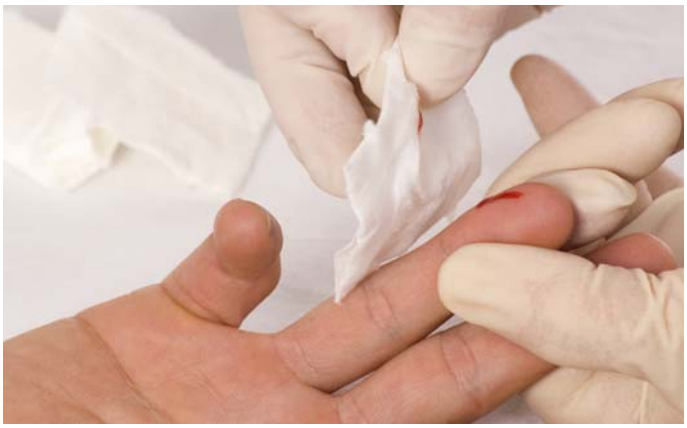
## LEGAL COMPLIANCE - SAFE SYSTEMS OF WORK

A risk assessment must be carried out for tasks that involve the use of sharps. The risk assessment must look at the activities involving sharps that could cause harm to healthcare workers, patients, clients, visitors, contractors and volunteers and determine the control measures that can be implemented to minimise risk.

All healthcare workers with potential exposure to sharps

*FOCUS ON SHARPS: Sharps Injuries in Healthcare* ***cont.***

injuries should be offered vaccination. Risk assessment will determine which staff should avail of the hepatitis B vaccination programme available from the Occupational Health Department.



## IN THE EVENT OF A SHARPS INJURY

Immediate action to be taken,

- Encourage the wound to bleed
- Healthcare worker should not suck the injury site
- Irrigate the wound thoroughly with running water and soap. A nailbrush should not be used
- Dry and cover the wound with a waterproof dressing if necessary
- Report immediately to the Department Head
- Attend your local Emergency Department or Occupational Health unit (This will be determined by local guidelines).

An investigation must be carried out following the sharps injury to help prevent recurrence by identifying remedial measures required and monitoring their implementation.

The guidelines for the Emergency Management of Injuries, September 2012, published by the Health Protection Surveillance Centre, provide comprehensive guidance on the appropriate management of injuries where there is a risk of transmission of blood borne viruses and other infections. In the healthcare setting, follow up of healthcare workers post sharps' injury is through your local Occupational Health Department.

## FUTURE

The National Health and Safety Advisory Group in the Health Service Executive have now formed a sub-committee looking at a National Policy on the prevention of sharps injuries in the Healthcare sector.

The Health and Safety Authority (HSA) have produced a guide to the new regulations which is available on their website. This provides a clear breakdown of employers responsibilities under the new regulations.

## REFERENCES

Code of Practice on the prevention of transmission of Blood Borne viruses in the Healthcare setting 2005.

Safety, Health and Welfare at Work Act 2005.

Safety, Health and Welfare at Work (Biological Agents) Regulations, 2013 S.I No 572 of 2013.

The European Union (Prevention of Sharps Injuries in the Healthcare Sector) Regulations 2014 (S.I. No. 135 of 2014) .

Guide to the European Union Regulations 2014 (Prevention of Sharps Injuries in the Healthcare Sector), 2014.

Guidelines for the Emergency Management of Injuries, September 2012 Health Protection Surveillance Centre.

*Anne Marie Howard, HSE Occupational Health, South East*

# Sharps Case Studies

Typically just over 550 adverse events relating to needle stick injuries received by HSE employees are reported each year on the HSE National Adverse Event Management System (NAEMS). Many of these events are preventable and the root cause can be traced back to non-compliance with disposal and use policies. Although only a small proportion will go on to become claims the cost of an individual claim can be significant. The examples illustrate the preventable nature of most sharps injuries received in the workplace.

An employee received a needle stick to the thumb while cleaning a ward as they gathered up a small pile of dirt beside the sharps bin. The injury was caused by an unsheathed needle which was not attached to a syringe and only had a tip of plastic to the end of the needle. Management of occupational blood exposure was carried out immediately. The incident may have been prevented if sharps waste had been disposed of correctly in the bin provided, and if a simple dustpan and brush was used. **The case was settled for a moderate sum comprising of damages and costs!**

*Sharps Case Studies* ***cont.***

A porter received a needle stick injury to the palm of their hand from a blue canula needle when picking up clear bags of rubbish in the sluice room. The injured party experienced sleep disturbance, stress and anxiety and remained off work for a week on medical advice after the incident. It was alleged that the injured party was not offered counselling and/or post event treatment by the HSE and there was no record of training on the risk of such events. While these would not have prevented the event they may have reduced the impact on the injured party. Ultimately, had the needles been disposed of correctly the event would not have occurred. **The case was settled for a moderate sum comprising of damages and costs.**

## WHAT IS THE REAL COST OF A SHARPS CLAIM?

The above examples only illustrate one side of the cost equation, the direct costs. The SCA categorise direct costs to include settlement costs, plaintiff costs, SCA legal and other costs. Indirect or hidden costs are often overlooked and can actually outweigh these direct costs. Indirect costs may include, significant absenteeism, substitution of personnel resulting from absenteeism, additional administration, loss of service, loss of expertise, presenteeism etc.

The SCA conservatively estimates that a ratio of 1:2 (direct costs to indirect costs) may be appropriate in the case of employee injury claims. Based on settled amounts to date and associated estimated liabilities on active claims, the SCA estimates the total cost of claims arising from needle stick injuries to date will be approximately €3.2million.

The case study below illustrates the hidden costs in sharps injuries that shouldn't be ignored.

A porter was emptying bags when he was pricked by a needle to his right calf. The porter received no sharps or induction training which may in part have lessened the psychological trauma. Formal training, instruction or supervision to all staff may have prevented the needle being placed in an incorrect bin in the first instance.

**Direct Costs:**

The case was settled for a moderate sum to include legal costs.

**Indirect Costs/Loss in Service:**

Although this claim had a relatively low impact in terms of cost, a detailed analysis of the claim illustrated that 230 personnel hours were exhausted with this event. This included 180 hours dealing with the injury, associated occupational health procedures, sick leave process and 43 hours involving HSE personnel processing the claim. In this case we can estimate indirect costs may have been in the region of €25,250.

*Brian Larkin, Risk Officer, SCA*

## WELCOME

### SCA REMIT EXTENDS TO NEW HEALTHCARE ENTERPRISES

In keeping with Government policy to self-fund rather than purchase commercial insurance, the SCA personal injury and third party property damage scheme has been delegated a further 50 bodies in April of this year. 17 and the most notable of these are those delegated from the Department of Health. The SCA would like to extend their warmest welcome the voluntary Hospital Group and to HIQA on joining this indemnity scheme.

It is estimated that this Delegation Order will provide an immediate saving of €4million to the State with a rolling saving of €2million per year thereafter. Apart from the obvious premium savings, these bodies will now receive a specialised claims management service with vast experience operating in the health care environment. In addition the bodies will have access to free risk management services, risk forums and other risk initiatives undertaken by the SCA, championing a consistent approach to risk management across the public sector.

The SCA over the next few months will be providing documentation and delivering a series of seminars to aid the transition from commercial insurance to State indemnity.

### ESTABLISHMENT OF THE CHILD AND FAMILY AGENCY

As you may be aware the Child and Family Agency was established on the 1st of January, 2014 and is responsible for improving well being and outcomes for children. Claims, and underlying risks, relating to personal injury and third party property damage associated with the negligence of the agency will be covered by State Indemnity. As with newly delegated healthcare enterprises the claims arising will be managed by the SCA and the CFA will have access to the SCA's risk management services.".

TUSLA An Ghníomhaireacht um Leanaí agus an Teaghlach Child and Family Agency

# Claims Review: Sharps Injury

The incident giving rise to this claim occurred in September 2010 in a maternity theatre. The plaintiff was an employee of an external firm which held the cleaning contract for the hospital.

The plaintiff sustained a needle stick injury whilst removing debris from the cloth of a mop which they had used to clean the floor of the theatre after a procedure. The plaintiff issued Circuit Court proceedings against both the employer and the hospital.

The SCA carried out a detailed investigation and established that the claimant had received all appropriate training from their employer with regard to sharps awareness and minimising the risk of sustaining a needle stick type injury. The SCA established the manner in which the plaintiff gripped both sides of the cloth was inappropriate and led to a very high risk of coming in contact with any incorrectly discarded needles.

Contact was made with the insurers of the cleaning contractors and a sizeable contribution was secured on the basis that the state would assume all potential liabilities in connection with the case. This was in exchange for the ongoing cooperation of the cleaning contractors with regard to the issue of contributory negligence against the plaintiff.

This case was heard at a Circuit Court in early 2014. The plaintiff made the case that they had been severely traumatised by the event, supported by a diagnosis of post-traumatic stress. The diagnosing psychiatrist was not available to give evidence in Court on the day and, in the normal course of events, the content of her report would not have been admissible. However, the Court read the report in its entirety. The only other witness called by the plaintiff was an engineer whose role was to highlight the self-evident risks involved in having unsheathed needles present in an operating theatre.

The first witness for the defendant was a local GP who advised the Court that, in his view, the plaintiff's allegations and complaints were not tangible as they had been reassured immediately, had all the necessary blood tests and was given the all-clear at six months. It had been established that they had no risk of infection at all. The SCA made the case that any anxiety or stress beyond the initial six month period was, in effect an irrational fear and was not compensable.

The SCA called in evidence the Acting Manager of the contractor based at the hospital who would have been the plaintiff's supervisor at the relevant time. This individual was in a position to confirm that the plaintiff received appropriate training and the manner in which she had described holding the cloth was contrary to this training. At the insistence of the Presiding Judge, the actual individual who had trained the plaintiff also gave evidence to Court to support this.

At the outset of his Judgment, the Judge asked for guidelines from the Barristers in relation to the level of appropriate damages for a case of this nature. The relevant jurisprudence in that regard was furnished to the Judge, namely general damages for cases of this nature falling between €7,000 and €15,000.

In the subsequent judgment, it was stated that there was a conflict of evidence between the plaintiff and the other witnesses as to how exactly they were trained. In the circumstances, it was felt that she must not have been properly trained and there was inadequate supervision on behalf of the defendants. In these circumstances, he found the plaintiff would succeed 100% and there would be no reduction for contributory negligence.

The Court ultimately awarded the plaintiff a generous sum plus costs. On many levels, this was a very unsatisfactory outcome for the defendant. Having carefully considered matters, the SCA ultimately informed the plaintiff it was would appeal the case. Appeal papers were lodged before the expiration period. Ultimately, the plaintiff accepted a lower settlement and the case was compromised on that basis.

*Paul Murray, Claims Manager, SCA*

# National Ambulance Service - CISM eLearning Tool

Have you noticed all the acronyms used now days in work-places to describe various processes and procedures? Conversations can seem like double Dutch sometimes at some workplaces. One such acronym is 'CISM'.

CISM stands for Critical Incident Stress Management, the technical description for CISM is that it's a comprehensive, integrative, multicomponent crisis intervention system. In simple terms CISM is psychological First Aid, most of us have benefited from first aid sometime or another in our lives. Essentially first aid is a basic simple intervention to prevent the injury from getting worse. Psychological First Aid can also be a simple intervention to prevent things from getting worse.

It has to be said Irish people are not great when it comes to mental health, in a report by the HSE in 2007 it suggests that all too often our reactions can be negative, uninformed and disinterested and yet mental health is vital for us all both at work and at home.

Employers have various legal duties and moral and ethical reasons to ensure employees are protected. In the emergency services CISM is used widespread as a system to provide support to staff but also to protect the organisation from litigious claims.

There is compelling evidence that CISM if used correctly will increase morale and reduced sick leave, consequently leading to increased efficiencies in the workplace. There are various examples of legal cases in Ireland where claims have cost the State hundreds of thousands of euros in compensation because effective support systems were not in place in the past. However there are also examples in the courts where CISM is used effectively and has protected the organisation.

## eLEARNING MODULE

At the National Ambulance Service (NAS) CISM committee, we have recently launched the first eLearning module on Critical Incident Stress Awareness Training in collaboration with the Pre-Hospital Emergency Care Council in early March. This is an initiative approach in learning and allows the user to access the learning module in their own time from their own device.

As work demands users can stop and start the training or they can complete it outside of work schedules, either way it is a very efficient way to deliver CISM training. The training module is also interactive and the user engages in the exercises at various different levels during the module. It must be noted the training module is of a very high quality with cases of real life stories and different examples of how one can access supports.

The module is evidence based on research conducted from the CISM Committee over the last ten years. Sharon Gallagher Principal Academic Researcher and Brian Glanville Clinical Psychologist at the CISM committee have been the lead professionals in developing the main content of the eLearning module.

I am personally delighted to see its launch, as it will deliver a practically high standard of training to all members of the National Ambulance Service at all grades. Sometimes training can be inconsistent, people might miss the training day, even with the best trainers there can be variations in the training, but an organisation can be assured of a particular standard of delivery with this method of eLearning.

However in saying that, I would issue a word of caution, Stress Awareness Training must work in conjunction with the CISM systems established. Peer Support Workers are key to the effective roll out of CISM in an organisation and while eLearning offers a credible standard of training it is vital that the human interaction given by the Peer Support Workers is fully supported by an organisation.

Having polices in place is hugely important for CISM to operate, but this has to be done in conjunction with the interaction of the Peer Support Worker. Peer Support Workers are trained persons that work in addition to their normal job, it is a confidential role and it supports workers at all levels of the organisation. The proactive management of critical incident stress management in the workplace or in the voluntary sector helps organisations prevent psychological injuries and ill-health at work.

As a Peer Support Worker, it's my experience that emergency workers often just need that 10 or 15 minutes to discuss issues that may be touching them. It is important to understand that it is quite normal to have strong feelings or emotions during or after an event. We have seen substantial changes in State organisations over a short few years and with continuous change ahead I see eLearning as part of that transformation as it fits into today's new working atmosphere. It offers a certain standard of training, it has a lower impact on the environment and certainly for larger organisations it can be significantly cheaper to deliver.

*David Maher, Joint Chair, NAS CISM Committee*

# Seminars on the Impact of State Indemnity

From November 2013 to February 2014, the State Claims Agency (SCA) hosted nationwide seminars for HSE staff on the implications of State Indemnity for risk (other than clinical risk), and associated claims management responsibilities. There were almost 350 attendees at the events held in Dublin, Cork, Limerick, Galway and Tullamore.

The purpose of the seminars was to provide senior managers in the HSE with an opportunity to meet with the SCA and gain an understanding of the implications of the State Indemnity model and how it has a bearing on operations and decision-making for managers within the HSE.

Information was presented on a number of topics with a selection of speakers, including representatives from the SCA, the HSA and the newly established HSE Risk Committee. The topics covered at the seminars included:

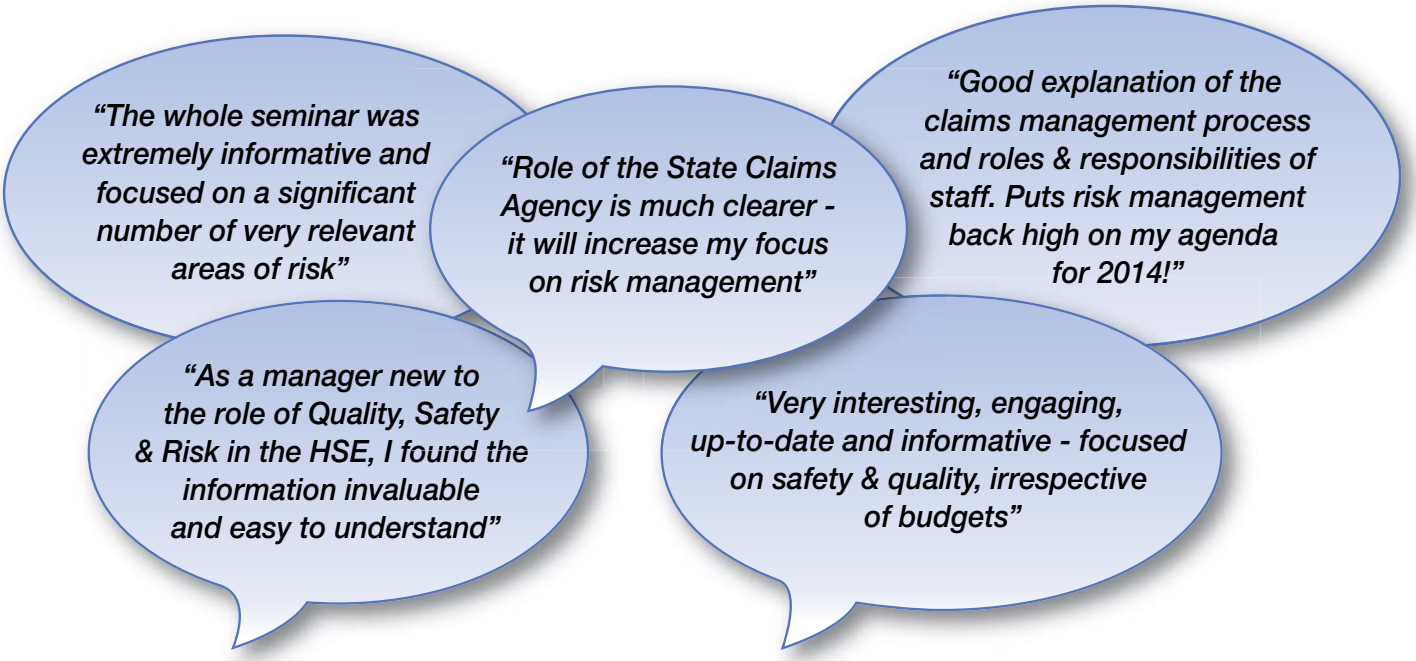
- State Indemnity explained and the Role of the SCA - Pat Kirwan, Deputy Director, Head of Risk and Operations, SCA.
- HSE Risk Committee - Role and Expectations - Tom Beegan, Chair, HSE Risk Committee.
- The Claims Management Process - Simon Watchorn, Head of Claims, SCA.
- Risk Management, Reducing Risk and Cost - Amy McGealy and Stephen Flynn, Risk Managers, SCA.
- Role of the Health and Safety Authority - Anne Maria O'Connor, Senior Policy Inspector, HSA.
- Upgrade to the National Adverse Event Management System (NAEMS, previously known as STARSWeb) - Pat Kirwan, Deputy Director, Head of Risk and Operations, SCA.

The seminars also incorporated a Question and Answer session which allowed for further discussion. Due to over-whelmingly positive feedback, the SCA will hold further seminars in late 2014.

If you feel this would be beneficial and are interested, please email us at stateclaims@ntma.ie.

*Amy McGealy, Risk Manager, SCA*

***From left to right:*** *Simon Watchorn, Head of Claims SCA; Anne Marie Oglesby, Clinical Risk Adviser CIS/SCA; Tom Beegan, Chair HSE Risk Committee; Stephen Flynn, Risk Manager SCA; Pat Kirwan, Deputy Director, Head of Risk and Operations, SCA.*



## State Claims Agency website

The SCA website has recently been updated and some of the previous guidance documents you may be familiar with may have moved.

Guidance documents are now available under the resources tab on the SCA website.

**www.stateclaims.ie**

## AFFINITY PEER LEARNING

Next **AFFINITY Peer Learning session** will be **Thursday June 12th** from **11.30-12.30pm** by Louise Brent of Waterford Regional Hospital, delivered to your workplace using telco and remote session technology (PDF presentation emailed in advance as backup).

**Format:** 20 minutes presentation and the rest Q&A.

While pertinent for hospital based personnel, the learnings will also be of use to those working in community settings.

To register your interest, please email Louise Holohan ASAP before Wed. June 4th. **lholohan@ntma.ie**

## Comments and Submissions

can be forwarded to

**stateclaims@ntma.ie**

## Biological Agents

The Safety, Health and Welfare at Work (Biological Agents) Regulations 2013 (S.I. No. 572 of 2013) sets out the minimum requirements for the protection of workers from the health risks associated with biological agents in the workplace. The regulations must be applied to any activity where workers are actually or potentially exposed to biological agents as a result of their work. These regulations were enacted on the 3rd January 2014 and have repealed and replaced the 1994 and 1998 Biological Agents Regulations.

In addition to the Regulations, a Code of Practice was issued in December 2013, which outlines biological agents and their classification, together with indications concerning control measures and levels.

*Copies of the Regulations and Code of Practice are available at:*

**www.hsa.ie/eng/Legislation/New_Legislation/Safety_Health_and_Welfare_at_Work_Biological_Agents_Regulations_2013/**

Clinical Indemnity Scheme invites you to

## Fetal Monitoring in Practice

**on Thursday 7th October, 2014**
**9am - 5pm**

*Facilitor:*

## Professor Sir Sabaratnam Arulkumaran

Professor Emeritus of Obstetrics & Gynaecology
St. George's University of London

in

**Centre for Midwifery Education**
located at
**Coombe Women and Infant's University Hospital, Dublin 8.**

*If you wish to attend this day, please email:* ***joreilly@ntma.ie***

## Fetal Monitoring in Practice

This is a practical continuing education programme provided for clinical staff with responsibility for cardiotocographic (CTG) monitoring and interpretation within the Irish maternity services.

It is primarily aimed for Staff Midwives, Clinical Midwife Managers (1 and 2), Non Consultant Hospital Doctors. Consideration will be given to any other clinical staff member who wishes to attend, pending on availability.

**The SCA newsletter is also available on our website @ www.stateclaims.ie under 'News' section**

## New Driving Guidance

The HSA, RSA and An Garda Síochána have published guidelines targeted at drivers entitled "Driving for Work - Driver Health Guidelines". The purpose of the guidelines is to make drivers more aware of the main health issues that may affect them and their ability to drive. The guidelines highlight a number of areas including considerations on your fitness to drive, common health conditions and maintaining a healthy lifestyle.

*A copy of the Guidance Document is available at:*

**www.rsa.ie/Documents/Driving%20for%20work/Driving_for_Work-Driver_Health_Guidelines.pdf**

The State Claims Agency,
Treasury Building,
Grand Canal Street, Dublin 2.