Clinical Indemnity Scheme
Newsletter

CIS Newsletter, October 2011

An Appraisal of the Legal Services Regulation Bill 2011

The Minister for Justice, Equality and Defence, Mr Alan Shatter, TD, published the awaited Legal Services Regulation Bill 2011 on 12th October, 2011. Minister Shatter, in publishing the Bill, stated the Bill *"provides for a greater transparency for legal costs and greater assistance and protection for consumers of legal services. It also provides an entirely independent dispute system to determine allegations of professional misconduct and a new system for legal costs adjudication where legal costs are in dispute".*

The Bill makes provision for three separate, key entities:

- A new, independent, Legal Services Regulatory Authority with responsibility for oversight of both of the legal professions.
- An Office of the Legal Costs Adjudicator to assume the role of the existing Office of the Taxing-Master which will be conferred with enhanced transparency in its functions. The legal costs regime will be brought out into the open with better public awareness and entitlement to legal costs information.
- An independent complaints structure to deal with complaints about professional misconduct - this would be supported by an independent Legal Practitioners Disciplinary Tribunal.

It is intended that the Legal Services Regulation Bill 2011, when enacted, will impact on legal costs associated with the management of claims. This is a most welcome development, having regard to the disproportionate costs associated with the management of clinical negligence cases, a matter which has been referred to in a previous editorial in this newsletter.

Section 81 of the Bill provides that the Taxing-Master's office will be known as the Office of the Legal Costs Adjudicator. It also provides for the appointment of:

The Chief Legal Costs Adjudicator

- The number of Legal Costs Adjudicators that the Minister determines to be the number necessary to ensure that the work of the Office may be carried out effectively and efficiently.

Significantly, *Section 83* permits the Chief Legal Costs Adjudicator, following consultation with the Minister, to prepare and publish legal costs guidelines. This is a welcome development, if and when the guidelines are published, as, hopefully, it will provide clarity for practitioners unlike the current taxation of costs system which is not easily understandable in relation to its determinations.

Section 95 sets out the matters to be ascertained in the course of an adjudication of legal costs. In particular, the Legal Costs Adjudicator must:

- Verify that the matter or item represents work that was actually done, or represents disbursements made or which the party concerned is obliged to discharge.
- Determine whether or not in the circumstances it was appropriate that a charge be made for the work concerned or the disbursement concerned.
- Determine what a fair and reasonable charge for that work or disbursement would be in the circumstances.

The Legal Costs Adjudicator must also, so far as reasonably practicable, ascertain:

- The nature, extent and value of the work concerned.
- Who carried out the work concerned.
- The time taken to carry out the work concerned.

Notably, *Section 82* makes provision for the establishment and maintenance of a register of determinations. Hopefully, this section will ensure that the decisions of the Chief Legal Costs Adjudicator, and

Editorial continued overleaf

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his/her fellow Legal Costs adjudicators will become a body of published precedents in respect of legal costs. This should bring significantly greater clarity concerning the drawing and settling of Bills of Costs.

The Bill, apart altogether from the issue of legal costs, makes provision for the establishment of legal partnerships and multi-disciplinary practices. It also makes provision for direct access to barristers in relation to non-contentious matters. Significantly, the practical effect of *Section 74* is to permit barristers to form a legal partnership such that barristers may be employed by or enter into partnerships with solicitors.

Part 7, in particular, represents a radical transformation of the existing legal services landscape. *Section 75* requires a newly established legal services regulatory authority to engage in a public consultation process, lasting no more than 18 months, to provide a report, inter alia, in relation to the manner in which legal partnerships and multi-disciplinary practises should be formed and operated.

Section 52 of the Bill makes provision for the establishment of a new Legal Practitioners Disciplinary Tribunal which will deal with complaints in relation to solicitors and barristers.

Returning to the issue of legal costs, *Section 89* prohibits a legal practitioner from charging any amount in respect of legal costs if:

- They are legal costs in connection with contentious business expressed as a specified percentage or proportion of any damages.
- They purport to set the legal cost to be charged to a junior counsel as a specified percentage or proportion of the legal costs paid to a senior counsel.

The net effect of this section is to remove the *two-thirds rule* as it has applied up to now concerning the engagement of junior counsel. This has always been a contentious issue for defendants and the insertion into the Bill of this section is a welcome change.

In summary, the Bill, introduced by Minister Shatter, is an overdue piece of intended legislation which will have long-lasting implications for legal practitioners and the issue of legal costs. In welcoming the Bill, some caution must be expressed as to how the Office of the Chief Legal Costs Adjudicator will impact on the disproportionately high legal costs associated with the management of clinical negligence claims, in particular. It is to be hoped that the establishment of the Office will:

(a) Bring much greater clarity to how Bills of Costs are drawn up; and

(b) Bring about a reduction in legal costs, generally.

The scope of the Bill is wide and is not confined to the issue of legal costs. Minister Shatter is to be congratulated for introducing this radical new Bill.

Implementation of an Early Warning System in Cavan Monaghan Hospital

In 2005, the Nursing Practice Development Department, conducted an audit which examined nursing documentation incor-porating patient observations. This identified that there was a clear need to review the Patient Observation Chart that was in use in the clinical areas at the time.

A quality improvement project was commenced by Nursing Practice Development to address limitations identified in patient observations and to examine alternative systems for recording patient observations. The model used for the project was the Quality Correction Cycle (Overveit, 1995), which was adapted to incorporate clinical audit. Clinical audit was a key part of the project, providing the data and process against which improvements/deterioration could be measured objectively (NICE, 2002).

Several literature reviews were undertaken, examining early warning systems and chart design. It became evident that an Early Warning System (EWS) needed to be implemented and hospitals utilising early warning systems, primarily in the UK and Northern Ireland, were directly contacted to assist in advancing the initiative.

A working group was established in the hospital, with multidisciplinary links, to progress the EWS. The new Patient Observation Chart subsequently developed, which incorporated a Physiological Observations Track and Trigger system. The Physiological Observation Track and Trigger System is a scoring system that fully integrates physiological observations with early warning scoring to identify patients at risk of clinical deterioration.

Significant interest was expressed in the project from other hospitals in the Dublin North East area and the project then moved to a regional level, involving the five acute hospitals. Following extensive regional consultation the new Patient Observation Chart incorporating the Early Warning System was finalised. Implementation of the early warning system was supported by development of a regional clinical guideline *'Guideline for Vital Signs Assessment of Adults and the use of Physiological Observation Track and Trigger System "POTTS" Cavan & Monaghan Louth/Meath Hospitals, HSE DNE (2008)* which incorporated evidence based practice in utilising the EWS and identified key standards required for the imple-

mentation of the system.

At this stage in Cavan Monaghan Hospital the Practice Development A/CNM2 was assigned as Project Lead dedicated to focus solely on the full roll out of the EWS and the Patient Observation (POTTS) Chart for 3 months. An extensive education programme targeting all nursing and medical staff was undertaken by trainers from the Practice Development team and Resuscitation Officers.

Clinical audit processes were incorporated significantly into the implementation of the initiative. A detailed audit of patient observations on the 'old' patient observation chart was undertaken in July 2008 in the clinical areas, involving 80 patient records, to provide a baseline against which improvements could be validated following implementation of the new Patient Observation (POTTS) chart. **The audit again confirmed significant issues in record keeping in patient observations management. For instance 65% of the patient observation charts were missing respiratory rate data, 35% were missing pulse rates, 20% blood pressure readings and 83% had no pain scores calculated.** This was in line with issues identified in the literature in relation to incomplete vital signs records. Given the vital importance of physiological information in assessing patients clinical conditions, and research indicating that patients with deteriorating clinical conditions were often not treated within appropriate time frames due to poor communication of their vital signs, changes needed to be expediently made.

The new Patient Observation chart 'POTTS' was introduced to all in-patient areas on 18th March 2009. A pilot had been conducted on three areas from 1st November 2008 and the chart was not removed from these areas. Minor changes were made to the chart in February 2009.

Following the pilot and introduction of the chart three further audits were undertaken, in line with the quality correction cycle (Pilots Nov 08, Dec 08, after full roll out April 2009). Following each audit, analysis was undertaken, reports written and the results fed back to the EWS (POTTS) Working Group and key stakeholders such as the Nursing Management Team, Operational meeting, ward meetings. Each CNM was also given a report for their specific clinical area, with key areas for development identified, and this assisted in focusing the ward teams on improvements. From this action plans were implemented to progress the initiative.

The EWS (POTTs) working group was reconvened in February 2010 to evaluate and review the implementation of the EWS initiative one year on, having being fully rolled out in March 2009. **As part of the 'anniversary' evaluation an audit was undertaken in April 2010. An assessment of the patients' physiological observations at a minimum every 12 hours was met 100%. This was a significant improvement on previous audits. Over 90% compliance was achieved in the areas; Labelling of the charts with the Patients name, Date of Birth and Medical Record Number; Recording of respiratory rate, pulse rate, blood pressure and SpO2, urine rate, responsiveness and time of the next observation being appropriate to the early warning score calculated. Again overall, this was a significant improvement on previous audits undertaken. Over 85% of the patients charts audited had an early warning score calculated for each observation.**

The audit results overall supported the indication that the early warning system and the new patient observation chart incorporating the physiological track and trigger system were becoming embedded as part of the patient assessment process, and that appropriate actions were in the main being undertaken.

Further reviews were subsequently undertaken by the Department of Anaesthesia in relation to EWS prior to critical care admission. The literature indicates delay in admission to critical care, as an independent variable for poor outcome . Audits undertaken showed an escalating trend in scores over the 72 hours prior to critical care admission with and EWS of 5 being the final average score immediately prior to critical care intervention. The clinical emphasis is still on timely review and importantly decision making at a senior level to avert deterioration, or institute timely escalation/resuscitation or construct an appropriate alternative pathway such as palliation and/or DNR order.

Conclusion

The introduction of the EWS, Patient Observation Track and Trigger System in Cavan Monaghan Hospital and associated education programme has had an overall positive impact on recording of patient observations. This potentially leads to enhanced patient clinical assessment and more appropriate activation of the early warning system to support appropriate early clinical interventions in managing the patient who is clinically deteriorating. The hospital plans to implement the National EWS, and to convert the current EWS system (POTTS) to the national MEWS, in line with the HSE (2011) *Guiding Framework and Policy for the National Early Warning System to Recognise and Respond to Clinical Deterioration.*

Kathleen McMahon, ADoN Nurse Practice Development Coordinator,
Dr Rory Page, Consultant Anaesthetist,
Gillian Whyte, Clinical Audit Project Facilitator,
Cavan Monaghan Hospital.

Modified Early Warning Score (MEWS)

What it the MEWS?

MEWS is a form of track and trigger scoring system used to identify the deteriorating patient (Morgan et al 1997). All patients have their vital signs measured and these are converted into a score. The higher the score the more abnormal the vital signs are and the sicker the patient. This score also triggers an appropriate escalation of treatment for acute deterioration in the patient's clinical condition (Gao, 2007). An algorithm is used to trigger the health-care professional to act according to the score.

HOWEVER, the MEWS is not a substitute for clinical judgement and not a predictor of the inevitable development of critical illness.

MEWS in Connolly Hospital

Connolly Hospital was the first Dublin Hospital to introduce the Modified Early Warning Score (MEWS) tool in 2010. The MEWS was introduced as a quality patient safety initiative to ensure early detection of patient clinical deterioration.

The MEWS committee was set up under the direction of Ms Mairead Lyons (Acting Director of Nursing) in May 2009 and consists of a Surgical Consultant, Medical Consultant, Anaesthetist, Medical Registrar, NCHD, ICU nursing staff, Resuscitation Officer, Nurse Practice Development staff. There were many barriers to its introduction as there was not substantial scientific evidence to support the sensitivities and specificities of the tool. However there is evidence that not having the tool results in failure to detect the deteriorating patient (NCEPOD 2005). There were also concerns of an increase in inappropriate calls to medical and surgical doctors. The algorithm used to trigger the healthcare professional on how to act includes specific times to review the patient. There were fears that these might not be met if the registrar was attending another emergency. The committee met many times to discuss and resolve the issues identified.

Project Summary

Project Aim: to introduce a quality initiative to detect or identify early recognition in a patient's condition and initiative a rapid response to same.

Project Objectives

1. Devise MEWS Policy
2. Devise MEWS Vital signs chart
3. Devise Audit tool
4. Set up pilot project on two wards
5. Devise Educational programme for introduction of MEWS. Follow up on long term education project.
6. Set up Bleep system and apply for Funding/business plan for same.

The Project was divided into 5 phases

Phase 1: Devise MEWS policy, MEWS vital signs observation chart, Algorithm for the escalation response to MEWS score, MEWS audit, Education programme for all doctors and nursing staff.

Phase 2: Hospital wide launch of MEWS December 2009 - Janurary 2010.

Phase 3: Audit of the MEWS vital signs chart and the activation of the MEWS response algorithm. Audit results suggested that more education was required for the successful implementation of the MEWS.

Phase 4: HIQA (2011) advises that a deteriorating patient should activate a direct line on-site response. Connolly Hospital chose a MEWS High Alert Bleep system as a rapid response system. This was facilitated by funding from the National Planning and Development Unit (NMPDU) to add a software module to the current bleep system in 2011. When there is a MEWS of 4 or more, or 3 in any single parameter, the bleep is used to alert the registrar of the need to review the patient, ideally within 30 minutes. Education was provided to all medical and nursing staff and a sticker already on all phones showing the cardiac arrest phone number was modified to guide staff on activating the MEWS bleep.

Going Forward

Continue to audit the use of the MEWS and the appropriate response to elevated scores. In addition HSE (2011) National Framework for recognition of the deteriorating patient makes recommendation for the implementation of the MEWS and compass education programme to support the introduction of the MEWS tool.

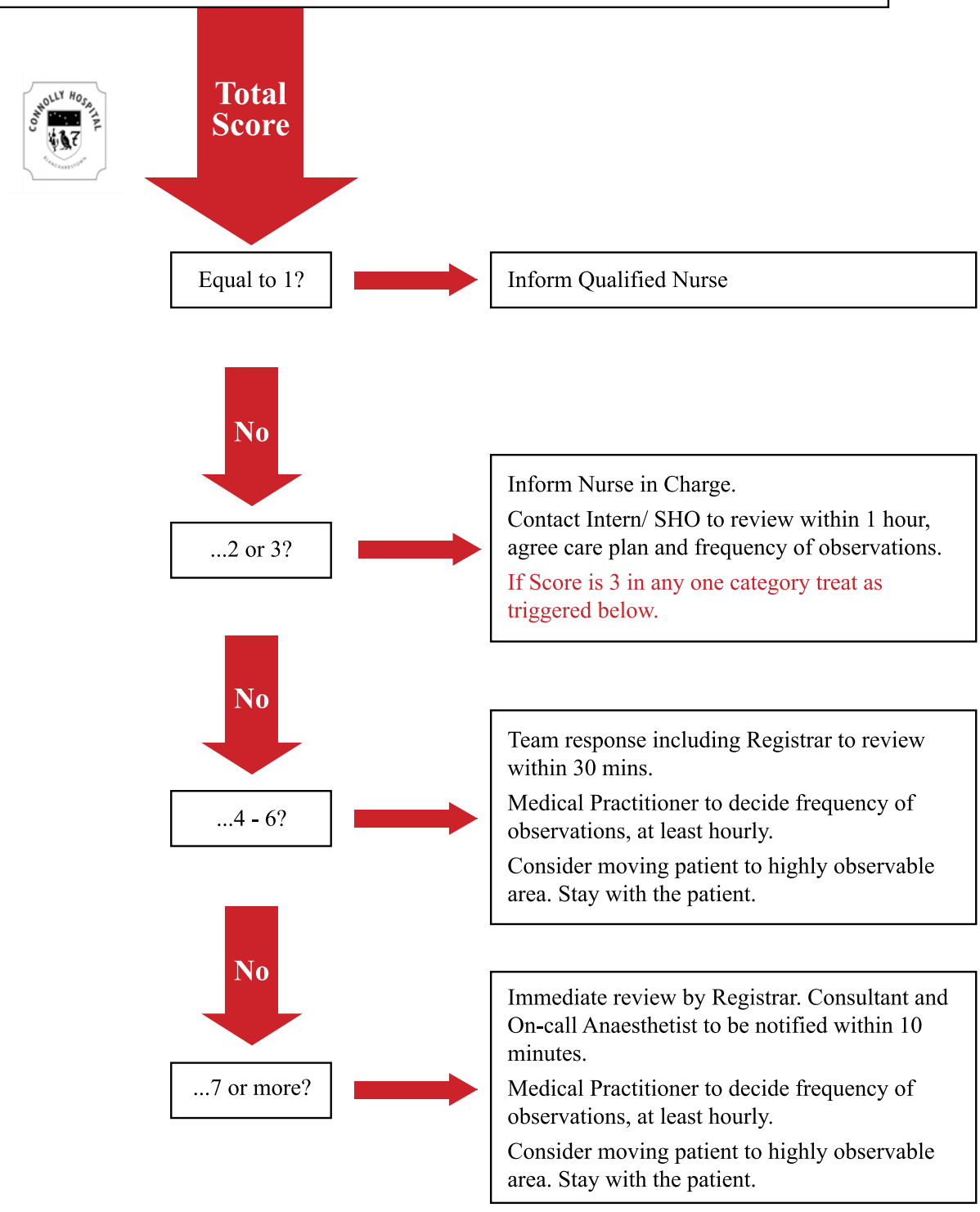
Reference

HSE2011 Guiding Framework and policy for the National Early Warning Score System to recognise and Respond to Clinical Deterioration

Gao et al. (2007). Systematic review and evaluation of physiological track and trigger warning systems for identifying at risk patients on the ward. Intensive Care Medicine 33: 667–79.

Morgan R, Williams F, Wright M.(1997) An early warning scoring system for detecting developing

Patient Observation Guideline for Early Warning Scoring System



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National Institute for Health and Clinical Excellence (2007): Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. Clinical Guideline 50. NICE. London

National Patient Safety Agency. (2007) Safer care for the acutely ill patient: learning from serious incidents. NPSA. London

Dolores Dempsey-Ryan, Acting Nurse Practice Development Co-ordinator, Connolly Hospital, Ext 01-6465184.

Case Study - Failure to diagnose an ectopic pregnancy...

Failing to diagnose an ectopic pregnancy and performing open surgery instead of "gold standard" laparoscopic surgery found not to be negligent.

It was held by Mr. Justice Quirke in the High Court case of *Laycock -V- Gaughan & The Guardians And Directors Of The Hospital For The Relief Of Lying-In Women,* that both the consultant and hospital doctors were not negligent in the care and treatment of the Plaintiff. The Plaintiff alleged that there was a failure to diagnose that her pregnancy was ectopic and that when the ectopic pregnancy was diagnosed, that the consultant undertook a laparotomy instead of the "gold standard" laparoscopic surgery.

The Court delivered its Judgment on the 21st January 2011 following several days Hearing in the High Court in December 2010.

The Plaintiff alleged that between the 3rd March 2004 and 19th March 2004 the Defendants failed to adequately monitor her symptoms and wrongly advised her in the first instance that she was routinely pregnant and that she had then had a spontaneous miscarriage. She alleged that in view of her ectopic pregnancy, there was an unnecessary delay in appropriate investigations and treatment which exposed her to the risk of a serious and life threatening injury.

In evidence, the consultant indicated that he had undertaken to perform a laparoscopy on the Plaintiff on the 19th March 2004, as he suspected an ectopic pregnancy. During the laparoscopic procedure, the consultant discovered that the Plaintiff was bleeding from within the fallopian tube. The volume of blood presented in the Pouch of Douglas made it very difficult to visualise the fallopian tube and so the consultant made the decision to immediately convert from a laparoscopy to a lapar-otomy. The consultant was required to then remove the right fallopian tube after confirmation of the ectopic pregnancy and chronic salpingitis.

The Plaintiff claimed that as a consequence of the open surgery, she was now left with an unnecessary abdominal scar and that she suffered unnecessary postoperative pain, discomfort and distress. The Plaintiff claimed that the surgical technique used by the consultant was incorrect, inappropriate and negligent and resulted in the Plaintiff suffering a greater level of pain and scarring than was necessary.

In essence, the Plaintiff alleged that the consultant performed the salpingectomy by way of open surgery where it was possible and desirable for him to have performed the surgery laparoscopically.

The consultant gave evidence that at the time, he was not experienced with this kind of laparoscopic surgery. He stated that there were three doctors in the hospital who were trained and experienced in laparoscopic surgery. The consultant did not consider referring the Plaintiff to one of these doctors, as it was 6pm on a Friday evening and the bleeding needed to be dealt with urgently. He told the Court that his primary concern was to stop the bleeding as the patient could have died.

Applying the principles in ***Dunne -v- National Maternity Hospital, 1989***, Mr. Justice Quirke found that evidence of failure to provide a patient with the most advanced and technically perfect treatment available is not necessarily evidence of negligence on the part of that doctor. The onus rests on the Plaintiff to prove that the course taken by a doctor was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a doctor of like qualification.

Mr. Justice Quirke was impressed by the Defendants expert medical witnesses. In evidence he stated that on the day the consultant *"was confronted with a potentially life threatening emergency and was obliged to take the safest course from his patient's viewpoint."* The expert stated that he himself was *"not trained in this type of laparoscopic surgery and if faced with the same situation today, he would not seek assistance from a colleague trained in laparoscopic surgery and that he would simply proceed to perform the surgery by laparotomy".*

It was further given in evidence for the Defence, that in 2004, 37% of ectopic pregnancies diagnosed in the National Maternity Hospital were surgically treated by laparotomy and that a number are still treated in this way.

Mr. Justice Quirke accepted that laparoscopic surgery resulted in a better cosmetic result and a speedier recovery but was convinced by the Defence evidence that it would have been both unsafe and potentially dangerous for the Plaintiff, if the consultant had chosen to continue by way of laparoscopy when he was unsure that he could do so safely. The Court also accepted that it would not have been reasonable or appropriate in the circumstances for the consultant to have suspended his investigation in order to search for laparoscopically skilled practitioners at a time when the Plaintiff required immediate surgical intervention.

The Plaintiff's claim was dismissed as the evidence put forward on her behalf fell short of establishing negligence or a breach of any duty owed to her by the Defendants.

Philip Fagan, FCII Claims Manager

Case Report - Duty of Care in Psychiatric Units

The State Claims Agency successfully defended an action alleging medical negligence on the part of a hospital in the case of **MC v HSE [2007/4483P]**

Background

Patient C had a long history of psychiatric illness and had been admitted to Hospital X as an inpatient on a number of occasions for lengthy periods. She was well known to the nursing staff and the Consultant Psychiatrist who had been in charge of her care for many years. Proceedings were brought in respect of a hospital stay in November and December 2005. On that occasion patient C was demonstrating symptoms of paranoia, delusion and aggression towards certain staff members. On the night on the 2nd of December and the morning 3rd of December 2005, she had a number of unexplained falls. At approx. 4pm on the 3rd of December, whilst in the company of her husband, she got up from her chair suddenly and after walking a few steps fell forward striking her head and sustained a fracture dislocation of her left shoulder. It was alleged by patient C that the injury to her shoulder had greatly impacted on her daily life and impaired her ability to carry out various household tasks.

The Claim

It was claimed on behalf of patient C that the hospital staff were negligent as they failed to manage the patient on one to one nursing observation in the days preceding her fall. The patient had a previous fall in 2003 while also as an inpatient in the hospital. It was argued that this failure to provide the one to one observation fell short of what was an acceptable standard of care due to the patient's previous history of falling. The patient's expert psychiatrist stated that had the patient been on this special observation it would on balance have prevented the fall.

In relation to the fall in 2003 the Consultant Psychiatrist in charge of her care said that it was due to problems with her medication which were resolved at that time. Both the nursing staff and the Consultant Psychiatrist gave compelling evidence that patient C did not respond well to continuous one to one nursing and instead at times it made her more anxious and aggressive and more likely to fall. Indeed the patient fell later that same evening while on one to one observation. The Consultant permitted the nursing staff to judge when she might need one to one nursing and to implement it themselves on an intermittent basis as they were with her the majority of the time and were best placed to make that decision.

The expert Psychiatrist, on behalf of the Hospital, stated that even if the patient had been on one to one observation it would not have prevented her fall because the level of observation required by one to one is a nurse staying within arm's length of the patient but not physically holding them in any supportive way. This would be especially true when her husband was visiting her as the nursing staff would sit some distance away to give them some privacy.

The Judgment

Ms Justice Mary Irvine found that the patient was unsuccessful in proving any element of her claim. She found that as a matter of fact the patient's condition was aggravated by nursing intervention and that one to one nursing did not serve as a method of improving the patient's own safety. She also accepted that the fall in 2003 was due to a particular drug and therefore not connected to the falls in 2005. Furthermore she found that the patient had not discharged the burden of proof demanded of a plaintiff in medical negligence proceedings.

Judge Irvine went on to state that even if she had accepted there was any liability on the part of the Hospital then the patient's case would still fail on causation as the one to one nursing would not, on the balance of probabilities, have prevented the fall that occurred.

Neasa Seoighe,
Solicitor/Claims Manager

NOTICE BOARD

Human Factors Study Day

The Human Factors Study Day is for Health professional educators, academics, regulators and practitioners from a variety of disciplines, colleges and sectors who are involved in Human Factors/Ergonomics education at undergraduate and post graduate levels.

Aim of the day is to build shared understandings, networks and an integrated approach to human factors education to help ensure new and existing healthcare professionals are 'fit for purpose'.

See webpage http://www.stateclaims.ie/ClinicalIndemnityScheme/HsEHN.html for details.

Places limited so book early.

Level 2 Systems Analysis Training

The Clinical Indemnity Scheme, based on feedback from previous attendees of Systems Analysis Training, has developed a Level 2 Systems Analysis Training course.

Those interested in attending this course will be expected to have completed previous Systems Analysis Training as provided by the Clinical Indemnity Scheme. Course content is based on those topics identified by delegates as areas that they would like further assistance with including how to conduct an interview and report writing.

This course is directed towards senior healthcare staff who will be expected to participate and take an active role in conducting reviews as part of their remit.

Date:
November 30th, 2011

Venue:
Farmleigh House in Phoenix Park, Dublin.

Spaces are limited so advanced booking is mandatory.

For further information and to book a place please contact administrator Jane O'Reilly joreilly@ntma.ie or (01) 644 8463.

Submissions invited for CIS newsletters "Quality improvement in action"

The CIS wish to showcase patient quality initiatives that are happening around Ireland of which there are many, both community and hospital based. In sharing the learning the promotion of quality continues.

If your enterprise would like to showcase a particular piece of work why not forward an abstract to ***aduffy@ntma.ie***

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

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