Topical issues in Risk Management
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Commission on Patient Safety and Quality Assurance describes governance under four broad headings:

1. Advocating for positive attitudes and values about safety and quality.

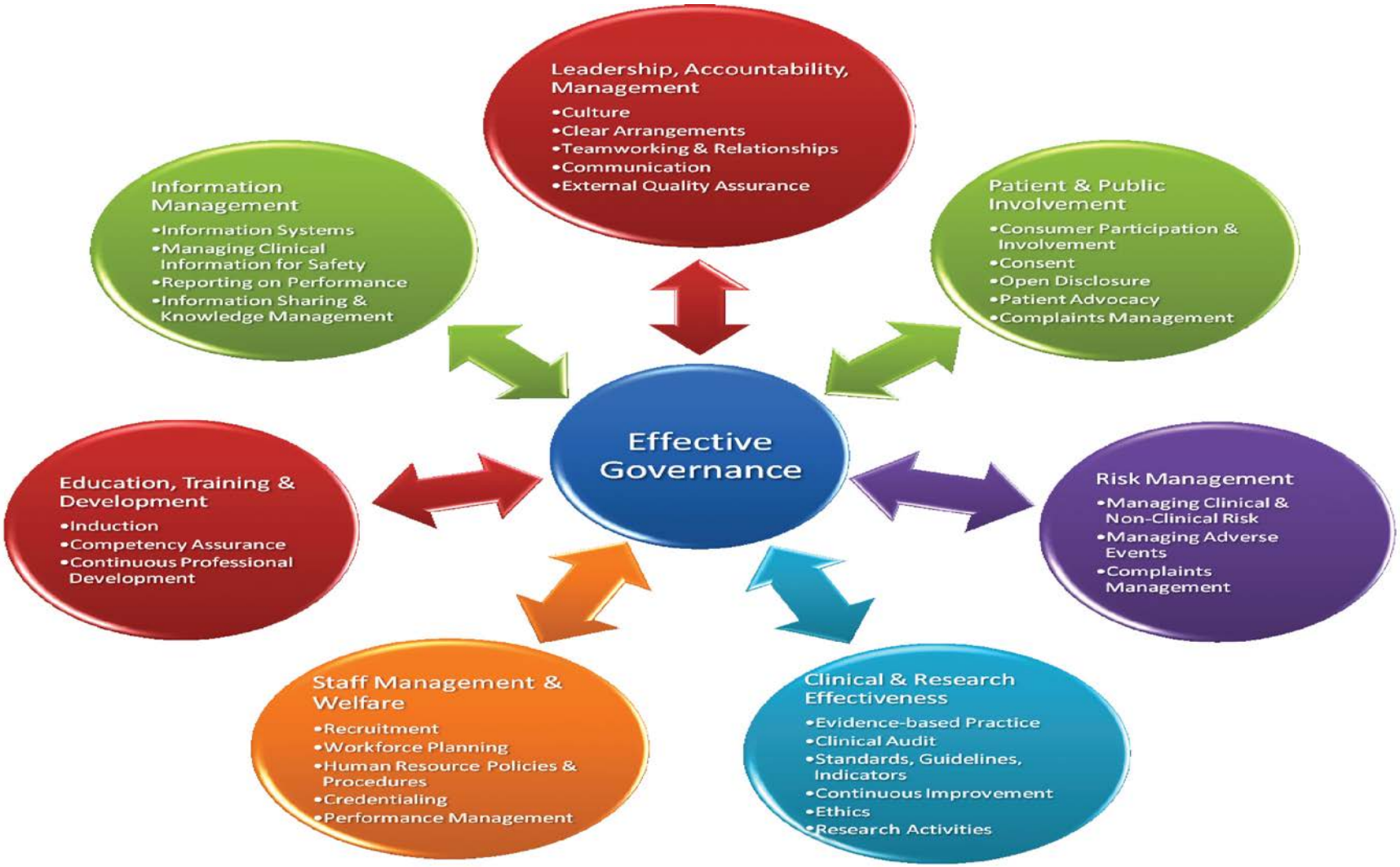
2. Planning and organising governance structures for safety and quality

3. Organising and using data and evidence

4. Patient focus

(Adapted form Braithewaite and Travaglia, 2008)

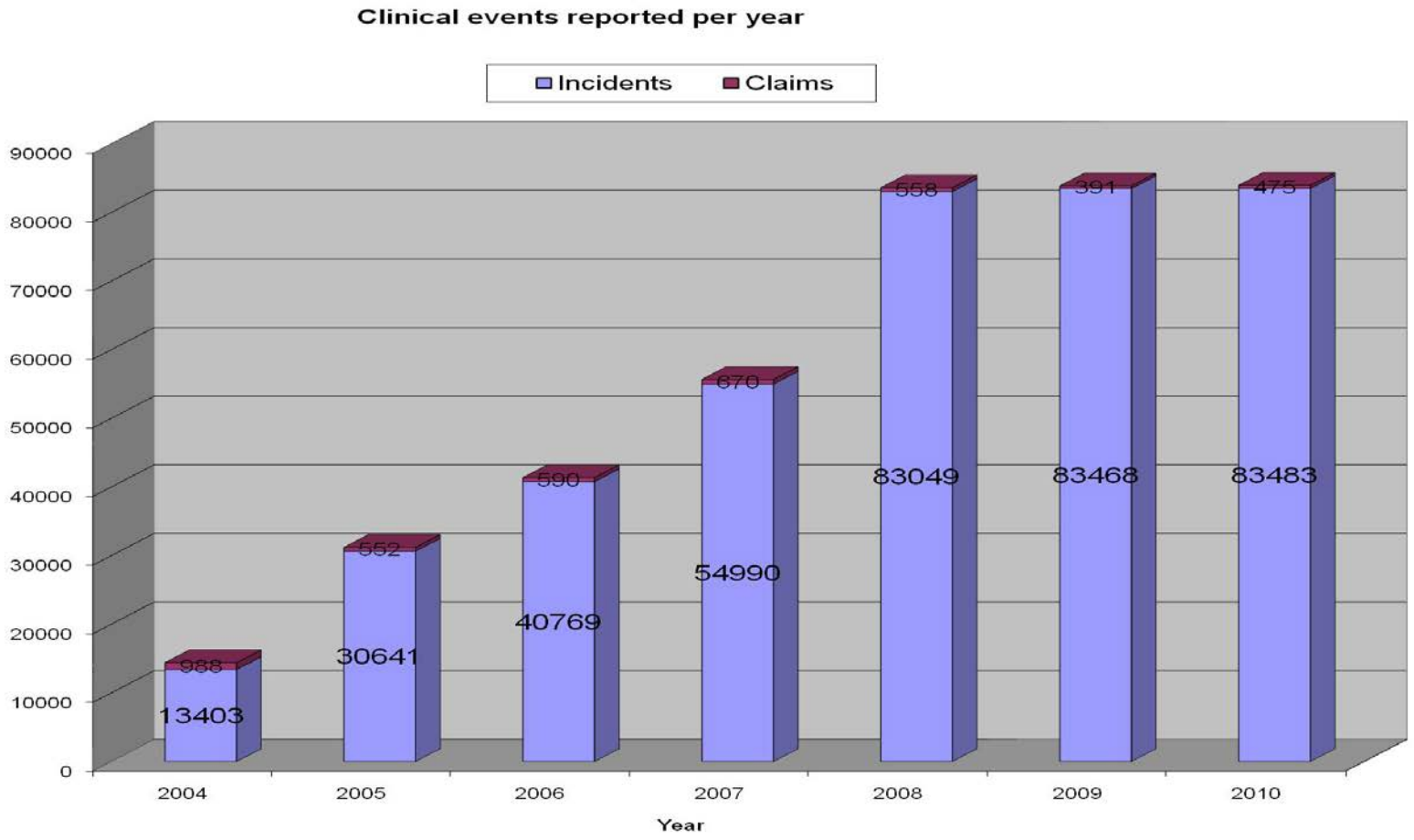
Diagram of the elements of governance



How does CIS drive and support patient safety?

- Collection and analysis of incident/near-miss data
- Closed claims analysis
- Training and education
- Collaboration with training/professional bodies, statutory and voluntary organisations.

389,803 clinical incidents / “near misses” logged on the live system to end of 2010.



4,224 of these events have gone on to become claims

Learning from Claims

- Team working
- Communication issues
- Consent
- Medical records, missing, incomplete, illegible, altered.
- Confidentiality

Systems Analysis Training-CIS

- Evidence based
- Generic
- Accredited
- Feedback/evaluation
- Over 1,200 healthcare professionals trained to date.
- Free!!!

Open Disclosure

Hippocrates warned of telling the patient the nature of their illness,

‘for many patients through this cause have taken a turn for the worse.’

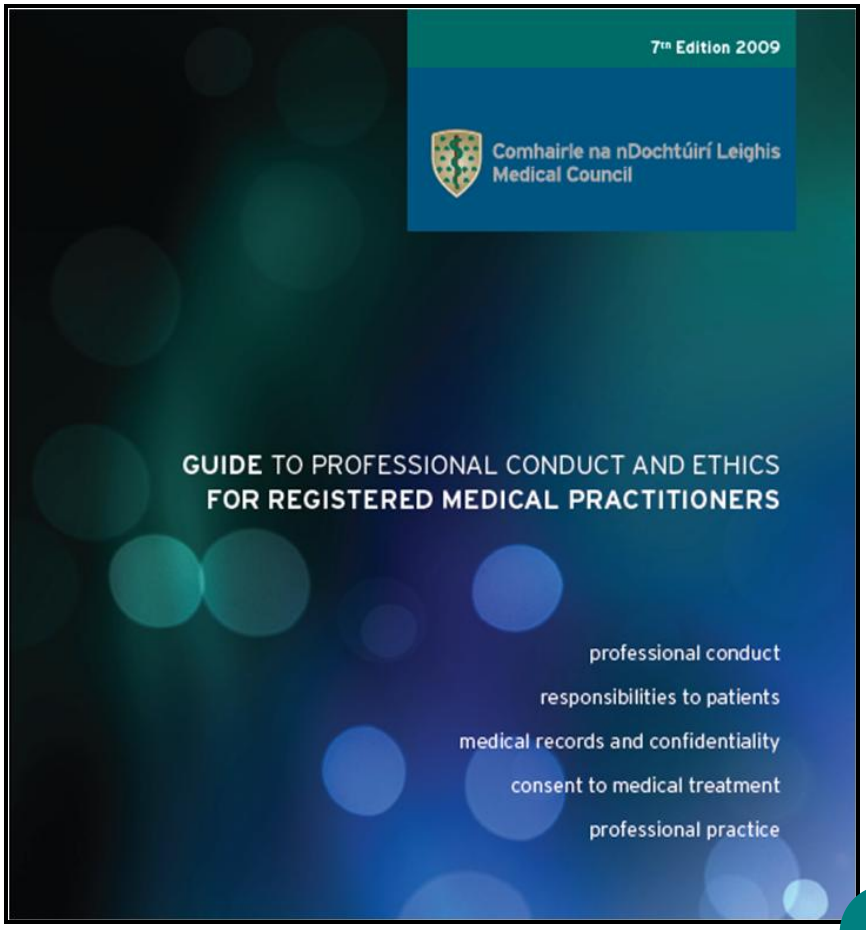
However, he admonished that the truth should be told, but to a third party instead of the patient.

Open Disclosure

- Following occurrence of a serious adverse event, patients and their families want
  - Acknowledgement
  - Explanation
  - Apology
  - Reassurance re prevention of recurrence

The Medical Council

"Patients and their families are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm."



Clinical Indemnity Scheme

"At the heart of open disclosure lies the concept of open, honest and timely communication. Patients and relatives must receive a meaningful explanation."

(Ciáran Breen, Director, State Claims Agency, 2009)

Harvard Study

Only 2% of negligent adverse events lead to clinical malpractice claims.

Vincent et al. Lancet 1994, 343:1609-13

University of Michigan Health System (UMHS) Ann Arbor, experience

2002, Adopted policy-

Move from, “Deny and defend”

To

“Apologise and learn when we’re wrong, explain and vigorously defend when we’re right and view court as a last resort”

University of Michigan Health System Claims experience

Year	No. new claims	No. open claims
2001	121	262
2002	88	220
2003	81	193
2004	91	155
2005	85	114
2006	61	106
2007	n/a	83
2008	n/a	63

USA Today, June 22, 2009. Journal of Health Sciences Law.Vol 2:2, 125-

University of Michigan Health System (UMHS) experience contd.

August 2001-August 2007

- Ratio of litigated cases : total reduced from 65-27%.
- Average claims processing time reduced from 20.3 months to 8 months.
- Insurance reserves reduced by > two thirds.
- Average litigation costs more than halved.
- Savings invested into patient safety initiatives.

Open Disclosure-Moving forward

- Legislation (Similar to other countries)
- Clinician engagement
- Leadership from management
- Education
- Training
- Support
- Evaluation
- Pilot sites

Harvey Cushing 1920

"Errors will be made, but it is from our mistakes, if we pursue them into the open instead of obscuring them, that we learn the most."

(Address before the New England Otological and Laryngological Society)