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National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Open Disclosure: the State Claims Agency's Perspective

Dr Cathal O'Keeffe, Head of Clinical Risk

Mary Godfrey, Senior Clinical Risk Manager

Mr Gary McCann, Solicitor/Senior Clinical Claims Manager

13 April 2022

Learning Outcomes

- ✓Explain the statutory role and functions of the State Claims Agency (SCA)
- ✓Outline the Clinical Risk Unit services and activities
- ✓Recognise the requirement to record Open Disclosure as part of incident reporting
- ✓Discuss the claims and inquest processes
- ✓Identify the learning from claims pertinent to Open Disclosure
- ✓Integrate documenting Open Disclosure in practice settings

Context: What is Open Disclosure?

Open disclosure is defined as an open, consistent, compassionate and timely approach to communicating with patients and, where appropriate, their relevant person following patient safety incidents….

It includes expressing regret for what has happened, keeping the patient informed and providing reassurance in relation to on-going care and treatment, learning and the steps being taken by the health services provider to try to prevent a recurrence of the incident

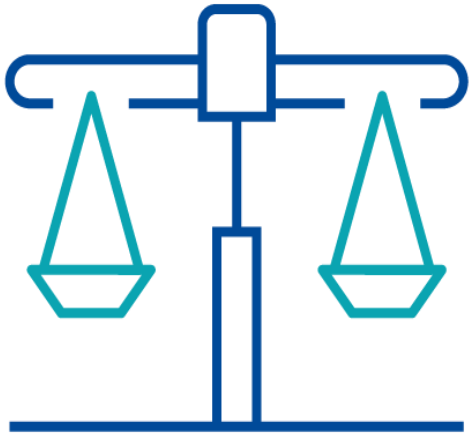
(HSE 2019).

State Claims Agency Involvement

2009:	Project manager nominated (Clinical Risk Unit) Initial work on draft guidelines
2010:	Collaboration with HSE on research, development and implementation of the recommendations of Commission on Patient Safety and Quality Assurance
2012:	Accredited national training programme developed for all sites
2012-2014:	Piloted in Mater Misericordiae University Hospital, Dublin and Cork University Hospital
2015:	'Train the Trainer' programme national roll out (HSE and SCA trainers)
2016:	Independent evaluation of the pilot programme
2018:	Representation on the HSE National Open Disclosure Steering Committee
2020:	Independent Patient Safety Council: Recommendations on a National Policy Framework for Open Disclosure in Healthcare
2022:	Open Disclosure Performance Measurement Programme (NIMS)

State Claims Agency and Indemnity

Our Core Legislation



National Treasury Management Agency (Amendment) Act 2000 (as amended)

….provides the legislative basis for the delegation of the management of personal injury and property damage claims against the State and State Authorities …

National Treasury Management Agency (Amendment) Act 2014

Insurance (Amendment) Act 2018

State Claims Agency: Objectives

- While **acting fairly and ethically in dealing with people** who have suffered injuries and/or damage, and their families**, *manage claims*** taken against the State so that the liability of the State is contained at the lowest achievable level.
- **Advise and assist State authorities** on the ***management of litigation risks*** to a best practice standard, in order to enhance the safety of employees, service users/patients and other third-parties and minimise the incidence of claims and the liabilities of the State.
- **Manage third party claims** for ***costs*** arising from all categories of claims taken against the State so that such claims for costs are contained at the lowest achievable level.

Claims Resolution

Risk Management

Legal Costs Management

NIMS (National Incident Management System)

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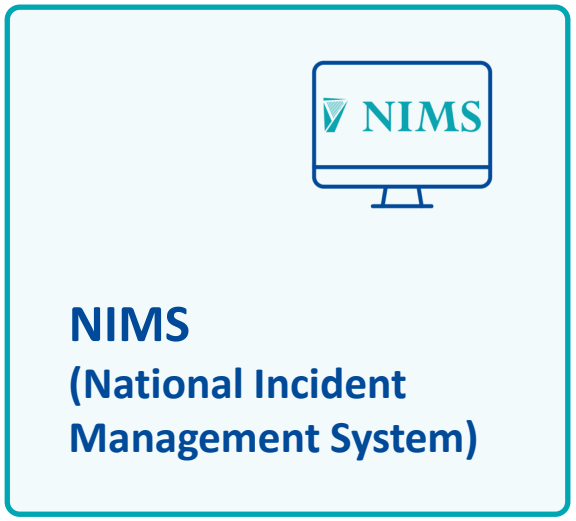
NIMS: National Incident Management System



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

Safety and insights. Powered by data.

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State Claims Agency

Our Risk Universe

146

State Authorities

Core of High Risk Activities

(including Medical Services, Defence and Security Services)

200,000

State Employees

Healthcare

- 1.7m hospital discharges
- 1.4m day cases
- 1.4m Emergency cases
- 3.3m Patients availing of services
- 62,000 Births

State Service Users

- Public services (Dept. Social Protection, Revenue, Dept,. Agriculture, Courts etc.)
- 4,000 Prisoners
- 60,000 Students
- 8.4m Visitors/tourists

State Property

10,000 Fleet

8,000 Estate

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State Claims Agency

Delivering our mandate through State indemnity schemes

Two State Indemnity Schemes operated by the State Claims Agency

General Indemnity Scheme (GIS)

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

Clinical Indemnity Scheme (CIS)

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

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Clinical Indemnity Scheme

Covered

- Professional medical services provided in public hospitals, clinics and healthcare facilities
- Clinical care during transfer of patients
- Representation at Coroners' Inquests
- Good Samaritan acts within island of Ireland

Did you know?
Principle of "enterprise liability" applies – the health and social care service assumes vicarious liability for the acts and omissions of its employees providing professional medical services.

Not Covered

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

NB: Supplementary professional/indemnity insurance required

Professional Medical Services

a) Services provided by registered medical practitioners or registered dentist or a diagnostic or palliative nature, or consisting of the provision of treatment, or the conduct of research in respect of any illness, disease, injury or other medical condition,

b) services provided by other health professionals in the performance of their duties, including pharmacists, nurses, midwives, paramedics ambulance personnel, laboratory technician, or

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

GIS v CIS Service User Cover Comparison

General Indemnity Scheme
'State of premises'

- Patient slips on wet floor and no hazard sign was in place
- Defective equipment injured patient e.g. hoist

Clinical Indemnity Scheme
'Professional medical services'

- Patient prescribed wrong medication
- Patient suffers unexpected injury during surgery

- There can be incidents which have both GIS and CIS causes
- Claims will determine most appropriate route
- Risk teams have an agreed Charter in place

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State Claims Agency

Clinical Indemnity State Authorities

Non consultant hospital doctors, nurses and clinical staff

Certain other ancillary health and social care providers

HSE

including voluntary health and social care sector

Public health doctors, nurses and other community-based clinical staff

Dentists providing public practice

Obligations of State Indemnity

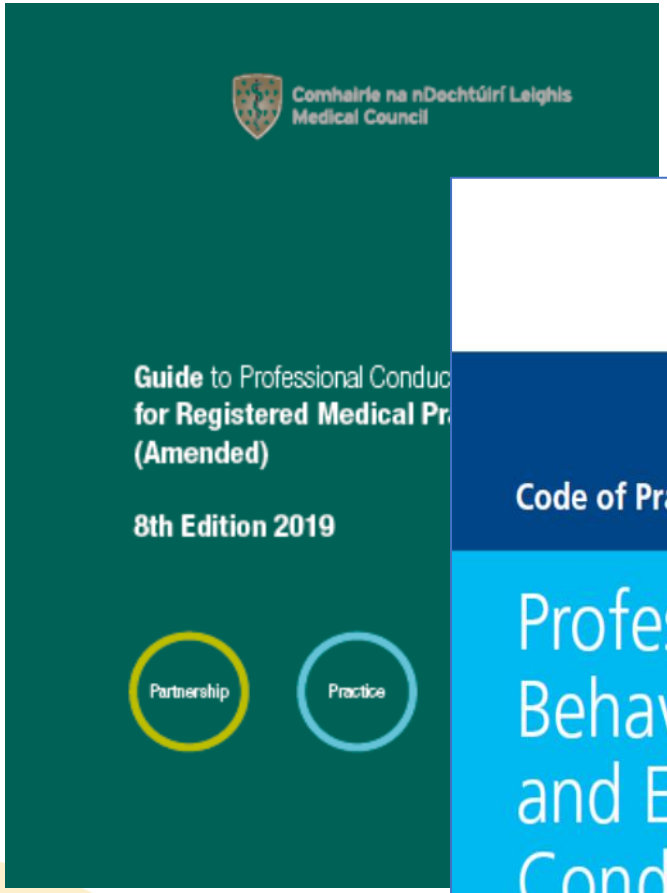
Under Section 11 NTMA (Amendment) Act 2000, State Authorities must:

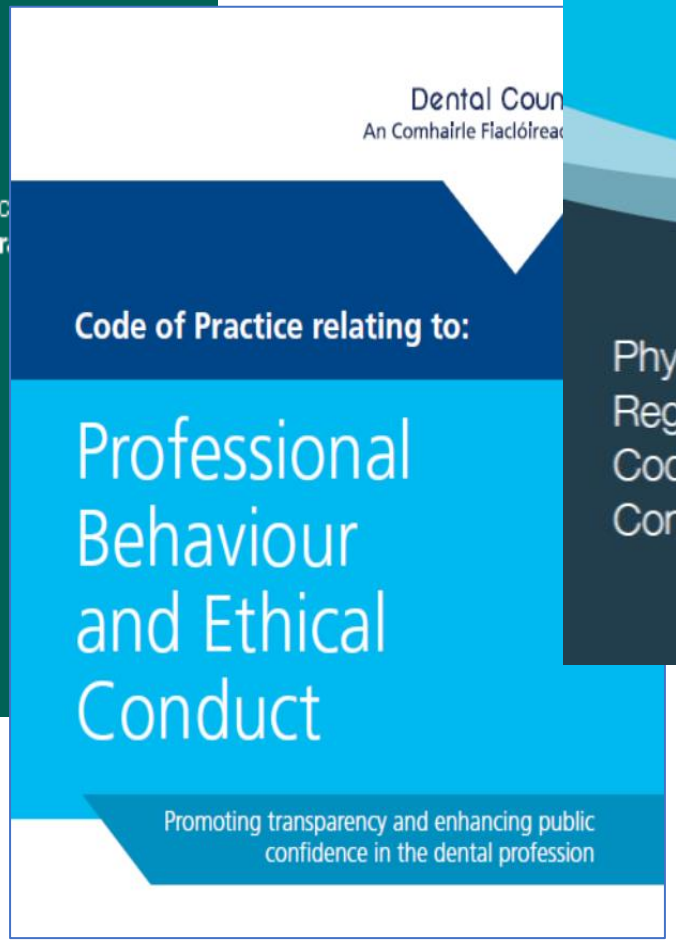
Report all adverse incidents/claims to the State Claims Agency

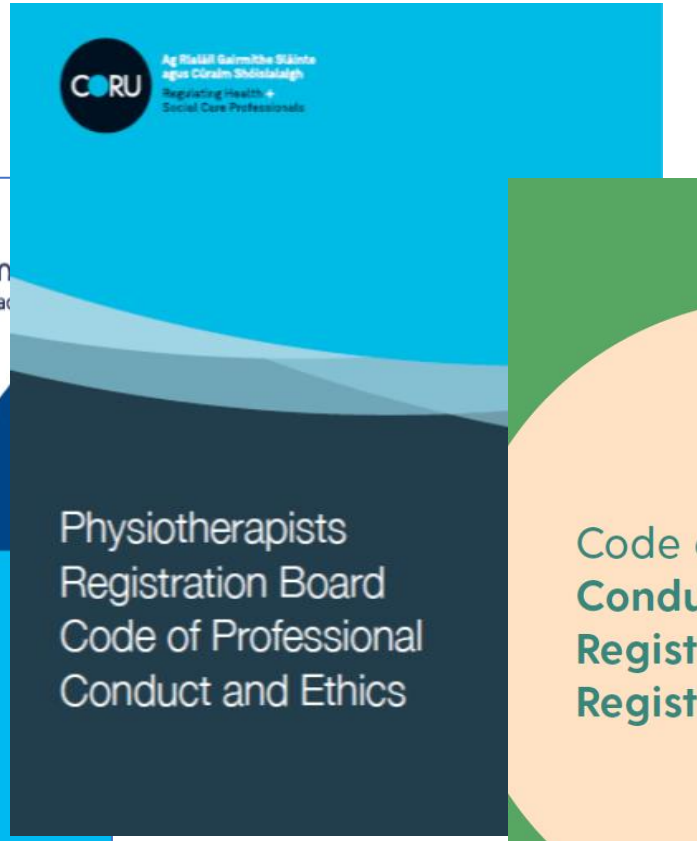
Furnish all necessary and requested information and documentation to the State Claims Agency

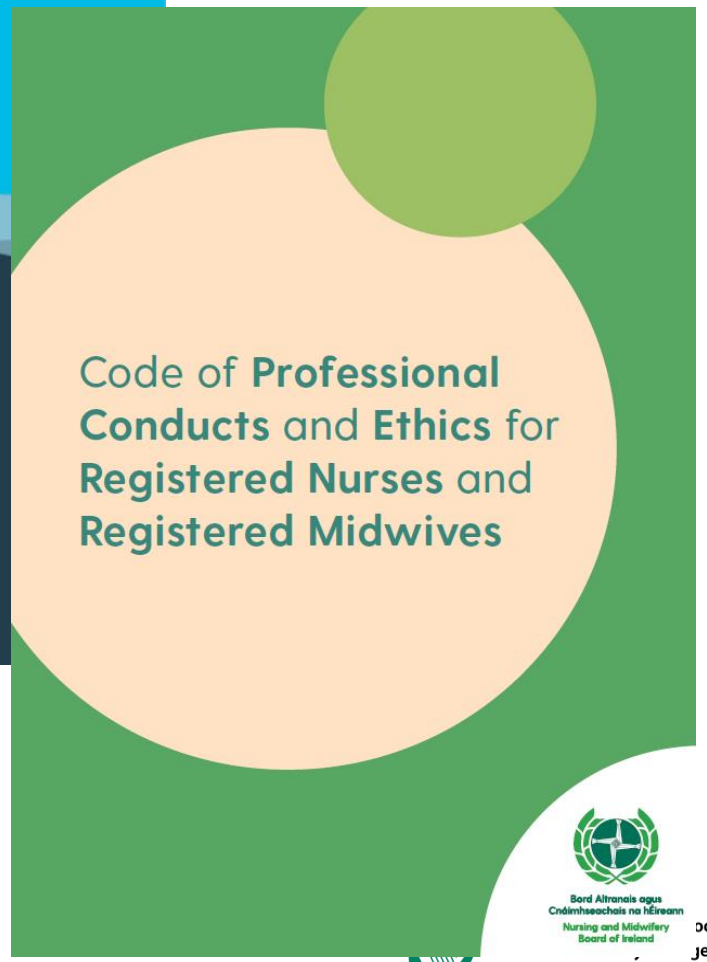
Permit and assist the State Claims Agency to investigate adverse incidents/claims

Professional Regulators: Indemnity Requirements









Bord Altranais agus Cnáimhseachais na hÉireann
Nursing and Midwifery Board of Ireland

ochta an Chisteáin Náisiúnta
gement Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

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State Claims Agency

Clinical Risk Unit

Clinical Risk Unit (CRU)

Education and learning activities

- Conferences, webinars and other events
- Publications
- Teaching

Data analysis and research

- Incident analysis
- Closed claims analysis

Enhanced patient safety
Reduced risk of litigation

Influence on national policy

- Influence on policy development and implementation
- Programme sponsorship and support

Risk management

- Clinical risk advice
- Engagement with enterprises on emerging risks

Incident Reporting

	Incidents Recorded
2017	169,081
2018	197,031
2019	213,284
2020	211,431

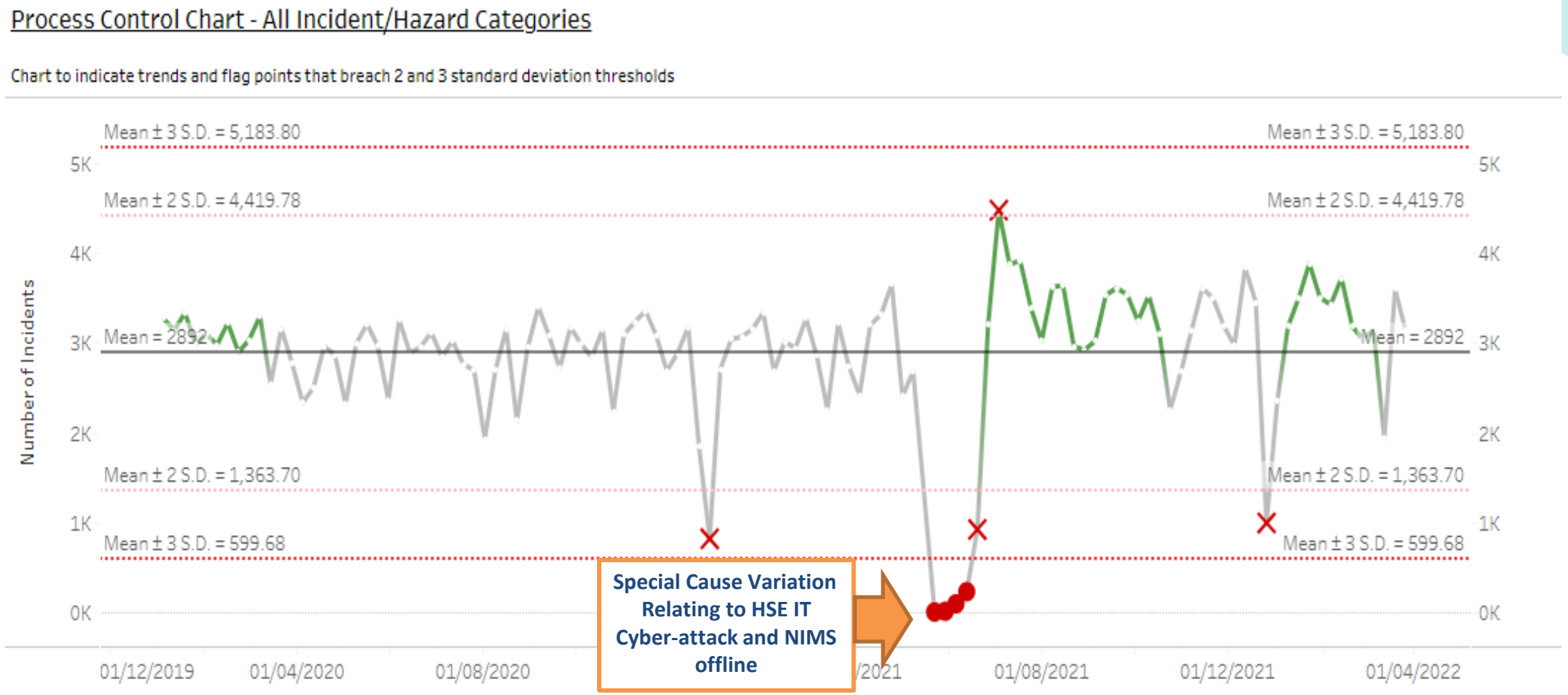
More than

2.07m

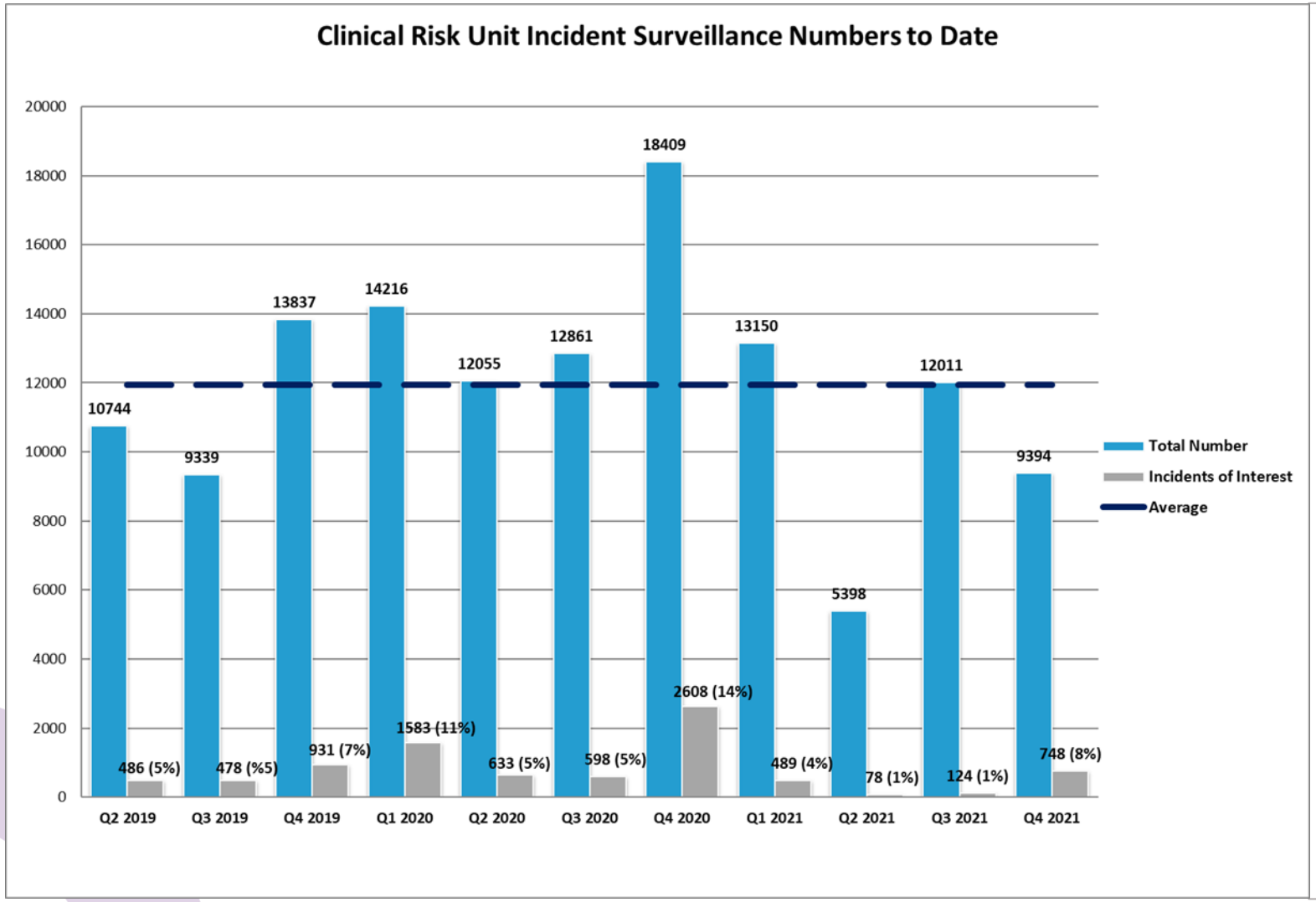
incidents reported by end 2020

(Refers to incidents reported by State Authorities via NIMS)

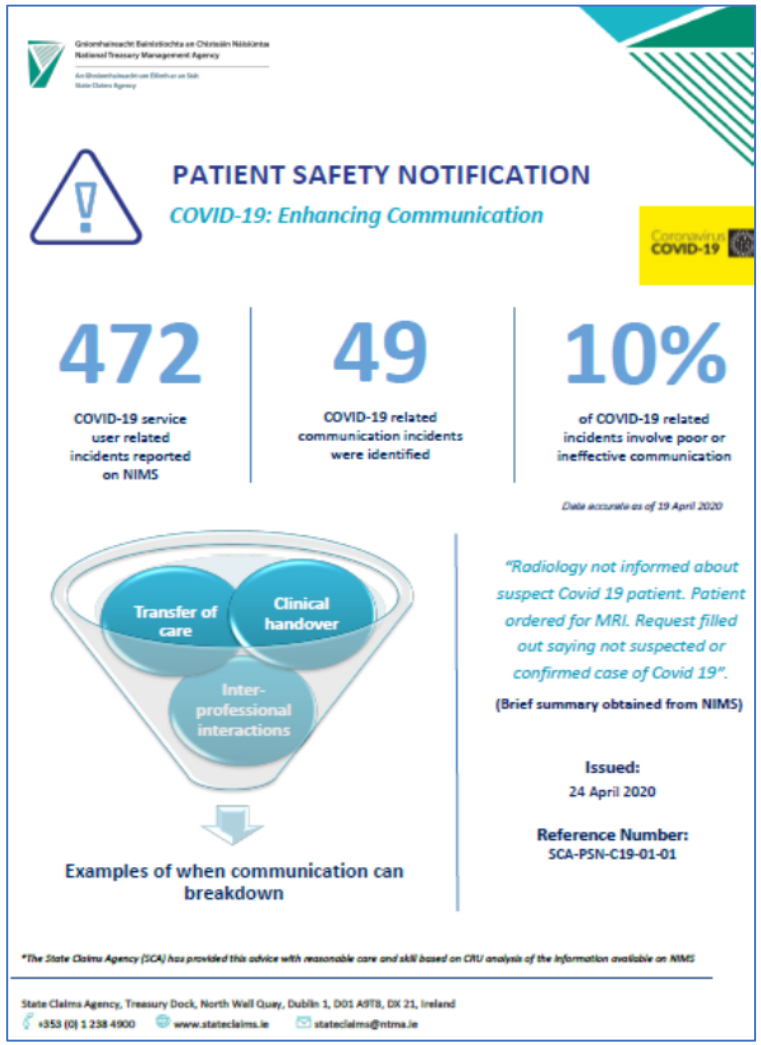
Total Service User Incidents



CRU: Incident Surveillance



CRU: Patient Safety Notifications



PATIENT SAFETY NOTIFICATION

COVID-19: Enhancing Communication

Coronavirus COVID-19

472
COVID-19 service user related incidents reported on NIMS

49
COVID-19 related communication incidents were identified

10%
of COVID-19 related incidents involve poor or ineffective communication

Data accurate as of 19 April 2020

Examples of when communication can breakdown

"Radiology not informed about suspect Covid 19 patient. Patient ordered for MRI. Request filled out saying not suspected or confirmed case of Covid 19".

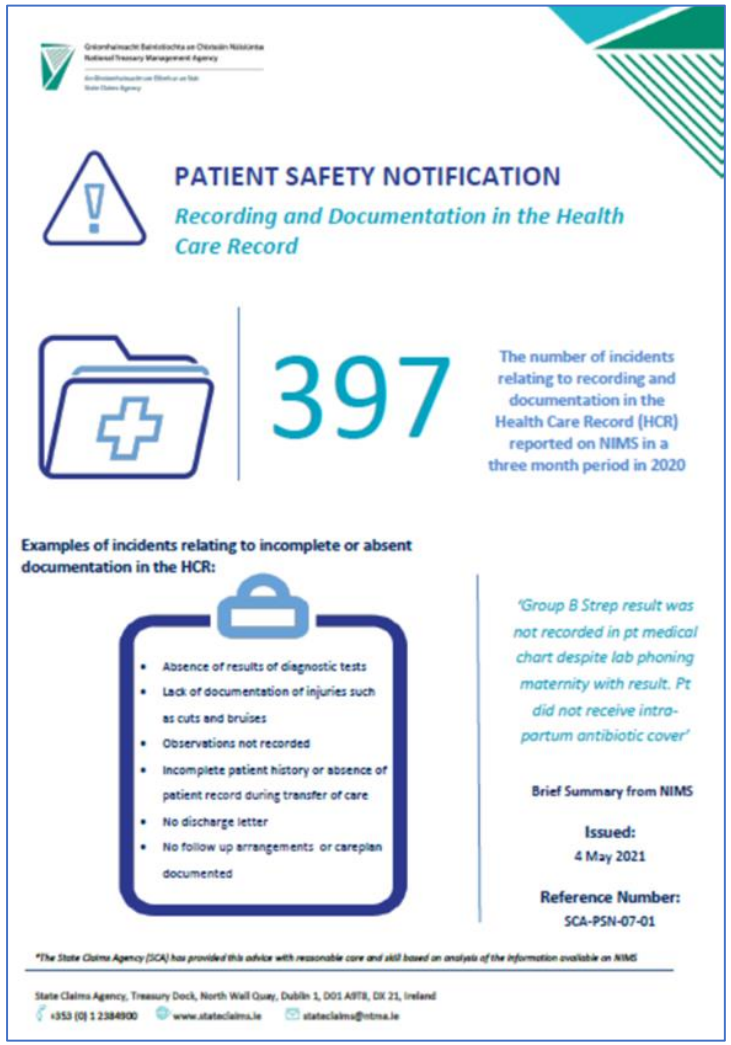
(Brief summary obtained from NIMS)

Issued:
24 April 2020

Reference Number:
SCA-PSN-C19-01-01

**The State Claims Agency (SCA) has provided this advice with reasonable care and skill based on CRU analysis of the information available on NIMS*

State Claims Agency, Treasury Dock, North Wall Quay, Dublin 1, D01 A9T8, DX 21, Ireland
+353 (0) 1 238 4900 www.stateclaims.ie stateclaims@ntma.ie



PATIENT SAFETY NOTIFICATION

Recording and Documentation in the Health Care Record

397
The number of incidents relating to recording and documentation in the Health Care Record (HCR) reported on NIMS in a three month period in 2020

Examples of incidents relating to incomplete or absent documentation in the HCR:

- Absence of results of diagnostic tests
- Lack of documentation of injuries such as cuts and bruises
- Observations not recorded
- Incomplete patient history or absence of patient record during transfer of care
- No discharge letter
- No follow up arrangements or careplan documented

'Group B Strep result was not recorded in pt medical chart despite lab phoning maternity with result. Pt did not receive intra-partum antibiotic cover'

Brief Summary from NIMS

Issued:
4 May 2021

Reference Number:
SCA-PSN-07-01

**The State Claims Agency (SCA) has provided this advice with reasonable care and skill based on analysis of the information available on NIMS*

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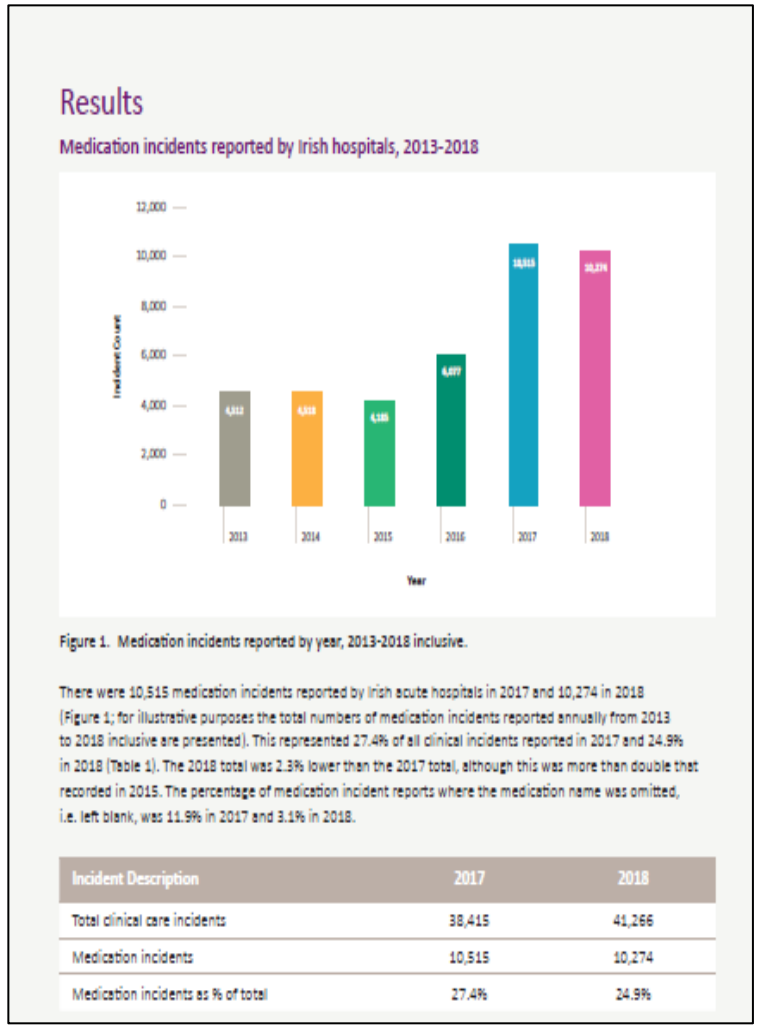
+353 (0) 1 2384900 www.stateclaims.ie stateclaims@ntma.ie

CRU: Medication Incidents Report



Results

Medication incidents reported by Irish hospitals, 2013-2018

Figure 1. Medication incidents reported by year, 2013-2018 inclusive.

There were 10,515 medication incidents reported by Irish acute hospitals in 2017 and 10,274 in 2018 (Figure 1; for illustrative purposes the total numbers of medication incidents reported annually from 2013 to 2018 inclusive are presented). This represented 27.4% of all clinical incidents reported in 2017 and 24.9% in 2018 (Table 1). The 2018 total was 2.3% lower than the 2017 total, although this was more than double that recorded in 2015. The percentage of medication incident reports where the medication name was omitted, i.e. left blank, was 11.9% in 2017 and 3.1% in 2018.

Incident Description	2017	2018
Total clinical care incidents	38,415	41,266
Medication incidents	10,515	10,274
Medication incidents as % of total	27.4%	24.9%

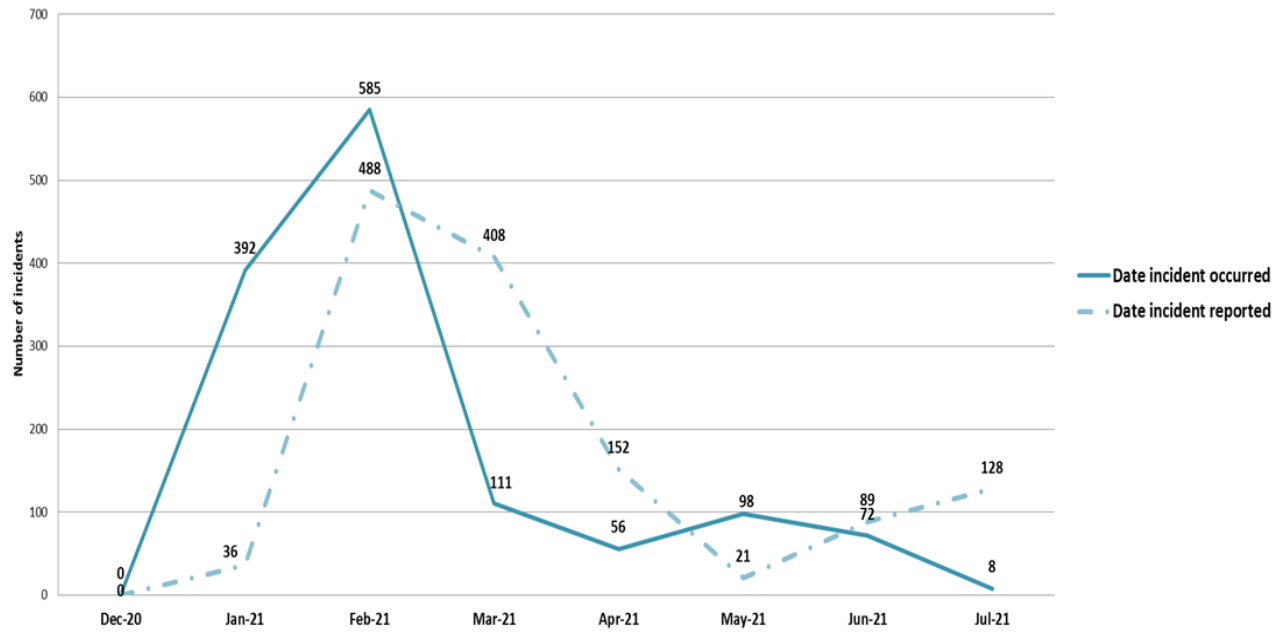
COVID-19 Vaccine Incidents Report

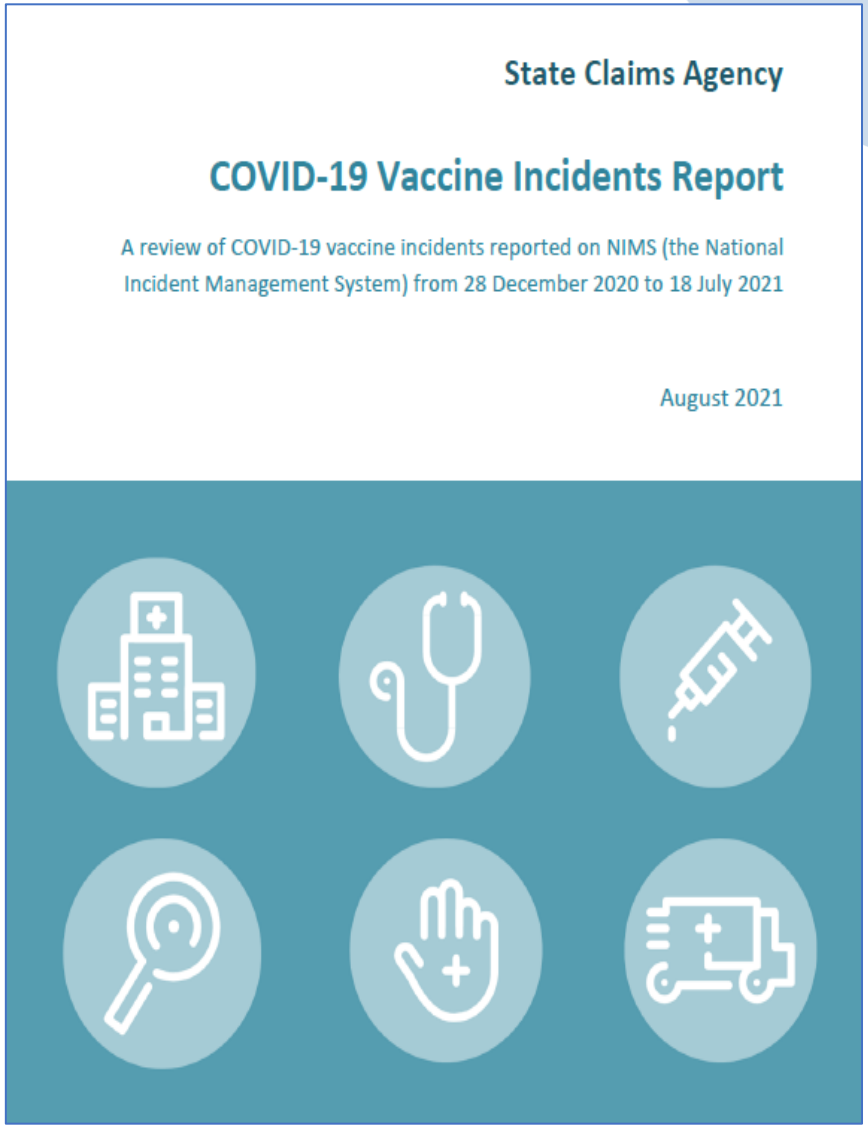
5,540
Number of COVID-19 service user incidents reviewed from 28 Dec 20 - 18 July 21 *

24%
of these were COVID-19 vaccine incidents

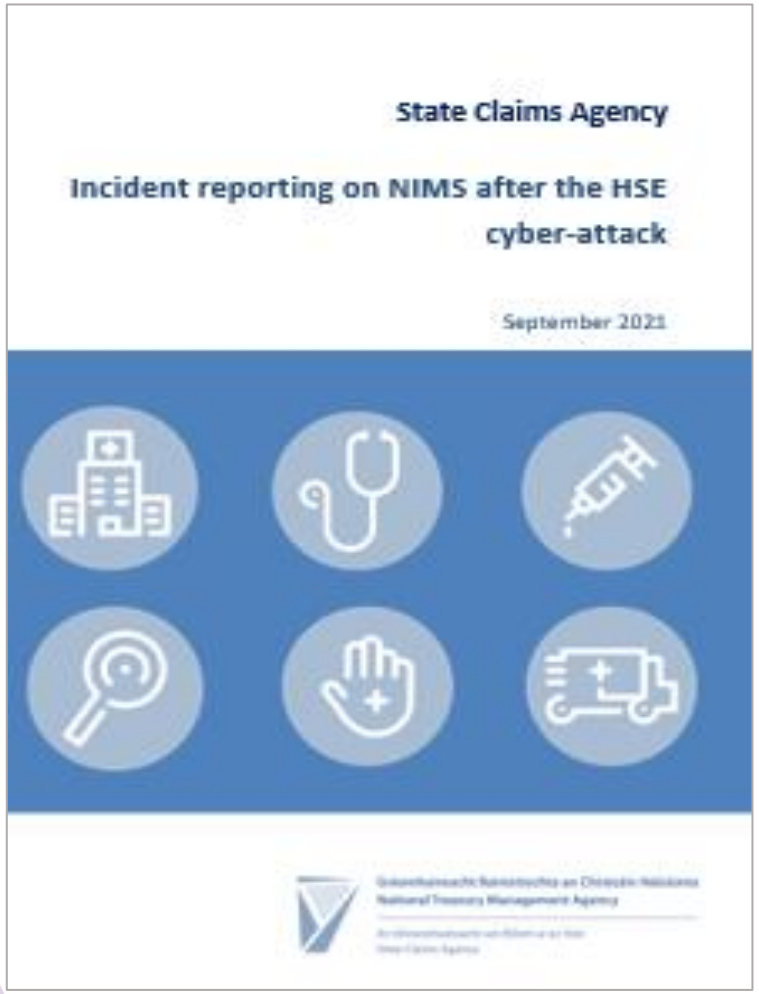
1,322
Number of COVID-19 vaccine incidents

Figure 2: COVID-19 vaccine incidents by 'date incident occured' (n=1,322) and 'date incident reported' (n=1,322)





HSE Cyber-Attack Type of Incidents Reported



- No access to IT systems
- No access to healthcare records
- Impact on provision of care / services
- Service user identification
- Manual systems workarounds
- Documentation issues
- Diagnostic imaging
- Cyber security

HSE Cyber-attack Incidents: Examples

No access to IT systems

Administration / Communication	Clinical care and patient information systems	Laboratory systems
• Unable to send communications to other health and social care services • Non-completion of COVID-19 pre-assessment questionnaire • Incident reporting system unavailable	• No access to electronic Health Care Records (HCRs) • No access to patient information systems e.g. IPMS, NIMIS, Compuscope system • Unable to access or compare previous blood results, radiological images and diagnostic test results • No access to review service user infection control status	• Delay processing of all samples including COVID-19 swabs • No electronic lab results, no mechanism to notify regarding infectious diseases • No labels available • No access to Blood Track, Healthlink, REES email system • Critical results not communicated

Summary of an incident extracted from NIMS relevant to this theme:

'Surgeon unable to view x-rays as a result of the HSE Cyber-attack. Patient and instruments were prepared for surgery. Discovered after screening that a different surgery was required'.

An example incident reported by community relating to the cyber-attack:

Patient d/c following birth of baby was faxed to nursing office however fax machine not operating due to cyber attack. D/c summary not received until 27/5/21 resulting in a delay postnatal visit

CRU Activities

Risk Management

- Clinical risk advice
- Engagement with enterprises
- Indemnity advice

National influence

- HSE
- National Women and Infants health Programme
- Open Disclosure
- Independent Patient Safety Council
- National consultations

NIMS

- Clinical Procedures
- COVID-19
- Vaccines
- ePO

CRU: Education

Education and learning activities

- Conferences, webinars and other events
- Publications
- Teaching

Higher Education Institutions:

- Undergraduate and post-graduate
- Post-graduate training bodies
- Health and social care services

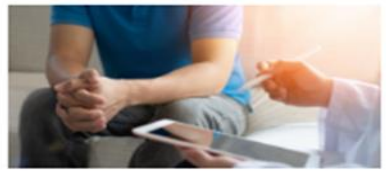
CRU: Publications

[*Available at:*
https://stateclaimsagency.newsweaver.com/iajgg65lgu/l01a49ch2s8]

Articles

Why clinical claims occur and how to avoid them

In this article, Dr Karen Power examines some of the common features seen in the SCA's portfolio of clinical claims.



Recording and documentation in the Healthcare Record

Natasha Coen and Mary Godfrey from the SCA's Clinical Risk Unit look at recording and documentation in the Healthcare Record (HCR).

Insulin: A high-risk medication

Mark McCullagh, Clinical Risk Adviser, looks at the risks presented by insulin and what healthcare organisations can do to reduce insulin-related patient harm.

NIMS update

An update on changes to the categorisation of clinical care incidents on NIMS, the National Incident Management System.

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Clinical Claims Unit

Claims Activity (to end-2020)

8,677
General Claims

3,498
Clinical Claims

12,175

Managing a Complex Claims Portfolio

The SCA was managing 12,175 active claims with an estimated outstanding liability of €4.03bn at end 2020

=

€4.03bn

Total Estimated Outstanding Liability

[*Available at*: https://www.ntma.ie/annualreport2020/documents/NTMA_Annual_Report_2020.pdf]

Clinical Claims Activity (to end-2020)

3,498

Managing a Complex Clinical Claims Portfolio

The SCA was managing 3,498 active clinical claims with an estimated outstanding liability of €3.03bn at end 2020

=

€3.03bn

Total Estimated Outstanding Liability relating to clinical claims in 2020

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Clinical Claims Unit - Our Role

- Conducting thorough and timely investigations of claims to conclude liability
- Commissioning medical and other expert reports
- Applying a notional reserve/ contingent liability to the claim
- Developing a claims resolution approach and making decisions relating to claim resolution
- Appointing in-house solicitors or panel firm solicitors, where necessary, to assist with the claim
- Continuously reviewing claims and monitoring reserves/contingent liability
- Offering and engaging in alternative dispute resolution methods, such as mediation, and in settlement negotiations
- Preparing for and going to trial where the claim or level of compensation sought is disputed
- Liaising with the State Authority during the claim resolution process and notifying it about the claim outcome
- Providing legal representation at inquests
- Collaborating with our Clinical Risk Unit to develop learning from closed claims

General Flow of a Claim…

Claim Resolution Process

1
Claim received by the State Claims Agency

2
Claim investigated by the State Claims Agency including engagement with State Authority

3
Decision to settle or defend/proceed to Trial by the State Claims Agency

4
Mediation or settlement negotiations entered into or prepare for Trial, based on decision

5
Liaise with State Authority as required and appropriate

6
Settlement/claim related payments paid by State Authority

7
Claim outcome notified to State Authority contact and file closed

When might we defend a claim?

- Strong factual or expert evidence
- Good documentation (procedures) and records (risk assessments, inspection checklists, evidence of training)
- Non-State party was the author of his misfortune
- Evidence that injury did not occur where or in the manner alleged
- Non-State party was responsible for the accident
- Amount of compensation sought is excessive
- Precedent case - legal point

Statute of Limitations

ADULT: 2 years from date of incident or date of knowledge (if later)

MINORS: 2 years from date of reaching majority or date of knowledge (if later)

INCAPACITY: Lack of mental capacity - no time limit

Possible Outcomes

- Settlement of the legal action
- Lodgement/ Tender into Court to satisfy the Plaintiff's claim
- Plaintiff discontinues the legal action
- Court Hearing

What do you do?

If a claim is made, do not be alarmed

Notify your Claims Co-ordinator/CIS

Review your involvement with reference to HCR

Prepare a statement/ report for CIS

- *"Privileged – Prepared in contemplation of litigation at the request of CIS"*

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Inquests

Inquests

Deaths that are

- Sudden
- Unexplained
- Violent or
- Unnatural

must be investigated by law by the Coroner (State Official) of the district in which the death occurred.

Deaths in Hospital

Death on arrival to hospital
Death within 24 hours of admission
Death due to surgical procedure or anaesthesia or as a result of a complication of surgery/anaesthesia
Death as a result of an allergic or toxic reaction to a drug
Maternal deaths
Certain healthcare acquired infections
Where there is any doubt as to the cause of death

Purpose of an Inquest

- A fact finding inquiry with or without a jury – not a Trial
- To ascertain who, when, where and how the person died
- To determine the medical cause of death
- Questions of civil or criminal liability should not be considered
- Inquisitorial
- Not adversarial

Notice of an Inquest

- Coroner will decide on the witnesses to be called
- Statement requested by Coroner or the Gardaí
- If asked for a statement by the Coroner, please notify the Hospital Litigation Co-ordinator
- You are entitled to legal representation at the Inquest
- Your role is to assist the Coroner/Jury in determining the cause of death

Statements

- ✓First, read the healthcare records….
- ✓ Name, qualifications and experience and position at the relevant time
- ✓ In chronological order, detail your involvement in the deceased patient's care
- ✓ Refer to entries in records, where relevant
- ✓ Address discrepancies in the records
- ✓ TRUE and ACCURATE account of the FACTS
- ✓Do not comment on the actions of any other person
- ✓Do not include matters of hearsay or opinion
- ✓ An expression of sympathy may be offered to the family
- ✓ Sign, date and keep a copy

Inquest hearing

- Evidence under oath
- An Garda Siochana will give evidence as to the identity of the deceased
- Statement will be read in to evidence
- Questions from the family's legal representative
- The Pathologist will give evidence as to the cause of death

Potential Verdicts

- Natural causes
- Narrative verdict
- Accident
- Misadventure/ Medical Misadventure
- Suicide
- Stillbirth
- Open verdict

Practical Advice

- “Prepare as if you are going to the High Court & act as if you going to a funeral”
- Have a copy of your statement and be familiar with it
- Address the Coroner as “Coroner”
- When answering questions be professional and concise
- You can refer to the medical records anytime
- You don’t understand the question?...say it
- You don’t know the answer?... say you don’t know
- Do not guess the answer!

Learning from Clinical Claims

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Closed Claims Learning Opportunities

Record adverse events on NIMS

Knowledge / skills and competency suitable to the task

Appropriate assessment and monitoring

Follow-up on diagnostic tests and investigations

Pay attention to discharge planning

Communicate clearly with colleagues

Communicate clearly with patients

Comprehensive consent, well documented

Careful documentation
No notes → no defence!

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Why things go wrong

Inadequate or substandard communication either with service users, or inter-professional communication with colleagues, multi-disciplinary teams or services, is a recurring issue

Common across all services and specialities

Communication issues identified in claims (analysis)

Substandard or omitted consent

Inadequate or omitted Open Disclosure

Substandard clinical documentation

Inadequate follow-up arrangements

Inadequate communication / care pathways between services

Inadequate communication between members of MDT

Failure to escalate to a senior decision maker

Inadequate communication with patients/service users

Deficits in communication is a common issue across all clinical services/specialties.

Evidence of Open Disclosure

Service	Number of Claims	Evidence of OD in % number of claims	Number of Claims
Maternity and Gynaecology	57	12	7
Perioperative	64	6	4
Medicine	46	9	4
Community	20	25	5
Children's	15	13	2

International Evidence

*"Analysis of claims tends to revolve around the **precipitating clinical factors**, such as a delay in diagnosis, incorrect surgical technique or medication error. However, the risk of complaint and litigation appears to have much more to do with **predisposing factors such as our communication skills**, sensitivity to patient needs and management of expectations…"*

Dr Mark Dinwoodie, MPS Casebook, May 2014

International Evidence

The Joint Commission | Joint Commission International

WHO Collaborating Centre for Patient Safety Solutions

World Health Organization

Aide Memoire

Patient Safety Solutions | volume 1, solution 3 | May 2007

"***Breakdown in communication*** was the leading root cause of sentinel events reported to the Joint Commission in the United States of America between 1995 and 2006…

Of the 25 000 to 30 000 preventable adverse events that led to permanent disability in Australia, ***11% were due to communication issues,*** in contrast to 6% due to inadequate skill levels of practitioners…"

International Evidence

The Doctor-Patient Relationship and Malpractice

Lessons From Plaintiff Depositions

Howard B. Beckman, MD; Kathryn M. Markakis, MD; Anthony L. Suchman, MD; et al

» Author Affiliations

Arch Intern Med. 1994;154(12):1365-1370. doi:10.1001/archinte.1994.00420120093010

"In our sample, the decision to litigate was often associated with a perceived lack of caring and/or collaboration in the delivery of health care. The issues identified included **perceived unavailability, discounting patient and/or family concerns, poor delivery of information, and lack of understanding the patient and/or family perspective.**"

International Evidence

In 2002 University of Michigan Health System adopted full disclosure policy 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"

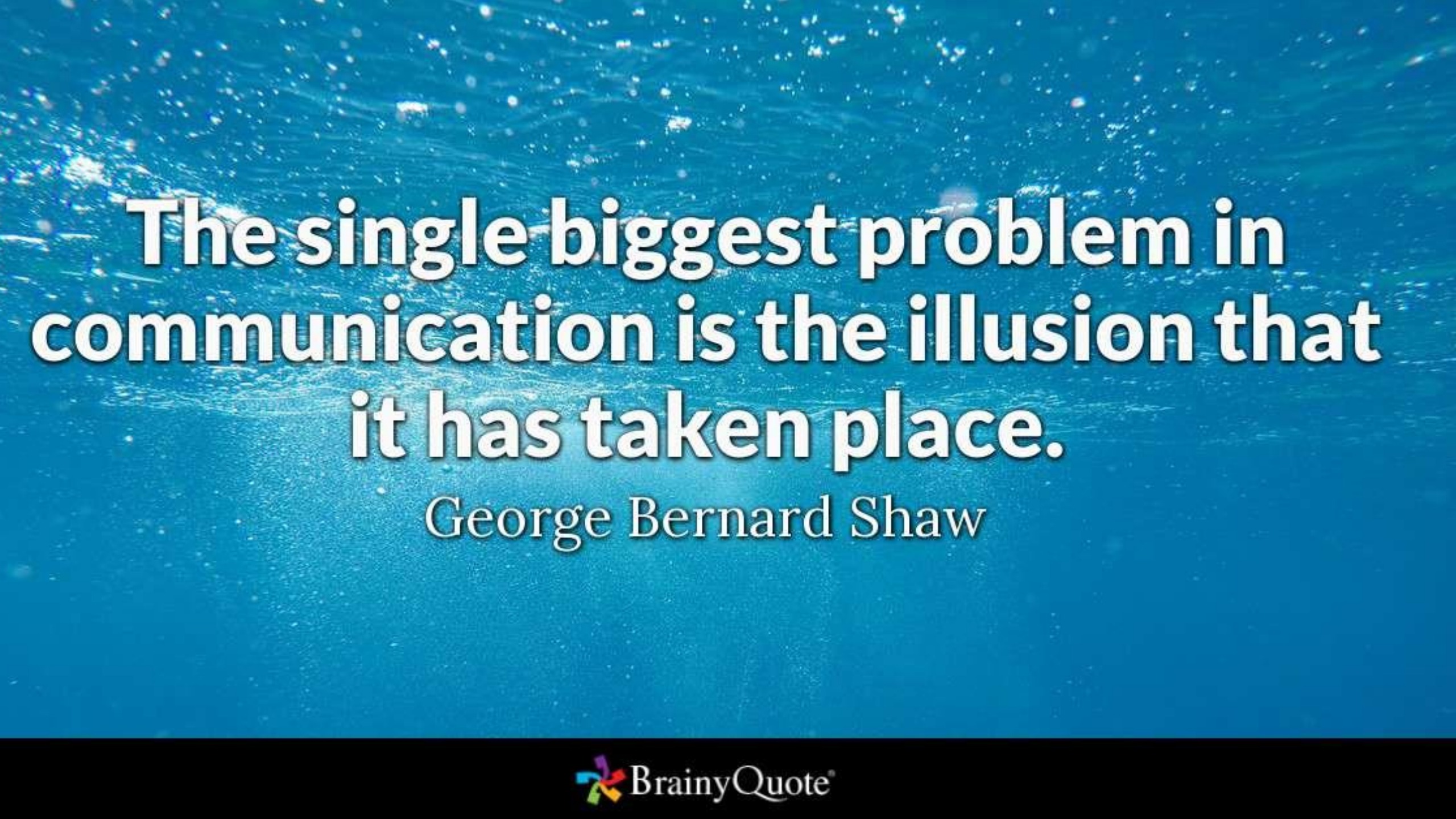
Between August 2001 and August 2007:

Ratio of litigated cases:	↓ from 65% to 27%
Average claims processing time:	↓ from 20.3 months to 8 months
Insurance reserves:	↓ by more than two thirds
Average litigation costs:	↓ more than halved.

State Claims Agency: Recommendations

- Open disclosure should be undertaken and recorded in relation to service user safety incidents in accordance with the HSE's Open Disclosure policy (HSE, 2019).

- Open disclosure should be recorded on NIMS, and if not, a rational for not doing so provided.


The single biggest problem in communication is the illusion that it has taken place.
George Bernard Shaw
BrainyQuote


THANK
YOU