



Clinical Indemnity Scheme



Assuring Quality Outcomes: ***Quality, Safety and Risk framework***

29th September, 2010

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Clinical Indemnity Scheme

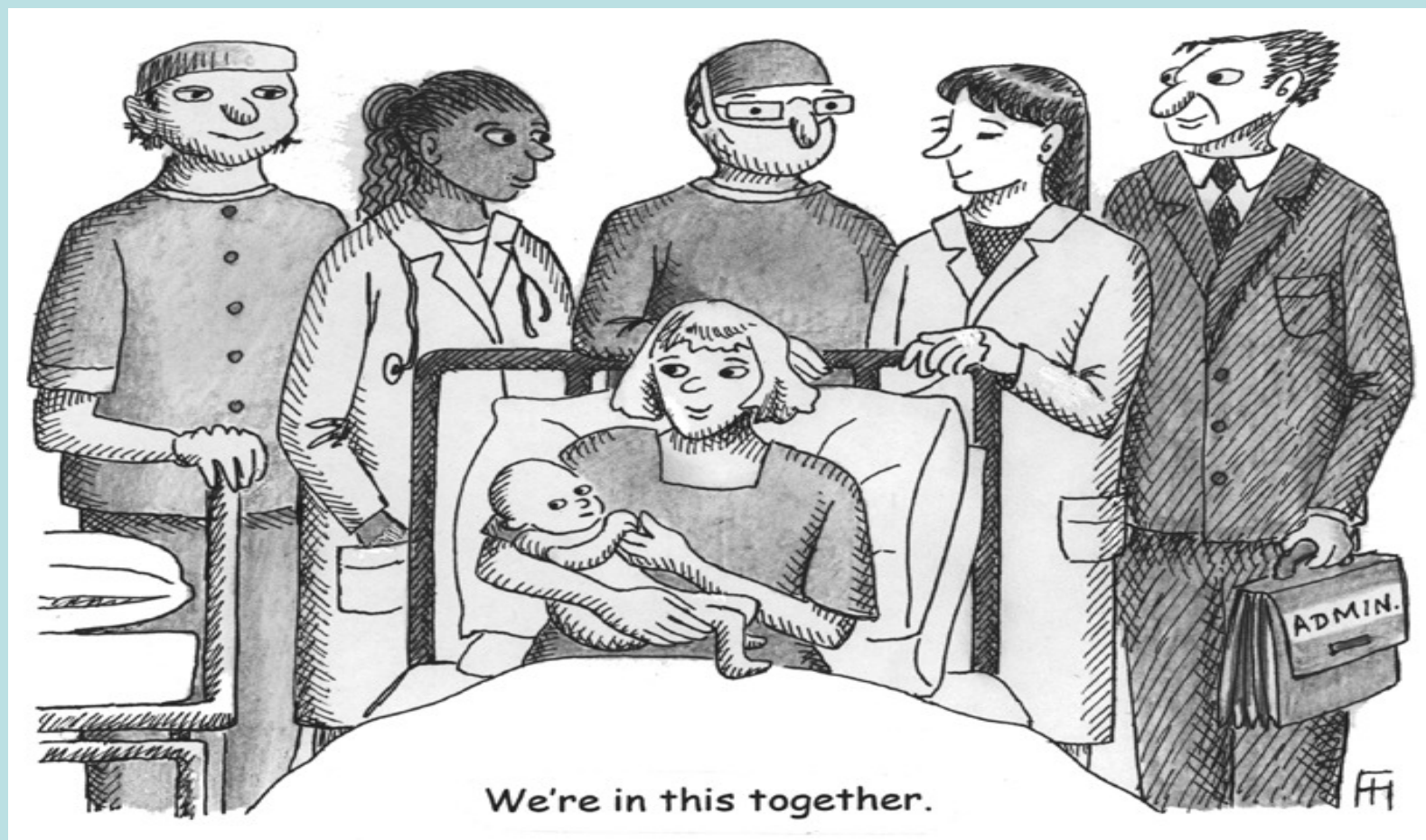


Objectives

- To probe the Quality, Safety and Risk framework needed to support person-centred positive risk taking for service users.



Enterprise Liability





Organisational Structure

National Treasury Management Agency
Manages National Debt

State Claims Agency

Manages claims against public bodies on behalf of the State
Est. under NTMA(Amendment) Act 2000. (Start date : 3 December 2001)

Clinical Indemnity Scheme

Manages claims/ risk management in Public Health sector
Est. 1 July 2002; Delegation Order made: 18 February 2003.

(S.I. No. 63 of 2003 National Treasury Management Agency (Delegation of Functions) Order 2003)



Clinical Indemnity Scheme (CIS)

Objectives

- To drive and support a patient safety culture**
- To reduce the number of clinical claims**
- To manage clinical claims in a cost-effective and timely manner**



Relevance of CIS to you

CIS will:-

- Offer Risk Management Advice and Support

And in the event of a claim/inquest:-

Represent your interests by

- Investigating and defending claims
- Appointing and liaising with legal team
- Instructing and liaising with experts
- Covering all of the legal costs of the case
- Paying a Court award or settlement, if applicable.



Perceptions

A social model of disability sees the social world as causing disability by the imposition of barriers rather than disability being the effect of impairments.

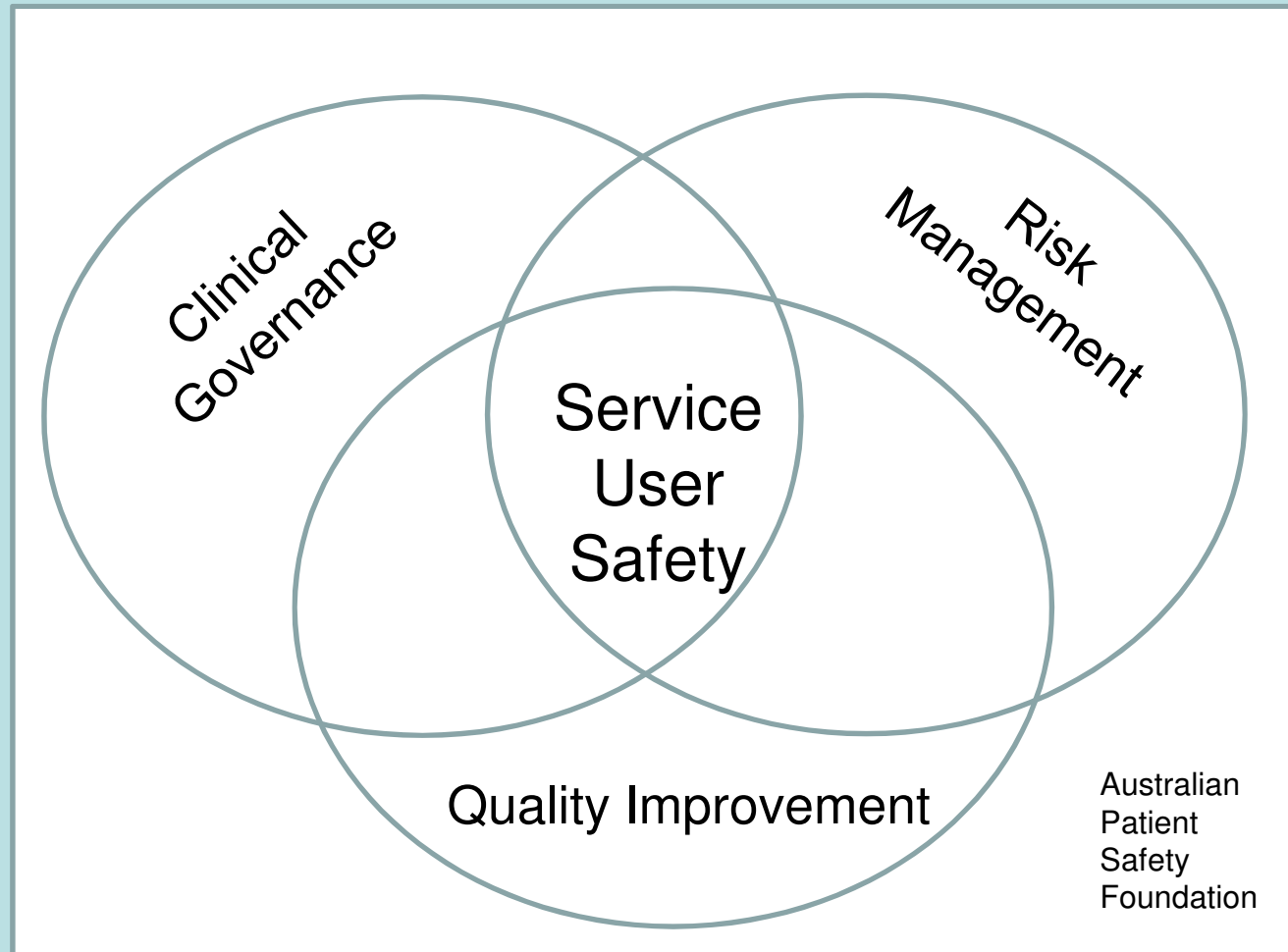
(Light & Quin, 2003)



Person Centred Planning

*“A way of discovering how a person wants to live their life and what is required to make that possible... The primary focus is **a person**... A balance has to be worked out between what is important **to** the person and what is important **for** them when there is a conflict between the two”*

NDA Guidelines on Person Centred Planning in the Provision of Services for
People with Disabilities in Ireland, 2005



“Primum Non Nocere” (Above all, do no harm)
Attributed to Hippocrates



Key Definitions

Patient/Service User Safety — the reduction of risk of unnecessary harm associated with health (and social) care *to an acceptable* minimum. WHO ICPS 2009

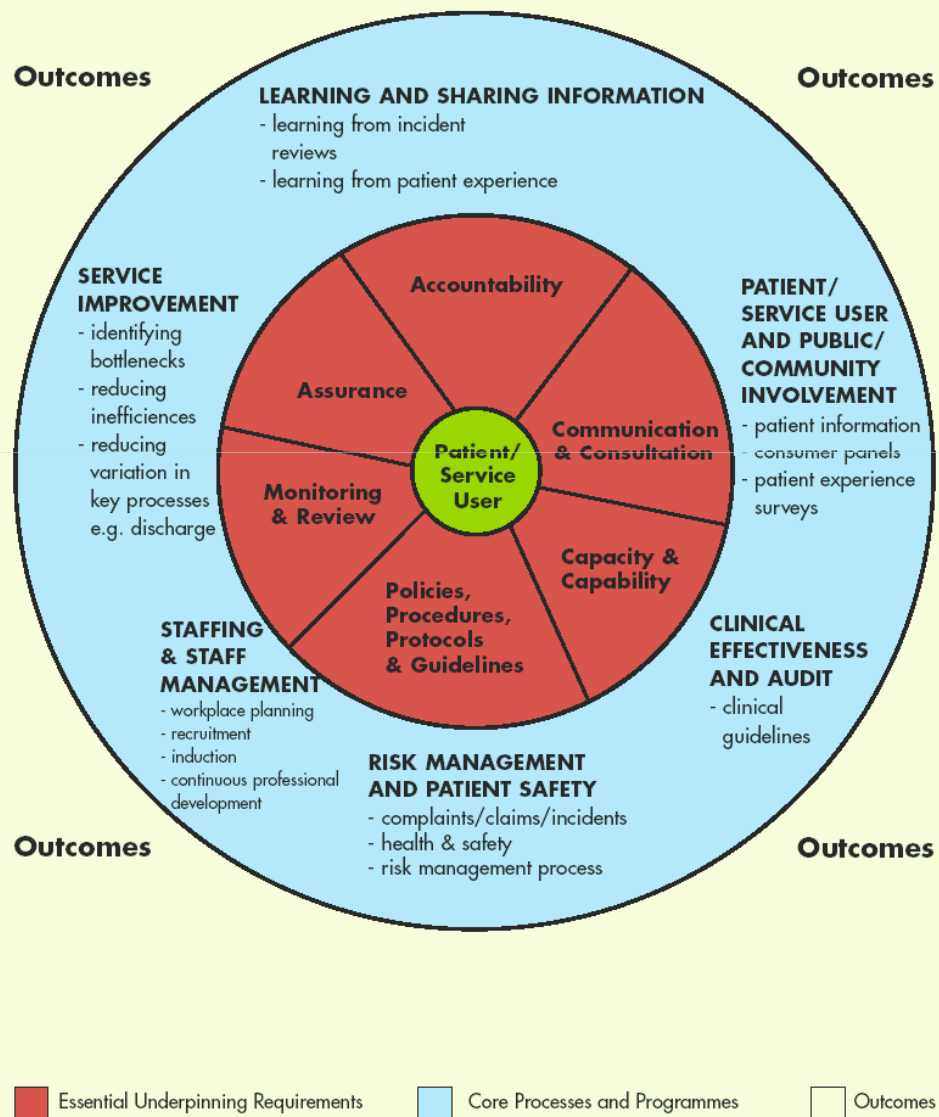
Clinical Governance – “ *a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care*” A First Class Service, 1998

Risk Management - “*The culture, process and structures that are directed towards realizing potential opportunities whilst managing adverse effects*” AS/NZS 4360:2004

Quality Improvement – “*organisational philosophy that seeks to meet patients/clients’ needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of care/service.*”
IHSAB, 2004



Integrated Quality, Safety and Risk Framework



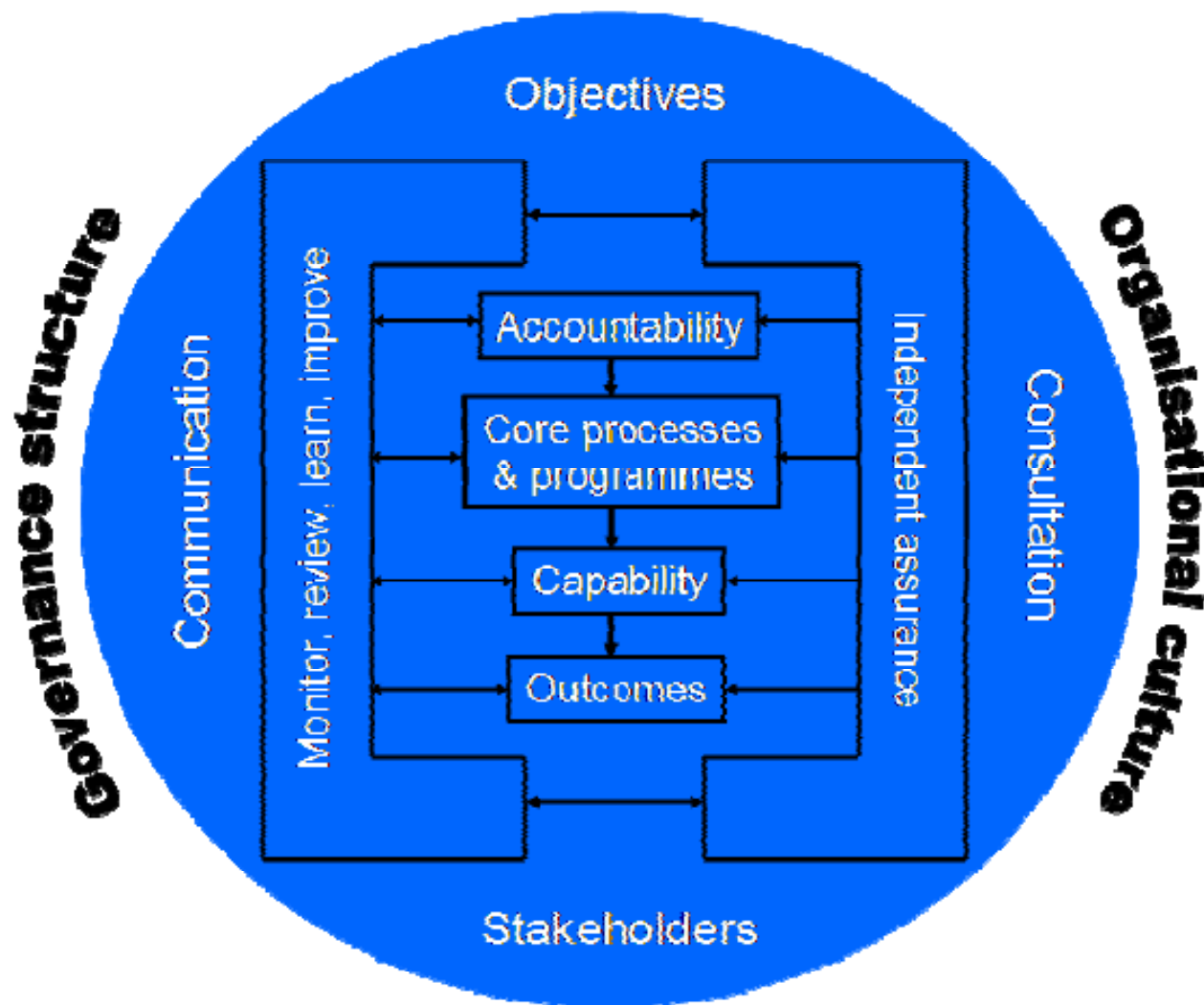
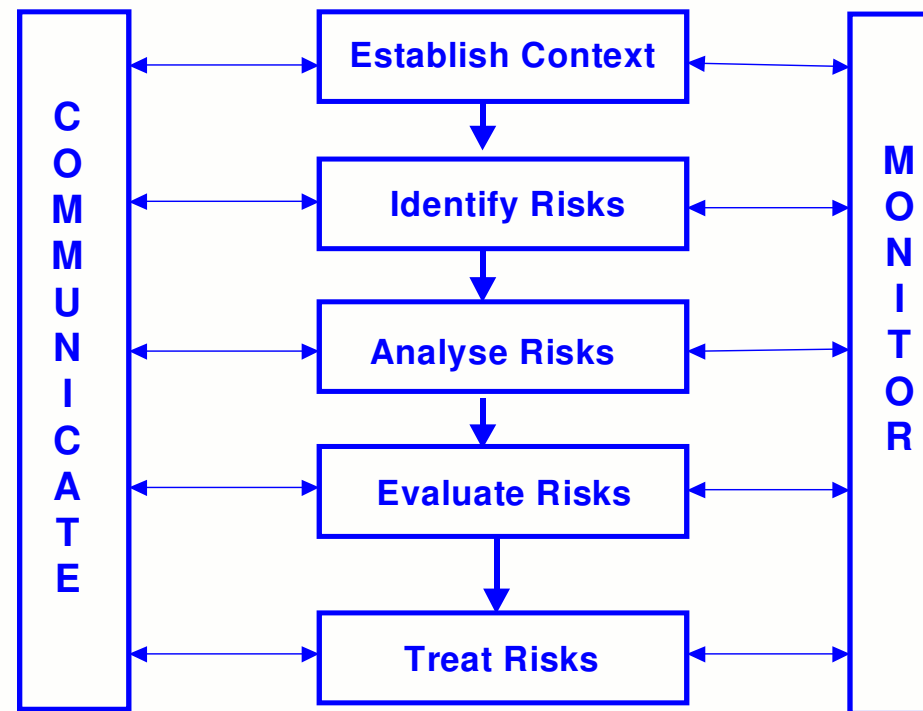
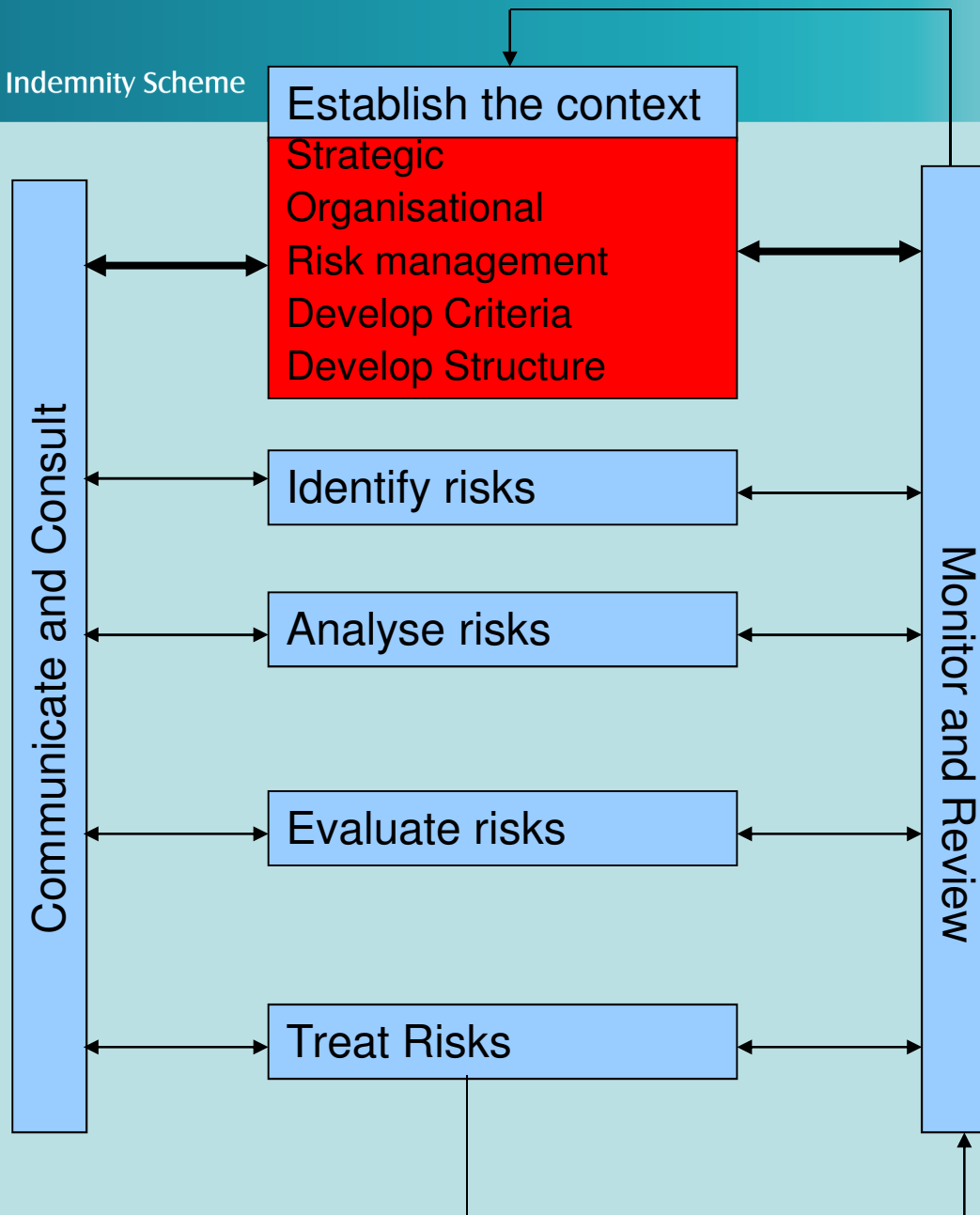


Figure 1 – Internal Control Model

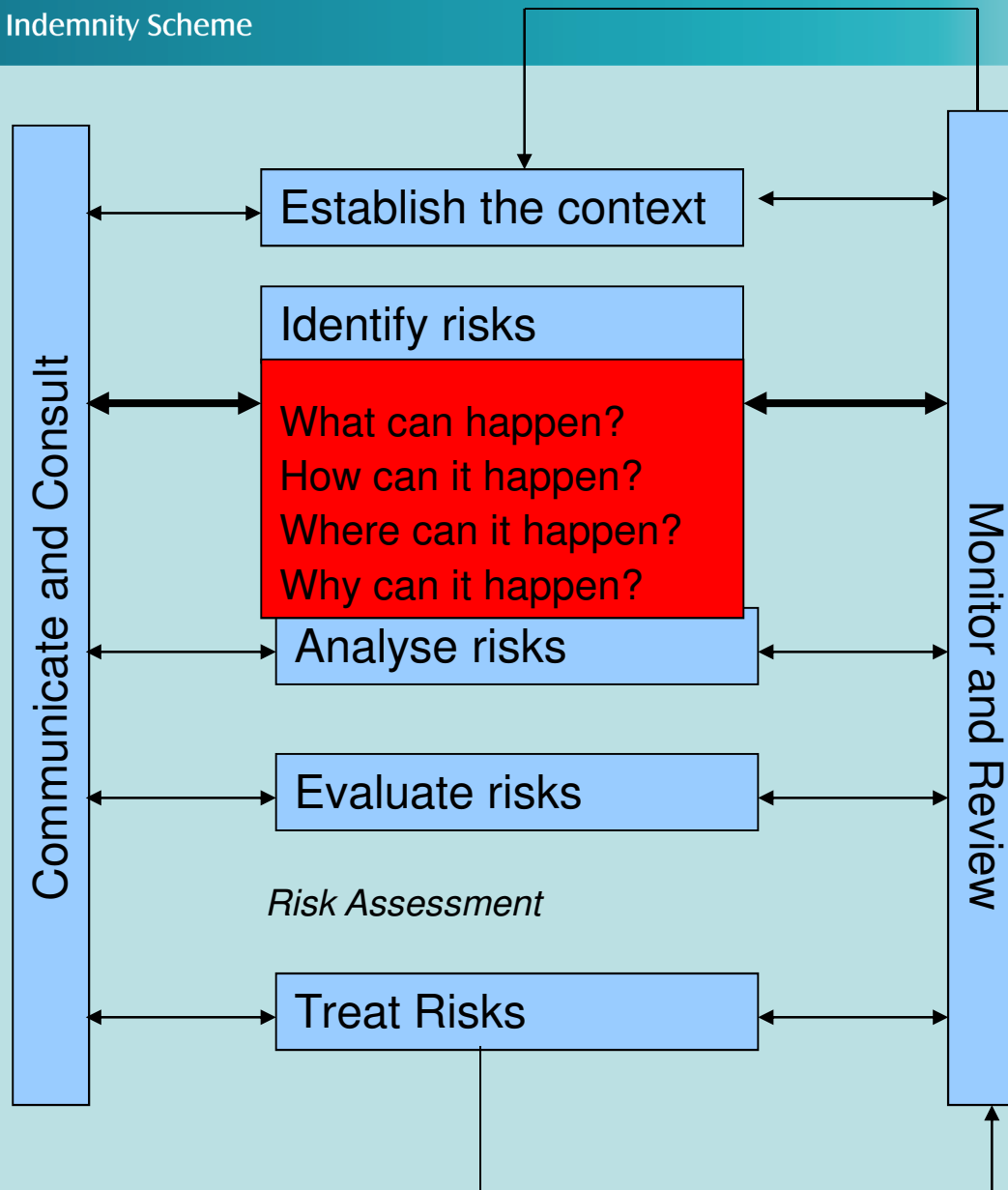
The Risk Management Process





Risk Management Overview

AS/NZS RM Standard
4360: 2004

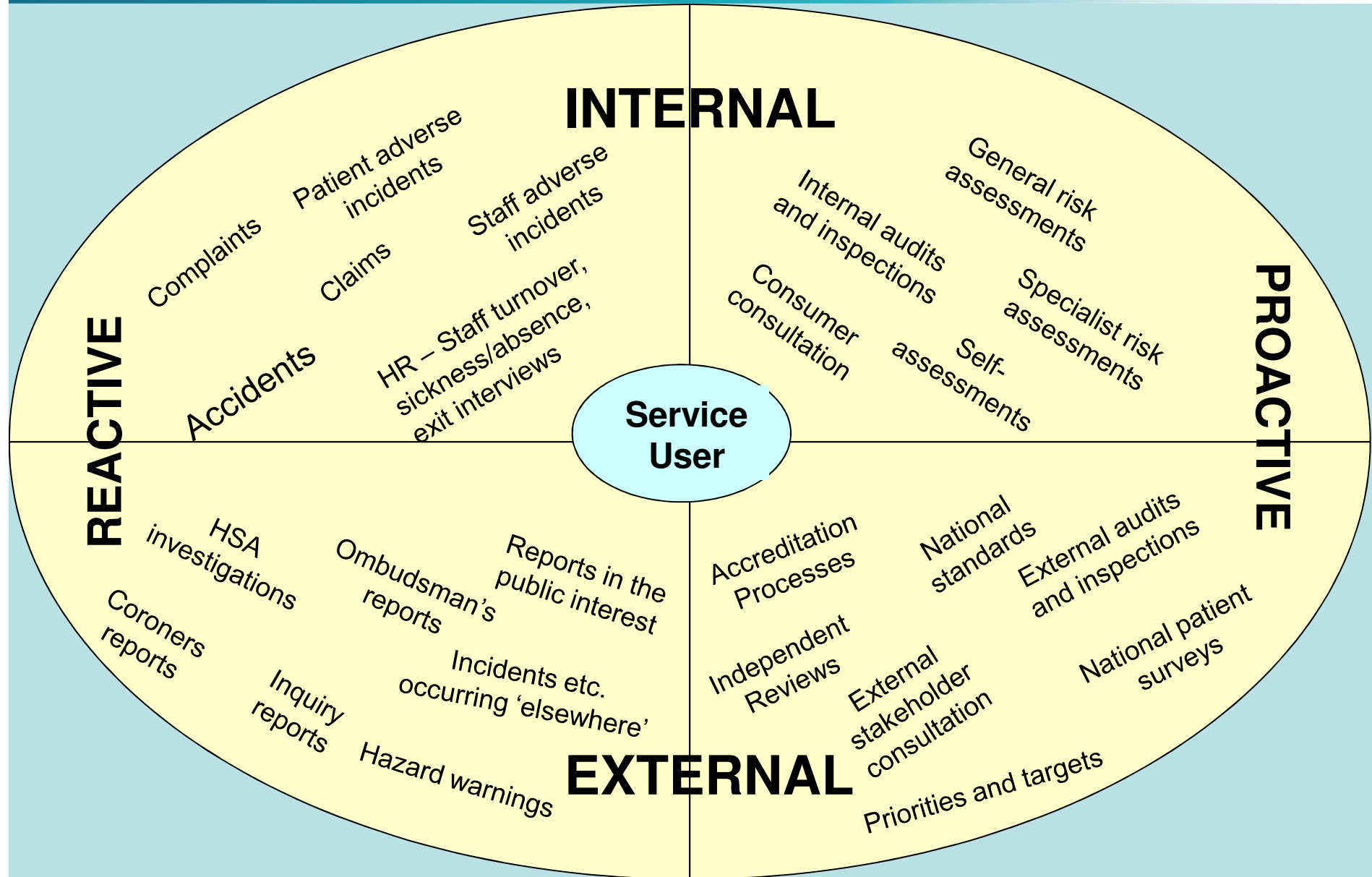


Risk Management Overview

AS/NZS RM Standard
4360: 2004



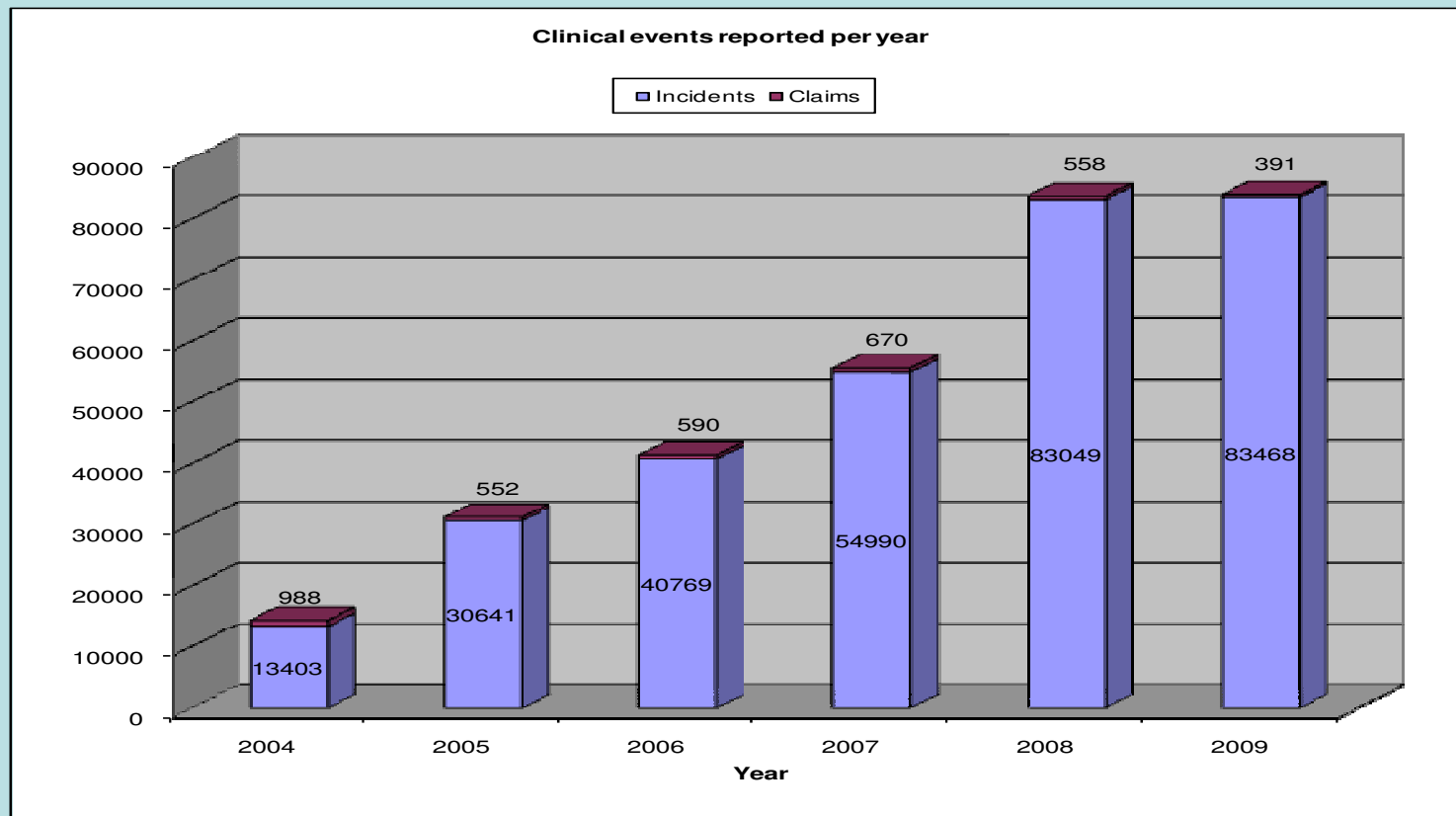
Sources of Risk Identification





STARSWeb

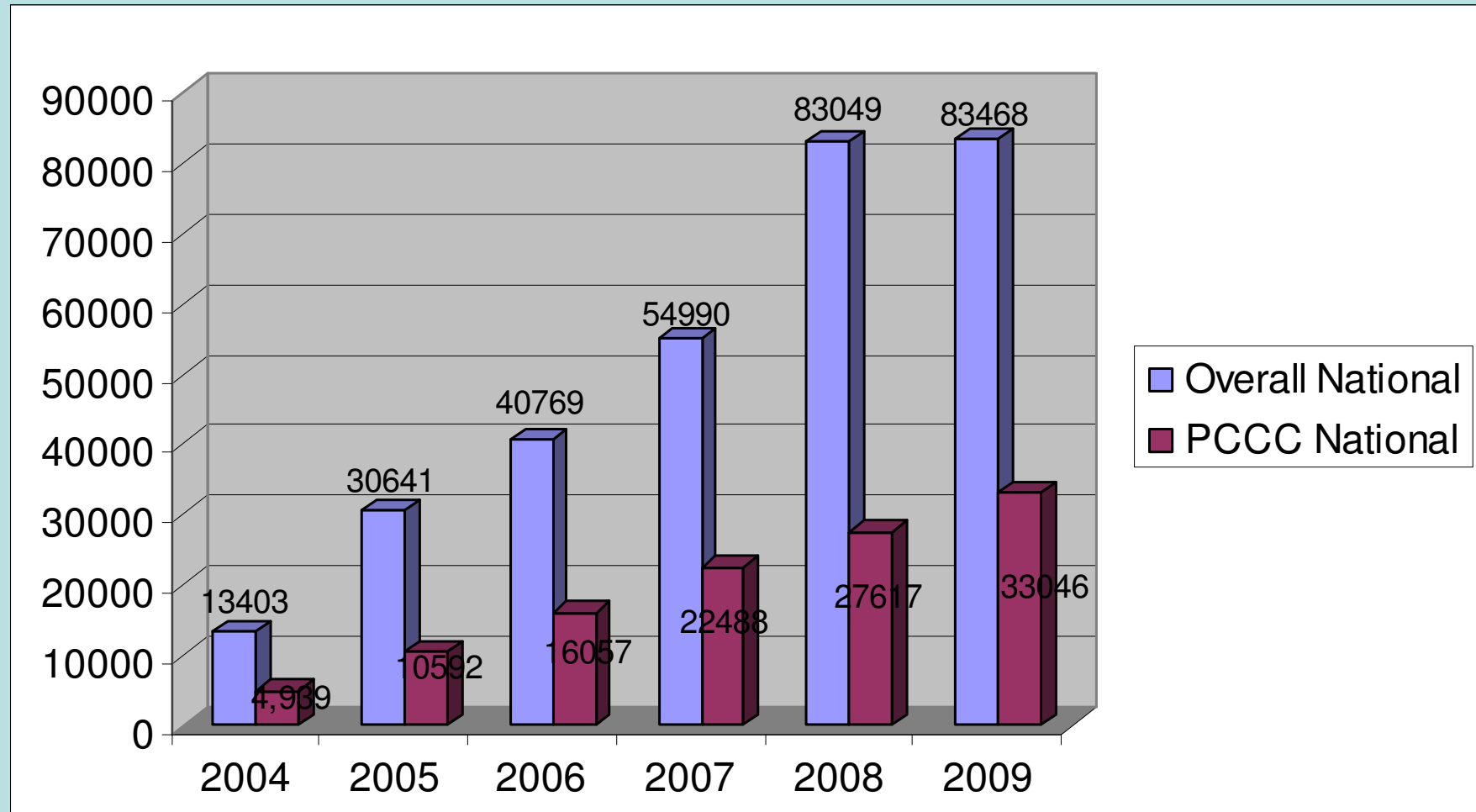
310,069 clinical incidents / “near misses” logged on the live system to end of 2009.



3,749 of these events have gone on to become claims



National & PCCC 2004-2009

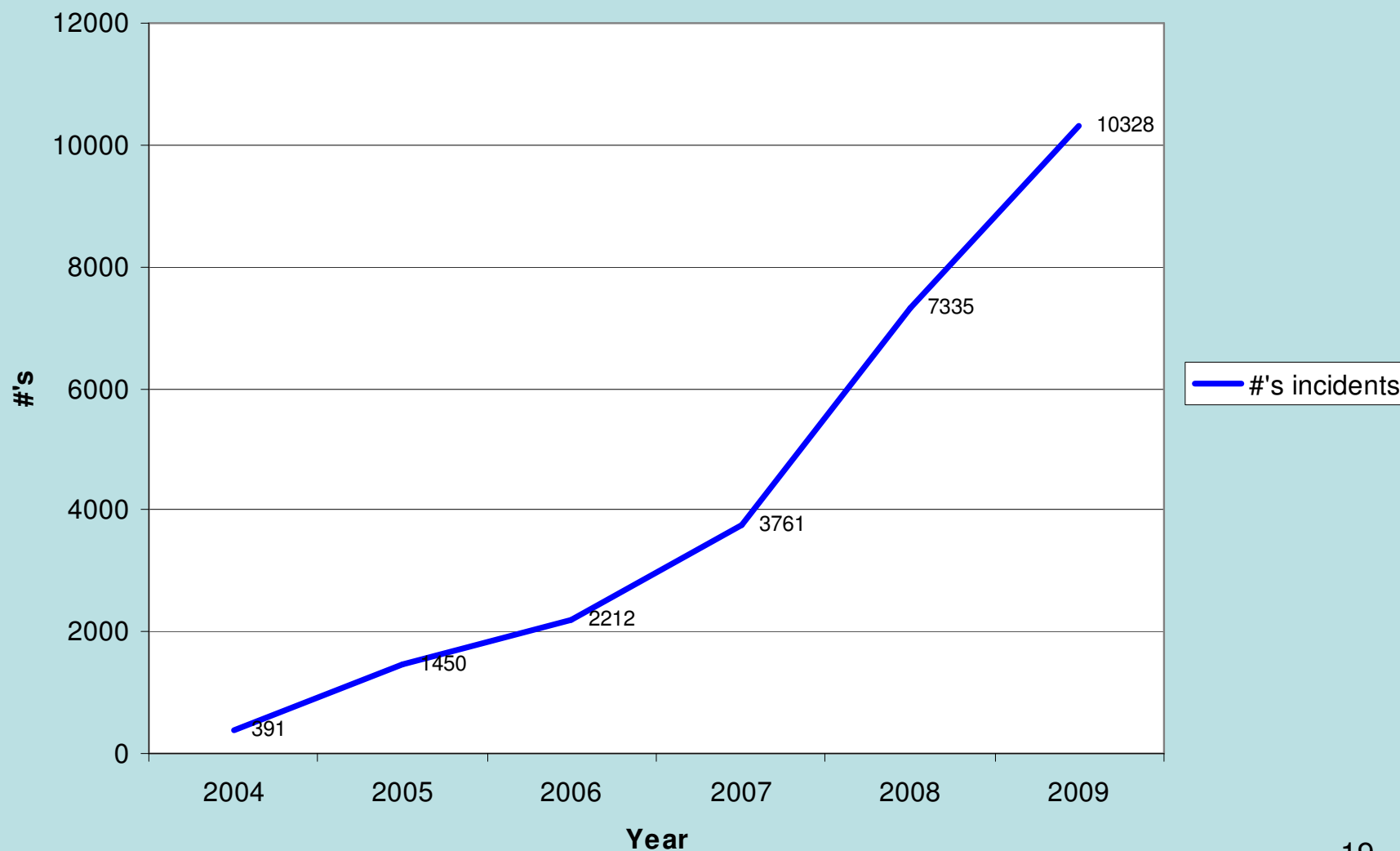




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Total Disability Incidents 1st Jan 2004 – 31st Dec 2009

n = 25,477





Clinical Indemnity Scheme

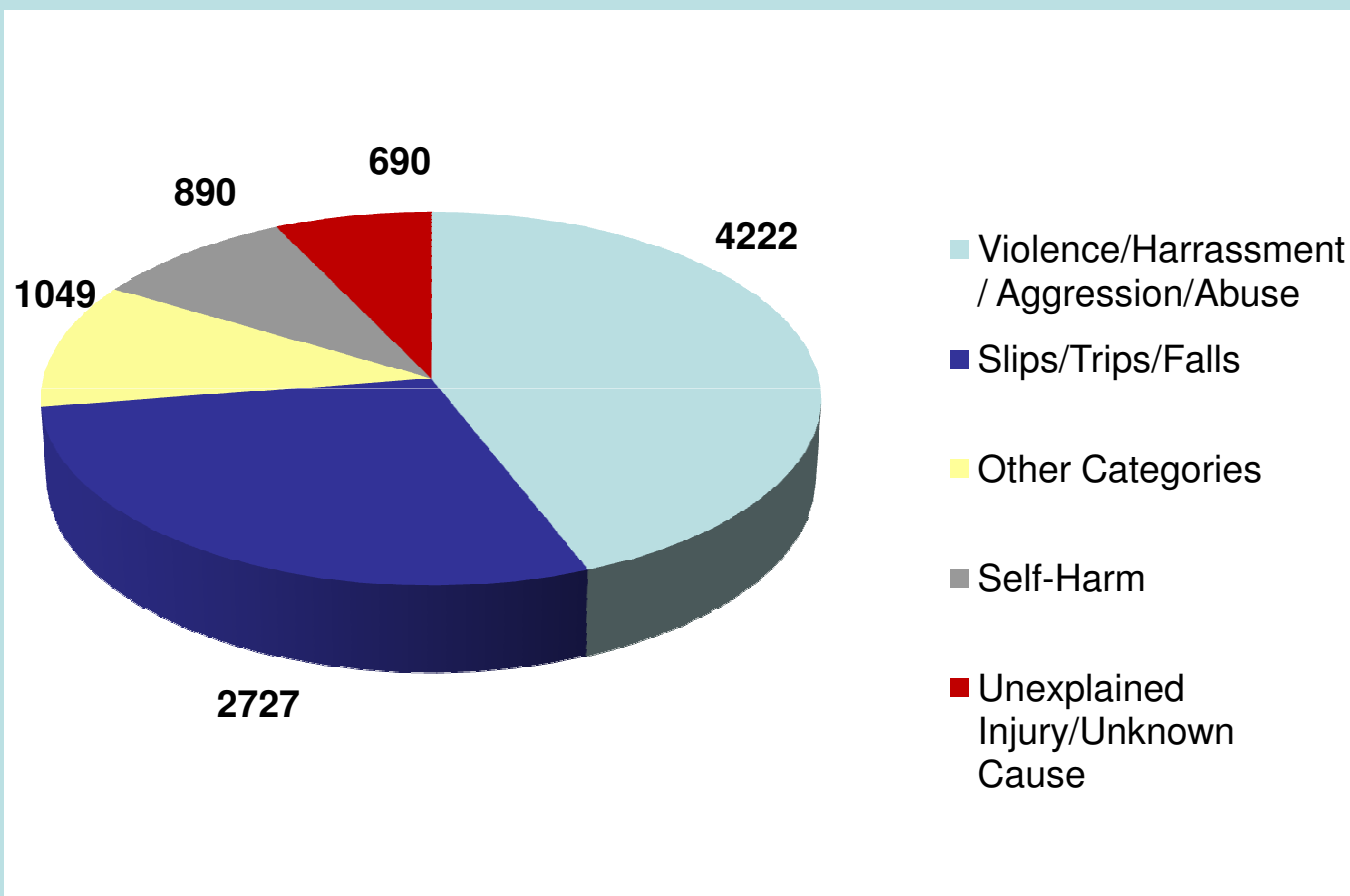
Disability Events Jan 2007- June 2010



	2007	%	2008	%	2009	%	2010	%
Medication incident	53	1.4%	188	2.50%	423	4.05%	206	3.65%
Diagnosis incident	0	0.0%	0	0.00%	1	0.01%	1	0.02%
Treatment incident	6	0.2%	7	0.09%	5	0.05%	7	0.12%
Inappropriate Behaviour	3	0.1%	63	0.84%	136	1.30%	73	1.29%
Consent / confidentiality incidents	0	0.0%	1	0.01%	1	0.01%	1	0.02%
Infection control incident	0	0.0%		0.00%	2	0.02%	1	0.02%
Equipment/Device Incident	14	0.4%	18	0.24%	29	0.28%	29	0.51%
Records/Documentation Incident	2	0.1%	4	0.05%	1	0.01%	1	0.02%
Absconsion	52	1.4%	100	1.33%	130	1.25%	92	1.63%
Self-Harm	233	6.2%	658	8.77%	821	7.87%	563	9.97%
STF	1,032	27.4%	2,065	27.51%	2,677	25.66%	1,218	21.58%
Unplanned events	482	12.8%	411	5.48%	266	2.55%	131	2.32%
Unexplained Injury/Unknown Cause	3	0.1%	337	4.49%	689	6.60%	473	8.38%
Violence/Harrassment/Aggression/Abuse	1,659	44.1%	2,951	39.32%	4,264	40.87%	2,224	39.40%
Other Categories	222	5.9%	702	9.35%	987	9.46%	625	11.07%
Total	3,761	100%	7,505	100%	10,432	100%	5,645	100%

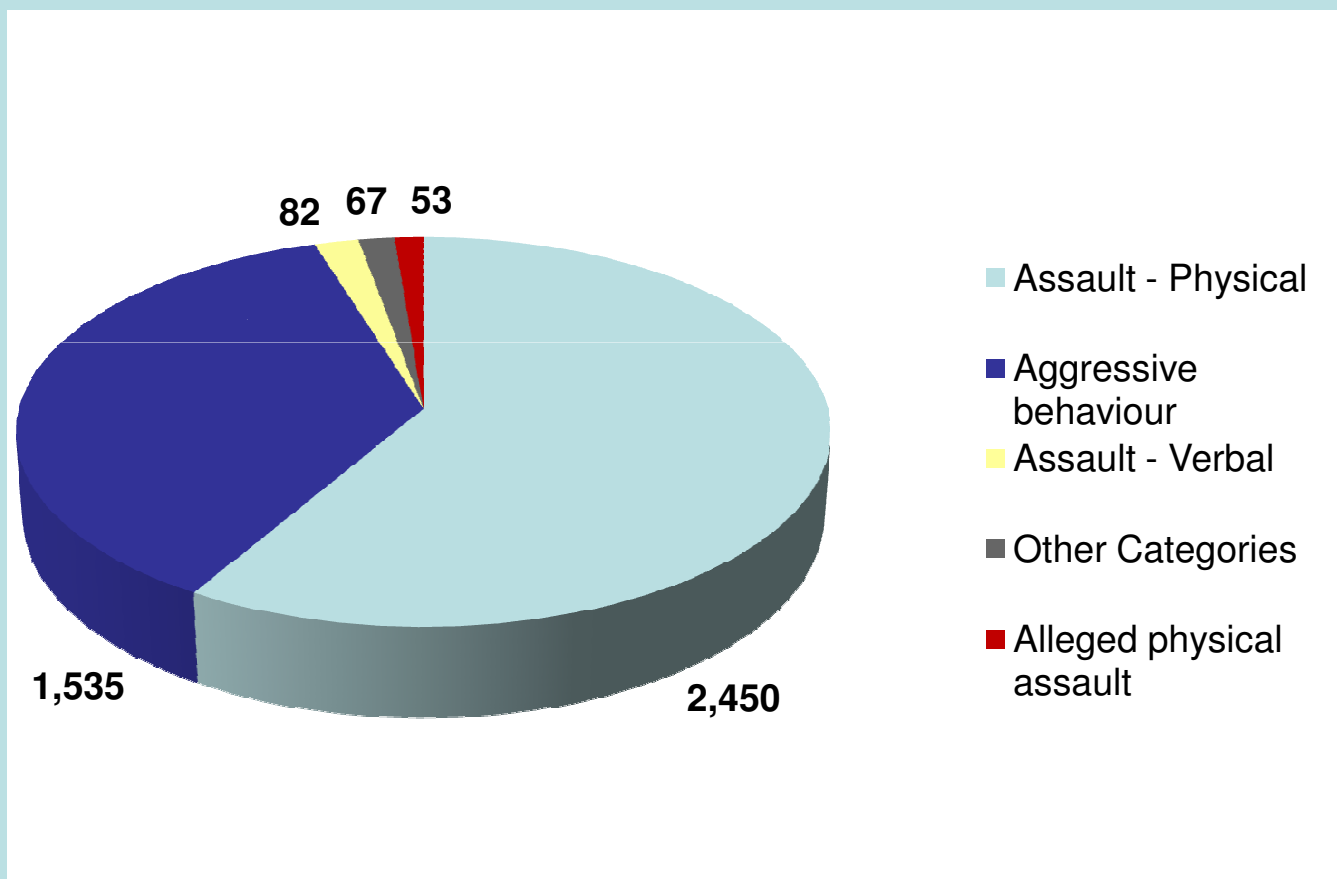


Top 5 Disability Events – Jan-Dec 2009



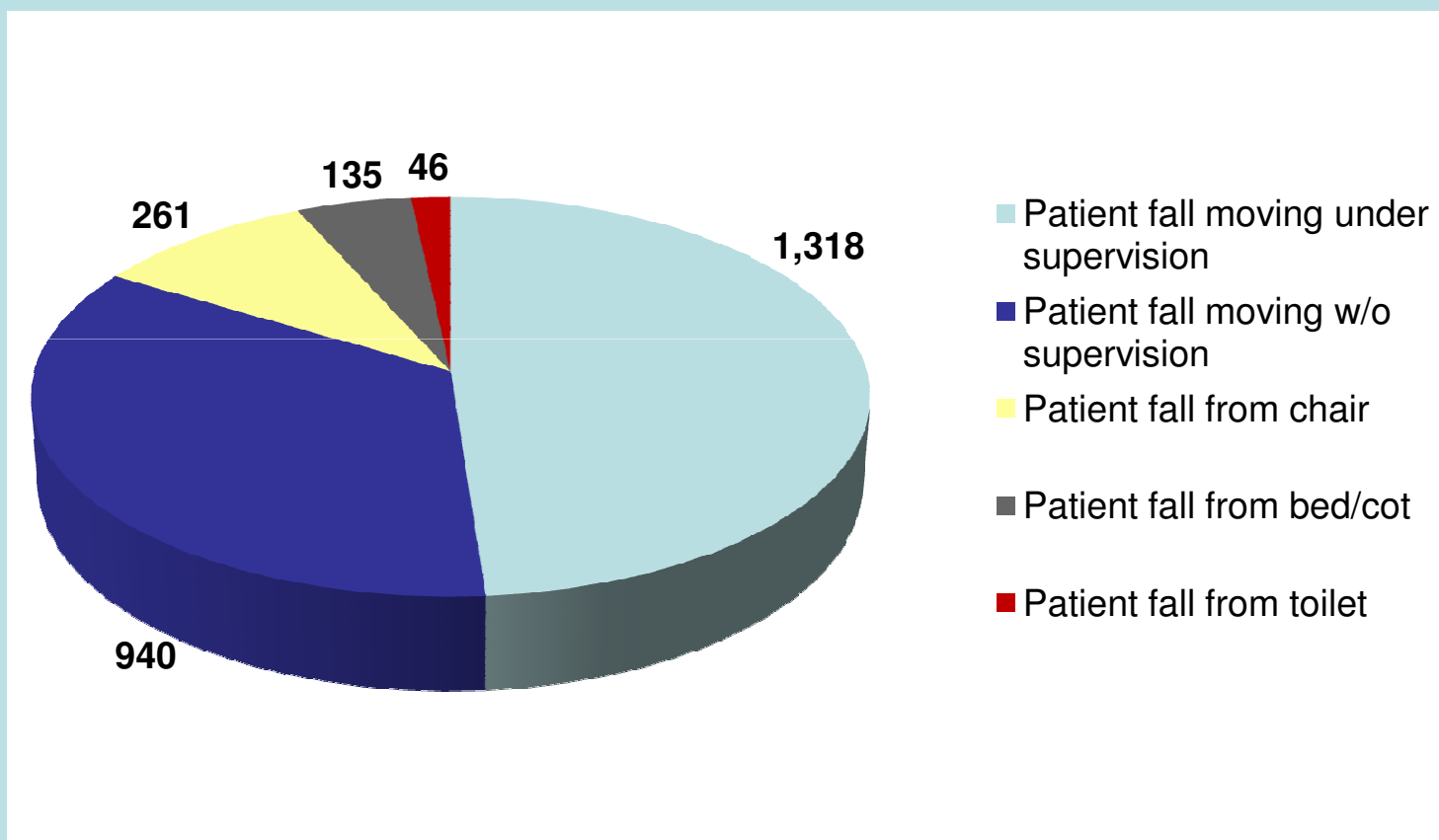


Top 5 Violence/Harassment/Aggression Events 2009



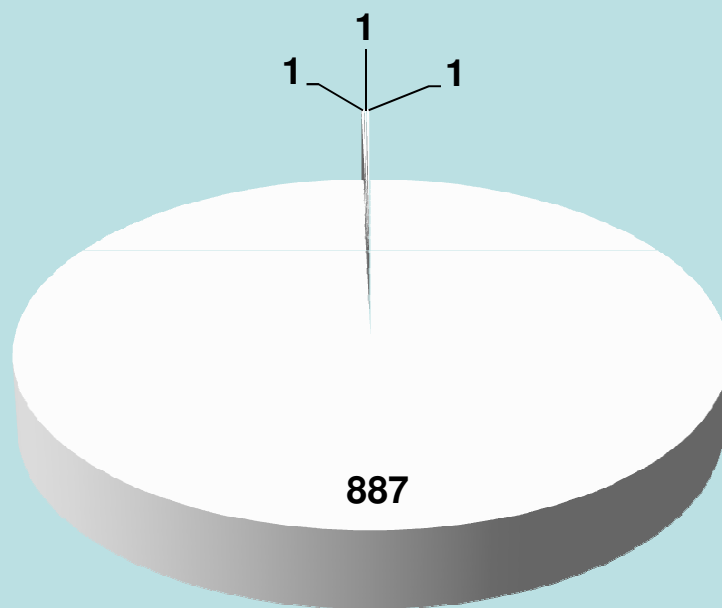


Top 5 Slips/Trips/Falls Events 2009





Self Harm Events 2009

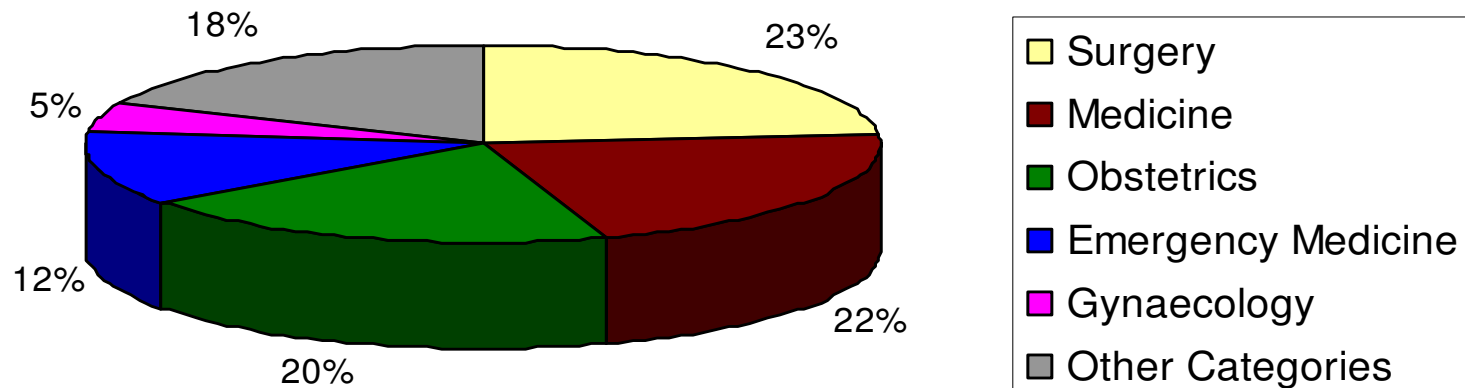


- Attempted self harm
- Assault - Physical
- Aggressive behaviour
- Other Categories



Claims submitted to SCA Jan.-Dec. 2009 (N=510)

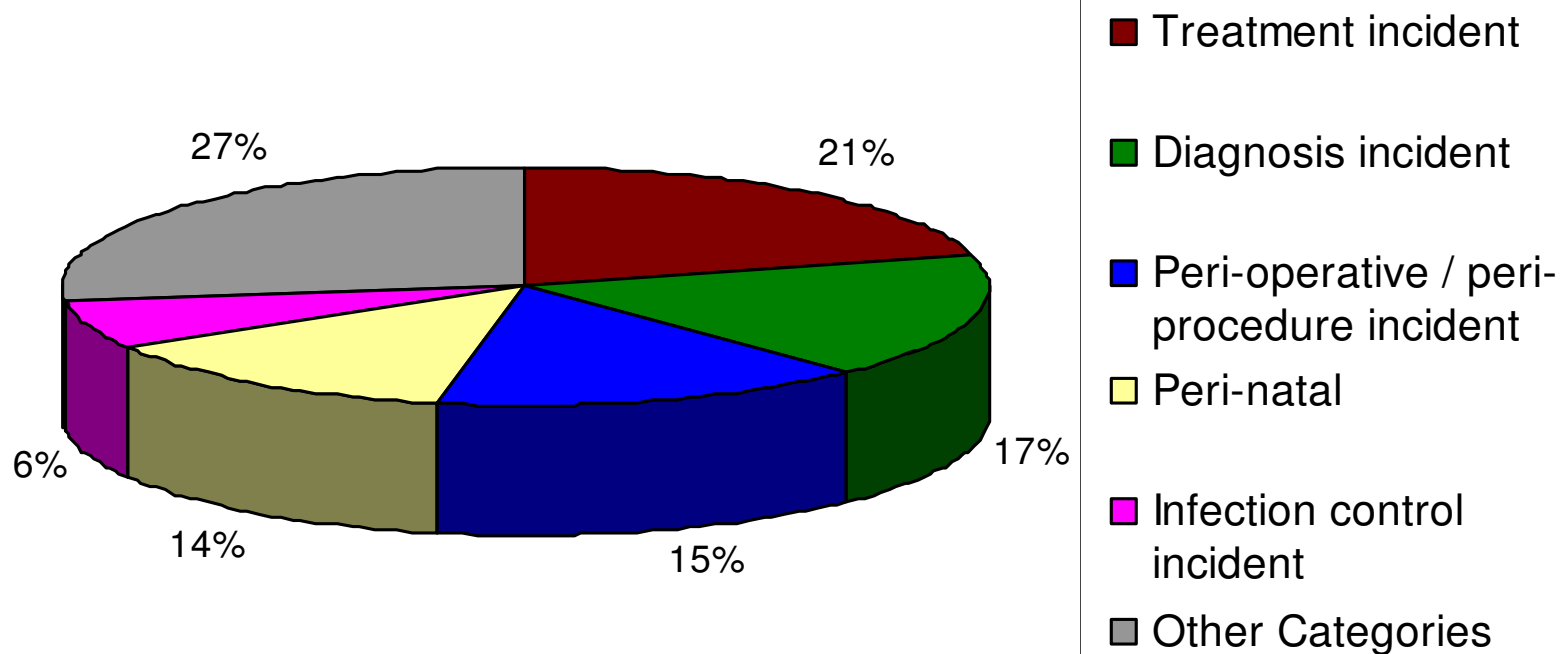
**Claims submitted by Specialty
(Jan-Dec 2009)**





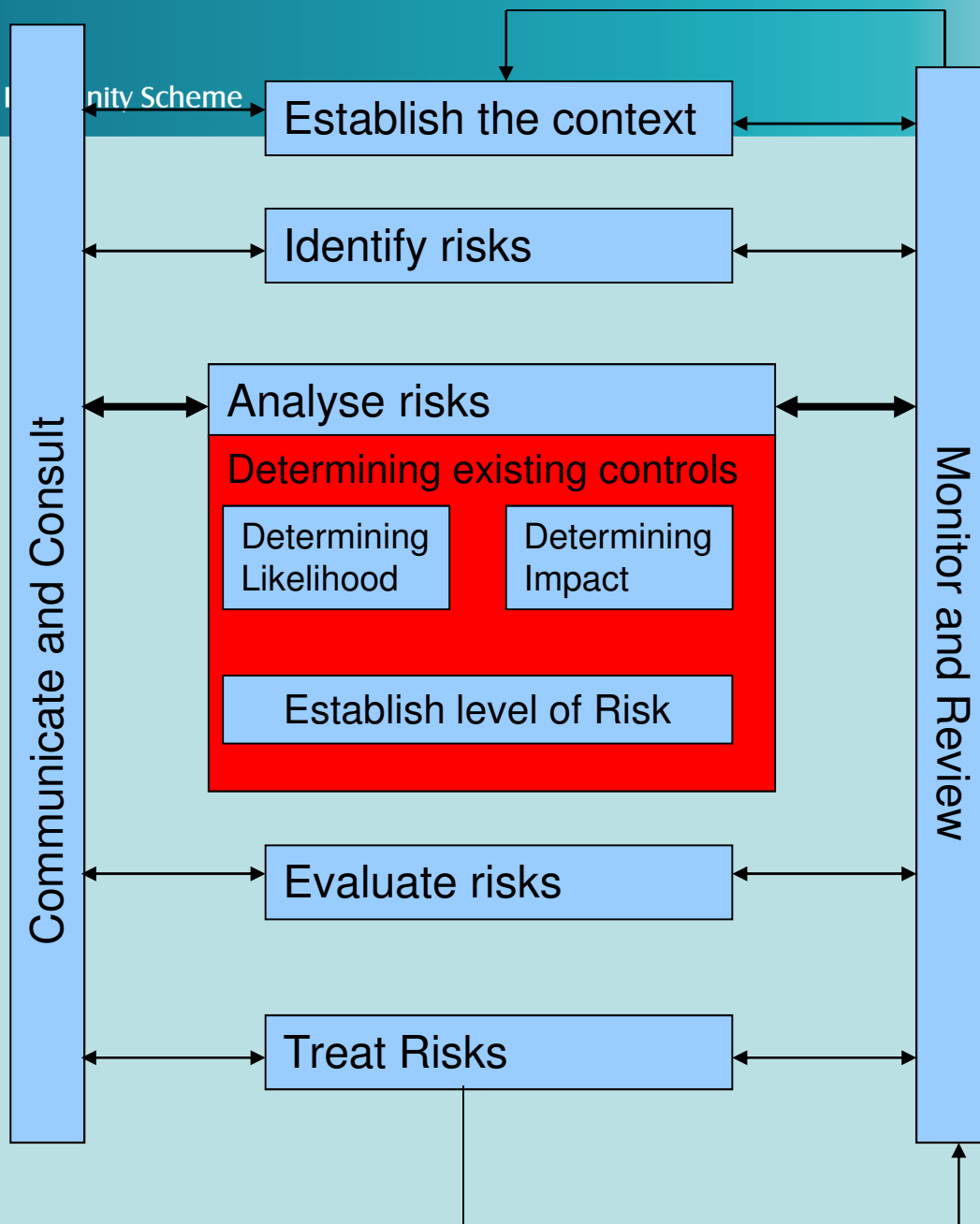
Claims submitted to SCA Jan.-Dec. 2009 (N=510)

**Claims submitted by incident type
(Jan-Dec 2009)**





Clinical Liability Scheme



Risk Management Overview

AS/NZS RM Standard
4360: 2004



HSE Risk Matrix

	Impact score				
<i>Likelihood</i>	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
<i>Almost certain (5)</i>	5	10	15	20	25
<i>Likely (4)</i>	4	8	12	16	20
<i>Possible (3)</i>	3	6	9	12	15
<i>Unlikely (2)</i>	2	4	6	8	10
<i>Rare/remote (1)</i>	1	2	3	4	5

Low Risk 1 – 5



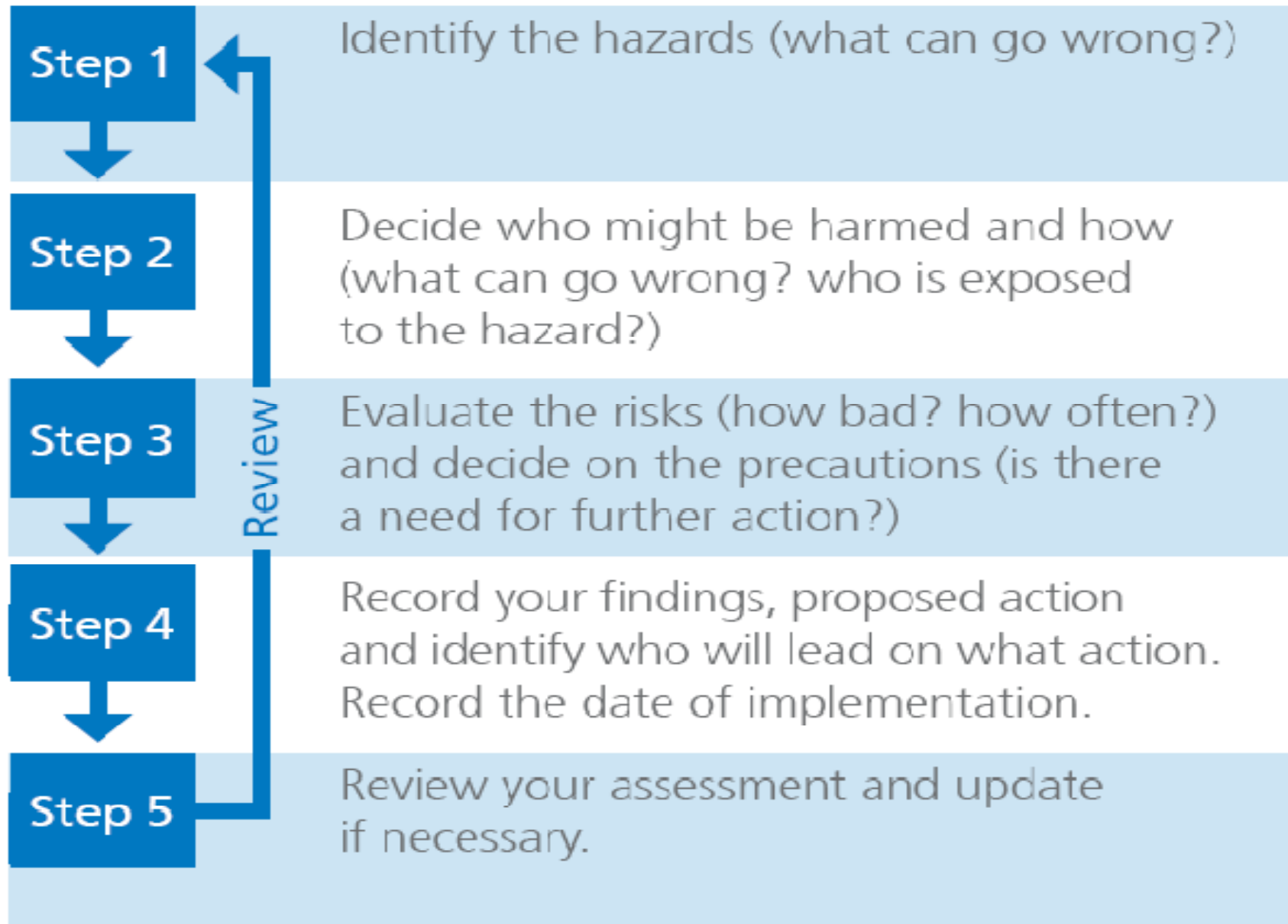
Moderate Risk 6 – 12



High Risk 15 - 25



Five steps to easy risk assessment



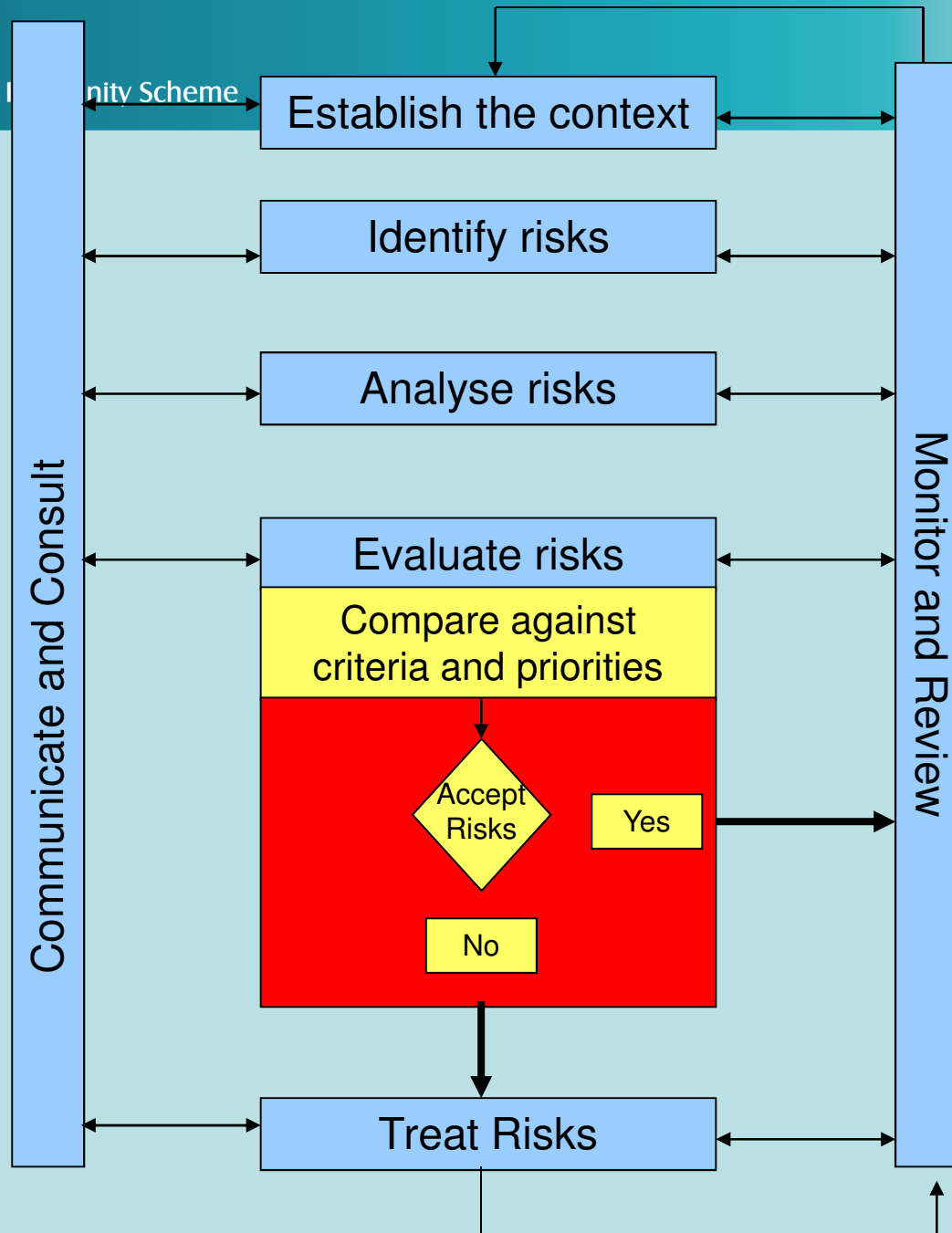


Risk Register

[illegible]



Clinical Liability Scheme

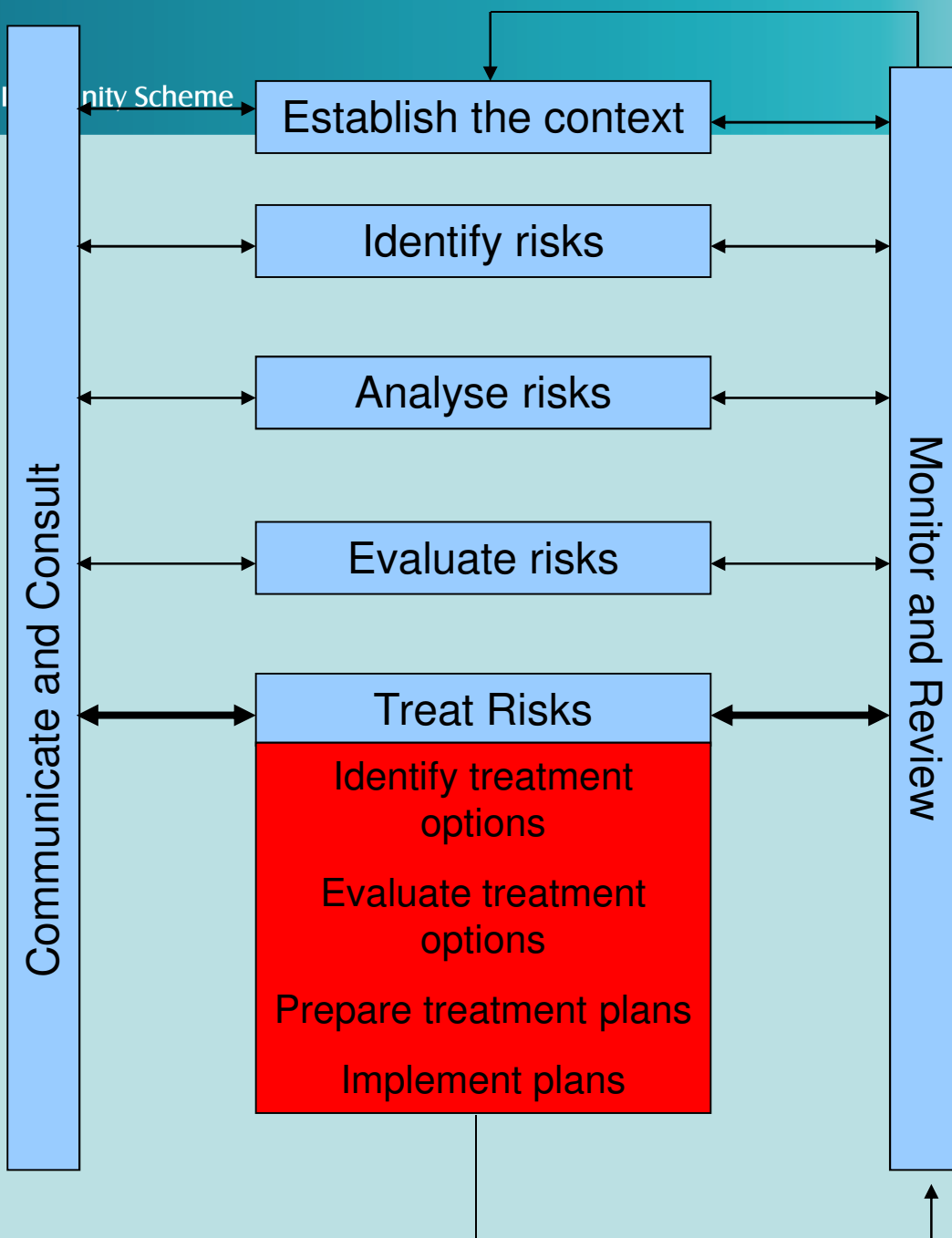


Risk Management Overview

**AS/NZS RM Standard
4360: 2004**



Clinical Liability Scheme



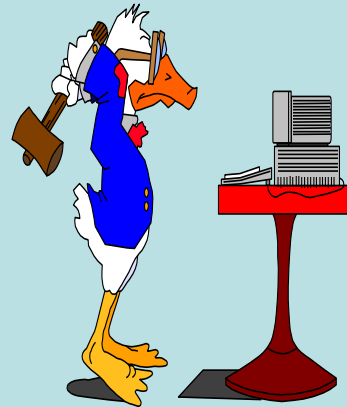
Risk Management Overview

**AS/NZS RM Standard
4360: 2004**



Treat/Control Risks

**ELIMINATE
or AVOID**

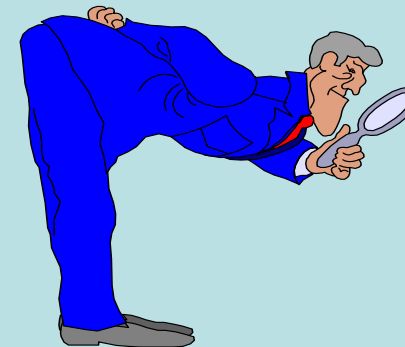


TRANSFER

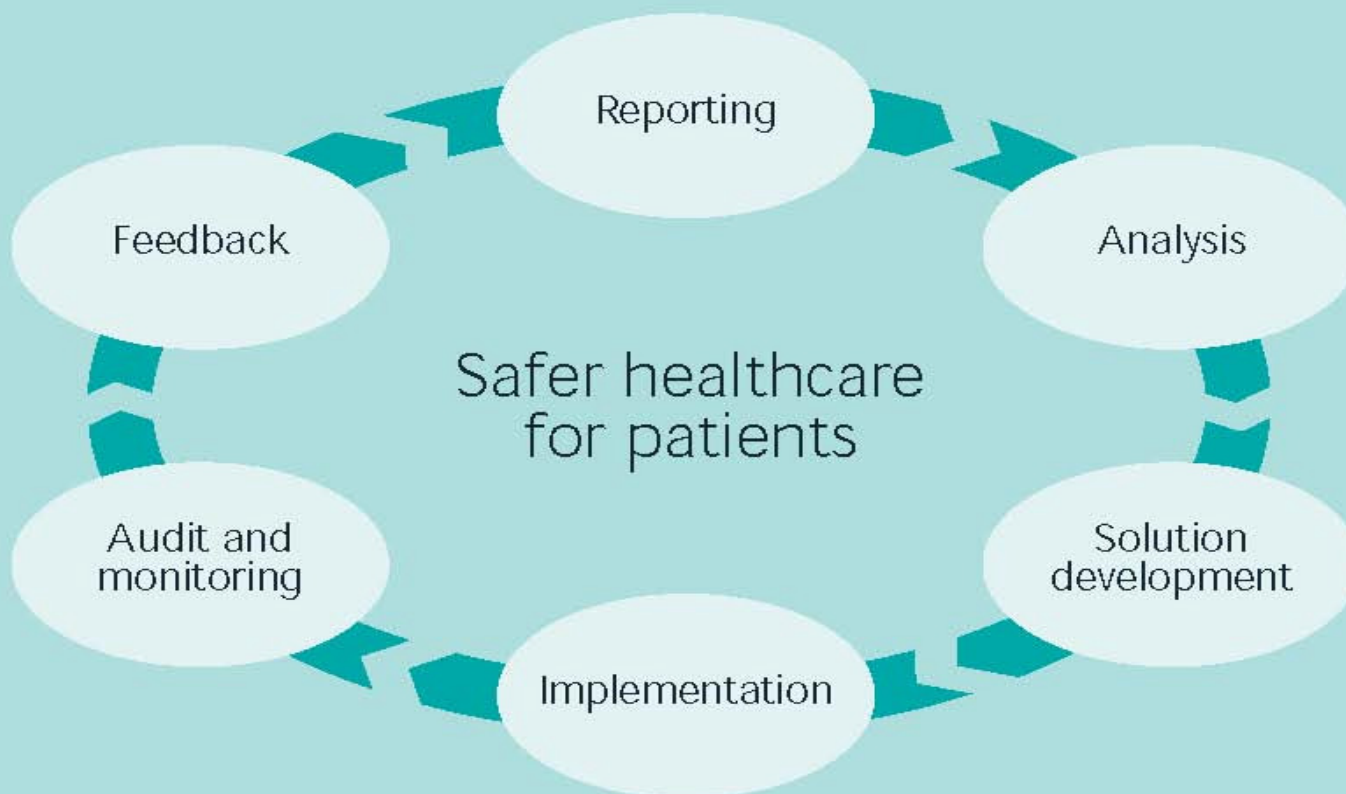


REDUCE

ACCEPT



Circle of safety





We all make mistakes!

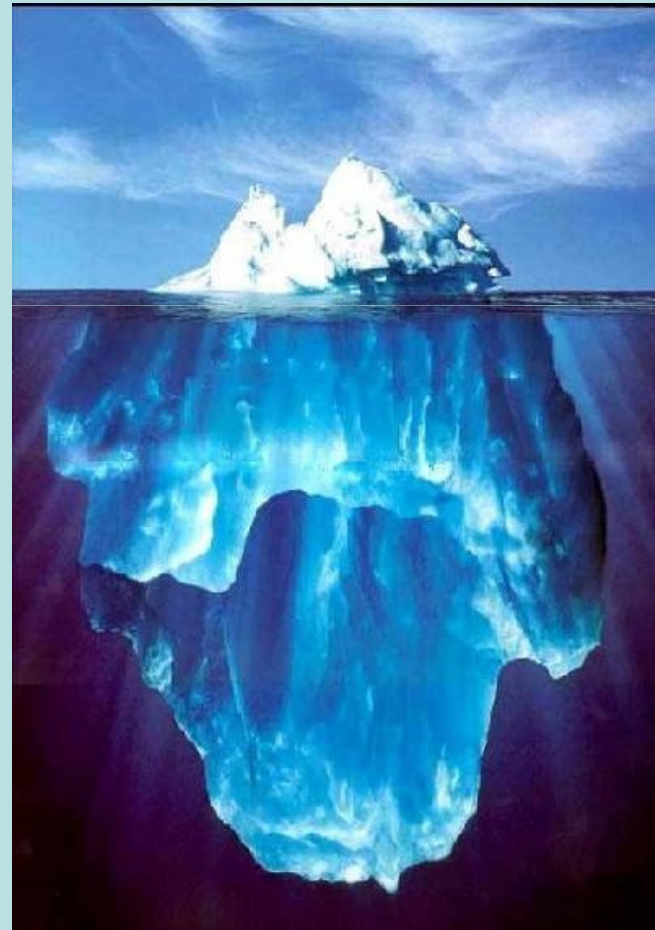




Why Bother?

“It is easier to perceive error than to find truth, for the former lies on the surface and is easily seen, while the latter lies in the depth, where few are willing to search for it”.

Goethe 1749-1832





Systems Analysis Review

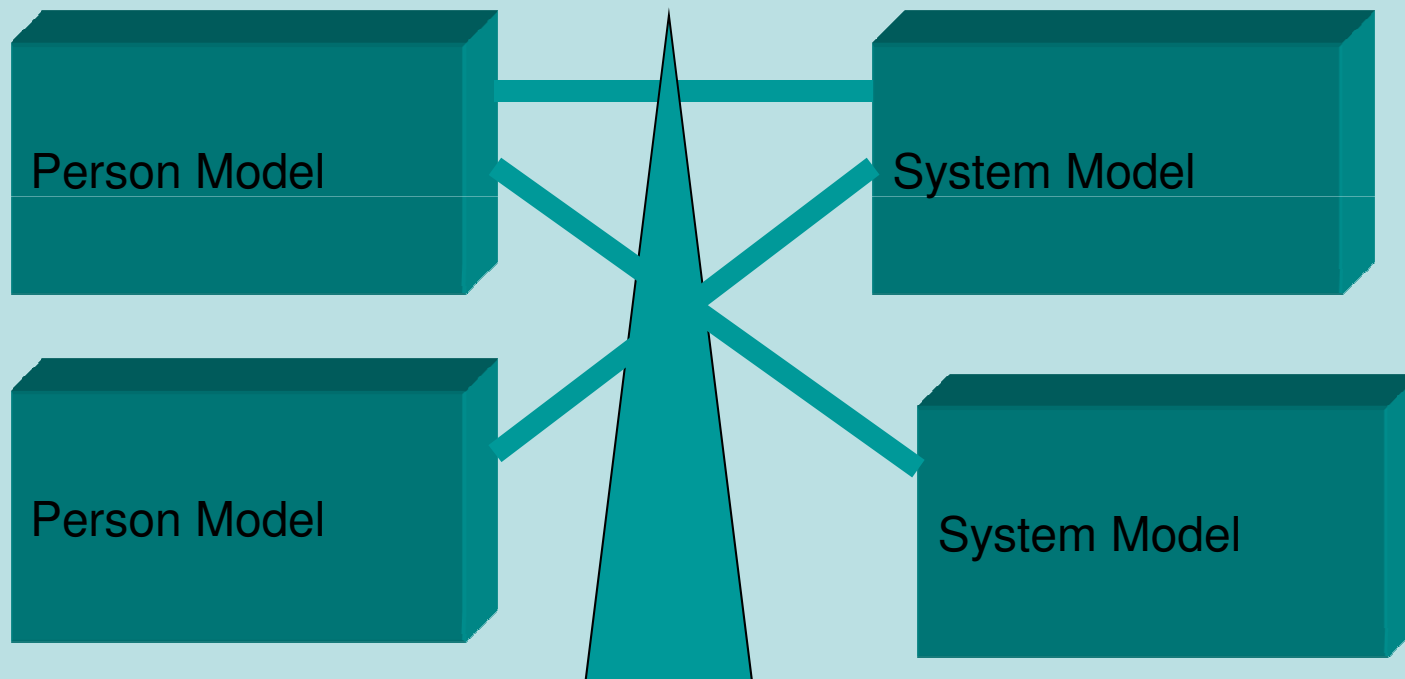
“The formal evaluation of an activity, method, procedure, or technique in which the entirety of the problem is examined in an attempt to improve the workflow.”

Root Cause Analysis (RCA)

“A systematic iterative process whereby the factors that contribute to an incident are identified by reconstructing the sequence of events and repeatedly asking **WHY** until the contributing factors have been elucidated.”



Getting the right balance



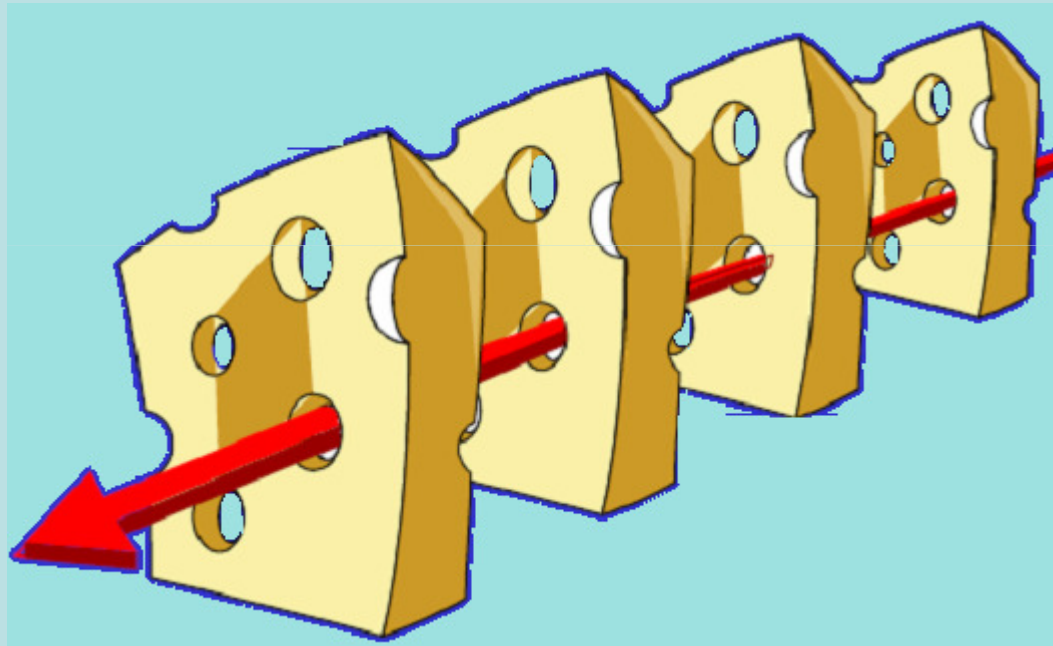


James Reason's Swiss Cheese Model

Some holes due to Active Failures

Some Holes Due to Latent Conditions

Hazards



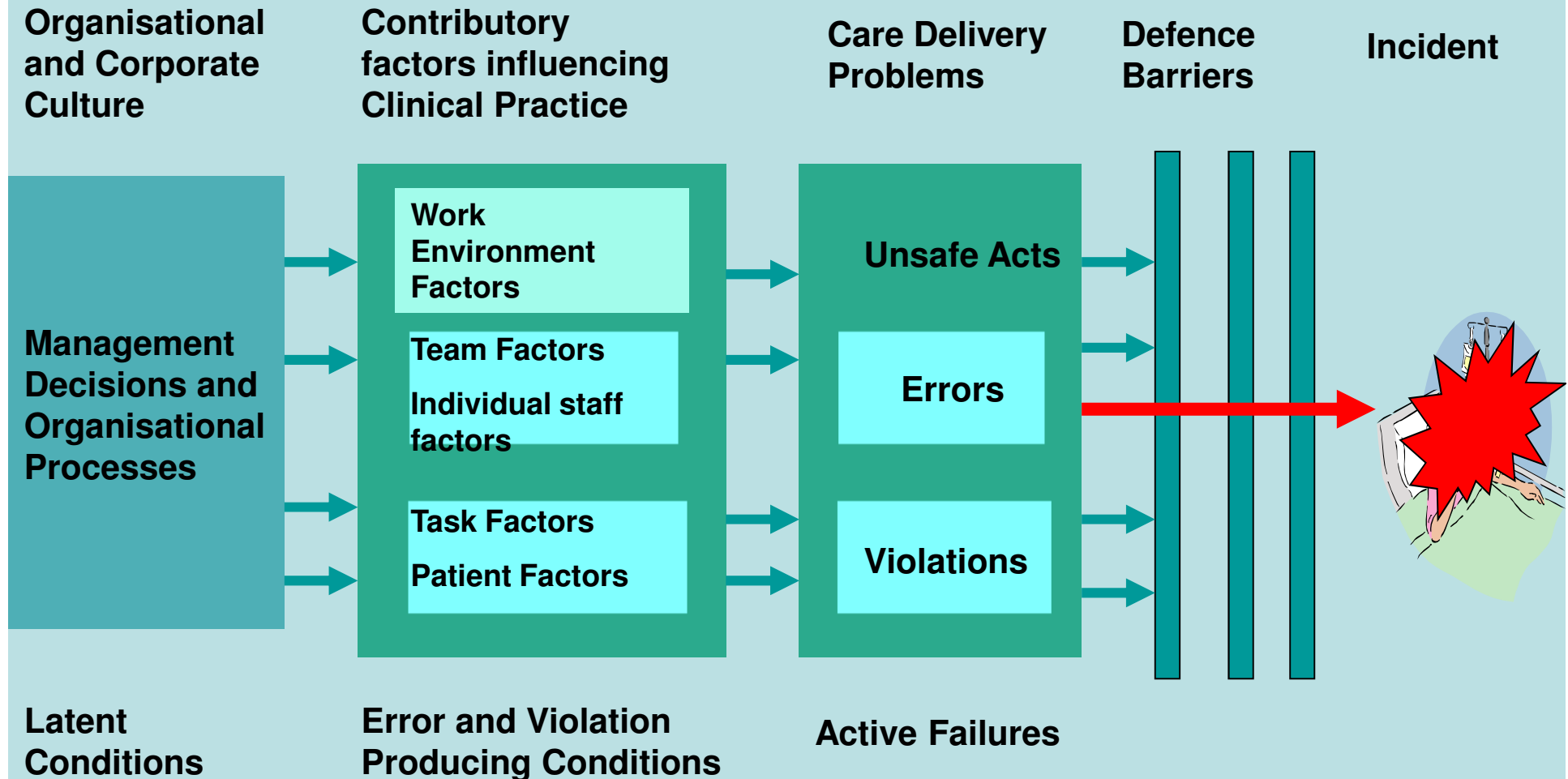
Losses

Defences, Barriers and Safeguards

James Reason, 1990



Understanding Adverse Event



(Adapted from "The Human Factor" James Reason)



Framework of contributory factor influencing clinical practice (Charles Vincent 1998)

Factor Types	Contributory Influencing Factor
Patient factors	Condition e.g. complexity and seriousness Language and communication Personality and social factors
Task factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results Decision-making aids
Individual (staff) factors	Knowledge and skills Competence Physical and mental health
Team factors	Verbal communication Written communication Supervision and seeking help Team structure (congruence, consistency, leadership etc.)



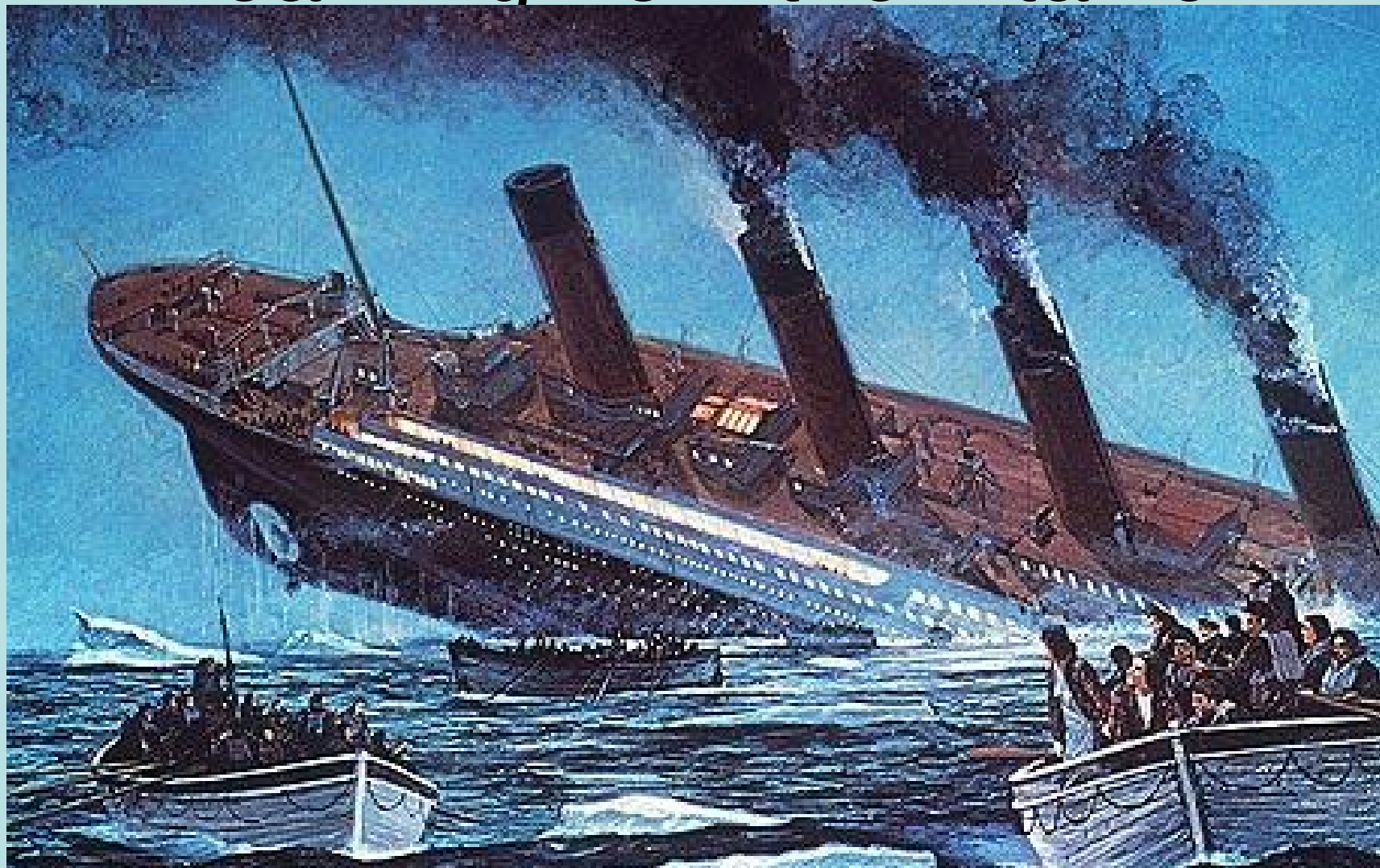
Framework of contributory factor influencing clinical practice (Cont'd)

Factor Types	Contributory Influencing Factor
Work environmental factors	Staffing levels and skills mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support Environment Time delays
Organisational and management factors	Financial resources and constraints Organisational structure Policy, standards and goals Safety culture and priorities
Institutional factors	Economic and regulatory context National health service executive Links with external organisations



Clinical Indemnity Scheme

Learning from the Titanic





Titanic sunk by steering blunder, new book claims

It was always thought the Titanic sank because its crew were sailing too fast and failed to see the iceberg before it was too late. Telegraph - 21st September, 2010



Background

Titanic leaves Southampton on her maiden voyage to New York April 10, 1912

The largest passenger steamship in the world collides with ice and sank with the loss of 1,517 lives.

The error was covered up in two inquiries on both sides of the Atlantic by the Senior Officer to prevent bankruptcy and preserve jobs. Truth revealed 100 years later by granddaughter in “Good as Gold”.



Response to serious adverse event.

- What?
- How?
- Why?
- Prevention of recurrence.



Clinical Indemnity Scheme

Framework of contributory factor influencing clinical practice (Charles Vincent 1998)



Factor Types	Contributory Influencing Factor
Patient factors	There were insufficient life boats for all passengers on board.
Task factors	<ul style="list-style-type: none">•No distress signal was sent for 45 minutes after striking ice.•Order to go to boats was only given when distress signal sent.•Steersman was trained under Rudder Orders. He panicked and turned the wheel the wrong way to avoid the iceberg. Although he tried to correct it, it was too late.
Individual (staff) factors	<ul style="list-style-type: none">•Some of the crew on the Titanic were used to the archaic Tiller Orders (sailing ships) and some were used to Rudder Orders (steam ships)•Captain, despite experience level in North Atlantic was accident prone and not used to size of ship (50K tonnes). He had crashed sister ship the Olympic in NY previously.
Team factors	<ul style="list-style-type: none">•As Titanic left Southhampton it missed a NY boat by 2 feet.•Miscommunication - First officer called “hard a-starboard” when iceberg spotted 2 miles away but it was misinterpreted by the Quartermaster who turned ship right instead of left.•There was a reluctance to send out the distress signal by crew.•Final meeting of 4 senior officers agreed to keep ship moving sinking ship earlier.



Factor Types	Contributory Influencing Factor
Work environmental factors	<ul style="list-style-type: none">•Some of the crew on the Titanic were used to the archaic Tiller Orders associated with sailing ships and some were used to Rudder Orders for steam boats.•Steering systems were the complete opposite of each other.
Organisational and management factors	<ul style="list-style-type: none">•Deliberate decision was taken to cover up the incident to prevent bankrupting the liner's owners and job losses for colleagues.•Chairman of the White Star Line persuaded the Captain to continue sailing adding pressure to the water already in the Hull, forcing open the bulkheads and sinking the ship sooner than otherwise – nearest ship was 4 hours away and if ship had stopped could have rescued them.
Institutional factors	<ul style="list-style-type: none">•Seagoing was undergoing enormous upheaval due to conversion from sail to steam ships.•This meant that there were two different steering systems with different commands attached in operation then.



Now it's Your Turn!!

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“To address this mistake we must use root-cause analysis. I’ll begin by saying it’s not my fault.”



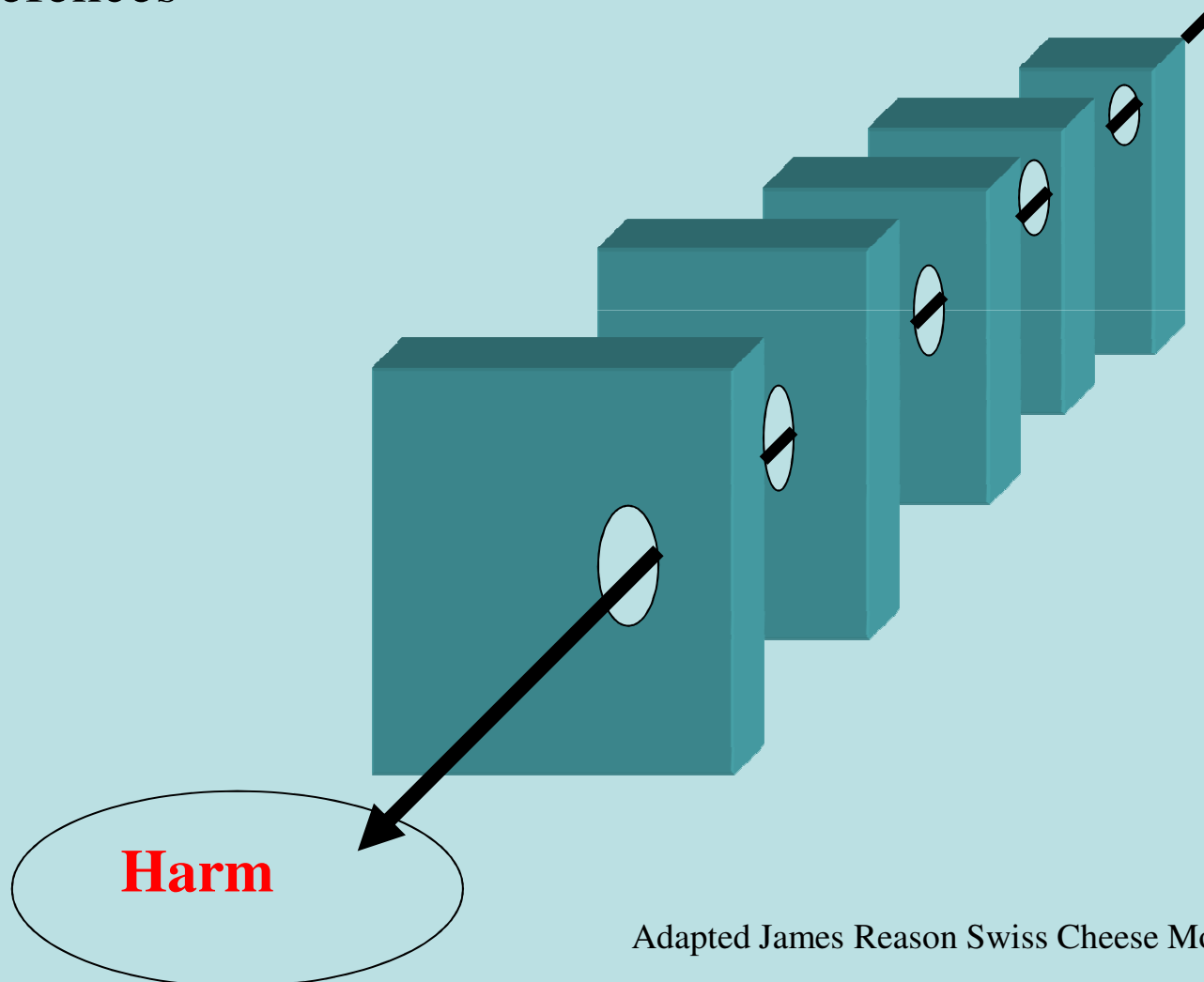
Video Case Study

Case Summary Mr Hamilton, a 21 year old man, has bipolar disorder. He lives at home with his father, who is his primary carer. He has been recently diagnosed with diabetes requiring insulin management.



Defences

The Gaps



Adapted James Reason Swiss Cheese Model



Doing the Right Thing –Open Communications

- The World Health Organisation (WHO) are promoting a culture of “Open Disclosure”.
- This essentially means **acknowledge** that an adverse event has occurred, **explain** what is known, **apologise** to the patient who has been injured by the event and commit to learning lessons to help **prevent reoccurrences**.
- Open disclosure needs to be supported by an open, just & responsible culture, policy development and staff training.



Clinical Indemnity Scheme

HSE Serious Incident Process



“any incident which involved or is likely to cause extreme harm, or is likely to become a matter of significant concern to service users, employees or the public.”

HSE SIMT Policy and Procedures:
http://hsenet.hse.ie/HSE_Central/simt/

“Learn from yesterday, live for today, hope for tomorrow. The important thing is not to stop questioning”
Albert Einstein



In conclusion

- SU safety depends on accountable **governance**, proactive **risk management & quality improvement** plans.
- Focus on **systems and processes**, not exclusively on individuals' performances.
- Following an adverse event, develop **practical recommendations and actions** for implementation in order to reduce the risk of service user safety events recurring.
- Communicate openly after an adverse event by **acknowledging** that it has occurred, **explaining** what is known, **apologising** to the SU who has been injured and committing to learning lessons to help **prevent reoccurrences**.

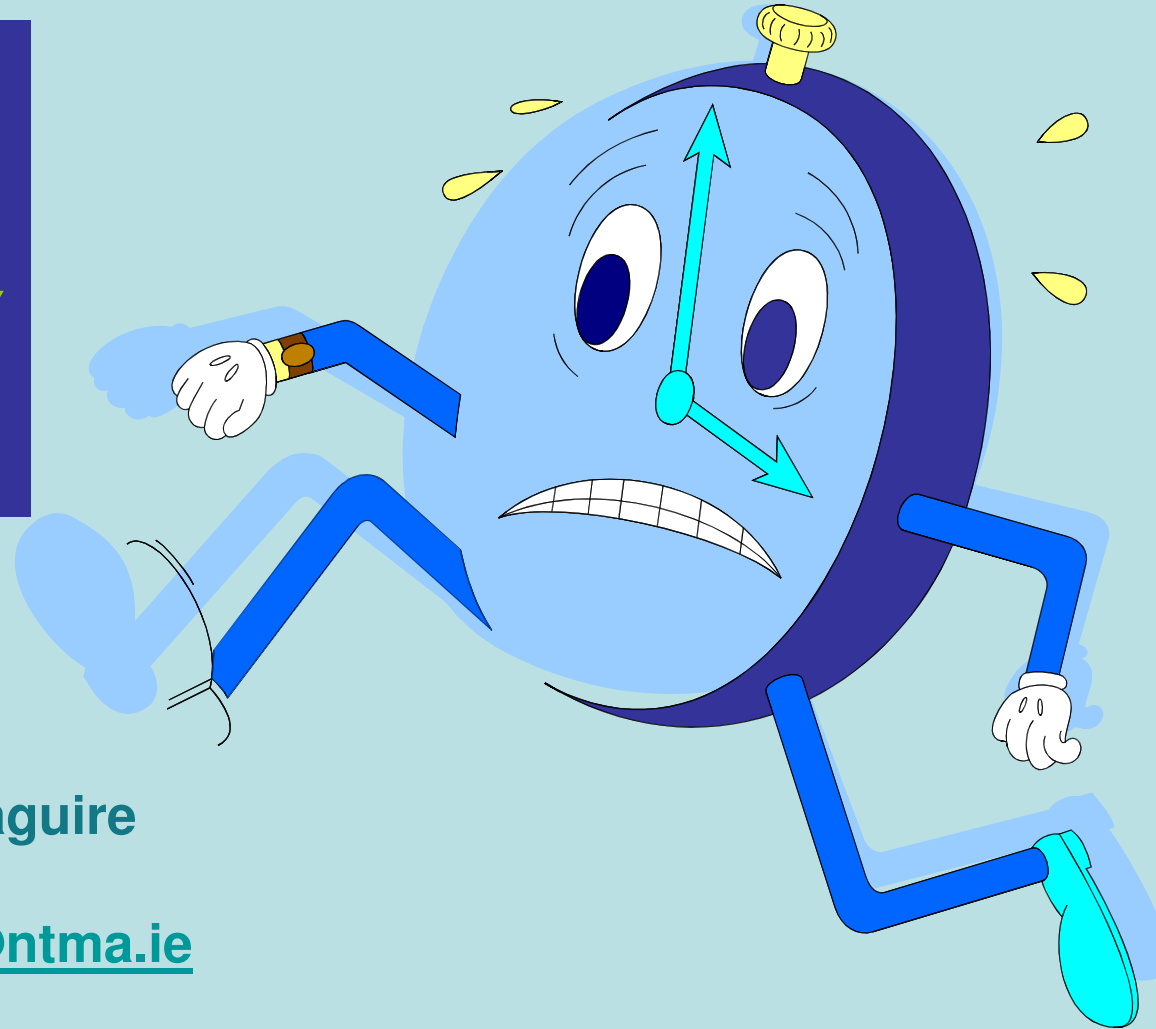
“Great discoveries and improvements invariably involve the cooperation of many minds.”

Alexander Graham Bell



Clinical Indemnity Scheme

*Thank you for
your time and
attention....any
questions ?*



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<http://www.stateclaims.ie/ClinicalIndemnityScheme/introduction.html>