

Raiders of the lost archives

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Objective:

The aim of reviewing closed claims documentation was to identify contributory factors with a view to establishing any learning from these adverse events.

Methods:

A data collection tool was developed to enable consistent qualitative analysis of claims within the CIS. This incorporates a number of the fields included in a UK claims analysis study and also reflects the data collection fields within the Irish STARSweb incident reporting system. A total of 64 cases were reviewed by the team of clinical risk advisors using the data collection tool.

Results:

A breakdown of the settled cases that were reviewed, according to specialty, is presented in Figure 1. As can be seen from the graph the top 3 specialties for the cases reviewed occurred within Emergency Medicine (35.9%, n=23), Obstetrics & Gynaecology (28.1% n=18) and Surgical Specialty (15.6%, n=10).

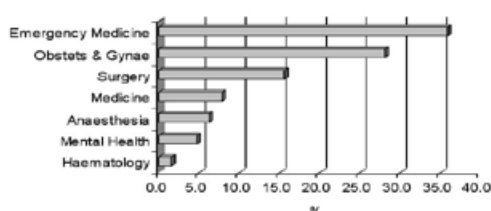


Figure 1: Settled Cases Reviewed by Specialty (n=64)

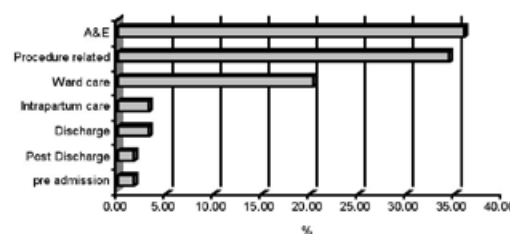


Figure 2: Phase of Care in which adverse event occurred.

As demonstrated in Figure 2, over a third (35.94%, n=23) of the adverse events occurred during the Accident & Emergency phase of care. 34.38% (n=22) of the cases were procedure related and 20.3% (n=13) were related events that occurred during ward care. A total of 155 contributory factors were identified among the 64 cases reviewed. A complete breakdown of all of the factors identified per category is presented in Table 1.

Conclusions:

The contributory factors identified by this exercise reflect similar factors identified in large international studies, where communication failure, late diagnosis or misdiagnosis and issues concerning staff competency feature prominently. The analysis of incident data alone provides a limited picture of patient safety issues, however if combined with analysis of claims more is learnt about both active and latent errors associated with serious adverse events. It provides a clearer picture of patient safety issues identifying adverse event types that require specific attention. As the State Claims Agency manages the incident reporting database and claims of clinical negligence within Ireland, the learning from reviewing these types of cases can be shared throughout Ireland with all the enterprises indemnified by the Clinical Indemnity Scheme in order to support patient safety.

Contributory factor		Contributory factor		Contributory factor		Contributory factor	
Adverse/Allergic Reaction	0	Practitioner Error	24	Availability of protocols/guidelines	10	Staffing levels/skills mix	4
Delay/Failure acting on formal result	8	User Error/failure to admit/ arrange admission	1	Communication Failure	7	Workload	1
Delay/failure in recognising complication	6	Failure to Monitor	4	Lack of effective leadership	1	Failure to seek consent	1
Delay /Failure to treat	10	Failure/Delay to perform tests	4	lack of supervision	5	Contaminated Instrument	1
Failure to interpret CTG correctly	0	Failure/Delay ordering appropriate tests	2	Safety Culture issues	4	Failure in Discharge Process	2
Failure to provide adequate information	3	Ineffective Treatment	2	Shift patterns	1	Inadequate Infection Control Procedures	1
Failure to undertake clinical assessment	3	Failure to refer for follow up	5	Lack of effective ongoing training	1	Failure to Obtain Informed Consent	1
Misdiagnosis	12	Admin/management support	5	Staff Knowledge/ skills/competency	22	Resource Issues	4

Table 1