Clinical Indemnity Scheme

Gníomhaireacht Éileamh an Stáit
State Claims Agency

Mistakes in Pre-hospital Care – keeping out of trouble.

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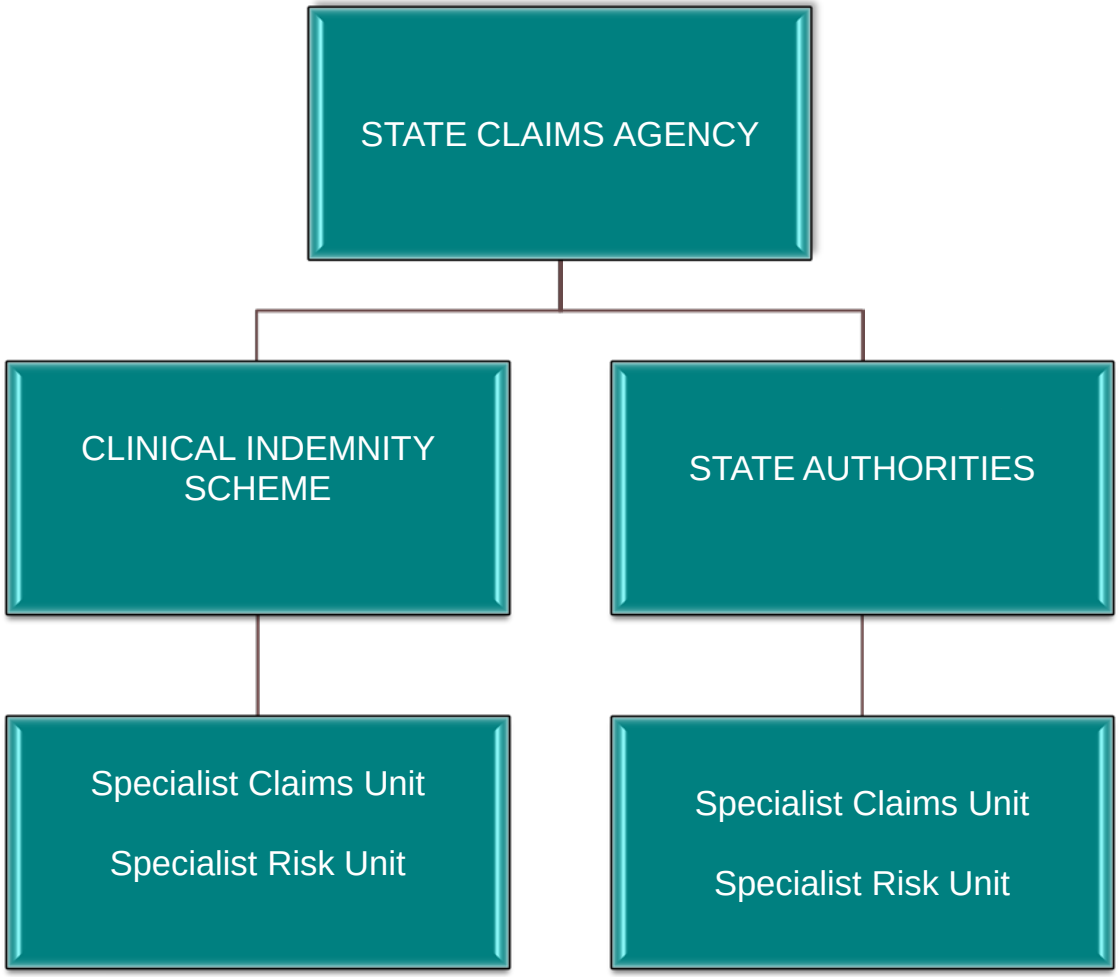
Tús Áite do Shábháilteacht Othar
Patient Safety First

CIS Structure



CIS Cover Inclusions

- Professional medical services
- Needle-stick injuries to patients during clinical care
- Good Samaritan acts within Ireland
- Representation at Coroners' Inquests
- Clinical care during transfer of patients

Pre-hospital emergency care service in Ireland

- NAS
- Fire Service
- Primary Care
- Emergency Departments
- Irish Coastguard
- Community Responders
- An Garda Síochána
- Red Cross
- Irish Defence Forces
- Navy Search & Rescue Services

Patient Safety in EMS

Patient Safety definition from ***Strategy for a National EMS***

Culture of Safety (Draft 3.1)

- *Patient safety in EMS is preventing medical errors (such as administering an incorrect medication) and other adverse events (such as dropping a patient) and decreasing the chance of harm to patients should such events occur*

What is our EMS Culture ?

- In many cases, newly hired EMTs and paramedics are paired with a partner or field training officer who either intentionally or unintentionally "undoes" responder safety and patient safety habits and beliefs instilled in the new employee's education program. This is commonly described as the *"that was all well and good in the classroom, but now let me show you how we do it in the real world"* effect.

NAS Stats:

- 1,500 frontline workforce
- Number & Types of Calls per year –

  999 = 210,000

  Urgent = 60,000

  Routine = 260,000

- Breakdown by code status

  Echo 2%; Delta 39%; Charlie 19%; Bravo 16%; Alpha 19%; Omega 5%

- Refusal of Care Rate = 7 – 8%

Personnel often work ……

- In chaotic unfamiliar environments
- Unfriendly & challenging
- Uncontrolled movement of people & vehicles
- Small poorly lit spaces
- Loud noises
- Work from compact bags
- Multiple handoffs
- 24/7; 365 days/yr
- Long shifts with few opportunities for meals or rest

Challenges in Pre-hospital Care

- Standardisation
- Taxonomy – common language
- Culture
- Medication safety
- Road Traffic Collisions
- High risk of accidents
- “Wake Effect”

Canadian Patient Safety in EMS Summit - Issues Identified (Canadian patient safety Institute, EMS Chiefs of Canada & Calgary EMS Foundation)

- Clinical Judgement & Training (95%)
- Medication Adverse Events (69%)
- Intubation (62%)
- Vehicle collisions (61%)

Prospective observational study - self reported adverse events –

- Lack of available resources 27%
- Communication problems 18%
- Prolonged response times 16%
- Resuscitation difficulties 16%
- Other treatment problems 10%
- Equipment problems 5%

Stella J, Davis A, Prehosp Disaster Med 2008

Aero-medical Adverse Event Database

Reported a rate of adverse events with possible or actual harm as 11.53 per 1000

- Communication listed as the root cause in 34% of events

- Patient management & clinical care as root cause in 20%

Seymour CW, Kahn JM, Crit Care 2008

Ambulance Service Clinical Events as of 18/06/2012 (n= 142)

Incident Type	Count
Treatment Incident	47
Equipment Incident	28
Unplanned Events	11
Slips trips falls	10
Medication Incident	7
Unexplained injury/unknown cause	2
Other	37

Clinical Judgement & Training:

- Poor clinical judgement is a far greater risk to patients than getting the wrong drug out of the bag.
- All too frequently, clinical decisions are made by well-intentioned but inexperienced or unsupervised EMS personnel which can have significant consequences to patients.
- It is not just about the technical skill, it is the decision making around the skill that is critical

Factors that contribute to medication Incidents

- Drawing up medications
- Administering medications in the back of a dark moving ambulance
- Lack of standardisation regarding contents & placement of items in drug boxes
- Lack of standardisation on how ambulances are stocked.
- Poor packaging design for vials and ampoules
- Lack of post procedure checklist
- Serious level of under reporting

Minimizing the Medication Risks

- Reduce medication incidents by better tracking and reporting
- Need to move away from a “culture of blame” in order to improve reporting
- Clearly written protocols, system checks and routine auditing of high risk medications
- Recording near miss events are as important for learning
- Develop a common taxonomy for EMS including sentinel events

Ambulance Service Employer Liability Events as of 18/06/2012 (n= 710)

Incident Type	Count
Violence/ harassment/aggression	193
Manual handling	101
RTC Crash	89
Slips/ trips / falls	76
Struck by/ contact with / collision	68
Equipment / device incident	53
Other	130

Ambulance Service Public Liability Events as of 18/06/2012 (n= 74)

Incident Type	Count
RTC Crash	34
Equipment / device incident	10
Slips /trips /falls	6
Struck by / collision	6
Environmental / Utilities	6
Manual Handling	2
Other	10

Reducing Risks of Vehicle Collision

- Improved driver education programs
- Stronger safety policies
- Introduction of dispatch systems have been shown to reduce the number of vehicles dispatched in emergency mode (AMPDS)
- Introduction of driver monitoring & feedback systems
- Using speed as a measure of quality has no meaning
- “Sterile Cockpit Rule” during periods of lights & siren driving
- Fostering a culture shift from “blame and shame” towards a learning culture is a key priority in improving safety

How to collectively improve Patient Safety

- Be open to team members raising safety concerns
- Be willing to report errors
- Collaborate with management
- Seek opportunities to expand knowledge
- Report safety hazards
- Perform safety checks, vehicle inventory & safety inspections
- Be willing to speak up if a partner appears fatigued or under mental or emotional stress

Tort Claims brought against EMS

Retrospective Study - 326 cases identified

- Vehicle collisions 37%
- Patient handling 36%
- Clinical Judgement 12%
- Delayed responses 8%

Wang, HE, Fairbanks, RJ. Ann Emerg Med 2008

NAS Claims – CL/EL/PL (as of 18/06/2012)

Claim Type	Claim	Closed
Clinical	2	4
Employer Liability	25	2
Public Liability	52	55

How will an enterprise knows there is a claim?

- Letter of complaint
- An incident report form
- Coroners inquest
- FOI request
- Anecdotal
- External regulator – HIQA
- Audit
- Trend

Statutory Limitation Periods

- Two-year limitation period where the plaintiff (claimant) seeks damages for personal injuries caused by negligence, nuisance or breach of duty
- Time does not run until a minor patient achieves eighteen years of age
- Time does not start to run against a plaintiff until his action accrued or, if later, his date of knowledge.
- No time limit in patients with intellectual disability

Investigation of Claims

- The medical records including PCR's are reviewed
- Statements requested from key clinical personnel
- Relevant expert evidence obtained
- Meetings arranged with witnesses, experts, solicitors, barristers and clinical claims managers
- Decision made to defend or settle, if possible
- When proceeding to trial, pre-trial consultations occur

Possible Outcomes

- Case Discontinued
- Settlement
- Trial – Judge Decides

Why Settle?

- Negligence
- Poor records – absent/ inadequate entries
- No records or missing records

Patient Safety Culture Going Forward:

- Encourage clear communication – use of structured tools
- Use of protocol books – (e.g. Field Guide 2011 for Pre-hospital care Practitioners)
- Use of dosing charts & use of calculators
- Clear clinical decision rules
- Standardised Equipment & Safety Checklists
- Ongoing/improved driver education programs including monitoring & feedback
- Audit

Contact Details:

Clinical Indemnity Scheme

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Emergency Medico-Legal Helpline

(01) 664 0909

Website: **www.stateclaims.ie**