CHAPTER 5

IDENTIFYING RISKS RELATING TO STANDARDS OF CARE

Purchasers of health care and patients or clients expect that the care which is provided should be in accordance with accepted standards. These standards are laid down in a variety of ways, and the publication of the Patient's Charter in 1991 made it explicit that patients or clients must be informed of the standards which they should expect. The development of health care contracting arising from the NHS reforms has fostered the preparation of quality standards and specifications by purchasers and providers.

This chapter deals with issues concerning standards of care, including:

- the duty to exercise reasonable skill and care (the Bolam Test)
- resuscitation
- staffing issues

Staffing issues are dealt with in more detail in chapter 8.

The Bolam Test

It was established as long ago as 1822 [1] that a medical practitioner has a duty to exercise reasonable skill and care in his treatment of a patient or client. This applies even if he acts without being asked to, for example treating the victim of a road accident. In some cases, he may owe a duty to third parties, for example a practitioner treating a pregnant woman owes a duty of care to the unborn child.

In the Bolam case [2] , it was found that " a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view" [3].

The courts have confirmed more recently [4] that the court is the final arbiter of a professional standard, this being defined as acting "in accordance with a practice rightly accepted as proper" by a body of skilled and experienced medical practitioners.

The standard of skill and care is determined by reference to the state of medical knowledge/science at the time of an incident, together with the specialisation of the medical practitioner and the application of the Bolam Test.

Although the Bolam Test applies specifically to medical staff, the principles can also be applied to other professional staff.

[1] Pippin –v– Sterrad, 1822
[2] Bolam –v– Friern Hospital Management Committee, 1957
[3] McNair J, p 122 at B [1957] The All England Law Reports
[4] Sidaway –v– Bethlem Royal Hospital and others, 1984

Resuscitation

It is generally thought that an "acceptable standard of care" includes the rapid identification of and response to a cardiac or respiratory arrest affecting a patient or client who is undergoing care, surgery, treatment or test. The extent of the response may differ dramatically from one health care provider to another and yet still be considered reasonable. The nature, extent and standard of response to an arrest in a theatre suite would be considerably different from that in a community home for people with learning disabilities. Provided that in each case rapid identification and response occurs in accordance with the practice "rightly accepted as proper" (see above), it is unlikely that a court would decide that there had been a negligent act or omission.

All premises where health care is provided should have a resuscitation policy, which should be known to all relevant staff. Surveys of 60 health care providers have shown that, of staff who described themselves as clinicians or professions allied to medicine or technicians involved in direct patient care:

- over 30% of all staff and over 20% of staff who consider it relevant **are not confident they can identify** a cardiac/respiratory arrest
- nearly 15% of all staff and nearly 10% of staff who consider it relevant **do not know how to summon qualified help** in the event of cardiac or respiratory arrest
- over 50% of all staff and over 43% of staff who consider it relevant **have not been trained** in resuscitation procedures by their current employers
- over 41% of all staff and over 32% of staff who consider it relevant **do not feel confident and competent** to participate in cardiac/respiratory resuscitation

These percentages are disturbing and reveal a lack of knowledge about basic safety procedures.

The first point to be addressed by a resuscitation policy is whether or not resuscitation should be attempted by staff in the immediate vicinity. In some small, non-acute units it may be appropriate that an ambulance be summoned rather than resuscitation being attempted by those unfamiliar with the techniques. A protocol covering the drugs to be used, the treatment to be administered and the extent to which a resuscitation attempt is to continue are also key features of an effective resuscitation policy. The lack of a written policy may place staff in a dilemma and lead to uncertainty and valuable time being lost in treating the patient or client.

Resuscitation equipment is often subject to vandalism or "borrowing" or, conversely, over-stocking. There are numerous examples of "crash trolleys" having drugs missing or out of date, or equipment not working correctly. All resuscitation equipment and supplies should be checked regularly, and a record kept of such checks.

■ **Action points**

There should be in each clinical area a written resuscitation policy, which includes the following elements:

- **the action to be taken immediately a cardiac or respiratory arrest is suspected**
- **arrangements for training and refreshing staff in resuscitation techniques and/or procedures**
- **an inventory of the equipment and drugs for resuscitation in each clinical area**
- **arrangements for checking equipment on at least a weekly basis, and a written record of such checks**

Staffing issues

Staffing levels are often a matter of concern to professional staff, since they may feel that levels (and skill mix, which is dealt with in detail in chapter 8) may be too low to provide safety for patients or clients and staff, particularly at certain times of the day. This is especially true of night cover, and at times of peak activity.

Purchasers and patients or clients will expect that the numbers of staff on duty in a health care provider will be sufficient to allow an acceptable standard of care and supervision to be given to all patients or clients. The required levels will, of course, vary with the number and type of patient or client concerned.

With increasing emphasis on increasing the efficiency and value for money of health care, and with the need to keep to a recognised budget, managers sometimes decide to reduce staffing levels. It is important for managers to remember that financial pressures may not be an acceptable defence against a claim for negligence.

■ **Action points**

Managers must satisfy themselves that there are at all times sufficient and appropriately trained staff available to provide a safe level of service.

Other issues for consideration

Other areas which are worthy of consideration include:

- adequate supervision of minors and people of impaired mental ability
- privacy and dignity, which are considered to be matters of quality, not risk, at present

CHAPTER 6

IDENTIFYING RISKS RELATING TO ASCERTAINING THE FACTS

This chapter highlights the importance of health records. The record contains a number of different documents, including medical notes, nursing notes, test requests and results, medication records, consent to treatment forms and correspondence between health care staff.

This chapter is divided into four main sections:

- ensuring correct treatment: guidance on record keeping
- securing confidentiality
- defending claims
- guidance on the preservation and storage of health records

Ensuring correct treatment

Errors in diagnosis and treatment can occur if the information in health records is either absent or illegible. A series of studies have shown that notes made by medical staff are not always signed in full and dated, are often illegible and may use unrecognisable or ambiguous abbreviations. Continuation sheets often do not bear the patient or client's name and identification number, giving rise to the risk of their being affixed to another patient or client's notes. Any corrections should be crossed through with a single line, initialled and dated. Correction fluid should not be used in health records.

Laboratory tests and other investigations are requested by medical staff to assist them in diagnosis or treatment. If the test is to be of use, the medical staff must see the results and decide on appropriate action. If the test results are not initialled by the doctor, there is no check or proof that they have been seen. Not only is this important so that correct treatment may be given, but also such documentation could be valuable in defending an allegation of medical negligence.

Drugs can generally only be administered when prescribed by a doctor and a medication record should be completed for each patient or client. The medication orders in the patient's record should be clear, describe the drug and the dosage, and contain details of the patient or client, including the name, identification number, height and weight and details of any allergies. All orders must be signed and dated by the prescribing doctor. Nursing staff who administer the drugs should indicate the time and details of each dose and give reasons for the non-administration of any dose. The medication record must be signed, indicating clearly the nurse administering the drug. Midwives can possess and supply certain drugs which they can administer on their own responsibility.

■ **Action points**

All clinical staff should be reminded of the importance of:

- **writing legibly and frequently in patient or clients' health records**

- **dating and signing in full all entries in health records**
- **writing the patient or client's full name and hospital number on each medical record continuation sheet**
- **initialling all test reports as having been seen prior to filing in the medical record**
- **exercising care in filling in medication records.**

Particular issues arise in connection with psychiatric records and those of people with learning disabilities. Decisions are often taken about the level of personal risk which it is acceptable to allow people to run, since a balance must be struck between the acceptable risks of a "normal life" and the greater vulnerability of these people. It is advisable for records to be kept of any decisions about the degree of risk which is considered to be acceptable for any one individual. It is also desirable to document the involvement of the individual concerned and their relative or advocate as appropriate.

Securing confidentiality

The obligation to retain the confidentiality of information about patients or clients rests with the trust or health authority which manages the service concerned. Any breach by an employee could lay the employer open to legal action.

The confidentiality of patient information can be compromised in a number of ways:

- insecure storage of health records

  records should be stored securely, away from observation by the public and preferably in locked storage units. There are many instances of records, particularly "dead" notes being stored in corridors or other areas to which the public has ready access. Equally, access to computerised information should be restricted;

- carelessness by staff in dealing with active records

  records should not be left unattended in areas used by the public. This applies to wards, out-patient departments and offices. Health records left in full view in medical and other professional staff's cars are particularly vulnerable;

  records should be put away at night in a drawer or other reasonably secure place;

  there should be an effective and compulsory tracking system for patients' and clients' records so that the whereabouts of a particular set of notes is known at any time. The system should be simple and quick to use, so that busy staff are not tempted to avoid it;

- careless talk

  discussions about individual patients or clients between health professionals have to take place all the time but care should be taken not to breach confidentiality. Patients

have commented that it is often embarrassing to hear detailed discussions about their fellow patients or clients and staff should be aware of the risk that may arise from visitors and other casual observers hearing clinical information about patients or clients;

- electronic transmission

  extracts of health records and test results may be transmitted by facsimile or electronic mail to ensure a speedy service. It is important to ensure that the information is sent to the correct location and that only the intended recipient will be able to access it. It is not unknown for facsimile machines to connect with the wrong number. Procedures should be developed to check that the information has reached the intended recipient.

Many hospitals and other health care providers require staff dealing with personal information to sign a confidentiality agreement. The need for confidentiality should be reinforced by managers at frequent intervals.

There may be particular problems about maintaining confidentiality when other agencies are involved in the care of patients or clients. The assessment procedure which is now required under Community Care legislation should be carried out by professionals from health, social services and other agencies. Staff of other agencies are, of course, bound by their own confidentiality code, but health staff have prime responsibility for details about the patient or client's health and, although information should be shared, health staff should be careful to share only that information which is relevant and with only those people who need to know it in order to perform their function.

■ **Action points:**

- **records should be stored securely, out of sight of casual observers**
- **a simple and compulsory tracking system should be used for health records which are withdrawn for any reason**
- **staff should be mindful when discussing details of patients or clients of their right to confidentiality**
- **staff should restrict themselves to releasing only relevant information about patients or clients to other agencies and only to those who need to have it**

Defending claims

Health records are the principal documents recording what is the intended and actual care and treatment of a patient or client, together with its outcome. For this reason, they are vital to the management of any claim for negligence. Discharge plans form an integral part of health records, and should not be discarded.

Negligence claims may often be notified for the first time several years after the relevant event. Staff change their jobs and clinical staff will see hundreds or thousands of patients

during their work in any one place, so it is unreasonable to expect staff to be able to remember, unaided, events which happened some time ago. Accurate and available health records are vitally important in establishing what happened.

In order to defend successfully a negligence claim, the provider of the care should be able to prove clearly that it has not been negligent. Alternatively, where negligence is obvious, a speedy settlement can be reached without incurring unnecessary legal costs.

Preservation and storage of health records

Health records may need to be used over a number of years. In addition, they should be preserved for the minimum periods specified in current Department of Health guidance [HC(89)20]. They should be stored in suitable conditions where they will not deteriorate, particularly maternity and children's records which should be retained for 25 years. Effective management of health records archiving and storage, whether in microfiche or original form, will ensure that notes are available for use in the event of patients or clients returning for further treatment or in the event of a negligence claim.

It is important that health records, whether paper, or computerised, are protected from fire, or other accidental or malicious damage. Fire detection is of particular importance given the large volume of papers which may be stored in one area. It is advisable that backups of computerised information are held securely in a separate location.

The filing of case notes often causes concern. Loose papers can be found inside torn covers, small items such as cardiotocographs and electrocardiographs can be lost. The back pocket of some record folders contains a variety of loose items and there are examples of health records being held together with "sandwich ties" or string.

There is an increasing incidence of patient or client held records, particularly child health records, which present their own problems when considering content, confidentiality and future availability.

■ **Action points:**

- **health record folders should be kept in good condition so that the covers act as a protective container for the important documents inside**
- **no papers should be filed without being secured to the body of the folder**
- **suitable wallets should be provided for small items such as CTGs and ECGs**

CHAPTER 7

IDENTIFYING RISKS RELATING TO CONSENT TO TREATMENT

There is a wealth of case law and guidance on the subject of consent to treatment by patients and clients and this manual does not purport to give a comprehensive guide to the subject. Guidance is contained in "A Guide to Consent for Examination or Treatment", issued under cover of HC(90)22. Legal advice should be sought in relation to any specific case in which health care professionals are in doubt.

Obtaining consent to treatment is an area almost entirely under the control of professional health care staff and not one in which managers are generally involved. But managers have a responsibility to ensure that professionals are fully aware of their obligations and understand the legal framework in which they are operating.

This chapter identifies the principal elements which need to be considered by health professionals treating patients or clients.

It covers the following areas:

- the duty to ask patients or clients for their consent
- the information which should be shared, both orally and in writing
- when and by whom information should be shared
- understanding and assimilation of information
- documentation

Advising the patient

It is a health care professional's duty to ask patients or clients specifically for their consent to any treatment. Consent is needed in all circumstances.

Regarding Sidaway –v– Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and Others (1984), in the report of the appeal to the House of Lords in 1985 it was stated that "the Bolam test applicable to diagnosis and treatment also applies to the doctor's duty to warn his patient of risks inherent in treatment recommended, in accordance with a practice accepted at the time by a responsible body of medical opinion. Although the decision on what risks should be disclosed, for the particular patient to be able to make a rational choice whether to undergo that treatment, is primarily a clinical judgement, the disclosure of a particular risk of serious adverse consequences might be so obviously necessary for the patient to make an informed choice that no reasonably prudent doctor would fail to disclose it".

It is a clear duty of the doctor concerned to provide the patient or client with information relating to all substantial or unusual risks involved in the particular procedure. It has long been established that patients or clients often fail to remember information given to them orally by doctors, and there has been an increasing tendency to provide written information

to patients or clients in the form of leaflets about the procedure. These may be either locally or more widely produced, for example by self-help groups.

Although the use of leaflets is to be commended, it should not be seen as an alternative to a thorough oral explanation by the doctor who will be undertaking the procedure. Doctors should encourage patients or clients to ask questions, and should answer them readily to the best of their ability.

■ **Action point**

- **doctors should be reminded of their legal obligations to advise patients or clients of any substantial or unusual risks arising from their treatment**

When and by whom should information be shared?

Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent at any time. In the case of procedures carrying any substantial risk or substantial side-effect, written consent should be obtained. The Department of Health has issued model forms which can be used or adapted for this purpose (HSG(92)32).

In one of the pilot studies, it was noticed that in some cases consent was sought and the form signed during an out-patient clinic a week before the operation. It is possible that insufficient time is available during a busy out-patient clinic to discuss the matter fully with the patient or client. Failure to explain procedures fully may result in litigation.

In the event of prior discussions having taken place at pre-admission clinics, this information should be verified immediately prior to the start of the relevant clinical procedure.

■ **Action points**

- **appropriate forms should be used to record patients' or clients' consent to all forms of treatment involving a substantial or unusual risk.**

Research and training

Consent should be sought when there is involvement of medical staff and other health care students in the care of patient. This would also apply to involvement in articles be to used for publication, whether in print or on film.

Local Research Ethics Committees often require patients or clients to complete a consent form prior to taking part in clinical trials. Consent for this form of treatment should be obtained in the same way as consent to operations or other procedures.

Special considerations

It is clear in emergency situations in which the patient or client's life is immediately threatened that, irrespective of the consent of the patient or a parent or guardian, the doctor may perform the necessary surgery or administer necessary drugs.

In circumstances where the person being treated is a minor, or a religious minority, or mentally impaired, the situation becomes more complex.

In respect of children's consent, following the Gillick case and the Children Act 1989, children over the age of 16 are entitled to give their own consent, or not, as the case may be. Children of "sufficient understanding" under that age may also give their own consent which will override that of their parents. The position is complicated, however, as already the courts in the case of Re B A Minor 1992 and other cases have modified this basic principle, giving a local authority or others with parental rights or responsibilities the right to give consent on a child's behalf. Special considerations may also apply where a child **refuses** (as opposed to consents to) treatment. The position is clearly complex and confusing, but if medical staff are in any doubt, they should seek legal advice as soon as possible with a view to applying to the High Court for a Declaration of the law in a particular case.

Adult consent for non-emergency treatment is more straightforward. Any individual of sound mind, has the right to refuse treatment for whatever reason, whether religious, cultural or personal. Refusal to comply with such a patient's or client's wishes by the doctor may constitute an assault. There are exceptions to this basic principle, particularly relating to patients or clients with mental impairment. Where a patient or client has a learning disability and is not able to make his or her own decisions, consent from the patient or client's guardian may be necessary.

However, where a patient's or client's mental impairment has led to aggressive or seriously irresponsible conduct, they may be compulsorily detained under the Mental Health Act. In this case, the need for consent is waived in respect of medical and nursing care for the patient's or client's mental disorder, but not for unassociated physical disorders. A guardian may be appointed on the patient or client's behalf and they will have considerable discretion over the patient or client's lifestyle. This is a very complex area, and reference should be made to the Mental Health Act 1983, particularly Sections 57, 58, 62 and 63.

Failure to take into account the above factors when obtaining consent in such special circumstances will be damaging to the relationship of trust and confidence between doctor and patient or client. It may also lead to otherwise avoidable legal action and the cost and adverse publicity that would result.

■ **Action point**

- **medical and, where appropriate, other clinical staff should be aware from whom they must obtain consent for treatment**

- **medical and other clinical staff must be fully aware of the legal considerations involved in obtaining consent.**

Understanding and assimilation of information

As mentioned earlier in this chapter, patients or clients do not always fully understand or retain information given to them by medical staff. Aids such as leaflets or tapes may help in this situation but should not be relied on as a substitute for careful explanation. Patients or clients may be unable to read. In strange and stressful surroundings, people retain only a little of what is said to them (maybe as little as 3 items of information per interview) so

professionals should not be afraid to **repeat** important items several times and on several occasions, **write down** important issues so that the patient can re-read them at home, or get the GP or health visitor or other suitable person (for example, a specialist nurse) to **visit** later and repeat what has been said. Any such visit must be recorded.

In areas where there are significant numbers of ethnic minorities, consideration should be given to the use of interpreters and/or multi-lingual leaflets so as to ensure that patients or clients have every opportunity of understanding clearly what it is that they are consenting to. Cultural differences should also be borne in mind.

The needs of physically or mentally impaired patients or clients also need to be taken into account.

Managers should be aware of the potential for medical staff themselves being difficult to understand due to technical jargon or heavy accents and doctors should be careful to use the simplest possible language to patients or clients, using medical terminology only if the patient or client is able to understand what is meant.

■ **Action points**

- **care should be taken to consider the special needs of individual patients or clients which may affect their ability to understand fully what is to be done**

- **in areas with large numbers of ethnic minorities, consideration should be given to using interpreters familiar with medical terminology and the implications of differing cultural values.**

CHAPTER 8

IDENTIFYING RISKS ARISING FROM WORKING BEYOND ONE'S COMPETENCE

Patients or clients and purchasers of health care are entitled to expect that the staff employed to carry out health care will be competent to practise. This chapter identifies some common issues which may compromise the competence of staff.

It addresses:

- the position of newly appointed staff who may be inexperienced in a particular area of practice
- training, supervision and support
- skill mix
- locum and agency staff

Professional accountability

In general, inexperience is no defence to an allegation of negligence and the standard of skill expected of a doctor would be that expected of practitioners with whom he claims to have similar skills. In the action Wilsher -v- Essex Area Health Authority (1986), the Court of Appeal held that a practitioner must display the standard of skill to be expected from a person holding his post in the hospital. It was irrelevant that he was new to the post and still in training. If a novice undertakes procedures in which he is not experienced, other than in an emergency, he is effectively claiming the skills of a suitably trained practitioner and will be judged against that standard. A junior doctor may avoid an allegation of negligence by consulting his senior colleagues; if an inexperienced doctor does not seek that advice of his senior when a prudent junior would have done so, he may be considered negligent.

Likewise, the UKCC Code of Professional Conduct for Nurses, Midwives and Health Visitors states that in the exercise of their professional accountability they should "acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner". The Code also states that they should "report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice" and "report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided".

Training, supervision and support

In the same way that patients or clients may reasonably expect to receive their care from competent staff, staff may reasonably expect that they will be suitably trained to do their jobs and that they will receive advice, appropriate supervision and support.

There is a possibility that managers may assume that staff transferring from another health employer will have received appropriate training for the job which they performed. But there

are examples of staff being appointed to posts for which they are not trained. Managers should ensure that newly appointed staff have received appropriate training at a suitably recent date.

Managers should ensure that staff attend training courses, even though this may cause difficulties in maintaining adequate levels of staff on duty. The pilot studies referred to in earlier chapters of this manual revealed several instances of staff carrying out functions for which they had not been adequately trained. In one instance, some medical staff involved in administering and controlling radiation had not attended recognised training courses as required by legislation relating to ionising radiations.

Support may be provided in the form of readily available written guidance and clinical protocols. This will help to ensure a consistent approach to diagnosis and treatment, particularly in areas of high staff turnover.

There should always be sufficient qualified staff available to give appropriate supervision, advice and support to less experienced staff. Failure to provide or utilise access to such advice places staff in a very vulnerable position, as discussed earlier in this chapter, and may be considered to present unacceptable risks to patients or clients being treated. Problems may arise where an individual is the sole practitioner of that profession within an organisation, and has no immediate peer support with whom to discuss problems or concerns.

Concern is often expressed about the level of supervision of wards, particularly at night. In one high risk area visited during the pilot studies, it was common for a D grade enrolled nurse to be left in charge at night on a regular basis in contravention of the nationally agreed terms on grading criteria. Although the difficulties in ensuring cover are acknowledged, such action leaves the hospital open to considerable risk in the event of an untoward incident occurring.

Practice nurses attached to GP surgeries often work with little professional supervision or support and care must be taken to ensure that they are not compromised.

■ **Action points**

- **managers should ensure that newly appointed staff have received suitable training for their post at a suitably recent date**
- **where specialist training is mandatory or advisory in a particular area, it is the manager's responsibility to ensure that staff are trained**
- **there should always be sufficient qualified staff available to provide advice and support to less experienced staff**

Skill mix

Hospitals and other health care providers are increasingly examining the skill mix of their staff to ensure that an acceptable standard of care is provided in the most cost efficient way. Re-profiling and the increasing use of unqualified staff can result in inadequate supervision and managers must take care to ensure that there is sufficient monitoring of these staff.

Particular problems may arise in community based premises, particularly those for people with a mental illness or learning disability, where for therapeutic purposes a decision has been made to replicate "normal" living conditions as closely as possible. Those staff who are available are expected to be multi-skilled. Care must be taken not to compromise safety in the effort to provide a more homely atmosphere and assessments of the needs and skills of individual clients should be undertaken and documented.

■ **Action points**

- **the increasing use of unqualified staff may give rise to inadequate supervision and managers should ensure that this is not the case**

- **in the case of community homes, care should be taken to ensure that the desire to create a home-like environment does not compromise the safety and wellbeing of residents or staff**

Locum and agency staff

There are often occasions when it is necessary to employ temporary staff to cover the absence of permanent staff. This may be done by the use of a "bank" of staff, by using an agency or by advertising.

Whichever means is used, it is essential that managers check the qualifications and registration of the temporary staff who are engaged. The onus is on local managers to ensure that the people they employ are suitably competent to carry out the work which is required, particularly since some posts receive little supervision and are themselves responsible for supervising other staff. It is not enough to think that it is the responsibility of the agency involved. Managers should remember that there are particular dangers involved for temporary staff who do not know the physical area in which they are to work and do not know whom they can ask for advice and support. There is a tendency to pay less attention to scrupulous checking of the credentials of temporary staff, since they will not be there for long. But it takes only one incident to cause major problems for the unit, and it can be argued that **more** attention should be paid when taking on temporary staff than in the case of permanent staff.

The report of the National Confidential Enquiry into Perioperative Deaths 1990 (NCEPOD)[1] found that, in 7% of the deaths, the most senior operating surgeon was a locum; similarly, of those anaesthetists working alone, 9% were locums. In some cases, the locums in both disciplines were "acting up", but often they admitted personally that they were inadequately trained or out of practice at particular procedures. A review of supervision of locum appointments at all grades in these specialties was recommended.

■ **Action points**

- **managers employing temporary staff should satisfy themselves that they are competent to fill the job and should give just as much attention to the credentials of temporary staff as those of permanent staff**

- **managers should always provide a basic induction for temporary or locum staff**

Care outside of specialty

Particular risk issues arise in hospitals where patients are concentrated into one ward rather than being spread in several partially filled wards. With the increased emphasis on efficiency, it is not uncommon for wards to be amalgamated, particularly at weekends, so as to minimise the number of staff required in the hospital.

Staff may be faced with caring for patients in a specialty in which they do not normally practise, with highly dependent patients, when they are not used to doing so, or with a higher proportion of dependent patients than usual, for example oncology patients in orthopaedic wards, or children being cared for in an adult-orientated ITU.

Risks can arise when nursing staff do not receive specific instructions or training regarding any specialist nursing care that may be required. It is desirable for additional written instructions to accompany patients being nursed in wards outside those designated for the specialty and which are staffed by staff who are used to dealing with patients from another specialty.

■ **Action points**

- **the risks inherent in asking staff to carry out duties to which they are not accustomed should be considered by managers and appropriate action taken to minimise the risks**

(1) Report of National Confidential Enquiry into Perioperative Deaths 1990, E A Campling, H B Devlin, R W Hoile, J N Lunn

CHAPTER 9

RISKS OF INJURY TO PATIENTS OR CLIENTS ARISING FROM FAILURE OF COMMUNICATION

Communication breakdowns can lead to serious consequences for patients or clients. This chapter identifies some issues which should be addressed to ensure that risks are minimised:

- interaction between parts of the health services, for example hospital and community services
- interaction between departments
- interaction between professional groups
- information given to patients or clients

Case law

A breakdown in communications can lead to errors of omission or commission, either of which is an extremely good starting point in establishing negligence if a legal claim is being considered.

The case of Coles –v– Reading and District Hospital Management Committee (1963) identified a number of elements of communication which are relevant to this section, so it is explained in some detail.

The patient had a crushed finger and initially attended a cottage hospital to be given first aid. No anti–tetanus injection was given and he was told by the sister to go immediately to another hospital for further examination and treatment. Instead of going to the hospital, the patient went home, where he was seen by his general practitioner (GP). He subsequently died of tetanus.

The hospital was found to have been negligent on the grounds of failure of proper communication (defined by the judge as "that which was reasonably necessary for safeguarding a patient's interests"). The Court held that the patient had not been told the importance of going to hospital, nor the risk involved in not going, so it was not properly explained to him and he should have been given a document detailing his treatment and the need for an anti–tetanus injection. The responsibility of ensuring that a proper system of communication existed rested on those in charge of a hospital, not on individual members of staff without any guidance. When transferring a patient from one hospital to another, there ought to be some communication, and any system which failed to provide for this was negligently wrong.

The general practitioner was also found to have been negligent because he assumed that, since the patient had been to a hospital, all that was necessary had been done.

Interaction between component services of the NHS

The Coles –v– Reading case is a good example of communication between component parts of a health service failing; the hospital/GP communication issue is one which receives a considerable amount of attention.

The main focus of communication problems between hospitals and GPs (and hospitals and other community–based health services) is the referral, admission and discharge of patients or clients. GPs often complain that they refer a patient or client for a specialist opinion and do not know if or when the patient or client receives an appointment, and also that there is slow communication of the results of a consultation. There are many examples of patients being admitted to hospital, perhaps through the Accident and Emergency Department, and discharged home without the GP knowing; it is particularly difficult for the GP when he is expected to take over the clinical management of the patient, including prescribing, if he does not know what treatment the patient has received, or what medication is currently in use.

Before a patient is discharged from hospital, a decision should be made about any continuing health or social care needs they may have. The provider unit should agree arrangements for meeting these needs with agencies before the patient is discharged, in consultation with the patient concerned. This should ensure that the services which the patient needs are ready in place when they arrive home. This is particularly important where several agencies are involved, typically district nurses, social workers and home support services such as home helps and meals on wheels. Guidance is given in the document "Community Care in the Next Decade and Beyond", and in HC(89)5 and HSG(92)4.

With the increasing availability of electronic communication, there should be less reason for discharge plans and letters or treatment summaries being delayed. In the past, efforts were sometimes made to communicate with GPs and others by telephone, but if the individual was not available at that time efforts were abandoned and written communication taking several days to arrive was sent instead. Facsimile machines are increasingly used for exchange of information and have proved to be very beneficial in improving and speeding up communication. Subject to confidentiality safeguards, their use is to be encouraged.

Conversely, GPs should ensure that hospital departments to which referrals are made, particularly in the case of direct referrals such as those for physiotherapy, are fully informed of patients or clients' conditions and needs. Such referrals may be made by telephone, but should always be confirmed in writing.

■ **Action points**

- **information about patients or clients should be communicated by the most efficient means so as to ensure that their treatment can be continued effectively**
- **all oral messages should be confirmed in writing**

Interaction between departments

It is important that all departments dealing with patients or clients are aware of all relevant information about their condition and treatment. There have been examples of patients known

to be HIV positive being sent to therapy departments with open wounds, without the therapy departments being aware of their HIV status. Similarly, in one of the pilot sites the policy of not providing identity bands for accident and emergency department patients resulted in two patients being confused by the X-ray department and receiving inappropriate examinations.

Although case notes may be transferred with patients, staff should not assume that their colleagues are able to assimilate all relevant information immediately. A brief note summarising the most important aspects will often be enough, and a simple pre-printed form could be devised. Such forms are already in use in some hospitals, and simple check boxes make it easy for receiving staff to form a quick view about the condition of the patient or client and any other relevant information on his circumstances.

■ **Action points**

- **staff should ensure that their colleagues have all relevant information about transferred patients. A simple check box form may assist**

Interaction between professional groups

In most cases, there will be a number of different professionals involved in providing the care for a patient or client. Good communication between them is vital to the efficient management of the patient or client's condition and his treatment and recovery.

In the Coles -v- Reading case, there was criticism of the fact that the nurse who saw the patient at the cottage hospital obtained advice on the telephone from the duty doctor which was not confirmed in writing.

An area where good interaction between professional groups is crucial is in maternity care, which is provided across hospital and primary care fields. It is essential that the roles and relationships between midwives, general practitioners and obstetricians are understood in order to give the woman, her baby and her family the style and type of care they require. In particular, it is important to note that the midwife has a defined sphere of practice and is accountable for that practice, which includes taking full responsibility for the care of a normal woman and baby throughout the childcaring episode.

In all cases, staff should remember that the welfare of the patient or client is more important than any professional boundaries and they should be prepared to communicate effectively to that end.

■ **Action points**

- **staff should ensure that professions liaise effectively to maximise the quality of care given to patients and clients**

Information given to patients or clients

Chapter 7 dealt in some detail with the information which should be given to patients or clients, and reference should be made to that chapter.

Coles -v- Reading again highlights an aspect of communication, that of ensuring that the patient understands the significance of the information or instructions which are being given to him.

The points made in chapter 7 about the services of interpreters are equally relevant here.

■ **Action point**

- **patients or clients should be given sufficient information about their condition to enable them to understand the importance of any instructions given by health care professionals**

CHAPTER 10

RISKS ARISING FROM DELAY IN TREATMENT

Patients or clients are able to sue health care providers for failure to provide correct diagnosis or treatment; a delay in diagnosis or treatment resulting in a deterioration of the physical or mental condition of a patient or client may give rise to a legal claim.

This chapter deals with:

- waiting time in accident and emergency departments
- admissions policy
- test results
- equipment breakdown or unavailability
- maternity departments and services for children
- availability of staff or facilities

Accident and emergency (A&E) departments

Delays in accident and emergency departments are a common cause of patient dissatisfaction in hospitals. At certain times of the day or night, there is often congestion in these departments and they are particularly vulnerable to disruption if an unusually large number of seriously ill or injured patients arrive within a short space of time.

One of the major difficulties in A&E departments is the mix of patients in the department at any one time. They will range from the very minor injury which could be treated at a GP surgery, to major trauma and life-threatening conditions. It is common practice for A&E departments to keep the seriously ill away from those with minor problems, to the extent of having separate entrances to the department, and this can lead patients to think that the staff are not working hard or that others are queue-jumping. Every patient in an A&E department will be anxious about his/her condition, and these elements often lead to aggression against staff, increasing the stress on them.

The Patient's Charter has set a national standard for the immediate assessment of patients in A&E departments. All A&E departments must ensure that patients are examined immediately by a trained professional so that their treatment needs can be prioritised quickly. Some A&E departments are using triage as a way of performing the assessment, others are conducting brief first assessments and undertaking a full scale triage assessment later. Problems can arise at three subsequent stages:

- delay after the initial assessment while the patient waits to see a doctor
- delay in procuring investigative tests such as X-rays and the results of them
- delay if the patient needs admission and there is difficulty in finding a vacant bed

There have been numerous sensational press reports of patients waiting unaccompanied for admission for many hours on trolleys in cold corridors and there have been cases where patients have been injured by falling from trolleys while waiting. The transfer of patients to specialist units, or neighbouring trusts if necessitated by the bed state, may also result in a delay in treatment.

Many A&E departments are coping with more patients than the number for which they were originally designed and staffed, and this presents its own pressures. Managers should consider carefully the risk which is presented to patients in some A&E departments and weigh the potential cost of a claim against the cost of making improvements in fabric or staffing. Purchasers of health care will be looking increasingly at the quality of service and failure to address this problem may lead to loss of income, particularly since a large proportion of patients admitted to hospital are seen initially in A&E.

Admissions policy

In some hospitals, it is the practice to admit all patients referred by GPs through the A&E department. This exacerbates the problems highlighted above.

An emergency admission ward adjacent to the A&E department could help to relieve the pressure on space and could allow patients awaiting admission to other wards to be accommodated in greater safety and comfort.

■ **Action points**

- **consideration should be given to the use of emergency admission wards to relieve pressure on A&E departments and beds**

Test results

Delay in interpretation of investigative test results can compromise the effective treatment of a patient. Difficulty can be experienced outside normal working hours, particularly in diagnostic departments supporting the A&E department. Medical staff, particularly juniors, should be aware of the procedures for obtaining urgent investigations and results out of normal hours.

■ **Action points**

- **junior medical staff should be aware of the procedures for obtaining investigations and tests out of normal working hours**

Equipment breakdown and availability

For diagnosis and treatment to be carried out quickly and efficiently, the necessary equipment must be readily available and in working order. The need for routine maintenance of equipment and replacement of obsolete items is emphasised in chapter 13.

In the event of equipment breaking down, arrangements should exist for it to be repaired as soon as possible and there should be sufficient equipment available for the professional staff to carry out their jobs effectively and efficiently. In one of the pilot sites, there were

insufficient sets of gynaecological instruments in the operating theatres; the measures taken of sterilising some items in situ had not resolved the problem of unavailability of equipment for later operations on the theatre list.

Maternity departments and services for children

In maternity departments it is important that expert help is on hand in the event of problems arising. The most expensive legal claims tend to arise from incidents occurring at birth and which result in brain damage or other disability.

There has been much debate over the future of small, local maternity hospitals and units, with supporters arguing that childbirth is not an illness and that mothers prefer to give birth in local, more homely surroundings rather than in the sterile, high technology environment of large hospitals. Options such as home birth, and birth in midwife/GP led units are part of a woman's choice about her maternity care. The recent report "Changing Childbirth" concludes that "there is no clear statistical evidence that having their babies away from general hospital maternity units is less safe for women with uncomplicated pregnancies". While this may be true, the wishes of mothers have to be balanced against the risk to mother and baby if there is no obstetric, anaesthetic or paediatric help available on site if problems arise. Even in larger units there may be problems arising from delays between summoning assistance and its arrival.

It is equally important to ensure that there are sufficient medical staff available, particularly in paediatrics, to cover the maternity department, children's wards and A&E at all times.

Availability of staff

The arguments in favour of adequate cover for maternity and children's services apply also to other specialties. On call rotas should allow for adequate cover, and medical staff should live close enough to the hospital to be readily available in the event of problems arising.

■ **Action points**

- **managers should satisfy themselves that there are adequate arrangements for cover by medical and other staff, to minimise risks to patients**

Availability of facilities

Problems may arise if designated emergency operating theatres are not available for use. This situation often means disruption of a planned surgical list in the main operating theatres and inevitable delay or cancellation of cases.

Many older hospitals have operating theatres sited above ground floor level, necessitating the use of bed lifts, which should be well maintained and reliable, for the transport of patients to and from the operating theatres. Older bed lifts are reported to break down frequently, causing the operating theatres to become congested with post-operative patients in a recovery state. This effectively cancels the operating list until the bed lift is repaired.

At night, or at weekends, problems with availability of theatres can be further compounded by any delay in "on call" personnel travelling to the hospital to prepare and staff the operating theatres.

Where a maternity department has a designated operating theatre, it is not uncommon for this to be administered and staffed by the main operating theatre department; in certain instances, these operating theatres may be kept locked out of working hours and keys held by the main theatre department. This precludes maternity staff preparing the theatre in the event of requiring the facilities urgently, as in the case of a caesarian section for fetal distress, when time is of the essence. Where a maternity department has a designated operating theatre managed and staffed by other than maternity unit staff, there should always be immediate access so that there is no delay when an obstetric emergency arises.

CHAPTER 25

REPORTING AND COMMUNICATION

It is fundamental to an effective risk management programme that potential risks and actual incidents are reported to management and that appropriate follow-up action is taken.

The chapter identifies steps to ensure effective reporting, under the following headings:

- immediate action
- the scope of and need for reporting
- forms
- routes for communication
- collation and analysis of information
- action
- feedback

Immediate action

The action taken by staff and managers immediately after an untoward incident can significantly affect the outcome. If the injured party receives sympathy, counselling and support, the risk of a legal claim ensuing is much reduced. However, this must be done sensitively and without admission of guilt in circumstances where there may, legally, be no negligence. Clear procedures, supported by training of managers, will facilitate good practice and minimise the incidence of legal claims.

The scope of and need for reporting

Incident reporting should cover **all areas, including fire, theft, assault, employee accident and patient or client injury, together with adverse patient or client incidents**. Statistical evidence demonstrates that it is the clinical areas from which health care providers suffer their greatest individual financial losses. Additionally, accidents to staff can result in expensive claims; investigating potential claims at the incident stage could facilitate the defence of future claims and thus reduce costs.

The first notification of a claim is often in the form of a solicitor's letter, sometimes a year or more after the date of the occurrence. Prior notice is not commonly provided by a hospital's traditional incident reporting system, and as a result the health care provider is at a great disadvantage in defending a claim. It is extremely difficult to reconstruct details of the occurrence several years later: health records may be unavailable, witnesses or staff move on, individuals relocate and memory fades. These factors make the development of a successful defence much more difficult. Although in many areas complaints procedures have facilitated earlier investigation, the centralised reporting of adverse clinical events is comparatively rare.

It is essential not only that all incidents which may give rise to a liability claim are reported, but that they should be reported promptly and in a manner which allows for the appropriate information to be gathered and preserved against the possibility of future legal action. Reporting of near misses where there has been no actual injury or loss may enable appropriate action to be taken to prevent future incidents.

Early identification of potential liabilities will not only affect the outcome and cost of liability claims, but will also lead to early identification of systems, practices or equipment which are not contributing to the highest standard of patient or client care.

Forms

Busy staff often resent the additional workload imposed by reporting incidents, some of which may appear to be trivial, so it is important to ensure that methods for reporting are as simple as possible and take minimal time to complete.

Conventional reporting systems require the incident reporter to send forms in a variety of different directions. A standardised reporting system using no more than two forms, one for actual or potential personal injury and one for property, is recommended. Incident forms should be completed promptly at the management or supervisory level and sent to a designated person who will take the necessary action. Wherever possible, staff who may be involved in completing incident report forms should receive training in the purpose for which the forms will be used and in how to fill them in. Written guidelines may be useful.

Routes for communication

Chapter 24 highlighted the importance of having one person designated as the risk manager for each health care organisation. All incident reports should be routed through a designated individual, whose responsibility it will be to ensure that appropriate people are informed and witness statements obtained where necessary. Staff completing incident forms should not be expected to decide which managers and departments need to receive the information; that is for the risk manager to decide, in the light of the risk management procedure which operates within the organisation.

Collation and analysis

The designated person will scan the forms and analyse the details. A computerised database is a good method to use for recording details of incidents, since it allows easy preparation of summary information and facilitates trending and tracking (see chapter 26). Untoward incident reporting systems are available commercially, together with supporting computer software.

Regular reports on actual or potential incidents should be prepared by the risk manager and submitted to the chief executive. It may be useful to distribute a regular bulletin throughout the health care organisation to promote awareness of risk management and thereby increase reporting of incidents.

Action

The incident form manager will scan the forms and will refer action to the appropriate individuals. He or she will operate a system which allows action to be followed up and logged. Asking people to take action without ensuring that it has taken place will not be enough to convince a Court that the health care provider has taken adequate steps to deal with a hazard.

Feedback

In order to promote confidence in the reporting system, it is important that the reporters of incidents are advised of the action which is taken as a result of their report.

■ **Action points**

- **a procedure should be devised and implemented, covering the action to be taken by line managers in the event of an incident involving actual or potential injury, loss or damage**
- **all incidents involving actual or potential injury, loss or damage should be reported immediately**
- **a simple reporting procedure using no more than two forms should be introduced**
- **a designated individual should be responsible for initiating further communication or enquiries and ensuring that appropriate action is taken**

CHAPTER 26

IMPLEMENTING RISK MANAGEMENT – TRACKING, TRENDING, MONITORING AND PROJECTION

This chapter outlines the techniques which can be used in controlling risk management activities. It covers:

- tracking
- trending
- monitoring
- projection

Tracking

Tracking is the recording of data, and assimilation of information, enabling patterns to be observed. There are two main methods of tracking: through manual systems or through computerised systems, used to establish the frequency of one or more criteria.

The foundation of a good tracking system is a comprehensive incident reporting system and this has been covered in the last chapter. Comprehensive systems are no use, however,if the information gained is not used; for information to be used, it must be recorded in a way which allows it to be accessed easily and manipulated against different criteria.

Although it is possible to have such a system operated manually, it is much more flexible if computerised. This can be done relatively inexpensively on a personal computer with an appropriate software package.

Trending

Trending is the comparison of information produced in tracking reports over a period of time.

When a normal pattern has been established, a rise in incidents in a given area, or at a particular time of day should become apparent, and can be investigated.

Identifying trends and reporting back to relevant departments alerts them to the fact that there is an area which is worth analysing and exploring in more detail and which may result in a reduction of problems.

Monitoring

Monitoring of any given criteria recorded on incident forms gives a useful early warning system of a downturn in standards and an increase in incidents which may result in a legal claim.

The raising of staff awareness which may be generated by the introduction of a new reporting system, and training in its use, is likely to result in an increase in the number of reported

incidents. Managers should be wary of inferring that this indicates a downturn in standards; it is likely that the level of incidents in the past has been underestimated due to a failure to report untoward incidents.

As monitoring continues and information is fed back to departments, they are able to see the effect of risk control measures introduced.

Projection

The ability to project trends and costs is particularly important for financial planning. Once norms have been established, it becomes possible to anticipate the number of incidents of a given type which are likely to occur in following years.

These projections can take into account increased volume of work, improved equipment and so on, and can then be measured against actual results. The reasons for differences can be assessed and action taken to reduce risk. They are also of value when considering the level of insurance deductible to be assumed by trusts, giving a guide to previous loss patterns.

■ **Action points**

- **steps should be taken to implement a tracking, trending and monitoring system for untoward incidents, and reports produced regularly.**

CHAPTER 27

IMPLEMENTING RISK MANAGEMENT – INVESTIGATION OF UNTOWARD INCIDENTS AND CLAIMS MANAGEMENT

This chapter deals with the reporting and investigation of untoward incidents and the management of claims.

An essential element of a risk management system is a procedure for identifying and reporting incidents and taking the action necessary to prevent a recurrence. Any system should be able to identify trends or patterns, pointing to areas for further investigation.

Systems exist in all health care providers for the reporting of accidents to patients or clients and staff and the same form is usually meant to cover "untoward incidents". There is seldom any definition of what constitutes an untoward incident, and there is often no mechanism for reporting damage to property with the exception of fire damage.

The chapter is divided into six main sections:

- definition of an incident
- reporting incidents
- investigating incidents
- financial implications
- risk management implications
- claims management

Definition of an incident

An incident for the purposes of risk management is:

> **any event which has given or may give rise to actual or possible personal injury, to patient dissatisfaction or to property loss or damage**

This definition covers all areas including patient or client injury, fire, theft, assault and employee accident.

Reporting incidents

As stated in chapter 25, busy staff often resent the additional workload imposed by reporting incidents, some of which may appear to be trivial. It is important that all staff realise that the purpose of reporting an incident is not to apportion blame to any individual or group of people but to identify potential problems or, where a problem has already arisen, to expedite a remedy. The culture of the organisation must not allow staff to feel that they are "telling tales" about their colleagues and the procedure must not be seen as punitive. Many staff will

quote occasions where the defective electricity socket, the missing light bulb or the hole in the carpet has been reported time after time, without any action being taken. So it is important that remedial action is taken promptly to ensure that the reporting system is not discredited. Conversely, the taking of action demonstrates a positive approach to the management of risk and helps to change the culture of the organisation.

■ **Action points:**

- **there should be a standardised incident reporting system**
- **staff who may be involved in completing incident report forms should receive appropriate training**
- **a clear message should be given to staff that the reporting of untoward incidents will not result in punitive action against that staff member**

Investigating incidents

When the designated staff member receives incident forms and scans them, he or she will decide what further information is needed and what action needs to be taken. Witness reports may be needed, photographs may need to be taken, defective equipment may need to be removed from use and steps taken to prevent a recurrence. It is important that any allegedly defective equipment or other item is preserved, together with its maintenance records, evidence of purchase, packaging and batch numbers for smaller items, since it may have to be produced in subsequent actions, either to prove that it was not defective or to engage another party, such as the supplier, in the action. Equipment which may deteriorate with age while in storage (such as rubber bath mats implicated in a fall or back injury) should be photographed.

There should be clearly agreed arrangements for prompt photographic support to be provided to the member of staff investigating incidents. This may be through a Medical Photography Department, or through the provision of a camera to the Risk Management Team.

Managers should be sympathetic to the fact that many staff who are asked to provide witness statements will never have written such a statement before; such staff will be very worried about putting comments in writing and may, in some cases, have genuine difficulties in writing without their colleagues and managers realising the fact. Witnesses should be offered help and support by the Risk Management Team in preparing their statements, but they should confine themselves to what they actually saw, rather than speculating on what happened. It is far better simply to state the facts, for example "Mrs J was found on the floor", unless the witness actually saw her fall.

In addition to individual witness statements, it is useful to record the names of all staff on duty at the time of the incident, perhaps in the form of the staff rota. It may also be useful to record where staff were positioned when the incident took place. It can sometimes be several years before a claim is made and it is often difficult to track which staff were involved.

■ **Action points:**

- **the member of staff receiving incident reports should take prompt and thorough action to ensure that steps are taken to provide or preserve evidence which may be needed in any future claim**

- **any allegedly defective equipment or other item should be withdrawn from use immediately and preserved as far as practicable**

Financial implications

An untoward incident results in many obvious, and hidden, costs: paying claims, replacing staff temporarily or permanently and replacing buildings or equipment. There can also be further consequential losses, for example the loss of a kitchen due to fire requires finance for the rebuilding, for the provision of alternative catering services during the rebuilding work and, if the kitchen has an income generation function, the loss of income and business. There are also costs to the organisation in the time taken to investigate incidents, and the effect of any adverse publicity.

Risk management does involve expenditure, but this can be offset by reduced losses and payments for damages, improved staff morale, less working days lost through staff injury and improvements in the quality of care given to patients or clients.

Risk management implications

Thorough investigation of an incident should reveal a number of elements which should be considered for further action, outside of dealing with the consequences of the specific incident:

- was the incident preventable?
- what measures are in place to prevent a recurrence?
- what other measures are recommended to prevent a recurrence?

The member of staff designated to act on incident forms should take responsibility for investigating these matters, with the appropriate departments, and reporting to senior management on the actions which have been or need to be taken.

The views of independent professional observers, who may be involved in the event of litigation, can give useful pointers to ways in which an organisation can minimise risk in future. Managers should read experts' reports and transcripts of any judgements given against their organisation in order to be more fully informed about the presence of risk.

In the past, many remedial actions have been shelved because they have financial implications and because other projects are seen to have a higher priority. But as we have seen earlier in this manual, expenditure on reducing risk is often money well spent.

In the event of a claim being pursued, evidence of a similar occurrence or prior knowledge of a hazard without any remedial action having been taken will immediately place the health

care provider at a disadvantage when deciding whether to defend the case or negotiate a settlement.

■ **Action points**

- **the cause of incidents should be thoroughly investigated and any measures which could prevent a recurrence should be defined**

- **managers should examine reports produced by experts in the course of litigation, together with the transcript of any judgement made against their organisation**

- **if a decision is reached that no further action is to be taken, this should be explicitly documented, giving reasons for that decision.**

Claims management

This section includes advice on :

- designating a claims manager
- involving legal and insurance professionals
- administration of documents

There is much evidence that the British are becoming more litigation-minded and there are now a number of firms of solicitors who specialise only in personal injury claims. As a result, health care providers should also adopt a professional approach to claims management which will lead to speedy conclusion of personal injury cases and to minimising the cost to the provider in both compensation and legal fees.

Damages awarded in personal injury claims are now considerably higher than used to be the case, and judges are increasingly awarding structured settlements, which help to safeguard the interests of the claimant rather than his associates.

The emphasis in this section is on health providers, but there is merit in named individuals being designated by purchasing health authorities to take an interest in these matters.

Health circular HC(89)34 stated that one identified individual with an appropriate level of understanding of legal processes, who is responsible for liaison with the legal professionals, insurance companies and the like should be designated as the **claims manager** for each health provider. This should be a named individual employed by the health care provider within its line management framework who is the named point of contact with these professionals, in order to maintain control of the process and to avoid conflicting messages.

There are a variety of ways of **involving specialists** with the knowledge required to take professional action on claims: providers may choose to employ a suitably qualified individual direct (either on their own or in association with other providers), to contract with a company which specialises in claims management, to retain a firm of solicitors or to rely on a service provided by other agencies, for example former regional health authority legal departments.

Whichever option is adopted, the claims manager should retain control of the process. He or she should take care to select an appropriate legal specialist.

It is particularly important that the claims manager co-ordinates access by the legal/insurance professionals to the staff of the health care provider. Uncontrolled access will lead to the claims manager not being aware of the exact progress of a case at a given time. He will also need to ensure that the legal professionals give regular updates on the progress of cases; it is not unknown for a hospital to discover almost by chance that a sensitive case is going to court in a few days time after several years of apparent inactivity, although relevant staff have been asked to attend as witnesses! The staff will assume that the managers of the hospital or other provider know the situation direct from the solicitors.

The claims manager should ensure that all staff involved in a case are regularly updated on its progress.

It should also be the role of the claims manager to **administer the documents** for claims. The master files should not be removed from the claims manager's office. Each claim should be referenced and all documents relating to it similarly referenced. There should be a record sheet at the beginning of the file which is regularly updated with brief details of correspondence, telephone calls, movement of documents such as case notes etc; and a summary sheet should be prepared at regular intervals giving brief details of the claim and its progress so that there is snapshot of the current situation. The chief executive and the Board should receive regular reports on the progress of claims and the summary sheets can be used for that purpose, anonymously if appropriate.

■ **Action points**

- **one individual should be designated as the claims manager, with responsibility for co-ordinating contact between the provider unit and the legal professionals**
- **the claims manager should ensure that legal professionals provide regular updates on progress for each claim**
- **claims documentation should be controlled by the claims manager**
- **the chief executive and the Board should receive regular reports on the progress of claims**

Settlement

The claims manager should recommend that cases be settled where there is advantage in so doing. This may be in order to minimise the legal costs involved in a protracted defence, or following advice on liability and the defensibility or otherwise of the claim. The chief executive should ensure that there is a clear procedure for decision making on the settlement of claims. It must be clear who has the authority to decide on settlement and quantum and the limits to that authority.

It is often difficult for staff who have been involved in a claim to accept that settlement out of court is the most sensible course of action. They may see this as the hospital or Authority admitting that the staff failed or were otherwise "guilty". The claims manager should ensure that staff receive a clear explanation of the reasons for settling and, where appropriate, an explicit assurance that this does not mean that they have done anything wrong. In some circumstances, it may be appropriate to offer counselling.

■ **Action points**

- **there should be clear guidelines on the authority to agree settlements of claims**
- **staff should receive an explanation of the reasons for settling a claim out of court, and offered counselling where appropriate**