

Commission on Patient Safety and Quality Assurance

Minutes of 7th meeting

5th July 2007

Summary of Action Points

	Action	By whom	Deadline
1	Invite the Mental Health Commission to make a submission	Secretariat	
2	Contact to be arranged between Commission and HSE working group on risk management and quality.	Ms Edwina Dunne	
3	Earlier start time to discuss research being carried out on regulatory bodies	Chair, Dr. Richard Brennan, Ms Edwina Dunne, Mr Dermot Smyth	
4	Arrange meeting with Prof Clifford Hughes (Australia) early September	Secretariat	
5	Circulate links to documents on doctors and apology law	Chair	
6	Subgroup reports to be produced Circulate	Chair (or deputy chair) of each subgroup Secretariat	ASAP

Commission Members in attendance:

Chair: Dr. Deirdre Madden, Senior Lecturer in Law, University College Cork
Dr. Richard Brennan, General Practitioner, Kilkenny
Ms. Edwina Dunne, Head of Quality & Risk, HSE
Dr. Ailis Quinlan, Clinical Indemnity Scheme
Ms Margaret Murphy, Patient/Carer representative, Cork City
Mr Dermot Smyth, Assistant Secretary, Department of Health and Children
Dr. Alf Nicholson, Consultant Paediatrician, Our Lady of Lourdes Hospital (sub-group morning session)

Secretariat:

Mr. Luke Mulligan, Department of Health and Children
Mr Aidan Clancy, Department of Health and Children
Ms. Elaine Tallon, Department of Health and Children
Ms. Ailish Corr, Department of Health and Children

Introductions

The Chair opened the meeting and thanked those in attendance.

Agenda Item 1 – Apologies

Dr. Eibhlín Connolly, Deputy Chief Medical Officer, Dept of Health and Children
Dr. Tracey Cooper, CEO, Health Information and Quality Authority
Dr. Mary Hynes, Director of Quality and Risk, National Hospitals Office, HSE
Mr Paul Fox, Process Engineering Manager, Bausch and Lomb, Waterford
Mr Tiberius Pereira, Patient/Carer Representative, Dublin
Dr. Gabriel Scally, Regional Director of Public Health, NHS
Mr. Tim Delaney, Head of Pharmacy, AMNCH
Ms. Mary Duff, Director of Nursing, St. Vincent's Hospital
Prof. Muiris X. FitzGerald, Physician

Agenda Item 2 - Minutes of Previous Meeting / matters arising

The minutes of the last meeting were agreed.

Action points from minutes

Action Point 1 – Scoping documents that were circulated to subgroups prior to meeting were discussed. It was agreed that research would proceed during the summer and would be coordinated through the secretariat. Researchers would then provide progress reports in September. Dr Paul Kavanagh has agreed to carry out research work on the regulatory bodies in the healthcare system.

Action Point 2 – no observations on previous minutes were received from members who could not attend.

Action Point 3 – Reports of the subgroup meetings were completed and circulated.

Agenda Item 3 – Correspondence

No correspondence was noted

Agenda Item 4 - Subgroups

Sub-group 1 did not meet on this occasion. The Chairs of sub-group 2 & 3 presented a verbal report from the earlier subgroup meetings.

Sub-group 2 highlighted issues that arose during their discussion of the scoping document. It was also noted that the researcher would not be able to undertake all the work involved in the scope so other avenues were discussed. The sub-group suggested that the Mental Health Commission should be invited to make a submission to the Commission.

Subgroup 3 outlined the presentation they had received on licensing and, in particular, the information received on licensing regimes in other jurisdictions.

It was agreed that some members of the Commission will meet earlier at further meetings to consider the results of the research on regulatory bodies in the healthcare system.

It was agreed that all the researchers will be requested to meet with the Secretariat on a regular basis to coordinate the work and in particular to ensure that the research is not duplicated. The products of this research will be sent to the chair of the relevant sub-group and then circulated to all members of the Commission.

It was agreed that Dr Gabriel Scally will now act as chair of sub-group 1.

Agenda Item 6 – Meeting with Ms Rebecca O’Malley

Ms O’Malley, who had been the victim of a recent medical error, attended the Commission meeting accompanied by her husband Tony. Ms O’Malley thanked the Chair and those present for the invitation to attend the meeting and for giving her the opportunity to share her views with the Commission. She then addressed the Commission in relation to her own particular case and on a number of issues related to medical errors generally.

Ms O’Malley said that she felt she was very badly treated by the system and she wanted an investigation into what precisely happened in her case when she was misdiagnosed and the reason for the delay in communicating this vital information to her when it was discovered. She expressed dissatisfaction with the initial HSE report into her case indicating that it did not uncover how the error occurred. She also pointed out that the patient was not the only victim of her breast cancer; her family in particular were also victims.

Ms O’Malley accepted that some level of error is inevitable. She stated that errors are routed in failures of the system and that professionals do not set out to make errors. She conveyed to the Commission that she would like to see the introduction of a robust system of mandatory reporting of medical errors involving the patient being told, a national independent register of such events being kept and learning to be derived from the system.

Ms O’Malley expressed the strong view that patients had a right to be informed whenever an error occurred. She cited the values of disclosing errors to patients including diffusing anger. She also referred to evidence of a significant reduction in litigation costs where information and sincere apologies are forthcoming to patients. In order to ensure that this right is vindicated, it must be enshrined in legislation. She cited a number of analogous situations where legislation proved necessary to ensure modified behaviour and pointed to mandatory medical error reporting regimes in Denmark, Florida and Saskatchewan.

Ms O’Malley indicated that she was happy that the HIQA investigation into her case had commenced and she expects that this process will provide the answers for her.

The statement was followed by a brief discussion on the issues.

Ms O'Malley indicated that she would make a submission in writing to the Commission and has agreed that she would be happy to attend another meeting with the Commission at a later date.

The Chair thanked the O'Malleys for their attendance and their very worthwhile contribution.

Any other Business

None

Next meeting

Thursday 20th September 2007 – Westin Hotel, Dublin 2

Signed _____

Dr Deirdre Madden

Chairperson

Commission on Patient Safety and Quality Assurance

Date _____