Your Complaint Matters

Quarter 3

Complaints Casebook

Grúpa Ospidéal Bhaile Átha Cliath Lár Tíre FSS
Dublin Midlands Hospital Group HSE
Páirtnéir Acadúil Coláiste na Tríonóide Baile Átha Cliath
Academic Partner Trinity College Dublin

DUBLIN MIDLANDS HOSPITAL GROUP

WWW.HSE.IE/DMHG

@DMHospitalGroup

057 9358060

CASEBOOK Q3

DMHG

OVERVIEW

The Dublin Midlands Hospital Group has been operational since 2015. The Dublin Midlands Hospital Group catchment population covers communities from Dublin, Kildare, Laois, and Offaly. The resident population of this catchment area is approximately 800,387.

SEVEN HOSPITAL SITES

- St. James's Hospital;
- Tallght University Hospital;
- Midland Regional Hospital Tullamore;
- Midland Regional Hospital Portlaoise;
- Naas General Hospital;
- The Coombe Womens' and Infants' University Hospital; and
- St. Lukes' Radiation and Oncology Network.nding and Development

PARTNERS

- Trinity College Dublin is the formal academic partner for the Dublin Midlands Hospital Group and will have a significant role in developing and enhancing academic excellence in teaching, research and innovation to drive improved health for the population of the Dublin Midlands Hospital Group

Case 1

COMMUNICATION & INFORMATION

Status
Not upheld
recommendation made

Background

The patient attended the Emergency Department (ED) with symptoms of a urinary tract infection. She has recently moved to Ireland. Before attending the ED she had contacted the local General Practitioner (GP) but they had no available appointments for new patients. After 4 or 5 hours waiting she left the hospital on the advice of another patient and she went to a GP the following day. She received an invoice from the Hospital. She wanted to confirm that the invoice issued was correct since she did not receive any attention and was not informed that she would receive an invoice when she left the Emergency Department. She emphasised that she is new to the country and does not know the system.

Examination

The complaint was investigated by the Complaints Officer. The patient's Healthcare Record was checked and it was noted that she was triaged by the ED Triage Nurse. Standard observation tests were performed including Blood Pressure, Temperature check, Oxygen saturation and a Urine test to check for infection. The Finance Department were asked to put the bill on hold while the complaint was under investigation. They confirmed that all patients who present and register at the Emergency Department incur a statutory €100 charge. This is an Irish government levy applied to all Emergency Department presentations without a referral from
a GP.

Outcome

A decision was made not to waive the patient's invoice for this admission to hospital. A copy of the Guide to the Emergency Department charges was sent to the patient for their information. The Complaints Officer recommended that the Finance Department update this information on Patient Charges Information Leaflet to address this issue which has given rise to several similar complaints. have now place a sign on the reception desk with guidance for patients with muliplie appointments on the same day.

Case 2

COMMUNICATION & INFORMATION

Status
Upheld
recommendation made

Background

The complaint was made by a gentleman who, along with his daughter, was visiting a family member who was a patient in the Hospital. As he went through the doors he was approached by a member of staff and he alleged that the staff member very quickly and aggressively said " excuse me this is meal time and we have a meal time policy." He told her that he completely understood but had some things to give to his wife and would just be a moment. He alleges that the staff member over reacted and threatened to call security. The visitor understands the meal time protection policy but was very taken back by the way himself and his daughter were treated. He felt that they had been treated very poorly by this member of the team.

Examination

This complaint was investigated by the Complaints Officer and the Ward Manager. The relevant staff member was identified and spoken with and it was recommended that appropriate training be undertaken.

Outcome

The hospital apologised for the manner in which the message around ‘Mealtimes Matter’ was communicated. We explained that we support a policy of ‘Mealtimes Matter’ in the hospital, which ultimately discourages interruptions to patients, by both staff and visitors, at mealtimes with the aim of providing an environment conducive to eating and allow staff to provide patients with support and assistance with meals. In general, visiting is not permitted during mealtimes with the exception of one family member per patient where assistance is being provided to the patient to eat. However, our staff are advised to communicate this message to visitors in a sensitive and meaningful way, where the welfare of the patient is kept to the forefront. We have also used the details of the complaint, in an anonymised fashion, in order to provide learning to all staff. We hope that in doing so, we will be able to prevent a recurrence of such incidents, and improve the way in which we communicate our message to visitors and family members going forward.

Case 3

Status
Partially upheld & Not Upheld
recommendation made

Background

Patient complained about lack of privacy in Emergency Department; treatment of finger injury, and, dispute payment of invoice. Invoice put on hold pending outcome of examination of complaint.

Examination

The complaint was forwarded to relevant consultants for response to issues raised. It was explained that it is common practice to treat minor injuries involving the hand, toe and foot on chairs to reduce waiting times and for patient's convenience. An apology was made that Patient felt privacy was breached whilst in the Emergency Department. This element of the complaint was partially upheld. Treatment of finger injury - Patient was given paracetamol and it was appropriate and common to offer additional analgesia, if required for patient comfort. During treatment, equipment was accidentally dropped and a nurse changed her gloves .It was appropriate that the equipment was changed after dropping the initial set and those gloves were used. Not changing equipment would be against best practice. Following review of the medical chart, discussions with NCHD involved in the patient care and review of x-ray performed in another hospital, the Consultant advised that the wound appeared to be at the tip of the finger, away from bone, joint and tendon ligament, and therefore, did not necessarily need an x-ray. Doctors must use clinical judgment to decide if an x-ray is needed, which, when performed in another hospital, demonstrated no fracture. The wound was appropriately cleaned and dressed. This element of the complaint was not upheld. Invoice for treatment - this element of the complaint was not upheld since the treatment of the finger injury was appropriate. In line with Health regulations, the invoice for Emergency Department attendance was re-instated.

Outcome

The complaint concerning lack of privacy was partially upheld. The element concerning the treatment of the finger injury was not upheld. The invoice for the treatment was re-instated. Emergency Department to review the space available to examine patients and remind ED team the importance of maintaining patient's privacy.

Case 4

Status
Partially upheld

Background

Patient complained about bleeding following attempted catheterisation.

Examination

Patient complaint was acknowledged in writing. The complaint forwarded to relevant consultants for response to issues raised. The patient was seen in the Emergency Department following a fall, with numbness in left leg, and difficulty in passing urine. Review of the medical chart showed that the patient was examined and x-rayed. Provisional diagnosis of nerve entrapment was considered. An attempt was made to pass a urinary catheter to check residual urine. During the procedure, urethral trauma occurred and doctors were unable to ‘pass’ the catheter. Bleeding from the urethra is not uncommon and can happen when there is difficulty in catheterization, or if it attempted on a couple of occasions. The patient treatment was discussed with Urology team on call in another hospital and, after observation of 6-8 hours, the patient was referred to the surgical team, following advice from that hospital. The surgical team passed an 18 Gauge catheter, urine was drained. The patient was commenced on antibiotics and has follow up with the Urology team.

Outcome

Emergency Department to review the information provided to patients when consenting for urethral catheterization

Case 5

Status
Upheld

Feedback

Background

Parent attended an OPD clinic with their child. The feedback acknowledged the exceptional service they provide to our children with their knowledge and expertise was made. The author also recognize the wonderful efforts to encourage an environment of health promotion and preventative medicine, educating us and empowering us to Be healthier.' Feedback was given regarding the vending machine with 'an unhealthy selection of snacks in the waiting room of the children's clinic.' Comment was made regarding the 'children getting upset and pestering their parents for the unhealthy treats' with the opinion that 'we are sending out an unhealthy message to the children'. A suggestion was made to move the vending machine to another area.

Outcome

In response the Hospital thanked the individual for the positive acknowledgement of the Paediatric services. Comments in relation to the vending machine were taken on board. An explanation was offered - the vending machine had been installed in the Outpatient department as a result of a significant number of requests by members of the public attending clinics. Many parents felt the department is located a considerable distance from the nearest shop and wished to have access to snacks while waiting for appointments. It was agreed that the location of the vending machine is not appropriate in the waiting room where it is visible to young children. The location of the vending machine was changed.

Case 6

Status
Upheld

Background

Patient attended diagnostics area for scans referred by internal Consultant of the Public Hospital. The Patient realised following this scan that he had insurance cover for an Orthopedic procedure in external Private Hospital so opted for treatment outside. When the patient requested copies of the various scans/reports the hospital was made aware that would not be available to external private hospital

Examination

The Hospital confirmed that the Patient did attend and had various scans completed. The Complaints Officer liaised with Diagnostic Area to advise that regardless of what Hospital patient would attend in the future. The results and scans were personal information to the patient and the patient was entitled to access and receive copies.

Outcome

Staff to be made aware of Legislation pertaining to personal information and access to same e.g. FOI & GDPR.

Case 7

Background

Child attended Hospital having attended Private Rooms of Consultant and admitted as Private Patient. Parent of child disputed charges as not accommodated in Private Room. The parent advised that they were happy to pay the private fee to the Consultant but did not feel that private (multi occupancy fee) should apply re the accommodation.

Examination

The Complaints Officer received confirmation from Admissions Office regarding private status of Patient. The Complaints officer was also provided with Private Insurance form signed on admission by parent agreeing to the charge. In addition the Complaints Officer was also made aware of a letter issued to parent advising of paperwork and signature on file and that levy/charge remained outstanding

Outcome

Following examination it was recommended that staff improve their communication with the Public when requesting signature on admission regarding Public V Private charges and also advising of “Private to Consultant” and “Private to the Hospital” regardless of the accommodation type

Case 8

Background

A patient e-mailed the Patient Advocacy Department acknowledging the care he had received when he had a surgical procedure carried out on the day ward I had a surgical procedure carried out. l was under the care of the staff of the day ward. The procedure was carried out . I want to thank all of the staff involved in my care including the non-medical staff. Not only were my physical needs addressed but and as important my emotional and mental needs were also addressed. I don't know what the procedure is in place to let all of them know how well they worked on the day but I would like them to know how much I appreciate their work”

Examination

The Patient Advocacy Department shared the feedback with the Consultant, Anaesthetist Staff and day ward staff thanking them for the care, compassion and commitment shown to this patient. The department acknowledged receipt of the correspondence to the patient with an undertaking to share with the staff involved.

Outcome

Positive feedback to staff is meaningful and boosts morale. A reminder that the impact of holistic care of a patient is of high value. The importance of team work and aiming to provide a patient with the best experience possible in varying circumstances. A review of the process so that it makes it easier for patients to provide feedback (currently reviewing the website).

Case 9

Background

A comprehensive letter was received into the Patient Advocacy Department with a detailed time line of events from the family of a recently deceased patient. The family outlined patients care and treatment . The family consistently alerted both nursing and medical staff to the fact that they felt the patient's condition was deteriorating. They reported that the patient was presenting with new symptoms such as sweating, confusion, shaking, pain, difficulty breathing, difficulty moving and dehydration. Nursing and medical staff reassured the family on several occasions. The family felt that staff were looking at figures instead of reviewing the physical symptoms of the patient. Unfortunately the patient passed away (RIP)

Examination

The letter of complaint was received into the Patient Advocacy Department through e-mail and acknowledged to the family Representative of the patient who was representing the family. The complaint was then sent onto relevant treating clinicians. As this patient had many co-morbidities there were several departments involved. A copy of the correspondence was also sent to the Risk Management Department for consideration by the Serious Incident Management Team (SIMT). SIMT reviewed the case and recommended a meeting with the family. The Director of Nursing, Director of Quality Safety and Risk Management and the Patient Advocacy Manager met with the family plus an external advisor that the family included in the meeting. The meeting was conducted in an open and transparent manner. An apology was offered at the outset of the meeting and the Director of QSRM outlined the sequence of events in detail from her review of the healthcare record. The Family were listened to and information clarified and questions answered. Both Directors finalised the meetings with an apology and outlined opportunity for learning with a commitment to oversee these changes implemented.

Learning

- There was a gap in communication when the patient was moved out of HDU / Critical Care area outside of normal working hours.
- Staff did not pick up on the urgency of the family's concerns who believed the patients' condition was deteriorating.
- Nursing and medical staff relied on the Early Warning Score and other clinical results and did not seem to review the patient holistically.
- Nursing staff missed opportunities to advocate on behalf of the patient with the input of the Nursing Site Manager.
- A senior decision maker review may have initiated a conversation with the patient and family around care options which would have facilitated a different end of life experience.
- Staffing and continuity of care is a challenge over a holiday period.

Recommendations

- Formal Medical Handover now takes place whereby every newly admitted patient is discussed and the care of the patient is formally transferred face to face from one clinical service to another
- Medical registrar roster patterns and staffing have been reviewed for holiday periods with increase cover agreed for these periods – arranged based on preliminary review of case
- Medical registrar on call cover increased during weekdays – from January 2019 – already in train to commence prior to review of case
- Liaising with DMHG on Critical Care Outreach service. Formal handover to relevant clinical team on call when patients are transferred from higher to lower levels of care during out of hours periods identified as required during preliminary review of case agreed with Critical Care Lead.

Effective Communications

The meeting held with the family, Director of Nursing, Director QSRM and Patient Advocacy was beneficial. An apology to the family was offered at the outset of the meeting and set the tone of the meeting. The meeting was not rushed and facilitated time for full discussion.

The meeting was held in an open, honest and transparent manner which the family did not expect. They had prepared for a more adversarial approach.

The Director of QSRM requested that the case would be presented at Grand Rounds, using a pseudonym. The family were pleased at this suggestion. They felt their father would be in agreement. Presented the case at Grand Rounds to coincide with Sepsis Awareness Week.