This is the report of a systems analysis investigation of an incident and the management of that incident. Sections should not be read in isolation. Rather, the report should be read in its entirety to give context to each section of the report.
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1. Executive Summary

This is the report of the investigation commissioned by the Regional Director of Operations (RDO), Health Service Executive (HSE) West in collaboration with the National Incident Management Team (NIMT). The incident in relation to the discharge and transfer of the patient occurred on the 23rd of November 2007, and it relates to the transfer of the patient from Mid-Western Regional Hospital Ennis (MRHE) to Regina House Community Nursing Unit (CNU), Kilrush. The patient required supplementation oxygen. The patient arrived at Regina House at approximately 14.40 hrs and passed away a short period of time after arriving (less than 30 minutes). The patient was pronounced dead at 15.10 hrs (RIP).

The partner of the patient made a complaint to Mid-Western Regional Hospital Ennis about the incident, which the hospital initially endeavoured to respond to according to the “Your Service Your Say” HSE Complaints Management Policy.

The hospital’s first complaint report was issued to the complainant on the 29th of February, 2008. A subsequent complaint response was issued by the hospital to the complainant on the 7th of October, 2008. The results of an internal review of the complaint were issued to the complainant on the 21st of October, 2009.

In summer 2010, the Regional Director of Operations (RDO) West was contacted by the complainant and requested the involvement of the National Incident Management Team (NIMT).

The RDO requested the NIMT to support an investigation of this incident and the management of the complaint arising from it and this culminated in the current report.

The purpose of this incident investigation was to:

− Establish precisely what happened and what failures if any occurred in relation to the care and management of the patient and in particular from the time of the GP’s call to the Ambulance Service on 21st November, 2007, his subsequent care and management by Mid-Western Regional Hospital Ennis, Ambulance Services, and in Regina House until his death on 23rd November, 2007 so that the HSE can identify all lessons that can be learned from the experience and so that the likelihood of recurrence is removed or reduced.

− The review will also examine the HSE’s response to the death of the patient in the context of its Risk Management Policies and Procedures and its statutory obligations. The review will also have regard to the explanations volunteered by the GP and Regina House staff following the death of the patient. It will also review the response to the complaint relating to the incident made to Mid-Western Regional Hospital Ennis on 10th December 2007.

− If systems failure(s) were identified, a further purpose of the review was to identify the causes of these failures and the actions necessary to remedy these so as to prevent, or if prevention was impossible, to reduce the likelihood of recurrence of such failures as far as was reasonably practicable.

It is acknowledged that the events of the 23rd of November 2007 were devastating for the patient, the patient’s partner and the patient’s family.
The partner of the patient emphasised that she wished to establish precisely what happened and that any investigation undertaken should focus on learning from the incident so that it would not happen again.

**Key Findings**

The investigation of the clinical incident identified the following Care Delivery Problems (CDP’s):

<table>
<thead>
<tr>
<th>Care Delivery Problem 1</th>
<th>The decision to discharge the Patient from MWRHE to Regina House</th>
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<tbody>
<tr>
<td>Care Delivery Problem 2</td>
<td>The management of Oxygen administered to the Patient at MWRHE and Regina House.</td>
</tr>
<tr>
<td>Care Delivery Problem 3</td>
<td>The management of the transfer of the Patient from the medical ward at MWRHE to Regina House.</td>
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</tbody>
</table>

In relation to Care Delivery Problem 1, the Independent Clinical Expert, nominated to the Review Team by the Forum of Post-Graduate Training Bodies, observed that on transfer to the medical ward, an undated entry in the Patient’s healthcare records reported restlessness and increasing shortness of breath with an oxygen saturation level of 88% on 15 litres of supplemental oxygen. There was evidence of significant clinical deterioration from the evening of the 22nd of November onwards as documented in the nursing notes. The patient’s end of bed observations on the 23rd of November reported an oxygen saturation level of 76%. A full blood count and arterial blood gas had been taken from the patient on the morning of the 23rd of November which ultimately showed an increasing white cell count of 19.6 and a significant derioration in his arterial oxygenation (P(O2): 4.76). These results were not available to staff prior to the patient’s discharge and transfer to Regina House. This was due to the fact that a blood gas analyser was out of order.

The External Independent Clinical Expert further observed that the patient had advanced Idiopathic Pulmonary Fibrosis (IPF) (formerly known as Cryptogenic Fibrosing Alveolitis (CFA)) and was in the terminal stage of his illness. There is evidence of a significant deterioration in his underlying condition during his hospital stay. In that context, the patient was not medically fit for ambulancene transfer to Regina House on the 23rd November 2007.

In relation to care delivery problem 2, Oxygen delivered via nasal canula is generally prescribed in Litres per Minute and Oxygen delivered by a face mask is generally prescribed in percentages. The External Clinical Expert observed that it was evident that there was confusion in the prescription of oxygen for the patient from his admission via the Emergency Department, his stay on the medical ward and throughout his subsequent transfer and admission to Regina House. The Oxygen flow rate had been prescribed in litres per minute or as a percentage and via either a nasal canula or a face mask. Consequently it was unclear exactly what rate of oxygen was being administered at a particular time.

With regard to care delivery problem 3, the investigation team identified that there was a lack of policies, procedures and guidelines for the transfer of patients between healthcare facilities including those requiring supplemental oxygen therapy.
The review of the management of the complaint that arose out of this case, identified the following complaint management service delivery problems (SDP’s):

<table>
<thead>
<tr>
<th>Complaint Management</th>
<th>Service Delivery Problem 1</th>
<th>There was a lack of clarity about the need to conduct a robust investigation of this complaint in the first instance (i.e. when the incident occurred and/or when the complaint was made) that covered all areas of the service involved, and that identified and satisfactorily addressed all pertinent issues.</th>
</tr>
</thead>
</table>

In relation to the lack of clarity about the need to conduct a robust investigation of this complaint in the first instance (i.e. when the incident occurred and/or when the complaint was made) that covered all areas of the service involved, and that identified and satisfactorily addressed all pertinent issues - this complaint was initially managed by the Complaints Liaison Officer at Mid-Western Regional Hospital Ennis according to the HSE’s complaint management policy and procedures “Your Service Your Say”. This Officer’s remit extended to cover only the Mid-Western Regional Hospital at Ennis and while links were made to include the ambulance service in this investigation and while considerable work was done on this investigation, including the implementation of recommendations arising from the initial hospital complaint investigation - there was no national policy for the management and investigation of incidents at the time, and no policy clarity about how complaint and incident management should be reconciled. This, and the nature of the structures and processes in place at the time, and the fact that these were in flux, prevented those involved from seeing all of the pertinent complaint issues in all their complexity. All of these factors contributed to the lack of clarity about the need to conduct a robust investigation of this complaint in the first instance that covered not only Mid-Western Regional Hospital Ennis and the Ambulance Service, but also included Regina House Nursing Home - and that identified all pertinent issues.

The fact that a robust systems analysis investigation did not occur in the first instance in this case meant an incomplete and inaccurate complaint investigation report issued which was very disappointing for the complainant and meant that the HSE did not derive all possible learning from the experience of this complaint/incident.
In relation to the lack of clarity about the need to proceed with a full systems analysis investigation as recommended by the complaint review process (which occurred in October 2009) when there were external investigations including investigations by An Garda Síochána and the Professional Regulators - in a manner that balanced the need for the HSE to achieve its safety objective with the need not to jeopardise any investigation by these external agencies - the hospital manager recalled receiving verbal legal advice that the case was “sub judice” (i.e. under judicial consideration) and that therefore, no further HSE investigation should proceed. The legal advisor stated to the review team that their best recollection did not confirm that they advised against appropriate investigation into the matter, as the legal advisor was unaware that any other investigation was required or called for other than the Garda investigation. The review team found that this emphasised the lack of clarity about the need for the investigation of this complaint to proceed in spite of external investigations including investigations by An Garda Síochana and the Professional Regulators.

The fact that there were no clear policies, procedures or guidelines to support staff in understanding exactly how to conduct investigations in a manner that ensured that these investigations would not jeopardise any future criminal proceedings or other external investigations including investigations by Professional Regulators contributed to this lack of clarity.
Summary of Recommendations

**Recommendation 1:** **Arterial Blood Gas Analysis.**

It is recommended that arrangements are made for safe systems in relation to arterial blood gas analysis including but not limited to ensuring that there is access to working gas analysers and appropriate contingency arrangements for when arterial blood gas analysers are out of order.

**Recommendation 2:** **Care Planning and Discharge Planning.**

It is recommended that a care plan and discharge plan is developed for every patient following admission to hospital based on the Health Service Executive Code of Practice for Integrated Discharge Planning (2008)\(^1\). This should be reflected in hospital policy and procedures and include provision for audits of compliance. The Hospital should ensure it audits compliance as soon as possible following receipt of this report and at a minimum of yearly thereafter.

**Recommendation 3:** **Develop National Guidelines for Oxygen Therapy**

It is recommended that national multi-disciplinary guidelines be developed, implemented and audited to provide clear direction for the clinically appropriate prescription, administration and management of oxygen therapy. The guidelines must include a standardised format to be used across all clinical settings for oxygen administration. These should consider the source of oxygen, i.e. piped oxygen supply cylinder or concentrator device. Guidelines should identify whether the rate is recorded in litres per minute or as a percentage and the delivery mode to be used (i.e. nasal cannula/mask). These guidelines should focus on, but may not be limited to the prescription, administration and management of oxygen therapy;

- By General Practitioners
- During clinical handovers
- During ambulance transfers
- At recipient facilities
- In low technology community settings
- When portable oxygen supplies are running low

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\(^1\) Please note: The 2008 Health Service Executive Code of Practice for Integrated Discharge Planning is expected to be replaced with a 2013 version in quarter 4 2013.

It is recommended that national guidelines be developed for the transfer of patients between healthcare facilities. These guidelines should provide direction to staff as to the key patient specific information that must be communicated during a structured patient handover to the receiving facility and to the Ambulance Controller when requesting an ambulance transfer. This should specify the patient’s diagnosis, current condition, supplemental oxygen requirements and delivery mode, and any cardiac or other monitoring devices required. This will ensure that the receiving facility has the necessary equipment available and ready and that an appropriately equipped ambulance and suitably qualified personnel are allocated to the task. These guidelines should include guidance for the transfer of critically and / or terminally ill non-ventilated patients requiring supplementation oxygen therapy to and from palliative care and respite services – arranged by General Practitioners / and other medical practitioners. Training should be provided to support the implementation of these guidelines and compliance audits completed.

Recommendation 5: Optimise Complaint and Incident Reporting and Management Policies and Procedures, Structures and Processes

It is recommended that the HSE review the HSE complaint and incident reporting, management and investigation policies and procedures, structures and processes to ensure that:

1. Complaints and incidents are investigated in all their complexity, including that the scope of the investigation goes across all of the services involved in the incident or issue complained of.

2. Complaints and incidents recognise the commonality of complaints and incidents (i.e. complaints are service user reported incidents) and the consequent need for common methods of identifying, managing, investigating and learning from them.

3. Sufficiently robust methods of investigation are deployed, namely, systems analyses investigations.

4. The need to proceed with internal HSE investigations is clear when there are external investigations by professional regulators, an Garda Síochána, and legal proceedings, and provided that HSE investigations are conducted in a manner that is impartial, fair, evidence based and that they do not prejudice future legal proceedings or investigations by Professional Regulators. See also recommendation 7 and recommendation 8.
Recommendation 6: Training for Complaint and Incident Investigators, Managers and Clinicians Should Be Optimised

This should include the development, implementation and evaluation of the effectiveness of a training programme for complaint and incident investigators, managers and clinicians on the management and investigation of complaints and incidents to include:

1. How to conduct robust systems analysis investigations.
2. How to ensure that the scope of investigations should go across all services involved in the incident or issue complained of.
3. How to ensure that the commonality of complaints and incidents (i.e. complaints are service user reported incidents) is recognised and the consequent need for common methods of identifying, managing, investigating and learning from them.
4. The importance of proceeding with HSE investigations when there are investigations by external agencies including but not limited to Professional Regulators, An Garda Síochána, legal proceedings etc. (As per the Memoranda of Agreement as outlined in recommendation 8 below)
5. How to conduct HSE investigations in a manner that is impartial, fair, evidence based and that does not prejudice future criminal and civil legal proceedings, or investigations by external agencies including but not limited to investigation by the Professional Regulators. (As per the Memoranda of Agreement as outlined in recommendation 8 below).

Recommendation 7: Governance Arrangements for Complaint and Incident Management Should Be Optimised.

This should include a review of HSE governance arrangements to ensure that suitable management and governance structures and processes are in place that satisfactorily manage risks and safety - including the management and investigation of complaints and incidents - within the structure and at the interfaces between health service structures.
Recommendation 8: Arrangements for HSE investigations when external agency investigations are ongoing or anticipated should be clarified.

This should include the development of Memoranda of Agreement (or an equivalent) between the HSE and external agencies that may have a role in investigating complaints and incidents, specifying exactly how the HSE might conduct investigations in order to balance the need to achieve HSE safety objectives with the need not to jeopardise concurrent or future investigations by such external agencies - including but not limited to investigations arising from criminal proceedings and investigations by the Professional Regulators.

Following development of these Memoranda of Agreement (or an equivalent) there should be:

- Communication of these Memoranda or the equivalent to the relevant personnel in the HSE
- Training of relevant staff on how to conduct investigations in order to balance the need to achieve HSE safety objectives with the need not to jeopardise concurrent or future investigations by external agencies as per the memoranda of agreement
- Evaluation of the effectiveness of these Memoranda of Agreement and associated training, including audit of compliance with the conditions as set out in these Memoranda of Agreement.

Recommendation 9: Healthcare Records Should be Enhanced

To ensure that healthcare records are enhanced, all relevant staff should be aware of and adhere to the HSE Standards and Recommended Practices for Healthcare Records Management QPSD-D-006-3 V3.0”, in particular the guidelines contained in this document in relation to clinical records.

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2 This document can be accessed by HSE staff at the following link http://hsenet.hse.ie/intranet/qualitypatientsafety/?importUrl=http://localhost:82/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/hcrgmt.html
2. Apology:

The Health Service Executive would like to acknowledge and apologise to the partner and the family of the patient for the traumatic and tragic events that occurred on the 23rd of November 2007 that led to his untimely and tragic death (R.I.P.).

The Health Service Executive acknowledges that the patient and the patient’s partner’s experience on the 23rd of November 2007 was devastating.

The willingness of the patient’s partner to share her experience was invaluable in allowing this investigation and the health services to learn, and in helping the investigation to make recommendations to improve the arrangements in place for the management of oxygen therapy in our services; the discharge and transfer of patients, especially critically ill patients requiring supplemental oxygen therapy; and the more efficient and effective management of complaints and incidents by the Health Service Executive.
3. Acknowledgement:

It is acknowledged that the events of the 23rd of November 2007 were devastating for the patient, the patient’s partner and the patient’s family.

The Health Service Executive (HSE) would like to thank the patient’s partner and the patient’s family for their cooperation with the investigation process and recognise that it occurred in extremely sad and difficult circumstances.

The HSE and in particular the RDO HSE West and the NIMT wishes to thank the partner of the patient, for her patience and understanding in relation to the investigation of the clinical incident and management of the complaint.

The HSE would also like to thank all staff for their co-operation with this investigation process.
3. Methodology

This is the report of the investigation commissioned by the Regional Director of Operations, Health Service Executive West in collaboration with the National Incident Management Team. The investigation relates to an incident which occurred on the 23rd of November 2007, relating to the discharge and transfer of the patient from Mid-Western Regional Hospital Ennis to Regina House Community Nursing Unit (CNU), Kilrush. The patient required supplementation oxygen. The patient arrived at Regina House at approximately 14.40 hrs and passed away a short period of time after arriving (less than 30 minutes). The patient was pronounced dead at 15.10 hrs (RIP). The investigation also considers the management of a complaint made by the partner of the patient to Mid-Western Regional Hospital Ennis about the incident which the hospital responded to according to the “Your Service Your Say” HSE Complaints Management Policy.

Related aspects of the complaint were referred to various HSE Offices, An Garda Síochána, the Professional Regulators, HIQA and the Department of Health.

The investigation was undertaken using the methodology for Incident Reviews outlined in the HSE Toolkit of Documentation to Support Incident Management (May 2009) which is based on the London Protocol (2006) for systems analysis3 an internationally recognised methodology for investigating adverse incidents in healthcare.

The reviewers who undertook this investigation were:

- Cora McCaughan, (Chairperson), Co-chairperson of the National Incident Management Team (NIMT)
- John McElhinney (Reviewer)  
  Clinical Risk Advisor, Sligo General Hospital
- Professor Seamas Donnelly, Consultant Respiratory Physician  
  Nominated by the Forum of Post-Graduate Training Bodies to give external independent clinical input to the clinical incident element of this review

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3 A systems analysis investigation is a structured investigation that aims to identify the systems cause(s) of an incident or complaint and the actions necessary to eliminate the recurrence of the incident or complaint or where this is not possible to reduce the likelihood of recurrence of such an incident or complaint as far as possible. Healthcare services carry out incident investigations using systems analysis to find out what happened, how it happened, why it happened, what the organisation can learn from the incident and what changes the organisation should make to prevent future harm arising from its causes.
Sources of Information Reviewed by the Investigation Team

While carrying out this investigation of a) the clinical incident and b) the management of the complaint the reviewers examined the following literature and documentation:

- Medical Records of the patient.
- Correspondence and communications (e.g. letters, emails faxes, administrative records) in relation to the management of the complaint.
- Correspondence and communications (e.g. letters, emails faxes, administrative records; Record of Verdict of the Inquest held 16th of July 2009) in relation to the clinical incident.
- Health Service Executive (2009), “Tool Kit of documentation to Support the Health Service Executive Incident Management”.
- Health Service Executive, RDO West (2008), “Administration of Oxygen Therapy to Adult Patients” Guidelines signed off by the HSE West Policy, Procedures and Guidelines Committee.
- HSE West (25.09.08) Administration of Oxygen to Adult Patients.

During the review of the medial records it was identified that, on occasion, the quality of the record keeping was of a lower standard than is necessary. Examples included:

- Not all entries were dated.
- Not all entries were timed.
- There was a tendency for notes not to be written contemporaneously. Occasionally, notes pertained to an extended period of time.
- The patient’s name and record number (i.e. hospital number) did not appear on every page of the record.
- There were aspects of care recalled at interview during this investigation, and which are alluded to in this investigation report which were not recorded in the healthcare records by the clinicians concerned but which should have been recorded.
To investigate the clinical incident element of this investigation interviews were undertaken with the individuals involved in the care of the patient between the 21st and the 23rd of November 2007.

A total of 17 people were interviewed to inform the clinical incident element of this investigation report.

Those interviewed included individuals from:
- Mid-Western Regional Hospital Ennis
- St. John’s Hospital Limerick
- Ambulance Services
- Regina House, Community Nursing Unit, Kilrush
- The Patient’s GP.

In advance of interview, staff were provided with the terms of reference for the investigation and were informed of their entitlement to be accompanied to interview. Prior to interview staff were also informed of the process for the preparation of the draft report whereby they would have an opportunity to review and comment on / check the factual accuracy of the draft report.

The interviews (held in person) were conducted by two reviewers. The interviews were conducted in a manner that aimed to ensure that the optimal levels of information were obtained whilst ensuring that the individuals being interviewed were treated with dignity and respect. The objective of the interviews was for staff to provide any information relating to the rationale for clinical management of the patient and to give information about the clinical care provided that may not have been included in the healthcare records. Where possible, the investigation team asked open ended questions, with staff encouraged to recall their version of the clinical management of the patient. A number of follow up interviews, correspondences and phone calls were conducted.

The investigation of the complaint management element of the investigation was primarily a paper-based desktop review of all relevant documentation and correspondences related to the complaint. Where the reviewers required clarification of issues/timelines etc staff were contacted to speak to the relevant issues/documentation.

The reviewers also had meetings, a number of telephone conversations and a number of correspondences with the partner of the patient including:

- Teleconference with investigation team and patient advocate held 8th of December, 2010
- Face-to-face meeting held 6th of May, 2011
- Face-face meeting held 5th of July, 2013
- Face-to-face meeting held 19th of July 2013

The partner of the patient (and her advocate) and the patient’s family members also provided the investigation team with documentation for the investigation team to consider.

All information gathered during the documentation/literature review and interview stages of the investigation process was treated confidentially. Information gathered
was maintained securely, electronic documents were password protected and codes were used to replace the names of individuals involved in the incident.

On completion of the interview and documentation/literature review process a Draft Report was prepared; the Draft Report was shared with all staff who were interviewed as part of the clinical incident investigation and/or who had a role in the complaint management element of this case - to ensure that the report was factually accurate; amendments were made to correct any erroneous information contained in the draft report. When commenting on draft reports staff were reminded that draft reports may contain factual inaccuracies. The process of receiving feedback on the draft report is to correct any factual inaccuracies in advance of finalisation of the report. This process is followed to ensure fair procedures are applied and is integral to the process of compiling patient safety investigation reports.

The Draft report included recommendations to address those issues which were identified as contributing to the incident and feedback was sought on the recommendations identified.

On the basis of the process described above, the Final Report of the investigation was developed and finalised.
4. Background to the incident.

The investigation relates to an incident which occurred on the 23rd of November 2007, relating to the discharge and transfer of the patient from Mid-Western Regional Hospital Ennis to Regina House Community Nursing Unit (CNU), Kilrush. The patient required supplementation oxygen. The patient arrived at Regina House at approximately 14.40 hrs and passed away a short period of time after arriving (less than 30 minutes). The patient was pronounced dead at 15.10 hrs (RIP).

The investigation also considers the management of a complaint made by the partner of the Patient to Mid-Western Regional Hospital Ennis about the incident which the hospital responded to according to the “Your Service Your Say” HSE Complaints Management Policy.
5. Investigation of the clinical incident.

Introduction

Section 5 chronicles the sequence of events involved in this incident. This was compiled using information from the patient’s healthcare record, related correspondence including that of his partner, the Complainant, and following interviews with the healthcare staff involved and with the patient’s partner.

5.1 Background to the clinical incident

The patient in question, was a 73 year old gentleman with a history of respiratory failure due to Idiopathic Pulmonary Fibrosis (IPF) (formerly known as Cryptogenic Fibrosing Alveolitis (CFA). This is a progressive pulmonary fibrotic condition - mainly affecting the older adult - that has no specific treatment. This diagnosis had been made in 2001 at St James Hospital, Dublin. The patient had subsequently been transferred to the care of a Limerick based Consultant Respiratory Physician in 2003/4. The course of his illness over the following years had followed a progressive slow decline up until 2007. The patient also suffered from Ischaemic Heart Disease and had undergone an angioplasty procedure in 1998 and Cor Pulmonale, which was associated with his longstanding pulmonary fibrosis.

At the time of these events the patient had been living in his own home with his partner and was dependent on supplementary oxygen as he had reached the end stage of his illness. During the months preceding the patient’s admission to MWRHE there had been an accelerated decline in the functional capacity of his lungs. This was reflected in an increase in his oxygen requirement to 8-10 litres per minute. This oxygen was administered in his home via two oxygen concentrators used simultaneously. The two oxygen concentrators had the capacity to deliver an approximate maximum level of 10 litres per minute and was controlled in general by the patient’s partner. The patient’s partner also managed the need to have back-up oxygen cylinders and equipment at the ready (i.e. flow valve, tubing, cannula & cylinder in case of power failure or equipment malfunction).
5.2 Chronology of the clinical incident

Pre admission: November 2007

The Clinical Nurse Manager (CNM) at Regina House advised during interview with the review team that she had received a telephone call from the General Practitioner in the days leading up to the 21st of November 2007 and the events described below. That call indicated that the patient was likely to be transferred to Regina House for Palliative Respite Care with a view to the patient being established on a morphine based pain relief regime.

Pre admission: Morning of Wednesday 21st of November 2007

11.20 am 21st of November 2007

The patient’s partner had advised in correspondence to the review team that:

“[patient]’s condition suddenly deteriorated at home at 11.20am approximately on Wednesday 21st November. I called our GP who arrived very promptly. For the first time ever I turned our home oxygen unit up to the maximum of 10 litres/minute, but oxygen saturation levels were only 68%. I then switched him to the cylinder & increased the flow rate to 12 litres/minute.

The General Practitioner (GP) advised the review team that he had been contacted by the patient’s partner as the patient’s condition had deteriorated. The GP further advised that he had attended the patient in his home in Kilrush and had noted that he was in acute respiratory distress with an oxygen saturation level of 68%. He stated that the patient was exhibiting distress on the least physical exertion and appeared to be cyanosed. The GP had noted in his referral letter to MWRHE that the patient was tachycardic on examination with a heart rate of 118 beats per minute. The patient had been scheduled to be admitted to the Palliative Care Unit, Regina House, Kilrush for a period of Palliative Respite Care. However due to a deterioration in his overall condition the GP advised in his letter to the admitting physician that:

“He will require ‘ICU’ and insertion of urinary catheter4 …” when you can do no more, for transfer back to a bed in Palliative Care Unit Regina House”. “If CXR not showing acute infection for transfer back to PCU into which he was due to be admitted today. 5

The patient’s partner had advised in correspondence to the review team that:

[the patient]t was scheduled to go to Regina House for a period of Respite Care and not Palliative Care as stated in the Healthcare Records’, “the whole idea was to give me a break”.

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4 The patient had recently complained that he had been suffering severe dyspnoea when going to the toilet.
5 The GP subsequently advised in correspondence to the review team that he wished to emphasise that this referral letter was written hastily in an emergency situation where the patient was acutely distressed and required urgent transfer to a hospital setting. Moreover the GP stressed that he had no access to the healthcare records of the patient at that point in time and could not therefore include detailed medical information or a list of the prescribed medications.
The Clinical Nurse Manager (CNM) at Regina House advised during interview with the review team that she had received a telephone call from the General Practitioner indicating that the patient was not now coming to Regina House as he had been admitted to MWRHE.

**Wednesday the 21st of November 2007: 14.30hrs-15.36hrs**
**Ambulance Transfer to Mid-Western Regional Hospital Ennis (MWRHE)**

The Ambulance Service was contacted and attended the patient at his residence. He was transferred to the Emergency Department (ED) at the MWRHE accompanied by his partner. The Ambulance staff had recorded that oxygen was administered at a rate of 15 litres per minute via a non rebreather mask for the duration of the journey resulting in oxygen saturation levels of 86% to 95%.

**Wednesday the 21st of November 2007: 15.05 -15.06**

A fax was received by MWRHE, which had been sent from the GP and included a copy of a letter from the Patient’s Consultant Respiratory Physician at St. John’s Hospital, Limerick dated 08.10.2007. This letter summarised the patient’s medical history and current condition. There was a handwritten note by the GP on the top of this letter which stated that:

“Patient to arrive by ambulance – is in acute distress. ?ICU bed. Letter to accompany. This report for your information. Mary in Palliative Care is familiar with case. Discussed with Assistant Matron. If not bed ? St. Johns”

**Wednesday the 21st of November 2007: 15.50hrs Arrival at Emergency Department (ED) MWRHE**

The patient arrived in the ED at MWRHE where his oxygen saturation level was recorded in the healthcare records by the medical staff in the ED at 62%, with other vital signs stable and a Temperature of 37.4 Centigrade. Medical staff in the ED had also noted in the healthcare records that the patient was at the end stage of his illness and had been identified in the GP’s referral letter as being scheduled for transfer to a palliative care centre. It was also documented by medical staff that he had been maintained on 8-10 litres/minute of oxygen ‘portable’ at his home.

**Wednesday the 21st of November 2007: 16.50hrs ED, MWRHE**

An Electrocardiograph (ECG) was recorded with the heart rhythm noted to be Sinus Tachycardia, by definition a heart rate of greater than 100 beats per minute. The patient also had a chest X-Ray performed in the Radiology Department.

The patient’s partner advised the review team that a porter had brought the patient to the Radiology Department with an oxygen cylinder attached to the trolley. The porter had then left the area. The patient’s partner recalled that the cylinder oxygen supply had expired shortly thereafter and the patient became very distressed as there was no other source of oxygen available. The patient’s partner advised that she had summoned assistance urgently whereupon an individual came into the room and connected the patient to another oxygen cylinder which had been stored underneath the trolley and he had subsequently recovered. It was the recollection of the patient’s partner’s that the patient was in severe respiratory distress as a result of this event.
before being transferred back to the ED where arrangements were made for his admission to a medical ward\(^6\).

It was evident from the healthcare record that a range of blood tests had been conducted while the patient was being treated in the ED. These included Arterial Blood Gas levels which were recorded by the doctor as being taken while the patient was breathing 6 litres of oxygen per minute. The ED medical staff had also documented that the patient wished to have a urinary catheter inserted as he suffered shortness of breath on going to the toilet. This had not been carried out and medical staff had documented that: ‘…the side effects had been explained to him’.

**Wednesday the 21st of November 2007: 19.30hrs Male Medical Ward MWRHE**

The patient was transferred from the ED where the plan as documented in the medical records by the doctor was to:

"admit - for 60% O2 initially"

The patient was admitted to a male medical ward at approximately 19.30 by Registered Nurse 1 who documented that the patient had oxygen saturation levels of 88% on 6 litres of oxygen per minute.

The Drug Prescription Kardex contained a written prescription on page 4 for 60% Oxygen with the route recorded as ‘FM’ (facemask) in the regular prescription section\(^7\), \(^8\).

**Wednesday the 21st of November 2007 – Thursday the 22nd of November: 20.00hrs to 08.00hrs Male Medical Ward MWRHE**

Registered Nurse 2 noted that the patient remained short of breath overnight and had maintained oxygen saturation levels of 89%-92% on a rate of 60% inspired oxygen. Register Nurse 2 further noted that the patient's Oxygen saturation had reduced to 80% and that the patient required a Nimbus mattress®. The nursing staff from the medical ward, who were interviewed by the review team, advised that the patient had received his oxygen through a face mask. It was also noted that he had received Nebulised medications and Intravenous antibiotics.

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\(^{6}\) The patient’s partner provided this information at a meeting with the review team after the review team had interviewed staff in relation to this incident. Therefore, the review team was not in a position to consider this matter in interviews with staff. The review team believes that the recommendations of this investigation should address the issues that contributed in this event.

\(^{7}\) The Consultant Physician advised the review team that this prescription for 60% Oxygen could be achieved by administering between 6 – 15 Litres of oxygen per minute and that this gave the nursing staff scope to adjust the rate to achieve an acceptable oxygen saturation level.

\(^{8}\) The patient’s partner informed the review team that in addition to managing all of the respiratory equipment in their home she also managed the oxygen conserving devices. It is her recollection that from March 2006 the patient had continuously required oxygen at 8/9 litres/minute. She further advised that during the last week or two prior to his sudden deterioration on 21st November 2007 the patient was receiving oxygen at 9 litres/minute. The patient’s partner told the review team during interview that it had been commonplace for her to check the oxygen flow rate several times a day, “it’s what I did every day, several times some days for the 5 years that I was managing the oxygen., and it’s what I did every time I visited him in Ennis Hospital”. It is her clear recollection that the patient was receiving oxygen at 12-15 litres/minute via nasal cannula at all times during his stay at MWRHE.
Thursday the 22\textsuperscript{nd} of November: 08.00hrs-20.00hrs Male Medical Ward MWRHE

Nursing staff noted that the patient was continuously administered 12 litres of Oxygen and that Oxygen saturation levels were between 75\% and 95\%. Nursing staff also note that the patient was cyanosed on minimal exertion.

The patient had been seen that morning by the Consultant Physician and other medical staff who documented that the patient’s oxygen saturation level was 93\%. They prescribed an intravenous diuretic drug and requested that a sputum specimen be sent for culture and sensitivity.

Registered Nurse 3 noted that the patient had fluctuating oxygen saturation levels throughout the day ranging between 75\% and 95\% on 12 litres of inspired oxygen. The patient had also been treated by a physiotherapist who noted that he had been receiving 12 litres of oxygen via ‘fm’ (facemask). Registered Nurse 3 also noted that the patient had used a commode and had been using a urinal to pass urine. She also documented that the patient had not had a urinary catheter inserted.

Thursday the 22\textsuperscript{nd} of November: 
20.00hrs – 23.50hrs Male Medical Ward MWRHE

Registered Nurse 2, noted that the patient had been very short of breath and agitated at 21.00hrs. His oxygen saturation level had decreased to 68\% but had recovered to 88\% following the administration of a nebuliser and an increased rate of inspired oxygen. Registered Nurse 2 noted that the patient continued on 60\% Oxygen Therapy.

The on call doctor had visited the ward and noted that he visited the patient at the request of nursing staff due to the patient’s restlessness. This doctor noted that he had examined the patient; that the patient was restless; had shortness of breath; that his oxygen saturation level had decreased to 60\% and that it subsequently increased to 88\% after the Oxygen was increased to 15L/M. This doctor had also prescribed a Morphine based drug (Oromorph® 2.5mgs).

Thursday the 22\textsuperscript{nd} of November: 
23.50hrs Male Medical Ward MWRHE

The nursing staff documented in the Drug Prescription Chart that Oromorph® 2.5mgs was administered.

Friday the 23\textsuperscript{rd} of November: MWRHE

07.40 hours
The nursing staff had documented in the Drug Prescription Chart that Oromorph® 2.5mgs was administered again

Registered Nurse 2 noted in the healthcare records that the patient had been incontinent and was very breathless when his bed sheets were changed that morning with oxygen saturation levels of 84\%.
09.15 hours approximately

The patient’s partner advised the review team that she together with the patient’s daughter had telephoned the GP to ask if he had heard anything from MWRHE and why the patient had not been admitted to ICU. The GP Advised the patient’s partner that there had been no contact between himself and MWRHE.

Registered Nurse 4 documented that the patient had been very breathless on the least exertion that morning. He was noted to be receiving 6 litres per minute of oxygen which resulted in saturation levels of 80%-86%.

10.00 hours

The patient’s end of bed observations reported the following:

→ Oxygen saturation level of 76%
→ Blood Pressure 130/75mmHg
→ The patient was apyrexial (i.e. the patient did not have a temperature).

10.00 hours approximately

The Clinical Nurse Manager 2 (CNM2) of the male medical ward advised the review team during interview that she had received a telephone call that morning from the GP in relation to the possible transfer of the patient to the Palliative Care Unit at Regina House. The CNM 2 recalled passing the telephone to the Medical Senior House Officer who advised the GP that she did not know the patient as she had been off duty at the time of his admission to MWRHE.

The Medical Senior House Officer informed the review team during interview that she recalled that the GP had advised her that a bed was currently available in the Palliative Care Unit at Regina House and that he wished for the patient to be transferred there while this bed remained vacant. The GP advised during an interview with the review team and in written correspondence that he had contacted the medical ward to inform them of the availability of a bed in the Palliative Care Unit and that he had not actively promoted the transfer of the patient on that particular day.

The Medical Senior House Officer indicated to the GP that she would contact the Consultant Physician immediately and pass on this information. The Medical Senior House Officer contacted the Consultant Physician and advised him of the telephone conversation with the GP. The Consultant Physician advised in correspondence to the review team that during that telephone discussion with the Medical Senior House Officer he had stated 'no decision of transferring The patient to Regina House to be made until I'll see the patient.'.

The Medical Senior House Officer recalled during interview with the review team that she had accompanied the Consultant Physician to the ward where the patient was located. The Consultant Physician advised that he had told the patient of the telephone call from the GP advising of the availability of a bed at Regina House and stated that the GP wished for be transferred there. It was the recollection of both the Consultant Physician and of the Medical Senior House Officer that the patient indicated that if this was the wish of his partner that he would also be in agreement to be transferred to Regina House. The Consultant Physician advised in correspondence to the review team that it is his recollection that he had held the aforementioned conversation with the patient at approximately 13.00 hours and had spoken to the General Practitioner by telephone after midday.
10.22 hours

Call from Ennis General Hospital Switch Board to Mid-Western Regional Ambulance Services booking an AS3\(^9\) ambulance with stretcher to transfer the patient to Regina House.

10.28 hours

The CNM at Regina House advised the review team at interview that she had received a telephone call from MWRHE to inform her of the planned transfer of the patient. Telephone records showed that this call was made at 10.28 and was of 67 seconds duration. The review team asked all of the clinical staff on the medical ward at MWRHE if they had made this telephone call but each denied being the staff member concerned. It is the recollection of the CNM that she had mentioned the lack of a piped oxygen supply at Regina House during the telephone conversation with the unidentified staff member from MWRHE. The CNM had informed the unidentified staff member that an oxygenator was available at Regina House and recalled that the staff member from MWRHE had agreed that this ‘was ok’. The CNM recalled that she had also requested that the medical ward telephone to notify Regina House when the patient had left MWRHE.

Some time after 10.28 hours

The patient was seen that morning by a Physiotherapist on the male medical ward who documented in the healthcare record that his condition was discussed with nursing staff and that he was unsuitable for treatment that day and noted that the patient was for transfer to Regina House.

11.30 hours

The CNM at Regina House and Registered Nurse 7 advised the review team in separate interviews that the CNM at Regina House had advised Registered Nurse 7 of the patient’s expected arrival at Regina House at a time that day yet to be confirmed.

11.45 hours approximately

The patient’s partner and the members of the medical team have different recollections of the sequence of events that followed.

The patient’s partner advised the review team that she and the patient’s daughter met the Consultant Physician on a corridor near the X-ray department on the ground floor of MWRHE.

The patient’s partner recalled that the decision to transfer the patient to Regina House had already been taken by the medical team when she spoke with them at 11.45am. The patient’s partner advised at interview that neither she nor the patient’s daughter wanted the patient to be transferred to Regina House due to the serious nature of his condition. It is her recollection that they voiced their strong objections when advised by the Consultant Physician of the proposed transfer and requested

\(^9\) An AS3 transfer was defined as a routine transfer. The general perception of this amongst ambulance staff was that of an uncomplicated patient with minimal or no interventions required.
that the patient remain in the medical ward at MWRHE until the next day at a minimum.  

The Consultant Physician told the review team that it is his recollection that he met and spoke to the patient’s partner together with the Medical Registrar at the entrance to the male medical ward. The Consultant Physician advised that during the conversation that followed the patient’s partner had insisted that the patient be transferred to Regina House but that the Consultant Physician had disagreed with this. The Medical Registrar had recalled during interview with the review team that during the conversation the patient’s partner had requested that the patient be transferred to Regina House but that the Consultant Physician voiced his opposition to this suggestion.

The Medical Registrar advised during interview with the review team that he had accompanied the Consultant Physician to the Radiology Department following their meeting with the patient’s partner and the patient’s daughter.

The Consultant Physician informed the review team he had gone to the Radiology Department with the Medical Registrar and discussed the patient’s chest x-ray with a Locum Consultant Radiologist. The Consultant Physician advised during interview that he had queried whether there was any radiological evidence of an acute infectious cause for the patient’s recent deterioration. The Consultant Physician recalled that the Locum Consultant Radiologist had informed him that there were chronic fibrotic changes throughout both lungs however no acute changes were evident. It is the Medical Registrar’s recollection that the Radiologist had identified ‘bilateral pulmonary shadowing’ but had stated that this was not due to an acute illness. The Locum Consultant Radiologist advised in correspondence with the review team that he had no recollection of this meeting nor of the details of any related conversation.

Registered Nurse 4 documented in the healthcare records that a conversation had taken place between the Consultant Physician and ‘family members’ that morning. The Consultant Physician had written in the healthcare record of the patient “feeling better, wife insisted to bring him to Regina House” “Likes to go the Regina House”. This entry in the healthcare records was untimed.

The Consultant Physician advised in correspondence to the review team that he had requested information from the patient’s Consultant Respiratory Physician at St John’s Hospital, Limerick. It was his recollection that a fax had subsequently been received at MWRHE at 13.05 which contained the letter dated 8th October 2007 which had originally been sent to the patient’s General Practitioner. The healthcare records of the patient included a copy of a fax which had been sent on the 21st November 2007 as outlined earlier in this report.

The Consultant Physician advised the review team that he had telephoned the GP later that Friday morning to discuss the patient. It is the Consultant Physician’s recollection that during that telephone conversation the GP advised again of the availability of a bed in the palliative care unit at Regina House. Subsequently, the Consultant Physician decided to discharge the patient for transfer to Regina House.

The Medical Senior House Officer advised during interview with the review team that she had written the drug prescription sheet and the Discharge Summary on that

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10 The review team received a letter from the patient’s Daughter which indicated that the patient’s daughter’s recollection of events were in line with the patient’s partner’s recollections as outlined here.
Friday morning. The review team examined copies of this documentation. The prescription sheet contained the times and doses of medications together with a prescription for Oxygen 60%. The Discharge Summary contained the results of an Arterial Blood Gas taken in the ED during admission on 21st November while the patient was on 6 litres of Oxygen per minute with the 6 L circled. It remained unclear if this was circled at the time of the request or at a later point in time. There was also a large amount of other data, much of it numerical, including drug dosages, blood test results and oxygen saturation levels. Both of these documents were sent by fax machine to Regina House. There was also a later note in the healthcare records that the Blood Gas Machine at MWRHE was broken and that another Arterial Blood Gas sample taken on the morning of discharge had not been ‘done’.

The CNM at Regina House advised the review team at interview that a faxed prescription sheet and Discharge Summary had been received from the medical ward at MWRHE. The CNM advised that due to the upcoming weekend she had taken the prescription to the GP’s office in order that all medications could be dispensed while the local pharmacy was open.

**12.49 hours**

Paramedic 2 advised during interview with the review team that they had received a request from the Ambulance Controller to transfer a patient from MWRHE to Regina House, Kilrush: this task was allocated AS3\(^{11}\) status. Paramedic 2 also advised that they had subsequently received a further task to transport a second ‘sitter’ patient to another healthcare facility.

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**Friday the 23\(^{rd}\) of November: 13.00hrs – 14.40hrs:**

*Ambulance Transfer to Regina House, Kilrush.*

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**13.00 hours or 13.23 hours.**

It is the patient’s partner’s recollection that they left the medical ward at MWRHE at 13.00hrs. The nursing notes written retrospectively by RN4 record that the patient left the ward at 13.00hrs. The ambulance crew advised during interviews with the review team that they had arrived on the Medical Ward at 13.23 to collect the patient. The ambulance crew were advised by nursing staff that the patient would require oxygen for the journey therefore Paramedic 1 returned to the vehicle and retrieved a portable oxygen cylinder. Paramedic 2 advised that there was no verbal handover from the nursing staff on the medical ward to the ambulance crew.

**13.10 – 13.15 hours**

It is the patient’s partner’s recollection that the patient was wheeled into the ambulance at approximately 13.10 - 13.15pm and that she had sat in the ambulance and accompanied the patient on the journey.

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\(^{11}\) An AS3 transfer was defined as a routine transfer. The general perception of this amongst ambulance staff was that of an uncomplicated patient with minimal or no interventions required.
13.15 hours

It is the patient’s partner’s recollection that she enquired of Paramedic 2 as to the Oxygen flow rate that the patient was receiving and had been advised that it was 14 litres per minute. The patient’s partner requested that the flow rate be increased to 15 litres per minute which Paramedic 2 did.

13.30 – 13.55hrs hours approximately

It is the patient’s partner’s recollection that at approximately 13.30pm the doors were closed and the ambulance moved across the road to St. Joseph’s Hospital Ennis. The ambulance crew had also been tasked to collect another patient from St Josephs Hospital in Ennis who was to be transferred to St Teresa’s healthcare facility after the patient was admitted to Regina House.

Both ambulance crew members recalled during interview with the review team that they had provided the patient with an additional blanket when they collected the other patient from St. Joseph’s Hospital Ennis, as it was their practice to leave the ambulance doors open for observation and access/egress purposes.

13.55hrs approximately

It is the patient’s partner’s recollection that the ambulance departed Ennis for Kilrush at 13.55pm approximately. Paramedic 2 advised the review team at interview that during the ambulance journey to Regina House the patient received inspired oxygen at 15 litres/minute via a Non Rebreather facemask and had heart rhythm and oxygen saturation monitoring in place. It was the patient’s partner’s recollection that the oxygen had been administered in transit via nasal cannula. Paramedic 2 recalled that the patient’s oxygen saturation level remained at or below 71% throughout the journey.

Friday the 23rd of November: 14.40hrs Regina House, Kilrush.

The ambulance crew transferred the patient from the ambulance to the palliative care unit in Regina House via a trolley using their portable oxygen cylinder at a flow rate of 15 litres per minute. Both Paramedics advised during interview with the review team that the nursing staff had greeted the patient with familiarity and intimated that they were aware of the nature of his condition. The CNM and nursing staff advised at interview that it was their practice to greet all new patients in a friendly manner in order to make them feel welcome and relaxed in their new surroundings. They further advised that they were unaware of the specific nature of the patient’s condition with their only sources of information being the brief telephone conversation with an unidentified nurse from the medical ward and the faxed material received that morning from MWRHE.

Registered Nurses 5 and 6 recalled during their separate interviews that they had requested the patient’s partner to wait outside the room while the transfer was

12 Paramedic 2 advised at interview that it was her view that increasing Oxygen flow to 15L/minute would not have a material impact on the oxygen concentration that the patient was receiving. During interview with the review team, paramedic 2 stated that:

“I explained that once the bag is full, that’s as much oxygen as can be delivered. [the patient] was on 14L and the bag was full. His partner asked that he be put up to 15L. I did this, but I knew it would not make a difference as the bag was full”.

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completed as there was limited space due to the clinical staff and equipment present. It is the recollection of Paramedic 2 that the patient requested that both the oxygen supply from the ambulance cylinder and the supply from the Regina House concentrator be used simultaneously during his transfer from the ambulance trolley to the hospital bed. Paramedic 2 recalled that nursing staff had indicated to her that they would commence the oxygen concentrator on 4 litres per minute but that she had reminded the nurse that the patient had been receiving 15 litres per minute while on the ambulance supply. Paramedic 2 recalled being informed by a nurse that 6 litres per minute was the maximum they could provide and that she had adjusted the oxygen concentrator. Registered Nurses 5, 6 and 7 advised during separate interviews with the review team that they each had no recollection of this conversation with Paramedic 2 nor of any request from the patient that both sources of oxygen be used simultaneously. They also advised the review team that the transfer was completed using the ambulance oxygen supply only and that the patient was then switched to the oxygen concentrator.

It is the recollection of Registered Nurse 5 that she removed a bottle of water which the patient had been holding and he proceeded to assist in moving himself across to the bed with minimal help from nursing staff. He immediately requested the return of the bottle of water which Registered Nurse 6 recalled was handed back to him immediately. Paramedic 1 and 2 informed the review team that they recalled telling the nursing staff that they had another patient awaiting transfer in the ambulance before they departed the room. Registered Nurses 5, 6, and 7 recalled that there was no verbal handover between the ambulance crew and the nursing staff at Regina House. Paramedic 2 advised the review team that as the nursing staff appeared to be very familiar with the patient and his condition they deemed a formal handover to be unnecessary. Registered Nurses 5, 6 and 7 advised that they had no recollection of the ambulance crew informing them that they had another patient in the ambulance awaiting transfer. Neither Registered Nurses 5, 6 or 7 suggested to the review team during interviews that they had requested a handover from the ambulance crew.

Registered Nurses 5, 6 and 7 recalled at interview that the patient became extremely distressed and called out that there was not enough oxygen coming from the concentrator. It is the recollection of Registered Nurse 5 that she checked the flow through the tubing with her hand and recalled that she had felt the oxygen flow coming through. The patient’s partner advised during interview and in written correspondence to the review team that she had heard the patient calling out in great distress from her position outside and returned to the room. It is the patient’s partner’s recollection that the patient was saying “no oxygen” and that she told the nurses he required 15 litres of oxygen per minute. The patient’s partner recalled that a nurse said to her that they did not have piped oxygen in Regina House.

It was the recollection of Registered Nurse 6 that one of the nursing staff brought an oxygen cylinder from the nearby storeroom into the room. This source was capable of delivering a maximum rate of 4 litres of oxygen per minute. Registered Nurse 7 recalled that they switched the patient to the cylinder-based oxygen supply but as it could only deliver a maximum of 4 litres per minute they quickly changed back to the

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13 The capacity of the concentrator in Regina House Community Nursing Unit at that time was 5 litres per minute.
14 The CNM informed the review team during an interview that it was usual practice for a handover to occur when a Regina House resident returned from an acute hospital stay or a new resident arrived for admission.
oxygen concentrator which delivered 5 litres per minute. Registered Nurse 7 advised the review team that she went to the nurses’ office and rang the GP to attend Regina House urgently. The patient’s partner advised in correspondence to the review team that it was her recollection that the nursing staff had not switched the patient to the oxygen cylinder as there had been no oxygen tubing available nor was there a key to open the cylinder.

It is the recollection of the CNM that on returning to Regina House from her lunch break she went to the room where the patient was located. She recalled during interview with the review team that he was in severe respiratory distress and extremely cyanotic. Registered Nurse 5 advised during interview that she ran to the nurses’ office and used the telephone there to call the ambulance control room. This was located in the grounds of the Community Hospital, Kilrush (situated directly across the road from Regina House). She advised that it had been her intention to request that any available ambulance crew attend with their oxygen supply but there had been no answer to this call.

Friday the 23rd of November: 14.50hrs – 15.10hrs Regina House, Kilrush.

Nursing staff recalled that the patient was extremely distressed and had great difficulty breathing at this point. The CNM noted retrospectively that his partner was present and was very upset that the patient was gasping for air. Registered Nurse 6 recalled being of the opinion that the patient was nearing death and asked his partner to come to the bedside and hold the patient’s hand. The patient’s partner advised in correspondence to the review team that it is her recollection that the patient had lost consciousness after calling out ‘No oxygen’ and had not been ‘gasping’. The patient’s partner also advised the investigation team that nursing staff did not ask her to come to the bed because she had never left the patient’s side.

The General Practitioner arrived in the room and listened to the patient’s chest and pronounced death at 15.10 hours. May he rest in peace.

Registered Nurse 6 advised during interview with the review team that a secretary had made telephone contact with the Ambulance Control and requested that the Ambulance return to Regina House. Paramedic 2 stated at interview that they were contacted by the Ambulance Control Centre after completing the transfer of their second patient and requested to return to Regina House as there had been a “problem with oxygen”. The ambulance crew returned to Regina House but the patient had already died. The GP recalled that he accompanied the patient’s partner to an adjacent room where he explained that death had been expected in the patient’s case.

15 The GP subsequently advised the review team at interview that he had hoped to be able to create a situation where the patient would die in a controlled and dignified manner.
At 17.00hrs, the CNM at Regina House made an entry in the patient’s Healthcare Record as follows:

"...[GP] informed the coroner and took death certificate with him. Death was not unexpected. ...."

This entry refers to a telephone conversation between the GP and the coroner which occurred sometime between the time of the patient’s death at 15.10 hours and 17.00 hours when the CNM made the entry to the healthcare record.
5.3. Care/Service Delivery Problems associated with the clinical incident

Care Delivery Problems are problems that arise in the process of care, usually through actions or omissions by employees. Several Care Delivery Problems may be involved in one incident and involve two essential features:

(i) care deviated beyond safe limits of practice
(ii) the deviation had at least a potential direct or indirect effect on the eventual adverse outcome for the service user, employee or general public. (Toolkit of documentation to support the Health Service Executive Incident Management (2009))

Although a Care Delivery Problem (CDP) may be caused by what a staff member did or did not do in a particular situation; it has been recognised that there are usually systemic causes (which may not be immediately apparent) which contributed to the staff member’s actions or omissions. In order to prevent a recurrence of the same problem the systemic causes that contributed to what the staff member did or did not do must be corrected as far as is practicable.

Three Care Delivery Problems were identified in this case and are described below. Then, using the Framework of Contributory Factors Influencing Clinical Practice included in the London Protocol, (Taylor-Adams, S., Vincent, C., 2004) and the Toolkit of Documentation to Support Incident Management in the HSE (2009) the contributory factors for each Care Delivery Problem are identified. In order to comply with good systems analysis methodology contributory factors for each Care Delivery Problem may be considered under the following headings; Patient/Service User Factors; Task and Technology Factors; Individual (Staff) Factors; Team Factors; Work Environmental Factors; Organisational and Management Factors and Institutional Context Factors.

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<td>The management of the transfer of the Patient from the medical ward at MWRHE to Regina House.</td>
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5.4 Contributory factors and recommendations in the clinical incident

The Framework of Contributory Factors Influencing Clinical Practice (see appendix 2) as described in the London Protocol (2005) for Serious Incident Investigation, and the HSE toolkit of documentation to support incident management (2009) were utilised to identify the following contributory factors for each Care Delivery Problem.

| Care Delivery Problem 1 | The decision to discharge the Patient from MWRHE to Regina House |

The Independent Clinical Expert, nominated to the Review Team by the Forum of Irish Post-Graduate Medical Training Bodies, observed that an untimed entry by the doctor on call on the medical ward on the night prior to discharge had indicated that the patient had been restless with increased shortness of breath with an oxygen saturation level of 88% on 15 litres of supplemental oxygen. There was evidence of significant clinical deterioration from the evening of the 22nd of November onwards as documented in the nursing notes. The patient’s end of bed observations on the 23rd of November reported an oxygen saturation level of 76%. A full blood count and arterial blood gas had been taken from the patient on the morning of the 23rd of November which ultimately showed an increasing white cell count of 19.6 and a significant derioration in his arterial oxygenation (P(O2): 4.76). These results were not available to staff prior to the patient’s discharge and transfer to Regina House. This was due to the fact that a blood gas analyser was out of order.

**Recommendation 1: Arterial Blood Gas Analysis.**

It is recommended that arrangements are made for safe systems in relation to arterial blood gas analysis including but not limited to ensuring that there is access to working gas analysers and appropriate contingency arrangements for when arterial blood gas analysers are out of order.

The External Independent Clinical Expert further observed that the patient had advanced Idiopathic Pulmonary Fibrosis (IPF) (formerly known as Cryptogenic Fibrosing Alveolitis (CFA) and was in the terminal stage of his illness. There is evidence of a significant deterioration in his underlying condition during his hospital stay. In that context, the patient was not medically fit for ambulanace transfer to Regina House on the 23rd November 2007.

The decision making process which ultimately led to the transfer of the patient from MWRHE to Regina House is described differently by the clinicians involved and the patient’s partner. The patient’s partner stated that it was her wish and that of the patient’s family that he should remain as an inpatient in the MWRHE for a longer period and that this view was expressed clearly to the Consultant Physician. The GP advised the review team that on the morning of discharge he had not actively promoted the transfer of the patient but had merely advised of the availability of a bed in Regina House Palliative Care Unit. The Consultant Physician stated to the Review Team that he made the decision to transfer the patient as this had been requested by the GP, the patient’s family and had been agreed to by the patient during a conversation on the morning of the 23rd November. The Consultant Physician stated that his preference was to continue to treat the patient at the
MWRHE for ‘a few more days’. The Senior House Officer and the Medical Registrar advised the Review Team that they recalled being clear, prior to the patient’s discharge on the 23rd of November, that the Consultant Physician’s preferred option had been to continue to treat the patient at the MWRHE.

**Care Delivery Problem 1**

**Contributory Factors: Task and Technology Factors.**

Lack of a clear policy and guidelines on Care Planning/Discharge Planning at MWRHE

The letter from the GP to the admitting Physician at MWRHE had suggested that the patient would require admission ‘for catheterisation’ and possible transfer to the Intensive Care Unit (ICU). The letter also indicated that the patient ‘on completion of his treatment, be transferred to the Palliative Care Unit at Regina House’ and ‘if CXR not showing acute infection for transfer to PCU into which he was due to be admitted today’. The GP advised in correspondence to the review team that he wished to emphasise that this referral letter was written hastily in an emergency situation where the patient was acutely distressed and required urgent transfer to a hospital setting. Moreover the GP stressed that he had no access to the healthcare records of the patient at that point in time and could not therefore include detailed medical information or a list of the prescribed medications.

The patient’s partner had advised in correspondence to the review team that:

> ‘Patient was scheduled to go to Regina House for a period of Respite Care and not Palliative Care as stated in the Healthcare Records’,…” the whole idea was to give me a break”.

The Clinicians at MWRHE admitted the patient for assessment and management of his deteriorating respiratory function with a view to stabilising his condition prior to transfer to the Palliative Care Unit at Regina House. The fact that the patient was in the final stages of Respiratory Failure and that he had been referred to a Palliative Care Centre would mitigate against admission to an Intensive Care Unit where the emphasis is on critical care interventions such as mechanical ventilation. Conversely the emphasis in palliative care medicine is on comfort measures and symptom management. It was apparent from the interviews carried out by the Review Team with the clinicians involved that they had formulated their own treatment plan predominantly based on the clinical evidence before them rather than relying on the information contained in the GP referral letter.

The transfer of the patient was arranged at short notice on a busy Friday morning in the medical ward at MWRHE. One regular nursing staff member was on sick leave and nursing staff from other areas had been sent to the medical ward to assist.

The communication process involved in the transfer of the patient from the medical ward at MWRHE to the Palliative Care Unit at Regina House was inadequate. This resulted in key information being omitted or not being communicated clearly. There was a short telephone conversation between an unidentified nurse from the medical ward at MWRHE and the CNM at Regina House. Despite interviewing the clinical staff involved the individual who made this telephone call could not be identified.

The investigation team identified that a call was made through the switchboard at MWRHE to the Regional Ambulance service at 10.22am on the 23rd of November.
2007, in relation to the patient’s transfer to Regina House. The investigation team checked whether it was possible to identify the caller from ambulance service records including recordings of calls. However, the system in place at that time could not provide such information.

As far as can be ascertained, there was no comprehensive nurse to nurse handover of the patient during the short telephone conversation between the staff on the medical ward at MWRHE and the CNM at Regina House nor did this conversation include accurate information about the extent of the patient’s oxygen requirements. There was no documentation provided or transmitted by fax machine related to the patient’s nursing care requirements. The Discharge Summary, which was sent by fax machine from the MWRHE to Regina House, contained a large amount of hand written information. This included the results of an Arterial Blood Gas with ‘on 6L’ circled and written in the Medication section. The patient’s oxygen requirement was recorded as 60% on a separate prescription sheet which was also sent by fax at the same time.

The prescription sheet which was faxed to Regina House did include the rate of oxygen required by the patient written as 60% in the treatment section titled ‘Rx’. This went unnoticed by the nursing staff at Regina House as the CNM had taken the prescription sheet to the local pharmacy in order to have the prescription filled before the pharmacy closed. Consequently the only piece of documentation with the rate of oxygen required by the patient was unavailable to the nursing staff preparing for the patient’s admission.

The ambulance staff advised the review team that they did not receive a formal clinical handover from the nursing staff on the medical ward at the MWRHE prior to commencing the transfer of the patient nor did they provide a formal clinical handover to nursing staff on their arrival at Regina House. This resulted in key information related to the patient’s clinical condition and oxygen requirements not being communicated.

The ambulance crew arrived at Regina House unannounced and delivered the patient to the prepared room. The patient was transferred from the ambulance trolley to the bed with nursing staff and ambulance crew present. There are differing recollections of events about the specific details of the conversation between the ambulance crew and nursing staff however it is agreed that no formal handover was conducted. This again resulted in key information related to the patient’s clinical condition and oxygen requirements not being communicated to the nursing staff at Regina House.

There had been no documented nursing care plan developed for the patient on his admission to MWRHE. A nursing care plan would have included the clinical objectives of his admission and the steps required for his subsequent discharge. This would have involved discussions with his partner and family members and brought clarity to the situation. The review team understand that no formal care plan or discharge planning document was in use at Mid-Western Regional Hospital Ennis at the time.\(^\text{16}\)

\(^{16}\) The HSE National “Code for integrated discharge planning” (2008) states that: “Integrated discharge planning shall include the patient and as appropriate, the family/carer in the development and implementation of the patient’s discharge plan and shall ensure that steps
The review team are of the view that the lack of formal care and discharge planning processes in this case contributed to sub-optimal planning and communications - between the clinicians and the family and all relevant healthcare providers in relation to the discharge plan for the patient.

**Recommendation 2: Care Planning and Discharge Planning.**

It is recommended that a care plan and discharge plan is developed for every patient following admission to hospital based on the Health Service Executive Code of Practice for Integrated Discharge Planning (2008). This should be reflected in hospital policy and procedures and include provision for audits of compliance. The Hospital should ensure it audits compliance as soon as possible following receipt of this report and at a minimum of yearly thereafter.

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are taken to address necessary linkages with other healthcare providers in order to ensure a seamless transition from one stage of care to the next”.

17 Please note: The 2008 Health Service Executive Code of Practice for Integrated Discharge Planning is expected to be replaced with a 2013 version in quarter 4 2013.
Care Delivery Problem 2  

The management of Oxygen administered to the Patient at MWRHE and Regina House.

Contributory Factor Care Delivery Problem 2:  
Lack of policy for the documentation of oxygen delivery rates and modalities.

Oxygen delivered via nasal canula is generally prescribed in Litres Per Minute and Oxygen delivered by a face mask is generally prescribed in percentages. The External Clinical Expert observed that it was evident that there was confusion in the prescription of oxygen for the patient from his admission via the Emergency Department, his stay on the medical ward and throughout his subsequent transfer and admission to Regina House. The Oxygen flow rate had been prescribed in litres per minute or as a percentage and via a either nasal canula or a face mask. Consequently it was unclear exactly what rate of oxygen was being administered at a particular time. There was no policy in place at the time of these events to provide clear guidance to clinicians on the prescription, administration, management and documentation of oxygen for patients at the MWRHE.

Recommendation 3:  
Develop National Guidelines for Oxygen Therapy

It is recommended that national multi-disciplinary guidelines be developed, implemented and audited to provide clear direction for the clinically appropriate prescription, administration and management of oxygen therapy. The guidelines must include a standardised format to be used across all clinical settings for oxygen administration. These should consider the source of oxygen, i.e. piped oxygen supply cylinder or concentrator device. Guidelines should identify whether the rate is recorded in litres per minute or as a percentage and the delivery mode to be used (i.e. nasal cannula/mask). These guidelines should focus on, but may not be limited to the prescription, administration and management of oxygen therapy;

- By General Practitioners
- During clinical handovers
- During ambulance transfers
- At recipient facilities
- In low technology community settings
- When portable oxygen supplies are running low

Contributory Factor Care Delivery Problem 2:  
Task and Technology Factors  
Lack of oxygen delivery equipment and familiarity with oxygen delivery systems among nursing staff at Regina House

Nursing staff at Regina House advised the Review Team that it was unusual for them to care for a patient who required high volumes of oxygen. Consequently they had neither the equipment required to deliver oxygen at high volumes nor the familiarity with such oxygen delivery systems at the time of the incident. Local guidelines on the Administration of Oxygen Therapy to Adult Patients entitled “Guidelines in Oxygen Therapy Regina House Community Nursing Unit” were signed off in the HSE West Region on the 5th of February 2008 and staff at Regina House have received training in these guidelines. The Oxygen delivery systems at Regina House were
upgraded in the aftermath of this incident to include additional cylinders and flow meters capable of high flow Oxygen delivery.

**Recommendation 3: Develop National Guidelines for Oxygen Therapy**

It is recommended that national multi-disciplinary guidelines be developed, implemented and audited to provide clear direction for the clinically appropriate prescription, administration and management of oxygen therapy. The guidelines must include a standardised format to be used across all clinical settings for oxygen administration. These should consider the source of oxygen, i.e. piped oxygen supply cylinder or concentrator device. Guidelines should identify whether the rate is recorded in litres per minute or as a percentage and the delivery mode to be used (i.e. nasal cannula/mask). These guidelines should focus on, but may not be limited to the prescription, administration and management of oxygen therapy:

- By General Practitioners
- During clinical handovers
- During ambulance transfers
- At recipient facilities
- In low technology community settings
- When portable oxygen supplies are running low
Care Delivery Problem 3  Management of the transfer of the Patient from MWRHE to Regina House.

Contributory Factor:  Task and Technology Factors:
Lack of policies, procedures and guidelines for the transfer of patients between healthcare facilities including those requiring supplemental oxygen therapy

The ambulance personnel who completed the transfer did not provide a clinical handover to the nursing staff at Regina House in the mistaken belief that the nursing staff were familiar with the patient and his medical history.

The concept of Palliative Care for patients not suffering from terminal cancer was a relatively new concept for staff at Regina House. The nursing staff in the Palliative Care Unit were accustomed to receiving terminally ill cancer patients with different nursing care needs than those of the patient. Those patients would generally have required pain management and symptom control. This appears to have influenced the nursing staff not to seek a formal clinical handover from the ambulance personnel when the patient arrived at Regina House.

The transfer of the patient was assigned as an AS 3 level task which is defined as a routine transfer. This was based on the information received from the staff on the medical ward when the ambulance request was made. The general perception of this level of task among ambulance personnel is that of the transfer of an uncomplicated patient with minimal or no interventions required.

The review team are of the view that the lack of clear patient transfer protocols specifically relating to the transfer of patients requiring supplemental oxygen led to the patient being transferred from the medical ward to the ambulance service and from the ambulance service to Regina House in an informal manner.

It is recommended that national guidelines be developed for the transfer of patients between healthcare facilities. These guidelines should provide direction to staff as to the key patient specific information that must be communicated during a structured patient handover to the receiving facility and to the Ambulance Controller when requesting an ambulance transfer. This should specify the patient's diagnosis, current condition, supplemental oxygen requirements and delivery mode, and any cardiac or other monitoring devices required. This will ensure that the receiving facility has the necessary equipment available and ready and that an appropriately equipped ambulance and suitably qualified personnel are allocated to the task. These guidelines should include guidance for the transfer of critically and/or terminally ill non-ventilated patients requiring supplementation oxygen therapy to and from palliative care and respite services – arranged by General Practitioners/and other medical practitioners. Training should be provided to support the implementation of these guidelines and compliance audits completed.

The investigation team identified issues in relation to the quality of documentation which may have contributed to this incident as follows:

- Not all entries were dated.
- Not all entries were timed.
- There was a tendency for notes not to be written contemporaneously. Occasionally, notes pertained to an extended period of time.
- The patient’s name and record number (i.e. hospital number) did not appear on every page of the record.
- There were aspects of care recalled at interview during this investigation, and which are alluded to in this investigation report which were not recorded in the healthcare records by the clinicians concerned but which should have been recorded.

Recommendation 9: Healthcare Records Should be Enhanced

To ensure that healthcare records are enhanced, all relevant staff should be aware of and adhere to the *HSE Standards and Recommended Practices for Healthcare Records Management QPSD-D-006-3 V3.0”* in particular the guidelines contained in this document in relation to clinical records.

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18 This document can be accessed by HSE staff at the following link:

Introduction

Section 6 chronicles the sequence of events involved in management of the complaint arising out of the incident described in section 5 of this report. This was compiled using information from the complaint file, related correspondence including correspondence from the Complainant, and following receipt of feedback to draft reports from the complainant and those involved in the management of the complaint and follow up telephone conversations with those involved in the management of the complaint as required.

6.1. Background to the management of the complaint.

In December 2007, the partner of the patient made a complaint to Mid-Western Regional Hospital Ennis about the incident which occurred on the 23rd of November 2007. The hospital endeavoured to conduct an investigation of the complaint according to “Your Service Your Say”, the HSE’s complaint management policy, and issued their response to the complainant in April 2008. The complaint was subsequently referred by the complainant to various HSE Offices. Aspects of this case were referred to other bodies including An Garda Síochána, Professional Regulators, HIQA and the Department of Health.

6.2. Chronology of the Complaint Management

**Friday the 23rd of November 2007.**

An incident report form was completed in relation to this incident involving the patient by Acting CNM II at Regina House.

**Friday the 23rd of November 2007: 20.00hrs approx.**

Telephone call from the Acting CNM II at Regina House to the DoN (Regina House) informing the DoN about the incident by telephone. The DoN (Regina House) was on leave on the 23rd of November 2007.

**Monday the 26th of November 2007 approx.**

Telephone call from the DoN (Regina House) to the Risk Advisor where the DoN advised the Risk Advisor about the incident that occurred in relation to the patient on the 23rd of November.

**Thursday the 29th of November 2007.**

Phone call from the complainant to, A/Director of Nursing 1 MWRHE reporting what happened to the patient.
Monday the 10th of December 2007.

Letter of complaint posted by the complainant to Hospital Manager, MWRHE.

Issues raised in this letter included the following:

- The decision to discharge the patient
- The transfer by ambulance and
- The patient’s required Oxygen flow rate at Regina House and
- How the patient’s proper and safe handover at Regina House should be conducted under appropriate medical supervision.

Wednesday the 12th of December 2007.19

Letter from Staff Officer 1, MWRHE to the complainant thanking her for her letter of 10th of December 2007 and sympathising. Staff Officer 1 advises the complainant that she will be investigating and for the complainant to expect a response by the 10th of January 2008.

Letter from Staff Officer 1, MWRHE to The A/Chief Ambulance Officer attaching letter of complaint of 10th of December 2007 from the complainant for response.

Letter from Staff Officer 1, MWRHE to The Consultant Physician, MWRHE attaching letter of complaint of 10th of December 2007 from the complainant for response.

Tuesday the 8th of January 2008.

Letter from Staff Officer 1, MWRHE to the complainant following up on her letter to the complainant of the 12th of December 2007 advising the complainant that unfortunately she is still awaiting reports from The Consultant Physician MWRHE and the A/Chief Ambulance Officer and consequently Staff Officer 1 can not issue a response to the complainant. Staff Officer 1 indicates to the complainant that she hopes to be in a position to provide a response on the 24th of January 2008.

Letter from Staff Officer 1, MWRHE to The A/Chief Ambulance Officer following up on her letter of 12th of December 2007 for response.

Letter from Staff Officer 1, MWRHE to the Consultant Physician MWRHE following up on her letter of 12th of December 2007 for response.

The date stamp on the incident report form completed by the Acting CNMII at Regina House on the 23rd of November 2007 indicates that it was received in the Risk Advisor’s Office on this date (i.e. the 8th of January 2008)20

19 Some time around this date, Staff Officer 1 at MWRHE contacted the Risk Advisor by phone requesting that the Risk Advisor might give input to the complaint investigation of this case. This request for an input by the Risk Advisor resulted in him/her submitting the following documents to the complaint investigation process:
   → “Comments re patient [patient’s name]” 23rd of January 2008
   → “Clinical Response Re Patient [patient’s name] (To support the complaint response)” 21st of February 2008
Wednesday the 9th of January 2008.

Letter from The Consultant Physician MWRHE to Staff Officer 1, MWRHE in response to letter of complaint of the 10th of December 2007 from the complainant.

Friday the 11th of January 2008.

Letter from The Chief Ambulance Officer, to Staff Officer 1, MWRHE in response to letter of complaint of 10th of December 2007 from the complainant.

Wednesday the 23rd of January 2008.

Document entitled “Comments re Patient [patient’s name]” which was conducted to contribute to the complaint investigation was issued by The Risk Advisor to Hospital Manager MWRHE.

Friday the 1st of February 2008.

Letter from the complainant and family of the patient to The Hospital Manager, MWRHE stating that they have not yet received a response (the complainant had been advised to expect a response by the 24th of January 2008) and that they will be reviewing their position if they do not receive a satisfactory report within 10 days.

Wednesday the 6th of February 2008.

Letter from the Hospital Manager MWRHE to the complainant and the Family of the patient acknowledging their letter of the 1st of February 2008 which arrived on the 5th of February 2008 and advising that a report will issue shortly.

Thursday the 7th of February 2008.

Letter from Staff Officer 1, MWRHE to The Consultant Physician MWRHE stating that the discharge summary states requirements were 6 litres O2 not 60% O2 and requests explanation in order to respond to the complainant.

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20 The DoN at Regina House advised that she held the incident form while she reviewed and addressed issues in relation to this incident including discussing the incident with the staff involved to determine what happened; arranging to procure a second concentrator, tubing, face masks and Y connectors to enable for two concentrators to be used in series; and arranging for British Oxygen Company (BOC) to provide training to staff on the safe use of oxygen. The date stamp on the incident report form indicates that it was received in the Office of the Risk Advisor on the 8th of January 2008.
Friday the 8th of February 2008.

Letter from The Consultant Physician MWRHE to Staff Officer 1, MWRHE clarifying that:

“…on the patient’s hand-written discharge summary, it was not mentioned that the patient was discharged on six litres of oxygen. On his discharge summary, it was mentioned that the Arterial Blood Gases were done in Ennis General Hospital when the patient was on six litres of oxygen”.

The following guidelines were approved:

“Guidelines on Oxygen Therapy, Regina House, Community Nursing Unit”

Tuesday the 12th of February 2008.

Letter from Staff Officer 1, MWRHE to The Consultant Physician MWRHE requesting a full and detailed report of the patient’s O2 requirements on his admission, what he was given while an inpatient, and an explanation as to why, given his condition, there was no detailed requirements for Oxygen given on his Patient Discharge Summary.

Thursday the 21st of February 2008.

A document entitled “Clinical response re Patient…”(To support complaint response)” issued by The Risk Advisor to Hospital Manager MWRHE.

Monday the 25th of February 2008.

E-mail from Staff Officer 1, MWRHE to Hospital Manager MWRHE stating that the complainant has left a message asking Staff Officer 1, MWRHE to ring her. Staff Officer 1 advises Hospital Manager MWRHE that reports are outstanding for the complaint investigation and that Staff Officer 1, MWRHE is following up.

Friday the 29th of February 2008.

Letter from The Consultant Physician MWRHE to Staff Officer 1, MWRHE clarifying that:

“…ABG’s demonstrated type 1 respiratory failure. As a result, he received six to eight Litres of Oxygen through mask. Kept his Oxygen saturation around 90%. Though it was written on the treatment card, 60% of Oxygen, his oxygen saturation maintained around 90% through 6 – 8 Litres of Oxygen through mask. Kept his Oxygen saturation around 90%.

Though it was written on the treatment card, 60% of Oxygen, his oxygen saturation maintained around 90% through 6-8 Litres of oxygen which makes the given oxygen concentration around 40%”

The quote above is a direct quotation from the letter from Consultant Physician A to Staff Officer 1, MWRHE. During this investigation, Consultant Physician A advised the review team that this letter should have read as follows:
“ABG demonstrated type 1 respiratory failure. As a result, he received six to fifteen litres of oxygen through face mask or nasal canulae to keep his oxygen saturation around 90%. It was written on the treatment kardex 60% of oxygen and his oxygen saturation maintained around 90% by giving 6-15 litres of oxygen through nasal canulae or face mask.”

Letter from Hospital Manager, MWRHE to The Complainant as follows:

− Apologising for delay in issuing the report
− Outlines findings of complaint investigation
− States that standard format of the discharge summary and staff training needs around O2 therapy have been prioritised as areas for attention.
− Sympathises
− Invites The Complainant to contact him if he can be of further assistance.

1.26pm

E-mail from the complainant to the Regional Health Office Galway. The subject line of the e-mail was “Non response to formal complaint to Mid-Western Regional Hospital Ennis”. This e-mail advises that the family sent a formal letter of complaint to the Administrator MWRHE on 10th of December, 2007; that the family was assured that they would receive a response by 10th of January 2008; That on 11th of January 2008 the family received a letter requesting an extension to 24th of January 2008; That by 01.02.2008 the family had not received a response so the family wrote a second letter; That the Administrator MWRHE confirmed receiving this letter on 5th of February 2008 and promised that the report would issue shortly; That 3 weeks had passed since then and the family had heard nothing; That the family and the complainant sent a formal letter of complaint to the Administrator, MWRHE on December 10th 2007.

2.36pm:

E-mail from the Regional Health Office Galway to the Complainant and copied to the Area Manager of Consumer Affairs, HSE West acknowledging receipt of the complainant’s e-mail and advising that the Regional Health Office was forwarding the complaint, through this e-mail, to the Area Manager for Consumer Affairs HSE West who will deal with the complaint.


12.58hrs

E-mail from the Senior Executive Office in the Office of the Area Manager for Consumer Affairs, HSE West to the complainant acknowledging the complainant’s e-mail of 29th of February 2008 to the Regional Health Office Galway and advising that this office (i.e. the Office of Consumer Affairs HSE West) understood that a response issued to the complainant on the 29th of February, 2012. This e-mail further advised the complainant that if she was unhappy with the response she received she had the right to request a review of her complaint from the Head of Consumer Affairs and the e-mail included contact details for the Head of Consumer Affairs in the HSE.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.03hrs</td>
<td>E-mail from the complainant to the Senior Executive Officer in the Office of the Area Manager for Consumer Affairs, HSE West stating that “Today is Mon 3rd March, and we have received no response so far”.</td>
<td></td>
</tr>
<tr>
<td>16.55hrs</td>
<td>E-mail from the Senior Executive Officer in the Office of the Area Manager for Consumer Affairs HSE West to the complainant stating that: “The response was issued on the 29th February 2008, hopefully it will arrive in tomorrow’s post. If you have not received your response in the next day or two, you might let me know and I will follow up on it for you.”</td>
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**Wednesday 5th of March 2008.**

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<th>Details</th>
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<tbody>
<tr>
<td>15.04hrs</td>
<td>E-mail from Senior Executive Officer in the Area Office for Consumer Affairs HSE West to the complainant attaching a copy of a letter from Hospital Manager MWRHE by way of a complaint response. The e-mail states that the letter issued on Friday the 29th of February 2008. The e-mail states that as stated in the e-mail of the 3rd of March 2008 that if the complainant is unhappy with the response that she has the right to request a review of her complaint and the e-mail includes contact details of the Head of Consumer Affairs who should be contacted to request such a review.</td>
<td></td>
</tr>
<tr>
<td>17.02hrs</td>
<td>E-mail from the complainant to the Senior Executive Officer in the Area Office of Consumer Affairs HSE West stating that that day was Wednesday the 5th of March and that no response had been received from MWRHE.</td>
<td></td>
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</table>

**Thursday the 6th of March 2008.**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>11.34am</td>
<td>E-mail from the Senior Executive Officer in the Area Office for Consumer Affairs HSE West to the complainant attaching the letter of complaint response from the Hospital Manager MWRH and advising that she (i.e. Senior Executive Officer in the Area Office for Consumer Affairs) had sent an e-mail at 15.04hrs on the previous day the 5th of March 2008 attaching the letter of complaint response from the Hospital Manager MWRH.</td>
<td></td>
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**Monday the 10th of March 2008.**

The incident report form completed by the Acting CNMII at Regina House on the 23rd of November 2007 was entered onto StarsWeb system in the Risk Advisor’s Office. 

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21 The Risk Advisor advised the investigation team, that as far as she could recall, she may have held the inputting of the incident to the CIS STARSWeb system back as the complaint had come into the Acute Hospital Services section and he/she was involved in the examination of this in Mid-Western
Tuesday the 8th of April 2008.

Letter from Solicitors on behalf of The Complainant to Hospital Manager MWRHE, re complaint response of 29th of February 2008 raising issue with the complaint response, pointing out that there was a prescription for 60% 02 in the discharge note, requesting acknowledgement of a failure by the HSE in their duty of care to the late patient and a clear and unambiguous apology for that lapse. If this is not received, The Complainant will be instituting proceedings.

Friday the 11th of April 2008.

The complainant contacts Patient Focus, a Patient Advocacy Association.

Friday the 11th of April 2008.

Letter from Staff Officer 1, MWRHE to Complainant’s Solicitors acknowledging receipt of their letter of the 8th of April 2008 and advising that they will be in contact in due course.

Friday the 11th of April 2008.

E-mail from Staff Officer 1, MWRHE to the Hospital Manager MWRHE regarding a conversation she had with the Complainant. In this e-mail, Staff Officer 1, MWRHE advises the Hospital Manager MWRHE that - before the family meeting with the Hospital Manager MWRHE, the family have a number of questions as follows:

- Who will be at the meeting?
- What is the purpose of the meeting?
- Unless the purpose is to acknowledge failure and apologise, they would have concerns about the usefulness of the meeting.
- They do not want to listen to medical terminology.
- They have requested that a senior member of the HSE be at the meeting i.e. The CEO of the HSE.

Monday the 2nd of May 2008.

Letter from Hospital Manager MWRHE to the complainant’s solicitor suggesting a meeting with the complainant and the family of the patient, if agreeable with them - to discuss their concerns raised by their solicitor in earlier correspondence.

Regional Hospital Ennis. It is in the context of this involvement and examination that the risk advisor generated the following documents:

- “Comments re [patient’s name]” (23rd of January 2008)
- “Clinical Response re [patient’s name]” (21st of February 2008)
Friday the 6th of June 2008.
Letter from Staff Officer 1, MWRHE to The Complainant referring to telephone conversation of last week and apologising for the delay in responding to her. Advises that she spoke to the Hospital Manager and he asked Staff Officer 1 to respond to her queries as follows:

- Attendees at the meeting would be Consultant Physician, MWRHE, The Hospital Manager, Ward Manager Male Medical Ward and The Clinical Risk Manager
- The purpose would be to examine and discuss the care and treatment given prior to discharge to Regina House

Monday the 21st of July 2008.
Letter from the Complainant’s Solicitors to The MWRHE in response to the Hospital Manager MWRHE’s letter of 2nd of May 2008 and Staff Officer 1 MWRHE’s letter of 6th of June 2008 which states:

“We refer to your letter of the 2nd of May last and subsequent letter of the 6th of June from [Staff Officer 1], directly to our client in response to a query that our client has as to the purpose of the meeting, which you were proposing.

Our client has considered the response, which states that the purpose of the meeting would be to examine and discuss the care and treatment given to [the patient] prior to his discharge to Regina House in November 2007.

Our client has no issues whatever with the HSE in relation to the care and treatment given and sees no point in having a meeting for that purpose. Our client and the [named] family are entirely satisfied that [the patient] received all appropriate care and treatment while he was a patient in Ennis General Hospital. Their concerns, however, relate to the transfer of [the patient] to Regina House and the issues have been raised in our letter to you of the 8th of April last. We again repeat that our client is simply seeking an acknowledgement that there were shortcomings in the transfer of the patient from Ennis General Hospital to Regina House and that no risk assessment was conducted, which would have indicated the significant danger that [the patient] would be exposed to, namely the absence of an adequate oxygen supply, if such transfer was made. The fact that the transfer was made and the danger became immediately apparent with fatal results is the matter that concerns our client most. For that reason, a discussion on his care and treatment prior to transfer to Kilrush is not really appropriate, but in our client’s opinion, would only serve to distract from the real issues in this matter, which are set out in our letter of the 8th of April last. …”

Wednesday the 23rd of July 2008.
Letter from Staff Officer 1, MWRHE to the Complainant’s Solicitors acknowledging receipt of their letter of 21st of July 2008 today and advising that the Hospital Manager, MWRHE is on leave and will return on 5th of August 2008.
Friday the 15th of August 2008.

Letter from Hospital Manager, MWRHE to The Complainant referring to her recent correspondence acknowledging failures and apologising:

“We have reviewed the process concerning the transfer of [the patient], and I wish to acknowledge problems identified in the transfer process. We sincerely apologise for these shortcomings.”

Tuesday the 2nd of September 2008.

Letter from The Complainant to Hospital Manager, MWRHE noting from his letter of the 15th of August 2008 that he had reviewed the process of transfer and that he acknowledged the problems. She requests a copy of the review and details of the measures put in place as a result.

Tuesday the 23rd of September 2008.

Letter from Mr. R, Patient Focus to Hospital Manager MWRHE following up on The Complainant’s letter of the 2nd of September 2008 and requesting an indication of when The Complainant would receive a response.

Wednesday the 24th of September 2008.

The Complainant sent a brief summary of the incident to HIQA as HIQA had requested submissions in relation to patient care as they were doing an investigation of MWRHE at this time.

Thursday the 25th of September 2008.

HSE West Guidelines entitled “Administration of Oxygen Therapy to Adult Patients” were signed off by the HSE West Policy, Procedures and Guidelines Committee.

Thursday the 25th of September 2008.

HIQA acknowledged contact from the Complainant of 24th of September and agreed to discuss this on the 26th of September.

Thursday the 2nd of October 2008.

Memorandum from Hospital Manager MWRHE to all Consultants requesting them to review with their Non Consultant Hospital Doctor’s the importance of ensuring that all discharge summaries are completed accurately and in full.

Friday the 3rd of October 2008.

The Complainants solicitor is advised by the Coroner that an Inquest will be held into the death of the patient.
Tuesday the 7th of October 2008.

Letter from Hospital Manager, MWRHE to The Complainant referring to her correspondence of the 4th of September 2008. Apologises for the delay in responding. Summarises that a number of staff members were contacted in the complaint investigation and that the complaint response was made based on responses from these personnel. Summarises two areas identified for local action:

1. Need to review standard format of the discharge summary,
2. The need to address staff training needs concerning O2 therapy

Advises junior staff were spoken to regarding bullet 1 above and that this was followed up by correspondence to Consultants. This letter advises the complainant that the discharge summary is under review. Attaches draft discharge summary.

In relation to O2 training needs as per bullet 2 above, the letter outlines that training had been delivered and planned. The letter advises the complainant that guidelines for the administration of O2 therapy to adult patients have been circulated for comment prior to ratification.

This letter encloses the following:

- Document entitled “Comments re Patient [patient name]” which was conducted to contribute to the complaint investigation and which was issued by The Risk Advisor to the Hospital Manager MWRHE on the 23rd of January 2008
- Document entitled “Clinical response [patient name]” (To support complaint response)” issued by The Risk Advisor to the Hospital Manager MWRHE on 21st of February 2008.
- Guidelines for Oxygen administration (25th of September 2008)

March 2009.

Toolkit of documentation to support incident management in the HSE signed off by the HSE Management Team and the Risk Committee.

Tuesday 16th of July 2009.

Inquest before a jury in Kilrush.

Verdict: Medical Misadventure.

Wednesday the 17th of July 2009.

Letter from the County Coroner, to the Risk Advisor enclosing a copy of Record of Verdict of the Inquest held 16th of July 2009 and recommendations that:

“.. in future transfers between medical facilities - that there should be greater levels of communications between all parties including medical personnel and family members.”
Tuesday the 28th of July 2009.

Letter from The Complainant to the Medical Records Office MWRHE requesting a copy of the patient’s Medical Records.

Letter from Mr. R, Patient Focus to the Head of Quality and Risk, HSE. Mr. R gives a brief background of the case. Mr. R requests that the Head of Quality and Risk facilitates an independent review of the circumstances surrounding the patient’s death.

Friday the 31st of July 2009.

Consent form for release of Medical Records sent to the Consultant Physician MWRHE and Consultant Surgeon A, MWRHE.

Tuesday the 11th of August 2009.

Letter from The Complainant to A/Director of Nursing 2, MWRHE requesting, under FOI, the name of the nurse who phoned the Clinical Nurse Manager (CNM) at Regina House on the 23rd of November 2007.

Wednesday the 12th of August 2009.

Letter from FOI Decision Maker, St. Joseph’s Hospital to The Complainant acknowledging receipt of passport and seeking legal documentation to support FOI application.

Letter from FOI Decision Maker, St. Joseph’s Hospital to The Complainant referring to FOI request received that day.

Tuesday the 18th of August 2009.

E-mail from Mr. R, Patient Focus to Staff Officer 1, MWRHE on behalf of The Complainant stating that The Complainant had requested a copy of the patient’s medical notes and that unfortunately, The Complainant’s solicitor is on holidays. Asking for any way of assisting with release based on identification already furnished.

Friday the 4th of September 2009.

E-mail from Staff Officer 1, MWRHE to Mr. R, Patient Focus stating that she is working on the release of the MWRHE records. She advises that the FOI Decision Maker, St. Joseph’s Hospital - is working on release of records from Regina House.

Monday the 7th of September 2009.

Letter from the FOI Decision Maker to the Complainant.
Thursday the 10th of September 2009.

10:25hrs:
E-mail from the Personal Assistant (PA) of the Head of Consumer Affairs, HSE to the Consumer Affairs Area Officer, HSE West stating that further to their phone conversation she is attaching the letter from Mr. R, Patient Focus to Head of Quality and Risk, HSE of 28th of July 2009.

10:57hrs:
E-mail from the Consumer Affairs Area Officer, HSE West to Staff Officer 1, MWRHE regarding correspondence from Mr. R, Patient Focus to the Head of Quality and Risk. This e-mail requests information about the status of complaint management. If concluded asks for copy of complaint response as this is required before it can be decided if an internal review should take place.

11:14hrs:
E-mail from Staff Officer 1, MWRHE to Hospital Manager, MWRHE forwarding e-mail from the Consumer Affairs Area Officer, HSE West of 10.57hrs.

11:45hrs:
E-mail from Hospital Manager, MWRHE to The Risk Advisor re letter from Mr. R, Patient Focus, to the Head of Quality and Risk, HSE of 28th of July 2009 asking if there is any further documentation on this.

Friday the 11th of September 2009.

E-mail from The Complainant to the Head of Quality and Risk, HSE requesting an update. The Head of Quality and Risk refers The Complainant to the Head of Consumer Affairs.

Monday the 14th of September 2009.

E-mail from PA to the Head of Quality and Risk HSE to the complainant acknowledging the e-mail of the 11th of September and advising that the matter was referred to the Office of the Head of Consumer Affairs.
**Tuesday the 15th of September 2009.**

Letter from A/Section Officer MWRHE (Formerly Staff Officer 1, MWRHE) to the Area Manager, Consumer Affairs, HSE West by way of response to Area Manager, Consumer Affairs, HSE West’s e-mail of 10th of September 2009. Encloses copies of:

- Original complaint by The Complainant dated 10th of December 2007 which was acknowledged on the 12th of December 2007
- Document entitled “Comments re Patient [patient’s name]” which was conducted to contribute to the complaint investigation and which was issued by The Risk Advisor to Hospital Manager MWRHE on the 23rd of January 2008
- Document entitled “Clinical response re [patient’s name]” (To support complaint response)” which was issued by The Risk Advisor to Hospital Manager MWRHE on 21st of February 2008.
- Copy of the updated discharge summary form
- Copy of the response as issued from Hospital Manager MWRHE 29th of February 2008
- Copy of further response as issued by Hospital Manager MWRHE, 7th of October 2008

Advises that a meeting was offered to the complainant by letter on the 6th of June 2008 and that this offer or a meeting was declined in a letter from the complainants representing solicitor on the 21st of July 2008 (See entry for 21st of July 2008 above).

**Wednesday the 16th of September 2009.**

E-mail from Staff Officer 1 MWRHE to A/Director of Nursing 2 MWRHE advising that The Complainant has looked for the name of the nurse who made the phone call of 23rd of November 2007. The Staff Officer 1 MWRHE states that there is nothing in the medical notes to indicate that a phone call was made and asks the A/Director of Nursing 2 MWRHE to check the day book for that day to see if there is any indication of the staff member name or otherwise.

**Wednesday the 16th of September 2009.**

Letter from FOI Decision Maker to Complainant attaching a copy of the Medical Records.

**Thursday the 15th of October 2009.**

Letter from the Complainant to A/Director of Nursing 2 MWRHE requesting name of the staff nurse who phoned CNM Regina House 23rd of November 2007.
Wednesday the 21st of October 2009.

Letter from The Complaint Review Officer, Consumer Affairs to The Complainant re CAREV/0096/2009 attaching a copy of the review report of this complaint and recommendations as follows:

“The Review Officer recommends that given the circumstances of what happened that a full incident review is undertaken on this case at local level”.

The report is copied to RDO HSE West; the Head of Quality and Risk; and Mr. R, Patient Focus.

Letter from The Complaint Review Officer, Consumer Affairs to The Hospital Manager MWRHE re CAREV/0096/2009 attaching a copy of the review report of this complaint. This letter advised the Hospital Manager, MWRHE that Consumer Affairs have been advised by the Ombudsman’s Office that the family have initiated legal proceedings. The Complaint Review Officer recommends that a full incident review is undertaken on this case at local level. This letter advises Hospital Manager MWRHE that he has 30 working days to notify the complainant, and The Complaint Review Officer of the steps taken to implement this recommendation.

Thursday the 22nd of October 2009.

E-mail from A/Director of Nursing 2 MWRHE to Staff Officer 1, MWRHE stating that she does not have a name for the nurse who rang Regina House re Oxygen Flow Rate.

Thursday the 5th of November 2009.

Letter from The Complaint Review Officer Consumer Affairs to Hospital Manager MWRHE following up on his recommendation for a full incident review, he now asks:

“Please ensure that the appointed person is independent of the previous investigation”.

Sunday the 8th of November 2009.

15:56hrs:

E-mail from The Complainant to Staff Officer 1, MWRHE attaching 2 pages from the medical records stating reasons for the attachment as follows:

- Staff Officer 1, MWRHE was acting for Hospital Manager MWRHE during some of The Complainant’s correspondence
- In Hospital Manager MWRHE’s response of 28th of February 2008 he made reference to a phone call by one of the nursing staff at MWRHE to Regina House on 23rd of November 2007. The Complainant needs to know the name of the nurse who made the phone call.
- The complainant advises that she has made a complaint to An Bord Alatranais (ABA) but ABA advised her that she needed to know the name of the nurse and that she should get this from the Director of Nursing at MWRHE.

22 At a meeting between the complainant and the investigation team, the investigation team was advised that the family initiated legal proceedings in early November 2009
She has sent a number of letters to A/Director of Nursing 2 MWRHE over the last 3 or 4 months but has not received a reply. Attached copy of page completed by the nurse who completed the discharge. There was still no reply.

The complainants' letter asks for confirmation of the name of the nurse and whether it is the same nurse referred to in Hospital Manager MWRHE letter of the 28th of February.

**Monday the 9th of November 2009.**

E-mail from Staff Officer 2, MWRHE to A/Director of Nursing 2 MWRHE regarding the fact that she received a phone call from The Complainant stating that she had written to A/Director of Nursing 2 MWRHE a number of times in relation to the name of a nurse and had no response. This e-mail stated that the Complainant appreciated that A/Director of Nursing 2 MWRHE was busy but she would like the A/Director of Nursing 2 MWRHE to respond in some form to her written request (even to tell her that A/Director of Nursing 2 MWRHE can not give her the name of the nurse). She passed The Complainant’s mobile number and her e-mail address to the A/Director of Nursing 2 MWRHE.

**10:02hrs:**
E-mail from Staff Officer 1, MWRHE, to The Hospital Manager, MWRHE forwarding e-mail of 8th of November 2009 to the Hospital Manager, MWRHE.

Letter from A/Director of Nursing 2 MWRHE to the Complainant in response to The Complainant's query of the 15th of October 2009 advising that A/Director of Nursing 2 MWRHE carried out an intensive investigation to try to identify who contacted Regina House and that she had been unsuccessful. She advised that she spoke to the nurse who completed the discharge summary and that she had no recollection of making any call to Regina House.

**Monday the 9th or Tuesday the 10th of November 2009.**

Telephone conversation between the complainant and the Complaints Review Officer in relation to the review process and the fact that a Garda investigation was underway.

**Tuesday the 10th of November 2009.**

E-mail from Staff Officer 1, MWRHE, to The Complainant thanking her for her e-mail of the 8th of November 2009 and advising that she has forwarded it to The Hospital Manager MWRHE for action.

**Thursday the 12th of November 2009.**

Letter from Hospital Manager MWRHE to The Complaint Review Officer Consumer Affairs referring to their telephone conversation that day and confirming that the matter has been referred by The Complainant to An Garda Síochána as a criminal matter. Therefore, he believes that it is now “sub judice” (i.e. Under judicial consideration and therefore prohibited from public discussion elsewhere).

Letter from Ms. B, Consumer Affairs to The Complainant following up on the review of the complaint dated 21.10.2009 and recommendation made by The Complainant
Review Officer, Consumer Affairs. Ms. B, Consumer Affairs has been informed by The Complaint Review Officer, Consumer Affairs that they are suspending the review given that the matter is being investigated by the relevant regulatory bodies and the Gardaí. The Complaint Review Officer, Consumer Affairs noted The Complainant's request for the name of a particular nurse and that The Complainant had been in contact with the Hospital Manager MWRHE about it. The Complaint Review Officer therefore requested that the Hospital Manager MWRHE respond directly to The Complainant about this matter.

Letter from The Complainant to Hospital Manager MWRHE referring to the Hospital Manager MWRHE’s correspondence of 29th of February 2008:

- Refers to phone call to Regina House alluded to in the complaint response and stating that it is not logged in the patient records.
- Requests nurse’s name
- Complainant states that she hopes to hear from The Hospital Manager MWRHE within 2 weeks.

**Tuesday the 17th of November 2009.**

Letter from Hospital Manager MWRHE to the Complainant. This letter refers to the Complainant’s letter of the 12th of November 2009 and states the Hospital Manager MWRHE has reviewed the matter with the A/Director of Nursing. The Hospital Manager MWRHE states that he regrets that he has not been able to identify the person who it is reported that made telephone contact with Regina House.

**Thursday the 19th of November 2009.**

Letter from The Complainant to The Complaint Review Officer, Consumer Affairs asking him to re-open the review he proposed and subsequently suspended because of the Garda investigation etc.

**Friday the 20th of November 2009.**

Letter from the Complainant to The Hospital Manager MWRHE:

- Acknowledges The Hospital Manager MWRHE’s letter or 17th of November 2009
- Queries whether the Risk Advisor was questioned about the phone call to Regina House
- Queries whether Registered Nurse 4 was questioned about the phone call to Regina House
- Whether Registered Nurse 4 was the only staff nurse assigned to care for the patient.
- Points out the issue about the information to Regina House that the patient was on 6L/min of Oxygen
- Asks if the call to the ambulance service for transport to Regina House was documented and who made the call.
**Tuesday the 24th of November 2009.**

Letter from The Hospital Manager MWRHE to A/Director of Nursing 2 MWRHE enclosing correspondence of the 20th of November 2009 from the Complainant asking A/Director of Nursing 2 to review and revert in relation to The Complainant’s questions.

**Wednesday the 25th of November 2009.**

E-mail from Ms. C, Ombudsman’s Office to The Complaint Review Officer, Consumer Affairs re:

- Spoke with Ms. D, Consumer Affairs last Friday about this case
- Ms. D Consumer Affairs suggest Ms. C, Ombudsman’s Office should e-mail The Complaint Review Officer, Consumer Affairs about the review
- Understands this review is suspended pending Garda investigation
- Wonders if it would be possible to reconsider this given the seriousness of events
- Concerned about risks to others due to issues with Oxygen supply
- Queries whether there is a way around the difficulty with proceeding due to the Garda Investigation

E-mail from Mr. R, Patient Focus to Staff Officer 1, EMWRHE requesting:

- Whether the Risk Advisor is a registered nurse and if so to furnish her pin number
- To furnish pin number for Registered Nurse 4.

**Friday the 27th of November 2009.**

E-mail from Mr. R, Patient Focus to Staff Officer 1, MWRHE asking for early attention to the matter (As per the e-mail from Mr. R, Patient Focus to Staff Officer 1, MWRHE of 25.11.2009).

E-mail from Staff Officer 1, MWRHE to Mr. R, Patient Focus in response to Mr. R’s e-mail of 25th of November 2009 as above stating that she was forwarding the e-mail to Hospital Manager for his attention.

E-mail from Staff Officer 1, MWRHE to Mr. R, Patient following on from her e-mail of earlier on 27th of November 2009 (as above) stating that she has spoken to Hospital Manager MWRHE and he has advised that all Nursing Matters will be dealt with by A/Director of Nursing 2 MWRHE.

**Monday the 30th of November 2009.**

E-mail from Staff Officer 1, MWRHE to Mr. R, Patient Focus, stating that she understood The Hospital Manager wrote to The Complainant in the past week or so advising that following a review of the matter with the A/Director of Nursing 2 MWRHE they have been unable to identify the person who is reported to have made the telephone contact with Regina House.
**Tuesday the 1\textsuperscript{st} of December 2009.**

E-mail from Mr. R, Patient Focus to Staff Officer 1, MWRHE stating that he notes Staff Officer 1, MWRHE’s e-mail of 30\textsuperscript{th} of November 2009. However, the risk report states that a phone call was made etc. This e-mail advises that at this stage, the Complainant has no option except to leave the matter in the hands of the statutory authorities. Mr. R requests confirmation as to whether the Risk Advisor is a registered nurse.

**Tuesday the 8\textsuperscript{th} of December 2009.**

E-mail from The Complaint Review Officer, Consumer Affairs to Hospital Manager MWRHE attaching e-mail of 25\textsuperscript{th} of November 2009 (as above) from Ms. C, Ombudsman’s Office to The Complaint Review Officer, Consumer Affairs. States that The Complaint Review Officer, Consumer Affairs advised Ms. C, Ombudsman’s Office that the review will not go ahead and Ms. C, Ombudsman’s Office seeks reassurance that something similar will not happen to another patient. Asks for advice about what has been done to ensure that this won’t happen again.

**Monday the 14\textsuperscript{th} of December 2009.**

Letter from the Complainant to the Hospital Manager seeking access under FOI to itemised telephone records of the 23\textsuperscript{rd} of November 2007 between 9.00am and 3.00pm.

**Wednesday the 16\textsuperscript{th} of December 2009.**

E-mail from The Complainant to the PA to Hospital Manager MWRHE regarding the letter to Hospital Manager MWRHE sent 20\textsuperscript{th} of November 2009 (as above) asking that PA confirm receipt of letter.

**Wednesday the 16\textsuperscript{th} of December 2009.**

E-mail from PA to Hospital Manager MWRHE to the Complainant acknowledging letter of 20\textsuperscript{th} of November 2009 and stating that she will bring it to The Hospital Manager MWRHE’s attention and forward response at earliest.

**Monday the 21\textsuperscript{st} of December 2009.**

Letter from Hospital Manager MWRHE to the Complainant stating that Registered Nurse 4 was not the only nurse attending the patient.

**Wednesday the 30\textsuperscript{th} of December 2009.**

Letter from Staff Officer to the Complainant regarding the request for records. Advising that the FOI Decision Maker was responsible for processing the FOI request. Gives phone contact details. Advises that a final decision would normally be sent within four weeks. They will advise in writing if it takes longer. Advises of right to review under FOI Acts and attaches Summary of Review Rights.
Thursday the 21st of January 2010.

E-mail from Ms. B, Consumer Affairs to PA to Hospital Manager MWRHE attaching e-mail from The Complaint Review Officer, Consumer Affairs to The Hospital Manager MWRHE of 8th of December 2009 and e-mail of 25th of November 2009 from Ms. C, Ombudsman’s Office (as above) requesting an update on the matter.

Friday the 22nd of January 2010.

E-mail from PA to The Hospital Manager MWRHE copying e-mails as above from Ms. B, Consumer Affairs of 21st of January 2010; The Complaint Review Officer, Consumer Affairs 8th of December 2009 and Ms. C, Ombudsman’s Office 25th of November 2009.

Copy of Inquest Verdict and recommendations sent by Coroner to Director, Serious Incident Management Team as requested by Mr. R, Patient Focus.

Monday the 25th of January 2010.

Letter from Mr. R, Patient Focus to the Director of the HSE Serious Incident Management Team.

Tuesday the 26th of January 2010.

08.51hrs:
E-mail from to the Director of the Serious Incident Management Team to Quality and Risk Advisor National Hospital Office attaching letter from the Coroner dated 22nd January 2011 and requesting a discussion in relation to this case.

12.02hrs:
E-mail from Quality and Risk Advisor National Hospitals Office to Director Serious Incident Management Team advising that – to his/her knowledge – that this was the subject of a full systems analysis with implementation of controls. Recommends contacting Hospital Manager MWRHE, or the Risk Advisor.

13:29hrs:
E-mail from PA to the Director of the Serious Incident Management Team to Hospital Manager MWRHE as follows:

- Received a query regarding this case
- Requests information about whether full systems analysis was conducted and whether recommendations were implemented.

Wednesday the 27th of January 2010.

Letter from the Director of the Serious Incident Management Team to Mr. R, Patient Focus acknowledging his letter of the 15th of January as above.

E-mail PA to the Director of the Serious Incident Management Team to Hospital Manager MWRHE forwarded to the PA to the Hospital Manager, MWRHE.
Letter from Hospital Manager MWRHE to the Complaint Review Officer, Consumer Affairs as follows:

- Referring to recent correspondence regarding the review
- That as the matter is “sub judice\textsuperscript{23},” confirms formal review will be completed upon completion of Garda investigation
- Notes that the matter has been referred to the relevant regulatory bodies
- Notes the following actions from initial complaint investigation:
  ⇒ Review format of discharge summary (Done. Copy enclosed)
  ⇒ Training on Oxygen therapy and update guidelines for Oxygen administration (Done. Copy enclosed)
- Confirms that they will welcome the complainant’s input in the systems analysis when Garda Investigation is Complete.

\textbf{Thursday the 28\textsuperscript{th} of January 2010.}

Letter from the Director of the Serious Incident Management Team to Mr. R, (Note: This letter was sent prior to receiving letter of 27.01.2010 as above from Hospital Manager MWRHE) stating that the case was the subject of a full systems analysis with implementation of controls and this is an on-going process. She also advises that there has been a review of ambulance services nationally.

Letter from the Hospital Manager MWRHE to the Complainant regarding the FOI Request of 14\textsuperscript{th} of December as above and enclosing the phone records requested.

\textbf{Friday the 29\textsuperscript{th} of January 2010.}

Letter from Mr. R, Patient Focus to the Director Serious Incident Management Team:

- Thanking the Director of the Serious Incident Management Team for letter 28\textsuperscript{th} of January 2010
- Requesting involvement in the full systems analysis
- Requests update on the status of the review and if reviewers will meet The Complainant and Patient Focus as part of the review.

\textbf{Monday the 1\textsuperscript{st} of February 2010.}

Letter from the Director Serious Incident Management Team to Mr. R, Patient Focus indicating she is not involved in the systems analysis review of this case and suggesting the Mr. R contact the Hospital Manager MWRHE. Gives contact details for Hospital Manager, MWRHE.

\textsuperscript{23} Under judicial consideration.
Tuesday the 2\textsuperscript{nd} of February 2010.

Letter from Mr. R, Patient Focus to the Hospital Manager MWRHE:

- Refers to recent correspondence to the Director of the Serious Incident Management Team who suggested that they contact the hospital manager MWRHE
- Requesting involvement in full systems analysis
- Requests update on the status of the review and if reviewers will meet the Complainant and Patient Focus as part of the review.

Thursday the 3\textsuperscript{rd} of February 2010.

Letter from Hospital Manager MWRHE to Mr. R, Patient Focus.

- Refers to and acknowledges Mr. R's correspondence of 2\textsuperscript{nd} of February 2010
- As matter is sub judice, confirms formal review will be completed upon completion of Garda investigation
- Notes matter referred to the relevant regulatory bodies
- Notes actions from initial complaint investigation:
  \[ \Rightarrow \text{Review format of discharge summary (Done)} \]
  \[ \Rightarrow \text{Training on Oxygen therapy and update guidelines for Oxygen administration (Done)} \]
- Confirms that they will welcome the complainant’s input in systems analysis when the Garda Investigation is complete

Friday the 4\textsuperscript{th} of February 2010.

Letter from the Director of the Serious Incident Management Team to the Mr. R. Patient Focus advising Mr. R’s letter of the 2\textsuperscript{nd} of February has been forwarded to the relevant people in Quality and Risk.

Tuesday the 23\textsuperscript{rd} of February 2010.

Letter from Mr. R. Patient Focus to the Director of the Serious Incident Management Team (SIMT) relating to confusion arising regarding the status of the review and dissemination of learning from correspondence from the Hospital Manager and from the Directorate of the Serious Incident Management Team. He also expressed reservations about the current systems analysis review being carried out locally indicating the preference of the complainant for an external lead on such a review. Finally this letter expresses a wish to have a meeting with the Director of the SIMT so that the Director of the SIMT might appreciate the complainants’ concerns.
Thursday the 18\textsuperscript{th} of March 2010.

Letter from Mr. R, Patient Focus to the Director of the Serious Incident Management Team further to his letter as above of the 23\textsuperscript{rd} of February asking her if she will agree to meet him and The Complainant.

Monday the 22\textsuperscript{nd} of March 2010.

Telephone conversation between the Director of the Serious Incident Management Team and Mr. R. Patient Focus. Director of the Serious Incident Management Team to contact the Regional Director of Operations (RDO) HSE West in relation to setting up a meeting between the RDO HSE West and the complainant.

Wednesday the 31\textsuperscript{st} of March 2010.

E-mail from Mr. R, Patient Focus to the Director of the Serious Incident Management Team asking if contact had been made with the RDO HSE West

E-mail from the Director of the Serious Incident Management Team to Mr. R, Patient Focus stating that file was passed on to the RDO HSE West and to expect contact in the not too distant future but not in the following two weeks.

Tuesday the 13\textsuperscript{th} of April 2010.

E-mail from Mr. R, Patient Focus to the Director of the Serious Incident Management Team stating that there had been no contact from the RDO HSE West and requesting assistance that a date could be set as soon as possible for a meeting.

Letter from the Complainant to the CEO of the HSE copied to the Minister of Health; the Fine Gael TD with responsibility for Health; and HIQA and attaching:

- Document entitled “Comments re Patient [patient’s name]” which was conducted to contribute to the complaint investigation and which was issued by The Risk Advisor to Hospital Manager MWRHE on the 23\textsuperscript{rd} of January 2008
- Document entitled “Clinical response re Patient [patient’s name]” (To support complaint response)” which was issued by The Risk Advisor to Hospital Manager MWRHE on 21\textsuperscript{st} of February 2008
- Discharge Prescription

E-mail from the Director of the Serious Incident Management Team to Mr. R. Patient Focus acknowledging earlier e-mail and stating that:

“… have handed your correspondence to [RDO HSE West] who will be in touch in due course”

E-mail from Mr. R. Patient Focus to the Director of the Serious Incident Management Team to Mr. R, Patient Focus seeking contact details for the RDO HSE West.

E-mail from the Director of the Serious Incident Management Team to Mr. R, Patient Focus with contact details for the RDO HSE West.
E-mail from the RDO HSE West to Mr. R, Patient Focus stating that he will be meeting with the Complainant on a date and time that is convenience for the complainant and that the Hospital Manager MWRHE is organising this meeting.

Thursday the 15th of April 2010.

E-mail from Ms. F, Office of the CEO of the HSE to the Head of Consumer Affairs attaching letter from the Complainant to CEO. Requesting the Head of Consumer Affairs to please deal directly and copy CEO on response.

E-mail from the PA to the Head of Consumer Affairs to Ms. D and Ms B, Consumer Affairs attaching letter from The Complainant asking whether the Complainant proceeded with a legal case or can it be reviewed now?

E-mail from Ms. B, Consumer Affairs to Hospital Manager, MWRHE attaching letter from the Complainant to CEO requesting response/comment to be forwarded.

Wednesday the 21st of April 2010.

Telephone discussion between the Hospital Manager MWRHE and Mr. R, Patient Focus where the Hospital Manager indicated that he did not think a meeting was appropriate given that a civil case was pending. He also indicated that the matter was not subject to a systems analysis review.

Response on behalf of the CEO of the HSE from the PA to the Head of Consumer Affairs to the Complainant advising that a copy of The Complainant’s letter of 13th of April 2010 has been sent to Hospital Manager MWRHE for his attention and response and that Consumer Affairs Office will contact The Complainant when they receive a response.

Response on behalf of the Minister of Health from the Private Secretary to Minister advising that the Complainant’s letter has been sent to the CEO of the HSE who will arrange for the matters raised to be investigated and a reply will be issued directly to the Complainant.

Monday the 26th of April 2010.

Letter from Mr. R, Patient Focus to Dr. G, Local Health Manager giving a background to this case and alluding to the findings of the inquest; asking if a systems analysis risk review has been carried out by HSE PCCC and requesting a copy of it. This letter advises that Mr. R, Patient Focus, and the Complainant are willing to meet the Local Health Manager to discuss the matter.

Tuesday the 4th of May 2010.

Telephone discussion between Hospital Manager MWRHE and Mr. R, Patient Focus. The Hospital Manager stated that the RDO HSE West was now happy to meet the complainant and discussed possible dates for this meeting and who might be in attendance.
Thursday the 6th of May 2010.

Letter from Mr. R, Patient Focus to RDO HSE West by way of a follow up to the conversation of the 4th of May as above regarding arranging a meeting with the Complainant and seeking an independent systems analysis.

Tuesday the 11th of May 2010.

E-mail from Ms. B, Consumer Affairs, to Hospital Manager MWRHE seeking clarification as to whether the Garda investigation of this complaint has been completed and when the formal review will take place.

Wednesday the 12th of May 2010.

Letter from the PA to the Head of Consumer Affairs to the complainant stating that a full systems review has not taken place and that the advice from the risk advisor was part of the complaint investigation. This letter states that - following the complainants request for a review the Complaint Review Office, Consumer Affairs recommended a full incident review. The letter further advises that - due to the ongoing Garda investigation - this recommendation has not been implemented. This letter also states that the Hospital Manager, MWRHE has advised that on completion of the Garda investigation a full incident review will take place.

Friday the 14th of May 2010.

E-mail from RDO HSE West to the Complainant and Mr. R., Patient Focus suggesting 11th of June for meeting.

Monday the 17th of May 2010.

E-mail from Mr. R., Patient Focus stating that 11th of June was suitable for the meeting.

Wednesday the 19th of May 2010.

Letter from the General Manager, LHM Office to Mr. R. Patient Focus in response to Mr. R’s letter to Local Health Manager of the 26th of April 2010 as above stating that a systems analysis review was not commissioned following the death of the patient and that:

“…a commitment was given to doing a systems analysis on completion of the Garda investigation which is currently in progress…”

This letter outlines that issues highlighted during the complaint investigation at MWRHE were addressed at Regina House, Kilrush and the two outlying Community Nursing Units. The General Manager, LHM Office thanks Mr. R. Patient Focus for the offer of a meeting and advises that the General Manager thinks this will be appropriate when the review is complete.
Thursday the 10th of June 2010.

E-mail from RDO West to Complainant and Mr. R., Patient focus re meeting 11th June and details of time and venue of meeting.

Friday the 11th of June 2010.

Meeting between the Complainant, RDO HSE West; Mr. R, Patient Focus (Participating by speaker phone) where the RDO HSE West agrees to an independent review.

Wednesday the 23rd of June 2010.

E-mail from Mr. R, Patient Focus to the RDO HSE West for update on the review as promised.

Thursday the 1st of July 2010.

E-mail from Mr. R, Patient Focus to the RDO HSE West for update on the review as promised.

Friday the 9th of July 2010.

Letter from Mr. R, Patient Focus to the National Director Quality and Clinical Care stating that a systems analysis risk review has never been carried out and that this is incompatible with HSE policy.

Thursday the 22nd of July 2010.

Letter from the National Director Quality and Clinical Care to Mr. R, Patient Focus stating that a complaint investigation and complaint review have been completed and that the Hospital Manager MWRHE has confirmed that the matter is under consideration by the DPP and that the intention is that a systems analysis review will take place once the matter is no longer sub-judice.

Friday the 23rd of July 2010.

E-mail from the RDO HSE West to Mr. R, Patient Focus stating that he will revert with arrangements regarding the proposed review.

Wednesday the 28th of July 2010.

E-mail from the RDO HSE West to The Complainant stating that he is finalising the arrangements for the proposed review and that the delay is due to annual leave.
Friday the 30th of July 2010.

Letter from Mr. R, Patient Focus to the National Director Quality and Clinical Care outlining the core facts of the cases and that the patient died in the care of the HSE and that no systems analysis review had been carried out and expressing an opinion that this is totally incompatible with HSE Policy24.

Thursday the 19th of August 2010.

E-mail from The Complainant to the RDO HSE West expressing annoyance that she is still awaiting details of the proposed review.

Wednesday the 25th of August 2010.

Letter from the RDO HSE West to the Complainant apologising for the delay and promising to revert as soon as possible.

Monday the 13th of September 2010.

Letter from Mr. R., Patient Focus to the RDO HSE West alleging continued inaction.

E-mail from Office of the RDO HSE West stating that the RDO HSE West will be on annual leave until 27th of September 2010.

Letter from the A/RDO HSE West stating that it would be amiss for them to proceed with the independent review until they were given clear direction and recommendation from the DPP.

Friday the 17th of September 2010.

Letter from Mr. R, Patient Focus to the A/RDO HSE West stating that it is not the role of the DPP to give clear direction or recommendation to the HSE, that HSE in this case has not enacted it’s own policy on incident management and that direction should be taken from the HSE’s own policies.

Tuesday the 28th of September 2010.

Letter from Mr. R, Patient Focus to the RDO HSE West wishing to discuss the matter of the proposed review as a matter of urgency.

Monday the 4th of October 2010.

Letter from RDO West to Mr. R., Patient Focus confirming Independent review to take place in coming weeks and that he will be in further contact to discuss progress.

24 The Office of the National Director Quality and Clinical Care advised the investigation team that there was no copy of this letter on file. The investigation team received a file copy of this letter from Mr. R, Patient Focus.
**Wednesday the 20th of October 2010.**

E-mail from Mr. R, Patient Focus to the RDO HSE West stating that it is now over 4 months since the RDO HSE West gave the commitment to authorise an independent review, that Patient Focus and the Complainant are growing more frustrated with the continued inaction and stating that they will have to raise this matter at a higher level if some progress does not happen soon.

**Wednesday the 28th of October 2010.**

Letter from Mr. R, Patient Focus to the RDO HSE West requesting immediate update re proposed review, pointing out that they have received no information regarding the membership of the proposed review group or suggested Terms of Reference, that given the seriousness of this case and lack of any review by the HSE since 2007 Patient Focus want to ensure that the proposed review is meaningful and relevant.

**Sunday the 31st of October 2010.**

E-mail from the Complainant to the RDO HSE West stating that his continued inaction regarding the proposed review is unacceptable, humiliating, abusive and inexcusable.

**8.15pm; Tuesday the 2nd of November 2010.**

Phone call from the RDO HSE West to The Complainant stating that Head of the Serious Incident Management Team and the Clinical Risk Advisor, Sligo General Hospital are to take charge of the review and that the Clinical Risk Advisor, Sligo General Hospital will be in touch in the next few days.

**Tuesday the 9th of November 2010.**

Letter from Mr. R, Patient Focus to the RDO HSE West requesting immediate update regarding the Terms of Reference and the membership of the group so that they can propose their amendments to these and pointing out that the Clinical Risk Advisor Sligo General Hospital had not been in contact with The Complainant.

E-mail from Office of the RDO Hse West to Mr. R., Patient Focus acknowledging receipt of letter.

**Thursday the 11th of November 2010.**

The Clinical Risk Advisor first got details of the case on the 11th of November 2010. He was not aware until that point that the Complainant had been informed that (s)he would be in contact with her.

**Wednesday the 17th of November 2010.**

Letter from RDO HSE West to Mr. R., Patient Focus acknowledging earlier letter and outlining membership of Review Team.
Letter from Mr. R, Patient Focus to the CEO of the HSE giving background of this case and points out that a systems analysis review has never been carried out. This is copied to the RDO HSE West.

Letter from Mr. R. Patient Focus to the RDO HSE West regarding an immediate update and stating that the behaviour of the HSE is being totally obstructive in this case. That it is now 3 years since the patient’s death; that no systems analysis has taken place which is in breach of HSE policy, and that the promised contact by the Clinical Risk Advisor Sligo General Hospital had not yet taken place.

Thursday the 18th of November 2010.

Letter from Mr. R Patient Focus to RDO HSE West regarding the lack of consultation on membership of the Review Team and Terms of Reference. Also seeking a copy of the terms of reference and an urgent meeting to try to get the matter back on track.

Letter from Acting Manager MWRHE to the RDO HSE West, attaching a copy of the file they hold on this case and noting that it is for an internal review.

Friday the 19th of November 2010.

Phone call from Head of the Serious Incident Management Team (SIMT) to Mr. R. from Patient Focus advising that the Head of the SIMT and the Clinical Risk Advisor from Sligo General Hospital would be conducting the review of this case.

14:25
E-mail from the Head of the Serious Incident Management Team to Mr. R. Patient Focus following up on telephone call earlier that day stating that (s)he and the Risk Advisor Sligo General Hospital would like to meet the Complainant at the Complainant’s earliest convenience by way of a courtesy meeting and to agree the terms of reference. This e-mail proposes the 30th of November and the 6th of December for the meeting. This e-mail states that the reviewers are happy to go to a venue that is agreeable to the Complainant.

14:35
E-mail from Mr. R. Patient Focus to the Head of the SIMT advising he will discuss with the Complainant and revert.

15:34
E-mail from the Head of the SIMT thanking Mr. R. Patient Focus for his e-mail.

15:45
E-mail from Mr. R. Patient Focus to the Head of the SIMT suggesting 12.00noon on the 30th of November West County Hotel Ennis for a meeting with the Complainant.

15:50
E-mail from the Head of the SIMT to Mr. R. Patient Focus advising that 12.00noon on the 30th of November West County Hotel Ennis is suitable to the Head of the SIMT and the Clinical Risk Advisor Sligo General Hospital.

The timings on these e-mails are as per the timings on the Head of the SIMT’s electronic record of these e-mails. These e-mail communications are documented above as they occurred chronologically, although timings appear not to be chronological. This is probably due to a lack of synchronicity between the clocks on the PC’s of the Head of the SIMT and Mr. R from Patient Focus respectively.
Letter from the RDO HSE West to Mr. R., Patient Focus stating that the RDO HSE West had confirmation from the Head of the SIMT that a preliminary meeting with the review team had been arranged.
6.3 Complaint Management Service Delivery Problems

Service delivery problems are failures identified during the analysis of an incident which are associated with the way a service is delivered and the decisions, processes and systems that are part of the whole process of service delivery.

These service delivery problems result from systemic contributory factors which must be identified and appropriately managed in order to prevent future problems arising from these factors or where this is not possible to reduce the risk of future problems as far as is reasonably practicable.

An analysis of the management of the complaint in this case identified the following two Complaint Management Service Delivery problems:

<table>
<thead>
<tr>
<th>Complaint Management Service Delivery Problem 1:</th>
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<tbody>
<tr>
<td>There was a lack of clarity about the need to conduct a robust investigation of this complaint in the first instance (i.e. when the incident occurred and/or when the complaint was made) that covered all areas of the service involved, and that identified and satisfactorily addressed all pertinent issues.</td>
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<table>
<thead>
<tr>
<th>Complaint Management Service Delivery Problem 2:</th>
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</thead>
<tbody>
<tr>
<td>There was a lack of clarity about the need to proceed with a full systems analysis investigation as recommended by the complaint review process (in October 2009) when there were external investigations including investigations by An Garda Siochána - in a manner that balanced the need for the HSE to achieve its safety objective with the need not to jeopardise investigations by these external agencies.</td>
</tr>
</tbody>
</table>

The framework of contributory factors (See Appendix 2) was applied to identify the factors that contributed to each of these two complaint management service delivery problems as follows:
6.4 Complaint Management Contributory Factors and Recommendations

Factors that contributed to Complaint Management Service Delivery Problem 1:

There was a lack of clarity about the need to conduct a robust investigation of this complaint in the first instance (i.e. when the incident occurred and/or when the complaint was made) that covered all areas of the service involved, and that identified and satisfactorily addressed all pertinent issues.

Contributory Factors: Task and Technology Factors that contributed to the lack of clarity about the need to conduct a robust investigation of this complaint.

The toolkit of documentation to support incident management in the HSE (2009) indicates that an incident such as this requires a robust systems analysis investigation of care delivered by Mid-Western Regional Hospital Ennis, Ambulance Services and Regina House to determine any care and/or service delivery problems that contributed to the incident and the factors that contributed to these so that the HSE could take action to address the causes in the interest of safety to future services users and so that a full explanation and apology could be given to the complainant.

The methods of the investigation in this case - namely, seeking written answers to specific questions - did not enable identification of the care or service delivery problems and their causes/contributory factors in this case. Furthermore, the initial investigation did not provide for a meeting or interview with the family members to determine the chronology of events that led up to the incident from the family’s recollection, nor for the family members to receive a draft chronology of the report so that they could check it for factual accuracy.

There was no national policy for the management and investigation of incidents at the time of this incident. The HSE incident management policies and procedures and the tool-kit of documentation to support incident management was published in 2009 and it would have been sometime after this before training would have been delivered and the procedures embedded throughout the HSE.

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26 A systems analysis investigation (formerly called “root-cause-analysis”) is a structured investigation that aims to identify the systems cause(s) of an incident or complaint and the actions necessary to eliminate the recurrence of the incident or complaint or where this is not possible to reduce the likelihood of recurrence of such an incident or complaint as far as possible. Healthcare services carry out incident investigations using systems analysis to find out what happened, how it happened, why it happened, what the organisation can learn from the incident and what changes the organisation should make to prevent it happening again.
Incident reporting at Mid-Western Regional Hospital Ennis was governed at the time the incident occurred in November 2007 by the former Mid-Western Health Board’s Incident Reporting Policy (August 2004). This policy stated that incidents must be reported, analysed and evaluated and that lessons learned from incident analysis should be implemented to enhance safety. Changes had occurred to the organisational structure in the interim since this policy was published in August 2004 which were not reflected in the policy document. In addition, there was no specific guidance in relation to who exactly should conduct investigations, what investigation methodology should be used, and what kind of investigation report should be produced.

The DoN at Regina House advised that (s)he was on leave the 23rd of November 2007 when the incident occurred and that (s)he became aware of the incident at approximately 20.00hrs when (s)he received a telephone call in relation to the incident from the Acting CNM II at Regina House. The DoN advised the investigation team that (s)he made telephone contact with the Risk Advisor in relation to the incident on Monday the 26th of November 2007; that the DoN reviewed the incident with staff during the week following the incident; and that (s)he endeavoured to address the issues in relation to this incident including arranging to procure a second concentrator, tubing, face masks and Y connectors to enable for two concentrators to be used in series; arranging for the Guidelines on Oxygen Therapy for Regina House to be developed and signed off (these were approved on the 5th of February 2008) and arranging for British Oxygen Company (BOC) to provide training to staff on the safe use of oxygen.

Some time shortly after the 12th of December Staff Officer 1 at MWRHE contacted the Risk Advisor by phone requesting that the Risk Advisor might give input to the complaint investigation of this case. This request for an input by the Risk Advisor resulted in him/her submitting the following documents to the complaint investigation process:

- “Comments re patient [patient’s name]” 23rd of January 2008
- “Clinical Response Re Patient [patient’s name] (To support the complaint response)” 21st of February 2008

The Risk Advisor advised the investigation team that around the time between December 2007 and May 2008 (s)he undertook site visits and inspections of Regina House Nursing Home and the other community nursing units in the area to ensure that they had appropriate equipment for the safe use of oxygen including oxygen cylinders; concentrators; tubing; Y connectors; and an appropriate range of oxygen masks to match the concentration of oxygen to be delivered. The Risk Advisor advised the Directors of Nursing at the community nursing units in the area that they must arrange for the delivery of training in the safe use of oxygen by BOC to nursing staff in their units; and (s)he was involved in the consultation and engagement for the development of the HSE West Guidelines for “Administration of Oxygen Therapy to adult patients” which were signed off on the 25th of September 2008.

The policy and procedure for managing complaints in the HSE currently and at the time of the incident are described in the “Your service your say” document. The Local Complaints Liaison Officer (Also Staff Officer 1 MWRHE) was assigned and trained in accordance with this policy, and this Complaints Liaison Officer endeavoured to address the complaint in this case as per the policy. The “Your Service Your Say” policy does not cater for a thorough systems analysis investigation of a complaint. It does enable for linkages with risk management if an incident is deemed to have
The documents entitled “Comments re Patient [patient’s name]” and “Clinical response re Patient [patient’s name]” were prepared by the Risk Advisor to contribute to the complaint investigation in the context of this link between the complaints management process and risk management if an incident is deemed to occur in the case where a complaint has been made as foreseen in the “Your Service Your Say” policy. These documents developed by the Risk Advisor did not follow a “root-cause-analysis” or a “systems analysis methodology”. Staff advised the Investigation Team that the culture at the time the incident occurred did not recognise the value of systems analysis investigation of such complaints. The investigation team was advised by the National Incident Management Team (NIMT) that there is evidence of a number of cases from a number of areas around the country which occurred at around the time this incident occurred; where the areas did not appear to have a culture of conducting systems analysis investigations of incidents, nor did they appear to have a culture of conducting systems analysis investigations of incidents that were being addressed in the complaint management process. The National Incident Management Team has arranged to ensure that there is clarity in relation to this in training and other communications and in the Guidelines for Systems Analysis Investigation of Incidents and Complaints which were published in 2012.

The complainant and the patient’s family wrote a letter of complaint to MWRHE on the 10th of December 2007 and this alluded to concerns about:

- The decision to discharge the patient
- The transfer by ambulance and
- His required Oxygen flow rate at Regina House and
- How his proper and safe handover at Regina House should be conducted under appropriate medical supervision.

The Complaints Liaison Officer in this case had a remit to coordinate the complaint as appropriate on behalf of the Complaints Officer who was the Hospital Manager at MWRHE and as stated the Complaints Liaison Officer did this in accordance with the “Your Service Your Say Policy”. To this end the Complaints Liaison Officer responded promptly on the 12th of December 2007 to the initial letter of complaint which was posted on the 10th of December. Also on the 12th of December, the Complaints Liaison Officer wrote separate letters to the A/Chief Ambulance Officer and the Consultant Physician attaching the letter of complaint of the 10th of December and requesting a response. Some time around this time the Complaints Liaison Officer made contact with the Risk Advisor and requested him/her to give input to the complaint investigations. As the Complaints Liaison Officer had not received a response from the A/Chief Ambulance Office nor the Consultant Physician, she wrote to the complainant on the 8th of January 2008 following up on her letter to the complainant of the 12th of December 2007 and advising she was unfortunately still awaiting reports from the Consultant Physician and the A/Chief Ambulance Officer and that she consequently could not provide a response to the complainant. She advised that she hoped to provide this response on the 24th of January 2008. On the same day, the Complaints Liaison Officer wrote again to the A/Chief Ambulance Officer and the Consultant Physician following up on her letters to them of the 12th of December and requesting a response.

The Complaints Liaison Officer received responses from the Consultant Physician and from the Chief Ambulance Officer the 9th and the 11th of January 2008 respectively and comments in relation to this case from the Risk Advisor on the 23rd of January 2008. The Hospital Manager wrote to the complainant and the family on
the 6th of February acknowledging their letter of the 1st of February 2008 which had arrived on the 5th of February and advising that a report would issue shortly. On the 7th of February 2008 the Complaints Liaison Officer wrote to the Consultant Physician stating that the discharge summary stated requirements were 6 litres O2 not 60% O2 and requested an explanation in order that she might respond to the Complainant. The Consultant Physician responded via a letter dated the 8th of February clarifying that:

“…on the patient’s hand-written discharge summary, it was not mentioned that the patient was discharged on six litres of oxygen. On his discharge summary, it was mentioned that the Arterial Blood Gases were done in Ennis General Hospital when the patient was on six litres of oxygen”.

The Complaints Liaison Officer responded on the 12th of February 2008 to the Consultant Physicians letter of the 8th of February requesting a full and detailed report of the patient’s Oxygen requirements on his admission, what he was given while an inpatient, and an explanation as to why, given his condition, there was no detailed requirements for Oxygen given on his Patient Discharge Summary.

On the 21st of February the Risk Advisor’s response to support the complaint response issued and the Consultant Physician responded on the 29th of February clarifying that:

“…ABG’s demonstrated type 1 respiratory failure. As a result, he received six to eight Litres of Oxygen through mask. Kept his Oxygen saturation around 90%. Though it was written on the treatment card, 60% of Oxygen, his oxygen saturation maintained around 90% through 6 – 8 Litres of Oxygen through mask. Kept his Oxygen saturation around 90%.

Though it was written on the treatment card, 60% of Oxygen, his oxygen saturation maintained around 90% through 6-8 Litres of oxygen which makes the given oxygen concentration around 40%”

The quote above is a direct quote from the actual letter from Consultant Physician A to Staff Officer 1, MWRHE. During this investigation, Consultant Physician A advised the team that this letter should have read as follows:

“ABG demonstrated type 1 respiratory failure. As a result, he received six to fifteen litres of oxygen through face mask or nasal canullae to keep his oxygen saturation around 90%. It was written on the treatment kardex 60% of oxygen and his oxygen saturation maintained around 90% by giving 6-15 litres of oxygen through nasal canullae or face mask.”

Finally, also on the 29th of February 2008 the Hospital Manager wrote to the Complainant by way of a written response to the initial complaint letter of the 10th of December 2008. In this letter the Hospital Manager apologised for the delay in issuing the report; Outlined the findings of the complaint investigation; Stated that the standard format of the discharge summary and staff training needs around oxygen therapy have been prioritised as areas for attention; Sympathising with the complainant; and inviting the Complainant to contact him if he could be of further assistance.

There were a number of factual inaccuracies in the complaint response. The response addressed some of the pertinent issues in this case namely the need to
review the standard format of the discharge summary and the staff training needs around oxygen therapy. It did not address issues around the use of concentrators, decision making in relation to patient transfers in general; nor specifically issues surrounding decision making and the management of transfers of acutely ill patients requiring supplemental oxygen.

The above illustrates that there was evidence that the Complaints Liaison Officer endeavoured to follow the “Your Service Your Say” Complaint Management Policy and Procedure and that she linked with the local risk advisor, and sought information from the relevant clinicians and managers. While the complaint investigation did consider the role of the Consultant Physician and the Ambulance Service, it did not consider the role of the family of the patient; the other Healthcare Workers including the Healthcare Workers at Regina House. The meeting proposed with the family as per the letter from the Complaints Liaison Officer to the Complainant on the 6th of June 2008 was to include attendees from Mid-Western Regional Hospital Ennis only, and did not include attendees from National Ambulance Service nor Regina House. It is accepted that it may not always be necessary or feasible to have representatives from all areas implicated in a complaint or incident at meetings with families, but it is important that the scope of an investigation is appropriate and includes all pertinent services. The correspondence of the 6th of June 2008 stated that the purpose of this meeting with the family was to examine and discuss the care and treatment given prior to discharge to Regina House. The Complainant responded on the 21st of July stating that they had no problem with care at Mid-Western Regional Hospital Ennis so that a meeting about this was not necessary and that the issue was the ambulance transfer and care at Regina House and the need to acknowledge failures and to apologise. The Hospital Manager responded on the 15th of August acknowledging failures and apologising:

“We have reviewed the process concerning the transfer of [patient’s name.], and I wish to acknowledge problems identified in the transfer process. We sincerely apologise for these shortcomings.”

There is evidence, with hindsight, that this investigation did not encompass all the pertinent service areas namely Mid-Western Regional Hospital Ennis, Ambulance Services and Regina House, and consequently, it could not identify all the salient issues.
The fact that a robust systems analysis investigation did not occur in the first instance in this case meant an incomplete and inaccurate complaint investigation report issued which was very disappointing for the complainant and meant that the HSE did not derive all possible learning from the experience of this complaint/incident. It also meant that the complaint was referred to other offices and agencies; culminating in over 42 people being involved in the management and investigation of this complaint including the following non-exhaustive list:

- The complainant, Mr. R from Patient Focus; and the complainants solicitors
- A/DoN 1
- A/DoN 2
- Hospital Manager MWRHE and A/Hospital Manager MWRHE and his PA
- Staff Officer 1 MWRHE
- A/Chief Ambulance Officer
- The Consultant Physician
- The Risk Advisor
- RDO HSE West and members from the Office of the RDO HSE West
- The Head of Quality and Risk and his/her PA
- The Director of the Serious Incident Management Team and his/her PA
- The Head of Consumer Affairs, his/her PA, and Ms. B.
- The Complaint Review Officer
- Ms. C from the Office of the Ombudsman
- Staff at the Office of the Minister of Health
- The former CEO of the HSE and the Current CEO of the HSE and their staff
- An FOI Officer
- The Area GM for Quality and Risk
- The Area Office for Consumer Affairs
- The National Director of Quality and Clinical Care and his/her PA
- Members of the National Incident Management Team
- The three members of the current investigation team.
- The staff that were interviewed in the current investigation some of whom participated in investigations by the Professional Regulators; An Gardaí and the inquest.

Referral of matters related to this complaint meant that several external agencies were involved in the investigation of this complaint including An Garda Síochána; the Office of the Minister of Health; The Coroners Office; The Gardai; The Health Information and Quality Authority, The Professional Regulators; Agencies involved in the Management of the litigation including the Clinical Indemnity Scheme; and the Office of the Ombudsman.

The challenge to the HSE of co-ordinating and managing all these disparate elements, individuals and external agencies was enormous and the situation became incompatible with effective complaint and incident investigation and management.
Recommendation 5: Optimise Complaint and Incident Reporting and Management Policies and Procedures, Structures and Processes

It is recommended that the HSE review the HSE complaint and incident reporting, management and investigation policies and procedures, structures and processes to ensure that:

1. Complaints and incidents are investigated in all their complexity, including that the scope of the investigation goes across all of the services involved in the incident or issue complained of.

2. Complaints and incidents recognise the commonality of complaints and incidents (i.e. complaints are service user reported incidents) and the consequent need for common methods of identifying, managing, investigating and learning from them.

3. Sufficiently robust methods of investigation are deployed, namely, systems analyses investigations.

4. The need to proceed with internal HSE investigations is clear when there are external investigations by professional regulators, an Garda Síochána, and legal proceedings, and provided that HSE investigations are conducted in a manner that is impartial, fair, evidence based and that they do not prejudice future legal proceedings or investigations by Professional Regulators. See also recommendation 7 and recommendation 8.
Contributory Factors: Individual (Staff) Factors that contributed to the Lack of clarity about the need to conduct a robust investigation of this complaint.

At the time when this incident occurred, some training was delivered to complaints officers about investigating complaints according to the “Your Service Your Say” Complaints Management Policy.

The local risk advisor had received training in incident investigation including training with Consequences UK, and the Clinical Indemnity Scheme, but this had not covered the investigation of complaints which were managed under a separate policy as per the “Your Service Your Say” document.

The managers and clinicians involved in this incident had not received effective training in the management and investigation of complaints and incidents as no comprehensive policies and procedures for the management of both complaints and incidents, nor training to support these existed at the time.

Recommendation 6: Training for Complaint and Incident Investigators, Managers and Clinicians Should Be Optimised

This should include the development, implementation and evaluation of the effectiveness of a training programme for complaint and incident investigators, managers and clinicians on the management and investigation of complaints and incidents to include:

1. How to conduct robust systems analysis investigations.

2. How to ensure that the scope of investigations should go across all services involved in the incident or issue complained of.

3. How to ensure that the commonality of complaints and incidents (i.e. complaints are service user reported incidents) is recognised and the consequent need for common methods of identifying, managing, investigating and learning from them.

4. The importance of proceeding with HSE investigations when there are investigations by external agencies including but not limited to Professional Regulators, An Garda Síochána, legal proceedings etc. (As per the Memoranda of Agreement as outlined in recommendation 8 below)

5. How to conduct HSE investigations in a manner that is impartial, fair, evidence based and that does not prejudice future criminal and civil legal proceedings, or investigations by external agencies including but not limited to investigation by the Professional Regulators. (As per the Memoranda of Agreement as outlined in recommendation 8 below).
Contributory Factor: Organisational & Management factors that contributed to the lack of clarity about the need to conduct a robust investigation of this complaint.

This incident occurred at a time of major HSE restructuring and at that time Mid-Western Regional Hospital Ennis and the Ambulance service fell under the auspices of the former National Hospital Office service nationally. They had separate management structures locally. Regina House fell under the auspices of the former National Primary, Community and Continuing Care Office. There was no local management or governance structure that oversaw the management of these services locally and consequently, there was no overarching structure that could oversee and ensure the safety of service provision across and between these services including the need to identify and manage hazards and risks and to effectively manage and investigate complaints and incidents that involved all of these services.

It is accepted that there will never be a health service structure that oversees all of the pathways across and between services that service users may take. But there is a need to ensure that suitable management and governance structures are in place which satisfactorily manage risks and safety, including complaints and incidents within a given health service structure and at the interface between that structure and other health service structures.

It is also accepted that significant structural changes have been made in the HSE in the interim; that progress has been made in developing best practice models of care delivery across the clinical care programmes of which governance and safety management are a fundamental element; and that national, regional and local structures and processes to satisfactorily manage and investigate complaints and incidents have been enhanced.

Staff involved in the management of this complaint confirmed that a full systems analysis investigation was not commissioned at the time the complaint was made. They further confirmed that the culture, structures and processes at the time the incident occurred did not recognise the value of systems analysis investigations of such incidents/complaints, nor did it support conducting such investigations. Finally on this matter, staff indicated that changes in the interim have raised awareness of the value of systems analysis investigations in circumstances such as this complaint. They cited these changes to include the following:

- Establishing the Office of Regional Directors of Operations (RDO Office)
- Establishing a Regional Incident Management Team
- Establishing a National Incident Management Team and Serious Incident Management Team
- Publishing the HSE Toolkit of Documentation to Support Incident Management (2009) and associated training
- Establishing a Quality and Risk Department for the former Mid-Western Area

Policies in place did not include a National or Local Incident and Complaints Management Policy which enabled for incidents and complaints to be managed and investigated robustly and commonly. The Review Team found that these issues with complaint and incident management structures and policies contributed to challenges with "seeing" this incident in all its scope, complexity and severity at the time.
Recommendation 7: Governance Arrangements for Complaint and Incident Management Should Be Optimised.

This should include a review of HSE governance arrangements to ensure that suitable management and governance structures and processes are in place that satisfactorily manage risks and safety - including the management and investigation of complaints and incidents - within the structure and at the interfaces between health service structures.

Factors that contributed to Complaint Management Service Delivery Problem 2:

There was a lack of clarity about the need to proceed with a full systems analysis investigation as recommended by the complaint review process (in October 2009) when there were external investigations including investigations by An Garda Síochána - in a manner that balanced the need for the HSE to achieve its safety objective with the need not to jeopardise investigations by these external agencies.

Contributory Factors: Institutional Context factors that contributed to the lack of clarity about the need to proceed with a full systems analysis investigation.

The letter from Mr. R, Patient Focus on behalf of the complainant to the Head of Quality and Risk on the 28th of July 2009 resulted in the matter being referred from the Head of Quality and Risk to the Office of the Head of Consumer Affairs. This in turn triggered an Internal Review of the management of this complaint as per the Your Service Your Say Document. The report of this Review was issued from the Complaint Review Officer to the complainant and copied to the Head of Quality and Risk and to Mr. R, Patient Focus on the 21st of October 2009. The recommendation of the complaint review was as follows:

"The Review Officer recommends that given the circumstances of what happened that a full incident review is undertaken on this case at local level".

The Complaint Review Officer followed up with a letter to the Hospital Manager on the 5th of November 2009 asking that:

"Please ensure that the appointed person is independent of the previous investigation".

The Hospital Manager wrote to the Complaints Review Officer on the 12th of November 2009 confirming that the matter had been referred by the Complainant to An Garda Síochana as a criminal matter and that he believed therefore that the matter was sub judice. The hospital manager recalled receiving verbal legal advice that the case was “sub judice” (i.e. under judicial consideration) and that therefore, no further HSE investigation should proceed. The legal advisor stated to the review team that their best recollection did not confirm that they advised against appropriate investigation into the matter, as the legal advisor was unaware that any other investigation was required or called for other than the Garda investigation.

A letter issued on the same day from the Office of Consumer Affairs advising the Complainant on behalf of the Complaint Review Officer that the review was being
suspended given that the matter was being investigated by the relevant regulatory bodies and An Garda Síochána.

The complainant responded in a letter to the Complaint Review Officer on the 19th of November asking that the HSE review be re-opened.

The Ombudsman wrote to the Complaint Review Officer on the 25th of November querying whether there was a way around the difficulty with proceeding due the Garda Investigation - given the seriousness of events.

The “Your Service Your Say” policy - which was in place at the time of this incident - indicates that HSE complaint investigations may proceed provided they are conducted in a manner that does not jeopardise criminal proceedings or investigations by other external agencies including the Professional Regulators.

The HSE toolkit of documentation to support incident management (2009) intends and implies that investigations should proceed even if investigations by external agencies are ongoing or anticipated, but it is not overtly explicit in this regard.

The investigation team was advised by the National Incident Management Team (NIMT) that there is evidence of a number of cases from a number of areas around the country around the time of the complaint review process in October 2009 where the areas did not appear to be clear of the need to conduct systems analysis investigations of incidents when investigations were anticipated or were being conducted by external agencies such as an inquest; investigations by the Gardaí; civil litigation being managed by the Clinical Indemnity Scheme; and investigations by professional and other regulators. The National Incident Management Team has arranged to ensure that there is clarity in relation to this in training and other communications and in the Guidelines for Systems Analysis Investigation of Incident and Complaints which were published in 2012.

Based on the above the review team found that there was a lack of clarity amongst those involved in the investigation of this complaint that the local investigation could proceed even if investigations by external agencies were ongoing or anticipated.

The fact that there were no clear policies, procedures or guidelines to support staff in understanding exactly how to conduct investigations in a manner that ensured that these investigations would not jeopardise any future criminal proceedings or other external investigations including investigations by Professional Regulators contributed to this lack of awareness.

The review team also found that at the time of the incident involving the patient in 2007 and at the time this incident was being investigated in the interim - there were no written Memoranda of Agreement between the HSE and external agencies that have a role in investigating incidents in the HSE - specifying exactly how the HSE might conduct investigations in order to balance the need to achieve HSE safety objectives with the need not to jeopardise concurrent or future investigations by such external agencies including but not limited to investigations falling out of criminal proceedings and investigations by the Professional Regulators.
Recommendation 8: Arrangements for HSE investigations when external agency investigations are ongoing or anticipated should be clarified.

This should include the development of Memoranda of Agreement (or an equivalent) between the HSE and external agencies that may have a role in investigating complaints and incidents, specifying exactly how the HSE might conduct investigations in order to balance the need to achieve HSE safety objectives with the need not to jeopardise concurrent or future investigations by such external agencies - including but not limited to investigations arising from criminal proceedings and investigations by the Professional Regulators.

Following development of these Memoranda of Agreement (or an equivalent) there should be:

- Communication of these Memoranda or the equivalent to the relevant personnel in the HSE
- Training of relevant staff on how to conduct investigations in order to balance the need to achieve HSE safety objectives with the need not to jeopardise concurrent or future investigations by external agencies as per the memoranda of agreement
- Evaluation of the effectiveness of these Memoranda of Agreement and associated training, including audit of compliance with the conditions as set out in these Memoranda of Agreement.
### 7. Summary of Recommendations

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<tr>
<th>Recommendation 1: Arterial Blood Gas Analysis.</th>
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<tr>
<td>It is recommended that arrangements are made for safe systems in relation to arterial blood gas analysis including but not limited to ensuring that there is access to working gas analysers and appropriate contingency arrangements for when arterial blood gas analysers are out of order.</td>
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<th>Recommendation 2: Care Planning and Discharge Planning.</th>
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<tr>
<td>It is recommended that a care plan and discharge plan is developed for every patient following admission to hospital based on the Health Service Executive Code of Practice for Integrated Discharge Planning (2008)[27]. This should be reflected in hospital policy and procedures and include provision for audits of compliance. The Hospital should ensure it audits compliance as soon as possible following receipt of this report and at a minimum of yearly thereafter.</td>
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<th>Recommendation 3: Develop National Guidelines for Oxygen Therapy</th>
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<td>It is recommended that national multi-disciplinary guidelines be developed, implemented and audited to provide clear direction for the clinically appropriate prescription, administration and management of oxygen therapy. The guidelines must include a standardised format to be used across all clinical settings for oxygen administration. These should consider the source of oxygen, i.e. piped oxygen supply cylinder or concentrator device. Guidelines should identify whether the rate is recorded in litres per minute or as a percentage and the delivery mode to be used (i.e. nasal cannula/mask). These guidelines should focus on, but may not be limited to the prescription, administration and management of oxygen therapy;</td>
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<tr>
<td>• By General Practitioners</td>
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<tr>
<td>• During clinical handovers</td>
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<tr>
<td>• During ambulance transfers</td>
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<tr>
<td>• At recipient facilities</td>
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<tr>
<td>• In low technology community settings</td>
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<tr>
<td>• When portable oxygen supplies are running low</td>
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</tbody>
</table>

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27 Please note: The 2008 Health Service Executive Code of Practice for Integrated Discharge Planning is expected to be replaced with a 2013 version in quarter 4 2013.
**Recommendation 4: Develop National Guidelines on the Transfer of Patients.**

It is recommended that national guidelines be developed for the transfer of patients between healthcare facilities. These guidelines should provide direction to staff as to the key patient specific information that must be communicated during a structured patient handover to the receiving facility and to the Ambulance Controller when requesting an ambulance transfer. This should specify the patient's diagnosis, current condition, supplemental oxygen requirements and delivery mode, and any cardiac or other monitoring devices required. This will ensure that the receiving facility has the necessary equipment available and ready and that an appropriately equipped ambulance and suitably qualified personnel are allocated to the task. These guidelines should include guidance for the transfer of critically and / or terminally ill non-ventilated patients requiring supplementation oxygen therapy to and from palliative care and respite services – arranged by General Practitioners / and other medical practitioners. Training should be provided to support the implementation of these guidelines and compliance audits completed.

**Recommendation 5: Optimise Complaint and Incident Reporting and Management Policies and Procedures, Structures and Processes**

It is recommended that the HSE review the HSE complaint and incident reporting, management and investigation policies and procedures, structures and processes to ensure that:

1. Complaints and incidents are investigated in all their complexity, including that the scope of the investigation goes across all of the services involved in the incident or issue complained of.

2. Complaints and incidents recognise the commonality of complaints and incidents (i.e. complaints are service user reported incidents) and the consequent need for common methods of identifying, managing, investigating and learning from them.

3. Sufficiently robust methods of investigation are deployed, namely, systems analyses investigations.

4. The need to proceed with internal HSE investigations is clear when there are external investigations by professional regulators, an Garda Síochána, and legal proceedings, and provided that HSE investigations are conducted in a manner that is impartial, fair, evidence based and that they do not prejudice future legal proceedings or investigations by Professional Regulators. See also recommendation 7 and recommendation 8.
Recommendation 6: Training for Complaint and Incident Investigators, Managers and Clinicians Should Be Optimised

This should include the development, implementation and evaluation of the effectiveness of a training programme for complaint and incident investigators, managers and clinicians on the management and investigation of complaints and incidents to include:

1. How to conduct robust systems analysis investigations.
2. How to ensure that the scope of investigations should go across all services involved in the incident or issue complained of.
3. How to ensure that the commonality of complaints and incidents (i.e. complaints are service user reported incidents) is recognised and the consequent need for common methods of identifying, managing, investigating and learning from them.
4. The importance of proceeding with HSE investigations when there are investigations by external agencies including but not limited to Professional Regulators, An Garda Síochána, legal proceedings etc. (As per the Memoranda of Agreement as outlined in recommendation 8 below)
5. How to conduct HSE investigations in a manner that is impartial, fair, evidence based and that does not prejudice future criminal and civil legal proceedings, or investigations by external agencies including but not limited to investigation by the Professional Regulators. (As per the Memoranda of Agreement as outlined in recommendation 8 below).

Recommendation 7: Governance Arrangements for Complaint and Incident Management Should Be Optimised.

This should include a review of HSE governance arrangements to ensure that suitable management and governance structures and processes are in place that satisfactorily manage risks and safety - including the management and investigation of complaints and incidents - within the structure and at the interfaces between health service structures.
Recommendation 8: Arrangements for HSE investigations when external agency investigations are ongoing or anticipated should be clarified.

This should include the development of Memoranda of Agreement (or an equivalent) between the HSE and external agencies that may have a role in investigating complaints and incidents, specifying exactly how the HSE might conduct investigations in order to balance the need to achieve HSE safety objectives with the need not to jeopardise concurrent or future investigations by such external agencies - including but not limited to investigations arising from criminal proceedings and investigations by the Professional Regulators.

Following development of these Memoranda of Agreement (or an equivalent) there should be:

- Communication of these Memoranda or the equivalent to the relevant personnel in the HSE
- Training of relevant staff on how to conduct investigations in order to balance the need to achieve HSE safety objectives with the need not to jeopardise concurrent or future investigations by external agencies as per the memoranda of agreement
- Evaluation of the effectiveness of these Memoranda of Agreement and associated training, including audit of compliance with the conditions as set out in these Memoranda of Agreement.

Recommendation 9: Healthcare Records Should be Enhanced

To ensure that healthcare records are enhanced, all relevant staff should be aware of and adhere to the HSE Standards and Recommended Practices for Healthcare Records Management QPSD-D-006-3 V3.0",28 in particular the guidelines contained in this document in relation to clinical records.

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28 This document can be accessed by HSE staff at the following link
Appendix 1: Terms of Reference for This Investigation

Terms of Reference
Review of care – [Patient’s Name]. RIP

Introduction

These are the terms of reference for an investigation commissioned by Mr. John Hennessy, RDO, HSE West into an incident/complaint that arose about the care delivered to the patient from the 21st November 2007 when he was brought by Ambulance to Ennis General Hospital to his discharge on 23rd November 2007 and his subsequent death on 23rd November 2007 at Regina House Kilrush and the subsequent management and investigation of the complaint / incident by the HSE.

Purpose of the Investigation/Review

The purpose of this incident investigation is to establish precisely what happened and what failures if any occurred in relation to the care and management of the patient and in particular from the time of the GP’s call to the Ambulance Service on 21st November 2007 to the time of his death on 23rd November 2007.

If systems failures are identified, a further purpose of the review is to identify the causes of these failures and the actions necessary to remedy these so as to prevent, or if prevention is impossible, to reduce the likelihood of recurrence of such failures as far as is reasonably practicable. The purpose of the investigation into the circumstances surrounding the incident is to:

- Establish precisely what happened to the patient and in particular from the time of the GP’s call to the Ambulance Service on 21st November 2007 to his admission to Ennis General Hospital, his subsequent care and management by Ennis General, Ambulance Services and Primary and Community Care Services in Regina House until his death on 23rd November 2007 so that the HSE can identify all lessons that can be learned from the experience so that the likelihood of recurrence is removed or reduced.

- The review will also examine the HSE’s response to the death of the patient in the context of its Risk Management Policies and Procedures and its statutory obligations. The review will also have regard to the explanations volunteered by the GP and Regina House staff following the death of the patient. It will also review the response of the complaint relating to the incident made to Ennis General Hospital on 10th December 2007.

- If during the course of its work the Review Team identifies any intentional plans, actions or issues of professional underperformance the commissioner of this review is to be notified immediately

- The Review Team will enlist any additional medical or professional expertise as required

- The review team will also have regard to the review already carried out by HIQA at Ennis General published in April 2009 and to the findings and recommendations arising from the Inquest held on 16th July 2009.
The Review Team will prepare a written report with its findings and any appropriate recommendations.

The Review Team will ensure that those affected by the incident (the patient’s partner and family) receive an explanation of the events leading up to the incident, the causes of the incident and the actions required to prevent future harm arising from these causes as far as is reasonably practicable.

Scope of the Investigation/Review

The scope of this investigation will primarily but not exclusively focus on the period from the 21st November 2007 when the patient was admitted to Ennis General to the time of his death in Regina House, Kilrush on 23rd November 2007. The Review Team will have access to the [patient's name]'s complete medical records in the event of requiring details of previous admissions etc.

The time frame of this investigation/review will be the shortest sufficient period of time to ensure the investigation purposes as outlined will be achieved. It is proposed that this investigation will be completed by the end of March 2011. The final timeframe will be stipulated and adhered to unless good and valid reasons for extending this timeframe become apparent during the review process. The patient's partner and family will be advised if there is to be any deviation from the proposed timeframe.

Investigation Team

The Investigation Team will consist of Ms. Cora McCaughan, Head of the Serious Incident Management Team (Lead Reviewer), Mr. John McElhinney, Clinical Risk Advisor, Sligo General Hospital.

The services of a Respiratory Physician and/or other necessary medical expertise as required will be sought through the Royal College of Physicians in Ireland. Any other external professional expertise required will be sought through the appropriate professional body with the approval of the commissioner of this review.

The review team will work in collaboration with the following representatives as required:

- Managers of the relevant services where the incident/complaint occurred.
- Consultants and other relevant Medical Personnel involved in [patient name]'s care.
- Any representative of any discipline as is appropriate given the circumstances of the incident/s being reviewed.
- Ennis General Hospital and Clare PCCC Risk Advisors,
- The patient [patient’s name]’s General Practitioner.
- The partner and family of the patient [patient’s name].

Investigation Method

The investigation will follow the HSE Investigation Procedure as per the Toolkit of Documentation for the Management of Incidents (2009) and will be cognisant of the rights of all involved to privacy and confidentiality; dignity and respect; due process; and natural and constitutional justice.
This will involve a review of all relevant Healthcare Records, documentation and interviews with all relevant personnel giving care to the patient [patient’s name] as well as his partner and family.

The investigation will commence following the first meeting with the service user and will be expected to be completed by the end of March 2011, provided some unforeseen circumstance does not arise.

Communications
The review team will communicate with HSE staff through the commissioner; and with the service user directly through Mr. Jim Reilly of Patient Focus.

Report
Following completion of the investigation, an anonymised draft report will be prepared by the investigation team, outlining the findings and identifying any actions required to remove or reduce, as far as is reasonably practicable, the risks identified by this investigation.

All who participated in the investigation process will be given an opportunity to give input into the draft report in the interests of natural justice, and for the purpose of ensuring that the report is accurate and correct.

This draft investigation report will then be provided to the partner and family of the patient [patient’s name] for comment.

Final Report and Action Plan
The final report of the investigation will follow the template for Incident Investigation Reports in Appendix 3 of the Systems Analysis Section of the HSE Incident Management Toolkit (2009).

Recommendations and Implementation
The report when finalised, will be presented to the Regional Director of Operations, HSE West, and Commissioner of the report. A copy will also be given to the relevant Hospital and Local Health Managers and to the patient’s partner and family.

Implementation of the recommendations will be undertaken by local managers who will oversee the implementation of the applicable recommendations.

Local managers will communicate nationally applicable recommendations to the appropriate National Director and National Directors will oversee the implementation of any nationally applicable recommendations.

These terms of reference have been agreed between the Review Team and the complainant.

Signed:

Signed:
### Appendix 2: Framework of Contributory Factors (Influencing Practice)

<table>
<thead>
<tr>
<th>Factor Types</th>
<th>Contributory Influencing Factors</th>
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<tbody>
<tr>
<td>Patient/Service User Factors</td>
<td>Condition (complexity &amp; seriousness)</td>
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<tr>
<td></td>
<td>Language and communication</td>
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<tr>
<td></td>
<td>Personality and social factors</td>
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<tr>
<td></td>
<td>Psychological, existing mental health condition, stress</td>
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<tr>
<td>Task and Technology Factors</td>
<td>Task design and clarity of structure</td>
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<td></td>
<td>Availability and use of protocols, policies, standards</td>
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<td></td>
<td>Policies etc. relevant, unambiguous, correct and realistic</td>
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<td></td>
<td>Availability and accuracy of test results</td>
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<td></td>
<td>Decision-making aids</td>
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<tr>
<td>Individual (Staff) Factors</td>
<td>Knowledge and skills</td>
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<tr>
<td></td>
<td>Competence – education, training, supervision</td>
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<tr>
<td></td>
<td>Physical, psychological and mental health illness</td>
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<tr>
<td>Team Factors</td>
<td>Verbal communication</td>
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<td></td>
<td>Written communication</td>
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<td></td>
<td>Supervision and seeking help</td>
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<tr>
<td></td>
<td>Team structure (leadership, congruence, consistency etc.)</td>
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<tr>
<td>Work Environmental Factors</td>
<td>Staffing levels and skill mix</td>
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<td></td>
<td>Workload and shift patterns</td>
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<td></td>
<td>Administrative and managerial support</td>
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<td></td>
<td>Environment – Physical and cognitive</td>
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<td></td>
<td>Design, availability and maintenance of equipment</td>
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<tr>
<td>Organisational &amp; Management</td>
<td>Organisational structure</td>
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<tr>
<td>Factors</td>
<td>Financial resources and constraints</td>
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<td></td>
<td>Policy, standards and goals</td>
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<tr>
<td></td>
<td>Quality &amp; Safety culture and priorities</td>
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<tr>
<td>Institutional Context Factors</td>
<td>Economic and regulatory context</td>
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<td>National health service executive</td>
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<td></td>
<td>Links with external organisations</td>
</tr>
</tbody>
</table>

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Appendix 3: References

Health Service Executive Mid-Western Area (2004) *Incident Reporting Policy and Procedure*

Health Service Executive Mid-Western Area (2005) *Healthcare Risk Management Strategy*

Health Service Executive Mid-Western Area (2005) *Disclosure Policy*

Health Service Executive, Regina House Nursing Unit (2008) *Guidelines on Oxygen Therapy Regina House Community Nursing Unit* Guidelines signed off by the Director of Nursing Regina House Nursing Unit.

Health Service Executive, RDO West (2008), “*Administration of Oxygen Therapy to Adult Patients*” Guidelines signed off by the HSE West Policy, Procedures and Guidelines Committee.

Health Service Executive (2009). “*Code of Practice for Integrated Discharge Planning*”

Health Service Executive (2009), *Tool Kit of documentation to Support the Health Services Executive Incident Management*.

Health Service Executive (2011), “*Standards and Recommended Practices for Healthcare Records Management*”

Intensive Care Society of Ireland, (2005) “*Transportation of the critically ill*”
