Report to the Department of Health and Families NT

On

Governance of Complaint Handling

And

Implementation of Open Disclosure

At

Royal Darwin Hospital

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Foreword

The catalyst for this report was adverse criticism of The Department of Health and Families (DHF) from the Health and Community Services Complaints Commission (HSCSS) report on their investigation into a sexual assault on an infant in ward 5 B of the Royal Darwin Hospital (RDH) in2006

The Minister for Health Dr. Chris Burns, in response to the recommendations of the report of HCSCC requested an independent consultant be engaged to review the governance of the complaints system, and to explore the options and make recommendations regarding the principles of Open Disclosure promulgated by the Australian Council for Safety and Quality in Health Care (ACSQHC)

The Terms of Reference required a report to the Minister and the Chief Executive of DHF summarising:

> "The findings in relation to the governance of complaints and prioritised recommendations to support system improvement.
>
> The findings in relation to implementation of Open Disclosure principles at RDH and prioritised recommendations to support progression.
>
> RDH current compliance with Australian Standard 4269 complaints handling"

This report does not look at security arrangements or the overall governance of RDH; other consultants have been engaged to review these matters.

The Royal Darwin Hospital (RDH) is an extremely busy hospital operating at or exceeding 100% bed occupancy most of the time. It is a diverse tertiary teaching hospital and operates a wide range of services in isolation from other hospitals of its kind. It has many unique features including a large indigenous clientele.

Despite its isolation, uniqueness, and past achievements, improvement is required in the area of quality assurance, complaints management, incident reporting and Open Disclosure.

The complaints handling policy statements for both internal and external complaints issued in October 2008 by The Department of Health and Families (DHF) satisfy the the Australian Standard 4269. The promulgation and implementation however does not satisfy either the Australian Standard or the DHF policies.

I am confident that individual officers of RDH handle complaints effectively, professionally and with appropriate compassion. The system however requires substantial improvement. There is break down in communication about complaints handling within RDH. The patient advocate and complaints manager is required to record all complaints and report monthly to the Safety and Quality Assurance manager so they can be analysed and forwarded to the Executive. It is widely accepted at RDH that the complaints Manager is not informed of many complaints as many are lodged in the divisions. Divisions are either unwilling or do not know they have a responsibility to notify complaints to a central point. Accepting complaints at the point of service and having them resolved there is commendable . It is essential however that these complaints be recorded at one point so they can be analysed and changes made to policy or procedures if warranted. It is a matter of urgency that RDH management issue a directive spelling out the detail of who does what, and how the recording and communication has to work

Despite the difficulties that exist at RDH timely and accurate responses must be achieved to the HCSCC

More education and training is required for the overall subject of consumer involvement, including encouraging complaints handling and Open Disclosure.

DHF has pursued a responsible strategy regarding Open Disclosure. There are a number of difficulties for the DHF to resolve before full Open Disclosure can be implemented.

The enactment of appropriate legislation to give qualified protection to health professionals is essential.

Education programs for all relevant staff needs to be developed and taught
A culture of confidence in clinical leadership at RDH and support from DHF executives needs to develop. Open Disclosure is about system improvement not about laying blame. DHF and RDH should take immediate action to move toward full Open Disclosure

Recommendations

1. That the General Manager issue an instruction to all relevant staff setting out how complaints are to be recorded and communicated to a central point.

2. That RDH ensure sufficient human resources are provided to the Safety and Quality Assurance Unit for the monitoring and analysis of Complaints, Incidents, and Open Disclosure events.

3. That the proposed software program for the Quality Assurance Unit for the tracking of complaints be procured and installed as soon as possible.

4. That the satisfactory completion of the RDH Orientation program be mandatory before staff commence operational duty

5 That staff have access to Orientation subjects through electronic equipment for interactive self learning

6 That a customer satisfaction survey be developed and used at time of separation

7 That a brochure be developed on where and how to make a complaint, suitable for public distribution

8 That a permanent appointment be made to the Director of Nursing position

9 That DHF and RDH immediately set in motion actions to implement the provisions of the Open Disclosure Standard

10 That action be taken to have legislation enacted to provide appropriate legal protection for staff during reviews of adverse events

11 That a comprehensive program of education and training be developed for all staff including Aboriginal Liaison Officers on complaints handling, incident reporting, and Open Disclosure

12 That RDH establish a quality assurance process to monitor and evaluate compliance with the Open Disclosure Standard

13 That the record and evaluation of events be consistently reported to the Governance of the hospital

A brief snapshot of

Royal Darwin Hospital

The Royal Darwin Hospital (RDH) has many unique features; it is an extremely busy hospital operating at over 100% occupancy for most of the time. The number of public patients per 1000 weighted population is more than twice the National average. It is a diverse tertiary teaching hospital and operates in isolation from other hospitals of its kind

It is not possible to put up a "full house" sign so ambulances can by pass them to another similar hospital; professional staff do not have colleagues in a similar institution to discuss matters of like interests or to collaborate on services.

It has a multi cultural clientele approximately 60% of which is indigenous and approximately 70% of whom are from isolated rural areas; arguably the sickest population group in Australia. Doctors feel inhibited in making early discharges because they know their patients are not going home to a satisfactory home environment for convalescence or able to make a quick return to hospital if a relapse were to occur.

It provides a wide range of services probably more than that required of any other hospital servicing a similar size population.

It has a proud record of clinical achievement and is currently recognised for its outstanding ability to deal with both domestic and international crises.

Despite the isolation, uniqueness and past achievements there is need for improvement in quality assurance, complaints management, incident reporting and Open Disclosure.

Health Complaints 6

Complaints offer an opportunity for health services and particularly hospitals to receive feed back from consumers and their carers or significant others. Staff of these services needs to be open to frank discussion with their consumers and provide honest feed back to the complainants in a timely and appropriate way.
The Australian Standard 4269 states that:

> "For effective complaints handling, there needs to be commitment at all levels within the organisation. It is particularly important that this is demonstrated at, and promoted from, the organisations highest level. A commitment to responding positively to complaints should cover both internal and external complaints, allowing staff and consumers to contribute to the improvement of the organisation's services or products. This is an essential prerequisite for the development of an organisational culture which acknowledges the consumer's right to complain and which actively solicits consumer feed back.
>
> This commitment should be reflected in the adoption and dissemination of documented policies and procedures for the resolution of complaints. Management commitment is also demonstrated in the provision of training."

The Complaints Handling policy statements of the Northern Territory Department of Health (DHF) and Families issued in December 2008 for both internal and external complaints supports the thrust of this document and commences with the following statement;

> "this policy affirms the right of Department of Health and Families (DHF) service users to provide feed back about our services and to have complaints heard and resolved"

The policy continues to cover the necessary Principles, Scope and Training that would be essential for satisfactory complaints handling.

However, it is one thing to have a written policy in place but quite a different matter to ensure that the implementation is satisfactory.

Internal "incidence" and "near miss" reporting is also fundamental to quality service provision and requires a trusting Clinical governance culture lead by consistent and strong leadership. The absence, until recently, of a fulltime Director of Medical Services and only acting Directors of Nursing and recent appointment of the Manager of Quality Assurance Unit does little to inspire confidence that this has been the case in recent times.

One description of the complaints system given to me at Royal Darwin Hospital (RDH) was "not working: chaotic: bizarre" It became clear on further investigation that this description was not about how the complaints were handled at the coal face, more a description of a breakdown in communications regarding complaints and a lack of an effective understanding of the intended system.

I am sure the handling of complaints by the designated Complaints Manager is handled effectively and professionally with appropriate compassion. However many complaints are not seen by her or communicated to her for recording and notification to senior executives.

Many complaints are received and resolved in the program divisions. This procedure is appropriate, as it is desirable for complaints to be resolved at the point of service. Effective resolution at the point of service usually results in greater satisfaction for the complainant and allows changes to procedures to be made or recommended within the Divisions, however there is an essential need for all complaints to be recorded and monitored to their resolution by a central point to facilitate system change if warranted

A clear instruction from the General Manager setting out the role and function of the complaints Manager and the Co-Directors of Divisions in regard to the handling of complaints, including the need for Co-Directors to inform the Complaints Manager immediately a complaint is received. This action does not absolve the Division from resolving the complaint in a timely and compassionate way. They may however receive assistance from the complaints officer in processing the complaint if required.

One of the roles of the Complaints Manager is to provide Management, through the Quality assurance Unit with a comprehensive record of complaints. The Quality Assurance Unit is then able to analyse the complaints so as to recommend changes to policies or procedures if deemed desirable.

There appears to be an overly defensive attitude taken by many staff regarding complaints. Action needs to be taken by way of education and training to overcome this attitude. Complaints need to be encouraged as a means of receiving consumer feed back so services can be improved.

More education is required at orientation sessions and more staff should attend orientation. The Annual Report of DHF on Orientations contained the following statement;

> "3068 new employees commenced in 2007-08 and of these, 1158 participated in orientation programs across the NT"

That is to say 63% of staff did not attend an orientation session. It could safely be assumed that many of these would have been RDH staff and this was confirmed by discussions with staff who acknowledge the difficulties of getting staff to attend orientation after they have commenced work in the wards.

Steps should be taken to make orientation mandatory before staff commence operational duty. Interactive CDs should be developed for those who have not attended orientation and for refresher training from time to time.

It is understandable that health professionals want to spend most of their time on their clinical expertise, but consumer participation should improve clinical outcomes. Consumer feed back needs to be recognised as an essential part of core business

Consumer feed back should not be limited to complaints as there is certain to be an enormous number of satisfied consumers of services from RDH A system of Customer Satisfaction surveys should be developed and implemented. Elements that these surveys should include would be: an appropriately designed Pamphlet that would include an explanation that suggestions and complaints would be valuable to RDH so that services can be continually improved. Provision for complimentary remarks, for suggestions that consumer's feel they would like to make but not to complain about. It would need to include a clear statement that consumers are free to make complaints and that staff will assist them to do so if required.

A pamphlet of this nature should be given to the patient or carer or significant other person on admittance to the hospital and on separation, This is not a new idea, major hotel chains do it all the time, however hospitals are required to encourage and make it easy for consumers of their services to complain. Both national standards and departmental complaints policy are clear on this point.

Indigenous people make up about 60% of the patient population of RDH at any one time, approximately 70% of these come from rural areas, all of whom English would be a second or third language and most of whom would only have a superficial understanding of the concepts of the language. Their needs should be given special attention. Indigenous people are grossly under represented in the complaints figures. The exact figures are not available; however less than 5% of complaints are received from 60% of the population of RDH.

The Manager of Aboriginal Liaison Unit told me that Aboriginal Liaison Officers (ALO's) are not permitted to take complaints. Faced with a potential complaints situation the ALO's tell the consumer to go to the complaints office on the first floor to make their complaint. This is not in the spirit of encouraging complaints. The Complaints Manager however said ALO's are able register complaints and have done so in the past.

It is also in the national Standards that a consumer should only be required to tell their story once. The rural aboriginal is already out of his or her comfort zone by being in a complex institution that they do not understand, they are unlikely for a host of reasons to go to another office and tell their story to a white stranger. ALO'S should be able to accept complaints and should receive whatever additional training that may be required to do this effectively.

An illustration of the reluctance of indigenous people to complain is the case of sick women and her escort from Arnhem Land who was sent in for admittance and treatment at the hospital, arrived at 11AM waited all day to be admitted until 10PM she then told the hospital she could not wait any longer and needed to lie down and sleep. She left the hospital and stayed at a hostel for the night returning the next morning only to be told that she would have to go through the entire procedure again to get a bed. Later that day she told the Manager of Aboriginal Liaison Unit that she could not take any more and returned home to Arnhem Land without having received the treatment the Rural Doctor had recommended. She would not go to the first floor to make a complaint and the ALO could not accept the complaint herself. This is an unacceptable process, not to mention the social and financial cost for no benefit.

However The Complaints Manager refutes that a complaint was not lodged. One thing is certain about these contradictory statements: i.e. that better communications are needed and that more training is required.

Open Disclosure

Open Disclosure is the frank and honest discussion between patients, their carers and health providers about an adverse event, resulting in harm to the Patient, during treatment. It is surrounded by many complex issues not the least of which is the perceived risk of litigation.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed a standard for Open Disclosure.

The Australian Health Ministers Council in April 2008 agreed to work towards open disclosure but requested the ACSQHC to do further research on 100 case studies to firm up the already known benefits.

The ACSQHC in their document Open Disclosure Standard say;

> "In working towards an environment that is as free as possible from adverse events there is a need to move away from blaming individuals to focussing on establishing systems of organisational responsibility while at the same time maintaining professional accountability. In this context, health care organisations need to foster an environment where people feel supported and are encouraged to identify and report adverse events so the opportunities for systems improvement can be identified and acted upon."

The DHF did not participate in the 2007 pilot study in 40 facilities in 7 jurisdictions and the private sector. However the DHF has actively investigated the implications of Open Disclosure for the NT since the Australian Health Ministers Council decision in April 2008'

The pilot study of 2007 demonstrated that the Open Disclosure Standard is robust, practical and of value to health care practitioners and consumers, but did not include significant numbers of indigenous patients or patients who have English as a second language.

In conjunction with the Australian Commission on Safety and Quality in Health Care (ACSQHC), DHF has been working on identifying key issues and developing an Open Disclosure model, which will address the cultural needs of indigenous clients as well as people of other cultures.

In support of this aim The Commissions Principal Medical Advisor and a senior policy officer who have the responsibility to progress Open Disclosure nationally, were invited to the NT to explore a range of issues in implementing Open Disclosure in the NT.

In company with a senior representative of the DHF they made an extensive tour of rural areas. In East Arnhem Land the team visited three communities in the Yolngu Homelands accompanied by the Gove Hospital Quality Manager and Aboriginal Health Worker

The team met with Aboriginal Health Workers, Aboriginal Liaison Officers, and quality managers and interested clinical staff in each region, seeking feedback in relation to the level of support for Open Disclosure in the NT. At the same time gathering information on the issues which might surround the introduction of Open Disclosure for indigenous communities.

I am advised by the DHF senior officer involved that feedback from these discussions were positive, however concerns over a number of cultural issue were raised including;

> "Pay back- there was concern that unless there was very clear communication, the injured person might think that the aboriginal person interpreting was involved in the error and may then attract Pay Back;
>
> Many indigenous people have large and complex families who may all wish to be involved in the disclosure process.
>
> A significant level of training would be required for Aboriginal Health Workers and interpreters
>
> Concern was raised about the impact in relation to the complex belief systems of some indigenous people. Eg. Many Yolno people of East Arnhem Land believe that evil spirits make them sick and that clinical staff use magic to make them well,
>
> There were also concerns of medical staff regarding the impact of Open Disclosure on their relationships and trust with their aboriginal patients.
>
> Some Aboriginal Liason officers in Darwin felt strongly that disclosures should be accompanied with compensation."

Commission staff also met with interpreters from a variety of different cultures in Darwin who pointed out a number of other issues. For example in Thai culture, where an elderly patient is involved in an error, it would be inapropriate to make a disclosure to them. This should be made to the person's children who then decide if the parent should be told.

Despite the difficulties and complexities of the subject it is essential that DHF move to implement Open Disclosure as soon as possible

Not to engage in open and honest dialogue is costly in social, emotional and financial terms, as the Monash University's Centre for Health Economics emphasise with the following statement concerning the severity of adverse events in Australian hospitals.

> "With preventable deaths reportedly occurring at a rate equivalent to a Bali bombing every 3 days."

There are many other examples in the literature which indicate the high costs of adverse events and some research which suggests much lower costs resulting from litigation where Open Disclosure has occurred.

Some criteria for moving DHF forward to implementing full Open Disclosure are:

> One of the essential actions for the NT government to ensure that health professionals cooperate fully in the implementation of Open Disclosure is to enact Qualified Privilege legislation which would give Doctors and other Health Professionals the confidence to make disclosures without fear of litigation. This type of legislation would not absolve them from action brought about by negligence.
>
> A rigorous and wide spread education program needs to be implemented across the DHF to ensure that a culture of honesty and openness toward patients is developed.
>
> There is also a need for a culture of support and sharing of information among colleagues rather than a blaming environment.
>
> Leadership in this must come from the top management down. Clinical leadership has been lacking at RDH for some time. RDH has functioned without a fulltime Director of Medical Services. A recent appointment to this position looks promising. The senior Quality Assurance Officer has only been in place since August 2008 and the permanent appointment of a Director of Nursing has not been completed at the time of writing.
>
> Health Professionals need to become confident of senior executive support rather than a blaming culture, bearing in mind that most errors come from systematic breakdown rather than individual error.
>
> Studying closely the outcomes of the 100 case studies currently being carried out by ACSQHC and from this develop a fact sheet for professionals guidance

It is premature at this time to recommend the immediate implementation of full Open Disclosure. It is not too soon to recommend progressing rapidly to that end. The best beginning to Open Disclosure is for clear honest discussion between Doctor and patient about a particular treatment before treatment begins.

In compiling this report the following people have been consulted

Dr. David Ashbridge	Chief Executive	DHF
Penny Parker	Quality Manager Acute Care	DHF
Louise O'Riordan	Clinical Safety and Quality Management	RDH
Sally Bates	Secretary Governance Group	RDH
Dr. Peter Satterthwaite	Chair Governance Group	RDH
	Director Medical Services and Education	RDH
Maureen Brittan	Act/Director of Nursing	RDH
Jill Macandrew	Senior Director Office of Chief Executive	DHF
Dr. Len Notarus	General Manager	RDH
Robyn Harrison	Patient Advocate and Complaints Manager	RDH
Janet King	Support Services Quality Coordinator	RDH
Peter Beirne	Executive Director Acute Care	DHF
Carolyn Richards	Commissioner, Health and Community Services Complaints Commission	HCSCC
Dr.. Lesley Barclay AO	Professor Health Services Development	CDU
Dr. G.A.Goodhand	General Practice (medical)	P.P.
Dr. Paul Bauert	Director Paediatrics	RDH
Jan Evans	Deputy General Manager	RDH
Suzanne Cameron	Complaint and Sentinel Event Coordinator	DHF
Margie Rajak	Manager Aboriginal Liason Unit	RDH
Mary Mc'Carthy	Hospital Chaplain	RDH
Sharon Sykes	Co Director (nursing) Division of Surgery and Critical Care	RDH

Legend

DHF	Department of Health and Families
RDH	Royal Darwin Hospital
HCSCC	Health & Community Services Complaints Commission
P.P.	Private Practice
CDU	Charles Darwin University

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Northern Territory Hospital Network DHF

Better Practice Guidelines Complaints Management
For Health Care Services July 2004 ACSQHC

Update Australian Commission on Safety and Quality in Health Care

Code of Health and Community Rights and Responsibilities HCSCC

Corporate Governance Management Environment Sept 2008 DHF

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(Outcomes regarding safety and quality accreditation reforms)

Leading Clinical Governance in Health Services 2005 VQC
(The Chief Executive officer and Senior Manager Roles)

Better Complaints Management Policy and Guidelines 2002
By Robyn Harrison DHF

Monash University – Centre for Health Economics 2007 MU

References Cont.

Legend

ACSQHC	Australian Council for Safety and Quality in Health Care
DHF	Department of Health and Families
MU	Monash University
VQC	the Victorian Quality Council
AHMC	Australian Health Ministers Council
ACSQH	Australian commission for Safety and Quality Health Care
HCSCC	Health and Community Services Complaints Commission