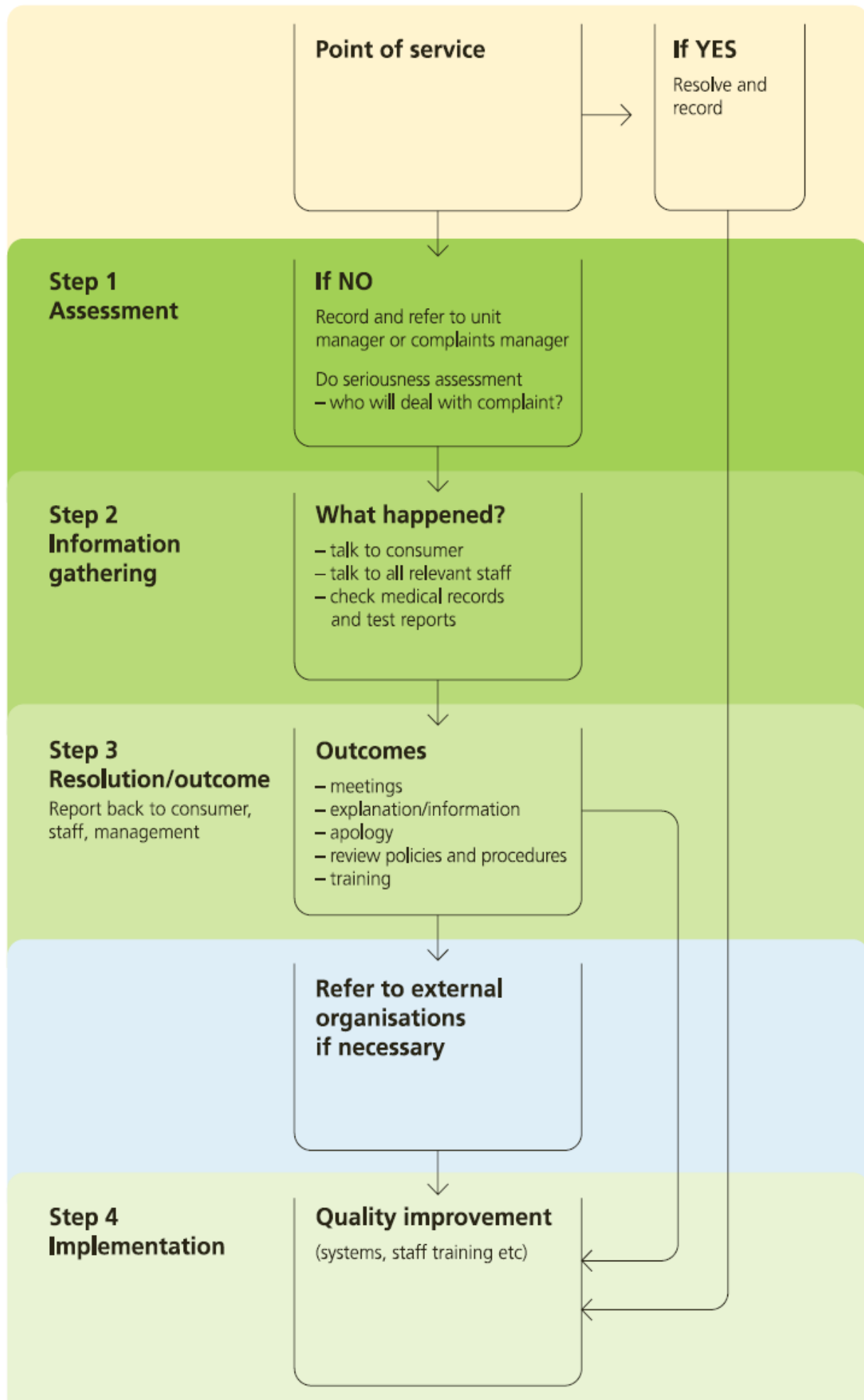


Flow chart of complaint management



CHECKLIST FOR COMPLAINTS REQUIRING INVESTIGATION

Step 1: Assessment

- The seriousness of the complaint or problem needs to be assessed – this can be done using a seriousness assessment matrix.
- The organisation needs to decide who will do this assessment. Ideally it can be done by the staff member who receives the complaint – the assessment can then be reviewed by the complaints manager. Some organisations may prefer the unit manager or complaints manager to do the seriousness assessment.
- The seriousness assessment will determine:
 - who will deal with the complaint, and
 - who needs to be notified.
 - Generally complaints should be dealt with by the unit involved, with support from the complaints manager.
 - For more serious matters or those with broader implications for the organisation, senior management and the Board will need to be notified at least and possibly also participate in the resolution.
 - If a software system is used for the matrix and incorporated into the organisation's computerised data collection system, it will automatically notify the designated senior staff. Otherwise, this can be done manually.

For the purposes of Ms Murray's Complaint:

- The seriousness of the complaint has been assessed using a seriousness assessment matrix (SAM). At the last meeting which was interrupted due to unavoidable circumstances, the group had assessed the complaint using the SAM and reached agreement that the complaint was serious and warranted investigation.
- The Complaints Manager, the ED Director and the nurse manager of ED also determined that:
 - The Complaints Manager will deal with the complaint with their support.
 - As well as the executive management, the Complaints Manager and the managers in the ED (who already know about the complaint), the quality team, Director of Medical Services and Director of Nursing are also notified because of the clinical issues involved.
 - A Root Cause Analysis investigation will not be undertaken at this stage.
- The complaint has been entered into the Complaints Register.

Step 2: Information gathering

- ***Approach***
 - Keep an open mind when gathering information.
 - Don't make assumptions about what has happened and don't draw conclusions until all the information is assembled.
 - The complaints system is non-punitive.
 - When analysing what went wrong or why there is a problem, systems should be examined to see how changes can be made and how individuals can be supported to prevent recurrence.

- ***Talk to the consumer***
 - Talk to the person who has made the complaint to ensure there is clear understanding of all aspects involved and of what the complaint is about.
 - It is important at this stage to make sure that you have the consumer's 'story' as they present it.
 - Take it down as they say it, without filtering or interpreting the information, to get a complete picture of the consumer's perspective and the context of what happened.
 - Ask questions to clarify or expand on what they have told you.
 - The consumer should also be given the chance to ask questions.
 - Explain to the consumer how the complaint procedure works, what will happen next, who will get back to the consumer, and how long it is likely to take.
 - In some cases it may also be useful to refer them to a support/advocacy group.
 - When talking to the consumer it is important for the staff member not to be defensive and to maintain a courteous and professional approach.

- ***Keep the consumer informed***
 - When dealing with a complaint that involves some investigation and gathering of information, keeping in regular contact with the consumer is important.
 - If there are a number of different personnel to get information from, this may take time. If so, contact the consumer, by telephone if possible, to let them know what is happening and where the complaint process is up to.
 - Be direct and as honest with them as possible.
 - Most people understand that delays are inevitable, but they need to know that action is being taken.
 - Even if there is no progress, a regular telephone call can go a long way towards establishing good faith and will help resolve the complaint in the long run.

- ***Talk to the staff***
 - Ensure all relevant people are consulted about the complaint, while protecting the confidentiality of those involved.
 - Keep accurate records of the steps in the investigation, including all discussions, information gathered and conclusions reached.
 - A successful investigation is conducted objectively, with an open mind and without bias. This means focusing on the facts of what happened, rather than relying on people's feelings or interpretations.

- However, remember that any staff members involved may be feeling a degree of anxiety or stress about what has happened, depending on the circumstances.
 - This will be helped by giving them the opportunity to explain their perspective fully and clearly.
 - Staff need to be listened to and supported.
 - Sometimes information received from different staff members will be inconsistent. It is common for different people to have different perceptions of the same event. The person investigating the complaint needs to bear this in mind.
- ***Be efficient***
 - Try not to let the investigation drag on.
 - Timely resolution is good for both staff and consumers.
 - Set timelines at the outset and try to stick to them.

Step 3: Resolution/outcome

- Resolving a complaint should be seen as a joint problem-solving exercise. Once all the relevant information is to hand, discuss options for resolution with staff and the consumer. These may include:
 - **meetings** between the patient, their family and staff. For some complaints, more than one meeting is needed.
 - **an explanation** – giving information to consumers can go a long way towards resolving complaints and is consistent with open disclosure principles. Ensure the explanation is factual and understood by the consumer.
 - **an apology** – staff do not need to be afraid of apologising for mistakes – an apology is not the same as an admission of liability and it can be a powerful aspect of complaint resolution.
 - **an undertaking to review** policies and procedures with a view to improving outcomes. It can be helpful to analyse what happened and why by gathering together key staff members. This will help identify resolution options and any policy or procedural changes needed. It is most important that staff be involved in complaint resolution and given the opportunity to suggest systemic changes that may be required.
- The organisation needs to decide what it considers a realistic outcome, balancing the needs of the consumer against the needs of the organisation as a whole. Take into account what the consumer wants, while recognising what is reasonable. Use the complaint to make practical changes that will benefit all patients.
- ***Outcomes involving individual staff***
 - Although the focus is on systemic issues, the role of the staff cannot be ignored.
 - The individuals concerned should be encouraged to talk about what is happening and offered support if needed. There is help available for professionals who are having problems at work, eg employee assistance schemes and medical defence organisations offer counselling, communication training etc.

- If there are concerns about the professional conduct of an individual, consider also the need for referral to the relevant registration body

Tips for successful resolution:

- ❖ Do not become defensive.
- ❖ Be flexible and problem-solving in approach.
- ❖ Approach it as a joint problem.
- ❖ Identify the consumer's key issues and concerns.
- ❖ Identify any constraints to your power.
- ❖ Look for outcomes that will satisfy both parties.
- ❖ Try to establish objective principles, without rigidly rejecting the consumer's subjective concerns.

Step 4: Implementation

- Ensure that the outcome is clearly communicated to the consumer, staff and management, and that it is integrated into quality improvement systems. The following should be done:
 - Enter the resolution/outcome into the relevant complaints data collection tool.
 - Implement any actions decided on as part of the resolution.
 - Provide information to quality improvement teams, risk managers and managers of relevant training programs.
 - Provide information on complaints and outcomes to senior management, including the Board of management.
 - Monitor effectiveness of outcomes.
 - Report back to the consumer, family member or friend who made the complaint. Tell the consumer about any specific changes that the organisation has made as a consequence of their complaint and how the effectiveness of outcomes will be monitored.
 - Ensure that any changes identified by quality or risk management teams are communicated adequately to staff and are implemented and monitored.

In a small community, the organisation may sometimes need to inform the public about general changes to procedure or approach, in order to retain the community's support or restore confidence in the organisation.

Open disclosure principles

1. **Openness and timeliness of communication** – information should be provided in an open and honest manner.
2. **Acknowledgement** – adverse events should be acknowledged to the patient and their support person as soon as practicable.
3. **Expression of regret** – the patient and their support person should receive an expression of regret for any harm from an adverse event as early as possible.
4. **Recognition of the reasonable expectations of the patient and their support person** – they can expect to be fully informed, to be treated with empathy and respect, and to be given support.
5. **Staff support** – staff should be encouraged to recognise and report adverse events and supported through the open disclosure process.
6. **Integrated risk management and systems improvement** – investigations should focus on the management of risk and on improving systems of care.
7. **Good governance** – adverse events should be analysed and there should be a system of accountability so that changes to prevent recurrence are implemented and their effectiveness reviewed.
8. **Confidentiality** – the privacy and confidentiality of patients, carers and staff should be protected, in accordance with state and federal law.

adapted from *Open Disclosure Standard: A national standard for open communication in public and private hospitals, following an adverse event in health care*, Australian Council for Safety and Quality in Health Care, July 2003

About Open Disclosure ...

- The National Standard on Open Disclosure has yet to be endorsed by the Australian Health Ministers and continues to be trialled around Australia.
- Open disclosure is about clear communication between clinician and patient.
- In general, it is the ethical and legal responsibility of a treating clinician to inform a patient of matters which may have an adverse outcome on the patient's health. Exceptions to this ethical and legal responsibility are very limited and are only legitimate when it can be demonstrated that such information may do the patient harm.

How it can be done...

1. Expression of regret or apology
(does not create liability)
2. Known clinical facts
3. Patient's questions/concerns
4. Discussion of ongoing care
5. Any side effects to look out for
6. What happens next
(investigation of the adverse event and feedback)
7. Contact details in case of further concerns or questions

Keep the consumer informed

- Let consumers know what is happening & where process is up to
- Be direct & honest as possible
- Most people understand that delays are inevitable, but need to know that action is being taken
- Even if no progress, a regular telephone call can go a long way towards establishing good faith & help resolve the complaint in the long run

49 Sunnyside Street
Jeribombera Vic 1234
14 June 2006

Dear Ms Bellamy

I had the misfortune to have to use the services of your hospital when my young son Kyle got the gastric badly, a month ago.

We arrived at your emergency department at 6.30am on 15 October this year. There was hardly anyone in the waiting room.

I went up to the desk and told the woman there that my son had been vomiting all night had now got really bad diarrhoea and was really sick.

She told me to sit down and the triage nurse will call you in soon.

After sitting there for 20 minutes with Kyle in my arms I went up to the desk again and asked when the nurse or doctor can see us. Kyle was whimpering and still dry reaching and I was getting more and more worried. He is normally such a placid little one and happy. He has hardly ever been sick.

The woman at the desk said that the staff were really busy with really sick people and they will be out to see you as soon as possible. I got really upset and told her to get a doctor now; my baby can't wait any longer.

She told me to sit down and she would call someone.

I could here laughing and talking out from behind where the woman was sitting and it didn't sound like the staff were that busy. I felt like I did not matter and I was getting more and more angry. I was crying. I was so upset.

I heard the woman saying to someone when she disappeared that 'you'd better come and see this woman, she is getting toey. Her baby is sick.'

A nurse came out within a very short while and told me he was the triage nurse and took me into an office where he asked me what Kyle's problem was. When I told him I had been waiting about half an hour he apologised and said he was very sorry we had to wait that long. He then looked at Kyle and asked me questions.

He looked worried when I told him that Kyle had been vomiting all night and he could see himself that Kyle was very sick. He said he would go and tell the doctor. He was back very quickly and he took me to a cubicle where a doctor arrived within a couple of minutes.

My sense of relief was short lived. This is where the nightmare began.

The doctor looked as though he was 16 he didn't listen to a word I said although I was trying to tell him just how sick Kyle was. The doctor ripped Kyle's clothes off roughly and seemed to get cross when Kyle started to cry. He kept saying that all babies get tummy bugs and they are as good as gold within 24 hours and that 'there is no need for this child to be admitted to hospital. Just make sure he drinks lots and no food until the diarrhoea and vomiting stop.' He gave me a brochure on children and gastroenteritis and told me to read it.

I was surprised that he only felt Kyle's tummy, didn't take his temperature nor undo his nappy.

I kept saying to him I have never seen Kyle so sick. I can't take him home as I am really worried. He said he could understand my distress but insisted that there was nothing more that the hospital could do. I begged him to keep him in just for the day so they could watch him and see what I meant. He said all parents get overanxious about their children when they are sick and all they need to do is relax.

I rang my partner very distressed and asked him to pick us up from the hospital. We got half way home and Kyle went really funny in his car seat. He went all rigid, his eyes rolled back into his head and then he went floppy. I screamed at Darren to turn around and go back to hospital.

We went straight to the emergency department through the door to where the doctors were. The same doctor came up to us and I screamed at him "go away I don't want you touching my child again". Another, older, woman came up, said she was a doctor and asked what was wrong.

I was hysterical by this time and I could only hold Kyle out and say he's really sick. She took him took one look at him and said we need to look after this baby.

She was fantastic. After Kyle had a drip and woke up a bit he went up to children's ward where he stayed in isolation for five days.

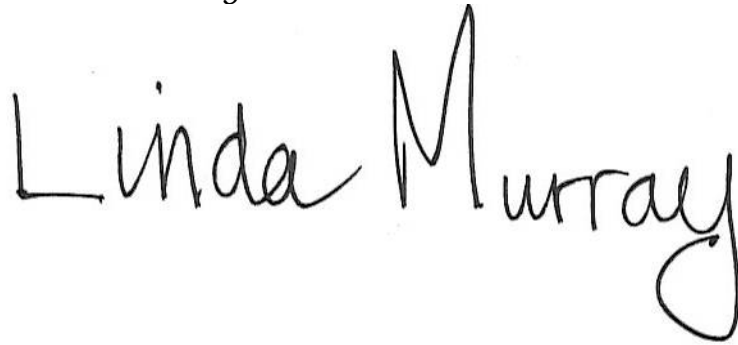
I am writing this letter because when I tried to talk to the head of the emergency department about what happened I didn't feel they were very understanding. I am writing this letter so that something is done, so that other parents do not have to go through what we went through.

We are lucky that we have Kyle with us today. If it hadn't been for Dr Jackie Townsend I think he would have died.

I feel a bit sorry for that young doctor he obviously knows nothing about young children and how well there mum's know them. But, he should have listened to what I was telling him.

I want to know what you are going to do about the young doctor and your emergency department to stop this happening again.

Yours sincerely

A handwritten signature in black ink that reads "Linda Murray". The script is cursive and fluid, with a large, prominent 'M'.

Linda Murray

**Investigation Findings Relating to (some of) the Issues Raised in a
Complaint from Ms Linda Murray
Jeribombera Hospital – 30 July 2006**

- The triage process was not functioning according to the health service's procedures when Ms Murray and Kyle Murray arrived at Jeribombera Hospital on 16 May 2006.
- The procedures require that an appropriately experienced, skilled and qualified registered nurse be located in the Triage Station in the ED waiting area.
- In this case Kyle and Ms Murray experienced a 30 minute delay in triage due to:
 - The rostered Triage Nurse had left work at 5am after a call notifying her that her father had had a serious fall and was currently being transferred from the nursing home to another local hospital.
 - The senior nurse on duty, after consultation with the night nurse manager, attempted to cover this 2 hour gap in the roster by rotating other ED staff out into Triage as the need arose.
 - The ED clerk at the ED Reception was requested to contact staff when a new patient presented, for this 2 hours.
 - The ED clerk advised that she had left a note in the staff station notifying them of Kyle and Ms Murray's arrival as all staff were with patients in the cubicles. She did not feel comfortable interrupting their work. She knew there had been a number of serious presentations during the course of that shift and staff were 'stretched thin'.
 - On the second occasion the ED clerk left her station and informed the new resident doctor that she met at the staff station that there was a very distressed mother and sick baby who had been waiting in the ED waiting area for about 20 minutes without being seen by Triage.
 - The doctor said he would be out to see them as soon as possible.
 - It was another 10 minutes before a nurse came out and assessed Kyle as requiring immediate medical attention.
- Ms Murray's allegations concerning the behaviour and clinical assessment of Dr Roberts were supported by: information in the health care records; staff who witnessed at least some of the exchange; as well as the doctor's own account of the consultation:
 - He did not introduce himself.

- He did not incorporate the views, concerns and opinions expressed by Ms Murray into his clinical assessment and decision making about Kyle's condition.
- There were significant concerns raised about the adequacy of Kyle's clinical assessment and the advice given to Ms Murray.
- The decision to discharge a seriously ill infant was not appropriate given the history and presentation.
- The allegation that Dr Roberts had handled Kyle roughly was not supported by information provided by Dr Roberts and RN Jefferies who witnessed the examination.
- The investigation identified problems in the organisation's scheduling of orientation for new clinical staff such as Dr Roberts. He was working his third shift in the hospital ED, without access to a suitable supervisor; and without knowing how to access all the clinical resources he required to do his work safely.

Marie Benton
Complaints Manager

David Pendleton
Nurse Manager – Emergency Department

References & Resources

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Health Services Review Council

Complaint handling in health services

A full day seminar for frontline staff and complaints officers

**An Education Package for Health Services
TRAINER'S RESOURCES**



March 2007

Prepared by

**The Health Services Review Council of Victoria
with the assistance of Amanda Adrian and Susan Bunting
with funding from the**

Department of Human Services and the Victorian Managed Insurance Association

Contents

1. Introduction
2. Adopting a systematic approach to complaints including the use of the Serious Assessment Matrix, and the steps of assessment, information gathering, resolution and implementation
3. Case Study
4. An understanding of the skills and techniques used in managing complaints including negotiation, problem solving, barriers to communication, and understanding and resolving conflict

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Step 1: Assessment – 15 mins</p> <p>SAM is a complaint and incident assessment tool that supports a non-punitive and learning approach to risk minimisation. The tool may be incorporated into the computer system or used manually.</p> <p>The events of the incident or complaint are analysed across two axes – the probability of the events occurring in the future and the seriousness of the events. A seriousness/probability score (SPS) is obtained. The SPS gives staff a guide to what level of response is appropriate.</p> <p>The organisation determines who completes the SAM assessment. It could be the complaints manager or the person who received the complaint, for instance. If using SAM in electronic form, once complaint is assessed, the system automatically flags action or information to designated staff.</p> <p>Let's explore the seriousness dimension in more detail. Key factors in determining seriousness include extent of injury, length of stay, level of care required, actual or estimated resource costs and impact on quality health care service delivery. You will note the consequences to the person or organisation escalate as we move from the minor to catastrophic categories.</p> <p>The probability categories display an escalation of consequences from remote to frequent. The person completing the matrix relies on her/his experience when determining which category is relevant. When reviewed by the complaints manager or a senior member of staff the category may be changed when supported by knowledge of other similar incidents. The probability score will show what action is needed. Read through each of the four categories and note the action required.</p>	<p>14</p> <p>15 – SAM Matrix</p> <p>16 – Seriousness categories</p> <p>17 – Probability categories</p> <p>18 – Seriousness/probability score</p>		<p>pp. 47-50</p>

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Step 2: Information gathering – 20 mins Planning the approach to information gathering for this complaint – who, how and timeline – whole group – led by facilitator Identify who would provide the information, in what form and the timeline for the process. Also identify an approach to information gathering, factors to consider when talking with consumers and staff and ensuring the process is efficient.</p> <ul style="list-style-type: none"> ● Approach <ul style="list-style-type: none"> ○ Keep an open mind when gathering information. ○ Don't make assumptions about what has happened and don't draw conclusions until all the information is assembled. ○ The complaints system is non-punitive. ○ When analysing what went wrong or why there is a problem, systems should be examined to see how changes can be made and how individuals can be supported to prevent recurrence. ● Talk to the consumer <ul style="list-style-type: none"> ○ Talk to the person who has made the complaint to ensure there is clear understanding of all aspects involved and of what the complaint is about. ○ It is important at this stage to make sure that you have the consumer's 'story' as they present it. ○ Take it down as they say it, without filtering or interpreting the information, to get a complete picture of the consumer's perspective and the context of what happened. ○ Ask questions to clarify or expand on what they have told you. ○ The consumer should also be given the chance to ask questions. ○ Explain to the consumer how the complaint procedure works, what will happen next, who will get back to the consumer, and how long it is likely to take. ○ In some cases it may also be useful to refer them to a support/advocacy group. ○ When talking to the consumer it is important for the staff member not to be defensive and to maintain a courteous and professional approach. 	<p>19</p> <p>20</p> <p>21</p>		<p>p. 19</p>

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p><i>Open disclosure</i></p> <p>Open disclosure is a process integral to complaints management. Repeated phrases: Just wanted someone to say sorry; don't want it to happen to anyone else. Open disclosure and complaints seek to deal with these concerns.</p> <p>Open disclosure is the primary responsibility of the treating clinician: usually not undertaken by complaints staff or managers.</p> <p>Hand out a copy of the National Guideline. Go through the brief steps of 'doing' open disclosure. Stress how they relate to good clinical practice and ethical responsibilities. Reiterate that open disclosure should not be undertaken by complaints staff or managers.</p> <ul style="list-style-type: none"> • Keep the consumer informed <ul style="list-style-type: none"> ○ When dealing with a complaint that involves some investigation and gathering of information, keeping in regular contact with the consumer is important. ○ If there are a number of different personnel to get information from, this may take time. If so, contact the consumer, by telephone if possible, to let them know what is happening and where the complaint process is up to. ○ Be direct and as honest with them as possible. ○ Most people understand that delays are inevitable, but they need to know that action is being taken. ○ Even if there is no progress, a regular telephone call can go a long way towards establishing good faith and will help resolve the complaint in the long run. 	<p>22 – About open disclosure</p> <p>23 – How it can be done</p> <p>24</p>	<p>Handout 5 – Open disclosure principles</p>	<p>p. 7</p> <p>p. 20</p>

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<ul style="list-style-type: none"> ● Talk to the staff <ul style="list-style-type: none"> ○ Ensure all relevant people are consulted about the complaint, while protecting the confidentiality of those involved. ○ Keep accurate records of the steps in the investigation, including all discussions, information gathered and conclusions reached. ○ A successful investigation is conducted objectively, with an open mind and without bias. This means focusing on the facts of what happened, rather than relying on people's feelings or interpretations. ○ However, remember that any staff members involved may be feeling a degree of anxiety or stress about what has happened, depending on the circumstances. ○ This will be helped by giving them the opportunity to explain their perspective fully and clearly. ○ Staff need to be listened to and supported. ○ Sometimes information received from different staff members will be inconsistent. It is common for different people to have different perceptions of the same event. The person investigating the complaint needs to bear this in mind. 	25		p. 20
<ul style="list-style-type: none"> ● Be efficient <ul style="list-style-type: none"> ○ Try not to let the investigation drag on. ○ Timely resolution is good for both staff and consumers. ○ Set timelines at the outset and try to stick to them. ○ Be clear about the type and sources of information required to evaluate each issue. ○ Comprehensive identification of issues at the beginning of the process will save the time required to backtrack. ○ Be succinct when writing any reports. 	26		p. 20

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
BREAK 15 mins	27		
<p>A systematic approach to complaints continued... Total time 30 mins</p> <p>Step 3: Resolution and outcomes – 15 mins</p> <p>Identify the range of potential resolution processes and outcomes and speculate on the resolution techniques and possible outcomes of the resolution processes from what you know about this complaint to date. This will aid the identification of the types and scope of information required during the fact-finding part of the resolution process.</p> <ul style="list-style-type: none"> • Resolving a complaint should be seen as a joint problem-solving exercise. Once all the relevant information is to hand, discuss options for resolution with staff and the consumer. These may include: <ul style="list-style-type: none"> ○ meetings between the patient, their family and staff. For some complaints, more than one meeting is needed. ○ an explanation – giving information to consumers can go a long way towards resolving complaints and is consistent with open disclosure principles. Ensure the explanation is factual and understood by the consumer. ○ an apology – staff do not need to be afraid of apologising for mistakes – an apology is not the same as an admission of liability and it can be a powerful aspect of complaint resolution. ○ an undertaking to review policies and procedures with a view to improving outcomes. It can be helpful to analyse what happened and why by gathering together key staff members. This will help identify resolution options and any policy or procedural changes needed. It is most important that staff be involved in complaint resolution and given the opportunity to suggest systemic changes that may be required. 	28 29 – Resolution options		pp. 20-21

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Managing the resolution meeting can make or break satisfactory resolution of a complaint. The trainer should step through slides 30-35 to familiarise them with the systematic active role managers will take in resolution meetings.</p> <ul style="list-style-type: none"> • The organisation needs to decide what it considers a realistic outcome, balancing the needs of the consumer against the needs of the organisation as a whole. Take into account what the consumer wants, while recognising what is reasonable. Use the complaint to make practical changes that will benefit all patients. • Outcomes involving individual staff <ul style="list-style-type: none"> ○ Although the focus is on systemic issues, the role of the staff cannot be ignored. ○ The individuals concerned should be encouraged to talk about what is happening and offered support if needed. There is help available for professionals who are having problems at work, eg employee assistance schemes and medical defence organisations offer counselling, communication training etc. ○ If there are concerns about the professional conduct of an individual, consider also the need for referral to the relevant registration body. • Outcomes of health complaints may include: <ul style="list-style-type: none"> • Complaint not substantiated <ul style="list-style-type: none"> ○ Provide information • Complaint substantiated <ul style="list-style-type: none"> ○ Policy, procedure or protocol change ○ Expression of regret ○ Staff or consumer education ○ Information provided ○ Service to be provided ○ Monitor trend ○ Systems review, process audit ○ External referral. <p>The solution may be an explanation of what caused a delay in an outpatients' department with an apology.</p>	<p>30-35 – Managing the resolution meeting</p> <p>36 – Outcomes involving staff</p> <p>37 – Outcomes of health complaints</p>		<p>p. 21</p>

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
3. CASE STUDY	44		
<p style="text-align: right;">Total time 55 mins</p> <p>Setting the Scene – 2 mins</p> <p>You are the Director of ED for Jeribombera Health Service. You are sitting in your office on a Monday morning. You are taking the opportunity to catch up on some work from the last couple of weeks as it has been a very hectic time.</p> <p>The first thing you come across in the In-tray is a letter from Ms Linda Murray that has been forwarded via the CEO's office with a handwritten post-it note attached: <i>Please manage this complaint and resolve asap.</i> <i>Faye Bellamy (CEO)</i></p> <p>You read the complaint and enter the details of the complaint into the complaint register. Now it's time to examine the complaint prior to discussions with relevant staff.</p> <p>Review the letter of complaint – 3 mins</p> <p>Ask participants to read the letter of complaint. Ask them to underline any sections that raise issues for them while reading the letter.</p> <p><i>Dear Ms Bellamy</i> <i>I had the misfortune to have to use the services of your hospital when my young son Kyle got the gastric badly, a month ago.</i></p> <p><i>We arrived at your emergency department at 6.30am on 15 October this year. There was hardly anyone in the waiting room.</i></p> <p>I went up to the desk and told the woman there that my son had been vomiting all night had now got really bad diarrhoea and was really sick . . .</p>	45	46 – Letter of complaint Handout 6 – Letter of Complaint	

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Whole group review of issues and handling factors from complaint – 20 mins</p> <p>The facilitator will lead the discussion and provide more or less material depending on the responses of the group and the time available to complete the exercise. Reference will be made to specifics on slides, and in addition, the facilitator will ask additional questions of 4 roughly divided groups.</p> <p>The group will be divided into 4, with 15 minutes to formulate their answers to the following questions:</p> <p>Group 1: What are your initial responses to this complaint? Do you have a gut reaction? What are your first thoughts? Do you have an emotional response? Do you see a role for complaints education and support for staff?</p> <p>Group 2: What might be other underlying reasons Ms Murray has made this complaint as well as those she has outlined in the complaint letter? For example, protect others; find out what happened; if appropriate action is taken may re-establish trust in hospital; an opportunity to express her concerns, obtain an apology and be acknowledged; and productive way to channel her anger.</p> <p>Group 3: Identify the issues that the complaint raises. Identifying issues at the beginning of the process reduces the likelihood of using additional resources and extending the time taken to handle the complaint when issues are identified towards the end of the process. Now we will look at some issues identified by party. You will also note mention of handling factors – these are considerations specific to a party that need to be kept in mind during the resolution process. While speaking to the slides periodically ask participants whether they agree with a particular issue or whether they have additional issues.</p>	47-56	Use Trainer's annotated Letter of Complaint for issues and discussion points	

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Group 4: In addition to the issues specifically raised by Ms Murray, are there other issues that you can identify that should also be addressed? Identifying all of the issues from the consumer and health service perspectives maximises the potential for the successful resolution of the complaint and organisational learning flowing from the complaints handling process.</p> <p>Some key elements to draw from the exercise – 5 mins</p> <ul style="list-style-type: none"> • A thorough analysis of the complaint during the early stages is critical to support an appropriate SAM assessment. • You may wish to have a second person participate in the complaint analysis phase sometimes we may miss something that is blatantly obvious to another. • Having a means to identify parties, associated issues and handling factors assists throughout the complaints process. It can be easy to forget or go off the rails. • Identifying issues not necessarily raised by the complainant: <ul style="list-style-type: none"> ○ increases the potential to identify gaps and areas of service that may require improvement. ○ has the potential to increase the complainant's trust in the process and outcome. ○ demonstrates the health service's commitment to using complaints for learning. 	57		
<p>BREAK 15 mins</p>	58		

TOPICS & ACTIVITIES			SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE																		
<p>Examples of Reframing</p> <table border="1"> <thead> <tr> <th>Function of reframe</th> <th>Statement by party</th> <th>Reframe by facilitator</th> </tr> </thead> <tbody> <tr> <td>Remove sting from language</td> <td>The nurses ignored me and Kyle. They are selfish and uncaring.</td> <td>You felt abandoned by nurses who are there to care for people.</td> </tr> <tr> <td>Focus on the positive</td> <td>I have lost faith in the hospital. They wait until people are almost dead before seeing them.</td> <td>Reducing waiting times to be triaged would be important?</td> </tr> <tr> <td>Focus on interests</td> <td>I deserve \$3000 for my suffering.</td> <td>You have suffered and want that acknowledged.</td> </tr> <tr> <td>Focus on the future</td> <td>I haven't relaxed since the hospital stuffed up Kyle's care.</td> <td>What would help you relax?</td> </tr> <tr> <td>Turn a demand into an option</td> <td>I demand a written apology in the local paper.</td> <td>You want an apology for what you have experienced. Right now you prefer that apology to be in the local paper.</td> </tr> </tbody> </table> <p>Be careful with reframing as the party may perceive it as mere parroting or manipulation. Use it sparingly and with authenticity.</p> <p>MANAGING CONFLICT – 5 mins We respond to conflict by</p> <ul style="list-style-type: none"> • fight – aggressive behaviour • flight – passive behaviour • assertion – expressing emotions, thoughts and needs without violating rights of others • submission. 			Function of reframe	Statement by party	Reframe by facilitator	Remove sting from language	The nurses ignored me and Kyle. They are selfish and uncaring.	You felt abandoned by nurses who are there to care for people.	Focus on the positive	I have lost faith in the hospital. They wait until people are almost dead before seeing them.	Reducing waiting times to be triaged would be important?	Focus on interests	I deserve \$3000 for my suffering.	You have suffered and want that acknowledged.	Focus on the future	I haven't relaxed since the hospital stuffed up Kyle's care.	What would help you relax?	Turn a demand into an option	I demand a written apology in the local paper.	You want an apology for what you have experienced. Right now you prefer that apology to be in the local paper.	72-77		
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TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Managing conflict</p> <ul style="list-style-type: none"> • Assertiveness skills 'I' statements – minimises defensive responses, models assertive communication, clearly conveys message. Three main elements – a description of: <ul style="list-style-type: none"> • the event or action of interest • my response • my desired result. Example – a patient is conveying concerns about another member of staff in a verbally aggressive way. A 'fight' response may be: 'No wonder the other staff member walked out of your room mid-sentence if you were this aggressive and intrusive. I can't hear myself think. Will you be quiet for a moment!' An assertive response may be: 'When I hear abusive language I feel distressed and want to leave. I'd like to help and I need to hear what happened before I can help.' After the 'I' statement explore the other person's response – active listening. Suggest a solution if not forthcoming from the other person. • Active listening skills – as discussed above • Conflict management strategies <ul style="list-style-type: none"> ○ Manage your own emotions: <ul style="list-style-type: none"> • Recognise them as your emotions • Give yourself opportunities to release anger <ul style="list-style-type: none"> • Go for a walk • Debrief with colleague or friend (whilst respecting confidentiality) • Take responsibility – are the emotions related to your life and triggered by the current situation? Are you projecting emotions onto people or a situation? 			

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<ul style="list-style-type: none"> ○ Manage conflict in others: <ul style="list-style-type: none"> • Listen • Do not ask them to calm down – likely to inflame them further • Explain clearly what is happening and why • Keep your tone even and not condescending • Apologise for delays or mistakes • Look for solutions • Communicate respect • Avoid escalation. <p>PROBLEM SOLVING – 5 mins</p> <p>A problem can essentially be defined as the gap between the present state of affairs and the desired state of affairs, and the issues that have to be dealt with in order to get to the desired state.</p> <p>Identifying a problem is the easy part of the equation. One of the most common situations requiring leadership is that of problem solving. It requires cognitive, behavioural and linguistic skills.</p> <ul style="list-style-type: none"> • Defining problem – the problem takes into account the people involved, relationships, values, beliefs and perceptions, and the physical, policy and practice environment. • Solution – contains alternatives and resources that allow us to overcome, transform or avoid the problem. If the alternatives available do not address all the elements of the problem then an insufficient solution will arise. 	78-80		

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>General problem solving cycle</p> <ul style="list-style-type: none"> • Gathering information about the problem and its parameters – investigation, brainstorming and parties telling their stories. • Reviewing the information in order to select relevant factors that address issues. • Applying the information in the formulation of a plan or solution. <p>NEGOTIATION – 8 mins</p> <p>During negotiations there is usually a tension between co-operation and competition, between agreement and pursuing individual goals that may be inconsistent with the other person's goals. Also the parties are weighing up whether they gain more by continuing the negotiation or by doing nothing or something else. These two characteristics of negotiation guide our actions as a facilitator. We aim to expand mutual gains by increasing the zone of agreement. We may do this by increasing the range of possible outcomes from which the parties may choose. As a facilitator you may create options that the other parties may not have considered.</p> <p>Rather than haggling, giving in and then feeling exploited or viewing resolution as a contest to win, health service negotiations employ principled negotiation, which has been described as:</p> <p><i>... deciding issues on their merits rather than through a haggling process. Mutual gains are emphasised and where interests conflict, fair objective standards should be relied upon. It is said to be hard on the issue, but soft on people.</i></p> <p>Elements of negotiation</p> <ul style="list-style-type: none"> • Separate the people from the problem <ul style="list-style-type: none"> ○ It's normal for emotions to be expressed during complaints resolution. ○ Use and encourage the use of 'I' language. ○ Support a problem solving relationship. 	81-85		

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<ul style="list-style-type: none"> • Focus on interests not positions <ul style="list-style-type: none"> ○ Positions are what you want and interests are why you want them. ○ By expanding positions into interests, mutual interests may emerge that may increase the zone of agreement. ○ Example <ul style="list-style-type: none"> ○ Position statement <ul style="list-style-type: none"> ▪ 'will you please shut up' ○ Possible interests <ul style="list-style-type: none"> ▪ 'I haven't been sleeping well since my operation. The noises of the ward are incessant, particularly in the morning at nurse shift change. Is there some way noise can be reduced?' • Create options for mutual gain. Condliffe notes there are four obstacles to this outcome: <ul style="list-style-type: none"> ○ premature judgement ○ searching for the single answer ○ the assumption of a fixed pie ○ thinking that solving the issue is their problem. <p>Other tips to assist win-win negotiations and discussions</p> <ul style="list-style-type: none"> • If you or your proposal is attacked or if a firm proposal is made, eg 'You are only interested in covering up for the hospital, you'll hear from my lawyers.' <ul style="list-style-type: none"> ○ Progress is undermined if you respond by attacking the other person ○ Rather than defending yourself or your ideas, invite criticism and advice ○ Recast personal or professional attacks as an attack on the problem ○ Use objective criteria to evaluate issues, eg clinical standards and determine viable options. <p>Successful outcomes:</p> <ul style="list-style-type: none"> • satisfies the needs or interests of all parties • best of available options • addresses improvement opportunities. 			

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>PUTTING IT ALL INTO PRACTICE: THE CASE STUDY REVISITED – 40 mins</p> <p>This exercise uses the previous case study.</p> <p>Review of investigation report – 10 mins</p> <p>Investigation findings relating to some of the issues raised in a complaint from Ms Linda Murray – Jeribombera Hospital – 30 July 2006</p> <ul style="list-style-type: none"> • The triage process was not functioning according to the health service’s procedures when Ms Murray and Kyle Murray arrived at Jeribombera Hospital on 16 May 2006. • The procedures require that an appropriately experienced, skilled and qualified registered nurse be located in the Triage Station in the ED waiting area. • In this case Kyle and Ms Murray experienced a 30 minute delay in triage due to: <ul style="list-style-type: none"> ○ The rostered Triage Nurse had left work at 5am after a call notifying her that her father had had a serious fall and was currently being transferred from the nursing home to another local hospital. ○ The senior nurse on duty, after consultation with the night nurse manager, attempted to cover this 2 hour gap in the roster by rotating other ED staff out into Triage as the need arose. ○ The ED clerk at the ED Reception was requested to contact staff when a new patient presented, for this 2 hours. ○ The ED clerk advised that she had left a note in the staff station notifying them of Kyle and Ms Murray’s arrival as all staff were with patients in the cubicles. She did not feel comfortable interrupting their work. She knew there had been a number of serious presentations during the course of that shift and staff were ‘stretched thin’. 	86-90	Handout 7 – Investigation Findings	

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<ul style="list-style-type: none"> ○ On the second occasion the ED clerk left her station and informed the new resident doctor that she met at the staff station that there was a very distressed mother and sick baby who had been waiting in the ED waiting area for about 20 minutes without being seen by Triage. ○ The doctor said he would be out to see them as soon as possible. ○ It was another 10 minutes before a nurse came out and assessed Kyle as requiring immediate medical attention. <ul style="list-style-type: none"> ● Ms Murray's allegations concerning the behaviour and clinical assessment of Dr Roberts were supported by: information in the health care records; staff who witnessed at least some of the exchange; as well as the doctor's own account of the consultation: <ul style="list-style-type: none"> ○ He did not introduce himself. ○ He did not incorporate the views, concerns and opinions expressed by Ms Murray into his clinical assessment and decision making about Kyle's condition. ○ There were significant concerns raised about the adequacy of Kyle's clinical assessment and the advice given to Ms Murray. ○ The decision to discharge a seriously ill infant was not appropriate given the history and presentation. ● The allegation that Dr Roberts had handled Kyle roughly was not supported by information provided by Dr Roberts and RN Jefferies who witnessed the examination. ● The investigation identified problems in the organisation's scheduling of orientation for new clinical staff such as Dr Roberts. He was working his third shift in the hospital ED, without access to a suitable supervisor; and without knowing how to access all the clinical resources he required to do his work safely. 			

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Participants to break into 3 groups – 15 mins</p> <p>Group 1 – Identify service improvements that must flow from the findings of the investigation and how that feedback can be provided to Mr & Ms Murray. Ask the group to address risk elements and improvements for the delay in triage and clinical assessment and management.</p> <ul style="list-style-type: none"> ● Risk elements relating to the delay in triage <ul style="list-style-type: none"> ○ No one in Triage Station ○ Staff shortage ○ Clerical staff placed into an inappropriate position where they were asked to monitor an area where acutely ill people were present. ● Risk elements in clinical assessment and management plan <ul style="list-style-type: none"> ○ New junior medical staff arriving to do routine rotation not adequately orientated to the clinical area or organisation ○ Doctor was not experienced in paediatric care and this was his first rotation to ED as a resident. ○ Listening and communication skills of the doctor were inadequate to deal with a seriously ill child and a distressed mother. <p>Group 2 – Make recommendations about the resolution meeting, eg who should attend, whether an apology is indicated and the form it should take.</p> <ul style="list-style-type: none"> ● Attendees <ul style="list-style-type: none"> ○ Ms & Mr Murray – with Kyle if they wish – may not have alternative care and/or may wish staff to appreciate how vulnerable and precious he is ○ A support person of their choice if desired – should be offered ○ Complaints manager to facilitate the meeting ○ ED Director – as clinical leader and to provide an apology for the initial non-resolution. 			

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Group 3 – Identify any preliminary information to be provided before the meeting, supports for both complainant and staff and potential challenges that may arise during the course of the meeting.</p> <ul style="list-style-type: none"> • Preliminary information <ul style="list-style-type: none"> ○ Invite potential participants to attend meeting ○ Explain purpose of meeting <ul style="list-style-type: none"> ▪ Provide information on findings of investigation ▪ Have any aspect of the findings and outcomes explained ▪ Provide the complainant with an opportunity to re-establish trust in the service. • Supports <ul style="list-style-type: none"> ○ Provide an opportunity for the complainant and the Director to ask questions and express any concerns ○ Perhaps practise the wording of any apology ○ Offer an opportunity for the Director to debrief after the meeting ○ Spend a few informal moments with the complainant after the meeting ○ Complainant may have a support person present. • Potential challenges <ul style="list-style-type: none"> ○ Emotional response of participants ○ Insufficient time scheduled for the meeting ○ Additional issues or information may be raised during the meeting ○ Consumer focus on blame rather than service improvement ○ Consumer may not accept outcomes as being sufficient. 			
<p>Report back – 15 mins</p>			

TOPICS & ACTIVITIES	SLIDES	RESOURCES FOR TRAINER & PARTICIPANTS	GUIDE REFERENCE
<p>Wrap up – 5 mins</p> <ul style="list-style-type: none"> • Trainer thanks participants. • Notes any issues that have come out of the education session and improvements identified for the next session. • Recaps key considerations in complaints handling and response. • Further support and information can be obtained from the references provided to the participants. • Encourage participants to explore the resources and references that have been provided. • Any final housekeeping issues are mentioned. • Request participants to evaluate session. 	91-92	<p>Handout 8 – References & Resources</p> <p>Handout 9 – Local evaluation form</p>	

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- Health Complaints Toolkit: Guidelines for health services in the management of complaints*, Health Services Liaison Association, Victoria, 2000.
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- Making Feedback Work for You*, Queensland Health, 2002.
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Annotated Letter of Complaint

49 Sunnyside Street
Jeribombera Vic 1234
14 June 2006

Dear Ms Bellamy

I had the misfortune to have to use the services of your hospital when my young son Kyle got the gastric badly, a month ago.

We arrived at your emergency department at 6.30am on 15 October this year. There was hardly anyone in the waiting room.

I went up to the desk and told the woman there that my son had been vomiting all night had now got really bad diarrhoea and was really sick.

She told me to sit down and the triage nurse will call you in soon.

After sitting there for 20 minutes with Kyle in my arms I went up to the desk again and asked when the nurse or doctor can see us. Kyle was whimpering and still dry reaching and I was getting more and more worried. He is normally such a placid little one and happy. He has hardly ever been sick.

The woman at the desk said that the staff were really busy with really sick people and they will be out to see you as soon as possible. I got really upset and told her to get a doctor now; my baby can't wait any longer.

TRAINER'S NOTES:

1. Who are the parties?

- Kyle Murray
- Linda Murray
- Darren Murray
- ED clerk
- Triage nurse
- People laughing in background
- Doctor 1 – name unknown – he did not introduce himself
- Doctor Jackie Townsend
- ED Director
- Faye Bellamy – CEO

2. Issues and handling factors by parties:

KYLE MURRAY

Context – dependent. Acute gastro-enteritis, severe dehydration & associated effects

Issues

- Reported delay in assessment of up to 30 minutes
- Discharged from ED in critical state, collapsed on way home, requiring urgent readmission & attention.

LINDA MURRAY

Context – felt abandoned and helpless. Frustrated by delays and poor communication, anger and fear mounting, trust of individuals and "the system" diminishing by the moment.

Handling factors:

- Important to explain complaints process including review options

She told me to sit down and she would call someone.

I could here laughing and talking out from behind where the woman was sitting and it didn't sound like the staff were that busy. I felt like I did not matter and I was getting more and more angry. I was crying. I was so upset.

I heard the woman saying to someone when she disappeared that 'you'd better come and see this woman, she is getting toey. Her baby is sick.'

A nurse came out within a very short while and told me he was the triage nurse and took me into an office where he asked me what Kyle's problem was. When I told him I had been waiting about half an hour he apologised and said he was very sorry we had to wait that long. He then looked at Kyle and asked me questions.

He looked worried when I told him that Kyle had been vomiting all night and he could see himself that Kyle was very sick. He said he would go and tell the doctor. He was back very quickly and he took me to a cubicle where a doctor arrived within a couple of minutes.

My sense of relief was short lived. This is where the nightmare began.

The doctor looked as though he was 16 he didn't listen to a word I said although I was trying to tell him just how sick Kyle was. The doctor ripped Kyle's clothes off roughly and seemed to get cross when Kyle started to cry. He kept saying that all babies get tummy bugs and they are as good as gold within 24 hours and that 'there is no need for this child to be admitted to hospital. Just make sure he drinks lots and no food until the diarrhoea and vomiting stop.' He gave me a brochure on children and gastroenteritis and told me to read it.

*I was surprised that he **only felt Kyle's tummy, didn't take his temperature nor undo his nappy.***

- If facts are established an apology would be appropriate. Who would give it? In person?
- May be understandably angry and otherwise emotional – critical to display compassion and understanding.
- Role of Darren (husband) in complaints process to be clarified.
- Unsuccessful attempt at point of service complaint resolution – hence letter to CEO. Relationship with Director of ED coloured by that experience.

ED CLERK

Context – exposed to risk by gap in triage. Some frustration about triage delay. Issues

- Possible delay in alerting team to need for triage
- System design issue – ED clerk being put in this position

Handling Factors

- Potentially defensive that complaint was made.
- May feel responsible for delay in triage. Important to point out her non-clinical role as one of the frontline team. Enable her to contribute ideas on how situation could be improved.

DOCTOR 1

Context – senior resident on first rural placement, with little paediatric experience. Third shift at hospital, weekend & did not know other staff well, including immediate supervisor. Had not completed orientation.

Issues

- Adequacy of introduction to Ms Murray
- Understanding of and response to views, concerns and opinions expressed by Ms Murray
- Method of handling Kyle
- Adequacy of examination and assessment of Kyle and advice to Ms Murray
- Appropriateness of discharge
- Adequacy of supervision, experience and orientation

Handling Factors

- Will need to have complaints process clearly explained

I kept saying to him I have never seen Kyle so sick. I can't take him home as I am really worried. He said he could understand my distress but insisted that there was nothing more that the hospital could do. I begged him to keep him in just for the day so they could watch him and see what I meant. He said all parents get overanxious about their children when they are sick and all they need to do is relax.

I rang my partner very distressed and asked him to pick us up from the hospital. We got half way home and Kyle went really funny in his car seat. He went all rigid, his eyes rolled back into his head and then he went floppy. I screamed at Darren to turn around and go back to hospital.

We went straight to the emergency department through the door to where the doctors were. The same doctor came up to us and I screamed at him "go away I don't want you touching my child again". Another, older, woman came up, said she was a doctor and asked what was wrong.

I was hysterical by this time and I could only hold Kyle out and say he's really sick. She took him took one look at him and said we need to look after this baby.

She was fantastic. After Kyle had a drip and woke up a bit he went up to children's ward where he stayed in isolation for five days.

I am writing this letter because when I tried to talk to the head of the emergency department about what happened I didn't feel they were very understanding. I am writing this letter so that something is done, so that other parents do not have to go through what we went through. We are lucky that we have Kyle with us today. If it hadn't been for Dr Jackie Townsend I think he would have died.

I feel a bit sorry for that young doctor he obviously knows nothing about young children and how well there mum's know them. But, he should have listened

- Requires support person to assist him through complaints process in which he is clearly going to be a central player.

TRIAGE NURSE

Context – triage nurse not at triage station for 30 minutes after Ms Murray & Kyle arrive. Had to be summonsed by ED clerk.

Issues

- Attendance at triage station at front of ED
- Delay in triage

Handling Factors

- Additional issues may be identified as more information comes to hand
- Requires support person to assist him through complaints process in which he is clearly going to be a central player.

PEOPLE LAUGHING IN BACKGROUND

Issues

- Sick or worried people in waiting room not understanding context of staff merriment & staff recognition of this
- Acoustics & design of ED a problem.

ED DIRECTOR

Context – had managed initial unsuccessful point of service complaint resolution attempt

Issues

- Adequacy of ED paediatric and triage policy and guidelines
- Adequacy of the point of service attempt at resolution

Handling Factors

- Appropriateness of ED Director leading next attempt at complaint resolution.
- Does ED Director need to take immediate corrective action or wait until the outcome of the complaint process?

to what I was telling him.

I want to know what you are going to do about the young doctor and your emergency department to stop this happening again.

Yours sincerely

Linda Murray

Linda Murray