2015-2016 Report Regarding The Complaint Examination Procedure

Submitted by
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Dr Paul Warshawsky Medical examiner

2015-2016 was the first year of operation of the CIUSSCOM given the adoption of Bill 10 on April 1, 2015.

The year was characterized by change and adaptation. The priority of this office was to assure continuity of access and to build coherence into the management of complaints across all sites of the CIUSSS. This coherence included definitions used to register complaints, assistances and interventions, as well the definition of the elements of complaints in the provincial statistical data base SIGPAQS (Système d’informatio de gestion sur les plaintes et sur l’amélioration de la qualité des services).

Before offering the statistics, it is important to point out that the efforts noted above impact on the numbers, as there were changes in the definition of certain activities. For example, there was a conscious effort in the work of this office to increase the number of assistances and decrease the number of complaints.

The advantage of this approach is broad. Assistance means that we intervene quickly and directly to help patients resolve dissatisfaction or obtain a service that they are having difficulty accessing. In order to accomplish this, we reach out to colleagues, managers, staff etc., to find the most efficient and direct solution.

An outcome of this approach is to build partnerships within the system, create mutual understanding of roles and promote early identification of solutions for similar situations. Ultimately it prevents further complaints, but most importantly for the user, it offers a faster resolution to their problem than the complaint process. It gives them more confidence in the health care establishment and helps them feel supported and empowered. The creation of the CIUSSS allows this approach to cross establishment lines, identifying and sometimes creating more efficient inter-establishment trajectories for the user.

Finally with the creation of the Complaints office and the merging of several commissioners less than one office, a system was created which offered collegiality, support and coverage to a formerly isolated position. Having the opportunity to share concerns about certain situations and build on the experience and expertise of teammates, inevitably leads to a more efficient and effective process for users.
Statistics

<table>
<thead>
<tr>
<th></th>
<th>Complaints</th>
<th>Assistances</th>
<th>Interventions</th>
<th>Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-2016</td>
<td>334</td>
<td>1213</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(961 ré : services)</td>
<td></td>
<td></td>
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<tr>
<td>2014-2015</td>
<td>573</td>
<td>1054</td>
<td>25</td>
<td>29</td>
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Breakdown of complaints by mission

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<thead>
<tr>
<th></th>
<th>CHSGS (JGH)</th>
<th>CHSLD</th>
<th>CLSC</th>
<th>CR</th>
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<tbody>
<tr>
<td>2015-2016</td>
<td>256</td>
<td>33</td>
<td>36</td>
<td>5 TED (intellectual)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 DP (physical)</td>
</tr>
<tr>
<td>2014-2015</td>
<td>398</td>
<td>55</td>
<td>96</td>
<td>4 CRD</td>
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<td>12 DP</td>
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Motives of complaints

- Quality of care: 32%
- Interpersonal Relations: 27%
- Access: 19.5%
- Physical Environment: 8.5%
- Financial: 6.5%
- Particular Rights: 6.5%

Measures

The complaints process offers two types of corrective measures; individual and systemic. In total, 78 of the 334 complaints resulted in measures. 84% of those measures were individual and included such activities as reimbursement for contested fees, attainment of services, or mediation with a staff or team, encadrement of a staff or the review and revision of a care plan. It was this latter activity that was the most frequent individual measure applied (46%)

Systemic measures included activities such as the improvement of handicapped access, the updating of policies and procedures and the review of the eligibility of users for certain programmes, including confirming the responsibility of managers to assure that the users who were eligible were given access. In all situations the measures were applied and the complainants informed.
Complaints examined by Medical Examiner

<table>
<thead>
<tr>
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<tr>
<td>2015-2016</td>
<td>80</td>
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<tr>
<td>2014-2015</td>
<td>95</td>
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Breakdown of complaints by mission

<table>
<thead>
<tr>
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<th>CHSGS (JGH)</th>
<th>CHSLD</th>
<th>CLSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-2016</td>
<td>75</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2014-2015</td>
<td>82</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

Motives in complaints

Quality of care 71%
Interpersonal Relations 20%
Access 09%

Measures

Complaints examined by the medical examiner are by their nature individual, thus the measures applied are most frequently individual. Communication is a central issue in a majority of complaints and involves the manner in which the information is shared. In several situations at the JGH, the medical examiner did suggest that the Communication workshops, offered by the Humanization of care Committee, be attended as a means of improving communication skills, increasing sensitivity and preventing repeated complaints.

However there were three areas identified by the medical examiner where a systemic insufficiency contributed to complaints and which need to be addressed more comprehensively. These were: the management of severe pain in the Emergency room; the provision of better summaries of care including specific indications for follow-up of patients who had been seen in Emergency or had been hospitalized for a period of time or had received a sustained period of rehabilitation; and the nighttime medical coverage in the acute care setting.

Revision Committee

Due to the implications of Bill 10 and the complexities involved in assuring that the Revision Committee of the CIUSSS was properly constituted, there was no committee in place until the latter part of 2015-2016. There were several requests to the Revision Committee that are now been addressed. The statistics in this regard will be reflected in next year’s annual report.
Themes identified in complaints by motive

Over the years, the 3 most frequent motives for complaints have always been: quality of care, accessibility and interpersonal relationships. This year is the same, although quality of care was the most frequent this year as opposed to accessibility last year. The following offers a summary of the themes from this year for all of the complaints.

**Quality of Care 32%**

There are many subjective components in quality of care. However, we see particular concerns from patients regarding lack of clarity and information about their care and condition. A lack on continuity is the most frequent element in this type of complaint. This includes being receiving different information from different interveners and being unclear about follow up either post hospitalization or post Emergency Room visit.

Another important element in this type of complaint is users’ perception that the care they are receiving does not match what they believe they need. Included here are delays in having requests of help bells responded to both in long term care and acute care. While this is a consistent a source of dissatisfaction there are no clear standards about what is a “reasonable” delay. The issue of pain management is characterized in this grouping as well.

**Interpersonal relations 27%**

This motive includes such issues as communication, attitude and respect. The way information is transmitted is often as important as the information itself. People who are ill or dependent on others are particularly sensitive to the tone and body language of those who provide the care. It is extended as well to those who help them access the care (ex receptionists, secretaries, unit coordinators etc.). Staff, who feels hurried, overwhelmed or under pressure by workload are often perceived as being disrespectful or “not caring”.

Users who have the opportunity to actively exchange with their health care providers are generally more satisfied despite the outcome. The issue of discussion of levels of intervention, while not being the focus of many complaints, was a type of complaint that generated intense feelings.

**Accessibility 19.5%**

Accessibility to care includes issues such as telephone access, access to specialists, delays for diagnostic tests, cancellations of appointments, surgeries, etc. Telephone access in OPD clinics and some CLSCs, as well as access to medical appointments, remains a major source of dissatisfaction. In 2015-2016 telephone access was not logged as complaints but rather as assistance. This accounted for a large part of the decrease in number of complaints. However there was an overall increase in the number of telephone access dissatisfactions that were registered (168 in 2014-2015 vs. and 203 in 2015-2016). Cancellations of surgery also fall into this category.
**Physical Environment 8.5%**

This motive includes issues such as comfort of facilities, accessibility for the handicapped, lost items, parking costs, cleanliness etc. At the JGH there was an increase of complaints regarding lost items. This loss most frequently occurred in the transfer between units. There was a decrease in the number of complaints regarding cleanliness except in one site where the cleanliness of linens was raised as a concern. With the opening of Pavilion K at the JGH, while there were concerns expressed about handicapped access in the common areas and garage, patients and visitors frequently expressed their appreciation for the comfort and quality of the rooms.

**Financial Concerns 6.5%**

This refers to complaints for fees such as room or telephone fees, ambulance transport, fees for patients not covered by Medicare and long term care fees. The number of complaints remained constant. In particular non-insured patients requiring hospitalization or women delivering babies presented particular challenges given the fee structure and policies suggested by the MSSS.

The office of the CQSSS intervened in several situations confirming the rights of patients to receive certain documents despite not being covered by Medicare. There were also situations where a lack of information regarding the implication of certain choices such as requesting private or semi-private rooms, leads to contentious bills. In longterm care and rehabilitation centers, similar concerns are seen particularly when a resident is temporarily hospitalized.

Finally in one CR, a complaint lead not only to the revisiting of a particular financial benefit of residents, but also the imputability of managers in assuring that complaints were efficiently addressed and resolved with regard to users rights.

**Particular rights 6.5%**

This element refers to issues such as choice of establishment or professional, access to a user’s medical record, confidentiality, accommodation and linguistic rights. There was an overall decrease in this type of complaint. However the issue of access to medical records in OPD clinics at the JGH remains challenging. Further, access to care by staff and professionals capable of expressing themselves clearly in either English and French has led to complaints. There remains an obligation of the CIUSSS to assure the availability of staff that can assist when a professional is unable to adequately express themselves in either language. This occurs more when there are residents or students from outside of Quebec.

**Observations and suggestions for improvement**

1. Telephone access remains a major source of dissatisfaction for users trying to reach their health care professionals. The CIUSSS needs to identify and implement solutions such as online access to appointments, centralized appointment function where users can change, propose or confirm appointments.
Further an automated calling system to confirm appointments might reduce calls into clinics and the incidence of missed appointments. Finally at the JGH in particular there are varying availability of voicemails options for patients who cannot get through to the clinic. The CIUSS should adopt and implement a standard approach with regard to voicemails including a target delay for return of calls.

2. The management of pain for patients consulting Emergency and their ability to receive relief while awaiting further examination, has been a focus of a few complaints. Nurses either in triage, RAZ or PODS are usually the first to see patients but are limited in their ability to help patients because they are not permitted to prescribe pain medications. Complainants have unfairly targeted nursing in these situations. The increase in the numbers of patients consulting the ED, thus increasing wait times, contributes to this issue. The Medical examiner has shared this concern with the Leadership of the Emergency Department who have committed to examining their practice to try to optimize the care provided.

3. Users have a right to give informed consult about care they are about to receive. Informed consent however implies that they receive the information they need. This involves a range of issues from surgery to room selection. Over the past year, efforts were made to clarify on the room request forms, options and the financial implications therein. With Pavilion K, this issue has greatly diminished, although it remains in the legacy floors. Information must be as clear and transparent as possible. The issue of a resident in an Intermediate resource continuing to be financially responsible for the bed, in spite of being hospitalized in acute care, lead to a contentious situation. Again, users and family should be able to easily access information that they need, in order to understand their rights and obligation.

The CIUSS needs to find more efficient and comprehensive ways of providing this type of information. This can be done through pamphlets, user handbooks, welcome packages, the website, information sessions etc. Financial implications for noninsured patients are included in this area. Given the directives of the MSSS regarding the additional tariffs for non-insured patients, the information about these costs should be much more available and accessible.

4. Often medical coverage at night is assured by medicine residents who are not familiar with the patients or even the service. Thus they have to consult the record of care and are dependent on the comprehensiveness and legibility of the notes of their colleagues to get a good understanding of the patient’s situation. This places the resident and the staff in a vulnerable situation. Each clinical unit should examine their clinical coverage to ensure that it meets the needs of the patients and provides the covering staff the information they need to provide care in this circumstance.

5. There are frequent complaints in many of the centers, particularly the JGH, about delays in answering call bells. There are no standards that one can use to determine the validity of this complaint. Complaints are most often a function of expectations not being met. Standards regarding delays in responding to request for help should be set not as absolutes but rather as barometers on which patients can base their expectations. This will also ensure that complaints are objectively assessed and goals for improvement can be established. A patient whether continent or not should always be encouraged and supported to use the washroom or commodes. The promotion of hygienic undergarments or encouraging patients to relieve themselves in bed, is strongly discouraged for the dignity of users, except where no alternative is possible.
6. Continuity of care is challenging in acute care. This is affected by the rotation of staff, residents, medical students and attending physicians. Further, once an episode of care is concluded, whether it is through Emergency, a hospitalization or a period in a rehabilitation program, users would benefit from written summaries of their episode of care with an emphasis on what follow ups are required by the user. This would serve not only for users, but for caregivers as well who are often unable to decipher the priorities for follow-up.

7. Communication remains a big element in the provision of quality care. Communication must always be respectful, clear concise and open, allowing for some exchange. This issue should remain a key priority for the administration of the CIUSSS and staff should be given opportunities to improve their skills through training, supervision, consultation and built into annual evaluations.

8. Patient rights are accompanied by patient responsibilities. The CIUSSS should use the patient Bill of rights developed by the Users Committee of the Jewish General Hospital as a model to be applied at all sites of the CIUSSS. The focus should be to clarify the expectation of the establishment as well as the expectation and rights of the users.

9. Access to medical records should be centralized and standardized. Information about what users have a right to and do not have a right to should be made available on the website of CIUSSS the process of accessing those records should also be available on the website.

10. The loss of personal items is an ongoing problem particularly in acute care where the turnover of patients is so high. These losses, which include valuables such as jewelry, electronic devices, medical devices, money, clothes etc., not only have a financial implication on the center and the patient, but increase a patient sense of insecurity within the establishment. This includes allegations by certain patients and family members of theft. This type of allegation places staff and patients alike in a vulnerable situation. This type of loss seems to occur more frequently during the transit of a user between departments or sites. The CIUSSS should through its communication department launch a multi focused campaign both encouraging users and families not to keep any valuables in the centres, but also to promote an environment where protection of peoples belongings becomes a shared responsibility for everyone and vigilance is strengthened.

11. Supports and services to families with children with special needs remains a source of dissatisfaction. This is particularly true where children have more than one vulnerability or need i.e. physical, intellectual and psychiatric resources are required to help a child attain their potential. Families should not be forced to shop for services but need to be taken in hand in the community and offered a clear trajectory through the system. The inception of the CIUSSS should facilitate this access to care.

12. Engaging in a discussion about Levels of intervention is difficult at the best of times. However, this is a discussion that most frequently happens during the sudden hospitalization of a patient. This discussion is often precipitated by a physician or a resident who is meeting the patient for the first time and at a moment of great anxiety for the patient and family. Physicians who follow these patients in the community or out-patient departments, are really in a much better position to address this and should be encouraged to do so, particularly for patients with serious or life threatening conditions. The CIUSSS should also offer to these and all physicians training about how to have this type of discussion sensitively and respectfully.
13 Complaints about accidents such as falls or errors of medication are generally handled by Risk Management. However concerns about how this process has unfolded, do come to the attention of the commissioner. In several situations it appears that while incident reports were completed, and disclosure done, there was some confusion about who has to take other steps that would be helpful to users and family, such as apologies, informing them about the measures that will be taken to reduce the risk of repeat accidents, support to the user and options available for follow up, if required. It is suggested that the CIUSSS undertake a review and reminder of the Risk management process for all staff, with focus on clarifying responsibilities of the members of treatment or care teams.

14 There were several complaints related to cancelled surgeries, both scheduled surgeries and those being done on a trauma list. Some complaints involved repeated cancellation. Cancellations, particularly repeated cancellations, result in anxiety and dissatisfaction. While surgical cancellations may not be avoidable, how the cancellation is handled, what support is made available to the patient and how the procedure is rescheduled could mitigate the frustration.

Annex 1

Complaints Commissioner Staff

Rosemary Steinberg, Commissioner of complaints and Quality of Services
Hanh Vo Assistant Commissioner of complaints and Quality of Services
Claude Malette Interim Assistant Commissioner of complaints and Quality of Services
Helen Vassiliou Administrative
Kimberly Dagenais Administrative staff

Medical Examiners

Dr Paul Warshawsky
Dr Martin Black
Dr Markus Martin
Dr Rubin Becker
Dr Alexander Motard
Dr Ron Ludman
Dr Stella Adonatos
Annex 2 List of Sites Included in Report

1. Info Santé
2. MAB-Mackay
3. Constance-Lethbridge
4. Maimonides
5. Miriam Home
6. Father Dowd
7. CHSLD Henri Bradet
8. CHSLD Juif de Montreal
9. CHSLD St-Andrew’s
10. CHSLD St-Margaret
11. CLSC Cote des Neiges
12. CLSC de Benny Farm
13. CLSC Metro
14. CLSC Parc-Extension
15. CLSC René-Cassin
16. CSSS Cavendish
17. CSSS de la Montagne
18. Hôpital de réadaptation Catherine Booth
19. Hôpitale Mont-Sinai
20. Hôpital Richardson
21. Les pavillons de LaSalle-Cavendish
22. Hôpital General Juif de Montreal
23. Maison Bleue Cote des Neiges
24. Maison Bleue de Parc-Extension
25. Maison de Naissances Cote des neiges
26. Manoir Renaissance
27. Point de service Outremont
28. Résidence Solomon (Le Boulevard)
29. Ressources de la Montagne
30. Site Plaza