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Submission:

Canberra Health Services Consumer Feedback Management Policy and Procedure

Submitted by email to:
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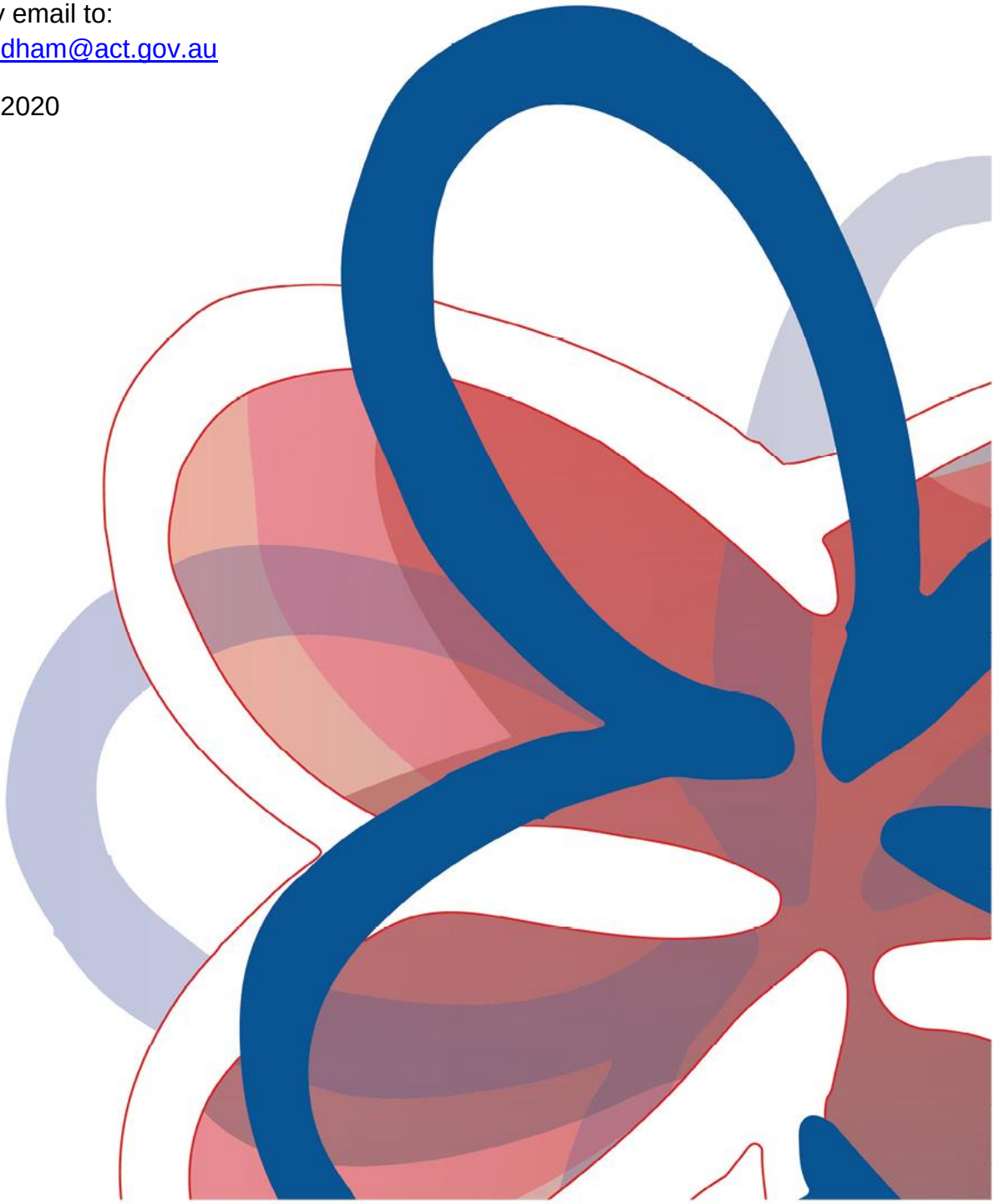

Submission: Canberra Health Services Consumer Feedback Management Policy and Procedure

This submission has been prepared by the ACT Mental Health Consumer Network (the Network) in response to the invitation from the Heather Needham, Senior Manager Patient Experience/Quality Improvement (4 December 2019).

The Network is funded by ACT Health to be the peak systemic advocacy body for mental health consumers in the ACT. We represent the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is committed to social justice and the inclusion of people with lived experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

General Comments

The Policy and Procedure are well structured and written. Unfortunately, feedback from Network members indicates that the experience of consumers providing feedback does not reflect either the Policy or the Procedure. By way of example we present two member case studies. Please note that while the interactions with Canberra Health Services were not related to treatment of mental ill health they clearly convey limitations with the current system. Furthermore, these concerns would be magnified for people using Canberra Health Services for treatment of mental ill health.

Case study A

Ms X has consented to her case being used for the purposes of providing a case study that contrasts her experience with the BLAST – Believe, Listen, Apologise, Solve and Thank – approach recommended in Section 3 of the Procedure and detailed in Attachment 2. Ms X requested that a copy of her Act Health file from her complaint be provided to the Network for the purposes of this submission. The case study will draw upon

- Ms X's Webform submission (represented by the use of *blue italics*);
- email correspondence between Canberra Health Services staff (represented by the use of *green italics*); and
- conversations with Ms X.

Context

I was attending an appointment in radio-oncology on the morning of 22 July, one week after chemotherapy treatment. At the time I arrived, two receptionists were operating a single computer in tandem – one seated (hereafter referred to as R1) and one standing beside R1 (hereafter referred to as R2). Whilst waiting for my turn to be served, I noticed that R2 was coughing heavily, not covering her mouth and not wearing a mask. Knowing myself to be immuno-compromised I stood back from the reception desk, explained that I had recently had chemo and asked to R2 to step away from the counter so that I could approach because in my estimation she was sick, and I had been advised by my oncologist to try to avoid sick people wherever possible.

Believe
R1 asked R2 to step back, but she moved only a single step back.

In Ms X opinion, the fact that R2 only took one step back indicates that R2 did not *believe* that Ms X had a genuine concern. As stated in Attachment 2 to the Procedure, "The perception of the issue for the consumer is real to them, even though you may think they have it wrong" (p13). Ms X then repeated her concerns.

I stated that I was immuno-compromised and was not willing to come to the desk while she was still standing close. R1 asked R2 to step away from the counter, which she did,

Even after repeating her concerns R2 did not take on board Ms X's concerns and had to be asked to leave the reception area by R1. Clearly R2 did not "Take a second, relax, and listen" and did not try "to understand it from … [Ms X's] perspective".

Listen
[R1] then remarked to me "Oh, she's not sick. She just has a cough".

While R1 paid attention to Ms X's concern she seemed to have decided how to respond to the issue before being done listening and had her response ready.

Apologise
This indicates that both people [R1 & R2] were oblivious to the risk a coughing person posed to patients and general public which is particularly disturbing given this occurred in the Cancer Centre where many patients have compromised immunity.

There was no apology as recommended in the BLAST approach. A more appropriate response may have been:

> *I understand your concerns about R2. And I agree it is very important that staff members who are ill do not have contact with immunocompromised people. In this case, R2 suffers from allergies, so her coughing is not the result of a germ that can be transmitted to you or anyone else. I apologise that this has concerned you, but I can assure you that you are not at risk.*

Even had R1 done this, Ms X believes that the presence of someone coughing around immunocompromised people without wearing a mask or covering their mouth with their elbow is a risk that should not be taken. People can be contagious before symptoms appear. Therefore, there is no way of knowing whether or not R2 had become recently infected with a virus.

Solve

Upon returning to the reception desk after my appointment, the only person there was R2. I stayed back from the counter, and upon seeing me R2 said she would go to find someone to assist me. In my opinion R2 appeared annoyed at having to do this.

On this occasion R2 did identify a solution that was acceptable to Ms X. However, she appeared to do so only under sufferance, indicating once again that R2 did not believe Ms X had a genuine concern.

Another person (R3) was brought from another part of the radio-oncology section to assist me. R3 appeared to more clearly understand my concerns, as she not only came right away but also disinfected the pen before handing it to me to sign the Medicare form.

By the end of her visit to the Canberra Regional Cancer Centre was Ms X's concerns were treated with the respect they warranted. However, she was not thanked for raising what she considers a very basic concern common to many people using the Centre. There was also no long-term solution to the presence of someone on reception coughing without appropriately covering their mouth.

Thank

Ms X has no recollection of being thanked, but concedes this may have occurred.

What would you like to happen?

As a matter of urgency, I would like all reception staff to receive training on how and to limit exposure of patients to germs and why this is especially important in the context of cancer patients and others who are immuno-compromised.

What actually happened?

Within six days the complaint being made online, the Operations Manager contacted Ms X by phone. In her written summary of the conversation with Ms X she stated:

All staff are aware that they must not attend the workplace if they are unwell, and particularly in front line positions where they are directly dealing with our patients

The staff member in question suffers from allergies, and this was the case when the patient was in the Centre

The first two points provide an explanation from the Centre's perspective. It does not address the fact that a staff member can be contagious before symptoms appear, and may have contracted a virus since being diagnosed with allergies—if formal diagnosis of allergies was in fact received. Consequently, there is no way of knowing whether R2 was infectious or not at the time. Notwithstanding concerns around infection, it is socially unacceptable not to cover one's mouth when coughing—particularly in a hospital setting. Furthermore, there was no indication that R2 acknowledged the validity of Ms X's concerns. Her response on the day certainly suggested otherwise.

Ms X asked that the staff member let the patients know it was an allergy, and to wear a face mask if she was coughing regularly

The Operation Manager's notes do not indicate whether Ms X's request was granted.

Ms X was happy with the outcome, and I reiterated to her that all staff are aware that out patients are particularly susceptible while neutropenic

In fact, Ms X was *not* happy with the outcome. She felt that her concerns had been categorised as irrelevant because R2 had been deemed to only be suffering from allergies at the time of contact. However, Ms X had no energy to take the matter further given her treatments. It would be more accurate to say that she was resigned to having her complaint treated as a 'check list' exercise.

This case study also raises another important issue of a consumer's capacity to provide feedback while unwell, and the likelihood of them doing so once they are feeling well.

Ms X was significantly unhappy with her initial experience and raised it with colleagues upon her return to work. She did this, in part, to validate her expectation that someone coughing ideally should be wearing a mask or coughing into their elbow if caught unawares, particularly staff in a medical setting where immunocompromised people are common. Her colleagues agreed with her assessment and encouraged her to make a formal complaint. Given that she was currently undergoing chemotherapy her capacity to even complete an online form was limited. Therefore, a colleague drafted the initial detail to make the process easier.

This raises an important point about consumer capacity to provide feedback while unwell. We wonder how many others who have used the Canberra Regional Cancer Centre may have been uneasy about the presence of a coughing staff member. Ms X's feedback was only possible because she had others to support her.

Ms X relayed the content of her conversation with the Operations Manager soon after taking the call. Once again colleagues offered to follow-up. Ms X did not refuse the offer, but she was not enthusiastic as she considered doing so would be pointless given her experience with the process up until that time. As there is always more work to do than time available, the follow up did not occur. It was only the opportunity to comment on the Consumer Feedback Policy and Procedure that meant Ms X was able to revisit the experience.

Summary

While the feedback in this case study was not about treatment for mental ill health, the same lessons apply to feedback about mental health treatment. It is important to understand that the issue for the consumer is real to them, and it should be treated as a legitimate concern. It is also vital that the staff member receiving the feedback keep an open mind about its veracity. This is a respectful way to approach any feedback. Listening is essential to understanding the consumer's perspective. If the staff member does not listen they cannot hope to understand or be open to alternative perceptions. A sincere apology will often diffuse a situation, however, the apology must be sincere. The best solutions often arise from involving the complainant in identifying a way to resolve their concern. Finally, the service and its staff can always learn from consumer feedback. Hence, it is appropriate to

acknowledge a consumer's contribution to quality improvement.

Case study B

Mr A shared his story verbally with the Network and has consented to his case being used for the purposes of providing a case study. Mr A has dyslexia, which is a learning disorder that involves difficulty reading due to problems identifying speech sounds and learning how they relate to letters and words.[1] On three occasions he provided verbal feedback to a unit within Canberra Health Services, but each subsequent conversation indicated that his feedback was not captured.

The Network understands that Canberra Health Services offers a variety of ways to provide feedback – online, written and verbal. However, we note only one is mentioned on the website https://www.health.act.gov.au/about-our-health-system/consumer-feedback/i-want-provide-feedback-about-public-health-service and this is effectively useless to someone with dyslexia and many other learning disabilities.

Just as there should be 'no wrong door' in mental health services[2], the Network would like to see a 'no wrong door' policy in consumers providing feedback. This should explicitly include feedback given verbally to clinical and other staff.

Summary

Some consumers wishing to provide feedback may not be able to do so within the options generally available (e.g. written, online). Some may also need support to provide their feedback. CHS staff members have a legal obligation under the *Mental Health Act* 2015 (ACT) to support mental health consumers to exercise their right to provide feedback.

Specific feedback

The difficulties faced by consumers in providing feedback are magnified for consumers experiencing mental ill health. Therefore, it is essential that BLAST is enacted as intended and described in Attachment 2 to the Procedure.

[1] Mayo Clinic. Dyslexia Website. Accessed 28 Feb 2020 at https://www.mayoclinic.org/diseases-conditions/dyslexia/symptoms-causes/syc-20353552.

[2] No Wrong Door. Accessed 28 Feb 2020 at https://nowrongdoor.org.au/mental-health-charter/

Consumers experiencing mental ill health may need support to provide feedback. It is a legal requirement for CHS to provide that support according to the first principle of the *Mental Health Act* 2015 (ACT):

> *a person with a mental disorder or mental illness has the same rights and responsibilities as other members of the community and is to be supported to exercise those rights and responsibilities without discrimination* (page 5)

Therefore, anyone receiving feedback, in any form, from a consumer experiencing mental ill health should offer whatever support the consumer requires to provide feedback.

Consumers who experience mental ill health often find that their physical ailments are not accorded the time and attention they warrant when they present for treatment of their physical ailments. Similarly, consumers report that their feedback appears to be treated differently—with less seriousness—compared to feedback provided by other health consumers. The status of an individual's mental health is perceived to affect the value of the feedback. This should not occur.

A consumer's capacity to provide feedback while unwell from any form of illness is often limited. Furthermore, once people have undergone lengthy treatments they often pass a point where they do not wish to revisit the negative issue or situation that distressed them. The lack of capacity while unwell and the unwillingness to revisit negative memories is amplified for consumers who have received treatment for the mental ill health.

Recommendations

1) CHS staff members receive training in the BLAST approach. Ideally the training would involve consumers.
2) CHS staff members receive training about their obligations under the *Mental Health Act* 2015 (ACT), particularly in terms of capacity and support.
3) CHS staff members should regularly share and reflect upon the verbal feedback they receive from consumers in the course of their normal duties.
4) CHS explore ways to capture feedback during treatment, while minimising the impost on consumers who are providing it.