1 Executive summary

Introduction

In the late summer of 2008, serious concerns were raised by family members of two patients – the late Ann Moriarty and the late Edel Kelly – about the potential risks to the health and welfare of patients at the Mid-Western Regional Hospital (MWRH) Ennis, following the treatment that their family members had received.

In September 2008, the Health Information and Quality Authority (the Authority), at the request of the Minister for Health and Children and following agreement from the Board of the Authority, announced it would undertake an investigation of the arrangements for providing services at MWRH Ennis. Subsequently, further families came forward to the Authority with concerns in relation to care their family members received across a variety of different services provided at MWRH Ennis.

The Investigation did not set out to undertake a forensic investigation of each of these patients' care. However, the experiences of all the families who came forward informed the investigation and helped to shape the review of the quality and safety of services provided in MWRH Ennis. The Investigation Team met with and interviewed seven families of patients, and or patients, at the outset of the investigation.

Their experiences related to a variety of different services provided at MWRH Ennis and are captured within the various relevant sections of this report. It should be noted from the outset of this report that their courage in coming forward will benefit future patients and enable high quality, safer services to be provided at MWRH Ennis.

The investigation consisted of a review of clinical practices, systems and processes within the services covered by the Terms of Reference. This included a documentation review, at both local and national level, site visits to MWRH Ennis, data analysis, and interviews with patients and their relatives as well as with clinical and non-clinical health services staff.

Findings

International evidence shows that patients with specific conditions obtain safer and better outcomes when treated by clinicians who routinely care for high numbers of patients with such conditions. Patients receive poorer outcomes when they are cared for by clinicians working in systems where they only occasionally care for patients with specific conditions. In this context the Investigation Team concluded that the MWRH Ennis will have an important part to play in providing high quality and safe services for its community. However, the Hospital will need to change the range and types of services it provides for its patients in the future.

Key findings in the area of the planning and provision of clinical services at MWRH Ennis include the following:

- Change for safety must happen. It is unsafe to keep the configuration of services at MWRH Ennis as they are and these changes must take place safely and effectively
- Acute, complex and specialist services are not sustainable at MWRH Ennis. This is because there are not sufficient numbers of patients presenting with these conditions to enable professional healthcare teams to maintain their clinical skills and expertise. Continuing these acute services, including acute and complex surgery, cancer surgery, level 2/3 critical care (see Glossary for definition of the levels) and 24-hour emergency department services, in their current structure, exposes patients to potential harm
- MWRH Ennis does not have sufficient volumes of patients attending out of hours to justify emergency department and operating theatre resources being available on a 24-hour basis
- In the course of the investigation, a number of patient safety issues were identified by the Authority. The HSE was notified and interim recommendations were made to address these issues (see Appendix 6). These recommendations must continue to be implemented as an immediate priority.
- The provision of more staff and resources at MWRH Ennis will not address the fundamental issue of professional teams maintaining their clinical skills and expertise in the area of surgery, critical care, emergency care, children's and maternity services. This is dependent on sufficient numbers of patients attending MWRH Ennis with certain conditions.

Key findings in the area of corporate governance and leadership at MWRH Ennis include the following:

- The lack of clarity around local accountability and the authority to make decisions means that there is no single person at hospital level who is fully accountable for the quality and safety of services
- There were limited systems in place for effective clinical governance in order to provide the necessary assurance for patients
- Risk management processes were not pro-active. Adverse events, complaints and claims processes were not formally integrated within MWRH Ennis and therefore the outcomes from these processes are not patient focused.

These findings are serious issues of patient safety that are at the heart of safeguarding the public and therefore the implementation of these changes is a priority and should not be compromised in the current fiscal climate.

The Investigation Team heard from some patients and relatives, who had highlighted concerns in relation to their care and the management of their complaints, describe how they only wanted an acknowledgement that a problem had occurred and or an apology but believed that these were not always forthcoming in a timely way. They also believed that best practice was not complied with in relation to how information and a diagnosis was given to patients and families.

This investigation also found examples of good non-acute care being provided at MWRH Ennis and a committed ethos from Hospital staff. It was clear that there are areas where the work of MWRH Ennis could be greatly expanded, in parallel with the consolidation of acute surgical and emergency department services at an alternative location, in the interests of patient safety.

The Investigation Team makes a number of recommendations as result of its findings; these are highlighted in boxes in Chapters 2, 8 and 9. The recommendations are grounded in international evidence where available and cover the most important areas for promoting quality and safety. The Investigation Team recognises that these areas are interdependent and should be taken together as an integrated package of measures to improve safety and quality. Consequently, the recommendations in this report are presented in "clusters" to facilitate addressing them as integrated issues. Where recommendations have national as well as local dimensions, these are set out in the relevant box. In the interests of brevity the Investigation Team has tried to highlight recommendations in areas of particular importance only.

However, it should be noted that its commentary includes a number of important issues that need to be addressed which are not covered by the recommendations but nevertheless merit action by the HSE.

International evidence also shows a move towards providing the greatest possible amount of safe and appropriate healthcare as close as possible to where people are living, such as enhanced diagnostic testing locally, non-emergency day case surgery and a range of outpatient services. Such services provided in MWRH Limerick could in fact migrate to centres such as MWRH Ennis.

Conclusions

What has driven this investigation is patient safety and quality, and one clear overriding finding arising from the investigation is – change for safety must happen.

It is unsafe to keep the service configuration at MWRH Ennis as it currently is. However, there are significant opportunities for high quality, appropriate services to be provided at MWRH Ennis in the future but these must be safe for the benefit of the public. To promote patient safety and improved quality, the clinical services in MWRH Ennis need to change to provide appropriate, timely local access to non-acute patient care such as diagnostics, day surgery and rehabilitation as part of an integrated regional hospital network.

To do this safely and effectively will require experienced leadership and management skills; detailed planning; communication and coordination. It is important to ensure that the reassignment of existing resources and necessary changes to the infrastructure should take place before the services for patients are moved.

Healthcare is understandably a high priority for people and this is reflected in the concerns of politicians and others both locally and nationally. For changes to be implemented effectively that will result in safer, higher quality of care, people receiving services need to understand the reasons and benefits of those changes.

The Investigation Team recognises the challenge of providing timely and appropriate access to local services whilst at the same time providing safe services that secure the best outcomes for patients. These factors can often be competing but safety must always take precedence.

This means the case for change has to be developed and communicated clearly and effectively to the public. Clinicians and other healthcare workers in hospitals in the midwest regional hospital network, and the local community, need to be fully involved in the change process.

The Investigation Team developed the clear impression, that within the HSE management, at a local, network and national level, there exists a commitment and desire to improve services for patients. The need for change had been acknowledged, although the implementation processes remain a significant challenge.

However, a comprehensive programme of change that is effectively led and managed, needs to be undertaken. This will take time to implement and the HSE should ensure that appropriate facilities, resources and staff are in place throughout the current Mid-Western Hospital Network in order that changes in the location of patient care can be safely accommodated.

The HSE should, as a priority, undertake a review of the clinical and non-clinical management, leadership and governance arrangements at Mid-Western Regional Hospital Limerick to ensure that the governance arrangements and organisational structure are fit for purpose, and that clinicians and managers in key positions have the capacity and capability to manage the new role of the Hospital.

In drawing its conclusions at the completion of the investigation, and making its recommendations, the Investigation Team recognises the scale of the transition process and the associated management challenges and are of the opinion that this should be undertaken openly, transparently and through an active process of engagement with the public, local stakeholders and staff so that the difficult discussions that are required for the benefits of safe services take place to build a thriving, appropriate and safer future for MWRH Ennis.