HSE Your Service Your Say

HSE Anonymised Feedback Learning Casebook 2021

Welcome to the 2021 edition of the **HSE Anonymised Feedback Learning Casebook**. The past year has been another challenging one, both for service providers and Service Users.

Responding to the COVID 19 pandemic remained a national priority with a continuing impact on resources and disruption to normal health service delivery.

While feedback received continued to be examined and responded to with the learning captured and shared, the publication of quarterly casebooks during 2021 was not possible. A full year 2021 casebook has again been compiled presenting a sample of the feedback received and dealt with during the past year.

The casebook is part of the HSE's commitment to use feedback as a tool for learning and to facilitate the sharing of that learning. The cases included in the 2021 edition, although each unique, present themes and issues that need to be examined in the context of quality and service improvement.

The casebook presents a total of 28 cases covering both complaints and compliments received by Hospitals, and Community Healthcare Organisations.

The casebook contains 8 complaints from Hospital Groups and 9 from Community Healthcare Organisations that were investigated and/or reviewed along with their outcomes. The casebook also features 7 compliments from Hospital Groups and 4 from Community Healthcare Organisations which highlight the learning to be gained from positive feedback.

The main themes for the 2021 casebook relate to *communication and information, safe and effective care* and *access*, with these categories featuring in 26 cases (11 compliments and 15 complaints).

The key categories of *safe and effective care* and *communication and information* feature in the majority of the compliments presented. Some compliments also relate to *dignity and respect* and *access*.

The categories of *communication and information, access* and *safe and effective care* feature in the majority of the complaints received. Other categories such as *dignity and respect, and accountability* also feature.

The dominant category for complaints relates to *communication and information* and concern issues such as the provision of information, delay and failure to communicate, general communication skills and meeting diverse information needs. *Safe and effective care* covers issues relating to treatment and care, tests, continuity of care and discharge. *Access* also features as a key category and issues relate to appointment delays, accessibility and resources as well as visiting times.

For dignity and respect, issues around delivery of care and end of life care were raised while accountability concerned issues around overcharging and use of resources.

The cases presented, both complaints and compliments, offer services an opportunity to reflect on service delivery, to understand the issues experienced by Service Users, to examine the measures and initiatives used to address these and how such methods can be utilised in their area to address or prevent similar issues.

The casebook will be widely circulated to staff within the HSE and shared with Complaints Managers who will consider the learning from these cases to guide decision making to improve services and the Service User experience.

Hospital Group

Category: Communication and Information (information)
Status: Compliment

Background to Compliment

The compliment was made following a complaint investigation. The complaint concerned the scheduling for a day case surgery and the requirement for a COVID test to be performed prior to admission.

The parent made the necessary arrangements for the COVID test with their GP and the test was completed. However, it subsequently came to light that the test was not taken within 48 hours of the admission, which is a requirement, thus causing the surgery to be postponed.

The parent wrote to the Hospital's Patient Advocacy service to advise of the upset and frustration that this postponement caused and to relay that it could have been avoided had they been made aware of this 48 hour rule for the COVID test. The parent further advised that this information was not included on the admission letter received and if it had been clearly communicated, the situation could have been avoided.

Nature of positive feedback

The Hospital's Patient Advocacy service received a compliment from the parent of a Service User, who wrote to express their thanks and to advise how impressed they were that a recommendation that arose from a recent complaint they had made had been implemented. The parent thanked Patient Advocacy and the wider hospital for actively listening to their complaint issue and using the learning from it to improve the patient journey.

Outcome and Learning

Patient Advocacy are acutely aware of the importance of good communication and information and in this case a recommendation was made by the Complaints Officer to Operational Services Management to include the addition of a line in the admissions letter advising that a COVID test is required to be done within 48 hours of admission for surgery. Following this recommendation and the implementation of same, the parent received a re-scheduled admission letter with a new surgical date which included the information around the timing of the required COVID test.

The parent of the Service User was delighted to see the positive outcome and service improvement that arose from the complaint and this prompted the follow up compliment to the Patient Advocacy Department.

The complaint highlighted how poor communication and information can have a significant and negative impact on a Service User. However, the compliment received from the parent shows how important it is for those who use our services and who share their experience with us to see how that is used to change service delivery for the better.

The also demonstrates to staff how feedback can be used to make a difference and that is also what motivates our Service Users to submit their feedback.

Hospital Group

Category: Communication and Information (delay and failure to communicate)
Status: Upheld

Background to Complaint

The parent of a deceased patient contacted the Hospital's Patient Advocacy Department in order to raise their frustration and disappointment. Following attendance at a bereavement meeting at the hospital it was agreed that changes would be made to the death certificate of their child to more accurately reflect cause of death. However, several months passed and the amended certificate had not been issued to the family which caused additional and unnecessary distress and prompted their contact with the Patient Advocacy Department.

Investigation

Upon receipt of the complaint, the Complaints Officer contacted the Medical Social Worker (MSW) who had worked with the family, and the Consultant who had completed the death notification, to advise them of this complaint. The Complaints Officer determined that the MSW and the Consultant understood that the death had been registered by the family and a death certificate had been issued by the Civil Registration Office. Unfortunately, they were unfamiliar with the process for amending a registered death certificate.

The Complaints Officer contacted the relevant external agency. Once it was confirmed that the death had been registered, the Complaints Officer requested the process of how to re-register the death and have an amended death certificate issued to the family.

The Complaints Officer communicated the process to the MSW and the Consultant. The Consultant immediately undertook to take the necessary steps as was agreed at the bereavement meeting.

A sincere and heartfelt apology was given to the family for the upset caused.

Outcome and Learning
The key issue for staff involved in this complaint was a deficit in knowledge of what to do in the event that a death certificate required an amendment, particularly if the certificate had already been registered.

The Patient Advocacy Manager has developed an educational session on the process for establishing whether or not a certificate has been registered and what to do in the event that changes are to be made to the certification. This session will be delivered to all Medical Social Workers with the aim of avoiding a recurrence of this family's experience.

Hospital Group

Category: Communication and Information (communication skills) (information)
Status: Compliment

Background to Compliment
The Hospital's Patient Advocacy Department received a compliment via the hospital's website feedback form. This compliment documented a young Service User's visit to the Injury Pod in the Emergency Department whereby they were treated by the Advanced Nurse Practitioner (ANP).

Nature of Positive Feedback
The parent of the Service User wrote to express how fortunate they were to have the ANP look after them, how the young Service User was put at ease straight away by the manner and approach of the ANP. The parent further advised that the ANP was able to settle the Service User and put them at ease by focusing and speaking directly to them. The parent wished to express their sincere thanks for this approach, for the expert care given and to report that the Service User was healing very well.

Outcome and Learning
Patient Advocacy spoke with one of the Senior Consultants in the Emergency Department (ED) and was advised that they currently have one ANP in place in the department, working in the Injury Pod. Due to the nature of the injury pod the ANP is afforded a little more time with Service Users and this is used to make them feel calm, welcome and at ease. The ANP engages the Service User in general chat and then proceeds to discuss their injury in layman's terms and advise on how the clinicians will go about treating same. The ANP takes a personal approach with the Service User. This approach also puts parents / guardians at ease allowing for trust and a rapport to be developed, presenting an opportunity to discuss the Service User's and parents/guardians expectations.

The ANP advised that all clinicians in the Emergency Department work as a team with Consultants, Doctors and Nurses all providing mentoring and guidance to each other to find the best approach to patient care. Currently the ANP is working alongside an ANP candidate and a number of Non-Consultant Hospital Doctors (NCHDs) in the Emergency Department, all of whom have the opportunity to see the benefits of a warm friendly and focused approach to patient care and the merit of good communication skills, which as this compliment exhibits leads to an enhanced Service User experience.

Hospital Group

Category: Safe and Effective Care (treatment and care)
Status: Upheld

Background to Complaint
The family of a Service User wrote in to express their disappointment at the level of care provided to their relative who attended the Accident and Emergency Department (ED) with a GP Referral and complications of a disorder.

The family expressed disappointment with the care received in the ED. The Service User was reviewed by a doctor and referred for an x-ray. The x-ray showed no new changes and the Service User was discharged back to their GP. The Service User continued to have pain and returned to their GP who referred them to another hospital where they were admitted for treatment.

The family felt that this was an unacceptable standard of care and that it fell short of that which the HSE are mandated to provide to the public and they were dissatisfied with the treatment provided by the doctor.

Investigation
The Complaints Officer made personal contact with the family and reassured them that their complaint would be examined and sought relevant consent from the Service User. The Complaints Officer forwarded the complaint to the Consultant in Emergency Medicine and to the General Manager of the Hospital.

The Consultant in Emergency Medicine reviewed the complaint and the relevant notes and spoke to the treating doctor. The Consultant also reviewed the care provided on the day in question.

Outcome and Learning
The Consultant in Emergency Medicine apologised to the Service User/family for the care received in the ED department on this occasion, and was available to the Service User/family, if they wished to discuss further.

As a result of this complaint, the Consultant in Emergency Medicine shared and discussed a number of training articles with the ED clinical team to enhance their learning on the topic of complications of this particular disorder. The Consultant also arranged for the Senior Podiatrist in the Hospital to provide additional educational training sessions in the ED on the assessment and management of the disorder. The ED Consultant and team also reviewed guidelines used by the podiatry team in relation to recommended care and treatment for this condition.

Key learning from this case was that further and ongoing training is required by clinical teams for the management of complex disorders and the complications that can arise and that this is in line with emerging clinical evidence.

Hospital Group

Category: Communication and Information (diverse needs)
Status: Upheld

Background to Complaint
A husband complained that his wife did not receive the correct information from an interpreter arranged by the hospital when she attended an antenatal appointment in the scanning department. In his complaint, he stated that his wife was returning from each hospital visit upset and worried about the health of their unborn child. The couple had to travel a distance regularly for appointments in the hospital. Due to COVID restrictions at the time, the husband could not attend antenatal appointments with his wife. The incorrect information came to light when the woman had to attend an emergency department of another hospital, where it transpired that the translator was mixing up clinical terminology.

Investigation
Following investigation with the clinical team and the translation service provider, it was verified that the same interpreter had been arranged for each hospital visit to translate over the telephone (COVID restrictions) and that the issues raised in the complaint were valid.

Outcome and Learning
The Hospital Patient Advocacy Officer liaised with the clinical staff in the scanning department and antenatal clinic. Following discussion, it was agreed that the husband would attend and act as his wife's interpreter for the remainder of her antenatal care arranged due to the late stage of her pregnancy and her current anxiety levels.

The couple were very grateful for the outcome and thanked all those who assisted with their complaint.

A formal apology was also provided to the couple for the added stress and upset this had caused them.

The Translator Service Provider was also contacted to highlight the issues raised in the complaint, the impact on this patient and the risk that remote translation (over the phone) poses. Patient Services were also made aware of the risks posed by providing remote translation services to women attending the hospital.

Hospital Group

Category: Dignity and Respect (delivery of care)
Status: Upheld

Background to Complaint
Complaint raised verbally by a Service User who had an eating disorder regarding the manner in which they were spoken to by a Care Assistant. When asked about their weight by the Care Assistant (following the patient weighing themselves on the scales) the Service User stated that the Care Assistant stated, 'What, you are so big', and 'You are such a big girl'.

Investigation
The Senior Nurse Manager on duty spoke to the Service User and apologised. A verbal complaint form was completed and the Service User expressed she wished for this complaint to be dealt with formally through stage 2 of the Your Service Your Say process.

The complaint was investigated by the Complaints Officer and the Ward Manager.

The Care Assistant in question was spoken with, and informed that the behaviour and comment was totally unacceptable and was removed from the situation immediately and redeployed to another ward.

Due to the nature of the complaint a preliminary screening of the complaint was carried out to ensure that this complaint did not fall under the HSE's Trust in Care policy, which it didn't.

Outcome and Learning
Another Care Assistant was allocated to sit with the patient for the remainder of the day.

An incident report form was completed.

The Agency that the Care Assistant in question was employed through was contacted and the incident and consequences discussed.

All staff involved in the Service User's care apologised for the distress and offense caused.
A formal letter of apology including the actions taken was issued to the Service User who was satisfied with same.

Hospital Group

Category: Access (appointment delays), Safe and Effective Care (test), Communication and Information (information) and Dignity and Respect (end of life care)
Status: Upheld

Background to Complaint
The Service User experienced delays in receiving a follow-up appointment and was concerned about the amount of time taken. They expressed concerns about the lack of appropriate facilities for a person who has received bad news. The Service User also received mixed information from two different departments about the need for a diagnostic procedure which led to them being unclear as to whether or not this was required.

Investigation
After receiving the complaint, the Complaints Officer conducted a stage 2 investigation under Your Service Your Say. The Complaints Officer discussed the issues raised with the Clinical Nurse Manager (CNM) and the ward staff involved. A review of the medical chart was also undertaken. An investigation report was issued to the Service User.

The Service User was unhappy with the response issued from the hospital and submitted a request for a Stage 3 internal review. A Review Officer was appointed. The Review Officer sought additional information and made contact with the Service User to establish the terms of the review. The Review Officer spoke with staff members involved in the Service User's care and issued a final report detailing the findings and learning from the review process.

Outcome and Learning
- The hospital apologised for their error regarding the booking of the follow-up appointment.
- The issue relating to lack of space for people receiving bad news was noted and upheld.
- The review highlighted the potential for miscommunication on calls between Service Users and administrative staff especially where clinical issues were being discussed.
- It was noted that the absence of a named Clinical Lead contributed to inconsistency in guidelines and practices where care was being delivered to the same person across multiple departments.
- The waiting time for review at the Assessment Unit was also deemed to be too long.

The recommendations from the review included issues to be highlighted to the hospital management team and a number of actions have resulted.

- A commitment has been given to review available spaces and identify a designated area for a person receiving bad news.
- The process of communication between Service Users and hospital staff was reviewed, specifically for calls that would benefit from clinical staff input. A process was developed and implemented for the administrative staff to request clinical input during a call if this is required.
- A named Clinical Lead for the service was identified and tasked with reviewing interdepartmental communication and information sharing processes. This will also improve communication between the hospital and Service Users. The importance of having a named Clinical Lead to provide oversight and drive standards where multiple services or departments are involved is a key learning from this review.

Hospital Group

Category: Safe and Effective Care (treatment and care) and Communication and Information (delay and failure to communicate)
Status: Partially Upheld

Background to Complaint
A relative of a Service User made a complaint about the pain medication prescribed as being inadequate to relieve the person's pain as a result of a pressure injury. The family also felt that the seriousness of the pressure injury was not conveyed accurately to them at the time of discharge.

Investigation
The Complaints Officer confirmed the consent of the Service User to investigate the complaint received and access their personal information for the purposes of investigation. The Complaints Officer reviewed the Service User's medical chart. They also spoke with the Clinical Nurse Manager and the medical staff involved. These staff members reported that the Service User was pain-free at the time of discharge and therefore was only given the necessary medications at that time.

The relative of the Service User was dissatisfied with the response from the hospital and requested a Stage 3 internal review. A Review Officer was assigned and undertook a preliminary assessment of the request for review and met with the Clinical Nurse Manager and the hospital's Quality Manager to undertake a chart review.

The Review Officer issued a final report detailing the findings and learning from the review process.

Outcome and Learning
The Review Officer noted that the pressure injury developed while in hospital and also subsequently deteriorated during the stay. The level of pain reported by the hospital staff and documented in the medical chart did not align with that described by the Service User's family. However, this could not be investigated further but the lack of communication between the hospital and family members ahead of discharge was noted.

Learning:
Safe and Effective Care:
This complaint highlighted the importance of training staff to recognise those at risk for developing complications while in hospital and the need to ensure the training is supported by regular clinical audit to ensure standards of care are maintained.

As a result, the hospital is to re-launch a campaign aimed at preventing pressure ulcers which will improve both the monitoring of and care given to patients at risk of developing these injuries.
Additional education sessions aimed at improving identification of those at risk for pressure ulcers will be provided. Further auditing will be undertaken of the documentation and interventions provided to ensure that they are minimising the risk of pressure ulcers across the hospital.

Communication:
This case demonstrates that clear and consistent communication to the Service User and their family (as appropriate) is central to effective discharge planning and will be highlighted to staff.

Hospital Group

Category: Communication and Information (information) and Safe and Effective Care (continuity of care), (discharge)
Status: Upheld

Background to Complaint
An older Service User was electively admitted for surgery. The Service User lives with their spouse with no other support at home. The Service User asked on two occasions if additional time in the hospital post-surgery could be provided. However, the Service User was discharged home within 24 hours with a drain in situ and was referred to a community support service. The Service User complained that there was an assumption of knowledge around the post-surgery recovery and that their concerns were not taken into consideration. The Service User was given a prescription for medication and not given any written or verbal information about their prescription or what to expect. The Service User became disorientated and confused with this medication at home. The Service User also had a negative experience with the community service and submitted a complaint to the particular service also. The Service User was upset at how the written complaint was responded to. The Service User felt there should have been greater sensitivity to the complaint and someone should have phoned to discuss this in more detail upon receipt of same. Instead the Service User received a lengthy written response. The Service User requested a review of the response and contacted PALS for support.

Investigation
Upon receipt of the call from the Service User the PALS manager took a detailed description of the Service User's experience and interaction with the hospital to date. The issues were themed and assigned to the appropriate areas. The Community Service met with the Service User directly and resolved the matter. The Complaints Officer who had responded to the complaint was contacted and advised of the Service User's dissatisfaction at the response. A face to face meeting with the Service User, the treating Consultant, the Clinical Nurse Manager and the PALS manager took place where all issues relating to the response were aired and addressed. A week later the Service User decided not to proceed to the review stage or go to the Ombudsman.

Outcome and Learning
The primary issues relating to this complaint were how the Service User was communicated with pre and post surgery and the 'assumption of knowledge' that they would appreciate what to expect on discharge home. While the Service User underestimated the personal toil that recovery would take on them, the hospital presumed they would manage despite living with an elderly spouse with no immediate family. The opportunity to refer to the PALS manager at an earlier stage would have enabled a quicker resolution to the complaint and mitigated the stress of the Service User by demonstrating a level of empathy, compassion and acknowledgment of their experience as well as supporting them through the complaints process.

The Service User should have been contacted by phone and offered a meeting in person before the written response was issued to acknowledge their experience and demonstrate an understanding of the severity of the complaint.

Hospital Group

Category: Communication and Information (information)
Status: Partially Upheld

Background to Complaint
A Service User wrote to express her distress following a surgical procedure. The Service User advised that when they woke after surgery that they were was being held down by staff and it felt like they were being strangled. The Service User also advised that the following day when they looked at their neck in the mirror they noted bruising. The Service User advised that when they raised this with staff at the time there appeared to be a communication deficit. A statement was taken from the Service User on the ward, they were examined and discharged without an explanation.

Investigation
The Complaints Officer contacted all staff involved in the Service User's care. The Complaints Officer was advised that the patient had undergone anaesthetic delirium. The Service User did not remember or recollect the period whereby in order to keep their airways clear from obstruction a 'thrust procedure' was performed. The nursing staff were trying to support the Service User and protect them from falling from the bed. The Service User had begun to recollect what they experienced whilst on the ward and coming around from the anaesthetic, following the delirium. When the Service User brought this to the attention of staff on the ward they should have ensured that a member of the anaesthetic team was afforded an opportunity to visit the Service User and explain what had happened. Due to the deficits in communication the Service User reflected whilst at home and submitted a complaint in relation to what she perceived was an attempt by medical personnel to strangulate.

Outcome and Learning
The Complaints Officer set up a virtual meeting with the Service User and the Anaesthetics Team to go through the phases of care in chronological order to address the issues raised in the complaint. The Service User was very happy with this approach. The following learning resulted for the hospital.

- All multidisciplinary team members will continue to engage and attend the National Communications Programme which will support and drive optimum engagement and communications with the multidisciplinary team internally and also with the Service User.

- Promote Service User engagement, while an inpatient, to ensure they are informed, happy with their care and communicated with optimally.

- Quality improvement initiative surrounding patient information leaflet to include content on 'emergence delirium', which can develop as a result of anaesthesia, during transition from unconsciousness to complete wakefulness. Such information will assist Service Users to understand and process this experience, should it occur.

Hospital Group

Category: Safe and Effective Care (treatment and Care)
Status: Compliment

Background to Compliment
A Service User went into unexpected labour at 33 weeks gestation and underwent an emergency caesarean section. The Service User was in a state of shock and found the suddenness of the experience traumatic, particularly as her partner or any family member could not be with her.

Nature of Positive Feedback
The Service User wrote to the hospital to compliment the ward nurses who took excellent care of her. The Service User highlighted their little touches of kindness that 'brought me back from the brink' on many occasions. The Service User stated that the most important aspect of the care she received, for her, was the compassion and understanding that the nurses displayed. The Service User thanked the nurses sincerely for the kindness and love shown to her.

Outcome and Learning
This compliment was shared with the nursing staff who were delighted to know that their care made such a difference. The compliment also highlighted how important the personal touch is and how being cared for with compassion, empathy and understanding can contribute to a person's recovery and well-being.

Hospital Group

Category: Safe and Effective Care (treatment and care)
Status: Compliment

Background to Compliment
A Service User completed the Your Service Your Say online feedback form following their attendance and experience at the hospital's medical assessment unit.

Nature of Positive Feedback
A Service User felt compelled to relate their experience as the staff, from start to finish, were so friendly, supportive and competent. The nurses carried out the relevant tests and completed the necessary documentation so expertly all the while ensuring that the Service User was comfortable and not in any pain. The Service User was also regularly asked if they needed anything to eat or drink during their assessment. The examining doctor was very supportive and thorough. This approach was so appreciated especially as the Service User was aware how much stress the hospital was under. The Service User also noted that strict adherence to infection prevention control measures was clearly evident. The Service User felt so well looked after and wanted to thank the very competent, friendly and supportive staff.

Outcome and Learning
This compliment was passed onto the staff of the medical assessment unit who were happy that their care and attention had such a positive impact on the Service User. The compliment demonstrated that a caring, compassionate and personal approach has a positive and lasting impact on a Service User even when in a stressful situation for them.

Hospital Group

Category: Communication and Information (communication skills) and Dignity and Respect (behaviour)
Status: Compliment

Background to Compliment
A spouse of an older Service User contacted the hospital to advise of an upcoming out-patient appointment. The spouse advised that the Service User has a number of medical conditions which makes wearing a mask for longer than about 10 minutes very uncomfortable. Any longer and the Service User gets breathless and panicky. Prior to the appointment the spouse rang the receptionist of the clinic to discuss how best to manage the Service User as they were at risk of panicking and leaving thereby wasting the appointment and not getting the necessary review.

Nature of Positive Feedback
The Receptionist advised the spouse that they would look into this and contact them back.
The spouse received the call-back, as promised, from this 'very nice' receptionist who advised that she had discussed the Service User's case with one of the nurses and they had a plan to progress the Service User as speedily as possible through the clinic. When the Service User arrived at the clinic, the staff were expecting them. They took great care and they ushered the Service User to a quiet place to sit and ensured that the Service User was seen promptly, thereby reducing the time spent in the clinic.

The spouse advised that this receptionist went out of her way to assist and really listened and heard the concerns raised. This spouse said that this was an example of values in action as purported by the hospital and deserving of acknowledgement. The spouse wished to thank this receptionist for her kindness and for taking the Service User's situation into account. The Service User was also delighted with the care and attention received and wishes to sincerely thank this receptionist and all the staff involved.

Outcome and Learning
This compliment highlights the importance of listening to a Service User and understanding their individual care needs. The Receptionist took the time to listen, discussed the case with a nurse and put in place a solution to enable the Service User to attend the appointment while minimising any stress and resulted in a positive experience at the clinic.

Hospital Group

Category: Communication and Information (information) and Safe and Effective Care (treatment and care)
Status: Compliment

Background to Compliment
A Service User attended the Emergency Department (ED) of a hospital where they waited over 5 hours to see a doctor. It was an extremely busy night in the ED.

Nature of Positive Feedback
The Service User contacted the hospital to advise how a 'very nice' porter escorted them from Triage to the treatment cubical where they had to wait to be seen by the doctor. The Service User stated how the porter was so nice and reassuring and took time out to sit and talk. This put the Service User at ease and alleviated some of the stress of the situation. The Service User was then seen by 'a lovely' doctor and nurse. They introduced themselves and the Service User was delighted to have their names. They talked the Service User through everything they did. The Service User stated in their compliment to the Hospital that these three staff members made the time in the ED a much better experience and for that, thanked them all sincerely.

Outcome and Learning
This compliment highlights the importance of taking time to talk to Service Users especially if they seem distressed. Taking even a small amount of time to reassure them makes their experience so much better. The compliment also highlights the importance of staff introducing themselves and keeping the Service User fully informed of all elements of their care. The care and attention shown by these staff members turned what could have been a negative experience into a very positive one.

Hospital Group

Category: Safe and Effective Care (treatment and care)
Status: Compliment

Background to Compliment
A young Service User was diagnosed with a chronic condition that they were unfamiliar with. They regularly attended a hospital unit for treatment over a number of years, but has recently been transferred to a specialist Consultant and is now no longer under the care of the unit.

Nature of Positive Feedback
The Service User wrote to the unit to thank them most sincerely for their high standard of care and attention which they feel greatly contributed to the improvement of the condition. The Service User highlighted the professionalism of the staff and their dedication to helping over the years. The Service User stated that they have fond memories of their time in the clinic and with the staff. The Service User stated that everyone attending feels indebted to them for the care they provide. The Service User was greatly appreciative of the care received and wished the staff well.

Outcome and Learning
The compliment was forwarded to the staff of the unit. They knew the Service User well and were delighted to know that they made such a difference to the quality of their life and that their time in the unit was positive.
This compliment further reinforces the power of the personal touch in clinical care. The human element of care cannot be underestimated and can have a powerful and lasting impact on a person and can be a positive force in their care and recovery.

Community Healthcare Organisation

Category: Access (resources), Dignity and Respect (End of Life Care) and Safe and Effective Care (Continuity of Care)
Status: Compliment

Background to Compliment
The community care and supports provided to a Service User, particularly during end of life care, which provided comfort to the family.

Nature of Positive Feedback
The family contacted the office of the HSE Chief Executive Officer to express their gratitude for the treatment and care provided to their loved one, highlighting the fantastic care from the doctor, careers, the Public Health Nurse and the community nurses, not forgetting the hospital staff. All the appropriate equipment was provided when needed, everything was done and ultimately this was of great comfort to the family. The family wanted to highlight that regular services continued to run well due to fantastic people who work for the HSE.

Outcome and Learning
The office of the HSE Chief Executive Officer acknowledged the compliment and expressed sympathy for the family's recent bereavement. The office of the CEO sent the compliment to the Chief Officer of the relevant Community Healthcare Organisation (CHO) for onward issue to the relevant services and staff involved.

The compliment was gratefully received by staff working in direct service provision and were delighted that their efforts to support their Service User had such a positive impact on a family's experience at a difficult and sad time. It is important to share positive feedback with staff to demonstrate the far-reaching impact of pro-active and compassionate engagement.

Community Healthcare Organisation

Category: Communication and Information (delay and failure to communicate) and Access (accessibility / resources)
Status: Upheld

Background to Complaint
A parent whose child was going through the referral and initial engagement stages for CAMHS (child and adolescent mental health services), raised concerns regarding accessing the service. The parent outlined difficulties regarding (1) delays in communication, (2) issues with trying to contact the service on the phone (phone not being manned and messages not being responded to), and (3) issues with completing a pre-engagement questionnaire, which is used by the service as an assessment tool. The parent stated that (4) as a family, accessing the service for the first time, there was no knowledge of the service or what to expect, and no point of contact within the service.

Investigation
The Complaints Officer assigned to the complaint carried out an investigation, liaising with the Complainant, the Service Manager and a Psychiatrist who had interacted with the family. The Complaints Officer extracted the main issues that caused the parent concern and discussed the expectations from the complaints process. The parent hoped that service improvement would result from the investigation, in the areas that were highlighted.

The Complaints Officer raised the complaint with the Service Manager, who was very open to discuss ways to make the initial engagement phase as user-friendly as possible for families. The Service Manager explained the delay in communicating with the parent was a result of the staff member assigned going on leave and remaining on unplanned leave due to unforeseen circumstances, for an extended period. The Service Manager provided a comprehensive explanation to the parent on the necessity to complete the pre-engagement questionnaire as comprehensively as possible as it is an assessment tool that the service uses to determine what supports a child requires. This had not been fully explained to the parent at the outset. Addressing the matter of the parent having difficulties contacting the service, the Service Manager acknowledged that this was an issue at present as administration staff were working from home on Occupational Health advice and that they only had temporary cover, a risk assessment had been completed to escalate this and have it addressed.

Outcome and Learning
The Complaints Officer discussed the points raised within the complaint with the Service Manager and together discussed how the Service User experience could be improved. Areas for improvement were identified.

- The current risk assessment and risk rating in respect of monitoring the CAMHS phone are to be reviewed to include this complaint, and escalated again through the relevant channels to be addressed.
- Alternative ways of managing the phone for the service to be identified. Options include; (i) ensuring staff who are working from home have work mobiles and the CAMHS phone or voicemail is diverted to those; (ii) establishing a procedure for a nominated person to check the voice messages at an agreed frequency (minimum daily) and responded to within an agreed timeframe.

- CAMHS to issue a communication to all open cases/Service Users in the event of any planned or unplanned disruptions that affects their service provision.
- CAMHS to explain and highlight the importance of the pre-engagement questionnaire as an assessment tool and the necessity for it to be completed in full.
- CAMHS to draft a 'Service Offer', which outlines what the Service User can expect from CAMHS, introduce the team, provide contact details of the service, and advise of any other relevant information that will make the process easy and accessible to everyone who uses the service. This Service Offer should be provided to each new referral on their initial engagement with CAMHS. The Service Offer should be reviewed and updated annually or as required, to reflect any changes to the service. Best practice would indicate that a child and parent version would be the most user-friendly approach, and it is recommended that two versions are made available.

The Complaints Officer apologised to the parent for the difficulties experienced and set out how CAMHS would use the complaint to make improvements in service delivery.

Community Healthcare Organisation

Category: Communication and Information (communication skills) and Safe and Effective Care (treatment and care)
Status: Compliment

Background to Compliment
A Service User contacted the National Your Service Your Say office to advise that they had presented for their first COVID 19 PCR test recently and had been quite anxious about what to expect.

Nature of the Positive Feedback
The Service User advised that every staff member encountered at the test centre was "brilliant". The environment was calm and the two nurses in particular who performed the actual test did so with humour and professionalism. The Service User stated that this approach effectively settled any nerves and enabled them to receive all the necessary information while being provided with a high standard of care.

Outcome and Learning
The compliment was forwarded to the relevant Community Healthcare Organisation (CHO). The CHO contacted the Service User to acknowledge receipt of the compliment, to thank them for taking the time to submit their feedback and to advise that the compliment would be forwarded to the General Manager and the team at the COVID Test Centre.

Valuable learning can be taken from this feedback in terms of being mindful of Service Users' perspectives, expectations and concerns. While focusing on the clinical aspect of a particular task is important, at times, it can be at the expense of the overall Service User experience. This feedback highlights how important soft skills, such as good interpersonal communication, are in terms of providing a safe, effective and trusted service to the public.

Community Healthcare Organisation

Category: Communication and Information (communication skills) and Access (appointment delays)
Status: Upheld

Background to Complaint

A Service User attended what was expected to be a routine podiatry appointment. However, at the start of the appointment it was outlined that the appointment would involve a detailed overall assessment of the Service User's podiatric health, the completion of an extensive and newly developed questionnaire, the use of several new devices, none of which were previously used in past treatments, and the requirement to provide numerous signed consents to sharing of personal data to organisations both within and outside of the HSE.

In the complaint submitted by the Service User the concern was raised that the data-gathering was hurried and disorganised; that the list of consent questions were simply checked off, and the Podiatrist did not wait to receive consent before moving on to the next question resulting in the Service User having to interject several times to ask for further clarification. The Service User felt, from their perspective, that the process of completing these significant forms of consent for data sharing was a hurried, casual and box-ticking exercise, and viewed it as a form of coercion. The Service User stated that they were not advised in advance of the appointment of what to expect. The Service User also stated in the complaint that the several new podiatry devices that were introduced at the appointment and utilised by the Podiatrist, were not identified or their purpose explained. The Service User further outlined that the podiatrist mentioned a number of possible remedial curatives, but that following the appointment the Service User had difficulty recalling what they were due to the unfamiliar technical language used and proposed that this could be easily addressed if the suggestions had been provided in writing prior to leaving the appointment.

In the complaint, the Service User outlined that the appointment notification stressed the importance of punctuality and instructed the Service User to telephone the podiatrist's office on arrival in car park and await notice to enter. On arrival, the Service User called the number eight times without response. The voice recording on the office phone stated that the office was closed due to the pandemic. The Service User felt that they had no option but to enter the building without consent over the phone being provided. The Service User stated that the Podiatrist was significantly late for the appointment and that on informing the Podiatrist of the out of date voice recording, the Podiatrist stated that they were not aware of it.

Investigation

The Complaints Officer met with the Service User to discuss the issues raised in the complaint. The Complaints Officer then met with the Podiatrist to review the matter and discuss any possible service improvements that could be suggested based on the feedback and the Podiatrist's experience in frontline service provision. The Complaints Officer then liaised with the Service Manager in terms of how service improvement could be implemented.

Outcome and Learning

The Complaints Officer addressed each issue within the complaint and made recommendations for service improvement which have since been implemented.

- Voicemail message: It was acknowledged that this may have led to confusion and annoyance as the wrong information was being relayed. The voice mail message was amended and will be updated as necessary to reflect any changes in service access impacting Service Users.
- Consent form and data protection issue: It was acknowledged that being presented with this documentation at the beginning of an appointment can be overwhelming as people need time to read and process what is being asked of them. It was recommended that all new patients receive the consent forms with their appointment letter. This will allow Service Users to read the information in their own time and discuss with their family if they wish. The Podiatrist will then review the consent form at the start of the appointment and answer any questions that Service Users may have.
- Punctuality of the Podiatrists: An apology and explanation was provided by the Podiatry Manager for the waiting time experienced by the Service User. It was explained that there can be occasions when a clinic runs late or where a Podiatrist has been delayed with another task, and that each Podiatrist tries their best to run an efficient clinic.
- Introduction of new technology: A response was provided by the Podiatry Manager which outlined how the service is continually trying to ensure the delivery of the highest quality treatment with the most appropriate instruments. However, the Podiatry Manager acknowledged that having information about what to expect at a podiatry appointment prior to the actual appointment may better prepare a client and manage any anxiety. An information leaflet has been developed and will be issued with the appointment letter and the consent form.

  The leaflet provides information to new and existing patients under the following headings:
  ~ Aim of Podiatry Service
  ~ How long will my appointment take?
  ~ What do I need to bring?
  ~ What will happen at the assessment?
  ~ The type of instruments a Podiatrist may use (and pictures of the instruments)
  ~ Contact information for the service
  ~ How to provide feedback

  A copy of the new Podiatry Information Leaflet accompanied the complaint report that was issued to the Service User.

The learning and service improvement that has resulted from the investigation into this Service User's experience will be shared and carried forward for the benefit of future patients of the Podiatry Service.

Community Healthcare Organisation

Category: Communication and Information (communication skills)
Status: Compliment

Background to Compliment
A Service User contacted their local Community Healthcare Organisation following their recent experience at the local HSE COVID-19 Test Centre. They were anxious as they didn't know what to expect.

Nature of the Positive Feedback
While the Service User stated that it was a nervous and difficult experience to go through, the staff in the centre were so polite, friendly and reassuring. The Service User had a very positive experience and was very impressed with the care and treatment received. Being from a customer service background, the Service User stated that they know what good service looks like and so felt compelled to contact the service to highlight the excellent customer care received and to thank and say 'well done and keep up the good work' to the staff involved.

Outcome and Learning
The compliment was forwarded to team at the COVID Test Centre. The staff were delighted to hear how their care and approach turned a stressful situation into a more positive experience for that Service user.

This compliment highlights how important the human aspect of clinical care is in a person's treatment and how it can positively contribute to their overall experience even in a difficult situation.

Community Healthcare Organisation

Category: Communication and Information (information)
Status: Upheld

Background to Complaint
A family member, who is the sole carer of another family member, with multiple medical issues, sent in a complaint regarding access to respite services.

On contacting the Older Person Residential Unit, the family member (carer) was informed that due to COVID-19 the facility was not available for respite. The family member (carer) was aware that private nursing homes in the area were able to accommodate respite.

The family member (carer) outlined in a telephone call with the Complaints Officer that they had subsequently attempted to contact the Director of Nursing for the Residential Unit by telephone on a few occasions with no answer.

Following this, the family member (carer) contacted a Public Health Nurse about respite services and was advised to make a complaint.

Investigation
At the time of the complaint, respite services were not being provided in the Older Person Residential Unit due to the guidelines surrounding COVID-19 for HSE residential services.

The HSE had contracted respite beds in two private nursing homes with specific admissions criteria.

The family member (carer) did not receive information in relation to what respite services the HSE was providing and how to apply, either from the Older Person Residential Unit or from the Public Health Nurse.

Outcome and Learning
Following the complaint, the family member (carer) was given the appropriate information and assisted in applying for HSE respite care by the Director of Nursing of the Residential Unit. The family member (carer) was able to access respite care for the family member needing it in a HSE-funded nursing home bed. An apology was given to the complainant.

This feedback resulted in learning for the service.

A learning notice was issued to all social care staff who may be in receipt of service enquires from members of the public, outlining the process required.

- The process will ensure that the enquirer is put in contact with the manager of the appropriate service. If this is not immediately possible, the enquirer's contact details are to be taken and given to the service manager along with the nature of the query.
- The process also stressed that HSE staff should assist the public with their enquiries and attempt to resolve issues locally prior to advising that a complaint should be made.

Community Healthcare Organisation

Category: Access (accessibility and resources) and Communication and Information (information)
Status: Partially upheld with recommendations

Background to Complaint
The complaint was made by a parent who attended a clinic with young children and was dissatisfied at being unable to access the building due to the restrictions arising from COVID infection prevention protocols. As a result, both the parent and children had to wait outside without shelter in inclement weather until access was allowed.

Investigation
The information was examined and it was established that an appointment letter had issued to the Service User though, due to an administrative oversight, it had not included information about COVID related attendance restrictions operating at the centre at the time.

An apology for the oversight was issued.

Additionally, it was acknowledged that the Health Centre was located in an old building and that the premises contributed significantly to the difficult circumstances in terms of physical access on the day.

Outcome and Learning
There was learning for the service in terms of ensuring that relevant information about constraints in the circumstances of attendance at a centre be included with appointment information at the time.

The service also acknowledged the difficulties of attendance for the Service User and their family in terms of the physical environment at the centre.

Recommendations were implemented both in relation to issuing relevant information with appointments and also in transferring the family case to a home based service to ease issues in terms of access for the family at the centre.

Community Healthcare Organisation

Category: Safe and Effective Care (treatment and care)
Status: Compliment

Background to Compliment
Compliment received through the National Your Service Your Say office regarding a positive experience at a local testing centre.

Nature of Positive Feedback
A parent had to bring their young child for a COVID test. The parent submitted a compliment to the national office following the experience. The compliment was forwarded to the relevant CHO.

The parent stated that the staff were extremely efficient, very polite, kind and friendly. The tester was very reassuring and put the young child completely at ease. The tester explained everything that was going to happen. The parent felt that the staff of the COVID testing centre provided excellent service under stressful conditions. The parent wanted to thank the staff and say well done.

Outcome and Learning
Although the parent could not be contacted directly to thank them for this feedback, the compliment was passed to the Testing Centre and brought to the attention of the staff. It was important to highlight to staff that time and effort taken to explain the process and make a person or young child as comfortable as possible results in a very positive experience in an otherwise stressful situation.

Community Healthcare Organisation

Category: Communication and Information (information) and Accountability (finance)
Status: Not upheld with recommendations

Background to Complaint
A Service User provided feedback via the National Your Service Your Say office querying why a full box of facemasks was provided to people attending centres for a COVID test and considered this to be a waste of resources.

Investigation
The circumstances were examined and it was established that the national policy specified that attendees for a COVID test should be provided with a box of facemasks.

The rationale behind this policy is that it is not possible to know who will test positive at time of attendance, or their contact exposure otherwise. A boxed quantity of facemasks is therefore issued to each attendee for use in their home and/or with personal contacts as necessary pending the test result to limit potential emission of infectious particles.

Outcome and Learning
The Service User was advised of the policy as above and that masks be worn by people with a confirmed COVID-19 diagnosis throughout their infectious period and also by those who are household contacts of confirmed COVID-19 cases.

This feedback resulted in the recommendation that staff explain the purpose and use of face masks being provided as per the policy when issuing on-site at centres.

Community Healthcare Organisation

Category: Accountability (finance)
Status: Upheld

Background to Complaint
A complaint was received regarding a General Practitioner who charged a General Medical Services (GMS) card holder for a routine monitoring blood test.

Investigation
The Complaints Officer contacted the GP requesting the reason for the charge. The GP responded stating that blood tests were not covered under the GMS contract and referred to a copy of a poster that was issued by the Irish Medical Organisation which states Phlebotomy services (routine Blood Tests) are not covered.

Upon further investigation this was found, however, to be in breach of part 11 of the GP's contract which states the following:

A medical practitioner shall provide for all eligible persons, on behalf of the HSE, all proper and necessary treatment of a kind usually undertaken by a GP and not requiring special skill or experience of a degree of a kind which a GP cannot reasonably be expected to possess and ensure that no discrimination or differentiation is exercised as between the treatment of eligible and private patients.

Outcome and Learning
It was determined that it would be expected that a GP is capable of taking bloods and therefore it is a skill a GP would be expected to possess and if the GP is performing blood tests for private patients they will need to also perform them for GMS patients as not to discriminate.

The GP agreed to refund the patient for the cost of the blood test on this occasion.

The charging of GMS patients for routine blood tests has become a common occurrence and while resolved on a case by case basis the learning shows it needs to be addressed nationally.

Community Healthcare Organisation

Category: Communication and Information (information)
Status: Upheld

Background to Complaint
Complaint from a General Medical Services (GMS) card holder in relation to accessing their GP. Client found it difficult to contact the GP surgery stating that the phones were constantly engaged.

Investigation
The Complaints Officer contacted the practice and discussed the issue with the practice who confirmed the phones were under pressure with the demand on the service.

Outcome and Learning
The practice acknowledged the phones need to be upgraded and they have commenced the installation of a system with a higher capacity.
The practice also recorded a message informing patients that they are experiencing a very high level of calls and that if the patient leaves a voice mail they will get back to them as soon as possible.

Community Healthcare Organisation

Category: Access (visiting times)
Status: Not Upheld

Background to Complaint
The complainant was contacting to advise of their upset in relation to restrictions on visiting times for a family member, who is a resident in a public long stay unit.

Investigation
The long stay unit in question was providing four indoor visits per week at the time of this complaint. The visits were to be pre-booked to protect meal times as well as complying with local Infection Prevention and Control (IPC) COVID committee guidelines on temperature monitoring and completion of declaration forms. All visiting was accommodated without additional resources and ensured all residents receive their fair share of visits per week.

The Director of Nursing of the long stay unit in question provided information regarding the visits recorded for the complainant with their family member.

It was identified that the spouse of the family member had pre-booked all of the four visits available. However, it was highlighted that two visitors are permitted at each visit. The complainant could have accompanied the spouse at any of these visits. In addition, outdoor and window visits were limitless in compliance with the Long Stay Unit's IPC COVID committee guidelines.

Outcome and Learning
The Director of Nursing agreed that they would ensure that all residents' family members were advised again of the four visits per resident and that two people can attend each visit. All staff were advised of the importance of communication with family members at this difficult time.

Community Healthcare Organisation

Category: Dignity and Respect (Alleged inappropriate behaviour) and Communication and Information (communication skills)
Status: Partially Upheld

Background to Complaint
A parent contacted their local health centre with a query in relation to funding for glasses for children with disabilities. In the complaint, the parent stated that the staff on the phone were rude and advised that they don't provide that service. The parent explained how they felt that this was unfair. The staff suggested that the parent use their domiciliary care allowance to pay for them and abruptly ended the call.

Investigation
The Complaints Officer contacted the health centre and spoke with the manager and then the staff involved. The staff admitted that the parent was correct in what they said. The staff acknowledged and expressed regret for the hurt and upset that was caused.

The funding grant in relation to glasses was in fact changed and not handled by the local health centre. This was not upheld. However, the attitude and manner of the staff in the way they spoke to the parent was upheld.

The Complaints Officer actively listened to the parent and contacted then as promised to keep them updated even when there was little or no information to share.

Outcome and Learning
All staff completed customer service training.

It is important that staff communicate with empathy, patience and respect. Good communication goes a long way to developing and maintaining a positive relationship with a Service User. This is especially important where a person may be upset or even angry.

Following the service interaction, the parent stated that they lost faith in the HSE. However, the approach of the Complaints Officer, who engaged in regular and clear communication with the parent and kept them updated and informed on the status of the complaint, restored their faith.

The Complaints Officer enshrined the HSE's core values; Care, Compassion, Trust and Learning.
All staff should demonstrate these values on a daily basis with all stakeholders.