HSE Your Service Your Say

Anonymised Feedback Learning Casebook
Quarter 1 2023

The first quarter edition of the casebook for 2023 presents a total of 20 cases covering both complaints and compliments received by Hospital Groups and Community Healthcare Organisations.

The casebook features a total of **10 complaints**; 7 complaints from Hospital Groups and 3 from Community Healthcare Organisations that were investigated and/or reviewed along with their outcomes. The casebook also features **10 compliments,** 8 from Hospital Groups and 2 from Community Healthcare Organisations, which highlight the learning to be gained from positive Patient and Service User feedback.

Key issue categories:

Complaints

- *Communication and Information*
- *Safe and Effective Care*
- *Access*
- *Dignity and Respect*

Compliments

- *Communication and Information*
- *Safe and Effective Care*
- *Improving Health*
- *Dignity and Respect*
- *Participation*

The publication of the casebook is part of the HSE's commitment to use Patient and Service User feedback as a tool for learning and to facilitate the sharing of that learning.

Introduction

The cases presented in the casebook contain themes and issues that need to be examined in the context of quality and service improvement. The learning gained from Patient and Service User feedback helps target and prioritise improvement efforts as well as highlighting good practice to be promoted and replicated.

The casebook features a total of 20 cases comprising of 10 complaints and 10 compliments received by Hospital Groups and Community Healthcare Organisations covering the first quarter of 2023.

The dominant theme for complaints in this Q1 2023 edition of the casebook relate to *Communication and Information* with this category featuring in all 10 complaint cases presented. Other categories such as *Safe and Effective Care, Access and Dignity and Respect* feature in 6 of the 10 complaint cases presented.

Communication and Information relates to issues such as general communication skills, providing information, keeping the patient/service user informed, telephone etiquette, signage to direct and relay information and the timeliness of the provision of information.

Safe and Effective care issues concern the carrying out of treatment procedures, the timeliness of test results that can impact on scheduled follow up appointments, the identification of an incident, as well as the careful and respectful noting of patent data on health care records. *Access* relates to appointments such as organising, rescheduling and booking in and for *Dignity and Respect*, the main issue relates to how care was delivered within a clinical setting and being aware how behaviour can impact on others.

The positive feedback received mainly related to the category of *Communication and Information* with this featuring in 8 out of the 10 compliments presented. The other categories of positive feedback featured are *Safe and Effective Care, Improving Health, Participation and Dignity and Respect* with one or more of these categories represented in 8 of the 10 compliments presented.

The casebook will be widely circulated to staff within the HSE and shared with Complaints Managers who will consider the learning from these cases.

Learning from feedback is fundamental in providing high quality healthcare services. Listening to and acting on the views, concerns and experiences of patients, Service Users and their families enable us to guide decision making to improve services and provide the best possible care.

Hospital Group

Category: Safe and Effective Care (Treatment and Care); Communication and Information (Communications Skills)
Status: Upheld

Background to Complaint
A Patient was scheduled to have a procedure under sedation. The procedure was completed and the Patient advised the staff after the procedure that they had a horrible experience during the procedure and felt the whole procedure. They felt that sedation was not sufficient for such a procedure and suggested that the hospital change its policy of completing the procedure using sedation and instead have it completed under general anaesthetic.

Investigation
The Complaints Officer had a number of conversations with the Patient who explained their experience. The Complaints Officer brought the complaint to the attention of the Clinical Nurse Manager (CNM2) for the Unit and the treating Consultant. The CNM2 and the Consultant reviewed the Patient's chart and the CNM2 discussed the issues raised with the Patient.
It was explained to the Patient that is was the Hospital's policy to complete such procedures under sedation. This allows for a quicker recovery period and also for patients to leave the Hospital relatively soon after their procedure has been completed.

Outcome and Learning
The Complaints Manager apologised to the Patient for their experience of the service as it had not met their expectations.

It was agreed by the admitting Consultant following consultation with a Consultant colleague that the Patient, who required a repeat of the procedure, be offered that procedure at a different hospital where it could be completed under general anaesthetic. This was offered to the patient, who was very happy to accept the offer. A referral was made to the alternative Hospital and the Patient was accepted.

Listening to the Patient's concerns and acknowledging these enabled the hospital to respond appropriately, and, where possible, put in place alternative arrangements to address the concerns and meet the Patient's needs.

Hospital Group

Category: Communication and Information (Information)
Status: Compliment

Background to Compliment
The Chronic Kidney Disease (CKD) nurses run patient information evenings for patients who are suitable for kidney transplant. This involves talks from the CKD nurses, Renal Consultants and previous dialysis patients of the Hospital who have had successful kidney transplants in the hospital and wish to share their experiences.

Nature of Positive Feedback
A Patient who had attended one of the information sessions shared their feedback with the Hospital which was very positive.

The Patient stated that they felt much calmer about their kidney disease and felt confident about the prospect of going through a possible transplant. They stated that they found the information session very beneficial and would recommend it to all patients facing the same health issues.

A second Patient also wrote to the service thanking them for the information session, stating that it was a fantastic evening, well presented in a clear and easy manner to understand.

Outcome and Learning
The service was very happy to receive this positive feedback which was shared with all of the staff involved. These sessions are a valuable source of information for renal patients who are waiting for a transplant as it allows them to hear from experts in the field as well as previous dialysis patients who have been through the transplant process and raise any queries they may have.

A successful working kidney transplant will mean that the patient no longer requires dialysis. Transplant patients can live longer and have a better quality of life than those who remain on dialysis. Providing expert information helps patients to understand and prepare for the journey they are on and answer their questions in a calm and supportive environment.

Hospital Group

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

Background to Compliment
A Patient had an accident and attended the Emergency Department (ED) in the Hospital following the accident. The Patient wrote to the Hospital following their discharge to compliment the staff on their experience of the ED.

Nature of Positive Feedback
The Patient wrote that they wished to express nothing but praise for all staff involved in their care; from the ambulance crew who were lovely, to the nurses, doctors and staff who completed the various tests that the Patient required. The Patient continued that the staff were efficient, polite, attentive and knowledgeable.

The Patient also complimented the catering staff who provided them with soup and sandwiches, an incredibly welcome surprise.

Outcome and Learning
This positive feedback was communicated to all staff involved in the care of this Patient who were very appreciative to hear this. It is very encouraging that the Patient had such a positive experience.

Hospital Group

Category: Communication and Information (Communication Skills) (Information); Participation (Patients/Family/Relatives)
Status: Compliment

Background to Compliment
A young Patient attended the ED Paediatric department of the Hospital with their Parent. The Parent of the child wrote to the Hospital to compliment the loveliest of staff that they met in the Hospital.

Nature of Positive Feedback
The Parent wrote that their child was looked after so well. Staff were kind, gentle and did everything to put their child at ease. The Parent complimented the nursing staff who were so nice and calm and caring. They took time to answer all of their child's questions and reassure them. The staff provided toys and books to keep their child entertained. When their child was admitted to the Paediatric Department, they also met with fantastic staff on the ward, all so patient and kind. They spoke to their child respectfully and again answered all of their questions. The Parent also wrote that they were blown away when a treat was provided by the doctor for their child which was dropped into the room.

The Parent complimented the food. As it was over the Christmas period, both the Patient and their family were delighted to receive Christmas dinner including a visit from Santa. The letter concluded by acknowledging the level of professionalism and care shown which blew the family away.

Outcome and Learning
The very positive feedback was shared with all of the staff involved. It demonstrates that clear, effective communication is essential and provides great comfort to both patients and their families. When doctors and nurses are speaking to patients, especially children and their parents/carer's, listening and communicating using clear understandable language is critical in providing reassurance and contributing to a positive care experience. The compliment also highlights the importance of making the effort to create a child friendly hospital environment.

Hospital Group

Category: Safe and Effective Care (Test); Communication and Information (Information); Access (Appointment)
Status: Upheld

Background to Complaint
A Patient attended the Hospital for an appointment. Upon arrival the Patient was informed that their appointment would need to be rescheduled as the results of their CT scan, which was required for the appointment, had not been reported on. The Patient made a complaint as they were upset that they had a wasted journey and had even organised a person to bring them to the appointment as it was some distance from their home.

Investigation
The Complaints Officer discussed the complaint with both the Outpatients Secretary and the Radiology Services Manager. The reading of the CT scan had been outsourced and unfortunately was not ready for the appointment. The Consultant advised on the morning of the appointment to cancel the appointment due to the absence of the CT scan report, which was necessary for the review appointment. Efforts were made to contact the Patient to advise of the cancellation and a rescheduled appointment but the Patient could not be contacted.

Outcome and Learning
The Complaints Officer made contact with the Patient and apologised for their experience and that the service provided was far from satisfactory.

The Patient requested an appointment at a different Hospital, which was closer to their home. This was organised for the Patient.

Following this complaint, all staff involved were advised to check and ensure that test results are available prior to review appointments. If they are not available the appointment must be rescheduled in a timely manner.

Hospital Group

Category: Safe and Effective Care (Treatment and Care); Communication and Information (Delay and Failure to Communicate) (Information)
Status: Upheld

Background to Complaint
This complaint was received from a family member of a Patient who had received an anonymous letter which stated that the patient received care that was not in line with best practice. This caused significant distress to the family member who then made contact with the hospital to ascertain what had happened in relation to the Patient's care.

Investigation
The initial investigation by a Complaints Officer discovered that there was a clinical incident in relation to the Patient's care during a procedure. The Complaints Officer referred the complaint onward to be logged as an incident and separately managed under the Incident Management Framework (IMF).

Unfortunately, due to a change of staff and miscommunication between services, the family were not informed of the complaint being progressed as an incident and investigated under the IMF. Consequently, the family experienced a significant delay in communication from the Hospital who were waiting on the outcome of the incident review.

The completion of the incident review had also taken a long period of time as it required the input of an external expert. Following the review, it was recommended that a clinical audit be undertaken.

In the interim, the family had made repeated contact with the hospital for updates and had not received timely responses. This was due in part to changes in, and unplanned absences of personnel in the quality and complaints departments which added to the frustration and distress of the Patient and their family.

New staff appointed to the Quality and Patient Safety Office re-established contact with the family to update them on the progress of the complaint and to see what could be done, from the family's perspective, to bring this issue to a satisfactory conclusion.

The family were extremely upset that they had not received any replies to their correspondence for a significant period of time. The family said that the only request they made was for a meeting with the Service Manager and the Consultant Physician involved. This was immediately organised and a meeting date and time agreed with the family.

Outcome and Learning
At the meeting, the issues of poor communication from the service, together with the delays and lack of response when updates were requested by the family, were discussed at length and apologies were given. The family were also issued with a copy of the Incident Review Report. The care of the Patient was discussed and any questions the family had were answered. The family expressed their upset in relation to the timeline and the delay in meeting with hospital personnel. However, the family were satisfied with the conduct and outcome of the meeting and felt that all their questions were finally answered and they were happy to bring the matter to a conclusion.

The key learning for the service as a result of this case was to highlight the importance of open disclosure and communication and engagement with patients and their families throughout the complaints process as, in this case, the lack of engagement and communication compounded what was a very traumatic time.

This complaint involved issues that could be investigated under Your Service Your Say but also clinical judgement* issues that required examination under a different process. It is essential that matters of clinical judgement are identified quickly and referred to the proper process. It also highlighted the importance of communication with patients and/or their families to outline how issues will be examined and then provide regular updates throughout the process.

**Clinical judgment is defined as being a decision made or opinion formed in connection with the diagnosis, care or treatment of a patient.*

Hospital Group

Category: Communication and Information (Information)
Status: Point of Contact Complaint - resolved

Background to Complaint
A Patient returned an Inpatient Feedback Form to the Maternity ward following the birth of their child. The Patient reported a positive experience with the Midwives during their childbirth experience. However, the Patient stated that they were dissatisfied with their experience with the Anaesthetist.

Investigation
The PALS Coordinator contacted the Patient by telephone as requested on their form. The Patient firstly emphasised that their experience with the midwives was very positive. The Patient then described their experience of epidural anaesthetic. The Patient stated that the first anaesthetist who attended was “very rough” and “couldn’t get the epidural in”. The Patient described how this experience was distressing. Subsequently a second anaesthetist arrived who was successful in administering the epidural anaesthetic.

With the Patient’s permission, the PALS Coordinator reviewed the Patient’s notes. The PALS Coordinator subsequently had another telephone conversation with the patient and explained to them that the first anaesthetist who attempted the epidural injection was a Senior House Officer (SHO) and when that attempt was unsuccessful, the SHO contacted the Consultant Anaesthetist for assistance. The second anaesthetist who attended the Patient was the Consultant and administered the epidural successfully.

Outcome and Learning
The PALS Coordinator expressed regret that the Patient had found the experience distressing but assured them that the SHO followed best practice by contacting the Consultant Anaesthetist when the first attempt was unsuccessful. The PALS Coordinator informed the Patient of the formal complaints process should they wish to make a complaint. The Patient stated that they were satisfied with the explanation and would not pursue a formal complaint at this time. The Patient asked for details on how to obtain a copy of their medical notes. The PALS Coordinator emailed the Patient details on how to make a Subject Access Request.

Keeping a patient informed of what is happening during a procedure can help alleviate distress and provide reassurance regarding actions taken.

Hospital Group

Category: Safe and Effective Care (Treatment and Care); Communication and Information (Communication Skills) (Information)
Status: Compliment

Background to Compliment
A Patient was admitted to a surgical day ward to undergo an elective surgical procedure. The Patient provided very positive feedback via Your Service Your Say, together with suggestions to further improve the patient experience. The Patient was subsequently contacted by a Group Quality & Patient Safety staff member to elicit further information on some of the helpful suggestions offered.

Nature of Positive Feedback:
- **Dignity & Respect**. The Patient related the overall experience as 'fantastic' stating that they were made to feel very comfortable. They were seen promptly on arrival. Each staff member introduced themselves providing their name together with an explanation of the procedure and an explanation of what was going to occur.
- **Safe & Effective Care:** The Patient felt that the experience was very 'patient centred'. The use of various aids were explained with assistance provided in their use. Each clinical staff member took a detailed history of the Patient. The Patient felt particularly safe as they were provided with a colour coded theatre cap used only for patients with a particular history. The feedback included positive remarks with regard to approach to record and safeguard the Patient's personal property.
- **Communication & Information:** At all times, the Patient was informed of what was happening and described the discharge information as excellent and thorough. At all times, the Patient stated that they were treated respectfully by staff.

Outcome and Learning:
During discussion with the Patient, reference was made to the hospital appointment letter. The Patient felt that the appointment letter provided conflicting information regarding the need to fast and did not provide any information regarding what personal belongings to bring to hospital. The appointment letter read as being directed only to the parents of paediatric admissions advising parents to only bring one child with them. There was also reference to a daily charge without any reference to exemptions, which led to the Patient bringing cash with them on admission. Arising from this discussion with the Patient and with the staff in the surgical day unit, the following recommendations for service improvement were made.

1. Revision of the hospital appointment letter to provide clear unambiguous information as follows:

    - Clear information relating to requirement to fast/ light breakfast, etc.
    - Suggested list of items a patient may require
    - Make clear the importance of ensuring ample time to liaise with ones GP prior to admission regarding the possibility of the need to discontinue certain medications before undergoing a surgical procedure.
    - Make clear any necessary information relating to health insurance or hospital charges.
    - Revise letter to reflect the demographic nature of service users, ensuring the availability of appointment letter in various languages.

- Review letter on a scheduled basis to ensure up to date and accurate information is provided to patients.

2. Consider revising the approach to obtaining a patient's history as each clinical member of staff took a detailed, thorough but repetitive history. While the Patient felt safe, it also led them to wonder if staff were communicating effectively as a team.
3. The provision of a wall clock for patient comfort. Patients have usually surrendered their watch/phone on admission in preparation for theatre.
4. Need to have clear signage requesting patients to keep noise to a minimum in consideration of others who are in the recovery stage following surgery.
5. Provide some basic written post-operative information as it is not always easy to recollect verbal information provided following a general anaesthetic.

This feedback and recommendations was provided to the Clinical Nurse Manager together with support for implementation of recommendations.

Hospital Group

Category: Communication and Information (Communication Skills); Safe and Effective Care (Infection Prevention and Control)
Status: Compliment

Background to Compliment
The Parent of a young Patient took the time to contact the Your Service Your Say Team in relation to a recent attendance by their child for a procedure. The compliment documented their child's attendance from start to finish and highlighted the little things that were done by all staff to make the child's experience a good and positive one.

Nature of Positive Feedback
The child's Parent expressed how happy they were with how all staff engaged with their child. Another thing that they noted was the excellent adherence to hand hygiene. All the nurses and the doctor made the procedure more comfortable and they really listened to their child as they could tell how nervous they were. The whole experience was much less traumatic than it could have been for both the child and the Parent. This will make the child's next attendance an easier experience for both.

Outcome and Learning
The compliment was passed onto all staff involved in the Patient's care. The compliment demonstrated that the simple things like listening to a young patient and knowing how to make them feel at ease really makes a difference to the whole experience for everyone involved. It can also turn what could have been a negative experience into a positive one where a young patient will not be nervous coming again for another procedure.

Hospital Group

Category: Communication and Information (Communication Skills); Safe and Effective Care (Treatment and Care); Improving Health (Holistic Care) (Catering)
Status: Compliment

Background to Compliment
The Patient was admitted to Acute Medical Assessment Unit and remained there 3 nights and was transferred to Surgical 1 for a period of care.

Nature of Positive Feedback
The Patient expressed deepest thanks to all who looked after them so wonderfully from the moment of admission until discharge. The attention received, day and night, in both the Acute Medical Assessment Unit and in Surgical 1 was amazing. Everyone from porters, housekeeping staff, catering staff, nurses and doctors, were kind, helpful, caring and supportive. The constant attention from all staff, checking frequently about their needs, and the staff's cheerfulness and professionalism, gave the Patient a great sense of comfort and security. In particular the patient expressed gratitude to the Day Nurse on Surgical 1 and the Night Nurse. The Patient stated that they were exceptionally attentive and competent in all they did for the Patient and to their fellow patients on the ward. They lifted their spirits and made time for each person despite being so busy. Lastly, the Patient wished to thank those who prepared and served the lovely meals, the chaplain, and those who maintain the beautiful oratory with memories of it being a place of so much consolation during the Patient's late Parent's many stays in the hospital. The Patient thanked the General Manager and the Senior Administrative team for careful management of the wonderful Hospital.

Outcome and Learning
This compliment was circulated to all relevant managers/staff and to the staff mentioned to ensure that they are aware that the professional and excellent care they provide every day to the patients in their care is noticed, appreciated and most welcome. An acknowledgement issued from the Office of the General Manager of the Hospital to the Patient thanking them for taking the time to submit this positive feedback and that is was appreciated by the staff.

Hospital Group

Category: Communication and Information (Information); Safe and Effective Care (Health Care Records)
Status: Upheld

Background to Complaint
A Patient attended Cardiology Services and subsequently a referral to the CATH lab was made. The Patient noted on copy of referral that “denies alcohol” was noted. Patient took offense to this phrase, indicating that it made it sound like they were not being truthful regarding their alcohol consumption (Patient does not drink alcohol at all).

Investigation
The complaint was acknowledged. The appointed Complaints Officer met with the doctor who made the referral. The doctor advised that this is the standard and universal terminology used in referrals in clinical settings to denote that a patient doesn’t consume or hasn’t consumed alcohol. The Complaints Officer phoned the Patient to apologise for the upset and distress caused. The Complaints Officer provided an explanation regarding the terminology used and reassured the Patient that in no way was the doctor intending to insult them or imply that they were lying or that they drank. A response letter outlining same was also issued to the Patient, with information on their right to request an internal review or to request a review from the Office of the Ombudsman.

The Patient sought an internal review of their complaint. The review recommended that the Patient’s records / referral letter be amended and the phrase “denies alcohol” be replaced with agreed wording to suit both the Patient and the hospital/doctor.

Outcome and Learning
A Complaints Officer should endeavour to resolve the complaint to the satisfaction of the complainant giving due consideration to their rights under the Data Protection and FOI acts.
In addition the terminology used in referrals / clinical settings should be explained and discussed with patients to avoid any misinterpretation or misrepresentation.

Hospital Group

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

Background to Complaint
A Patient had an appointment at 5pm and arrived 10 minutes ahead of time as requested in appointment letter. The Patient took a seat in the waiting area although no administration staff were available to direct patients. The Patient was left waiting until 6:45pm even though the appointment letter had said it would be an average of 20 minutes of a wait. The Patient was attending for a procedure and was nervous as they were aware the procedure would be uncomfortable and even painful. However, having experienced a wait time of nearly 2 hours, they felt that this increased their anxiety.

While the Patient was very pleased with the service they received during the procedure, they did not receive an apology from any member of staff at the clinic nor was it acknowledged by any staff that the wait time was excessive. The Patient requested their concerns to be addressed so that other patients would not have the same experience.

Investigation
The complaint was brought to the attention of the Manger of the service for examination.

Outcome and Learning
A response issued to the Patient which contained a formal apology for their experience on the day. The response also outlined how the clinic is run by GP's and supported by a healthcare assistant but unfortunately, has no administration support. The Manager highlighted that the following actions are in progress following the Patient's feedback:

- Review of signage for clinic.
- Review of checking in process.
- Recruitment of administration staff approved.
- Meeting with staff members to discuss the management of the waiting area and the need to update patients if delays are likely.

The Patient was thanked for their feedback and the service improvements that have resulted and how these will be of benefit to them in the future and for other patients.

Hospital Group

Category: Communication and Information (Communication Skills); Dignity and Respect (Ethnicity)
Status: Compliment

Background to Compliment
A Patient submitted a compliment to the Hospital stating that they would be forever grateful for the care they and their child received, in particular from the Paediatrics Registrar who looked after their child in the NICU.

Nature of Positive Feedback
The Patient and their child were readmitted after discharge through the baby clinic and the Patient stated how they were very distressed but that the Paediatrics Registrar was amazing. The Patient stated that the Registrar is the kindest and most genuine doctor they have ever met. Not only did the Registrar look after their child with exceptional care but the Registrar also looked after the Patient. The Registrar was also very respectful of the Patient's partner's cultural background.

The Registrar was very professional and very approachable and the Patient felt at such ease leaving their child in the hospital knowing that they were being looked after by this doctor. The Patient stated how the Registrar is a credit to the hospital and they feel that the Hospital are incredibly lucky to have such an amazing doctor on site and every parent and baby who enters the hospital is lucky to have them care for their child.

Outcome and Learning
This compliment was brought to the attention of the Paediatrics Registrar who was delighted that their attention to the care of their young patient and the family brought much comfort in such an anxious time.

Hospital Group

Category: Communication and Information (Diverse \needs)
Status: Compliment

Background to Compliment
The Parent of a Patient wrote to the Hospital to relay, "*A massive thank you to all the staff on the Surgical Day Unit (SDU)*". The Parent advised that their child had a diagnosis of ADHD, intellectual disabilities and Autism and stated that during their child's appointment all of the staff they encountered on the unit "*made a very stressful day a lot easier*".

Nature of Positive Feedback
The Hospital contacted the Parent to thank them for this feedback and establish what learning from their experience could be shared throughout the organisation. The Parent advised that travelling to the hospital is very stressful for their child and their family and that this is a constant concern when having to go somewhere outside of their normal day to day routine. However, from the moment the family arrived into the SDU, the Parent confirmed that staff immediately identified this child's additional needs and without having to request any assistance, staff members:

- Arranged for a quiet room for the family within the ward.
- Reassured them that their child being noisy was not a problem.
- Enquired on what distractions / toys might help their child become more comfortable and then provided a number of toys throughout the child's stay.

The Parent noted how the staff on the ward put them at ease and they wanted to relay their sincere thanks to staff "for their understanding & compassion".

Outcome and Learning
The Clinical Nurse Manager (CNM) of the SDU reported that all staff consistently strive to assist patients with additional needs. SDU caters for children with any additional needs and are skilled in identifying these. They have experience working closely with children who have a diagnosis of Autism and ADHD. Staff on the ward are aware that extra supports like providing a quiet room, distractions and reassurance are invaluable to the patient and their family.

This compliment highlights the importance of having experienced and empathetic staff members who can assess and modify their approach when required. By quickly identifying this child's additional needs and providing specialist assistance, the child's visit was transformed from a stressful upsetting experience to a largely positive one. The Parent reported that their child will not have the same fear when attending the hospital on their next visit.

Hospital Group

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
The Parent of a Patient with additional needs contacted the Hospital by phone to register a complaint. The Patient was scheduled to attend a surgical Outpatient Department (OPD) clinic, however, the appointment was cancelled at short notice as the consultant was unavailable due to illness. The Parent advised on the call that they were understanding of the cancellation as it was a circumstance that could not be avoided but noted their disappointment with the lack of communication from the OPD clinic about how the clinic operates. The Parent advised how they must put a big effort into planning these appointments as their child, the Patient, has additional needs. A trip to a hospital is something that they need to be very prepared for as the Patient finds certain situations very difficult to cope with. The Parent advised that they attempted to contact the clinic numerous times over the 3 weeks leading up to the appointment date but nobody answered their calls.

Investigation
The Complaints Officer met with the Clinical Nurse Manager (CNM) of the OPD Clinic. The Complaints Officer relayed the dissatisfaction the Parent had described at not being able to get through to a member of the OPD clinic team. It was noted that the Parent was frustrated as they could not get the information needed to prepare the Patient adequately for the OPD appointment.

The CNM contacted the Parent and spoke to them. They apologised that the Parent was not able to get through to the clinic. They then discussed the various concerns of the Parent and what they needed to know in advance of the appointment. These included:

- How busy the clinic is generally?
- Would there be much younger children present, possibly making noise?
- Is there somewhere else the Patient could wait to be seen?
- Is there a map of the hospital available so the Patient has a visual idea of what to expect?
- Is the appointment time given actually the time they will be seen?
- How long will the appointment itself take?
- Will there be more than one doctor in the room for the appointment?
- Is there going to be a physical examination on the day?
- The need for surgery should not be spoken about in front of the Patient. Any such conversation will have to be well planned out and delivered with their Parents present.
- The language used to ask the Patient questions needs to be considered.

Outcome and Learning
The CNM agreed a plan with the Parent for the Patient's next appointment to the OPD. They also agreed to liaise closer to that date to reiterate the agreed plan and to identify any new concerns or developments. The CNM also undertook to communicate all of the Patient's additional needs to the Consultant in advance of the next appointment.

The Parent was very satisfied with this outcome and made reference to how the initial negative experience was turned into a positive one. The Parent was hopeful that it would have a lasting effect for future attendances at the hospital.

From the point of view of a family with a child with additional needs, it can be extremely challenging to have to attend an appointment without being able to properly prepare. The family now have clarity and a detailed personalised and child centred plan.

This will also benefit other patients and parents in attendance at the clinic as their experience will also be enhanced if the plan for the patient with additional needs is executed properly.

Community Healthcare Organisation

Category: Communication and Information (Communication Skills) (Information) (Participation); Improving Health (Empowerment) (Holistic Care)
Status: Compliment

Background to Compliment
A Public Health Nurse runs a Breastfeeding Support Group every week. A Service User attends this Group and has been attending for almost 4 months, since their child was 3 weeks old. The compliment was submitted through the HSE Website and forwarded to the Team and Public Health Nurse.

Nature of Positive Feedback
The Service User contacted the service to say that the Public Health Nurse (PHN) is absolutely amazing! The Service User stated that the PHN has helped them with breastfeeding and when they finished breastfeeding, the PHN helped them to manage to move onto bottle feeding safely. The Service User stated that the PHN was, 'an absolute sweetheart and I can honestly say I would have been lost without her'. The Service User stated that the PHN always goes above and beyond and is happy to answer any questions or address any worries. The PHN is always ready and willing to help. The Service User felt that they could not say enough good things about the PHN and the amazing help they have given to the Service User over the last almost 4 months.

Outcome and Learning
The feedback from the Service User who attended the Breastfeeding Support Group provided valuable information on service delivery. The Public Health Nurse put a lot of time and effort into developing the Group and it is great that the information and support provided through the Group makes such a positive difference to those attending and is also a lovely recognition of such an important service.

Community Healthcare Organisation

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

Background to Compliment
A Service User contacted the service that manages the Parkinson's Voice Group. The Parkinson's Voice Group is an initiative that seeks to provide clients with a way to practice their voice exercises, offers clients an opportunity to connect with other Service Users with Parkinson's and provide support and encouragement in a safe and supportive environment.
The Group reduces the reliance on ongoing individual speech and language therapy sessions.
The Group moved online during the COVID pandemic and has maintained this format which has proven hugely successful.

Nature of the Positive Feedback
The Service User commented that the Group provides an "*excellent therapeutic input with consistent, skilled therapist lead*." The Service User also noted that this initiative offers those suffering with Parkinson's "*successful Speech Therapy on-line in a group context with pleasant therapists.*"

Outcome and Learning
Establishing different ways to support people living with chronic conditions, such as Parkinson's, can offer a valuable connection with others experiencing the same condition as well as access to skills and other supports to assist in managing and coping with the condition. In addition, having such services also available online, where appropriate, can enable clients with mobility issues, and those without transport, to continue to engage easily in such Groups and benefit from meaningful and productive interactions that they might not otherwise have been able to access.

Community Healthcare Organisation

Category: Communication and Information (Telephone Calls)
Status: Upheld

Background to Complaint
A Parent of a young child made a complaint regarding the behaviour of a staff member following a telephone call to access a service. When the Parent phoned the clinic after a number of previous calls, the staff member who answered the phone on this occasion refused repeatedly to give their name or their position and said that it was their first day. The Parent felt disrespected and that the experience was very upsetting.

Investigation
An investigation was carried out. The staff member was requested for their response to the complaint. The staff member advised that they had initially refused to give their name but had later done so. The staff member accepted that they should have given their name to the Parent earlier in the conversation and has committed to offering their name during telephone calls in future. When they said it was their first day, they meant it was their first day in the week at that particular clinic location, as they work at a number of locations. The Staff member was not, therefore, aware of the Parent's earlier communication with the clinic.

Outcome and Learning
An explanation and an apology was provided to the Parent.

Following this complaint staff were reminded to ensure that '*hello my name is*' be used when answering telephone calls and for staff to give their name and title, location or any other information that is considered relevant.

The '*Hello my name is*' campaign is simple – reminding staff to go back to basics and introduce themselves to Service Users properly. It is the start of making a vital human connection and building person-centred compassionate care.

Community Healthcare Organisation

Category: Communication and Information (Information); Access (appointment)
Status: Upheld

Background to Complaint
An afternoon clinic was cancelled at short notice. Text communication was sent to the affected Service Users with rescheduled appointment times for earlier in the day. However, no option was given to contact the service regarding the new allocated times. A Service User made a complaint regarding the cancelling of their appointment at short notice and with no consideration for their time or the arrangements that they had to put in place to attend the clinic in the first instance. The Service User was extremely annoyed at having taken the afternoon off work to attend the original afternoon appointment but with morning commitments and a distance to travel, the Service User was unable to attend the new earlier appointment time.

Investigation
The afternoon clinic had been cancelled due to staff vacancies, unscheduled absences and training.

Outcome and Learning
The complaint was resolved when an exception was made for the Service User to attend a clinic appointment during lunch hour.

Clinic administration should make direct contact with service users if it is necessary to cancel appointments and reschedule within 48 hours. Distance travelling to clinics should also be considered in the rescheduling of clinics within a tight timeframe.

Community Healthcare Organisation

Category: Communication and Information (Communication Skills) (Information); Access (Appointment) (Facilities); Dignity and Respect (Delivery of Care) (Alleged Inappropriate Behaviour)
Status: Upheld

Background to Complaint
The Parent of a Service User issued a complaint to their local oral health services expressing concern regarding services provided to their young child.

In the complaint, the Parent stated that communication with the Clinician treating their child had been poor for some time. The Parent felt that they had a condescending manner when discussing their child's oral hygiene. Their child was due to have extensive treatment soon but initial work needed to be done to improve their oral hygiene before the treatment could commence. The Parent also stated that they were uncomfortable with the manner in which the Clinician spoke to them, that they felt the Clinician was often abrupt in their manner and said inappropriate things such as advising how much experience they had and that the child was lucky to be obtaining their services.

On one of the visits to the clinic, the Parent stated that they and their child arrived to the unit for an appointment which the Parent thought was for a procedure. The Parent stated that they arrived and pressed the intercom button and immediately gained entry. The Parent stated that they sat in the reception area for over half an hour (no porter was present that day). After some time, the Parent asked a passing nurse if the wait would be much longer and stated that the nurse answered abruptly that the Parent should have checked in. The Parent states that as there was no one to check in with, as the porter was absent, they did not know what to do. The Parent stated that the nurse advised that the Parent was lucky the specialist was willing to still see their child.

When their child was eventually seen, the Parent was told by the Clinician that although the hygiene had improved it was still not up to standard to carry out the procedure. The Parent stated that the Clinician motioned for them to come and take a look. At this point the Parent stated that the Clinician took a dental probe to their child's gum and poked until it bled. The Parent said that they found this upsetting. The Parent also stated that the nurse asked the Clinician if they would advise about the information session for the family. The Parent alleges that the Clinician replied that there was no point as they wouldn't understand as they are not medically trained and that they would just proceed with booking the procedure when the hygiene was up to standard.

The Parent stated that they got very upset and asked the clinician when they intended to carry out the procedure, if at all. Communication broke down and the Parent advised that they became quite upset at this point and was removed from the room by, who they assumed was the Practice Manager. The Parent said they thought they would be given a chance to discuss what had happened and why they were upset about their child's treatment and the interaction that had just taken place. However, the Parent stated that the person who had removed them from the room just shushed them, walked them down a hall and out the door, closing the door behind them.

Investigation
The Complaints Officer called the Parent to arrange to meet with them and the Principal Dental Surgeon who would address the clinical elements raised in the complaint. The meeting took place the following week.

In the interim the Complaints Officer arranged to meet the Clinician with the Principal Dental Surgeon and the Practice Manager to discuss the complaint. The Principle Dental Surgeon and the Complaints Officer arrived to the building early to do a walk around and inspect the areas of concern raised in the complaint, such as, can you access the building by pressing the bell, enter the reception and be left to sit there potentially for half an hour unattended. They also looked at the signage in the building, general communication with the Service User and the Parent as well as correspondence that that was issued regarding appointments for the Service User.

Outcome and Learning
The meeting went ahead with a statement being provided by the Clinician and the Practice Manager.

The following points were noted from the meeting:
- Communication with the Parent/Service User was not ideal.
- While the Clinician thought they were being clear with the plan regarding the Service User's treatment it was not followed up in writing.
- Appointments issued for the Service User was not communicated efficiently.
- Appointment letters issued did not outline what treatment would be offered at each session, leading to confusion and unrealistic expectations.
- It was also advised that there was an issue with the printer at the time the Service User was attending the service, which made information difficult to read. This may have led to further confusion for the Parent/Service User.

Recommendations / Actions arising from this complaint:
- The Service User will be moved to another Clinician as it was mutually felt that the family/ patient and doctor relationship was beyond repair.
- An apology was issued regarding the communication failure from the Clinician.
- In relation to the information session not proceeding on the basis that, the Parent '*wouldn't understand as they aren't medically trained*', it was explained to the Parent that no malicious intention was meant. The information session was to be provided at the time of the procedure - a dual purpose appointment. It was best to provide the information at the time of the procedure as against some time in advance of the procedure taking place. This process is to be reviewed and the finalised process is to be clearly set out for Service Users and their Parents as appropriate.
- In relation to referencing the Clinician's years of experience, the Clinician advised that they were only trying to reassure the Parent and Service User of their experience and expertise. It was noted that English is not the Clinician's first language. This feedback will be taken on board.

Further improvements agreed by the service.
- In order to prepare the Service User for treatment, the oral health service is offering oral hygiene support also. These appointments will be booked immediately, with a view to commencing further treatment in early March.

- In relation to Service Users/Parents presenting to the unit, there will be additional signage to direct Service Users/Parents on how to check in to the clinic and there will be a contingency plan put in place should the porter be out sick.
- Appointment letters will now issue with a clear notice as to what the appointment is for.
- In relation to the issue raised regarding the lack of support provided to the Parent on the day by a Senior Manager, following a review of this issue, there was a recommendation made to the Head of Service Primary Care to review current processes in the unit to ensure that adequate resources are in place should a service user or their family wish to provide feedback or require support in relation to complaint management.

All issues were addressed at the meeting with the Parent of the Service User and the complaint was closed informally with follow-up up correspondence issued to them confirming the recommendations agreed with a copy issuing to the Head of Primary Care.