# HSE Your Service Your Say

## HSE Anonymised Feedback Learning Casebook Quarter 3 2022

The publication of 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.

This edition of the casebook presents a total of 18 cases covering both complaints and compliments received by Hospital Groups, Community Healthcare Organisations and National Services.

The casebook features a total of **11 complaints**; 5 complaints from Hospital Groups and 6 from Community Healthcare Organisations that were investigated and/or reviewed along with their outcomes. The casebook also features **7 compliments;** 4 from Hospital Groups, 2 from Community Healthcare Organisations and 1 from a National Service which highlights the learning to be gained from positive feedback.

**Key issue categories:**

Complaints

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

Compliments

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

# Introduction

The HSE welcomes and encourages those who use our services to share their experience with us. Feedback, both positive and negative, can provide unique insights into the standards of care those who use our services receive and is integral to business improvement.

Learning from feedback is fundamental in providing high quality services. Listening to and acting on the views, concerns and experiences of patients, service users and their families enable us to provide the best possible care feedback.

The learning gained from Patient and Service User experience helps target and prioritise improvement efforts as well as highlighting good practice to be promoted and replicated.

The cases presented in the case, 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 18 cases comprising of 11 complaints and 7 compliments received by Hospital Groups, Community Healthcare Organisations and National Services covering the third quarter of 2022.

The dominant theme for complaints in the Q3 2022 edition of the casebook relate to *Communication and Information* with this category featuring in 8 of the 11 complaint cases presented. Other categories such as *Access*, *Accountability*, *Dignity and Respect and Safe and Effective Care* featured in 6 of the 11 complaint cases presented.

*Communication and Information* concerns issues such as general communication skills and the provision of clear and easy to understand information as well as keeping the patient/service user informed. *Access* also features prominently with issues around accessibility such as parking as well as appointments. For Dignity and Respect, the issues concern end of life care while *Safe and Effective Care* relates to issues regarding the treatment and care received. Accountability related issues around responding to patient feedback.

The positive feedback received also mainly related to the category of *Communication and Information* with this represented in 5 of the 7 compliments presented. Other categories featured include *Safe and Effective Care* and *Dignity and Respect*.

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 across services 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 Patient and Service User experience.

## Hospital Group

**Category:** Communication and Information (Information) (Communication Skills)
**Status:** Partially Upheld

**Background to Complaint**
A patient logged a complaint about not being able to obtain blood forms from the hospital so that bloods could be done at their local hospital instead of having to go to the GP as there is a cost issue with having these done by the GP. The patient spoke with a nurse and alleged that the Nurse was inconsiderate of their request. The patient was unhappy with the interaction. The patient also stated that if they could not get the blood forms, their bloods would not be monitored and they had no follow up appointment with the service.

**Investigation**
A letter of complaint was sent to the Complaints Officer. The Complaints Officer liaised with the Advanced Nurse Practitioner in Rheumatology regarding the issues raised. The Advanced Nurse Practitioner prepared a response addressing the issues raised by the patient. The Complaints officer prepared a final report on the matter and issued this to the Complainant.

**Outcome and Learning**
The complaint highlighted issues that gave rise to actions to strengthen and enhance communication of information about and provided by the service.

Training and information sessions were provided to:

- Ensure appropriate engagement and interactions with patients and families.
- Ensure that staff are aware of the limits of service provision so that they can communicate this early to patients and their families.
- Ensure that Staff check patients and families' understanding of what can or cannot be provided by the service/hospital so as to manage expectations. Specifically, to advise patients that whoever writes the blood forms are also responsible for monitoring the results. Rheumatology nurses do not have capacity to monitor all these results.
- Ensure that Rheumatology patients are aware that, unfortunately, they are not covered under the chronic disease list and therefore bloods will need to be paid for when done by the GP.
- Reassure patients that, despite the hospital not being able to provide the service themselves, the hospital does link with healthcare providers in the wider community and can address any situations that arise.

## Hospital Group

**Category:** Communication and Information (Communications Skills) (Information)
**Status:** Compliment

**Background to Compliment**
A patient was admitted to the Hospital via the Emergency Department with complex needs. The patient is a wheelchair user and non-verbal. The Patient Advocacy Liaison (PALS) team were contacted by the patient's spouse as they were concerned that the patient would develop a pressure ulcer, as the patient had unfortunately developed multiple pressure sores on a previous admission. The patient's spouse was unhappy with the lack of implementation of a care plan in relation to the patient's hygiene needs and the need for frequent repositioning to reduce the risk of developing pressure sores. The patient's spouse also requested a pressure relieving mattress for the patient.

**Nature of Positive Feedback**
The PALS Manager contacted the Clinical Nurse Manager (CNM) on the ward and discussed the details of the concerns that the patient's spouse had raised with them. The CNM made contact with the patient's spouse and advised her of the nursing care plan that was in place for the patient and that a pressure relieving mattress would be placed on the patient's bed.

**Outcome and Learning**
The patient's spouse phoned the PALS team to let them know how happy they were that their voice had been heard.

The patient's spouse expressed their satisfaction and appreciation for the help and assistance they had received and relayed that they could really notice a difference in the patient's mood and felt that they were being well cared for. The patient's spouse also commented that they had also observed the delivery of care and described it as 'amazing'.

The patient's spouse complimented the PALS service and was delighted with the follow up and support.

The importance and value of communicating effectively with patients and their families was highlighted to all staff involved.

Communication is one of the most important skills and alleviates a lot of concerns and worries for patients and their families.

Once patients and their families are aware of the procedures and the time line, they feel reassured with the care that they are getting. Using the Assist Model[1] is very important as it has a step by step approach to effective communication. Having the service user centre and first in our approach keeps us grounded and on the right path.

[1] The Assist Model is a best practice communication tool – more information available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/assist-model-of-communication-poster-june-2021-.pdf

## Hospital Group

**Category:** Dignity and Respect (End of Life Care); Communication and Information (Communication Skills)
**Status:** Upheld

**Background to Complaint**
After an accidental death took place in the community, a Coroner's case was instigated and a Post Mortem (PM) Examination was arranged to be completed in the City Mortuary. As the deceased was a child, it was agreed by the Hospital Pathologist that an initial portion of the PM examination would take place in the hospital and the PM would then be completed in the City Mortuary. The deceased was not a patient of the hospital and had been pronounced dead at the scene of an accident.

The immediate family members of the deceased arrived to the Hospital with the deceased and their expectation was that they would stay with the deceased. Extended family members also made their way to the Hospital. The family did not have a good experience whilst attending the Hospital. They felt they were not given enough time and access to the deceased. The family went home and the deceased was brought to the City Mortuary for the PM to be completed.

Some weeks afterwards, the family spoke with another bereaved family. The other family spoke very highly of the supports that the Hospital had provided them during their own bereavement. They outlined how they felt supported at the time of their bereavement and through several processes in the weeks and months afterwards. They could not understand how this family had such a different experience. The family then contacted the Hospital with a complaint.

**Investigation**
The Complaints Officer spoke with various members of staff involved on the evening in question. The Complaints officer felt that communication between staff was unclear. The Hospital Pathologist had not been clear with Radiology in the Hospital about what was expected and this was compounded by the Hospital Mortuary Technician being on leave that day. Furthermore, the family arriving in the ambulance was unexpected. In the context of a partial PM being carried out by the Hospital in a coroner's case, the Nursing Lead placed in charge of engaging with the family was unclear of exact timelines around the PM and transfer to City Mortuary and the protocol around providing access to the family and arranging ongoing bereavement support.

**Outcome and Learning**
Albeit belatedly, Medical Social Work engaged with the family and linked them in with the appropriate bereavement supports including referral to First Light (service for parents whose child has died), the information and support day run by the social work department and inclusion in the Hospital remembrance service and book.

Assistant Director of Nursing Site Managers have developed an algorithm so that no matter what is occurring in the Hospital at any given time, out of hours' staff members are aware of the necessity to contact the Medical Social Work Department as soon as possible in order to provide family with guidance around process, provide immediate support, link the family in with more local services and invite them to Hospital run events.

In addition, an 'End of life Coordinator' has also been appointed whose remit is to drive such improvements along with other aspects of End of Life care and support.

## Hospital Group

**Category:** Communication and Information (Delay and Failure to Communicate)
**Status:** Upheld

**Background to Complaint**
The parent of a patient wanted an update from the treating Doctor. The patient was an in-patient and the parent was frustrated that they were not getting any response to requests for information.

**Investigation**
The Complaints Manager brought the complaint directly to the attention of the treating Doctor and asked the Doctor if they could make a call to the parent to discuss their complaint.

The Doctor apologised to the patient's parent for not getting in touch sooner and took the time to answer all of the parent's questions relating to the care of the patient.

**Outcome and Learning**
The parent of the patient was very pleased and very thankful that the Doctor had taken the time to address concerns and that the Doctor had taken the time to call the parent.

The parent of child also followed up with a call to the Complaints Officer to thank them for their assistance.

This complaint highlights the importance of making sure that all parents are kept fully informed of their child's medical condition and care plan. Parents need to be given the time to meet with and discuss their child's care with the medical teams treating them.

## Hospital Group

**Category:** Communication and Information (Information) (Delay and failure to Communicate)
**Status:** Upheld

**Background to Complaint**
The hospital was contacted by the parent of a patient who was extremely concerned that the patient had no follow up on test results. The parent thought that here was no treatment plan in place for the patient or if there was one, it had not been communicated or discussed with them.

The parent was concerned that the lack of follow up would have an adverse effect on the patient and that their condition may worsen as a result.

**Investigation**
The Complaints Officer contacted the secretary of the treating Consultant. The treating Consultant offered to retrieve the patient's healthcare records and review them along with the complaint with the Paediatric Consultant.

The patient had a further appointment and was seen by the Consultant and Registrar in the Paediatric Day Ward. The parent of the patient had an opportunity to discuss their concerns with the Consultant and a plan was put in place for the care of the patient. This included a new prescription being sent to the patient's GP which was communicated to the parent.

The Complaints Officer organised for the Consultant's secretary to call the patient's GP to confirm that they had received this prescription.

The GP advised that they would fax the prescription to the Pharmacy and the Complaints Officer followed up with the parent to confirm this arrangement.

The Complaints Officer contacted the complainant to confirm the closure of the complaint to their satisfaction. The parent responded to the Complaints Officer directly and expressed their gratitude for following up and ensuring that their concerns for the patient had been listened to and addressed.

**Outcome and Learning**
The importance of clearly communicating with patients and their families, particularly the families of young patients was highlighted to the Consultant and their team. By listening to the parent's story, deficits in communication were identified and a plan put in place with the medical team to address these deficits. The importance of arranging follow up appointments and completing actions agreed at appointments was also highlighted.

## Hospital Group

**Category:** Dignity and Respect (End of Life Care); Communication and Information (Communication Skills) (Information)
**Status:** Compliment

**Background to Compliment**
The family of a patient who passed away wrote to the Hospital to highlight the positive experience they had with staff at the Hospital when they were experiencing the tragic and heart breaking loss of their child.

The patient had been transferred from a Maternity Hospital to Paediatric Intensive Care Unit (PICU) at the Hospital but sadly passed away in their parents' arms.

**Nature of Positive Feedback**
Clinical Nurse Specialist (CNS) team communicated clearly with the family about the treatment and care plan that their child would receive. The clear communication from the CNS team was felt by this family to be wonderfully supportive.

The whole PICU team (Consultants, Nurses, Medical Social Workers, Psychologists, Chaplin and Medical Photographers) wrapped themselves around the child and the entire family and ensured that their every need was met. The family felt the level of support they received was truly outstanding.

The team were hugely supportive in providing what was needed so that they could bring their child home and attend the funeral.

**Outcome and Learning**
The family suffered a heart-breaking loss in the Hospital but they wanted to say that the way they were treated by the staff supported them through their ordeal. The family said that the level of care and attention that their child received was a great comfort to them and that they feel it will continue to give them comfort as the years pass.

Staff working in a kind, compassionate, collaborative and professional way despite an extremely stressful environment can make a difference and have a lasting impact. These efforts provided solace to a distressed family and made a difference to their experience.

## Hospital Group

**Category:** Safe and Effective Care (Patient Property)
**Status:** Compliment

**Background to Compliment**
A family member of a patient emailed the Patient Advocacy Liaison (PALS) team to ask for help to locate the patient's suitcase, which had their personal belongings. The patient had been brought into the Hospital by ambulance and had been transferred to a number of different wards before eventually being moved to the Intensive Care Unit (ICU). The family member could not locate the suitcase or find anyone to help them locate the suitcase and this was a source of significant distress. The family member advised that the patient would be very upset by the loss of some of the personal items within.

**Nature of Positive Feedback**
The PALS Manager went to Emergency Department to search for the suitcase but could not find it. They then went to the various areas that the patient had been since they arrived in the Hospital and still could not locate the suitcase. They emailed the National Ambulance Service and asked them to link with the Paramedic crew who brought the patient in to the Hospital to see if they remembered the patient's suitcase. They responded and were able to identify specifically what room they had left the suitcase in. The PALS Manager went back to Emergency Department and spoke to the Clinical Nurse Manager 3 and a search of the ward was arranged. The suitcase was eventually found and was returned to the patient in ICU.

PALS contacted the patient's relative to tell them the news and they were overwhelmed and delighted that the personal belongings had been found.

**Outcome and Learning**
The patient's relative took the time to write a heartfelt note to the PALS team to thank the PALS Manager for the efforts that went into locating the patient's suitcase. The family member felt that by going the extra mile to find the suitcase that the Hospital staff provided reassurance to them and their family that the Hospital cared about all aspects of the patient and what was valuable and important to the patient and their family.

The learning from this is that, while the loss of personal property occurs and may seem to be of less priority to the business of the day, all staff need to be cognisant of the importance of recognising what a patient / family see as really important.

By providing support, with what appears to be minor or non-clinical issues, staff can help build a trusting and empathetic relationship between the patient, their family and the Hospital and provide a positive care experience.

## Hospital Group

**Category:** Access (Parking)
**Status:** Upheld

**Background to Complaint**
Complaint regarding no access to disabled parking spaces when patient arrived for their physiotherapy appointment. This was due to the fact that the existing spaces were inaccessible as a result of refurbishment works and scaffolding that was erected for same.

**Investigation**
The Complaints Co-ordinator in the hospital referred the complaint to a Delegated Complaints Officer, with a copy issued to the Maintenance Manager and the hospital's newly designated Access Officers for their review and input.

Examination of the complaint indicated that in planning for refurbishment works and relocation of buildings (portacabin), there was an oversight in relation to the access to disabled car parking spaces in close proximity to the main hospital building and indeed the rehabilitation/physiotherapy department.

**Outcome and Learning**
As a result of a collaborative response to this complaint, the following actions have been put in place;

- There is one disabled car park space now available at main reception and this will revert to 2 spaces once the temporary reception (portacabin) is removed.
- There is a company scheduled to arrive on site to mark out 4 disabled car parking spaces in the public car park near the Physiotherapy Department. This was the area identified by the Access Officers with a greater need for disabled car parking spaces.
- There are also a further 3 disabled car parking spaces planned for the main entrance where you enter the hospital grounds over the next few weeks.

The learning from this complaint is that in order to ensure appropriate access to buildings, an Access Officer should be invited to be part of the Project/Building Meetings multidisciplinary team meetings.

In the response to the Complainant, in addition to outlining the actions taken as a result of their feedback and apologising sincerely for the distress caused to them on this occasion, it was advised that should a similar situation arise in the future, prior to the above actions being carried out, that the Complainant should contact reception from their car and the assistance of a porter to help them to their appointment would be provided.

This satisfactorily closed the complaint.

## Hospital Group

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

**Background to Compliment**
Patient attending Hospital appointment.

**Nature of Positive Feedback**
Patient stated that as they had not attended the Hospital previously they were a bit apprehensive and nervous. However, from the minute they went inside they felt as ease. The patient stated that they had come from the underground car park and when they got to the door they realised they had forgotten their face mask. However, a staff member promptly offered them a spare one of theirs. The patient, when they got out of the lift they had to ask for directions to the particular building for the appointment. The asked a passing member of staff and they couldn't have been more helpful and brought the patient to another lift and pointed them in the right direction. When the patient got to the clinic they were met by the registration staff who was equally as lovely and couldn't have been more helpful. The patient stated how they had been emailing the registration staff back and forth regarding appointments and they always replied promptly and without fail.

The patient received their procedure at the clinic by the doctor and the patient commented on how the doctor was so reassuring and nice and explained everything and put them at ease. In fact all the staff working alongside the doctor were reassuring.

The patient stated how they were genuinely amazed by the efficiency of every single person that they came into contact with, so much so that they felt they had to put pen to paper, as they am well aware that people usually only write in to complain.

The patient stated that they only have the upmost praise for the kindness and care that they received and all their dealings with the registration staff in the clinic.

**Outcome and Learning**
Staff being kind and helpful on a patient's journey is something a patient will never forget and puts them at ease at an anxious and upsetting time.

## National Service

**Category:** Communication and Information (Information)
**Status:** Compliment

**Background to Complaint**
Following discharge from a maternity hospital, a Service User was advised to have a smear test after having a baby as this was HSE policy. When the service user tried to act upon the advice given they told that they were not eligible and would have to pay to have this done privately.

The Service User was extremely disappointed and wanted to know why, if it was HSE policy to have a smear after having a baby, was it not offered under the screening service for free?

Also the Service User wanted to know why there had been a change from 3 year screening to 5 year screening.

**Investigation**
The programme contacted the relevant staff in the maternity hospital to discuss this case and it was identified that a midwife in the maternity hospital had quoted out of date information. The programme provided the maternity hospital with the correct up-to-date information which was that a Service User does not require a postnatal screening test unless they are due to have a screening test within the normal recall recommendations.

The Complaints Officer apologised to the Service User for their experience and provided a full explanation around the recall times for screening being extended from 3 years to 5 years which was due to screening progressing from smear tests to HPV screening.

**Outcome and Learning**
The Complaints Officer, together with the Quality Assurance team, developed a communications improvement plan which included:

1. Maternity hospitals were formally advised of all up-to-date information to ensure that all midwives could provide the correct information to new mothers going forward.
2. The Screening Training Unit are developing a significant education intervention for all maternity units on relevant and accurate information provision to Service Users.

This will ensure that, going forward, the correct information is provided to all Service Users by their service provider.

## Community Healthcare Organisation

**Category:** Communication and Information (Information); Safe and Effective Care (Participation)
**Status:** Compliment

**Background to Compliment**
A parent of a young person who had engaged with Child and Adult Mental Health Services (CAMHS) contacted the HSE via Your Service Your Say to provide feedback on their experience of CAMHS and the impact of that engagement on their family.

**Nature of Positive Feedback**
The parent expressed their gratitude for the service, commitment and dedication the staff showed to them as a parent and to their child throughout the engagement with the service. The parent highlighted the professionalism, kindness and compassion that they experienced.

The parent outlined the impact of their child's mental health on the family and how the child was 'not present' and 'absent', and thanked the team for bringing their child back to them. The parent thanked the team for the learning they have gained and for keeping the child at the centre of all decisions and the care plan, stating that the overall experience was the epitome of 'person-centred' care. The parent concluded that they cannot thank the team enough and the impact on the family has been immeasurable.

**Outcome and Learning**
This feedback evidences the positive impact that good communication, as well as keeping the service user at the centre of decisions relating to their care, can have not only on the person who uses the service but on their wider family circle.

## Community Healthcare Organisation

**Category:** Accountability (Patient Feedback)
**Status:** Not Upheld

**Background to Complaint**

The Complainant, a 'close relative', requested a review of a delegated Complaints Officer's decision not to investigate a complaint as it fell outside of the permitted timeframe as set out Your Service Your Say and Part 9 of the Health Act 2004.

The delegated Complaints Officer, having examined the complaint, liaised with the 'close relative' and reviewed the Service User files, ascertained that the subject matter of the complaint related to issues in 2016 and 2017. As the complaint was only submitted in late 2021 it was therefore decided that the complaint was outside the statutory 12-month time period for submitting a complaint as set under Section 47, Health Act, 2004.

The Complainant, 'close relative' sought a review of the delegated Complaints Officer's decision submitting further documentation and extracts from a Freedom of Information request. The key issues outlined and highlighted by the 'close relative', concerned the care, treatment and engagement provided by the HSE Public Health Nurse, the Safeguarding Team, and the provision of supports provided by a third party provider.

**Investigation**

The delegated Review Officer appointed to examine the complaint and the decision of the delegated Complaints Officer undertook the following steps and interactions so as to gather and inform themselves of all aspects of the complaint:

The delegated Review Officer liaised with key services identified within the complaint i.e. safeguarding, public health nursing, and the third party service provider and held a meeting with the 'close relative' so as to listen to the family and the human impact of the matters raised and to establish circumstances around the delay in making the complaint within the statutory time frames.

The delegated Review Officer examined Section 47 of the Health Act, 2004 which states:

'*Section 47(1) states that – A complaint must be made within the specified period or any extension of that period allowed under Section 47(3).*

*Section 47(2) states that the specified period is 12 months beginning before or after the commencement of this section, but not later than – (a) the date of the action giving rise to the complaint, or (b) if the person by whom or on whose behalf the complaint is to be made did not become aware of that action until after that date, the date on which he or she becomes aware of it.'*

*Section 47(3) states that a complaints officer may extend the time limit for making a complaint if in the opinion of the complaints officer special circumstances make it appropriate to do so.'*

The key issues for the delegated Review Officer were:

(i) awareness on the part of the 'close relative' of the issues giving rise to the complaint at an earlier time to the actual submission of the complaint, and
(ii) whether or not the delegated Complaints Officer had erred in their examination of the complaint and the applicable legislation, as while it was clear that the complaint related to a period of time outside of the 12-month time frame, the delegated Complaints Officer can exercise discretion as set out under section 47(3) and determine if there were any special circumstances to extend the time frame for making a complaint.

With regard to the awareness of the complainant of the issues giving rise to the complaint, the delegated Review Officer concluded that there was sufficient evidence to suggest the Complainant, 'close relative' could have reasonably acquired the facts arising during 2016 and 2017. This was clearly set out by the Complainant, 'close relative' in their initial complaint. In addition, there were further opportunities to establish facts. These reasonable options included initiating the Freedom of Information request sooner and not waiting for over 4 years in addition to raising matters at the time as opposed to waiting until many years later to raise a complaint.

The delegated Review Officer also examined whether there were special circumstances for extending the time frame for making a complaint as provided for under section 47(3). Whilst there were some factors that may have contributed to a delay, there was no special circumstances which allowed for over a 4-year delay in initiating a complaint.

**Outcome and Learning**
The delegated Review Officer decided as follows:

The passage of time was too long to render this a valid complaint examinable under the Heath Act, 2004. The time delay impacts in carrying out a full, proper and fair examination.

Following the review, the delegated Review Officer decided that they were unable to vary or amend the delegated Complaints Officer's decision and therefore affirmed the original decision.

Learning:

- The importance of understanding and communicating the time limits for submitting a complaint as set out under Section 47(2) of the Health Act, 2004;
- The importance of delegated Complaints Officers fully examining the awareness and knowledge of the complainant of the issues giving rise to the complaint as per Section 47(2)(b);
- Importance of the delegated Complaints Officer to consider 'special circumstances' as provided for under Section 47(3) that may impact on submitting a complaint within the 12-month time frame;
- Importance of meeting the complainant to explore the complaint, reasons and causes for delay in submitting a complaint and the importance of the human element involved in making a complaint.

## Community Healthcare Organisation

**Category:** Access (Accessibility / Resources)
**Status:** Upheld

**Background to Complaint**
The Civil Registration Service received three complaints from the Office of An Coimisinéir Teanga (the Language Commissioner) regarding its failure to provide services in Irish to service users who wanted to conduct their business in Irish, as provided for by the Official Languages Act 2003. The complaints specifically referred to the service's failure to respond in Irish to communication received in Irish.

**Investigation**
The investigation confirmed that the Civil Registration service had not complied with the legislation by responding in English to communication received in Irish. The Act also provides that headed stationery and signage must be in Irish and English or Irish only.

The service has since contacted the complainants and the Office of An Coimisinéir Teanga and apologised for failing to respond in Irish. The service has also committed to updating its signage and automated responses in line with the Act.

**Outcome and Learning**
Staff in the Civil Registration Service were made aware of their statutory obligations under the Act and how to access translation services as required. The HSE has information on the Official Languages Act and the HSE's Irish Language Strategy 2019-2023 at https://www.hse.ie.

## Community Healthcare Organisation

**Category:** Communication and Information (Delay and Failure to Communicate) (Information)
**Status:** Upheld

**Background to Complaint**
A complaint from a Service User of Home Support Services. The home care agency providing care on behalf of the HSE had ceased bringing the Service User for a daily walk. This upset the Service User as this was the only chance that they had of getting out of the house every day.

**Investigation**
When the agency was contacted to discuss the complaint, they advised that yes this was in fact the case. The agency advised that the reason for the change was that their insurance had changed that year and one of the stipulations of their new insurance policy was not to take clients away from their home. The agency had advised the client of this prior to this taking effect, giving the client sufficient notice.

**Outcome and Learning**
As the daily walk was a key part of the Service User's care, the Home Support Office have sourced a new agency who will continue to take the Service User for their daily walks.

Communication between the agency and the Home Support Office needs improvement:

- significant changes to the provision of care needs is to be notified to the HSE in order for the HSE to plan with Service Users.
- any communication between the agency and the client should be also sent to the HSE Home Support Office.

## Community Healthcare Organisation

**Category:** Communication and Information (Information)
**Status:** Upheld

**Background to Complaint**
Person wished to receive 2nd COVID Booster Vaccination under 'immunocompromised' category. HSE website indicated that this was an eligible category and advised such persons to 'consult their GP'. Person attended at vaccination centre to learn that they must have a letter from their GP confirming immunocompromised status, and so was refused a vaccine.

Website did not specifically say that a letter from the GP indicating immunocompromised status was required, and Complainant first learned of this on turning up at the vaccination centre.

**Investigation**
The HSE website was not clear in indicating that a GP or Consultant letter was required to confirm eligibility for vaccination under 'immunocompromised' category. Patient received an apology from the Operational Lead at the vaccination centre and was invited to return for vaccination with a GP Letter.
The website was updated to clearly state that a GP or consultant letter was required in order to obtain the vaccine. Patient was notified of this and thanked for their feedback.

**Outcome and Learning**
Requirement for HSE online information to be comprehensive and absolutely clear on the requirements for access to vaccination under the categories determined by Public Health, and to communicate this effectively.

## Community Healthcare Organisation

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

**Background to Compliment**
A parent who attended the dentistry service with their children.

**Nature of Positive Feedback**
The parent advised how all of their children have had numerous appointments with the dental service and that the dentist and the staff including the nurses, have all been so kind and gentle with the children. They treated them with respect, explained everything to them in simple terms, and ensured that as their parent, I also understood. A very professional and kind service.

**Outcome and Learning**
The positive review was circulated to all staff to acknowledge the professional service provided. It's important for managers to communicate compliments to staff and to acknowledge good customer service.

## Community Healthcare Organisation

**Category:** Communication and Information (Delay and Failure to Communicate); Accountability (Patient Feedback)
**Status:** Upheld

**Background to Complaint**
The family of a service user emailed Your Service Your Say regarding their dissatisfaction with the time delay in the completion of a Systems Review on the care provided to their late relative, a former resident of one of the mental health units.

A Systems Review was commissioned by the Area Director of Nursing following the receipt of an anonymous complaint in relation to the care provided to the late resident during the twelve month period prior to the receipt of the complaint.

The complaint was initially submitted anonymously and in line with Section 5.4 of the HSE Trust in Care Policy 2005 it was not possible to proceed with a formal investigation into the matters raised. However, the Mental Health Services Management agreed that a review should be undertaken of the matters raised in the anonymous complaint with a view to providing assurances with regard to the delivery of care at the particular residential unit.

Arising from the above decision the Area Director of Nursing, Mental Health Services commissioned a Systems Review be undertaken with a view to an examination of the matters raised. This Systems Review was undertaken in line with the HSE's Incident Management Policy Framework 2020 which adopts a system based approach and methodology.

In line with standard practice terms of reference for the completion of the Systems Review were devised and provided to the family and two experienced senior managers (Social Work and Nursing) both external to the unit were assigned to complete the review. The timeframes for the completion of the review were noted as being twelve weeks from the date of commencement.

**Investigation**
The Complaints officer assigned examined the complaint and undertook an investigation which included the following:

- Discussion of complaint and issues arising with Area Director of Nursing
- Discussion of complaint and review with Senior Social Worker and member of Review Team
- Discussion of complaint with Mental Health Management Team
- Discussion of complaint with Mental Health Quality & Patient Safety Advisor

The Complaints officer understood that the Systems Review was very comprehensive and comprised analysis of the clinical file which comprised of 890 clinical notes in the period covered by the review. In addition the review group examined all documentation on the Service User's file which included Integrated Care Plan ( ICP), Risk Assessments, Falls Risk Assessments, Medical Reviews, Multi-Disciplinary Review, Nursing Assessments and Care Plans, review and reports of Health & Social Care Professionals including Occupational Therapy, Social Work and Dietician, Seating Assessment Review, Therapy Activity notes, Sleep Charts, Behavioural Observation Charts, Medicine Prescription and Administration Records ( MPAR) and Admission and Discharge records.

From their investigation the Complaints Officer was aware of a number of contributory factors which impacted in terms of the delay in issuing of the Systems Review namely; the unexpected unavailability of the nursing manager and non-replacement of this resource, as well as the pressures which the service experienced during COVID-19 and the Cyber-attack.

**Outcome and Learning**
The Complaints Officer based on the available documentation and evidence upheld the complaint as outlined.

The Complaints Officer acknowledged the dissatisfaction as articulated by the family in their complaint in relation to the delayed timeframes which were excessive and unacceptable, for the issuing of the Systems Review. This fell well short of expectations in adhering to the timeframes as outlined in the terms of reference, was unacceptable and deeply regrettable.

The Complaints Officer apologised sincerely for the service's shortcomings in this regard. The Complaints Officer acknowledged that there was a lack of oversight and action by senior management in terms of adherence to the timeframes in the completion of the review and that there was a lack of timely and accurate communications from the Review Commissioner to the family with regard to the delay.

The HSE is committed to seeking learning from our experiences and how issues are managed and in this regard there are a number of learnings which the Mental Health Services need to acknowledge and implement with a view to ensuring that similar delays in the completion of Systems Reviews do not reoccur in the future.

The Complaints Officer has reviewed this case in particular the learnings arising from same with the Mental Health Management Team, Review Team as well, Mental Health Quality & Patient Safety Advisor.

The following recommendations were made arising from the investigation of this complaint;

- That in future all Systems Reviews will be included as a standing agenda item at the Mental Health Quality & Patient Safety Committee with a view to ensuring greater overview of reviews being completed.
- That in future the members of System Review Teams ensure that the Commissioner of such reviews are updated in terms of adherence to timeframes and any other issues arising in terms of their completion.
- That Mental Services seek to maximize the number of staff nominated to participate in Systems Reviews across nursing, medical and health & social care disciplines.
- That all staff nominated to participate in Systems Reviews within the Mental Health Services receive appropriate and updated training as required.
- That the Commissioner of Systems Reviews ensure timely communication with families in relation to timeframes and rationale for delays in the completion of system reviews.

## Community Healthcare Organisation

**Category:** Access (Appointment); Safe and Effective Care (Treatment and Care)
**Status:** Upheld

**Background to Complaint**
The parent of a Service User contacted a Complaints Officer to make a complaint regarding the home support service provided to their young child. Their child had complex care needs and was in receipt of 16 hours home care from an agency funded by the HSE. The parent was dissatisfied with the service for numerous reasons. The parent felt that the child was not receiving the full hours of the allotted package with carers often leaving before the hours were completed or not turning up to do the shift. A complaint was made to the Disability Manager of the care company but the situation didn't improve and the complaint was escalated to the relevant Disability Manager in the HSE.

**Investigation**
Upon receipt of the complaint, the HSE Disability Manager contacted the Service User's parent by telephone. During the call, the parent provided further insight into the child's care needs and expressed the wish for the home support hours be reconfigured into larger blocks on specific days of the week. The parent also asked for these hours to be delivered by the same Carer. The HSE Disability Manager communicated this information to the relevant Home Care Provider. In addition, the HSE Disability Manager contacted the Assistant Director of Public Health Nursing who arranged a Paediatric Community Assessment Tool (PCAT) to be carried out in the Service User's home in order to progress a formal application for new Nursing Support hours.

**Outcome and Learning**
Following the HSE Disability Manager's consultation with the Home Care provider, the home care package was restructured into larger blocks and on the day's the Ccomplainant had requested. The Home Care provider also agreed that the same Carer would provide this support to the family. This arrangement commenced shortly thereafter.

The HSE Disability Manager received a compliment from the family following the resolution of this matter. The parent thanked the HSE Disability Manager for their assistance. She added that the new arrangement should make a positive difference to their family. She also acknowledged the work of the Public Health Nursing Team with regard to a new Nursing Support Care package.