HSE Your Service Your Say

Anonymised Feedback Learning Casebook

Anonymised Feedback Learning

Casebook Q3 2023

14 Complaints

24 Cases

10 Compliments

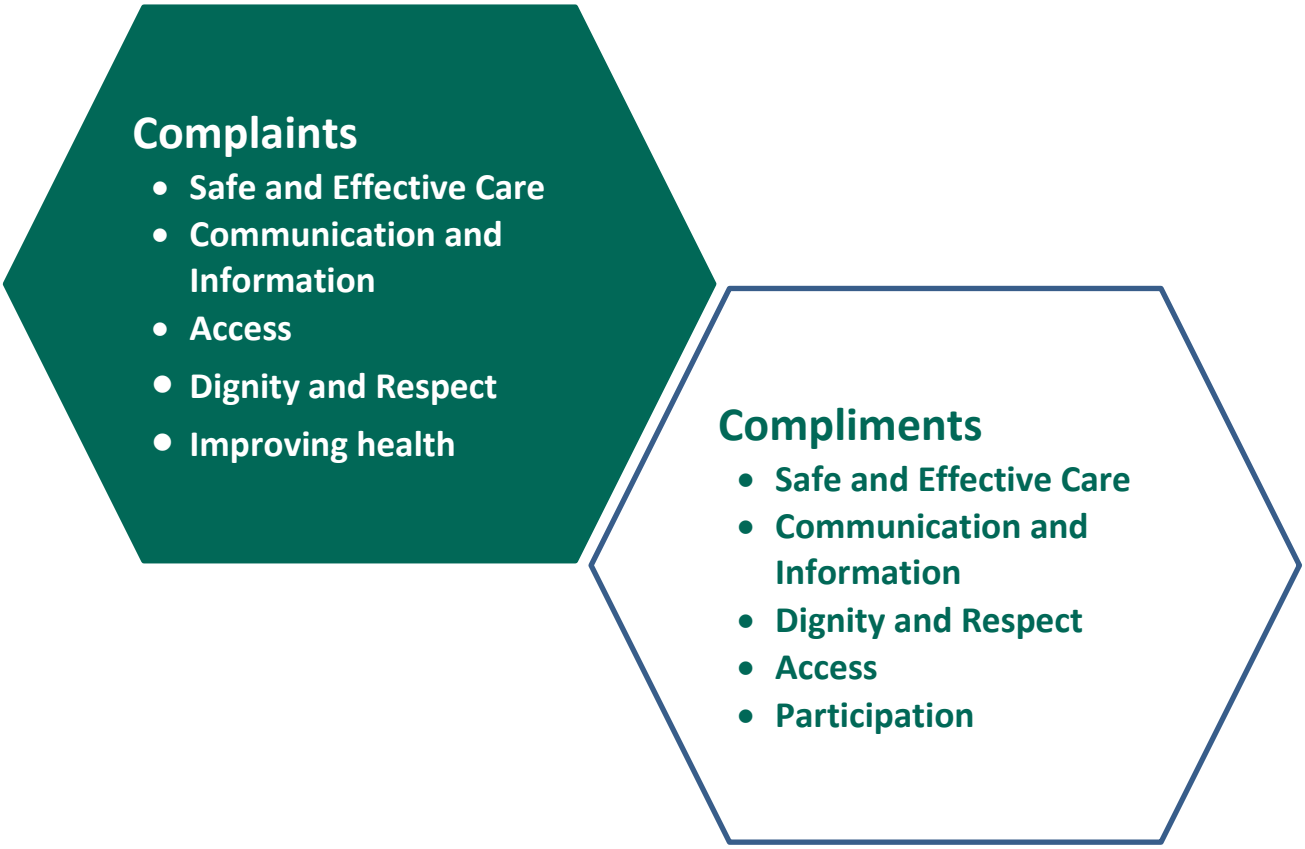
Introduction

The third quarter edition of the casebook for 2023 presents a total of 24 cases covering both complaints and compliments received by Hospital Groups, Community Healthcare Organisations and National Services.

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 **14 complaints**; 6 complaints from Hospital Groups, 7 from Community Healthcare Organisations and 1 from National Services that were investigated and/or reviewed along with their outcomes. The casebook also features **10 compliments;** 3 from Hospital Groups, 6 from Community Healthcare Organisations and 1 from a National Service, which highlight the learning to be gained from positive Patient and Service User feedback.

Key Categories



Complaints

The dominant theme for complaints in this Q3 2023 edition of the casebook relate to *Communication and Information* with this category featuring in 10 out of the 14 complaint cases presented. This was closely followed by *Safe and Effective Care* which featured in 5 of the complaint cases. Other categories such as *Access, Dignity and Respect and Improving Health* also featured.

Communication and Information related to issues such as accessing and being provided with information and updates in a timely manner as well as general communication skills such as how those using our services were spoken to, especially when delivering difficult or sensitive news including checking that any information, direction or explanations are understood.

Safe and Effective Care issues concerned the level of care and supports provided as well as issues around medication, health and wellbeing and discharge.

Access related to signage for facilities, as well as ensuring the availability of accurate service information as this can be a barrier to supporting people to access services. *Dignity and Respect* concerned how care is delivered and being responsive to individual needs while *Improving Health* concerned empowering Patients and Service Users through information and education.

Compliments

The positive feedback received mainly related to the category of Safe and Effective Care with this featuring in 6 out of the 10 compliments presented. The other categories of positive feedback featured are *Dignity and Respect* and *Communication and Information* with these categories represented in 5 and 3 respectively of the 10 compliments presented.

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.

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.

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

Hospital Group

Category: Communication and Information (Information)
Status: Partially upheld

Background to Complaint
An e-mail was received by the son of an elderly inpatient who was very unhappy that their parent had been moved from a single room to a six bedded ward:

Investigation
The Patient Advice and Liaison Service (PALS) contacted the Clinical Nurse Manager (CNM) to ensure that the patient was a priority for a single room when and if one became available.
PALS contacted the Assistant Director of Nursing (ADON) who advised it would be difficult to provide a single room for this patient as "*priority is given to patients requiring isolation and those reaching the end of their lives*".

PALS phoned the son of the Patient and discussed the issue. PALS went on to acknowledge receipt of his correspondence, in writing. In that correspondence PALS re-iterated that "*priority is given to patients requiring isolation and those reaching the end of their lives*". PALS apologised for any upset or distress that this may have caused and assured the family that they are available should any further concerns arise.

Outcome and Learning
Sometimes, staff have to deliver news to patients and their families that that they may not want to hear or agree with. To assist with such communications, it is important that staff:

- manage expectations early on
- deliver information clearly, sensitively and with full explanation
- ensure that the family feel that they have a point of contact should they need it and the door is not closed

Recommendations/Actions:

- PALS continue to provide assistance / support to patients and their families

Hospital Group

Category: Access (Hospital Facilities)
Status: Resolved informally

Background to Complaint
A Patient contacted the Patient Advice and Liaison Service (PALS) department by telephone and complained about the signposting to the hospital which they considered to be poor and was concerned that this may cause distress to patients trying to find the hospital.

Investigation
The issue was discussed with the Patient. PALS contacted the Environmental Services Deputy Manager who went out to check the signage. The Manager noted that the Patient was correct and reported the issue to the local County Council.

PALS reverted to the Patient to advise them of the action taken.
The County Council reverted to the Environmental Services Deputy Manager and advised of new signage for the hospital to be erected as part of the traffic works programme. The Patient was contacted once more and advised of the above.

Outcome and Learning
There can be much learned from informal complaints, just as much as from formal complaints. It is not always necessary to receive an issue in writing as much can be done through conversations. Patients' feedback is valuable to improving services.

Recommendations/Actions:
PALS continue to put as much emphasis on learning from informal complaints as formal complaints.

Hospital Group

Category: Communication and Information (Delay and Failure to Communicate)
Status: Not upheld

Background to Complaint
An e-mail was received from the son of a Patient which stated that that their father was, "*in the ward for over a week and is very weak, frustrated and worried and scared… umpteen plans have been suggested to him for his sickness but nothing is getting done."* The son asked what he and the family needed to do to get clear answers regarding their father's health.

Investigation
A copy of the correspondence was sent to the Consultant who was looking after the Patient and a telephone call also took place with the Consultant.

On the same day the Consultant spoke with the family member.

Communication had taken place the day before with the Patient's wife and three of the sons but the information was not shared with the wider family in a timely manner. The Consultant requested that the family nominate one family member to be the point of contact for future communication and disseminating of information.

Outcome and Learning
PALS acknowledged receipt of the correspondence with the Patient's son and advised of the steps taken. During the course of the conversation, the Patient's son voiced his appreciation for the quick action by PALS.

Learning:
Swift action when a patient is in the care of the Hospital helps avoid upset and distress for both the patient and family.

Recommendations/Actions:
- PALS continue to advocate for patients.
- PALS to continue to forge good relationships with all staff as working together for the common good of the patient is paramount.

Hospital Group

Category: Safe and Effective Care (Health and Safety Issues)
Status: Upheld

Background to Complaint
A Patient contacted the PALS department by e-mail and stated that they are currently an inpatient in a ward and their bed is beside the window. They complained that the cold and draught coming from the window is terrible. The Patient stated that the other patients on the ward are also complaining. They tried themselves to block the draught and cold. While the Patient understands that the windows are old they stated that, '*sick people we don't need to try ourselves to block out the cold and window in our room. Can you please get someone to look the window as soon as possible?'*

Investigation
A copy of the correspondence was sent to the Clinical Nurse Manager of the Ward in question to examine the issue raised.

Outcome and Learning
PALS acknowledged receipt of the correspondence with the Patient and apologised for any discomfort caused.

Technical Services attended the ward and sealed the window.

Learning:
The windows in the hospital are in excess of 25 years old. Technical Services are in the process of reviewing the windows in the ward block. This is in the early stages and when complete a more detailed refurbishment plan will be considered.

There is a technical services out of hours service so that issues such as this can be resolved 24/7 and ward areas have been reminded of same.

Recommendations/Actions:
- An out of hour's service is necessary for such situations.
- As the windows are 25+ years a refurbishment plan should be put in place.

Hospital Group

Category: Communication and Information (Communication Skills); Safe and Effective Care (Treatment and Care); Dignity and Respect (Delivery of Care)
Status: Compliment

Background to Compliment
An e-mail was received from a family into the Patient Advice & Liaison Service (PALS) that praised the care provided to their father following his passing at home. May he rest in peace.

Nature of Positive Feedback
In the email the family outlined how their father had mentioned particular staff during his stay in the hospital from the Emergency Department to the ward and outlined their particular acts of kindness. The family praised how their father was treated with the up most respect through the last few months. The family hoped that the compliments outlined in their email would brighten the staff members' day and get passed on to their managers to share.

Outcome and Learning
The PALS Department acknowledged receipt of the correspondence.
PALS offered condolences to the family and thanked them for taking the time to write such a lovely letter at a very difficult time. PALS also assured the family that they would share with all the staff involved.

Learning:
- Patients appreciate how staff make them feel as well as the clinical care provided to them.
- The importance of encouraging patients to write down their thoughts / questions.
- Sharing such positive feedback, in the patient's own words, is meaningful and encouraging for all staff.

Hospital Group

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

Background to Compliment
An e-mail was received into the Patient Advice & Liaison Service (PALS) through the HSE from a Patient who had been an inpatient in the Hospital on a number of occasions as well as attending outpatient appointments. The Patient was under many disciplines during that time and some of these included, infectious diseases, vascular, endocrinology and rheumatology.

Nature of Positive Feedback
The email stated that, "*I have never in my life seen anything like how they work things. I will be forever grateful for all they did for me. They were consistent and adamant to resolve the issue. I've actually never witnessed so many teams work together and not miss a beat*. *They went above and beyond and gave me a quality of life back!! To witness how these people work is astonishing. They do not get enough credit for all they do. Please thank them from me as I will never forget what they did for me. They definitely make a huge difference to people's lives*".

Outcome and Learning
The PALS Department acknowledged receipt of the correspondence within the recommended timeframe. PALS thanked the patient for their feedback. They logged the feedback and forwarded the correspondence to each of the relevant departments.

Learning:
- Importance of multi-disciplinary team work providing seamless care for patients to maximise outcome.
- Patients appreciate how staff make them feel as well as the clinical care provided to them.

Hospital Group

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

Background to Compliment
A Patient who was under the care of Orthopaedics and subsequently under the Infectious Diseases team submitted a compliment following their episode of treatment.

Nature of Positive Feedback
The Patient took the time to compose a poem to compliment the care, attention and treatment received during their stay from the various staff encountered.

Outcome and Learning
The poem was forwarded to all relevant managers and to the Hospital's Chief Executive Officer who in turn shared with PALS.

Learning:
- This poem was gratefully received by staff who acknowledged their pleasure and thanks to PALS.
- Importance of multi-disciplinary team work providing seamless care for patients to maximise outcome.

Hospital Group

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

Background to Compliment
A Patient submitted a letter to the Hospital Chief Executive Officer (CEO) to pass on their thanks to the wonderful staff that took care of them in the hospital.

Nature of Positive Feedback
The Patient stated that every member of staff, without exception, was kind, caring and supportive. The Patient was particularly grateful to the staff that they met during their stay who spent time helping to alleviate any anxiety before the operation and ensured a speedy recovery afterwards. The Patient finished by stating that while they hoped not to need to visit the hospital any time soon, but should they, they know that they will be in the capable hands of wonderful, caring people.

Outcome and Learning
The Office of the Hospital CEO shared the correspondence with the Interim Director of Nursing who in turn shared it with PALS department. PALS logged the feedback and forwarded the correspondence to each of the relevant departments.

Learning:
- Staff recognising patients' anxiety and supporting patients prior to a procedure has a profound impact on a patient's journey.
- Importance of multi-disciplinary team work providing seamless care for patients.

Hospital Group

Category: Dignity and Respect (Delivery of Care)
Status: Compliment

Background to Compliment
A letter was submitted to the Office of the Director of Nursing (DON) by a Patient thanking them and all the staff that they met during their recent stay in the Hospital / Ward.

Nature of Positive Feedback
The Patient outlined how they met only kindness from all the staff, such as kitchen staff, porters, pastoral persons, physios, x-ray technicians and doctors. Special mention was given to the nurses for their professionalism and support. The Patient complimented the staff stating how they made their stay in the hospital an easier experience during a difficult time in their "health Journey".

Outcome and Learning
The DON department acknowledged receipt of correspondence, thanking the Patient for their feedback and assuring them that it would be shared with relevant staff.

The Director of Nursing & Integrated Care emailed the relevant nursing team members and their line managers to acknowledge the positive feedback.

Learning:
- It is the complete multi-disciplinary team who have an impact on the patient's journey and everybody has a role to play in the patient's positive experience.
- Patients appreciate how staff make them feel as well as the clinical care provided to them.
- Sharing positive feedback is meaningful and encouraging for all staff.

Hospital Group

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

Background to Complaint
The PALS department received a telephone call from a Patient. The Patient outlined how they had received a letter to say that they were due to have a specific procedure. The Patient stated that they had concerns about the anaesthetic due to health issues that had arisen recently. However, they could not get through to that particular department themselves and so had to contact PALS.

PALS contacted the department's administrative team and outlined the Patient's fears.
The administrative team contacted the clinical team responsible for the Patient's treatment and care. The clinical team in turn contacted the Patient by telephone and discussed and allayed any fears that they had.

Investigation
The PALS team, during the call, established that the contact numbers for the specific department that the Patient was calling about were on the appointment letter, however the Patient was unable to get through to the department using those numbers.

The issue of contact was discussed with the department who phoned the Patient back.

Outcome and Learning
- Patients contact PALS for assistance as well as complaints and compliments.
- It is important to act swiftly on such requests and this can be done successfully through a telephone call as opposed to e-mailing or writing.
- Contacting the patient in a timely manner can help ease anxiety surrounding a planned procedure.

Recommendations/Actions:
- PALS continue to provide assistance to patients.
- Approval to recruit additional staff to provide a cross-specialty telephone answering service, which will improve the level of immediate response required.

Hospital Group

Category: Dignity and Respect (Delivery of Care); Safe and Effective Care (Treatment and Care) (Discharge); Communication and Information (Information); Improving Health (Catering)
Status: Upheld

Background to Complaint
The Parent of a Patient emailed the complaints department to register a complaint. The Patient's condition is such that it requires two-way isolation each time they attend the hospital. The Parent's complaint outlined what they felt were a number of shortfalls regarding their child's treatment that they had experienced during more recent stays at the hospital.

- One to one nursing which is a requirement for their child's condition had not been offered during their last three hospital stays.
- On a number of occasions, the Parent expressed disappointment in delays that they had experienced with regard to receiving prescriptions/medication, along with delayed updates from staff regarding discharge plans.
- On occasions that involved presentations to the Emergency Department, the Parent felt that staff were not adequately informed about their child's condition and therefore did not know the correct protocols.
- The Parent also felt that both they and their child were overlooked during meal times; having to prompt staff to provide meals as they are unable to leave the room due the isolation requirements.

This experience resulted in the Parent feeling overlooked and forgotten due to their child's isolation status within the hospital, despite them adhering to all required infection prevention and control guidelines on their part, and implored the staff to provide a more empathetic and considerate approach to their child's stay in hospital.

Investigation
The Complaints Officer shared the Parent's experience with the Clinical Nurse Manager III (CNM III) of the appropriate service. The Complaints Officer, who had also spoken with the Parent over the phone to discuss their complaint in greater detail, relayed the various shortfalls experienced by the family to the CNMIII.

Outcome and Learning
The CNM III examined the complaint, and provided their response to the Complaints Officer, addressing each of the issues that the Parent had outlined in their complaint.

- The CNMIII acknowledged the one to one nursing recommendation for this child's care but unfortunately due to staff shortages, it was not possible on the occasions highlighted by the Parent. Nursing Administration and Infection Control were notified.
- Delays were acknowledged in relation to medication and discharge prescriptions. Nursing staff raised this with their medical consultants at the time of the delays and subsequently, in order to expedite the writing of prescriptions and discharge documents to prevent undue delay for patients and their families.
- Regarding meal times, while the CNMIII is confident that food trolleys are available for all rooms on the ward at every mealtime, they expressed their apologies that this occurred for the family and have brought this experience to the attention of relevant Healthcare Assistant Staff.

- Regarding delays to administering medication; this was highlighted and hospital educators are carrying out update sessions on medication awareness for staff, inclusive of prescription times and administration.
- In relation to the Emergency Department, the CNMIII linked with the ED CNMIII to inform them of the treatment plan requirements for this Patient on presentations to ED and admissions to hospital.

The CNMIII expressed their deep regret for the family's negative experiences and extended their apologies again. The actions taken were communicated back to the Parent who was satisfied with the outcome and hoped that further interactions with the hospital would be more positive.

Hospital Group

Category: Safe and Effective Care (Treatment and Care); Dignity and Respect (Delivery of Care)
Status: Compliment

Background to Compliment
Following a number of recent admissions to hospital very soon after her child's birth, a mother complimented a number of staff who they had interacted with on a particular ward. The mother took the time out to write six individual compliments to the staff involved.

Nature of Positive Feedback
The Parent wrote of how the staff were kind to both her and her baby during their stays on the ward. She felt reassured by how the nurses were caring for her baby, so much so that she was able to get her first night of good sleep since her child had been born. She wrote of how the nurses gently cared for her new born, noticing preferred feeding and sleeping positions, which "*gave me peace of mind*" that staff were minding her child "*the way I would mind them myself*". She wrote of how staff listened and showed her compassion during a difficult time, both mentally and physically. Mum was grateful for staff "*understanding my feelings and being kind towards me as well*", and how they were thoughtful of her being in the postpartum period, ensuring she was comfortable, had food to eat and a quiet space to take breaks and pump milk for her new born child.

Outcome and Learning
The compliments were forwarded to the staff involved and to their line management. The common theme amongst all of these compliments was of how compassion and small acts of kindness can go a long way for families during difficult times in hospital. The mother wrote how "*it really means a lot, all these small gestures make a big impact*" and "*it's the little things that truly make a big difference*".

Community Healthcare Organisation

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

Background to Complaint
A Parent contacted the service in relation to accessing speech therapy for their twin children. The Parent advised that they had waited two and half years for speech therapy that would consist of six sessions provided within a group setting. According to the parent the wait for the service is delaying the children from starting school.

Investigation
Investigation of this issue involved the following:

- Discussion with Parent to obtain further details
- Discussion with the relevant clinician
- Discussion with the service as to the therapy model utilised

The Parent was reassured that the CHO is making every effort to recruit staff where there are vacancies. Speech and language therapists have been advertised for both locally and nationally. There has also been efforts to source staff from agency also to no avail. The CHO will continue on with the recruitment process.

The Parent queried why there was two speech and language waiting lists in the CHO. It was explained that there was one for assessment and the other was for the therapy. The rationale for this is seen as an interim measure to provide other supports while awaiting therapy, otherwise the other model that could be utilised would mean one waiting list which would invariably be longer. The CHO also advised the Parent that have managed to reduce waiting times from two and half years to currently under twelve months for assessment.

The CHO further advised that in order to manage the waiting list for Speech and Language Therapy, a lot of sessions are provided in group settings. Children, such as the Parent's twins, identified as requiring the speech pathway can receive their sessions together. However, should one of the children require a different pathway then they will be placed in a separate and more appropriate group. Each group can have up to four children attending per session.

Outcome and Learning
The Parent was thanked for their feedback. The wider view and recommendations from this complaint was sent forward to the Accountable Officer to consider conducting a health needs analysis of the service in the near future as the catchment population is increasing, as are referrals to the service while available resources remain at the same level.

Community Healthcare Organisation

Category: Safe and Effective Care (Treatment and Care); Dignity and Respect (Delivery of Care) and Participation (Patients / Family / Relatives)
Status: Compliment

Background to Compliment
The Integrated Care Programme for Older Persons (ICPOP) team in the CHO have developed a crisis management pathway to support older persons to live as independently as possible in their own home, as appropriate. However, in some cases this is not possible and those service users, for a wide variety of reasons, transition to long term residential care. The ICPOP team received a letter from the family whose relative had received care within this crisis management pathway due to their progressive dementia.

Nature of Positive Feedback
The letter conveyed the family's gratitude for the care that their loved one had received whilst they were living at home and also for the support that the team had provided to their relative and the family as they made that transition to long term care.

The family detailed how they found the domiciliary aspect of the service extremely beneficial to their relative as the care that was put into place for them was bespoke to their environment, interests and wishes. The family also referenced how, as their relatives disease progressed, they found it difficult to accept the challenges that they faced on a day to day basis providing care and how difficult the decision to transition to long term care had been. The letter conveyed how once the ICPOP team became involved they felt listened to and supported through their journey with their relative. The letter detailed their thanks and also praise for the service they received. They also specifically mentioned the clinical knowledge and competence of the team in addition to the compassion they showed.

Outcome and Learning
The progressive nature of dementia and the challenges that accompany this for families and carers requires a holistic response, supporting not just the patient but also those around them. The importance of confident and clinically competent staff cannot be underestimated. These skills, combined with a patient centred service delivering a bespoke approach to individual and family's needs, allows the service to wrap around patients and families and provide the guidance they require as they navigate their healthcare journey.

Community Healthcare Organisation

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

Background to Complaint
A request for a service increase to a Service User with dementia was submitted to the Home Care Support Assistant (HCSA) service. The Public Health Nurse completed a thorough referral and visited the Service User while their daughter was present. The Service User with dementia agreed to the service increase at that time. A visit the next day to plan the increase in the support was scheduled by the manager. However, the daughter was unable to be present at that meeting. The Service User's spouse attended. During that visit the Service User was adamant that they wanted no increase in service. No service increase was therefore arranged.

The daughter contacted and spoke with the manager by phone and the reason for no increase was explained. A complaint was subsequently submitted to the service.

Investigation
An online meeting was arranged, as one of the complainants' lives abroad, to discuss the complaint.

In the complaint, it stated that the manager did not treat the daughter who had phoned in with respect during their conversation.

The Complaints Officer, during the online meeting with the complainants, ascertained that there was no complaint with regard to the interaction with the Service User and their spouse at the most recent home visit. The Complaints Officer also ascertained the daughter based in Ireland is feeling overwhelmed and suggested that she was upset at the hearing about the decision not to increase the service. Given that the service increase was refused at a moment in time during a home visit and being mindful of the Service User's dementia, the service re-offered an increase in the service provided. This was accepted. Although the increase was not for the full hours requested, as the Service User was refusing assistance with personal care, it was agreed to revisit and review the service provision regularly.

Outcome and Learning
- Need to offer at point in time. When asking a service user to make a decision, the service will offer that decision again at a different point of time with a different staff member (if appropriate) to ensure that the decision made is the will and preference of the service user regardless of their diagnosis.
- Delay assessment if person very vulnerable /dementia diagnosis. Service to be mindful of the natural supports from family and that these need to be taken into consideration when assessing for supports. In this case the natural support was overwhelmed and unable to provide the continued level of support. The Service User may have made a different decision if they had all the information available to them at the time. The service will assess information from all relevant stakeholders before making a determination.
- To ensure that staff are fully trained in managing communications with and delivering sensitive news to Service Users and their families while also ensuring that staff are supported following difficult interactions as well as following the receipt of a complaint.

Community Healthcare Organisation

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
A complaint was submitted from a Parent who advised that they require Speech and Language Therapy (SLT) for their child but that they could not find out how to access the service or where to get help for their child. The Parent advised they tried to "google" SLT services and could not find an answer.

Investigation
The Complaints Officer contacted the Parent to ask for more information, i.e. child's name, address and date of birth. The Complaints Officer advised the mother of the complaints management process under the Your Service Your Say policy.

The Complaints Officer sent a copy of the complaint to the Community Healthcare Manager (CHN) for examination and also asked if they could advise of the SLT referral pathway and also advise if there was any learning / educational material that could be passed to the parent while the child is awaiting assessment. The CHN manager responded to the Complaints Officer and advised that the SLT manager contacted the Parent and outlined the various referral pathways and also provided information on drop-in clinics which provide advice to parents while their child is on the waiting list. The CHN Manager also advised that the SLT manager issued referral forms to the Parent and that the child was referred to their service and advised of the current waitlist.

Outcome and Learning
The Complaints Officer contacted the Parent and advised them of the investigation outcome. The Parent was extremely grateful and happy for all of the assistance provided and grateful of the drop-in advice clinic leaflet provided to her by the SLT manager. The Parent was also advised that if they have questions about services provided by the HSE to go to the HSE website or contact their local primary care centre who will provide direction and assistance to them.

The Complaints Officer contacted the SLT manager to acquire a copy of the SLT advice leaflet for future knowledge and the CHN manager also provided referral pathways for all services to the Complaints Officer for any future cases. The Complaints Officer completed their investigation report and issued this to the Parent along with the local Primary Care Centre's contact number.

The Parent was extremely grateful and happy to have received such a quick response and for the issues that were causing concern to be resolved so quickly.

The importance of clear communication was a key learning from this complaint. It is important to provide the correct information and educational material to parents which will provide assistance to them until the assessment takes place. It was also important to highlight to parents to use the HSE website or to contact their local Primary Care Centre for information going forward as this information is factual and the primary care staff can guide them and answer any questions they may have about referrals or services.

The CHN manager provided the Complaints Officer with a copy of the referral pathways document, which can now be used as reference for any future cases.

Community Healthcare Organisation

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

Background to Compliment
The Integrated Care Programme for Older Persons (ICPOP) team offer a supportive discharge pathway for older person's living in an area who have been admitted to the local hospital. The team encourage feedback from patients who had entered this pathway to inform the service going forward.

Nature of Positive Feedback
A Patient commented on the importance of the interventions that the team had put in place for them on their discharge home. The Patient also highlighted how having access to the team after their period of illness transitioning from acute hospital care back to living independently in her own home and community was invaluable in supporting that.

Outcome and Learning
The importance of hearing the patient voice when service providers are evaluating service provision is extremely important and highlights how the challenges that older persons experience as they transition from different care landscapes can be supported by pathways of care as demonstrated and developed by ICPOP teams.

Community Healthcare Organisation

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

Background to Complaint
A Service User submitted a complaint expressing dissatisfaction that their concerns were not adequately addressed and that they felt misunderstood by the doctor who was on call at the time of their appointment. Furthermore, the Service User had voiced frustration that the prescribed medicine and its associated side effects were not thoroughly explained by the doctor.

Investigation
The Complaints Officer called the Service User to go through the issues. The Complaints Officer also arranged a call with the Consultant to discuss the complaint. The Consultant Psychiatrist and the Community Mental Health Nurse followed up with the Service User and discussed their queries including those around the prescribed medication. The Consultant spoke to the doctor and the doctor expressed that they had no intention to cause distress to the Service User and regretted any distress caused. The doctor welcomed the feedback.

Outcome and Learning
The investigation determined that:
- communication with the Servicer User was not appropriate and clear
- Clinicians should provide more information to the Service User about prescribed medicines
- not having the right resources has impacts on the quality of care

Recommendations:
- Clinicians should actively seek feedback from service users.
- Leaflets regarding prescribed medications should be shared and explained clearly to service users. These leaflets should be in plain English.
- Encouraging patients to read Patient information Leaflets and medication guides on the HSE website.
- Line managers should provide feedback and guidance on receipt of challenging communications delivered by someone who reports to them.

Community Healthcare Organisation

Category: Safe and Effective Care (Treatment and Care) (Medication)
Status: Upheld

Background to Complaint
A Service User was in respite for two weeks. A complaint was received from a family member regarding the occurrence of a medication error and also in days that followed a fall incident which resulted in the transfer of the Service User to an acute hospital for treatment.

Investigation
Open disclosure was completed following the medication incident. A Team discussion was held and learning was identified.

Open disclosure happened again on the night the Service User fell. The Service User was found immediately by staff, was assessed and subsequently admitted to hospital. Communication was maintained before and following transfer to hospital.

Staff continued communication with the family during the process. Follow up calls were made, open disclosure, reassurance and support given.

Outcome and Learning
The complaint was upheld and an apology given regarding both incidents. A meeting was held with the nursing team where support was provided and learning identified and discussed. A falls incident preliminary screening was completed where learning was discussed and recommendations made.

- Staff identified key learning regarding medication reconciliation during admission.
- Staff identified the importance and value of open disclosure/communication and supporting family through-out the process.
- Staff identified the importance and value of 30 minute comfort check in ensuring the safety of the service user.
- Increased awareness on management of fall incidents.
- Staff identified the importance of utilising the evidence based learning resources to achieve best practice.

Community Healthcare Organisation

Category: Improving Health (Holistic Care); Dignity and Respect (Delivery of care)
Status: Compliment

Background to Compliment
Two weeks respite was facilitated for a couple. They stayed in the same house and same room.

Nature of Positive Feedback
Both Service Users sent letters of compliment to all staff (nurses, HCA, cleaning and catering staff) and appreciation given for the lovely meals beautifully presented. They stated, "*You are all magnificent, from your welcome smiles, the sincere and meaningful attention to all our needs, your efficient and skilful administration of our medical requirements, every nationality is here and welcome. We are proud of you*."

Outcome and Learning

- To continue to aspire to deliver a quality service to all our service users.
- The importance of paying attention to detail and person centred care.
- The importance of looking at all resources and how we can meet the unique needs of our service user.
- The compliment highlighted the valued skills of each team member towards achieving best care outcome.
- Compliment also showcased diversity and inclusiveness.

Community Healthcare Organisation

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

Background to Complaint
A Service User complaining over a long period of time and involving many services including primary care, mental health, GP and hospitals pain management specialists. While individual complaints were being addressed appropriately under procedures in relation to individual services, the Service User was becoming increasingly frustrated. The Service user complained about the lack of engagement with primary care services and mental health. The Service User raised concerns regarding mobility issues with reference to primary care provision. Lack of cross-service communication between primary care teams, GP, mental health services and hospital pain management specialists. A lack of trust developed between the Service User and those working in services involved in the delivery of care.

Investigation
As part of the investigation a multi-disciplinary meeting was held and included all services involved in the treatment and care of the Service User. Contrary to issues highlighted by the Service User concerning lack of service and communication, all services demonstrated how they were engaging in the delivery of care and communicating with the Service User.

Outcome and Learning
Following the meeting, information in respect of all services engaged in the provision of care with names and contact information of the key personnel involved in the care plan were provided to the Service User. This would ensure that all services were accessible to the Service User and that communication channels were open.

The GP service advised on the consolidation of pain consultancy, delivered by one team and linking with specialists when required.

The meeting proved invaluable in the management of the many complaints submitted by the Service User. The insight given in respect of all services engaging and the level which they are involved in the Service User's care brought clarity to the case. The importance of keeping the lines of communication open going forward was recognised and would ensure the delivery of a more co-ordinated level of care to the Service User.

The advantages of multi-disciplinary and cross-service case conferences were recognised, not only for the management of complaints, but in the management of a care plan with multiple issues and the involvement of multiple services.

This complaint highlighted the importance of clear communication and engagement with service users regarding their care plan and collaboration with all services to coordinate care and treatment. This would build on HSE values of care, compassion and trust.

This complaint also highlighted the advantages of building and maintaining communication channels between acute and community services in the delivery of safe and effective care.

Community Healthcare Organisation

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
Following a fall at home, a Service User was advised by attending hospital staff that a recommendation for bedrail use should be obtained from their GP in order to obtain a bedrail from HSE equipment services.

The Service User's family member subsequently attended the Public Health Nursing department with a GP letter of recommendation for a bedrail for their relative.

At that point they were advised by the Public Health Nurse (PHN) on duty that the circumstances of bedrail use are specific to the assessed needs of the service user in situ and that a bedrail could only be provided following an appropriate clinical and/or risk assessment by a Public Health Nurse (PHN) in the service user's home.

A complaint was made to the Public Health Nursing department in relation to the conflicting information provided.

Investigation
The complaint was examined and the information provided by the PHN was confirmed as correct and accurate.

Outcome and Learning
The Public Health Nursing department engaged with the local GP and clarified information about the circumstances of prescribing Community Care Equipment and the role of the PHN in assessing needs and making recommendations for the provision of Aids and Appliances to service users in the community.

The learning from this complaint was around the need to ensure the provision of accurate information about resource access to service users and their families through effective engagement with relevant stakeholders.

National Service

Category: Communication and Information (Information); Improving Health (Empowerment)
Status: Partially Upheld

Background to Complaint
A complaint was received from a Service User who had recently attended for an appointment with one of the national screening programmes. The Service User raised a number of issues. Firstly, they were concerned about the type of screening tests used by the programme. They were concerned that the test type used was not sufficient to monitor changes in older persons. In addition, the Service User also queried, based on their age and history, whether the recall timeframe was appropriate. Lastly, they also expressed that the wording on the programme leaflet, and the letter they received, was not reassuring.

Investigation
As part of the investigation, the Complaints Officer engaged with the relevant screening programme staff to address each concern raised and explore what information was required to provide a full explanation and reassurance to the Service User. Additionally, the Complaints Officer liaised with other departments such as Public Health and the Communications Department to ensure accurate and up to date information was given to the Service User in response to the concerns raised.

Outcome and Learning
A response was issued to the Service User that included an apology to them that they were dissatisfied with the service provided. Clarification and reassurance was provided about the concerns raised. All issues raised in the complaint were brought to the attention of the relevant senior management with the aim of these being considered for future service improvements.

1. The National Screening Service Programmes and teams will continue to work with their service providers to find better ways of reassuring service users about the effectiveness of screening when questions or concerns are raised at the point of contact.
2. The feedback about screening programme letters and leaflets will be escalated to the Information Hub team for consideration for future revisions.

National Service

Category: Communication and Information (Information); Access (Appointment)
Status: Compliment

Background to Compliment
A new Service User got in touch to find out if they were registered with one of the screening programmes. There was some confusion over their identity on the database, so clarification was sought. To comply with GDPR and Data Protection legislation it was important to deal sensitively with this matter to confirm the Service User's details.

Once confirmed, the service wanted to find out why there was a difficulty in identifying this person in the first instance and also address their query relating to registration.

By working with the Service User, the screening service was able to verify their personal details and confirm that the information held was accurate.

By auditing the information that was held on this Service User, the screening service discovered that confusion regarding their identity had arisen because they had a preference for an alternative name, which was different to the name on their public record and consequently on the system.

Nature of Positive Feedback
The Service User commended the Complaints Officer on their professionalism, diligence and thoroughness in relation to the information sought and provided about the service.

Outcome and Learning
The key learning identified was that by being thorough and providing as much clear information as possible, while ensuring compliance with organisational and statutory requirements, results in positive service user experience that builds trust and confidence.