HSE Your Service Your Say

HSE Anonymised Feedback Learning Casebook Quarter 2 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 22 cases covering both complaints and compliments received by Hospital Groups and Community Healthcare Organisations.

The casebook features a total of **14 complaints**; 8 complaints from Hospital Groups and 6 from Community Healthcare Organisations that were investigated and/or reviewed along with their outcomes. The casebook also features **8 compliments**, 7 from Hospital Groups and 1 from Community Healthcare Organisations which highlight the learning to be gained from positive feedback.

Key issue categories:

Complaints

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

Compliments

- *Communication and Information*
- *Safe and Effective Care*
- *Access*
- *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 22 cases covering 14 complaints and 8 compliments received by Hospital Groups and Community Healthcare Organisations covering the second quarter of 2022.

The main themes for complaints in the Q2 2022 edition of the casebook relate to *Communication and Information and Safe and Effective Care,* with these categories featuring in 10 of the 14 complaint cases presented. Other categories such as *Access*, *Dignity and Respect, Privacy* and *Accountability* also featured in 9 of the 14 complaint cases presented.

The positive feedback received also mainly relates to the key categories of *Communication and Information* and *Safe and Effective Care*, with these issue categories being represented in 7 of the 8 compliments presented. Other categories featured in the compliments are *Access* and *Dignity and Respect*.

The dominant category for complaints remains *Communication and Information* and concern 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. S*afe and Effective Care* relate to issues regarding the treatment and care received. *Access* also features prominently with issues around accessibility issues, resources and appointments.

For Dignity and Respect, issues around delivery of care and discrimination featured while Privacy featured issues around confidentiality. Accountability concerned issues around responding to patient feedback.

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

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

Hospital Group

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

Background to Complaint

A parent wrote into the Hospital to raise their concern about the treatment their child received when they presented to the Emergency Department (ED). The patient presented with a wrist injury and was placed in a splint. The family were given advice to return for x-ray in 10 days. Whilst attending a private clinic for another unrelated issue they were advised that surgery would be needed on the wrist. The parent was left with the opinion that surgery would not have been necessary if a cast had been used initially instead of a splint.

Investigation

The parent's concerns were brought to the attention of the ED Management Team. The team reviewed the medical notes, the radiology imaging and reports and reviewed the parent's concerns in relation to the medical care provided by the ED.

- ED Registrar noted the patient sustained a hyperextension injury to the left hand, causing pain to the wrist (distal radius) and to two of the hand bones (2nd and 3rd metacarpals). It was also noted the patient had mild scaphoid tenderness.
- X-rays of the left hand and wrist were performed and no fracture was apparent. This was subsequently confirmed by the Radiology consultant.
- Because of the concern over scaphoid tenderness, the treating doctor recommended the patient wear a splint to protect the scaphoid and gave advice specific to suspected scaphoid injuries to return for a repeat scaphoid X-ray in 10 days if the pain was still present.
- The patient attended for repeat X-ray 2 months after the initial x-ray. This X-ray showed radiological evidence of a healing scaphoid fracture. The patient then re-attended ED.
- The Advanced Nurse Practitioner liaised with the Orthopaedic Registrar on call. The Orthopaedic Registrar advised that the patient rest the left wrist for a month or until they were pain-free. If the pain was still present a month later, the patient was to be seen by the Orthopaedic team
- The scaphoid non-union eventually required surgical correction

Outcome and Learning

The ED Management Team wrote to the family and apologised for their dissatisfaction with their experiences in the ED and provided clarity around the processes for this type of injury and planned improvements.

- Wrist injuries concerning the scaphoid are the highest priority due to the fact that a missed fracture may compromise the blood flow within the scaphoid bone and result in slow healing or non-union of the bone.

- Scaphoid fractures are notoriously difficult to diagnose on X-ray imaging on the day of injury. This is why the ED manages all patients as though they have fractured their scaphoid bones, and specifically advise them to return for repeat X-ray in 10 days. In this case, the patient's next attendance was unfortunately 2 months later, when the X-ray that day confirmed a healing scaphoid fracture.

- The choice between a splint and a cast is usually assessed based on the patient being treating and the timing of the injury. For example, in a younger child who the ED suspect will remove the splint, a cast may be favourable whereas in an older child, a splint would have been acceptable as it would be expected that they would understand to keep it on. A splint allows patients to carry out most daily activities while maintaining alignment of the bones. A cast is very firm and fully encircling, and can when applied on day 1 of an injury, result in a lot of pain as the injured area can swell significantly over the days following injury. In patients who present a few days after the injury, a cast may be considered.

This patient was managed according to the ED protocol at the time of their attendance. However, the team noted this plan does rely on the patient's re-attendance for x-ray, which was recognised may be an area for improvement. Therefore, the ED has started to refer all suspected scaphoid injuries to the Orthopaedic fracture clinic. They may be placed into a splint or a cast as mentioned above.

The ED is also in the process of restructuring its entire scaphoid management plan in conjunction with the Orthopaedic and Radiology teams which may, in the future, incorporate the early use of MRI in scaphoid-suspicious injuries. MRI would be a far more sensitive modality compared to plain X-ray films but access to the MRI scanner as well as the expertise to read the images would be amongst the challenges with this plan.

This complaint led to the re-evaluation of the process regarding the management of suspected wrist injuries concerning the scaphoid.

Hospital Group

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

Background to Compliment

A parent wrote to the Hospital to compliment the "amazing care" their child received during a recent admission. The parent specifically wrote that they were so thankful to the nursing staff on the ward, who were "so lovely, kind and compassionate". The parent advised that the two nurses looking after their child were so caring and went above and beyond, even staying after their shift had ended, to ensure their child felt safe. The parent advised that these nurses were "phenomenal" and made them feel that their child's safety and wellbeing were paramount.

Nature of Positive Feedback

The Hospital followed up with the Assistant Director of Nursing for the ward regarding this compliment. The particular ward is a day unit which closes at 7pm. In this case, the patient was not ready to be discharged from the hospital at 7pm and required a little more time to recover before going home. The nurses taking care of the patient identified the extra stress and anxiety that the patient would experience from having to be moved to a different ward and being looked after by different staff. In order to avoid this happening the nurses decided to stay on the ward, past their shift time and continue to nurse the patient until they were fit for discharge.

Outcome and Learning
This compliment highlights the positive impact that putting a patient's needs first can have on their experience and care journey. In this case, the nurses truly did prioritise patient care as despite their shift having finished, both members of staff continued to support both the patient and their family until they were ready to be discharged from the ward.

The level of care provided by nursing staff on this occasion eased the anxieties of the parent and the emotions of the child and made them both feel safe and supported during a frightening time. The parent stated that she "appreciated it more than the nurses will ever know".

This compliment was shared with nursing staff as an exemplar of HSE values.

Hospital Group

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

Background to Complaint
Patient logged complaint following their negative experience during attendance for radiology imaging in the hospital. Patient felt that there was inadequate listening and response to their questions during the appointment and that the tone and gestures used were inappropriate. There was also a breakdown of communication between staff in the area prior to/during the appointment.

Investigation
Letter of complaint was sent to the Complaints Officer who liaised with the Treating Radiologist and Clinical Director of Radiology Services to discuss the issues raised in the letter of complaint.
Response prepared by the Clinical Director and treating Radiologist and sent to the Complaints Officer. Complaints officer issued response letter to the complainant.

Outcome and Learning
The Hospital apologised that the patient was upset by their recent experience. The complaint resulted in a number of process changes.

- Vetting system for referrals to be re-appraised by the Radiology Department to ensure correct allocation of particular types of referrals.
- Streamlining of bookings for the ultrasound service to allow more time to assess patients.

In addition, the complaint highlighted the importance of good communication and the following was highlighted in the follow up with staff:

- The principals of effective communication and the importance of being mindful of tones/gestures to avoid misunderstandings.
- The importance of communicating clearly with patients and addressing questions, especially where particular types of referrals cannot be accommodated at the hospital.
- The value of a productive patient/doctor relationship and how to foster this.

Hospital Group

Category: Dignity and Respect (End of Life Care)
Status: Not Upheld

Background to Complaint
A complaint was received regarding the COVID-19 Protocols that were enforced in the Mortuary Department during COVID. The Complainant lost their child in a tragic road traffic accident, RIP, and was very unhappy with the restrictions enforced by the Mortuary Technician regarding personal protective equipment (PPE), viewing and proximity permitted to their child, touching their child and sitting with them for extended periods.

Investigation
The Mortuary Technician was given a copy of the complaint. The Mortuary Technician provided an extremely detailed chronology of the events which they had documented including explanations as to why certain protocols were in place. The Mortuary Technician offered their sincerely sympathy to the family regarding this requirement to enforce COVID protocols.

The Complainant remained unsatisfied and was angry with the staff member in question. They submitted further queries and raised additional concerns.

The Complaints Officer issued a comprehensive response to address these.

The Complainant, unfortunately, remained dissatisfied.

Outcome and Learning
Documentary evidence and written protocols and procedures supports investigation and assists in establishing facts in any case and therefore good record keeping should be promoted to all staff.

It is recognised that grief and the anger associated with grief, may, regretfully, result in no satisfactory outcome for a complainant regardless of any explanation provided.

It is also important to be aware of the stress experienced by staff members involved in a difficult and emotional complaint to provide support as required.

Hospital Group

Category: Communication and Information (Information)
Status: Not Upheld

Background to Complaint

The patient's sibling is the patient's advocate and attends all appointments. Patient's sibling was unhappy that they were refused access to a copy of the patient's scan result prior to attendance at the outpatient clinic, with no explanation given. Patient's sibling stated as a result they were unable to make choices and prepare questions and that the patient was unable to make fully informed decisions in advance of the appointment.

Investigation

The Clinical Nurse Specialist (CNS) liaised with the team who ordered the scan. The clinicians advised the CNS that the scan result is the type of result that needs to be discussed with the patient in the first instance. The report has to be correlated with the patient's clinical features and isn't a straightforward test. The results needed to be communicated in a proper clinical context initially. Once the result had been discussed with the patient the team would have no problem sending a copy to the patient's sibling (advocate).

Outcome and Learning

The General Data Protection Regulation (GDPR), under Article 15, gives individuals the right to request a copy of any of their personal data which are being 'processed' (i.e. used in any way) by 'controllers' (i.e. those who decide how and why data are processed).

However, the right of access is not an absolute one. It may be restricted in certain appropriate circumstances. Under Section 4(1) the Data Protection (Access Modification) (Health) Regulations, 1989 (S.I No 82 of 1989) which provides that the right of access can be restricted where the release could cause harm to the physical or mental health of the data subject.

Patient's sibling was not refused a copy of the result. Rather, the clinical team sought to defer providing a copy of the result directly to them until the clinical team had the opportunity to clinically review the data with the patient in person. It was considered that this deferral of the right of access was reasonable and justified.

However it was noted that clarification / explanation about the scan result being of a type that needs to be discussed with the patient in the first instance and that the results need to be communicated in a proper clinical context and that the sibling would then be afforded a copy would have been helpful.

Hospital Group

Category: Access (Accessibility and Resources) and Safe and Effective Care (Treatment and Care)
Status: Compliment

Background to Compliment
Patient transferred from one hospital for specialised surgery in another hospital. Following surgery and inpatient stay patient was discharged home as did not require transfer back to referring hospital. Patient and spouse were feeling overwhelmed and emotional with recent events and contacted the Patient Liaison Office (PLO) of the surgical hospital for advice and support.

Nature of Positive Feedback
The PLO team acted as a point of contact and a link with the specialised surgeons for the patient and their spouse. The PLO enabled communications with external specialists to assist and progress patients rehabilitation.

Outcome and Learning
The patient's spouse stated that they had an exceptionally positive and reassuring experience of the PLO team. They stated that the PLO service is truly delivering for the patient, their families and for the Hospital.

Having a dedicated patient liaison service can quickly address issues of concern for patients and their families and can assist them to navigate and access services. Such a service can provide valuable support and contribute to a positive patient experience.

Hospital Group

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

Background to Compliment
Patient attending ante-natal appointments and care received during inpatient stay.

Nature of Positive Feedback
The Consultant Obstetrician provided the highest standard of consistent care, consideration and was a wealth of knowledge which the patient stated was a great reassurance to them and their partner. The patient said that the Consultant Obstetrician gave the time needed to listen to their concerns, answer questions and advocate for them and their preferred birth plan. As a result the patient felt comfortable trusting the Consultant's clinical judgment, which they stated, was never forced but offered respectfully, giving them agency and the power to make their own informed decisions.

The patient expressed their gratitude to the Consultant for contributing to a really empowering and positive pregnancy and birthing experience. The patient highlighted how the Consultant was simply lovely, warm and kind in all interactions, despite how in demand they seemed to be.

Outcome and Learning
The Consultant Obstetrician's interactions with the patient and their partner greatly contributed to a positive experience throughout their care journey. The manner in which the patient was approached, and treated by the Consultant proved empowering and greatly added to the patient's confidence and comfort.

Listening to patients, providing time to address questions and information to aid understanding and reasons for decisions can reduce anxieties and build trust which contribute to a positive and empowering experience.

Hospital Group

Category: Communication and Information (Information)
Status: Compliment

Background to Compliment
The family of an elderly patient wrote to the Hospital as their relative had been a patient for some time and they were struggling to get updates from the clinical team caring for the patient. The letter was responded to by a phone call from a member of the Patient Advocacy Liaison (PALS) team and they wanted to compliment the team and explain the positive experience they had when they were contacted by the PALS team.

Nature of Positive Feedback
The family wrote to the Hospital to thank the Patient Advocacy Liaison (PALS) team for their help and communication regarding their relative. They really appreciated the regular updates provided by the PALS team and the video chats they facilitated that allowed them to speak to their relative on a number of occasions.

Regular communication was established between the family and the ward and a schedule for updates was agreed. A detailed discharge plan was being developed for the patient with the input of the family for which they were very grateful.

The family continued by highlighting the great service provided by the PALS team, who they complimented for working hard to provide advocacy for patients and were successful in providing a voice for the patient.

Outcome and Learning
The importance of effective and efficient communication was highlighted to the team on the wards including the clinical teams. With the support of the PALS team, the patient and their family were able to get the information they required which allowed them to plan for the patients discharge.

Hospital Group

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

Background to Compliment
The family of a patient wrote to compliment the work of the Patient Advisory Liaison Service (PALS) team in the Emergency Department of the Hospital. The family observed that the department was very busy while they were there, with a number of patients on trolleys. One patient in particular appeared very distressed and required reassurance and assistance.

Nature of Positive Feedback
The family observed a staff member approach the distressed patient and wrote to compliment the staff member's interaction with the patient. They stated that the staff member was so caring and empathetic, it actually them quite emotional watching the interaction. They observed the name badge the staff member was wearing and it indicated they were a member of the PALS team. They continued to observe the help provided by the PALS team member. The family listened as reassurance was provided to the patient. The compliment continued to state that when the PALS team were finished attending to the distressed patient, they turned with a smile to the family's relative and asked if they were okay. This PALS team member brought them a sleep mask and ear buds to help them sleep that night. The family felt that the PALS team member really was a shining light. The family would personally like to acknowledge their kindness and thank them for their empathy.

Outcome and Learning
The contents of this compliment were sent to the PALS team and also to the ED staff. The hospital promotes a process of ensuring that all positive feedback is shared with staff within and across services as this motivates staff to continue the good work that they do and to demonstrate the impact that such care has on patients.

Hospital Group

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

Background to Compliment
A patient was admitted to the Hospital unexpectedly and was very nervous, frightened and upset because they had no belongings with them and they felt very alone. There were visiting restrictions on the ward and the patient felt very isolated.

Nature of Positive Feedback
The relative of the patient wrote to the Hospital to compliment the Virtual Shop Service that had been introduced into the Hospital during the COVID pandemic, at a time when no visitors were permitted to visit their families and friends. Patients often found themselves without essential personal supplies and other small luxuries that patients treasure and appreciate when an inpatient.

The patient's relative complemented the Virtual Shop Service and stated that from the moment they were contacted on a Saturday afternoon, the service was faultless. The staff went out of their way to ensure that the family could place an order for supplies for their relative and the supplies were delivered early each morning including the daily newspaper which was invaluable to the patient. Nothing was too much to ask and the staff that delivered the order did so with a smile and had a few minutes for a chat. The relative stated that they provided stellar service and that their kindness was appreciated by all of the patient's family.

Communication via WhatsApp, and a final phone call to the shop for payment, made for a seamless experience. The patient's family ended their compliment by stating "Well done to all the staff for their invaluable service."

Outcome and Learning
The outcome and learning from this complement is so positive, encouraging and motivating for the staff and management who so professionally and caringly manage the Virtual Shop Service in the Hospital.

The learning from this compliment is that even the small gestures of good will and kindness that we can give to patients is appreciated and these kind acts can help make our patients' stay more pleasant. This compliment supports the hospital's values; "Working together, caring for you"

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
A patient made contact with the Hospital through Your Service Your Say to pay a compliment to the staff they had come into contact with while a patient in the Day Ward of the Hospital.

Nature of Positive Feedback
The patient stated that the staff they had met throughout their time in the Day Ward were so kind and professional. The complimented all grades of staff from Pre-Op Assessment, Day Ward, Theatre, Clerical and Hospitality. The patient felt that they could not have been treated with more courtesy or respect. Clinical expertise, was executed with such skill, attention to detail and the regard for the patient's comfort and care was lovely to witness first hand. The patient advised that they believed that this is what good health care looks like and sincerely thanked all involved in their care.

Outcome and Learning
This compliment was forwarded to all the Departments mentioned to highlight the effect their commitment to a patient centred service has on the patient's experience and also to accentuate the positive feedback and appreciation from the patient. The patient focus and person centred care demonstrates the extent to which this can have a positive impact on the patient's experience and journey.

Hospital Group

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

Background to Complaint
A relative of a patient submitted a complaint through Your Service Your Say regarding their parent's care while an inpatient. The relative was concerned and upset that they had received no communication from the ward about their parent's care. They went on to say that they had not received any communication and were not made aware of any plan of care for their parent. The relative stated that they had left numerous messages with staff on the ward and had still received no call back with information. The relative stated that the patient was confused and was unable to advocate for themselves. The relative said that their parent had a procedure completed but that the family were not informed as to why this procedure was necessary. The relative was further concerned that their parent's personal hygiene was not being taken care of and this was causing a great deal of stress for the family as their loved one's appearance was always very important to them.

Investigation
The complaint was sent to a member of the Patient Advocacy Liaison Team who contacted the family and used the ASSIST[1] approach to provide assurance to the family that they would link directly with the patient and the clinical team and provide an update to the family. The PALS team member brought the family's concerns to the attention of the Clinical Nurse Manager on the ward. It was arranged for the Clinical Nurse Manager in conjunction with the clinical team to make contact with the family and provide a clear clinical update on their parent's care, provide a diagnostic update and a treatment pathway.

The issue of personal hygiene was raised with the ward and they were asked to ensure they communicated with the patient and provided assistance with their personnel hygiene.

The relative was very happy with the quick response to their complaint. They were provided with a clear clinical update and reassured that their relative was being cared for by the staff on the ward.

Outcome and Learning
The importance of communicating effectively with patients and their relatives, as appropriate, was highlighted to all staff involved and the wider clinical teams. Effective communication is one of the most important skills for staff to have and it greatly alleviates a lot of the concerns and worries of both patients and their relatives.

[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: Communication and Information (Communication Skills) (Information); Dignity and Respect (Discrimination); Access (Accessibility / Resources)
Status: Upheld

Background to Complaint
A complaint was received from a patient that was unhappy with a number of aspects of their experience while attending the Hospital for an outpatient's appointment. The raised some as complaints and others as concerns which included:

- The patient was unhappy with the information that was requested from them by the Security Officer that they met on arrival at the Hospital.
- The patient felt they had been treated in a discriminatory manner by staff in the Radiology department and that they provided an unacceptable standard of care
- The patient also raised accessibility issues.

Investigation
The complaint was fully investigated by the Complaints Officer.
The Security Staff in the hospital assist with implementing the Hospital's visiting policy and ensure adherence to the visitor guidelines. They also carry out regular checks on the wards to ensure compliance with visiting guidelines. All patients and visitors are met on arrival by a Security Officer. Security Officers check where visitors are going to and provide assistance/directions and ensure compliance with the established visiting hours in line with the Hospitals Visiting Policy.

The questions that were asked of the patient were standard questions at the time. On review of the service, following receipt of the complaint, the Security Manager acknowledged that there was room for improvement in how the Security Officers interact with patients and visitors and offered an apology to the patient for their experience. Improving communication will be highlighted to all security staff and added to their tool box training which is held regularly with the security staff.

This communication piece has also been shared with the Hospitals volunteers who also greet patients and visitors while providing a pathfinding service.

The patient stated that on arrival in the Radiology department, they were checked in and advised to "take a seat" despite being a wheelchair user. They found this very demeaning and felt discriminated against by the comment. When this was brought to the attention of the reception staff, they offered a sincere apology to the patient for any hurt or distress this comment caused. They did not intend in any way to offend the patient.

The Portering Services Manager apologised to the patient for any inconvenience caused to them by the delay in responding to a request for assistance. The service was experience particularly high levels of calls on the day and were under pressure to meet all the calls for assistance. The Portering Service makes every effort to respond to requests for assistance in a timely manner but unfortunately on this occasion, the service fell below the standard set and which was also expected by the patient.

Additional training has been provided to the Portering staff on customer service skills and the importance of introducing themselves to all patients they interact with on a daily basis, by using the phrase "*Hello, My name is…… "*. It is clear on this occasion that this was not the case and for this the Portering Services Manager has apologised.

The Portering Services Manager has since spoken to all porters reminding them of the importance of good communication and customer service to all our service users and patients.

The patient was also unhappy about the lack of wheelchairs available at the main entrance of the Hospital. On occasion the Hospital does experience a high volume of requests for wheelchairs and to provide assistance to patients from the main entrance. The Hospital is actively managing this situation and all staff are aware of the importance of having a chair available at the main entrance for patients/visitors.

Accessibility to the Radiology department was also raised by the patient. The double doors to the X-ray department waiting area are manual opening double doors. The Hospital has been assessing different options of design for these doors to be more user- friendly and have confirmed that plans have finalised to replace the doors.

Outcome and Learning

The Services Managers have since spoken to all staff reminding them of the importance of good communication and customer service to all our service users and patients. Another piece of learning is to be cognisant at all times of our Values in Action and, in particular the values: "*Am I putting myself in other people's shoes*" and "*Am I aware that my actions can impact on how patients feel*". This learning was also going to be used by the Service Managers in their customer service training going forward.

Hospital Group

Category: Safe and Effective Care (Treatment and Care) and Communication and Information (Communication Skills)
Status: Not Upheld

Background to Complaint
A complaint was received from the parents of a patient that visited a Local Injuries Unit (LIU) and an Emergency Department(ED). The complaint related to long delays for the management of an injury.

Investigation
The complaint was investigated by the Clinical Nurse Manager 2 (CNM 2), who made contact with the parent of the patient and listened to their complaint. The CNM 2 took a detailed account of the complaint and read it back to the parent to ensure that all details had been captured accurately.

The patient was a minor. The patient was accompanied by their parent. The patient experienced a 3-4 hour wait before being seen. The parent felt that their attempts to give the history of a previous similar injury for the patient were not listened to and they had concerns that the pain medication prescribed was inadequate. The parent felt the past injury information was very important to how the current injury was managed.

Low dose medication was administered and the first attempt to resolve the injury was unsuccessful. Gas and air was then administered and second attempt also failed. Morphine was then administered and a second doctor attempted to resolve the injury for a third time but it was unsuccessful also.

A decision was made to transfer the patient to an Emergency Department(ED) within the Group and the patient was given sedation for the journey and as there was no ambulance available, the parent transported the patient to the ED in their car. The patient's injury was successfully resolved in the ED.

The Hospital apologised to the patient and their family for their experience of the service in the LIU.

Outcome and Learning
The learning from this complaint was the understanding of the frustration and anxiety experienced by patients and their families when they feel they are not listened to.

Communication is important when speaking with patients and their families to avoid causing additional frustration and anxiety in what can already be a stressful time for them.

Hospital Group

Category: Communication and Information (Communication Skills); Accountability (Patient Feedback)
Status: Upheld

Background to Complaint
The patient had suffered a back spasm with severe pain at home and was brought to the Emergency Department (ED) by private ambulance. In their original letter of complaint the Complainant had described their poor experiences in the ED and Radiology Department. The Complainant had described the key issues of concern as being related to the time it had taken from presentation to being assessed/triaged, poor pain management, staff behaviour/ attitude and the lack of basic care and compassion. The episode of care included clinical assessment by nursing and medical staff, the administration of analgesia/anti spasmodic medications, the manner in which X- rays had been obtained, lack of any offer of refreshments over an eight hour period and the rushed discharge from the ED with no advice as to follow up or further investigations.

The Complainant described how they and their parent had been spoken to in a rude and dismissive manner by a member of nursing staff and how the entire episode of care lacked empathy, compassion and respect. The Complainant also described how the attending doctor had been dismissive of the Complainant's attempts to describe their symptoms and appeared to disregard the complaint regarding inadequate pain control. The same doctor subsequently asked the Complainant on several occasions why they were still in the ED after they (the doctor) had decided that the Complainant could be discharged for GP follow up. The Complainant outline that this was due to the Complainant being unable to get dressed without assistance, after their parent had been directed to leave the ED due to COVID 19 restrictions.

The Complainant presented to their family doctor two weeks after these events and subsequent investigations revealed the presence of metastatic cancer with lesions in the breast, lymph nodes, spine, pelvis, lungs and liver.

Investigation
There was a seven months delay in the investigation of the complaint under Stage 2 of Your Service Your Say (YSYS) and the response seemed to only issue following the intervention of a family friend who was a local solicitor. The Complainant requested an Internal Review under Stage 3 of YSYS and this resulted in all except one of the issues raised being upheld or partially upheld by the Review Team.

Outcome and Learning
The Review Investigation made a number of recommendations including the immediate implementation of staff training in Values in Action and Caring Behaviours in the ED, aggregated analysis of complaints related to this ED to identify and address recurring themes with the involvement of Human Resources if performance management issues emerged.

The hospital has also requested the Complainant to participate in an educational video to describe their experiences which will be used for staff education and in induction programmes.

Community Healthcare Organisation

Category: Communication and Information (Information); Access (Accessibility / Resources)
Status: Issue 1 Upheld and Issue 2 Not Upheld

Background to Complaint
Complainant submitted a complaint on behalf their sibling who was a long-term resident in an Older Persons Community Hospital, to Your Service Your Say.

The Complainant stated that their sibling received a one page letter of refusal from the service in response to their application for funding for a specialised wheelchair, with a brief rationale provided that the decision was due to there being no funding available. Complainant stated that no option to have this decision reviewed was provided, only an option to make a complaint via Your Service Your Say (YSYS). The Complainant felt that this letter lacked empathy and indicated that this one decision was 'absolute'. The Complainant stated that the application for funding had been accompanied by a detailed Occupational Therapy (OT) assessment outlining the need and that due to their sibling's health and communication needs, the requirement for the specialised wheelchair was essential to their quality of life.

Investigation
The Delegated Complaints Officer (DCO) assigned to the complaint liaised with the Complainant for further information and to confirm consent was provided by their sibling to make the complaint, which was confirmed.

The DCO extracted two issues for investigation – Issue 1. Communication; Issue 2. Service Issues: validity of the decision making process on funding applications.

The DCO met with the OT Manager, the Service Manager and the General Manager for Older Persons Services (OPS). The DCO reviewed all relevant documentation including the Standard Operating Procedure (SOP) for the Handling of Funding Applications in OPS that was in place.

From discussions with the Service Manager and General Manager, the DCO was informed that there is no specific budget for the funding of specialised aids and equipment within the service at present but that a business case was currently being drafted in consultation with the OTs for national funding and it was hoped that this will lead to an increase in the budget for next year.

Outcome and Learning
Following the investigation into ***Issue 1. Communication***, the DCO decided the following:

- The decision letter that issued did not offer an option to have the decision reviewed;
- The option to make a complaint to Your Service Your Say (YSYS) in relation to the decision to refuse funding is not the correct pathway for review of such decisions and therefore was not correctly referenced in the SOP;
- The decision letter that issued to the service user was a standard letter and lacked empathy;
- The decision letter omitted to include any alternative options to the applicant in terms of how their request could be accommodated or what other funding options might be available to them;

- The SOP required to be amended to include a right to have decisions reviewed by the General Manager, and to clearly outline the end to end pathway and decision-making process for funding applications in OPS

This issue was upheld - The DCO acknowledged that the impact of a decision to refuse funding is great on the Applicant. The DCO accepted that the decision letter was brief and lacked any option to have the decision reviewed. The DCO made the following recommendation for service improvement:

The current SOP for the Handling of Funding Applications in Older Persons Services Community Hospitals to be reviewed to include the following:

- An outline of the decision-making process to include that applications should be accompanied by both a clinical opinion of an OT and input from the Director of Nursing with a cost benefit analysis for each application, to be approved by the Older Persons Service Manager;
- Clarity regarding the decision-making being based on available funding; that is not a clinical decision or challenge to an OT opinion;
- An outline of the process for review of decisions to refuse funding; to include that the review is carried out by the General Manager for Older Persons Services, and a timeframe for a review response to issue to the Applicant;
- A draft decision letter for funding approvals;
- A draft decision letter for funding refusals to include an acknowledgement of the impact of this decision on the Applicant, the review option available to the Applicant, and any alternative equipment or funding options that may be available.

Following the investigation into ***Issue 2. Service Issues:*** **validity of the decision making process on funding applications,** the DCO decided the following:

The DCO did not uphold this issue - It was apparent that the decision to approve or reject funding applications was based on the available budget and the appropriate supporting clinical assessment. The Older Persons Service Manager outlined that the OTs in the service seek to source equipment in a number of ways by working together with their colleagues to consider options available and via an internal repository of pre-used equipment within services that is put onto a shared portal that OTs can access. While this specific issue was not upheld, the DCO made the following recommendation for service improvement:

- Older Persons Service Manager to engage with the OT team to discuss the current budget available for funding for specialised aids and equipment, the updates to the SOP as per recommendations outlined for Issue 1 above, and to advise of the Business Case seeking additional funding. The purpose of this engagement is to ensure that everyone involved in the care and support of service users has a clear understanding of the pathways for funding applications, the budgetary restrictions that impact decisions regarding funding, and what each person's role is within that process so as to manage service users' expectations around available funding and what the service can provide.

The Recommendations were sent to the Accountable Officer (head of the relevant service) and were accepted and implemented.

Community Healthcare Organisation

Category: Privacy (Confidentiality)
Status: Upheld

Background to Complaint
The service received negative feedback in writing that a request for personal information had been made in a non-private setting by a member of security staff at a COVID-19 vaccination centre.

A service user attending for a COVID-19 vaccination was asked their age by the member of security staff managing admissions at the vaccination centre. The service user was dissatisfied at being asked for specific personal information in a non-private setting.

While the actions related to a non-HSE member of staff the communication was managed directly by the service as it took place in the context of service provision at the vaccination centre.

Investigation
Information was sought from the vaccination centre site-lead in relation to the role and responsibilities of security staff and the management of attendees at the vaccination centre.

The site-lead confirmed that security staff at the time were required to confirm with attendees at point of admission that they fell within the age range for the cohort being administered vaccinations on the day.

This preliminary check was to prevent the possibility of a service user being admitted and then subsequently refused the vaccine at a later stage in the process within the centre.

The site-lead confirmed that the process was to confirm only that the attendee fell within the age range of the scheduled cohort for the day - not to request the specific age of individual attendees.

Outcome and Learning
A written response issued to the service user advising of the process as should have taken place in terms of establishing the age range only on entering the centre.

The response included an apology and advice that the security company had been notified of the feedback.

The service user acknowledged the response and confirmed otherwise that the experience of the vaccination process and staff was very positive.

The site-lead confirmed that security staff for the centre were reminded of the requirement to confirm an age range only with attendees and not to request the specific age of any individual.

Community Healthcare Organisation

Category: Access (accessibility / resources)
Status: Upheld

Background to Complaint
Gay Men's Health Service (GMHS) commenced using a new online appointment based system (Swiftqueue) in 2021 and in January 2022 opened up a new pre-exposure prophylaxis (PrEP) / 'New PrEP' appointments option to the public (instead of the current Swiftqueue waiting list method) with a view that patients would have more visibility and autonomy over their appointments and to reduce the internal administrative burden of managing waiting lists. With the New PrEP system 8 new appointments were made available each Tuesday on a first come basis.

Investigation
In late April 2022, GMHS commenced recording complaints (via email and phone) relating to the inability to get a PrEP appointment using Swiftqueue. Eight complaints were recorded as of 21st June 2022. Many of the emails outlined the frustration of trying to get an appointment every Tuesday but to no avail with only eight places available on first come basis.

Using Swiftqueue, 'New PrEP' for appointments was having a negative impact on service users' experience while accessing the service. There was also an element of unfairness to the process as it was down to luck who would get the appointments each week. A local Risk Assessment was carried out and a decision was made to suspend 'New PrEP'.

Outcome and Learning
The Swiftqueue business manager is now looking into an alternative option (instead of New PrEP). A proper trial period will be put in place from the outset once a new option becomes available.

Community Healthcare Organisation

Category: Communication and Information (Communication Skills); Access (Appointment – other)
Status: Upheld

Background to Complaint
A parent with their child attended late for dental appointment. The parent parked in a restricted area and was told by the dental porter and security that the car would need to be moved. The parent complained about the manner in which they were spoken to. The dental porter advised the clinician treating the child that other patients should be seen first, as this parent was late for their appointment. The parent objected to a porter deciding the order in which patients should be seen.

Investigation
The complaint was raised with the Senior Dentist who spoke with the dental porter to confirm the details. The Senior Dentist then spoke with and apologised to parent for their experience on the day. The Principal Dental Surgeon also contacted the parent by email and apologised.

Outcome and Learning
Staff were reminded that all services users must be treated with respect and the importance of good communication. In addition, the order in which patients are seen is decided by the clinician.

Community Healthcare Organisation

Category: Access (Accessibility /Resources); Communication and Information (Information)
Status: Upheld

Background to Complaint
A complaint was made regarding the loss of a Home Care Package Service. The Home Care Company who provided this Home Care Package had advised that they were no longer able to offer this service due to the staff member leaving the company and they have been unable to hire a replacement carer to take over this package.

Investigation
The complaint was raised with the HSE Home Care Package Manager for the area who spoke with the Home Care Company that had handed back the Home Care Package to see why this occurred. The Home Care Company advised that it was due to a decision made by the Government to make changes to certain visas and that the person giving the care now could only work in a residential unit and not in home care. The carer, therefore, left the company to comply with these changes.

The Home Care Company advised that they were finding it extremely difficult to recruit staff in the area. Unfortunately this was circumstances beyond the control of the company and the HSE. The HSE Home Care Package Manager tried to source another company to take this Home Care Package but unfortunately all companies are experiencing difficulties in recruitment in this area. The HSE Home Care Package Manager worked with the Public Health Nurse to try and resolve this issue and has assisted the family in getting respite until another Home Care Company can be sourced.

Outcome and Learning
Provide for regular communication between the Home Support Office and the various agencies to flag any potential issues and provide an escalation pathway for critical issues such as recruitment where assistance from the national office is needed. This will hopefully help resolve issues before they result in Home Care Packages being handed back to the HSE.

Community Healthcare Organisation

Category: Privacy (Confidentiality)
Status: Upheld

Background to Complaint
A parent of a service user wrote to the HSE in early 2021 to submit a complaint. The parent advised that they received a letter from the services addressed to their child but that the letter itself referred to another child. The parent stated this was a data breach and wanted the matter investigated.

Investigation
An apology was provided for the delay in processing the complaint.
The Complaints Officer made contact with the Early Intervention Team requesting clarity on the matter raised. They have confirmed the information on file in relation to the complainant's child is correct on the database but unfortunately, due to human error, the envelope was addressed incorrectly. The Early Intervention Team issues a large volume of correspondence to other children's services and families.

In accordance with the General Data Protection Regulations (GDPR) and the Health Service Executive's (HSE) Data Protection Policy, the Complaint Officer confirmed the Early Intervention Team, in the area has reported this data breach to the Deputy Data Protection Officer, HSE.

Outcome and Learning
The complaint was upheld and apology given.

In order to mitigate the risk of a similar breach reoccurring, the Complaints Officer recommended the following for the twelve Community Disability Network Teams (CDNT) in the area.

- Anonymised factual details of what took place to be circulated to CDNT as a learning exercise.
- CDNT staff to complete GDPR training and become familiar with HSE's Data Protection Guidelines.
- Where practical, a clear desk policy should be in operation when correspondence has been issued.

The parent was thanked for their feedback and advised of the service improvement measures outlined above that would be implemented on foot of their feedback. The Accountable Officer (head of service) wrote to the complainant to advise that they were accepting all of the Complaints Officer's recommendations in relation to this complaint.

Community Healthcare Organisation

Category: Safe and Effective Care (Treatment and Care); Communication and Information (Communication Skills); Access (Accessibility / Resources)
Status: Compliment

Background to Compliment
A client was referred to their local HSE National Counselling Service by their GP to address low mood, anxiety which was affecting sleep and issues from childhood.

The client attended a number of counselling sessions. All sessions were conducted by telephone initially due to the COVID-19 pandemic.

Counselling ended by agreement as the client reported significant improvement. Clinical evaluation on the CORE Outcome Measure[2] indicated a reduction in symptoms.

Following discharge from counselling the client submitted a compliment about their counselling experience through Your Service Your Say.

Nature of Positive Feedback
Feedback provided by the client through Your Service Your Say was very positive about their experience of the counselling process and the counsellor they attended.

Regarding the counselling experience, the client stated how the "counselling has changed my life" and helped them to find happiness, a new way to live and also changed the critical narrative that they had towards events and themselves.

In relation to the counselling process, the client stated how the counsellor helped from day one even when previous therapy did not yield any significant, long term improvements. The client was grateful that the counsellor took the time to identify and understand the issues.

The client stressed how their relationship with the counsellor was very important and appreciated how the counsellor, "made me feel understood, without judgement, and I trusted her completely".

The client stated how they now feel "excited for my future. I have gotten back in control of my life."

[2] CORE stands for "Clinical Outcomes in Routine Evaluation" and the CORE system comprises tools and thinking to support monitoring of change and outcomes in routine practice in psychotherapy, counselling and any other work attempting to promote psychological recovery, health and wellbeing. The CORE outcome measure (CORE-10) is a session by session monitoring tool with items covering anxiety, depression, trauma, physical problems, functioning and risk to self. The measure has six high intensity/ severity and four low intensity/ severity items.

Outcome and Learning
The client experienced a positive outcome from counselling evidenced through the clinical outcome measure and the positive feedback received.

Key learnings that have been shared with the services and which reflect research findings regarding the effectiveness of counselling and psychotherapy include:

- The importance of trust in the counsellor to support and promote psychological change
- The significance for the client of feeling heard, understood and not judged.
- The benefits of telehealth, all sessions were conducted by telephone due to COVID-19 and by client choice. This did not impede the progress of counselling or the positive outcomes that were achieved.
- The provision of counselling by telephone optimised the client's access to the service.