HSE Your Service Your Say

Anonymised Feedback Learning Casebook
Quarter 4 2022

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

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

The casebook features a total of **12 complaints**; 6 complaints from Hospital Groups, 5 from Community Healthcare Organisations and 1 from a National Service that were investigated and/or reviewed along with their outcomes. The casebook also features **6 compliments,** all from Hospital Groups, which highlight the learning to be gained from positive Patient and Service User feedback.

Key issue categories:

Complaints

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

Compliments

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

Introduction

The casebook presents a total of 18 cases comprising of 12 complaints and 6 compliments received by Hospital Groups, Community Healthcare Organisations and National Services covering the fourth quarter of 2022.

The dominant theme for complaints in the Q4 2022 edition of the casebook relate to *Communication and Information* with this category featuring in 10 of the 12 complaint cases presented. Other categories such as *Access*, *Dignity and Respect, Safe and Effective Care, Accountability and Privacy* featured in 10 of the 12 complaint cases presented.

Communication and Information concerns issues such as general communication skills, keeping the patient/service user informed, signage, how information is relayed, the timeliness of the provision of information, checking understanding of the information provided and offering a reliable telephone service.

Access also featured prominently with issues around appointments delays and hospital facilities such as access to beds and overcrowding. For *Dignity and Respect*, the issues concerned treating the patient as a person, putting oneself in another's shoes, as well being aware how behaviour can impact on others. *Safe and Effective Care* related to how a person received care as well as raising issues around testing and diagnosis. *Privacy* concerned confidentiality of information while *accountability* related to issues around invoicing.

The positive feedback received mainly related to the category of *Dignity and Respect* around delivery of care and this featured in 5 out of the 6 compliments presented. The other categories of positive feedback featuring are *Communication and Information, Safe and Effective Care and Privacy* with one or more of these categories represented in all 6 compliments presented.

The cases presented in the casebook, although each unique, present themes and issues that need to be examined in the context of quality and service improvement. 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 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 that those who use our services receive and is integral to business improvement. The cases presented, both complaints and compliments, offer services an opportunity to reflect on service delivery, to understand the issues experienced by Service Users, to examine the measures and initiatives used across services to address these and how such methods can be utilised in their area to address or prevent similar issues.

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 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: Dignity and Respect (Delivery of care); Communication and Information (Communications Skills); Privacy (Confidentiality)
Status: Compliment

Background to Compliment
A child who had been suffering from anxiety had a very traumatic and disturbing episode of anger and aggressive behaviour one evening. The child's parents had to phone An Garda Síochána to come to their home and for an ambulance to bring them all to the Emergency Department (ED).

Nature of Positive Feedback
The family were seen by a Psychiatrist while in the ED. The child was deemed fit for discharge but the family were advised to return if there was any reoccurrence. On the journey home, the child became physically abusive and a danger to themselves again so the family presented back to the ED.

The family were initially told they would need to go through triage again. ED was extremely busy at this time and the family had to stand in a corridor with the child, screaming, hitting themselves and their parents. This was occurring while others looked on. The child was getting more and more distressed with every passing minute.

At this point the family encountered a member of the nursing team who, from the very start, was so caring and gentle with their child. The nurse found the family somewhere a little more private to wait and she brought the child some refreshments. Before the nurse left, she came to say goodbye to the family, she gave the child some encouraging supportive words and also bought a magazine for the child.

Outcome and Learning
The family described this episode as one of the most heart-breaking they have endured. They were watching their child, who is normally gentle and kind, scream abusive language and attempt to hurt themselves. It was a terrifying experience.

The family feel that this nurse did more for their child that day than anyone else. The child couldn't believe that someone who had never met them before could show such kindness. The facilities for adolescents/children with mental health issues in Emergency Departments are lacking but staff like this offer parents some compassion in these awful circumstances.

The feedback was shared with the team in order to highlight and reinforce how impactful a caring and compassionate approach can be even in such a distressing acute episode and the difference it made to this particular family.

Hospital Group

Category: Access (Accessibility /Resources), (Hospital Room facilities); (Admission (delays)); Communication and Information (Communication); Safe and Effective Care (Treatment and Care)
Status: Upheld

Background to Complaint
The parent of a patient who presented to the Emergency Department (ED) and was subsequently admitted to the hospital wrote to the hospital to highlight concerns about "the absolute lack of facilities" in the ED of the hospital.

The parent described very lengthy wait times as follows:
My child "was left waiting many hours waiting on a bed in ED (before being admitted) and many hours before even being seen by a doctor"
"I had to ask for help and tell them my child had a temperature multiple times"
"This hospital has been an utter disgrace with facilitating my child and their needs"
"The staff are a great help but the situation they are in is terrible…having to move kids around that are admitted and yet still have no bed on a ward and then they have to ask parents can they put their child on a corridor"

Investigation
The Hospital's Complaints Officer telephoned the parent and apologised for the poor experience they had in the ED, waiting to be seen initially and then, although being admitted, the subsequent wait for a bed. The Complaints Officer explained the difficulties that the hospital was experiencing at that time with unprecedented levels of attendance across all sites and the issues this causes in relation to access, communication and treatment and care.

Outcome and Learning
Unfortunately, the demand on services across the hospital can outweigh capacity and can result in the wait time experienced by this family. All patients are triaged and seen in order of the severity of their presentation. The hospital continues to work with the HSE to address patient waiting times.

The hospital can only continue to highlight to families presenting that patients will be triaged and seen in order of the severity of their presentation and unfortunately, in periods of high demand on services, advise that this may result in long wait times, delays in admission or access to wards. The Hospital understands the clear upset and distress this causes especially when a child is unwell and will continue to apologise to families for this.

The parent advised that they understood but hopes that improvements can be made over time. The parent appreciated the call and wanted to thank the ED staff for their help in such difficult circumstances.

Hospital Group

Category: Access (accessibility / Resources); Communication and Information (Information) (Telephone calls), Accountability (Finance)
Status: Partially Upheld

Background to Complaint
A complainant emailed regarding the timing of the hospital 'invoice' letter and the 'final notice' letter. The complainant was also unhappy with the wording of the 'final notice' letter. The complainant had recently been discharged from hospital. The complainant advised that it was an oversight that the original invoice was not paid. When the 'final notice' letter was received, the complainant stated that 'it felt threatening'. The complainant advised they made 25 attempts over a 5 day period to telephone the accounts department to settle the bill, however all calls remained unanswered. The complainant requested for the invoice to be waived as the payment team did not answer the calls.

Investigation
The complaint was investigated by the Complaints Officer who liaised with the Finance Manager.

The Finance Manager advised that a "bill run" is processed every Monday and Friday and this automatically generates an invoice for any patient that has been discharged within the period since the previous bill run was completed. This is why the complainant would have received the invoice shortly after discharge.

A final notice is automatically generated by the system if an invoice is unpaid 14 calendar days after the invoice is issued.

The Finance Manager also noted that staff absences had impacted the payment office answering all telephone calls.

Outcome and Learning
The issue regarding the timing and tone of the invoice and final notice letters was partially upheld.

The Finance Manager apologised for any distress caused by receipt of the final notice and agreed to amend the wording of the invoice and final notice letters and these amendments include:

- Highlighting the payment office opening hours
- Ensuring the telephone number for account queries is clearly indicated
- Discontinuation of the use of bold lettering on final notice letters
- Advising patients on the initial invoice letter that the next correspondence received would be a final notice.

The issue regarding the lack of telephone access to the service was upheld.
The Finance Manager apologised for the inconvenience caused by not being able to contact the payment office due to the volume of unexpected staff absences.

The issue regarding the payment of the invoice was not upheld.
The Finance Manager confirmed that, as the invoice related to the care and treatment received at the hospital, it remains valid.

Hospital Group

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

Background to Complaint
A complainant contacted the hospital advising that they had attended at the hospital for a procedure. The complainant advised that the results of the procedure were relayed to them via a telephone call. On reflection, some months later, the complainant felt that they did not clearly understand what the doctor had communicated and thought it would be offensive at the time to say so. The complainant stated that they had expected that a face to face appointment or consultation with the doctor would follow.

Investigation
The complaint was acknowledged. A copy of the Patient Advocacy Service leaflet was included and the complainant was advised that if they required assistance from this service that it was available to them. A copy of the complaint was forwarded to the relevant Consultant and the Scheduled Care Manager for examination. A review of the complainant's notes from the time of the procedure was undertaken.

Outcome and Learning
A face to face appointment was offered to the complainant within a short period of time. The complainant was happy to receive the appointment and was very satisfied with the outcome of the complaint.

The learning from this complaint is that communication to patients should be tailored and adapted to their individual needs. Staff members should always check preference for communication and the appropriateness of the method for communication as well as checking that the patient has understood the information that they were given or ask if they have any questions or if they need to clarify anything.

Hospital Group

Category: Safe and Effective Care (Diagnosis) (Test); Communication and Information (Information)
Status: Not Upheld

Background to Complaint
A complaint was received from a patient who had sustained an injury to their foot and who advised that they contacted the Emergency Department (ED) to enquire about being seen by a doctor. The complainant said that they were informed that the cost to be seen in the ED was €100.00 and this included the doctor's assessment and x-rays.

The complainant attended the ED and was seen by the doctor who examined their foot but was unable to determine if their toe was broken or bruised. The doctor insisted that x-rays were not needed.

The complainant contacted the hospital disputing the ED invoice of €100.00 on the basis that an x-ray was not carried out and a definitive diagnosis as to whether the toe was broken or bruised was not given.

Investigation
The Complaints Officer contacted the ED who advised that the complainant was correctly informed that the fee for attending ED was €100.00 which covers the clinical assessment and any tests the clinician determines as clinically necessary to include radiology tests.

The decision of the clinician around the ordering of an x-ray relates to the exercise of clinical judgement and is an excluded matter under Part 9 of Section 48 (1)(b) of the Health Act, 2004. The Complaints Officer therefore contacted the ED consultant and requested that they review the Complainant's ED assessment and provide a response. The ED consultant advised that best practice in the context of toe fractures would be to treat on their clinical presentation and not to x-ray as the x-ray will not alter the management which specifically is immobilisation for comfort, well-fitting shoes for support and analgesia (pain relief) as needed. Toe fractures heal themselves with no further intervention.

Outcome and Learning
The Complaints Officer in their response to the complainant advised that the ED invoice for €100.00 was valid and also included the ED Consultant response that outlined that that the injury was appropriately assessed and treated.

Staff in the ED to ensure that persons enquiring about the attendance fee understand that the fee covers clinical assessment and any tests that the treating clinician determines as clinically necessary. These can include radiology tests.

Ensure that signage in the ED waiting area clearly outlines this information.

Hospital Group

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

Background to Compliment
A patient and their spouse was attending the hospital for an appointment.

Nature of Positive Feedback
The spouse of the patient wrote into the hospital after the appointment to highlight their positive experience. In their letter they stated that they wished to take this opportunity to call out some of the team that delivered a kind, caring and helpful service.

The spouse highlighted how helpful and kind the nurse was when they entered and when they were moved to the ward they were equally well looked after by the team. When they left the ward there were contacted by a nurse from the ward to let them know that they had left a phone charger after them. As they made their way back to the ward to collect it, which was a distance away, a nurse came with it to them.

The staff at the information desk also couldn't have been more helpful.

The spouse further stated that while it is unfortunate that they experience many hospital visits due to ill health, meeting such kind, caring and helpful people that take excellent care of them make these visits so much more bearable. The spouse wished to call out each of them to say thank you for the kindness and care shown.

Outcome and Learning
The compliment was shared with the various staff members. Such feedback reinforces the importance of person-centred care and good communication and demonstrates how impactful this is on a person's experience and how it makes a positive difference during a challenging time in their lives.

Hospital Group

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

Background to Compliment
A patient attended a scheduled appointment in an out-patient clinic and during the consultation, the Consultant advised the patient that they required a minor procedure. The patient did not expect this to happen at that time as the Consultant was going on leave that evening. The patient was expecting to have this scheduled for when the Consultant was back.

Nature of Positive Feedback
The patient wrote to the Hospital to compliment the Consultant. The patient was the last person on the Consultant's list that day before they commenced a period of leave. However, the Consultant decided to complete the minor procedure on the patient that very day rather than referring them for a further appointment. Carrying out the procedure meant that the finishing time of the Consultant's clinic was delayed as was the start of the Consultant's period of leave.

The patient could not believe that the Consultant would take the time to complete the procedure there and then and not refer them for another appointment. They were most grateful especially as the Consultant was due to go on leave and delayed this to look after them.

Outcome and Learning
This compliment was shared with the Consultant and the team.
The Consultant's interaction with the patient and person-centred focus greatly contributed to a positive experience. The prioritisation of the treatment and its prompt delivery demonstrates the efficiency of the service and reflects the dedication of the Consultant and their team with responsibility for the service.

Hospital Group

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

Background to Compliment
A patient attended for a procedure and wrote in to compliment the team and two staff in particular for their outstanding patient care.

Nature of Positive Feedback
A patient contacted the hospital after attending for a procedure. The patient advised that they were very nervous when they arrived for the appointment. The patient stated that they were immediately put at ease by the caring and professional care received from the medical and nursing staff that they met during the appointment. Despite the team being very busy the patient was offered a “cup of tea” to help them relax. The patient felt that a lot of care, consideration and compassion was demonstrated by everyone they met.

Outcome and Learning
This compliment was passed onto all staff involved in the care of the patient and in particular the two staff members named as being extremely kind and caring. A little act of kindness and compassion goes a long way for a patient and they really appreciate it.

Hospital Group

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

Background to Compliment
The parents of a young patient wrote to compliment the arts and crafts classes provided for children while they wait for their outpatient's appointment. The arts and crafts classes are run by the Helium Arts Project, which is an award winning Irish charity giving children and young people, with lifelong physical health conditions, the chance to shine through arts and crafts.
The initiative, run through a series of arts-based workshops, created safe and inclusive spaces that inspire creativity, spark friendships and improve mental health and well-being.

Nature of Positive Feedback
The family wrote that they attended for an appointment with their child and were surprised and delighted to discover that there was arts and crafts facilitated for the children to occupy them while they waited. They said that it was a fantastic idea and made such a difference to their child who was very anxious about seeing the doctor. The facilitator of the arts and crafts session really engaged with the children and helped to take their minds off why there were in the hospital and made the waiting time pass quickly.

Outcome and Learning
This very positive feedback was well received by the staff in the Department and the staff involved in the Helium Arts Project. It demonstrates and reinforces the power of the project to enable younger patients to form good memories of their time using the services of the Hospital.

It also supports their families who may be anxious and worried. Seeing their children supported and enjoying this service helps them to cope with the hospital experience too.

Hospital Group

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

Background to Compliment
A young patient was admitted to the Hospital on three occasions during the year for various illnesses with admission stay ranging from 10 to 14 days.

Nature of Positive Feedback
The parents of the patient wrote to the Hospital to compliment the staff in the department and especially the nursing staff for their kindness, support, patience and care during what was a very difficult time for the patient and their family.

Outcome and Learning
This positive feedback has been shared with all of the staff in the Department in the Hospital. It was very much welcomed by all staff especially during a very busy period for the department. It demonstrates that the values of kindness and compassion are so important to patients and their families and supports a more positive journey through hospital services.

Hospital Group

Category: Communication and Information (Communication Skills) (Information); Dignity and Respect (Delivery of Care); Access (Accessibility and Resources)
Status: Upheld

Background to Complaint
The family of a Patient with complex medical needs contacted the Hospital due to a procedure being cancelled on two occasions at short notice.

This was very distressing to both the family and Patient as this Patient was also undergoing other specialised treatment at that time. The family were upset at the distress caused by this and also that the Patient had fasted in preparation for a surgery which did not go ahead.

Investigation
On receipt of this complaint the Complaints Officer contacted the Patient directly to advise of the complaint being received and to discuss the background to the complaint. The Complaints Officer apologised to the Patient on behalf of the Hospital for their experience. The Complaints Officer followed up directly with the medical team involved in this Patient's care. The request for the procedure was put onto the IT system but was not booked, therefore the procedure did not go ahead. The Patient had given consent for one procedure and was informed that they would have to consent again for another procedure just before the procedure began. This caused stress, confusion and worry to the Patient.

Outcome and Learning
The medical team undertook to manage communication with the Patient more proactively around their upcoming procedure. The team were in a position to suggest a third date for this procedure and the Patient would be contacted by a member of the clinical team the week before their surgery to answer any questions regarding this procedure.

The Hospital's PALS Service also offered to act as a contact for the Patient and their family to offer support, information and to liaise with the medical team, which offered much reassurance to the family.

This complaint highlighted the importance of communication around scheduled procedures with Patients and ensuring that there was follow up when procedures may have to be re-scheduled.

The learnings from this complaint included the following:

- Enhanced communication with patients and their families
- Enhanced communication between the different teams involved in treating patients.
- Advanced planning regarding consent and informed decision making processes to avoid stress, worry and anxiety for patients in advance of procedures.
- Common understanding of IT and clinical procedure booking processes to ensure that when procedures are put up on the system that they are also booked correctly.

Hospital Group

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

Background to Complaint
A young Patient wrote into the Hospital following their attendance at the Hospital for an MRI scan. The Patient advised that they had been extremely anxious before attending for the diagnostic test and that they had a fear of needles.

The Patient wrote that during the MRI scan the staff member conducting the test seemed to be losing patience and moved the bed while the Patient was trying to get into the correct position. This frightened the patient. The scan was completed. However the Patient stated that they would be anxious if another such scan was required in the future due to this negative experience.

Investigation
The Complaints Officer followed up, on receipt on this complaint, with the Manager of the diagnostic unit. The Manager advised that it was unfortunate that 'needles' were mentioned to the Patient in build up to the MRI scan and that staff appeared to be rushing the scan.

A staff member had assisted the Patient by using their own Spotify to play the music preferred by the Patient to help put them at ease.

Outcome and Learning
The Complaints Officer contacted the parents of this young Patient and offered the suggestion of a Play Therapist who could assist the patient around future MRI scans.

The Play Therapist has developed a child friendly guide for children undergoing an MRI scan which uses children's own experiences and drawings to show what's involved the process which has now been shared with the MRI unit to aid staff in preparing children for the scan.

In addition, the play therapists will assist and provide support as requested by Radiology Staff for children identified as requiring assistance. This can be arranged in advance of a patient's attendance if it is clear that the support of the Play Therapist would be helpful.

The parents suggested that that there should be training for staff on how to deal with children undergoing such diagnostic tests and there should be more information available to parents. This suggestion was brought to the team for consideration.

They also suggested that there should be a better way for music to be played during this diagnostic test rather than just off radio stations to help put patients more at ease during the procedure. The Complaints Manager advised that, unfortunately, the music played was outside the control of the Diagnostics department.

The family of this Patient felt that their complaint had been listened to and were delighted with the suggestion of a Play Therapist. Their child was much less anxious about future procedures as a result of this intervention. This complaint also highlighted the importance of supporting children and their families in a child friendly approach.

National Service

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
A Service User contacted the National Screening Service (NSS) following a discussion he had with his GP.

The Service User had attended for a screening appointment and the outcome of the Service User's screening was that abnormalities had been detected. However, these abnormalities were outside of the conditions that the screening assessment is set up to report on, or refer onward for further review through the programme pathway.

It is standard practice within this screening programme that, when such abnormalities are detected, the Service User's GP is advised of the abnormalities so that appropriate follow up can be arranged and discussed with the Service User.

However, in the result letter issued by the screening service to the Service User, they are only advised of the outcome of the particular conditions that the screening assessment is designed to detect and any other abnormalities detected are not referenced in that letter.

The wording in the letter issued to the GP led the GP to assume that the Service User had been informed in their result letter about all of the findings including those that fell outside of the scope of the assessment.

This caused confusion during the discussion between the Service User and the GP and prompted the Service User's complaint to the NSS to highlight this.

Investigation
The Complaints Officer contacted the unit and together with the Programme Manager examined the result notification letters issued to GPs and to Service Users to identify how anomalies falling outside of the scope of the screening are reported on.

Outcome and Learning
The programme apologised to the Service User for the confusion that was caused. As a direct result of the complaint, the Programme Manager together with the Quality & Assurance Co-Ordinator reviewed and revised the wording of the letters that issue to GPs and the result letters that issue to Service Users, particularly following an assessment where abnormalities are detected that fall outside the scope of the screening assessment purpose.

Consequently, Service Users will now be advised to contact their GP where any incidental findings are discovered through screening with the programme. The newly worded letter will be rolled out in 2023.

Community Healthcare Organisation

Category: Privacy (Confidentiality)
Status: Upheld

Background to Complaint
A Service User made a number of complaints over a period of time and had also submitted additional correspondence with queries on the process which they copied to a named advocate. A staff member phoned the advocate and left a voice mail referencing the Service User's communication. The Service User subsequently complained that contact with their advocate had taken place without their knowledge or consent.

Investigation
The Complaint Officer confirmed consent with the Service User to disclose the complaint information as may be necessary to the examination of the issues raised. The Complaints Officer spoke with the staff member who was the subject of the complaint and established that the staff member did not at any point speak with the advocate and was able to confirm with them that no personal or confidential information had been provided by the staff member to the advocate.

Outcome and Learning
The Complaint Officer concluded that there was no actual disclosure of personal or confidential information about the Service User by the staff member to the advocate.
However, the Complaint Officer determined that the staff member should have confirmed consent with the Service User to make contact with the advocate in the first instance.
A recommendation was therefore made to uphold the complaint.
An apology was provided to the Service User.

Learning:
The examination of a complaint is a legitimate purpose to access the necessary personal and confidential information of a Service User as may be held by the service.

However, where a complaint includes issues that relate to third parties, for example, service providers (under a Section 38 or 39 arrangement) or other HSE services (for example hospital services referenced with a complaint submitted to a community service) or services provided by independent contractors (GPs, dentists) it is incumbent on the Complaints Officer, in line with GDPR, to advise the complainant of any third party involvement and establish consent with the complainant to refer that issue of the complaint to the third party for their examination and direct response to the complainant or provide the details for the Service User to send their complaint directly to the third party.

Where a complaint makes reference to an advocate, contact should be made with the Service User to establish their preference and consent with regard to the service's contact and communication with the advocate, particularly where contact with the advocate is deemed necessary for the examination of the complaint.

Where a third party makes a complaint on a Service User's behalf, consent of that third party to make the complaint needs to be established with the Service User and how the Service Users wishes for the third party to be communicated / involved within the complaints process.

Community Healthcare Organisation

Category: Communication and Information (telephone calls)
Status: Upheld

Background to Complaint
A complainant contacted their local CHO to advise that they could not get through to the Occupational Therapy Section in their local Primary Care Centre. They were seeking an update on a wheelchair that was required for their family member.

Investigation
The Complaints Officer sent a copy of the complaint to the Occupational Therapy Manager for examination.

The Occupational Therapy Manager advised that while the telephone system has the capacity to take messages and that these are ordinarily responded to within 2 working days, on this occasion, due to unexpected staff leave, only one staff member was available to cover calls for three locations. This unfortunately meant that return calls to clients were delayed. The Manager apologised for the inconvenience and any worry and upset caused to the complainant as a result of not being able to get through to the service and no return call being received.

Regarding the update on the wheelchair, the Occupational Therapy Manager advised the Complaints Officer that the client was on the priority 3 waiting list following a review of their referral and based on their needs. The wait time for clients on the priority 3 list is approximately 12 months.

The Complaints Officer contacted the complainant and advised them of the procedure in place in the Occupational Therapy Service regarding referrals, assessment and prioritisation. However the Occupational Therapy Service would amend the prioritisation of the client if needs had changed since the initial referral.

The complainant contacted the Complaints Officer and advised of the revised needs of their family member and how the wait time would negatively impact on them and affect their mobility and independence.

The Complaints Officer contacted the Occupational Therapy Manager and informed them of the change in the client' needs. Occupational Therapy services engaged with the client and their family. The client was reassessed and the prioritisation revised in line with priority guidelines. The client received the required wheelchair.

Outcome and Learning
Once becoming aware of an issue, the Occupational Therapy Services engaged with the client and their family. This enhanced two-way communication between the client, their family and services allowed for information to be shared accurately and trigger a re-assessment resulting in the re-prioritisation of the client on the waiting list and enabling the client to access the required equipment earlier than scheduled and minimise any negative impact on mobility.

The response to the complaint and the outcome was positively received by the family who complimented the services involved and expressed their appreciation for the engagement and assistance received.

Good communication is vital in the delivery of health services and the positive engagement of Occupational Therapy Services with the client and their family to support them and their changing needs demonstrates the HSE's core values of Care, Compassion, Trust and Learning in action.

Community Healthcare Organisation

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
A complaint was made by a family member on behalf of a Service User of Home Support Services by a family member.
The complaint contained two issues.

1. That no notification of a decision relating to the Service's User's application for home support was received.
2. That a staff member had been rude to the Service User on the phone when they were enquiring about their Home Care application.

Investigation
The Complaints Officer contacted the manager in Home Support Services. They looked into what steps this Service User's application had gone through after it was received. It was noted on the file that the application was not appropriate for this service. There was no additional correspondence on the file and, therefore, it had to be determined that no response issued.

A decision then issued to the Service User with the right to appeal the decision. An apology was also issued.

The manager of the service spoke to the staff member regarding the interaction over the telephone with the Service User. The staff member advised that they were aware of the call in question and had brought it to the attention of the Administration Manager. The staff member issued an apology in writing to the Service User. The staff member stressed that they did not mean to come across as being rude, that this was definitely not their intention.

The service also issued an apology for the phone interaction and the staff member received additional support and training regarding customer service.

Outcome and Learning
Communication and Information – Processes within the service should be looked at to ensure that the Service Users are made aware of the status of their application at all times and that they are advised that all applicants have the right to appeal.

Training – All administration staff should undergo training in customer service. HSeLanD courses should be utilised.

Community Healthcare Organisation

Category: Dignity and Respect (Alleged inappropriate behaviour)
Status: Partially Upheld

Background to Complaint
A complaint was received from a Service User in relation to a conversation conducted between two staff members in a Primary Care Centre. The complainant stated that two reception staff in the main reception area in the Primary Care Centre had inappropriate conversations in the workplace about suicide. The complainant could not recall the names of the staff, however remembered that it was two females. As a Service User of Mental Health Services, they found the conversation "upsetting and triggering" (Service User's own words in YSYS feedback form).

Investigation
- Identify the staff members that were working that day
- Speak with the staff who may have been involved
- Establish the facts identified in the complaint

Four female administration staff cover the reception area in the Primary Care Centre. On the particular day in question one staff member was off-site, narrowing it down to a possibility of three staff members who may have had the conversation.

Of the three staff members, one has since left the HSE. The Complaint Officer spoke with the two remaining staff members asking them to recall any conversation they may have had in the reception area regarding suicide.

Neither staff member recalled having a lengthy conversation about suicide. They did mention that the staff member who left did say there were a number of suicides in their neighbourhood recently.

It was also advised to the Complaints Officer that, in addition to the administration staff, staff from other disciplines within the centre also have access to the reception area and they may have been mistaken for reception staff.

The Complaints Officer was unable to ascertain the extent of the conversation that may have taken place regarding suicide.

Outcome and Learning
While it is important for staff to converse with each other in the workplace, there is a responsibility on all staff to respect others. Staff need to be cognisant of the topics discussed that could be considered personal or sensitive, especially where there are Service Users within audible range.

There is a renewed awareness with all staff in relation to communication in the workplace. Being mindful of the way we communicate and how people interpret these conversations goes a long way and has a big impact.

We need to be cognisant at all times of our Values in Action and in particular the value: "*Am I aware that my actions can impact on how people feel?*" It is important to remember that each Service User is an individual with individual circumstances. With additional staff training in this area, staff have been made aware of how their words and actions can impact on others.

Community Healthcare Organisation

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
A person arrived at a COVID Testing Site to have a PCR Test. Whilst finding the location of the group of buildings in the compound, there was no clear signage to the actual testing location which was a porta-cabin at the rear. The complainant spent a deal of time driving around the site attempting to identify the test location.

Investigation
The General Manager in charge of the COVID Test Site telephoned the complainant to apologise for the inconvenience and frustration caused in trying to locate the facility.

Outcome and Learning
Signage has since been erected.
The complainant was happy with this and agreed that the complaint was resolved.

Requirement for clear directional signage to individual HSE Services.