Your Service Your Say

Anonymised Feedback Learning Casebook

Quarter 2 2025

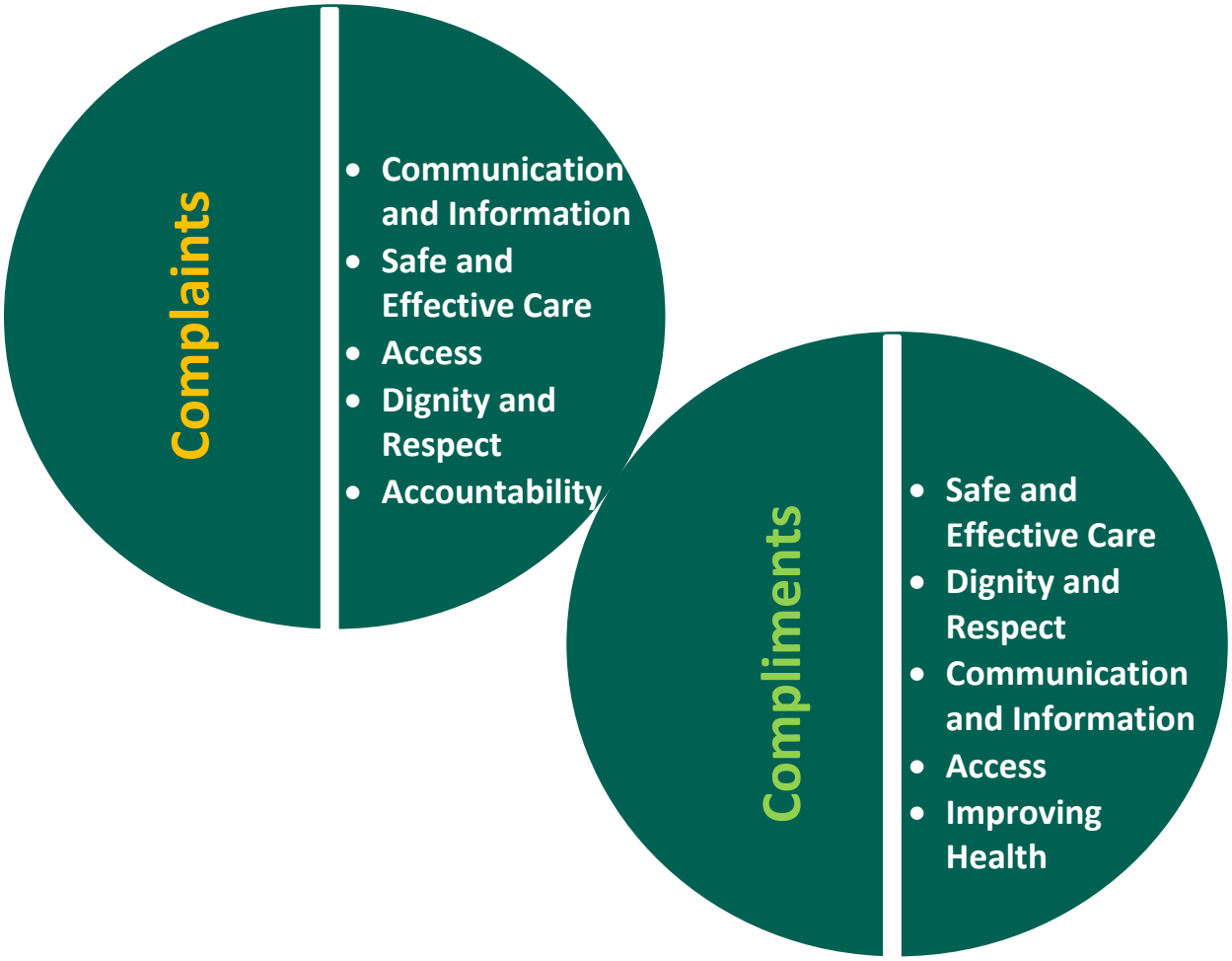
Introduction

Welcome to the quarter 2 edition of the 2025 national anonymised feedback learning casebook. The casebook presents a total of **18 cases** covering both complaints and compliments received by hospitals and community services.

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

The second quarter edition of the 2025 casebook features a total of **11 complaints**; 5 complaints from hospitals and 6 from community services that were investigated along with their outcomes. The casebook also features **7 compliments;** 5 from hospitals and 2 from community services that highlight the learning to be gained from positive patient and service user feedback.

Key Categories



Complaint Issues

Communication and Information

Communication and Information related primarily to delays and failures to communicate with patients, services users and their families. The complaints featured issues of patient requests not being communicated between services causing lack of communication with a parent and resulting in unnecessary upset to a child. Lack of updates on care or timely communication around changes in the condition of a patient to the family causing distress also feature. Lack of communication regarding delays in a scheduled diagnostic test caused an extremely prolonged, uncomfortable and unreasonable wait time in a facility. Failure to communicate in a timely manner the absence of a loved one from a residential care facility caused unnecessary upset to a family. Lack of communication regarding the status of an application caused uncertainty and frustration even though the services involved were in communication with each other during the process.

Issues under *Communication and Information* also concerned providing timely and accurate information from treating medical staff and to ensure that families are aware of the clinical terminology that might be used or recorded by medical staff even if providing layman explanations of the condition. Providing clear information around resources provided and explaining how these work, when these can be used and any limitations and to check understanding. To consider the diverse communication needs of a patient or service user and to ensure all options to enhance and support communication are considered.

Safe and Effective Care

Safe and Effective Care issues concerned the need for clear referral and onward treatment pathways between hospitals operating under treatment schemes to ensure appropriate follow up and management of a patient post procedure. Use of clinical terminology in healthcare records that are available to families when not previously explained or issues around abbreviations and legible handwriting on records impacting on legibility and understanding by all audiences featured.

Safe and Effective care issues also concerned the careful handling of a patient's private property. Health and safety issues related to ensuring the safety and security of residents in long stay facilities and better monitoring and reporting around absconsion.

Other complaint categories such as ***Access, Dignity & Respect*** **and** ***Accountability*** were also identified within the cases.

Access concerned visitation during COVID and the strict application of guidance without the consideration of the particular needs of the vulnerable patient and lack of consideration of a more nuanced approach based on compassionate grounds. Accessibility and Resource issues under *Access* related to access through the Emergency Department (ED) for immunocompromised oncology patients as well as lack of access to services when positions become vacant and the need to consider alternative means to ensure the provision and continuity of service.

Dignity and Respect concerned respectful interactions and providing a respectful space / environment for a person in active end of life. *Accountability* related to the timing around the issuing of invoices especially following a bereavement.

Compliment Categories

Safe and Effective Care

Safe and Effective Care concerned the quality of the treatment and care provided by staff which was appreciated by a service user and which reassured staff as to the level of care delivered and reinforced good practice. Treatment and care was also highlighted by a parent whose child was undergoing a procedure and praised staff for the great care they showed to the patient and for being supportive and understanding towards the parent.

Dignity and Respect

Dignity and Respect concerned the delivery of care and the difference it made when care was delivered holistically, taking into account individual and family needs as well as with compassion and understanding to provide a reassuring and positive experience.

Communication and Information

Communication and Information related to staff taking the time to introduce themselves, using new communication aids as part of a patient partnership quality improvement initiative that helped to assist patients and families to know what to expect and who they would be dealing with. In addition clinical handovers were conducted in the presence of the family so everyone was kept informed and felt involved in the care being provided. This was very reassuring to the family and contributed to the positive experience.

Other categories of positive feedback featured are ***Access*** and ***Improving Health***. Access related to a new initiative, the Purple Pathway, that was introduced to facilitate a more streamlined route through the Emergency Department (ED) and which was much welcomed by patients who praised the efficiency of the service as well as the knowledgeable, friendly caring and compassionate staff whom they encountered. Improving Health related to the dedication of staff in health promotion to empower and support people to quit smoking.

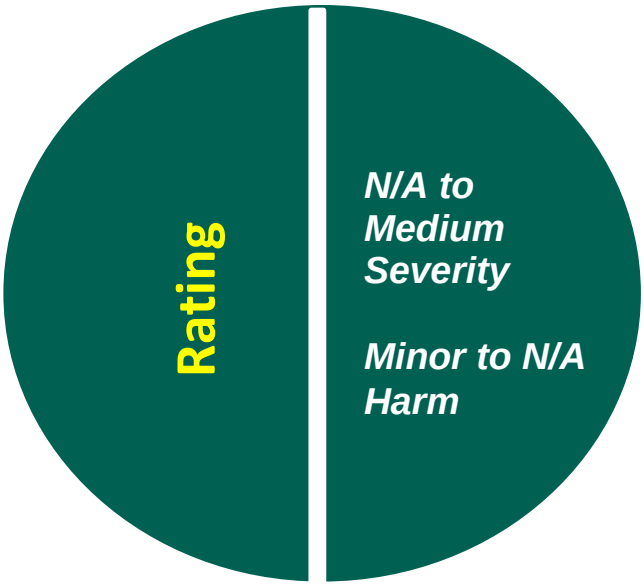
HCAT Classification

The Healthcare Complaints Audit Tool or HCAT is an innovative method of classifying complaints developed by the London School of Economics (LSE). HCAT, which has been tested for suitability within the Irish healthcare sector, offers an improved classification system that will support the identification of systemic issues and trends within services leading to improvements in healthcare delivery and ensuring high standards of quality and safety

By applying HCAT to complaints, it can assist services to identify 'hot spots' for harm, i.e. an area in care where harm occurs frequently, as well as 'blind spots', i.e. areas in care that are not easily observed.

HCAT is now a mandatory feature of complaints recording on the national Complaints Management System (CMS).

Where HCAT has been applied to the complaints presented in this casebook, the rating has been assessed as:



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

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

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

Hospital Services

Category: Communication and Information (*Delay and Failure to Communicate*)
HCAT Severity: N/A
HCAT Harm: N/A
Status: Upheld

Background to Complaint
The parent of a patient submitted a complaint raising concerns over the treatment their child received when attending for a procedure under general anaesthetic (GA). The patient had received a number of GA's in the past and had a history of becoming distressed upon waking in the recovery unit. The parent had therefore requested to be present with their child in the recovery unit so that they could be present when they awoke. While staff had assured the parent that they would be called before the patient woke up, on more than one occasion they arrived at the recovery unit and the patient was awake and very upset. On the most recent occurrence which led to the complaint, the parent's experience was that they could hear how upset the child was before they had even arrived at the recovery unit, and that their child had an episode of increased heartrate as a result of the stressful experience. The parent felt staff had repeatedly ignored their advice on what was best for their child, and that staff were not doing enough to protect their child's emotional wellbeing.

Investigation
The Complaints Officer brought the complaint to the attention of the Clinical Nurse Manager (CNM) of the Day Ward, and to the CNM of the Radiology unit who spoke with the staff involved on the day of the family's most recent experience. Staff on the ward had provided assurance that they do inform the recovery unit of parental requests, but on this occasion the message appears not to have been communicated. The CNM's identified an area of potential miscommunication between departments

Outcome/Learning
Staff sincerely apologised to the family and for the stress and upset caused to both patient and parent, they thanked them for their feedback which was used constructively to help improve services.

The CNMs worked on an initiative to improve communication and devised a document called "What Matters to Me", an additional attachment to patient files outlining when families have special requests. This would be trialled across three departments in the hope to alleviate and prevent any reoccurrence for parents and patients.

The complaint highlighted how a breakdown in communication between areas can result in a poor experience for both patient and parent. While staff have good intentions to pass on parental requests, the introduction of a new patient chart initiative to help document requests would help to ensure more optimal communication and in turn, a better service user experience.

Hospital Services

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

Background to Compliment
The parent of a young patient wrote to the hospital to highlight their positive experience regarding the handover process when their child was an inpatient.

Nature of Positive Feedback
The parent was impressed by how informative all staff they encountered were, how the Clinical Nurse Manager (CNM) introduced the nursing team and made sure the nurses received both parent and child's name. The compliment highlighted how a newly introduced information whiteboard in the patient's room encouraged both child and parent involvement in the care of the child. The utilisation of the whiteboard improved communication between healthcare staff and the parent and child, by clearly displaying things such as:

- The name of the patient's nurse,
- Who their treating doctor is,
- The patient's plan for the day,
- What matters to the patient,
- How the parent even featured on the board as the named person minding the patient

The parent wrote how involved they felt when nursing handover was carried out in the presence of parent and child, and how this process kept them informed of all their child's needs. The parent said '*Handover happened between nursing in front of us. I thought this was excellent. I have never been involved as much in my child's care*,' and even '*my six-year-old told their Dad the treatment plan from hearing it that morning*'.

Outcome and Learning
The complaints officer acknowledged the correspondence with the parents and thanked them for their very valuable and meaningful feedback. The feedback was brought to the attention of relevant staff.

On engaging with staff about the whiteboard, it was established that the CNM of the ward was leading out on a Quality Improvement (QI) project to improve communication between staff and families. The CNM had identified a gap in communication between healthcare professionals and parents, in which some parents were experiencing frustration at not being informed enough, which could potentially lead to an increase in complaints. The aim of the project was to improve communication between patients, their families, and healthcare professionals, and to place an emphasis on staff introducing themselves to patients and their families.

A whiteboard in each inpatient room includes the following information points and is updated every day for each patient.

- Hello my name is (patient name)
- My nurse
- My doctor
- My team (SLT, physio, dietitian, MSW etc.)
- Who looks after me (parent/guardian)
- Today I feel
- My plan today
- What matters to me
- What needs to be done to go home

The QI project included engaging with the hospital's patient advisory council before the pilot went live, and then again afterward. The CNM also engaged with a parental advisory group before the pilot went live and again for feedback after the pilot phase. The project received approval and funding to be piloted, and feedback to date has been positive. The results have been presented to the Nursing Executive Board, to the local Quality, Safety and Risk Management group and this project is currently being implemented in a number of clinical areas across the organisation.

The feedback highlighted how involving parents and children in their care can significantly improve the child and family experience during hospitalisation. In this case, parent and child both felt informed and involved. Improving the family experience in this way can reduce dissatisfaction in families, reduce complaints, develop trust, and also improve the experience of the healthcare professionals. In addition, it also showed the benefits of involving patients and caregivers in the early stages when developing QI projects.

Hospital Services

Category: Communication and Information (*Information*) (*Delay and Failure to Communicate*); Safe and Effective Care (*Health Care Records*)
HCAT Severity: N/A
HCAT Harm: N/A
Status: Partially Upheld

Background to Complaint
A family member of a recently deceased patient contacted the Complaints Office to express dissatisfaction regarding the information recorded on a death certificate. They reported that 'sepsis' was noted as the cause of death and stated that they had not been informed that the patient had sepsis during their admission. The family expressed dissatisfaction with communication from the medical team. Despite requesting updates during the patient's inpatient admission, they reported that no updates were provided. Additionally, the family raised concerns about the delay in releasing the deceased person's remains from the hospital to the undertaker.

Investigation
The complaint was investigated by the Medical Consultant and Intensive Care Unit (ICU) consultant with responsibility for the treatment and care of the deceased patient, the ICU Clinical Nurse Manager and the Assistant Director of Nursing.

The investigation concluded that the use of the term sepsis on the hospital's death notification form and subsequent death certificate was clinically appropriate in the circumstances. However, it was acknowledged that reading this term caused the family shock and distress, and an apology was offered for this.

During communication with the family, the ICU team had used more commonly understood terms and layperson language to describe the patient's condition and presence of severe infection and not the word sepsis.

The review of the patient's electronic records revealed that family members had received regular updates from the medical team. A short delay in releasing the deceased's remains was experienced, while the hospital waited for the coroner's decision regarding the requirement for a post-mortem examination. The patient's remains could not be released by the hospital to the undertakers while this decision was pending.

Outcome/Learning
A written response was provided to the complainant in which the patient's medical history and a detailed explanation of the treatment and care provided was outlined. Assurance was given that the treatment and care provided was appropriate.

An apology was provided to the family for the distress caused when they read the word 'sepsis' on the death certificate and it was acknowledged that alternative words were used to describe 'sepsis' during communication with family members, for ease of comprehension.

The response clarified that the delay in releasing the deceased's remains was a result of waiting for the coroner's decision, in accordance with policy.

This complaint highlights the importance of communication with family members and choice of language. While the team endeavoured to provide comprehensible information, not using the clinical term 'sepsis' resulted in concerns at a later time when that word was seen on official documents. Despite the provision of regular updates by the team the information needs of the family were not met.

Hospital Services

Category: Safe and Effective Care (*Continuity of Care*)
HCAT Severity: Low
HCAT Harm: Minimal
Status: Upheld

Background to Complaint
A patient was part of the Cross Border scheme for Ears Nose and Throat (ENT). The patient had their procedure carried out in the treating hospital but felt that the aftercare was not appropriate. The patient presented to their local Hospital with a bleed as they were advised to do so by the treating hospital. The local hospital then tried to transfer the patient to a larger tertiary hospital for follow up care but the tertiary hospital would not accept the patient. The patient was then admitted under the Medical Team of their local hospital.

Investigation
The complaints officer contacted the Director of Operations of the local hospital to ascertain the correct pathway for patients who experience post procedure complications carried out under the scheme.

Outcome/Learning
The local Hospital will be revisiting the ENT pathway with the larger tertiary Hospital with a view to avoiding such an issue in the future and ensuring that there is clear communication guidance and a definitive post care pathway for patients availing of the scheme.

Hospital Services

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

Background to Compliment
A patient underwent a procedure in the Endoscopy Unit and subsequently required surgery and admission to a surgical ward. Following their discharge, the patient provided feedback through HSE Your Service Your Say.

Nature of positive feedback
The patient acknowledged the excellent care they received from the time of their diagnosis to discharge following their surgery. They thanked the consultant the surgical team and every single staff member they engaged with during their health care journey.

Outcome and Learning
This compliment provided assurance to staff regarding patient satisfaction with the quality of care provided. Receiving compliments and words of thanks reinforces positive practice and can have a powerful impact on staff wellbeing.

Hospital Services

Category: Communication and Information (*Delay and Failure to Communicate*)
HCAT Severity: Low
HCAT Harm: Minimal
Status: Upheld

Background to Complaint
A patient at 29 weeks gestation was admitted with abdominal pain. The patient was monitored but was discharged as it was the weekend and advised to return Monday for an ultrasound scan. When the patient re-presented on Monday no scan was carried out. The scan was eventually carried out on Tuesday. The patient had remained in hospital for 24 hrs waiting for the scan. The patient expressed their dissatisfaction with the experience.

Investigation
The Clinical Nurse Manager (CNM) 3 contacted the patient and listened while they recounted their experience. The CNM apologised on behalf of the Service and reassured them that their experience would be shared with staff and improvements made. The patient was happy with this.

Outcome/Learning
The complaint was discussed at a multi-disciplinary team meeting.
Staff will attend communication training in the coming months to ensure appropriate communication with patients to keep them informed.

Hospital Services

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

Background to Compliment
A parent attended the Emergency Department with their daughter who was in extreme pain and after consultation with the Doctor on call it was advised to attend the hospital.

Nature of positive feedback
The parent wrote into the hospital after their experience and said that, '*from the moment we entered the hospital and from our first interaction with the porter, reception, triage nurse and then staff of the emergency department, we were dealt with swiftly and compassionately. The service was of such high standard.*

My daughter was assessed both by the surgical and gynaecology team. No stone was left unturned. My daughter was in the operating theatre within 7 hours. As a parent I highly compliment the nursing staff who were so supportive to me while my daughter was in surgery and the Surgeon who briefed me afterwards. Thankfully after a successful operation she was discharged the following day. My daughter has a diagnosis of Autism and although she didn't disclose this, the care and compassion shown by everyone made her experience and mine a very positive one.'

Outcome and Learning
The feedback was shared and discussed with the staff. Such positive feedback reinforces to staff how their interactions with patients and their families and the care and compassion shown, can make such a difference to a person's experience, particularly at such an anxious and stressful time.

Hospital Services

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

Background to Compliment
A parent attended a dental appointment with a follow up surgical procedure in the hospital with their child who has a diagnosis of Developmental Coordination Disorder (DCD) and struggles with new places and people and was terrified of the dentist after a very bad experience.

Nature of Positive Feedback
The parent wrote into the service after their experience and said when they attended the appointment the dentist and the nurse were fantastic with their child and were really calm and understanding and reassured them that everything was going to be okay. This really helped the child to relax. A follow up procedure was required the next day in the hospital to get some teeth removed. The parent said how their child was very scared as they didn't know what to expect and the procedure was going to be done under anaesthetic. On the morning of the procedure the parent explained how they meet the same nurse again and the dentist and that their child was so happy to see the nurse as she had gained the child's trust at the appointment. This really helped to settle their child. The nurse and dentist explained everything to the child.

In the theatre just before the child was placed under an anaesthetic, the parent stated how they were holding their child's hand when the dental nurse came up beside them and held their child's other hand and said not to worry that they would mind their child. The parent found this very reassuring and it made them feel so much better leaving their child to undergo the procedure.

The parent felt the need to write into the service to express how grateful they were for the service received and for the staff who went above and beyond to help them and their child.

Outcome and Learning
The positive feedback was shared and discussed with staff. The person centred and compassionate approach was highlighted as important in building trust and providing a reassuring and positive experience for patients and their families.

Hospital Services

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

Background to Compliment
A new initiative was introduced into the Hospital called the 'Purple Pathway'.
The Purple Pathway, created within the Emergency Department (ED), provides a protected space where Advanced Nurse Practitioners (ANP's) and an Emergency Doctor Registrar review patients with minor injuries and provide treatment.

The ANPs autonomously assess, diagnose, treat, prescribe and discharge an agreed set of patients with injuries, supported by clinical guidelines developed in collaboration with the Consultants in Emergency Medicine. Since its introduction, the service has grown significantly and more recently the ANPs introduced a new streaming service as part of a Quality Improvement initiative directing injured patients through a separate pathway once triaged, within the Purple Pathway with the aim to provide a more streamlined improved service in a dedicated area "The Injury Assessment and Treatment Area" within the ED.

Ireland has adopted a strong policy position in support of ANP's as essential contributors to a modern, efficient and patient centred healthcare system. The role is seen as centre to Sláintecare. Both the HSE and Department of Health support the development of these roles to enhance capacity, reduce wait times and improve patient access.

Nature of Positive Feedback
The Purple Pathway within the Hospital has garnered much support and praise from those who have been treated under this initiative.

Patients and their families who have been treated under this initiative submitted their feedback complimenting the care and treatment provided under this pathway.

'*I recently attended the ED with my child and was treated via the Purple Pathway- It was so efficient and we received excellent treatment and were triaged, seen and treated in a short period of time. My child was not exposed to the possibilities of a long visit to ED and equally we were in and not clogging the system for any longer than was required. We were treated in a friendly professional manner and would like to compliment this pathway but also (triage) and ANP for their excellent work'.*

'I am writing to express my sincere gratitude for the fantastic care my child received yesterday and in particular from the Purple Pathway team. Our ANP was amazing! So professional, knowledgeable, kind and compassionate. My child was very upset and nervous attending the emergency department but was so well looked after and we could not have got better care. It was such a relief to get fast tracked out of the main ED department and into the Purple pathway. It really is such a valuable service and we both can't thank you enough for such great care!'

'My parent had to go to the ED on Sunday afternoon due to an ongoing issue. They were seen by a doctor in the ED through the purple pathway. All the staff in the purple pathway were efficient and excellent and so kind and professional when dealing with my parent. The Doctor explained in a simple yet comprehensive way what was going to happen and what further treatment may be required. The Doctor's knowledge and bed side manner are a credit to them.'

Outcome and Learning
This initiative within the Hospital is addressing long wait times, providing safe, effective and efficient care, responding to challenging capacity issues and is very positively received and appreciated by service users. It is changing the long established negative narrative and perception of long wait times and inefficient care. It is delivering a better patient experience and also providing value for money.

Hospital Services

Category: Access (*Accessibility and Resources*) (*Visiting Times*); Communication and Information *(Information*) (*Diverse Needs*)
HCAT Severity: N/A
HCAT Harm: N/A
Status: Partially Upheld

Background to Complaint
A complaint was received from the parents of their adult child who had passed away (RIP) following treatment for cancer received at the Hospital during the COVID pandemic. The parents lodged a complex and multifaceted complaint, but following receipt of the investigation report expressed dissatisfaction with both the investigation and its findings.

The complaint related to the care and treatment of the patient, their child, RIP, who had a registered disability together with a significant hearing impairment.

The parents contacted the Consumer Services Department of the Hospital to outline their dissatisfaction with the investigation report relaying that they had requested an independent review as they felt that the Stage 2 investigation undertaken by the Consumer Services Department at the hospital indicated a conflict of interest.

Investigation:
An internal review under Stage 3 of the Your Service Your Say process was conducted.

All clinical staff relevant to the complaint were interviewed where possible and clinical and administrative records reviewed. However, due to the time lapse and subsequent staff movement, there were limitations to the investigation. Additionally as some staff names were not provided, it was not possible to identify particular staff members.

Outcome and Learning
The review made a number of findings and recommendations with learning for the Hospital.

- The impact of pandemic visitation restrictions on patients and their families cannot be underestimated. The Hospital adhered to the National Guidance which was reviewed and updated daily at the COVID management meetings. Decisions around visiting were based on the levels of COVID within both the hospital and the community. However, compassionate visitation was facilitated on a case by case basis at the time. Given the vulnerabilities of this adult child which were further complicated by their communication deficits, there should have been more person centred considerations to facilitate family visitation based on compassionate grounds.

In recognition of the difficulties experienced by patients and families during the pandemic, the Hospital updated their visiting policy to incorporate the principles of John's Campaign[1].

John's Campaign allows hospitals to demonstrate an ethos of care and compassion visibly and tangibly. Incorporating John's Campaign ensures that the Hospital is advocating for those in its community who find it hard to cope in unfamiliar situations. Welcoming carers, ensures we recognise that they are experts in their loved one's needs. The Hospital has shaped its visiting policy to advocate for patients who often do not have the power to lend their voices to the debate and dialogue around hospital visitation rights. John's Campaign envelops patient and family-centred models of care. It recognises patient carers as partners in care, well versed in their loved one's medical history and with the potential to assist with medical decision-making and discharge planning. The Hospital recognises and welcomes carers and by adopting John's Campaign, it demonstrates a commitment to protect and care for those who are often less likely to speak up for themselves.

- On review of the Nursing notes the patient was assessed using the Modified Roper, Logan and Tierney Nursing Assessment Tool. In these assessments, the patient's hearing impairment was documented. It was noted that the patient had their hearing aid with them on admission. A communication care plan was developed to meet the patient's communication needs due to their hearing impairment. In none of these assessments was the requirement for an interpreter documented.

  Following discussion with the Infection Prevention and Control team, at the time there were no masks available that met the infection prevention and control specifications and that also had a clear pane to allow for lip reading.

  Face masks that meet the appropriate specification with a clear panel for lip reading for people who have hearing difficulties to be sourced. It is clear from the Nursing assessments that the patient had a hearing impairment requiring the use of a hearing aid, however the care plan does not reflect if an interpreter was considered. The Nursing Assessment and Care plan procedure document has been updated. The Hospital has implemented the John's Campaign as outlined above. This would have ensured that the parents of the patient would have been part of their care and supported with any requirements.

[1] John's Campaign is a UK-based initiative supported by the HSE in Ireland, focused on ensuring that the presence and knowledge of family carers are integrated into the care of individuals with dementia and other complex needs in healthcare settings. This campaign advocates for the right of carers to stay with their loved ones, even outside of standard visiting hours, to provide essential support and familiarity, particularly for those with cognitive impairment or communication difficulties.

- The Hospital uniform and work dress code policy was also reviewed in relation to the difficulty experienced by the family in identifying staff and their particular discipline when interacting with them.

  The hospital attaches high importance to ensuring that all employees project a professional and respectful image in keeping with public expectation of health and social care staff by clearly outlining the code of dress. This includes the requirement for staff to wear clear identifiers such as identity badges. However, during the COVID 19 pandemic, due to Infection Prevention and Control requirements, staff were provided with scrub suits which impacted on the proper identification of staff and their discipline.

  Although normal regulations in relation to wearing of uniforms has now resumed post the COVID 19 pandemic, the Hospital has rolled out new staff name (lapel) badges to ensure consistency and ease of identification. This badge has been designed in line with easy read guidance.

  It has been further recommended that signage highlighting each uniform and which staff discipline this represents to be prominently displayed throughout the hospital as part of the new updated uniform and work dress code policy

  The Hospital has also implemented the "*Hello, My Name is*" Policy and has also updated their patient information book that includes information in relation to staff uniforms and how to identify staff by their uniform.

- The patient was provided with an alert card. The alert (red) card is given to all patients on chemotherapy. It is an alert card containing a patient's chemotherapy regime, hospital number, a few things to look out for as well as the numbers to contact if feeling unwell. It has the acute oncology/haematology triage Clinical Nurse Specialist number and the Haematology/ Oncology ward number. The usual practice is if the person phones between 08:00-17:30 they will speak to the Triage nurse (out of hours they contact the ward), and a triage sheet is completed. If, based on the assessment, it is deemed necessary, the person is advised to attend the Emergency Department (ED). The Oncology Nursing staff contact the ED and the Nurse in Charge informs them that an oncology/haematology patient is presenting. The ED will perform their own triage based on their clinical assessment and refer to the medical team on call.

  The family were of the understanding that this alert card would assist them with being fast tracked through the Emergency Department (ED) on the grounds of their adult child's immunocompromised status.

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  However, this card is not for the purposes of fast tracking oncology patients through the ED and is not an access card.

  Although processes were appropriately followed in this case, the use of the word Triage on the alert card may be misconstrued as having an impact on decision making around Emergency Department Triage.

  It was recommended that Oncology staff communicate the specific purpose of the alert card when it is being used.

- The issue of the perceived lack of impartiality and conflict of interest of Hospital site Complaints Officers investigating their own complaints was also cited in the Review request.

  Reassurance was provided that persons investigating and reviewing complaints under the HSE Your Service Your Say policy are appointed Complaints Officers and Review Officers under Part 9 of the Health Act 2004, section 49(1) (a) and under S.I No. 652/2006 of the Health Act 2004 (Complaints) Regulations 2006 regulation 5(3) and are independent in the exercise of their function. Additionally, complainants may also seek further external and independent examination of their complaint from the Office of the Ombudsman or Ombudsman for Children as appropriate.

Community Services

Category: Safe and Effective Care (*Patient Property*)
HCAT Severity: Low
HCAT Harm: N/A
Status: Upheld

Background to Complaint
A service user living in a long stay mental health unit contacted the Complaints Officer regarding the loss of their belongings valued at €250 which they allege was lost/removed by staff following their transfer of accommodation due to onsite works being undertaken in the unit.

Investigation
The Complaints Officer undertook an investigation into the matter raised and liaised with the Assistant Director of Nursing, unit staff and the Area Financial Accountant. It was acknowledged that on the balance of probability that the service user's belongings may have been inadvertently removed from service user's room as part of a general clear out within the unit during the period when onsite works were being completed by an external contractor.

While there was no receipt available to validate the cost of the belongings, the Unit staff visited the shop where the items were purchased and obtained a duplicate receipt.

Outcome and Learning
The Complaints Officer issued a formal apology to the service user tor the upset and distress caused and arranged for reimbursement of the cost of the items in full. The Assistant Director of Nursing undertook to ensure that in future staff would be more vigilant with service users' belongings.

Community Services

Category: Dignity and Respect (*Alleged Inappropriate Behaviour*)
HCAT Severity: Low
HCAT Harm: Minimal
Status: Upheld

Background to Complaint
A complaint was made in relation to the reception staff at in one of the local community services. The complainant advised that the receptionist was being repeatedly rude and disrespectful to them. The behaviour has made the complainant lose trust in the service.

Investigation
The Complaints Officer made contact with the service user to clarify the service being referred to. Once this information was received the Complaints Officer conducted a formal investigation and engaged with the service and the staff member's line manager. The line manager spoke with the staff member about the complaint who acknowledged the issue and offered a sincere apology.

Outcome and Learning
The staff member took responsibility for their behaviour and offered a sincere apology for the upset caused. The staff member attended additional training around dignity and respect to promote positive engagement and reduce the likelihood of this situation occurring again.

The Complaints Officer followed up with complainant to confirm and ensure that their experience had improved.

The commitment to respectful communications and respecting a person's dignity is central to our ethos and practices when delivery our services.

Community Services

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

Background to Compliment
Family of service user was very complimentary of a Public Health Nurse in one of the Primary Care Health Centres in relation to the care and support given to their parent in their own home to the extended family.

Nature of Positive Feedback
The family thanked and praised the Public Health Nurse for the dignity and respect shown to their parent during such a vulnerable time in their life. The family also noted the lovely bond and meaningful connection that their parent developed with the Public Health Nurse which provided both the parent and the family with much comfort.

Outcome and Learning
The feedback was shared with the Public Health Nurse who was delighted to know that their care and attention was a source of comfort to their patient and to the wider family.

This valuable feedback highlights the vital role of public health nurses in the community. It demonstrates the importance of one-to-one care, especially in the comfort and privacy of a person's home. The nursing role is often demanding yet this PHN, who took the time to ensure that the service user was involved in their own care, showed empathy and most of all kindness to this service user building a trusting and caring patient–carer relationship.

Sharing feedback like this is important as it affirms the hard work and dedication of public health nurses and healthcare providers, reminding them that their compassion and commitment are truly valued and appreciated across their communities.

Community Services

Category: Communication and Information (*Delay and Failure to Communicate*); Safe and Effective Care (*Health and Safety Issues*)
HCAT Severity: Low
HCAT Harm: N/A
Status: Upheld

Background to Complaint
The service user went absent from a unit. The service user's daughter received a phone call from their parent saying that they were on their way home.

The service user's daughter, who was the next of kin, was upset as they were not informed by staff that their family member had left the premises. In addition, when they contacted the unit, the family were incorrectly informed that the person was on the premises when in fact they were not.

A complaint was submitted raising concerns about safety, risk management, and the delay in being updated.

Investigation
The Complaints Officer conducted a thorough investigation and identified key Issues:

Patient Safety & Risk:
- Failure to prevent a resident from leaving the premises without staff knowledge.

Communication Breakdown:
- The daughter was not promptly informed, despite being listed as the primary contact.

Inconsistent Procedures:
- Gaps in adherence to local protocols for missing patient alerts and family notification timelines.

Investigation Findings:
- The patient exited through an unsecured front gate. While the clinical team focused on locating the patient and contacting An Garda Síochána, they did not delegate communication responsibilities and so family communication was overlooked and did not happen. Contact details for the next of kin were recorded and easily accessible in the file.

Outcome and Learning
A written apology was issued to the complainant acknowledging the delay and distress caused. In addition, a face to face meeting was offered to discuss and rebuild trust.

Following the complaint and its investigation a number of improvements have resulted:

Improved Communication Protocols
- Local Guideline drafted and saved on staff shared folder and safety folder on the units
- A clear communication flow chart/Standard Operating procedure (SOP) developed to assign responsibility for contacting the family contact/next of kin within 30 minutes of a patient absconding.

Access to Contact Information
- All staff are aware as to the location of family/next of kin contact information via the patient file.

Security Review:
- Physical security of all exits reviewed.
- A business case has been submitted for funding for an external secure outdoor recreational space for patients.

Staff Training:
- Refresher training is planned for all unit staff on missing person protocol, risk stratification, and compassionate communication with families.

This case reinforced the importance of balancing clinical priorities with compassionate family engagement, the need for role clarity in crisis situations as well as ensuring that patient safety is embedded within daily operational culture.

Community Services

Category: Access (*Accessibility / Resources*); Communication and Information (*Information*)
HCAT Severity: Medium
HCAT Harm: Minor
Status: Upheld

Background to Complaint
A child availing of a Children's Disability Network Team (CDNT) service had no access to the necessary speech & language support when service was in place. An Augmentative and Alternative Communication (ACC) Device was recommended and provided by CDNT. However the Speech & Language Therapist left their post which resulted in there being no access to training with a speech therapist for parents or teachers in the school around the use of the device to support the child's development.

After a significant wait a new therapist joined the team but unfortunately had to take unexpected leave. The service was cancelled again at short notice and the parents complained that this was totally unacceptable and felt that there were being given excuse after excuse by the service. They were extremely distressed by the years of waiting for support that was essential for their child's development and even when the speech and language therapy (SLT) service finally commenced with CDNT after a long wait, the post became vacant once again causing a further delay in service.

Investigation
On investigation this child and their parents had been looking for an SLT support service for a number of years and had complained regularly through all routes to the HSE. The investigation also found that there was also a lack of regular communication between the service and the family.

It was established that all SLT posts on the CDNT are currently vacant. While waiting for the vacant posts to be permanently filled the service is currently in negotiations regarding the acquiring of agency staff with the specialised experience to provide the necessary support for a child using an ACC device to join the CDNT team.

Outcome/Learning
A private speech therapist was acquired by the CDNT and this was communicated to the Parents. The CDNT Manager engaged with the parents to address any outstanding issues in relation to the delivery of the service. An apology for the distress and upset caused by the delays and cancellations in service was provided to the family.

The feedback highlighted the importance of communication and collaborative engagement between family and service. The requirement to explore other means of delivering a service was identified as was the necessity for a protocol for the escalation of issues such as resource issues that directly impact a child's development and care. The resolution of the complaint demonstrated how essential collaboration between services is to deliver a positive outcome.

Community Services

Category: Communication and Information (*Delay and Failure to Communicate*), Dignity and Respect (*End of Life Care*), Safe and Effective Care (*Healthcare Records*), Accountability (*Finance*)
HCAT Severity: N/A
HCAT Harm: N/A
Status: Partially Upheld

Background to Complaint
A complex complaint was received in relation to a residential unit for older persons.

The complaint was made by a resident's family. There were a number of elements to the complaint relating to the level of care that the resident received, concerning:

- End of life care in a noisy environment
- Delay in moving the resident to a single room
- Errors on the death notification certificate
- Invoice sent at an inappropriate time
- Delay in conducting meetings
- Communication with the family

Investigation
The complaint was investigated by a Complaints Officer under Stage 2 of the Your Service Your Say policy. Four elements of the complaint were upheld. This concerned the elements around communication, movement to a single room, delay in conducting one meeting, and errors on the death notification certificate.

The investigation included a review of the resident's care notes as well as conducting interviews with relevant staff such as the Director of Nursing, the Medical Registrar, Administration and Nursing staff. Discussions were also held with the complainants, the resident's family.

Outcome and Learning
Following completion of the investigation, recommendations were made and an action plan has been forwarded to the Resident's family (the complainants), by the Head of Service for Older Persons.

It was recommended that a learning notice be issued to nursing staff and medical staff to record communications to family members in relation to the care of the deteriorating patient in the patient case notes to ensure family members are contacted when a patient enters a phase of active end of life care.

It was also recommended that a local standard operating policy should be developed and implemented to prioritise, where possible, the availability of a quiet space for a patient who is at active end of life stage, and to communicate to nursing managers to support the policy.

The Complaints Officer further recommended that a standard operating policy is created for Community Nursing Units to determine a timeline for the issue of Residential Support Services Maintenance and Accommodation Contribution (RSSMAC) invoices to the legal representatives of a patient who has died, with consideration for grieving families.

The Complaints Officer also recommended that a communication is issued to medical staff in relation to the completion of death notification forms outlining that abbreviations are not permitted. If written, the hand writing must be legible. The Complaints Officer further recommended that death notification paperwork is checked by relevant staff prior to release to families.

The Complaints Officer did note in their report that, '*while it is recognised that there is learning around communications in the care of a deteriorating patient, appropriate actions were taken in caring for the resident once the end of life care plan was implemented. It is noted that the resident's wishes for a blessing from a priest were carried out, and that staff did their best to provide palliative care in a rehab setting and to provide comfort to the family members'*.

The recommendations are currently in the process of being implemented.

Community Services

Category: Communication and Information (*Delay and Failure to Communicate*)
HCAT Severity: Low
HCAT Harm: N/A
Status: Upheld

Background to Complaint
An application was made for day-service provision from a family. The HSE Disability Services Officer (DSO) assessed the applicant in their home and subsequently made a referral to a suitable independent provider. That referral was accepted and the provider then prepared a business case for funding that was submitted for approval to Day Services Team Finance Meetings (DSTFM).

After a time the parent contacted the service complaining about delays in communication and updates in relation to that application.

Investigation
At the time of the complaint, the business case was still being processed through the list of submissions by the DSTFM, and had not yet been approved. The parent complained about the lack of communication and update by the Disability Services Officer (DSO).

On examination of the information it was established that the service user was also already engaged with community Mental Health Services (MHS) and had been assigned a Social Worker.

In that context there were three parties with potential responsibility for communicating information to the service user and their family; the representative of the independent provider, the DSO and the MHS Social Worker.

In this instance it became apparent that, while these parties were engaging with each other around updates and information, a point of communication for update had not been clearly identified to the parent.

While there was communication and updates from the representative of the independent provider, the parent also expected updates from the DSO and complained that these were not being provided.

Outcome and Learning
The Complaints Officer identified these circumstances, upheld the complaint about delay and provided an apology as appropriate to the parent for the lack of clarity on communication.

In terms of learning it was acknowledged that information about the lines of communication was important to ensure effective contact with the service user and their family and to manage their expectations and understanding of process.

To that end the representative of the independent provider was identified to the parent as the relevant point of contact for the provision of information on access to the day service support. A communication protocol has also since been incorporated into the Disability Day Service Referral Standard Operating Procedure (SOP).

Community Services

Category: Improving Health (*Empowerment*)
Status: Compliment

Background to Compliment
Service user wrote into the their local Health Promotion and Improvement Office after having listened to RTE Radio One's Live Line programme and hearing first hand from numerous members of the public about the HSE's QUIT programme and after their own experience.

Nature of Positive Feedback
The Service User wanted to congratulate all the staff delivering a truly wonderful stop smoking service. The service user wanted to thank and acknowledge staff for going above and beyond, supporting engagement and offering professional support to those wishing to quit smoking. The service user highlighted how they had listened to the stories from older people who proved that it was never too late to try and quit.

Outcome and Learning
The feedback was shared with staff and they were delighted to know that their efforts were having a positive impact on lives and that they were helping people to successfully quit smoking. The feedback motivated staff to continue their work helping and supporting people to stop smoking.